Queensland Health

Service Agreement 2022/23 – 2024/25

Gold Coast Hospital and Health Service

Queensland Government

Gold Coast Hospital and Health Service, Service Agreement 2022/23 - 2024/25

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

Acknowledgement

Jingeri.

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

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1. Introduction

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

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

1.3 The parties will ensure that planning and delivery of health services is consistent with the strategies and priorities set out by government. The parties recognise the importance of the HHS' Health Equity Strategy (as defined in the Act) and the parties commitment to improving health and wellbeing outcomes and achieving health equity for Aboriginal and Torres Strait Islander peoples.

2. Scope

2.1 This service agreement covers the period from 1 July 2022 to 30 June 2025.

2.2 The parties have identified the services to be provided by the HHS, the funding for the provision of those services, the performance measures applicable to the services and data requirements.

3. Services

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

(a) the applicable conditions of all national agreements and national partnership agreements between the Queensland Government and the Commonwealth Government and commitments under any related implementation plans; and

(b) the applicable conditions of each agreement or arrangement for funding between the Department and the HHS and commitments under any related implementation plans, which conditions and commitments may be recorded separately to this service agreement but for which funding is (or becomes) provided in Schedule 2.

3.2 The HHS is required to deliver the services outlined in this service agreement for which funding is provided in Schedule 2.

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

3.4 If the HHS wishes to terminate or reduce service levels for a service for which funding is provided in Schedule 2, this will remain subject to negotiation and agreement by the Department at its discretion.

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

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

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

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

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

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

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

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

4. Performance and Accountability Framework

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

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

5. Data supply requirements

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

(a) fulfil legislative obligations;

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

(c) monitor and support performance improvement;

(d) manage this service agreement;

(e) support clinical innovation; and

(f) facilitate evaluation and audit.

5.2 The parties agree and acknowledge that:

(a) the Department will keep the HHS informed of the Department's data requirements; and

(b) data will be provided as required, or permitted, by law.

6. Hospital and Health Service accountabilities

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

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

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

(b) cabinet decisions;

(c) Ministerial directives;

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

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

(f) all industrial instruments;

(g) all health service directives and health employment directives; and

(h) all policies, guidelines and implementation standards, including human resource policies.

6.3 As part of the commitment to achieving First Nations health equity, the HHS will prioritise the elimination of racial discrimination and institutional racism within its service and ensure that Aboriginal and Torres Strait Islander peoples have access to culturally safe and responsive health services.

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

6.5 The HHS will ensure that health service employees employed by the Chief Executive[1] who perform work for the HHS are managed in accordance with any applicable delegations and directions from the Chief Executive.

6.6 The HHS will ensure that effective asset management systems are in place, working in collaboration with the Department.

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

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

6.9 The HHS will provide to the Chief Executive reports of a type, and at the intervals, agreed between the parties, or as reasonably specified by the Chief Executive.

7. Department accountabilities

7.1 The Department will perform its obligations under this service agreement including, in return for the HHS performing its obligations and delivering the services, providing funding to the HHS as stipulated in this service agreement (as amended).

7.2 The Department will:

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

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

7.3 The Chief Executive will appoint health service employees to perform work for the HHS for the purpose of enabling the HHS to perform its functions under the Act.

7.4 The Chief Executive will consult, cooperate, and coordinate with the HHS to ensure legal compliance with the *Work Health and Safety Act 2011* and other legislation as it applies to the scope, nature and location of operations associated with this service agreement.

7.5 The Chief Executive will appropriately perform and fulfil their functions under the Act.

8. Achieving health equity with First Nations Queenslanders

8.1 Through legislative amendments to the Act and the Hospital and Health Boards Regulation 2012, and the release of *Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework* (2021), Queensland Health has strengthened its commitment to improving health and wellbeing outcomes and achieving health equity for First Nations peoples.

8.2 The HHS will develop a Health Equity Strategy to demonstrate the HHS's activities and key performance measures to achieve health equity with First Nations peoples that is compliant with legislative requirements. The Health Equity Strategy will act as the principal

[1] In this service agreement the term Chief Executive takes the meaning applied in the Act, which is the Chief Executive of Queensland Health, but which is generally referred to as the Director-General.

accountability mechanism between community and the HHS in achieving health equity for First Nations Queenslanders and forms a key part of the Queensland Government's commitment to the *National Agreement on Closing the Gap* (2020).

