Gold Coast Hospital and Health Service

Service Agreement

2016/2017 – 2018/2019

Queensland Government

Gold Coast Hospital and Health Service

Service Agreement 2016/17 - 2018/19

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1. Introduction

1. Queensland Health is committed to strengthening performance and improving services and programs that will better meet the needs of the community.
2. 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.
3. 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.
4. 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 and 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

(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

1. This Service Agreement is regulated by the National Health Reform Agreement and the provisions of the *Hospital and Health Boards Act 2011.*
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. The *Hospital and Health Boards Act 2011* states that it 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

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.
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 the Department of Health Strategic Plan. 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.

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 the Department of Health Strategic Plan.
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.
5. This Service Agreement is underpinned by and is to be managed in line with the following supporting documents:
   (a) Investment Environment 2016/17
   (b) Delivering a High Performing Health System for Queenslanders – Performance Framework
   (c) Health Funding Principles and Guidelines 2016/17

5. Objectives of the Agreement

1. This Service Agreement is designed to:
   - specify the hospital services, other health services, teaching, research and other services to be provided by the HHS;
   - specify the funding to be provided to the HHS for the provision of the services;
   - specify the performance measures for the provision of the services;
   - specify the performance and other data to be provided by the HHS to the Chief Executive;
   - provide a platform for greater public accountability; and
   - facilitate the achievement of State and Commonwealth Government priorities, services, outputs and outcomes while ensuring local input.

6. Scope

1. This Service Agreement outlines the services that the Department of Health will purchase from the HHS during the period of this agreement.
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 (HSQ) and eHealth Queensland.

7. Performance Framework

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.
2. The Performance Framework uses key performance indicators (KPIs) to monitor the extent to which HHSs are delivering the high level objectives set out in this Service Agreement. The KPIs against which the HHS's performance will be measured are detailed in Schedule 3 of this Service Agreement.
3. The parties agree to constructively implement the Performance Framework.

8. Period of this Service Agreement

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.
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.
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.
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

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 agreement must give written notice of the proposed amendment to the other party.
2. The process for amending this Service Agreement is set out in Schedule 5.

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

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.
2. The Department of Health and HHS may terminate or temporarily suspend a service by mutual agreement having regard to the following obligations:
   - any proposed service termination or suspension must be made in writing to the other party;
   - 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;
   - the parties agree a notice period following which termination, or temporary suspension, will take effect; and
   - patient needs, workforce implications, relevant government policy and HHS sustainability are to be considered.
3. The Department of Health, in its role as statewide health system manager:
   - may not support the termination or temporary suspension and request the HHS to maintain the service;
   - 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.
4. The HHS will:
   - 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
   - minimise any risk or inconvenience to patients associated with service termination, temporary suspension or transfer.
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

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.
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

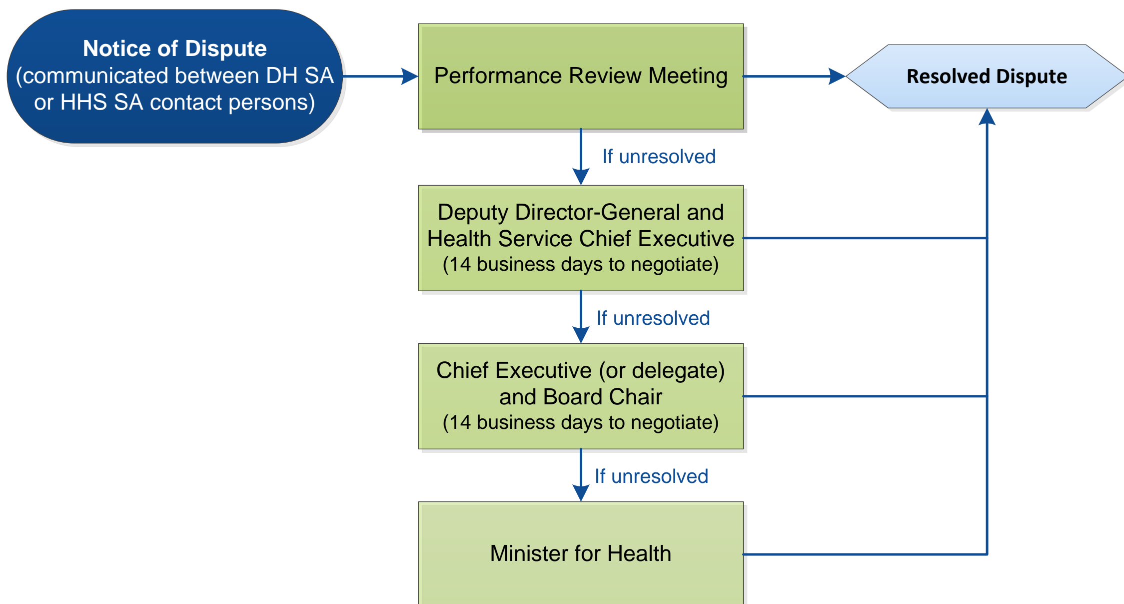
The HHS will provide to the Chief Executive the performance data and other data, including data pursuant to ad hoc requests, set out in Schedule 4 ‘Data Reporting

Requirements' in accordance with the Schedule, including in relation to the form, manner and the times required for the provision of data.

14. Dispute Resolution

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.
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.
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 section 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.
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.
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.
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



14.1 Resolution of a Dispute

1. 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.
2. 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.

14.2 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.

14.3 Disputes arising between Hospital and Health Services

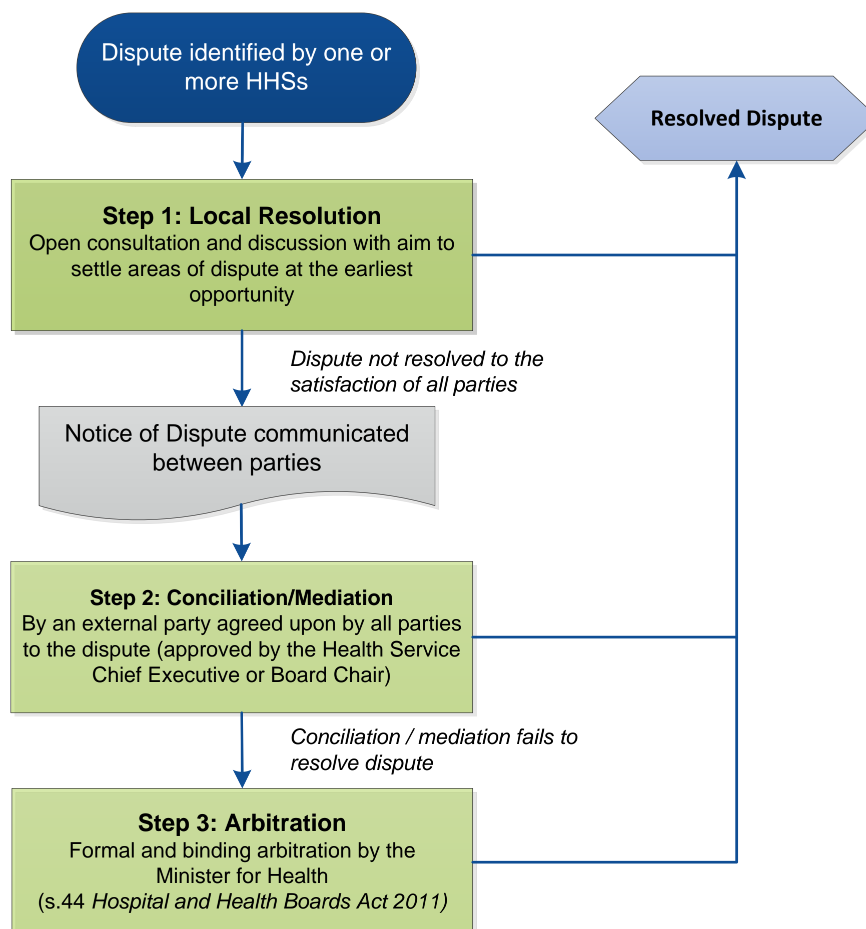
1. In the event of a dispute arising between two or more HHSs (an inter-HHS dispute), the process set out in figure 2 will be initiated. Resolution of inter-HHS disputes will be through a tiered process, commencing with local resolution and culminating if required with formal and binding arbitration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

2. If the HHS wishes to escalate a dispute that 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.

3. Management of inter-HHS relationships should be informed by the following principles:

   - 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.
   - 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 (CSCF).
   - 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.
   - All HHSs abide by the agreed dispute resolution process.
   - 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

1. If a party (affected party) is prevented or hindered by force majeure from fully or partly complying with any obligation under this 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 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 agreement as promptly as possible; and
   (c) give written notice to the other party within five days of the cessation of the force majeure.
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 agreement during the force majeure and the HHS must comply with that direction.
3. Neither party may terminate this agreement due to a force majeure event.

