Queensland Health

Service Agreement 2025/26 – 2027/28

Gold Coast Hospital and Health Service

July 2025

Queensland Government

Gold Coast Hospital and Health Service, Service Agreement 2025/26 – 2027/28

Acknowledgement

We respectfully acknowledge the Traditional Owners and Cultural Custodians of the lands, waters, and seas across Queensland. We pay our respects to Elders past and present, while recognising the role of current and future leaders in shaping a better health system.

We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have made to our communities and recognise that our collective responsibility as government, communities and individuals is to ensure equity and equality, recognition, and advancement of Aboriginal and Torres Strait Islander peoples in Queensland in every aspect of our society.

We respectfully acknowledge the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination, and commitment of Aboriginal and Torres Strait Islander communities in caring for their health and wellbeing.

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We acknowledge the Traditional Custodians of the land in which we work, live and grow, the Kombumerri, Wangerriburra, Bullongin, Minjungbal and Birinburra peoples of the Yugambeh Language speaking nation. We also pay our respects to Elders past, present and emerging. We also acknowledge other Aboriginal and Torres Strait Islander people present today.

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Operative Terms

1. Introduction

1.1 In performing this service agreement, Queensland Health (the '**Department**') and the Gold Coast Hospital and Health Service (**HHS**) will act consistently with the object of the *Hospital and Health Boards Act 2011* (Qld) (**Act**).

1.2 The Department and the HHS operate as part of a networked system and agree to work collaboratively with each other, with other HHSs and with the Queensland Ambulance Service in the best interests of the Queensland public sector health system.

1.3 The parties will ensure that planning and delivery of health services is consistent with the strategies and priorities set out by government.

1.4 The parties recognise the importance of the HHS's Health Equity Strategy (as defined in the Act) and the parties' commitment to improving health and wellbeing outcomes and achieving health equity for Aboriginal and Torres Strait Islander peoples.

2. Service Agreement

2.1 Term

This service agreement commences on 1 July 2025 and expires on 30 June 2028.

2.2 Documents making up the service agreement and hierarchy

(a) This service agreement is made up of:

(i) these terms known as the 'Operative Terms';

(ii) schedules 1 to 4;

(iii) each of the reference documents included in Appendix 1; and

(iv) any other document expressly incorporated by reference.

(b) If there is any inconsistency between the documents which make up the service agreement, then the order of documents above will prevail in descending order of precedence.

2.3 Scope

This service agreement specifies the services to be provided by the HHS, the funding for the provision of those services, the performance measures applicable to the services and data requirements.

3. Services

3.1 In delivering services, the HHS is required to meet:

(a) 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; and

(b) the applicable conditions of each agreement or arrangement for funding between the Department and the HHS and commitments under any related implementation plans, which conditions and commitments may be recorded separately to this service agreement but for which funding is (or becomes) provided in Schedule 1.

3.2 The HHS is required to deliver the services outlined in this service agreement for which funding is provided in Schedule 1.

3.3 Where issues arise which prevent the HHS from providing a service or necessitate a reduction in the level or scope of a service provided, prompt notification must be made to the Department and impacted HHSs, with appropriate details. The HHS must minimise any clinical risk or public health risk or adverse impact to patient experience or the health of the community that may result from service disruption. The Department will respond to the HHS on any requirements it has concerning service delivery and any adjustments triggered by under delivery.

3.4 If the HHS wishes to terminate or reduce service levels for a service for which funding is provided in Schedule 1, this will remain subject to negotiation and agreement by the Department at its discretion.

3.5 For any new services proposed during the term of this service agreement, the parties agree:

(a) the service must meet a demonstrated clinical or public health need and provide value for money;

(b) the commencement of a new service, including the implementation of new models of care, may occur where the service has been commissioned by the Department, a funding stream is in place and any conditions relating to the funding have already been agreed; and

(c) if the HHS wishes to commence providing a new service that has not been commissioned by the Department, this will remain subject to negotiation and agreement by the Department at its discretion.

3.6 It is acknowledged that there may, from time to time, need to be service delivery changes between HHSs. Management of inter-HHS relationships should be informed by the following principles:

(a) HHSs should maintain the proportion of out of HHS work undertaken unless as a result of agreed repatriation of patients;

(b) each HHS should manage patients from its own catchment population if it is within its clinical capability to do so as specified by the *Clinical Services Capability Framework*;

(c) where it is proposed that a service move from one HHS to another, the Department will consider, as part of its review under clauses 3.4 and 3.5, whether the respective Health Service Chief Executives endorse the proposed change in patient flows; and the funding required to follow the patient; and

(d) arrangements for the provision of services by another HHS or delivery of regional services across multiple HHSs should be clearly documented and communicated.

4. Performance and Accountability Framework

4.1 The *Performance and Accountability Framework* sets out the framework within which the Department monitors and manages the performance of public sector health services in Queensland.

4.2 The parties will act consistent with the *Performance and Accountability Framework*.

4.3 Schedule 3 (Performance Measures) describes how the HHS's performance will be measured under the service agreement.

5. Outcomes Framework

5.1 Queensland Health is shifting its funding focus from "volume" to "outcomes" through the Health Outcomes Framework. This approach ensures healthcare services are measured by their real-world impact on people's lives: focusing on patient experience, clinical effectiveness and long-term health improvements. It also lays the foundation for future funding models that link investment to measurable health outcomes, creating a more sustainable and high-performing system.

5.2 The Health Outcomes Framework is anchored in the Health Outcomes Atlas, built on six system outcome sectors, structured across five tiers, and disaggregated by Priority Populations and Health System Domains to ensure a comprehensive and equitable approach to measuring and improving health outcomes.

5.3 The Health Outcomes Framework is structured across five tiers:

(a) The System Tier (Long-term): The highest level, setting overarching system-wide goals and direction. This tier articulates Queensland Health's long term (5-10 years) vision for the health system, guiding investment and strategic priorities to achieve sustainable improvements in health outcomes.

(b) Strategic Tier (Medium-term): Focused on medium-term goals and plans, ensuring alignment with the system-wide vision. This tier drives Queensland Health and HHS priorities through service agreements, system-wide strategies, and statewide programs.

(c) Service Tier (Short-term): Addresses specific services, branches, or departments within Queensland Health and HHSs. This tier ensures alignment with strategic priorities and operational plans, translating high-level system goals into service-level actions.

(d) Operational Tier (Short-term): Translates strategic objectives into day-to-day activities within services and business units. It focuses on short-term (1–2 years) impact, ensuring that frontline care delivery and health service operations contribute to broader system improvements.

(e) Tactical Tier (Short-term): The most granular level, where specific initiatives, investments, and interventions are implemented. This tier focuses on team-based and individual actions, using targeted measures to assess effectiveness, efficiency and impact.

6. Data Supply Requirements

6.1 The following principles guide the collection, supply, 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 6.2 below to be fulfilled.

6.2 The HHS will provide the Department with all clinical and non-clinical data that is reasonably required to support the effective management of the public sector health system. This will include, but is not limited to, data that is required to:

(a) fulfil legislative obligations;

(b) deliver accountabilities and obligations to State and Commonwealth Governments; including related to the provision and reconciliation of activity data by the Administrator of the National Health Funding Pool;

(c) monitor and support improvement in performance, safety and quality of health services;

(d) manage this service agreement;

(e) monitor and support workforce management; including progress towards the State Government's health workforce commitments;

(f) support clinical innovation;

(g) facilitate evaluation and audit;

(h) comply with the Department's reporting obligations under section 41JM(5) of the *Therapeutic Goods Act 1989* (Cth); and

(i) support the management and maintenance of public sector land, building and other assets.