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

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

8.5 The HHS will report publicly on progress against the Health Equity Strategy.

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

8.7 The HHS will participate as a partner in the design, development and implementation of the new *Queensland First Nations Health Workforce Strategy for Action.*

9. General

9.1 Sub-contracting

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

(b) The HHS must ensure that any sub-contractor who has access to confidential information (as defined in the Act) or personal information (as defined in the *Information Privacy Act 2009* (Qld)) complies with obligations no less onerous than those imposed on the HHS.

9.2 Insurance

The HHS must:

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

(b) comply with reasonable requests or directions from the Department in this regard.

9.3 Amendment

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

10. Counterparts

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

10.2 In the event that any signature executing this service agreement or any part of this service agreement is delivered by facsimile transmission or by scanned e-mail delivery of a '.pdf' format data file or equivalent of the entire agreement, the signature will create a valid and binding obligation of the party executing (or on whose behalf the signature is executed) with the same force and effect as if the signature page were an original. For the avoidance of doubt, this service agreement may be in the form of an electronic document and may be electronically signed.

10.3 For execution under this clause 10 to be valid the entire service agreement upon execution by each individual party must be delivered to the remaining parties.

Execution

Executed as an agreement in Queensland

Signed by the Chief Executive, Queensland Health:)

.....

Signature of Chief Executive

SHAUN DRUMMOND

.....

Name of Chief Executive (print)

.....

(date)

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

.....

Signature of Hospital and Health Board Chair

Ian Langdon

.....

Name of Hospital and Health Board Chair (print)

21 June 2022

.....

(date)

Execution

Executed as an agreement in Queensland

Signed by the Chief Executive, Queensland Health:)

.....

Signature of Chief Executive

SHAUN DRUMMOND

.....

Name of Chief Executive (print)

29 June 2022

.....

(date)

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

.....

Signature of Hospital and Health Board Chair

.....

Name of Hospital and Health Board Chair (print)

.....

(date)

Schedule 1 HHS profile

1. HHS profile

This Schedule does not apply to this HHS.

Schedule 2 Funding and purchased activity and services

This Schedule 2 sets out:

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

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

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

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

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

1. Introduction

1.1 The HHS will deliver the services for which funding is provided in this Schedule 2. In providing these services, the HHS will ensure that:

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

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

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

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

(i) other HHSs;

(ii) non-government organisations;

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

(iv) Queensland Ambulance Service;

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

(vi) primary care providers;

(vii) other government departments and agencies; and

(viii) private providers;

(e) models of care and service delivery arrangements are consistent with evidence-based practice and offer value for money;

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

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

(h) innovation and continuous improvement is supported.

2. Purchased health services

2.1 Table 4, Table 5 and Table 6 outline the activity and service streams which the Department agrees to purchase from the HHS pursuant to this service agreement.

2.2 More generally, this will include the following:

2.3 **Statewide Services**

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

(b) The HHS will:

(i) collaborate with the Department and other HHSs in the implementation of, and adherence to, the governance and oversight arrangements for statewide services;

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

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

2.4 **Clinical Statewide Services and Clinical Support Statewide Services provided**

The HHS will provide the statewide services listed in Table 1.

Table 1 Statewide Services

Service Name	Categorisation
Queensland Pelvic Mesh Service	Clinical Statewide Service

2.5 **Regional services**

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

(a) Basic Physician Training Pathway;

(b) Eating Disorders service; and

(c) Mental health clinical indicator team program.

2.6 Prevention services and population health services

(a) The HHS will provide a range of services with a focus on the prevention of ill-health and disease, including:

(i) Specialist Public Health Units;

(ii) preventive health services;

(iii) immunisation services;

(iv) sexually transmissible infections including HIV and viral hepatitis;

(v) tuberculosis services; and

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

(b) Services will be provided in line with public health related legislation and the service delivery and reporting requirements outlined in the *Public Health Practice Manual*, as these relate to the services provided.

