

Central Queensland Hospital and Health Service

Service Agreement 2013/2014 – 2015/2016 Deed of Amendment August 2015

Parties

Central Queensland Hospital and Health Service
And
Queensland Health

Central Queensland HHS Service Agreement 2013/2014 – 2015/2016 Deed of Amendment August 2015

Published by the State of Queensland (Queensland Health), August 2015



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Introduction

In accordance with section 35 of the *Hospital and Health Boards Act 2011*, a service agreement is in place between the parties to this deed.

The service agreement is binding on the parties and can be amended in accordance with section 39 of the *Hospital and Health Boards Act 2011* and the terms of the service agreement.

The parties have agreed to vary the terms of the service agreement on the terms of this deed.

The amendments made by this deed will be published on the service agreements and deeds of amendments website (www.health.qld.gov.au/system-governance/health-system/managing/agreements-deeds/default.asp) within 14 calendar days of the effective date of this deed.

Definitions

In this deed:

Amendment Proposal means the written notice of a proposed amendment to the terms of the service agreement by the Chief Executive (or Deputy Director General) or the Hospital and Health Service (HHS) to the other party, as required under section 39 of the *Hospital and Health Boards Act 2011*.

Chair means the Chair of the Hospital and Health Board.

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

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

Deed of Amendment means the resolved amendment proposals.

Effective Date means the date the deed is executed (signed) by both parties.

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

Parties means the Chief Executive and the HHS to which the agreement applies.

Service Agreement means the service agreement between the Department of Health and the HHS made in accordance with section 35 of the *Hospital and Health Boards Act 2011*, including the schedules in annexures, as amended from time to time.

Interpretation

Unless expressed to the contrary, in this deed of amendment:

- words in the singular include the plural and vice versa
- any gender includes the other genders

- if a word or phrase is defined its other grammatical forms have corresponding meanings
- “includes” and “including” are not terms of limitation
- 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
- a reference to:
 - i. a party is a reference to a party to this deed of amendment
 - 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
- any legislation includes subordinate legislation under it and includes that legislation and subordinate legislation as modified or replaced
- 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
- headings do not affect the interpretation of this deed

General

This deed may only be varied or replaced by a document executed by the parties.

Each party must promptly do whatever any other party reasonably requires of it to give effect to this deed and perform its obligations under it.

Unless expressly stated otherwise in this deed, each party must pay its own legal and other costs and expenses of negotiating, preparing, executing and performing its obligations under this deed.

This deed contains the entire understanding between the parties as to the subject matter of this deed.

This deed supersedes all previous negotiations, understandings, representations, memoranda or commitments concerning the subject matter contained within this deed.

No oral explanation or information provided by any party to another:

- (a) affects the meaning or interpretation of this deed; or
- (b) constitutes any collateral agreement, warranty or understanding between any of the parties.

Amendments to Service Agreement, May 2015 Revision

The service agreement 2013/2014 – 2015/2016 August 2015 revision attached as Appendix One contains all the amendments agreed to by the parties through the amendment window that commenced on 15 May 2015.

When the deed has been executed by both parties the effective execution date will be added to the “Execution” section, at the end of paragraph 1, where it currently states ‘XX YY 2015’

Execution

Executed as a deed in Queensland

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


.....
Witness signature

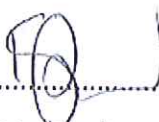

.....
Signature of Chief Executive

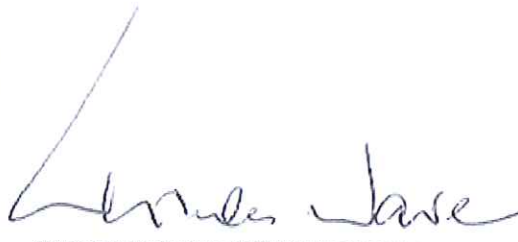
Lauren Brace
.....
Name of Witness (print)

MICHAEL WALSH
.....
Name of Chief Executive (print)

9/9/15
.....
(date)

Signed by the Chair, Central)
Queensland Hospital and Health Board,)
in the presence of:)


.....
Witness signature


.....
Signature of Hospital and Health Board
Chair

KRISTY RICHARDSON
.....
Name of Witness (print)

Roy Charles Ware
.....
Name of Hospital and Health Board
Chair (print)

31 August 2015
.....
(date)

Appendix 1

Appendix 1

Central Queensland Hospital and Health Service

Service Agreement

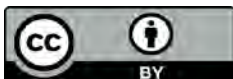
2013/2014 – 2015/2016

August 2015 Revision

Central Queensland Hospital and Health Service

Service Agreement 2013/14 - 2015/16 August 2015 Revision

Published by the State of Queensland (Queensland Health), August 2015



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1. Introduction

1. Queensland Health is committed to strengthening performance and improving services and programs that will better meet the needs of the community.
2. The development of service agreements between the Chief Executive, Department of Health and Hospital and Health Services (HHSs), assists this process by formally assigning accountability for the high level outcomes and targets to be met during the period to which the service agreement relates.
3. The content and process for the preparation of this service agreement is consistent with the requirements of the *Hospital and Health Boards Act 2011*. Key elements of this service agreement include the hospital, health and other services to be provided by the HHS; funding provided to the HHS for the provision of these services; key performance indicators and other obligations of the parties.
4. Fundamental to the success of this agreement is a strong collaboration between the HHS and its Board and the Department of Health. This collaboration is supported through the relationship management group whose members comprise representatives from both the HHS and the Department of Health and which provides the routine forum within which a range of aspects of HHS (and system wide) performance are discussed and jointly addressed.

2. Interpretation

Unless expressed to the contrary, in this service agreement:

- (a) words in the singular include the plural and vice versa
- (b) any gender includes the other genders
- (c) if a word or phrase is defined its other grammatical forms have corresponding meanings
- (d) “includes” and “including” are not terms of limitation
- (e) no rule of construction will apply to a clause to the disadvantage of a party merely because that party put forward the clause or would otherwise benefit from it
- (f) a reference to:
 - (i) a party is a reference to a party to this service agreement
 - (ii) a person includes a partnership, joint venture, unincorporated association, corporation and a government or statutory body or authority
 - (iii) a person includes the person’s legal personal representatives, successors, assigns and persons substituted by novation
- (g) any legislation includes subordinate legislation under it and includes that legislation and subordinate legislation as modified or replaced
- (h) a reference to a role, function or organisational unit is deemed to transfer to an equivalent successor role, function or organisational unit in the event of organisational change or restructure in either party.

- (i) an obligation includes a warranty or representation and a reference to a failure to comply with an obligation includes a breach of warranty or representation
- (j) headings do not affect the interpretation of this service agreement
- (k) unless the contrary intention appears, a reference to a schedule, annexure or attachment is a reference to a schedule, annexure or attachment to this service agreement
- (l) unless the contrary intention appears, words in the service agreement that are defined in schedule 5 'Definitions' have the meaning given to them in that schedule.

3. Legislative and Regulatory Framework

1. This service agreement is regulated by the National Health Reform Agreement and the provisions of the *Hospital and Health Boards Act 2011*.
2. The National Health Reform Agreement (NHRA) requires the State of Queensland to establish service agreements with each HHS for the purchasing of health services and to implement a performance and accountability framework including processes for remediation of poor performance. The *Hospital and Health Boards Act 2011* states under section 35(3) that the service agreement executed between the Chief Executive and the Hospital and Health Board Chair binds each of them.
3. The *Hospital and Health Boards Act 2011* states that it recognises and gives effect to the principles and objectives of the national health system agreed by the Commonwealth, State and Territory governments, including the Medicare principles and health system principles set out in section 4. Section 5 of the *Hospital and Health Boards Act 2011* states that the object of the Act is to establish a public sector health system that delivers high-quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system. This service agreement is an integral part of implementing these objectives and principles.

4. Context

1. Ensuring the provision of public health services across Queensland requires clear priorities, supportive leadership and staff who work together and across each level of the health system.
2. The priorities for the Queensland public sector health system are defined in the *Department of Health Strategic Plan 2014-2018* and in the Statement of Government Health Priorities.
3. In accordance with section 9 of the Financial and Performance Management Standard 2009, HHSs are required to develop a strategic plan. The HHS's strategic plan will reflect local priorities and will be developed considering the shared Queensland priorities outlined in the *Department of Health Strategic Plan 2014-2018* and the Statement of Government Health Priorities.

4. In delivering health services, HHSs are required to meet the applicable conditions of the Council of Australian Government national agreements and national partnership agreements (NPAs) between the Queensland Government and the Commonwealth Government and commitments under any related implementation plans.
5. This service agreement is underpinned by and is to be managed in line with the following supporting documents:
 - (a) Investment Environment 2015/16
 - (b) Hospital and Health Services Performance Management Framework
 - (c) Health Funding Principles and Guidelines 2015/16

5. Objectives of the agreement

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

6. Scope

1. This service agreement outlines the services that the Department of Health will purchase from the HHS during the 2015/16 financial year.
2. This service agreement does not cover the provision of clinical and non-clinical services by the Department of Health to the HHS. Separate arrangements will be established for those services provided by the Health Support Queensland (HSQ) and the Health Services Information Agency (HSIA).

7. Performance Management Framework

1. The *Hospital and Health Service Performance Management Framework* (the Performance Management Framework) sets out the systems and processes that the Department of Health will employ to fulfil its responsibility as the overall manager of public health system performance. These processes include, but are not limited to, assessing and monitoring HHS performance and, as required, intervening to manage identified performance issues.
2. The Performance Management Framework defines the in-year service agreement management rules for financial adjustments.

- The key performance indicators (KPIs) against which the HHS's performance under the Performance Management Framework will be measured are detailed in schedule 3 of this service agreement.

8. Period of this Service Agreement

- This service agreement commences on 1 July 2013 and expires on 30 June 2016. 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.
- In this service agreement, references to years are references to the period commencing on 1 July and ending on 30 June unless otherwise stated.
- Using the provisions of the *Hospital and Health Boards Act 2011* as a guide, the parties will enter into negotiations to finalise funding and purchased activity for the outer years six months before the end of the preceding year.
- 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

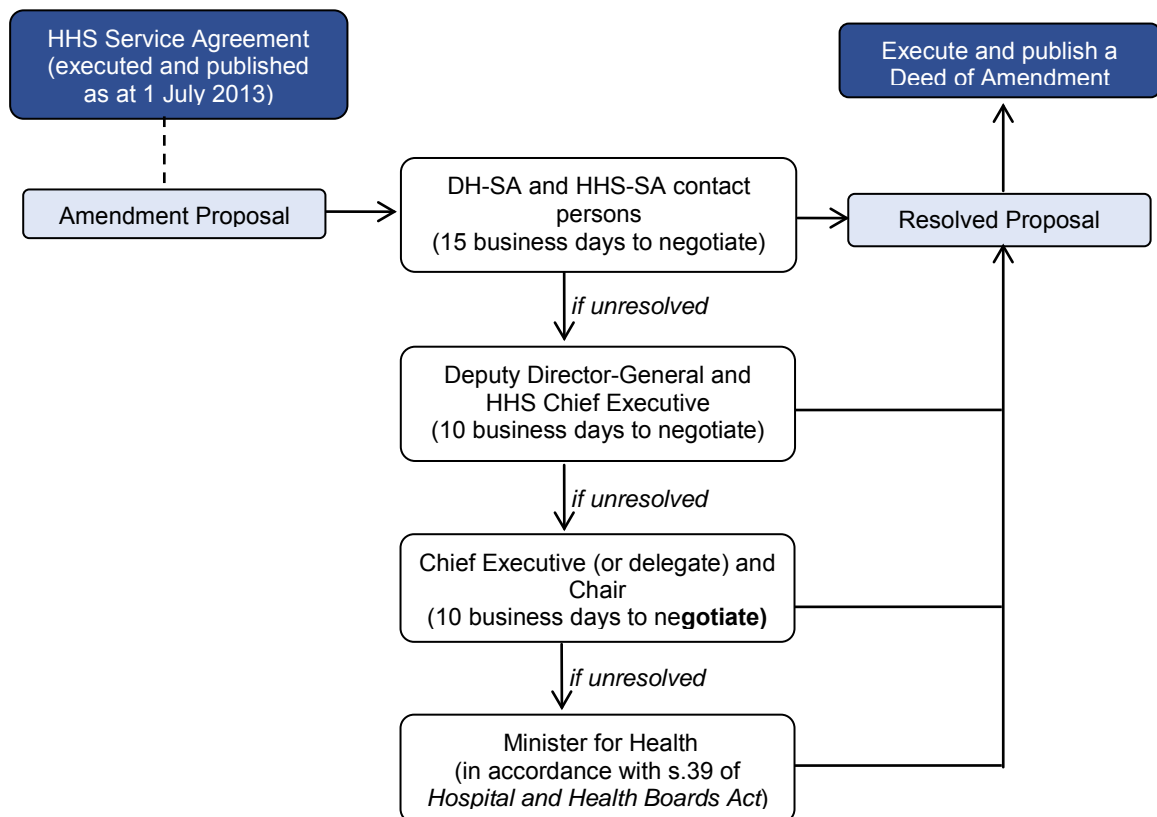
- Section 39 of the *Hospital and Health Boards Act 2011* requires that, if the Chief Executive or the HHS want to amend the terms of a service agreement, the party wishing to amend the agreement must give written notice of the proposed amendment to the other party (amendment proposal).
- In order for the Department of Health to manage amendments across all HHS service agreements and their effect on the delivery of public health services in Queensland, amendment proposals will be negotiated and finalised during set periods of time during the year (amendment windows). The parties recognise two types of amendments to the service agreement:
 - an amendment to the service agreement that only affects the value and/or purchased activity levels
 - other amendments to the service agreement (e.g. a variation to the content of schedule 1).
- While a party may submit an amendment proposal at any time, negotiation will only commence at the dates below for each amendment window:

Table 1 Amendment Proposal Exchange Dates

Year	Amendment window number	Amendments to service agreement value and/or purchased activity	Other amendments
2015/16	Amendment window 1	25 September 2015	25 September 2015
	Amendment window 2	5 February 2016	Not applicable
	Amendment window 3	27 May 2016	27 May 2016

4. An amendment proposal is made by:
 - the Chief Executive or responsible Deputy Director-General signing and providing an amendment proposal to the Hospital and Health Service – Service Agreement (HHS-SA) contact person prior to the commencement of any amendment window
 - the Health Service Chief Executive signing and providing an amendment proposal to the Department of Health Service Agreement (DH-SA) contact person prior to the commencement of any amendment window.
5. Subject to the terms of this agreement, any requests for amendment made outside these periods are not an amendment proposal for the purposes of this agreement and need not be considered by the other party until the next window. A party giving an amendment proposal must provide the other party with the following information:
 - (a) the reasons for the proposed amendment
 - (b) the precise drafting for the proposed amendment
 - (c) any information and documents relevant to the proposed amendment
 - (d) details and explanation of any financial, activity or service delivery impact of the amendment.
6. Negotiation and resolution of amendment proposals will be through a tiered process commencing with the DH-SA and HHS-SA contact person and culminating if required with the Minister for Health, as illustrated in figure 1.

Figure 1 Amendment Proposal Negotiation Resolution



7. If the Chief Executive considers that an amendment proposal (whether made by the Deputy Director-General or a Health Service Chief Executive) relates to an

urgent matter, the Chief Executive (or delegate) may reduce the negotiation period.

