Gold Coast Hospital and Health Service

Service Agreement

2016/2017 – 2018/2019

April 2019 Revision

Queensland Government

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Service Agreement 2016/17 - 2018/19 April 2019 Revision

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An electronic version of this document is available at www.health.qld.gov.au/system-governance/health-system/managing/default.asp

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1. Introduction

A Queensland Health is committed to strengthening performance and improving services and programs that will better meet the needs of the community.

B The development of Service Agreements between the Chief Executive, Department of Health and Hospital and Health Services (HHSs), assists this process by formally assigning accountability for the high level outcomes and targets to be met during the period to which the Service Agreement relates.

C The content and process for the preparation of this Service Agreement is consistent with the requirements of the *Hospital and Health Boards Act 2011*. Key elements of this Service Agreement include the services to be provided by the HHS; funding provided to the HHS for the provision of these services; performance indicators; data reporting requirements and other obligations of the parties.

D Fundamental to the success of this Agreement is a strong collaboration between the HHS and its Board and the Department of Health. This collaboration is supported through Performance Review Meetings attended by representatives from both the HHS and the Department of Health which provide the routine forum within which a range of aspects of HHS (and system wide) performance are discussed and jointly addressed.

2. Interpretation

Unless expressed to the contrary, in this Service Agreement:

(a) words in the singular include the plural and vice versa;

(b) any gender includes the other genders;

(c) if a word or phrase is defined its other grammatical forms have corresponding meanings;

(d) “includes” and “including” are not terms of limitation;

(e) no rule of construction will apply to a clause to the disadvantage of a Party merely because that Party put forward the clause or would otherwise benefit from it;

(f) a reference to:

i. a Party is a reference to a Party to this Service Agreement;

ii. a person includes a partnership, joint venture, unincorporated association, corporation and a government or statutory body or authority;

iii. a person includes the person’s legal personal representatives, successors, assigns and persons substituted by novation;

(g) any legislation includes subordinate legislation under it and includes that legislation and subordinate legislation as modified or replaced;

(h) a reference to a role, function or organisational unit is deemed to transfer to an equivalent successor role, function or organisational unit in the event of organisational change or restructure in either Party;

(i) an obligation includes a warranty or representation and a reference to a failure to comply with an obligation includes a breach of warranty or representation;

(j) headings do not affect the interpretation of this Service Agreement;

(k) unless the contrary intention appears, a reference to a Schedule, annexure or attachment is a reference to a Schedule, annexure or attachment to this Service Agreement; and

(l) unless the contrary intention appears, words in the Service Agreement that are defined in Schedule 6 'Definitions' have the meaning given to them in that Schedule.

3. Legislative and regulatory framework

3.1. This Service Agreement is regulated by the National Health Reform Agreement and the provisions of the *Hospital and Health Boards Act 2011.*

3.2. The National Health Reform Agreement requires the State of Queensland to establish Service Agreements with each HHS for the purchasing of health services and to implement a performance and accountability framework including processes for remediation of poor performance. The *Hospital and Health Boards Act 2011* states under section 35(3) that the Service Agreement executed between the Chief Executive and the Hospital and Health Board Chair binds each of them.

3.3. The *Hospital and Health Boards Act 2011* recognises and gives effect to the principles and objectives of the national health system agreed by the Commonwealth, State and Territory governments, including the Medicare principles and health system principles set out in section 4. Section 5 of the *Hospital and Health Boards Act 2011* states that the object of the Act is to establish a public sector health system that delivers high-quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system. This Service Agreement is an integral part of implementing these objectives and principles.

4. Health system priorities

4.1. Ensuring the provision of public health services across Queensland requires clear priorities, supportive leadership and staff who work together and across each level of the health system.

4.2. The priorities, goals and outcomes for the Queensland public sector health system are defined through the Queensland Government's objectives for the community and *My health, Queensland's future: Advancing health 2026*. The Queensland Government, Premier or the Minister for Health may articulate key priorities, themes and issues from time to time. HHSs have a responsibility to ensure that the delivery of healthcare services in Queensland is consistent with these strategic directions and priorities.

4.3. In accordance with section 9 of the *Financial and Performance Management Standard 2009*, HHSs are required to develop a strategic plan. The HHS's strategic plan will reflect local priorities and will be developed considering the shared Queensland priorities outlined in the Queensland Government's objectives for the community and *My health, Queensland's future: Advancing health 2026*.

4.4. In delivering health services, HHSs are required to meet the applicable conditions of the Council of Australian Governments national agreements and national partnership agreements (NPAs) between the Queensland Government and the Commonwealth Government and commitments under any related implementation plans.

4.5. This Service Agreement is underpinned by and is to be managed in line with the following supporting documents:

(a) Advancing Health 2026: Planning for a Healthier Future The Statewide Health System Plan;

(b) Delivering a High Performing Health System for Queenslanders – Performance Framework; and

(c) Health Funding Principles and Guidelines 2018/19.

5. Objectives of the Service Agreement

This Service Agreement is designed to:

(a) specify the hospital services, other health services, teaching, research and other services to be provided by the HHS;

(b) specify the funding to be provided to the HHS for the provision of the services;

(c) specify the performance measures for the provision of the services;

(d) specify the performance and other data to be provided by the HHS to the Chief Executive;

(e) provide a platform for greater public accountability; and

(f) facilitate the achievement of State and Commonwealth Government priorities, services, outputs and outcomes while ensuring local input.

6. Scope

6.1. This Service Agreement outlines the services that the Department of Health will purchase from the HHS during the period of this Service Agreement.

6.2. This Service Agreement does not cover the provision of clinical and non-clinical services by the Department of Health to the HHS. Separate arrangements will be established for those services provided by Health Support Queensland and eHealth Queensland.

7. Performance Framework

7.1. *Delivering a High Performing Health System for Queenslanders: Performance Framework* (the Performance Framework) sets out the framework within which the Department of Health, as the overall manager of public health system performance, monitors and assesses the performance of public sector health services in Queensland. The systems and processes employed for this purpose include, but are not limited to, assessing and monitoring HHS performance, reporting on HHS performance and, as required, intervening to manage identified performance issues.

7.2. The Performance Framework uses Performance Measures to monitor the extent to which HHSs are delivering the high level objectives set out in this Service Agreement. The KPIs and other measures of performance against which the HHS will be assessed and benchmarked are detailed in Schedule 3 of this Service Agreement.

7.3. The parties agree to constructively implement the Performance Framework.

8. Period of this Service Agreement

8.1. This Service Agreement commences on 1 July 2016 and expires on 30 June 2019. The Service Agreement framework is in place for three years in order to provide HHSs with a level of guidance regarding funding and purchased activity for the outer years.

8.2. In this Service Agreement, references to years are references to the period commencing on 1 July and ending on 30 June unless otherwise stated.

8.3. Using the provisions of the *Hospital and Health Boards Act 2011* as a guide, the Parties will enter into funding and purchased activity negotiations for the following year six months before the end of the current year.

8.4. In accordance with the *Hospital and Health Boards Act 2011* the Parties will enter negotiations for the next Service Agreement at least six months before the expiry of the existing Service Agreement.

9. Amendments to this Service Agreement

9.1. Section 39 of the *Hospital and Health Boards Act 2011* requires that, if the Chief Executive or the HHS wish to amend the terms of a Service Agreement, the Party wishing to amend the Service Agreement must give written notice of the proposed amendment to the other Party.

9.2. The process for amending this Service Agreement is set out in Schedule 5 of this Service Agreement.

10. Publication of amendments

The Department of Health will publish each executed Deed of Amendment within 14 days of the date of execution on www.health.qld.gov.au/system-governance/health-system/managing/default.asp.

11. Cessation of Service delivery

11.1. The HHS is required to deliver the Services outlined in this Service Agreement for which funding is provided in Schedule 2. Any changes to Service delivery must ensure maintenance of care and minimise disruptions to patients.

11.2. The Department of Health and HHS may terminate or temporarily suspend a Service by mutual agreement having regard to the following obligations:

(a) any proposed Service Termination or Suspension must be made in writing to the other party;

(b) where it is proposed to terminate or temporarily suspend a Service that is provided on a Statewide or Regional basis, the HHSs which are in receipt of that Service must also be consulted;

(c) the parties agree a notice period following which Termination, or temporary Suspension, will take effect; and

(d) patient needs, workforce implications, relevant government policy and HHS sustainability are to be considered.

11.3. The Department of Health, in its role as statewide health system manager:

(a) may not support the Termination or temporary Suspension and request the HHS to maintain the Service; and

(b) will reallocate existing funding and activity for the terminated or temporarily suspended Service inclusive of baseline Service Agreement funding and in-year growth funding on a pro-rata basis.

11.4. The HHS will:

(a) work with the Department of Health to ensure continuity of care and a smooth transfer of the Service to an alternative provider where this is necessary; and

(b) minimise any risk or inconvenience to patients associated with Service Termination, temporary Suspension or transfer.

11.5. In the event that a sustainable alternative provider cannot be identified and this is required, the Service and associated patient cohort will continue to remain the responsibility of the HHS.

12. Commencement of a new Service

12.1. In the event that the HHS wishes to commence providing a new Service, the HHS will notify the Department of Health in writing in advance of Commencement.

12.2. The Department of Health will provide a formal response regarding the proposed new Service to the HHS in writing. The Department of Health may not agree to purchase the new Service or to provide funding on either a recurrent or non-recurrent basis.

13. Provision of data to the Chief Executive

The HHS will provide to the Chief Executive the performance data and other data, including data pursuant to ad hoc requests, set out in Schedule 4 of this Service Agreement in accordance with the Schedule, including in relation to the form, manner and the times required for the provision of data.

14. Dispute resolution

14.1. The dispute resolution process set out below is designed to resolve disputes which may arise between the Parties to this Service Agreement in a final and binding manner.

14.2. These procedures and any disputes addressed or to be addressed by them are subject to the provisions of the *Hospital and Health Boards Act* 2011, including in respect of any directions issued under that legislation or by Government in respect of any dispute.

14.3. Resolution of disputes will be through a tiered process commencing with the Performance Review Meeting and culminating, if required, with the Minister for Health, as illustrated in Figure 1. Use of the dispute resolution process set out in this clause should only occur following the best endeavours of both parties to agree a resolution to an issue at the local level. The dispute resolution process is not intended for the resolution of ongoing issues or performance related issues. At each stage of the dispute resolution process, the Parties agree to cooperate.

14.4. If a dispute arises in connection with this Service Agreement (including in respect of interpretation of the terms of this Service Agreement), then either Party may give the other a written Notice of Dispute.

14.5. The Notice of Dispute must be provided to the DH-SA Contact Person if the notice of dispute is being given by the HHS and to the HHS-SA Contact Person if the Notice of Dispute is being given by the Department of Health.

14.6. The Notice of Dispute must contain the following information:

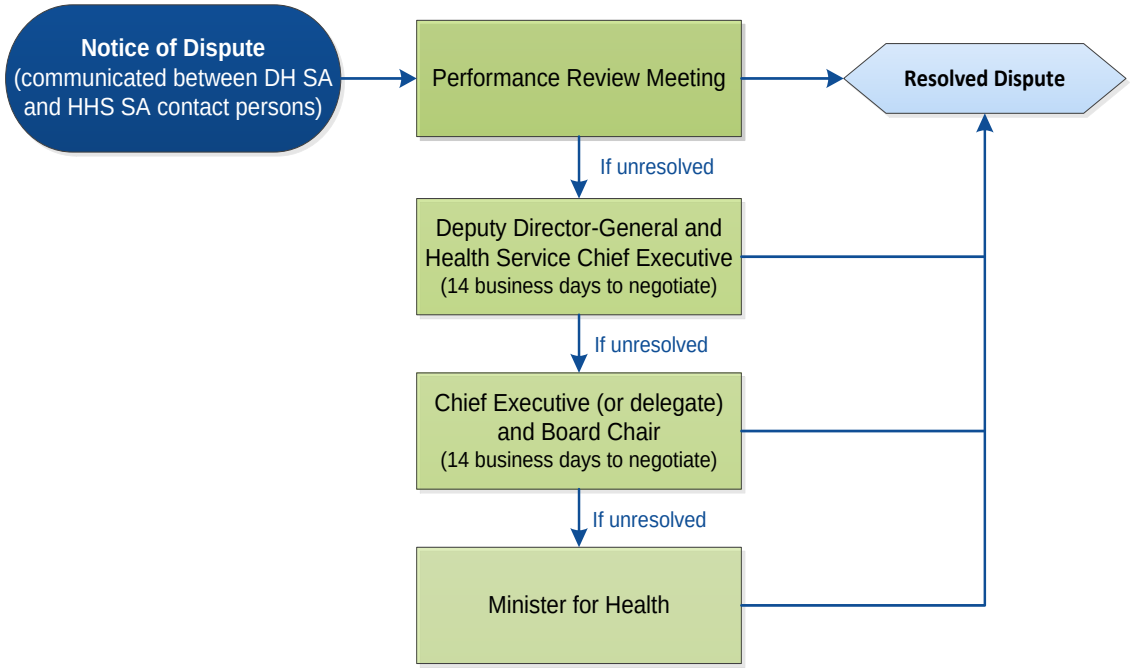
(a) a summary of the matter in dispute;

(b) an explanation of how the party giving the Notice of Dispute believes the dispute should be resolved and reasons to support that belief;

(c) any information or documents to support the Notice of Dispute; and

(d) a definition and explanation of any financial or Service delivery impact of the dispute.

Figure 1 Dispute resolution process



14.7. **Resolution of a dispute**

(a) Resolution of a dispute at any level is final. The resolution of the dispute is binding on the Parties, but does not set a precedent to be adopted in similar disputes between other Parties.

(b) The Parties agree that each dispute (including the existence and contents of each Notice of Dispute) and any exchange of information or documents between the Parties in connection with the dispute is confidential and must not be disclosed to any third party without the prior written consent of the other Party, other than if required by law and only to the extent required by law.

14.8. **Continued performance**

Notwithstanding the existence of one or more disputes, the HHS must continue to perform and comply with this Service Agreement to the best of their abilities given the circumstances.

14.9. **Disputes arising between Hospital and Health Services**

(a) In the event of a dispute arising between two or more HHSs (an Inter-HHS Dispute), the process set out in Figure 2 will be initiated. Resolution of Inter-HHS Disputes will be through a tiered process, commencing with local resolution and culminating if required with formal and binding arbitration by the Minister for Health under the provisions of the *Hospital and Health Boards Act 2011*, section 44.

(b) If the HHS wishes to escalate a dispute, the HHS will be expected to demonstrate that best endeavours (including Chair and Board involvement) to resolve the dispute between all parties at an informal and local level have taken place.

(c) Management of inter-HHS relationships should be informed by the following principles:

i. HHSs should maintain (for both the base level of funding and growth) the proportion of out of HHS work undertaken unless as a result of agreed repatriation of patients.

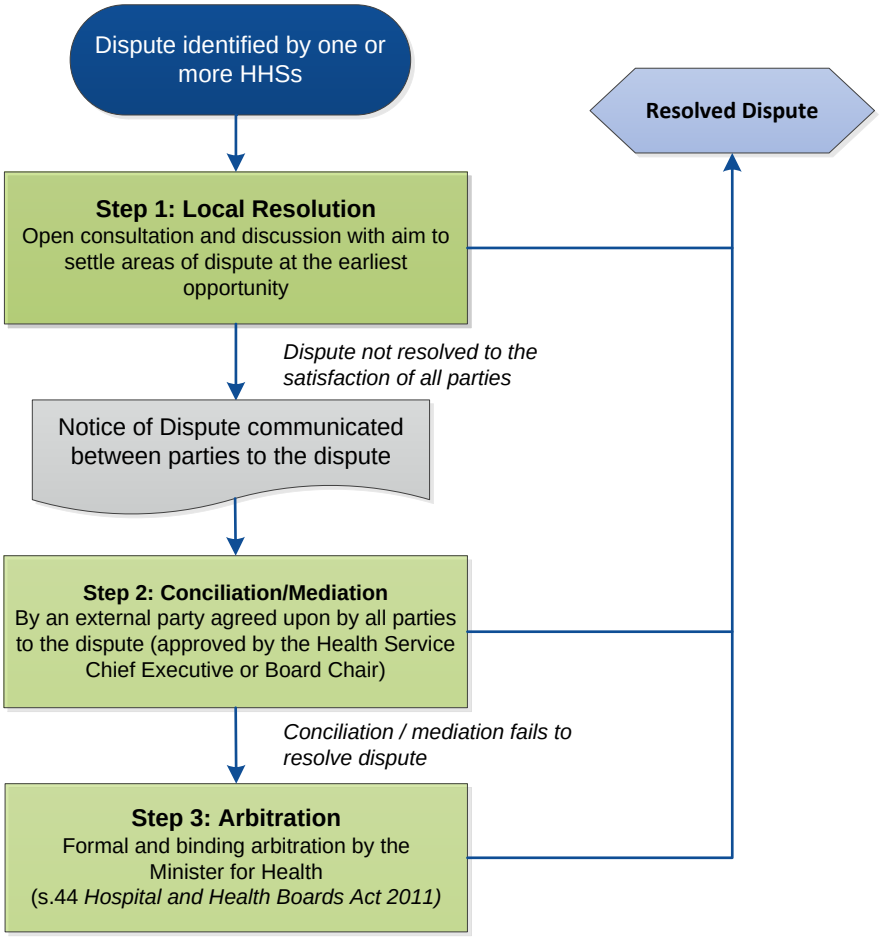
ii. All HHSs manage patients from their own catchment population if it is within their clinical capability to do so as specified by the Clinical Services Capability Framework.

iii. Where it is proposed that a Service move from one HHS to another, agreement between the respective Health Service Chief Executives will be secured prior to any change in patient flows. Once agreed, funding will follow the patient.

iv. All HHSs abide by the agreed dispute resolution process.

v. All HHSs operate in a manner which is consistent with the health system principles and objectives as set out in the National Health Reform Agreement and the *Hospital and Health Boards Act 2011*.

Figure 2 **Inter-HHS dispute resolution process**



15. Force Majeure

15.1. If a Party (affected Party) is prevented or hindered by Force Majeure from fully or partly complying with any obligation under this Service Agreement, that obligation may (subject to the terms of this Force Majeure clause) be suspended, provided that if the affected Party wishes to claim the benefit of this Force Majeure clause, it must:

(a) give prompt written notice of the Force Majeure to the other Party of:

i. the occurrence and nature of the Force Majeure;

ii. the anticipated duration of the Force Majeure;

iii. the effect the Force Majeure has had (if any) and the likely effect the Force Majeure will have on the performance of the affected Party's obligations under this Service Agreement; and

iv. any disaster management plan that applies to the party in respect of the Force Majeure.

(b) use its best endeavours to resume fulfilling its obligations under this Service Agreement as promptly as possible; and

(c) give written notice to the other Party within five days of the cessation of the Force Majeure.

15.2. Without limiting any other powers, rights or remedies of the Chief Executive, if the affected Party is the HHS and the delay caused by the Force Majeure continues for more than 14 days from the date that the Chief Executive determines that the Force Majeure commenced, the Chief Executive may give directions to the HHS regarding the HHS's performance or non-performance of this Service Agreement during the Force Majeure and the HHS must comply with that direction.