16. Hospital and Health Service Accountabilities

1. Without limiting any other obligations of the HHS, it must comply with:
   - the terms of this Service Agreement;
   - all legislation applicable to the HHS, including the *Hospital and Health Boards Act 2011*;
   - all Cabinet decisions applicable to the HHS;
   - all Ministerial directives applicable to the HHS;
   - all agreements entered into between the Queensland and Commonwealth governments applicable to the HHS;
   - all regulations made under the *Hospital and Health Boards Act 2011*;
   - all industrial agreements; and
   - all health services directives applicable to the HHS.
2. The HHS will ensure that the accountabilities set out in Schedule 1 of this Service Agreement are met.

17. Department of Health Accountabilities

1. Without limiting any other obligations of the Department of Health, it must comply with:
   - the terms of this Service Agreement;
   - the legislative requirements as set out within the *Hospital and Health Boards Act 2011*;
   - all regulations made under the *Hospital and Health Boards Act 2011*; and
   - all Cabinet decisions applicable to the Department of Health.
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:
   - provide state-wide health system management including health system planning coordination and standard setting;
   - provide the HHS with funding specified under Schedule 2 of this Service Agreement;
   - provide and maintain payroll and rostering systems to the HHS unless agreed otherwise between the parties;
   - operate 13 HEALTH as a first point of contact for health advice with timely HHS advice and information where appropriate to local issues; and
   - balance the benefits of a local and system-wide approach.
3. The Department of Health will endeavour to purchase services in line with Clinical Prioritisation Criteria, where these are in place, in order to improve equity of access and reflect the scope of publicly funded services.
4. The Department of Health will maintain a public record of the CSCF levels for all public facilities based on the information provided by HHSs and endorsed by the Deputy Director-General Clinical Excellence Division.

17.1 Workforce Management

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

- 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
- ensure delivery of the services prescribed in this Service Agreement.

18. Indemnity

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 agreement;

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

(c) a breach of this 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.

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:

- Indemnity for Queensland Health Medical Practitioners HR Policy I2
- Queensland Government Indemnity Guideline

as amended from time to time.

3. The indemnity referred to in this clause will survive the expiration or termination of this 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.

20. Execution

Executed as an agreement in Queensland

Signed by the Chief Executive, Queensland Health in the presence of:)
)
)

Witness signature

Signature of ACTING Chief Executive

~~Michael Walsh~~

TAMARA WISEMAN

Name of Witness (print)

RUSSELL BOWLES

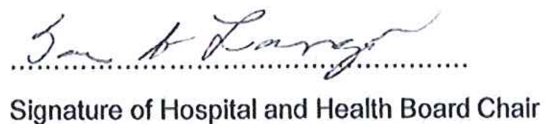
Name of ACTING Chief Executive (print)

30.06.2016

(date)

Signed by the Chair, Gold Coast Hospital and Health Board, in the presence of:)
)
)

Witness signature



Signature of Hospital and Health Board Chair

LISA BEARHAM

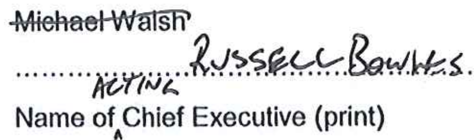
Name of Witness (print)

IAN A LANGDON

Name of Hospital and Health Board Chair (print)

29/06/16

(date)



Schedule 1
HHS Accountabilities

1. Purpose

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

1. The HHS must ensure that:
   - 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.
   - 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.
   - 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.
   - 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 (CSCF) of the facility/s at which the service is provided).
   - All facilities have undertaken a baseline self-assessment against the CSCF (version 3.2).
   - The Department of Health is notified when a change to the CSCF baseline self-assessment occurs through the established public hospital CSCF notification process.
   - In the event that a CSCF 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.

- Processes for access to specialist surgical and medical services in line with Clinical Prioritisation Criteria (CPC) are implemented, where these are in place, in order to improve equity of access to specialist services.
- 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.
- 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.
- The *Strategic Plan for Organ Donation* is implemented in order to support an increase in organ donation rates in Queensland.
- 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.
- 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.

2. Through accepting the funding levels defined in Schedule 2 'Funding and Purchased Activity and Services', 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.

2.1 Accreditation

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 (AHSSQA) Scheme.
2. Accreditation will be against the ten clinical National Safety and Quality Health Service (NSQHS) Standards and will include any other standards offered by the accrediting agency, engaged by the HHS.
3. Accreditation of residential aged care facilities by the Australian Aged Care Quality Agency will continue.
4. General practices owned or managed by the HHS are to be externally accredited. Accreditation of general practices will be in accordance with the current edition of the Royal Australian College of General Practitioners (RACGP) published accreditation standards.
5. Mental health services must maintain accreditation against the NSQHS Standards and the National Standards for Mental Health Services.
6. For the purpose of accreditation, the performance of the HHS against the NSQHS Standards can only be assessed by accrediting agencies that are approved by the Australian Commission on Safety and Quality in Healthcare (ACSQHC).

7. The HHS will select their accrediting agency from among the approved agencies. A list of approved accrediting agencies is available from the ACSQHC website at www.safetyandquality.gov.au.
8. Following an accreditation event the HHS will provide to the Executive Director, Patient Safety and Quality Improvement Service:
   - a copy of the ‘not met’ report within two days of receipt by the HHS;
   - the accreditation report within seven days of receipt by the HHS, providing no significant patient risks have been identified (see below for significant patient risk); and
   - immediate advice should any requirement of a rectification period after the accreditation event not be met resulting in the facility not being accredited.
9. If a HHS does not meet accreditation requirements at a mid-cycle survey or full survey, the HHS has 90 days to address any core not met actions.
10. The award recognising that the HHS has met the NSQHS Standards will be issued for a period of up to four years.
11. The HHS will apply to an approved accrediting agency for a re-accreditation assessment prior to the expiry of their current accreditation period.

2.2 Significant Patient Risk

1. The AHSSQA Scheme requires approved accrediting agencies to notify regulators if a significant risk of patient harm is identified during an onsite visit to a health service organisation.
2. Where a surveyor identifies one or more major risks in a health service organisation that could result in significant harm to patients the following actions are to be taken:
   - surveyors are to notify both the HHS and their accrediting agency that a significant issue has been identified;
   - surveyors and/or an accrediting agency are to negotiate with the HHS a plan of action and timeframe to remedy the issues; and
   - an accrediting agency is to notify the Executive Director, Patient Safety and Quality Improvement Service that a significant issue has been identified and confirm the action being taken, within two days of a surveyor confirming a significant patient risk.

2.3 Non-accreditation

1. After the period to address not met core actions, the accrediting agency will review any not met core actions and informally notify the HHS if they have met the requirements, in which case no further action is required.
2. If the HHS has not met accreditation requirements after the 90 day period, the accrediting agency and the HHS will inform the Executive Director, Patient Safety and Quality Improvement Service Unit within two business days. The Patient Safety and Quality Improvement Service will discuss any serious risks at the HHSs Performance Review Meeting.

2.4 Responsive Regulatory Process

1. A responsive regulatory process is utilised in the following circumstances:
    - where a significant patient safety risk is identified by a certified accrediting agency during a mid-cycle or full survey against the NSQHS Standards
    - where a HHS has failed to address 'not met' core actions of the NSQHS Standards within specified timeframes.
2. An initial regulatory response will begin with a process of verifying the scope, scale and implications of the reported issues, review of documentation, and may include one or more site visits.
3. The regulatory process may include one or a combination of the following actions:
    - seek further information from a HHS
    - request a progress report for the implementation of an action plan
    - escalate non-compliance to the Performance Review Meeting
    - provide advice, information on options or strategies that could be used to address the non-met actions within a designated time frame
    - connect the hospital to other hospitals that have addressed similar deficits or have exemplar practice in this area.
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:
    - restrict specified practices/activities in areas/units or services of the HHS where the NSQHS Standards have not been met
    - suspend particular services at the HHS until the area/s of concern are resolved
    - suspend all service delivery at a facility within an HHS for a period of time.

2.5 Provision of clinical products/consumables in outpatient settings

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.
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.
3. Where guidelines exist (e.g. Guideline for Compression Garments for Adults with Malignancy Related 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.

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 following rules should apply:
   - the treating HHS shall provide prescription(s) for an adequate initial supply. this shall comprise:
     (i) 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

     (ii) non-reimbursable medicines, one month's supply or a complete course of treatment, whichever is the lesser.
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.
6. For non-reimbursable medicines listed on the LAM for the condition being treated, the residential HHS is responsible for ongoing supplies.
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.

2.6 Land, Buildings and Maintenance

1. 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.*
2. 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).
3. The HHS will proactively address the recommendations within the final Asset Management Capability Assessment report within a two year timeframe or as mutually agreed.
4. 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.
5. 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.

6. Nothing in clause 2.6.5, above:
   (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 2.7.

2.7 Occupational Health and Safety

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.
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.
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.
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.