8. The in-year service agreement management rules for financial adjustments detailed in the Performance Management Framework describe the occasions when financial adjustments will be made as a result of variation in activity. Financial adjustments will be confirmed through the relationship management group which will take account of any relevant matters identified in the analysis/reviews conducted. Financial adjustments will be set out in a deed of amendment or may be determined in any manner set out in a deed of amendment. End of year technical adjustments may be determined after the financial year end in the manner set out in the deed of amendment (without the requirement for a further deed of amendment). This provision will survive expiration of this service agreement.
9. If the Chief Executive at any time:
 - (a) considers that an amendment agreed with the HHS may or will have associated impacts on other HHSs
 - or
 - (b) considers it appropriate for any other reasonsthen the Chief Executive may:
 - (a) propose further amendments to any HHS affected
 - and
 - (b) may address the amendment and/or associated impacts of the amendment in other ways, including through the exercise of any statutory powers and/or statutory directions under the *Hospital and Health Boards Act 2011*.
10. Amendment proposals that are resolved will be documented in a deed of amendment to this service agreement and executed by the Chief Executive and the Chair.
11. Only upon execution of a deed of amendment by both the Chief Executive and the Chair will the amendments documented by that deed be deemed to be an amendment to this agreement.

10. Publication of Amendments

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

11. Cessation of Service Delivery

1. The HHS is required to deliver the services outlined in schedule 1 of this service agreement for which funding is provided in schedule 2. Any changes to service delivery must ensure maintenance of care and minimise disruptions to patients.
2. The Department of Health and HHS may terminate or temporarily suspend a service by mutual agreement having regard to the following obligations:

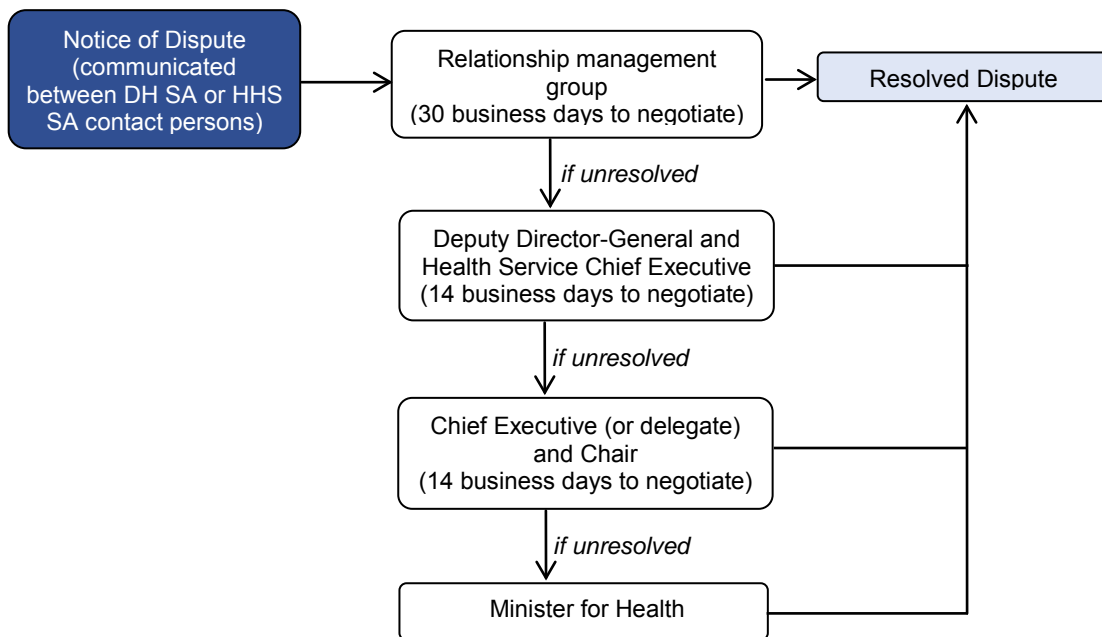
- any proposed service termination or suspension must be made in writing to the other party
 - where it is proposed to terminate or temporarily suspend a service that is provided on a statewide or hosted basis, the HHSs which are in receipt of that service must also be consulted
 - the parties agree a notice period following which termination, or temporary suspension, will take effect
 - patient needs, workforce implications, relevant government policy and HHS sustainability are to be considered.
3. The Department of Health, in its role as statewide health system manager:
 - may not support the termination or temporary suspension and request the HHS to maintain the service
 - will reallocate existing funding and activity for the terminated or temporarily suspended service inclusive of baseline service agreement funding and in-year growth funding on a pro-rata basis.
 4. The HHS will:
 - work with the Department of Health to ensure continuity of care and a smooth transfer of the service to an alternative provider where this is necessary
 - minimise any risk or inconvenience to patients associated with service termination, temporary suspension or transfer.
 5. In the event that a sustainable alternative provider, cannot be identified and this is required, the service and associated patient cohort will continue to remain the responsibility of the HHS.

12. Dispute Resolution

1. The dispute resolution process set out below is designed to resolve disputes which may arise between the parties to this service agreement in a final and binding manner.
2. These procedures and any disputes addressed or to be addressed by them are subject to the provisions of the *Hospital and Health Boards Act 2011*, including in respect of any directions issued under that legislation or by Government in respect of any dispute.
3. Resolution of disputes will be through a tiered process commencing with the relationship management group and culminating, if required, with the Minister for Health, as illustrated in figure 2. Use of the dispute resolution process set out in this section should only occur following the best endeavours of both parties to agree a resolution to an issue at the local level. The dispute resolution process is not intended for the resolution of ongoing issues or performance related issues. At each stage of the dispute resolution process, the parties agree to cooperate.
4. Other than disputes about amendments to this service agreement (which are addressed under the heading “Amendments to this Service Agreement” above), if a dispute arises in connection with this service agreement (including in respect of interpretation of the terms of this service agreement), then either party may give the other a written notice of dispute.

5. The notice of dispute must be provided to the DH-SA contact person if the notice of dispute is being given by the HHS and to the HHS-SA contact person if the notice of dispute is being given by the Department of Health.
6. The notice of dispute must contain the following information:
 - (a) a summary of the matter in dispute
 - (b) an explanation of how the party giving the notice of dispute believes the dispute should be resolved and reasons to support that belief
 - (c) any information or documents to support the notice of dispute
 - (d) a definition and explanation of any financial or service delivery impact of the dispute.

Figure 2 Dispute Resolution Process



12.1 Resolution of a Dispute

1. Resolution of a dispute at any level is final. The resolution of the dispute is binding on the parties, but does not set a precedent to be adopted in similar disputes between other parties.
2. The parties agree that each dispute (including the existence and contents of each notice of dispute) and any exchange of information or documents between the parties in connection with the disputes 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.

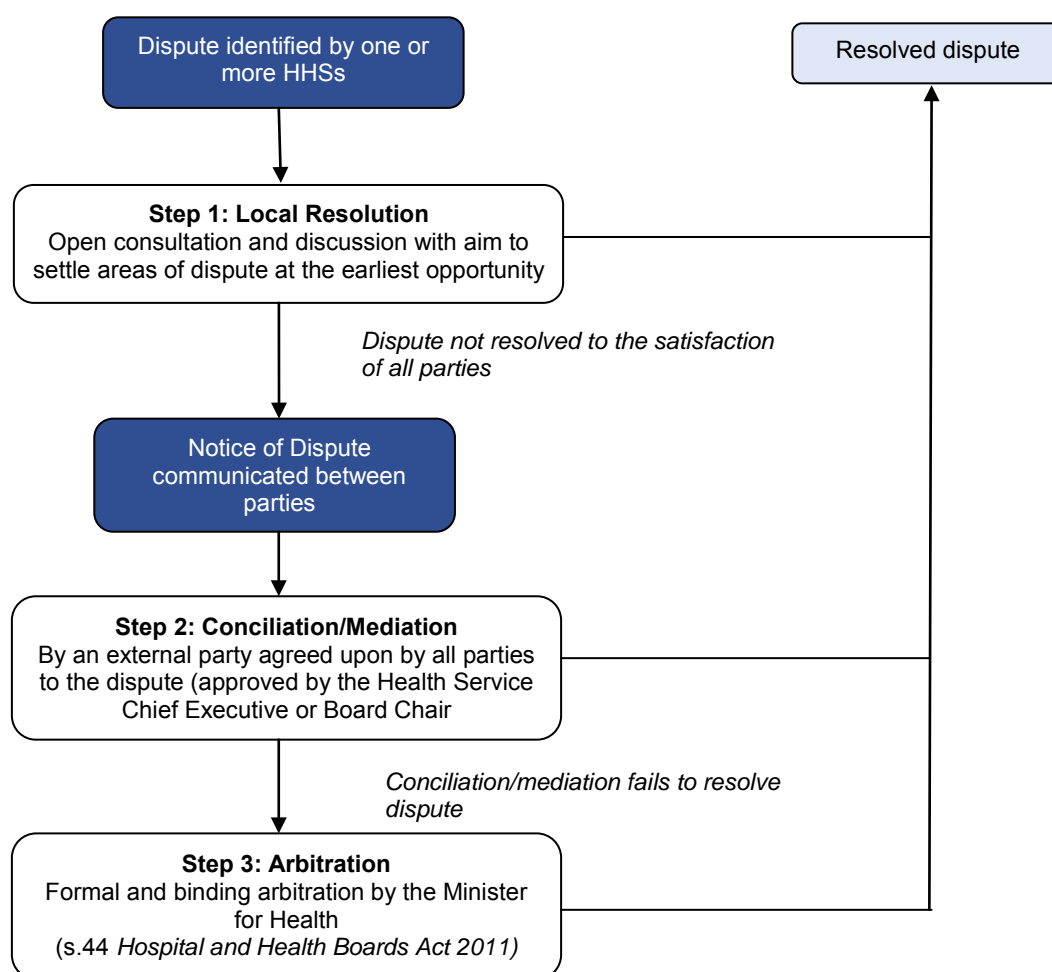
12.2 Continued Performance

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

12.3 Disputes arising between Hospital and Health Services

1. In the event of a dispute arising between two or more HHSs (an inter-HHS dispute), the process set out in figure 3 will be initiated. Resolution of inter-HHS disputes will be through a tiered process, commencing with local resolution and culminating if required with formal and binding arbitration by the Minister for Health under the provisions of the *Hospital and Health Boards Act 2011*, section 44.
2. If the HHS wishes to escalate a dispute that HHS will be expected to demonstrate that best endeavours (including Chair and Board involvement) to resolve the dispute between all parties at an informal and local level have taken place.
3. Management of inter-HHS relationships should be informed by the following principles:
 - HHSs should maintain (for both the base level of funding and growth) the proportion of out of HHS work undertaken unless as a result of agreed repatriation of patients.
 - All HHSs manage patients from their own catchment population if it is within their clinical capability to do so as specified by the Clinical Services Capability Framework (CSCF) v3.2
 - Where it is proposed that a service move from one HHS to another agreement between the respective Health Service Chief Executives will be secured prior to any change in patient flows. Once agreed, funding should follow the patient.
 - All HHSs abide by the agreed dispute resolution process.
 - All HHSs operate in a manner which is consistent with the health system principles and objectives as set out in the National Health Reform Agreement and the *Hospital and Health Boards Act 2011*.

Figure 3 Inter-HHS Dispute Resolution Process



13. Force Majeure

1. If a party (affected party) is prevented or hindered by force majeure from fully or partly complying with any obligation under this agreement, that obligation may (subject to the terms of this force majeure clause) be suspended, provided that if the affected party wishes to claim the benefit of this force majeure clause, it must:
 - (a) give prompt written notice of the force majeure to the other party of:
 - (i) the occurrence and nature of the force majeure
 - (ii) the anticipated duration of the force majeure
 - (iii) the effect the force majeure has had (if any) and the likely effect the force majeure will have on the performance of the affected party's obligations under this agreement
 - (iv) any disaster management plan that applies to the party in respect of the force majeure
 - (b) use its best endeavours to resume fulfilling its obligations under this agreement as promptly as possible
 - (c) give written notice to the other party within five days of the cessation of the force majeure.

2. Without limiting any other powers, rights or remedies of the Chief Executive, if the affected party is the HHS and the delay caused by the force majeure continues for more than 14 days from the date that the Chief Executive determines that the force majeure commenced, the Chief Executive may give directions to the HHS regarding the HHS's performance or non-performance of this agreement during the force majeure and the HHS must comply with that direction.
3. Neither party may terminate this agreement due to a force majeure event.

14. Hospital and Health Service Accountabilities

1. Without limiting any other obligations of the HHS, it must comply with:
 - the terms of this service agreement
 - all legislation applicable to the HHS, including the *Hospital and Health Boards Act 2011*
 - all Cabinet decisions applicable to the HHS
 - all Ministerial directives applicable to the HHS
 - all agreements entered into between the Queensland and Commonwealth governments applicable to the HHS
 - all regulations made under the *Hospital and Health Boards Act 2011*
 - all health services directives applicable to the HHS.
2. The HHS must ensure that:
 - All persons (including off site reporting radiologists) who provide a clinical service for which there is a national or Queensland legal requirement for registration, have current registration and only practise within the scope of that registration.
 - All persons who provide a clinical service, and who fall within the scope of current credentialing policies (i.e. including medical, dental, nursing, midwifery and allied health), have a current scope of clinical practice and practise within that scope of clinical practice (which includes practising within their registration conditions and within the scope of the Clinical Services Capability Framework (CSCF) of the facility/s at which the service is provided).
 - All facilities have undertaken a baseline self-assessment in September 2014 against the CSCF.
 - The Department of Health is notified when a change to the 2014 CSCF self-assessment occurs through the notification process established by the Patient Safety Unit.
 - Agree to implement processes for access to specialist surgical and medical services in line with Clinical Prioritisation Criteria (CPC), where these are in place, in order to improve equity of access to specialist services. A progressive implementation program for CPC will commence from 1 July 2015.
 - The obligations regarding the payment and planning for blood and blood products and best practice as set out under the National Blood Agreement are fulfilled for the facilities for which funding is provided.

- The facilities and services outlined in schedule 1 'Hospital and Health Service Profile', for which funding is provided in schedule 2 'Purchased Activity and Funding' continue to be provided.
3. Through accepting the funding levels defined in schedule 2 'Purchased Activity and Funding', the HHS accepts responsibility for the delivery of the associated programs and reporting requirements to State and Commonwealth bodies as defined by the Department of Health.