6.3 The parties agree and acknowledge that:

(a) the Department will keep the HHS informed of the Department's data requirements; and any changes to these over the course of this agreement;

(b) data will be recorded by the HHS in accordance with the *Enterprise Architecture* Health Service Directive available in Appendix 1;

(c) data will be provided as required, where permitted, by law.

6.4 Further details on data supply requirements and prescribed timeframes for data submission, are provided online as detailed in Appendix 1.

7. Hospital and Health Service Accountabilities

7.1 The HHS will perform its obligations under this service agreement.

7.2 As applicable to the HHS and its services, the HHS will comply with:

(a) legislation and subordinate legislation, including the Act;

(b) cabinet decisions;

(c) Ministerial directives;

(d) agreements entered into between the Queensland and Commonwealth governments (or agreements with others in furtherance of such agreements), of which it is informed;

(e) agreements entered into between the Department and other Queensland Government entities, of which it is informed;

(f) agreements entered into with another HHS(s), including Networked Services Agreements;

(g) all industrial instruments;

(h) all Health Service Directives and Health Employment Directives authorised and issued by the Chief Executive of the Department;

(i) all Whole of Government Policies and Departmental policies, including those related to Information and Communication Technology, Human Resources and asset management; and

(j) all other policies, guidelines, and implementation standards.

7.3 As part of their legislative requirement and commitment to achieving First Nations health equity, the HHS is required to eliminate racial discrimination and institutional racism within its service in an endeavour to ensure that Aboriginal and Torres Strait Islander peoples have access to culturally safe and responsive health services.

7.4 The HHS will ensure that effective health service planning and delivery systems are in place, working in collaboration with the Department.

7.5 To support the achievement of the Queensland-Commonwealth Partnership's (QCP) vision and commitment to work together to tackle health system challenges that cannot be

overcome by any one organisation, HHSs are required to prepare and submit Joint Regional Needs Assessments in accordance with the assessment framework and toolkit provided online as detailed in Appendix 1.

7.6 HHSs must operate clinical service delivery consistent with the *National Safety and Quality Health Service Standards*. The HHS is expected to escalate any concerns that arise at the conclusion of a formalised assessment.

7.7 The HHS will ensure that health service employees employed by the Chief Executive who perform work for the HHS are managed in accordance with any applicable delegations and directions from the Chief Executive.

7.8 The HHS will maintain accreditation to the standards required by the Department.

7.9 The HHS will appropriately perform and fulfil its functions under the Act.

7.10 The HHS 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.

7.11 To support the delivery of safe, well integrated, community-based health and social services to Queenslanders, the HHS will comply with the principles and requirements outlined in the Department's *Non-Government Organisation (NGO) Operating Framework*. The NGO Operating Framework and a list of contracted NGOs managed through the Community Services Funding Branch (including HHS coverage) is available online via Appendix 1.

8. Department Accountabilities

8.1 The Department will perform its obligations under this service agreement including, providing funding to the HHS as specified in this agreement (as amended), in exchange for the HHS performing its obligations and delivering the specified services and outlined in the *Hospital and Health Boards Act 2011*.

8.2 The Department will:

(a) comply with applicable legislation and subordinate legislation, including the Act, as it relates to this service agreement;

(b) perform the system manager role (as defined in the Act) through the Chief Executive; and

(c) provide a range of services to the HHS as set out in Schedule 2.

8.3 The Chief Executive will:

(a) appoint health service employees to perform work for the HHS for the purpose of enabling the HHS to perform its functions under the Act,

(b) appropriately perform and fulfil their functions under the Act, and

(c) consult, cooperate, and coordinate with the HHS to ensure legal compliance with the *Work Health and Safety Act 2011,* the *Work Health and Safety Regulation 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:

(i) *Managing the Risk of Psychosocial Hazards at Work Code of Practice 2022 (Qld)*;

(ii) other applicable Codes of Practice;

(iii) electrical safety legislation;

(iv) building and fire safety legislation; and

(v) workers' compensation legislation.

9. Achieving Health Equity with First Nations Queenslanders

9.1 Through the Act, the *Hospital and Health Boards Regulation 20*23, and *Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework* (2021), the Department and each HHS affirms its commitment to improving health and wellbeing outcomes and achieving health equity with First Nations peoples.

9.2 The HHS will develop and resource a First Nations Health Equity Strategy, compliant with legislative requirements. An implementation plan, accompanying the strategy, demonstrates the HHS's activities and key performance measures to achieve health equity with First Nations peoples. The Health Equity Strategy will act as the principal accountability mechanism between the Aboriginal and Torres Strait Islander community and the HHS in achieving health equity with First Nations Queenslanders and forms a key part of the Queensland Government's commitment to the *National Agreement on Closing the Gap* (2020).

9.3 The HHS is required to 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.

9.4 The HHS will ensure that commitment and leadership is demonstrated through implementing the actions and achieving the key performance measures outlined in the Health Equity Strategy.

9.5 The HHS will report publicly every year on progress against the Health Equity Strategy.

9.6 The HHS will support the implementation of other supplementary policies and strategies to drive health equity across the public health system, including relevant election commitments.

9.7 The HHS will participate as a partner in the implementation and achievement of Queensland's *HealthQ32 First Nations First Strategy 2032* in addition to HHS commitments within their Health Equity Strategy.

10. Dispute Resolution

10.1 Where a dispute arises in connection to this agreement, either between the Department and one or more HHSs or between HHSs, every effort should be made to resolve the dispute at the local level. If local resolution cannot be achieved, the dispute resolution processes, accessible through Appendix 1, must be followed.

11. General

11.1 Sub-contracting

(a) The HHS must have appropriate systems in place to ensure that any subcontractor is accredited (as applicable), qualified, and otherwise fit to perform any services for which it is contracted.

(b) The HHS must ensure that any sub-contractor who has access to confidential information (as defined in the Act) or personal information (as defined in the *Information Privacy Act 2009* (Qld)) complies with obligations that are equivalent to those imposed on the HHS.

11.2 Insurance and Claims

(a) The HHS must:

(i) hold and maintain the types and levels of insurances that the HHS considers appropriate according to its functions, accountabilities and obligations; and

(ii) comply with reasonable requests or directions issued by the Department in this regard.

(b) The HHS must identify, pursue, and, where reasonable, maximise claim settlement outcomes for losses incurred by utilising all available coverage under the Department's insurance arrangements and other reimbursement avenues (including, for example, its *Disaster Recovery Funding Arrangement*).

(c) For the purposes of complying with the *Significant Litigation Directions* issued at the direction of Cabinet, including section 6.1, the HHS must provide the following information to the Department:

(i) the nature, history, and current status of each matter (that is considered to be a significant litigation matter);

(ii) the parties to the matter; and

(iii) the legal service provider (i.e. Crown Law or other legal service provider).

11.3 Indemnity

(a) 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:

(i) Indemnity for Queensland Health Medical Practitioners HR Policy I2 (QH-POL-153:2020); and

(ii) Queensland Government Indemnity Guideline.

(b) 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.

11.4 Asset Maintenance

(a) The HHS will ensure that effective and efficient asset management practices and systems are in place in accordance with the *Queensland Government Building Policy Framework and Guideline* (available online, as detailed in Appendix 1), while working in collaboration with the Department and that a minimum investment in operational repairs and maintenance is made. The HHS will:

(i) develop an annual maintenance budget to include an allocation for operational (OPEX) repairs and maintenance of 1.25 per cent of the undepreciated asset replacement value (UARV) of the building portfolio or a financially qualified percentage detailed in the approved Strategic Maintenance Plan (SMP);

(ii) collect and store condition assessment, maintenance expenditure and other asset related information/data as mandated in Health Service Directive, *Enterprise Architecture* (as detailed in Appendix 1); and

(iii) provide and practice comprehensive strategic and maintenance planning activities to sustainably manage assets and optimise asset usability to deliver safe and quality patient-centric healthcare services, as outlined in the *Queensland Government Building Policy Framework – Growth and Renewal: Planning, construction, maintenance, and performance (December 2024.)*

11.5 Amendment

The process for amending this service agreement is provided for under the Act and further outlined in Schedule 4.