2.8 Workforce Management

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.
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 agreement.
3. 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:

- terms and conditions of employment specified by the Department of Health in accordance with section 66 of the *Hospital and Health Boards Act 2011;*
- health service directives, issued by the Chief Executive under section 47 of the *Hospital and Health Boards Act 2011*;
- health employment directives, issued by the Chief Executive under section 51A of the *Hospital and Health Boards Act 2011;*
- any policy document that applies to the health service employee;
- any Industrial Instrument that applies to the health service employee;
- the relevant HR delegations manual; and
- any other relevant legislation.

4. This includes but is not limited to ensuring health service employees are suitably qualified to perform their required functions.
5. 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.
6. 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.*
7. 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 sets out:

- the activity purchased by the Department of Health from the HHS (Table 2.3)
- the funding provided for delivery of the purchased activity (Table 2.3)
- specific funding commitments (Table 2.4)
- the criteria and processes for financial adjustment associated with the delivery of purchased activity and specific funding commitments
- 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 2.2)
- 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

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. 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 section 3 of this Schedule.
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.
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.
5. Should the HHS be unable to deliver the activity that has been funded the Department of Health has the discretion to determine whether a financial adjustment should be applied. This will follow a joint process with the HHS to understand the cause of the under-delivery and any remedial action plan.
6. 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.

2.1 Efficient Growth Funding

1. In 2016/17, 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.
2. Efficient growth funding is based on growth of National Weighted Activity Units (NWAUs), and calculations are performed by the National Health Funding Body on behalf of the Administrator of the National Health Funding Pool.
3. During the 2016/17 financial year, Commonwealth NHRA funding paid to the State of Queensland will be based on an estimate of the NWAU activity to be delivered in Queensland. Any reconciliation adjustments based on 2016/17 actual activity and funding decisions made by the Administrator of the National Health Funding Pool will be passed on to the HHS during the 2017/18 financial year.
4. Should additional funding be recognised by the Administrator of the National Health Funding Pool reconciliation of 2016/17 actual activity, rather than retain this funding centrally the Department of Health will provide funding direct to those HHSs that produce more NWAUs than purchased in 2016/17.
5. HHSs will only be eligible for Efficient Growth funding if the purchased QWAU activity targets are achieved.
6. To assist with cash flow, the Department of Health will allocate Efficient Growth funding for the HHS at any time based on the calculation methodology set out in the specification sheet titled 'Efficient Growth National Weighted Activity Units (NWAUs)' referenced at Appendix 1, rather than waiting until funding is receipted centrally from the Commonwealth. In accordance with the NHRA, Queensland will allocate Efficient Growth funding based in growth of NWAUs.
7. In order to allocate funding to HHSs, actual 2016/17 NWAUs will be assessed against the HHSs NWAU target as stated in Table 2.1, taking into account the volume growth and price change in the national model.
8. Funding adjustments will be made as follows:
   - where a HHS exceeds its NWAU target as stated in Table 2.1, it will receive an additional 45% of the Queensland ABF Price (QEP) per additional NWAU
   - where a HHS is below its NWAU target as stated in Table 2.1, funding will be reduced by 45% of the QEP for each NWAU below target
   - where a HHS is below its NWAU target because a specifically funded initiative has not yet commenced or is operating below capacity and growth in purchased activity in year is not being delivered, funding will be reduced at 100% of the QEP
   - where a HHS is outside the activity tolerance identified in Table 2.5 and is not delivering on its key performance indicators, funding will be reduced at 100% of the QEP
9. Funding adjustments will be actioned through the process set out in section 2.3 Schedule 5 of this Service Agreement, although HHSs may input accruals into the general ledger during the year to better reflect likely efficient growth funding flows.

10. Funding is provided on the basis that the Commonwealth government funds efficient growth in 2016/17 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.
11. 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 on 29 September 2017.
12. HHSs should refer to the supporting document 'Health Funding Principles and Guidelines 2016/17' 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.
13. In April 2016 a Heads of Agreement extended Efficient Growth funding for the period 2017/18 to 2019/20, where growth in Commonwealth funding for public hospitals will not exceed 6.5% a year. The impact of this agreement on 2017/18 and onwards will be determined when further details are available.

Table 2.1 NWAU target 2016/17

Service Stream	2016/17 NWAU target (N1617)
Inpatient	103,188.9
Outpatient	19,029.5
Procedures & Interventions	15,310.3
Emergency Department	22,080.6
Sub & Non-Acute	10,183.9
Mental Health	9,019.4
TOTAL	**178,812.6**

3. Financial Adjustments

3.1 Specific Funding Commitments

1. As part of the Service Agreement Value, the services, programs and projects set out in Table 2.4 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.
2. 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 2.4.
3. On receipt of any notice under clause 3.1(2) 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.
4. 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 3.1 of Schedule 2. The Adjustment Notice will be issued through the process set out in section 2.3 of Schedule 5.

5. Following receipt of an Adjustment Notice under clause 3.1(4) 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.
6. The parties acknowledge that adjustments made under this clause 3.1 of Schedule 2 may vary the Service Agreement Value and/or a specific value recorded in Table 2.4. Where the Service Agreement Value and/or a specific value recorded in Table 2.4 is varied, the variation will be recorded in a Deed of Amendment issued following the next available Amendment Window as identified in Table 5.1, Schedule 5.

3.2 Activity Targets

1. 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 2.5 of Schedule 2 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.
2. 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:
   - inpatients
   - emergency department
   - sub and non-acute
   - mental health
   - interventions and procedures
   - outpatients
   - non-ABF block funded services
   - commitments linked to specific funding allocations including but not limited to those outlined in Table 2.4.
3. 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.
4. Table 2.5 demonstrates the financial adjustment that may be applied when activity thresholds have been breached.

3.3 Financial Adjustments – other

1. The Annual Healthcare Purchasing Plan includes a range of funding adjustments which aim to incentivise cost and clinically effective care. 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 2.6.

2. The Department of Health must reconcile the applicable purchasing incentives in Table 2.6 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.
3. Funding adjustments must be based on the requirements contained in the relevant specification sheet for that purchasing incentive.
4. If the parties are unable to reach agreement in relation to any funding adjustments that are identified, the provisions of Clause 14 Dispute Resolution will apply to resolve the dispute.
5. When the parties have agreed on a funding adjustment, the Chief Executive (or delegate) will immediately issue an Adjustment Notice to the HHS-SA Contact Person confirming any funding adjustment that has been made in accordance with this clause 3.3 of Schedule 2. The Adjustment Notice will be issued through the process set out in section 3.3 of Schedule 5.
6. Following receipt of an Adjustment Notice under clause 3.3 (6) of Schedule 2, the parties will comply with the Adjustment Notice and immediately take the steps necessary to give effect to the requirements of that Adjustment Notice.
7. 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 5.1, Schedule 5.

3.4 Public and private activity/Own Source Revenue

1. 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.
2. Where a HHS is above its OSR target in respect of private patients, it will be able to retain the additional OSR with no compensating adjustments to funding from other sources.
3. Conversely where a HHS is below its OSR target in respect of private patients, it will experience a reduction in revenue with no compensating adjustments to funding from other sources.
4. Budget adjustments for changes in OSR from private patients will be actioned through the process set out in Schedule 5 of this Service Agreement.

4. Funding Sources

1. The four main funding sources contributing to the HHS Service Agreement value are:
   - Commonwealth funding
   - State funding
   - Grants and Contributions
   - Own Source Revenue (OSR).
2. Table 2.2 provides a summary of the funding sources for the HHS and mirrors the total value of the Service Agreement included in Table 2.3a.

Table 2.2 Hospital and Health Service Funding Sources 2016/17

Funding Source	Value ($)
Activity Based Funding	1,005,125,486
Clinical Education and Training[1]	-35,042,224
Own Source Revenue contribution in ABF funded services	-58,826,873
Pool Account – ABF Funding (State and Commonwealth)[2]	**911,256,389**
Block Funding and Clinical Education and Training	73,229,686
State Managed Fund – Block Funding (State and Commonwealth)[3]	**73,229,686**
Locally Receipted Funds (Including Grants)	**19,075,098**
Locally Receipted Own Source Revenue (ABF)	**58,826,873**
Locally Receipted Own Source Revenue (Other activities)	**21,005,373**
Department of Health Funding[4]	**206,231,350**
TOTAL	**1,289,624,770**

5. Funds Disbursement

1. The Chief Executive of the Department of Health 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 2.7.

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[1] 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 ABF 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.

[2] 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.

[3] 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.

[4] 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.

2. However, the State (represented by the Chief Executive) will not:
    - redirect Commonwealth payments between HHSs
    - redirect Commonwealth payments between funding streams (e.g. from ABF to Block Funding)
    - adjust the payment calculations underpinning the Commonwealth's funding.
3. Payment of ABF and Block Funding to the HHS will be on a fortnightly basis.
4. Further information on the disbursement of funds is available in the supporting document Health Funding Principles and Guidelines 2016/17.

