Service Agreement

2019/20 – 2021/22

Metro North Hospital and Health Service

July 2020 Revision

Queensland Government

Metro North Hospital and Health Service

Service Agreement 2019/20 - 2021/22, July 2020 Revision

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

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1. Introduction

1.1 The Queensland Public Sector Health System is committed to strengthening performance and improving services and programs in order to meet the needs of the community and deliver improved health outcomes to all Queenslanders.

1.2 The development of Service Agreements between the Chief Executive 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.

1.3 The content and process for the preparation of this Service Agreement is consistent with the requirements of the *Hospital and Health Boards Act 2011*. As such this Service Agreement specifies:

(a) the Health Services and other services to be provided by the HHS;

(b) the funding which is provided to the HHS for the provision of these services and the way in which the funding is to be provided;

(c) the Performance Measures that the HHS will meet for the services provided;

(d) data supply requirements; and

(e) other obligations of the Parties.

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

2. Interpretation

Unless expressed to the contrary, in this Service Agreement:

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

(b) any gender includes the other genders;

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

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

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

(f) a reference to:

(i) a Party is a reference to a Party to this Service Agreement;

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

(iii) a person includes the person's legal personal representatives, successors, assigns and persons substituted by novation;

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

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

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

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

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

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

3. Legislative and regulatory framework

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

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

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

4. Health system priorities

4.1 Ensuring the provision of Public Sector Health Services across Queensland requires clear priorities, supportive leadership and staff who work together and across each level of the Public Sector Health System. The Parties recognise that they each have a mutual and reciprocal obligation to work collaboratively with each other, with other Hospital and Health

Services (HHS) and with the Queensland Ambulance Service in the best interests of the Queensland Public Sector Health System.

4.2 The priorities, goals and outcomes for the Queensland Public Sector Health System are defined through:

(a) *Our Future State: Advancing Queensland's Priorities* - the Queensland Government's objectives for the community; and

(b) *My health, Queensland's future: Advancing health 2026* – the vision and strategy for Queensland's health system.

4.3 The Parties will also work collaboratively to deliver the *Queensland Health 2020/21 System Priorities.* The *Queensland Health 2020/21 System Priorities* establishes a tactical framework which will ensure that the Queensland Public Sector Health System delivers sustainable, high quality and timely Health Services during 2020/21, whilst remaining positioned to respond effectively to the COVID-19 pandemic.

4.4 Additionally, the Queensland Government, Premier or the Minister for Health and Minister for Ambulance Services (The Minister) may articulate key priorities, themes and issues from time to time.

4.5 HHSs have a responsibility to ensure that the delivery of Public Sector Health Services in Queensland is consistent with these strategic directions and priorities.

4.6 The Parties will collectively identify, develop, implement and evaluate strategies that support the delivery of priorities identified by the Minister, and which align with a Value-Based Healthcare approach to the delivery of Health Services.

4.7 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, the Ministers' articulated priorities and *My health, Queensland's future: Advancing health 2026*.

4.8 The Parties have a collective responsibility to contribute to a sustainable Public Sector Health System in Queensland. Planning and delivery of Health Services will be aligned with the system planning agenda set out in *Queensland Health System Outlook to 2026 for a sustainable health service* in order to ensure a coordinated, system-wide response to growing demand for Health Services.

4.9 In delivering Health Services, HHSs are required to meet the applicable conditions of all national agreements and national partnership agreements between the Queensland Government and the Commonwealth Government and commitments under any related implementation plans.

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

(a) Queensland Health System Outlook to 2026 for a sustainable health service;

(b) Performance and Accountability Framework 2020/21; and

(c) Purchasing Policy and Funding Guidelines 2020/21.

5. Objectives of the Service Agreement

This Service Agreement is designed to:

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

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

(c) specify the Performance Measures for the provision of the services;

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

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

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

6. Scope

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

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

7. Performance and Accountability Framework

7.1 The Performance and Accountability Framework sets out the framework within which the Department, as the overall manager of Public Health System Performance, monitors and assesses the performance of Public Sector Health Services in Queensland. The systems and processes employed for this purpose include, but are not limited to, assessing and monitoring HHS performance, reporting on HHS performance and, as required, intervening to manage identified performance issues.

7.2 During 2020/21 the Performance and Accountability Framework will support delivery of the *Queensland Health System Priorities 2020/21* which focus on realising positive changes to the Public Sector Health System through providing sustainable, timely, safe and high-quality Health Services in the right setting whilst remaining ready to respond to the COVID-19 pandemic.

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

7.4 The Parties agree to constructively implement the Performance and Accountability Framework.

8. Period of this Service Agreement

8.1 This Service Agreement commences on the Effective Date and expires on 30 June 2022. The Service Agreement framework is in place for three years in order to provide HHSs with a level of guidance regarding funding and purchased activity for the outer years.

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

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

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

9. Amendments to this Service Agreement

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

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

10. Publication of amendments

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

11. Cessation of service delivery

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

11.2 The Department and HHS may Terminate or temporarily Suspend a Health Service or other service by mutual agreement having regard to the following obligations:

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

(b) where it is proposed to Terminate or Suspend a Statewide Service, or a Regional Service, the HHSs which are in receipt of that service must also be consulted;

(c) the Parties must agree on a reasonable notice period following which Termination, or Suspension, will take effect; and

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

11.3 The Department, in its role as the Queensland Public Health System manager:

(a) may, in its unfettered discretion, not support a requested Termination or Suspension and require the HHS to maintain the service; and

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

11.4 The HHS will:

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

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

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

12. Commencement of a new service

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

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

12.3 In the event that a change to an established Referral Pathway is proposed which would result in the direction of patient referrals to an alternative HHS on a temporary or a permanent basis:

(a) the new Referral Pathway must be agreed by all impacted HHSs prior to its implementation; and

(b) following agreement of the new Referral Pathway, if there is an identifiable and agreed impact to funding the Department will redistribute funding and activity between HHSs in alignment with new Referral Pathway.

13. Provision of data to the Chief Executive

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

14. Dispute resolution

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

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

14.3 Resolution of disputes will be through a tiered process commencing with the Performance Review Meeting and culminating, if required, with the Minister, as illustrated in Figure 1.

14.4 Use of the dispute resolution process set out in this clause should only occur following the best endeavours of both Parties to agree a resolution to an issue at the local level. The dispute resolution process is not intended for the resolution of ongoing issues or performance related issues. At each stage of the dispute resolution process, the Parties agree to cooperate.

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

14.6 The Notice of Dispute must be provided to the D-SA Contact Person if the notice is being given by the HHS and to the HHS-SA Contact Person if the notice is being given by the Department.

14.7 The Notice of Dispute must contain the following information:

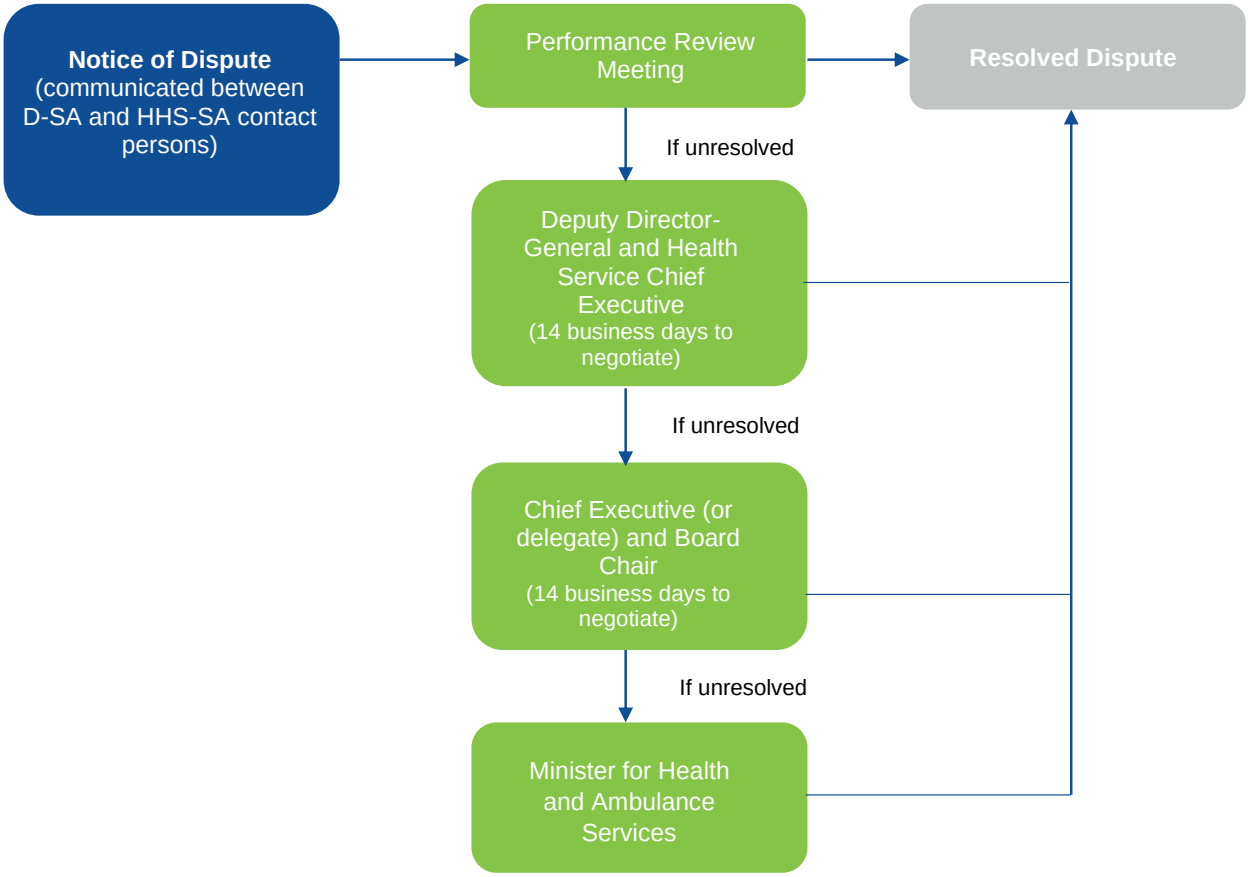
(a) a summary of the matter in dispute;

(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



14.8 Resolution of a dispute

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

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

14.9 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.

14.10 Disputes arising between Hospital and Health Services

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

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

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

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

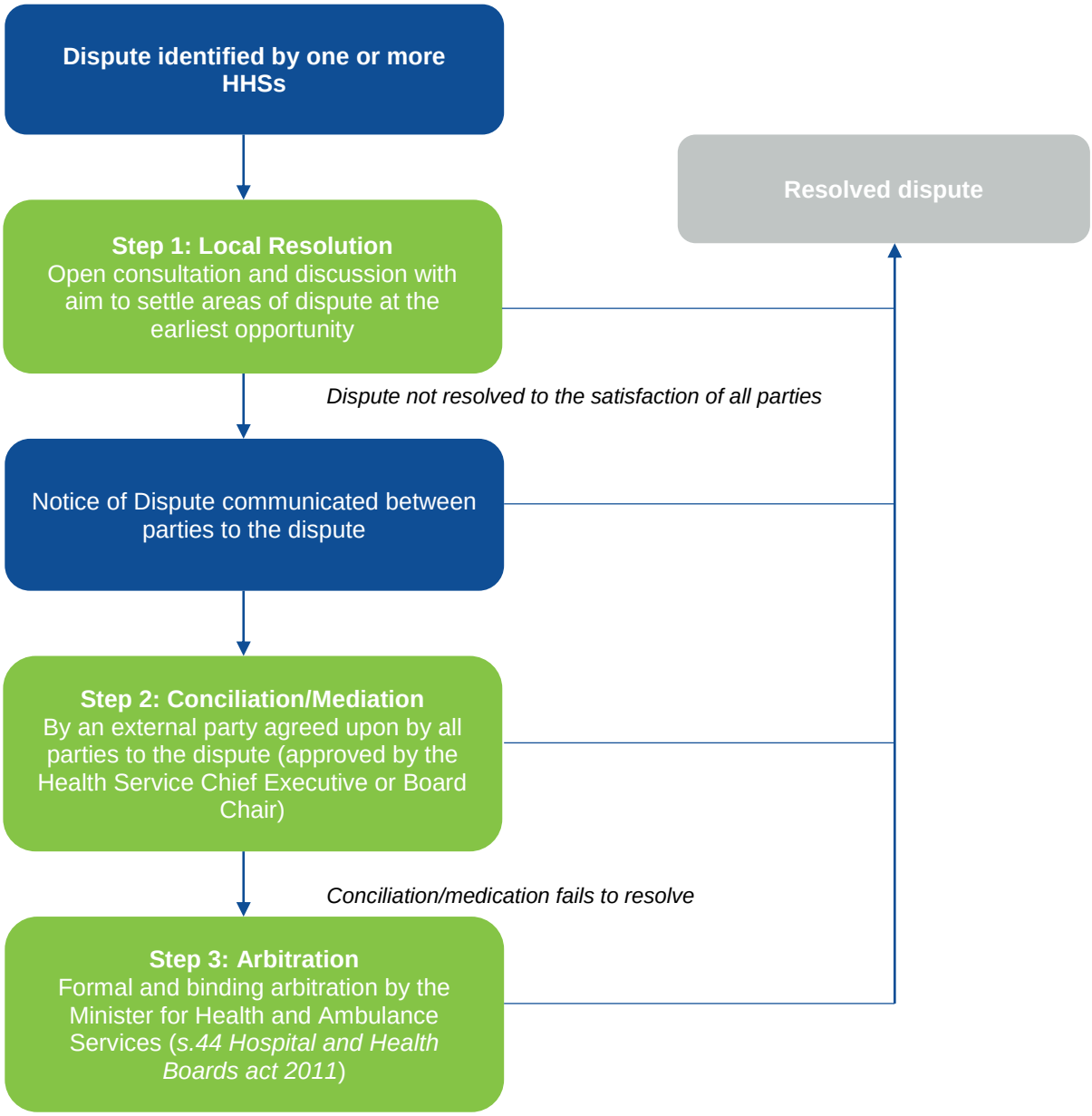
(ii) All HHSs manage patients from their own catchment population if it is within their clinical capability to do so as specified by the Clinical Services Capability Framework.