14.1 Accreditation

1. All Queensland public hospitals, day procedure services and health care centres (howsoever titled) managed within the framework of HHSs are to maintain accreditation under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme.
2. Accreditation will be against the ten clinical National Safety and Quality Health Service (NSQHS) Standards and will include any other standards offered by the accrediting agency, engaged by the HHS.
3. Accreditation of residential aged care facilities by the Australian Aged Care Quality Agency will continue.
4. General practices owned or managed by the HHS are to be externally accredited. Accreditation of general practices will be in accordance with the current edition of the Royal Australian College of General Practitioners (RACGP) published accreditation standards.
5. Mental health services must maintain accreditation against the NSQHS Standards and the National Standards for Mental Health Services.
6. For the purpose of accreditation, the performance of the HHS against the NSQHS Standards can only be assessed by accrediting agencies that are approved by the Australian Commission on Safety and Quality in Healthcare (ACSQHC).
7. The HHS will select their accrediting agency from among the approved agencies. A list of approved accrediting agencies is available from the ACSQHC website at www.safetyandquality.gov.au.
8. Following an accreditation event the HHS will provide to the Senior Director, Patient Safety Unit:
 - a copy of the 'not met' report within two days of receipt by the HHS
 - the accreditation report within seven days of receipt by the HHS, providing no significant patient risks have been identified (see below for Significant Patient Risk); and
 - immediate advice should any requirement of a rectification period after the accreditation event not be met resulting in the facility not being accredited.
9. If a HHS does not meet accreditation requirements at a mid-cycle survey or full survey, the HHS has 90 days to address any core not met actions.
10. The award recognising that the HHS has met the NSQHS Standards will be issued for a period of up to four years.

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

14.1.1 Significant Patient Risk

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

14.1.2 Non accreditation

1. After the period to address not met actions, the accrediting agency will review any not met actions and informally notify the HHS if they have met the requirements, in which case no further action is required.
2. If the HHS has not met accreditation requirements after the 90 day period, the accrediting agency and the HHS will inform the Senior Director, Patient Safety Unit within two business days. The Patient Safety Unit will discuss any serious risks at the HHSs Relationship Management Group meeting. If issues remain unresolved, the Department of Health responsive regulatory process will be activated.

14.1.3 Responsive Regulatory Process

1. A responsive regulatory process is utilised in the following circumstances:
 - where a significant patient safety risk is identified by a certified accrediting agency during a mid-cycle or full survey against the NSQHS Standards
 - where a HHS has failed to address 'not met' core actions of the NSQHS Standards within specified timeframes.
2. An initial regulatory response will begin with a process of verifying the scope, scale and implications of the reported issues, review of documentation, and may include one or more site visits.
3. The Senior Director, Patient Safety Unit will provide to the Patient Safety Board for review, the action plan agreed between the HHS and the accrediting agency using the regulatory process. The Patient Safety Board will escalate any significant patient safety issues to the Health Commissioning Board.

4. The regulatory process may include one or a combination of the following actions:
 - seek further information from a HHS
 - request a progress report for the implementation of an action plan
 - escalate non-compliance to the Health Commissioning Board
 - provide advice, information on options or strategies that could be used to address the non-met actions within a designated time frame
 - connect the hospital to other hospitals that have addressed similar deficits or have exemplar practice in this area.
5. In the case of serious or persistent non-compliance and where required action is not taken by the HHS, the response may be gradually escalated. The Health Commissioning Board may undertake one or a combination of the following actions:
 - restrict specified practices/activities in areas/units or services of the HHS where the NSQHS Standards have not been met
 - suspend particular services at the HHS until the area/s of concern are resolved
 - suspend all service delivery at a facility within an HHS for a period of time.

14.2 Provision of clinical products/consumables in outpatient settings

1. Upon discharge as an inpatient or outpatient, and where products/consumables are provided free of charge or at a subsidised charge, the treating HHS shall bear the initial costs of products/consumables provided to the patient/consumer as part of their care. These costs shall be met by the treating HHS for a sufficient period of time to ensure the patient/consumer incurs no disruption to their access to the clinically prescribed clinical products/consumables.
2. Unless otherwise determined by the HHS providing the clinical products/consumables, ongoing direct costs (beyond an initial period following discharge as an inpatient) of the provided products/consumables shall be borne by the residential HHS of the outpatient/consumer.
3. Where guidelines exist (e.g. Guideline for Compression Garments for Adults with Malignancy Related Lymphoedema: Eligibility, Supply and Costing and Guideline for Home Enteral Nutrition Services for Outpatients: Eligibility, Supply and Costing), standardised eligibility criteria and charges should apply.
4. Where a patient is supplied with medicines on discharge, or consequent to an outpatient appointment, that are being introduced to a patient's treatment, the following rules should apply:
 - the treating HHS shall provide prescription(s) for an adequate initial supply. this shall comprise:
 - (i) for medicines reimbursable under the Pharmaceutical Benefits Scheme (PBS), including the Section 100 Highly Specialised Drugs Program – the quantity that has been clinically-appropriately prescribed or the maximum PBS supply, whichever is the lesser

- (ii) or non-reimbursable medicines, one month's supply or a complete course of treatment, whichever is the lesser.
- 5. For medicines that are non-reimbursable under the PBS, and which are not included in the Queensland Health List of Approved Medicines (LAM), the residential HHS shall be responsible for ongoing supply, provided that the treating HHS has provided the residential HHS with documentary evidence of the gatekeeping approval at the treating HHS for the non-LAM medicine.
- 6. For non-reimbursable medicines listed on the LAM for the condition being treated, the residential HHS is responsible for ongoing supplies.
- 7. PBS-reimbursable prescriptions issued by a public hospital may be dispensed at any other public hospital that has the ability to claim reimbursement. Patients may, in accordance with hospital policy, be encouraged to have their PBS prescriptions dispensed at a private pharmacy of their choice.

14.3 Land, Buildings and Maintenance

- 1. The HHS will ensure building and infrastructure assets are managed in accordance with the specifications of any relevant transfer notices published as a gazette notice by the Minister for Health under section 273A of the *Hospital and Health Boards Act 2011*.
- 2. The service agreement includes funding provision for regular maintenance of buildings and infrastructure. The Department of Health has determined that a sustainable budget allocation for annual maintenance expenditure is 2.15% of the undepreciated asset replacement value of the building portfolio (or the nominated percentage in the approved Annual Maintenance Plan).
- 3. The HHS will proactively address the recommendations within the final Asset Management Capability Assessment report within a two year timeframe or as mutually agreed.
- 4. The HHS will be pro-active in its asset planning, management and maintenance, and will provide support for the adopted maintenance budget allocation through appropriate maintenance and risk mitigation strategies for buildings and infrastructure.
- 5. For land, buildings and parts of buildings where the Department of Health is, or is intended to be, the exclusive occupier under specific occupancy or ground leases implemented pursuant to clauses 1.7 (c) and 1.8 respectively (where applicable) of a Transfer Notice, the Department of Health is deemed to be in control of that land, building or part of a building for the purpose of work health and safety law.
- 6. Nothing in clause 13.3.5, above:
 - a) removes any work health and safety responsibilities shared with another party or parties in accordance with work health and safety law; or
 - b) limits the arrangements for the provision of work health and safety services provided in clause 13.4.

14.4 Occupational Health and Safety

1. The HHS, whether prescribed or not prescribed as an employer, will continue to provide occupational health and safety practitioner services to all workers (for Queensland Health) working within the geographic boundary of the HHS, unless other arrangements are agreed in writing by the Department of Health and the HHS. This includes safety arrangements for emergency and evacuation management, employee incident investigation, workers compensation, rehabilitation and reporting.
2. The HHS shall implement and maintain a health and safety system which conforms to a recognised health and safety standard, such as *AS4801 Occupational Health and Safety Management System* or an equivalent standard as agreed by the Chief Executive.
3. The HHS will monitor health and safety performance, and shall provide to the Chief Executive reports of a type, and at the intervals, agreed between the Parties, or as reasonably specified by the Chief Executive.
4. The Chief Executive will monitor health and safety performance at the system level. Where significant health and safety risks are identified, or performance against targets is identified as being outside tolerable levels, the Chief Executive may request further information from the HHS to address the issue(s) and/or make recommendations for action.

14.5 Workforce Management

1. For HHSs which are not prescribed as employers, health service employees (excluding persons appointed as a Health Executive and contracted senior health service employees) are employees of the Chief Executive as provided for in the *Hospital and Health Boards Act 2011*. Where the HHS is not prescribed as an employer, the Chief Executive will provide health service employees to perform work for the HHS.
2. Subject to a delegation by the Chief Executive under section 46 of the Act, the HHS is responsible for the day-to-day management (the HR management functions) of the Health Service Employees provided by the Chief Executive to perform work for the HHS under this agreement.
3. The HHS will exercise its decision-making power in relation to all HR management functions which may be delegated to it by the Chief Executive under section 46 of the Act, in respect of the Health Service Employees, in a lawful and reasonable manner and with due diligence, and in accordance with:
 - terms and conditions of employment specified by the Department of Health in accordance with section 66 of the *Hospital and Health Boards Act 2011*
 - health service directives, issued by the Chief Executive under section 47 of the *Hospital and Health Boards Act 2011*
 - health employment directives, issued by the Chief Executive under section 51A of the *Hospital and Health Boards Act 2011*
 - any policy document that applies to the health service employee
 - any Industrial Instrument that applies to the health service employee

- the relevant HR delegations manual
 - any other relevant legislation.
4. This includes but is not limited to ensuring Health Service Employees are suitably qualified to perform their required functions.
 5. Where the HHS is prescribed as an employer, the HHS will be the employer of the health service employees working for the HHS, and will manage its employees in accordance with section 66 of the *Hospital and Health Boards Act 2011* and applicable health service directives and health employment directives.
 6. Persons appointed in a HHS as a health executive or contracted senior health service employees are employees of the HHS, regardless of whether the HHS is prescribed as an employer or not as per section 20 of the *Hospital and Health Boards Act 2011*.
 7. All HHSs shall provide to the Chief Executive human resource, workforce, and health and safety reports of a type, and at the intervals, agreed between the Parties, or as reasonably specified by the Chief Executive.

14.6 Provision of Data to the Chief Executive

The HHS will provide to the Chief Executive the performance data and other data, including data pursuant to ad hoc requests, set out in schedule 4 'Data Reporting Requirements' in accordance with the schedule, including in relation to the form, manner and the times required for the provision of data.

15. Department of Health Accountabilities

1. Without limiting any other obligations of the Department of Health, it must comply with:
 - the terms of this service agreement
 - the legislative requirements as set out within the *Hospital and Health Boards Act 2011*
 - all regulations made under the Hospital and Health Boards Act 2011
 - all Cabinet decisions applicable to the Department of Health.
2. The Department of Health will work in collaboration with HHSs to ensure the public health system delivers high quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system. In support of realising this objective, in accordance with section 5 of the *Hospital and Health Boards Act 2011* the Department of Health will:
 - provide state-wide health system management including health system planning coordination and standard setting
 - provide the HHS with funding specified under schedule 2 of this service agreement
 - provide and maintain payroll and rostering systems to the HHS unless agreed otherwise between the parties

- operate 13 HEALTH as a first point of contact for health advice with timely HHS advice and information where appropriate to local issues
 - balance the benefits of the local and system-wide approach.
3. The Department of Health will endeavour to purchase services in line with CPC, where these are in place, in order to improve equity of access and reflect the scope of publicly funded services. A progressive implementation program for CPC will commence from July 2015.

15.1 Workforce Management

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

- perform work for the HHS for the purpose of enabling the HHS to perform its functions and exercise powers under the Act
- ensure delivery of the services prescribed in the service agreement between the Chief Executive and the HHS.

16. Indemnity

1. The HHS indemnifies the Department of Health against all and any liabilities, claims, actions, demands, costs and expenses made by any person which may be brought against or made upon or incurred by the Department of Health arising directly or indirectly from or in connection with any of the following:
- (a) any wilful, unlawful or negligent act or omission of the HHS or an officer, employee or agent of the HHS in the course of the performance or attempted or purported performance of this agreement
 - (b) any penalty imposed for breach of any applicable law in relation to the HHS's performance of this agreement
 - (c) a breach of this agreement
 - (d) except to the extent that any act or omission by the Department of Health caused or contributed to the liability, claim, action, demand, cost or expense.
2. For employees employed by the Chief Executive, the Chief Executive (or delegate) will provide indemnity for Health Service Employees working in and for the HHS seeking indemnity in accordance with:
- Indemnity for Queensland Health Medical Practitioners HR Policy I2
 - *Queensland Government Indemnity Guideline*
- as amended from time to time.
3. The indemnity referred to in this clause will survive the expiration or termination of this agreement.

17. Legal Proceedings

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

- (a) is transferred to a HHS under section 307 of the *Hospital and Health Boards Act 2011*
- (b) is otherwise retained by the Department of Health

each party must (at its own cost):

- (a) do all things
- (b) execute such documents
- (c) share such information

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

18. Execution

1. The terms of this service agreement were agreed under the provisions set out in the *Hospital and Health Boards Act 2011*, section 35 on 28 June 2013, and were subsequently amended by the deeds of amendment entered into pursuant to section 39 of the *Hospital and Health Boards Act 2011* and executed on:
 - 29 October 2013
 - 30 January 2014
 - 29 April 2014
 - 6 August 2014
 - 12 August 2014
 - 4 December 2014
 - 1 May 2015; and
 - XX YY 2015
2. This revised service agreement consolidates amendments arising from 2013/14 amendment windows one, two, three and four and 2014/15 amendment windows one, two and three.
3. Execution source documents are available on the service agreement website www.health.qld.gov.au/system-governance/health-system/managing/default.asp

Schedule 1

Hospital and Health Service Profile

1. Purpose

This schedule provides an overview of Central Queensland HHS; and sets out:

- the services
- the teaching training and research responsibilities
- the hosted services

which the HHS is required to provide throughout the period of this service agreement and which are funded through schedule 2 (Purchased Activity and Funding) of this service agreement.

2. Hospital and Health Service Overview

1. The HHS is responsible for the area assigned under the Hospital and Health Boards Regulation 2012. The Central Queensland HHS covers an area of 114,000 square kilometres in regional Queensland, extending from Miriam Vale in the south, inland to the Central Highlands and north along the Capricorn Coast.
2. The HHS services a resident population of just over 221,978¹ and includes the regional centres of Rockhampton and Gladstone. Rockhampton Hospital is the main referral hospital for the HHS providing secondary level care, with referral to Brisbane for tertiary services.
3. The population is culturally diverse and is dispersed over a wide and largely rural geographical area. The HHS is home to an increasing refugee population and a growing non-resident population associated with the mining industry.
4. Indigenous Australians make up 2.5% of the HHS population, which is 7.1% of Queensland's total Indigenous Population.
5. A project to expand Rockhampton Hospital is underway at a cost of \$244 million. Part of this development includes a Regional Cancer Care Centre on the Rockhampton Hospital site which is scheduled to be completed in June 2014.

¹ Source: Population Projections (Medium Series) by Age and Sex for Health Service Districts (HHS), Queensland (based on 2006 census figures; ASGC 2011, released April 2012)

3. Services and Facilities

3.1 Facilities

1. The HHS has six hospital facilities:
 - Biloela Hospital
 - Capricorn Coast Hospital (Yeppoon)
 - Emerald Hospital
 - Gladstone Hospital
 - Moura Hospital
 - Rockhampton Hospital.
2. The HHS also provides services from Multi-Purpose Health Centres located at the following sites:
 - Baralaba
 - Blackwater
 - Mount Morgan
 - Springsure
 - Theodore
 - Woorabinda.
3. Outpatient clinics are operated at Gemfields, Capella and Duinga.