6. Purchased Services

6.1 State Funded Outreach Services

1. 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:
    - historical agreements for the provision of outreach services will continue as agreed between HHSs
    - funding will remain part of the providing HHS's funding base
    - activity should be recorded at the HHS where the service is being provided
    - 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.
2. Where new or expanded state funded outreach services are developed the following principles will apply:
    - 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
    - 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
    - any proposed expansion or commencement of outreach services will be negotiated between HHSs
    - 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
    - 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

- the activity should be recorded at the HHS where the service is being provided.

3. In the event of a disagreement regarding the continued provision of state funded outreach services:
    - any proposed cessation of outreach services will be negotiated between HHSs to mitigate any potential disadvantage or risks to either HHS
    - 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.

6.2 Telehealth Services

1. 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.
2. 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.
3. 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.

6.3 Newborn Hearing Screening

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

- provide newborn hearing screening in all birthing hospitals and screening facilities
- 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.

6.4 Statewide Services

This section does not apply to this HHS.

6.5 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 the clauses in this Service Agreement titled ‘Disputes arising between Hospital and Health Services’.

1. **Basic Physician Training Pathway**
    - 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.
    - 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.
2. **Eating Disorders Service**
    - Services to Darling Downs, Gold Coast, Metro South, South West, and West Moreton HHSs.
3. **Mental Health Clinical Indicator Program**
    - Services to Darling Downs, Gold Coast, Metro South, South West, and West Moreton HHSs and Mater Health Services Child and Youth Mental Health.
    - Contribute to statewide activities as part of the Queensland Mental Health Clinical Improvements Team.

6.6 Rural and Remote Clinical Support

This section does not apply to this HHS.

7. Primary and Community Health Services

The following funding arrangements will apply to the primary and community health services delivered by the HHS:

- 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 and community healthcare needs including through delivery of the services identified in Table 2.3b. HHSs have the discretion to allocate funding across primary and community health services according to local priorities.
- Department of Health specified funding models for consumer information services, disability, residential care, environmental health, offender health services, home and community medical aids, primary health care, community mental health services, and alcohol and other drugs services. The funding specified for these programs is listed in Table 2.3b.
- Department of Health community health service grants

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

7.1 Public Health Services

7.1.1 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:

- a specialist communicable disease epidemiology and surveillance, disease prevention and control service
- a specialist environmental health service, which includes assessment and coordination of local responses to local environmental health risks
- regulatory monitoring, enforcement and compliance activity on behalf of the Department of Health.

7.1.2 Public Health Events of State Significance

1. 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.
2. Support services may also include but are not limited to:
   - the provision of immunisation clinics
   - contact tracing
   - provision of prophylactic medications
   - public health risk assessment
   - non-communicable disease cluster assessment.
3. 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.

7.1.3 Preventive Health Services

The HHS will:

- 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
- maintain delivery of the school based youth nursing program throughout Queensland secondary schools
- promote brief interventions, lifestyle modification programs and other prevention, promotion or early intervention activities, in conjunction with key primary care partners.

7.1.4 Immunisation Services

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

- national immunisation program
- opportunistic immunisation in health care facilities
- special immunisation programs
- 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.

7.1.5 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.*

7.1.6 Sexual Health and Viral Hepatitis Services

The HHS will:

- 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)*
- 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
- maintain or increase the service level of BBV and STI related outreach services
- maintain or increase psychiatrist/psychologist sessions provided to people impacted by BBVs and STIs
- maintain or increase the level of support for the Metro South HHS based Contact Tracing Support Officer program
- maintain or increase the level of support for the Metro South HHS based cross-District BBV and STI Coordinator program
- 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.

7.2 Cancer Screening Services

1. The HHS will:
   - provide bowel cancer screening services in accordance with the National Bowel Cancer Screening Program:
     - services to be provided across Gold Coast HHS excluding the Statistical Local Areas (SLAs) of Jacobs Well-Alberton, Ormeau-Yatala, and Kingsholme-Upper Coomera
     - services to be provided within Metro South HHS for the SLAs of Scenic Rim (R) – Beaudesert, and Greenbank-Boronia Heights only.
   - provide BreastScreen Queensland (BSQ) services, including screening services through Mobile Vans, in accordance with the BreastScreen Australia Accreditation Standards, the BreastScreen Queensland Standards Policy and Protocols Manual and national policies:
     - services to be provided across the Gold Coast HHS
     - services to be provided within the Metro South HHS for the Scenic Rim (R) – Beaudesert and parts of the Logan LGA (Beenleigh, Bethania-Waterford, Eagleby, Edens Landing-Holmsview, Jimboomba-Logan Village, Mt Warren Park, Wolffdene-Bahrs Scrum) only.
   - allow the use of the HHS BSQ Mobile asset by other HHSs during periods where practical to maximise utilisation of BSQ Mobile fleet
   - 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.
2. 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.
3. 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.

7.3 Oral Health Services

The HHS will:

- ensure that oral health services are provided to the eligible population at no cost to the patient[5] and that the current range of clinical services will continue

[5] 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.

- ensure that oral health services fulfil the relevant obligations related to Commonwealth Government dental funding program/s
- ensure that the repair, maintenance and relocation services to the mobile dental fleet continues to be provided by the Mobile Dental Clinic Workshop in Metro South HHS.

7.4 Offender Health Services

The HHS will:

- provide health services to prisons located within the HHS (Offender Health Service)
- provide the Department of Health with an annual report detailing the Offender Health Services which have been provided to prisons within the HHS
- 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
- 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
- provide offenders with smoking cessation support.

7.5 Refugee Health

This section does not apply to this HHS.

8. Teaching Training and Research

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

8.1 Clinical Education and Training

1. The HHS will:
    - 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
    - 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
    - comply with the terms and conditions of students from Australian education providers participating in the Student Placement Deed Framework
    - only accept clinical placements of students from Australian education provides participating in the Student Placement Deed Framework

- 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:
  - medical students
  - nursing and midwifery students
  - pre-entry clinical allied health students
  - interns
  - rural generalist trainees
  - vocational medical trainees
  - first year nurses and midwives
  - re-entry to professional register nursing and midwifery candidates
  - dental students
- 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
- 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
- comply with the state-wide vocational medical training pathway models including:
  - The Queensland Basic Physician Training Pathway
  - The Queensland Intensive Care Training Pathway
  - The Queensland Basic Paediatric Training Network.
- support the provision of placements by the Queensland Physiotherapy Placement Collaborative for physiotherapy pre-entry students via the Physiotherapy Pre-registration Clinical Placement Agreement
- provide clinical area placements for dietetics pre-entry students from additional funding provided through relevant agreements with Universities.

2. In addition, the Health Practitioner (Queensland Health) Certified Agreement (No 2) 2011 (the HP agreement) requires Hospital and Health Services to:
   - continue to support development of allied health research capacity through continued implementation and retention of health practitioner research positions provided through the HP agreement
   - 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.
3. 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.

8.2 Health and Medical Research

The HHS will:

- articulate an investment strategy for research (including research targets and performance measures) which integrates with the clinical environment to improve clinical outcomes
- 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)
- 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)
- develop systems to capture research and development expenditure and revenue data and associated information on research.

Table 2.3a HHS Finance and Activity Schedule 2016/17 – 2018/19 – Summary

		2016/17 Q19 QWAU	2016/17 Funding $ (Price: $4755.66)	Non-Legally Binding 2017/18 Q19 QWAU	Non-Legally Binding 2017/18 Funding $ (Price: $4711.05)	Non-Legally Binding 2018/19 Q19 QWAU	Non-Legally Binding 2018/19 Funding $ (Price: $4655.06)
Activity Funding	Inpatients	112,993	$537,357,140	113,019	$532,438,341	115,081	$535,708,790
	Outpatients	25,241	$120,038,379	25,448	$119,887,593	25,943	$120,768,335
	Procedures & Interventions	18,615	$88,524,715	18,932	$89,188,325	19,300	$89,843,538
	Emergency Department	21,783	$103,593,626	22,154	$104,370,198	22,586	$105,136,943
	Sub & Non-Acute	9,885	$47,010,856	10,054	$47,363,264	10,249	$47,711,214
	Mental Health	11,245	$53,478,143	11,645	$54,861,971	11,872	$55,265,009
	Prevention & Primary Care	4,103	$19,514,738	4,184	$19,709,193	4,265	$19,853,984
	Subtotal	**203,866**	**$969,517,597**	**205,436**	**$967,818,883**	**209,296**	**$974,287,814**
	Other Activity Funding (SGs & CET)	0	$40,816,517	0	$41,836,930	0	$42,882,853
	Activity Funding Subsidy/(Contribution)	0	($5,208,627)	0	($2,129,294)	0	($1,163,322)
	Activity Funding Total	**203,866**	**$1,005,125,486**	**205,436**	**$1,007,526,519**	**209,296**	**$1,016,007,345**
Other Funding#	Block Funded Hospitals	0	$0	0	$0	0	$0
	Population Based Funded Services	0	$123,574,586	0	$120,380,667	0	$121,674,265
	Other Specific Funding	0	$160,924,698	0	$153,329,883	0	$153,016,478
	PY Services moved to Activity Funding	0	$0	0	$0	0	$0
	Other Funding Total	**0**	**$284,499,283**	**0**	**$273,710,549**	**0**	**$274,690,742**
Grand Total		**203,866**	**$1,289,624,770**	**205,436**	**$1,281,237,068**	**209,296**	**$1,290,698,087**

