EXHIBIT 228

Queensland Health

West Moreton

2012-13 Service Agreement

Queensland Government

EXHIBIT 228

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LIST OF APPENDICES

Introduction

As an organisation, Queensland Health is committed to strengthening performance and improving services and programs that will better meet the needs of the community.

The development of service agreements (**Service Agreements**) between the Chief Executive and Hospital and Health Services (HHSs), assists this process by formally assigning accountability for the expected high level outcomes and targets to be met during the period to which the service agreement relates.

The content and process for the preparation of this service agreement is consistent with the requirements of the *Hospital and Health Boards Act 2011* (HHBA). 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; the Hospital and Health Service Performance Framework; key performance indicators; purchasing initiatives and agreement value. However, based on the recent appointment of board chairs and members and the limited opportunity for the board to thoroughly understand the HHS it controls, the Chief Executive has decided the final terms of this first service agreement (in accordance with s.317 of the HHBA).

Fundamental to the success of this agreement is a strong partnership between the HHS and its Board and the department/system manager. This partnership is supported through the relationship management group whose members comprise representatives from both the HHS and system manager and which provides the routine forum within which a range of aspects of HHS (and system wide) performance are discussed and jointly managed.

Definitions

In this service agreement:

Amendment Proposal means the written notice of a proposed amendment to the terms of this Service Agreement by the Chief Executive or the HHS 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 ‘Amendments to this Service Agreement’.

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

Chair means the Chair of the Hospital and Health Board of the Service.

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

Deed of Amendment means the Resolved Amendment Proposals.

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-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.

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 ten Business Days (or such longer period agreed in writing between the parties) from the date an amendment proposal is received by the other party.

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

Performance Framework means the Hospital and Health Services Performance Framework 2012-2013 annexed to this service agreement.

Queensland Health-Service Agreement (QH-SA) Contact Person means the position nominated by the system manager as the primary point of contact for all matters relating to this service agreement.

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.

Relationship Management Group means the body to be established on the terms of reference specified by the system manager 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. The relationship management group members comprise:

- the QH-SA Contact Person and the HHS-SA Contact Person;
- Executive Directors from the Finance, Access Improvement Service, Planning and Healthcare Purchasing areas; and
- Senior Executive representatives nominated by the HHS, including the Chief Finance Officer , Chief Operating Officer, Director of Performance or equivalent.

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

Service Agreement means this service agreement and the HHS Performance Framework 2012-2013 including the schedules in annexures, as amended from time to time.

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

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

System Manager means the Department of Health (or Queensland Health), acting through the Chief Executive.

Other terms are defined within each of the schedules of this service agreement.

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; and

   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) 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; and

i) headings do not affect the interpretation of this service agreement.

Objectives of the Agreement

This service agreement is designed to:

- Specify the hospital services (with respect to outcomes and outputs), 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.
- Ensure state and commonwealth priorities, services, outputs and outcomes are achieved.
- Facilitate the progressive implementation of a purchasing framework that is based on an activity based funding mechanism.

This service agreement outlines the services that the system manager will purchase from the HHS during the 2012-2013 financial year.

This service agreement does not provide for the provision of clinical and non clinical services by the system manager to the HHS. Separate arrangements will be established for these services including a Health Services Support Agency (HSSA) Support Services Agreement and the Information and Communication Technology (ICT) Support Service Agreement.

Regulatory and Legislative Framework

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 HHS binds each of them.

A HHS is a statutory body under the *Financial Accountability Act 2009* and the *Statutory Bodies Financial Arrangements Act 1982*, and is a unit of public administration under the *Crime and Misconduct Act 2001*. HHSs are responsible for ensuring they comply with this legislation as it applies to them.

Under the *Hospital and Health Boards Act 2011* one of the functions of HHSs is to comply with the health service directives that apply to the HHS. Section 50 of the *Hospital and Health Boards Act 2011* states that a health service directive is binding on the HHS to which it relates. The HHS must also comply with other directives, such as Ministerial directives applied under the *Public Service Regulation 2008*.

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.

Strategic Context

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.

The priorities for the Queensland public sector health system are defined in the Statement of Government Health Priorities as included in Schedule 1 of this agreement.

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 Schedule 1.

In delivering health services, HHSs are required to meet the applicable conditions of the CoAG National Agreements and National Partnership Agreements (NPAs) between the Queensland Government and the Commonwealth Government and commitments under any related Implementation Plans. A summary of obligations is provided at Schedule 7 to this Service Agreement.

HHSs are further required to ensure that all applicable whole of Government policies and requirements issued by the Queensland or Commonwealth Governments are complied with and that strategic planning undertaken is informed by whole of Government statewide plans and priorities and that any reporting requirements specified within statewide plans are complied with.

Hospital and Health Service Performance Framework 2012-2013

The NHRA requires the State of Queensland to establish a service agreement with each HHS and to implement a performance and accountability framework that includes processes for remediation of poor performance.

The HHS Performance Framework 2012-2013 recognises the changing nature of the relationship between HHSs, as independent statutory bodies, and the system manager, as the manager of the public health system in Queensland. In this context, it sets out a transparent, rules-based process for monitoring performance against clearly identified targets and includes a protocol for managing performance issues, including poor performance. The HHS Performance Framework 2012-2013 also recognises high performance.

The Key Performance Indicators (KPIs) against which the HHS's performance will be measured are detailed in Schedule 5 of this service agreement. The HHS Performance Framework 2012-13 forms part of the terms of this agreement and is included at Appendix 2.

Period of this Service Agreement

This service agreement commences on 1 July 2012 and expires on 30 June 2013.

In this service agreement, references to 2012-2013 are references to the period commencing on 1 July 2012 and ending on 30 June 2013.

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 (i.e. 31 December 2012).

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 system manager to manage amendments across all HHS service agreements and their effect on the delivery of public health in Queensland, amendment proposals will only be negotiated and finalised during set periods of time during the year (**Amendment Windows**). Whilst a party may submit an amendment proposal at any time, negotiation will only commence at the dates below for each amendment window;

- Amendment Window 1: 31 August 2012;
- Amendment Window 2: 30 November 2012;
- Amendment Window 3: 28 February 2013; and
- Amendment Window 4: 17 May 2013.

An amendment proposal is made by:

- The Chief Executive (or delegate) signing and providing an amendment proposal to the HHS-SA Contact Person prior to the commencement of any amendment window.
- The Chair of the HHS signing and providing an amendment proposal to the QH-SA Contact Person prior to the commencement of any amendment window.

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. A party giving an amendment proposal must provide the other party with the following information:

a) the reasons for the proposed amendment;

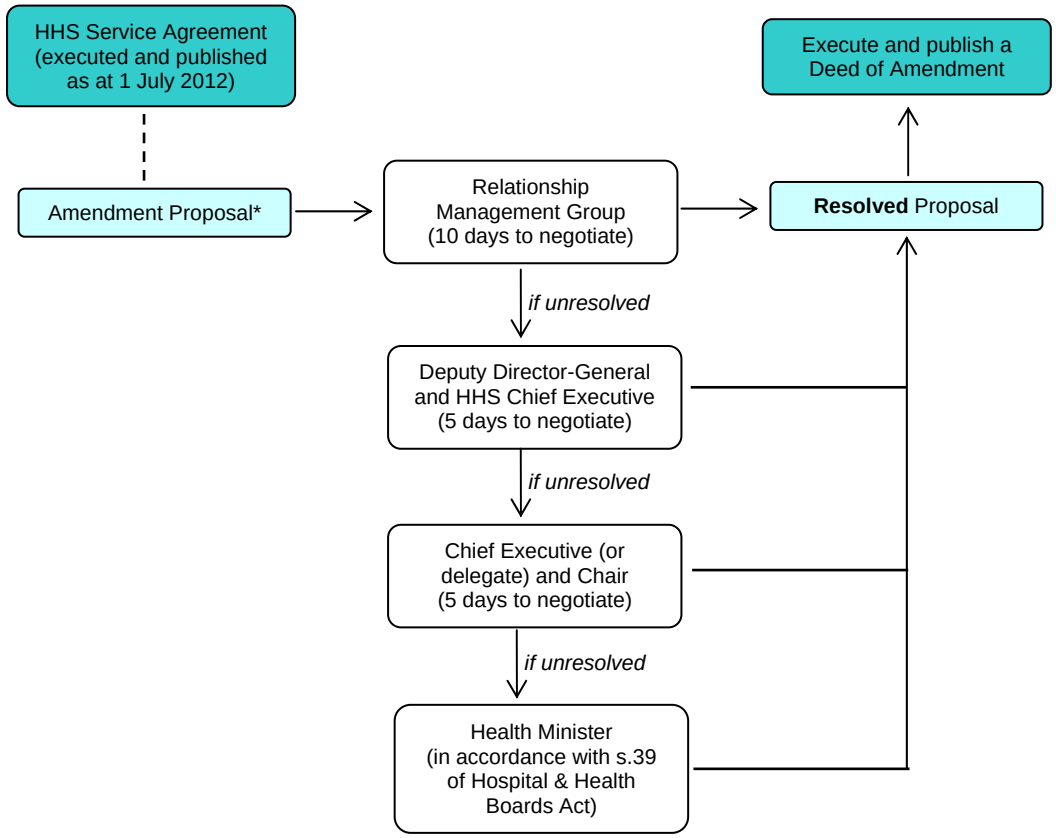
b) the precise drafting for the proposed amendment;

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

d) details and explanation of any financial or service delivery impact of the Amendment.

Negotiation and resolution of amendment proposals will be through a tiered process commencing with the relationship management group and culminating if required with the Health Minister, as illustrated in Figure 1 following.

Figure 1: Amendment Proposal Negotiation and Resolution



* If the Chief Executive considers that an Amendment Proposal (whether made by the Chief Executive or a Chair) relates to an urgent matter, the Chief Executive (or delegate) may reduce the Negotiation Period.

The In-year Service Agreement Management Rules for 2012-2013 detailed in Schedule 3 Part C to this service agreement 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. These adjustments will then be executed by means of an Amendment.

If the Chief Executive at any time:

e) considers that an Amendment agreed with the HHS may or will have associated impacts on other HHSs; or

f) consider it appropriate for any other reasons,

then the Chief Executive may,

g) propose further Amendments to any HHS affected; and

h) 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*.

Amendment Proposals that are resolved will be documented in a deed of amendment (**Deed of Amendment**) to this service agreement and executed by the Chief Executive (or delegate) and the Chair by the following dates:

- Amendment Window 1: 30 September 2012;
- Amendment Window 2: 31 December 2012;
- Amendment Window 3: 31 March 2013; and
- Amendment Window 4: 14 June 2013.

Only upon execution of a Deed of Amendment by both the Chief Executive (or delegate) and the HHS Chair will the amendments documented by that deed be deemed to be an amendment to this agreement.

Publication of Amendments

The system manager will endeavour to publish each executed Deed of Amendment within 14 days of the date of execution on a website specified by Queensland Health.

Amendments Arising from State Budget Announcements

All items within this Service Agreement are subject to further adjustment as a result of State Budget announcements for 2012-13.

Dispute Resolution

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.

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.

Resolution of disputes will be through a tiered process commencing with the relationship management group and culminating if required with the Health Minister, as illustrated in Figure 2 following. 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. Escalation through the dispute resolution process should be implemented only as a means of last resort. 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 and assist in respect of any requests for additional information or documents.

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 (**Notice of Dispute**).

The Notice of Dispute must be provided to the QH-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 Chief Executive.

The Notice of Dispute must contain the following information:

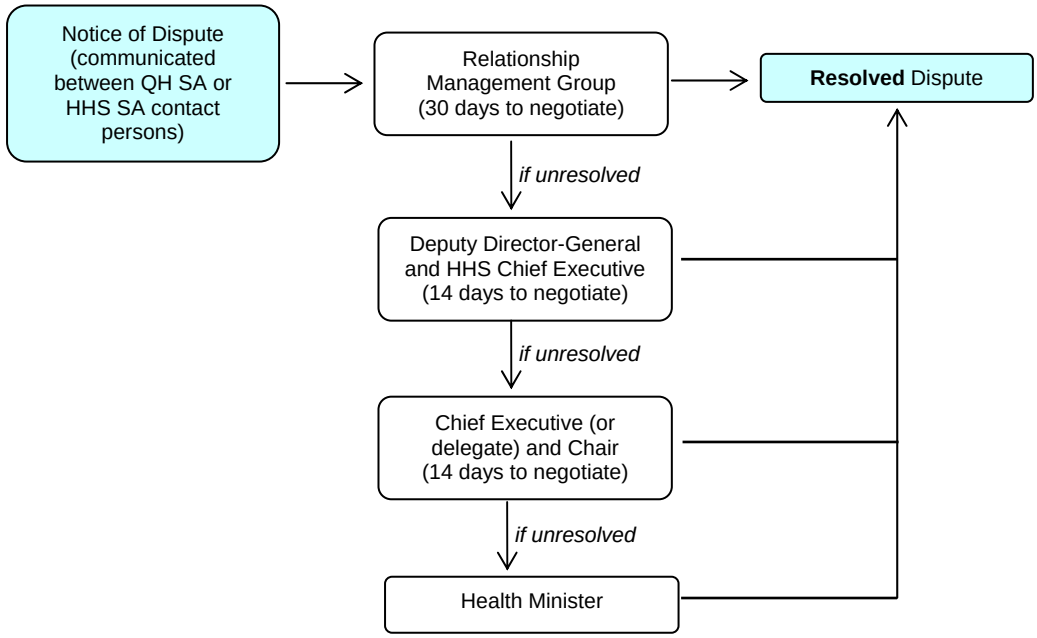
i) a summary of the matter in dispute;

j) an explanation of how the party giving the Notice of Dispute believes the dispute should be resolved and reasons to support that belief;

k) any information or documents to support the Notice of Dispute; and

l) a definition and explanation of any financial or service delivery impact of the dispute.

Figure 2: Dispute Resolution Process



Resolution of a Dispute

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.

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.

Continued Performance

Notwithstanding the existence of one or more disputes, the HHS must continue to perform and comply with this service agreement. Where the HHS claims that it cannot or will not comply with any aspect of this service agreement because of any dispute, the Chief Executive may direct the HHS to perform in a particular manner and the HHS must immediately comply with that direction.

Disputes between Hospital and Health Services

If a dispute arises between the HHS and another HHS or HHSs, the HHS is to have regard to guidance and/or directives that may be issued by the system manager from time to time in respect of the resolution of such disputes. If agreed by both parties the dispute can be referred to the system manager for dispute resolution.

Force Majeure

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:

m) give prompt written notice of the Force Majeure to the other party of:

- the occurrence and nature of the Force Majeure;
- the anticipated duration of the Force Majeure;
- the effect the Force Majeure has had (if any) and the likely effect the Force Majeure will have on the performance of the Affected Party's obligations under this agreement; and
- any Disaster Management Plan that applies to the party in respect of the Force Majeure;

n) use its best endeavours to resume fulfilling its obligations under this agreement as promptly as possible; and

o) give written notice to the other party within 5 days of the cessation of the Force Majeure.

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' performance or non-performance of this agreement during the Force Majeure and the HHS must comply with that direction.

Neither party may terminate this agreement due to a Force Majeure event.

Hospital and Health Service Accountabilities

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 Board Act 2011*;
- All Cabinet decisions applicable to the HHS;
- All Ministerial directives applicable to the HHS;
- All regulations made under the *Hospital and Health Board Act 2011*; and
- All health services directives applicable to the HHS.

The HHS must ensure that:

- All persons at Queensland Health facilities (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 service framework of the facility/s at which the service is provided).

- All Queensland public hospitals, day procedure services and health care centres (howsoever titled) are to maintain accreditation under the Australian Health Service Safety and Quality Accreditation Scheme against clinical and non-clinical standards. The scheme is scheduled to commence on 1 January 2013.
- Each HHS will appoint an accrediting agency/s from a panel of accrediting agencies listed on the Australian Commission on Safety and Quality in Healthcare (ACSQHC) web site.
- The clinical standards must include those contained in the ACSQHC's 10 clinical National Safety and Quality Health Service (NSQHS) standards. The ACSQHC is currently providing advice on the application of the NSQHS standards for rural, remote, dental and community services.
- The non-clinical standards will be those used by the HHS appointed accrediting agency/s.
- Accreditation of Residential Aged Care Facilities by the Aged Care Standards and Accreditation Agency will continue.
- General practices owned or managed by HHSs are to be externally accredited from 1 July 2012.
- Accreditation of general practices will be in accordance with the 4th Edition of the Royal Australian College of General Practitioners published accreditation standards.
- All facilities must undertake a self assessment in September each year against the Clinical Services Capability Framework (CSCF) to ensure the maintenance and provision of high quality, safe and sustainable services which meet the healthcare needs of our community. This self assessment must be reported annually to the system manager.
  - For 2012-2013 the baseline assessment will be the 2011 assessment against CSCF version 3. The system manager recognises that CSCF levels can change during the course of a year. HHSs will ensure that the system manager is advised of any changes in CSCF level through the notification process established by the Centre for Healthcare Improvement (CHI).
  - Where funding is directly linked to CSCF level, the system manager may seek to obtain verification of a change in level notified by a HHS, for example through review of the service by a Clinical Network.

Workforce Management

Health Service Employees (excluding persons appointed as a Health Executive) are employees of the Chief Executive as provided for in the *Hospital and Health Boards Act 2011*. The Chief Executive will provide Health Service Employees to perform work for the Service.

The Service will have control of the day-to-day management of these Health Service Employees. The HHS will administer this control in accordance with:

- terms and conditions of employment specified by Queensland Health in accordance with s 66 of the Hospital and Health Boards Act 2011;
- Health Service Directives, issued by the Chief Executive under s 47 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; and
- any other relevant legislation.

Schedule Ten details this arrangement.

Occupational Health and Safety

The HHS will continue to provide occupational health and safety practitioner services to all employees working within the geographic boundary of the HHS, unless other arrangements are made by the System Manager or Health Service Support Agency. This includes safety arrangements for employee incident investigation, workers compensation, rehabilitation and reporting.

The HHS is required to meet all of the accountabilities outlined in the following schedules:

Schedule 1 **Strategic Priorities**	This schedule outlines the strategic priorities which will inform all planning activities undertaken with the HHS and which will guide the delivery of services within each HHS.
Schedule 2 **Hospital and Health Service Profile**	This schedule provides a high level profile of the HHS and details the services and facilities that the HHS will continue to provide from 1 July 2012
Schedule 3 **Healthcare Purchasing and Service Agreement Value**	This schedule provides an overview of the Purchasing Framework and details the services being purchased from the HHS.
Schedule 4 **Funding Source and Schedule**	This schedule outlines the payments to be made to the HHS during the term of the agreement.
Schedule 5 **Key Performance Indicators**	This schedule outlines the Key Performance Indicators and targets that the HHS will be required to meet during the financial year and which will form the basis of performance management and escalation processes outlined in the Performance Framework.
Schedule 6 **Hospital and Health Service Development and Risk Action Plans**	This schedule outlines the approach to the progressive management and monitoring against the HHS Development Action Plan and Risk Action Plan as agreed following the readiness assessment process undertaken by Ernst & Young.
Schedule 7 **Commonwealth Agreement Obligations**	This schedule provides a summary of HHS obligations for 2012-2013 against the National Partnership Agreements and other Commonwealth Agreements.
Schedule 8 **Closing the Gap Obligations**	This schedule describes the accountabilities of the HHS with respect to the various state commitments to closing the gap in Indigenous health outcomes.
Schedule 9 **Mental Health and Alcohol and Other Drugs Treatment Services**	This schedule details the mental health services being purchased from the HHS and the associated performance measures to monitor the delivery of these services.
Schedule 10 **Workforce Management**	This schedule details the requirements relating to the day-to-day management of Health Service Employees (excluding persons appointed as a Health Executive) by the HHS.

The HHS will work in partnership with the system manager to deliver a public health system that delivers high quality hospital and other health services to the residents of Queensland.

System Manager Accountabilities

Without limiting any other obligations of the system manager, it must comply with:

- The terms of this service agreement;
- The legislative requirements as set out within the *Hospital and Health Board Act 2011*;
- All regulations made under the *Hospital and Health Board Act 2011*; and
- All Cabinet decisions applicable to Queensland Health.

The system manager will work in partnership 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 Board Act 2011* the system manager will;

- provide state-wide health system management including health system planning, coordination and standard setting, and
- balance the benefits of the local and system-wide approach.

Indemnity

The Hospital and Health Service indemnifies the system manager 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 system manager arising directly or indirectly from or in connection with:

p) any wilful, unlawful or negligent act or omission of the Hospital and Health Service or an officer, employee or agent of the Hospital and Health Service in the course of the performance or attempted or purported performance of this agreement, or

q) any penalty imposed for breach of any applicable law in relation to the Hospital and Health Service's performance of this agreement, or

r) a breach of this agreement,

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

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

Legal Proceedings

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

s) is transferred to a Service under section 307 of the Hospital and Health Boards Act 2011; or

t) is otherwise retained by the Department,

each party must (at its own cost):

u) do all things;

v) execute such documents; and

w) share such information,

in its possession and control that 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.

EXHIBIT 228

Execution

IMPORTANT

The terms of this service agreement have been decided by the Chief Executive under the provision set out in the *Hospital and Health Boards Act 2011*, s317.

Executed as an agreement in Queensland

Signed by **The Chief Executive, the Director-General, Queensland Health** in the presence of:)
)
)

Witness signature

Signature of Chief Executive

RACHEL JAGODZINSKI

Name of Witness (print)

DR ANTHONY O'CONNOR

Name of Chief Executive (print)

28/6/2012

(date)

Schedule 1
Strategic Priorities

Purpose

This schedule outlines the strategic priorities which will inform all planning activities undertaken with the HHS and which will guide the delivery of services within each HHS.

Statement of Government Health Priorities

Hospital and Health Services are required to ensure that HHS strategic planning is in alignment with the **Statement of Government Health Priorities** 2012 (SoGHP), as shown overleaf.