2.7 Aboriginal and Torres Strait Islander health services

The HHS will provide Aboriginal and Torres Strait Islander specific health services and initiatives consistent with the principles and objectives of the Queensland Government's *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2022 – Policy and Accountability Framework*. These service and initiatives will be delivered in line with guidance from the Aboriginal and Torres Strait Islander Health Division.

2.8 Mental health alcohol and other drugs services

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

2.9 Oral health services

The HHS will provide oral health services to people who meet the eligibility criteria for accessing public dental services in Queensland. Services will be delivered in line with guidance from the Office of the Chief Dental Officer.

2.10 Prisoner health services

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

2.11 Youth detention services

This clause does not apply to this HHS.

2.12 Refugee health

This clause does not apply to this HHS.

2.13 **State-funded outreach services**

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

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

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

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

3. Teaching training and research

The HHS will provide the teaching, training and research programs for which funding is provided within Schedule 2 and as described below.

3.1 **Clinical education and training**

(a) The HHS will provide education and training placements for the following professional groups consistent with and proportionate to the capacity of the HHS and will support and align with stipulated placement terms governing clinical placements in Queensland Health facilities;

(i) medical students;

(ii) nursing and midwifery students;

(iii) pre-entry clinical allied health students;

(iv) interns;

(v) rural generalist trainees;

(vi) vocational medical trainees;

(vii) first year nurses and midwives;

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

(ix) dental students;

(x) allied health rural generalist training positions;

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

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

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

(d) The HHS will continue to implement and retain the following positions provided through clauses to the *Health Practitioners and Dental Officers (Queensland Health) Certified Agreement (No 3)*:

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

(ii) clinical educator positions provided through the Clinical Education

Management Initiative for Health Practitioners.

(e) 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.

3.2 **Statewide training, education and research**

This clause does not apply to this HHS.

3.3 **Health and medical research**

The HHS will:

(a) develop and implement a strategy to drive increased research activity and its translation into clinical practice;

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

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

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

4. Delivery of purchased activity

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

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

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

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

4.5 The Department will reconcile in-scope activity, as defined in the Activity Reconciliation specification sheet (available online, as detailed in Appendix 1), delivered by the HHS against the purchased in-scope activity targets outlined in Table 4.

4.6 Activity reconciliation will be undertaken in February (for the July to December period) and August (for the January to June period) each year and will be derived through application of the methodology which is documented in the Activity Reconciliation specification sheet.

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

4.8 Under delivery of in-scope activity, as defined in the Activity Reconciliation specification sheet, will be withdrawn from the HHS at 100% of the Queensland Efficient Price (QEP).

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

4.10 Any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 2 and 4 of this service agreement.

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

5. Delivery of purchased services

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

5.2 These program or project services may be the subject of separately agreed conditions tied to that funding and the focus of detailed monitoring by the Department.

5.3 Conditions may include, but are not limited to:

(a) establishment and/or commencement of services;

(b) delivery of activity;

(c) workforce obligations;

(d) establishment of oversight committees;

(e) opening or upgrades to facilities;

(f) program evaluation;

(g) program management;

(h) reporting or notification obligations; and

(i) attainment of performance standards.

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

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

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

5.7 Any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 2 and 4 of this service agreement.

6. Financial adjustments

6.1 **Activity targets**

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

(b) Activity will be monitored at the purchasing hierarchy level. Providing the HHS meets all relevant KPIs and specific funding allocations, the HHS has the ability to negotiate the transfer of activity across the purchasing hierarchy with the Department.

(c) Table 2 demonstrates the financial adjustment that will be applied when activity thresholds have been breached.

(d) The HHS may not utilise the provisions within AASB15 *Revenue from Contracts with Customers* to override the application of any financial adjustment made by the Department in line with Table 2.

Table 2 Financial adjustments applied on breach of activity thresholds

Example of Breach	Description	Financial Adjustment
Over performance	Activity exceeds that specified in the service agreement value for in-scope activity as shown in Table 4.	Purchasing contracts are capped and an HHS will not be paid for additional activity with the exception of activity that is in scope for the identified purchasing incentives as set out in Table 3.
Under performance	Activity is below that specified for in-scope activity as shown in Table 4.	Purchased activity and the related funding will be withdrawn at 100% of the Queensland Efficient Price and reallocated to an alternate provider that can undertake the activity. Refer to Table 4 for the HHS QWAU target.
Failure to deliver on service commitments linked to specific funding allocations	Specific funding allocations National Partnership Agreements.	It is at the discretion of the Department to withdraw allocated funding pro rata to the level of under delivery.
For all other types of activity variance, any financial adjustment will be made at the discretion of the Department.		