Minor Capital/Equity

Minor Capital / Equity			2016/17 Funding $		2017/18 Funding $ Non-Legally Binding		2018/19 Funding $ Non-Legally Binding
Total			**$3,543,000**		**$0**		**$0**

For details see Table 2.3b Other Funding Detail

Table 2.3b HHS Finance and Activity Schedule 2016/17 – 2018/19 Other Funding Detail

Model Type	Category	Units	2016/17 Activity	2016/17 Amendments $	2016/17 $	Non-Legally Binding 2017/18 Amendments $	2017/18 $	2018/19 Amendments $	2018/19 $
Block Funded Hospitals	Block Funded Hospitals		0	$0	$0	$0	$0	$0	$0
	Subtotal		**0**	**$0**	**$0**	$0	**$0**	$0	**$0**
Population Based Funded Services	Alcohol, Tobacco and Other Drugs		0	$0	$6,863,457	$0	$6,978,736	$0	$7,070,929
	Community Care Programs		0	$0	$907,184	$0	$907,184	$0	$907,184
	Community Mental Health		0	$3,500,000	$52,150,307	$0	$57,692,970	$0	$58,526,828
	Other Community Services		0	($15,437)	$38,723,819	$0	$33,460,889	$0	$34,073,817
	Other Funding Subsidy /(Contribution)		0	$0	$17,834,507	$0	$14,349,944	$0	$14,349,944
	Primary Health Care		0	$0	$7,095,311	$0	$6,990,943	$0	$6,745,562
	Subtotal		**0**	**$3,484,563**	**$123,574,586**	$0	**$120,380,667**	$0	**$121,674,265**
Other Specific Funding	Aged Care Assessment Program		0	$0	$2,571,513	$0	$0	$0	$0
	Commercial Activities		0	$0	($6,125,376)	$0	($5,306,346)	$0	($5,427,418)
	Consumer Information Services		0	$0	$0	$0	$0	$0	$0
	Depreciation		0	$0	$76,737,606	$0	$76,737,606	$0	$76,737,606
	Disability Residential Care Services		0	$0	$0	$0	$0	$0	$0
	Environmental Health		0	$0	$4,704,157	$0	$4,812,907	$0	$4,899,878
	Home and Community Care (HACC) Program		0	$0	$5,830,712	$0	$6,034,787	$0	$6,034,787
	Home and Community Medical Aids & Appliances		0	$0	$997,015	$0	$1,015,376	$0	$1,034,196
	Home Care Packages		0	$0	$0	$0	$0	$0	$0
	Interstate Patients		0	$0	$49,239,570	$0	$49,239,570	$0	$49,239,570
	Multi-Purpose Health Services		0	$0	$0	$0	$0	$0	$0
	Offender Health Services	Prisoners	117	$0	$739,610	$0	$739,610	$0	$739,610
	Patient Transport		0	$0	$5,110,695	$0	$5,204,811	$0	$5,301,280
	Research		0	$0	$1,501,467	$0	$1,517,013	$0	$1,549,439
	Residential Aged Care		0	$0	$0	$0	$0	$0	$0
	Specific Allocations		0	$0	$6,872,755	$0	$595,624	$0	$98,624
	State-Wide Functions		0	$0	$3,984,800	$0	$3,978,750	$0	$4,048,731
	Transition Care		0	$0	$8,760,174	$0	$8,760,174	$0	$8,760,174
	Subtotal		**117**	**$0**	**$160,924,698**	$0	**$153,329,883**	$0	**$153,016,478**
PY Services moved to Activity Funding	Breastscreen	Screens	0	$0	$0	$0	$0	$0	$0
	IHPA Block Funded Services - TPN, HEN, HV		0	$0	$0	$0	$0	$0	$0
	Oral Health	WOOS	0	$0	$0	$0	$0	$0	$0
	Subtotal		**0**	**$0**	**$0**	$0	**$0**	$0	**$0**
Total			**117**	**$3,484,563**	**$284,499,283**	$0	**$273,710,549**	$0	**$274,690,742**

Table 2.3c Specified Grants

Program	Funding
High Cost Outliers	$3,590,344
Limited Indication Medication Scheme	$439,944
PET Service	$1,744,004
Grand Total	**$5,774,293**

Table 2.4 Specific Funding Commitments

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Queensland Aboriginal and Torres Strait Islander Health Investment Strategy	$397,849 $266,755	0	2016/17 2017/18	The HHS will deliver the initiatives and outcomes outlined in memorandum HQ000404, through the provision of services including: • Mungulli Aboriginal and Torres Strait Islander Community Based Chronic disease and Respiratory Service • Indigenous hospital liaison services • Queensland Health Aboriginal and Torres strait Islander Cultural Capability Framework 2010-2033
BreastScreen	$4,346,600 (including $28,600 for after-hours screens)	34,000 screens (including 1,904 after-hours screens)	2016/17	Provision of BreastScreen services targeting women aged 50-74 years old (women 40-49 years are also eligible). Funding may be adjusted where the activity delivered varies from the purchased levels
Oral Health Services	$14,389,348	248,092 WOOS	2016/17	Funding and activity targets included in this table only relate to State dental funding programs at this time. As per correspondence HP000251, details of Commonwealth Government funded dental programs are yet to be released. HHSs are expected to maintain current levels of oral health activity and will not take any steps to reduce services ahead of confirmation of any changes to Commonwealth dental funding. State funding will be provisionally allocated in amendment window 1 to fund the first quarter of the Commonwealth Government dental program consistent with 2015/16 NPA allocations. Note that service items funded by Medicare under the Child Dental Benefit Schedule will not contribute towards activity targets. Funding may be adjusted where the activity delivered varies from the purchased levels.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Gold Coast University Hospital running costs	*$20,500,000* $16,720,000	0	*2015/16* 2016/17	Additional funding has been provided to reflect the additional fixed costs associated with running the Gold Coast University Hospital. The HHS and the Department of Health are working collaboratively to monitor progress.
Graduate Nursing and Midwifery Initiative (HHS)	$752,150	0	2016/17	Employment of additional graduates FTE: • 2016/17: 30 • 2017/18: 31 • 2018/19: 38 HHS participation in annual statewide graduate experience survey. Update of graduate portal for all graduates who applied to the HHS. Annual reporting of graduate intake numbers required.
Graduate Nursing and Midwifery Initiative (Nurse Educator)	$227,516	0	2016/17	Employment of 1.5 FTE Nurse Educators. If program performance requirements are not met in-year funding may be withdrawn.
Nurse Navigator roles	$1,390,701 $5,163,538 $7,389,769	0	2016/17 2017/18 2018/19	Employment of Nurse Navigators: • 1 Oct 2016: 5 • 1 Jul 2017: 10 • 1 Oct 2017: 15 • 1 Oct 2018: 10 • 1 May 2019: 5 TOTAL: 45 If program performance requirements are not met in-year funding may be withdrawn.
Management Information System Project – phase 1	*$2,490,000* $497,000 $497,000	0	*2015/16* 2016/17 2017/18	Funding to be provided over three years 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.
ENT Outpatient Reduction Strategy	$2,274,694 (Recurrent)	478 WAUs	2016/17	ENT outpatient long waits (including elective surgery conversions) will be reduced and eliminated by 30 June 2017 and then maintained over time.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
ICE Initiative	$955,056 (Recurrent)	201 WAUs	2016/17	Delivery of Drug and Alcohol Brief Intervention Team services within the Gold Coast University and Robina Hospital Emergency Departments (3 x new FTEs) and alcohol and other drug treatment and community engagement for young people aged 12 to 25 years (2.5 FTEs). Reporting of treatment service episodes delivered and community engagement activity undertaken according to local Project Plans.
Specialist Outpatients	*$9,964,615*	*2,167 WAUs*	*2015/16*	*Non-recurrent funding for:* • *1984 ENT specialist outpatient long waits and associated conversions to elective surgery, to reduce current 1,616 (reportable January 2016) long waits (funding includes an element of growth) to 0 by 30 June 2016.* • *1,681 ophthalmology specialist outpatient appointments and associated conversions to elective surgery, to reduce current 1,350 long waits (reportable January 2016) (funding includes an element of growth) to 0 by June 2016.* • *441 general surgery specialist outpatient appointments and associated conversions to elective surgery and endoscopies, to reduce the current long waits 1,291 (reportable January 2016).* • *Commence reducing neurosurgery specialist outpatient long waits.* • *Achieve an overall specialist outpatient long wait list no greater than 6,737.*
Mental Health Maternal and Baby unit	$3,500,000 $4,500,000	0 0	2016/17 2017/18	Recurrent investment of $3.5 million increasing to $4.5 million in 2017/18, provided to fund a parent and infant unit at Gold Coast University Hospital. WAUs may be assigned to this funding in amendment window 1 2016/17, based on finalisation of the service profile, together with an assessment of the likely WAUs to be generated by the unit.
Mental Health Older Persons Unit	$1,000,000 $2,000,000	0 0	2016/17 2017/18	Recurrent investment of $1 million increasing to $2 million in 2017/18, provided to commission an older persons bed unit at Gold Coast University Hospital.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Specialist Outpatients	$9,232,341	1941 WAUs	2016/17	Non-recurrent funding to: • Further reduce neurosurgery long waits currently 842, and associated conversions to elective surgery, to achieve zero long waits by June 2017 • 1,331 general surgery specialist outpatient appointments and associated conversions to elective surgery and endoscopies, to reduce current long waits 1,291 (reportable January 2016) to achieve a target to be negotiated as part of the 2016/17 service agreement negotiations. • The funding is provided to support the above initiatives to reduce specialist outpatient long waits to deliver a proposed overall long wait target of 4700 by December 2016. The proposed target will be confirmed as part of the end of year performance review informed by the 30 June 2016 position. • Should the reduction in the long wait patient target not be delivered the equivalent percentage in funding of the under delivery against the patient target may be returned to the Department.
Minor Capital Funding	$3,543,000	0	2016/17	Minor Capital methodology is under review. Should there be changes to the methodology, adjustments to funding will be made at the first opportunity, as detailed in Schedule 5 of this service agreement.
Independent Patient Rights Advisers	$410,000 $504,000 (Recurrent)	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.
Enterprise Bargaining	$17,133,380	0	2016/17	95% 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 2016/17. Subject to the terms and conditions of the agreements once executed a funding adjustment may be required.
Specific Growth	$16,605,422	4,988 WAUs	2016/17	4988 WAUs have been funded at 70% of the Queensland Efficient Price to support growth in inpatients, procedures and interventions at Gold Coast University Hospital.