Government Plans

In addition to delivering against the SoGHP, the Hospital and Health Services are required to ensure that strategic planning undertaken is informed by both existing Queensland Whole of Government plans and Commonwealth Government plans as applicable. These are listed below for the reference of the Service.

Queensland Whole of Government Plans

Alignment is required but not limited to the following Queensland Whole of Government plans and priorities including any reporting requirements specified within these documents:

- Queensland Multicultural Action Plan, 2011-14
- Queensland Government Multicultural Policy, 2011
- Queensland Health Disability Service Plan 2011-2014
- Queensland Pandemic Influenza Plan, 2009
- Aboriginal and Torres Strait Islander Health Framework Agreement, 2002
- Torres Strait Health Framework Agreement, 2007
- Close the Gap Statement of Intent, 2008
- Queensland Plan for Mental Health, 2007
- Queensland Drug Action Plan, 2011

Commonwealth Government Plans

Alignment is required but not limited to the following Commonwealth Government plans:

- National Maternity Services Plan, 2010-2015
- Australian Government Disaster Response Plan (COMDISPLAN)
- National Strategic Plan for TB Control in Australia Beyond 2000
- National Palliative Care Strategy – Supporting Australians to Live Well at the End of Life
- Second National Sexually Transmissible Infections Strategy, 2010-2013
- Third National Hepatitis C Strategy, 2010-2013
- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013
- Fourth National Mental Health Plan
- National Drug Strategy 2010-2015

EXHIBIT 228

Statement of Government Health Priorities

The Queensland Government is committed to ensuring better healthcare outcomes for Queenslanders. There is a real need to replace the current managerial emphasis in health with a clear focus on the patient and the clinician. We need to shift resources to the frontline of health care, and ensure that every taxpayer dollar spent on health provides value for money for patients. We also need to decentralise decision-making, and empower communities and those working on the front line to have a greater say in how care is designed and delivered. Only by doing so will we improve health services and health outcomes, and ensure that the health system meets the needs of all Queenslanders.

Values

These drivers are reflected in the six values listed below. Together, these guide the Government's policies and actions to improve health outcomes for Queenslanders.

- Better services for patients
- Better healthcare in the community
- Valuing our employees and empowering frontline staff
- Empowering local communities with a greater say over their hospital and local health services
- Value for money for taxpayers, and
- Openness.

Priorities for Action

Revitalising Services for Patients

- Improve access and reduce waiting times to emergency departments, elective surgery and specialist diagnostic services – especially for those in rural and regional communities.
- Work with Medicare Locals to ensure a greater range of hospital services is provided in the community and in the home.
- Establish a new Maternal and Child Health Service staffed by nurses with experience in maternal and child health to provide home visits and free community clinics for families with infants up to the age of one.
- Reduce rates of chronic disease in the community by investing in health awareness and prevention campaigns.
- Engage with the Queensland Aboriginal and Islander Health Council to further advance the health of Indigenous people in Queensland.

Reforming Queensland's Health System

- Decentralise the delivery of healthcare in Queensland and give greater decision-making to Hospital and Health Boards to manage their hospitals and other health services in their communities.
- Establish rigorous oversight of the preparedness of Boards to take on additional responsibilities, and monitoring of the performance of Hospital and Health Services.
- Empower local communities with a greater say over their hospital and local health services.
- Ensure a smooth transition to the new national health funding system.

Focusing Resources on Frontline Services

- Identify wasteful and unnecessary expenditure (particularly in ICT), and ensure there are rigorous checks and balances on all spending.
- Streamline bureaucracy and reduce the transaction costs of red tape in health.
- Manage the growth in per capita health expenditure to ensure that health services and outcomes in Queensland are both affordable and sustainable.
- Improve the management of health budgets and finances.

Restoring Accountability and Confidence in the Health System

- Improve transparency of expenditure and on measures of success such as waiting times to give Queenslanders the true picture of our health system.
- Encourage a culture of frank and fearless advice from a professional and permanent public service.
- Ensure that the planning of future health services is based on population growth, demographics and health needs.
- Ensure that critical health infrastructure projects such as the Sunshine Coast University Hospital and the Queensland Children's Hospital are delivered on time, within budget and at low cost to the taxpayer.

June 2012

Schedule 2
Hospital and Health Service Profile

Purpose

This schedule:

- Provides an overview of West Moreton HHS; and
- Sets out the services which the HHS is required to provide throughout the 2012-2013 financial year and which are funded in accordance with schedule 3b (Service Agreement Value) of this service agreement.

By accepting the funding levels defined in Schedule 3, the HHS accepts responsibility for delivery of the associated programs and the reporting requirements to State and Commonwealth bodies as defined by the System Manager.

Definitions

In this Schedule 2:

- **Ambulatory Care** - 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
- **Clinical Services Capability Framework** - The Clinical Services Capability Framework for Public and Licensed Private Health Facilities v3.0 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** - Clinical services, such as pharmacy, pathology, diagnostics and medical imaging, that support the delivery of inpatient, outpatient and ambulatory care
- **Community Service** means services delivered outside of the hospital setting.
- **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 four years of age or older and have not completed Year 10 of secondary school.
  - Children who are younger than four years of age or have completed Year 10 of secondary school if they are dependents of current concession card holders or hold a current concession card themselves.
  - Other adults and children who meet specific eligibility criteria as defined in the Implementation Standard for Eligibility to Access Publicly Funded Oral Health Services.
- **Facility** - a physical or organisational structure that may operate a number of services of a similar or differing capability level.

- **Inpatient Service** – 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).
- **Outpatient service –** services delivered to non-admitted non-emergency department patients in defined locations
- **Outreach services** – outreach services refers to a range of services with a number of sub groups as follows:
  - Hospitals outreaching visiting services to other (usually smaller) hospitals within the same HHS
  - Hospitals outreaching visiting services to other (usually smaller) hospitals outside of the HHS
  - Hospitals outreaching services to community centres
  - Hospitals and/or community centres outreaching services to patients homes
- **Primary Care** - 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.
- **Service** - a clinical service provided under the auspices of an organisation or facility
- **Statewide service** - services for the whole of Queensland provided from only one or two service bases within Queensland as self-sufficiency in these services cannot be maintained due to the inadequate volume of cases. The service may include a statewide regulatory, coordination and/or monitoring role.
- **Super-speciality service** - services with a high level of clinical complexity. Includes the pre- and post-procedural care associated with highly specialised, high-cost, low-volume procedures. These services require a critical mass of highly specialised and often scarce clinical expertise.
- **Telehealth -** the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Hospital and Health Service Overview

The HHS is responsible for the HHS Area assigned to the HHS under the Hospital and Health Boards Regulation 2012. Situated 40 kilometres to the west of Brisbane, the HHS Area extends from Ipswich in the east, Boonah in the south, north to Esk and west to Gatton.

West Moreton HHS Area has the fastest growing population in the state and is anticipated to increase by over 50% from 249,576 to 379,660[1] by 2021. The demographic within this HHS Area is diverse and includes 13.4% of the population being born overseas and 3.6% Indigenous Australians (11.3% of the state total).

The HHS Area supports one main acute care hospital, four rural hospitals and The Park Centre for Mental Health. The Park Centre for Mental Health is a large hospital based and community mental health service which caters for all age groups across the range of mental health care, including forensic mental health and specialist services. The HHS also provides primary health care services, ambulatory services, acute and non-acute care, aged care and oral health care services.

[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)

Hospital Services and Facilities

Facilities

The HHS is responsible for operating the following hospital facilities. The levels allocated to each facility under the CSCF (v3.0) based on the 2011 self assessment is noted at Appendix 1.

- Ipswich Hospital
- Gatton Hospital
- Laidley Health Service
- Boonah Health Service
- Esk Health Service
- The Park Centre for Mental Health

Clinical Services Provided

The HHS will continue to provide the following services through the facilities listed above (Note: not all facilities provide all services and some services may be provided only in a limited capacity i.e. on an emergency basis):

Inpatient Services

- Breast Surgery
- Anaesthetic Services
- Cardiology
- Children's Services
- Colorectal Surgery
- Dental Surgery
- Geriatric Medicine
- Ear, Nose & Throat
- Endocrinology
- Gynaecology
- Gastroenterology
- Haematology
- Psychiatry, including Forensic Psychiatry
- Respiratory Medicine
- Thoracic Surgery
- Urology
- Palliative Care
- Pain Management
- Medical Oncology
- Head and Neck Surgery
- Immunology & Infections
- Neurology
- Neurosurgery
- General Medicine
- General Surgery
- Maternity
- Ophthalmology
- Orthopaedics
- Plastic & Reconstructive Surgery
- Drug & Alcohol
- Renal
- Rheumatology
- Nuclear Medicine
- Vascular Surgery
- Critical Care
- Sub-Acute Care

Outpatient and Ambulatory Services

- Emergency Department
- Drug & Alcohol
- Allied Health (including psychology, audiology, physiotherapy, podiatry, occupational therapy, social work and speech pathology)
- Older persons
- Diabetes
- General Paediatrics
- Internal Medicine
- Maternity

- Infectious Diseases
- Cardiology
- Chemotherapy
- Rheumatology
- Thoracic Medicine
- Gynaecology
- Orthopaedic Surgery
- Oncology
- Urology
- Palliative Care
- Rehabilitation
- Renal
- Mental Health
- General Surgery
- Ear Nose & Throat
- Ophthalmology
- Plastic & Reconstructive Surgery

The HHS will also purchase a range of clinical support services from the Health Services Support Agency (HSSA), including Pathology, Radiology and Forensic and Scientific Services.

Statewide Services

The HHS has oversight responsibility for the following Statewide services provided by the Park:

- Extended treatment and rehabilitation/dual diagnosis
- high security program
- adolescent unit services

Outreach and Telehealth Services

The HHS forms part of a referral network with other HHSs. The HHS must ensure continued effective provision of these outreach services, and will be required to participate in the following bodies of work to be undertaken in 2012-13 to inform the development of an appropriate purchasing model for outreach services in 2013-14:

- Outreach Data Collection Project – to ensure the explicit identification of outreach activity across the 3 major data collections for outpatient, inpatient and emergency services.
- Telehealth/Outreach Costing Study – to inform development of an appropriate pricing structure for outreach and telehealth service delivery.
- Telehealth/Outreach Substitutability Study – to determine which service types can, and should be, delivered by telehealth or by face-to-face outreach for the different clinical streams.

As a minimum, the HHS must maintain all outreach services which were provided within the financial year 2010-2011. Any adjustments to the level or mix of services must be agreed by both parties.

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

Primary Health and Community Services

Facilities

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

- Boonah Health Service
- Gatton Hospital
- Goodna Community Health Centre
- Esk Health Service
- Laidley Health Service
- Ipswich Health Plaza

Services Provided

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

- Older People's Health
- Oral Health
- Child Health
- School Health
- Home and Community Care
- Mental Health
- Family Support Service
- Women's Health
- Aboriginal and Torres Strait Islander Health
- Community Rehabilitation
- Child & Youth Mental Health
- Chronic Disease Management
- Alcohol Tobacco and Other Drug Services
- Community Health Programs
- Health Information Service
- Sexual Health Services

This list is not exhaustive and both parties agree to work collectively in 2012-2013 to more accurately identify services that should be provided from within non-ABF funding and make sure they are costed correctly.

Pending the completion of this work the HHS should continue to provide services where special recurrent allocations have been made to the identified Health Service District in prior years.

Communicable Disease Control and Immunisation Services

Tuberculosis Services

The HHS will ensure free access for all people to tuberculosis diagnostic and management services ensuring full adherence to treatment and appropriate screening.

Immunisation Services

The HHS will maintain or improve existing immunisation coverage through continuation of current immunisation services including national immunisation program, opportunistic immunisation in healthcare facilities and special immunisation programs.

The HHS will deliver the school based vaccination program as specified in the Immunisation Policy and associated Implementation Standard for the School Based Vaccination Program.

Communicable Disease Control

The HHS will continue to contribute to and support communicable disease prevention and control including ensuring timely notification of notifiable communicable diseases, provision of immunisation clinics as required for outbreaks/pandemics/emergency response, assistance with contact tracing and provision of prophylactic medications.

Sexual Health and Viral Hepatitis Services

The HHS will:

- Maintain or improve access to all existing Needle and Syringe Programs and continue to develop programs in response to local need.
- Maintain existing sexual health clinic service including access to S100 prescriber/s and authorised sexual health nurse/s.
- Maintain existing Indigenous sexual health outreach program.
- Maintain psychiatrist/psychologist services to people impacted by HIV, viral hepatitis and STIs.
- Maintain support for Metro South HHS based Contact Tracing Support Officer program.
- Maintain support for Darling Downs HHS based cross District HIV, Viral Hepatitis and Sexual Health Coordinator program.

- Maintain support for state funded HIV, viral hepatitis and sexual health funded community based programs for at risk populations including access to relevant resources.
- Maintain support for existing viral hepatitis and sexual health offender outreach programs.

Cancer Screening Services

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.
- Continue to provide Queensland Bowel Cancer Screening Program (QBCSP) services in accordance with the National Bowel Cancer Screening Program policy documents and the QBCSP Policy Manual.
  - Services to be provided across West Moreton HHS excluding the Statistical Local Area (SLA)'s of Lockyer Valley (R) - Gatton, Lockyer Valley (R) - Laidley.
  - Services to be provided within Metro South HHS for the SLA of Wacol only.
  - Services to be provided within Metro North HHS for the SLA of Karana Downs-Lake Manchester only.
  - Services to be provided within Darling Downs HHS for the SLA's Cherbourg, South Burnett (R) - Kingaroy, South Burnett (R) - Murgon, South Burnett (R) - Nanango, Western Downs (R) - Wambo, and South Burnett (R) - Wondai only.

The HHS will continue to provide BreastSreen Queensland service in accordance with the BreastScreen Australia National Accreditation Standards, the BreastScreen Queensland Standards, Policy and Protocols Manual and national policies.

- Services to be provided across the West Moreton HHS including Ipswich Local Government Area (LGA), parts of the Scenic Rim, Somerset, and Lockyer Valley LGAs.
- Services to be provided within Metro North HHS for Karana Downs-Lake Manchester Statisical Local Areas only.

The System Manager will provide the HHS with funding of $1.818 million for BreastScreen Queensland Services for the target number of women screened: 10,000 in 2012-13.

Preventative Health Services

The HHS will:

- Maintain delivery of the school based youth nursing program throughout Queensland secondary schools
- Maintain delivery of chronic disease and risk factor prevention strategies funded through the Indigenous Chronic Disease Package, targeting nutrition, physical activity, alcohol consumption and tobacco use.

Oral Health Services

- The HHS will ensure that Oral Health Services are provided to the Eligible Population at no cost to the patient and that the current range of clinical services will continue. These services will be provided, at a minimum, to the level provided in 2011-12.
- The HHS will 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 as formerly managed by the Office of the Chief Dental Officer.

Offender Health Services

The HHS will:

- Provide oral health services to South Queensland Correctional Centre (Gatton) which is located in Darling Downs HHS.
- Continue to host the statewide management of medical records for all Queensland prisoners (archiving facility provided at no cost by Queensland Corrective Services at Arthur Gorrie Correctional Centre)

- Provide appropriate health services to prisons located within your HHS consistent with the Memorandum of Understanding in relation to the provision of health services in Queensland Correctional Centres between Queensland Health and the Department of Community Safety.
- Where necessary, for both health and security reasons, agree for the transportation of the prisoner to the Princess Alexandra Security Unit for tertiary and secondary health services.
- Participate in the development, and operate within the agreed parameters, of governance arrangements with Queensland Corrective Services and Department of Community Safety.
- Be familiar with Queensland Corrective Services and Department of Community Safety procedures and the safety and security principles and acknowledge the associated security and impacts of the correctional environment.
- Apply existing Offender Health Services policy, procedure and/or guidelines and the Royal Australian College of General Practitioners Standards for Health Service in Australian Prisons.
- Work within the 2012 Business Planning Framework for nursing which includes the Nursing Service Profiles and the funded FTE.
- On release of a prisoner, medical records are to be transferred to Arthur Gorrie for long term archiving.
- Ensure medical records transfer with the prisoner when they are moving to another facility.

Funding for Offender Health Services will be added 'in-year' via a service agreement variation.

Mental Health Facilities and Services

The HHS will provide an integrated acute and community mental health service, including both community and inpatient care. Specialised alcohol, tobacco and other drug treatment services (ATODS) will also be provided.

The HHS will provide a range of specialist extended care mental health and forensic programs through the Park Centre for Mental Health (The Park), including an integrated forensic mental health service and high secure facility.

The key accountabilities and performance requirements placed on West Moreton HHS with regard to the continued delivery of specialised mental health and alcohol and other drug treatment services are specified in Schedule 9 of this service agreement.

Teaching, Training and Research

The HHS will provide the teaching, training and research programs for which funding is identified within Schedule 3 of this Service Agreement and as described below.

Four principles underpin the provision of teaching (generally referred to as clinical education and training) and research within and across Hospital and Health Services:

- Sustainability - Clinical education and training and research programs are maintained and support investment in pre-entry clinical education and assist the development of a sustainable workforce.
- Consistency – Clinical education and training of clinicians is managed in a consistent manner across Hospital and Health Services to support transferability and flexibility.
- Efficiency – Clinical education and training and research programs are managed in a way that promotes the efficient use of available resources within and across Hospital and Health Services.
- Collaboration - Hospital and Health Services work together to promote appropriate clinical workforce distribution and meet community needs.

Hospital and Health Services will continue to:

- Provide placements for:

  - medical students
  - nursing students
  - pre-entry clinical placement for allied health students
  - interns
  - rural generalist trainees
  - vocational medical trainees
  - first year nurses and midwives
  - oral health students
- Participate in vocational medical rotational training schemes and facilitation of the movement of vocational trainees between Hospital and Health Services.

In addition, the *Health Practitioner (Queensland Health) Certified Agreement (No 2) 2011* (the HP agreement) requires Hospital and Health Services to:

- Continue to implement the models of care projects that are trialling advanced/extended scope of practice roles, use of support staff and integration of health services across the continuum. This includes the evaluation of these trials, quarterly reporting on the trials, renegotiation of trials, approval of successful models and the permanent implementation of these new approved roles/positions by or before 31 August 2013 as provided under clause 51.3 of the HP agreement.

Health and Medical Research

The HHS will:

- work with the Office of Health and Medical Research (OHMR) to 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 2010].
- work with OHMR to develop mechanisms for monitoring site research activity in line with National Health and Medical Research Council Guidelines [Clinical Trials Action Group Report 2011].

work with OHMR to develop systems to capture Research and Development expenditure and revenue data and associated information on research.

Schedule 3
Healthcare Purchasing and Service Agreement Value

Introduction

All elements relating to healthcare purchasing by the System Manager from the HHS in 2012-2013 are detailed within this schedule.

The schedule has been structured as follows:

- PART A – The 2012-2013 Healthcare Purchasing Framework: description of the seven purchasing intentions for 2012-2013.
- PART B – Service Agreement Value: itemisation of the services to be purchased from the HHS in 2012-2013 including both the activity based funding components and the non-activity based funding components. A total service agreement value is provided within the Service Agreement offer table.
- PART C – In-Year Service Agreement Management Rules for 2012-2013: description of the in-year service agreement management rules that will apply to all services purchased in 2012-2013.

Definitions

In this Schedule 3:

- **Activity Based Funding (ABF)** –The funding framework which is used to manage how public health care services are 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 the cost 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.
- **Activity Management Plan** means a plan agreed between the System Manager and the HHS which outlines the agreed approach to managing activity volumes back to the levels or thresholds outlined within the Service Agreement Value.
- **Block Funding** means Funding for those services which are outside the scope of ABF.
- **Day Case** means a treatment/procedure undertaken where the patient is admitted and discharged on the same date.
- **Diagnosis Related Group (DRG)** is a broad classification system for grouping clinically similar patients together. Within the ABF model a cost weight is assigned which determines the relative level of payment.
- **Extended Day Case** means a treatment/procedure undertaken where the patient is admitted and discharged within a 23 hour period, including an overnight stay if necessary.
- **Never events** means serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- **Own Source Revenue (OSR)** means, as per Section B13 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)
  - 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 be treated as public or private patients, therefore allowing their private health insurance to work for them. Private patient fees are also classed as OSR.

- **Purchasing Intentions (PI) Specification** means the document which details the aim, rationale and specification for each purchasing initiative.
- **Purchasing Model means** the calculation tool which applies the purchasing methodology. It comprises two modules; a 'growth module' which calculates the activity to be purchased and a 'calculation module' which calculates and applies the impact of the purchasing adjustments.
- **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.
- **Service Agreement Value** means the figure set out in Schedule 3 Part B as the expected annual Service Agreement value of the Services purchased by the System Manager.
- **Tolerances** means the agreed variation from the agreed activity volumes outside of which an activity management plan would be required. For 2012-2013 this is +/-1% overall or on any specific category.

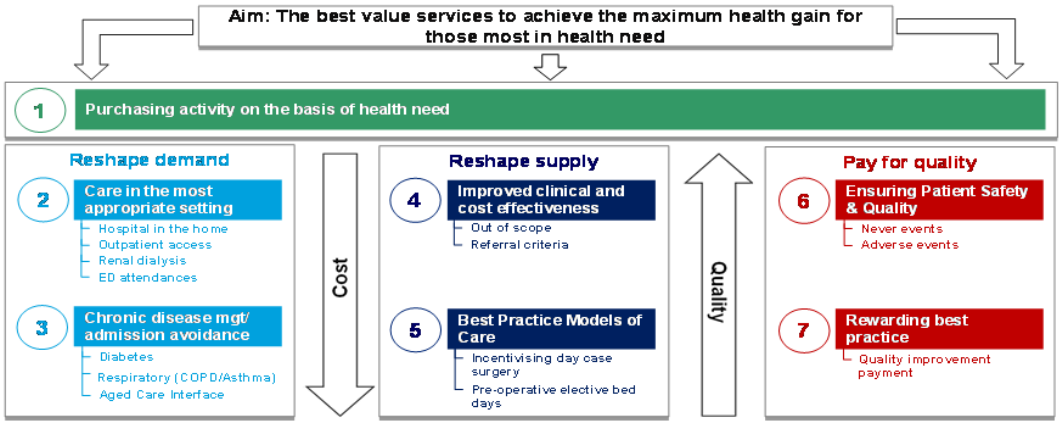
PART A: The 2012-2013 Healthcare Purchasing Framework

Healthcare purchasing is the act of the System Manager committing resources with the aim of improving health, reducing inequalities and enhancing patient experience. It is a key function of the System Manager. Each financial year the System Manager will consult HHSs about the Purchasing Intentions.