12. Counterparts

12.1 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.

12.2 In the event that any signature executing this service agreement or any part of this service agreement is delivered by e-mail delivery of a '.pdf' format data file or equivalent of the entire agreement, 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.

12.3 For the avoidance of doubt, this service agreement may be in the form of an electronic document and may be electronically signed.

12.4 For execution under this clause 12 to be valid, the entire service agreement upon execution by each individual party must be delivered to the remaining parties.

Execution

(a) **Executed** as an agreement in Queensland

Signed by the Chief Executive, Queensland Health:)

.....

Signature of Chief Executive

DAVID ROSENGREN

.....

Name of Chief Executive (print)

17 June 2025

.....

(date)

Signed for and on behalf of the Gold Coast Hospital and Health Service:)

.....

Signature of Hospital and Health Board Chair

.....

Name of Hospital and Health Board Chair (print)

.....

(date)

Execution

(a) **Executed** as an agreement in Queensland

Signed by the Chief Executive, Queensland Health:)

.....

Signature of Chief Executive

DAVID ROSENGREN

.....

Name of Chief Executive (print)

.....

(date)

Signed for and on behalf of the Gold Coast Hospital and Health Service:)

Cindy Shannon Digitally signed by Cindy Shannon Date: 2025.06.19 09:17:42 +10'00'

.....

Signature of Hospital and Health Board Chair

Professor Cindy Shannon AM

.....

Name of Hospital and Health Board Chair (print)

19/06/2025

.....

(date)

Schedule 1 Funding and Purchased Activity and Services

This Schedule 1 sets out:

(a) the services which are to be provided by the HHS;

(b) the activity purchased by the Department from the HHS;

(c) the funding provided for delivery of the purchased activity;

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

(e) the sources of funding that this service agreement is based on and the way these funds will be provided to the HHS.

1. Introduction

1.1 The HHS will deliver the services for which funding is provided in this Schedule 1. In providing these services, the HHS will ensure that:

(a) all statewide and national policy frameworks, guidelines, protocols and implementation standards applicable to the service provided are followed;

(b) participation in national programs is facilitated and supported, including where these programs are provided by the Commonwealth Government;

(c) service delivery partnerships, including with other HHSs, primary care organisations and non-government organisations, are maintained and operate effectively;

(d) collaboration and engagement with the Department and other service providers and stakeholders is initiated and maintained to ensure that an integrated system of treatment, care and support is in place and to facilitate the delivery of comprehensive and effective services. This may include but is not limited to:

(i) other HHSs;

(ii) non-government organisations;

(iii) Aboriginal and Torres Strait Islander community-controlled health organisations;

(iv) Queensland Ambulance Service;

(v) services provided through the Department (for example, Pathology Queensland);

(vi) primary care providers;

(vii) other government departments and agencies; and

(viii) private providers;

(e) models of care, service delivery arrangements and public health (population level promotion, protection and prevention) functions are consistent with evidence-based practice and offer value for money;

(f) services are provided on an equitable basis to the community, and processes are in place to ensure that services reach identified target populations, high risk groups and hard to reach communities;

(g) referral networks and pathways continue to operate effectively; and

(h) innovation and continuous improvement are supported.

2. Purchased Health Services

The activity and service streams which the Department agrees to purchase from the HHS pursuant to this service agreement more generally includes, but is not limited to, the following:

2.1 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 and include the following:

(i) government election commitments;

(ii) newly commissioned services;

(iii) newly commissioned funding for Networked Services and/or Statewide Services; and

(iv) other key investments relating to system priorities as determined by the Department.

(b) Unless stated otherwise, the funding and activity detailed in Table 1 represents the total recurrent and non-recurrent value of the services purchased for the current financial year to date and any associated requirements. A detailed breakdown of funding is available via the Healthcare Purchasing Model.

(c) The HHS will promptly notify the Department if the HHS forecasts an inability to achieve commitments linked to the specific funding commitments included in Table 1.

(d) Services detailed in Table 1 may be subject to regular reporting via the *System Performance Reporting (SPR) Data Reporting Portal.*

(e) Other specifically funded commitments and the terms associated with such funding are outlined via the *Specific Funding Commitment Specifications* which are available online as outlined in Appendix 1.

Table 1 Specific Funding Commitments

Investment	Funding ($)	Recurrent / Non-Recurrent	QWAU (Q27)	Requirements
Government Election Commitments				
Not applicable to this HHS				
Newly Commissioned Services				
Not applicable to this HHS				
Key Investments				
Bed Capacity				
Bed Capacity Initiatives	$26,200,000	Non-Recurrent	4457	Funding to support the operation of 7 General Medical Acute Zone beds and 35 outsourced beds to 30 June 2026. Funding comprised of $22,900,000 transacted in BB 2025-26 and $3,300,000 transacted in previous Amendment Windows for 2025-26. Monthly reporting will be required through the System Performance Reporting (SPR) Data Reporting Portal. This investment will be subject to financial reconciliation.
Accelerated Infrastructure Delivery Program (AIDP) - Gold Coast University Hospital Sub-acute expansion	TBA	Recurrent	TBA	Funding from General Growth to support newly commissioned operation of the AIDP GCUH sub-acute expansion (68 beds). Monthly reporting will be required through the System Performance Reporting (SPR) Data Reporting Portal on the commissioning status.
Planned Care				
Planned Care Initiatives	$20,000,000	Non-Recurrent	3403	Monthly reporting will be required through the System Performance Reporting (SPR) Data Reporting Portal. This investment will be subject to financial reconciliation as part of the annual activity reconciliation.
Other				
Pelvic Mesh Service	$5,620,000	Recurrent	529	Funding to support the Queensland Pelvic Mesh Service. Funding comprised of $2,620,000 transacted in BB 2025-26 and $3,000,000 transacted recurrently in prior year allocation (GOL-AW2-FY24-33). Reporting may be required through appropriate email correspondence. This investment will be subject to financial reconciliation.
Magnetic Resonance Guided Focused Ultrasound (MRgFUS) - Incisionless Surgery	$2,400,000	Recurrent	408	Funding to support the continuation of the MRgFUS service post completion of the pilot program. Reporting may be required through appropriate email correspondence. This investment will be subject to financial reconciliation.

Brain and Spinal Cord Injury (BaSCI) Service	$844,906	Recurrent	144	Funding to support the ongoing delivery of services within the BaSCI programs previously funded by the Commonwealth non-recurrently. Reporting may be required through appropriate email correspondence.

2.2 Statewide Services

(a) The designation of a service as a statewide service (either a clinical statewide service or a clinical support statewide service) will be determined by the Department, consistent with the stipulated governance arrangements for such services.

(b) The HHS will:

(i) collaborate with the Department and other HHSs in the implementation of, and adherence to, the governance and oversight arrangements for statewide services including annual reporting and risk management where risks impact the sustainability of the service;

(ii) participate in, and contribute to, the staged review of the purchasing model for identified statewide services; and

(iii) ensure that referral pathways in and out of each statewide service are followed.

2.3 Clinical Statewide Services and Clinical Support Statewide Services

(a) The HHS will provide the statewide services listed in Table 2.

Table 2 Statewide Services

Service Name	Categorisation
Queensland Pelvic Mesh Service	Clinical Statewide Service

2.4 Networked Services

(a) A networked service is the delivery of clinical services to a defined population by two or more HHSs through a formal arrangement which results in better outcomes than could be achieved independently.