15.3. Neither Party may terminate this Service Agreement due to a Force Majeure event.

16. Hospital and Health Service accountabilities

16.1. Without limiting any other obligations of the HHS, it must comply with:

(a) the terms of this Service Agreement;

(b) all legislation applicable to the HHS, including the *Hospital and Health Boards Act 2011*;

(c) all Cabinet decisions applicable to the HHS;

(d) all Ministerial directives applicable to the HHS;

(e) all agreements entered into between the Queensland and Commonwealth governments applicable to the HHS;

(f) all regulations made under the *Hospital and Health Boards Act 2011*;

(g) all industrial agreements; and

(h) all health services directives applicable to the HHS.

16.2. The HHS will ensure that the accountabilities set out in Schedule 1 of this Service Agreement are met.

17. Department of Health accountabilities

17.1. Without limiting any other obligations of the Department of Health, it must comply with:

(a) the terms of this Service Agreement;

(b) the legislative requirements as set out within the *Hospital and Health Boards Act 2011*;

(c) all regulations made under the *Hospital and Health Boards Act 2011*; and

(d) all Cabinet decisions applicable to the Department of Health.

17.2. The Department of Health will work in collaboration with HHSs to ensure the public health system delivers high quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system. In support of realising this objective, in accordance with section 5 of the *Hospital and Health Boards Act 2011* the Department of Health will:

(a) provide state-wide health system management including health system planning coordination and standard setting;

(b) provide the HHS with funding specified under Schedule 2 of this Service Agreement;

(c) provide and maintain payroll and rostering systems to the HHS unless agreed otherwise between the parties;

(d) operate 13 HEALTH as a first point of contact for health advice with timely HHS advice and information where appropriate to local issues; and

(e) balance the benefits of a local and system-wide approach.

17.3. The Department of Health will endeavour to purchase services in line with Clinical Prioritisation Criteria, where these have been developed, in order to improve equity of access and reflect the scope of publicly funded services.

17.4. The Department of Health will maintain a public record of the Clinical Service Capability Framework levels for all public facilities based on the information provided by HHSs.

17.5. **Workforce management**

Where a HHS is not prescribed as an employer, the Chief Executive agrees to provide Health Service Employees to:

(a) perform work for the HHS for the purpose of enabling the HHS to perform its functions and exercise powers under the *Hospital and Health Boards Act 2011;* and

(b) ensure delivery of the services prescribed in this Service Agreement.

18. Indemnity

18.1. The HHS indemnifies the Department of Health against all and any liabilities, claims, actions, demands, costs and expenses made by any person which may be brought against or made upon or incurred by the Department of Health arising directly or indirectly from or in connection with any of the following:

(a) any wilful, unlawful or negligent act or omission of the HHS or an officer, employee or agent of the HHS in the course of the performance or attempted or purported performance of this Service Agreement;

(b) any penalty imposed for breach of any applicable law in relation to the HHS's performance of this Service Agreement; and

(c) a breach of this Service Agreement

except to the extent that any act or omission by the Department of Health caused or contributed to the liability, claim, action, demand, cost or expense.

18.2. For employees employed by the Chief Executive, the Chief Executive (or delegate) will provide indemnity for Health Service Employees working in and for the HHS seeking indemnity in accordance with:

(a) Indemnity for Queensland Health Medical Practitioners HR Policy I2; and

(b) Queensland Government Indemnity Guideline

as amended from time to time.

18.3. The indemnity referred to in this clause will survive the expiration or termination of this Service Agreement.

19. Legal proceedings

Subject to any law, and for any demand, claim, action, liability or proceedings for an asset, contract, agreement or instrument that:

(a) is transferred to a HHS under section 307 of the *Hospital and Health Boards Act 2011;*

(b) is otherwise retained by the Department of Health

each Party must (at its own cost):

(a) do all things;

(b) execute such documents; and

(c) share such information

in its possession and control that is relevant to and which is reasonably necessary to enable the other party to institute or defend (as the case may be) any demand, claim, liability or legal proceeding for which it is responsible.

Execution

A The terms of this Service Agreement were agreed under the provisions set out in the *Hospital and* Health *Boards Act,* section 35 on 8 July 2016, and were subsequently amended by the Deeds of Amendment entered into pursuant to section 39 of the *Hospital and Health Boards Act 2011* and executed on 8 May 2017; 12 June 2017; 18 July 2017; 11 January 2018; 22 June 2018; 16 October 2018; 16 January 2019 and 11 June 2019.

B This revised Service Agreement consolidates amendments arising from:

- 2016/17 Amendment Window 2 (in-year variation);
- 2016/17 Supplementary Amendment Window;
- March 2017 Periodic Adjustment;
- 2017/18 Amendment Window 1 (annual budget build);
- 2017/18 Amendment Window 2 (in-year variation);
- 2017/18 Amendment Window 3 (in-year variation);
- 2018/19 Amendment Window 1 (annual budget build);
- 2018/19 Amendment Window 2 (in-year variation); and
- 2018/19 Amendment Window 3 (in-year variation).

C Execution source documents are available on the service agreement website www.health.qld.gov.au/system-governance/health-system/managing/default.asp

Schedule 1 HHS Accountabilities

1. Purpose

A Without limiting any other obligations of the HHS, this Schedule 1 sets out the key accountabilities that the HHS is required to meet under the terms of this Service Agreement.

B This Schedule also gives regard to the Charter of Responsibility which sets out the legislative roles and responsibilities of the Department of Health and HHSs consistent with the *Hospital and Health Boards Act 2011* and provides a framework and shared commitment to support the operation of the Queensland Health system.

2. Registration, credentialing and scope of clinical practice

2.1. The HHS must ensure that:

(a) all persons (including off site reporting radiologists) who provide a clinical service for which there is a national or Queensland legal requirement for registration, have and maintain current registration throughout their employment and only practise within the scope of that registration;

(b) all persons who perform roles for which eligibility for membership of a professional association is a mandatory requirement, have and maintain current eligibility of membership of the relevant professional association throughout their employment in the role; and

(c) all persons who provide a clinical service, and who fall within the scope of current credentialing policies (i.e. including medical, dental, nursing, midwifery and allied health), have a current scope of clinical practice and practise within that scope of clinical practice (which includes practising within their registration conditions and within the scope of the Clinical Services Capability Framework of the facility/s at which the Service is provided).

2.2. Confirmation of registration and/or professional memberships is to be undertaken in accordance with the processes outlined in 'Health Professionals Registration: medical officers, nurses, midwives and other health professionals HR Policy B14', as amended from time to time.

3. Clinical Services Capability Framework

3.1. The HHS must ensure that:

(a) all facilities have undertaken a baseline self-assessment against the Clinical Services Capability Framework (version 3.2);

(b) the Department of Health is notified when a change to the Clinical Services Capability Framework baseline self-assessment occurs through the established public hospital Clinical Services Capability Framework notification process; and

(c) in the event that a Clinical Services Capability Framework module is updated or a new module is introduced, a self-assessment is undertaken against the relevant module and submitted to the Department of Health.

3.2. The HHS is accountable for attesting to the accuracy of the information contained in any Clinical Services Capability Framework self-assessment submitted to the Department of Health.

4. Clinical Prioritisation Criteria

The HHS must ensure that:

(a) processes for access to specialist surgical and medical services in line with Clinical Prioritisation Criteria are implemented, where these have been developed, in order to improve equity of access to specialist services; and

(b) General Practice Liaison Officer (GPLO) and Business Practice Improvement Officer (BPIO) programs are maintained in order to deliver improved access to specialist outpatient services, including through (but not limited to) their contribution to the development and implementation of statewide Clinical Prioritisation Criteria.

5. Service delivery

5.1. The HHS will submit to the Department of Health an Annual Healthcare Delivery Plan using the prescribed format in advance of the commencement of each financial year. The Annual Healthcare Delivery Plan will include, but is not limited to:

(a) the health system and local priorities to be addressed by the HHS; and

(b) the delivery plans that will be implemented by the HHS to address the health system and local priorities.

5.2. The HHS must ensure that:

(a) the Services outlined in this Service Agreement, for which funding is provided in Schedule 2 'Funding and Purchased Activity and Services' continue to be provided;

(b) the obligations regarding the payment and planning for blood and blood products and best practice as set out under the National Blood Agreement are fulfilled for the facilities for which funding is provided;

(c) the *Strategic Plan for Organ Donation* is implemented in order to support an increase in organ donation rates in Queensland; and

(d) information regarding the HHSs facilities and Services provided, as listed in the '2013/14 – 2015/16 Service Agreement: March 2016 Revision', is maintained for public use on an approved website.

5.3. Through accepting the funding levels defined in Schedule 2 of this Service Agreement, the HHS accepts responsibility for the delivery of the associated programs and reporting requirements to State and Commonwealth bodies as defined by the Department of Health.

6. Accreditation

6.1. All Queensland public hospitals, day procedure services and health care centres (howsoever titled) managed within the framework of HHSs are to maintain accreditation under the Australian Health Service Safety and Quality Accreditation Scheme[1].

6.2. In the period up to January 2019, accreditation will be against the ten clinical National Safety and Quality Health Service standards and will include any other standards offered by the accrediting agency, engaged by the HHS.

6.3. From January 2019, accreditation will be assessed against the National Safety and Quality Health Service standards[2] (NSQHS standards) second edition.

6.4. Mental health services within the HHS will maintain accreditation against the NSQHS standards and the National Standards for Mental Health Services.[3]

6.5. Residential aged care facilities will maintain accreditation by the Australian Aged Care Quality Agency (AACQA).

6.6. General practices owned or managed by the HHS are to be externally accredited in accordance with the current edition of the Royal Australian College of General Practitioners (RACGP) accreditation standards and in line with the National General Practice Accreditation Scheme.

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[1] www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/australian-health-service-safety-and-quality-accreditation-scheme/
[2] www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/
[3] www.safetyandquality.gov.au/our-work/mental-health/

6.7. For the purpose of accreditation, the performance of the HHS against the NSQHS standards and the performance of general practices owned or managed by the HHS against the RACGP standards can only be assessed by accrediting agencies that are approved by the Australian Commission on Safety and Quality in Healthcare (ACSQHC).

6.8. The HHS will select their accrediting agency from among the approved accrediting agencies. The ACSQHC and the RACGP provide a list of approved accrediting agencies which are published on their respective websites at www.safetyandquality.gov.au and www.racgp.org.au/your-practice/standards/resources/accreditation/.

6.9. If the HHS does not meet the NSQHS standards accreditation requirements, the HHS has 90 days to address any not met actions. If the HHS does not meet the other accreditation standards requirements (Mental Health, RACGP and AACQA), a remediation period will be defined by the accrediting agency.

6.10. Following assessment against NSQHS, Mental Health, AACQA and RACGP standards, the HHS will provide to the Executive Director, Patient Safety and Quality Improvement Service:

(a) immediate advice if a significant patient risk (one where there is a high probability of a substantial and demonstrable adverse impact for patients) is identified during an onsite visit, also identifying the plan of action and timeframe to remedy the issue as negotiated between the surveyors/assessors and/or the respective accrediting agency and the HHS;

(b) a copy of any 'not met' or 'not met with recommendation/s' report within two days of receipt of the report by the HHS;

(c) the accreditation report within seven days of receipt of the report by the HHS; and

(d) immediate advice should any action be rated not-met by the accrediting agency following the remediation period of an accreditation event, resulting in the facility or service not being accredited. Responsive regulatory processes may be enacted under clause 7 below.

6.11. The award recognising that the facility or service has met the required accreditation standards will be issued by the assessing accrediting agency for the period determined by their respective accreditation scheme.

6.12. The HHS will apply to an approved accrediting agency for a re-accreditation assessment prior to the expiry of their current accreditation period.

7. Responsive regulatory process for accreditation

7.1. A responsive regulatory process is utilised in the following circumstances:

(a) where a significant patient risk is identified by a certified accrediting agency during an accreditation process; and/or

(b) where a HHS has failed to address 'not met' actions of the specified standards within required timeframes.

7.2. An initial regulatory response will begin with a process of verifying the scope, scale and implications of the reported issues, a review of documentation, and may include one or more site visits by nominated specialty experts.

7.3. The regulatory process may include one or a combination of the following actions:

(a) seek further information from a HHS;

(b) request a progress report for the implementation of an action plan;

(c) escalate non-compliance and/or risk to the Performance Review Meeting;

(d) provide advice, information on options or strategies that could be used to address the non-met actions within a designated time frame; and/or

(e) connect the hospital to other hospitals that have addressed similar deficits or have exemplar practice in this area.

7.4. In the case of serious or persistent non-compliance and where required action is not taken by the HHS, the response may be gradually escalated. The Department of Health may undertake one or a combination of the following actions:

(a) restrict specified practices/activities in areas/units or services of the HHS where the specified standards have not been met;

(b) suspend particular services at the HHS until the area/s of concern are resolved; and

(c) suspend all service delivery at a facility within an HHS for a period of time.

8. Closing the gap in health outcomes

8.1. The *Queensland Health Statement of Action towards Closing the Gap in Health Outcomes* is a commitment to addressing systemic barriers that may in any way contribute to preventing the achievement of health equity for all Aboriginal and Torres Strait Islander Queenslanders. The statement is

expected to mobilise renewed efforts and prompt new activities aimed at closing the health gap.

8.2. In line with the *Queensland Health Statement of Action towards Closing the Gap in Health Outcomes,* the HHS will ensure that commitment and leadership is demonstrated through:

(a) developing a Closing the Gap Health Plan that identifies:

i. the health needs of the Aboriginal and Torres Strait Islander people and communities which it serves; and

ii. the specific actions and initiatives it will take to address the identified health need and improve health outcomes.

(b) strengthening the involvement of Aboriginal and Torres Strait Islander people in health service governance arrangements and health service planning;

(c) improving workforce participation and local engagement; and

(d) increasing input in decision making from Aboriginal and Torres Strait Islander people, organisations and the community.

8.3. The HHS will develop an ongoing dialogue with the Department of Health to progress and report on key actions taken and health service initiatives aligned to the *Queensland Health Statement of Action towards Closing the Gap in Health Outcomes*.

9. Provision of clinical products/consumables in outpatient settings

9.1. Upon discharge as an inpatient or outpatient, and where products/consumables are provided free of charge or at a subsidised charge, the Treating HHS shall bear the initial costs of products/consumables provided to the patient/consumer as part of their care. These costs shall be met by the Treating HHS for a sufficient period of time to ensure the patient/consumer incurs no disruption to their access to the clinically prescribed clinical products/consumables.

9.2. Unless otherwise determined by the HHS providing the clinical products/consumables, ongoing direct costs (beyond an initial period following discharge as an inpatient) of the provided products/consumables shall be borne by the Residential HHS of the outpatient/consumer.

9.3. Where guidelines exist (e.g. Guideline for Compression Garments for Adults with Lymphoedema: Eligibility, Supply and Costing and Guideline for Home Enteral Nutrition Services for Outpatients: Eligibility, Supply and Costing), standardised eligibility criteria and charges should apply.

9.4. Where a patient is supplied with medicines on discharge, or consequent to an outpatient appointment, that are being introduced to a patient's treatment, the

Treating HHS shall provide prescription(s) for an adequate initial supply. This shall comprise:

(a) for medicines reimbursable under the Pharmaceutical Benefits Scheme (PBS), including the Section 100 Highly Specialised Drugs Program – the quantity that has been clinically-appropriately prescribed or the maximum PBS supply, whichever is the lesser; or

(b) for non-reimbursable medicines, one month's supply or a complete course of treatment, whichever is the lesser.

9.5. For medicines that are non-reimbursable under the PBS, and which are not included in the Queensland Health List of Approved Medicines (LAM), the Residential HHS shall be responsible for ongoing supply, provided that the Treating HHS has provided the Residential HHS with documentary evidence of the gatekeeping approval at the Treating HHS for the non-LAM medicine.

9.6. For non-reimbursable medicines listed on the LAM for the condition being treated, the Residential HHS is responsible for ongoing supplies.

9.7. PBS-reimbursable prescriptions issued by a public hospital may be dispensed at any other public hospital that has the ability to claim reimbursement. Patients may, in accordance with hospital policy, be encouraged to have their PBS prescriptions dispensed at a private pharmacy of their choice.

10. Land, buildings and maintenance

10.1. The HHS will achieve the capital expenditure and associated delivery milestones for projects led by the HHS on an annual basis as established in the annual baseline exercise and where relevant amended to reflect state budget outcomes. Actual performance data will be recorded as submitted through the monthly capital reporting process and published via the System Performance Reporting (SpR) tool.

10.2. The HHS will ensure building and infrastructure assets are managed in accordance with the specifications of any relevant transfer notices published as a gazette notice by the Minister for Health under section 273A of the *Hospital and Health Boards Act 2011.*

10.3. The Service Agreement includes funding provision for regular maintenance of buildings and infrastructure. The Department of Health has determined that a sustainable budget allocation for annual maintenance expenditure is 2.15% of the undepreciated asset replacement value of the building portfolio (or the nominated percentage in the approved Annual Maintenance Plan).

10.4. The HHS will proactively address the recommendations within the final Asset Management Capability Assessment report within a two year timeframe or as mutually agreed.

10.5. The HHS will be pro-active in its asset planning, management and maintenance, and will provide support for the adopted maintenance budget

allocation through appropriate maintenance and risk mitigation strategies for buildings and infrastructure.

10.6. For land, buildings and parts of buildings where the Department of Health is, or is intended to be, the exclusive occupier under specific occupancy or ground leases implemented pursuant to clauses 1.7 (c) and 1.8 respectively (where applicable) of a Transfer Notice, the Department of Health is deemed to be in control of that land, building or part of a building for the purpose of work health and safety law.

10.7. Nothing in clause 10.6, of Schedule 1:

(a) removes any work health and safety responsibilities shared with another party or parties in accordance with work health and safety law; or

(b) limits the arrangements for the provision of work health and safety services provided in clause 11.

11. Occupational health and safety

11.1. The HHS, whether prescribed or not prescribed as an employer, will continue to provide occupational health and safety practitioner services to all workers (for Queensland Health) working within the geographic boundary of the HHS, unless other arrangements are agreed in writing by the Department of Health and the HHS. This includes safety arrangements for emergency and evacuation management, employee incident investigation, workers compensation, rehabilitation and reporting.

11.2. The HHS shall implement and maintain a health and safety system which conforms to a recognised health and safety standard, such as AS4801 Occupational Health and Safety Management System or an equivalent standard as agreed by the Chief Executive.

11.3. The HHS will monitor health and safety performance, and shall provide to the Chief Executive reports of a type, and at the intervals, agreed between the Parties, or as reasonably specified by the Chief Executive.

11.4. The Chief Executive will monitor health and safety performance at the system level. Where significant health and safety risks are identified, or performance against targets is identified as being outside tolerable levels, the Chief Executive may request further information from the HHS to address the issue(s) and/or make recommendations for action.