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

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

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

Figure 2 Inter-HHS dispute resolution process



15. Force Majeure

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

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

(i) the occurrence and nature of the Force Majeure;

(ii) the anticipated duration of the Force Majeure;

(iii) the effect the Force Majeure has had (if any) and the likely effect the Force Majeure will have on the performance of the Affected Party's

obligations under this Service Agreement; and

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

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

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

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

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

16. Hospital and Health Service accountabilities

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

(a) the terms of this Service Agreement;

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

(c) all Cabinet decisions applicable to the HHS;

(d) all Ministerial directives applicable to the HHS;

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

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

(g) all Industrial Instruments applicable to the HHS; and

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

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

17. Department accountabilities

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

(a) the terms of this Service Agreement;

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

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

(d) all Cabinet decisions applicable to the Department.

17.2 The Department will work in collaboration with HHSs to ensure the Public Sector 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 will:

(a) provide overall management of the Queensland Public Sector Health System including health system planning, coordination and standard setting;

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

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

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

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

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

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

17.5 **Workforce management**

The Chief Executive agrees to appoint Health Service Employees to:

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

(b) deliver the services specified in this Service Agreement.

17.6 The Chief Executive, whether in the capacity of a Person Conducting a Business or Undertaking as an employer or as a building owner or occupier, will consult, cooperate and coordinate with the HHS to ensure legal compliance with the *Work Health and Safety Act 2011* and other legislation as it applies to the scope, nature and location of operations associated with this Service Agreement. This includes, but is not limited to:

(a) codes of practice;

(b) electrical safety legislation;

(c) building and fire safety legislation; and

(d) workers' compensation legislation.

18. Insurance

18.1 The HHS must hold and maintain for the period of this Service Agreement the types and levels of insurances that the HHS considers appropriate to cover its obligations under this Service Agreement.

18.2 Without limiting the types and levels of insurances that the HHS considers appropriate, any insurance policies taken out by the HHS under this clause must include appropriate coverage for the following:

(a) public and product liability insurance;

(b) professional indemnity insurance; and

(c) workers' compensation insurance in accordance with the *Workers' Compensation and Rehabilitation Act 2003* (Qld).

18.3 The HHS will be deemed to comply with its requirements under clauses 18.1 and 18.2(a) and 18.2(b) if it takes out and maintains a current insurance policy with the Queensland Government Insurance Fund.

18.4 Any insurance policies held by the HHS pursuant to this clause must be effected with an insurer that is authorised and licensed to operate in Australia.

18.5 The HHS must maintain a current register of all third-party guarantees.

18.6 The HHS must, if requested by the Department, promptly provide a sufficiently detailed certificate of currency and/or insurance and policy documents for each insurance policy held by the HHS pursuant to this clause.

18.7 The HHS warrants that any exclusions and deductibles that may be applicable under the insurance policies held pursuant to this clause will not impact on the HHS's ability to meet any claim, action or demand or otherwise prejudice the Department's rights under this Service Agreement.

18.8 The HHS must immediately advise the Department if any insurance policy, as required by this clause, is materially modified or cancelled.

19. Indemnity

19.1 The HHS indemnifies the Department 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 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, a Health Service Employee, Health Executive, Senior Health Service Employee or an officer, employee or agent working for the HHS in the course of the performance or attempted or purported performance of this Service Agreement;

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

(c) a breach of this Service Agreement,

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

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

20. Indemnity arrangements for officers, employees and agents

20.1 Indemnity arrangements for officers, employees or agents working for the Public Sector Health System are administered in accordance with the following policy documents, as amended from time to time:

(a) Indemnity for Queensland Health Medical Practitioners HR Policy I2 (QH-POL-153:2014); and

(b) Queensland Government Indemnity Guideline.

20.2 The costs of indemnity arrangements provided for Health Service Employees, Health Executives, Senior Health Service Employees, or officers, employees or agents working for the HHS are payable by the HHS.

21. Legal proceedings

21.1 This clause applies if there is any demand, claim, liability or legal proceeding relating to assets, contracts, agreements or instruments relating to the HHS, whether or not they are:

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

(b) retained by the Department.

21.2 Subject to any law, each party must (at its own cost) do all things, execute such documents and share such information in its possession and control that is relevant, 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.

22. Sub-contracting

22.1 The Parties acknowledge that the HHS may sub-contract the provision of Health Services and other services that are required to be performed by the HHS under this Service Agreement.

22.2 The HHS must ensure that any sub-contractor who has access to confidential information (as defined in section 139 of the *Hospital and Health Boards Act 2011*) and/or personal information (as defined in section 12 of the *Information Privacy Act 2009*) complies with obligations no less onerous than those imposed on the HHS.

22.3 The HHS agrees that the sub-contracting of services:

(a) will not transfer responsibility for provision of the services to the sub-contractor; and

(b) will not relieve the HHS from any of its liabilities or obligations under this Service Agreement, including but not limited to obligations concerning the provision of data in accordance with Schedule 4 (Data Supply Requirements).

23. Counterparts

23.1 This Service Agreement may be executed in two or more identical copy counterparts, each of which together will be deemed an original, but all of which together will constitute one and the same instrument.

23.2 In the event that any signature executing this Service Agreement or any part of this Service Agreement is delivered by facsimile transmission or by scanned e-mail delivery of a '.pdf' format data file or equivalent, the signature will create a valid and binding obligation of the Party executing (or on whose behalf the signature is executed) with the same force and effect as if the signature page were an original.

23.3 For execution under this clause 23 to be valid the entire Service Agreement upon execution by each individual Party must be delivered to the remaining parties.

Execution

A. The terms of this Service Agreement were agreed under the provisions set out in the *Hospital and* Health *Boards Act,* section 35 on 27 June 2019, and were subsequently amended by the Deed of Amendment entered into pursuant to section 39 of the *Hospital and Health Boards Act 2011* and executed on 10 January 2020; 15 May 2020; 22 June 2020; 26 June 2020 and 1 October 2020.

B. This revised Service Agreement consolidates amendments arising from:

- 2019/20 Amendment Window 2 (in-year variation);
- 2019/20 Amendment Window 3 (in-year variation);
- 2020/21 Amendment Window 1 (annual budget build);
- April 2020 Extra-ordinary Amendment Window; and
- May 2020 Extra-ordinary Amendment Window.

C. Execution source documents are available on the service agreement website https://www.health.qld.gov.au/system-governance/health-system/managing/agreements-deeds.

Schedule 1 HHS Accountabilities

1. Purpose

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

2. Registration, credentialing and scope of clinical practice

2.1 The HHS must ensure that:

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

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

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

2.2 Confirmation of registration and/or professional memberships is to be undertaken in accordance with the processes outlined in 'Health Professionals Registration: medical officers, nurses, midwives and other health professionals HR Policy B14 (QH-POL-147:2016)', as amended from time to time.

3. Clinical Services Capability Framework

3.1 The HHS must ensure that:

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

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

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

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

4. Clinical Prioritisation Criteria

4.1 The HHS must ensure that:

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

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

5. Service delivery

5.1 The HHS will work with collaboratively with other healthcare service providers to ensure that an integrated pathway of care is in place for patients. This will include, but is not limited to:

(a) other HHSs;

(b) Primary Care providers;

(c) non-government organisations; and

(d) private providers.

5.2 The HHS must ensure that:

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

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

(c) the *Queensland Organ Donation Strategy 2018-2020* is implemented in order to support an increase in organ donation rates in Queensland.

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

6. Accreditation

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

6.2 Accreditation will be assessed against the National Safety and Quality Health Service standards[2] (NSQHS) second edition.

6.3 Residential aged care facilities will maintain accreditation by the Aged Care Quality and Safety Commission (ACQSC).

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

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

6.6 The HHS will select their accrediting agency from among the approved accrediting agencies. The ACSQHC and the RACGP provide a list of approved accrediting agencies which are published on their respective websites (www.safetyandquality.gov.au and www.racgp.org.au.

6.7 If the HHS does not meet the NSQHS standards accreditation requirements, the HHS has 60 days to address any not met actions. If the HHS does not meet the other accreditation standards requirements (RACGP and ACQSC), a remediation period will be defined by the accrediting agency.

6.8 Following assessment against NSQHS, ACQSC and RACGP standards, the HHS will provide to the Executive Director, Patient Safety and Quality Improvement Service, Department.

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

(b) a copy of any ‘not met’ reports within two days of receipt of the report by the HHS;

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

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

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

[2] www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/

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

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

6.11 Where the HHS funds non-government organisations to deliver health and human services the HHS will ensure, from the Effective Date of this Service Agreement, that:

(a) within 12 months HHS procurement processes and service agreements with contracted non-government organisations specify the quality accreditation requirements for mental health services as determined by the Department; and

(b) as the quality accreditation requirements for subsequent funded service types are determined by the Department, procurement processes and service agreements with contracted non-government organisations reflect these requirements within 12 months of their formal communication by the Department to HHSs.

7. Responsive regulatory process for accreditation

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

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

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

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

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

(a) seek further information from the HHS;

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

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

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

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

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

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

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

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

8. Achieving health equity for First Nations Queenslanders

8.1 The *Queensland Health Statement of Action towards Closing the Gap in Health Outcomes* is a commitment to addressing systemic barriers that may in any way contribute to preventing the achievement of health equity for all First Nations people. The statement is expected to mobilise renewed efforts and prompt new strategies for achieving health equity for First Nations Queenslanders.

8.2 The HHS will develop a Health Equity Strategy (previously referred to as the Closing the Gap Health Plan) to demonstrate the HHS's activities towards achieving health equity for First Nations people. The Health Equity Strategy will supersede the existing Closing the Gap Health Plan and act as the principal accountability mechanism between community and Government in the pursuit of Health Equity for First Nations Queenslanders.

8.3 The Health Equity Strategy will:

(a) be co-designed, co-developed and co-implemented by the First Nations community and the HHS; and

(b) demonstrate an evidence-based approach to priority setting.

8.4 The HHS will review the Health Equity Strategy at least once every three years and will publish the Health Equity Strategy in a way that allows it to be accessed by members of the public.

8.5 In line with the *Queensland Health Statement of Action towards Closing the Gap in Health Outcomes,* the HHS will ensure that commitment and leadership is demonstrated through implementing actions outlined in the Health Equity Strategy. The actions will, at a minimum:

(a) promote and provide opportunities to embed the representation of First Nations people in leadership, governance and the workforce;

(b) improve local engagement and partnerships between the HHS and First Nations people, communities and organisations to enable co-design, co-development and co-implementation;

(c) improve transparency, reporting and accountability in Closing the Gap progress; and

(d) demonstrate co-design, co-development, co-implementation and co-leadership of health programs and strategies.

8.6 The HHS will:

(a) establish and maintain an ongoing dialogue with the Department to progress and report on key actions taken and Health Service initiatives aligned to the *Queensland Health Statement of Action towards Closing the Gap in Health Outcomes*;

(b) establish and maintain an ongoing dialogue with the Department to progress and report on key actions taken and health service initiatives and strategies to attract,

recruit, support and retain a First Nations people workforce and workforce models commensurate to the HHS population and aligned to the benchmarks prescribed in the Workforce Diversity and Inclusion Strategy 2017-2022; and

(c) report publicly on progress against the Health Equity Strategy. Progress will be reported on an annual basis as a minimum.

9. Provision of Clinical Products/Consumables in outpatient settings

9.1 Upon discharge as an inpatient or outpatient, and where products/consumables are provided free of charge or at a subsidised charge, the Treating HHS will bear the initial costs of products/consumables provided to the patient/consumer as part of their care. These costs will 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 Clinical Products/Consumables.

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

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

9.4 Where a patient is supplied with medicines on discharge, or consequent to an outpatient appointment, that are being introduced to a patient's treatment, the Treating HHS will provide prescription(s) and an adequate initial supply. This will comprise:

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

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

9.5 For medicines that are non-reimbursable under the PBS, and which are not included in the Queensland Health List of Approved Medicines (LAM), the Residential HHS will 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. This evidence may be:

(a) a copy of the individual patient approval; or

(b) where the medicine is subject to a 'blanket approval' at the Treating HHS, a copy of the blanket approval, and a statement that the patient meets the criteria to be included under that approval.

9.6 This evidence is to be provided pro-actively to the Director of Pharmacy (or, for non-Pharmacist sites, the Director of Nursing and the HHS Director of Pharmacy) for the hospital nominated under clause 9.8 below.

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

9.8 The Treating HHS will inform the patient about the ongoing supply arrangements and agree which hospital, within the patient's Residential HHS, they should attend for repeat supplies. The patient will be advised to contact the pharmacy at the nominated hospital regarding their requirements at least a week before attending for repeat supply.

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

10. Capital, land, buildings, equipment and maintenance

10.1 **Capital**

(a) The HHS will:

(i) achieve annual capital expenditure within an acceptable variance to its allocation in the State's published Budget Paper 3 – Capital Statement, as specified in the capital expenditure performance KPI target.

(ii) record capital expenditure data in the capital intelligence portal each month. Data will be published through the System Performance Reporting (SPR) platform.

(iii) achieve all Priority Capital and Health Technology Equipment Replacement Program capital expenditure requirements and associated delivery milestones, as funded, and undertake all capital expenditure performance reporting requirements in the capital intelligence portal on a monthly basis.

(iv) comply with all other capital program reporting requirements, as identified in Schedule 4, Table 13.

10.2 **Asset Management**

(a) The Service Agreement includes funding provision for regular maintenance of the HHS's building portfolio.

(b) The Department has determined that a total sustainable budget allocation that equates to a minimum of 2.81% of the un-depreciated asset replacement value of the Queensland Public Health System's building portfolio is required to sustain the building assets to achieve expected life-cycles. The sustainable budget allocation is a combination of operational and capital maintenance funding.

(c) The HHS will conduct a comprehensive assessment of the maintenance demand for the HHS's building portfolio to ascertain the total maintenance funding

requirements of that portfolio. The assessment must identify the following for the portfolio:

(i) regulatory requirements;

(ii) best practice requirements;

(iii) condition-based requirements;

(iv) lifecycle planning requirements; and

(v) reactive maintenance estimates based on historical information, including backlog maintenance liabilities and risk mitigation strategies.

(d) The HHS will allocate an annual maintenance budget that reasonably takes into account the maintenance demand identified by the assessment in its reasonable considerations, without limiting the scope of such reasonable considerations including financial affordability linked to risk assessment. The annual maintenance budget will equate to either:

(i) 2.81% of the un-depreciated asset replacement value of the HHS's building portfolio; or

(ii) an alternative percentage amount determined by the HHSs as a result of its considerations.