(b) The HHS will provide the Networked services listed in Table 3:

Table 3 Networked Services

This table does not apply to this HHS.

2.5 Regional Services

(a) A regional service is 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.

(b) It is recommended that the HHS establish a formal agreement with the recipient HHS(s) regarding the roles and responsibilities of regional service provision and receipt.

(c) The HHS has responsibility for the provision and/or coordination of the following regional services:

Table 4 Regional Services

Service Name	Recipient HHS(s)
Basic Physician Training	Coastal rotation: Metro South
Lavender Unit – mother and baby mental health unit	Statewide
Mental Health Clinical Indicator Team Program	Darling Downs, Metro South, South West, West Moreton
Secure Mental Health Rehabilitation Unit	To be advised

2.6 State-funded Outreach Services

(a) Where state-funded outreach services are provided:

(i) funding for the service will remain part of the providing HHS's funding allocation; and

(ii) the activity must be recorded at the HHS where the outreach service is being provided.

(b) Any changes to the provision of outreach services will follow the requirements set out in clause 3 of the Operative Terms.

2.7 Public Health Services

(a) The HHS will provide a range of public health services (population level promotion, protection and prevention) to promote and protect health, prevent illness and disease and manage risk, including specialist multi-disciplinary and Public Health Units, which may incorporate the following services:

(i) environmental health services, including risk assessment, regulation and enforcement in relation to environmental hazards, food safety, medicines and therapeutic goods, mosquitos and other vectors, pest management, poisons, radiation safety, chemical safety and water quality;

(ii) communicable disease services including immunisation, blood-borne viruses, sexually transmissible infections, infection prevention and control, response to notifiable conditions including mosquito-borne diseases, tuberculosis and rheumatic heart disease;

(iii) management of public health incidents, emergencies and disasters, including preparedness and response activities;

(iv) population level health promotion services;

(v) population health screening including, but not limited to, cancer screening services and newborn blood spot screening;

(vi) public health epidemiology for the surveillance and monitoring of population health status, risks, protective and promoting factors, and threats to health;

(vii) mitigation and adaptation in response to climate risks.

(b) Services will be provided in line with public health related legislation and the service delivery and reporting requirements outlined in the Public Health Service Schedule of this agreement.

(c) Delivery of these services may be coordinated through specialist Public Health Units, sexual health services, tuberculosis services, and other specialist areas of the HHS, or a combination of these. Services may also be provided by another HHS as part of an agreed arrangement, or through delivery of regional services across multiple HHSs.

(d) Health Service Directives may outline specific requirements for the delivery of some of these services.

2.8 Aboriginal and Torres Strait Islander Health Services

The HHS will provide Aboriginal and Torres Strait Islander specific health services and initiatives consistent with the principles and objectives of the Queensland Government's *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 – Policy and Accountability Framework* and the priorities committed to in the HHS's Health Equity Strategy. These services and initiatives will be delivered in line with guidance from the First Nations Health Office and the *First Nations First Strategy 2032.*

2.9 Mental Health, Alcohol, and Other Drugs Services

The HHS will provide treatment, care and support for individuals who are, or may be, experiencing substance use disorders and/or other mental health disorders, mental health crisis and suicidal distress, and their families and carers. Services will be delivered in line with guidance from the Mental Health, Alcohol and Other Drugs Strategy and Planning Branch.

2.10 Oral Health Services

(a) The HHS will provide oral health services to people who meet the eligibility criteria for accessing public dental services in Queensland.

(b) Services will be delivered in line with guidance from the Office of the Chief Dental Officer and the Department's *Oral Health Services Plan*.

(c) The repair, maintenance and relocation service for the mobile dental fleet will continue to be provided by the Mobile Dental Clinic Workshop in Metro South HHS.

2.11 Prisoner Health Services

The HHS will provide services for prisoners consistent with the principles, responsibilities and requirements specified in the *Memorandum of Understanding (Prisoner Health Services)* between the Department and Queensland Corrective Services and in line with guidance from the Office of Prisoner Health and Wellbeing.

2.12 Youth Detention Services

This clause does not apply to this HHS.

2.13 Refugee Health

This clause does not apply to this HHS.

2.14 Intellectual and Developmental Disability Mental Health (IDDMH) Teams

Intellectual and Developmental Disability Mental Health teams will provide mental health services to people with intellectual and developmental disability.

2.15 Intergovernmental Agreements and Federation Funding Agreements

The HHS will provide services for which it has been funded by the Commonwealth and State, including any existing Federal Funding Agreements as detailed on the *Federal Financial Relations* website listed under Appendix 1.

3. Teaching, Training and Research

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

3.1 Clinical Education and Training

(a) The HHS will provide education and training placements for the following professional groups consistent with and proportionate to the capacity of the HHS and will support and align with stipulated placement terms governing clinical placements in public sector health service facilities:

(i) medical students;

(ii) nursing and midwifery students;

(iii) pre-entry clinical allied health students;

(iv) interns;

(v) rural generalist trainees;

(vi) vocational medical trainees;

(vii) first year nurses and midwives;

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

(ix) dental students;

(x) allied health rural generalist training positions;

(xi) Aboriginal and Torres Strait Islander Health Workers and Aboriginal and Torres Strait Islander Health Practitioners.

(b) The HHS will prioritise quality clinical education and training in rural and remote sites to promote rural workforce recruitment and retention.

(c) The HHS will comply with the state-wide vocational medical training pathways.

(d) The HHS will support profession specific and inter-profession statewide allied health clinical education programs.

(e) The HHS will continue to implement and retain the following positions provided through clauses to the *Health Practitioners and Dental Officers (Queensland Health) Certified Agreement (No 4) 2022*:

(i) health practitioner research positions provided through the Research Package for Health Practitioners; and

(ii) clinical educator positions provided through the Clinical Education Management Initiative for Health Practitioners.

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

3.2 Statewide Training, Education, and Research

(a) **Mental Health, Alcohol and Other Drugs Training, Education, and Research**

This clause does not apply to this HHS.

(b) **Clinical Skills Development Service**

This clause does not apply to this HHS.

(c) **Child Health Programs**

This clause does not apply to this HHS.

(d) **State-wide Vocational Training Pathways**

This clause does not apply to this HHS.

3.3 Health and Medical Research

The HHS will:

(a) develop and implement a strategy to drive increased research activity and its translation into clinical practice, and public health practice (population level promotion, protection and prevention);

(b) support increased and equitable access to clinical trials for patients;

(c) support clinicians to undertake research linked to their practice; and

(d) ensure high quality and timely research governance approval processes.

4. Delivery of Purchased Activity

4.1 The HHS is required to maintain accurate activity forecasts in the purchased target module of the Decision Support System (DSS) at all times. This information is imperative to the Department's assessment of State performance against the national Soft Cap and for outer-year planning. Activity forecasts must accurately reflect financial forecasts reported to the Finance Branch monthly. To increase the robustness of information available to

inform decision making, the Department may undertake an internal end of year forecast of activity using the seasonal approach method (see Appendix 1: *QWAU Forecasting – In-year using seasonality methodology*).

4.2 The Department and the HHS will monitor actual activity against purchased levels and will act as necessary to ensure delivery of purchased levels is achieved. The HHS has a responsibility to only recognise revenue that is linked with actual activity delivered against purchased volumes.

4.3 The HHS will actively monitor variances from purchased activity levels and notify the Department as soon as the HHS becomes aware of significant variances.

4.4 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.

4.5 The HHS will undertake regular quality audits. The HHS is encouraged to publish its data quality framework describing audits undertaken and results achieved. For further information, refer to the *Delivery of Purchased Activity – Requirement for Quality Audits* specification sheet as detailed in Appendix 1.