6.2 National Partnership on COVID-19 Response

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

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

(i) undertaken activity that is in-scope for the State Public Health Payment, as defined under the *National Partnership on COVID-19 Response*, during the reporting period*;* and/or

(ii) undertaken activity that is in-scope for the Hospital Services Payment, as defined under the *National Partnership on COVID-19 Response*, during the reporting period; and

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

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

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

(e) All funding that is provided through the State Public Health Payment and the Hospital Services Payment will be subject to a reconciliation to be undertaken by the Administrator of the National Health Funding Pool. The HHS will be required to provide evidence to support claims for additional costs. If the HHS is unable to provide the required evidence with their expenditure claim, funding received may be recalled subject to reconciliation.

(f) Funding adjustments will be actioned through the processes outlined in Schedules 2 and 4 of this service agreement.

6.3 Purchasing incentives

(a) The purchasing approach includes a range of funding adjustments which aim to incentivise high quality and high priority activity, support innovation and evidence-based practice, deliver additional capacity through clinically and cost effective models of care and dis-incentivise care which provides insufficient or no benefit for patients. This includes incentive payments for HHSs who achieve targets in specific priority areas. The purchasing incentives are detailed in Table 3. The Department must reconcile the applicable purchasing incentives in Table 3 in line with the timeframes specified in the relevant purchasing specification sheet. The Department must provide a copy of the reconciliation statement to the HHS.

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

(c) Any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 2 and 4 of this service agreement.

Table 3 Purchasing Incentives 2022/23

Incentive	
Quality Improvement Payment (QIP)	
Antenatal care for First Nations Women	Payments for achieving two Closing the Gap targets for First Nations women: • to attend five or more antenatal visits with their first antenatal first taking place in the first trimester; and • to stop smoking by 20 weeks gestation.
Purchasing incentives	
Virtual care incentive	Incentive funding to increase the number of specialist outpatient services which are provided in virtual settings.
Own source revenue growth	Incentivise the recognition of own source revenue through matching growth in own source revenue with public activity growth funding.
ABF model localisations	
Sentinel events	Payment withdrawn for sentinel events as per the national ABF model.
Advance Care Planning (ACP)	QWAUs for HHSs who offer ACP discussions to admitted patients, non-admitted outpatients, community health patients and Emergency Department patients.
Emergency Department Did Not Wait (DNW)	Zero QWAUs for DNWs.
Fractured neck of femur	QWAUs reduced by 20% for non-timely surgical treatment of fractured neck of femur.
Hospital in The Home (HITH)	QWAUs increased for Hospital in the Home (HITH) admissions of Residential Aged Care Facility residents.

Incentive	
Out-of-scope services	Nil QWAUs for out-of-scope procedures.
Pre-operative bed days	QWAUs for long stay days above the upper trim point less ICU days reduced equivalent to pre-operative days, up to a maximum of 3 days, for elective episodes.
Smoking cessation (community mental health)	QWAUs for smoking cessation activity for community mental health patients.
Smoking cessation (inpatients)	QWAUs for smoking cessation activity for publicly funded inpatients.
Stroke care	10% QWAU loading for acute stroke patients admitted to Statewide Stroke Clinical Network-endorsed stroke unit care.
Telehealth (admitted patients)	QWAUs for provider-end of in-scope admitted patient telehealth activity.
Commissioning mechanisms	
High-cost home support	Funding for approved individuals requiring 24-hour home ventilation.
Patient flow initiative	Provision of non-recurrent WAU-backed funding to participating HHS who successfully implement agreed recommendations.
Rapid access clinics	Recurrent WAU-backed funding to support the implementation of rapid access clinics to reduce pressure on emergency departments.
Expansion of sub-acute and long stay care	Additional funding to increase the availability of and access to care for sub-acute and long stay patients, thereby improving access to care in a range of settings and releasing capacity within acute facilities.
Connected Community Pathways	Funding to incentivise evidence-based and innovative models of care which promote the delivery of care outside acute facilities and support shared-care partnership arrangements.