(e) The HHS will submit an annual asset management and maintenance plan, approved by the Health Service Chief Executive, to the Department that:

(i) outlines the maintenance demand assessment undertaken by the HHS under Schedule 1, clause 10.2(c)

(ii) confirms the annual maintenance budget determined by the HHS under Schedule 1, clause 10.2(d)

(f) The HHS will submit an annual Statement of Building Portfolio Compliance to the Department for each year of the Term of this Service Agreement.

(g) The HHS will continue to proactively develop and address the recommendations within the final Asset Management Capability Report that was issued to the HHS as part of the transfer notice process.

10.3 **Property**

(a) 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 under section 273A of the *Hospital and Health Boards Act 2011.*

(b) For land, buildings and parts of buildings where the Department 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 is deemed to be in control of that land, building or part of a building for the purpose of work health and safety law.

10.4 Nothing in clause 10.3(b) of Schedule 1:

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

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

11. Occupational health and safety

11.1 The HHS, whether in the capacity of a Person Conducting a Business or Undertaking as an employer or as a building owner or occupier, will consult, cooperate and coordinate to ensure legal compliance with the *Work Health and Safety Act 2011* and other legislation as it applies to the scope, nature and location of operations associated with this Service Agreement. This includes, but is not limited to:

(a) codes of practice;

(b) electrical safety legislation;

(c) building and fire safety legislation; and

(d) workers' compensation legislation.

11.2 The HHS will establish, implement and maintain a health and safety management system which conforms to recognised health and safety management system standard AS/NZS 4801 *Occupational Health and Safety Management System* or ISO45001 *Occupational Health and Safety Management Systems* or another standard as agreed with the Chief Executive.

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

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

12. Workforce management

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

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

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

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

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

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

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

(vi) the relevant HR delegations manual; and

(vii) any other relevant legislation.

12.2 The HHS must ensure that Health Service Employees are suitably qualified to perform their required functions.

12.3 Persons appointed in an HHS as a Health Executive or Senior Health Service Employees are employees of the HHS

12.4 All HHSs will 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.

13. Medically authorised ambulance transports

13.1 The HHS will:

(a) utilise the Queensland Ambulance Service (QAS) for all road ambulance services not provided by the HHS. This includes both paramedic level and patient transport level services where the patient requires clinical care;

(b) follow the *Medically Authorised Ambulance Transports Operational Standards* when utilising QAS services; and

(c) ensure that performance data for ambulance services authorised by the HHS is collected and provided to the Department in line with agreed data supply requirements.

Schedule 2 Funding, purchased activity and services

1. Purpose

This Schedule 2 sets out:

(a) The activity purchased by the Department from the HHS (Table 4, Table 6 and Table 8);

(b) The funding provided for delivery of the purchased activity (Table 4; Table 5; Table 6; and Table 7);

(c) Specific funding commitments (Table 1);

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

(e) The sources of funding that this Service Agreement is based on and the manner in which these funds will be provided to the HHS (Table 3); and

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

2. Delivery of purchased activity

2.1 The Department and the HHS will monitor actual activity against purchased levels.

2.2 The HHS has a responsibility to actively monitor variances from purchased activity levels and will notify the Department immediately via the D-SA Contact Person as soon as the HHS becomes aware of significant variances.

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

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

2.5 With the exception of the programs, services and projects that are specified in Table 1, during 2020/21 no financial adjustment will be applied where the HHS is unable to deliver or exceeds the activity that has been funded, in recognition of the Commonwealth Government's treatment of the National Health Reform Agreement to support the response to the COVID-19 pandemic.

2.6 The activity purchased through this Service Agreement for 2020/21 is based on the activity purchased recurrently in 2019/20 and includes the productivity dividend.

2.7 The activity purchased in the Service Agreement for 2021/22 will be based on the activity purchased recurrently in 2020/21 including the productivity dividend.

2.8 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.

2.9 The Department is required to report HHS activity data to the Independent Hospital Pricing Authority and the Administrator of the National Health Funding Pool. The HHS will maintain its efforts to accurately record the delivered activity and submit this data to the Department in accordance with the requirements set out in Schedule 4.

2.10 The HHS should refer to the supporting document to this Service Agreement 'Healthcare Purchasing Policy and Funding Guidelines 2020/21' for details regarding the calculation of Weighted Activity Units. Supporting documents are available on-line as detailed in Appendix 1.

3. Financial adjustments

3.1 **Specific funding commitments**

(a) As part of the Service Agreement Value, the services, programs and projects set out in Table 1 have been purchased by the Department from the HHS. These services will be the focus of detailed monitoring by the Department.

(b) The HHS will promptly notify the D-SA Contact Person if the HHS forecasts an inability to achieve commitments linked to the specific funding commitments included in Table 1.

(c) On receipt of any notice under clause 3.1(b) of Schedule 2, it is at the discretion of the Chief Executive (or delegate) to withdraw allocated funding pro rata to the level of under delivery if the program is not being delivered according to the program objective or is not being delivered in full.

(d) If the Chief Executive (or delegate) decides to withdraw allocated funding, the Chief Executive (or delegate) will immediately issue an Adjustment Notice to the HHS-SA Contact Person confirming any adjustment that has been made in accordance with this clause 3.1 of Schedule 2. The Adjustment Notice will be issued through the process set out in clause 3.4 or 3.5 of Schedule 5.

(e) Following receipt of an Adjustment Notice under clause 3.1(d) of Schedule 2, the Parties will comply with the Adjustment Notice and immediately take steps necessary to give effect to the requirements of that Adjustment Notice.

(f) The Parties acknowledge that adjustments made under this clause 3.1 of Schedule 2 may vary the Service Agreement Value and/or a specific value recorded in Table 1.

(g) Where the Service Agreement Value and/or a specific value recorded in Table 1 is varied, the variation will be recorded in a Deed of Amendment issued following the next available Amendment Window.

Table 1 Specific Funding Commitments

Service/Program/Project	Funding	Activity	Timeframe	Conditions
BreastScreen	*$6,694,515* $6,899,132 (comprises screening activity funding; Incentive funding; fixed allocations – e.g. Biomedical Technology Services, lease of premises, state-wide hosted services and 2.5% non-labour escalation)	*43,600 total screens Incentive 1: 4,500 screens Incentive 2: 220 screens* 44,100 total screens Incentive 1: 5,000 screens Incentive 2: 220 screens	*2019/20* 2020/21	Provision of BreastScreen services targeting women aged 50-74 years old (women 40-49 years and 75+ are also eligible, although not actively recruited). Incentive funding: • Incentive 1: $30 per screen for out of hours screens in the target age group 50 to 74, where BreastScreen Queensland (BSQ) Registry appointment time is before 8am on weekdays, 5pm and after on weekdays and all-day weekends; and • Incentive 2: $90 per screen for 1st and 2nd screens in the target age group 50 to 74 above the 2015/16 BSQ Service specific baseline. Note Incentive 1 and Incentive 2 activity is a subset of the total screening activity. Funds may be withdrawn should the HHS not meet their screening target.
Surgical, Treatment and Rehabilitation Service (STARS)	$39,999,492 (recurrent)	8,252 WAUs	2020/21	Funding to support the operationalisation of the STARS. The service has been commissioned to be operational from February 2021. Elective Surgery, Gastrointestinal Endoscopy and Outpatient Initial Service Events to be negotiated and specifically commissioned by the DOH on review of SEQ service needs.
Hospital in The Home (HITH)	*$1,500,000* $1,700,000	*309 WAUs* 351 WAUs	*2019/20* 2020/21	The HHS will deliver the initiatives and outcomes as outlined in the Residential Aged Care Facility Support Services and HITH COVID-19 Funding -memorandum C-ECTF 20/4081. The HHS will provide a reconciliation of expenditure through End of Year, and unspent funds may be withdrawn and returned to the department.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Oral Health Services	$37,657,981 (recurrent)	696,605 WOOS	2020/21	Delivery consistent with the Oral Health Policy Framework. Funding does not include Commonwealth National Partnership Agreement funding. Funding may be adjusted where the total oral health activity delivered varies from the purchased levels. Oral health activity (WOOS) for the 0-15 year age group shall not be less than that achieved in 2017/18. Oral health activity (WOOS) includes activity claimed under the Child Dental Benefits Schedule but excludes dental treatment delivered under general anaesthetic in public hospitals.
Oral Health Centre	*$7,943,665* *$5,600,000* $4,550,000	*141,656 WOOS* *0* 82,727 WOOS	*2019/20* *2019/20* 2020/21	Funding may be adjusted if not spent in year.
Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033 - Investment Strategy 2018-21	*$4,302,165* $3,847,250	*0* 0	*2019/20* 2020/21	The HHS will deliver the initiatives and outcomes outlined in the performance requirements issued by the Aboriginal and Torres Strait Islander Health Division in memorandum C-ECTF-19/5767. Funding may be adjusted, and/or unspent funds redirected or recovered where project performance requirements are not met.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Enterprise Bargaining (EB)	*$66,939,876* $18,980,829 $479 (comprises both recurrent and non-recurrent funding)	*0* 0 0	*2019/20* 2020/21 2021/22	Funding has been allocated in full for the following EB agreements: • *Nurses and Midwives (Queensland Health and Department of Education and Training) Certified Agreement (EB10) 2018* (Base wages and certain entitlements)*;* and • *Medical Officers (Queensland Health) Certified Agreement (MOCA5) 2018.* Legislative amendments have been introduced under the *Industrial Relations Act 2016* to give effect to a 2.5% increases under the following agreements as new agreements are yet to be certified: • *Queensland Public Health Sector Certified Agreement (No.9) 2016;* • *Queensland Health, Building, Engineering & Maintenance Services Certified Agreement (No.6) 2016;* and • *Health Practitioners' and Dental Officers (Queensland Health) Certified agreement (No. 2) 2016.* Funding which have been allocated recurrently in previous years have been recalled for the following streams as wage increase are not yet approved: • HES-DSO; • SES-SO; and • VMO Subject to the terms and conditions of the agreements once executed a funding adjustment may be required. Full details can be found on the Budget and Analysis SharePoint platform.
Nurses and Midwives EB10 Innovation Fund: • Provider at Triage Project • Trauma Informed Care Project • Development of a nursing led model to manage a vulnerable population project	*$1,053,585* $244,637	*0* 0	*2019/20* 2020/21	Funding has been provided under the *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018,* clause 44.6, Innovation Fund. The HHS will deliver the project, evaluation and reporting as outlined in memos: • C-ECTF-19/8765; • C-ECTF-19/8768; and • C-ECTF-19/8769. Funding may be withdrawn if project requirements are not met.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Connecting Care to Recovery 2016-2021: A plan for Queensland's Mental Health	$3,846,595 (recurrent)	0	2020/21	Provision of services to include: • Eating Disorders Outreach Service; • Cross Age Gender Clinic Service; • Queensland Fixated Threat Assessment Centre; • Classified Patient Co-ordinator; • Queensland Health Victim Support Service; and • Police Communications Mental Health Liaison.
• Independent Patient Rights Advisers	$841,000 (recurrent)	*0*	*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*.
• Indigenous Mental Health Intervention Program (IMHIP)	*$2,100,000*	*0*	*2019/20*	To continue the IMHIP to June 2020.
• Queensland Eating Disorders Service (QuEDS)	*$145,000*	*0*	*2019/20*	1 HP4 for the treatment component of the QuEDS.
• Ed-LinQ Program	$162,500 (recurrent)	*0*	*2019/20*	Expand the reach of the existing Ed-LinQ program in Metro North HHS.
• Youth Mental Health Capital Program	*$675,574*	*0*	*2019/20*	Project Officer to undertake commissioning for the Youth Step Up Step Down (Y-SUSD), and part year operational funding for clinical staffing to support commencement of Step Up Step Down (SUSD).
	$1,150,893 (recurrent)	0	2020/21	Operational funding for the Y-SUSP including clinical staffing and non-labour costs to provide an integrated service in collaboration with a non-government organisation
	$187,233 (recurrent)	*0*	*2019/20*	Operational funding (Senior Clinician) for Y-SUSD Unit.
• State-wide Telephone Service for Diversion Programs	*$650,000*	*0*	*2019/20*	Deliver a State-wide Telephone Service for police and court diversion programs in line with service guidelines for brief intervention.
Prisoner health services – revised base funding	$10,153,478 (recurrent)	*0*	*2019/20*	The HHS will use this funding to provide primary health care services for prisoners in Woodford Correctional Centre in accordance with the Memorandum of Understanding established between