4.6 If the HHS wishes to convert activity between purchased activity types, programs and levels, the HHS must negotiate this with the Department based on a sound, needs-based rationale.

4.7 The Department will reconcile in-scope activity, as defined in the *Activity Reconciliation* specification sheet (available online, as detailed in Appendix 1), delivered by the HHS against the purchased in-scope activity targets outlined in Table 7. The Department has discretion to undertake detailed activity analysis and compliance auditing where a HHS has exceeded its activity targets.

4.8 Activity reconciliations will be undertaken in the applicable end of year technical amendment window and subsequent amendment window 2 and will be derived through application of the methodology which is documented in the *Activity Reconciliation* specification sheet.

4.9 Should the HHS be unable to deliver the activity that has been funded, a financial adjustment will be applied.

4.10 Funding and corresponding activity that is withdrawn from the HHS may be reallocated to an alternate provider that can undertake the activity.

4.11 Any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 1 and 4 of this service agreement.

4.12 The HHS will maintain its efforts to accurately record the delivered activity and submit this data to the Department in accordance with the agreed requirements.

5. Delivery of Purchased Services

5.1 As part of the service agreement, the Department purchases a range of services (or deliverables) from the HHS for the delivery of certain programs and projects.

5.2 These program or project services may be the subject of separately agreed conditions tied to that funding and the focus of detailed monitoring by the Department. Such conditions may be outlined in *Specific Funding Commitment Specifications*, which are available online as outlined in Appendix 1.

5.3 Conditions may include, but are not limited to:

(a) establishment and/or commencement of services;

(b) delivery of activity;

(c) workforce obligations;

(d) establishment of oversight committees;

(e) opening or upgrades to facilities;

(f) program evaluation;

(g) program management;

(h) reporting or notification obligations; and

(i) attainment of performance standards.

5.4 The HHS will ensure that the conditions are achieved within the stipulated time period.

5.5 The HHS will notify the Department if the HHS forecasts an inability to achieve program or project objectives or the conditions.

5.6 The Department may withdraw allocated funding pro rata to the level of under delivery if the services for a specified program or project are not being fully delivered according to the objectives or conditions.

5.7 Any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 1 and 4 of this service agreement.

6. Financial Adjustments

6.1 Activity Targets

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

(b) Activity will be monitored at the purchasing hierarchy level. Providing the HHS meets all relevant KPIs and specific funding allocations, the HHS has the ability to

negotiate the transfer of activity across the purchasing hierarchy with the Department.

(c) Table 5 demonstrates the financial adjustment that will be applied when activity thresholds have been breached.

(d) The HHS may not utilise the provisions within AASB15 Revenue from Contracts with Customers to override the application of any financial adjustment made by the Department in line with Table 5.

Table 5 Financial Adjustments Applied on Breach of Activity Thresholds

Example of Breach	Description	Financial Adjustment
Over performance	Activity exceeds that specified in the service agreement value for in-scope activity as shown in Table 7.	Purchasing contracts are capped and an HHS will not be paid for additional activity apart from activity that is in scope for the identified purchasing incentives as set out in Table 6 (where applicable.)
Under performance	Activity is below that specified for in-scope activity as shown in Table 7.	Purchased activity and the related funding will be withdrawn at 100% of the Queensland Efficient Price and reallocated to an alternate provider that can undertake the activity. The reconciliation will be undertaken as outlined in the *Activity Reconciliation* Specification. Refer to Table 7 for the HHS QWAU target.
Failure to deliver on service commitments linked to specific funding allocations	Specific funding allocations National Partnership Agreements.	It is at the discretion of the Department to withdraw allocated funding pro rata to the level of under delivery.
For all other types of activity variance, any financial adjustment will be made at the discretion of the Department.		

6.2 Purchasing Approach

(a) The purchasing approach includes a range of funding adjustments (purchasing incentives and ABF model localisations) that aim to incentivise high quality and high priority activity, support innovation and evidence-based practice, deliver additional capacity through clinically and cost-effective models of care and dis-incentivise care providing insufficient or no benefit for patients. This includes incentive payments for HHSs who achieve targets in specific priority areas. The funding adjustments are detailed in Table 6. The Department must reconcile the applicable funding adjustments in Table 6 in line with the timeframes specified in the relevant purchasing specification sheet. The Department must provide a copy of the reconciliation statement to the HHS.

(b) Funding adjustments must be based on the requirements contained in the relevant purchasing specification sheet.

(c) Any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 1 and 4 of this service agreement.

Table 6 Funding Adjustments

Funding adjustment	
Purchasing incentives and disincentives	
Workforce Incentive - Endoscopy Workforce	This Purchasing Incentive supports the increase to the Endoscopy workforce by investing in the advanced training of Rural Generalists and Nurse Practitioners to assist with alleviating long waitlists and growing demand for endoscopy.
ED Stays Greater than 24 Hours	A disincentive will be introduced in 2025-2026 to disincentivise stays of greater than 24 hours in an Emergency Department (ED). This includes the financial clawback on the subsequent admission to any clinical unit of the hospital to the value of the WAU multiplied by the Queensland Efficient Price (QEP). The financial clawbacks on subsequent inpatient admissions will be managed as a manual reconciliation at quarterly amendment windows at the discretion of the Department.
Rapid Access Clinics	The establishment of alternative models of care that handle demand and facilitate patient flow are a high priority for Queensland Health. As such, suitable rapid access clinic models will be incentivised in Q28.
Same Day and Extended Day Surgeries	This purchasing incentive will encourage Hospital and Health Services to review their surgical performance and identify surgical DRGs that are suitable for same day or extended day care, that are not currently being managed as a same day or extended same day care.
ABF model localisations	
Admissions to Emergency Department Ward *(new)*	HHSs will not have activity associated with admissions to the ED, outside of recognised ED Short Stay Units (ED-SSU) recognised in the Queensland Funding Model.
Multi-disciplinary Indicator in Endoscopy *(new)*	A loading reduction will be applied to procedural/scope cases to disincentivise the growth in the use of the MDC indicator, where increased cost has not supported the use of the indicator and Queensland remains an anomaly in the national data set.
Child Health Checks *(shadow pricing)*	A QWAU loading has been incorporated into the Queensland Funding Model for every in-scope child health check performed in the community.
Funding for Unqualified Neonates	Reduced Diagnosis Related Group (DRG) QWAU for all maternal delivery episodes with a liveborn outcome, discounted by the Diagnosis Related Group (DRG), with QWAUs re-allocated for unqualified neonates.
Maternity Care for First Nations Women	Additional QWAU are paid to HHSs to incentivise maternity care provided to First Nations mothers during pregnancy and to incentivise smoking cessation during pregnancy.
Sentinel Events	Payment withdrawn for sentinel events as per the national ABF model.
Advance Care Planning (ACP)	QWAUs for HHSs offering ACP discussions to admitted patients, non-admitted outpatients, community health patients and Emergency Department patients.
Emergency Department Did Not Wait (ED DNWs)	Zero QWAUs for DNWs.
Fractured Neck of Femur (NOF)	QWAUs reduced by 20% for non-timely surgical treatment of fractured neck of femur.
Hospital in The Home (HITH) for Residential Aged Care (RACF) Residents	QWAUs increased by 12.5% for Hospital in the Home (HITH) admissions of Residential Aged Care Facility residents.
Out-of-scope Cosmetic Services	Nil QWAUs for out-of-scope services.