6.4 Surgery Connect reimbursements

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

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

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

or

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

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

(c) Any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 2 and 4 of this service agreement.

6.5 **Financial adjustments – other**

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

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

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

(b) If the Chief Executive (or delegate) determines that previously allocated funding is to be recovered, any resulting changes to funding and purchased activity levels will be actioned through the processes outlined in Schedules 2 and 4 of this service agreement.

6.6 **Public and private activity/own source revenue**

(a) Own source revenue comprises grants and contributions, user charges and other revenues.

(b) Where an HHS is above its own source revenue target, it will be able to retain the additional own source revenue with no compensating adjustments to funding from other sources where the additional revenue is not attributable to a private patient consistent with clauses A9 to A13 and A44 of the *National Health Reform Agreement.*

(c) Where an HHS is below its own source revenue target in respect of private patients, it will experience a reduction in revenue with no compensating adjustments to funding from other sources.

(d) The HHS will make all efforts to identify and maximise revenue from appropriate third parties to ensure optimisation of available State and Commonwealth funding across the Queensland public sector health system.

(e) The own source revenue identified in Table 4 is an estimate generated by the HHS which allows all third-party funding sources associated with service delivery to be identified. The HHS will ensure that this estimate is substantiated and accurate to ensure no significant variances to actual revenue generated.

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

(g) Budget adjustments for changes in own source revenue from private patients will be actioned through the processes set out in Schedule 4 of this service agreement.

7. Funding sources

7.1 The four main funding sources contributing to the HHS service agreement value are:

(a) Commonwealth funding;

(b) State funding;

(c) grants and contributions; and

(d) own source revenue.

7.2 Table 4 provides a summary of the funding sources for the HHS and the total value of the service agreement.

8. Funds disbursement

8.1 The Department agrees to pay the HHS the amount described in Table 4 of Schedule 2, subject to:

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

(b) the terms of this service agreement.

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

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

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

(a) redirect Commonwealth payments between HHSs;

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

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

8.5 The Department will pay state-funded activity-based funding, block funding and system manager funding to the HHS on a fortnightly basis in line with receipt of the State Appropriation Payment. The payment made will be equal to 1/26th of the state-funded component of the service agreement value described in Table 4.

8.6 The Department will pay Commonwealth-funded activity-based funding and block funding on a monthly basis in line with receipt of the Commonwealth payment. The payment made will be equal to 1/12th of the Commonwealth funded component of the service agreement value described in Table 4.

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

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

Table 4 Gold Coast HHS Total Funding Allocation by Funding Source 2022/23

Funding Source	NWAU (N2122)	QWAU (Q24)	Value ($)
NHRA Funding			
ABF Pool			
ABF Funding (in scope NHRA)[2]			
Commonwealth[2]	257,013		$606,594,663
State		264,051	$784,123,871
State Specified Grants			$33,442,386
State-wide Services			$0
State Managed Fund			
Block Funding			
Small Rural Hospitals		0	$0
Teaching, Training & Research			$47,313,470
Non-Admitted Child & Youth Mental Health			$11,804,652
Non-Admitted Home Ventilation			$0
Non-Admitted Mental Health			$53,801,529
Other Non-Admitted Service			$0
Highly Specialised Therapies			$0
Total NHRA Funding	**257,013**	**264,051**	**$1,537,080,571**
Out of Scope NHRA			
Queensland ABF Model			
DVA		646	$3,730,009
NIISQ/MAIC		1,066	$7,063,231
Oral Health		3,667	$17,541,914
BreastScreen		940	$5,763,973
Total Queensland ABF Funding	**-**	**6,319**	**$34,099,127**
Discretely Funded Programs[3]			
Department of Health			$138,889,897
Locally receipted funds			$11,731,544
Total Discretely Funded Programs	**-**	**-**	**$150,621,441**
Own Source Revenue			
Private Patient Admitted Revenue[4]	*2,962*	3,273	$16,579,824
Non-Admitted Services		562	$4,224,037
Pharmaceuticals Benefits Scheme		8,353	$79,198,501
Other Activities[5]		1,221	$40,176,678
Total Own Source Revenue	**-**	**13,410**	**$140,179,040**