The purchasing framework is currently restricted to the 28 ABF facilities with the exception of 'Purchasing Activity on the Basis of Health Need', Own Source Revenue and the Quality Improvement Payment which will be HHS-wide. All purchasing initiative calculations are based on 2010-2011 actuals and/or actual in year (2012-2013) performance. The impact of each of these initiatives on the HHS is included within Part B (Service Agreement Value).

There are seven purchasing intentions within the framework for 2012-2013. These are illustrated in Figure 1 below, and further described in this schedule.

Figure 3.1: Healthcare Purchasing Framework 2012-2013



The Purchasing Model

The Purchasing Model is the calculation tool which applies the methodology. It comprises two modules; a 'growth module' which calculates the activity to be purchased and a 'calculation module' which calculates and applies the impact of the purchasing adjustments and generates the overall level of activity to be purchased. The output of the Model directly relates to the Service Agreement Value. The Model is maintained by the System Manager and is reviewed on an annual basis.

Purchasing Intentions

Each of the sections of this Part A is a summary only of each of the seven Purchasing Intentions (PIs). More detail regarding each particular PI is set out in the corresponding PI Specification which is available on the Queensland Health website on the HHS 2012-13 Service Agreement and Resources page. Specific calculations and budgets for each PI are determined by the Purchasing Model.

Resolving Inconsistencies

In the event of inconsistency between any of the following documents:

- this Service Agreement,
- the Purchasing Model; and
- a PI Specification;

The document higher in the list above shall prevail solely to the extent of the inconsistency.

Purchasing Intention 1: Purchasing activity on the basis of health need

The Purchasing Model projects for 2012-2013 what levels and types of activity need to be purchased from the HHS on the basis of current projections within the Acute Inpatient Modelling tool, service planning benchmarks and known areas of under investment by the HHS, as supplied to Healthcare Purchasing.

The methodology follows an agreed set of principles, ('Principles for Setting Activity Targets' endorsed by the ABF Project Board on 11 November 2011), which takes account of existing service plans, targets a more 'equitable' distribution of funding and ensures sufficient activity is purchased to enable National Partnership Agreement targets to be delivered.

The projections incorporate specific initiatives, for example, regional cancer centres, and are grouped into six activity categories as follows:

- Inpatients,
- Outpatients,
- Critical Care,
- Emergency Department,
- Sub-acute and Non-acute Patients, and
- Mental Health.

'Transitional costs' (i.e. lead-in costs agreed by finance for major infrastructure developments) will be fully funded in the Purchasing Model in 2012-2013 but no allowance has been made for increased costs associated with running new buildings at less than capacity; that is, no top up payments to ABF prices will be made.

Purchasing Intention 2: Care in the most appropriate setting

2.1 Hospital in the Home

A target of 1.5% of all inpatient admissions to be managed within Hospital in the Home (HITH) has been set. Admissions to be converted from inpatient to HITH have been funded at 63% (based on nationwide review of HITH costs) of the inpatient tariff. This model assumes substitution of acute care. As part of this change, 63% funding will also be provided for non-complex cellulitis which was the subject of the 2011-2012 purchasing initiative.

2.2 Outpatient Access

This initiative seeks to incentivise HHSs to recall patients to hospital outpatient appointments only when clinically necessary and to explore appropriate alternatives including discharging completely or discharging back to primary care. This is incentivised by reducing the purchased volume of public and face to face outpatient review appointments by 20% (excluding the clinic types of renal, transplants, cystic fibrosis and cancer treatments). Given recent HHS clinical audits, it is assumed that existing ratios can be reduced and in so doing more new outpatients can be seen in the key long wait specialities including ophthalmology, gastroenterology, orthopaedics etc. These new occasions of service will be funded as part of the growth within the health needs section.

2.2 Renal

This initiative seeks to promote the delivery of more renal dialysis in the home by paying the home dialysis price at the level of best practice benchmarks of 50% of dialysis to be undertaken at the patient's home (40% in Northern Queensland). It has been refined to include all modality types and exclude inter-HHS activity.

2.4 Emergency Department Attendances

In order to deliver improved value, a nil payment is made for Emergency Department (ED) 'did not waits' in ABF facilities. In addition, a new ED Admission policy will be implemented by the Centre for Healthcare Improvement in conjunction with clinical leads from 1 July 2012.

Purchasing Intention 3: Chronic disease management/admissions avoidance

One of the key initiatives, to improve clinical and cost effectiveness in the healthcare system is to manage chronic diseases outside the acute care setting and avoid admissions. In order to calculate the opportunity, this PI targets a clinically achievable reduction in admissions for non-complex diabetes (40% reduction), non-complex Chronic Obstructive Pulmonary Disease/ Asthma (25% reduction) and emergency medical admissions from the elderly (defined as 70 years and over - 5% reduction). The proposed avoided admissions are funded at a rate of 63% of the DRG cost weight. Performance will be tracked in-year on the basis of overall levels of medical admissions rather than for any specific DRG.

Purchasing Intention 4: Improved clinical and cost effectiveness

4.1 Out of Scope

Activity associated with vasectomies, reversal of vasectomies and laser refraction in accordance with the 'Scope of Publicly Funded Services' policy are deemed to be out of scope and will not be purchased.

4.2 Referral Criteria

This initiative aims to ensure a consistent approach to the selection and prioritisation of those patients that would benefit most from certain procedures which are in high demand. The focus for 2012-2013 is varicose vein surgery, hip and knee replacements and cataracts.

There are two elements to the initiative:

- Reduce activity volume for varicose vein surgery based on undertaking surgery only in accordance with the referral criteria as defined in the policy 'Scope of Publicly Funded Services' (ie *varicose veins are deemed to be not in scope except where there is a significant dysfunction or disability, or venous ulcers).*
- The Centre for Healthcare Improvement (CHI) to work with lead clinical groups to introduce referral criteria for orthopaedics (hip and knee replacements) and ophthalmology (cataracts) in order to ensure the most serious patients are seen and overall waiting times are reduced. There will be no financial adjustment for these issues.

Purchasing Intention 5: Best practice models of care

5.1 Incentivising Day Case Surgery

A range of DRGs will be funded as if they were either undertaken as a Day Case or an Extended Day Case, i.e. the value of the identified activity is adjusted to reflect the reduced costs of the shorter stay. DRG lists for Queensland have been identified based on the criteria that at least 50% of current activity in Queensland is undertaken on a same day or extended day basis. For the same day list the target is 90% of elective and 80% of the emergency activity to be undertaken as extended day. For extended day the target is 90% for all elective activity and 50% for the emergency activity (only 3 DRGs included, Appendicectomy, Hernia, Laparoscopic Cholecystectomy and Obesity procedures).

The full list of DRGs are available in the PI Specification.

5.2 Pre-operative Elective Bed Days

HHS funding has been reduced by a value equivalent to those elective surgery episodes where length of stay has been greater than trim point and pre-operative bed days were incurred; the maximum reduction will be the total number of pre-operative bed days.

Purchasing Intention 6: Ensuring patient safety

6.1 Never Events

The System Manager has defined a list of six 'Never events' for which it will not pay in 2012-2013. Due to the infrequency of these events there has been no adjustment made to baseline service agreement values, however in-year adjustments will be made in accordance with the service agreement amendment process. No payments will be made for these events or any related follow up work,

Never events in 2012-2013 are;

- Haemolytic blood transfusion reaction resulting from blood type incompatibility,
- Death or likely permanent harm as a result of bed rail entrapment or entrapment in other bed accessories,
- Infants discharged to the wrong family,
- Death or neurological damage as a result of Intravascular gas embolism,
- Procedures involving the retention of instruments or other material after surgery, and
- Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.

6.2 Adverse Events

This initiative reduces payments to HHSs in the event of a hospital acquired bloodstream infection ($10k reduction) and/or a stage 3 or 4 pressure injury ($30k or $50k reduction respectively). The reduced payments are based on international/national evidence of the additional hospital costs of patients who acquire these conditions.

Adjustments have been made to baseline Service Agreement Values (Schedule 3) based on 2010-2011 actuals. Progress in 2012-2013 will be monitored and if the level of incidence changes, corresponding financial adjustments will be made in accordance with the service agreement variation process.

Purchasing Intention 7: Quality Improvement Payment

In order to incentivise improved performance and patient care an uplift on ABF funding is made for those HHSs who achieve improved performance in three specific areas as follows:

- To achieve the 2013 National Elective Surgery targets (NEST) for patients seen within clinically recommended timescales as follows: Cat 1= 100%, Cat 2=87%, Cat 3 = 94%.
- To achieve a minimum of 95% of patients admitted as an emergency for repair of fractured neck of femur (#NoF) are taken to theatre within 48 hours of admission.

- To achieve the 2013 National Emergency Access Target (NEAT) of 77% of all ED patients having a length of stay of 4hrs or less and that 90% of all ED ambulance patients are off stretcher within 30 minutes.

Payments are linked to each of the three areas, but for each one the target has to be achieved in full for payment to be made. Compliance will be assessed in December 2012, and if successful, a HHS will receive 40% of the payment. If a HHS is compliant for the full year, the remaining amount will be paid in 2013-2014.

PART B. Service Agreement Value

The Finance and Activity Schedules in the following tables provide an itemised description of the volume and value of services that will be purchased from the HHS in 2012-2013. Whilst the services are itemised by facility to allow for ease of calculation purposes, purchasing is at the HHS level.

The following provisions are to be noted:

- Funding for Enterprise Bargaining agreements has been provided as follows:
  - EB8 (administrative, operational, demand, technical and professional stream employees) at a rate of 3.0%
  - Building, Engineering and Maintenance Service employees at a rate of 3.0%
  - Medical Officers at a rate of 3.0% (to be confirmed)
  - Nurses and Midwives at a rate of 2.5%
  - Health Practitioners at a rate of 2.5%
  - Visiting Medical Officers at a rate of 2.5%
  - Health Service Executives and Senior Officers at a rate of 2.5%
- Funding for non-labour costs escalation has been provided at a rate of 3.7%.
- HHS governance costs have been applied to the value of $1,288,727.
- Adjustments for efficiency have been applied at a rate of 0.5% of total budget with a further 0.5% applied (standard efficiency) on ABF expenditure where an ABF Facility is currently deemed to be inefficient. A review is currently taking place of the ABF Model and where a HHS's assessment changes from inefficient to efficient the second 0.5% described above will be returned to the HHS.
- In addition to standard efficiency targets an additional productivity requirement has also been applied to the finance schedule.
- It is acknowledged that the service agreement has been signed on the basis that the current position of clawbacks, which Divisions have made to Districts, is being reviewed and any changes agreed will be actioned in the first amendment window.
- With respect to 2011-2012 Health Service District deficits, these will be topsliced (non-recurrently) from HHS service agreement values in the first amendment window. However, deficits will only be top sliced up to a level where the combined impact of the standard efficiency requirement plus the impact of ABF (price and volume), plus the 2011-12 actual deficit, less any financial support (WAU or Non WAU backed including unfunded 2011-2012 indexed growth) already provided is less than 3% of the 2012-13 service agreement value.
- It is acknowledged by both parties that the spilt of non-ABF funding is provisional and will be further reviewed in 2012-2013 to ensure an accurate analysis informs the Service Agreement commencing 1 July 2013. As part of this analysis further work to identify special funding streams for specific outcomes will be identified. Should these outcomes not be specifically scheduled within this service agreement it does not mean that such outcomes should not be delivered by the HHS. During the first six months of 2012-2013 the System Manager will provide the HHS with a split of the service agreement value between recurrent and non-recurrent funds to aid future planning.
- It should be noted that on the basis of the growth being purchased by the System Manager it is anticipated that the total year to date FTE (as measured by MOHRI) will be no more than 2,563 FTE in 2012-13. This measure has also been included as an escalation KPI.

EXHIBIT 228

Finance and Activity Schedule: West Moreton

Facility	Ipswich Hospital		CSO West Moreton		PRIV West Moreton		<Blank>		<Blank>		<Blank>		<Blank>		Other Allocations		HHS Total (2012/13)		HHS (2011/12)		Change	
Units	WAU's	$	WAU's	$	WAU's	$	-	-	-	-	-	-	-	-	WAU's	$	WAU's	$	WAU's	$	WAU's	$
ABF Activity																						
Inpatient	28,121	122,592,117	-	-	-	-	-	-	-	-	-	-	-	-			28,121	122,592,117	25,969	108,388,777	2,151	14,203,340
Critical Care	2,120	9,240,027	-	-	-	-	-	-	-	-	-	-	-	-			2,120	9,240,027	2,120	8,846,284	-	393,743
Emergency Department (ED)	5,315	23,171,156	-	-	-	-	-	-	-	-	-	-	-	-			5,315	23,171,156	5,296	22,102,889	19	1,068,266
Mental Health	3,975	17,327,654	-	-	-	-	-	-	-	-	-	-	-	-			3,975	17,327,654	3,322	13,864,528	653	3,463,127
Sub acute	3,452	15,049,833	-	-	-	-	-	-	-	-	-	-	-	-			3,452	15,049,833	3,104	12,953,289	349	2,096,544
Outpatient	4,833	21,070,755	-	-	-	-	-	-	-	-	-	-	-	-			4,833	21,070,755	4,627	19,312,170	206	1,758,585
Total	47,816	208,451,542	-	-	-	-	-	-	-	-	-	-	-	-			47,816	208,451,542	44,437	185,467,938	3,378	22,983,604
Other ABF Adjustments																						
Non-WAU Demand Management	-	(400,000)	-	-	-	-	-	-	-	-	-	-	-	-	-	1,840,085	-	1,440,085	-	(1,840,085)	-	3,280,170
Efficiency Adjustment - TBC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	(1,830,244)	-	(1,830,244)	-	-	-	(1,830,244)
Transistional ABF Adjustment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16,421,877	-	(16,421,877)
Other ABF Adjustments	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8,319,632	-	8,319,632	-	-	-	8,319,632
Clinical Education & Training	-	7,880,034	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	7,880,034	-	7,656,111	-	223,923
Total	-	7,480,034	-	-	-	-	-	-	-	-	-	-	-	-	-	8,329,474	-	15,809,508	-	22,237,903	-	(6,428,396)
Site Specific Grants																			-	1,404,230		
Unlinked Diagnostics	-	844,783	-	-	-	-	-	-	-	-	-	-	-	-			-	844,783				
Blood Products	-	413,446	-	-	-	-	-	-	-	-	-	-	-	-			-	413,446				
Adult Congenital Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Brain Injury Rehabilitation Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Genetic Health Queensland	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Haemophilia Centre	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Hyperbaric Medicine Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Hyperbaric Outsourced	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Interim Care Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Lithotripsy	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Mater Contract - Palliative Care	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Neonatal Retrieval Service - North (	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Neonatal Retrieval Service - SE Qld	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Organ Transplant - Multiple DRGs	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Organ Transplant - Outpatients	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Orthotics & Prosthetics Department	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Outsourced - Lithotripsy & Hyperbar	-	91,600	-	-	-	-	-	-	-	-	-	-	-	-			-	91,600				
Outsourced - Oncology Outpatients	-	287,500	-	-	-	-	-	-	-	-	-	-	-	-			-	287,500				
Paediatric Retrieval Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Paediatric & Adolescent Gynaecolo	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Qld Centre for Gynaecological Onc	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Qld Spinal Cord Injuries Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Statewide Cerebral Palsy Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Statewide Haemophilia Centre	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Statewide Rehabilitation Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Statewide Telepaediatric Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Transplant Services - A01Z, A09A&	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Transplant multiple DRGs	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Tranplant Servs - OP Unlinked	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Neurosurgery Unit	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Respiratory Unit	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Deep Brain Stimulation	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Coil Insertions	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Cellular Therapy Lab (Bone Marrow	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Extra Corporeal Membrane Oxygen	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
Percutaneous Valve Replacement	-	-	-	-	-	-	-	-	-	-	-	-	-	-			-	-				
External Medical Cost Imbalance	-	368,250	-	-	-	-	-	-	-	-	-	-	-	-			-	368,250				
Total	-	2,005,578	-	-	-	-	-	-	-	-	-	-	-	-			-	2,005,578	-	1,404,230	-	601,348
Total ABF	**47,816**	**217,937,154**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**8,329,474**	**47,816**	**226,266,628**	**44,437**	**209,110,071**	**3,378**	**17,156,556**
Non-ABF																						
CSO Facilities	-	-	5,888	20,471,867	-	-	-	-	-	-	-	-	-	-	-	-	5,888	20,471,867	5,888	20,471,867	-	-
Priv Facilities	-	-	-	-	165	688,694	-	-	-	-	-	-	-	-	-	-	165	688,694	165	688,694	-	-
Peer Facilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Statewide Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Community Health	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6,291,478	-	6,291,478	-	-	-	6,291,478
Community Mental Health	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	7,562,396	-	7,562,396	-	-	-	7,562,396
Residential Aged Care	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Oral Health	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8,972,126	-	8,972,126	-	-	-	8,972,126
Shared Services Provider	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Patient Transport	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2,871,449	-	2,871,449	-	-	-	2,871,449
Tertiary Mental Health	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	53,833,424	-	53,833,424	-	-	-	53,833,424
Other Non-ABF	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	30,343,933	-	30,343,933	-	122,165,626	-	(91,821,694)
Other Funding - TIED	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	12,290,821	-	12,290,821	-	-	-	12,290,821
Total	-	-	5,888	20,471,867	165	688,694	-	-	-	-	-	-	-	-	-	122,165,626	6,053	143,326,188	6,053	143,326,188	-	(0)
Other Adjustments																						
Depreciation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8,532,471	-	8,532,471	-	8,252,324	-	280,147
Inflation (Non-ABF Only)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5,308,208	-	5,308,208	-	-	-	5,308,208
HHS Governance Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,288,727	-	1,288,727	-	-	-	1,288,727
Other Adjustments	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	(5,844,055)	-	(5,844,055)	-	-	-	(5,844,055)
Deficit Correction Adjustment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	(5,670,583)	-	(5,670,583)	-	(5,670,583)	-	-
2011/12 Deficit Rolled Forward	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transition Funding	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	83,008	-	83,008	-	-	-	83,008
Other Funding	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3,697,776	-	3,697,776	-	2,581,741	-	1,116,035
Non-ABF Total	**-**	**-**	**5,888**	**20,471,867**	**165**	**688,694**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**125,863,402**	**6,053**	**147,023,964**	**6,053**	**145,907,929**	**-**	**1,116,035**
Total	**47,816**	**217,937,154**	**5,888**	**20,471,867**	**165**	**688,694**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**134,192,876**	**53,868**	**373,290,591**	**50,490**	**355,018,000**	**3,378**	**18,272,591**

Itemised Activity Schedule: West Moreton

EXHIBIT 228

Inpatients	2012/13 Purchased	
Service Related Group (SRG)	**Episodes**	**WAU**
Breast Surgery	136	153
Cardiac Surgery	-	-
Cardiology	3,249	1,788
Chemotherapy & Radiotherapy	-	-
Colorectal Surgery	304	813
Dental Surgery	451	311
Dermatology	132	76
Diagnostic GI Endoscopy	2,383	950
Drug & Alcohol	418	194
Ear, Nose & Throat	1,816	1,175
Endocrinology	559	456
Extensive Burns	23	4
Gastroenterology	1,423	757
Gynaecology	1,327	1,216
Haematological Surgery	25	49
Haematology	175	139
Head & Neck Surgery	85	147
Immunology & Infections	823	869
Interventional Cardiology	-	-
Medical Oncology	327	320
Neurology	1,288	1,351
Neurosurgery	245	174
Non Subspecialty Medicine	1,567	950
Non Subspecialty Surgery	2,341	1,977
Obstetrics	3,345	3,664
Ophthalmology	436	189
Orthopaedics	3,268	5,257
Plastic & Reconstructive Surgery	409	453
Qualified Neonate	645	540
Renal Dialysis	7,789	1,426
Renal Medicine	187	156
Respiratory Medicine	2,292	2,278
Rheumatology	217	120
Thoracic Surgery	62	66
Tracheostomy	34	243
Transplantation	-	-
Upper GIT Surgery	724	948
Urology	1,184	1,001
Vascular Surgery	160	257
Inpatient Sub-Total	**39,851**	**30,468**

Critical Care	2012/13 Purchased	
Bed Type	**OBDs**	**WAU**
CCU	1,031	389
ICU	1,515	1,244
NICU	-	-
PICU	-	-
SCN	3,788	487
Critical Care Sub-Total	**6,334**	**2,120**

Emergency Department	2012/13 Purchased	
Presentation Type	**OOS**	**WAU**
Cat 1 (Admitted and Discharged)	463	179
Cat 2 (Admitted and Discharged)	4,088	860
Cat 3 (Admitted and Discharged)	16,299	2,385
Cat 4 (Admitted and Discharged)	17,618	1,595
Cat 5 (Admitted and Discharged)	4,785	288
Did Not Wait	-0	-
Died	36	8
Emergency Services Treated	17,506	1,976
Emergency Department Sub-Total	**60,794**	**7,291**

Sub and Non-Acute Patients	2012/13 Purchased	
Bed Type	**OBDs**	**WAU**
GEM	3,955	709
MAINT	4,713	814
PALLIATIVE	2,713	776
REHAB	10,354	2,078
SNAP Sub-Total	**21,735**	**4,378**

Mental Health	2012/13 Purchased	
Activity Type	**OBDs**	**WAU**
Designated Bed (Per Diem Activity)	14,422	3,831
Psychiatry - Acute (SRG)	628	163
Mental Health Sub-Total	**15,050**	**3,995**

Outpatients	2012/13 Purchased		2012/13 Purchased (New)		2012/13 Purchased (Review)		2012/13 Purchased (Other)	
Clinic Type	**OOS**	**WAU**	**OOS**	**WAU**	**OOS**	**WAU**	**OOS**	**WAU**
Medical	6,107	456	1,697	162	4,410	294	-	-
Surgical	27,551	1,365	11,380	702	16,171	662	-	-
Allied Health	24,948	1,274	5,848	308	13,729	758	5,371	208
Pre-Admission	6,298	411	1,956	139	4,342	273	-	-
Paediatric	1,872	111	484	36	1,389	75	-	-
Neonatal	-	-	-	-	-	-	-	-
Maternity	18,682	700	5,488	279	13,194	421	-	-
Alcohol & Drug	-	-	-	-	-	-	-	-
Sub Acute	8,376	595	301	35	474	27	7,601	532
Clinical Measurement	5,152	128	4,866	112	286	16	-	-
Wound Management	747	28	173	6	574	22	-	-
Pain Management	-	-	-	-	-	-	-	-
Cystic Fibrosis	-	-	-	-	-	-	-	-
Transplants	-	-	-	-	-	-	-	-
Endoscopy	1	0	1	0	-	-	-	-
Interventional Cardiology	-	-	-	-	-	-	-	-
Renal Medicine	378	33	29	4	349	29	-	-
Dialysis	-	-	-	-	-	-	-	-
Chemotherapy	1,209	462	54	21	1,155	441	-	-
Medical Oncology	154	12	-	-	154	12	-	-
Radiation Oncology	-	-	-	-	-	-	-	-
Clinical Haematology	-	-	-	-	-	-	-	-
Pharmacy	-	-	-	-	-	-	-	-
Community Health Services	-	-	-	-	-	-	-	-
District Nursing Services	-	-	-	-	-	-	-	-
Diagnostic Imaging	-	-	-	-	-	-	-	-
Psychiatry	-	-	-	-	-	-	-	-
Primary Care	-	-	-	-	-	-	-	-
Other	1,184	44	-	-	-	-	1,184	44
Outpatient Sub-Total	**102,660**	**5,617**	**32,277**	**1,804**	**56,228**	**3,029**	**14,156**	**784**

Overall Activity	+53,868

PART C. In-Year Service Agreement Management Rules for 2012-2013

Both the System Manager and the HHS have a mutual responsibility to respond to the health needs of their populations. They will co-operate to ensure that activity targets are constructed, monitored and reviewed, in accordance with the service agreement management framework to reflect the changing health needs of their populations, changes in the distribution profile of activity and casemix, the capacity requirements of national and local requirements and standards, and any innovative treatment or clinical practice recommended by advisory committees (e.g. a Clinical Network, the Queensland Policy and Advisory Committee for New Technology) and endorsed by Queensland Health Executive Management Team/Queensland Health Integrated Policy and Planning Executive Committee.