Funding adjustment	
Pre-operative Bed Days	QWAUs for long stay days above the upper trim point less ICU days reduced equivalent to pre-operative days, up to a maximum of 3 days, for elective episodes.
Smoking Cessation (Community Mental Health)	QWAUs for smoking cessation activity for community mental health patients.
Smoking Cessation (Inpatients)	QWAUs for smoking cessation activity for publicly funded inpatients.
Stroke Care	10% QWAU loading for acute stroke patients admitted to Queensland Stroke Clinical Network-endorsed stroke unit care.
Telehealth Admitted	QWAUs for provider-end of in-scope admitted patient telehealth activity.
Allied Health Led Workforce for Pelvic Health and Gastroenterology	QWAU loading for an in-scope service event for Pelvic Health and Gastroenterology recorded against an Other Health Professional.
Remote Patient Monitoring	QWAU loading for an in-scope non-admitted remote patient monitoring encounter per month per patient.

Surgery Connect Reimbursements

(d) The HHS will reimburse the Department for the actual costs of activity for nominated patient referrals to the Surgery Connect program where:

(i) the HHS has nominated the patient referral as HHS funded or HHS Direct on entry of the referral in the Surgery Connect Activity Navigator (SCAN); and

(ii) the HHS Chief Finance Officer has recorded approval of the nomination in SCAN; or

(iii) the HHS has obtained the Department's agreement to retrospectively convert a defined patient cohort to HHS funded status in SCAN.

(e) The HHS may only request retrospective conversion of activity to HHS funded within the financial year in which the activity has taken place.

(f) Any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 1 and 4 of this service agreement.

6.3 Financial Adjustments – Other

(a) Notwithstanding the provisions regarding the recognition of revenue as stipulated in AASB1058 Income of Not-for-Profit Entities and/or AASB15 Revenue from Contracts with Customers, the Department may seek to recover funding from an HHS that was provided through this service agreement which has:

(i) not been utilised in accordance with its intended purpose; and/or

(ii) not been utilised within the prescribed time period to deliver the agreed outcomes/services.

(b) Details regarding financial adjustments for specific funding commitments are outlined in Table 1 and in the *Specific Funding Commitment Specifications,* which are published online as detailed in Appendix 1.

(c) If the Chief Executive (or delegate) determines that previously allocated funding is to be recovered, any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 1 and 4 of this service agreement.

6.4 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 estimate, it will be able to retain the additional own source revenue with no compensating adjustments to funding from other sources where the additional revenue is not attributable to a private patient consistent with clauses A9 to A13 and A44 of the *National Health Reform Agreement.*

(c) Where an HHS is below its own source revenue estimate 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, within legislated limits.

(e) The own source revenue identified in Table 7 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 processes set out in Schedule 4 of this service agreement.

6.5 Activity Rebasing

(a) Funding adjustments for the subsequent financial year will be based on current year actuals, at year end, with adjustments to be made as follows:

(i) Where an HHS is below its QWAU target as stated in Table 7, activity targets and the related funding will be withdrawn at 100% of the Queensland Efficient Price.

(ii) Where an HHS is above its QWAU target as stated in Table 7, the decision to reinvest in the related additional activity will be at the sole discretion of the Department based on system priorities and subject to availability of funds.

(iii) Activity target actuals will be based on HHS data as utilised in the Department's year-end submission to the Independent Hospital Pricing Authority.

(iv) Funding adjustments will be actioned through the process set out in Schedule 4 of this Service Agreement.

7. Funding Sources

7.1 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.

7.2 Table 7 provides a summary of the funding sources for the HHS and the total value of the service agreement.

7.3 The HHS must undertake regular quality audits to check for potential duplicates in funding source, in particular the *National Health Reform Agreement* and Medicare given the Commonwealth's contribution to both funding sources. The HHS should take active steps to remedy areas of concern. A consumer's choice of funding arrangement should be reflected on a patient election form.

8. Funds Disbursement

8.1 The Department agrees to pay the HHS the amount described in Table 7 of Schedule 1, subject to:

(a) parliamentary appropriation and adequate funds being allocated to the Department; and

(b) the terms of this service agreement.

8.2 All payments under this service agreement will be made in accordance with the requirements of the *National Health Reform Agreement* and the Act.

8.3 The Chief Executive will direct the disbursement of both State and Commonwealth funding from the State Pool Account, the State Managed Fund, and the Department's Expenditure account to the HHS.

8.4 However, the Department (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.

8.5 The Department will pay state-funded activity-based funding, block funding and system manager funding to the HHS on a fortnightly basis in line with receipt of the State

Appropriation Payment. The payment made will be equal to 1/26th of the state-funded component of the service agreement value described in Table 7.

8.6 The Department will pay Commonwealth-funded activity-based funding and block funding monthly in line with receipt of the Commonwealth payment. The payment made will be equal to 1/12th of the Commonwealth funded component of the service agreement value described in Table 7.

8.7 Where the parties have agreed to amend the service agreement value or the Commonwealth contribution amount changes, the fortnightly and/or monthly payments will be adjusted to reflect the amended service agreement value.

8.8 Service agreement payments may be made outside of these timeframes with the approval of the Department's Chief Finance Officer.

Table 7 HHS Total Funding Allocation by Funding Source

Funding Source	25-26 NWAU (N2526)	25-26 QWAU (Q27)	25-26 Agreed ($)
NHRA Funding			
ABF Pool			
ABF Funding (In scope)[1]			
Commonwealth	309,872		$786,017,059
State		309,121	$1,060,461,640
State Grants			$83,098,843
Statewide Services			$93,078
FFA – Planned Care Investment	3,935	3,964	$23,300,000
FFA – Bed Capacity Investment	3,865	3,896	$22,900,000
Total ABF Funding (in scope)	**317,671**	**316,980**	**$1,975,870,620**
State Managed Fund			
Block Funding (State and Commonwealth)			
Small Rural Hospitals		0	$0
Teaching, Training & Research			$53,855,793
Community Mental Health	5,821	5,821	$36,726,078
Non-Admitted Home Ventilation			$0
Residential Mental Health Services		334	$0
Other Non-Admitted Services			$0
Highly Specialised Therapies			$0
Other Public Hospital Programs			$0
Total NHRA Funding	**317,671**	**323,135**	**$2,066,452,491**
Out of Scope NHRA			
Queensland ABF Model			
DVA		1,206	$7,088,378
NIISQ/MAIC		479	$2,813,050
Oral Health		2,464	$17,054,755
Oral Health – FFA		0	$0
BreastScreen		840	$6,307,524
Child Health Services	245	245	$4,740,974
FFA – Preventing Avoidable Hospitalisations	0	0	$0
Total Queensland ABF Funding	**-**	**5,233**	**$38,004,682**
Discretely Funded Programs[2]			
Department of Health	0	-131	$176,618,272
Locally Receipted Funds		0	$13,966,827
Research (Other OSR)		0	$4,596,718
Total Discretely Funded Programs	**-**	**-131**	**$195,181,817**

[1] The split between Commonwealth and State NHRA funding will change during the year as the purchased activity targets are updated and the National Health Funding Board updates their payment advice accordingly.

[2] Includes all other (non-ABF) State and Commonwealth funded health services including, but not limited to, Prisoner Health, Public Health and Prevention Services.

Funding Source	25-26 NWAU (N2526)	25-26 QWAU (Q27)	25-26 Agreed ($)
Own Source Revenue			
Private Patient Admitted Revenue[3]	3,854	3,899	$22,340,320
Pharmaceuticals Benefits Scheme		9,021	$96,987,557
Non-Admitted Services		2,479	$1,176,948
Other Activities[4]		602	$63,214,136
Oral Health – CDBS		0	$1,541,552
Total Own Source Revenue	**-**	**16,001**	**$185,260,513**
Locally Receipted Funds (exc. Discretely Funded Programs)[5]			$17,148,069
Depreciation			$132,090,000
GRAND TOTAL	**317,671**	**344,238**	**$2,634,137,572**

Bank Accounts			
ABF Pool (National Health Funding Pool)[6]			$1,967,675,302
State Managed Fund[7]			$90,581,871
System Manager			$176,618,272

[3] The estimated value of the revenue earned from private patients, based on OSR estimates provided by the HHS.