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

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

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

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

Funding Source	NWAU (N2122)	QWAU (Q24)	Value ($)
Locally Receipted Funds (exc. Discretely Funded Programs)[6]			$1,255,507
Depreciation			$81,160,000
NPA COVID-19 Response			
Hospital Services Payment			$0
State Public Health Payment			$0
COVID-19 Vaccine Payment			$0
Total NPA COVID-19 Response Funding	**-**	**-**	**$0**
GRAND TOTAL	**257,013**	**283,780**	**$1,944,395,686**

Pool Accounts			
ABF Pool (National Health Funding Pool)[7]			$1,458,260,047
State Managed Fund[8]			$112,919,651
System Manager			$138,889,897

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

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

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

Table 5 National Health Reform Funding

NHRA Funding Type	NWAU (N2122)	Commonwealth ($)	State ($)	Other State funding[9] DVA/MAIC/Oral Health/BreastScreen ($)	Total ($)
National Efficient Price (NEP)					**$5,597**
ABF Allocation (NWAU)					
Emergency Department	38,635	$91,184,979	$122,898,810	$5,522,991	$219,606,780
Acute Admitted	151,344	$357,197,276	$481,429,293	$0	$838,626,568
Admitted Mental Health	14,948	$35,279,389	$47,549,443	$0	$82,828,832
Sub-Acute	15,220	$35,920,824	$48,413,966	$0	$84,334,790
Non-Admitted	36,867	$87,012,195	$117,274,745	$28,576,136	$232,863,077
Total ABF Pool Allocation	**257,013**	**$606,594,663**	**$817,566,257**	**$34,099,127**	**$1,458,260,047**
Block Allocation					
Teaching Training and Research	-	$9,755,513	$37,557,957	-	$47,313,470
Small and Rural Hospitals[10]	-	$0	$0	-	$0
Non-Admitted Mental Health	-	$20,487,688	$33,313,841	-	$53,801,529
Non-Admitted Child & Youth Mental Health	-	$1,204,221	$10,600,431	-	$11,804,652
Non-Admitted Home Ventilation	-	$0	$0	-	$0
Other Non-Admitted Services	-	$0	$0	-	$0
Other Public Hospital Programs	-	$0	$0	-	$0
Highly Specialised Therapies	-	$0	$0	-	$0
Total Block Allocation	**-**	**$31,447,422**	**$81,472,229**	**-**	**$112,919,651**
Grand Total Funding Allocation					**$1,571,179,698**

[9] State funding transacted through the Pool Account; not covered under the NHRA

[10] Incorporating small regional and rural public hospitals, five specialist mental health facilities (Baillie Henderson Hospital, Jacaranda Place – Queensland Adolescent Extended Treatment Centre, The Park – Centre for Mental Health, Kirwan Rehabilitation Unit and Charters Towers Rehabilitation Unit) and the Ellen Barron Family Centre.

Table 6 Discretely Funded Programs (Non-ABF)

Discretely Funded Programs	$
Aged Care Assessment Program	$3,023,412
Alcohol, Tobacco and Other Drugs	$8,669,933
Community Health Programs	$38,080,291
Disability Residential Aged Care Services	$0
Home and Community Care Program (HACC)	$5,633,544
Interstate Patients (QLD residents)	$49,239,570
Multi-purpose Health Services	$0
Other State Funding	$22,682,554
Patient transport	$1,575,504
Prevention Services and Public Health	$10,440,213
Prisoner Health Services	$1,241,556
Research	$1,498,864
Transition Care	$6,098,000
Residential Aged Care Services	$2,438,000
TOTAL	**$150,621,441**