Service/Program/Project	Funding	Activity	Timeframe	Conditions
				Queensland Health and Queensland Corrective Services.
Halwyn Health Centre	*$1,000,000* $1,000,000	*0* 0	*2019/20* 2020/21	Provision of funding for the ongoing support of services at the Halwyn Centre. The HHS will provide a reconciliation of expenditure through End of Year for the next 2 years. Any underspends to be returned to the Department.
Halywn Health Centre – building maintenance	*$2,500,000*	*0*	*2019/20*	Funding to address maintenance requirements including lift replacement over the next 2 years. HHS to manage cash-flow. Unspent funds to be returned to the department in 2020/21 (end of year).
Residential aged care facility Support Services (RaSS)	*$620,000* $1,050,000	*0* 0	*2019/20* 2020/21	The HHS will deliver the initiatives and outcomes as outlined in the RaSS and Hospital in The Home COVID-19 Funding - memorandum C-ECTF 20/4081. The funding allocated is linked to the National Partnership Agreement on COVID-19 healthcare response and as such it will be a requirement of the HHS to capture accurate activity and expenditure of services delivered under this program. Unspent funds may be withdrawn and returned to the department.
Specialist Outpatient Strategy	$80,000,000 (recurrent)	*12,513 WAUs*	*2017/18*	Funding is provided to support the activity required to reduce specialist outpatient long waits and the conversions to elective surgery to maintain performance.
• Telehealth	$1,128,198 (recurrent)	*232 WAUs (Q22)*	*2019/20*	Funding is provided for Telehealth (tele-stress testing, remote chemotherapy, urology, speech pathology, respiratory, neurosurgery, endocrinology, clinical pharmacy and circulatory). Funding may be withdrawn if requirements are not met.
• General Practitioner with Special Interest (GPwSI)	*$583,323* $583,323 (recurrent)	*48 WAUs (Q22)* 48 WAUs (Q22)	*2019/20* 2020/21	The HHS will deliver the initiatives and outcomes outlined in memo C-ECTF-19/6469. Funding may be withdrawn if requirements are not met.
Community Mental Health Growth Allocation	$5,250,400 (recurrent)	*0*	*2018/19*	Provision of funding to support an increase of 33.3 Full Time Equivalents (FTEs) to enhance Older Persons and Community Mental Health Services.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
				Recruitment of FTEs to be monitored by the Mental Health Alcohol and Other Drugs Branch on a regular basis using the Mental Health Establishment Collection, with adjustments to be made in-year if FTEs not all recruited permanently.
Statewide Bariatric Surgery Initiative	*$77,421* $16,196	*0* 0	*2019/20* 2020/21	Funding is provided for the first three months of 2020/21 for a project officer to manage the administrative processes required to support the additional surgical services whilst awaiting the outcome of the Statewide Bariatric Surgery Initiative evaluation report.
Hospital car parking concession scheme	$327,000* (recurrent)	*0*	*2019/20*	If program performance requirements are not met in-year funding may be withdrawn. Monthly reporting of car parking concessions data on 'Car Parking Concessions Reporting template' required. Annual Hospital and Health Service Car Parking Concessions Criteria reporting required. *Includes $27,000 to assist with administrative costs.
	$138,000	*0*	*2019/20*	Top up to 2019/20 funding. Includes $23,000 to assist with administrative costs.
	$23,000 (recurrent)	0	2020/21	Funding for assistance with administrative costs.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Elective Surgery Volume Increase	$17,620,987 (recurrent)	*3,635 WAUs (Q22)*	*2019/20*	HHS to provide an additional 2,069 cases above 2018/19 actual elective surgery treatment. Funds may be withdrawn on a pro rata basis should the HHS not deliver on increased volume. This activity will be included in the elective surgery planned care target when this is confirmed.
Nurse Navigators	*$7,961,326* $8,239,945 $8,239,945 $8,239,945 (recurrent)	*0* 0 0 0	*2019/20* 2020/21 2021/22 2022/23	The total Nurse Navigator Program allocation (2015/16 – 2019/20) is 49 NG7 and 1 NG8. All Nurse Navigator Program Full Time Equivalent (FTE) is required to be appointed to a position ID that has 'Nurse Navigator' within the position title. The HHS is ineligible to appoint Nurse Navigator Program FTE to any pre-existing permanent positions which have been renamed to include 'Nurse Navigator' in the position title. The HHS is required to report monthly on: • Employed Nurse Navigator FTE; • Number of Nurse Navigator plans in place; and • Number of patients seen by Nurse Navigators.
Another 100 Midwives (Nursing)	*$1,869,015* $1,917,172 $911,046	*0* 0 0	*2019/20* 2020/21 2021/22	The HHS will deliver the initiatives and outcomes outlined in the performance requirements as per memo C-ECTF-18/8074. Funding may be withdrawn if requirements are not met.
Strength with Immersion Model (SwIM) • Gastroenterology and Perioperative Clinical Immersions • Mental Health Clinical Immersions • Neonate Clinical Immersions	 *$140,000* *$110,000* $120,000 *$81,000* $90,000	 *0* *0* 0 *0* 0	 *2019/20* *2019/20* 2020/21 *2019/20* 2020/21	The HHS will deliver the initiatives and outcomes outlined in the performance requirements as per memo C-ECTF-19/10193.
Mental Health Short Stay Unit	*$5,400,000* *$767,000* $4,587,631 (recurrent)	*0* *0* 946 WAUs (Q22)	*2019/20* *2019/20* 2020/21	Funding to support the Caboolture mental health expanded capacity to improve mental health performance, including $5,400,000 capital funding. Funding to be returned if not delivered.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
High risk foot patients seen/managed within 48 hours of referral to ambulatory services	$248,348 (recurrent) $178,162 (recurrent) $107,977 (recurrent) *$81,721*	*52 WAUs (Q21)* *37 WAUs (Q22)* *23 WAUs (Q21)* *0*	*2018/19* *2019/20* *2018/19* *2019/20*	The HHS will provide services as specified in the 2019/20 Ambulatory High Risk Foot Services specification sheet published on QHEPS. This recurrent allocation is to fund a full-time clinical position to support high risk foot services in other HHSs across Queensland via telehealth. Non-recurrent funding is provided for a clinician project officer (reporting to the statewide Diabetes Clinical Network Chair) to assist health services to implement efficient and effective service models and develop an evaluation framework.
Endovascular Clot Retrieval (ECR)	*$437,011* $446,157 (recurrent) $1,637,704 (recurrent)	*0* 0 *0*	*2019/20* 2020/21 *2019/20*	Funding is provided for the recruitment of 1.0 Full Time Equivalent Interventional Radiologist to support ECR services at the Royal Brisbane and Women's Hospital. Funding will be provided recurrently from 2020/21. If there is a delay to the recruitment, funding may be with drawn on a pro-rata basis. Recurrent funding to support the provision of ECR services in additional to the revenue received as Activity Based Funding.
Caboolture Hospital Emergency Department Expansion	$6,053,000 (recurrent)	*1,248 WAUs (Q22)*	*2019/20*	Funds may be withdrawn on a pro rata basis should there be a delay in commissioning.
Planned Care Volume Targets – Elective Surgery	$267,672,673 (Funding in existing service agreement)	29,527 elective surgery separations aligned with the elective surgery data collection, as reported on SPR and any outsourced elective surgery activity. 55,224 WAUs (Q22).	2020/21	Funding has been quarantined to support the ongoing delivery of planned care volumes during 2020/21. Quarantined funds have been determined based on agreed average Q22 WAUs for 29,527 Elective Surgery Separations (volume target). Volume targets to be reviewed and adjusted through the amendment window process to include any additional planned care investments. Performance will be monitored quarterly with reconciliation of the agreed planned care activity targets (number of day case and overnight treated patients). Should the agreed volume targets not be met, funding will be

Service/Program/Project	Funding	Activity	Timeframe	Conditions
				withdrawn at the calculated HHS average Q22 WAUs **per separation not delivered**: Example: 1 Case = 1.87 Q22 WAU or $9,065 (QEP) There will not be claw back of under delivery against Q22 WAUs target if the volume of elective day case and overnight separations has been delivered.
Planned Care Volume Targets – Gastrointestinal Endoscopy (GIE)	$70,956,175 (Funding in existing service agreement value)	21,658 Gastrointestinal Endoscopies aligned with the Gastrointestinal Endoscopy data collection, as reported on SPR and any outsourced GIE activity. 14,639 WAUs (Q22).	2020/21	Funding has been quarantined to support the ongoing delivery of planned care volumes during 2020/21. Quarantined funds have been determined based on agreed average Q22 WAUs for 21,658 Gastrointestinal Endoscopy Separations (volume target). Volume targets to be reviewed and adjusted through the amendment window process to include any additional planned care investments. Performance will be monitored quarterly with reconciliation of the agreed planned care activity targets (number treated GIE patients). Should the agreed volume targets not be met, funding will be withdrawn at the calculated HHS average Q22 WAUs per separation not delivered: Example: 1 Case = 0.68 Q22 WAUs or $3,276 (QEP) There will not be claw back of under delivery against Q22 WAUs target if the volume of GIE day case and overnight separations has been delivered.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Planned Care Volume Targets – Specialist Outpatients	$48,555,708 Funding in existing service agreement value	144,006 Specialist Outpatient initial service events as per the funding specification, and outsourced activity. 10,018 WAUs (Q22).	2020/21	Funding has been quarantined to support the ongoing delivery of planned care volumes during 2020/21. Quarantined funds have been determined based on agreed average Q22 WAUs for 144,006 Initial Service Events (volume target). Volume targets to be reviewed and adjusted through the amendment window process to include any additional planned care investments. Performance will be monitored quarterly with reconciliation of the agreed planned care activity targets (number of initial service events). Should the agreed volume targets not be met, funding will be withdrawn at the calculated HHS average Q22 WAUs per initial service event not delivered: Example: 1 Case = 0.070 Q22 WAUs or $337 (QEP) There will not be claw back of under delivery against Q22 WAUs target if the volume of initial service events has been delivered.
Care in the Right Setting (CaRS): • Virtual Emergency Department	*$843,321* $1,651,650	*0* 0	*2019/20* 2020/21	Services will be provided consistent with the CaRS application(s). If Service commencement does not align with the agreed implementation timeframes funding may be withdrawn on a pro-rata basis. If the agreed Service levels are not provided, funding may be withdrawn. Activity levels will be monitored regularly and cooperation with external evaluators is required. Where this Service includes Service provision to another (receiving) HHS: • If staffing is not available within the HHS to meet the agreed Service levels, the HHS will make alternate arrangements to ensure that the agreed Service levels are provided; and If the agreed Service levels are not provided, funding may be withdrawn and provided to the receiving HHS.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
Rapid Results Program *Delivering what matters: Advancing Kidney Care 2026 Collaborative*	$1,026,071 (recurrent)	*106 WAUs (Q22 part WAU backed)* 212 WAUs (Q22 fully WAU backed)	*2019/20* 2020/21	Funding is provided for implementation of a transplant coordination model and kidney supportive care model under the *Advancing Kidney Care 2026 Collaborative.* The HHS will ensure that the reporting requirements established for this initiative are met, including the provision of quarterly progress against agreed implementation milestones and outcome measures.
	$743,568	*0*	*2019/20*	To host the Advancing Kidney Care 2026 project. The project team supports the implementation of strategic directions under the *Advancing Kidney Care 2026 Collaborative* project.
Rapid Results Program *Delivering what matters: Frail and Older persons initiative*				
• Geriatric Emergency Department Intervention (GEDI)	$1,940,000 (recurrent)	*0*	*2019/20*	Funding is provided to implement the core principals of a Geriatric Emergency Department Intervention at Royal Brisbane and Women's Hospital, Caboolture Hospital, Redcliffe Hospital, The Prince Charles Hospitals and Inpatient Eat Walk Engage model of care (two wards) at Caboolture, Redcliffe and The Prince Charles Hospitals from 1 July 2019: The HHS will: • Establish the service in line with agreed timelines; • Establish a Steering Committee to provide oversight of the service development and operation; • Comply with the agreed reporting requirements, including progress against the identified project outcomes and performance measures; and • Participate in learning sessions and statewide working group meetings. Funds may be withdrawn if dedicated Frail Older Persons models of care are ceased.
• Inpatient geriatric model (Eat Walk Engage)	$660,000 (recurrent)	*0*	*2019/20*	
• Non-recurrent Initiative	*$472,000*	*0*	*2019/20*	Funding for the release of clinical leads.

Service/Program/Project	Funding	Activity	Timeframe	Conditions
COVID-19 First Nations Response	$842,237	0	2020/21	The HHS will implement and deliver the required actions under the HHS First Nations COVID-19 response including the delivery of initiatives and outcomes outlined in memorandum C-ECTF-20-9652. Funding is one-off in nature for discrete and time-limited activities that are directly attributable to managing the impacts of COVID-19 for First Nations peoples and must be in-scope under the existing financial guidelines for COVID-19 expenditure. HHSs are to retain appropriate supporting documentation to substantiate all expenditure under the National Partnership Agreement.

3.2 **National Partnership on COVID-19 Response**

(a) The Department will provide additional funding to the HHS under the State Public Health Payment component of the *National Partnership on COVID-19 Response* where actual additional cost is demonstrated.

(b) Funding will be provided where the HHS has:

(i) undertaken activity that is in-scope for the State Public Health Payment during the reporting period; and

(ii) met the reporting requirements in relation to COVID-19 expenditure, as prescribed under the *National Partnership on COVID-19 Response* and by the Department.

(c) The scope of the State Public Health Payment is defined as:

(i) additional costs that are attributable to the treatment of patients with diagnosed or suspected COVID-19; or

(ii) additional costs of activities directed at preventing the spread of COVID-19.

(d) Additional costs that are reimbursed through the State Public Health Payment will be excluded from the calculation of activity eligible for funding under the terms of the National Health Reform Agreement.

(e) There is no guarantee that the HHS will have access to additional funding under the State Public Health Payment.

(f) All funding that is provided through the State Public Health Payment will be subject to a reconciliation to be undertaken by the Administrator of the National Health Funding Pool. The HHS will be required to provide evidence to support claims for additional costs. If the HHS is unable to provide the required evidence on request, funding received may be recalled subject to reconciliation.

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

3.3 **Financial adjustments – other**

(a) The purchasing approach includes a range of funding adjustments which aim to incentivise high value care, that is care which delivers the best outcomes at an efficient cost, and dis-incentivise Low Benefit 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.

(b) The Department must reconcile the applicable purchasing incentives in Table 2 in line with the timeframes specified in the purchasing specification sheet included within the supporting document 'Purchasing Policy and Funding Guidelines 2020/21'. The Department must promptly provide a copy of the reconciliation statement to the HHS-SA Contact Person.

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

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

(e) When the Parties have agreed on a funding adjustment, the Chief Executive (or delegate) will issue an Adjustment Notice to the HHS-SA Contact Person confirming any funding adjustment that has been made in accordance with this clause 3.3 of Schedule 2. The Adjustment Notice will be issued through the process set out in clause 3.4(c) of Schedule 5.

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

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

Table 2 Purchasing Incentives 2020/21 (Summary)

Incentive	Description	Scope	Status for 2020/21	Funding Adjustment
Quality Improvement Payment (QIP) – Antenatal Visits for First Nations Women	Incentive payments for achieving targets for: • First Nations women attending an antenatal session during their first trimester, and attending at least 5 antenatal visits; and • First Nations women stopping smoking	All HHSs (excluding Children's Health Queensland)	Continues as per 2019/20 with new targets	50% advance payments made to HHSs with balance paid retrospectively based on performance.
Quality Improvement Payment (QIP) - Smoking Cessation (Community Mental Health)	Incentive payments for achieving targets for community mental health patients clinically supported onto the Smoking Cessation Clinical Pathway	All HHSs (excluding Children's Health Queensland and Mater Public Hospitals)	Continues as per 2019/20 with new targets	Paid retrospectively
High Cost Home Support Program	Payment for high cost 24 hour home ventilated patients meeting the eligibility criteria, where funding is not available through existing sources	All HHSs	Continues as per 2019/20	Paid retrospectively based on forecast costs
Telehealth	Incentive payments for additional outpatient activity volume, provision of telehealth consultancy for Inpatients, Emergency Department and Outpatients episodes and Store and Forward assessments	Inpatients, Emergency Department, Outpatients, and Store and Forward - all HHSs	Continues as per 2019/20 with Outpatients scope expanded to include rural and remote facilities across all HHSs	Paid retrospectively
Sentinel Events	Zero payment for national sentinel events	All ABF public hospitals	Continues as per 2019/20	Retrospective adjustment

3.4 Public and private activity/Own Source Revenue

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

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

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

(d) The HHS will make all efforts to identify and maximise revenue from appropriate third parties to ensure optimisation of available State and Commonwealth funding across the Queensland Public Sector Health System.