[4] Incorporates all OSR which is not identified elsewhere in Table 7.

[5] Includes items such as training programs and donations. Does not include locally receipted funds associated with discretely funded programs, e.g.Transition Care.

[6] Articulates the financial payment made to support in-scope ABF services under the NHRA including DVA, NIISQ, MAIC and BreastScreen Services. Applies to all HHSs except Central West HHS and Torres and Cape HHS.

[7] Articulates the payment made for block funded services under the NHRA, DVA, NIISQ and MAIC services.

Table 8 National Health Reform Funding

NHRA Funding Type	No. of In-scope services (NWAU)	No. of Out-of-scope services (QWAU)	Total Services (WAU)	ABF NEP ($)	State Price ($)	Funding for In-scope services at NEP ($)	Cwlth contribution for In-scope services ($)	State contribution for In-scope services ($)	State contribution for Out-of-scope services ($)	Total Funding ($)
National Efficient Price (NEP)		*a,b*		*c*	*d*			*e*		
ABF Allocation (NWAU)										
Emergency Department	50,077	1,229	51,306	$7,258	$5,878	$363,457,259	$123,905,372	$180,282,118	$7,903,691	$312,091,182
Acute Admitted	170,481	5,527	176,009	$7,258	$5,878	$1,237,352,067	$421,822,828	$613,751,539	$35,547,650	$1,071,122,017
Admitted Mental Health	17,183	514	17,696	$7,258	$5,878	$124,711,591	$42,515,140	$61,859,460	$3,303,177	$107,677,777
Sub-Acute	18,466	887	19,353	$7,258	$5,878	$134,026,054	$45,690,512	$66,479,622	$5,707,443	$117,877,576
Non-Admitted	51,348	4,936	56,284	$7,258	$5,878	$372,685,861	$127,051,474	$184,859,691	$31,742,721	$343,653,886
Community Mental Health	10,117	0	10,117	$7,258	$5,878	$73,426,719	$25,031,733	$36,421,131	$-	$61,452,864
Total ABF Allocation	**317,671**	**13,093**	**330,765**			**$2,305,659,551**	**$786,017,059**	**$1,143,653,561**	**$84,204,682**	**$2,013,875,302**
Block Allocation										
Teaching, Training and Research						$-	$15,432,382	$38,423,411	$-	$53,855,793
Small Rural Hospitals						$-	$-	$-	$-	$-
Other Mental Health						$-	$15,892,428	$20,833,650	$-	$36,726,078

Non-Admitted Home Ventilation						$-	$0	$0	$-	$0
Other Non-Admitted Services						$-	$-	$-	$-	$-
Other Public Hospital Programs						$-	$-	$-	$-	$-
Highly Specialised Therapies						$-	$-	$-	$-	$-
Total Block Allocation						**$-**	**$31,324,810**	**$59,257,061**	**$-**	**$90,581,871**
Grand Total Funding Allocation										**$2,104,457,172**

Notes

a. QWAU refers to Queensland Weighted Activity Units in Q27 phase (build on N2425)
b. DVA, NIISQ/MAIC, Oral Health, Child Health Checks and BreastScreen
c. Queensland Efficient Price used to Purchase growth QWAUs (Q27 phase)
d. NWAU x NEP
e. State funding transacted through the Pool/State Managed Fund Account; not covered under the NHRA
- NWAU estimates do not take account of cross-border activity
- NWAU is reported in N2526 phase

Table 9 Discretely Funded Programs (Non-ABF)

Discretely Funded Programs	Revenue Models	$
Aged Care Assessment Program	Commonwealth	$0
Alcohol, Tobacco and Other Drugs	State	$12,272,551
Clinical Innovation & Coordination	State	$292,305
Community Health Programs	State	$80,526,894
Disability Residential Care Services	State	$0
Home and Community Care (HACC) Program	Locally Receipted Funds	$5,633,544
Interstate Patients (QLD Residents)	State	$31,168,625
Multi-Purpose Health Services	Commonwealth	$0
Other State Funding	State	$32,663,062
Patient Transport	State	$0
Patient Transport: Aeromedical Retrieval	State	$1,047,942
Patient Transport: PTSS	State	$1,562,737
Prevention Services and Public Health	Commonwealth	$10,279,283
	State	-$194,081
Prisoner Primary Health Services	State	$1,230,717
	Capitation	$57,485
Research	Commonwealth	$1
	OSR	$4,596,718
Residential Aged Care Services	Commonwealth	$217,925
	Locally Receipted Funds	$0
	State	$2,881,024
Transition Care	Locally Receipted Funds	$8,333,283
	State	$2,611,802
Transitional Funding	State	$0
Discretely Funded Programs Total		**$195,181,817**
TOTAL		**$195,181,817**

Schedule 2 Services Provided by the Department

1. In Scope Services and Service Schedules

Table 10 Services Provided by the Department and Service Schedules

Provider	Service Provided	Link to Service Statement

Corporate Services Division (CSD)	• Corporate Enterprise Solutions
	• Finance Branch:
	  ○ Accounts Payable Service Provision
	  ○ Banking and Payment Services
		CSD Service Schedules

eHealth Queensland (eHQ)	• ICT Service	eHQ Service Schedule
Clinical Support Queensland (CSQ)	• Pathology Queensland (PQ) • Biomedical Technical Services (BTS) • Public Health (PH) Services • Central Pharmacy (CP) • Group Linen (GL) Services • Supply Chain (SC) Services • Transport and Logistic (TL) Services	Service Schedules - PQ, BTS, PH Service Schedules - CP, GL, SC, TL

Schedule 3 Performance Measures

1. Performance Measures

1.1 The performance of the HHS will be measured according to the assessment criteria and processes described in the *Performance and Accountability Framework*.

1.2 Existing performance indicators are mapped to the Health System Domains of the *Outcomes Framework*.

1.3 The detailed specifications for each of the performance measures listed in this service agreement are provided through performance measure attribute sheets.

1.4 The performance measures identified in this service agreement are applicable to the HHS unless otherwise specified within the attribute sheet.

Table 11 HHS Headline Performance Measures - Key Performance Indicators

Indicator Number	Health System Domain	Key Performance Indicator
001	Trauma and Illness	Ambulance Ramping
002	Planned Care	Total Elective Surgery Waiting List
003	Planned Care	Elective Surgery: Percentage of Patients who are Treated within the Clinically Recommended Time
004	Planned Care	Gastrointestinal Endoscopy: Percentage of Patients who are Treated within the Clinically Recommended Time
005	Planned Care	Specialist Outpatients: Percentage of Patients who Receive their Initial Specialist Outpatient Appointment within the Clinically Recommended Time
006	Stewardship	Missed Opportunity to Treat
007	Chronic and Complex	Potentially Preventable Hospitalisations
008	Prevention, Early Intervention and Primary Healthcare	Potentially Avoidable Deaths
009	Stewardship	Hospital Acquired Complications
010	Stewardship	Full Year Forecast Operating Position

Table 12 HHS Headline Performance Measures – Patient Safety Risk Events

Indicator Number	Health System Domain	Patient Safety Risk Event
011	Trauma and Illness	Ambulance Ramping Events Exceeding 2.5 Hours
012	Trauma and Illness	Emergency Department Length of Stays Greater than 24 Hours