Table 2.5 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 above the NWAU target, as set out in Table 2.1 • Activity that is in scope for the identified purchasing incentives as set out in clause 3.3 Schedule 2 and Table 2.6 The Department of Health retains the right to use its discretion to fund extra activity based on the outcomes of the review analysis.
Underperformance	Activity is below that specified within the finance and activity schedule but **within the relevant period's tolerance threshold of 1%**	No financial adjustment will occur, subject to the HHS demonstrating achievement of elective surgery targets and providing the HHS has achieved its QWAU target within tolerance (refer table 2.3a Schedule 2 and has achieved its NWAU target, refer clause 2.1, Schedule 2).
	Activity is below that specified within the finance and activity schedule and **outside of the relevant period's tolerance threshold of 1%**	Following confirmation that the HHS has taken all reasonable steps to produce the required level of activity, the contracted activity and the related funding may be withdrawn pro rata to the level of under delivery at full cost and reallocated to an alternate provider that can undertake the activity. Refer to table 2.3 Schedule 2 for the HHS QWAU target and clause 2.1 Schedule 2 for the HHS NWAU target.
Failure to deliver on commitments linked to specific funding allocations specified in this Schedule 2, Table 2.4	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.		

Table 2.6 Purchasing Incentives 2016/17 (Summary)

Incentive	Description	Scope	Status for 2016/17	Funding Adjustment
Stroke Unit Care	Payment loading for stroke unit care	ABF facilities with endorsed stroke unit	Continues as per 2015/16	ABF pricing model (Qld modification)
Quality Improvement Payment (QIP) - smoking cessation	Payment upon achievement of target for public inpatients and dental clinic patients clinically supported onto the Smoking Cessation Clinical Pathway	All HHSs (excluding Children's Health Queensland)	Continues as per 2015/16 with new inpatient targets and extension to dental setting	50% of available reward paid in advance with reconciliation for actuals
Quality Improvement Payment (QIP) - advance care plans	Payment upon provision of an opportunity for inpatients to contemplate an Advance Care Plan (ACP)	All HHSs	Targets replaced with a flat fee per in-scope ACP discussion	Paid retrospectively
Quality Improvement Payment (QIP) - staff immunisation	Payment upon achievement of target for clinical staff immunised with the influenza vaccine	All HHSs	New	50% of available reward paid in advance with reconciliation for actuals
Quality Improvement Payment (QIP) Cardiac Rehabilitation	Payment upon achievement of target for inpatients to access and attend cardiac rehabilitation services and programs	All HHSs (excluding Children's Health Queensland)	Continues as per 2015/16	50% of available reward paid in advance with reconciliation for actuals
Telehealth	Payment for additional outpatient activity volume, provision of telehealth consultancy for inpatients and Emergency Department patients as well as Store and Forward imaging assessment and clinical consultation	All ABF and non-ABF facilities	Continues as per 2015/16 with expanded in-scope services	Paid retrospectively
High cost patients	Payment for high cost in-scope individual patients	All HHSs	Removal of high cost low volume DRGs	Paid retrospectively
Fractured neck of femur timely surgical access	Payment discount for non-timely surgical treatment of fractured neck of femur (#NoF)	All ABF facilities who repair #NoF (including Mater)	Continues as per 2015/16	ABF pricing model (Qld modification)
Adverse events - BSI	Payment discount for hospital acquired Blood Stream Infections (BSI)	All ABF facilities (including Mater)	Continues as per 2015/16	Retrospective adjustment
Adverse events - pressure injury	Payment discount for hospital acquired Stage 3, Stage 4 and un-stageable pressure injuries	All ABF facilities (including Mater)	New stage added	Retrospective adjustment

Incentive	Description	Scope	Status for 2016/17	Funding Adjustment
Emergency Department 'Did Not Wait' (DNW)	No payment for DNWs	All ABF facilities (including Mater)	Continues as per 2015/16	ABF Pricing model (Qld modification)
Pre-operative elective bed days	Payment discount for long stay days equivalent to pre-operative days.	All ABF facilities (including Mater)	Continues as per 2015/16	ABF Pricing model (Qld modification)
Out-of-scope activity	No payment for out-of-scope activity	All ABF facilities (including Mater)	Continues as per 2015/16	ABF Pricing model (Qld modification)
Never Events	Zero payment for seven 'never' events.	All public facilities (including Mater)	Continues as per 2015/16 with new never event	Retrospective adjustment
Hospital in the Home (HITH)	Discounted price weight for specific non-complex DRGs or long stay days	All ABF facilities, (including Mater)	Continues as per 2015/16	ABF Pricing model (Qld modification)

Table 2.7 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:	2016/17
HHS	Gold Coast	Version for financial year:	
HHS ID		Version effective for payments from:	
		Version status:	27/05/2016

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	106,090	$4,883
Admitted acute private services	9,746	$4,883
Emergency department services	22,081	$4,883
Non-admitted services	21,694	$4,883
Mental health services	9,019	$4,883
Sub-acute services	10,184	$4,883
LHN ABF Total	**178,813**	

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	$37,022,238
Teaching, Training and Research	$36,207,448
Other block funded services	$0
Total block funding for LHN	**$73,229,686**

Schedule 3
Performance Indicators

1. Purpose

This Schedule outlines the performance indicators that apply to the HHS.

2. Performance Indicators

1. The Performance Framework uses performance indicators to monitor the extent to which the HHS is delivering the high level objectives set out in this Service Agreement.
2. There are two levels of performance indicator:
    i. Key Performance Indicators (KPIs) which are focused on the delivery of key strategic objectives and statewide targets. KPIs are identified as either Primary KPIs or Secondary KPIs. KPI performance will inform HHS performance assessments. The HHS should refer to the supporting document, 'Developing a High Performing Health System for Queenslanders: Performance Framework' referenced at Appendix 1 for further information on the performance assessment process.
    ii. 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.
3. The KPIs identified in Table 3.1 are applicable to all HHSs unless otherwise specified within the attribute sheet.
4. The HHS will meet the target for each KPI identified in Table 3.1 as specified in the attribute sheet.
5. The KPIs identified in Table 3.1 using italic text are under development. Data collection for these KPIs will commence on 1 October 2016. Reporting of performance will commence in January 2017.
6. The HHS should refer to the relevant attribute sheet for each performance indicator for full details. These are available on-line as referenced in Appendix 1.