(e) The Own Source Revenue identified in Table 3 is an estimate generated by the HHS which allows all third-party funding sources associated with service delivery

to be identified. The HHS will ensure that this estimate is substantiated and accurate to ensure no significant variances to actual revenue generated.

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

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

4. Funding sources

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

(a) Commonwealth funding;

(b) State funding;

(c) Grants and Contributions; and

(d) Own Source Revenue.

4.2 Table 3 provides a summary of the funding sources for the HHS and mirrors the total value of the Service Agreement included in Table 4.

Table 3 Hospital and Health Service funding sources 2020/21

Funding Source	Value ($)
NHRA Funding	
Activity Based Funding	2,477,209,706
Clinical Education and Training[3]	-85,720,142
Own Source Revenue contribution in ABF funded services	-147,217,806
Pool Account – ABF Funding (State and Commonwealth)[4]	**2,244,271,758**
Block Funding	126,860,124
Clinical Education and Training[3]	85,720,142
State Managed Fund – Block Funding (State and Commonwealth)[5]	**212,580,266**
Locally Receipted Funds (Including Grants)	**45,886,199**
Locally Receipted Own Source Revenue (ABF)	**147,217,806**
Locally Receipted Own Source Revenue (Other activities)	**145,995,274**
Department of Health Funding[6]	**356,006,094**
Total NHRA Funding	**3,151,957,397**
NPA Covid-19 Response	
Activity Based Funding	-
Hospital Services Payment – ABF Funding (State and Commonwealth)[7]	**-**
Block Funding	-
Clinical Education and Training[3]	-
Hospital Services Payment – Block Funding (State and Commonwealth)[5]	**-**
Public Health Funding (State and Commonwealth) [8]	**1,892,236**
Total NPA – COVID-19 Funding	**1,892,236**
TOTAL	**3,153,849,633**

[3] 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.

[4] 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.

[5] 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.

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

7 Hospital Services Payment - Funding provided under the COVID-19 National Partnership Agreement for activity that is attributable to the diagnosis and treatment of Medicare eligible patients with COVID-19 or suspected of having COVID-19; elective surgeries that have been rescheduled to free up public hospital capacity to respond to the COVID-19 outbreak; and may include activities related to the care of public patients being treated in private hospitals.

[8] Public Health Payment - Funding provided under the COVID-19 National Partnership Agreement for the State public health system's activity attributable to the treatment of patients with diagnosed or suspected COVID-19 or for activities directed at preventing the spread of COVID-19.

5. Funds disbursement

5.1 The Chief Executive will direct the disbursement of both State and Commonwealth funding from the State's National Health Funding Pool Sub Account and the State Managed Fund to the HHS. The Service Agreement and State level block payments to State managed funds from Commonwealth payments into the national funding pool are stated in Table 8.

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

(a) redirect Commonwealth payments between HHSs;

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

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

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

5.4 Further information on the disbursement of funds is available in the supporting document to this Service Agreement 'Purchasing Policy and Funding Guidelines 2020/21'.

Table 4 HHS Finance and Activity Schedule 2019/20 – 2021/22 – Summary by Purchasing Hierarchy

	ABF/NABF	ABF_SPLIT	Service Stream	2019/20 QWAU (Q22)	2019/20 Funding ($) (Price: $4847)	2020/21 QWAU (Q22)	2020/21 Funding) (Price: $4847)	2021/22 QWAU (QTBC)	2021/22 Funding (Price: $TBC)
Allocations excluding COVID-19	**ABF**	ABF	Inpatients	261,384	$1,190,490,365	263,738	$1,180,613,949		
			Outpatients	85,861	$371,034,841	95,003	$397,348,437		
			Procedures & Interventions	39,156	$193,300,087	40,288	$190,946,043		
			Emergency Department	39,667	$199,421,826	39,993	$199,179,206		
			Sub & Non-Acute	20,610	$111,365,894	20,632	$109,442,994		
			Mental Health	35,652	$156,026,611	36,755	$159,268,254		
			Prevention & Primary Care	9,738	$54,793,732	9,788	$49,550,778		
			Other ABF $	0	$66,605,953	0	$65,973,793		
		ABF Total		**492,068**	**$2,343,039,309**	**506,197**	**$2,352,323,454**		
		ABF Other	CET Funding	0	$80,719,057	0	$84,771,188		
			Specified Grants	0	$41,209,547	0	$40,115,065		
			PPP	0	$0	0	$0		
			EB Quarantined	0	$22,285,813	0	$0		
		ABF Other Total		**0**	**$144,214,417**	**0**	**$124,886,252**		
	Other Funding	Other Funding	Block Funded Services	2,861	$18,183,754	4,154	$25,340,330		
			Population Based Community Services	0	$196,754,167	0	$179,896,728		
			Other Specific Funding	0	$435,723,747	0	$453,946,505		
			PY Services moved to ABF	0	$0	0	$0		
			Prevention Services – Public Health	0	$17,183,687	0	$15,564,128		
		Other Funding Total		**2,861**	**$667,845,355**	**4,154**	**$674,747,691**		
	Allocations excluding COVID-19 TOTAL			**494,929**	**$3,155,099,081**	**510,351**	**$3,151,957,397**		

	ABF/NABF	ABF_SPLIT	Service Stream	2019/20 QWAU (Q22)	2019/20 Funding ($) (Price: $4847)	2020/21 QWAU (Q22)	2020/21 Funding) (Price: $4847)	2021/22 QWAU (QTBC)	2021/22 Funding (Price: $TBC)
COVID-19 related allocations	ABF	ABF	Inpatients	309	$1,500,000	0	$0		
			Outpatients	103	$500,000	0	$0		
			Procedures & Interventions	0	$0	0	$0		
			Emergency Department	0	$0	0	$0		
			Sub & Non-Acute	0	$0	0	$0		
			Mental Health	0	$0	0	$0		
			Prevention & Primary Care	0	$0	0	$0		
			Other ABF $	0	$0	0	$0		
		ABF Total		**413**	**$2,000,000**	**0**	**$0**		
		ABF Other	CET Funding	0	$0	0	$0		
			Specified Grants	0	$0	0	$0		
			PPP	0	$0	0	$0		
			EB Quarantined	0	$0	0	$0		
		ABF Other Total		**0**	**$0**	**0**	**$0**		
	Other Funding	Other Funding	Block Funded Services	0	$0	0	$0		
			Population Based Community Services	0	$0	0	$0		
			Other Specific Funding	0	$28,053,604	0	$1,892,237		
			PY Services moved to ABF	0	$0	0	$0		
			Prevention Services – Public Health	0	$0	0	$0		
		Other Funding Total		**0**	**$28,053,604**	**0**	**$1,892,237**		
	COVID-19 Allocations TOTAL			**413**	**$30,053,604**	**0**	**$1,892,237**		
Grand Total				**495,342**	**$3,185,152,685**	**510,351**	**$3,153,849,634**		

Table 5 Minor Capital and Equity

	2019/20 $	2020/21 $	2021/22 $
Minor Capital & Equity			
Cash			
MNT-Oct16-55 - 2016-17 New Technology Funding & Evaulation Program (NTFEP)	$0	$0	
SA 16-17.327 - Minor Capital funding Allocation 2016-17	$14,364,000	$14,364,000	
MNT-AW2-Oct17-70 NTFEP - Liquid Trial Lens	$0	$0	
MNT-AW2-Oct17-71 NTFEP - Near Infra-Red Fluorescence (NIRF) with ICG	$0	$0	
MNT-AW2-Oct17-86 ECG Flash Project	$0	$0	
SA 18-19.377 Minor Capital - fitout for HSQ BTS & Pathology	$0	$0	
MNT-AW3-Feb18-57 Transfer of funds for BTS Workshop relocation at RBWH	$0	$0	
MNT-AW3-Feb19-03 Block 7, Level 5, Stage 2 works	$0	$0	
MNT-AW3-Feb19-80 Multiple Capital Swaps - equity component	$0	$0	
MNT-AW3-FEB20-29 Lease funding swap per changes to AASB16 - equity component	$5,178,041	$0	
MNT-AW3-FEB20-31 2019-20 Multiple Capital Swaps - equity component	$9,490,440	$0	
MNT-BB2021-52 Lease funding swap per changes to AASB16 - equity component	$0	$20,994,157	
Non-Cash			
SA 17-18.619 Caboolture car park	$0	$0	
Grand Total	**$29,032,481**	**$35,358,157**	

Table 6 HHS Finance and Activity Schedule 2019/20 – 2021/22 Other Funding Detail

Agreement		Service Stream	Category	2019/20 $	2020/21 $	2021/22 $
Allocations excluding COVID-19	**Other Funding**	Block Funded Services	Block Funded Services	$18,183,754	$25,340,330	
		Block Funded Services Total		**$18,183,754**	**$25,340,330**	
		Population Based Community Services	Alcohol, Tobacco & Other Drugs	$12,073,313	$11,081,174	
			Community Care Programs	$1,238,910	$1,258,476	
			Community Mental Health	$102,214,304	$89,540,856	
			Community Mental Health – Child & Youth	$5,397,091	$4,518,126	
			Other Community Services	$48,330,462	$46,768,427	
			Other Funding Subsidy/(Contribution)	$18,402,793	$18,402,793	
			Primary Health Care	$9,097,293	$8,326,875	
		Population Based Community Services Total		**$196,754,167**	**$179,896,728**	
		Other Specific Funding	Aged Care Assessment Program	$3,855,170	$2,891,378	
			Commercial Activities	$58,406,320	$58,406,320	
			Consumer Information Services	$0	$0	
			Depreciation	$139,206,000	$159,837,000	
			Disability Residential Care Services	$12,615,675	$12,615,675	
			Environmental Health	$107,301	$143,265	
			Home & Community Care (HACC) Program	$0	$0	
			Home & Community Medical Aids & Appliances	$52,812	$52,812	
			Home Care Packages	$0	$0	
			Interstate Patients	$9,152,250	$9,152,250	
			Multi-Purpose Health Services	$0	$0	
			Prisoner Health Services	$10,316,176	$10,165,478	
			Oral Health	$0	$0	
			Patient Transport	$5,727,998	$5,727,998	
			Research	$15,724,003	$15,477,305	
			Residential Aged Care	$24,342,091	$24,497,931	
			Specific Allocations	$134,004,221	$132,765,363	
			State-Wide Functions	$4,812,522	$4,812,522	
			Transition Care	$17,401,208	$17,401,208	
		Other Specific Funding Total		**$435,723,747**	**$453,946,505**	
		Prevention Services – Public Health	Environmental Health (PH)	$2,740,785	$2,590,474	
			Other Community Services (PH)	$14,442,902	$12,973,654	

Agreement		Service Stream	Category	2019/20 $	2020/21 $	2021/22 $
		Prevention Services – Public Health Total		**$17,183,687**	**$15,564,128**	
	Allocations excluding COVID-19 Other Funding Total			**$649,661,601**	**$674,747,691**	
COVID-19 related allocations	**Other Funding**	Block Funded Services	Block Funded Services	$0	$0	
		Block Funded Services Total		**$0**	**$0**	
		Population Based Community Services	Alcohol, Tobacco & Other Drugs	$0	$0	
			Community Care Programs	$0	$0	
			Community Mental Health	$0	$0	
			Community Mental Health – Child & Youth	$0	$0	
			Other Community Services	$0	$0	
			Other Funding Subsidy/(Contribution)	$0	$0	
			Primary Health Care	$0	$0	
		Population Based Community Services Total		**$0**	**$0**	
		Other Specific Funding	Aged Care Assessment Program	$0	$0	
			Commercial Activities	$0	$0	
			Consumer Information Services	$0	$0	
			Depreciation	$0	$0	
			Disability Residential Care Services	$0	$0	
			Environmental Health	$0	$0	
			Home & Community Care (HACC) Program	$0	$0	
			Home & Community Medical Aids & Appliances	$0	$0	
			Home Care Packages	$0	$0	
			Interstate Patients	$0	$0	
			Multi-Purpose Health Services	$0	$0	
			Prisoner Health Services	$0	$0	
			Oral Health	$0	$0	
			Patient Transport	$0	$0	
			Research	$0	$0	
			Residential Aged Care	$0	$0	
			Specific Allocations	$28,053,604	$1,892,237	
			State-Wide Functions	$0	$0	
			Transition Care	$0	$0	
		Other Specific Funding Total		**$28,053,604**	**$1,892,237**	
			Environmental Health (PH)	$0	$0	

Agreement		Service Stream	Category	2019/20 $	2020/21 $	2021/22 $
		Prevention Services – Public Health	Other Community Services (PH)	$0	$0	
		Prevention Services – Public Health Total		**$0**	**$0**	
	COVID-19 Allocations Other Funding Total			**$28,053,604**	**$1,892,237**	
Grand Total				**$695,898,959**	**$676,639,928**	

Table 7 Specified Grants

Program	2019/20 $	2020/21 $	2021/22 $
Blood Clotting factors	$10,429,137	$10,493,433	
Centre for Gynaecological Oncology	-$0	-$0	
Comprehensive Epilepsy Program	$646,134	$650,117	
Genetic Health Queensland	$5,899,162	$5,935,530	
Haemophilia Centre	-$0	-$0	
High Cost Outliers	$9,565,457	$9,624,428	
Limited Indication Medication Scheme	$1,825,733	$1,836,989	
Neonatal Retrieval Service	$5,105,131	$5,136,604	
Paediatric Adolescent Gynaecology	$1,090,994	$1,097,720	
Percutaneous Valve Replacement	-$0	-$0	
PET Service	$0	$0	
PET/FDG production	$1,566,563	$1,576,221	
Qld Centre for Gynaecological Oncology	$1,117,987	$1,124,879	
Statewide AMS Service	$1,203,751	$1,211,172	
Statewide Haemophilia Centre	$1,144,065	$1,151,118	
18-19 Purch Initiatives (Final reconciliation) - Rewards	$1,045,433	$0	
Care at End of Life Project Team	$570,000	$0	
20-21 QIP - Antenatal care for Indigenous women	$0	$276,853	
Grand Total	**$41,209,547**	**$40,115,065**	

Table 8 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:**	2020/21
HHS	Metro North	**Version for financial year:**	
HHS ID		**Version effective for payments from:**	
		Version status:	07.07.2020

HHS ABF payment requirements:

Expected National Weighted Activity Unit (NWAU)		National efficient price (NEP) (as set by IHPA)
ABF Service group	**Projected NWAU – N2021 (Draft)**	
Admitted acute public services	238,763	$5,320
Admitted acute private services	22,229	$5,320
Emergency department services	38,824	$5,320
Non-admitted services	76,609	$5,320
Mental health services	27,679	$5,320
Sub-acute services	18,554	$5,320
LHN ABF Total – excluding COVID-19	**422,658**	**$5,320**
LHN ABF Total – COVID-19 NPA	**0**	**$5,320**

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	$6,509,860
Community mental health services	$116,062,230
Teaching, Training and Research	$85,720,142
Home ventilation	$4,288,034
Other block funded services	$0
Total block funding for LHN – excluding COVID-19	**$212,580,266**
Total funding for LHN under COVID-19 NPA State Public Health Payment	**$1,892,237**

6. Purchased services

6.1 State-funded Outreach Services

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

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

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

(iii) activity should be recorded at the HHS where the Health Service is being provided; and

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

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

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

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

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

(iv) the HHS is able to purchase the Outreach Service from the most appropriate provider including private providers or other HHSs. However, when a change to existing Health 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 Health Service;

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

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

(c) In the event of a disagreement regarding the continued provision of state-funded Outreach Services:

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

(ii) redistribution of funding will be agreed between the HHSs and communicated to the Department to action through the Service Agreement amendment processes outlined in Schedule 5 of this Service Agreement.