3.2 Services Provided

The HHS will continue to provide the following services through the facilities listed above (Note: not all facilities provide all services):

3.2.1 Inpatient Services

- Anaesthetic Services
- Breast Surgery
- Paediatric Services
- Cardiology
- Colorectal Surgery
- Critical Care
- Dental Surgery
- Dermatology
- Drug and Alcohol
- Ear, Nose and Throat
- Endocrinology
- Gastroenterology
- General Medicine
- General Surgery

- Gynaecology
- Haematology
- Head and Neck Surgery
- Immunology and Infections
- Maternity
- Medical Oncology
- Mental Health Services
- Neurology
- Neonatal Services
- Orthopaedics
- Palliative Care
- Plastic and Reconstructive Surgery
- Rehabilitation Services
- Renal
- Respiratory Medicine
- Rheumatology
- Urology
- Vascular Surgery.

3.2.2 Outpatient and Ambulatory Services

- Allied Health (including psychology, physiotherapy, occupational therapy, social work and speech pathology)
- Clinical Measurement
- Cardiology
- Dermatology
- Diabetes
- Drug and Alcohol
- Ear, Nose and Throat
- Emergency Medicine
- Endocrinology
- Gastroenterology
- General Surgery
- Genetics
- Gynaecology
- General Medicine
- Haematology
- Maternity
- Mental Health
- Neonatal
- Neurology
- Ophthalmology

- Paediatric Medicine
 - Palliative Care
 - Rehabilitation Services
 - Renal
 - Rheumatology
 - Thoracic Medicine
 - Urology.
1. The HHS will ensure that the General Practice Liaison Officer (GPLO) and Business Practice Improvement Officer (BPIO) programs are maintained in order to deliver improved access to specialist outpatient services, including through (but not limited to) their contribution to the development and implementation of statewide Clinical Prioritisation Criteria.

3.2.3 Procedures and Interventions

- Chemotherapy
- Dialysis
- Endoscopy
- Radiation Oncology.

3.2.4 State Funded Outreach Services

1. The HHS forms part of a referral network with other HHSs. Where state funded outreach services are currently provided, the HHS will deliver these services in line with the following principles:
 - historical agreements for the provision of outreach services will continue as agreed between HHSs
 - funding will remain part of the providing HHS's funding base
 - activity should be recorded at the HHS where the service is being provided
 - the Department of Health will purchase outreach activity based on the utilisation of the ABF price when outreach services are delivered in an ABF facility.
2. Where new or expanded state funded outreach services are developed the following principles will apply:
 - the Department of Health (in its function as system manager) will purchase outreach activity based on the utilisation of the ABF price when outreach services are delivered in an ABF facility
 - agreements between HHSs to purchase outreach services will be based on a cost recovery model which will ensure providing sites are not financially disadvantaged and annual increases will be consistent with the ABF model
 - any proposed expansion or commencement of outreach services will be negotiated between HHSs
 - the HHS is able to purchase the outreach service from the most appropriate provider including private providers or other HHSs. However, when a change to existing services is proposed, a transition period of at least 12 months will

- apply during which time the HHS will be required to continue to purchase outreach services from the HHS currently providing the service
- any changes to existing levels of outreach services need to be agreed to by both HHSs and any proposed realignment of funding should be communicated to the Department of Health to ensure that any necessary funding changes are actioned as part of the service agreement amendment process and/or the annual negotiation of the service agreement value
 - the activity should be recorded at the HHS where the service is being provided.
3. In the event of a disagreement regarding the continued provision of state funded outreach services:
- any proposed cessation of outreach services will be negotiated between HHSs to mitigate any potential disadvantage or risks to either HHS
 - redistribution of funding will be agreed between the HHSs and communicated to the Department of Health to action through the service agreement amendment process and/or the annual renegotiation of the service agreement value.

3.2.5 Telehealth

1. The HHS will support implementation of the Department of Health Telehealth program, including the telehealth emergency support service. The HHS will collaborate with the Department of Health, other HHSs, relevant non-government organisations and primary care stakeholders to contribute to an expanded network of telehealth services to better enable a program of scheduled and unscheduled care.
2. The HHS will ensure dedicated telehealth coordinators progress the telehealth agenda locally, driving stakeholder engagement, adoption, planning and implementation activities that will support and grow telehealth enabled services through substitution of existing face to face services and identification of new telehealth enabled models of care.
3. The HHS will ensure the Medical Telehealth Lead will collaborate with the network of HHS based Telehealth Coordinators and the Telehealth Support Unit to assist in driving promotion and adoption of telehealth across the state through intra and cross HHS clinician led engagement and change management initiatives as well as informing the development and implementation of clinical protocols and new telehealth enabled models of care.

3.2.6 Newborn Hearing Screening

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

- provide newborn hearing screening in all birthing hospitals and screening facilities
- provide where applicable, co-ordination, diagnostic audiology, family support, and childhood hearing clinic services which meet the existing screening, audiology and medical protocols available from the Healthy Hearing website

- provide data to the Healthy Hearing state-wide program in accordance with Healthy Hearing's protocols.

3.2.7 Rural and Remote Clinical Support

Darling Downs HHS will host clinical support functions on behalf of all HHSs operating rural and remote facilities as outlined in the Darling Downs service agreement.

Torres and Cape HHS will host the functions provided by the Rural and Remote Clinical Support Unit on behalf of all HHS operating rural and remote facilities as detailed in the Torres and Cape HHS service agreement.

3.2.8 Statewide Services

This section does not apply to this HHS.

3.2.9 Regional Services

The HHS has responsibility for the provision and/or coordination of the regional services listed below. It is recommended that the HHS establish a formal agreement with the recipient HHSs regarding the roles and responsibilities of regional service provision and receipt as described in the Definitions. In the event of a dispute regarding the provision of these services HHSs should refer to the clauses in this service agreement titled 'Disputes arising between Hospital and Health Services'.

1. Rockhampton Tuberculosis Control Unit

- The Rockhampton Tuberculosis Control Unit will provide the following services:
 - patient assessment and management of mycobacterial diseases
 - outpatient services onsite and clinics offsite
 - clinics as required at private health facilities, educational facilities and public areas and workplaces
 - screening services
 - BCG vaccination services.
- These services will be provided to the Central Queensland and Central West HHSs.

4. Primary Health, Community Services and Public Health

4.1 Facilities

The HHS will deliver primary health, community services and public health services in the following locations:

- Biloela
- Boyne Valley (Primary Healthcare Centre)
- Emerald

- Gladstone
- Mount Morgan
- Rockhampton.

4.2 Services Provided

A range of primary care, community services and public health services will be provided by the HHS, including:

- Aboriginal and Torres Strait Islander Health
- Aged Care
- Alcohol Tobacco and Other Drug Services
- Allied Health
- Chronic Disease Management
- Community Rehabilitation
- Health Promotion
- HIV, Hepatitis and Sexual Health
- Home and Community Care
- Hospital in the Home
- Infant and Child Health
- Maternity (including comprehensive post-natal services)
- Men's Health
- Mental Health
- Oral Health
- Palliative Care
- Post-acute Care
- Public Health
- School Health
- Sexual health promotion
- Transition Care
- Women's Health.

4.3 Public Health Services

4.3.1 Specialist Public Health Units

1. The HHS will provide public health services in line with public health related legislation and the service and reporting requirements outlined in the Public Health Practice Manual including:
 - a specialist communicable disease, epidemiology, surveillance, disease prevention and control service
 - a specialist environmental health service, which includes assessment and coordination of local responses to local environmental health risks

- undertake regulatory monitoring, enforcement and compliance activity on behalf of the Department of Health.
2. The Central Queensland Public Health Unit will also provide specialist communicable disease epidemiology and surveillance, disease prevention and control and environmental health services to Central West HHS. Central West HHS will provide accommodation and related support to those staff of the Central Queensland Public Health Unit located at Longreach.
 3. The HHS will provide data to support Queensland meeting the mandatory reporting requirements of the National Notifiable Diseases Surveillance System.

4.3.2 Public Health Event of State Significance

1. The HHS will contribute to and support investigation, prevention and control activities for communicable diseases and environmental hazards. These services include but are not limited to:
 - provision of immunisation clinics
 - contact tracing
 - provision of prophylactic medications
 - public health risk assessment
 - non-communicable disease cluster assessment.
2. The HHS will lead the investigation and response in situations where there is a risk of communicable disease transmission or environmental hazard exposure in their public hospitals.

4.3.3 Preventive Health Services

The HHS will:

- maintain delivery of risk factor prevention and early intervention programs and services targeting nutrition, physical activity, alcohol consumption, tobacco use, overweight and obesity and falls prevention
- maintain delivery of the school based youth nursing program throughout Queensland secondary schools
- promote brief interventions, lifestyle modification programs and other prevention, promotion or early intervention activities.

4.3.4 Immunisation Services

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

- national immunisation program
- opportunistic immunisation in health care facilities
- special immunisation programs
- delivery of the annual school based vaccination program. Funding for service delivery for the school based vaccination program will be provided non-recurrently by the Department of Health according to the current funding model.

4.3.5 Tuberculosis Services

1. The HHS will ensure there is no financial barrier for any person to tuberculosis diagnostic and management services, ensuring full adherence to treatment and appropriate screening in accordance with *The Strategic Plan for Control of Tuberculosis in Australia: 2011-2015 and the Tuberculosis (TB) CDNA National Guidelines for the Public Health Management of TB*.
2. The HHS will provide data to support Queensland meeting the mandatory reporting requirements of the National Notifiable Diseases Surveillance System.

4.3.6 Sexual Health and Viral Hepatitis Services

The HHS will:

- maintain or increase service delivery at the Rockhampton Sexual Health and HIV Service by suitably qualified staff in accordance with a locally endorsed and dated Health Management Protocol to support the current *Drug Therapy Protocol – Sexual Health Program Nurse (including Reproductive Health)*
- maintain or increase the service level provided by the Rockhampton Liver Clinic Service including via telehealth where appropriate
- maintain or increase the service level of Indigenous Blood Borne Viruses (BBV) and Sexually Transmitted Infections (STI) related outreach
- maintain or increase service level of BBV and STI offender related outreach
- maintain or increase service level of psychiatrist/psychologist sessions level to people impacted by BBVs and STIs
- maintain or increase level of support for the Sunshine Coast HHS based Contact Tracing Support Officer program
- maintain or increase level of support for the Wide Bay HHS based BBV and STI Coordinator program
- maintain or increase level of support for BBV and STI community based programs for at risk populations including access to relevant resources including the Needle and Syringe Program.

4.4 Cancer Screening Services

1. The HHS will:
 - maintain the existing Mobile Women's Health Service in accordance with the Procedure Manual for Authorised Pap Smear Providers and national cervical screening policy documents:
 - services to be provided across Central Queensland HHS excluding Urandangie and Tieri
 - services to be provided to Central West HHS
 - services to be provided to Wide Bay HHS – Boyne Valley only.
 - maintain the existing Healthy Women's Initiative in accordance with the Principles of Practice, Standards and Guidelines for Providers of Cervical Screening Services for Indigenous Women and national cervical screening policy documents

- provide bowel cancer screening services in accordance with the National Bowel Cancer Screening Program:
 - services to be provided across Central Queensland HHS
 - services to be provided within Central West HHS excluding the Statistical Local Area (SLA)s of Barcaldine (R) - Aramac, Boulia, and Diamantina
 - services to be provided within Mackay HHS for the SLA of Isaac (R) – Broadsound only
 - services to be provided within Wide Bay HHS for the SLA of Gladstone (R) – Miriam Vale only.
 - provide BreastScreen Queensland (BSQ) services, including screening services through Mobile Vans, in accordance with the BreastScreen Australia Accreditation Standards, the BreastScreen Queensland Standards, Policy and Protocols Manual and national policies:
 - services to be provided across Central Queensland HHS
 - services to be provided within Central West HHS excluding for the Boulia and Diamantina Statistical Local Areas.
 - continue to provide mobile breast screening services to rural and remote areas
 - allow the use of the HHS BSQ Mobile asset by other HHSs during periods where practical to maximise utilisation of BSQ Mobile fleet
 - specifically, continued utilisation of the HHS BSQ Mobile asset during down periods where practical will be required in negotiation with the Darling Downs HHS.
2. While screening schedules are ideally finalised by HHSs six months in advance, confirmation of mobile and relocatable sites is required by the BreastScreen Queensland Registry eight weeks prior to commencement at each site to ensure invitations for screening are prepared and distributed to women in the catchment area.
 3. The repair and maintenance services for the BSQ mobile service fleet will be provided by the Mobile Dental Clinic Workshop in Metro South HHS. The Mobile Dental Clinic Workshop in Metro South HHS will meet the costs for these services subject to availability of allocated funding for this purpose in any given financial year.

4.5 Oral health Services

The HHS will:

- ensure that oral health services are provided to the eligible population at no cost to the patient² and that the current range of clinical services will continue
- ensure that oral health services fulfil the relevant obligations for the National Partnership Agreement for Adult Public Dental Services

² The HHS may provide oral health services on a fee-for-service basis to non-eligible patients in rural and remote areas where private dental services are not available.

- ensure that oral health services fulfil the relevant obligations under the Medicare Child Dental Benefits Schedule and that benefits are claimed where applicable
- ensure that the repair, maintenance and relocation services to the mobile dental fleet continues to be provided by the Mobile Dental Clinic Workshop in Metro South HHS.

4.6 Offender Health Services

The HHS will:

- provide health services to prisons located within the HHS (Offender Health Service)
- provide the Department of Health with an annual report detailing the Offender Health Services which have been provided to prisons within the HHS
- where necessary, for both health and security reasons, agree for the transportation of the prisoner to a Queensland Health Secure Unit for tertiary and secondary health services
- on release of a prisoner, transfer medical records to West Moreton HHS for long term archiving. The HHS must ensure that medical records transfer with the prisoner when they are moving to another facility
- provide offenders with smoking cessation support.

4.7 Refugee Health

This section does not apply to this HHS.

5. Residential and Aged Care Facilities

The HHS will manage the following residential facilities:

- Birribi
- Eventide Home Rockhampton
- North Rockhampton Nursing Centre
- Springsure Hospital Aged Care Facility.

6. Mental Health and Alcohol and Other Drug Facilities and Services

6.1 Facilities

The HHS will provide a range of integrated mental health services and specialised alcohol and other drug services at the following locations:

- Biloela Community Mental Health Service

- Capricorn Coast Health Service Alcohol Tobacco and Other Drug Service
- Emerald Community Mental Health Service
- Eventide Rockhampton (Psychogeriatric Unit)
- Gladstone Alcohol Tobacco and Other Drug Service
- Gladstone Community Mental Health Service
- Rockhampton Adult Community Mental Health Service
- Rockhampton Alcohol Tobacco and Other Drug Service
- Rockhampton Child and Youth Community Mental Health Service
- Rockhampton Hospital
- Woorabinda Alcohol Tobacco and Other Drug Service
- Woorabinda Multi-Purpose Health Service.

6.2 Services Provided

The HHS will continue to provide the following services through the facilities listed above and in accordance with national standards, including the National Standards for Mental Health Services (2010). Note: not all facilities provide all services and some services may be provided only in a limited capacity. Some services are provided on an outreach basis across other HHS (or multiple HHS where indicated):

6.2.1 Admitted Patient Mental Health services

- Adult Acute Inpatient Services (services to Central Queensland and Central West HHSs)
- Older Persons Extended Treatment Services.