Table 3.1 HHS Key Performance Indicators

Safe	
The health and welfare of service users is paramount	
• Minimise risk • Transparency and openness	• Avoid harm from care • Learn from mistakes
Key Performance Indicators	
Primary KPIs	
KPI No.	**Title**
P1	*Hospital Standardised Mortality Ratio*
Secondary KPIs	
KPI No.	**Title**
S1	Healthcare-associated Staphylococcus aureus (including MRSA) bacteraemia
Service Delivery Statement Linkage	
• Rate of healthcare-associated Staphylococcus aureus (including MRSA) bloodstream infections	

Effective	
Healthcare that delivers the best achievable outcomes through evidence based practice	
• Evidence based practice • Treatment directed to those who benefit • Clinical Capability	• Care integration • Optimise Health
Key Performance Indicators	
Primary KPIs	
KPI No.	**Title**
P2	*Unplanned readmission rates:* • *within 5 days of discharge* • *within 28 days of discharge*
Secondary KPIs	
KPI No.	**Title**
S2	*Potentially preventable hospitalisations*
S3	*Rate of absence without permission per 1,000 involuntary patient days*
Service Delivery Statement Linkage	
• Rate of community follow up within 1-7 days following discharge from an acute mental health inpatient unit • Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	

Efficient	
Available resources are maximised to deliver sustainable, high quality healthcare	
• Avoid waste	• Minimise financial risk
• Sustainable/productive	• Maximise available resources
Key Performance Indicators	
Primary KPIs	
KPI No.	**Title**
P3	Full year forecast operating position
P4	Minimum Obligatory Human Resource Information (MOHRI): • Average affordable MOHRI • Comparison against Service Delivery Statement
Secondary KPIs	
KPI No.	**Title**
S4	Average length of stay for defined range of Diagnosis Related Groups (DRGs)
S5	*Theatre utilisation*
Service Delivery Statement Linkage	
• Average cost per weighted activity unit • Total weighted activity units	

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
Key Performance Indicators	
Primary KPIs	
KPI No.	**Title**
P5	Complaints resolved within 35 calendar days
Secondary KPIs	
KPI No.	**Title**
S6	*Patient reported experience measure*
Service Delivery Statement Linkage	
• Not applicable	

Timely	
Care is provided within an appropriate timeframe	
• Treatment within clinically recommended time	
Key Performance Indicators	
Primary KPIs	
KPI No.	**Title**
P6	Emergency length of stay: • % of attendances at an Emergency Department who depart within 4 hours
P7	Patient off stretcher time: • % <30 minutes
P8	Elective surgery: • % of patients treated within the clinically recommended time
P9	Specialist outpatients: • % of specialist outpatients seen within the clinically recommended time • % of unseen specialist outpatients - reduction target
Secondary KPIs	
KPI No.	**Title**
S7	Upper and lower GI endoscopies: • % treated in time
Service Delivery Statement Linkage	
• 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 • Median wait time for elective surgery • Percentage of specialist outpatients waiting within clinically recommended times	

Equitable	
Consumers have access to healthcare that is responsive to need and addresses health inequalities	
• Fair access based on need	• Addresses inequalities
Key Performance Indicators	
Primary KPIs	
KPI No.	**Title**
P10	Access to oral health services
Secondary KPIs	
KPI No.	**Title**
S8	Telehealth utilisation rates
S9	Discharge against medical advice
Service Delivery Statement Linkage	
• Ambulatory mental health service contact duration	

People and Culture	
• Robust governance	• Engaged and trained workforce
• Clear leadership	• Culture of improvement
Primary, secondary and supporting indicators for the performance domain People and Culture will be developed during the term of this Service Agreement.	

Schedule 4
Data Reporting Requirements

1. Purpose

1. *The Hospital and Health Boards Act 2011*[6] (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.
2. This Schedule 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

1. The following principles guide the collection, storage, transfer and disposal of data:
   - Trustworthy – data is accurate, relevant, timely, available and secure
   - Private – personal information is protected in accordance with the law
   - Valued – data is a core strategic asset
   - Managed – collection of data is actively planned, managed and compliant
   - Quality – data provided is consistent and complete and undergoes regular validation.
2. The parties agree to constructively review the data reporting requirements as set out in this Schedule on an ongoing basis in order to:
   - ensure data reporting requirements are able to be fulfilled; and
   - minimise regulatory burden.

3. Roles and Responsibilities

3.1 Hospital and Health Services

1. The HHS will:
   - 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

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[6] 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.

- 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*
- provide other HHSs with routine access to data, that is not patient identifiable data, for the purposes of benchmarking and performance improvement
- provide data as required to facilitate reporting against the Performance Indicators set out in Schedule 3
- provide data as specified within the provision of a Health Service Directive
- 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
- as requested by the Chief Executive from time to time, provide to the Chief Executive data, whether or not specified in this Schedule 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.

2. 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

1. The Department of Health will:
   - produce a monthly performance report which includes:
     - actual activity compared with purchased activity levels
     - any variance(s) from purchased activity
     - performance information as required by the Department of Health to demonstrate HHS performance against the performance indicator targets specified in Schedule 3
     - 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 2.4.
   - utilise the data sets provided for a range of purposes including:
   - to fulfil legislative requirements
   - to deliver accountabilities to state and commonwealth governments
   - to monitor and promote improvements in the safety and quality of health services
   - to support clinical innovation.
   - 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 4.1 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
Allied Health Clinical Placement and New Graduate Data	Allied Health Professions Office of Queensland
BreastScreening Clinical Data	Chief Health Officer
Cervical Screening/Pap Smear Registry Data	Chief Health Officer
Clinical Incident Data Set	Patient Safety & Quality Improvement Service
Consumer Feedback Data Set	Patient Safety & 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 Health Statistics Unit)
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)	Health Statistics Unit
Newborn Hearing Screening	Children's Health Queensland.
Notifications Data	Chief Health Officer
Non-Admitted Patient Data	Health Statistics Unit
Patient Experience Survey Data	Patient Safety & Quality Improvement Service
Patient Level Costing Data	HHS Funding and Costing Unit
Perinatal Data Collection	Health Statistics Unit
Queensland Bedside Audit	Patient Safety & Quality Improvement Service

Data Set	Data Custodian
Queensland Hospital Admitted Patient Data Collection	Health Statistics Unit
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
Schedule 8 Dispensing data	Chief Health Officer
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 & Quality Improvement Service
Your Experience of Service (YES) Survey Collection (Mental Health)	Mental Health Alcohol and Other Drugs Branch

Table 4.2 Non-clinical data

Non-Clinical Data Set	Data Custodian
Asbestos management data	Asset & 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 Infrastructure Delivery
Conduct and Performance Excellence (CaPE)	Human Resources Branch
Expenditure	Finance Branch
Financial and Residential Activity Collection (FRAC)	Health Statistics Unit
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
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 & Property Services

Schedule 5
Amendments to this Service Agreement

1. Purpose

This Schedule 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

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 coming financial year. This approach is intended to provide clarity, certainty and transparency in relation to funding allocations.
2. Amendments to the drafting and clauses of this Service Agreement should be progressed for consideration as part of the annual budget build process.
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:
   - 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;
   - the number of Amendment Windows each year should be minimised to reduce the administrative burden on HHSs and the Department of Health;
   - Amendment Proposals should be minimised wherever possible and should always be of a material nature;
   - Amendment Window 2 is not intended to include funding or activity variations that could have been anticipated in advance of the financial year;
   - Amendment Windows are intended to provide a formal mechanism to transact funding or activity variations in response to emerging priorities;
   - Extraordinary Amendment Windows are not intended to be routinely used.
4. The Department of Health remains committed to the ongoing simplification and streamlining of amendment processes.

3. Process to amend this Service Agreement

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

- Amendment Windows;
- Extraordinary Amendment Windows;
- periodic adjustments; and

- end of year financial adjustments.

3.1 Amendment windows

1. 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 the Service Agreement will be negotiated and finalised during set periods of time during the year (Amendment Windows).
2. Amendment Windows are the primary mechanism through which amendments to the Service Agreement are made.
3. Amendment Windows occur twice within a given financial year:
   a) Amendment Window 1: Annual Budget Build
   b) Amendment Window 2: In-year variation
4. A party that wants to amend the terms of this Service Agreement must give an Amendment Proposal to the other party.
5. 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 5.1 (excluding Extraordinary Amendment Windows).

