Australian Government
Department of Health

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An Australian Government Initiative

Local Primary Healthcare Protocol

1. PARTIES

This Local Primary Healthcare Protocol is signed on the 9th day of December 2020 between:

Mackay Hospital and Health Service (**MHHS**)

And

Northern Queensland Primary Health Network (**NQPHN**)

2. BACKGROUND

2.1. This Local Primary Healthcare Protocol (**Protocol**) describes the relationship between MHHS and NQPHN (the **Parties**) to ensure the effective coordination and integration between healthcare providers in improving service delivery and health outcomes.

2.2. This Protocol is established pursuant to the prescribed requirements set out in the *Hospital and Health Boards Act 2011* (Qld), *Hospital and Health Board Regulation 2012* (Qld) and *National Health Reform Agreement*.

2.3. The Parties agree this Protocol does not create any legal relations between them. However, the matters set out in this Protocol are agreed to in principle by the Parties.

2.4. MHHS is an independent statutory body overseen by an appointed Hospital and Health Board, established on 1 July 2012. The responsibilities of the MHHS are set out in the *Hospital and Health Boards Act 2011* (Qld) and the *Financial Accountability Act 2009* (Qld) and subordinate legislation. MHHS operates according to the service agreement with the Department of Health which outlines the services to be provided, the funding arrangements and our performance indicators and targets.

2.5. NQPHN is an independent, not-for-profit organisation funded by the Australian Government to commission services to meet the health needs and priorities of the region. The NQPHN is overseen by a Board of Directors and has several member organisations (including MHHS). The NQPHN aims to improve health outcomes by working with GPs, pharmacists, dentists, nurses, allied health professionals, organisations specialising in chronic disease management, health promotion, aged care, mental health, and Aboriginal and Torres Strait Islander health – as well as secondary care providers, hospitals, and the wider community.

3. PURPOSE

3.1. The purpose of this Protocol is to:

(a) Support and promote cooperation between the Parties in the design, planning, improvement and delivery of health services;
(b) Outline how the Parties together will act and work in collaboration such that there is shared responsibility, accountability and decision-making to meet the Joint Objectives of the Parties;
(c) Provide context and guidance to a range of initiatives that continue to be developed between the Parties; and
(d) Improve the health outcomes of the community of Northern Queensland.

4. TERMS OF AGREEMENT

4.1. The term of this Protocol will be from 1 July 2020 and shall continue for a period of three years unless amended in accordance with this Protocol.

4.2. This Protocol will be jointly reviewed by both Parties within three years of its commencement.

4.3. Subject to the joint review of this Protocol, the Parties may agree to extend the term of this Protocol for an additional three years.

5. PRINCIPLES

5.1. The foundation of this Protocol is a commitment by both parties to act in good faith using best available evidence to reach consensus decisions on the basis of 'best for patient, best for system'.

5.2. The Parties will:

(a) Support clinical leadership, and in particular evidence-based service delivery;
(b) Conduct ourselves with honesty and integrity, and maintain a high degree of trust;
(c) Promote an environment of high quality, performance and accountability, and low bureaucracy;
(d) Strive to resolve disagreements co-operatively and wherever possible achieve consensus decisions;
(e) Adopt a patient-centred, whole-of-system approach and make decisions on a 'best for health outcomes' basis;
(f) Seek to use our collective finite resources as efficiently and effectively as possible in planning health services to achieve improved health outcomes for our populations;
(g) Balance a focus on the highest priority needs in our communities, while ensuring appropriate care across all our rural, remote and urban populations;
(h) Adopt and foster an open and transparent approach to sharing information; and
(i) Actively monitor and report on our alliance achievements, including public reporting.

5.3. The Parties are committed to working wherever possible and practical with each other as well as the national and state governments, other health service providers, and the community on matters and issues of common concern and interest.

6. JOINT OBJECTIVES

6.1. The Parties will work together to:

(a) Monitor the outcomes of initiatives and use that information to inform our stakeholders and to guide further decisions on prioritisation and service change.

(b) Develop arrangements for sharing health information data, staff, resources and allowing access to facilities and information management systems.
(c) Ensuring that technology and other eHealth solutions are designed and used with integrating the health system in mind to improve health outcomes, including the national My Health Record.
(d) Working together to simplify funding arrangements for the health system as a whole including governance arrangements.
(e) Ensure that health services address the needs of disadvantaged and at-risk groups, including Aboriginal and Torres Strait Islander people.
(f) Improving patient flows across neighbouring boundaries between services, including Hospital and Health Services.
(g) Develop a process for how our alliance will annually review its scope and objectives, to keep refreshing our strategy and approach to meet our objectives.
(h) Enhance service access and create an integrated, seamlessly coordinated health system across the health continuum.
(i) Identify, analyse and develop agreed priorities for local health needs, inform joint planning and policy imperatives.
(j) Meet performance requirements as articulated by the *National Health Performance Authority*.
(k) Influence and reform those areas of the health system for which they have responsibility.
(l) Ensure care is delivered in the right place at the right time by and to the right people.