12. Workforce management

12.1. For HHSs which are not prescribed as employers, Health Service Employees (excluding persons appointed as a Health Executive and senior Health Service Employees) are employees of the Chief Executive as provided for in the *Hospital and Health Boards Act 2011*. Where the HHS is not prescribed as

an employer, the Chief Executive will provide Health Service Employees to perform work for the HHS.

12.2. Subject to a delegation by the Chief Executive under section 46 of the *Hospital and Health Boards Act 2011*, the HHS is responsible for the day-to-day management (the HR management functions) of the Health Service Employees provided by the Chief Executive to perform work for the HHS under this Service Agreement.

(a) The HHS will exercise its decision-making power in relation to all HR management functions which may be delegated to it by the Chief Executive under section 46 of the *Hospital and Health Boards Act 2011*, in respect of the Health Service Employees, in a lawful and reasonable manner and with due diligence, and in accordance with:

i. terms and conditions of employment specified by the Department of Health in accordance with section 66 of the *Hospital and Health Boards Act 2011;*

ii. health service directives, issued by the Chief Executive under section 47 of the *Hospital and Health Boards Act 2011*;

iii. health employment directives, issued by the Chief Executive under section 51A of the *Hospital and Health Boards Act 2011;*

iv. any policy document that applies to the Health Service Employee;

v. any Industrial Instrument that applies to the Health Service Employee;

vi. the relevant HR delegations manual; and

vii. any other relevant legislation.

(b) This includes but is not limited to ensuring Health Service Employees are suitably qualified to perform their required functions.

(c) Where the HHS is prescribed as an employer, the HHS will be the employer of the Health Service Employees working for the HHS, and will manage its employees in accordance with section 66 of the *Hospital and Health Boards Act 2011* and applicable health service directives and health employment directives.

(d) Persons appointed in a HHS as a Health Executive or senior Health Service Employees are employees of the HHS, regardless of whether the HHS is prescribed as an employer or not as per section 20 of the *Hospital and Health Boards Act 2011.*

(e) All HHSs shall provide to the Chief Executive human resource, workforce, and health and safety reports of a type, and at the intervals, agreed between the Parties, or as reasonably specified by the Chief Executive.

Schedule 2 Funding and Purchased Activity and Services

1. Purpose

This Schedule 2 sets out:

(a) The activity purchased by the Department of Health from the HHS (Table 6, Table 7, Table 9, Table 10 and Table 11);

(b) The funding provided for delivery of the purchased activity (Table 6, Table 7, Table 9, Table 10 and Table 11);

(c) Specific funding commitments (Table 2);

(d) The criteria and processes for financial adjustments associated with the delivery of purchased activity and specific funding commitments;

(e) The sources of funding that this Service Agreement is based on and the manner in which these funds will be provided to the HHS (Table 5); and

(f) An overview of the purchased Services which the HHS is required to provide throughout the period of this Service Agreement.

2. Delivery of purchased activity

2.1. The Department of Health and the HHS will monitor actual activity against purchased levels, taking action as necessary to ensure delivery of purchased levels is achieved.

2.2. The HHS has a responsibility to actively monitor variances from purchased activity levels, and will notify the Department of Health immediately via the DH-SA contact person as soon as the HHS becomes aware that activity variances are likely to exceed agreed tolerances as detailed in clause 4.2 of this Schedule.

2.3. The HHS will also notify the Department of Health of deliberate changes to the consistent recording of activity within year that would result in additional activity being recorded for existing Services.

2.4. If the HHS wishes to move activity between purchased activity types and levels, for example, activity moving from outpatients to inpatients or from one inpatient Service Related Group (SRG) to another, the HHS must negotiate this with the Department of Health based on a sound needs based rationale.

2.5. Should the HHS be unable to deliver the activity that has been funded a financial adjustment will be applied. The contracted activity and the related funding may be withdrawn at 100% of the Queensland Efficient Price (QEP). This may be reallocated to an alternate provider that can undertake the activity.

2.6. If the underdelivery of activity relates to National Weighted Activity Units (NWAU), this funding and corresponding activity will be withdrawn from the HHS.

2.7. Any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 2 and 5 of this Service Agreement.

3. Efficient Growth funding

3.1. In 2018/19, the Commonwealth Government will fund 45% of Efficient Growth in public hospital services at Activity Based Funding (ABF) facilities as stated in the National Health Reform Agreement (NHRA) 2011, with both ABF and block funded services, subject to a cap of 6.5% growth (based on funding) from 2017/18.

3.2. Efficient Growth funding is based on growth of NWAUs, when reported in the same national funding model version, and calculations are performed by the National Health Funding Body on behalf of the Administrator of the National Health Funding Pool, within the 6.5% cap.

3.3. There is no guarantee that the HHS will have access to Efficient Growth funding for activity delivered above purchased levels. As part of the mid-year review of HHS performance, an assessment will be undertaken across the state to determine whether there is an opportunity for Efficient Growth funding to be re-allocated across HHSs in the event that an HHS is unlikely to meet its purchased activity target.

Table 1 NWAU target 2018/19

Service Stream	2018/19 NWAU target (N1819)
Inpatient	117,753
Outpatient	27,253
Procedures and Interventions	15,235
Emergency Department	25,930
Sub & Non-Acute	10,502
Mental Health	12,645
TOTAL	**209,318**

3.4. Funding adjustments will be made as follows:

(a) Where a HHS is below its target as stated in Table 1, funding and activity will be withdrawn at 100% of the QEP.

(b) Where a HHS is below, or is deemed not likely to meet, its NWAU target, any funding may be distributed to other HHSs.

3.5. Funding adjustments will be actioned through the process set out in clause 3.4 Schedule 5 of this Service Agreement.

3.6. Funding is provided on the basis that the Commonwealth government funds Efficient Growth in 2018/19 (capped at 6.5%) and that HHSs submit activity data in accordance with data schedules that identify standards in relation to the quality and timeliness of data for submission to national bodies.

3.7. Funding of Efficient Growth will be based on HHS data as utilised in the Department of Health's year-end submission to the Independent Hospital Pricing Authority. HHS data is to be submitted to the Department of Health at the latest by 21 September 2018.

3.8. HHSs should refer to the supporting document to this Service Agreement 'Health Funding Principles and Guidelines 2018/19' and the specification sheet titled 'Efficient Growth National Weighted Activity Units (NWAUs)' for further information. These documents are available online as detailed in Appendix 1.

4. Financial adjustments

4.1. **Specific funding commitments**

(a) As part of the Service Agreement Value, the services, programs and projects set out in Table 2 have been purchased by the Department of Health from the HHS. These services will be the focus of detailed monitoring by the Department of Health.

(b) The HHS will promptly notify the DH-SA Contact Person if the HHS forecasts an inability to achieve commitments linked to the specific funding commitments included in Table 2.

(c) On receipt of any notice under clause 4.1(b) of Schedule 2, it is at the discretion of the Chief Executive (or delegate) to withdraw allocated funding pro rata to the level of under delivery if the program is not being delivered according to the program objective or is not being delivered in full.

(d) If the Chief Executive (or delegate) decides to withdraw allocated funding, the Chief Executive (or delegate) will immediately issue an Adjustment Notice to the HHS-SA Contact Person confirming any adjustment that has been made in accordance with this clause 4.1 of Schedule 2. The Adjustment Notice will be issued through the process set out in clause 3.4 of Schedule 5.

(e) Following receipt of an Adjustment Notice under clause 4.1(d) of Schedule 2, the Parties will comply with the Adjustment Notice and immediately take steps necessary to give effect to the requirements of that Adjustment Notice.

(f) The Parties acknowledge that adjustments made under this clause 4.1 of Schedule 2 may vary the Service Agreement Value and/or a specific value recorded in Table 2. Where the Service Agreement Value and/or a specific value recorded in Table 2 is varied, the variation will be recorded in a Deed of Amendment issued following

the next available Amendment Window as identified in Table 18, Schedule 5.

Table 2 Specific Funding Commitments

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033 - Investment Strategy 2018-21	*$397,849* *$397,849* $397,849	*0* *0* 0	*2016/17* *2017/18* 2018/19	The HHS will deliver the initiatives and outcomes outlined in the performance requirements issued by the Aboriginal and Torres Strait Islander Health Branch for the provision of services, including: • Mungulli Aboriginal and Torres Strait Islander Community Based Chronic disease and Respiratory Service; • Indigenous hospital liaison services; and • Queensland Health Aboriginal and Torres strait Islander Cultural Capability Framework 2010-2033.
Queensland Sexual Health Strategy 2016 - 2021	*$68,796* *$137,591* $137,591 $137,591	*0* *0* 0 0	*2016/17* *2017/18* 2018/19 2019/20	Consistent with the *Queensland Sexual Health Strategy 2016-2021*, provide additional medical officer, advanced practice sexual health nursing or allied health professional hours to the Gold Coast Sexual Health Service to contribute to an improvement in the capacity to treat Sexually Transmissible Infections, Human Immunodeficiency Virus, viral hepatitis and provide psychological support to patients to enhance engagement in care and adherence with treatment. This investment must increase the occasions of service, irrespective of position type. An annual review of outcomes achieved against the success factors of the Queensland Sexual Health Strategy will be conducted by the Department of Health. If program performance requirements are not met in-year funding may be withdrawn.
BreastScreen	*$4,392,071* $4,581,890 (including $52,890 for after-hours screens) (recurrent)	*34,000 screens (including 1,904 after-hours screens)* 34,700 total screens (1,763 after-hours screen)	*2017/18* 2018/19	Provision of BreastScreen services targeting women aged 50-74 years old (women 40-49 years are also eligible).

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Oral Health Services	$14,389,348	276,873 WOOS	2018/19	As per memo C-ECTF-18/6621. Delivery consistent with Queensland Health's oral health policy framework. Funding may be adjusted where the total oral health activity delivered varies from the purchased levels. Oral health activity (WOOS) for the 0-15 year age group shall not be less than that achieved in 2017/18.
National Partnership Agreement (NPA) on Adult Public Dental Services	$2,514,593	45,720 WOOS	2018/19	Queensland is required to meet two performance targets during 2018/19, which are the 30 September 2018 target (for 1 April to 30 September 2018) and the 31 March 2019 target (for 1 October 2018 to 31 March 2019). HHSs must collectively meet these targets.
Management Information System Project – phase 1	*$2,490,000* *$497,000* *$497,000*	*0* *0* *0*	*2015/16* *2016/17* *2017/18*	Funding to be provided over three years (2017/18 third and final year of funding) to develop and rollout within each HHS the Management Information System Phase 1 to enable HHSs to better operationally manage the specialist outpatient and elective surgery waiting lists.
Nurse Navigator roles	*$1,390,701* *$5,163,538* $7,389,769	*0* *0* 0	*2016/17* *2017/18* 2018/19	2015/16 allocation: • 3 NG7; and • 2 NG8. 2016/17 – 2018/19 allocation: • 1 Oct 2016: 5 (4 NG7; 1 NG8); • 1 Jul 2017: 10 (NG8); • 1 Oct 2017: 15 (NG7); • 1 Oct 2018: 10 (NG7); and • 1 May 2019: 5 (NG7). Total allocation for Nurse Navigator Program (2015/16 – 2018/19) is: • 37 NG7; and • 13 NG8. Establishment of additional nursing positions at Grade 7 and 8 with a specific Job Description for a Nurse Navigator. HHS is ineligible to utilise a pre-existing permanent position which has been renamed. Monthly reporting regarding: • Full Time Equivalent Nurse Navigators employed; • Number of Nurse Navigator plans in place; and • Number of patients seen by Nurse Navigator. If program performance requirements are not met in-year funding may be withdrawn.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Graduate Nursing and Midwifery Initiative (HHS)	*$752,150* *$796,652* $3,752,334	*0* *0* 0	*2016/17* *2017/18* 2018/19	Employment of additional graduate Full Time Equivalents: • 2016/17: 30; • 2017/18: 31; and • 2018/19: 38. HHS participation in annual statewide graduate experience survey. Update of graduate portal for all graduates who applied to the HHS. Quarterly reporting on graduate enhancement projects. Annual reporting of graduate intake numbers required. * 25% funding provided. 75% provided either through reduction in productivity dividend (2016-17) or access to the commonwealth growth cap (17-18 and 18-19). Growth built into the base recurrently.
Another 100 Midwives (Nursing)	$2,697,384 $2,766,966 $2,838,376	0 0 0	2018/19 2019/20 2020/21	Funding is provided for the employment of 17.20 additional Full Time Equivalent (FTE) midwives during the 2018/19 –2020/21 period. The agreed position level breakdown for the total FTE is as follows: • 5.70 FTE at NG 5.4 (MGP)*; • 2.90 FTE at NG 5.4 (CORE)**; • 5.10 FTE at NG 6.1.4 (MGP)*; and • 3.50 FTE at NG 6.1.4 (CORE)**. Funding allocations are contingent on: • Creation of specific position IDs for new and additional midwifery positions; • Commencement of recruitment processes by 31 December 2018; and • Commencement of staff in recruited positions by 30 June 2019. If these requirements are not met, funding may be withdrawn. The HHS may not utilise a pre-existing permanent position which has been renamed. Quarterly reporting (FTE and Headcount) through to the Office of the Chief Nursing and Midwifery Officer, commencing March 2019, and including the status of recruitment to the new positions, until all new recruitment to positions to meet agreed total FTE at agreed levels is achieved. * MGP = Midwifery Group Practice model of care which includes annualised salary inclusive of an all purpose loading of 35%, in lieu of overtime, most penalties and allowances, and leave loading. Also includes PD, Training and

Service/Program/Project	Funding	Activity	Timeframe	Conditions
				on cost provisions (excluding leave loading) in Core costings** ** CORE = Core costings based on standard costing template values including PDA, 3.5% targeted training, Overtime (10%), Pens & Allowances (15%), and all on-costs
Specialist Outpatient Strategy: Improving the patient journey by 2020	*$9,000,000* $9,000,000	*1,877 WAUs* 1,892 WAUs	*2017/18* 2018/19	Funding is provided to support initiatives to maintain specialist outpatient long waits and the conversions to elective surgery. A target for the maximum number of specialist outpatient long waits to be achieved by June 2019 continues to be negotiated with the Department and the HHS as part of the broader performance management process. Should the reduction of long wait patients target not be delivered, the equivalent percentage in funding of the under delivery against the target will be returned to the Department of Health. If program performance requirements are not met in-year funding may be withdrawn.
• Models of Care (Scale and Spread)	*$696,833* $1,356,655	*48 WAUs* 0	*2017/18* 2018/19	
• Models of Care (Futures)	*$250,000* $320,000	*19 WAUs* 0	*2017/18* 2018/19	
• Clinical Prioritisation Criteria	*$165,265* $248,017	*0* 0	*2017/18* 2018/19	
Ear, Nose and Throat (ENT) Outpatient Reduction Strategy	*$1,369,622*	*223.84 WAUs*	*2017/18*	Revenue Received in Advance – funding initially allocated in 2016/17 to ensure zero long waits by 30 June 2017.
Reduction of ophthalmology long waits	*$934,838*	*143.75 WAUs*	*2017/18*	Revenue Received in Advance – funding initially allocated in 2016/17 to secure delivery of 435 additional ophthalmology outpatient episodes and elective surgery conversions to facilitate the elimination of outpatient long waits.
Reduction in endoscopy long waits	*$1,551,563*	*326.51 WAUs*	*2017/18*	Revenue Received in Advance – funding initially allocated in 2016/17 to support the reduction in the total number of endoscopy long waits to zero by 1 July 2017, as reported through the Gastrointestinal Endoscopy Data Collection.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Gastrointestinal Endoscopy growth funding	$8,703,480 (recurrent)	1,830 WAUs	1 July 2019	The funding is provided to deliver an additional 3,115 endoscopies and any consequential elective surgery or outpatient appointments connected with the additional endoscopies. This will enable the HHS to achieve the full year endoscopy activity target of 10,649 endoscopies in 2018/19 and maintain zero category 4,5 and 6 long waits throughout 2018/19, as reported through the Gastrointestinal Endoscopy Data Collection. If the long wait target is not achieved, funding may be withdrawn proportional to any under delivery against the full year endoscopy activity target. The HHS must also maintain an endoscopy surveillance (category 9) list and follow the recommendations in memo CE003265 dated 4/12/2017.
Winter Bed Management Strategy	$2,000,000	421 WAUs	2018/19	Funding is provided to the HHS to provide the following increased services: • Transfer unit at Robina; • Respiratory acute care unit; • Four additional beds in the Cardiology Unit; • Diagnostic services; • Hospital in the Home services; • Acute surgical unit theatres; • Nursing support to run day surgery; and • Paediatric day stay nursing support. Funding may be adjusted where the activity delivered varies from purchased levels.
Growth Allocation	$3,210,300	1,500 QWAU /1,462 NWAU	2018/19	Growth provided to HHS at marginal rate. Should the HHS under deliver against their purchased target up to this level of activity, funds will be withdrawn at 45%. Where the HHS under delivers by more than the marginal activity provided, the difference will be withdrawn at 100%.
Our Future State: Gold Coast Low Vaccination Coverage Project	$337,771	0	2018/19	The HHS will undertake the project and deliver the project outcomes as per the agreed project plan. Reporting requirements are as outlined in the project plan. If project performance requirements are not met funding may be withdrawn.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services				
• Mental Health Maternal and Baby unit	*$3,500,000* $4,600,000 (recurrent)	*0* *0*	*2016/17* *2017/18*	Non-recurrent investment of $3.5 million increasing to $4.6 million recurrent in 2017/18, provided to fund a parent and infant unit at Gold Coast University Hospital (GCUH).
• Mental Health Older Persons Unit	*$1,000,000* $2,000,000 (recurrent)	*0* *210 WAUs*	*2016/17* *2017/18*	Non-recurrent investment of $1 million increasing to $2 million recurrent in 2017/18, provided to commission an older persons bed unit at GCUH.
• Independent Patient Rights Advisers	*$328,000* $504,000 (recurrent)	*0* *0*	*2016/17* *2017/18*	Independent Patient Rights Advisers are to be employed or engaged in accordance with the *Mental Health Act 2016* and the Chief Psychiatrist Policy on Independent Patient Rights Advisers.
• Youth Mental Health Capital Program	$110,729 $76,548	*0* *0*	2018/19 2019/20	AO7 Project Lead to support commissioning of new Adolescent Day Program.
• Adult Eating Disorder Service Funding	$72,500	0	2018/19	Clinical Nurse Consultant to undertake leadership of the Adult Eating Disorder Service.
• Mental Health Recovery Service Pilot	$638,690	0	2018/19	Provision of clinical treatment services and development of a pilot Mental Health Recovery Service at three sites, to be delivered in collaboration with an Non-Government Organisation.
Community Mental Health Growth Allocation	$3,953,220 (recurrent)	0	2018/19	Provision of funding to support an increase of 24.05 Full Time Equivalent in support of the HHSs initiatives to enhance Community Mental Health Services, including a forensic mental health team. The HHS is required to submit a report to the Department, in December 2018, outlining the recruitment to the positions identified in the enhancement to community and forensic mental health business case submitted by the HHS. To support this statewide investment the Mental Health and Other Drugs Branch will monitor the additional staff at six monthly intervals through the Mental Health Establishment Collection as well as the anticipated increases to: • proportion of valid community mental health treatment packages; and • proportion of mental health service episodes with a documented care plan. If program performance requirements are not met in-year funding may be withdrawn.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Opioid Substitution Treatment (OST) in Correctional Centres	*$37,959* *(including pro-rata Full Time Equivalent and $6,256 for one-off equipment costs to support establishment of service delivery)* $130,466	*0* 0	*2017/18* 2018/19	Provision of OST in Numinbah Correctional Centre within allocated resources and agreed staffing profile and model of service; in partnership with Queensland Corrective Services.
Evolve Therapeutic Services (ETS)	$1,502,323	0	2018/19	Provision of ETS within allocated resources, in line with state-wide ETS Manual, noting variation in local contexts. Reporting requirements as defined by the Mental Health, Alcohol and Other Drugs Branch. If program performance requirements are not met in-year funding may be adjusted proportional to the under delivery against the agreed target.
Enterprise Bargaining (EB)	$31,005,333 (comprises both recurrent and non-recurrent funding)	0	2018/19	Funding has been allocated in full for following EB agreements: • The Queensland Public Health Sector Certified Agreement (No.9) 2016; • Queensland Health, Building, Engineering & Maintenance Services Certified Agreement (No.6) 2016; • Health Practitioners' and Dental Officers (Queensland Health) Certified agreement (No. 2) 2016; • Nurses and Midwives (Queensland Health and Department of Education and Training) Certified Agreement (EB10) 2018 (base wages); • Health Executive Service Officers/District Senior Officers (Directives 10/17 & 11/17); and • Visiting Medical Officer (Queensland Health Contract Advisory Committee Decision). 95% of funding has been provisionally allocated as an estimation of the funding required for enterprise agreements that are not yet executed and are expected to be approved in 2018/19. Non-recurrent funding has been allocated for special public holiday recreational leave reimbursement for nursing staff, back paid from March 2010. Subject to the terms and conditions of the agreements once executed a funding adjustment may be required.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Integrated Care	*$3,000,000*	*0*	*2017/18*	Fourth and final year of funding provided by the Department of Health to support the Integrated Care Project. The funding is subject to the HHS delivering key health service outcomes.
2017/18 New Technology Funding and Evaluation Program (NTFEP) – MiraQ Cardiac	*$184,330* $47,395	*0* 0	*2017/18* 2018/19	*2017/18 funding includes capital funding of $137,500.* If program performance requirements are not met in-year funding may be withdrawn.
South East Queensland Emergency Care Action Plan • Better service coordination	$426,000 (recurrent)	*88.84 WAUs*	*2017/18*	Funding to be provided to support the establishment of a centralised coordination hub across Gold Coast HHS. This will include: • Use of tools and resources to support rapid establishment; and • Establishment of 2.5 senior Queensland Ambulance Service supervisory roles in the central coordination hub.
• Improved models of emergency care	*$500,000* $500,000 (recurrent)	*0* 104.28 WAUs	*2017/18* 2018/19	Funding to be provided to support the implementation of new emergency models of care to enable improved emergency department flows across Gold Coast University Hospital. This includes: • More streamlined triage process; • Increased nursing resources to manage more complex short stay admissions; and • Establishment of 3 low acuity ambulance overflow bays in the emergency department.
High risk foot patients seen/managed within 48 hours of referral to ambulatory services	$291,686 (recurrent) $145,843 (recurrent)	61 WAUs 31 WAUs	2018/19 2019/20	Recurrent funding is provided for high risk foot ambulatory clinic services to enable patients to be assessed and a care plan initiated within two working days from referral. By the end of 2018-19 60% of patients with a new/recurrent foot ulceration, are to be assessed and a care plan initiated within the best practice timeframe of two working days from referral, with this target increasing to 80% by the end of 2019-20. A condition of this funding is that all HHSs are required to submit data on high risk foot clinic service activity via the Measurement Analysis and Reporting System (MARS), based on completion of the Queensland High Risk Foot Form developed by the Statewide Diabetes Clinical Network.