6.2.2 Community Ambulatory Mental Health Services

- 1300 Mental Health Access/Triage Services
- Acute Care Services
- Child and Youth Community Mental Health Services
- Community Care Services
- Consultation Liaison Psychiatry Services
- Ed-LinQ Program
- Evolve Therapeutic Services
- Forensic Liaison Program
- Indigenous Mental Health Services
- Mental Health Intervention Program
- Older Persons Mental Health Community Services
- Primary Care Liaison
- Prison Mental Health Service (services to Capricornia Correctional Centre)
- Rural and Remote Community Mental Health Services
- Service Integration Program.

6.2.3 Alcohol and Other Drug Services

- Alcohol Management Reform Initiative Treatment Services
- Alcohol, Tobacco and Other Drug Services
- Alcohol and Other Drug Consultation and Liaison Services
- Court Referral Treatment Services
- Inpatient Withdrawal Management and Support Service
- Needle and Syringe Program
- Non-government residential and non-residential rehabilitation services
- Opioid Treatment Programs
- Queensland Illicit Drug Diversion Initiative (QIDDI).

6.2.4 Clinical and Service Support Services

The HHS will continue to provide a range of services that support the functioning and delivery of integrated mental health services and specialised alcohol and other drug services, including:

- Consumer Companion Program
- Mental Health Act Liaison and Delegate Program (services to Central Queensland and Central West HHSs)
- Mental Health Information Management Program (services to Central Queensland and Central West HHSs)
- Pre commissioning Program for the Community Care Unit Capital Works Program.

6.2.5 Statewide services

This section does not apply to this HHS.

6.2.6 Regional Services

The HHS has responsibility for the provision and/or coordination of the following regional services. It is recommended that the HHS establish a formal agreement with the recipients of the services listed below 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 the clauses in this service agreement titled 'Disputes arising between Hospital and Health Services'.

- Court Liaison Service (services to Central Queensland and Central West HHSs).

7. Closing the Gap in Health outcomes for Aboriginal and Torres Strait Islander People

1. The *Queensland Government Aboriginal and Torres Strait Islander Health Investment Strategy 2013-16* (the Investment Strategy)(unpublished) articulates the broad, evidence-based investment priorities for services and programs aimed

at closing the health gap by 2033 and achieving sustainable health gains for Aboriginal and Torres Strait Islander people in Queensland.

2. To support the delivery of Indigenous health priorities, the HHS has been funded in schedule 2 to provide health services targeted to Aboriginal and Torres Strait Islander Queenslanders.
3. To ensure that Indigenous health commitments and goals are being met, the Department of Health will report annually against performance measures which underpin the Investment strategy. This report quantifies progress towards closing the gap in health inequality for Indigenous Queenslanders at a state-wide and HHS level.
4. The *Queensland Aboriginal and Torres Strait Islander Cardiac Health Strategy 2014-2017* (the Cardiac Strategy) has been developed to provide strategic direction in addressing disparities in cardiovascular health for Aboriginal and Torres Strait Islander people in Queensland. The HHS will develop an Aboriginal and Torres Strait Islander cardiac strategy and action plan for their region and population.
5. The Aboriginal and Torres Strait Islander Health Unit will produce reports on a six monthly basis which will measure both HHS and statewide performance against the Cardiac Strategy. This report will be provided to HHSs to allow them to track their own progress towards the goals and targets of the Cardiac Strategy.
6. More details on the specific funding and reporting requirements to address Aboriginal and Torres Strait Islander health disparities are available in the memorandum titled *2015-2016 Closing the Gap funding allocations to Central Queensland Hospital and Health Service*.

8. Teaching, Training and Research

1. The HHS will provide the teaching, training and research programs for which funding is identified within schedule 2 of this service agreement and as described below.
2. Four principles underpin the provision of teaching (generally referred to as clinical education and training) and research within and across HHSs:
 - Sustainability – Clinical education and training programs are maintained, support investment in re-entry and pre-entry clinical education, vocational training programs and assist the development of a sustainable and safe clinical workforce.
 - Consistency – Clinical education and training is managed in a consistent manner across HHSs to develop a workforce with flexible and transferable skills.
 - Efficiency – Clinical education and training programs are managed in a way that promotes the efficient use of available resources within and across HHSs.
 - Collaboration – HHSs work together to support education and training programs that provide sufficient number of appropriately trained and qualified staff to meet Queensland's clinical workforce requirements and ensure strong collaboration amongst the education, research, clinical translation and patient care programs.

8.1 Clinical Education and Training

1. The HHS will:
 - continue to support and align with the current Student Placement Deed Framework which governs clinical placements from relevant tertiary education providers in Queensland HHS facilities
 - comply with the obligations and responsibilities of Queensland Health under the Student Placement Deed, as appropriate, as operator of the facility at which the student placement is taking place
 - comply with the terms and conditions of students from Australian education providers participating in the Student Placement Deed Framework
 - only accept clinical placements of students from Australian education providers participating in the Student Placement Deed Framework
 - continue to provide training placements consistent with and proportionate to the capacity of the HHS. This includes, but is not limited to, the provision of placement for the following professional groups relevant to the HHS:
 - medical students
 - nursing and midwifery students
 - pre-entry clinical allied health students
 - interns
 - rural generalist trainees
 - vocational medical trainees
 - first year nurses and midwives
 - re-entry to professional register nursing and midwifery candidates
 - dental students
 - allied health supernumerary rural training position (generalist).
 - participate in vocational medical rotational training schemes, facilitate of the movement of vocational trainees between HHSs and work collaboratively across HHSs to support education and training program outcomes
 - report annually on the number of pre-entry clinical placements for allied health professions to the Allied Health Professions' Office of Queensland, Department of Health
 - comply with the state-wide vocational medical training pathway models including:
 - The Queensland Basic Physician Training Pathway
 - The Queensland Intensive Care Training Pathway
 - The Queensland Basic Paediatric Training Network.
 - provide clinical area placements for dietetics pre-entry students from additional funding provided through relevant agreements with Universities
2. In addition, the *Health Practitioner (Queensland Health) Certified Agreement (No 2) 2011* (the HP agreement) requires HHSs to:
 - continue to support development of allied health research capacity through continued implementation and retention of health practitioner research positions provided through the HP agreement

- support development of allied health clinical education capacity through continued implementation and retention of clinical educator positions provided through the HP agreement, continuing to provide allied health pre-entry clinical placements and maintaining support for allied health HP 3 to 4 rural development pathway positions.
3. The HHS will maintain or increase its contribution of staff to the Queensland Country Relieving doctors program and the receiving HHS will be responsible for wages, clinical governance and appropriate supervision of the junior medical relievers.

8.2 Health and Medical Research

The HHS will:

- articulate an investment strategy for research (including research targets and performance measures) which integrates with the clinical environment to improve clinical outcomes
- develop mechanisms for completing administrative governance for the approval of research in line with a national benchmark of 25 days (Standard Operating Procedures for Queensland Health Research Governance Officers, June 2013)
- develop mechanisms for monitoring site research activity in line with jurisdictional commitments and National Health and Medical Research Council Guidelines (Framework for Monitoring Guidance for the National Approach to Single Ethical Review of Multi-Centre research, January 2012)
- develop systems to capture research and development expenditure and revenue data and associated information on research.

9. Patient Travel Subsidy Scheme

The HHS will:

- implement and administer the Patient Travel Subsidy Scheme (PTSS) in accordance with the Guideline issued by the Chief Executive
- minimise unnecessary travel by patients through use of alternatives including Telehealth where available and appropriate
- administer the PTSS in a manner which elicits necessary data and information to monitor compliance with the Scheme.

Schedule 2

Purchased Activity and Funding

1. Introduction

This schedule sets out:

- the activity purchased by the Department of Health from the HHS (table 2.3)
- the funding provided for delivery of the purchased activity (table 2.3)
- specific funding commitments (table 2.2)
- the sources of funding that this service agreement is based on and the manner in which these funds will be provided to the HHS (table 2.4).

2. Delivery of Purchased Activity

1. The Department of Health and the HHS will monitor actual activity against purchased levels, taking action as necessary to ensure delivery of purchased levels. This process will be governed by the Performance Management Framework.
2. The HHS has a responsibility to actively monitor variances from purchased activity levels, and will notify the Department of Health immediately via the DH-SA contact person as soon the HHS becomes aware that activity variances are likely to exceed agreed tolerances.
3. The HHS will also notify the Department of Health of deliberate changes to the consistent recording of activity within year that would result in additional activity being recorded for existing services or activity moving between purchased activity types and levels, for example, activity moving from Inpatients to Outpatients.
4. The Department of Health may initiate a joint process with the HHS to determine whether a financial adjustment should be applied in relation to any activity target which has been breached within the relevant quarterly period.
5. Any determination regarding the application of financial adjustments for breach of activity targets will be governed by the process set out in the Performance Management Framework.
6. Where delivery of activity is above 2015/16 purchased levels, as determined in Public Queensland Weighted Activity Units (PQWAU), and a financial adjustment is applied, additional funding will be provided at 45% of the QEP.
7. Changes are to be agreed through the service agreement amendment process.

2.1 Funding where actual activity exceeds purchased activity

1. In 2015/16, the Commonwealth Government will fund 45% of 'efficient growth' in public hospital services at ABF facilities.

2. Efficient growth will be based on National Weighted Activity Units (NWAUs), and calculations will be performed by the Administrator of the National Health Funding Pool. This calculation will be performed at a statewide level, and paid to the State during the 2015/16 financial year.
3. Rather than retain this funding centrally for targeted commissioning of additional public sector health services, the Department of Health will instead provide funding direct to those HHSs that produce more public activity than was funded through the service agreement.
4. To assist with cash flow, the Department of Health will allocate efficient growth funding in-year rather than waiting until funding is receipted centrally from the Commonwealth.
5. So this can occur, PQWAUs have been established as the basis for assessing eligibility for, and allocating funding to HHSs. with ABF facilities, based on purchased PQWAUs as per the service agreement.
6. PQWAUs will cover those services that are in-scope for the national ABF model but valued, where possible, according to the Queensland ABF model.
7. PQWAUs will apply to ABF facilities only and will be calculated as follows:
 - (a) public admitted patients (including acute, sub and non-acute, mental health and admitted procedures and interventions) – calculated at full QWAU value
 - (b) private admitted patients – calculated at NWAU value, incorporating discounts in national ABF model
 - (c) public emergency department and non-admitted patients (including outpatients and non-admitted procedures and interventions) – calculated at full QWAU value.
8. The PQWAU target for the HHS is shown in table 2.1.
9. Where a HHS exceeds its PQWAU target as stated in the service agreement, it will receive an additional 45% of the Queensland ABF Price (QEP) per additional PQWAU.
10. Where a HHS is below its PQWAU target for its ABF facilities, funding will be reduced by 45% of the Queensland ABF Price or the budget cost per QWAU for that particular HHS if this is lower. Budget cost per QWAU can be calculated from the HHS Finance and Activity Schedule (table 2.3a) as follows:

(Total ABF Funding – Clinical education and training – site specific grants)/(Purchased ABF QWAUs).
11. Notwithstanding sub-paragraph 7 above:
 - (a) where a HHS is below its PQWAU target because a specifically funded initiative has not yet commenced or is operating below capacity and growth in purchased activity in year is not being delivered, funding will be reduced at 100% of the Queensland ABF Price
 - (b) where a HHS is outside its stated tolerance and is not delivering on its key performance indicators, funding will also be reduced at 100% of the Queensland ABF Price.
12. Budget adjustments will be effected to coincide with service agreement amendment windows with a final reconciliation at year end, although accruals

may be input into the general ledger during the year to better reflect likely revenue from the Commonwealth.

Table 2.1 PQWAU target 2015/2016

Service Stream	15/16 PQWAU target (PQ18)
Inpatient	26,815
Outpatient	5,379
Procedures & Interventions	3,977
Emergency Department	11,186
Sub & Non-Acute	4,173
Mental Health	3,494
TOTAL	55,025

2.2 Public and private activity/Own Source Revenue

1. In the Commonwealth funding model, private admitted services attract NWAUs but at a discounted rate compared to public admitted services. Private non-admitted services do not attract NWAUs and are out of scope for Commonwealth growth funding.
2. Where a HHS is above its OSR target in respect of private patients, it will be able to retain the additional OSR with no compensating adjustments to funding from other sources.
3. Conversely where a HHS is below its OSR target in respect of private patients, it will experience a reduction in revenue with no compensating adjustments to funding from other sources.
4. Budget adjustments for changes in OSR from private patients will be effected to coincide with service agreement amendment windows.

3. Specific Funding Commitments

1. As part of the service agreement value, the specific services, programs, and projects set out in table 2.2 have been purchased by the Department of Health from the HHS. These services will be the focus of detailed monitoring.

Table 2.2 Specific Funding Commitments

Service/Program	Funding	Activity	Timeframe	Conditions
Backlog Maintenance Remediation Program (BMRP)	\$2,336,000 \$2,336,000 \$2,336,000 \$2,336,000	0	2013/14 2014/15 2015/16 2016/17	<p>Annual BMRP allocation to address backlog maintenance identified prior to 31 December 2012 consists of:</p> <ul style="list-style-type: none"> • DoH allocation \$1,631,000 • HHS contribution \$705,000 <p>Backlog maintenance liability reduction targets are as follows:</p> <ul style="list-style-type: none"> • 2013/14 - \$2,336,000 (25%) • 2014/15 - \$4,672,000 (50%) • 2015/16 - \$7,008,000 (75%) • 2016/17 - \$9,345,000 (100%) <p>The BMRP Requirements document sets out the obligations of the HHS for the funding provided.</p> <p>BMRP expenditure is in addition to the HHS regular building maintenance activities and expenditure as demonstrated through an annual maintenance plan approved by the Chief Executive.</p>
BreastScreen	\$2,187,700	13,100 screens	2015/16	<p>Provision of breastscan services targeting women aged 50-74 years old (women 40-49 years are also eligible).</p> <p>Additional incentive funding is available pro rata for additional activity in excess of target for increased screening.</p>
Queensland Aboriginal and Torres Strait Islander Health Investment Strategy	\$764,590 \$407,460	0	2014/15 2015/16	<p>The HHS will deliver the initiatives and outcomes outlined in memorandum HQ000404, through the provision of services including:</p> <ul style="list-style-type: none"> • child and maternal health services • Indigenous hospital liaison services
Mental Health Community Care Unit (CCU)	\$2,780,458	605 WAU	2015/16	<p>Full-year recurrent funding provided based on 20 new CCU beds being fully operational.</p> <p>Should full operation be delayed, funding will be returned to the DoH from the HHS.</p> <p>This is in addition to the \$1,154,972 recurrent funding allocated in 2014/15.</p>

Service/Program	Funding	Activity	Timeframe	Conditions
Mental Health Older Persons Inpatient Unit (OPIU)	\$2,194,310	0	2015/16	Full-year recurrent funding provided based on 8 new OPIU beds being fully operational. Should full operation be delayed, funding will be returned to the DoH from the HHS.
Revitalisation of Regional, Rural and Remote Health Services	\$1,424,920	0	2015/16	Enhance rural health services specifically for screening, management and support of chronic disease, paediatric, child development, and step down rehabilitation; purchase of medical equipment for rural communities: \$725,331 Hospital in the Home <ul style="list-style-type: none"> Emerald, Blackwater, Springsure, Biloela, Baralaba, Moura, Theodore: \$349,795 Cancer Services <ul style="list-style-type: none"> Emerald, Biloela: \$349,794 Reporting requirements as defined by Service Needs, Access and Planning Branch.
Oral Health Services	\$739,806	12,755 WOOS	July to December 2015	Specific growth allocation; provided on the basis that the NPA for Adult Public Dental Services is yet to be confirmed. If confirmed this growth allocation may be replaced by an NPA allocation. Note that service items funded by Medicare under the Child Dental Benefit Schedule will not contribute towards activity targets.
Additional Activity	N/A	1410 WAU	2015/16	Funding and respective activity was provided in 2014/15 for delivery of Sub-Acute and RCC services. Where the HHSs has not delivered the negotiated level of activity, the activity shortfall for Sub-Acute and RCC services will need to be delivered in 2015/16 with no additional funding.
Additional Funding	\$2,000,000	0	2014/15	Funding was provided in 2014/15 to assist with the HHSs end of financial year position and in recognition of the HHSs significant investment in quality, safety and service improvement. Funding is contingent on the HHS not ending 2014/15 with a surplus operating position. If the HHS does end 2014/2015 with a surplus, an equivalent funding adjustment will be transacted in the next available window in 2015/16.