6.2 **Telehealth services**

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

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

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

6.3 **Newborn hearing screening**

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

(i) provide newborn hearing screening in all birthing hospitals and screening facilities; and

(ii) 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**

The HHS has responsibility for the provision and/or coordination of the following Statewide Services. It is recommended that the HHS establish a Formal Agreement with the recipient HHSs regarding the roles and responsibilities of Statewide Service provision and receipt as described in the Definitions. In the event of a dispute regarding the provision of these services HHSs should refer to clause 14.9 of the main terms and conditions of this Service Agreement.

(a) **Alcohol and Drug Information service**

(b) **Burns**

(c) **Clinical Skills Development Service**

(i) The HHS will operate the Clinical Skills Development Service (CSDS) on behalf of all HHSs.

(ii) The HHS will:

(A) undertake the maintenance and repair of CSDS simulation equipment across the HHSs, including the development and maintenance of an equipment replacement strategy

(B) provide ongoing training in simulation to HHS educators, instructors and coordinators

(C) meet the contractual obligations of the Clinical Access and Redesign Unit, Surgical Simulation Agreement

(D) deliver crisis resource management and specialty programs (such as birthing) in alignment with patient safety and Enterprise Bargaining requirements

(E) meet the capital depreciation costs for the CSDS simulation equipment statewide

(F) in collaboration and consultation with HHSs and the Department, review and update statewide obligations each year

(G) continue to develop the evidence to support patient safety and specialty training

(H) meet the contractual obligations of the Health Workforce Australia, Simulated Learning Environment agreement

(I) transfer of legacy eLearning programs

(J) expansion of pocket simulation sites to meet the Director-General target of 80 by 2014

(K) host and provide audiovisual technical support for the Centre for International Medical Graduates.

(L) host and provide a Pre-employment Structured Clinical Interview Services for International Medical Graduates including maintaining the required Australian Medical Council accreditation for such services.

(d) **Dovetail (Alcohol and Drug Services for Young People)**

(e) **Eating disorders service**

(f) **Genetic Health Queensland**

(g) **Heart and lung transplantation services**

(h) **Hospital Alcohol and Drug Services (HADS)**

(i) **Indigenous Youth Alcohol and Other Drug Treatment Network Support Service (Closing the Gap) – Dovetail**

(j) **Insight clinical education and training services**

(k) **Mental Health Clinical Collaborative**

(l) **Mental Health Clinical Improvement Team Program, including the Mental Health Clinical Indicator Program**

(m) **Neonatal retrieval services**

(i) The HHS is provided with a specified grant to support the statewide neonatal retrieval service referenced in Schedule 2. The HHS will ensure that the delivery and operation of neonatal retrieval services is consistent with the Governance and Operational Framework for Statewide Paediatric and Neonatal Retrieval Services. This includes but is not limited to:

(A) contributing to statewide neonatal retrieval services with dedicated clinician resources to be available 24 hours a day 7 days a week;

(B) provision of a dedicated, single point of neonatal medical coordination for Southern Queensland to be available 24 hours a day 7 days a week; and

(C) provision of a dedicated, single point of obstetric retrieval advice for Queensland to be available 24 hours a day 7 days a week.

(n) **Positron Emission Tomography (PET), specifically PET radiopharmaceutical production and manufacturing**

(o) **Queensland Heart Valve Bank[9]**

(p) **Statewide Forensic Mental Health services**

(q) **Statewide Food Services Support and Coordination Unit**

The HHS will continue to host the Statewide Food Services Support and Coordination Unit which will provide services statewide as listed below:

(i) measure compliance with and provide guidance in meeting the Food Service Best Practice Guideline (QH-GDL-448:2017) and the requirements of the Nutrition and Hydration mandatory standard in the National Safety and Quality Health Service Standards (2nd edition)

(ii) collect and analyse financial and quality performance indicators for comparison across HHSs

(iii) coordinate and support statewide food and fluid standing offer arrangements jointly with Health Support Queensland

(iv) advise and support HHSs in meeting the Food Safety Standards and Nutrition Standards for Meals and Menus

(v) source and coordinate cost effective and relevant training for foodservice and nutrition support staff

(vi) advise and support HHSs in trialling and implementing new models of food service delivery

(vii) provide audit capabilities to facilities outside Metro North HHS for food safety programs, nutrition standards for meals and menus and Queensland Health food service performance indicators on at least a cost

[9] The Queensland Heart Valve Bank is physically located within the Metro North HHS. However, operational and financial responsibility remains with Metro South HHS who coordinate activity on behalf of the state.

recovery basis.

(i) support food service research in partnership with Universities and student dietician food service placement projects to develop validated food service quality tools, collect quality data and implement and evaluate projects.

(r) **Strategic Operational Services Unit**

The HHS will provide services statewide as listed below:

(i) provide a support and guidance role to executive staff and HHS departments involved in cleaning and porterage/patient assistance services

(ii) develop, maintain and evaluate guidance documents relating to cleaning and porterage services

(iii) management/coordination of the Strategic Operational Services Advisory Network (SOSAN)

(iv) participate in/support the activities of the Public Hospital Oversight Committee (PHOC).

(s) **Statewide Comprehensive Epilepsy Service (CEP)**

(i) The HHS will provide statewide CEP services.

(ii) $4 million has been allocated by the Department for the ongoing support of the statewide CEP. Of this funding, $800,000 has been recurrently allocated to Mater Misericordiae Ltd for the provision of, but not limited to, general epilepsy clinic patients, epilepsy unit monitoring, craniotomy cases and stereoelectroencephalographic (SEEG) monitoring and surgery.

6.5 **Statewide and highly specialised clinical services**

The HHS will:

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

(b) collaborate with the Department and other HHSs in the development of Statewide Services Descriptions through the implementation of the Statewide Services Governance and Risk Management Framework. The Statewide Services Governance and Risk Management Framework guides the Department and HHSs in the strategic management, oversight and delivery of Statewide Services in order to optimise clinical safety and quality and ensure sustainability of services across Queensland.

6.6 **Regional Services**

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

these services HHSs should refer to clause 14.9 of the main terms and conditions of this Service Agreement.

(a) **Basic physician training pathway**

(i) The HHS will undertake the recruitment, selection, allocation and education of Queensland Basic Physician Trainees for the northside rotation on behalf of Mackay, Sunshine Coast and Central Queensland HHSs.

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

(b) **Community forensic outreach services**

Services to Central Queensland, Darling Downs, Gold Coast, Metro North, Metro South, Sunshine Coast, West Moreton and Wide Bay HHSs.

(c) **Court liaison program**

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

(d) **Dual disability program**

Services to Central Queensland, Central West, Children's Health Queensland, Metro North, Sunshine Coast and Wide Bay HHSs.

(e) **Mental health clinical cluster support program**

Services to Central Queensland, Central West, Children's Health Queensland, Metro North, Sunshine Coast and Wide Bay HHSs.

(f) **Outclient withdrawal management service**

6.7 **Rural and remote clinical support**

This clause does not apply to this HHS.

6.8 **Prevention Services, Primary Care and Community Health Services**

(a) The following funding arrangements will apply to the Prevention, Primary Care and Community Health Services delivered by the HHS:

(i) Department funding for Community Health Services. A pool of funding for these services is allocated to each HHS for a range of Community Health Services and must be used to meet local Primary Care and community healthcare and prevention needs including through delivery of the services identified in Table 6 and HHSs have the discretion to allocate funding across Primary Care and Community Health Services and Prevention Services according to local priorities.

(ii) Department specified funding models for consumer information services, disability, residential care, environmental health, prisoner health services, home and community medical aids, Primary Care, community mental health services, and alcohol and other drugs services. The funding

specified for these programs is listed in Table 6 and Department Community Health Service grants.

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

(b) **Prevention Services**

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

(i) **Specialist Public Health Units**

The HHS will:

(A) provide a specialist communicable disease epidemiology and surveillance, disease prevention and control service;

(B) maintain and improve, using a public health approach, the surveillance, prevention and control of notifiable conditions, including the prevention and control of invasive and exotic mosquitos, in accordance with national and/or State guidelines and ensure clinical and provisional notification of specified notifiable conditions are reported in accordance with the *Public Health Act* and Public Health Regulations;

(C) provide a specialist environmental health service, which includes assessment and coordination of local responses to local environmental health risks;

(D) undertake regulatory monitoring, investigation, enforcement and compliance activity on behalf of the Department;

(E) utilise specialist public health units to support the HHS through the provision of advice on prevention strategies and evidence; and

(F) manage the statewide Public Health Registrar Program.

(ii) **Preventive health services**

The HHS will:

(A) maintain delivery of risk factor prevention and early intervention programs and services targeting nutrition, physical activity, alcohol consumption and tobacco use; overweight and obesity and falls prevention; and

(B) promote brief interventions, lifestyle modification programs and other prevention, promotion or early intervention services.

(iii) **Immunisation services**

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

(A) national immunisation program;

(B) opportunistic immunisation in healthcare facilities;

(C) special immunisation programs; and

(D) delivery of the annual school immunisation program in accordance with the Guideline for Immunisation Services (QH-GDL-955:2014).

(iv) **Sexually transmissible infections including HIV and viral hepatitis**

The HHS will maintain and improve, using a public health approach, the prevention, testing, treatment and contact tracing of blood borne viruses and sexually transmissible infections with a continued focus on relevant identified target populations such as First Nations people and culturally and linguistically diverse populations through Services including, but not limited to:

(A) public health units;

(B) sexual health services;

(C) infectious diseases services;

(D) viral hepatitis services;

(E) syphilis surveillance services;

(F) needle and syringe programs; and

(G) existing clinical outreach and support programs in place between HHSs.

(v) **Tuberculosis services**

The HHS will ensure there is no financial barrier for any person to tuberculosis diagnostic and management services and will ensure that services are available in accordance with the Tuberculosis Control health service directive (qh-hsd-040:2018) and Protocol (qh-hsdptl-040-1:2018).

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

The HHS will comply with the *Declaration and Management of a Public Health Event of State Significance* health service directive (qh-hsd-046:2014).

(vii) **Cancer screening services**

The HHS will:

(A) maintain the existing Healthy Women's Initiative in accordance with the Principles of Practice, Standards and Guidelines for Providers of Cervical Screening Services for First Nations women and national cervical screening policy documents;

(B) ensure that all cervical screening services provided by the HHS are delivered in accordance with the National Competencies for Cervical Screening Providers and national cervical screening policy documents; and

(C) provide timely, appropriate, high quality and safe follow-up diagnostic services within the HHS for National Cervical Screening Program participants in accordance with the *National Cervical Screening Program Guidelines for the Management of Screen-detected Abnormalities, Screening in Specific Populations and Investigation of Abnormal Vaginal Bleeding* (2017) and national cervical screening policy documents.

(D) develop, implement and evaluate a plan to increase participation in bowel cancer screening and provide the Department with an evaluation report at the end of 2021/22;

(E) provide timely, appropriate, high quality and safe diagnostic assessment services for National Bowel Cancer Screening Program participants in accordance with the National Health and Medical Research Council's Clinical Guidelines for Prevention, Early Detection and Management of Colorectal Cancer (2017). Services to be provided:

- across Metro North HHS.

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

- across Metro North HHS excluding the Kilcoy, Caboolture, Caboolture-South, Beachmere-Sandstone Point, Bribie Island, Woodford-D'Aguilar, Burpengary, Elimbah, Upper Caboolture, Wamuran, Burpengary-East, Morayfield and Morayfield-East SA2s; and
- within Metro South HHS for the Corinda, Sherwood and Chelmer-Graceville SA2s only;

(G) develop and implement infrastructure plans to manage BSQ asset lifecycle performance and replacement schedules; and

(H) undertake statewide coordination for:

- the BSQ Clinical Module of the Certificate of Competency in Mammography (CCPM);
- the provision of orientation training and clinical oversight for BSQ Radiography Support Service radiographers; and
- BSQ Graduate Diploma of Mammography student placements.

6.9 **Oral health services**

The HHS will ensure that:

(a) oral health services are provided to the Eligible Population at no cost to the patient[10] and that the current range of clinical services will continue;

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

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

(d) the repair maintenance and relocation service for the mobile dental fleet continues to be provided by the Mobile Dental Clinic Workshop in Metro South HHS.

6.10 **Prisoner health services**

The HHS will:

(a) provide health Services for prisoners consistent with the principles, responsibilities and requirements specified in the Memorandum of Understanding (Prisoner Health Services) between Queensland Health and Queensland Corrective Services;

(b) provide the Department with an annual report regarding the provision of these Services; and

(c) establish local collaborative arrangements with Queensland Corrective Services to improve the health and well-being of prisoners and to contribute to the safe operation of the correctional centre.

6.11 **Refugee health**

This clause does not apply to this HHS.

6.12 **Adult sexual health clinical forensic examinations**

(a) The HHS will:

(i) provide 24 hour access to clinical forensic examinations for adult victims of sexual assault who present at a public hospital; and

(ii) provide the Department with a quarterly report on the number of examinations provided.

(b) The Service provided will be consistent with the principles of the Queensland Government inter-agency guidelines for responding to people who have experienced sexual assault and any standards issued pursuant to a Health Service Directive.