Table 13 HHS Performance Dimensions – Outcome Indicators

Indicator Number	Health System Domain	Outcome Indicator
013	Trauma and Illness	Hospital Access Target: Emergency Stays within 4 Hours - All
014	Trauma and Illness	Emergency Department Wait Time by Triage Category
015	Trauma and Illness	Emergency Surgery: Percentage of Patients Treated within Clinically Recommended Time
016	Planned Care	Complaints Resolved within 35 Calendar Days
017	Planned Care Prevention, Early Intervention and Primary Healthcare	Smoking Cessation Clinical Pathway (Public Hospital Inpatients and Dental Clients)
018	Chronic and Complex	Cardiac Rehabilitation
019	Maternity and Neonates	Proportion of Healthy Birthweight Babies (2,500 grams to 4,499 grams at Birth)
020	Mental Health, Alcohol and Other Drugs	Rate of Face-to-Face Community Follow Up Within 1-7 Days Following Discharge from an Acute Mental Health Inpatient Unit
021	Mental Health, Alcohol and Other Drugs	Proportion of Mental Health Alcohol and Other Drug Service Episodes with a Documented Care Plan
022	Mental Health, Alcohol and Other Drugs	Rate of Absent without Approval
023	Mental Health, Alcohol and Other Drugs	Rate of Seclusion Events
024	Mental Health, Alcohol and Other Drugs	Sustained Reduction in Suicide Counts and Rates of First Nations Peoples
026	Prevention, Early Intervention and Primary Healthcare	Access to emergency dental care
027	Prevention, Early Intervention and Primary Healthcare	Access to Oral Health Services for Children
028	Prevention, Early Intervention and Primary Healthcare	General Oral Health Care for First Nations Peoples (Adults and Children)
029	Prevention, Early Intervention and Primary Healthcare	Percentage of Oral Health Activity which is Preventive
030	Prevention, Early Intervention and Primary Healthcare	School Immunisation Program

Table 14 HHS Performance Dimensions – Safety and Quality Markers

Indicator Number	Health System Domain	Safety and Quality Marker
031	Planned Care	Healthcare Associated Staphylococcus Aureus (inc MRSA) Bacteraemia
032	Planned Care	Hospital Standardised Mortality Ratio (HSMR)

Indicator Number	Health System Domain	Safety and Quality Marker
033	Planned Care	Patient Reported Experience Measures (PREMS)
034	Planned Care	SAC1 Completion rates
035	Planned Care Maternity & Neonates	Sentinel Events
036	Chronic and Complex	Advance Care Planning

Table 15 HHS Performance Dimensions – Stewardship Indicators

Indicator Number	Health System Domain	Stewardship Indicator
037	Planned Care	Elective Surgery: Reduction of Long Wait Patients
038	Planned Care	Gastrointestinal Endoscopy: Reduction of Long Wait Patients
039	Planned Care	Specialist Outpatients: Reduction of Long Wait Patients
040	Planned Care	Theatre Utilisation: On-Time Theatre Starts
041	Planned Care	Theatre Utilisation: Preventable Day of Surgery Cancellations
042	Stewardship	Average Sustainable Queensland Health FTE
043	Stewardship	First Nations People Representation in the Workforce
044	Stewardship	Purchased Activity Variance
045	Stewardship	Year to Date Operating Position
046	Prevention, Early Intervention and Primary Healthcare	Access to Oral Health Services for Adults

Schedule 4 Amendments to this Service Agreement

1. Agreed Process to Amend this Service Agreement

1.1 General

The parties acknowledge that this service agreement is subject to amendment, which will generally occur through:

(a) amendment windows;

(b) extraordinary amendment;

(c) periodic adjustments;

(d) reference document amendments; and

(e) end of financial year reconciliation.

1.2 Amendment Windows

(a) There will be set periods of time nominated by the Department during the year (amendment windows) in which a party may propose an amendment and the parties will endeavour to negotiate and finalise proposals to amend this service agreement.

(b) Amendment proposals that are agreed will be documented in a deed of amendment to this service agreement.

(c) Further details on the amendment window process, including the timing of amendment windows, is provided online as detailed in Appendix 1.

1.3 Extraordinary Amendment

(a) Outside an amendment window, the Department and the HHS agree to limit any proposal to amend the terms of this service agreement to those where there is an urgent priority need to facilitate a funding allocation (extraordinary amendment). The parties will endeavour to negotiate and finalise any such proposal urgently.

(b) The process for submitting, negotiating, and resolving an extraordinary amendment is available online as detailed at Appendix 1.

(c) Agreed extraordinary amendments will be reflected in a notice signed by the Chief Executive and countersigned by the HHS Board Chair as accepted by the HHS and the Department.

1.4 Periodic Adjustments

(a) The service agreement value (and corresponding purchased activity) may be adjusted at any time to reflect funding variations that:

(i) occur on a periodic basis or in line with adjustments permitted for specific funding allocations;

(ii) are referenced in the service agreement; and

(iii) are based on a clearly articulated formula, an agreed basis or such other reasonably substantiated basis tied to performance.

(b) Periodic adjustments will be reflected in an adjustment notice issued by the Chief Executive (or delegate) to the HHS, based on relevant data, and subsequently formalised in a deed of amendment issued following the next amendment window.

1.5 Amendments on Notice

(a) The Department may, from time to time, amend the Service Schedules in Schedule 2, each of the reference documents in Appendix 1, and any other document expressly incorporated by reference in the service agreement by providing written notice to the HHS, issued by the Chief Executive (or delegate) and subject to the HHS agreeing in writing.

(b) Amendments agreed in accordance with clause 1.5(a) above:

(i) will apply on and from the date specified in the relevant notice; and

(ii) will be subsequently formalised in a deed of amendment issued following the next amendment window.

1.6 End of Financial Year Reconciliation

(a) There will be an end of financial year reconciliation process, with the scope defined by the Department and informed by Queensland Government Central Agency requirements.

(b) 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 position following conclusion of the end of financial year adjustments process.

(c) This clause will survive expiration of this service agreement.

Appendix 1 Reference Documents

Service Agreement:

- Clinical Services Capability Framework
- Data supply requirements
- Delivery of Purchased Activity – Requirement for Quality Audits specification sheet
- Disaster Recovery Funding Arrangement
- Dispute Resolution Process - current
- Enterprise Architecture Health Service Directive
- Federal Financial Relations – Federal Funding Agreements
- First Nations First Strategy 2032
- Health Practitioners and Dental Officers (Queensland Health) Certified Agreement (No.4) 2022
- Hospital and Health Boards Act 2011
- Hospital and Health Boards Regulation 2023
- Indemnity for Queensland Health Medical Practitioners
- Information Privacy Act 2009
- Joint Regional Needs Assessment Framework
- Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework
- Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 - Policy and Accountability Framework
- Managing the risk of psychosocial hazards at work Code of Practice 2022
- National Agreement on Closing the Gap
- National Health Reform Agreement (NHRA) 2020-25
- National Safety and Quality Health Service Standards

- Non-Government Organisation (NGO) Operating Framework and list of Contracted NGOs managed through the Community Services Funding Branch
- Performance Measures Attribute Sheets
- Public Health Service Schedule
- Queensland Government Building Policy Framework and Guideline
- Queensland Government Indemnity Guideline
- Queensland Health Performance and Accountability Framework
- QWAU Forecasting – In-year using seasonality methodology
- Service Agreement Amendment Process
- Significant Litigation Directions
- Specific Funding Commitment Specifications
- Specifications Supporting the Healthcare Purchasing Model
- Statewide Oral Health Services Plan
- Work Health and Safety Act 2011
- Work Health and Safety Regulation 2011

Supporting Policy Documents

- Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026
- HEALTHQ32: A vision for Queensland's health system
- Public Health 2032: A vision for public health services in Queensland
- Queensland Health Equity, Diversity, and Inclusion Statement of Commitment
- Statewide Services Reference Material

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