Service/Program	Funding	Activity	Timeframe	Conditions
\$30M outpatient reduction strategy: Reduction of Endoscopy Patients long waits	\$1,571,795	336 WAU	By 30 June 2015	HHS funding allocations through this initiative will be reviewed and evaluated in 2015/2016. Where activity targets were not met by 30 June 2015, HHSs are required to deliver the activity shortfall in 2015/2016.

2. The HHS will notify the Department of Health if the HHS forecasts an inability to achieve commitments linked to specifically allocated funding included in table 2.2.
3. Where funding has been provided for specific programs or commitments, it is at the discretion of the Department of Health to withdraw allocated funding pro rata to the level of under delivery if the program is not being delivered according to the program objective or is not being delivered in full.

4. Primary and Community Health Services

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

- The Department of Health funding for community health services. A pool of funding for these services is allocated to each HHS for a range of community health services and must be used to meet local primary and community healthcare needs including through delivery of the services identified in table 2.3b. HHSs have the discretion to allocate funding across primary and community health services according to local priorities.
- Department of Health specified funding models for consumer information services, disability, residential care, environmental health, offender health services, oral health services, home and community medical aids, primary health care, community mental health services, alcohol and other drugs services and Breast screen programs. The funding specified for these programs is listed in table 2.3b.
- Department of Health community health service grants
- Funding from other state government departments and the Commonwealth for specific programs (third party funded services).

Table 2.3a HHS Finance and Activity Schedule 2013/14 – 2015/16 – Summary

ABF

Service Stream	2013/14 Q18 QWAU	2013/14 \$ (Price: \$4562)	2014/15 (W3) Q18 QWAU	2014/15 \$ (W3) (Price: \$4558)	2015/16 Q18 QWAU	2015/16 \$ (Price: \$4597.05)	Change (14/15 to 15/16) QWAU	Change (14/15 to 15/16) \$ (Price: \$4597.05)
Inpatients	23,929	\$109,164,565	26,930	\$122,746,031	29,305	\$134,716,101	2,375	\$11,970,070
Outpatients	5,739	\$26,181,206	7,223	\$32,924,579	7,446	\$34,231,758	223	\$1,307,179
Procedures and Interventions	3,704	\$16,898,954	3,808	\$17,358,129	4,457	\$20,490,502	649	\$3,132,374
Emergency Department	9,971	\$45,485,536	9,602	\$43,766,277	11,186	\$51,423,312	1,584	\$7,657,034
Sub and Non-Acute	3,744	\$17,081,906	3,872	\$17,646,930	4,498	\$20,675,597	626	\$3,028,667
Mental Health	2,855	\$13,024,297	2,727	\$12,428,557	3,598	\$16,539,602	871	\$4,111,045
Subtotal	49,942	\$227,836,464	54,162	\$246,870,503	60,490	\$278,076,872	6,328	\$31,206,369
Clinical Education and Training	0	\$8,804,477	0	\$8,812,774	0	\$9,434,039	0	\$621,265
Specified Grants*	0	\$519,274	0	\$529,871	0	\$540,685	0	\$10,814
ABF Subsidy/(Contribution)	0	-\$1,923,116	0	\$7,268,552	0	-\$1,407,937	0	-\$8,676,489
Total ABF Funding	49,942	\$235,237,099	54,162	\$263,481,700	60,490	\$286,643,659	6,328	\$23,161,959

Non-ABF[#]

Category	2013/14 Q18 QWAU	2013/14 \$ (Price: \$4562)	2014/15 (W3) Q18 QWAU	2014/15 \$ (W3) (Price: \$4558)	2015/16 Q18 QWAU	2015/16 \$ (Price: \$4597.05)	Change (14/15 to 15/16) QWAU	Change (14/15 to 15/16) \$ (Price: \$4597.05)
NEC Block Funded Hospitals	13,277	\$68,858,734	13,302	\$71,457,416	9,356	\$51,391,379	-3,946	-\$20,066,037
Primary and Community Care	0	\$73,441,460	0	\$73,246,588	0	\$66,286,444	0	-\$6,960,144
Third Party Funded Services	0	\$29,887,321	0	\$31,652,500	0	\$31,861,487	0	\$208,987
Other Non-ABF Funding	0	\$51,934,018	0	\$47,146,407	0	\$52,812,422	0	\$5,666,015
Total Non-ABF Funding	13,277	\$224,121,533	13,302	\$223,502,911	9,356	\$202,351,733	-3,946	-\$21,151,178

Total	2013/14 Q18 QWAU	2013/14 \$ (Price: \$4562)	2014/15 (W3) Q18 QWAU	2014/15 \$ (W3) (Price: \$4558)	2015/16 Q18 QWAU	2015/16 \$ (Price: \$4597.05)	Change (14/15 to 15/16) QWAU	Change (14/15 to 15/16) \$ (Price: \$4597.05)
Grand Total	63,219	\$459,358,632	67,464	\$486,984,611	69,847	\$488,995,392	2,382	\$2,010,781

2015/16 Minor Capital/ Equity		2013/14 \$		2014/15 \$		2015/16 \$		Change (14/15 to 15/16)
Total	-	-	-	\$2,274,000	-	\$0	-	-\$2,274,000

[#] For details see Table 2.3b Other Non-ABF Funding

* For details see Table 2.3c Specified Grants

Table 2.3b HHS Finance and Activity Schedule 2013/14 – 2015/16 Non-ABF Summary

NEC Block Funded Hospitals

Category	Units	2015/16 Activity	2015/16 Baseline \$	2015/16 Growth \$	2015/16 \$
NEC Block Funded Hospitals		9,356	\$51,391,379	\$0	\$51,391,379
Subtotal		9,356	\$51,391,379	\$0	\$51,391,379

Primary and Community Healthcare Services

Category	Units	2015/16 Activity	2015/16 Baseline \$	2015/16 Growth \$	2015/16 \$
Alcohol, Tobacco and Other Drugs		0	\$3,744,243	\$0	\$3,744,243
Breastscreen	Screens	13,100	\$2,171,000	\$16,700	\$2,187,700
Community Mental Health		0	\$23,298,529	\$0	\$23,298,529
Consumer Information Services		0	\$0	\$0	\$0
Environmental Health		0	\$918,457	\$0	\$918,457
Home and Community Medical Aids and Appliances		0	\$0	\$0	\$0
Intellectual Disability Residential Care Services		0	\$3,646,829	\$0	\$3,646,829
Offender Health Services	Prisoners	601	\$2,365,730	\$1,391,008	\$3,756,738
Oral Health	WOOS	215,616	\$11,765,904	\$739,806	\$12,505,710
Other Community Services		0	\$13,775,291	\$0	\$13,775,291
Primary Health Care		0	\$2,452,947	\$0	\$2,452,947
Subtotal		-	\$64,138,930	\$2,147,514	\$66,286,444

Third Party Funded Health Services

Category	Units	2015/16 Activity	2015/16 Baseline \$	2015/16 Growth \$	2015/16 \$
Aged Care Assessment Program		0	\$736,482	\$0	\$736,482
Home and Community Care (HACC) Program		0	\$474,553	\$0	\$474,553
Community Care Programs		0	\$40,707	\$0	\$40,707
Home Care Packages		0	\$209,130	\$0	\$209,130
Multi-Purpose Health Services		0	\$3,707,508	\$0	\$3,707,508
Residential Aged Care		0	\$24,103,599	\$0	\$24,103,599
Transition Care		0	\$2,589,508	\$0	\$2,589,508
Subtotal		0	\$31,861,487	\$0	\$31,861,487

PY Services moved to ABF

Category	Units	2015/16 Activity	2015/16 Baseline \$	2015/16 Growth \$	2015/16 \$
ABF Equivalent Activity delivered by Outsourced Provider		0	\$0	\$0	\$0
IHPA Block Funded Services - TPN, HEN, HV		0	\$0	\$0	\$0
Subtotal		0	\$0	\$0	\$0

Other Non-ABF Funding

Category	Units	2015/16 Activity	2015/16 Baseline \$	2015/16 Growth \$	2015/16 \$
Commercial Activities		0	\$1,617,830	\$0	\$1,617,830
Depreciation		0	\$26,359,025	\$0	\$26,359,025
Interstate Patients		0	\$1,854,452	\$0	\$1,854,452
Patient Transport		0	\$22,603,972	\$0	\$22,603,972
Research		0	\$246,716	\$0	\$246,716
Specific Allocations		0	\$0	\$0	\$0
State-Wide Functions		0	\$130,427	\$0	\$130,427
Subtotal		0	\$52,812,422	\$0	\$52,812,422

Table 2.3c Specified Grants

Program	Funding
High Cost Outliers	\$540,685
Grand Total	\$540,685

5. Funding Sources

- The four main funding sources contributing to the HHS service agreement value are:
 - Commonwealth funding
 - State funding
 - Grants and Contributions
 - Own Source Revenue (OSR).
- Table 2.4 provides a summary of the funding sources for the HHS and mirrors the total value of the service agreement included in table 2.3a.

Table 2.4 Hospital and Health Service Funding Sources 2015/16

Funding Source	Value (\$)
State and Commonwealth - ABF Funding³	
Activity Based Funding	286,643,659
Clinical Education & Training ⁴	-9,434,039
Pool Account – ABF Funding	277,209,620
State and Commonwealth - Block Funding⁵	
Block Funding	59,646,486
Clinical Education & Training ⁴	9,434,039
State Managed Fund – Block Funding	69,080,525
Locally Received Funding	16,232,720
Locally Received Own Source Revenue	33,180,891
Department of Health Funding⁶	93,291,636
TOTAL	488,995,392

³ Pool Account - ABF Funding includes: Inpatient; Critical Care; Emergency Department; Mental Health; and Outpatient each allocated a proportion of Other ABF Adjustments.

⁴ Clinical Education and Training (CET) is classified as Teaching, Training and Research Funding under the National Model and funded as a Block Funded Service. Under the State Model, CET is included as 'Other ABF' and forms part of the 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.

⁵ State Managed Fund - Block Funding includes: CSO Facilities; Primary Care Outpatient Centres; 29% of Community Mental Health (estimate of Hospital Auspiced); Tertiary Mental Health; and Research/Training.

⁶ Department of Health Grants represents funding by the Department of Health for items not covered by the National Health Reform Agreement including such items as: Primary Health Care; Prevention, Promotion and Protection; and Depreciation.

3. State election commitments and state budget outcomes once confirmed, may lead to further modification of the funding amounts and will be actioned through an amendment process.

6. Funds Disbursement

1. The Chief Executive of the Department of Health will direct the disbursement of both State and Commonwealth funding from the State's National Health Funding Pool Sub Account and the State Managed Fund to the HHS. The service agreement and state level block payments to state managed funds from Commonwealth payments into national funding pool are stated in table 2.5.
2. However, the State (represented by the Chief Executive) will not:
 - redirect Commonwealth payments between HHSs
 - redirect Commonwealth payments between funding streams (e.g. from ABF to Block Funding)
 - adjust the payment calculations underpinning the Commonwealth's funding.
3. Payment of ABF and Block Funding to the HHS will be on a fortnightly basis.
4. Further information on the disbursement of funds is available in the supporting document Health Funding Principles and Guidelines 2015/16.

Table 2.5 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:	2015/16
HHS	Central Queensland	Version for financial year:	
HHS ID		Version effective for payments from:	
		Version status:	10 Aug 2015

HHS ABF payment requirements:

Expected National Weighted Activity Unit (NWAU)		National efficient price (NEP) (as set by IHPA)
ABF Service group	Projected NWAU	
Admitted acute public services	24,950	\$4,971
Admitted acute private services	3,604	\$4,971
Emergency department services	11,182	\$4,971
Non-admitted services	6,337	\$4,971
Mental health services	2,315	\$4,971
Sub-acute services	3,285	\$4,971
LHN ABF Total	51,673	

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	\$49,703,039
Community mental health services	\$9,505,882
Teaching, Training and Research	\$9,871,604
Other block funded services	\$0
Total block funding for LHN	\$69,080,525

7. Funding Adjustments

1. The healthcare purchasing framework includes a range of funding adjustments which aim to incentivise cost and clinically effective care. This includes incentive payments, such as Quality Improvement Payments (QIP), for HHS who achieve quality targets in specific areas of priority. Applicable purchasing initiatives for 2015/16 are summarised in table 2.6.
2. The HHS should refer to the relevant purchasing initiative specification sheet for full details. These are available on-line as detailed in Appendix 1.