The HHS will manage activity so as to achieve the requirements and performance standards identified in this Service Agreement and so as to ensure that all services are provided to patients within the time limits set out (for example, NEST and NEAT).

Where, the HHS engages sub-contractors to provide particular services on their behalf the HHS remains accountable for the performance of the overall contract, and it is therefore important that relevant requirements are reflected in any subcontractor arrangements.

The System Manager and the HHS will monitor actual activity against purchased levels, taking action as necessary to ensure delivery of purchased levels. This process (in-year service agreement management) will be governed by the Performance Framework.

Service Agreement Monitoring and Reporting

The Performance Framework establishes the Relationship Management Group (RMG) which oversights the management of this service agreement and aims to ensure that services are being delivered in accordance with this schedule. The RMG is also an opportunity for the HHS to raise issues relevant to their HHS area for consideration (eg proposed service developments, local capacity issues etc.).

Both parties to this service agreement are represented on the RMG.

Service agreement management will be an ongoing process, and includes a monthly analysis of activity undertaken and regular two way communication between each HHS and the System Manager.

A monthly performance report must be produced by the System Manager for the HHS which will include:

- actual activity compared with decided activity levels;
- any variance(s) from decided activity; and
- performance information as required by the System Manager to demonstrate compliance with purchasing initiative KPIs e.g. activity relating to treatments which are outside the Scope of Publicly Funded Services, home dialysis rates etc. This information will also be used in the verification and negotiation of any financial adjustments (due to activity under-performance, quality adjustments i.e. QIP, never events, adverse events).

The HHS will also have a responsibility to actively monitor variances from purchased activity levels, and will notify the System Manager immediately via the QH-SA contact person as the HHS becomes aware of the following occurrences;

- if the HHS forecasts that there will be variances (which are likely to exceed decided tolerances) in performance of emergency activity in any of the services compared to the levels set out in the Service Agreement Value,
- if the HHS forecasts there will be variances (which are likely to exceed decided tolerances) in performance of elective activity in any of the services against any maximum waiting time targets specified in the Service Agreement, or against forecast activity specified under the Service Agreement Value,
- if the HHS forecasts an inability to demonstrate compliance with any purchasing KPIs, and

- if the HHS forecasts an inability to achieve commitments linked to specifically allocated funding, for example, Regional Cancer Centre, persistent pain, sub acute, mental health etc.

In order to differentiate true activity variations from variations which may be due to coding/counting improvements the System Manager will implement counting and coding audits for all HHSs. These will be undertaken every two years as part of a rolling program.

The HHS has a minimum requirement, which will be subject to 'in-year' change, to provide the following information on a monthly basis to their QH-SA contact person: actual, year-to-date and forecast (by month) information for FTEs (as recorded by MOHRI), expenditure, OSR and activity. Activity reporting is to be provided as per the layout contained in Schedule 3 Part B.

Service Agreement Thresholds

The Service Agreement Value will specify a forecast threshold or tolerance for each type of activity to function as an early warning of where the actual level of demand varies from the forecast threshold, with the intent that any breach of the forecast threshold will be reviewed by the relevant parties without delay.

Tolerances, which if exceeded in any quarter, trigger a requirement for an Activity Management Plan. The tolerances are set for 2012-2013 at +/- 2% overall or on any specific category. These categories are;

- Inpatients,
- Outpatients,
- Critical Care,
- Emergency Department,
- Subacute, and
- Mental Health.

Activity Management Plan Following Activity Variations

If the HHS breaches the activity threshold then the HHS will notify the QH-SA contact person of the breach, and the System Manager and the HHS will agree an Activity Management Plan within one month.

The Activity Management Plan may include an analysis of the following matters for the period in which a threshold has been breached;

- primary, secondary, tertiary and internal (consultant to consultant) referrals,
- outpatient conversion rates,
- zero short lengths of stay,
- waiting list volumes for patients within the category of the breached threshold,
- coding (depth and completeness), and
- any other analysis or auditing as may be reasonably required by the System Manager/HHS to understand and address the contributory factors.

The Activity Management Plan will specify any thresholds which have been breached, and the HHS will make proposals to remedy the relevant breach.

The Activity Management Plan will include specific locally-agreed trajectories and timescales within which requirements will be achieved. The System Manager may exercise further rights available to it, in respect of the matters contemplated by the Activity Management Plan in accordance with the Performance Framework, should there be:

- any breach by the HHS of an Activity Management Plan; or
- a failure by the HHS to implement an Activity Management Plan.

Financial Adjustment for Variations in Activity

The System Manager may initiate a joint process with the HHS to determine whether any financial adjustment should be applied in relation to any activity which has been breached within the relevant quarterly financial period.

This joint process will take account of any relevant matters identified in the analysis/reviews conducted, after which:

- for over performance i.e. activity exceeds that specified in the Service Agreement Value (all types of activity) , it is at the System Manager's discretion whether to make payment to the HHS in respect of the activity or part of the activity that caused the breach or to which the breach relates.
- for under performance i.e. activity is below that specified within the Service Agreement Value (elective activity) but within the agreed quarterly tolerance threshold no financial adjustment will occur, subject to the HHS demonstrating achievement of NEST.
- for under performance (elective activity with particular reference to the six long specialities described later) outside of the agreed quarterly tolerance, following confirmation that the HHS has taken all reasonable steps to produce the required level of activity, the contracted activity and the related funding may be withdrawn at full cost and reallocated, following advice from Access Improvement Service, to an alternate provider that can undertake the activity.
- for under performance (emergency activity with) there will be no withdrawal of funding.
- for all other types of activity variance the System Manager retains discretion in so far as any financial adjustment being made.
- in the case of failure to deliver on commitments linked to specific funding allocations (e.g long waits, Regional Cancer Centre, specific program funding eg. Closing the Gap, sub-acute, Mental Health, persistent pain) it is at the System Manager's discretion whether to withdraw allocated funding.

Financial Adjustments for Quality

Never Events

On a quarterly basis, the System Manager will make a financial adjustment if necessary to reflect the HHS's actual performance in relation to the number of never events.

Adverse Events

On a quarterly basis, the System Manager will reconcile the actual number of adverse events compared with the forecast and make a financial adjustment in line with the service agreement amendment process.

Quality Improvement Payment

QIP payments to providers are non-recurrent and are additional to actual Service Agreement Values. For 2012-2013, the financial value of the QIP scheme is calculated as 0.35% of the ABF component of the HHS's service agreement value.

The table overleaf represents the potential additional revenue which the Service could gain if the relevant targets are achieved.

During and at the end of each financial year, the System Manager will make financial adjustments as necessary based on the HHSs performance in relation to the goals set out within the QIP.

Performance will be reconciled as at 31 December 2012 and part payment (40%) will be made at that point (30 days after activity data is finalised), with the remainder to be paid in the year following achievement i.e. 2013-2014. It is also proposed that those HHSs that are already achieving this target will also be paid according to this Schedule 3. Payments are linked to each of the three QIP goals, but for each one the target has to be achieved in full for payment to be made – there will be no part payment for part achievement.

Table 3.1: Potential Additional Revenue

Procedural Performance			
	Jul 2012 - Dec 2012 (40% payable if targets achieved)	Jan 2013 – Jun 2013 (60% payable if targets achieved)	TOTAL
NEAT	$132,136	$198,205	$330,341
#NoF	$44,045	$66,068	$110,114
NEST	$132,136	$198,205	$330,341
Total QIP	$308,318	$462,477	$770,796

Specific Areas of Monitoring in 2012-2013

As part of the 2012-2013 Service Agreement Value, the following additional services will be purchased where relevant by the System Manager from the HHS and will be the focus of detailed in-year tracking and potential adjustments:

- Regional Cancer Centres;
- NPA Schedule 2 Subacute;
- Mental Health Plan;
- Persistent Pain; and
- Elective Surgery activity in six long wait specialties (orthopaedics, plastic surgery, gastroenterology, ophthalmology, urology and neurosurgery).

In addition, where funding has been provided for specific programs, the System Manager retains the right to withdraw funding if the program is not being delivered according to the program objective or not being delivered in full.

Schedule 4
Funding Source and Schedule

Purpose

This schedule details the sources of funding that this service agreement is based on and the manner in which these funds will be provided to the Service.

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)

The OSR purchasing initiative aims to increase the value of OSR generated by publicly funded health services. The initiative provides an incentive in the system to ensure that public hospitals can provide a higher level of activity for all HHS populations by capturing all funding sources. A target of 80% has been set for private health insurance conversion rates for inpatients. A 60% bulk bill target has been set for "new" outpatient appointments and a 40% bulk bill target set for "review" outpatient appointments. This excludes Allied Health, Nursing, CoAG 19.2 exempt/Rural & Remote Medicare Benefits Scheme registered sites, compensable patients, emergency department non-admitted, home dialysis and "other". OSR stretch targets for 2012-13 will not be offset against service agreement values but are included within this Schedule 4.

The following table (Table 4.1) provides a summary of the funding sources for the HHS and mirrors the total value of the Service Agreement included at Schedule 3 Part B above.

Table 4.1: Hospital and Health Service Funding Sources 2012-13

Funding Source	Value ($)
Pool Account – ABF Funding[2]	
State	130,555,290.00
Commonwealth	72,064,177.00
State Managed Fund – Block Funding[3]	
State	76,022,142.00
Commonwealth	34,963,387.00
Locally Receipted Grants	6,275,344.00
Locally Receipted Own Source Revenue	14,124,528.00
System Manager Grants[4]	39,285,723.00
TOTAL	**373,290,591.00**

[2] Pool Account - ABF Funding includes: Inpatient; Critical Care; Emergency Department; Mental Health; and Outpatient each allocated a proportion of Other ABF Adjustments (less Clinical Education) and Site Specific Grants. The totals included within this table are included in the Commonwealth Local Hospital Network Service Agreement Table included at the end of this Schedule 4.

[3] State Managed Fund - Block Funding includes: Subacute; CSO Faciities; Primay Care Outpatient Centres; 29% of Community Mental Health (estimate of Hospital Auspiced); Tertiary Mental Health; Clinical Education and Research/Training. The total included here for the Commonwealth contribution to the State Managed Fund can be found in the Commonwealth Local Hospital Network Service Agreement Table included at the end of this Schedule 4.

[4] System Manager Grants represents funding by the System Manager for items not covered by the National Health Reform Agreement including such items as: Primary Health Care; Prevention, Promotion and Protection; and Depreciation.

Funds Disbursement

The Chief Executive, as System Manager, 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.

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

- redirect Commonwealth payments between HHSs; or
- redirect Commonwealth payments between funding streams (eg. from ABF to Block Funding); or
- adjust the payment calculations underpinning the Commonwealth's funding.

Payment of ABF and Block Funding to the HHS will be on a fortnightly basis.

Figure 4.2 overleaf details the funding flows to Hospital and Health Services and other organisations as required.

Due to timing considerations, the National Weighted Activity Units (NWAUs) expressed in this Service Agreement are an approximation only and may not be comparable with NWAUs reported by other jurisdictions. They have been calculated by estimating the amount of funding proposed under this service agreement that is within scope with respect to the national ABF model and dividing this number by the National Efficient Price (NEP). No adjustments have been made for the range of overheads that are included in the NEP but that are currently borne corporately by the State as the system manager.

Reporting of Service Level Data

In accordance with Section B74 and B75 of the National Health Reform Agreement, the System Manager is responsible for providing Service Level Agreements including service level data to the Administrator. The reporting of service level data will follow the format, developed by the Commonwealth as shown in the Local Hospital Network Service Agreement Template[5] included at the end of this Schedule 4.

Potential Funding Reductions

If the HHS fails to maintain improvements in Emergency Department data quality realised through the Business Practice Improvement Officer (BPIO) Program, the System Manager may withdraw funding from the HHS equivalent to that provided for the BPIO program in 2011-2012.

[5] Terminology within this section and within the Local Hospital Network Service Agreement Template reflects that within the National Health Reform Agreement. I.e. Local Hospital Networks equates to Hospital and Health Services within Queensland.

Figure 4.2: State and Commonwealth Funding Flows

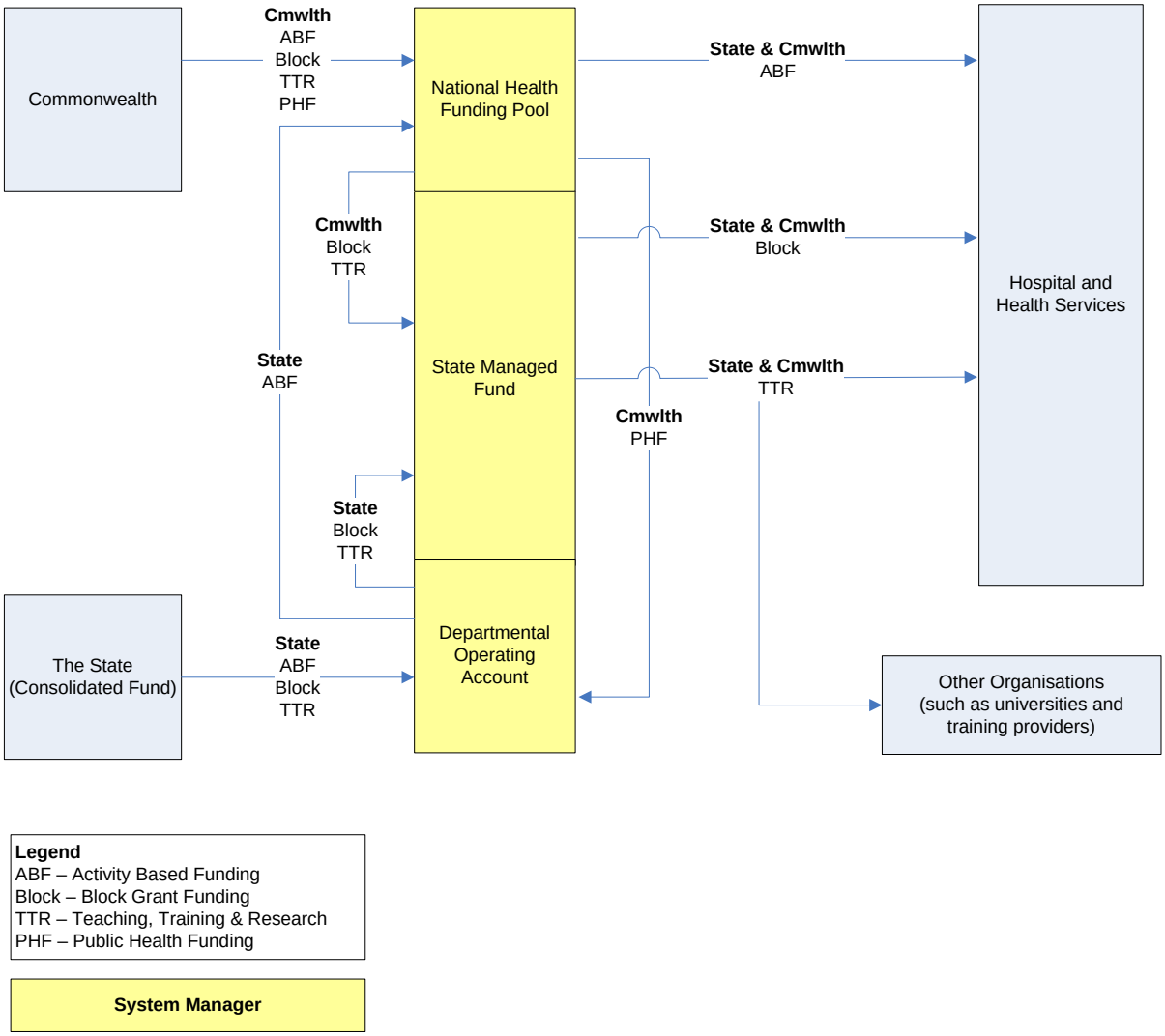


EXHIBIT 228

Hospital and Health Service Agreement

Author: HRIG Operations Subgroup Support Team Last edited: 22/06/2012

State:	QLD	Service agreement for financial year:	2012-13
HHS	West Moreton	Version for financial year:	1.000
HHS ID		Version effective for payments from:	July 2012
		Version status:	Final

HHS ABF payment requirements:

Expected National Weighted Activity Unit (NWAU)			IHPA Adjustments and Commonwealth Funding Contribution												State/Territory adjustments (if any*) and Funding Contribution (*these may simply be the IHPA adjustments, &/or they may include adjustments specific to the state, hospital or LHN)										
	ABF Service group	Expected NWAU (using IHPA weighting rules) prior to any applicable adjustments	Indigenous adjustment (as stated in IHPA pricing framework)	% of expected NWAU subject to adjustment	Outer regional adjustment (as stated in IHPA pricing framework)	% of expected NWAU subject to adjustment	Remote adjustment (as stated in IHPA pricing framework)	% of expected NWAU subject to adjustment	Very remote adjustment (as stated in IHPA pricing framework)	% of expected NWAU subject to adjustment	Total expected NWAU modified for IHPA adjustments	National efficient price (NEP) (as set by IHPA)	C'w % funding rate	C'w ABF funding contribution	Adjustment one (as set by state)	% of expected NWAU subject to adjustment	Adjustment two (as set by state)	% of expected NWAU subject to adjustment	Adjustment three (as set by state)	% of expected NWAU subject to adjustment	Adjustment four (as set by state)	% of expected NWAU subject to adjustment	Total expected state NWAU modified for adjustments	State price	State ABF funding contribution (ex GST)	GST if applicable (show actual amount, as GST may not apply to all of the payment)#	State ABF funding contribution (incl GST)
	Admitted public	30,252	1.050	5%	1.087	0%	1.153	0%	1.194	0%	30,341	$4,808	35.57%	$51,884,641									30,341	$4,808	$93,996,970	$0	$93,996,970
	Admitted private	2,154	1.050	5%	1.087	0%	1.153	0%	1.194	0%	2,160	$4,808	35.57%	$3,694,383									2,160	$4,808	$6,692,941	$0	$6,692,941
	Non-admitted	4,578	1.050	5%	1.087	0%	1.153	0%	1.194	0%	4,591	$4,808	35.57%	$7,851,257									4,591	$4,808	$14,223,755	$0	$14,223,755
	Emergency Department and/or Emergency Services	5,034	1.050	5%	1.087	0%	1.153	0%	1.194	0%	5,049	$4,808	35.57%	$8,633,896									5,049	$4,808	$15,641,625	$0	$15,641,625
	LHN ABF Total	**42,018**									**42,142**			**$72,064,177**									**42,142**		**$130,555,290**	$0	**$130,555,290**

Not applicable

Basis for establishing expected NWAU:

Due to timing considerations, the National Weighted Activity Units (NWAUs) expressed in this Service Agreement are an approximation only and may not be comparable with NWAUs reported by other jurisdictions They have been calculated by estimating the amount of funding proposed under this service agreement that is within scope with respect to the national ABF model and dividing this number by the National Efficient (NEP). No adjustments have been made for the range of overheads that are included in the NEP but that are currently borne corporately by the State as the system manager.