4.2. **Activity targets**

(a) The Department of Health may initiate a joint process with the HHS to determine whether a financial adjustment should be applied in relation to any purchased activity which has breached the thresholds identified within Table 3 within the relevant quarterly period. This process will take into account any relevant matters that have been identified in a review/analysis of the breach as well as the outcomes of the activity plan implemented to address the activity breach.

(b) Financial adjustments will be made through the processes detailed in Schedule 5. Adjustments will be based on the purchased activity levels specified in this Schedule, including the activity levels purchased overall as well as for specific categories as follows:

i. inpatients;

ii. emergency department;

iii. sub and non-acute;

iv. mental health;

v. procedures and interventions;

vi. outpatients;

vii. non-ABF block funded services; and

viii. commitments linked to specific funding allocations including but not limited to those outlined in Table 2.

(c) Activity will be monitored at the service stream level. Providing the HHS meets all relevant KPIs and specific funding commitments, the HHS has the ability to negotiate the transfer of activity across service streams with the DH-SA Contact Person.

(d) Table 3 demonstrates the financial adjustment that may be applied when activity thresholds have been breached.

Table 3 Financial adjustments applied on breach of activity thresholds

Example of Breach	Description	Financial Adjustment
Over performance	Activity exceeds that specified in the Service Agreement Value (all types of activity)	Purchasing contracts are capped and a HHS will not be paid for additional activity with the exception of activity that is in scope for the identified purchasing incentives as set out in clause 0 Schedule 2 and Table 4. The Department of Health retains the right to use its discretion to fund extra activity based on the outcomes of the review analysis.
Under performance	Activity is below that specified within the finance and activity schedule	Contracted activity and the related funding may be withdrawn at 100% of the QEP and reallocated to an alternate provider that can undertake the activity. Refer to Table 6 and Table 7 for the HHS QWAU target and Table 1 for the HHS NWAU target.
Failure to deliver on commitments linked to specific funding allocations specified in this Schedule 2, Table 2	Specific program funding National Partnership Agreements	It is at the discretion of the Department of Health to withdraw allocated funding pro rata to the level of under delivery in accordance with the activity levels specified in Schedule 2.
For all other types of activity variance, any financial adjustment will be made at the discretion of the Department of Health.		

4.3. **Financial adjustments – other**

(a) The purchasing approach includes a range of funding adjustments which aim to incentivise high value care, that is care which delivers the best outcomes at an efficient cost. This includes incentive payments for HHS who achieve quality targets in specific areas of priority. The purchasing incentives that apply to this Service Agreement are detailed in Table 4.

(b) The Department of Health must reconcile the applicable purchasing incentives in Table 4 in line with the timeframes specified in the purchasing specification sheet referenced at Appendix 1. The Department of Health must promptly provide a copy of the reconciliation statement to the HHS-SA Contact Person.

(c) Funding adjustments must be based on the requirements contained in the relevant specification sheet for that purchasing incentive.

(d) If the Parties are unable to reach agreement in relation to any funding adjustments that are identified, the provisions of clause 14 in the standard terms of this Service Agreement will apply to resolve the dispute.

(e) When the Parties have agreed on a funding adjustment, the Chief Executive (or delegate) will issue an Adjustment Notice to the HHS-SA Contact Person confirming any funding adjustment that has been made in accordance with this clause 0 of Schedule 2. The Adjustment

Notice will be issued through the process set out in clause 3.4(c) of Schedule 5.

(f) Following receipt of an Adjustment Notice under clause 3.4 of Schedule 5, the Parties will comply with the Adjustment Notice and immediately take the steps necessary to give effect to the requirements of that Adjustment Notice.

(g) The Parties acknowledge that the funding adjustments may vary the Service Agreement Value recorded in Schedule 2. Where the Service Agreement Value recorded in Schedule 2 is varied, the variation will be recorded in a Deed of Amendment issued following the next available Amendment Window as identified in Table 18.

Table 4 Purchasing Incentives 2018/19 (Summary)

Incentive	Description	Scope	Status for 2018/19	Funding Adjustment
Quality Improvement Payment (QIP) – Antenatal Visits for Indigenous Women	Incentive payments for achieving targets for: 1. Indigenous women attending an antenatal session during their first trimester, and attending at least 5 antenatal visits; and 2. Indigenous women stopping smoking	All HHSs (excluding Children's Health Queensland)	New	Paid retrospectively
Quality Improvement Payment (QIP) – Patient Wellness Pathway	Incentive payments for each Wellness Pathway completed and received by the Health Contact Centre for in-scope adult public hospital patients on hip, knee or shoulder elective wait lists.	All HHSs (excluding Children's Health Queensland)	New	Paid retrospectively
Quality Improvement Payment (QIP) - Smoking Cessation (Community Mental Health)	Incentive payments for achieving targets for community mental health patients clinically supported onto the Smoking Cessation Clinical Pathway	All HHSs (excluding Children's Health Queensland)	Continues as per 2017/18 for community mental health patients only (discontinued for public inpatients and dental clinic patients)	Paid retrospectively
High Cost Home Support Program	Payment for high cost 24 hour home ventilated patients	All HHSs	Continues as per 2017/18	Paid retrospectively

Incentive	Description	Scope	Status for 2018/19	Funding Adjustment
Telehealth	Incentive payments for additional outpatient activity volume, provision of telehealth consultancy for inpatients and Emergency Department episodes and Store and Forward assessments	Outpatients - Central West, North West, South West and Torres and Cape HHSs only Inpatients and Emergency Department, Store and Forward - all HHSs	Continues as per 2017/18 with outpatient scope limited to identified HHSs and admitted provider scope expanded to include other health professionals	Paid retrospectively
Advance Care Planning (ACP)	Payments for HHSs that offer admitted, non-admitted and community health patients treated in or funded by Queensland Health public facilities the opportunity to contemplate an ACP and document the outcome	All HHSs	Funding may be available up to $4M should there be unexpended 2018/19 QIP program budget	Paid retrospectively if budget available
Sentinel Events	Zero payment for new national sentinel events.	All ABF public hospitals	List changed from 2017/18 never events	Retrospective adjustment
Emergency Department 'Did Not Wait' (DNW)	No payment for DNWs	All ABF public hospitals	Continues as per 2017/18	ABF Pricing model (Qld modification)
Fractured neck of femur timely surgical access	Payment discount for non-timely surgical treatment of fractured neck of femur (#NoF)	All ABF public hospitals	Continues as per 2017/18	ABF pricing model (Qld modification)
Hospital in the Home (HITH)	Discounted price weight for specific non-complex DRGs with no HITH component or long stay days with a HITH component	All ABF public hospitals	Application of discount changed for non-complex DRGs	ABF Pricing model (Qld modification)
Out-of-scope activity	No payment for out-of-scope activity	All ABF public hospitals	Continues as per 2017/18	ABF Pricing model (Qld modification)
Pre-operative elective bed days	Payment discount for long stay days equivalent to pre-operative days.	All ABF public hospitals	Continues as per 2017/18	ABF Pricing model (Qld modification)
Stroke Unit Care	Payment loading for stroke unit care	ABF public hospitals with endorsed stroke unit	Continues as per 2017/18	ABF pricing model (Qld modification)

4.4. **Public and private activity/Own Source Revenue**

(a) Own Source Revenue comprises Grants and Contributions, User Charges and Other Revenues.

(b) In the Commonwealth funding model, private admitted services attract NWAUs but at a discounted rate compared to public admitted services. Private non-admitted services do not attract NWAUs and are out of scope for Commonwealth growth funding.

(c) Where a HHS is above its Own Source Revenue target in respect of private patients, it will be able to retain the additional Own Source Revenue with no compensating adjustments to funding from other sources.

(d) Conversely where a HHS is below its Own Source Revenue target in respect of private patients, it will experience a reduction in revenue with no compensating adjustments to funding from other sources.

(e) The HHS will make all efforts to identifiy and maximise revenue from appropriate third parties to ensure optimisation of available State and Commonwealth funding across Queensland Health.

(f) The Own Source Revenue identified in Table 5 is an estimate generated by the HHS which allows all third party funding sources associated with service delivery to be identified. The HHS will ensure that this estimate is substantiated and accurate to ensure no significant variances to actual revenue generated.

(g) The HHS will routinely revise and update the estimate to ensure alignment between the Service Agreement and Queensland Treasury's reporting system (TRIDATA).

(h) Budget adjustments for changes in Own Source Revenue from private patients will be actioned through the process set out in Schedule 5 of this Service Agreement.

5. Funding sources

5.1. The four main funding sources contributing to the HHS Service Agreement value are:

(a) Commonwealth funding;

(b) State funding;

(c) Grants and Contributions; and

(d) Own Source Revenue.

5.2. Table 5 provides a summary of the funding sources for the HHS and mirrors the total value of the Service Agreement included in Table 6 and Table 7.

Table 5 Hospital and Health Service funding sources 2018/19

Funding source	Value ($)
Activity Based Funding	1,255,360,336
Clinical Education and Training[4]	-41,545,330
Own Source Revenue contribution in ABF funded services	-78,420,618
Pool Account – ABF Funding (State and Commonwealth)[5]	**1,135,394,389**
Block Funding and Clinical Education and Training[4]	91,642,032
State Managed Fund – Block Funding (State and Commonwealth)[6]	**91,642,032**
Locally Receipted Funds (Including Grants)	**13,184,051**
Locally Receipted Own Source Revenue (ABF)	**78,420,618**
Locally Receipted Own Source Revenue (Other activities)	**24,374,940**
Department of Health Funding[7]	**206,786,455**
TOTAL	**1,549,802,485**

[4] Clinical Education and Training (CET) is classified as Teaching, Training and Research Funding under the National Model and funded as a Block Funded Service. Under the State Model, CET is included as 'Other ABF' and forms part of the Activity Based Funding total. To comply with the requirements of the National Health Reform Agreement, funding must be paid as it is received, therefore from a funding source perspective, CET has been reclassified to Block Funding.

[5] Pool Account - ABF Funding (State and Commonwealth) includes: Inpatient; Critical Care; Emergency Department; Sub and Non Acute; Mental Health; and Outpatient activities each allocated a proportion of Other ABF Adjustments.

[6] State Managed Fund - Block Funding (State and Commonwealth) includes: block funded hospitals; standalone specialist mental health hospitals; community mental health; and teaching, training and research.

[7] Department of Health Funding represents funding by the Department of Health for items not covered by the National Health Reform Agreement including such items as: Prevention, Promotion and Protection; Depreciation, and other Health Services.

6. Funds disbursement

6.1. The Chief Executive will direct the disbursement of both State and Commonwealth funding from the State's National Health Funding Pool Sub Account and the State Managed Fund to the HHS. The Service Agreement and state level block payments to state managed funds from Commonwealth payments into the national funding pool are stated in Table 12.

6.2. However, the State (represented by the Chief Executive) will not:

(a) redirect Commonwealth payments between HHSs;

(b) redirect Commonwealth payments between funding streams (e.g. from ABF to Block Funding); and/or

(c) adjust the payment calculations underpinning the Commonwealth's funding.

6.3. Payment of Activity Based Funding and Block Funding to the HHS will be on a fortnightly basis.

6.4. Further information on the disbursement of funds is available in the supporting document to this Service Agreement 'Health Funding Principles and Guidelines 2018/19'.

Table 6 HHS Finance and Activity Schedule 2016/17 – 2018/19 – Summary by Purchasing Hierarchy

	ABF_SPLIT	Service Stream	2016/17 QWAU (Q19)	2016/17 Funding $ (Price: $4755.66)	2017/18 QWAU (Q19)	2017/18 Funding $ (Price: $4795)	2018/19 QWAU (Q21)	2018/19 Funding $ (Price: $4756)
ABF	ABF	Inpatients	113,409	$543,261,657	123,749	$578,570,436	124,398	$593,135,505
		Outpatients	25,180	$119,353,704	28,059	$138,311,271	32,974	$141,509,813
		Procedures & Interventions	19,497	$92,577,460	21,315	$100,058,132	21,737	$70,981,531
		Emergency Department	21,783	$103,475,600	24,273	$113,027,322	27,552	$129,298,602
		Sub & Non-Acute	9,885	$48,371,661	10,361	$49,800,645	10,805	$50,257,032
		Mental Health	11,245	$53,814,483	12,125	$56,977,674	15,515	$87,815,379
		Prevention & Primary Care	4,484	$21,415,685	4,227	$20,935,516	4,503	$22,443,078
	ABF Total		**205,484**	**$982,270,250**	**224,108**	**$1,057,680,996**	**237,483**	**$1,095,440,942**
	ABF Other	CET Funding	0	$35,042,224	0	$41,393,199	0	$41,545,330
		Specified Grants	0	$5,774,293	0	$5,918,650	0	$6,066,616
		PPP	0	$0	0	$0	0	$0
		Other ABF $	0	$16,314,430	0	$34,223,079	0	$85,530,624
	ABF Other Total		**0**	**$57,130,947**	**0**	**$81,534,928**	**0**	**$133,142,570**
Other Funding	Other Funding	Block Funded Services	0	$0	1,378	$734,797	0	$753,167
		Population Based Community Services	0	$126,861,759	0	$110,760,677	0	$117,370,997
		Other Specific Funding	0	$161,742,383	0	$171,219,793	0	$183,127,232
		PY Services moved to ABF	0	$0	0	$0	0	$0
	Other Funding Total		**0**	**$288,604,142**	**1,378**	**$282,715,267**	**0**	**$301,251,396**
Own Source Revenue (variances transacted during the year)	ABF	Inpatients	0	$0	0	$0	0	$0
		Outpatients	0	$0	0	$0	0	$0
		Procedures & Interventions	0	$0	0	$0	0	$0
		Emergency Department	0	$0	0	$0	0	$0
		Sub & Non-Acute	0	$0	0	$0	0	$0
		Mental Health	0	$0	0	$0	0	$0
		Prevention & Primary Care	0	$0	0	$0	0	$0
	ABF Total		**0**	**$0**	**0**	**$0**	**0**	**$0**
	ABF Other	Other ABF $	0	$9,703,471	0	$15,340,249	0	$26,776,824
	ABF Other Total		**0**	**$9,703,471**	**0**	**$15,340,249**	**0**	**$26,776,824**
	Other Funding	Block Funded Services	0	$0	0	$0	0	$0
		Population Based Community Services	0	$0	0	$0	0	$0
		Other Specific Funding	0	-$6,095,661	0	-$5,686,265	0	-$6,809,247
	Other Funding Total		**0**	**-$6,095,661**	**0**	**-$5,686,265**	**0**	**-$6,809,247**
Grand Total			**205,484**	**$1,331,613,149**	**225,487**	**$1,431,585,176**	**237,483**	**$1,549,802,485**

Table 7 HHS Finance and Activity Schedule 2016/17 – 2018/19 – Summary by Value-based Healthcare Grouping 2018/19