Schedule 3 Performance Measures

1. Performance Measures

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

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

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

1.4 HHSs are also required to report against the agreed key performance measures in their Health Equity Strategy.

Table 7 HHS Performance Measures – Key Performance Indicators

Key Performance Indicators
Hospital Acquired Complications
Hospital Access Target (admitted patients) • % of emergency stays within 4 hours
Emergency Department stays greater than 24 hours
Emergency Department wait time by triage category
Face to face community follow up within 1-7 days of discharge from an acute mental health inpatient unit
Patient off stretcher time
Lost minutes per ambulance (in development)
Patient flow target: time between the decision to admit and patient leaving the Emergency Department (in development)
Category 1 elective surgery patients treated within the clinically recommended timeframe
Elective surgery patients waiting longer than the clinically recommended timeframe
Emergency Surgery (placeholder - measure to be determined)
Category 1 patients who receive their initial specialist outpatient appointment within the clinically recommended timeframe
Patients waiting longer than clinically recommended for their initial specialist outpatient appointment
Category 4 gastrointestinal endoscopy patients treated within the clinically recommended timeframe
Gastrointestinal endoscopy patients waiting longer than the clinically recommended timeframe
Access to oral health services (adults)
Access to oral health services (children)
Potentially Preventable Hospitalisations – First Nations peoples: • Diabetes complications • Selected conditions
Reduction in the proportion of Aboriginal and Torres Strait Islander failure to attend appointments
Telehealth utilisation rates: • Number of non-admitted telehealth service events
Forecast operating position: • Full year • Year to date

Average sustainable Queensland Health FTE
Capital expenditure performance
Proportion of mental health and alcohol and other drug service episodes with a documented care plan
Proportion of overnight inpatients discharged by 10am

Table 8 HHS Performance Measures - Safety and Quality Markers

Safety and Quality Markers
Sentinel Events
Hospital Standardised Mortality Ratio
Healthcare-associated Staphylococcus Aureus (including MRSA) bacteraemia
Severity Assessment Code (SAC) analysis completion rates
Patient Reported Experience

Table 9 HHS Performance Measures – Outcome Indicators

Outcome Indicators
Rate of seclusion events
Rate of absent without approval from acute mental health inpatient care
Reperfusion therapy for acute ischaemic stroke
Access to emergency dental care
First Nations peoples representation in the workforce
General oral health care for First Nations peoples
% of low birthweight babies born to Queensland mothers
Complaints resolved within 35 calendar days
Advance care planning
Smoking cessation clinical pathway
Potentially Preventable Hospitalisations (diabetes complications)
Potentially Preventable Hospitalisations (non-diabetes complications)
The percentage of oral health activity which is preventive
Cardiac rehabilitation
Adolescent vaccinations administered via the statewide School Immunisation Program

Schedule 4 Amendments to this service agreement

1. Agreed process to amend this service agreement

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

(a) amendment windows;

(b) extraordinary amendment;

(c) periodic adjustments; and

(d) end of financial year reconciliation.

1.2 **Amendment windows**

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

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

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

1.3 **Extraordinary Amendment**

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

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

(c) Agreed extraordinary amendments will be reflected in a notice issued by the Chief Executive countersigned as accepted by the HHS, which notice will be replaced when the extraordinary amendment is subsequently formalised in a deed of amendment issued following the next amendment window.

1.4 **Periodic adjustments**

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

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

(ii) are referenced in the service agreement; and

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

(periodic adjustment).

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

1.5 End of financial year reconciliation

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

(b) The Department will provide the HHS with a reconciliation of all service agreement funding and purchased activity for the prior financial year. This will reflect the position following conclusion of the end of financial year adjustments process.

(c) The impact of end of financial year adjustments on subsequent year funding and activity will be incorporated in the service agreement through the deed of amendment executed following the next available amendment window.

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

Appendix 1 Reference Documents

Hospital and Health Boards Act 2011

National Health Reform Agreement (NHRA) 2020-25

System Outlook to 2026 - for a sustainable health service

Queensland Health Performance and Accountability Framework

My health, Queensland's future: Advancing health 2026

Department of Health Strategic Plan 2021-2025

Local Area Needs Assessment (LANA) Framework

Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 - Policy and Accountability Framework

Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026

National Agreement on Closing the Gap

Queensland Health Workforce Diversity and Inclusion Strategy 2017 to 2022

Performance Measures Attribute Sheets

Purchasing Initiatives and Funding Specifications

Public Health Practice Manual

National Partnership on COVID-19 Response

Statewide services reference material

Service agreement amendment processes

Data supply requirements

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