Table 5.1 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
AW1: Annual Budget Build	13 April 2018	2018/19 budget build
AW2: In-year variation	5 October 2018	2018/19 in-year variations

6. An Amendment Proposal is made by:
   - 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
   - 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.
7. 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.
8. A party giving an Amendment Proposal must provide the other party with the following information:
   (a) the rationale for the proposed amendment;

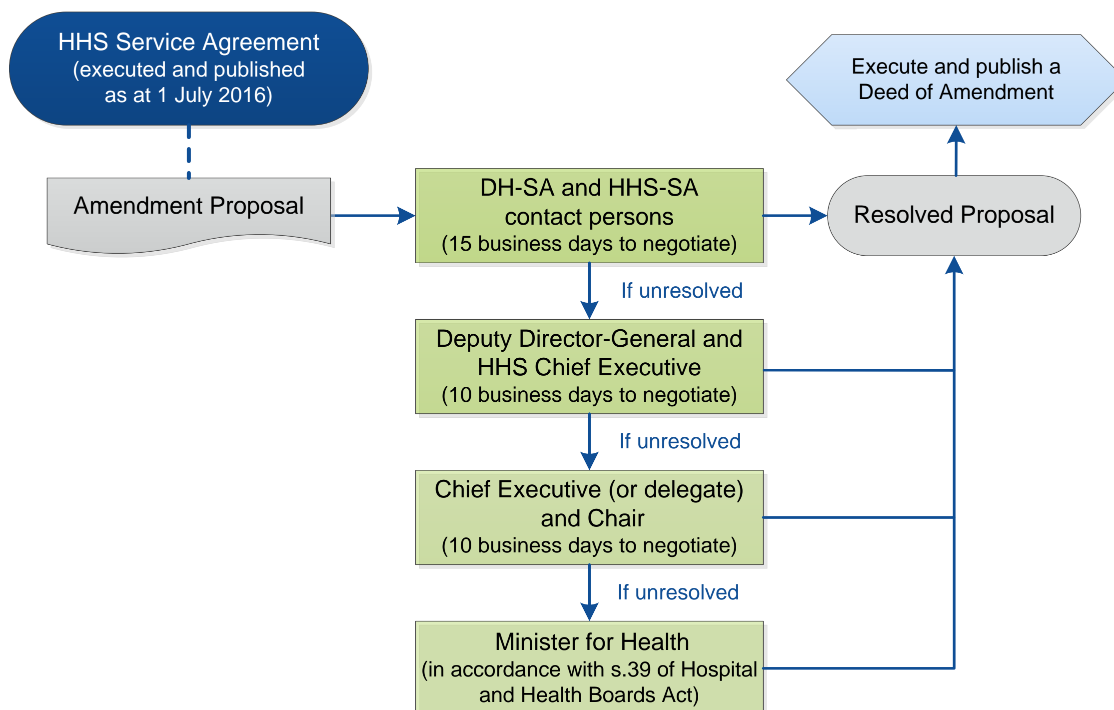
(b) the precise drafting for the proposed amendment;

(c) any information and documents relevant to the proposed amendment; and

(d) details and explanation of any financial, activity or service delivery impact of the amendment.

9. Negotiation and resolution of Amendment Proposals will be through a tiered process, as outlined in figure 3.

Figure 3 Amendment Proposal Negotiation Resolution



10. The negotiation periods identified in Figure 3 may be reduced in the complete discretion of the Chief Executive.

11. 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.

12. If the Chief Executive at any time:

(a) considers that an amendment agreed with the HHS may or will have associated impacts on other HHSs

or

(b) considers it appropriate for any other reasons

then the Chief Executive may:

(a) propose further amendments to any HHS affected

and

(b) 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*.

13. Amendment Proposals that are resolved will be documented in a Deed of Amendment to this Service Agreement and executed by the parties.

14. Only upon execution of a Deed of Amendment by the parties will the amendments documented by that deed be deemed to be an amendment to this Service Agreement.

3.2 Extraordinary Amendment Windows

1. A party that wants to amend the terms of this Service Agreement outside of an Amendment Window outlined in Table 5.1 must give an Extraordinary Amendment Proposal to the other party.
2. An Extraordinary Amendment Proposal may only be formally negotiated and resolved outside of an Amendment Window outlined in Table 5.1 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.
3. 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.
4. 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.
5. 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.
6. Negotiation and resolution of Extraordinary Amendment Proposals will be through a tiered process at outlined in Figure 3.
7. The negotiation periods identified in Figure 3 may be reduced in the complete discretion of the Chief Executive.
8. 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.
9. Extraordinary Amendment Proposals that are resolved must be executed by both parties.
10. The parties must comply with the terms of the Extraordinary Amendment Proposal from the date that the final party executed the Extraordinary Amendment Proposal.
11. 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 will expressly exclude the application of the Extraordinary Amendment Proposal and only the terms of the deed will apply.

3.3 Periodic adjustments

1. The Service Agreement Value may be adjusted outside of an Amendment Window to allow for funding variations that:
   - occur on a periodic basis;
   - are referenced in the Service Agreement; and

- are based on a clearly articulated formula.

2. 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.
3. The Chief Executive (or delegate) will issue an Adjustment Notice to the HHS-SA Contact Person confirming any funding adjustment that has been made.
4. 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.
5. 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.
6. 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 2.4 Schedule 2 will be formalised in a Deed of Amendment issued following the next available Amendment Window as identified in Table 5.1, Schedule 5.

3.4 End of financial year adjustments

1. End of year financial adjustments may be determined after the financial year end outside of the Amendment Window process.
2. The scope will be defined by the Department of Health and informed by Queensland Government Central Agency requirements.
3. 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.
4. 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.
5. 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 5.1 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 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:

- 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:
- Pensioner Concession Card issued by the Department of Veteran's Affairs
- Pensioner Concession Card issued by Centrelink
- Health Care Card (this includes Low Income Health Care Card Holders who are automatically eligible for services)
- Commonwealth Seniors Health Card
- Queensland Seniors Card
- children who are Queensland residents and are:
- eligible for dental program/s funded by the Commonwealth Government; or
- four years of age or older and have not completed Year 10 of secondary school; or
- 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 5.1 Schedule 5.

Extraordinary Amendment Window means an Amendment Window that occurs outside of the Amendment Windows specified in Table 2.1 Schedule 5, in accordance with the provisions of section 2.2 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:

- which is outside of the reasonable control of the party claiming that the event has occurred; and
- 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:

- Statewide or Regional service provision
- ensure equitable and timely access to entire catchment (clinical and non-clinical)
- provide training and consultation services where this is appropriate within the agreed model of care (clinical and non-clinical)
- timely discharge or return of patients to their place of residence (clinical services)

- adequate communication practices to enable ongoing effective local health care, including with the patient's General Practitioner where required (clinical services)
- Recipient HHS
- utilisation of standardised referral criteria, where they exist, to ensure appropriate use of statewide services (clinical services)
- timely acceptance of patients being transferred out of statewide services (back-transfers) (clinical services)
- 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 Act or by a prescribed Service under section 67(3) of the Act. 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 5.1 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.

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:

- Medicare ineligible patients, such as overseas visitors (not covered under reciprocal agreements), people in community detention and overseas students studying in Australia
- compensable patients with an alternate funding source, such as:
- workers' compensation insurers
- motor vehicle accident insurers
- personal injury insurers
- Department of Defence
- Department of Veterans' Affairs
- 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 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:

- the DH-SA contact person and the HHS-SA contact person
- Executives nominated by the Department of Health
- Executives nominated by the HHS

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

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:

- Indemnity for Queensland Health Medical Practitioners HR Policy I2 (QH-POL-153)
- 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 PI 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.

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.

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:

- live interactive video and audio links for clinical consultations and education
- 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
- teleradiology to support remote reporting and provision of clinical advice associated with diagnostic images
- 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:

- **Hospital and Health Services Service Agreements**
- **Investment Environment 2016/17**
- **Delivering and High Performing Health System for Queenslanders: Performance Framework**
- **Health Funding Principles and Guidelines 2016/17**

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

Department of Health Strategic Plan

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

A Health System for Queenslanders: Charter of Responsibility

[link to follow]

Annual Healthcare Purchasing Plan 2016/17

[link to follow]

Healthcare Purchasing Incentive Specification sheets

http://qheps.health.qld.gov.au/hpfp/html/purchasing_framework.htm

Key Performance Indicators and Supporting Indicators

http://qheps.health.qld.gov.au/cpmb/html/sam-hhs-kpi.htm

Key Performance Indicator Attribute Sheets

http://qheps.health.qld.gov.au/cpmb/html/sam-hhs-kpi.htm

Data Set Specifications

http://qheps.health.qld.gov.au/cpmb/html/sam-data-set-specs.htm

Abbreviations

ABF	Activity Based Funding
ACSQHC	Australian Commission on Safety and Quality in Healthcare
AHSSQA	Australian Health Service Safety and Quality Accreditation
BBV	Blood Borne Viruses
BMRP	Backlog Maintenance Remediation Program
BSI	Blood Stream Infection
CET	Clinical Education and Training
CPC	Clinical Prioritisation Criteria
CSCF	Clinical Service Capability Framework
DH-SA	Department of Health – Service Agreement
DNW	Did Not Wait
DRG	Diagnosis Related Group
FTE	Full Time Equivalent
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
QEP	Queensland Efficient Price
QIP	Quality Improvement Payment
QWAU	Queensland Weighted Activity Unit
SDS	Service Delivery Statement
SRG	Service Related Group
STI	Sexually Transmitted Infections
VLAD	Variable Life Adjusted Display
WOOS	Weighted Occasions Of Service

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