State level block payments to state managed funds from Commonwealth payments into national funding pool

State block funding payment requirements:

Commonwealth block funding for state:				
Block funding component	**Commonwealth block funding contribution (as agreed bilaterally) (ex GST)**	**Basis**	**GST (to the extent applicable)**	**Contribution incl GST to be paid to SMF**
Mental Health	$17,653,372		$0	$17,653,372
Rural	$6,449,181		$0	$6,449,181
Sub-acute	$5,184,020		$0	$5,184,020
Teaching, Training and Research	$5,676,813		$0	$5,676,813
Total block funding for state	**$34,963,387**		$0	$34,963,387

Reporting requirements by LHN - block funding paid (total including Commonwealth) per LHN, as set out in service agreement:

Amount (Commonwealth and state) and basis for each amount of block funding from state managed fund to LHN:				
Block funding component (LHN W)	**Commonwealth and state block funding contribution (ex GST)**	**Basis**	**GST (to the extent applicable)**	**Contribution incl GST to be paid to LHN**
Mental Health	$56,037,731		$0	$56,037,731
Rural	$20,471,867		$0	$20,471,867
Sub-acute	$16,455,821		$0	$16,455,821
Teaching, Training and Research	$18,020,110		$0	$18,020,110
Total block funding for LHN	**$110,985,529**		$0	$110,985,529

Schedule 5
Key Performance Indicators

Purpose

This schedule outlines the Key Performance Indicators (KPIs) and their associated targets that the HHS will be required to meet during the 2012-2013 financial year.

Key Performance Indicators

The KPIs defined within this Schedule are used within the Performance Framework to monitor the extent to which HHS are delivering the high level objectives set out within this Service Agreement and to inform the performance category which is allocated to each HHS on a monthly basis.

The terms of the Performance Framework form part of the terms of this Service Agreement.

The KPIs for 2012-13 have been listed in the following table and have been defined as either 'escalation' KPIs or 'monitoring' KPIs in accordance with how they are utilised within the Performance Framework.

Escalation KPIs are critical system markers which operate as intervention triggers. This means that underperformance in an escalation KPI triggers immediate attention, analysis of the cause of the deviation, and consideration of the need for intervention. This provides an early warning system to enable appropriate intervention as a performance issue arises within critical performance areas.

Monitoring KPIs are used as supporting indicators to assist in providing context to escalation KPIs when triggered within a specific domain. Monitoring KPIs will be reported through similar processes as escalation KPIs, when data is made available.

Table 5.1: Key Performance Indicators

KPI No.	Level	Key Performance Indicator (KPI)	Target	HHS applicable	Link
SAFETY AND QUALITY			***Target***		***Link***
E1	Escalation	Never Events	0	All HHSs	2012-13 Purchasing Framework - Queensland Health National Safety and Quality Health Service Standards
E2	Escalation	Hospital acquired 3rd and 4th stage Pressure Injuries	5% of 2010-11 actuals	All HHSs	2012-13 Purchasing Framework - Queensland Health National Safety and Quality Health Service Standards
E3	Escalation	Healthcare-associated *Staphylococcus aureus* (including MRSA) bacteraemia	20% of 2010-11 actuals	All HHSs	National Performance and Accountability Framework National Healthcare Agreement (P139)
M1	Monitoring	Falls Risk Assessment	70% compliance	All HHSs	National Safety and Quality Health Service Standards
M2	Monitoring	VTE Risk Assessment Documentation at Point of Care	50%	All HHSs	Queensland Health Strategic Plan 2011-2015 Health Quality and Complaints Commission, Surgical Safety Standard: Prevention of VTE
M3	Monitoring	Hospital Standardised Mortality Ratio (HSMR)	HSMR < 100 *or* HSMR not statistically significant to 100	All HHSs	National Performance and Accountability Framework
M4	Monitoring	Death in low-mortality Diagnostic Related Groups (DRGs)	Death in low-mortality DRG < 100 *or* Death in low-mortality DRG not statistically significant to 100	All HHSs	National Performance and Accountability Framework

KPI No.	Level	Key Performance Indicator (KPI)	Target	HHS applicable	Link
M5	Monitoring	In hospital mortality rates of: ▪ Acute myocardial infarction; ▪ Heart failure; ▪ Stroke; ▪ Fractured neck of femur; ▪ Pneumonia.	Within control limits	All HHSs	National Performance and Accountability Framework Australian Commission on Safety and Quality in Health Care – National Core, hospital-based outcome indicators
M6	Monitoring	Unplanned hospital readmission rates for patients discharged following management of: ▪ Acute Myocardial Infarction; ▪ Heart failure; ▪ Knee replacement; ▪ Hip replacement; ▪ Depression; ▪ Schizophrenia; ▪ Paediatric tonsillectomy and adenoidectomy.	Within control limits	All HHSs	National Performance and Accountability Framework Australian Commission on Safety and Quality in Health Care – National Core, hospital-based outcome indicators
M7	Monitoring	Healthcare associated Clostridium difficile infections	TBA	All HHSs	National Performance and Accountability Framework
M8	Monitoring	Acute stroke care in recognised stroke unit	50% of patients - with existing stroke unit 20% of patients - developing a stroke unit	Activity Based Funding (ABF) HHS	2012-13 Purchasing Framework - Queensland Health
M9	Monitoring	Fractured Neck of Femur to theatre in 2 days of admission	95%	Activity Based Funding (ABF) HHS	2012-13 Purchasing Framework - Queensland Health
M10	Monitoring	Hospital Acquired Bloodstream infections (all)	20% of 2011-11 actuals	All HHSs	2012-13 Purchasing Framework - Queensland Health
M11	Monitoring	Renal dialysis treatment received at home	50% (except North Qld: 40%)	All HHSs (where applicable)	2012-13 Purchasing Framework - Queensland Health

KPI No.	Level	Key Performance Indicator (KPI)	Target	HHS applicable	Link
ACCESS			***Target***		***Link***
E4	Escalation	National Emergency Access Target (NEAT): % of ED attendances who depart within 4 hours of their arrival in ED	2012: 70% 2013: 77%	Activity Based Funding (ABF) HHS	National Partnership Agreement on Improving Public Hospital Services Schedule C – National Emergency Access Target
E5	Escalation	Emergency Department: % seen within recommended timeframe: Category 1: within 2 minutes Category 2: within 10 minutes Category 3: within 30 minutes Category 4: within 60 minutes Category 5: within 120 minutes	80% of all categories Category 1: 100% Category 2: 80% Category 3: 75% Category 4: 70% Category 5: 70%	Activity Based Funding (ABF) HHS	National Partnership Agreement: By 2012-13, 80 per cent of emergency department presentations are seen within clinically recommended triage times
E6	Escalation	Patient Off Stretcher Time (POST): < 30 mins (%)	90%	Activity Based Funding (ABF) HHS	
E7	Escalation	Elective Surgery: % treated within the clinically recommended timeframe for their category: Category 1: within 30 days Category 2: within 90 days Category 3: within 365 days	2012: Category 1: 89.0% Category 2: 81.0% Category 3: 91.0% 2013: Category 1: 100% Category 2: 87.0% Category 3: 94.0%	Activity Based Funding (ABF) HHS	National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target (Part 1)
E8	Escalation	Elective Surgery: Number of patients waiting more than the clinically recommended timeframe for their category: Category 1: within 30 days Category 2: within 90 days Category 3: within 365 days	0	Activity Based Funding (ABF) HHS	Queensland Health Strategic Plan 2011-2015
E9	Escalation	Activity: variance between purchased ABF activity and YTD recorded ABF activity, by Service Group (Inpatients, Outpatients, ED, Mental Health, Critical Care and SNAP)	0% to +/-1%	All HHSs	2012-13 Purchasing Framework - Queensland Health

KPI No.	Level	Key Performance Indicator (KPI)	Target	HHS applicable	Link
M12	Monitoring	Emergency Department: median waiting time	20 minutes	Activity Based Funding (ABF) HHS	Queensland Health Strategic Plan 2011-2015
M13	Monitoring	Emergency Department 'Did not wait's	0	Activity Based Funding (ABF) HHS	2012-13 Purchasing Framework - Queensland Health
M14	Monitoring	Elective Surgery Volume	Maintain 2010-11 baseline actuals	Activity Based Funding (ABF) HHS	National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target (Part 1)
M15	Monitoring	Reduction in elective surgery long waits: Average overdue wait time (in days) for those who have waited beyond the recommended time	2012: Category 1: 0 Category 2: 67 Category 3: 61 2013: Category 1: 0 Category 2: 45 Category 3: 41	Activity Based Funding (ABF) HHS	National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target (Part 2)
M16	Monitoring	In each Elective Surgery Category, of the patients who have not had their procedure within the clinically recommended time, the 10% of patients who have waited the longest must have their procedure in each year. Category 1: within 30 days Category 2: within 90 days Category 3: within 365 days	The 10% who have waited the longest (per category)	Activity Based Funding (ABF) HHS	National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target (Part 2)
M17	Monitoring	Elective Surgery Cancellations (hospital initiated)	10%	Activity Based Funding (ABF) HHS	Queensland Health Patient Flow Strategy
M18	Monitoring	Elective Surgery: median waiting time	25 days	Activity Based Funding (ABF) HHS	Queensland Health Strategic Plan 2011-2015
M19	Monitoring	Pre-operative elective bed days	0	Activity Based Funding (ABF) HHS	2012-13 Purchasing Framework - Queensland Health
M20	Monitoring	Provision of Appropriate Surgical Services at Rural Hub Hospitals (where applicable)	Baseline in 2012-13	Rural HHSs (where applicable)	Queensland Health Strategic Plan 2011-2015

KPI No.	Level	Key Performance Indicator (KPI)	Target	HHS applicable	Link
M21	Monitoring	Categorisation of new case outpatient referrals (within 5 days of receipt of referral)	100%	All HHSs (where applicable)	Queensland Health Patient Flow Strategy
M22	Monitoring	Category 1 Outpatients: % waiting in time	95%	All HHSs (where applicable)	Queensland Health Patient Flow Strategy
M23	Monitoring	Ambulatory care access (Outpatient ratio)	As per purchased levels	Activity Based Funding (ABF) HHS	2012-13 Purchasing Framework - Queensland Health
M24	Monitoring	Inpatient separations undertaken as Hospital in the Home (HITH)	1.5%	All HHSs (where applicable)	2012-13 Purchasing Framework - Queensland Health
M25	Monitoring	Cancer care pathway – waiting times for cancer care	TBA	All HHSs (where applicable)	National Performance and Accountability Framework
M26	Monitoring	Telehealth Non-admitted Occasions of Service	Baseline in 2012-13	All HHSs	Queensland Health Strategic Plan 2011-2015
EFFICIENCY AND FINANCIAL PERFORMANCE			***Target***		***Link***
E10	Escalation	YTD Operating Position	Balanced or surplus	All HHSs	Financial Accountability Act 2009 Financial & Performance Management Standard 2009
E11	Escalation	Full-year Forecast Operating Position (Agreed position between System Manager and HSS)	Balanced or surplus	All HHSs	Financial Accountability Act 2009 Financial & Performance Management Standard 2009
E12	Escalation	Own Source Revenue Budget	Balanced or surplus	All HHSs	Financial Accountability Act 2009 Financial & Performance Management Standard 2009
E13	Escalation	YTD average FTE (MOHRI head count)	HHS specific; as per detail in Schedule 3 (part B)	All HHSs	
M27	Monitoring	Cost per WAU (by ABF facility, by peer group)	Variance to funded price of WAU	Activity Based Funding (ABF) HHS	National Performance and Accountability Framework
M28	Monitoring	Relative Stay Index for multi-day stay patients	TBA	All HHSs (where applicable)	National Performance and Accountability Framework
M29	Monitoring	Day of surgery admission rates for non-emergency multi-day stay patients	TBA	All HHSs (where applicable)	National Performance and Accountability Framework

KPI No.	Level	Key Performance Indicator (KPI)	Target	HHS applicable	Link
M30	Monitoring	Day case surgery rates	90% achievement	Activity Based Funding (ABF) HHS	2012-13 Purchasing Framework - Queensland Health
M31	Monitoring	Extended day case surgery rates	80% achievement	Activity Based Funding (ABF) HHS	2012-13 Purchasing Framework - Queensland Health
M32	Monitoring	Out of scope procedures	0	All HHSs (where applicable)	2012-13 Purchasing Framework - Queensland Health
M33	Monitoring	Clinical data coded within recommended timeframe	100%	All HHSs	2012-13 Purchasing Framework - Queensland Health
M34	Monitoring	Maintenance Expenditure	HHS specific (as determined by Asset and Property Services)	All HHSs	Queensland Health Building & Infrastructure Maintenance Policy
M35	Monitoring	Facility Condition Index	2% to 4%	All HHSs	Queensland Health Building & Infrastructure Maintenance Policy
M36	Monitoring	Planned Maintenance Expenditure Ratio	60% to 70%	All HHSs	Queensland Health Building & Infrastructure Maintenance Policy
PATIENT EXPERIENCE			***Target***		***Link***
M37	Monitoring	Complaints acknowledged within 5 calendar days	80%	All HHSs	National Safety and Quality Health Service Standards
M38	Monitoring	Emergency Department Patient Experience	50% (Queensland Health)	All HHSs (where applicable)	National Performance and Accountability Framework: Measures of the patient experience with hospital services
WORKFORCE			***Target***		***Link***
M39	Monitoring	Hours lost (WorkCover) vs Occupied FTE	0.40	All HHSs	Queensland Health Strategic Plan 2011-2015
M40	Monitoring	Sick leave	3.5%	All HHSs	Queensland Health Strategic Plan 2011-2015
CLOSING THE GAP			***Target***		***Link***
E14	Escalation	Achievement of Closing the Gap escalation indicators contained within Schedule 8 of the Service Agreement. Listed below:	Achieve quarterly targets for escalation indicators (listed below)	All HHSs	- Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033.

KPI No.	Level	Key Performance Indicator (KPI)	Target	HHS applicable	Link
E14.1		CTG KPI 1 – Estimated level of completion of Indigenous status – specifically the reporting of 'not 'stated' on admission	Less than 1% of 'not stated'	All HHSs	- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013. - Aboriginal and Torres Strait Islander Health Framework Agreement. - Torres Strait Health Framework Agreement. - Close the Gap Statement of Intent. - National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. - Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033.
E14.2		CTG KPI 2 – Percentage of in-scope separations of Aboriginal and Torres Strait Islander consumers from the HHS's acute mental health inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated (in person or via videoconference), was recorded in one to seven days immediately following that separation	55% of in-scope separations of Aboriginal and Torres Strait Islander consumers	All HHSs	
E14.3		CTG KPI 3 – The proportion of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice (DAMA)	HHS specific (Quarterly targets. As per Schedule 8)	All HHSs	
E14.4		CTG KPI 4 – Percentage of Aboriginal and Torres Strait Islander Cultural Practice Program participants by facility	HHS specific (Quarterly targets - based on staff numbers at beginning of financial year. As per Schedule 8)	All HHSs	
M41	Monitoring	CTG KPI 1 – Estimated level of completion of Indigenous status (including the reporting of 'not 'stated' on admission)	HHS specific (as per schedule 8)	All HHSs	
M42	Monitoring	CTG KPI 5 – Number of Indigenous Hospital Liaison Officers, including gender specific Aboriginal and Torres Strait Islander Hospital Liaison Officers	HHS specific (as per schedule 8)	All HHSs	
M43	Monitoring	CTG KPI 6 – The number of Aboriginal and Torres Strait Islander people as a percentage of the total HHS workforce: using MOHRI Occupied Headcount	HHS specific (as per schedule 8)	All HHSs	
M44	Monitoring	CTG KPI 7 – Number of potentially preventable hospitalisations (PPH) – vaccine preventable, acute and chronic	HHS specific (as per schedule 8)	All HHSs	
M45	Monitoring	CTG KPI 8 – Increase Indigenous participation in BreastScreen Queensland for women aged 50-69 years within the BreastScreen Queensland Service Catchment	HHS specific (as per schedule 8)	Where applicable (if listed in Schedule 8)	
MENTAL HEALTH AND ALCOHOL AND OTHER DRUG TREATMENT SERVICES			***Target***		***Link***
E15	Escalation	Achievement of Mental Health & Alcohol and Other Drug Treatment Services escalation indicators contained within Schedule 9 of the Service Agreement. Listed below (where applicable) :	Achieve target (listed below) in greater than 67% of the escalation indicators	All HHSs	- Fourth National Mental Health Plan. - Queensland Plan for Mental Health. - Alcohol Management Reform

KPI No.	Level	Key Performance Indicator (KPI)	Target	HHS applicable	Link
E15.1		- Ambulatory service contacts	100% of ambulatory service targets	All HHSs	Initiative. - 2011-12 Queensland Drug Action Plan. - National Drug Strategy 2010-2015.
E15.2		- Ambulatory service contacts: Duration (hours)	100% of ambulatory service targets	All HHSs	
E15.3		- Extended treatment facility and psychiatric hospital beds (Accrued patient days in block funded mental health facilities)	95% of accrued patient day target delivered	All HHSs	
E15.4		- Closure of ATODS Client Intake	Closure period less than 2 weeks	All HHSs	
E15.5		- Number of dedicated hospital alcohol and other drugs withdrawal beds	95% open	Where applicable (if listed in Schedule 9)	
E15.6		- Significant variation in number of dedicated residential alcohol and other drugs withdrawal beds	95% open	Where applicable (if listed in Schedule 9)	
M46	Monitoring	Rate of community follow up within 1 – 7 days following discharge from an acute mental health inpatient unit	55%	All HHSs	
M47	Monitoring	Proportion of inpatient service episodes where an End of Episode/Discharge Summary clinical note is recorded within 48 hours of discharge	35%	All HHSs	
M48	Monitoring	Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	14%	All HHSs	
M49	Monitoring	Proportion of service episodes where a consumer has a nominated General Practitioner	30%	All HHSs	
M50	Monitoring	Change in consumers' clinical outcomes	Baseline in 2012-13	All HHSs	
M51	Monitoring	Proportion of service episodes where a consumer is secluded at least once	10%	All HHSs	
M52	Monitoring	Proportion of in-scope outcome collection occasions where required clinical outcome measure(s) were recorded	40%	All HHSs	
M53	Monitoring	Number of specialised alcohol and other drug treatment service contacts by program by agency	> 80% of same quarter previous year	All HHSs	
M54	Monitoring	Proportion of specialised alcohol and other drug treatment service contacts by treatment type by agency	< 20% change to same period previous year	All HHSs	
M55	Monitoring	Proportion of ATODS-IS mandatory data items entered: 95% of mandatory data entered other than "Not stated/Unknown"	< 5%	All HHSs	

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KPI No.	Level	Key Performance Indicator (KPI)	Target	HHS applicable	Link
M56	Monitoring	Significant variation in source of referrals for alcohol and drug diversion programs	< 20% change to historical rate	All HHSs	
M57	Monitoring	Significant variation in source of referrals for children's alcohol and other drugs residential programs	< 20% change to historical rate	Where applicable (if listed in Schedule 9)	
M58	Monitoring	Significant variation in number of specialist clinical education and, consult and liaison sessions delivered by Dovetail	< 20% change to historical rate	Where applicable (if listed in Schedule 9)	
M59	Monitoring	Significant variation in number of specialist clinical education and training sessions delivered by InSight	< 20% change to historical rate	Where applicable (if listed in Schedule 9)	

Schedule 6
Hospital and Health Service Development and Risk Action Plans

Purpose

This schedule outlines the approach to the progressive management and monitoring against the HHS Development Action Plan and Risk Action Plan as agreed following the Readiness Assessment process undertaken by Ernst & Young.

Development Action Plans

The Hospital and Health Service will provide to the System Manager a Development Action Plan (DAP), endorsed by the Chair, in August 2012. This Development Action Plan will include HHS identified development priorities in addition to the organisational development priorities identified within the HHS's Final Readiness Assessment Report[6].

Reporting Requirements

The level and frequency of management and monitoring of achievement against HHS DAPs will be determined in accordance with the HHS' Readiness Assessment Level and is outlined within the HHS Performance Framework included at Appendix 2. Management of performance will be by the respective Hospital and Health Board for those HHSs who have achieved a high overall result with a requirement for variance reporting where issues are identified by the Board. However, for those HHSs who have achieved an overall rating of 1 to 3, progress reporting will be required to the System Manager on a monthly, three monthly and six monthly basis respectively.

Risk Action Plans

The 2012-13 Risk Action Plan (RAP) for the Service (as endorsed by the Chair and System Manager prior to execution of this Service Agreement) includes those risk implications identified within the HHS's Final Readiness Assessment Report[7].

Reporting Requirements

The level and frequency of management and monitoring of achievement against HHS RAPs will be determined in accordance with the HHS' Readiness Assessment Level and is outlined within the HHS Performance Framework included at Appendix 2. Management of performance will be by the respective Hospital and Health Board for those HHSs who have achieved a high overall result with a requirement for self assessment and variance reporting where issues are identified by the Board. However, for those HHSs who have achieved an overall rating of 1 to 3, progress reporting will be required to the System Manager on a monthly, three monthly and six monthly basis respectively.

Corporate Mentoring

In order to provide the System Manager with assurance that DAP and RAP requirements are being met to a satisfactory level and within the timeframes identified, corporate mentoring will be required for those Services with a Readiness Assessment Level of '1' or '2'.

For those Services with a Readiness Assessment Level of '1', targeted support will be defined by the System Manager with the requirement for a Corporate Mentor to be engaged to provide assurance to the System Manager on DAP and RAP actions.

[6] Within Ernst & Young issued Final Readiness Assessment report see Section 3 – Required Organisational Development.

[7] With Ernst & Young issued Final Readiness Assessment report see Section 2 – District risk implications for the system.

For those Services with a Readiness Assessment Level of ‘2’, a Corporate Mentor will be required to be engaged to provide assurance to the System Manager on DAP and RAP actions.

For those Services with a Readiness Assessment Level of ‘3’, the System Manager may suggest options for areas which would benefit from Corporate Mentoring for consideration by the HHS Board.

Utilisation of Corporate Mentoring by those Services with a Readiness Assessment Level of ‘4’ will be at the discretion of the HHS Board.