			2016/17 QWAU (Q19)	2016/17 Funding $ (Price: $4755.66)	2017/18 QWAU (Q19)	2017/18 Funding $ (Price: $4795)	2018/19 QWAU (Q21)	2018/19 Funding $ (Price: $4756)
ABF	ABF	Cancer	13,189	63,302,952	14,004	66,990,090	15,942	62,540,421
		Chronic Disease	49,599	237,360,963	53,440	251,402,297	53,817	242,070,958
		Maternity, Obstetrics & Neonates	15,291	72,419,560	17,103	82,194,769	19,048	91,875,682
		Mental Health	11,245	53,814,483	12,125	56,977,674	15,515	87,815,379
		Palliative, Maintenance & Frail Elderly	6,515	32,028,275	6,743	32,573,182	7,602	37,983,010
		Planned Care	16,887	80,479,033	18,794	91,589,922	21,611	95,433,160
		Prevention, Early Intervention & Primary Healthcare	9,378	44,231,053	10,308	49,412,470	10,858	46,223,058
		Statewide Services	594	2,712,678	686	3,139,616	882	3,480,439
		Trauma & Illness	82,786	395,921,255	90,905	423,400,977	92,208	428,018,835
		Other	0	0	0	0	0	0
	ABF Total		**205,484**	**$982,270,250**	**224,108**	**$1,057,680,996**	**237,483**	**$1,095,440,942**
	ABF Other	Cancer	0	3,608,902	0	5,150,476	0	8,410,476
		Chronic Disease	0	13,402,355	0	19,127,288	0	31,233,930
		Maternity, Obstetrics & Neonates	0	4,349,482	0	6,207,401	0	10,136,384
		Mental Health	0	3,663,781	0	5,228,797	0	8,538,370
		Palliative, Maintenance & Frail Elderly	0	1,727,735	0	2,465,752	0	4,026,453
		Planned Care	0	5,111,172	0	7,294,453	0	11,911,487
		Prevention, Early Intervention & Primary Healthcare	0	2,418,290	0	3,451,284	0	5,635,778
		Statewide Services	0	171,737	0	245,096	0	400,230
		Trauma & Illness	0	22,677,494	0	32,364,382	0	52,849,461
	ABF Other Total		**0**	**$57,130,947**	**0**	**$81,534,928**	**0**	**$133,142,570**
Other Funding	Other Funding	Cancer	0	0	166	88,661	0	88,661
		Chronic Disease	0	0	98	52,190	0	52,190
		Maternity, Obstetrics & Neonates	0	0	154	82,081	0	82,081
		Mental Health	0	57,123,639	0	58,544,810	0	64,415,336
		Palliative, Maintenance & Frail Elderly	0	17,914,893	0	17,867,865	0	17,684,677
		Planned Care	0	0	886	472,082	0	472,082
		Prevention, Early Intervention & Primary Healthcare	0	61,934,338	71	55,898,133	0	57,445,147
		Statewide Services	0	9,095,494	4	9,110,358	0	9,184,696
		Trauma & Illness	0	0	0	0	0	0
		Other	0	142,535,778	0	140,599,087	0	151,826,527
	Other Funding Total		**0**	**$288,604,142**	**1,378**	**$282,715,267**	**0**	**$301,251,396**

			2016/17 QWAU (Q19)	2016/17 Funding $ (Price: $4755.66)	2017/18 QWAU (Q19)	2017/18 Funding $ (Price: $4795)	2018/19 QWAU (Q21)	2018/19 Funding $ (Price: $4756)
Own Source Revenue (variances transacted during the year)	ABF	Cancer	0	0	0	0	0	0
		Chronic Disease	0	0	0	0	0	0
		Maternity, Obstetrics & Neonates	0	0	0	0	0	0
		Mental Health	0	0	0	0	0	0
		Palliative, Maintenance & Frail Elderly	0	0	0	0	0	0
		Planned Care	0	0	0	0	0	0
		Prevention, Early Intervention & Primary Healthcare	0	0	0	0	0	0
		Statewide Services	0	0	0	0	0	0
		Trauma & Illness	0	0	0	0	0	0
	ABF Total		**0**	**$0**	**0**	**$0**	**0**	**$0**
	ABF Other	Cancer	0	612,958	0	969,027	0	1,691,464
		Chronic Disease	0	2,276,338	0	3,598,671	0	6,281,578
		Maternity, Obstetrics & Neonates	0	738,743	0	1,167,881	0	2,038,568
		Mental Health	0	622,279	0	983,763	0	1,717,185
		Palliative, Maintenance & Frail Elderly	0	293,449	0	463,915	0	809,776
		Planned Care	0	868,113	0	1,372,402	0	2,395,566
		Prevention, Early Intervention & Primary Healthcare	0	410,737	0	649,336	0	1,133,434
		Statewide Services	0	29,169	0	46,113	0	80,492
		Trauma & Illness	0	3,851,685	0	6,089,141	0	10,628,762
	ABF Other Total		**0**	**$9,703,471**	**0**	**$15,340,249**	**0**	**$26,776,824**
Other Funding	Other Funding	Cancer	0	0	0	0	0	0
		Chronic Disease	0	0	0	0	0	0
		Maternity, Obstetrics % Neonates	0	0	0	0	0	0
		Mental Health	0	0	0	0	0	0
		Palliative, Maintenance & Frail Elderly	0	0	0	0	0	0
		Planned Care	0	0	0	0	0	0
		Prevention, Early Intervention & Primary Healthcare	0	0	0	0	0	0
		Statewide Services	0	0	0	0	0	0
		Trauma & Illness	0	0	0	0	0	0
		Other	0	-6,095,661	0	-5,686,265	0	-6,809,247
	Other Funding Total		**0**	**-$6,095,661**	**0**	**-$5,686,265**	**0**	**-$6,809,247**
Grand Total			**205,484**	**$1,331,613,149**	**225,487**	**$1,431,585,176**	**237,483**	**$1,549,802,485**

Table 8 Minor Capital and Equity

	2016/17 $	2017/18 $	2018/19 $
Minor Capital & Equity			
Cash			
GOL-Oct16-32 - Reduction in Endoscopy long waits - capital	$254,000	$0	$0
SA 16-17.325 - Minor Capital funding Allocation 2016-17	$3,543,000	$3,543,000	$3,543,000
GOL-AW2-Oct17-15 NTFEP - MiraQ Cardiac	$0	$137,500	$0
GOL-AW2-Oct18-41 ieMR Infrastructure Uplift	$0	$0	$5,000,000
Non-Cash			
-	-	-	-
Grand Total	**$3,797,000**	**$3,680,500**	**$8,543,000**

Table 9 HHS Finance and Activity Schedule 2016/17 – 2018/19 Other Funding Detail

			2016/17 $	2017/18 $	2018/19 $
Other Funding	Block Funded Services	Block Funded Services	$0	$734,797	$753,167
	Block Funded Services Total		**$0**	**$734,797**	**$753,167**
	Population Based Community Services	Alcohol, Tobacco and Other Drugs	$7,148,050	$7,148,301	$7,252,000
		Community Care Programs	$907,184	$928,684	$936,772
		Community Mental Health	$57,123,639	$58,544,810	$64,415,336
		Other Community Services	$40,006,028	$33,956,370	$35,225,536
		Other Funding Subsidy/(Contribution)	$14,349,946	$2,882,725	$2,178,307
		Primary Health Care	$7,326,913	$7,299,786	$7,363,046
	Population Based Community Services Total		**$126,861,759**	**$110,760,677**	**$117,370,997**
	Other Specific Funding	Aged Care Assessment Program	$2,831,343	$2,862,814	$2,840,313
		Commercial Activities	-$6,125,376	$6,312,265	$6,777,371
		Consumer Information Services	$0	$0	$0
		Depreciation	$76,445,043	$75,928,976	$81,170,000
		Disability Residential Care Services	$160,688	$160,688	$0
		Environmental Health	$4,711,515	$4,707,091	$4,707,091
		Home and Community Care (HACC) Program	$5,842,546	$6,035,206	$6,035,206
		Home and Community Medical Aids & Appliances	$1,034,267	$1,002,510	$1,002,510
		Home Care Packages	$0	$0	$0
		Interstate Patients	$49,239,570	$49,239,570	$49,239,570
		Multi-Purpose Health Services	$0	$0	$0
		Offender Health Services	$800,381	$817,526	$920,327
		Oral Health	$0	$0	$0
		Patient Transport	$5,110,695	$5,110,695	$5,110,695
		Research	$1,753,840	$1,498,864	$1,498,864
		Residential Aged Care	$0	$0	$0
		Specific Allocations	$6,872,755	$4,736,687	$10,944,045
		State-Wide Functions	$3,984,800	$3,997,746	$4,072,084
		Transition Care	$9,080,315	$8,809,157	$8,809,157
	Other Specific Funding Total		**$161,742,383**	**$171,219,793**	**$183,127,232**

			2016/17 $	2017/18 $	2018/19 $
Own Source Revenue (variances transacted during the year)	Block Funded Services	Block Funded Services	$0	$0	$0
	Block Funded Services Total		**$0**	**$0**	**$0**
	Population Based Community Services	Alcohol, Tobacco and Other Drugs	$0	$0	$0
		Community Care Programs	$0	$0	$0
		Community Mental Health	$0	$0	$0
		Other Community Services	$0	$0	$0
		Primary Health Care	$0	$0	$0
	Population Based Community Services Total		**$0**	**$0**	**$0**
	Other Specific Funding	Commercial Activities	-$6,095,661	-$6,312,265	-$6,777,371
		Home and Community Care (HACC) Program	$0	$0	$0
		Home and Community Medical Aids & Appliances	$0	$0	$0
		Research	$0	$0	$0
		Residential Aged Care	$0	$0	$0
		Specific Allocations	$0	$626,000	-$31,876
		State-Wide Functions	$0	$0	$0
		Transition Care	$0	$0	$0
	Other Specific Funding Total		**-$6,095,661**	**-$5,686,265**	**-$6,809,247**
	Prevention & Primary Care		$0	$0	$0
Grand Total			**$282,508,481**	**$277,029,002**	**$294,442,149**

Table 10 HHS Finance and Activity Schedule 2016/17 – 2018/19 Other Funding Detail by Value-based Healthcare Grouping 2018/19

			2016/17 $	2017/18 $	2018/19 $
Other Funding	Cancer	Block Funded Hospitals	$0	$88,661	$88,661
		Other Funding Subsidy/(Contribution)	$0	$0	$0
	Cancer Total		**$0**	**$88,661**	**$88,661**
	Chronic Diseases	Block Funded Hospitals	$0	$52,190	$52,190
		Other Funding Subsidy/(Contribution)	$0	$0	$0
	Chronic Disease Total		**$0**	**$52,190**	**$52,190**
	Maternity, Obstetrics & Neonates	Block Funded Hospitals	$0	$82,081	$82,081
		Other Funding Subsidy/(Contribution)	$0	$0	$0
	Maternity, Obstetrics & Neonates Total		**$0**	**$82,081**	**$82,081**
	Mental Health	Block Funded Hospitals	$0	$0	$0
		Community Mental Health	$57,123,639	$58,544,810	$64,415,336
		Other Funding Subsidy/(Contribution)	$0	$0	$0
	Mental Health Total		**$57,123,639**	**$58,544,810**	**$64,415,336**
	Palliative, Maintenance & Frail Elderly	Aged Care Assessment Program	$2,831,343	$2,862,814	$2,840,313
		Block Funded Hospitals	$0	$0	$0
		Disability Residential Care Services	$160,688	$160,688	$0
		Home and Community Care (HACC) Program	$5,842,546	$6,035,206	$6,035,206
		Home Care Packages	$0	$0	$0
		Multi-Purpose Health Services	$0	$0	$0
		Other Funding Subsidy/(Contribution)	$0	$0	$0
		Residential Aged Care	$0	$0	$0
		Specific Allocations	$0	$0	$0
		Transition Care	$9,080,315	$8,809,157	$8,809,157
	Palliative, Maintenance & Frail Elderly Total		**$17,914,893**	**$17,867,865**	**$17,684,677**
	Planned Care	Block Funded Hospitals	$0	$472,082	$472,082
		Other Funding Subsidy/(Contribution)	$0	$0	$0
	Planned Care Total		**$0**	**$472,082**	**$472,082**
	Prevention, Early Intervention & Primary Healthcare	Alcohol, Tobacco and Other Drugs	$7,148,050	$7,148,301	$7,252,000
		Block Funded Hospitals	$0	$37,865	$37,865
		Community Care Programs	$907,184	$928,684	$936,772
		Consumer Information Services	$0	$0	$0
		Environmental Health	$4,711,515	$4,707,091	$4,707,091
		Home & Community Medical Aids & Appliances	$1,034,267	$1,002,510	$1,002,510
		Offender Health Services	$800,381	$817,526	$920,327
		Oral Health	$0	$0	$0
		Other Community Services	$40,006,028	$33,956,370	$35,225,536
		Other Funding Subsidy/(Contribution)	$0	$0	$0

			2016/17 $	2017/18 $	2018/19 $
		Primary Health Care	$7,326,913	$7,299,786	$7,363,046
	Prevention, Early Intervention & Primary Healthcare Total		**$61,934,338**	**$55,898,133**	**$57,445,147**
	Statewide Services	Block Funded Hospitals	$0	$1,917	$1,917
		Community Mental Health	$0	$0	$0
		Other Funding Subsidy/(Contribution)	$0	$0	$0
		Patient Transport	$5,110,695	$5,110,695	$5,110,695
		Specific Allocations	$0	$0	$0
		State-Wide Functions	$3,984,800	$3,997,746	$4,072,084
	Statewide Services Total		**$9,095,494**	**$9,110,358**	**$9,184,696**
	Trauma & Illness	Block Funded Hospitals	$0	$0	$0
		Community Mental Health	$0	$0	$0
		Other Funding Subsidy/(Contribution)	$0	$0	$0
	Trauma & Illness Total		**$0**	**$0**	**$0**
	Other	Block Funded Hospitals	$0	$0	$18,370
		Offender Health Services	$0	$0	$0
		Commercial Activities	-$6,125,376	$6,312,265	$6,777,371
		Depreciation	$76,445,043	$75,928,976	$81,170,000
		Interstate Patients	$49,239,570	$49,239,570	$49,239,570
		Other Funding Subsidy/(Contribution)	$14,349,946	$2,882,725	$2,178,307
		Specific Allocations	$6,872,755	$4,736,687	$10,944,045
		Research	$1,753,840	$1,498,864	$1,498,864
	Other Total		**$142,535,778**	**$140,599,087**	**$151,826,527**
Own Source Revenue (variances transacted during the year)	Cancer	Block Funded Hospitals	$0	$0	$0
	Cancer Total		**$0**	**$0**	**$0**
	Chronic Disease	Block Funded Hospitals	$0	$0	$0
	Chronic Disease Total		**$0**	**$0**	**$0**
	Maternity, Obstetrics & Neonates	Block Funded Hospitals	$0	$0	$0
	Maternity, Obstetrics & Neonates Total		**$0**	**$0**	**$0**
	Mental Health	Block Funded Hospitals	$0	$0	$0
		Community Mental Health	$0	$0	$0
	Mental Health Total		**$0**	**$0**	**$0**
	Palliative, Maintenance & Frail Elderly	Block Funded Hospitals	$0	$0	$0
		Home and Community Care (HACC) Program	$0	$0	$0
		Residential Aged Care	$0	$0	$0
		Transition Care	$0	$0	$0
	Palliative, Maintenance & Frail Elderly Total		**$0**	**$0**	**$0**
	Planned Care	Block Funded Hospitals	$0	$0	$0
	Planned Care Total		**$0**	**$0**	**$0**
	Prevention, Early	Alcohol, Tobacco and Other Drugs	$0	$0	$0

			2016/17 $	2017/18 $	2018/19 $
	Intervention & Primary Healthcare	Block Funded Hospitals	$0	$0	$0
		Community Care Programs	$0	$0	$0
		Home & Community Medical Aids & Appliances	$0	$0	$0
		Oral Health	$0	$0	$0
		Other Community Services	$0	$0	$0
		Primary Health Care	$0	$0	$0
	Prevention, Early Intervention & Primary Healthcare Total		**$0**	**$0**	**$0**
	Statewide Services	Block Funded Hospitals	$0	$0	$0
		State-Wide Functions	$0	$0	$0
	Statewide Services Total		**$0**	**$0**	**$0**
	Trauma & Illness	Block Funded Hospitals	$0	$0	$0
	Trauma & Illness Total		**$0**	**$0**	**$0**
	Other	Commercial Activities	-$6,095,661	-$6,312,265	-$6,777,371
		Research	$0	$626,000	-$31,876
		Specific Allocations	$0	$0	$0
	Other Total		**-$6,095,661**	**-$5,686,265**	**-$6,809,247**
Grand Total			**$282,508,481**	**$277,029,002**	**$294,442,149**

Table 11 Specified Grants

Program	2018/19 Funding
High Cost Outliers	$3,772,106
Limited Indication Medication Scheme	$462,216
PET Service	$1,832,295
Grand Total	**$6,066,616**

Table 12 **Hospital and Health Service Service Agreement and State Level Block Payments to state managed funds from Commonwealth payments into national funding pool**

State:	QLD	**Service agreement for financial year:**	2018/19
HHS	Gold Coast	**Version for financial year:**	
HHS ID		**Version effective for payments from:**	
		Version status:	1/05/2019

HHS ABF payment requirements:

Expected National Weighted Activity Unit (NWAU)		National efficient price (NEP) (as set by IHPA)
ABF Service group	**Projected NWAU**	
Admitted acute public services	118,837	$5,012
Admitted acute private services	10,939	$5,012
Emergency department services	25,930	$5,012
Non-admitted services	30,465	$5,012
Mental health services	12,645	$5,012
Sub-acute services	10,502	$5,012
LHN ABF Total	**209,318**	**$5,012**

Note: NWAU estimates do not take account of cross-border activity.

Reporting requirements by HHS - total block funding paid (including Commonwealth) per HHS, as set out in Service Agreement:

Amount (Commonwealth and state) for each amount of block funding from state managed fund to LHN:	
Block funding component	**Estimated Commonwealth and state block funding contribution (ex GST)**
Block funded hospitals	$0
Community mental health services	$49,343,536
Teaching, Training and Research	$41,545,330
Home ventilation	$753,167
Other block funded services	$0
Total block funding for LHN	**$91,642,032**

7. Purchased Services

7.1. State funded Outreach Services

(a) The HHS forms part of a referral network with other HHSs. Where state funded Outreach Services are currently provided the HHS will deliver these Services in line with the following principles:

i. historical agreements for the provision of Outreach Services will continue as agreed between HHSs;

ii. funding will remain part of the providing HHS's funding base;

iii. activity should be recorded at the HHS where the Service is being provided; and

iv. the Department of Health will purchase outreach activity based on the utilisation of the Activity Based Funding (ABF) price when Outreach Services are delivered in an ABF facility.