[10] 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.

7. Teaching training and research

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

7.1 **Clinical education and training**

(a) The HHS will:

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

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

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

(iv) only accept clinical placements of students from Australian education providers participating in the Student Placement Deed Framework, except in the case of placements at the oral health centre established by the HHS at the University of Queensland School of Dentistry in accordance with the University of Queensland Oral Health Alliance. In the event that there is an inconsistency between the education model agreed under the Oral Health Alliance and the Student Placement Deed the education model will take precedence to the extent of any inconsistency;

(v) continue to provide training placements consistent with and proportionate to the capacity of the HHS. This includes, but is not limited to, planning and resourcing for clinical placement offers in collaboration with other HHSs and the Department, and the provision of placements for the following professional groups relevant to the HHS:

(A) medical students

(B) nursing and midwifery students

(C) pre-entry clinical allied health students

(D) interns

(E) rural generalist trainees

(F) vocational medical trainees

(G) first year nurses and midwives

(H) re-entry to professional register nursing and midwifery candidates

(I) dental students

(J) allied health new graduate and pre-registration positions

(K) allied health rural generalist training positions

(L) additional supernumerary radiation oncology medical physics trainees to allow completion of the Training Education and Assessment Program by December 2015

(M) Aboriginal and Torres Strait Islander Health Workers and Aboriginal and Torres Strait Islander Health Practitioners

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

(vii) report, at the intervals and in the format agreed between the Parties, to the Department on the pre-entry clinical placements provided under the Student Placement Deed Framework;

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

(A) The Queensland Basic Physician Training Network;

(B) The Queensland General Medicine Advanced Training Network;

(C) The Queensland Intensive Care Training Pathway;

(D) The Queensland Basic Paediatric Training Network;

(E) The Queensland General Paediatric Advanced Training Network; and

(F) The Queensland Neonatal and Perinatal Medicine Advanced Training Network;

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

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

(xi) oversight profession specific (Medical Radiation Professions and Dietetics and Nutrition) and inter-professional statewide allied health clinical education programs.

(b) In addition, the Health Practitioners and Dental Officers (Queensland Health) Certified Agreement (No 2) 2016 (the HP agreement) requires Hospital and Health Services to:

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

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

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

7.2 Health and medical research

The HHS will:

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

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

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

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

Schedule 3 Performance Measures

1. Purpose

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

2. Performance Measures

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

2.2 Each Performance Measure is identified under one of four categories:

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

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

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

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

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

2.4 The Performance Measures identified in Table 9; Table 10 and Table 11 are applicable to the HHS unless otherwise specified within the attribute sheet.

2.5 The HHS will meet the target for each KPI identified in Table 9 as specified in the attribute sheet.

2.6 The Performance Measures identified in italic text are for future development.

2.7 Further information on the performance assessment process is provided in the supporting document to this Service Agreement, Performance and Accountability Framework 2020/21 referenced at Appendix 1 to this Service Agreement.

Table 9 HHS Performance Measures – Key Performance Indicators

Key Performance Indicators	
Safe	
The health and welfare of service users is paramount	
• Minimise risk	• Avoid harm from care
• Transparency and openness	• Learn from mistakes
Title	
Hospital Acquired Complications	
Emergency length of stay: • % of Emergency Department attendances who are admitted as an inpatient, including to a short stay unit, and whose Emergency Department length of stay is within 4 hours	
Number of Emergency Department stays greater than 24 hours	
Emergency Department wait time by triage category	
Rate of face to face community follow up within 1-7 days of discharge from an acute mental health inpatient unit	
Timely	
Care is provided within an appropriate timeframe	
• Treatment within clinically recommended time	
Title	
Patient off stretcher time: • % of patients transferred from Queensland Ambulance Service into the Emergency Department within 30 minutes	
Elective surgery: • % of category 1 patients treated within the clinically recommended time	
Elective surgery: • Number of ready for care patients waiting longer than the clinically recommended timeframe for their category	
Specialist outpatients: • % of category 1 patients who receive their initial specialist outpatient appointment within the clinically recommended time	
Specialist outpatients: • Number of ready for care category 1 patients waiting longer than clinically recommended for their initial specialist outpatient appointment	
Gastrointestinal endoscopy: • % of category 4 patients who are treated within the clinically recommended time	
Gastrointestinal endoscopy: • Number of patients waiting longer than clinically recommended timeframe for their category	
Access to oral health services: • % of patients on the general care dental wait list waiting for less than the clinically recommended time	

Equitable	
Consumers have access to healthcare that is responsive to need and addresses health inequalities	
• Fair access based on need	• Addresses inequalities
Title	
Potentially Preventable Hospitalisations – First Nations People	
Telehealth utilisation rates: • Number of non-admitted telehealth service events	
Efficient	
Available resources are maximised to deliver sustainable, high quality healthcare	
• Avoid waste	• Minimise financial risk
• Sustainable/productive	• Maximise available resources
Title	
Forecast operating position: • Full year • Year to date	
Average sustainable Queensland Health FTE	
Capital expenditure performance	
Patient Centred	
Providing Healthcare that is respectful of and responsive to individual patient preferences, needs and values	
• Patient involved in care	• Patient feedback
• Respects patient/person values and preferences	• Care close to home
Title	
Proportion of mental health service episodes with a documented care plan	
Proportion of beds vacated by 11am	

Table 10 HHS Performance Measures - Safety and Quality Markers

Safety and Quality Markers	
Safe	
The health and welfare of service users is paramount	
• Minimise risk • Transparency and openness	• Avoid harm from care • Learn from mistakes
Title	
Sentinel Events: • Number of wholly preventable sentinel events	
Hospital Standardised Mortality Ratio	
Healthcare-associated Staphylococcus Aureus (including MRSA) bacteraemia: • Rate per 10,000 patient days	
Severity Assessment Code (SAC) closure rates: • % of incidents closed within the prescribed timeframe	
Unplanned Readmission Rates	

Table 11 HHS Performance Measures – Outcome Indicators

Outcome Indicators	
Safe	
The health and welfare of service users is paramount	
• Minimise risk • Transparency and openness	• Avoid harm from care • Learn from mistakes
Title	
Rate of seclusion events per 1,000 acute mental health admitted patient days	
Rate of absent without approval from acute mental health inpatient care	
Timely	
Care is provided within an appropriate timeframe	
• Treatment within clinically recommended time	
Title	
Reperfusion therapy for acute ischaemic stroke: • Proportion of patients treated with either IV thrombolytic drugs or endovascular clot retrieval	
Access to emergency dental care: • % of emergency courses of care for adult dental patients that commence within the recommended waiting times	
Equitable	
Consumers have access to healthcare that is responsive to need and addresses health inequalities	
• Fair access based on need	• Addresses inequalities
Title	
First Nations people representation in the workforce: • % of the workforce who identify as being First Nations people	
Completed general courses of oral health care for First Nations people adult patients	
Low birthweight: • % of low birthweight babies born to Queensland mothers	
Patient Centred	
Providing Healthcare that is respectful of and responsive to individual patient preferences, needs and values	
• Patient involved in care	• Patient feedback
• Respects patient/person values and preferences	• Care close to home
Title	
Complaints resolved within 35 calendar days	
Advance care planning: • The proportion of approaches made to people who are identified as being at risk of dying within the next 12 months, or suitable for an advance care planning discussion, and who are offered the opportunity to consider, discuss and decide their preferences for care at the end of life	

Effective	
Healthcare that delivers the best achievable outcomes through evidence-based practice	
• Evidence based practice	• Care integration
• Treatment directed to those who benefit	• Optimise Health
• Clinical Capability	
Title	
Uptake of the smoking cessation clinical pathway for public hospital inpatients and dental clients	
Potentially Preventable Hospitalisations – diabetes complications: • The number and proportion of hospitalisations of people with Diabetes complications that could have potentially been prevented through the provision of appropriate non-hospital health services.	
Potentially Preventable Hospitalisations – non-diabetes complications: • The number and proportion of hospitalisations of people with non-Diabetes complications that could have potentially been prevented through the provision of appropriate non-hospital health services.	
% of oral health activity which is preventive	
Cardiac rehabilitation: • Proportion of public cardiac patients that are referred to cardiac rehabilitation and complete a timely patient journey	
Adolescent vaccinations administered via the statewide School Immunisation Program	

Schedule 4 Data Supply Requirements

1. Purpose

1.1 *The Hospital and Health Boards Act 2011*[11] (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.

1.2 This Schedule 4 specifies the data to be provided by the HHS to the Chief Executive and the requirements for the provision of the data.

2. Principles

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

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

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

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

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

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

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

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

(b) minimise regulatory burden.

3. Roles and responsibilities

3.1 **Hospital and Health Services**

(a) The HHS will:

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

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

[11] 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.

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

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

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

(vi) provide activity data that complies with the national data provision timeframes required under the Independent Hospital Pricing Authority (IHPA) data plan for Commonwealth funding. Details of the timeframes are specified in the 'Commonwealth Efficient Growth Funding and National Weighted Activity Units (NWAUs)' specification sheet included in the supporting document Purchasing Policy and Funding Guidelines 2020/21 and the clinical placement data supply requirements; and

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

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

3.2 **Department**

The Department will:

(a) produce a monthly performance report which includes:

(i) actual activity compared with purchased activity levels;

(ii) any variance(s) from purchased activity;

(iii) performance information as required by the Department to demonstrate HHS performance against the Performance Measures specified in Schedule 3 of this Service Agreement; and

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

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

(i) to fulfil legislative requirements;

(ii) to deliver accountabilities to state and commonwealth governments;

(iii) to monitor and promote improvements in the safety and quality of Health Services;

(iv) to support clinical innovation; and

(c) advise the HHS of any updates to data supply requirements as they occur.

Attachment A Data Supply Requirements

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

Table 12 Clinical data

Data Set	Data Custodian
Aged Care Assessment Team data via the Aged Care Evaluation (ACE) database	Strategic Policy Unit
Alcohol Tobacco and Other Drug Treatment Services	Mental Health Alcohol and Other Drugs Branch
Alcohol and Other Drugs Establishment Collection	Mental Health Alcohol and Other Drugs Branch
Allied Health Clinical Placement Activity Data	Allied Health Professions Office of Queensland
Australian and New Zealand Intensive Care Society (ANZICS) Data Collection	Healthcare Improvement Unit
BreastScreening Clinical Data	Executive Director, Preventive Health Branch
Clinical Incident Data Set	Patient Safety and Quality Improvement Service
Clinical Placement Data (excluding Allied Health)	Workforce Strategy Branch
Consumer Feedback Data Set	Patient Safety and Quality Improvement Service
Elective Surgery Data Collection	Healthcare Improvement Unit
Emergency Data Collection	Healthcare Improvement Unit
Gastrointestinal Endoscopy Data Collection	Healthcare Improvement Unit
Hand Hygiene Compliance Data	Communicable Diseases Branch
Healthcare Infection Surveillance Data	Communicable Diseases Branch
Maternal Deaths	Queensland Maternal and Perinatal Quality Council (through Statistical Services Branch)
Mental Health Act Data	Mental Health Alcohol and Other Drugs Branch
Mental Health Activity Data Collection	Mental Health Alcohol and Other Drugs Branch
Mental Health Carer Experience Survey Collection	Mental Health Alcohol and Other Drugs Branch
Mental Health Establishments Collection	Mental Health Alcohol and Other Drugs Branch
Monthly Activity Collection (including admitted and non-admitted patient activity and bed availability data)	Statistical Services Branch
Newborn Hearing Screening	Children's Health Queensland
Notifications Data	Chief Health Officer
Patient Experience Survey Data	Patient Safety and Quality Improvement Service
Patient Level Costing and Funding Data	HHS Funding and Costing Unit
Perinatal Data Collection	Statistical Services Branch
Queensland Bedside Audit	Patient Safety and Quality Improvement Service
Queensland Health Non-Admitted Patient Data Collection	Statistical Services Branch
Queensland Hospital Admitted Patient Data Collection	Statistical Services Branch
Queensland Needle and Syringe Program (QNSP) data	Chief Health Officer
Queensland Opioid Treatment Program Admissions and Discharges	Chief Health Officer
Radiation Therapy Data Collection	Healthcare Improvement Unit

Data Set	Data Custodian
Residential Mental Health Care Collections	Mental Health Alcohol and Other Drugs Branch
Schedule 8 Dispensing data	Chief Health Officer
School Immunisation Program – Annual Outcome Report	Communicable Diseases Branch
Specialist Outpatient Data Collection	Healthcare Improvement Unit
National Notifiable Diseases Surveillance System	Chief Health Officer
Vaccination Administration data	Chief Health Officer
Variable Life Adjusted Display (VLAD) CM (collection of hospital investigations)	Patient Safety and Quality Improvement Service
Your Experience of Service (YES) Survey Collection (Mental Health)	Mental Health Alcohol and Other Drugs Branch

Table 13 Non-clinical data

Non-Clinical Data Set	Data Custodian
Asbestos management data	Capital and Asset Services Branch
Asset Management • Planning • Maintenance • Maintenance Budget • Statement of Building Portfolio Compliance • Benchmarking & Performance Data	Capital and Asset Services Branch
Conduct and Performance Excellence (CaPE)	Human Resources Branch
Expenditure	Finance Branch
Financial and Residential Activity Collection (FRAC)	Statistical Services Branch
Graduate Nursing Recruitment Data Statewide using the Public Service Commission Graduate Portal System	Office of the Chief Nursing and Midwifery Officer
Hospital Car Parks (including Government Portfolio Model funding arrangements)	Capital and Asset Services Branch
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
Sustaining Capital Reporting Requirements (other than minor capital)	Capital and Asset Services Branch
Whole of Government Asset Management Policies data	Capital and Asset Services Branch

Schedule 5 Amendments to this Service Agreement

1. Purpose

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

2. Principles

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

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

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

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

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

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

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

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

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

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

3. Process to amend this Service Agreement

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

(a) Amendment Windows;

(b) Extraordinary Amendment Windows;

(c) periodic adjustments; and

(d) end of year financial adjustments.

3.2 Amendment Windows

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

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

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

(i) Amendment Window 1: Annual Budget Build;

(ii) Amendment Window 2: In-year variation; and

(iii) Amendment Window 3: In-year variation.

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

(e) While a Party may submit an Amendment Proposal at any time, an Amendment Proposal will only be formally negotiated and resolved during one of the Amendment Windows outlined in Table 14 (excluding Extraordinary Amendment Windows).