Schedule 7
Commonwealth Agreement Obligations

Purpose

The table below summarises the HHS's obligations for 2012-2013 against NPAs and other Commonwealth Agreements which have been entered into by Queensland Health on behalf of the State. With respect to all National Partnership commitments listed in the following table, HHSs are required to observe the following requirement outlined in Schedule E section E26 of the Intergovernmental Agreement on Federal Financial Relations;

> "Commonwealth and State officials will reach prior agreement on the nature and content of any events, announcements, promotional material or publicity relating to National Partnerships or activity under them. The cooperative nature of National Partnerships, and the roles and contributions of both the Commonwealth and the States and Territories, will be acknowledged and recognised appropriately in any announcement or other promotional material or publicity relating to approved project or program activity, outputs or outcomes, including on signs, through the use of coats of arms or logos and on plaques affixed to new and refurbished buildings. Appropriate Commonwealth and State Government representatives will be invited to participate in opening ceremonies, product launches or similar events."

Table 7.1: HHS Obligations relating to Agreements between the Commonwealth and Queensland Governments

Agreement	Implementation Plan	HHS Obligation	Completion Date
National Partnership Agreement - Health Infrastructure	Indigenous Mobile Dental Infrastructure	▪ Service Delivery Report - update on service delivery in relation to items listed under section 18 (b) of the Implementation Plan.	1 Dec 2012
		▪ Service Delivery Report - update on service delivery in relation to items listed under section 18 (b) of the Implementation Plan.	1 Jun 2013
		▪ Contribute to the planning, development and implementation of state-wide NPDI activities (including data collection and reporting).	30 Jun 2013

		▪ Establish or redevelop programs to facilitate implementation of the NPDI within the HHS. ▪ Deliver training programs developed locally, state-wide or nationally where appropriate, that support professional practice to implement the key elements of the NPDI (across the perinatal mental health workforce including midwives, child and maternal health nurses, Aboriginal health workers, community health nurses, allied health professionals, specialised mental health service providers, General Practitioners, private practitioners and child protection services). ▪ Facilitate pathways to care through the development of local partnerships with a range of HHS, other government, private and non-government providers. ▪ Provide specialist assessment and brief intervention in partnership with a primary care provider for women who are at risk of experiencing moderate or severe perinatal disorders (including those from specific population groups such as rural communities, Aboriginal and Torres Strait Islander people and culturally and linguistically diverse populations). ▪ Undertake collaborative community awareness activities and promotion of help seeking behaviours in relation to perinatal depression.	On going
		Reports, including documented pathways to care; development of service provider networks; development of mental health professional networks; perinatal mental health workforce development initiatives facilitated during the six month period; perinatal mental health community awareness initiatives facilitated during the six month period.	Due 21 Nov 2012 and 26 Jun 2013
National Partnership Agreements - Improving Public Hospitals Services	Schedule E - Project 16 New subacute beds	▪ Boonah Hospital: 6 subacute beds (using existing infrastructure) ▪ Quarterly progress report and annual project acquittal ▪ Annual activity target Occupied Bed Days = 1968	Ongoing for life of Agreement.
	Schedule E - Project 16 New subacute beds	▪ Ipswich: 10 bed GEMS Unit, ▪ Quarterly progress report and annual project acquittal ▪ Annual activity target Occupied Bed Days = 3280 and Occasions Of Service = 150.	Ongoing for life of Agreement.
	Schedule E - Project 17 Non-admitted subacute services	▪ Ipswich: Centre based rehabilitation ▪ Quarterly progress report and annual project acquittal ▪ Annual activity target Occasions Of Service = 3650	Ongoing for life of Agreement.
	Schedule E - Project 17 Non-admitted subacute services	▪ Ipswich: Provision of palliative care in the home for heart failure ▪ Quarterly progress report and annual project acquittal ▪ Annual activity target Occasions Of Service = 1110	Ongoing for life of Agreement.
Medical Specialist Outreach Assistance Program (MSOAP)	NOTE: implementation detail coordinated by State's nominated Liaison Officer (ORRH)	For those HHSs receiving or providing MSOAP funded services: ▪ Activity report on completion of outreach service ▪ Monthly review of program expenditure	 As required Monthly as required

		▪ Annually complete the service review questionnaire	Annually as advised
Medical Specialist Outreach Assistance Program Maternity Services (MSOAP MS)	NOTE: implementation detail coordinated by State's nominated Liaison Officer (ORRH)	For those HHSs receiving or providing MSOAP MS funded services: ▪ Activity report on completion of outreach service ▪ Monthly review of program expenditure ▪ Annually complete the service review questionnaire	 As required Monthly as required Annually as advised
Medical Specialist Outreach Assistant Program Indigenous Chronic Disease (MSOAP ICD)	NOTE: implementation detail coordinated by State's nominated Liaison Officer (ORRH)	For those HHSs receiving or providing MSOAP ICD funded services: ▪ Activity report on completion of outreach service ▪ Monthly review of program expenditure ▪ Annually complete the service review questionnaire	 As required Monthly as required Annually as advised

Schedule 8
Closing the Gap Obligations

Purpose

This Schedule articulates the key accountabilities and performance responsibilities that are the contribution of HHSs to the overall effort for closing the gap in health outcomes for Aboriginal and Torres Strait Islander Queenslanders.

Government Commitments

Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 articulates the Queensland Government's long-term strategy to eliminate the health gap and to sustain health status improvement. *Making Tracks* incorporates the Queensland Government's formal commitments for improving Aboriginal and Torres Strait Islander Health.

These commitments are:

- The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013, (signed 2003)
- The Aboriginal and Torres Strait Islander Health Framework Agreement, (signed 2002 and ongoing)
- The Torres Strait Health Framework Agreement, (signed 2007)
- The Close the Gap Statement of Intent, (signed 2008)
- The National Partnership Agreement on Indigenous Early Childhood Development, (signed 2008)
- The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, (signed 2009).

The overarching commitment under *Making Tracks*, the Close the Gap Statement of Intent and the National Partnership Agreements is to close the gap in health inequality between Indigenous and non-Indigenous Queenslanders by 2033 and to sustain health gains thereafter.

The delivery of culturally capable and responsive health services is addressed in the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033*. Participation in the Aboriginal and Torres Strait Islander Cultural Practice Program is mandatory for all staff and provides knowledge and skills to support culturally capable care.

Indigenous-specific Funding Requirements

The continuing Government commitment to Close the Gap will require each HHS to at least maintain their current level of resources for Indigenous health care, and to put any new funding towards the priorities identified in *Making Tracks*.

Indigenous loading received under the ABF model is to be used for specific hospital outputs (such as Aboriginal and Torres Strait Islander hospital liaison services, culturally appropriate care pathways, strategies to improve recruitment and retention of Aboriginal and Torres Strait Islander staff across services in clinical and non-clinical roles) and to undertake activity against the specific key performance indicators identified in Table 8.1.

Funding provided for specific initiatives and programs for improving Aboriginal and Torres Strait Islander health outcomes is to remain quarantined and tied to the purpose for which it was allocated. Funding areas within the System Manager will require reports on funded activities identified in Table 8.2.

Partnerships

Effective partnerships are a key enabler for improving access to services for Aboriginal and Torres Strait Islander people. Accordingly, the HHS is to collaborate locally with relevant Medicare Locals as well as Aboriginal and Torres Strait Islander Community Controlled Health Services to improve health service coordination for Indigenous communities.

Indicators for Improved Aboriginal and Torres Strait Islander Health Outcomes

Table 8.1: Indicators for Improved Aboriginal and Torres Strait Islander Health Outcomes

	Key Performance Indicators[8]	Current Performance	Target 2012-13
Performance Indicators – Escalation			
KPI 1	Estimated level of completion of Indigenous status in Queensland acute public hospitals 2012-13 (including the reporting of not stated on admission)	Status: 71-90% Not stated: 2.2%	Status: over 90% Not stated: 2012-13 target - less than 1%
KPI 2	Percentage of in-scope separations of Aboriginal and Torres Strait Islander consumers from the HHS's acute mental health inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated (in person or via videoconference), was recorded in one to seven days immediately following that separation	New indicator – no baseline currently set	55% of in-scope separations of Aboriginal and Torres Strait Islander consumers from the HHS's acute mental health inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated (in person or via videoconference), was recorded in one to seven days immediately following that separation
KPI 3	The proportion of Aboriginal and Torres Strait Islander patients who discharged themselves from hospital against medical advice (DAMA)	2010-11: 2.5%	2012-13 quarterly reduction target: 0.21% Q1: 2.29% Q3: 1.87% Q2: 2.08% Q4: 1.66%
KPI 4	Percentage of Aboriginal and Torres Strait Islander Cultural Practice Program participants by facility	New indicator – no baseline currently set	2012-13 target: 50% of staff within each individual facility to participate in the Aboriginal and Torres Strait Islander Cultural Practice Program[9] (Quarterly reporting target – 12.5% per quarter – based on staff numbers at start of financial year)
Performance Indicators – Monitoring			
KPI 5	Number of Indigenous Hospital Liaison Officers, including gender specific Aboriginal and Torres Strait Islander Hospital Liaison Officers	Current workforce not quantified	2012-13 target: minimum requirement of 2 Indigenous Hospital Liaison Officers
KPI 6	The number of Aboriginal and Torres Strait Islander people as a percentage of the total HHS workforce: using MOHRI Occupied Headcount	2011-12: 2.27% (as at March 2012)	2012-13 target: 2.27%

[8] All Indigenous KPI's currently reported on QHEPS (http://qheps.health.qld.gov.au/hic/pdf/qhpi_atsi/2011/ind_definitions.pdf) also form part of this schedule of indicators for monitoring performance and will continue to be reported on annually (with the exception of Percentage of 'Not Stated' status and DAMA which are quarterly KPI's for escalation as per Schedule 5)

[9] Individual facilities within a HHS include hospitals, community health services, primary health care clinics and any other relevant health facilities

KPI 7	Number of potentially preventable hospitalisations (PPH) 2012-13 (vaccine preventable, acute & chronic) ▪ Age standardised rate for potentially preventable hospitalisations, acute conditions, 2012-13 ▪ Age standardised rate for potentially preventable hospitalisations, chronic conditions, 2012-13 ▪ Age standardised rate for potentially preventable hospitalisations, vaccine preventable conditions, 2012-13	Data not currently available	2012-13 target will be available end June 2012
KPI 8	Increase Indigenous participation in BreastScreen Queensland for women aged 50-69 years within the BreastScreen Queensland Service Catchment[10]	2009/10 participation rate: 51.8%	2012-13 target: 57.6% for all women aged 50-69 years

Table 8.2: Indigenous Specific Funding Summary

Project	Project Deliverables	Funding Allocation[11]	Funding Source
Greater Brisbane Indigenous Sexual Health Worker (ISHW) hub and spoke service support model [Project ID 55052]	The creation of five new ISHW positions [spokes] in Ipswich [1], Logan / Princess Alexandra Hospital [2], Redcliffe / Caboolture [2] and a mobile hub as support to the ISHW manager position at Biala to develop, deliver and evaluate sexual health promotion and screening activities regarding sexually transmissible infections and blood borne viruses and early teenage pregnancies within the Aboriginal and Torres Strait Islander population	$79,986	Chronic Disease Indigenous Health [Queensland Health Indigenous Health Funding Package] [State Funding]
ABCD Implementation - 1.2 A06 FTE [Project ID 55280]	Support ABCD program implementation	$179,340	Council of Australian Governments [COAG] Closing the Gap in Indigenous Health Outcomes National Partnership Agreement (IHONPA) [State Funding]
Chronic Disease Services in Youth Detention Settings [Project ID 61773]	Employ a Clinical Coordinator / Project Officer, Indigenous Health Worker and a Nutritionist to increase the capacity of the Health Services Unit at the Brisbane Youth Detention Centre at Wacol	$187,644	Council of Australian Governments [COAG] Closing the Gap in Indigenous Health Outcomes National Partnership Agreement (IHONPA) [State Funding]

[10] BreastScreen Queensland Service catchment includes West Moreton HHS (Ipswich LGA, parts of Scenic Rim, Somerset, Lockyer Valley LGA's), Metro North HHS (Karana Downs-Lake Manchester SLA only)

[11] Funding for 2012-13, identified in Table 8.2, is subject to performance as per relevant project Memorandums of Understanding

Project	Project Deliverables	Funding Allocation[11]	Funding Source
Care for Indigenous Stroke Survivors in Queensland [Project ID 61797]	Establish additional Indigenous-specific stroke services	$242,674	Council of Australian Governments [COAG] Closing the Gap in Indigenous Health Outcomes National Partnership Agreement (IHONPA) [State Funding]
QH Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033	Implement the Aboriginal and Torres Strait Islander Cultural Practice Program and provide local cultural orientation specific to the respective local community for to all staff prior to, or at the commencement of work in that community	$110,000	Council of Australian Governments [COAG] Closing the Gap in Indigenous Health Outcomes National Partnership Agreement [IHONPA] [State Funding]
Component A: Aboriginal and Torres Strait Islander Young People's Health and Wellbeing Program [Project ID 63740]	Employ two FTE 004 Aboriginal and Torres Strait Youth Health Workers [or similar] to: ▪ Increase knowledge and skills associated with general health, self-care and sexual and reproductive health ▪ Prevent the uptake of tobacco, alcohol and other substances at a young age ▪ Build resilience through skills development, decision making and problem solving ▪ Increase health literacy and ability to effectively navigate the primary health care system ▪ Ensure access to health services, especially prevention and early intervention services	$150,888	Closing the Gap: National Partnership Agreement on Indigenous Early Childhood Development Element 2 – Key Initiative 1: Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Young People in Queensland [Commonwealth Funding]
Component B: Queensland Aboriginal and Torres Strait Islander Young People's Sexual and Reproductive Health Program	Employ two FTE Aboriginal and Torres Strait Islander Health Workers to enable expansion of testing and treatment for sexually transmissible infections and blood borne viruses in young Aboriginal and Torres Strait Islander people within or at risk or entering custodial settings or disenfranchised from schools	$180,000	Closing the Gap: National Partnership Agreement on Indigenous Early Childhood Development Element 2 – Key Initiative 1: Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Young People in Queensland [Commonwealth Funding]
Component D: Queensland Aboriginal and Torres Strait Islander Maternal and Infant Care Program [Project ID 63742]	Recruit 0.5 FTE 004 Aboriginal and Torres Strait Islander Maternal and Infant Care Health Worker [or similar] to provide high quality, women centred antenatal, postnatal and infant care services	$37,722	Closing the Gap: National Partnership Agreement on Indigenous Early Childhood Development Element 2 – Key Initiative 2: Improving Aboriginal and Torres Strait Islander Queenslanders' Access to Maternity and Infant Care Health Care Services [Commonwealth Funding]
Component D: Queensland Aboriginal and Torres Strait Islander Maternity and Infant Care Program [Project ID 63745]	Employ one FTE Grade 7 Midwife and 0.5 FTE 004 Aboriginal and Torres Strait Islander Maternal and Infant Care Health Worker [or similar] to provide high quality, women centred antenatal, postnatal and infant care services	$234,182	Closing the Gap: National Partnership Agreement on Indigenous Early Childhood Development Element 2 – Key Initiative2: Improving Aboriginal and Torres Strait Islander Queenslanders' Access to Maternity and Infant Care Health Care Services

Project	Project Deliverables	Funding Allocation[11]	Funding Source
			[Commonwealth Funding]
Funding Source Reporting Requirements			
Chronic Disease Indigenous Health [Queensland Health Indigenous Health Funding Package]	▪ Performance Reports due 31 October and 30 April, including evidence of expenditure relevant to specific project activity for each reporting period ▪ Annual Financial Report due on 31 July		
Council of Australian Governments [COAG] Closing the Gap in Indigenous Health Outcomes National Partnership Agreement (IHONPA)	▪ Performance Reports due 15 October and 15 April, including evidence of expenditure relevant to specific project activity for each reporting period ▪ Annual Financial Report due on 31 July		
Council of Australian Governments [COAG] Indigenous Early Childhood Development National Partnership Agreement [IECD NPA]	▪ Performance Reports due 15 December and 31 July, including evidence of expenditure relevant to specific project activity for each reporting period ▪ Annual Financial Report due on 31 July		

Schedule 9
Mental Health and Alcohol and Other Drugs Treatment Services

Purpose

This schedule has been developed to outline the key accountabilities and performance responsibilities that are the contribution of the West Moreton Hospital and Health Service to the continued delivery of specialised mental health and alcohol and other drug treatment services (AODTS). The delivery of these services will continue to be in accordance with the Queensland Government's formal commitments and strategic priorities as defined within the following national and statewide agreements:

- the Fourth National Mental Health Plan (4th NMHP),
- the Queensland Plan for Mental Health 2007-17 (QPMH),
- the 2011-12 Queensland Drug Action Plan (QDAP), and
- the National Drug Strategy 2010-2015 (NDS).

Queensland Health is committed to ensuring that resources which are dedicated to mental health and alcohol and other drugs services and programs are maintained for intended purposes, and that identified key performance indicators are met.

Strategic Priorities for Mental Health and AODTS

The strategic priorities for mental health in Queensland are drawn from the Queensland Plan for Mental Health 2007-17, the Fourth National Mental Health Plan, and the forthcoming Ten Year Roadmap for Mental Health. The five priority areas of the QPMH guide the reform of the mental health system and inform investment over the ten year period from 2007-17. Benchmarks for specialised mental health service delivery are defined including 40 mental health inpatient beds per 100,000 population and 70 community mental health positions per 100,000 population.

The strategic priorities for AODTS are in accordance with the Queensland Government's commitment to providing programs and services designed to build safe and healthy communities through minimising alcohol, tobacco and other drug related health, social and economic harms.

Strategic and service planning for the delivery of mental health and AODTS undertaken within West Moreton HHS in 2012-13 should align with the principles, priorities and outcomes outlined in the QPMH, the 4th NMHP, the Ten Year Roadmap for Mental Health, the QDAP, the AMR and the NDS.

Services to be Purchased

Activity Based Funding Activity

The HHS will provide inpatient mental health services in line with the volumes, price and quality requirements as outlined in Schedule 3 Part B of this Agreement.

Non-Activity Based Funding Activity

In addition to the above, the Non-ABF Activity component of Schedule 3 Part B contains block funding for a range of mental health and alcohol and other drug services. The HHS undertakes to expend these funds to ensure the delivery of the services and programs identified below.

Operation of New Inpatient Units

- 9-bed High Secure Unit $1,768,962
- 20-bed Extended Treatment and Rehabilitation Forensic Unit $2,692,210

Minimum Community and Mental Health Service Targets

- Psychiatric hospital / extended treatment facility of 180 beds at The Park Centre for Mental Health, supplying 59,130 accrued patient days.
- 135,028 ambulatory service contacts, equivalent to 111,734 hours, qualifying for collection in the Mental Health National Minimum Data Set (NMDS), Community Mental Health Collection (CMHC).
- Maintain the current 217.98 FTE of the HHS community mental health service and associated programs. This will include the maintenance of recurrently funded program areas and non-recurrent initiatives, as detailed, including the:
  - Service Integration Program
  - EdlinQ Transcultural Statewide Program
  - Mental Health Intervention Program
  - National Perinatal Depression Initiative (NPDI) Program
  - Evolve Therapeutic Service
  - Mental Health Information Management Program
  - Recovery and Resilience (Disaster Recovery) Program
  - Prison Mental Health Program
- Maintenance of current effort in the Queensland Centre for Mental Health Learning program including:
  - MHPOD initiative ($130,000 non-recurrent)
  - workforce development initiatives ($200,000 non-recurrent)
  - forensic training course ($140,000 non-recurrent)
- Maintenance of current effort in Queensland Centre for Mental Health Research.
- Maintenance of the Benchmarking Unit Program.
- Maintenance of the Mental Health Library Program.
- Maintenance of the Service Evaluation and Research Unit.
- Maintenance of Training Initiative in honour of Mark Hansen ($27,000 non-recurrent).
- Implementation of Seclusion and Restraint Project ($80,000 non-recurrent).
- Implementation of the Park Redevelopment Project ($500,000 non-recurrent).

Minimum Specialised Alcohol and Other Drugs Treatment Service Targets

- Maintain existing staffing for alcohol, tobacco and other drugs services, including drug diversion and opioid treatment programs, of 18.4 FTE.
- Maintenance of existing specialist alcohol, tobacco and other drugs services in accordance with evidence-based practice and current Queensland Health clinical guidelines.
  - 3,293 ambulatory service contacts qualifying for collection in the Alcohol and Other Drug Treatment Services National Minimum Data Set and Alcohol, Tobacco and Other Drugs Services-Information System (ATODS-IS).
- Maintenance of existing drug diversion programs in accordance with whole-of-government Policy and Procedure documents including:
  - The Queensland Drug Court Program.
- Maintenance of existing opioid treatment programs in accordance with the *Queensland Opioid Treatment Program Clinical Guidelines*.
  - 230 clients as a minimum number of places with an anticipated future target of 60% of the estimated opioid dependant persons within the HHS.
- Maintenance of existing family support, consultation and liaison and Indigenous outreach services.

- Maintenance of entry of all alcohol, tobacco and other drugs client information and data onto the ATODS-IS.

Performance Management

Key Performance Indicators

HHS performance with respect to mental health and alcohol and other drugs treatment services will be monitored and reported on a regular basis. The following "escalation" and "monitoring" Key Performance Indicators, as applicable to this HHS, will inform and provide context to any response or intervention with respect to performance management of these services:

Escalation Key Performance Indicators

- Ambulatory service contacts: 100% of ambulatory service targets.
- Ambulatory service contacts: 100% of ambulatory service duration (hours).
- Extended treatment facility and psychiatric hospital beds: 95% of accrued patient day target delivered.
- Closure of ATODS Client Intake: closure period <2 weeks.