(b) Where new or expanded state funded Outreach Services are developed the following principles will apply:

i. the Department of Health will purchase outreach activity based on the utilisation of the ABF price when Outreach Services are delivered in an ABF facility;

ii. agreements between HHSs to purchase Outreach Services will be based on a cost recovery model, which will ensure providing sites are not financially disadvantaged and annual increases will be consistent with the ABF model;

iii. any proposed expansion or commencement of Outreach Services will be negotiated between HHSs;

iv. the HHS is able to purchase the Outreach Service from the most appropriate provider including private providers or other HHSs. However, when a change to existing Services is proposed, a transition period of at least 12 months will apply during which time the HHS will be required to continue to purchase Outreach Services from the HHS currently providing the Service;

v. any changes to existing levels of Outreach Services need to be agreed to by both HHSs and any proposed realignment of funding should be communicated to the Department of Health to ensure that any necessary funding changes are actioned as part of the Service Agreement amendment process and/or the annual negotiation of the Service Agreement Value; and

vi. the activity should be recorded at the HHS where the Service is being provided.

(c) In the event of a disagreement regarding the continued provision of

state funded Outreach Services:

i. any proposed cessation of Outreach Services will be negotiated between HHSs to mitigate any potential disadvantage or risks to either HHS; and

ii. redistribution of funding will be agreed between the HHSs and communicated to the Department of Health to action through the Service Agreement amendment process and/or the annual renegotiation of the Service Agreement Value.

7.2. **Telehealth Services**

(a) The HHS will support implementation of the Department of Health Telehealth program, including the Telehealth Emergency Support Service. The HHS will collaborate with the Department of Health, other HHSs, relevant non-government organisations and primary care stakeholders to contribute to an expanded network of Telehealth Services to better enable a program of scheduled and unscheduled care.

(b) The HHS will ensure dedicated Telehealth Coordinators progress the Telehealth agenda locally, driving stakeholder engagement, adoption, planning and implementation activities that will support and grow Telehealth enabled services through substitution of existing face to face services and identification of new Telehealth enabled models of care.

(c) The HHS will ensure the Medical Telehealth Lead will collaborate with the network of HHS based Telehealth Coordinators and the Telehealth Support Unit to assist in driving promotion and adoption of Telehealth across the state through intra and cross HHS clinician led engagement and change management initiatives as well as informing the development and implementation of clinical protocols and new Telehealth enabled models of care.

7.3. **Newborn hearing screening**

In line with the National Framework for Neonatal Hearing Screening the HHS will:

(a) Provide newborn hearing screening in all birthing hospitals and screening facilities; and

(b) Provide where applicable, co-ordination, diagnostic audiology, family support, and childhood hearing clinic services which meet the existing screening, audiology and medical protocols available from the Healthy Hearing website.

7.4. **Statewide Services**

This clause does not apply to this HHS.

7.5. **Statewide and highly specialised clinical services**

The HHS will:

(a) Participate in and contribute to the staged review of the purchasing model for identified statewide and highly specialised clinical services; and

(b) Collaborate with the Department of Health and other HHSs to support the implementation of recommendations arising from the reviews of statewide and highly specialised clinical services in order to achieve the goals of efficient, equitable and high quality service provision.

7.6. **Regional Services**

The HHS has responsibility for the provision and/or coordination of the Regional Services listed below. It is recommended that the HHS establish a Formal Agreement with the recipient HHSs regarding the roles and responsibilities of Regional Service provision and receipt as described in the Definitions. In the event of a dispute regarding the provision of these services HHSs should refer to clause of the main terms and conditions of this Service Agreement.

(a) **Basic Physician Training Pathway**

i. The HHS will undertake the recruitment, selection, allocation and education of Queensland Basic Physician Pathway Trainees for the Coastal Rotation on behalf of Metro South HHS.

ii. These activities will be undertaken in line with the state-wide Queensland Basic Physician Training Pathway model, supported by a Pathway Rotation Coordinator (Senior Medical Officer) and Pathway Project Officer, hosted in the HHS.

(b) **Eating Disorders Service**

i. Services to Darling Downs, Gold Coast, Metro South, South West, and West Moreton HHSs.

(c) **Mental Health Clinical Indicator Program**

i. Services to Darling Downs, Gold Coast, Metro South, South West, and West Moreton HHSs and Mater Health Services Child and Youth Mental Health.

ii. Contribute to statewide activities as part of the Queensland Mental Health Clinical Improvements Team.

7.7. **Rural and remote clinical support**

This clause does not apply to this HHS.

8. Primary Care and Community Health Services

8.1. The following funding arrangements will apply to the Primary Care and Community Health Services delivered by the HHS:

(a) The Department of Health funding for Community Health Services. A pool of funding for these Services is allocated to each HHS for a range of Community Health Services and must be used to meet local Primary Care and community healthcare needs including through delivery of the Services identified in Table 9 and Table 10. HHSs have the discretion to allocate funding across Primary Care and Community Health Services according to local priorities.

(b) Department of Health specified funding models for consumer information services, disability, residential care, environmental health, offender health services, home and community medical aids, primary care, community mental health services, and alcohol and other drugs services. The funding specified for these programs is listed in Table 9 and Table 10.

(c) Department of Health community health service grants.

(d) Funding from other state government departments and the Commonwealth for specific programs (third party funded services).

8.2. **Public Health Services**

(a) **Specialist Public Health Units**

The HHS will provide public health services in line with public health related legislation and the service and reporting requirements outlined in the Public Health Practice Manual, including:

i. a specialist communicable disease epidemiology and surveillance, disease prevention and control service;

ii. a specialist environmental health service, which includes assessment and coordination of local responses to local environmental health risks; and

iii. regulatory monitoring, enforcement and compliance activity on behalf of the Department of Health.

(b) **Public Health Events of State Significance**

i. The HHS will contribute to and support investigation, prevention and control activities for communicable diseases and environmental hazards of state significance, and where mutually agreed with the Department of Health, lead them.

ii. Support services may also include but are not limited to:

A. the provision of immunisation clinics;

B. contact tracing;

C. provision of prophylactic medications;

D. public health risk assessment; and

E. non-communicable disease cluster assessment.

iii. The HHS will lead the investigation and response in situations where there is a risk of communicable disease transmission or environmental hazard exposure in their public hospitals.

(c) **Preventive health services**

The HHS will:

i. maintain delivery of risk factor prevention and early intervention programs and services targeting nutrition, physical activity, alcohol consumption, tobacco use, overweight and obesity and falls prevention, in conjunction with key primary care partners;

ii. maintain delivery of the school based youth nursing program throughout Queensland secondary schools; and

iii. promote brief interventions, lifestyle modification programs and other prevention, promotion or early intervention activities, in conjunction with key primary care partners.

(d) **Immunisation services**

The HHS will maintain or improve existing immunisation coverage through continuation of current immunisation services including:

i. national immunisation program;

ii. opportunistic immunisation in healthcare facilities;

iii. special immunisation programs; and

iv. delivery of the annual school based vaccination program. Funding for service delivery for the school based vaccination program will be provided non-recurrently by the Department of Health according to the current funding model.

(e) **Tuberculosis services**

The HHS will ensure there is no financial barrier for any person to tuberculosis diagnostic and management services, ensuring full adherence to treatment and appropriate screening in accordance with *The Strategic Plan for Control of Tuberculosis in Australia: 2011-2015,* and the *Tuberculosis (TB) CDNA National Guidelines for the Public Health Management of TB.*

8.3. **Sexual health and viral hepatitis services**

The HHS will:

(a) maintain or increase Blood Born Viruses (BBV) and Sexually Transmitted Infections (STI) service delivery at the Gold Coast Sexual

Health Clinic by suitably qualified staff in accordance with a locally endorsed and dated Health Management Protocol to support the current Drug Therapy Protocol – Sexual Health Program Nurse (including Reproductive Health);

(b) maintain or increase the service level provided by the Gold Coast Hospital hepatology services for people with hepatitis B and C, including via telehealth where appropriate;

(c) maintain or increase the service level of BBV and STI related outreach services;

(d) maintain or increase psychiatrist/psychologist sessions provided to people impacted by BBVs and STIs;

(e) maintain or increase the level of support for the Metro South HHS based Contact Tracing Support Officer program;

(f) maintain or increase the level of support for the Metro South HHS based cross-District BBV and STI Coordinator program; and

(g) maintain or increase the level of support for BBV and STI community based programs for at risk populations including access to relevant resources including the Needle and Syringe Program.

8.4. **Cancer screening services**

(a) The HHS will:

i. develop and implement a participation plan to promote bowel cancer screening and provide timely, appropriate high quality and safe diagnostic assessment services for National Bowel Cancer Screening Program participants in accordance with the National Health and Medical Research Council's *Clinical Guidelines for Prevention, Early Detection and Management of Colorectal Cancer* (2017):

A. services to be provided across Gold Coast HHS excluding the Statistical Local Areas (SLAs) of Jacobs Well-Alberton, Ormeau-Yatala, and Kingsholme-Upper Coomera; and

B. services to be provided within Metro South HHS for the SLAs of Scenic Rim (R) – Beaudesert, and Greenbank-Boronia Heights only.

ii. develop and implement a local service management plan to guide promotion and delivery of accessible breast screening for women in the target age group (50-74 years) through a BreastScreen Australia accredited service. The screening and assessment services should be delivered in accordance with the BreastScreen Queensland (BSQ) Quality Standards Protocols and Procedures Manual, BreastScreen Australia National Accreditation Standards and national policies:

A. services to be provided across the Gold Coast HHS; and

B. services to be provided within the Metro South HHS for the Beenleigh, Eagleby, Beaudesert, Bethania-Waterford, Mount Warren Park, Edens Landing-Holmview, Jimboomba, Logan Village, Greenbank, Munruben-Park Ridge South and Wolffdene-Bahrs Scrub SA2s only.

iii. allow the use of the HHS BSQ Mobile asset by other HHSs during periods where practical to maximise utilisation of BSQ Mobile fleet; and

iv. negotiate utilisation of the HHS BSQ Mobile assets controlled by the Central Queensland HHS and Mackay HHS to provide additional BSQ Mobile service fleet capacity during down periods where practical for these HHS BSQ Mobile assets.

(b) The HHS will schedule screening services through provision of BSQ mobile vans to increase accessibility for women living in rural and remote areas. While screening schedules are ideally finalised by HHSs six months in advance, confirmation of mobile and relocatable sites is required by the BreastScreen Queensland Registry eight weeks prior to commencement at each site to ensure invitations for screening are prepared and distributed to women in the catchment area.

(c) The HHS will develop and implement infrastructure plans to manage asset lifecyle performance and replacement schedules including mobile vans. The repair and maintenance services for the BSQ mobile service fleet will be provided by the Mobile Dental Clinic Workshop in Metro South HHS. The Mobile Dental Clinic Workshop in Metro South HHS will meet the costs for these services subject to availability of allocated funding for this purpose in any given financial year.

8.5. **Oral health services**

The HHS will ensure that:

(a) oral health services are provided to the Eligible Population at no cost to the patient[8] and that the current range of clinical services will continue;

(b) oral health services fulfil the relevant obligations related to Commonwealth Government dental funding program/s;

(c) service delivery is consistent with Queensland Health's oral health policy framework; and

(d) the repair, maintenance and relocation services to the mobile dental fleet continues to be provided by the Mobile Dental Clinic Workshop

[8] The HHS may provide oral health services on a fee-for-service basis to non-eligible patients in rural and remote areas where private dental services are not available.

in Metro South HHS.

8.6. **Offender health services**

The HHS will:

(a) provide health services to prisons located within the HHS (Offender Health Service);

(b) provide the Department of Health with an annual report detailing the Offender Health Services which have been provided to prisons within the HHS;

(c) where necessary, for both health and security reasons, agree for the transportation of the prisoner to a Queensland Health Secure Unit for tertiary and secondary health services;

(d) on release of a prisoner, transfer medical records to West Moreton HHS for long term archiving. The HHS must ensure that medical records transfer with the prisoner when they are moving to another facility; and

(e) provide offenders with smoking cessation support.

8.7. **Refugee health**

This clause does not apply to this HHS.

9. Teaching training and research

The HHS will provide the teaching, training and research programs for which funding is provided within Schedule 2 of this Service Agreement and as described below:

9.1. **Clinical education and training**

(a) The HHS will:

i. continue to support and align with the current Student Placement Deed Framework which governs clinical placements from relevant tertiary education providers in Queensland HHS facilities;

ii. comply with the obligations and responsibilities of Queensland Health under the Student Placement Deed, as appropriate, as operator of the facility at which the student placement is taking place;

iii. comply with the terms and conditions of students from Australian education providers participating in the Student Placement Deed Framework;

iv. only accept clinical placements of students from Australian education provides participating in the Student Placement Deed Framework;

v. continue to provide training placements consistent with and proportionate to the capacity of the HHS. This includes, but is not limited to, the provision of placements for the following professional groups relevant to the HHS:

A. medical students

B. nursing and midwifery students

C. pre-entry clinical allied health students

D. interns

E. rural generalist trainees

F. vocational medical trainees

G. first year nurses and midwives

H. re-entry to professional register nursing and midwifery candidates

I. dental students

vi. participate in vocational medical rotational training schemes, facilitate the movement of vocational trainees between HHSs and work collaboratively across HHSs to support education and training program outcomes;

vii. report annually on the number of pre-entry clinical placements for allied health professions to the Allied Health Professions' Office of Queensland, Department of Health;

viii. comply with the state-wide vocational medical training pathway models including:

A. The Queensland Basic Physician Training Pathway

B. The Queensland Intensive Care Training Pathway

C. The Queensland Basic Paediatric Training Network

ix. support the provision of placements by the Queensland Physiotherapy Placement Collaborative for physiotherapy pre-entry students via the Physiotherapy Pre-registration Clinical Placement Agreement; and

x. provide clinical area placements for dietetics pre-entry students from additional funding provided through relevant agreements with Universities.

(b) In addition, the Health Practitioners and Dental Officers (Queensland Health) Certified Agreement (No 1) 2015 (the HP agreement) requires Hospital and Health Services to:

i. continue to support development of allied health research capacity through continued implementation and retention of health practitioner research positions provided through the HP

agreement; and

ii. support development of allied health clinical education capacity through continued implementation and retention of clinical educator positions provided through the HP agreement, continuing to provide allied health pre-entry clinical placements and maintaining support for allied health HP 3 to 4 rural development pathway positions.

(c) The HHS will maintain or increase its contribution of staff to the Queensland Country Relieving doctors program and the receiving HHS will be responsible for wages, clinical governance and appropriate supervision of the junior medical relievers.

9.2. **Health and medical research**

The HHS will:

(a) Articulate an investment strategy for research (including research targets and Performance Measures) which integrates with the clinical environment to improve clinical outcomes;

(b) Develop mechanisms for completing administrative governance for the approval of research in line with a national benchmark of 25 days (Standard Operating Procedures for Queensland Health Research Governance Officers 2013);

(c) Develop mechanisms for monitoring site research activity in line with jurisdictional commitments and National Health and Medical Research Council Guidelines (Framework for Monitoring Guidance for the national approach to single ethical review of multi-centre research, January 2012); and

(d) Develop systems to capture research and development expenditure and revenue data and associated information on research.

Schedule 3 Performance Measures

1. Purpose

This Schedule 3 outlines the Performance Measures that apply to the HHS.

2. Performance Measures

2.1. The Performance Framework uses Performance Measures to monitor the extent to which the HHS is delivering the high-level objectives set out in this Service Agreement.

2.2. Performance Measures are grouped into four categories:

(a) Safety and Quality Markers which together provide timely and transparent information on the safety and quality of services provided by the HHS;

(b) Key Performance Indicators (KPIs) which are focused on the delivery of key strategic objectives and statewide targets. KPI performance will inform HHS performance assessments;

(c) Outcome Indicators which provide information on specific activities and interventions where there is a reasonable expectation or evidence that they make a positive contribution towards improving the health status and experience of patients; and

(d) Supporting Indicators which provide contextual information and enable an improved understanding of performance, facilitate benchmarking of performance across HHSs and provide intelligence on potential future areas of focus. Supporting Indicators are available on line as referenced in Appendix 1 to this Service Agreement.

2.3. The Performance Measures identified in Table 13, Table 14 and Table 15 are applicable to all HHSs unless otherwise specified within the attribute sheet.

2.4. The HHS will meet the target for each KPI identified in Table 13 as specified in the attribute sheet.

2.5. The Performance Measures identified in Table 13, Table 14 and Table 15 using italic text are under development.

2.6. The HHS should refer to the relevant attribute sheet for each Performance Measure for full details. These are available on-line as referenced in Appendix 1 to this Service Agreement.

2.7. The HHS should refer to the supporting document to this Service Agreement, 'Developing a High Performing Health System for Queenslanders: Performance Framework' referenced at Appendix 1 to this Service Agreement for further information on the performance assessment process.

Table 13 HHS Performance Measures – Key Performance Indicators

Key Performance Indicators
Timely
Care is provided within an appropriate timeframe
• Treatment within clinically recommended time
Title
Emergency length of stay: • % of attendances at an Emergency Department who depart within 4 hours
Emergency Department wait time by triage category
Patient off stretcher time: • % <30 minutes
Elective surgery: • % of patients treated within the clinically recommended time
Specialist outpatients: • % of specialist outpatients seen within the clinically recommended time • % of unseen specialist outpatients - reduction target
Upper and lower Gastrointestinal endoscopies: • % treated in time
Access to oral health services: • % of patients on the general care dental wait list waiting for less than the clinically recommended time
Telehealth utilisation rates
Efficient
Available resources are maximised to deliver sustainable, high quality healthcare
• Avoid waste • Minimise financial risk • Sustainable/productive • Maximise available resources
Title
Full year forecast operating position
Minimum Obligatory Human Resource Information (MOHRI): • Average affordable MOHRI • Comparison against Service Delivery Statement
Purchased activity variance
Funding and cost per Queensland Weighted Activity Unit (QWAU)
Capital expenditure performance
Theatre utilisation • Preventable day of surgery cancellations • Elective operating session on-time starts
Delayed transfers of care following an inpatient admission
Relative Stay Index
Linked Service Delivery Statement measures
• Percentage of patients attending emergency departments seen within recommended timeframes • Percentage of emergency department attendances who depart within four hours of their arrival in the department • Median wait time for treatment in emergency departments

- Percentage of elective surgery patients treated within clinically recommended times
- Number of elective surgery patients treated within clinically recommended times
- Median wait time for elective surgery treatment
- Percentage of specialist outpatients waiting within clinically recommended times
- Percentage of specialist outpatients seen within clinically recommended times
- Percentage of patients transferred off-stretcher within 30 minutes
- Percentage of public general dental care patients waiting within the recommended timeframe
- Average cost per weighted activity unit for ABF facilities
- Total weighted activity units
- Number of telehealth outpatients occasions of service

Table 14 HHS Performance Measures - Safety and Quality Markers

Safety and Quality Markers	
Safe	
The health and welfare of service users is paramount	
• Minimise risk • Transparency and openness	• Avoid harm from care • Learn from mistakes
Title	
Hospital Acquired Complications	
Sentinel Events	
Hospital Standardised Mortality Ratio	
Healthcare-associated Staphylococcus aureus (including MRSA) bacteraemia	
Severity Assessment Code (SAC) 1 - 4 Closure Rates	
Unplanned Readmission Rates	
Linked Service Delivery Statement measures	
• Rate of healthcare-associated Staphylococcus aureus (including MRSA) bloodstream infections	

Table 15 HHS Performance Measures – Outcome Indicators

Outcome Indicators	
Safe	
The health and welfare of service users is paramount	
• Minimise risk	• Avoid harm from care
• Transparency and openness	• Learn from mistakes
Title	
Rate of seclusion events	
Rate of absent without approval	
Rate of face to face community follow up within 1-7 days of discharge from an acute mental health inpatient unit	
% of Emergency Department stays greater than 24 hours	
Patient Centred	
Providing Healthcare that is respectful of and responsive to individual patient preferences, needs and values	
• Patient involved in care	• Patient feedback
• Respects patient/person values and preferences	• Care close to home
Title	
Patient reported experience	
Complaints resolved within 35 calendar days	
Proportion of mental health service episodes with a documented care plan	
Advanced care planning	
Equitable	
Consumers have access to healthcare that is responsive to need and addresses health inequalities	
• Fair access based on need	• Addresses inequalities
Title	
Aboriginal and Torres Strait Islander representation in workforce	
Number of completed courses of oral health care for Aboriginal and Torres Strait Islander adult patients	
Low birthweight	
Effective	
Healthcare that delivers the best achievable outcomes through evidence based practice	
• Evidence based practice	• Care integration
• Treatment directed to those who benefit	• Optimise Health
• Clinical Capability	
Title	
Uptake of the smoking cessation clinical pathway for inpatients and dental clients	
Potentially Preventable Hospitalisations – diabetes complications	
% of oral health activity which is preventive	
Cardiac rehabilitation	
Adolescent vaccinations administered via the statewide School Immunisation Program	
Reperfusion therapy for acute ischaemic stroke	
Maternity services outcomes	

Cardiac services outcomes
Linked Service Delivery Statement measures
• Rate of community mental health follow up within 1-7 days following discharge from an acute mental health inpatient unit: – Aboriginal and Torres Strait Islander – Non-Aboriginal and Torres Strait Islander • Ratio of Potentially Preventable Hospitalisations: – Rate of Aboriginal and Torres Strait Islander hospitalisations to non-Aboriginal and Torres Strait Islander hospitalisations • Percentage of babies born of low birth weight to: – Non-Aboriginal and Torres Strait Islander women – Aboriginal and Torres Strait Islander women • Percentage of oral health weighted occasions of service which are preventive

Schedule 4 Data Reporting Requirements

1. Purpose

A *The Hospital and Health Boards Act 2011*[9] (s.16(1)(d)) provides that the Service Agreement will state the performance data and other data to be provided by an HHS to the Chief Executive, including how, and how often, the data is to be provided.