Table 14 Amendment Window Exchange Dates

Amendment Window	Exchange Date	Primary Focus
Amendment Window 2: In-year variation	4 October 2019	2019/20 in-year variations
Amendment Window 3: In-year variation	14 February 2020	2019/20 in-year variations
Amendment Window 1: Annual Budget Build	27 March 2020	2020/21 budget build
Amendment Window 2: In-year variation	9 October 2020	2020/21 in-year variations
Amendment Window 3: In-year variation	12 February 2021	2020/21 in-year variations
Amendment Window 1: Annual Budget Build	26 March 2021	2021/22 budget build
Amendment Window 2: In-year variation	8 October 2021	2021/22 in-year variations
Amendment Window 3: In-year variation	11 February 2022	2021/22 in-year variations

(f) An Amendment Proposal is made by:

(i) the responsible Deputy Director-General signing and providing an Amendment Proposal to the HHS-SA Contact Person through Healthcare Purchasing and System Performance Division prior to the commencement of any Amendment Window; or

(ii) the Health Service Chief Executive signing and providing an Amendment Proposal to the D-SA Contact Person prior to the commencement of any Amendment Window.

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

(i) the rationale for the proposed amendment;

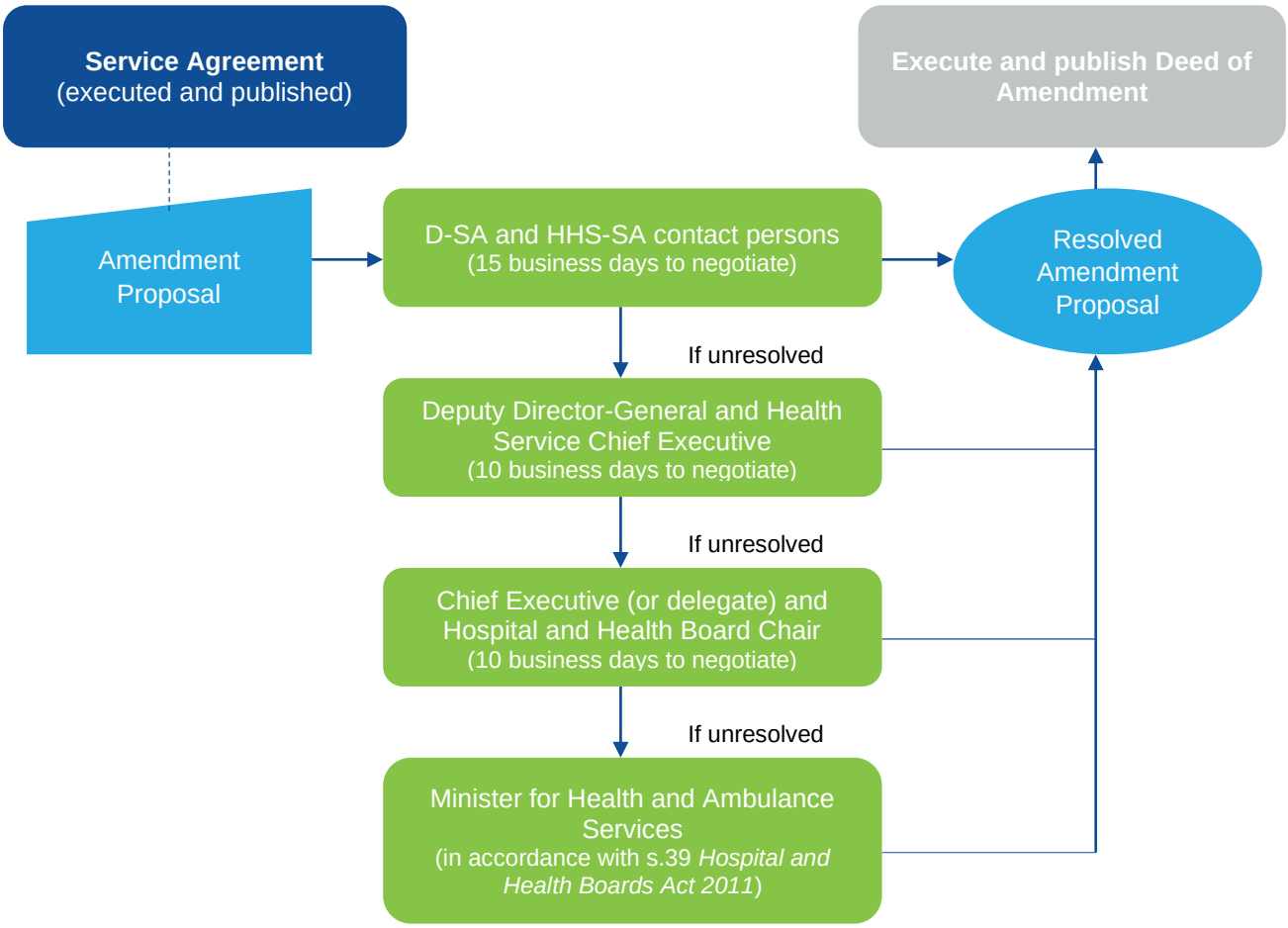
(ii) the precise drafting for the proposed amendment;

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

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

(h) Negotiation and resolution of Amendment Proposals will occur during the Negotiation Period through a tiered process, as outlined in Figure 3.

Figure 3 Amendment Proposal negotiation and resolution



(i) The timeframes identified in Figure 3 may be reduced in the complete discretion of the Chief Executive.

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

(k) If the Chief Executive at any time:

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

(ii) considers it appropriate for any other reasons,

then the Chief Executive may:

(iii) propose further amendments to any HHS affected; and

(iv) 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*.

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

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

3.3 **Extraordinary Amendment Windows**

(a) A Party that wants to amend the terms of this Service Agreement outside of an Amendment Window outlined in Table 14 must give an Extraordinary Amendment Proposal to the other Party.

(b) An Extraordinary Amendment Proposal may only be formally negotiated and resolved outside of an Amendment Window outlined in Table 14 to facilitate funding allocations where an urgent priority needs to be addressed in a timely manner and an Amendment Window is not available within an acceptable timeframe.

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

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

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

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

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

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

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

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

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

3.4 **Periodic adjustments**

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

(i) occur on a periodic basis;

(ii) are referenced in the Service Agreement; and

(iii) are based on a clearly articulated formula.

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

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

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

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

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

3.5 **End of financial year adjustments**

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

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

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

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

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

Schedule 6 Definitions

In this Service Agreement:

Activity Based Funding (ABF) means the funding framework for publicly-funded health care services delivered across Queensland. The ABF framework applies to those Queensland public sector health service 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. Amendment Windows commence on the relevant Exchange Date as specified in Table 14 Schedule 5 and end at the conclusion of the Negotiation Period.

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 public holiday in Brisbane.

Chair means the Chair of the Hospital and Health Board.

Chief Executive means the chief executive of the Department.

Clinical Product/Consumable means a product that has been Clinically Prescribed.

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 appropriate and, if so, the urgency of that referral.

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.

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

Deed of Amendment means the resolved amendment proposals.

Department means the department administering the *Hospital and Health Boards Act 2011* (Qld), which, at the date of this Service Agreement is known as 'Queensland Health'. To avoid any doubt, the term does not include the Hospital and Health Services.

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

Effective Date means1 July 2019.

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

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

(a) adults, and their dependents, who are Queensland residents; eligible for Medicare and, where applicable, currently in receipt of benefits from at least one of the following concession cards:

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

  (ii) Pensioner Concession Card issued by Centrelink;

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

  (iv) Commonwealth Seniors Health Card;

  (v) Queensland Seniors Card.

(b) children who are Queensland residents or attend a Queensland school, are eligible for Medicare, and are:

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

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

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

Exchange Date means the date on which the Parties must provide Amendment Proposals for negotiation, as specified in Table 14 Schedule 5.

Extraordinary Amendment Window means an Amendment Window that occurs outside of the Amendment Windows specified in Table 14 Schedule 5, in accordance with the provisions of clause 3.3 of Schedule 5.

Force Majeure means an event:

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

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

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

(a) Statewide or Regional service provision

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

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

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

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

(b) Recipient HHS

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

(ii) timely acceptance of patients being transferred out of Statewide Services (back-transfers) (clinical Services)

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

Health Executive means a person appointed as a health executive under section 67(2) of the *Hospital and Health Boards Act 2011.*

Health Service has the same meaning as set out in section 15 of the *Hospital and Health Boards Act 2011.*

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

Health Service Employee means all person, appointed as a 'health service employee' for the HHS under section 67(1) of the *Hospital and Health Boards Act 2011.*

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 unless otherwise specified.

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; onboarding; induction and orientation; capability, learning and development; industrial and employee relations; performance management; work health and safety and well-being; workforce planning; diversity and inclusion; and workforce consultation, engagement and communication.

Industrial Instrument means an industrial instrument made under the *Industrial Relations Act 2016.*

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.

Low Benefit Care means use of an intervention where evidence suggests it confers no or very little benefit on patients, or the risk of harm exceeds the likely benefit.

Minister means the Minister administering the *Hospital and Health Boards Act 2011* (Qld).

National Health Reform Agreement means the document titled *National Health Reform Agreement* made between the Council of Australian Governments (CoAG) in 2011, and incorporating all subsequent amendments agreed between the Commonwealth of Australia and the States and Territories.

Negotiation Period means a period of no less than 15 business days (or such longer period agreed in writing between the Parties) from each Exchange Date.

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 an HHS to another HHS.

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

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

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

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

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

  (i) workers' compensation insurers;

  (ii) motor vehicle accident insurers;

  (iii) personal injury insurers;

  (iv) Department of Defence; and/or

  (v) Department of Veterans' Affairs; and

  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.

Party means each of the Chief Executive and the HHS to which this Service Agreement applies.

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

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

(a) the D-SA Contact Person and the HHS-SA Contact Person;

(b) executives nominated by the Department; and

(c) executives nominated by the HHS.

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

Person Conducting a Business or Undertaking takes the meaning as defined in the *Work Health and Safety Act 2011,* section 5.

Prevention 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.

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 Sector Health Service has the same meaning as set out in the *Hospital and Health Boards Act 2011.*

Public Sector Health System means the Queensland public sector health system, which is comprised of the Hospital and Health Services and the Department.

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

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

Regional Service means a clinical (direct or indirect patient care) or non-clinical Health 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.

Referral Pathway means the process by which a patient is referred from one clinician to another in order to access the Health Services required to meet their healthcare needs.

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

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

Schedule means this Schedule to the Service Agreement.

Senior Health Service Employee means a person appointed under section 67(2) of the *Hospital and Health Boards Act 2011* in a position prescribed as a 'senior health service employee position' under the *Hospital and Health Boards Regulation 2012.*

Service Agreement means this service agreement including the Schedules and annexures, as amended from time to time.

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

State means the State of Queensland.

Statement of Building Portfolio Compliance means a declaration completed by the HHS stating that it has maintained compliance with all mandatory Acts, Regulations, Australian Standards and Codes of Practice applicable to the HHS' building portfolio.

Statewide Service means a service that is delivered by a lead provider to the State. A Statewide Service may be:

(a) a clinical service that is:

  (i) a low volume, highly specialised Health Service delivered from a single location;

  (ii) a highly specialised, or high risk[12], Health Service delivered in multiple locations or

  (iii) a prevention and/or health promotion service.

(b) a support service that is required to enable the delivery of specific direct clinical services; or

(c) services that have a primary role to provide clinical education services and/or training programs.

Statewide Service Description means a document that defines the Service to be provided by the HHS on a statewide basis and how the Statewide Service will be accessed and used by other HHSs across the State, including but not limited to:

(a) an overview of the Statewide Service;

(b) components of the Statewide Service;

(c) eligibility criteria;

(d) Service referrals and pathways; and

(e) governance and capability arrangements for the Statewide Service.

[12] A Health Service that, due to its nature, poses an increased threat of ongoing sustainability, efficiency and affordability.

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

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

Telehealth means the delivery of Health Services and information using telecommunication technology, including:

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

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

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

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

Terminate and 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.

Value-Based Healthcare means delivering what matters most to patients in the most efficient way. Value-Based Healthcare is characterised by:

(a) the identification of clearly defined population segments of patients with similar needs around which clinically integrated teams organise and deliver care, rather than designing and organising care around medical specialities, procedures or facilities;

(b) a focus on delivering health outcomes and the experience of receiving care as defined from the patient perspective, not just the system or clinical perspective;

(c) connection between outcomes and the costs required to deliver the outcomes; and

(d) an integrated approach across the full cycle of care with a focus on the goal of health rather than just treatment.

Key Documents

Hospital and Health Services Service Agreements and supporting documents including:

(a) Hospital and Health Services Service Agreements

(b) Queensland Health System Outlook to 2026 for a sustainable health service

(c) Performance and Accountability Framework 2020/21

(d) Purchasing Policy and Funding Guidelines 2020/21

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

My health, Queensland's future: Advancing health 2026

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

Queensland Health 2020-2021 System Priorities

[link to follow]

Department of Health Strategic Plan

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

Guideline for Immunisation Services

https://www.health.qld.gov.au/__data/assets/pdf_file/0026/147545/qh-gdl-955.pdf

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

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

HHS Performance Measures and Attribute Sheets

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

Data Supply Requirements

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

Australian Commission on Safety and Quality in Healthcare – National Safety and Quality Health Service Standards

https://www.safetyandquality.gov.au/standards/nsqhs-standards

Statewide Services Governance and Risk Management Framework

https://qheps.health.qld.gov.au/spb/html/statewide-services/statewide-services-governance-and-risk-management-framework

Public Health Practice Manual

https://qheps.health.qld.gov.au/__data/assets/pdf_file/0035/667754/public-health-prac-man.pdf

National Healthcare Agreement

http://www.federalfinancialrelations.gov.au/content/national_agreements.aspx

National Health Reform Agreement

www.federalfinancialrelations.gov.au/content/national_health_reform.aspx

Abbreviations

ACQSC	Aged Care Quality and Safety Commission
ABF	Activity Based Funding
ACSQHC	Australian Commission on Safety and Quality in Healthcare
CET	Clinical Education and Training
D-SA	Department – Service Agreement
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
Non-ABF	Non-Activity Based Funding
NPA	National Partnership Agreement
NSQHS	National Safety and Quality Health Service Standards
NWAU	National Weighted Activity Unit
PBS	Pharmaceutical Benefits Scheme
QAS	Queensland Ambulance Service
QIP	Quality Improvement Payment
QWAU	Queensland Weighted Activity Unit
RACGP	Royal Australian College of General Practitioners
SA2	Statistical Area Level 2

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