Monitoring Key Performance Indicators

- Rate of community follow up within 1-7 days following discharge from an acute mental health inpatient unit.
- Proportion of inpatient service episodes where an End of Episode/Discharge Summary clinical note is recorded within 48 hours of discharge.
- Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge.
- Proportion of service episodes where a consumer has a nominated General Practitioner.
- Change in consumers' clinical outcomes.
- Proportion of service episodes where a consumer is secluded at least once.
- Proportion of in-scope outcome collection occasions where required clinical outcome measure(s) were recorded.
- Number of specialised alcohol and other drugs treatment service contacts by program by agency.
- Proportion of specialised alcohol and other drugs treatment service contacts by treatment type by agency.
- Proportion of ATODS-IS mandatory data items entered: 95% of mandatory data entered other than "Not Stated/Unknown".
- Significant variation in source of referrals for alcohol and drug diversion programs.

Performance Reporting

Delivery of ABF related activity will be monitored through the processes and rules as described in Schedule 3 Part C.

Delivery of community mental health services will be assessed through the Community FTE Mental Health Collection, the Monthly Activity Collection, the Mental Health Establishments Collection, and annual service audits. The HHS undertakes to provide data to support these collections and audits.

Delivery of specialised alcohol and other drug treatment services will be monitored through the annual Specialised Alcohol and Other Drugs FTE Collection, the Alcohol and Drug Treatment Services National Minimum Data Collection and the ATODS-IS Monthly Service Activity Report. The HHS undertakes to provide data to maintain these collections and reports.

Schedule 10
Workforce Management

Recitals

Overall management of the public sector health system is the responsibility of Queensland Health, through the Chief Executive, pursuant to s 8 of the *Hospital and Health Boards Act 2011* (**the Act**).

The Hospital and Health Service is a statutory body established pursuant to s 17 of the Act.

The Chief Executive is responsible for managing State-wide industrial relations pursuant to s 8(3) of the Act.

The Chief Executive is authorised under the Industrial Relations Act 1999 to negotiate certified agreements for Health Service Employees and for other health system industrial relations matters, pursuant to s 10 of the Act.

Definitions

Act means the Hospital and Health Boards Act 2011.

Agreement means this Service Agreement.

Chief Executive means the Director-General of Queensland Health.

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

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

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

HR management functions means the formal system for managing people within the Service, including recruitment and selection; 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.

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

Parties means the Chief Executive and the Service.

Policy means any policy document that applies to Health Service Employees, including Queensland Health policies and Service policies.

Schedule means this schedule.

Provision of Health Service Employees

The Chief Executive agrees to provide Health Service Employees to:

- perform work for the Hospital and Health Service (**the Service**) for the purpose of enabling the Service to perform its functions and exercise powers under the Act ; and
- ensure delivery of the services prescribed in the Service Agreement between the Chief Executive and the Service.

Subject to a delegation by the Chief Executive under s 46 of the Act, the Service 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 Service under this Agreement.

The Service will, in the management of Health Service Employees, comply with all obligations owed to Health Service Employees under relevant legislation, directives, Policies and Industrial Instruments.

The Service will exercise its decision-making power in relation to all HR management functions which may be delegated to it by the Chief Executive under s 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:

- the relevant HR delegations manual;
- the terms and conditions of employment specified by Queensland Health in accordance with s 66 of the Act;
- Policies;
- Industrial Instruments; and
- any relevant legislation.

This includes, but is not limited to; ensuring Health Service Employees are suitably qualified to perform their required functions.

Reporting Requirements

The Service will provide to the Chief Executive HR and WH&S reports of a type, and at the intervals, agreed between the Parties, or as specified by the Chief Executive.

Indemnity

The Chief Executive or his or her delegate will provide indemnity for, and is the decision-maker, in respect of applications by Health Service Employees working in and for the Service seeking indemnity in accordance with:

- *Indemnity for Queensland Health Medical Practitioners HR Policy I2;* and
- *Indemnity for Queensland Health Employees and Other Persons HR Policy I3.*

Occupational Health and Safety

The Service, in the management of Health Service Employees, will comply with all obligations and responsibilities imposed, in accordance with the:

- *Work Health and Safety Act 2011*, and relevant Regulations and Codes of Practice made under the *Work Health and Safety Act 2011*;
- *Workers' Compensation and Rehabilitation Act 2003* and *Workers' Compensation and Rehabilitation Regulation 2003;*
- *Fire and Rescue Services Act 1990*;
- *Electrical Safety Act 2002*;
- Queensland Health Occupational Health and Safety Management System, including associated occupational health and safety Policies and implementation standards; and
- Safety Assurance Assessment Model including key performance indicators and audit/inspection programs.

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Appendix 1
Clinical Services Capability Framework – 2011 Self-assessment

	Hospital Facilities					Other
	Ipswich Hospital	Gatton Hospital	Laidley Hospital	Esk Hospital	Boonah Hospital	The Park Centre for Mental Health
Anaesthetic Services	5					3
Children's Anaesthetic Services	4					
Medication Services	5	2	2	2	2	4
Medical Imaging Services	4	2	2	2	2	
Pathology Services	4	2	2	2	2	1
Medical Services	5	2	2	2	2	2
Children's Medical Services	4	2	2	2	2	
Surgical Services	5					
Children's Surgical Services	3					
Perioperative						
▪ Operating suite	5					
▪ Endoscopy	5					
▪ Day surgery	4					
▪ Post anaesthetic care	5					3
▪ Post anaesthetic care (children)	3					
▪ Acute pain	5					
Emergency Services	5	2	2	2	2	
Children's Emergency Services	4					
Intensive Care Services	5					
Medical Oncology Services	3					
Palliative Care Services	5	2	2	2	2	
Cardiac Services						
▪ Cardiac medicine	4					
▪ Cardiac care unit	4					
▪ Cardiac diagnostic & interventional	3					
▪ Cardiac rehabilitation - inpatient	5					
▪ Cardiac rehabilitation - outpatient	5					
▪ Cardiac rehabilitation - ongoing prevention &	5					

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	Hospital Facilities					Other
	Ipswich Hospital	Gatton Hospital	Laidley Hospital	Esk Hospital	Boonah Hospital	The Park Centre for Mental Health
maintenance						
Maternity Services	4					
Neonatal Services	4					
Rehabilitation Services	4					
Renal Services	3					
Mental Health Services						
▪ Child & Youth Services						
– Ambulatory	5					
– Non-acute inpatient						6
▪ Adult Services						
– Ambulatory	5					
– Acute inpatient	5					
– Non-acute inpatient						5
▪ Older Persons Services						
– Acute inpatient	5					
▪ Statewide & Other Targeted Services						
– Adult forensic						6
– Emergency	5					
– Evolve therapeutic	5					

EXHIBIT 228

Queensland Health

Hospital and Health Services

Performance Framework 2012-13

Queensland Government

EXHIBIT 228

CONTENTS

Section 1: Introduction

1.1 Context and Purpose

This Performance Framework (the Framework) applies to the 17 Hospital and Health Services (HHS) in Queensland and to public health services provided by the Mater Health Services, South Brisbane. It sets out the framework within which the System Manager[1] will monitor and assess the performance of Hospital and Health Services, and will replace the Queensland Health Performance Management Framework (QHPMF) from 1 July 2012.

The Framework has been driven by implementation of the health reform program in Queensland which will result in significant changes to the governance and accountability of public health and hospital services from July 2012, including:

- The replacement of Health Service Districts with 17 statutory bodies (Hospital and Health Services) which each have responsibility for the delivery of public hospital services and a range of primary and community services
- A new role for the Department of Health as System Manager, with a focus on setting policy and managing performance of the public sector health system[2] rather than direct management of service delivery
- The establishment of service agreements between the System Manager and Hospital and Health Services as the key accountability mechanism and means of managing the performance of the health system
- The requirement placed on the System Manager to implement a performance management and accountability system, including processes for remediation of poor performance[3], and
- Implementation of the National Performance and Accountability Framework which will establish a robust national reporting framework for the health system and facilitate the achievement of key national health policy objectives.

The Performance Framework for Hospital and Health Services recognises the changing relationship between HHS and the System Manager and the devolution of accountability for service delivery to the HHS. Under these new governance arrangements the service agreement between the System Manager and each Hospital and Health Service will become the primary means through which the overall health system is managed and through which individual HHSs are held to account for the delivery of services. With the removal of direct line management responsibility for service delivery, the role of the System Manager will become focused on the management of the health system. This will require a strengthened focus on and commitment to effective performance management.

The Framework also acknowledges the requirements of the Queensland Government with regard to performance management of public sector services and puts in place processes to ensure these requirements are met.

1.2 Scope

The Framework sets out the system and processes that will be employed by the System Manager to fulfil its responsibility as the overall manager of health system performance. Its scope is limited to Hospital and Health Services and public health services provided by Mater Health Services, South Brisbane. It is recognised that a robust performance framework which

[1] The term 'System Manager' is used throughout this document to refer to the government department which will undertake the role of system manager following the establishment of Hospital and Health Services. The final name and structure of the new department is yet to be determined.

[2] The public health system is comprised of Hospital and Health Services and the Department (*Hospital and Health Boards Act 2011*, s8)

[3] *Hospital and Health Boards Act 2011, s35, s45*

holds the System Manager to account for delivery of its functions will also be required. This will be developed when the governance arrangements and organisational structure for the residual Queensland Health departmental functions beyond July 2012 have been confirmed.

1.3 Why is Performance Management important?

The Queensland Government is given responsibility for the delivery of a range of health services on behalf of the community, and is held to account by the public for its performance through the Parliamentary and electoral processes. Government departments and statutory bodies must therefore be accountable for their performance, both to the government and to the broader community. An effective performance framework provides the means by which this accountability is maintained.

All public sector organisations are required to demonstrate how they will deliver the priorities and objectives for the community which have been set by government through strategic plans. Performance management includes measuring the extent to which these priorities are delivered through monitoring and reporting of results. A key part of any performance framework is the ability to identify performance issues early and take appropriate action to address them. Good performance is also acknowledged.

1.4 Roles and Responsibilities

Hospital and Health Services and the System Manager each have binding roles and responsibilities with regard to performance management. These responsibilities are set out in legislation through the *Hospital and Health Boards Act 2011* and the *Financial Accountability Act 2009* and subordinate legislation. The *Mater Public Health Services Act 2008* provides the legislative framework for the relationship between the System Manager and Mater Health Services South Brisbane[4] with regard to the delivery of public health services. The roles and responsibilities are summarised in Table 1.

Table 1: Performance Management – Roles and Responsibilities

System Manager	Hospital and Health Services
Overall management of the public sector health system, including monitoring HHS performance *(Hospital and Health Boards Act 2011, s8)*	HHSs are individually accountable for their performance *(Hospital and Health Boards Act 2011, s9)*
Collection and validation of performance data supplied by HHSs and provision of data to the Commonwealth Government and relevant entities *(Hospital and Health Boards Act 2011, s9, s45)*	Providing performance data and reporting on their performance to the System Manager *(Hospital and Health Boards Act 2011, s9, s19)* Note: submission of data will also be covered by Health Service Directive: 'Data collection and provision of data to the chief executive'
Monitor the performance of HHSs and take remedial action when performance does not meet the expected standard *(Hospital and Health Boards Act 2011, s45)*	Managing HHS performance against the performance measures in the Service Agreement *(Hospital and Health Boards Act 2011, s19)*
Comply with the requirements set out within 'A Guide to the Queensland Government Performance Management Framework' (Financial and Performance Management Standard 2009, s11)	Comply with the requirements set out within 'A Guide to the Queensland Government Performance Management Framework' (Financial and Performance Management Standard 2009, s11)

[4] For the purposes of this Act, Mater Health Services includes the following hospitals located at South Brisbane – Mater Adult Hospital, Mater Children's Hospital, Mater Mothers' Hospital, Mater Misericordiae Private Hospital and Mater Misericordiae Women's and Children's Private Health Service.

Establish systems which support monitoring of performance against organisational objectives and provide performance information to the Director-General at least quarterly (Financial and Performance Management Standard 2009, s12)	Establish systems which support monitoring of performance against organisational objectives and provide performance information to the Hospital and Health Board at least quarterly (Financial and Performance Management Standard 2009, s12)
	Ensure the operations of the HHS are carried out efficiently, effectively and economically *(Hospital and Health Boards Act 2011, s19)*
	Entering into a Service Agreement with the Chief Executive (Director-General) *(Hospital and Health Boards Act 2011, s19)*
System Manager	**Mater Health Services**
Entering into an agreement with Mater Health Services for the provision of public health services, which may include initiatives, performance targets, priorities and other measures relating to the delivery of services. *(Mater Health Services Act 2008, s6)*	Entering into an agreement with the Chief Executive (Director-General) for the provision of public health services, which may include initiatives, performance targets, priorities and other measures relating to the delivery of services. Reporting to the System Manager regarding the delivery of services *(Mater Health Services Act 2008, s6)*

Further Reading:

Hospital and Health Boards Act 2011
http://www.legislation.qld.gov.au/Bills/54PDF/2012/HospNetOLAB12.pdf

Financial Accountability Act 2009
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/F/FinAccountA09.pdf

Financial and Performance Management Standard 2009
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/F/FinAccPManSt09.pdf

Mater Public Health Services Act 2008
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MaterPubHSA08.pdf

Section 2: National and State Requirements for Performance Management

2.1 National Requirements

In July 2011, the Council of Australian Governments (COAG) signed the National Health Reform Agreement on behalf of the Commonwealth Government and the States and Territories. The agreement sets out the architecture of the national health reform program, and includes a number of commitments which are designed to improve accountability of services and reporting of performance.

The Health and Hospital Services Performance Framework has been revised to be consistent with these national performance initiatives.

2.1.1 National Performance and Accountability Framework

The key objective of the National Performance and Accountability Framework (NPAF) is to support a safe, high quality Australian Health system through improved transparency and accountability.

It applies to all Australian public health and hospital services (through Hospital and Health Services in Queensland), private hospitals and primary care services (through Medicare Locals).

The NPAF supports the objectives set out within the National Health Reform Agreement (2011), specifically to:

- improve performance reporting through the establishment of the National Health Performance Authority (NHPA), and
- improve accountability through the Performance and Accountability Framework

2.1.2 National Performance Standards, Indicators and Targets for Health and Hospital Services

The National Performance and Accountability Framework includes a set of standardised national indicators which are designed to measure local health system performance and drive improved performance. The indicators span three domains of health service delivery:

- Equity
- Effectiveness, and
- Efficiency

These domains are further divided into sub-domains, as follows:

- Effectiveness - Safety and quality
- Effectiveness - Patient experience
- Equity and Effectiveness – Access, and
- Efficiency - Efficiency and financial performance.

The Key Performance Indicators (KPIs) identified within the Hospital and Health Services Performance Framework are aligned to the sub-domains within the NPAF.

The Australian Commission for Safety and Quality in Healthcare (ACSQHC) will be responsible for developing indicators for the measurement of safety and quality for approval by Health Ministers.

2.1.3 National Performance Reporting

A key objective of the national health reform program is to provide Australians with information about the performance of their health and hospital services in a way that is

nationally consistent and locally relevant[5]. The National Health Performance Authority (NHPA) was established in July 2011 as an independent statutory body with a role to report on the performance of the health system at a local level, including trends over time. The NHPA will be responsible for developing and producing reports on the performance of hospitals and healthcare services, including primary health care services.

In the first instance, for Hospital and Health Services these reports will take the form of hospital performance reports, which will be published via the MyHospitals website (http://www.myhospitals.gov.au/). These reports will cover:

- Service and financial performance standards and targets agreed by COAG
- The National Access Target and National Access Guarantee, and any new national standards agreed by COAG
- National Safety and Quality Health Service Standards (September 2011) developed by the Australian Commission for Safety and Quality in Healthcare (ACSQHC) and endorsed by Health Ministers

and will:

- Identify high performing organisations, to facilitate sharing of innovative and effective practices
- Identify poorly performing organisations to the Commonwealth and States and Territories to assist with performance management, and
- Provide a comparative analysis of the performance of hospitals and HHS across jurisdictions and across the public and private sectors, in order to identify best practice and ensure focus on the achievement of results.

The NHPA will not report on the performance of individual clinicians.

Monitoring and reporting the performance of primary health care, and specifically Medicare Locals, will be through Healthy Community Reports, which are expected to be published through a national website similar to that for Hospital Performance Reports.

2.2 Queensland Government Performance Management Requirements

2.2.1 Queensland Government Performance Management Framework

The Queensland Government Performance Management Framework (QGPMF) was developed following a number of reviews which highlighted the need for improved integration between planning, resourcing and performance reporting and better performance information. It is designed to:

> **Improve the analysis and application of performance information to support accountability, inform policy development and implementation and create value for clients, stakeholders and the Queensland community.**
>
> **(A Guide to the Queensland Government Performance Management Framework**
>
> **November 2011)**

The QGPMF enables a clear line of sight between planning, measuring and monitoring results and public reporting.

All Queensland Government departments and statutory bodies have a statutory responsibility to manage their performance under the *Financial Accountability Act 2009*, the *Financial and Performance Management Standard 2009* and the *Public Sector Ethics Act 1994*. In addition, the *Hospital and Health Boards Act 2011* places requirements for performance management on Hospital and Health Services and the System Manager. The QGPMF supports delivery of these legislative obligations by establishing the minimum requirements for Queensland public sector agencies (Government departments and statutory bodies) in relation to performance

[5] National Health Reform Agreement (2011), C1

management, including the development of strategic and operational plans and the publication of results through the Service Delivery Statement and an annual report.

Government Objectives for the Community

Under the QGPMF, the Government's objectives for the community along with other Government priorities, such as election commitments, priorities set internally through policy decisions and those imposed by external entities such as the Australian Government, are translated into agency objectives and performance indicators, then into services and service standards. This provides a clear line of sight between Government objectives and local service delivery.

Planning

Government agencies are the means by which the business of government is delivered. All agencies are therefore required to undertake planning to ensure that their objectives align to the whole of government direction.

As statutory bodies, Hospital and Health Services are required to develop a strategic plan for the HHS, and an operational plan for the HHS as a whole or levels of the organisation that are considered appropriate[6]. The strategic objectives for the public sector health system in Queensland are articulated through the Statement of Government Health Priorities (SoGHP) which sets out 4 priorities for action:

- Revitalising Services for Patients
- Reforming Queensland's Health System
- Focusing Resources on Frontline Services; and
- Restoring Accountability and Confidence in the Health System

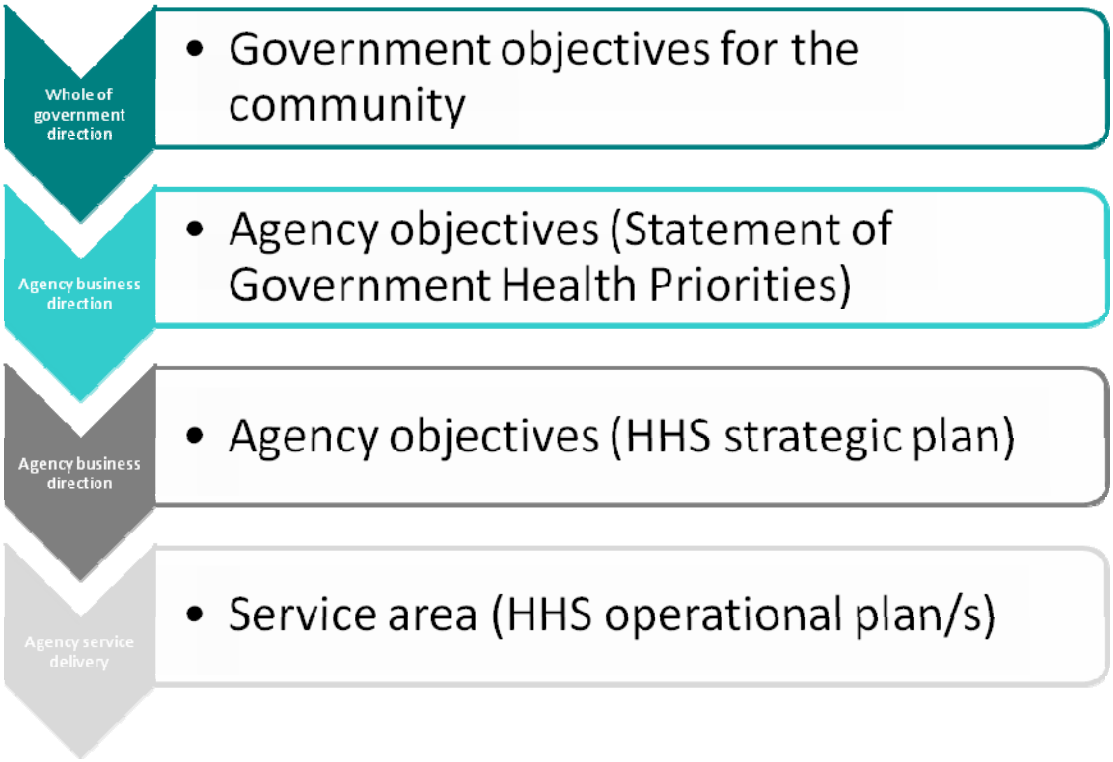
Hospital and Health Services must ensure the priorities and objectives identified within their strategic plans are in turn aligned with those set out within the SoGHP in order to maintain a clear line of sight between government priorities and direction and service delivery. This does not prevent HHSs identifying specific local priorities which are based on the needs of their communities.

Figure 1 overleaf illustrates how Government objectives are cascaded through the planning cycle within the Health context.

Strategic plans must also identify performance indicators that will describe how performance against the strategic objectives within the plan will be measured. For HHSs, the requirement to deliver on the strategic priorities set out through the Government Statement of Health Priorities, state government commitments and Commonwealth and State Government plans and priorities, is included in schedule 1 of the service agreement with the System Manager.

[6] Financial and Performance Management Standard 2009, Div 2,9

Figure 1: Alignment of government direction with service delivery



Monitoring and Reporting Results

HHS are required to publish information on their performance annually in the Service Delivery Statements (SDS) which form part of the State Budget papers. The SDS includes a description of achievements for the year, and a performance statement which reports each agency's estimated actual results against the targets set in the previous year's SDS.