B This Schedule 4 specifies the data to be provided by the HHS to the Chief Executive and the requirements for the provision of the data. It replaces the rescinded health service directive QH-HSD-019:2012, *Data Collection and Provision of Data to the Chief Executive.*

2. Principles

2.1. The following principles guide the collection, storage, transfer and disposal of data:

(a) Trustworthy – data is accurate, relevant, timely, available and secure;

(b) Private – personal information is protected in accordance with the law;

(c) Valued – data is a core strategic asset;

(d) Managed – collection of data is actively planned, managed and compliant; and

(e) Quality – data provided is complete, consistent, undergoes regular validation and is of sufficient quality to enable the purposes outlined in clause 3.2 of this Schedule 4 to be fulfilled.

2.2. The Parties agree to constructively review the data reporting requirements as set out in this Schedule 4 on an ongoing basis in order to:

(a) ensure data reporting requirements are able to be fulfilled; and

(b) minimise regulatory burden.

[9] Section 143(2)(a) of the *Hospital and Health Boards Act 2011* provides that the disclosure of confidential information (as defined in s.139 of the Act) to the Chief Executive by an HHS under a service agreement is a disclosure permitted by an Act.

3. Roles and responsibilities

3.1. Hospital and Health Services

(a) The HHS will:

i. provide, including the form and manner and at the times specified, the data specified in the data set specifications (Attachment A to this Schedule 4) in accordance with this Schedule 4;

ii. provide data in accordance with the provisions of the Hospital and Health Boards Act 2011, Public Health Act 2005 and Private Health Facilities Act 1999;

iii. provide other HHSs with routine access to data, that is not Patient Identifiable Data, for the purposes of benchmarking and performance improvement;

iv. provide data as required to facilitate reporting against the Performance Measures set out in Schedule 3 of this Service Agreement;

v. provide data as specified within the provision of a health service directive;

vi. provide activity data that complies with the national data provision timeframes required under the Independent Hospital Pricing Authority (IHPA) data plan for Commonwealth funding. Details of the timeframes are specified in the 'Efficient Growth National Weighted Activity Units' specification sheet referenced at Appendix 1; and

vii. as requested by the Chief Executive from time to time, provide to the Chief Executive data, whether or not specified in this Schedule 4 or the Service Agreement, as specified by the Chief Executive in writing to the HHS in the form and manner and at the times specified by the Chief Executive.

(b) Data that is capable of identifying patients will only be disclosed as permitted by, and in accordance with, the *Hospital and Health Boards Act 2011, Public Health Act 2005 and the Private Health Facilities Act 1999.*

3.2. Department of Health

The Department of Health will:

(a) Produce a monthly performance report which includes:

i. actual activity compared with purchased activity levels;

ii. any variance(s) from purchased activity;

iii. performance information as required by the Department of Health to demonstrate HHS performance against the

Performance Measures specified in Schedule 3 of this Service Agreement; and

iv. performance information as required by the Department of Health to demonstrate the achievement of commitments linked to specifically allocated funding included in Schedule 2, Table 2 of this Service Agreement.

(b) Utilise the data sets provided for a range of purposes including:

i. to fulfil legislative requirements;

ii. to deliver accountabilities to state and commonwealth governments;

iii. to monitor and promote improvements in the safety and quality of health services; and

iv. to support clinical innovation.

(c) Advise the HHS of any updates to data set specifications as they occur.

Attachment A Data Set Specifications

The HHS should refer to the relevant minimum data set for each data specification for full details. These are available on-line as referenced in Appendix 1.

Table 16 Clinical data

Data Set	Data Custodian
Aged Care Assessment Team data via the ACE database	Strategic Policy Unit
Alcohol Tobacco and Other Drugs Services data	Mental Health Alcohol and Other Drugs Branch
Alcohol and Other Drugs Establishment Collection	Mental Health Alcohol and Other Drugs Branch
Allied Health Clinical Placement and New Graduate Data	Allied Health Professions Office of Queensland
Australian and New Zealand Intensive Care Society (ANZICS) Data Collection	Healthcare Improvement Unit
BreastScreening Clinical Data	Chief Health Officer
Cervical Screening/Pap Smear Registry Data	Chief Health Officer
Clinical Incident Data Set	Patient Safety and Quality Improvement Service
Consumer Feedback Data Set	Patient Safety and Quality Improvement Service
Elective Surgery Data Collection	Healthcare Improvement Unit
Emergency Data Collection	Healthcare Improvement Unit
Gastrointestinal Endoscopy Data Collection	Healthcare Improvement Unit
Hand Hygiene Compliance Data	Chief Health Officer
Healthcare Infection Surveillance Data	Chief Health Officer
Maternal Deaths	Queensland Maternal and Perinatal Quality Council (through Statistical Services Branch)
Mental Health Act Data	Mental Health Alcohol and Other Drugs Branch
Mental Health Activity Data Collection	Mental Health Alcohol and Other Drugs Branch
Mental Health Establishments Collection	Mental Health Alcohol and Other Drugs Branch
Monthly Activity Collection (including admitted and non-admitted patient activity and bed availability data)	Statistical Services Branch
Newborn Hearing Screening	Children's Health Queensland.
Notifications Data	Chief Health Officer
Patient Experience Survey Data	Patient Safety and Quality Improvement Service
Patient Level Costing Data	HHS Funding and Costing Unit
Perinatal Data Collection	Statistical Services Branch

Data Set	Data Custodian
Queensland Bedside Audit	Patient Safety and Quality Improvement Service
Queensland Health Non-Admitted Patient Data Collection	Statistical Services Branch
Queensland Hospital Admitted Patient Data Collection	Statistical Services Branch
Queensland Needle and Syringe Program (QNSP) data	Chief Health Officer
Queensland Opioid Treatment Program Admissions and Discharges	Chief Health Officer
Radiation Therapy Data Collection	Healthcare Improvement Unit
Residential Mental Health Care Collections	Mental Health Alcohol and Other Drugs Branch
Schedule 8 Dispensing data	Chief Health Officer
School Immunisation Program – Annual Outcome Report	Communicable Diseases Branch
Specialist Outpatient Data Collection	Healthcare Improvement Unit
National Notifiable Diseases Surveillance System	Chief Health Officer
Vaccination Administration data	Chief Health Officer
Variable Life Adjusted Display (VLAD) CM (collection of hospital investigations)	Patient Safety and Quality Improvement Service
Your Experience of Service (YES) Survey Collection (Mental Health)	Mental Health Alcohol and Other Drugs Branch

Table 17 Non-clinical data

Non-Clinical Data Set	Data Custodian
Asbestos management data	Asset and Property Services
Asset Management **- Planning** **- Maintenance** **- Maintenance Budget** **- BMRP program** **- Benchmarking & Performance Data**	Asset and Property Services
Capital investment project and financial data (other than minor capital)	Capital and Asset Services
Conduct and Performance Excellence (CaPE)	Human Resources Branch
Department of Health Car Park Lease Agreements	Capital and Asset Services
Expenditure	Finance Branch
Financial and Residential Activity Collection (FRAC)	Statistical Services Branch
Graduate Nursing Recruitment Data Statewide using the Public Service Commission Graduate Portal System.	Office of the Chief Nursing and Midwifery Officer
Minimum Obligatory Human Resource Information (MOHRI)	Finance Branch
Minor Capital Funding Program expenditure & forecast data	Finance Branch
Recruitment Data	Human Resources Branch

Non-Clinical Data Set	Data Custodian
Revenue	Finance Branch
Queensland Health Workforce & Work Health & Safety Data	Human Resources Branch
Queensland Integrated Safety Information Project (QISIP)Solution Minimum Data Set	Human Resources Branch
Statewide employment matters	Human Resources Branch
Whole of Government Asset Management Policies data	Asset and Property Services

Schedule 5 Amendments to this Service Agreement

1. Purpose

This Schedule 5 sets out the mechanisms through which this Service Agreement may be amended during its term, consistent with the requirements of the *Hospital and Health Boards Act 2011.*

2. Principles

2.1. It is acknowledged that the primary mechanism through which HHS funding adjustments are made is through the budget build process that is undertaken annually in advance of the commencement of the financial year. This approach is intended to provide clarity, certainty and transparency in relation to funding allocations.

2.2. Amendments to the drafting and clauses of this Service Agreement should be progressed for consideration as part of the annual budget build process.

2.3. It is recognised that there is a requirement to vary funding and activity in-year. The following principles will guide amendments and amendment processes:

(a) funding allocations to HHSs should occur as early as possible within a financial year if unable to be finalised in advance of a given financial year;

(b) the number of Amendment Windows each year should be minimised to reduce the administrative burden on HHSs and the Department of Health;

(c) Amendment Proposals should be minimised wherever possible and should always be of a material nature;

(d) Amendment Windows 2 and 3 are not intended to include funding or activity variations that could have been anticipated in advance of the financial year;

(e) Amendment Windows are intended to provide a formal mechanism to transact funding or activity variations in response to emerging priorities;

(f) Extraordinary Amendment Windows are not intended to be routinely used.

2.4. The Department of Health remains committed to the ongoing simplification and streamlining of amendment processes.

3. Process to amend this Service Agreement

3.1. The parties recognise the following mechanisms through which an amendment to this Service Agreement can be made:

(a) Amendment Windows;

(b) Extraordinary Amendment Windows;

(c) periodic adjustments; and

(d) end of year financial adjustments.

3.2. **Amendment Windows**

(a) In order for the Department of Health to manage amendments across all HHS Service Agreements and their effect on the delivery of public health services in Queensland, proposals to amend this Service Agreement will be negotiated and finalised during set periods of time during the year (Amendment Windows).

(b) Amendment Windows are the primary mechanism through which amendments to this Service Agreement are made.

(c) Amendment Windows occur three times within a given financial year:

i. Amendment Window 1: Annual Budget Build;

ii. Amendment Window 2: In-year variation; and

iii. Amendment Window 3: In-year variation.

(d) A Party that wants to amend the terms of this Service Agreement must give an Amendment Proposal to the other party.

(e) While a Party may submit an Amendment Proposal at any time, an Amendment Proposal will only be formally negotiated and resolved during one of the Amendment Windows outlined in Table 18 (excluding Extraordinary Amendment Windows).

Table 18 Amendment Window Exchange Dates

Amendment Window	Exchange Date	Primary Focus
AW1: Annual Budget Build	*Completed*	*2016/17 budget build*
AW2: In-year variation	7 October 2016	2016/17 in-year variations
AW1: Annual Budget Build	14 April 2017	2017/18 budget build
AW2: In-year variation	6 October 2017	2017/18 in-year variations
AW3: In-year variation	9 February 2018	2017/18 in-year variations
AW1: Annual Budget Build	29 March 2018	2018/19 budget build
AW2: In-year variation	5 October 2018	2018/19 in-year variations
AW3: In-year variation	8 February 2019	2018/19 in-year variations

(f) An Amendment Proposal is made by:

i. the responsible Deputy Director-General signing and providing

an Amendment Proposal to the Hospital and Health Service – Service Agreement (HHS-SA) contact person through Healthcare Purchasing and System Performance Division prior to the commencement of any Amendment Window; or

ii. the Health Service Chief Executive signing and providing an Amendment Proposal to the Department of Health Service Agreement (DH-SA) contact person prior to the commencement of any Amendment Window.

(g) Subject to the terms of this Service Agreement, any requests for amendment made outside these periods, that are not actioned through the alternative mechanisms identified in this Schedule 5, are not an Amendment Proposal for the purposes of this Agreement and need not be considered by the other Party until the next Amendment Window.

(h) A Party giving an Amendment Proposal must provide the other Party with the following information:

i. the rationale for the proposed amendment;

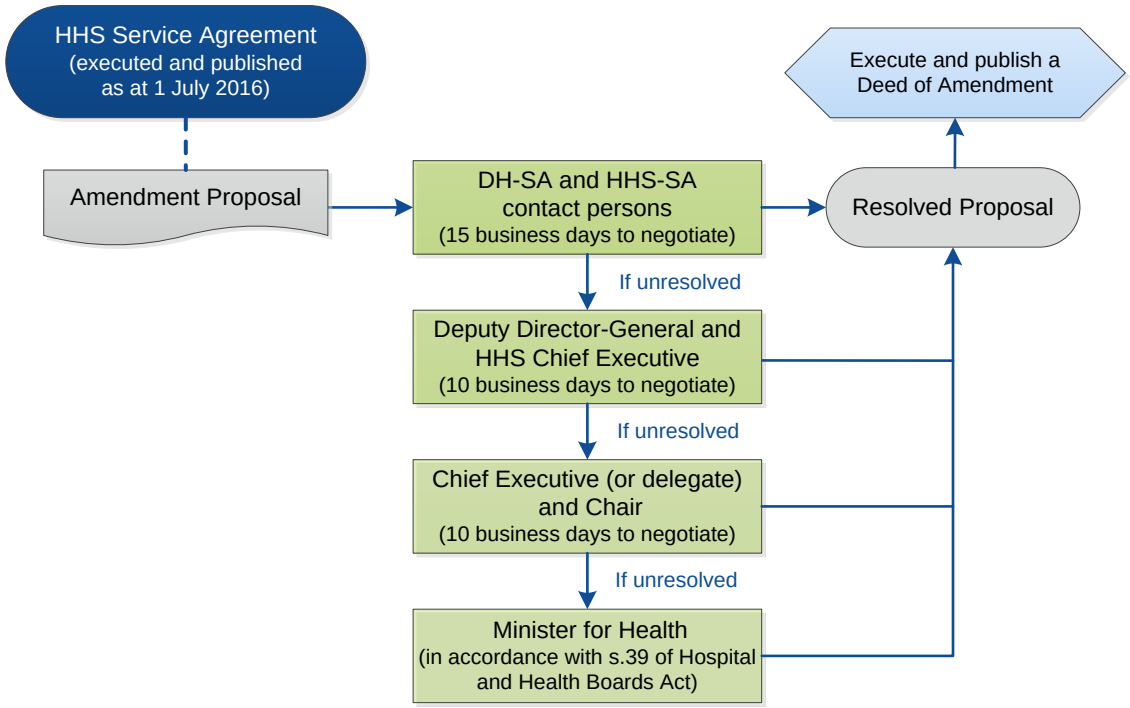
ii. the precise drafting for the proposed amendment;

iii. any information and documents relevant to the proposed amendment; and

iv. details and explanation of any financial, activity or service delivery impact of the amendment.

(i) Negotiation and resolution of Amendment Proposals will be through a tiered process, as outlined in Figure 3.

Figure 3 Amendment Proposal negotiation and resolution



(j) The Negotiation Periods identified in Figure 3 may be reduced in the complete discretion of the Chief Executive.

(k) In accordance with section 39(5) of the Hospital and Health Boards Act 2011, the parties must include any terms decided by the Minister for Health in the Service Agreement.

(l) If the Chief Executive at any time:

i. considers that an amendment agreed with the HHS may or will have associated impacts on other HHSs; or

ii. considers it appropriate for any other reasons,

then the Chief Executive may:

i. propose further amendments to any HHS affected; and

ii. may address the amendment and/or associated impacts of the amendment in other ways, including through the exercise of any statutory powers and/or statutory directions under the *Hospital and Health Boards Act 2011*.

(m) Amendment Proposals that are resolved will be documented in a Deed of Amendment to this Service Agreement and executed by the Parties.

(n) Only upon execution of a Deed of Amendment by the Parties will the amendments documented by that Deed of Amendment be deemed to be an amendment to this Service Agreement.

3.3. **Extraordinary Amendment Windows**

(a) A Party that wants to amend the terms of this Service Agreement outside of an Amendment Window outlined in Table 18 must give an Extraordinary Amendment Proposal to the other Party.

(b) An Extraordinary Amendment Proposal may only be formally negotiated and resolved outside of an Amendment Window outlined in Table 18 to facilitate funding allocations where an urgent priority needs to be addressed in a timely manner and an Amendment Window is not available within an acceptable timeframe.

(c) An Extraordinary Amendment Proposal that is issued by or on behalf of the Chief Executive must be given to the HHS-SA Contact Person through Healthcare Purchasing and System Performance Division.

(d) An Extraordinary Amendment Proposal that is issued by or on behalf of the HHS must be given to the DH-SA Contact Person through Healthcare Purchasing and System Performance Division.

(e) An Extraordinary Amendment Proposal may be issued by or on behalf of either Party at any time, noting the requirement that it relate to an urgent priority that necessitates timely resolution.

(f) Negotiation and resolution of Extraordinary Amendment Proposals will be through a tiered process at outlined in Figure 3.

(g) The Negotiation Periods identified in Figure 3 may be reduced in the complete discretion of the Chief Executive.