Table 2.6 Healthcare Purchasing Framework 2015/16 (Summary)

Initiative	Description	Applicable HHS	Status for 2015/16	Funding Adjustment
Quality Improvement Payment (QIP) – smoking cessation	For HHSs that achieve targets for the proportion of inpatients clinically supported onto the Smoking Cessation Clinical Pathway.	All HHSs	Continues as per 2014/15 with new targets	Paid retrospectively as in-year amendments
Quality Improvement Payment (QIP) - advanced care plans	For HHSs that achieve targets for the proportion of patients who have been given the opportunity to contemplate an Advanced Care Plan	All HHSs	Continues as per 2014/15 with new targets	Paid retrospectively as in-year amendments
Quality Improvement Payment (QIP) – childhood immunisation	For HHSs that achieve targets for the percentage of children fully immunised for their age cohort	All HHSs excluding Children’s Health Queensland and Mater Public	Continues as per 2014/15 with new targets	Paid retrospectively as in-year amendments
Nurse endoscopist	Same payment for the provision of endoscopy services whether undertaken by doctor or nurse endoscopist	All ABF facilities	Continues as per 2014/15	ABF Pricing model (Qld modification)
Telehealth	Incentivise uptake of telehealth activity by paying for additional outpatient activity volume or provision of telehealth consultancy for inpatients	All ABF and non-ABF facilities	Continues as per 2014/15 targets	Paid retrospectively as in-year amendments
High cost/low volume activity	Additional payments for unforeseen variations in high cost, low volume activity	Certain in-scope specialist providers only	In-scope high cost low volume DRGs reviewed	Paid retrospectively as in-year amendments
Fractured neck of femur timely surgical access	DRG payment discounted by 20% if surgical treatment of fractured neck of femur (#NoF) is not within two days	All ABF facilities who repair #NoF (including Mater)	Continues as per 2014/15	ABF Pricing model (Qld modification)

Initiative	Description	Applicable HHS	Status for 2015/16	Funding Adjustment
Adverse events - BSI	Disincentives to minimise hospital acquired Blood Stream Infections (BSI)	All ABF facilities (including Mater)	Continues as per 2014/15, LCCH added to peer group 1	No prospective adjustment made to service agreement this year (unlike in previous years). In-year amendments will be made retrospectively to reflect actual performance.
Adverse events - pressure injury	Disincentives to minimise hospital acquired Stage 3 and 4 Pressure Injuries	All ABF facilities (including Mater)	New stages added	No prospective adjustment made to service agreement this year (unlike previous years). In-year amendments will be made retrospectively to reflect actual performance
Adverse events - psychotropic medication	Disincentives to minimise hospital acquired injury associated with administration of psychotropic medication for mental health inpatients	All ABF facilities (including Mater)	Continues as per 2014/15	No prospective adjustment made to service agreement this year (unlike in previous years). In-year amendments will be made retrospectively to reflect actual performance.
Emergency Department 'Did Not Wait' (DNW)	No payment for DNWs	All ABF facilities (including Mater)	Continues as per 2014/15	ABF Pricing model (Qld modification)
Pre-operative elective bed days	For elective surgery, reduction in the payment of long day stays is applied where there is a pre-operative admission and the length of stay is greater than the trim point	All ABF facilities (including Mater)	Continues as per 2014/15	ABF Pricing model (Qld modification)
Outpatients	Retain Queensland price differential between new and review outpatient price weight	All ABF facilities (including Mater)	Continues as per 2014/15	ABF Pricing model (Qld modification)
Out-of-scope activity	No payment for activity identified as out of scope i.e. vasectomies, reversal of vasectomies and laser refraction	All ABF facilities (including Mater)	Continues as per 2014/15	ABF Pricing model (Qld modification)
Never Events	Zero payment for six 'never' events.	All public facilities (including Mater)	Continues as per 2014/15	Adjusted retrospectively as in-year amendments

Initiative	Description	Applicable HHS	Status for 2015/16	Funding Adjustment
Hospital in the Home (HITH)	HITH price of 85% and applied to three specific non-complex DRGs (pulmonary embolus, venous thrombosis and cellulitis).	All ABF facilities, (including Mater)	Continues as per 2014/15	ABF Pricing model (Qld modification)

Schedule 3

Key Performance Indicators

1. Purpose

This schedule outlines the KPIs and their associated targets that the HHS will be required to meet.

2. Key Performance Indicators

The KPIs defined within this schedule are used within the Performance Management Framework to monitor the extent to which HHSs are delivering the high level objectives set out within this service agreement..

Table 3.1 Key Performance Indicators

(Note: only KPIs which are applicable to the HHS are included in the table below)

KPI No.	Key Performance Indicator (KPI)	Target	HHS applicable	Strategic Link
Effectiveness – Safety and Quality				
1	In hospital mortality VLAD indicators <ul style="list-style-type: none"> • In hospital mortality rates for: • Acute myocardial infarction • Stroke • Fractured neck of femur • Pneumonia 	Upper level flags or no lower level flags	All hospitals with sufficient number of episodes of care to enable monitoring	<i>National Performance and Accountability Framework</i> <i>Department of Health Strategic Plan 2014/2018</i>
2	Unplanned Hospital Readmission VLAD Indicators Unplanned hospital readmission rates for patients discharged following management of: <ul style="list-style-type: none"> • Acute myocardial infarction • Heart failure • Knee replacements • Hip replacements • Depression • Schizophrenia • Paediatric Tonsillectomy and adenoidectomy 	Upper level flags or no lower level flags	All HHSs with sufficient number of episodes of care to enable monitoring	<i>National Performance and Accountability Framework</i> <i>Department of Health Strategic Plan 2014/2018</i>

KPI No.	Key Performance Indicator (KPI)	Target	HHS applicable	Strategic Link
3	Healthcare-associated infections Healthcare associated <i>staphylococcus aureus</i> (including MRSA) bacteraemia	Facilities with ≥5,000 days of patient care under surveillance for the reporting period: Rate is less than or equal to 2.0 per 10,000 patient days per healthcare facility Facilities with ≤5,000 days of patient care under surveillance for the reporting period: No specific target, any movement from zero to be discussed	All HHSs	<i>National Performance and Accountability Framework</i> <i>National Healthcare Agreement</i>
4	Rate of Seclusion Rate of seclusion per 1,000 acute mental health patient days	Child and adolescent: ≤15 seclusion events per 1,000 patient days General adult and older persons: ≤10 seclusion events per 1,000 patient days	Cairns and Hinterland Central Queensland Children's Health Queensland Darling Downs Gold Coast Mackay Metro North Metro South Sunshine Coast Townsville West Moreton Wide Bay	<i>Department of Health Strategic Plan 2014/2018</i> <i>National Safety Priorities in Mental Health</i> <i>National Standards for Mental Health Services</i> <i>National Safety and Quality Health Service Standards</i> <i>Queensland Mental Health, Drug and Alcohol Strategic Plan 2014/2019</i>
5	Community Mental Health Packages of Care Proportion of community mental health treatment packages of care that meet minimum expectations	≥75%	All HHSs	<i>Fourth National Mental Health Plan</i> <i>Queensland Mental Health, Drug and Alcohol Strategic Plan 2014/2019</i> <i>National Standards for Mental Health Services</i> <i>Department of Health Strategic Plan 2014/2018</i>
Equity and Effectiveness - Access				
6	Shorter stays in emergency departments % of patients who attended an emergency department/service who depart within four (4) hours of arrival	90%	All HHSs	<i>National Performance and Accountability Framework</i>

KPI No.	Key Performance Indicator (KPI)	Target	HHS applicable	Strategic Link
7	<p>Elective surgery</p> <p>Elective surgery patients treated within the clinically recommended time</p> <ul style="list-style-type: none"> • Category 1: 30 days • Category 2: 90 days • Category 3: 365 days 	<p>Category 1: ≥ 98.0%</p> <p>Category 2: ≥ 95.0%</p> <p>Category 3: ≥ 95.0%</p>	<p>Cairns and Hinterland</p> <p>Central Queensland</p> <p>Children's Health Queensland</p> <p>Darling Downs</p> <p>Gold Coast</p> <p>Mackay</p> <p>Metro North</p> <p>Metro South</p> <p>North West</p> <p>Sunshine Coast</p> <p>Townsville</p> <p>West Moreton</p> <p>Wide Bay</p>	
8	<p>Fewer long waiting specialist outpatients</p> <p>% of unseen specialist outpatients waiting more than the clinically recommended timeframe for their urgency category</p> <ul style="list-style-type: none"> • Category 1: 30 days • Category 2: 90 days • Category 3: 365 days 	≤HHS specific target	<p>Cairns and Hinterland</p> <p>Central Queensland</p> <p>Children's Health Queensland</p> <p>Darling Downs</p> <p>Gold Coast</p> <p>Mackay</p> <p>Metro North</p> <p>Metro South</p> <p>North West</p> <p>Sunshine Coast</p> <p>Townsville</p> <p>West Moreton</p> <p>Wide Bay</p>	
10	<p>Aboriginal and Torres Strait Islander potentially preventable hospitalisations</p>	≤ HHS quarterly, YTD and annual target	All HHSs except Children's Health Queensland	<p><i>National Indigenous Reform Agreement</i></p> <p><i>National Partnership Agreement Early Childhood Development</i></p> <p><i>National Healthcare Agreement Queensland Aboriginal and Torres Strait Islander Cardiac Health Strategy 2014/2017</i></p>

KPI No.	Key Performance Indicator (KPI)	Target	HHS applicable	Strategic Link
11	Aboriginal and Torres Strait Islander Discharge Against Medical Advice	≤ HHS quarterly, YTD and annual target	All HHSs except Children's Health Queensland	<i>Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033</i> <i>Queensland Aboriginal and Torres Strait Islander Cardiac Health Strategy 2014/2017</i>
Efficiency – Efficiency and Financial Performance				
13	Full-year forecast operating position The Hospital and Health Service (HHS) full-year forecast operating position	Balanced, surplus or an agreed non-recurrent deficit	All HHSs	<i>Financial Accountability Act 2009</i> <i>Financial and Performance Management Standard 2009</i> <i>National Performance and Accountability Framework</i>
14	Length of stay in public hospitals The average (mean) length of stay for a given Australian Refined Diagnosis Related Group (AR-DRG) for patients who stay one more nights in hospital	At or below AR-DRG target	Cairns and Hinterland Central Queensland Children's Health Queensland Darling Downs Gold Coast Mackay Metro North Metro South North West Sunshine Coast Townsville West Moreton Wide Bay	<i>National Health Performance Authority – Length of Stay in Public Hospitals 2011/12</i>
15	Funded and cost per QWAU Year to date funded and cost per Queensland Weighted Activity Unit (QWAU)	At or below the HHS specific funded price per QWAU	All HHSs with ABF facilities	<i>National Performance and Accountability Framework</i>
Effectiveness – Patient Experience				
16	Measures of patient experience with: <ul style="list-style-type: none"> • Maternity services • Small hospitals 	TBC	All HHSs	<i>National Performance and Accountability Framework</i>

Schedule 4

Data Reporting Requirements

1. Purpose

1. *The Hospital and Health Boards Act 2017* (s.16(1)(d)) provides that the service agreement will state the performance data and other data to be provided by an HHS to the Chief Executive, including how, and how often, the data is to be provided.
2. This schedule specifies the data to be provided by the HHS to the Chief Executive and the requirements for the provision of the data. It replaces the rescinded Health Service Directive QH-HSD-019:2012, Data Collection and Provision of Data to the Chief Executive.

2. Principles

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

3. Roles and Responsibilities

3.1 Hospital and Health Services

1. The HHS will:
 - provide, including the form and manner and at the times specified, the data specified in the data set specifications (Attachment A to this schedule 4) in accordance with this schedule.

⁷ Section 143(2)(a) of the *Hospital and Health Boards Act 2011* provides that the disclosure of confidential information (as defined in s. 139 of the Act) to the Chief Executive by an HHS under a service agreement is a disclosure permitted by an Act.

- provide data in accordance with the provisions of the *Hospital and Health Boards Act 2011*, *Public Health Act 2005* and *Private Health Facilities Act 1999*.
 - provide data where required as set out in the data set specification
 - provide other HHSs with routine access to data, that is not patient identifiable data, for the purposes of benchmarking and performance improvement
 - provide data as required to facilitate reporting against the Key Performance Indicators set out in schedule 3
 - as requested by the Chief Executive from time to time, provide to the Chief Executive data, whether or not specified in this schedule or the service agreement, as specified by the Chief Executive in writing to the HHS in the form and manner and at the times specified by the Chief Executive.
3. Data that is capable of identifying patients will only be disclosed as permitted by, and in accordance with, the *Hospital and Health Boards Act 2011* *Public Health Act 2005* and the *Private Health Facilities Act 1999*.

3.2 Department of Health

1. The Department of Health will:
- produce a monthly performance report which includes:
 - actual activity compared with purchased activity levels
 - any variance (s) from purchased activity
 - performance information as required by the Department of Health to demonstrate HHS performance against the KPI targets specified in schedule 3
 - performance information as required by the Department of Health to demonstrate the achievement of commitments linked to specifically allocated funding included in schedule 2, table 2.2.
 - utilise the data sets provided for a range of purposes including:
 - to fulfil legislative requirements
 - to deliver accountabilities to state and commonwealth governments
 - to monitor and promote improvements in the safety and quality of health services
 - to support clinical innovation.
 - advise the HHS of any updates to data set specifications as they occur.

Attachment A Data Set Specifications

Table 4.1 Clinical data

Data Set	Data Set Specification	Data Custodian
Aged Care Assessment Team data via the ACE database	<p>ACE is the Aged Care Assessment Program application used by Aged Care Assessment Teams (ACATs). The ACE system records information including client demographics, referrals and ACAT approval information. The system also summarises information to support Commonwealth government reporting requirements.</p> <p>This application enables the submission of statewide data to the Commonwealth in order to comply with contractual obligations and receive funding. The application also enables ACATs to transfer client approval information directly to Medicare Australia to facilitate access to aged care services.</p>	Health Systems Innovation Branch
Allied Health Clinical Placement and New Graduate Data	http://qheps.health.qld.gov.au/ahwac/content/clinplacedata.htm	Allied Health Professions Office of Queensland
BreastScreening Clinical Data	<p>As per the BreastScreen Australia Data Dictionary and as agreed from by the States, Territories and the Commonwealth Government</p> <p>www.aihw.gov.au/publication-detail/?id=60129550293</p>	Health Service and Clinical Innovation Division
Cervical Screening/Pap Smear Registry Data	<p>Data to support the reporting requirements of the National Cervical Screening Program as set out in the National Cervical Cancer Prevention Data Dictionary</p> <p>www.aihw.gov.au/publication-detail/?id=60129549329</p>	Chief Health Officer Branch
Elective surgery data collection	http://qheps.health.qld.gov.au/carudata/collections/default.htm	Health Systems Innovation Branch (Clinical Access and Redesign Unit)
Emergency Data Collection	http://qheps.health.qld.gov.au/carudata/collections/default.htm	Health Systems Innovation Branch (Clinical Access and Redesign Unit)
Financial and Residential Activity Collection (FRAC)	<p>http://qheps.health.qld.gov.au/hsu/datacollections.htm</p> <p>www.health.qld.gov.au/hsu/</p>	Health Statistics Branch
Gastrointestinal Endoscopy Data Collection	http://qheps.health.qld.gov.au/carudata/collections/default.htm	Health Systems Innovation Branch (Clinical Access and Redesign Unit)

Data Set	Data Set Specification	Data Custodian
Hand Hygiene compliance data	Data to comply with the requirements of the National Hand Hygiene Initiative and National Health Performance Authority reporting requirements www.myhospitals.gov.au/about-the-data/hand-hygiene	Chief Health Officer Branch
Healthcare infection surveillance data	Healthcare-associated bloodstream infections (BSI) and a subset of these data, healthcare-associated Staphylococcus aureus bloodstream (SAB) infections. http://meteor.aihw.gov.au/content/index.phtml/itemId/602698 SAB data specification as per the National Health Performance Authority reporting requirements: www.myhospitals.gov.au/about-the-data/healthcare-staphylococcus-aureus-bloodstream	Chief Health Officer Branch
Interpreter service data	Summary data, including service usage and expenditure, is extracted from the Interpreter Service Information System to fulfil annual Departmental reporting accountabilities: http://qhps.health.qld.gov.au/multicultural/interpreting/ISIS_userman.htm	Chief Health Officer Branch
Maternal Deaths	www.health.qld.gov.au/caru/networks/qmpqc_maternal.asp	Queensland Maternal and Perinatal Quality Council (through Health Statistics Branch)
Mental Health, Alcohol and Other Drugs Data Sets		
Alcohol Tobacco and Other Drugs Services data	Refer to the Health Service Directive for Enterprise Architecture (QH-HSD-015:2014). System and information requirements are available at: http://qhps.health.qld.gov.au/mentalhealth/clinsysinfo/atodsis/atodsis.htm	Mental Health Alcohol and Other Drugs Branch
Your Experience of Service (YES) Survey Collection (Mental Health)	Your Experience of Service (YES) is a voluntary annual survey collection designed to facilitate consumer engagement in service quality improvement and seek valuable feedback about what consumers and their families think about the care they receive. More information regarding the collection requirements is available at http://qhps.health.qld.gov.au/mentalhealth/govperf/performance/yes.htm	Mental Health Alcohol and Other Drugs Branch
Mental Health Act Data	Refer to the Health Service Directive for Enterprise Architecture (QH-HSD-015:2014).	Mental Health Alcohol and Other Drugs Branch
Mental Health Activity Data Collection	System and information requirements are available at: http://qhps.health.qld.gov.au/mentalhealth/cimha/resources.htm .	
Mental Health National Outcomes and Casemix Collection	Further information about legislative requirements is available at: www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealthR02.pdf and www.health.qld.gov.au/mha2000/resource_guide.asp	
Residential Mental Health Care Collection		