7. KEY PRIORITY AREAS

7.1. The Key Priority Areas agreed to under this Protocol should have regards to the:
(a) *National Health Performance Authority*;
(b) *Hospital and Health Boards Act 2011* (Qld) and *Hospital and Health Boards Regulation 2012* (Qld);
(c) Strategic Plans of the Parties;
(d) Better Health NQ Master Plan;
(e) MHHS's Employee Engagement Strategy and Consumer and Community Engagement Strategy;
(f) Australian Department of Health Primary Healthcare Network Guidelines;
(g) Australian Department of Health Primary Healthcare Network Program and Performance Quality Framework;
(h) NQPHN Strategic Investment Framework;
(i) NQPHN Engagement Strategy;
(j) NQPHN Health Outcomes Framework; and
(k) NQPHN Health Needs Assessments.

7.2. It is agreed that the Key Priority Areas of the Parties during the term of this Protocol include:
(a) improving continuity of care and transitions for patients moving between primary care and hospital settings;
(b) improving care coordination, particularly for the most complex patients;
(c) increasing the capacity and capability of the primary care sector;
(d) progressing detailed service and workforce planning, including potentially co-designed, co-developed and co-funded services;
(e) improving health literacy throughout the community;
(f) developing an integrated approach to chronic disease management; and
(l) PHN priority health areas:
    i. Mental Health & Alcohol and other Drugs treatments
    ii. Aged Care

iii. Chronic Disease
iv. Aboriginal and Torres Strait Islander Health
v. Workforce
vi. Digital
vii. Population Health

8. RESPONSIBILITIES OF PARTIES

8.1. The Parties recognise that communication is an integral component in ensuring the success of the Protocol. The Parties will meet on no less than a quarterly basis at Chief Executive (or delegate) level to discuss issues, strategies and progress priorities.

8.2. The Parties agree that the NQPHN will be responsible for monitoring and reporting against the effectiveness of the Protocol particularly in relation to achieving the Priorities.

8.3. A summary of the key issues discussed, and decisions made in each Party's Board meeting relevant to the Protocol will be made available to the other party, subject to the relevant Party's obligations of confidentiality and privacy.

9. GENERAL CONSIDERATIONS

9.1. Cooperative Arrangements

Initiatives developed for the Key Priority Areas outlined in clause 7.2 should be informed by input from clinicians, consumer, stakeholders and community engagement. In addition, initiatives will be informed by input from cooperative arrangements with other entities delivering services in the health, aged care and disability sectors to improve service delivery and health outcomes.

9.2. Governance

(a) The Chief Executives and Boards of the respective Parties hold joint responsibility for the endorsement and any amendment of this Protocol. Chief Executives and the executive leadership teams of the respective Parties will be the accountable officers responsible for the promotion, implementation and carriage of the Protocol.

(b) Each Party is to nominate a key contact person to act as a single point of reference and coordination for matters related to this Protocol. The person will also be responsible for:
   i. Coordinating their respective organisations involvement in the Protocol;
   ii. Ensuring proposed joint initiatives match agreed strategic direction and priorities;
   iii. Establishing new initiatives under the Protocol and ascertaining the type of working arrangement that will support it; and
   iv. Reporting.

9.3. Public Reporting

This Protocol and any revisions of this Protocol will be published in such a way that is accessible to members of the public.

9.4. Media

Media statements relating to this Protocol will be agreed to by both Parties prior to issue.

9.5. Conflicts of Interest

(a) Each Party needs to be aware of and actively manage any perceived or real conflicts of interest in relation to their staff participating in initiatives relating to this Protocol.

(b) A conflict of interest involves a conflict between official duties and private interests which could improperly influence the performance of official duties and responsibilities. A reasonable perception of a conflict of interest is where a fair-minded person, properly informed as to the nature of the interests held by the decision maker, might reasonably perceive that the decision maker might be influenced in the performance of his or her official duties and responsibilities.
(c) A conflict of interest may be real (actual or potential) or perceived. It can be pecuniary (involving financial gain or loss), or non-pecuniary (based on enmity or amity) and can arise from avoiding personal losses as well as gaining personal advantage, financial or otherwise.
(d) Conflict of interest includes conflict of commitment (where an individual has multiple and incompatible public duties).
(e) Both Parties are responsible for:
    i. Assessing their own private and personal interests and whether they conflict or have the potential to conflict;
    ii. Disclosing and managing any real (actual or potential) or perceived conflicts of interest, including reviewing disclosed conflicts on at least an annual basis to ensure that the information remains correct and that the management responses continue to be appropriate and effective; and
    iii. Not making decisions or seeking to influence the decisions of others in matters relating to an individual's private interest.

9.6. Privacy and Confidentiality

Shared information marked as confidential or regarded as commercial in confidence, clinically confidential or has privacy implications will be treated accordingly by either Party.

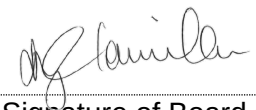
9.7. Intellectual Property

The resources and content developed as result of joint initiatives under this Protocol should reflect the involvement of both Parties. This would include use of the two corporate logos in the publication of paper based and electronic documents.

9.8. Dispute Resolution

In keeping with the intent of the Protocol, matters on which there are divergent views will be addressed with goodwill and in a respectful and courteous manner. Direct, localised negotiation should be used in the first instance to resolve any issues. If this is not possible, the issue should be escalated to the Party's named contact person. An independent mediator may be introduced if a matter is unable to be resolved after negotiation.

SIGNED by Mackay Hospital and Health Service on the 9th of December 2020:



Darryl Camilleri

Name of Board Chair (print) | Signature of Board Chair

SIGNED by Northern Queensland Primary Health Network on the 8th of December 2020:

Nicholas Loukas

Name of Board Chair (print) | Signature of Board Chair