(h) In accordance with section 39(5) of the Hospital and Health Boards Act 2011, the Parties must include any terms decided by the Minster for Health in the Service Agreement.

(i) Extraordinary Amendment Proposals that are resolved must be executed by both Parties.

(j) The parties must comply with the terms of the Extraordinary Amendment Proposal from the date that the final Party executed the Extraordinary Amendment Proposal.

(k) The terms of an executed Extraordinary Amendment Proposal will be documented in a Deed of Amendment to this Service Agreement and executed by the Parties. Once executed, the Deed of Amendment will expressly exclude the application of the Extraordinary Amendment Proposal and only the terms of the Deed of Amendment will apply.

3.4. **Periodic adjustments**

(a) The Service Agreement Value may be adjusted outside of an Amendment Window to allow for funding variations that:

i. occur on a periodic basis;

ii. are referenced in the Service Agreement; and

iii. are based on a clearly articulated formula.

(b) Adjustments to the Service Agreement Value and purchased activity that are required as a result of a periodic adjustment will be made following agreement between the Parties of the data on which the adjustment is based.

(c) The Chief Executive (or delegate) will issue an Adjustment Notice to the HHS-SA Contact Person confirming any funding adjustment that has been made.

(d) Following receipt of an Adjustment Notice, the parties will comply with the Adjustment Notice and immediately take the steps necessary to give effect to the requirements of the Adjustment Notice.

(e) A Deed of Amendment will not be issued immediately following periodic adjustment. The HHS will be provided with a summary of all transactions made through periodic adjustment on completion.

(f) Any funding adjustments agreed through periodic adjustment which result in a variation to the Service Agreement Value, purchased activity or the requirements specified within Table 2 Schedule 2 of this Service Agreement will be formalised in a Deed of Amendment issued following the next available Amendment Window as identified in Table 18, Schedule 5.

3.5. **End of financial year adjustments**

(a) End of year financial adjustments may be determined after the financial year end outside of the Amendment Window process.

(b) The scope will be defined by the Department of Health and informed by Queensland Government Central Agency requirements.

(c) The Department of Health will provide the HHS with a reconciliation of all Service Agreement funding and purchased activity for the prior financial year. This will reflect the agreed position between the parties following conclusion of the end of year financial adjustments process.

(d) The impact of end of year financial adjustments on subsequent year funding and activity will be incorporated in the Service Agreement through the Deed of Amendment executed following the next available Amendment Window.

(e) This clause will survive expiration of this Service Agreement.

Schedule 6 Definitions

In this Service Agreement:

Act means the *Hospital and Health Boards Act 2011*.

Activity Based Funding (ABF) means the funding framework which is used to fund public health care services delivered across Queensland. The ABF framework applies to those Queensland Health facilities which are operationally large enough and have the systems which are required to support the framework. The ABF framework allocates health funding to these hospitals based on standardised costs of health care services (referred to as 'activities') delivered. The Framework promotes smarter health care choices and better care by placing greater focus on the value of the health care delivered for the amount of money spent.

Adjustment Notice means the written notice of a proposed funding adjustment made by or on behalf of the Chief Executive in accordance with the terms of this Service Agreement.

Administrator of the National Health Funding Pool means the position established by the *National Health Reform Amendment (Administrator and National Funding Body) Act 2012* for the purposes of administering the National Health Funding Pool according to the National Health Reform Agreement.

Agreement means this Service Agreement.

Ambulatory Care means the care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. Can also be used to refer to care provided to patients of community-based (non-hospital) healthcare services.

Amendment Proposal means the written notice of a proposed amendment to the terms of this Service Agreement as required under section 39 of the *Hospital and Health Boards Act 2011*.

Amendment Window means the period within which Amendment Proposals are negotiated and resolved as specified in Table 18 Schedule 5 .

Block Funding means funding for those services which are outside the scope of ABF.

Business Day means a day which is not a Saturday, Sunday or bank or public holiday in Brisbane.

Cessation means to temporarily or permanently halt a service.

Chair means the Chair of the Hospital and Health Board.

Chief Executive means the chief executive of the department administering the *Hospital and Health Boards Act 2011.*

Clinical Network means a formally recognised group, principally comprising clinicians, established to address issues in quality and efficiencies of health care.

Clinical Product/Consumable means a product that has been clinically prescribed by a treating clinician.

Clinically Prescribed means prescribed by appropriately qualified and credentialed clinicians relative to the product.

Clinical Prioritisation Criteria means statewide minimum criteria to determine if a referral to specialist medical or surgical outpatients is necessary and, if so, the urgency of that treatment; and criteria to determine if further treatment is necessary and, if so, the urgency of that treatment.

Clinical Services Capability Framework means the Clinical Services Capability Framework for Public and Licensed Private Health Facilities which provides a standard set of minimum capability criteria for service delivery and planning. The Framework outlines the minimum service requirements, staffing, support services and risk considerations for both public and private health services to ensure safe and appropriately supported clinical service delivery. It applies to all public and private licensed facilities in Queensland. References to the Clinical Services Capability Framework in this Service Agreement mean the most recent approved version unless otherwise specified.

Clinical Support Service means clinical services, such as pharmacy, pathology, diagnostics and medical imaging that support the delivery of inpatient, outpatient and ambulatory care.

Commencement means the point at which a new service begins operation.

Community Health Service means non-admitted patient health services, excluding hospital outpatient services, typically delivered outside of a hospital setting.

Data Set Specifications means the specifications, set out at Attachment A – *Data Set Specifications* to Schedule 4 – *Data Reporting Requirements*, for the data required to be provided by HHSs to the Chief Executive in accordance with the Service Agreement.

Day Case means a treatment or procedure undertaken where the patient is admitted and discharged on the same date.

Deed of Amendment means the resolved amendment proposals.

Department of Health means Queensland Health, acting through the Chief Executive.

Department of Health-Service Agreement (DH-SA) Contact Person means the position nominated by the Department of Health as the primary point of contact for all matters relating to this Service Agreement.

Directive means a directive made under the Act, and directives forming part of the applied law.

Efficient Growth means the increased in-scope activity based services delivered by a HHS measured on a year to year basis in terms of both the Queensland efficient price for any changes in the volume of services provided and the growth in the national efficient price of providing the existing volume of services.

Eligible Population (Oral Health Services) refers to the proportion of the population for whom publicly funded oral health services is to be provided and is defined by the following criteria:

(a) adults, and their dependents, who are Queensland residents, and

where applicable, currently in receipt of benefits from at least one of the following concession cards:

i. Pensioner Concession Card issued by the Department of Veteran's Affairs;

ii. Pensioner Concession Card issued by Centrelink;

iii. Health Care Card (this includes Low Income Health Care Card Holders who are automatically eligible for services);

iv. Commonwealth Seniors Health Card;

v. Queensland Seniors Card.

(b) children who are Queensland residents and are:

i. eligible for dental program/s funded by the Commonwealth Government; or

ii. four years of age or older and have not completed Year 10 of secondary school; or

iii. dependents of current concession card holders or hold a current concession card.

Exchange Date means the date on which the parties must provide Amendment Proposals for negotiation during an Amendment Window, as specified in Table 18 Schedule 5.

Extraordinary Amendment Window means an Amendment Window that occurs outside of the Amendment Windows specified in Table 18 Schedule 5, in accordance with the provisions of clause 3.3 of Schedule 5.

Facility means a physical or organisational structure that may operate a number of services of a similar or differing capability level.

Force Majeure means an event:

(a) which is outside of the reasonable control of the party claiming that the event has occurred; and

(b) the adverse effects of which could not have been prevented or mitigated against by that party by reasonable diligence or precautionary measures, and includes lightning, earthquake, fire, cyclone, flood, natural disasters, health pandemics, acts of terrorism, riots, civil disturbances, industrial disputes and strikes (other than strikes involving that party, its agents, employees or suppliers), war (declared or undeclared), revolution, or radioactive contamination

Formal Agreement means an agreed set of roles and responsibilities relating to the provision and receipt of services designated as Statewide or Regional:

(a) Statewide or Regional service provision

i. ensure equitable and timely access to entire catchment (clinical and non-clinical)

ii. provide training and consultation services where this is appropriate within the agreed model of care (clinical and non-clinical)

iii. timely discharge or return of patients to their place of residence (clinical services)

iv. adequate communication practices to enable ongoing effective local health care, including with the patient's General Practitioner where required (clinical services)

(b) Recipient HHS

i. utilisation of standardised referral criteria, where they exist, to ensure appropriate use of statewide services (clinical services)

ii. timely acceptance of patients being transferred out of statewide services (back-transfers) (clinical services)

iii. equitable access to ongoing local health care as required (clinical services)

Health Executive means a person appointed as a health executive under section 67(2) of the Act.

Health Service Chief Executive means a health service chief executive appointed for a HHS under section 33 of the *Hospital and Health Boards Act 2011.*

Health Service Employees means all persons, existing and future, appointed as health service employees either by the Chief Executive under section 67(1) of the *Hospital and Health Boards Act 2011* or by a prescribed Service under section 67(3) of the *Hospital and Health Boards Act 2011.* For the purposes of this Schedule, health service employee excludes persons appointed as Health Executives.

Hospital and Health Board means the hospital and health board appointed under section 23 of the *Hospital and Health Boards Act 2011*.

Hospital and Health Service or **HHS** means the Hospital and Health Service to which this Agreement applies.

Hospital and Health Service Area means the geographical area for the HHS determined by the Hospital and Health Boards Regulation 2012.

Hospital and Health Service-Service Agreement (HHS-SA) Contact Person means the position nominated by the HHS as the primary point of contact for all matters relating to this Service Agreement.

HR Management Functions means the formal system for managing people within the HHS, including recruitment and selection (incorporating administrative support and coordination functions previously supplied by Queensland Health Shared Service Partner); induction and orientation; training and professional development; industrial and employee relations; performance management; work health and safety and well-being; workforce planning; equity and diversity; and workforce consultation, engagement and communication.

Industrial Instrument means an industrial instrument made under the *Industrial Relations Act 1999.*

Inpatient Service means a service provided under a hospital's formal admission process. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Inter-HHS Dispute means a dispute between two or more HHSs.

Key Performance Indicator means a measure of performance that is used to evaluate the HHSs success in meeting key priorities.

National Health Reform Agreement (NHRA) means the document titled *National Health Reform Agreement made between the Council of Australian Governments (CoAG) in 2011*.

Negotiation Period means a period of no less than 15 business days (or such longer period agreed in writing between the parties) from Exchange Date specified in Table 18 Schedule 5.

Notice of Dispute means the written notice of a dispute provided by the Chief Executive or the HHS to the other party or the written notice of a dispute provided by a HHS to another HHS.

Outcome Indicator means a measure of performance that provides information on specific activities and interventions where there is a reasonable expectation or evidence that they make a positive contribution towards improving the health status and experience of patients;

Outpatient Service means services delivered to non-admitted non-emergency department patients in defined locations.

Outreach Services means services delivered in sites outside of the HHS area to meet or complement local service need. Outreach services include services provided from one HHS to another as well as statewide services that may provide services to multiple sites.

Own Source Revenue (OSR) means, as per Section G3 of the National Healthcare Agreement, 'private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State and Territory'. The funding for these patients is called own source revenue and includes:

(a) Medicare ineligible patients, such as overseas visitors (not covered under reciprocal agreements), people in community detention and overseas students studying in Australia

(b) compensable patients with an alternate funding source, such as:

i. workers' compensation insurers;

ii. motor vehicle accident insurers;

iii. personal injury insurers;

iv. Department of Defence; and/or

v. Department of Veterans' Affairs.

(c) Medicare eligible patients can elect to be treated as a public or private patient, allowing HHS' to recoup a portion of the healthcare service delivery cost.

Parties means the Chief Executive and the HHS to which this Service Agreement applies.

Patient Identifiable Data means data that could lead to the identification of an individual either directly (for example by name), or through a combination of pieces of data that are unique to that individual.

Performance Review Meeting means the forum established which routinely reviews and discusses a range of aspects of HHS and system wide performance in accordance with the accountabilities contained within this Service Agreement and the Performance Framework. Attendance at Performance Review Meetings comprises:

(a) the DH-SA contact person and the HHS-SA contact person;

(b) Executives nominated by the Department of Health; and

(c) Executives nominated by the HHS.

Performance Framework means the reference document titled 'Delivering a High Performing Health System for Queenslanders – Performance Framework'.

Performance Measure means a quantifiable indicator that is used to assess how effectively the HHS is meeting identified priorities and objectives.

Policy means any policy document that applies to Health Service Employees, including HHS policies and Queensland Health policies that apply to HHS. These include but are not limited to:

(a) Indemnity for Queensland Health Medical Practitioners HR Policy I2 (QH-POL-153); and

(b) Governance framework for Health Employment directives (Policy Number A2 (QH-POL-415).

Prescribed Employer means a HHS which has been assessed and approved by the Minister for Health as having the capacity and capability to be an employer of health service employees and has subsequently been prescribed by Regulation in accordance with section 20 subsection 4 of the *Hospital and Health Boards Act 2011* to be an employer of health service employees

Procedures and Interventions means services delivered to non-emergency department patients for specified services: chemotherapy, dialysis, endoscopy, interventional cardiology and radiation oncology

Primary Care means first level healthcare provided by a range of healthcare professionals in socially appropriate and accessible ways and supported by integrated referral systems. It includes health promotion, illness prevention, care of the sick, advocacy and community development.

Public Health Event of State Significance means an event where the actual or potential impact extends beyond the community service by a particular Hospital and Health Service.

Public Health Services means programs that prevent illness and injury, promote health and wellbeing, create healthy and safe environments, reduce health inequalities and address factors in those communities whose health status is the lowest.

Quality Improvement Payment (QIP) means a non-recurrent payment due to the HHS for having met the goals set out in the QIP Purchasing Incentive Specification.

Queensland Government Central Agency means one or all of the Department of the Premier and Cabinet, Queensland Treasury, the Queensland Audit Office, the Public Service Commission and the Office of the Integrity Commissioner.

Queensland Health means collectively all Hospital and Health Services and the Department of Health

Referral Notice means the referral of a dispute which cannot be resolved within 30 days for resolution through discussions between the Chief Executive and the Chair.

Regional Service means a clinical (direct or indirect patient care) or non-clinical service funded and delivered, or coordinated and monitored, by an HHS with a catchment of two or more HHSs, but not on a statewide basis as defined in this Schedule. Service delivery includes facility based, outreach and telehealth service models.

Residential HHS means the HHS area, as determined by the Hospital and Health Boards Regulation 2012, in which the patient normally resides.

Safety and Quality Marker means a measure of performance that provides timely and transparent information on the safety and quality of services provided by the HHS;

Schedule means this Schedule to the Service Agreement.

Service means a clinical service provided under the auspices of an organisation.

Service Agreement means this Service Agreement including the Schedules in annexures, as amended from time to time.

Service Agreement Value means the figure set out in Schedule 2 as the expected annual Service Agreement value of the services purchased by the Department of Health.

Statewide Coordination means services with an identified single point of governance for services provided locally by resident HHS, with core responsibilities around strategic management and performance monitoring.

Statewide Service means a clinical (direct or indirect patient care) or non-clinical service funded and delivered, or coordinated and monitored, by a single HHS with a statewide geographical catchment. Service delivery includes facility based, outreach and telehealth service models.

Supporting Indicator means a measure of performance that provides contextual information to support an assessment of HHS performance.

Suspension means the temporary cessation of a service provided by the HHS under the terms of this Service Agreement. Suspension may result from, but is not exclusively due to, limitations in workforce capacity or issues regarding the safety or quality of the service provided.

Telehealth means the delivery of health services and information using telecommunication technology, including:

(a) Live interactive video and audio links for clinical consultations and education;

(b) Store and forward systems to enable the capture of digital images, video, audio and clinical data stored on a computer and forwarded to another location to be studied and reported on by specialists;

(c) Teleradiology to support remote reporting and provision of clinical advice associated with diagnostic images; and

(d) Telehealth services and equipment for home monitoring of health.

Termination means the permanent cessation of a service provided by the HHS under the terms of this Service Agreement.

Treating HHS means the HHS area, as determined by the Hospital and Health Boards Regulation 2012, in which a patient is receiving treatment.

Appendix 1 Key Documents

Hospital and Health Services Service Agreements and supporting documents including:

(a) Hospital and Health Services Service Agreements

(b) Advancing Health 2026: Planning for a Healthier Future The Statewide Health System Plan

(c) Delivering and High Performing Health System for Queenslanders: Performance Framework

(d) Health Funding Principles and Guidelines 2018/19

are available at: www.health.qld.gov.au/system-governance/health-system/managing/agreements-deeds

My health, Queensland's future: Advancing health 2026

www.health.qld.gov.au/__data/assets/pdf_file/0025/441655/vision-strat-healthy-qld.pdf

Department of Health Strategic Plan

www.health.qld.gov.au/system-governance/strategic-direction/plans/doh-plan

A Health System for Queenslanders: Charter of Responsibility

http://qheps.health.qld.gov.au/csd/business/governance-and-compliance/corporate-governance/doh-peak-body-governance-and-executive-committee-structures

Queensland Health Statement of Action towards Closing the Gap in health outcomes

https://qheps.health.qld.gov.au/atsihb/html/statement-of-action

Healthcare Purchasing Incentive Specification sheets

https://qheps.health.qld.gov.au/purchasing-performance/healthcare-purchasing/purchasing-funding-specs

HHS Performance Measures and Attribute Sheets

https://qheps.health.qld.gov.au/purchasing-performance/hhs-agreements/performance-kpis

Data Set Specifications

https://qheps.health.qld.gov.au/purchasing-performance/hhs-agreements/data-reporting-requirements

Capital program requirements and reporting

https://spr.health.qld.gov.au

Australian Commission on Safety and Quality in Healthcare – National Standards and Accreditation

https://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/

Abbreviations

ABF	Activity Based Funding
AAQCA	Australian Aged Care Quality Agency
ACSQHC	Australian Commission on Safety and Quality in Healthcare
BBV	Blood Borne Viruses
BMRP	Backlog Maintenance Remediation Program
BSI	Blood Stream Infection
CET	Clinical Education and Training
DH-SA	Department of Health – Service Agreement
DNW	Did Not Wait
DRG	Diagnosis Related Group
HHS	Hospital and Health Service
HHS-SA	Hospital and Health Service – Service Agreement
HITH	Hospital in the Home
KPI	Key Performance Indicator
LAM	List of Approved Medicines
MOHRI	Minimum Obligatory Human Resource Information
NHRA	National Health Reform Agreement
Non-ABF	Non-Activity Based Funding
NPA	National Partnership Agreement
NSQHS	National Safety and Quality Health Service
NWAU	National Weighted Activity Unit
OSR	Own Source Revenue
PBS	Pharmaceutical Benefits Scheme
QIP	Quality Improvement Payment
QWAU	Queensland Weighted Activity Unit
RACGP	Royal Australian College of General Practitioners
SA2	Statistical Area Level 2
SLA	Statistical Local Area
STI	Sexually Transmitted Infections
VLAD	Variable Life Adjusted Display

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