Data Set	Data Set Specification	Data Custodian
Mental Health Establishments Collection	Refer to the Health Service Directive for Enterprise Architecture (QH-HSD-015:2014). Information and system requirements are available at: http://qheps.health.qld.gov.au/mentalhealth/clinsysinfo/clinsysinfo.htm	Mental Health Alcohol and Other Drugs Branch
Monthly Activity Collection (including admitted and non-admitted patient activity and bed availability data)	http://qheps.health.qld.gov.au/hsu/datacollections.htm www.health.qld.gov.au/hsu/	Health Statistics Branch
Non-admitted Patient Data Collection	http://qheps.health.qld.gov.au/hsu/datacollections.htm www.health.qld.gov.au/hsu/	Health Statistics Branch
Notifications Data	<p>The HHS will ensure that notifications data is provided as per the requirements of the <i>Public Health Act 2005</i>. This includes the requirement to provide for the identification of, and response to, notifiable conditions in Queensland.</p> <p>Notifiable conditions required to be submitted under schedule 1 of the Public Health Regulations 2005 are listed at: www.health.qld.gov.au/cdcg/index/default.asp</p> <p>The details of data collected for notifiable conditions are described in the notification/surveillance forms located on the Communicable Disease Control Guidance and Information: A-Z at: www.health.qld.gov.au/cdcg/index/default.asp</p> <p>The HHS will ensure that additional data on notified conditions and programs are provided, as per the requirements of local and national agreements and strategies. For example, the HHS will provide data to monitor progress against the Strategic Plan for Control of Tuberculosis in Australia to support population of data sets required for monitoring progress against indicators for specific goals.</p> <p>The indicator details can be accessed at: www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3603i.htm</p>	Chief Health Officer Branch
Operating theatre data	http://qheps.health.qld.gov.au/caru/data/collections/default.htm	Health Systems Innovation Branch (Clinical Access and Redesign Unit)
Patient Experience Survey Data	The HHS will participate in the patient experience surveys conducted by the Queensland Government's Statistician's Office on behalf of Queensland Health. http://qheps.health.qld.gov.au/psu/patient-experience/default.htm	Health Systems Innovation Branch

Data Set	Data Set Specification	Data Custodian
Patient level costing data	The HHS will provide costed patient level data, in accordance with the Queensland Costing Guideline (2015/2016) and National Hospital Cost Data Collection (Round 19) admitted, non-admitted and emergency data. Where available feeder systems exist, the community and other health services are to be costed as the patient level and included in the data submission for completeness and reconciliation purposes.	Provider Engagement and Contract Delivery Branch
Patient Travel Subsidy Scheme (PTSS)	The HHS will provide the necessary data and information to monitor compliance with the PTSS, as set out in Health Service Directive <i>Patient Travel Subsidy Scheme</i> (QH-HSD-004:2012) Further information is available from: http://qheps.health.qld.gov.au/iptu/html/ptss.htm	Chief Health Officer Branch
Perinatal Data Collection	http://qheps.health.qld.gov.au/hsu/datacollections.htm www.health.qld.gov.au/hsu/	Health Statistics Branch
PRIME CI/CF (AIMS) Data	http://qheps.health.qld.gov.au/psu/prime/default.htm	Health Systems Innovation Branch
Queensland Bedside Audit	The Queensland Bedside Audit (QBA) collects data for reporting on elements of the National Safety and Quality Health Service Standards and other key safety and quality areas. Information is collected annually by Hospital and Health Services and submitted to PSU via completion of a data collection tool for all patients audited. Details of the audit requirements are available at: http://qheps.health.qld.gov.au/psu/qba/default.htm	Health Systems Innovation Branch
Queensland Hospital Admitted Patient Data Collection (QHAPDC)	http://qheps.health.qld.gov.au/hsu/datacollections.htm www.health.qld.gov.au/hsu/	Health Statistics Branch
Queensland Needle and Syringe Program (QNSP) data	The data definitions and guidelines for the Queensland Minimum Dataset for Needle and Syringe Programs can be accessed at : www.health.qld.gov.au/qnsp/html/publications.asp	Chief Health Officer Branch
Queensland Opioid Treatment Program Admissions and Discharges	Refer to the Health Service Directive for Enterprise Architecture (QH-HSD-015:2014). Information and system requirements are available at: http://qheps.health.qld.gov.au/mentalhealth/clinsysinfo/atodsis/atodsis.htm Public Sector Opioid Treatment Programs are required to submit all details of admissions and discharges to Medicines, Regulation and Quality as per the Opioid Treatment Program Guidelines: www.health.qld.gov.au/clinical-practice/guidelines-procedures/medicines/drugs-of-dependence/qld-opioid-treatment/default.asp	Chief Health Officer Branch
Radiation Therapy Data Collection	http://qheps.health.qld.gov.au/caru/data/collections/default.htm	Clinical Access and Redesign Unit

Data Set	Data Set Specification	Data Custodian
Schedule 8 Dispensing data	The monitoring of Drugs of Dependence System (MODDS) is used to capture schedule 8 dispensing data pursuant to the Health (Drugs and Poisons) Regulation 1996. Any Schedule 8 drug prescriptions dispensed to outpatients or as prescriptions on discharge are required to be reported to the Chief Executive. File requirements for export from I-Pharmacy to MODDS are in development	Chief Health Officer Branch
Specialist Outpatient Data Collection	http://qhps.health.qld.gov.au/caru/data/collections/default.htm	Clinical Access and Redesign Unit
Vaccination data	Vaccine administration data collection as per the Queensland immunisation schedule. www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/immunisation/schedule/default.asp#schedule www.humanservices.gov.au/health-professionals/services/australian-childhood-immunisation-register/	Chief Health Officer Branch
Vaccination Events data	Adverse Events Following Immunisation (AEFI) are mandated notifiable conditions in Queensland. Refer to requirements for notifications data. www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/ae-fi-reporting-form.pdf	Chief Health Officer Branch
Variable Life Adjusted Display (VLAD) CM (collection of hospital investigations)	http://qhps.health.qld.gov.au/psu/vlads/default.htm	Health Systems Innovation Branch

Table 4.2 Non-clinical data

Data Set	Data Set Specification	Data Custodian
Asbestos management data	HHSs manage asbestos and record asbestos management information in Computerised Maintenance Management System (CMMS). This data provides for adhoc whole of government reporting as required by the Department of the Premier and Cabinet.	Health Infrastructure Branch
Asset management benchmarking data	This data is required to enable Queensland Health to monitor performance in the areas of condition assessment, maintenance expenditure, CMMS usage, backlog maintenance, planned maintenance expenditure, and expenditure against backlog. This information allows HHSs to review their own performance and benchmark their asset management outcomes against other HHSs and external best practice industry members. Further performance requirements are being developed collegiately with HHS staff.	Health Infrastructure Branch

Data Set	Data Set Specification	Data Custodian
Asset management planning and maintenance planning data	A Total Asset Management Plan (TAMP) will be prepared annually to inform the State Health Infrastructure Plan, the State Infrastructure Plan and the budget process. Asset management and maintenance plans provide information for Backlog Maintenance Remediation Program (BMRP) reporting to the Minister for Health and Treasurer as specified in the service agreement.	Health Infrastructure Branch
Capital investment financial data	The HHS will report specific data items to the Department to enable monitoring of expenditure against minor capital funding on a monthly basis. Financial and Performance Management Standard: www.legislation.qld.gov.au/LEGISLTN/CURRENT/F/FinAccPMAnSt09.pdf Financial Accountability Handbook: www.treasury.qld.gov.au/publications-resources/financial-accountability-handbook/	Finance Branch
Expenditure	The HHS will ensure that actual, year to date and forecast expenditure data is available at major cost centre cluster and account code level. Data will be available within the Decision Support System (DSS) on a monthly basis. Own Source Revenue (OSR) projections will also be required for the forward estimates.	Finance Branch
Maintenance budget and activity data	The HHS will record maintenance budget and activity data (including backlog liability) in CMMS. This data is accessed on adhoc basis to assist with providing infrastructure status responses to the Chief Executive, Minister for Health, and Queensland Treasury.	Health Infrastructure Branch
Minimum Obligatory Human Resource Information (MOHRI)	The HHS will ensure that actual and year to date MOHRI data is available fortnightly in the Decision Support System (DSS). Forecast MOHRI will also be required.	Finance Branch
Revenue	The HHS will ensure that actual, year to date and forecast revenue data is available at major cost centre cluster and account code level. Data will be available within the Decision Support System (DSS) on a monthly basis. Own Source Revenue (OSR) projections will also be required for the forward estimates.	Finance Branch
Workforce data Statewide human resources (HR) and work health and safety (WHS) data for the Queensland Health system	Refer to Workforce data collection requirements http://qheps.health.qld.gov.au/hr/workforce-data/	Human Resource Services

Schedule 5 Definitions

In this service agreement:

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

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

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 by the Deputy Director-General (or equivalent) or the Health Service Chief Executive to the other party, as required under section 39 of the *Hospital and Health Boards Act 2011*.

Amendment Window means the period within which amendment proposals are negotiated and resolved as specified in the section 9 'Amendments to this Service Agreement'.

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

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

Cessation means to temporarily or permanently halt a service.

Chair means the Chair of the Hospital and Health Board.

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

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

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

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

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

Clinical Services Capability Framework means the Clinical Services Capability Framework for Public and Licensed Private Health Facilities v3.2 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.

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

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

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

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

Deed of Amendment means the resolved amendment proposals.

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

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

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

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

- adults, and their dependents, who are Queensland residents, and where applicable, currently in receipt of benefits from at least one of the following concession cards:
 - Pensioner Concession Card issued by the Department of Veteran’s Affairs
 - Pensioner Concession Card issued by Centrelink
 - Health Care Card (this includes Low Income Health Care Card Holders who are automatically eligible for services)
 - Commonwealth Seniors Health Card
 - Queensland Seniors Card
- children who are Queensland residents and are:
 - eligible for the Medicare Child Dental Benefits Schedule; or

- four years of age or older and have not completed Year 10 of secondary school; or
- dependents of current concession card holders or hold a current concession card.

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

Force Majeure means an event:

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

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

- Statewide or Regional service provision
 - ensure equitable and timely access to entire catchment (clinical and non-clinical)
 - provide training and consultation services where this is appropriate within the agreed model of care (clinical and non-clinical)
 - timely discharge or return of patients to their place of residence (clinical services)
 - adequate communication practices to enable ongoing effective local health care, including with the patient's General Practitioner where required (clinical services)
- Recipient HHS
 - utilisation of standardised referral criteria, where they exist, to ensure appropriate use of statewide services (clinical services)
 - timely acceptance of patients being transferred out of statewide services (back-transfers) (clinical services)
 - equitable access to ongoing local health care as required (clinical services)

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

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

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

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

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

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

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

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

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

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

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

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

Negotiation Period means a period of no less than 15 business days (or such longer period agreed in writing between the parties) from exchange date specified in table 1.

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

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

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

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

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

- compensable patients with an alternate funding source, such as:
 - workers' compensation insurers
 - motor vehicle accident insurers
 - personal injury insurers
 - Department of Defence
 - Department of Veterans' Affairs
- Medicare eligible patients can elect to be treated as a public or private patient, allowing HHS' to recoup a portion of the healthcare service delivery cost.

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

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

Performance Management Framework means the reference document titled 'Hospital and Health Service Performance Management Framework'.

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

- Indemnity for Queensland Health Medical Practitioners HR Policy I2 (QH-POL-153)
- Governance framework for Health Employment directives (Policy Number A2 (QH-POL-415)).

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

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

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

Public health event of state significance means an event where the actual or potential impact extends beyond the community service by a particular Hospital and Health Service.

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

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

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

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

Relationship Management Group means the body 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 Management Framework. The relationship management group members comprise:

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

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

Schedule means this schedule to the service agreement.

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

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

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

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

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

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

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

- live interactive video and audio links for clinical consultations and education
- store and forward systems to enable the capture of digital images, video, audio and clinical data stored on a computer and forwarded to another location to be studied and reported on by specialists
- teleradiology to support remote reporting and provision of clinical advice associated with diagnostic images
- telehealth services and equipment for home monitoring of health

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

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

Appendix 1 Key Documents

Hospital and Health Services Service Agreements and supporting documents including:

- **Hospital and Health Services Service Agreements**
- **Investment Environment 2015/16**
- **Hospital and Health Services Performance Management Framework**
- **Health Funding Principles and Guidelines 2015/16**

are available at:

www.health.qld.gov.au/system-governance/health-system/managing/default.asp

Healthcare Purchasing Framework – Specification sheets

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

Department of Health Strategic Plan 2014/2018

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

Abbreviations

ABF	Activity Based Funding
ACSQHC	Australian Commission on Safety and Quality in Healthcare
AHSSQA	Australian Health Service Safety and Quality Accreditation
BBV	Blood Borne Viruses
BMRP	Backlog Maintenance Remediation Program
BSI	Blood Stream Infection
CPC	Clinical Prioritisation Criteria
CSCF	Clinical Service Capability Framework
DH-SA	Department of Health – Service Agreement
DNW	Did Not Wait
DRG	Diagnosis Related Group
FTE	Full Time Equivalent
HHS	Hospital and Health Service
HHS-SA	Hospital and Health Service – Service Agreement
HITH	Hospital in the Home
KPI	Key Performance Indicator
LAM	List of Approved Medicines
MOHRI	Minimum Obligatory Human Resource Information
MPHS	Multi-Purpose Health Service
Non-ABF	Non-Activity Based Funding
NPA	National Partnership Agreement
NSQHS	National Safety and Quality Health Service
NWAU	National Weighted Activity Unit
OSR	Own Source Revenue
PBS	Pharmaceutical Benefits Scheme
PfO	Pay for Outcomes
PTSS	Patient Travel Subsidy Scheme
PQWAU	Public Queensland Weighted Activity Unit
QIP	Quality Improvement Payment
QWAU	Queensland Weighted Activity Unit
RBWH	Royal Brisbane and Women's Hospital
SARTMOC	Sexual Assault Response Team Model of Care
STI	Sexually Transmitted Infections
VLAD	Variable Life Adjusted Display
WOOS	Weighted Occasions Of Service