Within the SDS, performance information is presented by service areas, services and service standards.

Service areas are high level grouped related services which communicate the broad types of services which are delivered by a government agency.

Services are the activities undertaken by agencies that deliver outputs and collectively result in outcomes for clients, stakeholders and the community.

Service standards define a level of performance that is expected to be achieved by a service area or service.

The 2012-13 SDS will be confirmed following handing down of the 2012-13 state budget in September 2012.

Hospital and Health Services are also required to produce an annual report covering each financial year to the Minister which must then be tabled in the legislative assembly[7]. Annual reports are the principal way in which government departments and statutory bodies report to parliament and the wider community on their activities and performance, including financial performance.

HHSs will be required to report progress against election commitments where responsibility has been allocated to a HHS. Progress will be provided to Cabinet on a six monthly basis.

[7] Financial and Performance Management Standard 2009, s49 - 54

Further Reading:

National Health Reform Agreement (COAG)
http://www.coag.gov.au/docs/national_health_reform_agreement.pdf

National Performance and Accountability Agreement

http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/perfaccountframe-lp

A Guide to the Queensland Government Performance Management Framework (Department of the Premier and Cabinet) http://www.premiers.qld.gov.au/publications/categories/guides/perf-manage-framework.aspx

Agency Planning Requirements (Department of the Premier and Cabinet)
http://www.premiers.qld.gov.au/publications/categories/plans/planning-requirements.aspx

Annual Report Requirements for Queensland Government Agencies (Department of the Premier and Cabinet)
http://www.premiers.qld.gov.au/publications/categories/guides/annual-report-guidelines.aspx

State Budget – Service Delivery Statements (Queensland Treasury)
http://www.treasury.qld.gov.au/knowledge/docs/service-delivery-statements/index.shtml

Section 3: The Hospital and Health Services Performance Framework

The Hospital and Health Services Performance Framework provides an integrated process for the review, assessment and reporting of performance across the 17 Hospital and Health Services in Queensland. The Framework forms part of the service agreement between each Hospital and Health Service and the System Manager and is intended to give HHSs a clear understanding of how performance is managed across the public health system, including where concerns about performance are identified. It is a key part of the planning cycle and is undertaken in the context of the Statement of Government Health Priorities and the National Health Reform Agreement.

The Framework recognises the changing nature of the relationship between Hospital and Health Services, as statutory bodies and the principal providers of public health services, and the System Manager, as manager of the health system. In this context, Hospital and Health Boards are given responsibility for managing the performance of their HHS with intervention by the System Manager occurring in circumstances where the Board is either unable to rectify a performance issue/s and/or where the HHS is unable to demonstrate satisfactory progress against the Development Action Plan (DAP) and Risk Action Plan (RAP) agreed further to the Health Service District readiness assessment produced by Ernst & Young.

The Performance Framework sets out a transparent, rules-based process through which the System Manager will monitor HHS performance against clearly identified targets and includes a protocol for managing performance issues, including sustained poor performance. The Framework also recognises high performance.

3.1 Principles

The Framework is guided by seven overarching principles:

Transparent	The Framework is rules-based with clear pre-determined measures of performance and associated interventions which are easy to apply and understand
Proportionate	Interventions are based on the level of risk and take into account local circumstances
Consistent	The Framework is consistent with the objectives set out within the National Health Reform Agreement and enacted in the *Hospital and Health Boards Act 2011*.
Proactive	Performance issues are identified early and addressed quickly
Ownership	Accountability for performance at the level of organisations and individuals is understood and accepted
Responsibility	The System Manager and HHS each have a role to play in ensuring that performance expectations are met and that services meet the needs of our population
Balanced	A holistic view of HHS performance across a number of domains is considered when determining performance assessments or categories

3.2 Performance Requirements

3.2.1 Service Agreements

Hospital and Health Services are to meet the performance requirements which are set out in their service agreement with the System Manager. The service agreement is designed to:

- Specify the hospital services (with respect to outcomes and outputs), 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 Director-General
- Provide a platform for greater public accountability
- Ensure State and Commonwealth Government priorities, services, outputs and outcomes are achieved
- Facilitate the progressive implementation of a purchasing framework that incorporates activity based funding
- Set out the performance management arrangements that the System Manager will put in place to fulfil its statutory responsibility for the overall management of the public health system (through the Hospital and Health Services Performance Framework)

Service agreements are underpinned by a legislative framework that requires each HHS (through the Hospital and Health Board Chair) and the Director-General to enter into a binding service agreement[8]. With the transfer of direct line management responsibility for service delivery from the Director-General to the Hospital and Health Board, the service agreement now forms the primary vehicle through which the System Manager manages Hospital and Health Service performance and holds each HHS to account.

The service agreement includes a number of schedules which outline the accountabilities the Hospital and Health Service is required to meet. HHS performance against these schedules is monitored and reported on a regular basis (frequency will be determined by the performance indicators identified for each schedule). The content of 2012-13 service agreements and the performance monitoring requirements for each schedule is outlined in Table 2.

Table 2: 2012-13 Service Agreement Schedules and Performance Approach

Schedule	Content Summary	Performance Monitoring Requirements
Schedule 1 **Strategic Priorities**	This schedule outlines the strategic priorities which will inform all planning activities undertaken with the HHS and which will guide the delivery of services within each HHS.	HHS provides a six monthly self assessment, as described in section 3.2.3
Schedule 2 **Hospital and Health Service Profile**	This schedule provides a high level profile of the HHS and details the services and facilities that the HHS will continue to provide from 1 July 2012.	Regular relationship management meeting between both parties
Schedule 3 **Healthcare Purchasing and Service Agreement Value**	This schedule provides an overview of the Purchasing Framework and details the services being purchased from the HHS.	Key indicators monitored monthly through schedule 5. Regular relationship management meeting between both parties
Schedule 4 **Funding Sources and Schedule**	This schedule outlines the payments to be made to the HHS during the term of the Agreement.	No monitoring requirements
Schedule 5 **Key Performance Indicators**	This schedule outlines the Key Performance Indicators and targets that the HHS will be	Monthly performance reporting, as described in section 3.2.3

[8] *Hospital and Health Boards Act 2011*, s35 (3)

Schedule	Content Summary	Performance Monitoring Requirements
	required to meet during the year and which will form the basis of performance management and escalation processes outlined in the Performance Framework.	Regular relationship management meeting between both parties
Schedule 6 **Development and Risk Action Plans**	This schedule outlines the approach to the progressive management and monitoring against the HHS Development Action Plan and Risk Action Plan as agreed following the readiness assessment process undertaken by Ernst & Young	HHS to submit a progress report (frequency determined by level of risk and overall HHS performance category) against the milestones identified in their Development Action Plan and the strategies within the Risk Action Plan, as described in section 3.2.3
Schedule 7 **Commonwealth Agreement Obligations**	This schedule provides a summary of HHS obligations for 2012-13 against the National Partnership Agreements and other Commonwealth agreements.	HHS provides a six monthly self assessment, as described in section 3.2.3
Schedule 8 **Closing the Gap Obligations**	This schedule describes the accountabilities of the HHS with respect to the various state commitments to closing the gap in Indigenous health outcomes.	Quarterly reporting against all identified Escalation KPIs
Schedule 9 **Mental Health**	This schedule details the mental health services being purchased from the HHS and the associated performance measures to monitor the delivery of these services.	Quarterly reporting against all identified Escalation KPIs
Schedule 10 **Workforce Management**	This schedule details the requirements relating to the day-to-day management of Health Service Employees (excluding persons appointed as a Health Executive) by the HHS	Frequency and content of reports to be agreed between the System Manager and HHS.

3.2.2 Roles and Responsibilities

Both the System Manager and Hospital and Health Services have a role to play in ensuring that performance expectations are met and that services meet the needs of the population. An overview of key responsibilities with regard to performance management is outlined in Table 3.

Table 3: Performance Management – Roles and Responsibilities

System Manager	Hospital and Health Services
Establish and maintain a culture of performance improvement across the public health system	Establish and maintain a culture of performance improvement within the HHS
Implement the Performance Framework, including activating performance interventions where necessary	Comply with the requirements within the Performance Framework, including implementing strategies to address performance issues and secure ongoing performance improvement.
Set HHS performance categories (including any in year changes to performance category)	Establish an internal performance management system for the HHS
Schedule and co-ordinate relationship management meetings and performance review meetings between the System Manager and each HHS	Attend relationship management meetings and performance review meetings called by the System Manager
Ensure the Performance Framework document is current and coordinate updates as necessary, including consultation regarding any proposed changes.	Provide the Hospital and Health Board with regular information on the HHSs performance, including an assessment of performance related risks facing the HHS
Develop key performance indicators and associated targets and trigger points	Provide performance data to the System Manager
Provide performance data to the National Health Performance Authority (NHPA)	Participate in state-wide sharing of performance information across HHSs, including sharing of best practices and opportunities for learning and development

System Manager	Hospital and Health Services
Coordinate the production and distribution of monthly performance reports for each HHS and overall system performance	Engage in service agreement negotiations and respond to proposals in a timely manner.
Provide information and advice on HHS performance to the Minister (as per Minister's office requirements), including any risks or challenges to the achievement of strategic objectives	Provide a named point of contact within the HHS regarding the Service Agreement (negotiation and in year management). This will be the Hospital and Health Service - Service Agreement (HHS-SA) contact person as defined in the service agreement
Provide a regular performance report to the Director-General (or delegate), including an assessment of performance-related risks facing the public health system	Work closely with the System Manager to sustain and improve service provision and engage in constructive performance discussions
Co-ordinate state-wide sharing of performance information across HHS, including sharing of best practice and opportunities for learning and development	Advise the Director-General (and Minister as required) of any risks or challenges to the achievement of strategic objectives
Develop a purchasing framework for the health system	Deliver health services within the requirements of the Performance Framework
Co-ordinate the negotiation of service agreements, including issuing proposals and development of service agreement documentation	Provide information required for the State Budget, including for budget papers e.g. Service Delivery Statements
Provide a named Departmental point of contact for each HHS regarding their Service Agreement (negotiation and in year management). This will be the Queensland Health – Service Agreement (QH-SA) contact person as defined in the service agreement.	Provide milestones and other information to support monitoring the delivery of election commitments
Work closely with HHS to sustain and improve service provision and engage in constructive performance discussions	
Coordinate public sector health system State Budget requirements, including system wide, HHS and System Manager performance service standards	
Coordinate regular progress reports to Cabinet on election commitments for the Health Portfolio	

3.2.3 Measuring Performance

Measuring, or monitoring, performance is an essential part of performance management. Measuring performance increases the likelihood of agreed plans being followed, and of variations being identified and addressed in a timely manner. It also allows good performance to be acknowledged and shared and supports a culture of continuous learning and improvement.

The Hospital and Health Services Performance Framework is not designed to measure all aspects of Hospital and Health Service performance. Rather, it sets out how a cross section of performance across key priority areas is measured, including the strategic objectives for the public health system and standards and targets set by the Commonwealth and State Governments.

The Performance Framework utilises a number of tools to monitor and measure Hospital and Health Service performance. These include:

- Key Performance Indicators
- Development Action Plans and Risk Action Plans
- Independent and Self Assessments

Key Performance Indicators

Key performance indicators (KPIs) provide specific measures of system performance and are widely used by health systems across Australia and internationally as the basis for performance monitoring and assessment, response and intervention. The Performance Framework uses KPIs to monitor the extent to which Hospital and Health Services are delivering the high level objectives set out in the service agreement with the System Manager

and to inform the performance category which is allocated to each Hospital and Health Service.

When developing KPIs, the principles set by the Australian Bureau of Statistics Data Quality Standards and the specifications for KPIs set out within the National Performance and Accountability Framework are followed.

The KPIs are arranged under 7 performance domains:

- Access
- Efficiency and financial performance
- Safety and quality
- Patient experience
- Workforce
- Mental Health and Alcohol and Other Drugs
- Aboriginal and Torres Strait Islander Health

The first 4 domains align to the sub-domains within the National Performance and Accountability Framework, as identified in section 2.1.2.

The Performance Framework defines KPIs as either escalation KPIs or monitoring KPIs.

Escalation KPIs

Escalation KPIs are critical system markers which operate as intervention triggers. This means that underperformance in an escalation KPI triggers immediate attention, analysis of the cause of the deviation, and consideration of the need for intervention. This provides an early warning system to enable appropriate intervention as a performance issue arises within critical performance areas. The application of this process is outlined in Table 6.

Monitoring KPIs

Monitoring KPIs are used as supporting indicators to assist in providing context to escalation KPIs when triggered within a specific domain. Monitoring KPIs will be reported through similar processes as escalation KPIs, when data is made available.

Targets

Each KPI is supported by a set of target/s which measure the level of performance achieved. Where possible these targets are linked to performance levels agreed to in national agreements such as the Australian Healthcare Agreement and National Partnership Agreements, or set out within the National Performance and Accountability Framework, or defined by the State Government.

Targets must meet the following criteria:

- Clear and unambiguous – it must be clear what is to be achieved and within what timeframe
- Relevant – the target should reflect what the public health system is trying to achieve and should be aligned where possible to targets set in higher level documents (e.g. National Performance and Accountability Framework)
- Attributable – the targets must be capable of being influenced by actions which can be attributed to the Hospital and Health Service, it should be clear who has accountability for achieving the target, and what the consequences are if the target is not met
- Achievable – the target should be challenging but achievable within available resources

Trigger Points

Trigger points are also used to ensure that any risks to performance against the specified targets are escalated appropriately, and enable remedial action to be taken on a timely basis. The process for addressing performance issues which are identified through performance monitoring processes is covered in section 3.3.

A trigger point is a specified level of performance against a KPI, that when reached will 'trigger' that the target is at risk of not being met. Trigger points also serve to highlight areas of exceptional performance. Within the Performance Framework, trigger points have been based on a traffic light methodology:

Green Performance is currently on target or better than target

Amber Performance is unfavourable to target but is within agreed tolerance levels

Red Performance is unfavourable to target and is outside the tolerance levels

Table 4 provides an example of an escalation and a monitoring KPI, and the targets and trigger points.

A full list of the 2012-13 KPIs, and their associated targets, trigger points and tolerances is provided within schedule 5 of the service agreement and is also available on the Hospital and Health Service Service Agreement pages on the Queensland Health website (this will be operational from July 2012).

Table 4: Sample escalation and monitoring KPI

Escalation KPI	Target	Trigger (amber)	Trigger (red)
National Emergency Access Target (NEAT): % of ED attendances who depart within 4 hours of their arrival in ED	2012: 70% 2013: 77%	2012: 69.9% - 65.0% 2013: 76.9% - 70.0%	2012: < 65% 2013: < 70%
Monitoring KPI			
Category 1 Outpatients: % waiting in time	95%	94.9% - 85.0%	< 85%

Hospital and Health Service Development Action Plans and Risk Action Plans

Hospital and Health Services will be the principal provider of public sector health services across Queensland, and will be locally governed by a Hospital and Health Board. They will have significant autonomy, including for the financial management of the HHS. In order to prepare Health Service Districts for the transition to Hospital and Health Service status, Ernst & Young was engaged by the System Manager to establish and implement an independent 'HHS readiness' program. This program has included an assessment of the extent to which each district has met a set of 'pre-conditions' across the domains of Governance, Quality, People and Finance. These pre-conditions are designed to ensure the Hospital and Health Services have the processes, structure, plans, capability and capacity to operate as an independent statutory body from July 2012.

Further to this independent assessment, each HHS will produce a detailed Development Action Plan (DAP) which will draw on the development activities identified in their Ernst & Young report and will articulate the areas for development that the HHS will be required to progress to ensure that all pre-conditions are met over time; and a Risk Action Plan (RAP) which draws on the risk profile and mitigating strategies identified in each District's EY readiness assessment. The approach to the progressive management and monitoring against the DAP and RAP for each HHS will form schedule 6 of the HHS service agreement with the System Manager.

Progress against the DAP and RAP will be monitored based on a set of agreed milestones, with identified trigger points. The frequency of reporting will vary, according to the performance category allocated to the HHS. All HHSs are expected to escalate risks or failure to meet development milestones as appropriate between agreed reporting periods.

Independent and Self Assessments

The shared key goals and outcomes for the Queensland public sector health system are defined in the Statement of Government Health Priorities and are summarised in schedule 1 of the service agreement. Schedule 7 of the service agreement outlines the obligations placed on HHS by the Commonwealth Government through the National Partnership Agreements and other Commonwealth agreements. Hospital and Health Services are required to demonstrate how they are contributing to the delivery of these strategic and government priorities through a self assessment process to be submitted to the System Manager on a six

monthly basis. These self assessments are validated with information supplied by specialist teams within the System Manager, for example the Aboriginal and Torres Strait Islander Health Branch will provide advice on Hospital and Health Service performance against Closing the Gap milestones.

3.2.4 Reporting Performance

Hospital and Health Services are required to report regularly on their performance against the indicators and targets set within the schedules of their service agreement, as follows:

Schedule 1 **Strategic Priorities**	Six monthly
Schedule 2 **Hospital and Health Service Profile**	N/A
Schedule 3 **Healthcare Purchasing and Service Agreement Value**	Monthly
Schedule 4 **Funding Sources and Schedule**	N/A
Schedule 5 **Key Performance Indicators**	Monthly
Schedule 6 **Development and Risk Action Plans**	Frequency determined by HHS performance category
Schedule 7 **Commonwealth Agreement Obligations**	Six monthly
Schedule 8 **Closing the Gap Obligations**	Quarterly (escalation KPIs only)
Schedule 9 **Mental Health**	Quarterly
Schedule 10 **Workforce Management**	Frequency and content of reports to be agreed between the System Manager and HHS.

Note: Reporting schedules and data sources will be contained within KPI attribute sheets which will be available from July 2012 on the Hospital and Health Service Service Agreement pages on the Queensland Health website.

The System Manager will produce a monthly performance report for each Hospital and Health Service, covering all relevant schedules of the service agreement based on the reporting schedule for that month. This will include a dashboard report summarising each HHS's performance against the escalation KPIs identified in schedule 5 of the service agreement using a traffic light system (based on the traffic light methodology set out in section 3.2.2). This information will be submitted to the Director-General, or nominated committee, and will also be shared with all Health Service Chief Executives to support information sharing, learning and adoption of good practice (see also section 3.2.2). A template of the monthly performance dashboard report is under development and will be available on the Hospital and Health Service Service Agreement web pages when finalised (this website will be operational from July 2012).

The Minister may also specify additional requirements for reporting on Hospital and Health Service performance.

Public Reporting of Performance Information

Through the National Health Reform Agreement, the Commonwealth and State and Territory Governments have committed to providing the public with information about the performance of their health and hospital services[9].

[9] National Health Reform Agreement, C1

Nationally, this will be delivered through quarterly hospital performance reports which will be published through the MyHospitals website (http://www.myhospitals.gov.au/).

In Queensland information on the performance of Hospital and Health Services (currently Health Service Districts) is made available to the public through http://www.health.qld.gov.au/hospitalperformance/. Information on performance is also available through public documents such as budget papers and annual reports.

3.3 Operation of the Performance Framework

Operation of the Framework requires the System Manager to:

- Establish a starting performance category for each Hospital and Health Service (at 1 July 2012)
- Produce a monthly performance report and dashboard for each Hospital and Health Service
- Each month, allocate a performance category to each Hospital and Health Service based on their performance against the escalation KPIs in schedule 5 of the service agreement
- Identify performance issues and determine appropriate responses
- Determine when the performance response needs to be escalated or can be de-escalated
- Determine when a Hospital and Health Service no longer needs a performance response, and
- Identify sustained high performance

The key components of the Performance Framework are summarised in Figure 2.

3.3.1 Establishing the starting performance category

The establishment of Hospital and Health Services is consistent with a theme of devolution of managerial responsibility from central agencies to more local organisations which has been apparent across leading health systems around the world. The *Hospital and Health Boards Act 2011* provides the legislative framework for the establishment of Hospital and Health Services, and sets out the powers that HHSs will be granted from July 2012 as independent statutory bodies.

As outlined in section 3.2.3, the System Manager engaged Ernst & Young to prepare Health Service Districts for the transition to Hospital and Health Service status through establishing an HSS readiness program which assessed each District's readiness for statutory body status across four domains of Governance, Finance, People and Quality. The principle is that each Hospital and Health Service was required to demonstrate their capacity and capability to take on the functions and powers which are set out in the *Hospital and Health Boards Act 2011*. As a result of the independent readiness assessment each District was given a readiness assessment level of between 1 and 5, with 1 being the lowest and 5 the highest.

The System Manager will undertake a process to allocate a starting performance category for 2012-13 to each HHS prior to 1 July 2012. This process will take into account the EY readiness assessment report and level for each HHS, and an assessment of performance against the 2011-12 KPIs.

Following the assessment each Hospital and Health Service will be allocated a starting performance category for the 2012-13 financial year. The performance categories and criteria for each are outlined below:

High Performance	**For 12 continuous months:** Green in 50% of escalation KPIs* (which must include NEAT, NEST and Full Year Forecast) with Amber in the remaining escalation KPIs
Performing	**For each month:** Green or Amber in all escalation KPIs* which must include: Green in NEAT, NEST and Full Year Forecast

Underperforming (single or multidimensional)	**For a consecutive period of 1 to 3 months (single dimensional):** Red in any of the escalation KPIs* contained within a single domain OR **For a consecutive period of 1 to 3 months (multi dimensional):** Red in escalation KPIs* occurring across multiple domains
Serious Underperformance (single dimensional)	**For a consecutive period of 4 or more months:** Red in any of the escalation KPIs* contained within a singe domain
Serious Underperformance (multi dimensional)	**For a consecutive period of 4 or more months:** Red in escalation KPIs* occurring across multiple domains

* When referring to 'escalation KPIs' for establishing of performance categories for both the *Closing the Gap* domain and the *Mental Health & Alcohol and Other Drugs* domain, the performance domain 'KPI' is to be used, not the individual escalation KPIs contained within the domain (as per Table 5).

The criteria for each performance category are also detailed and incorporated in Table 6.

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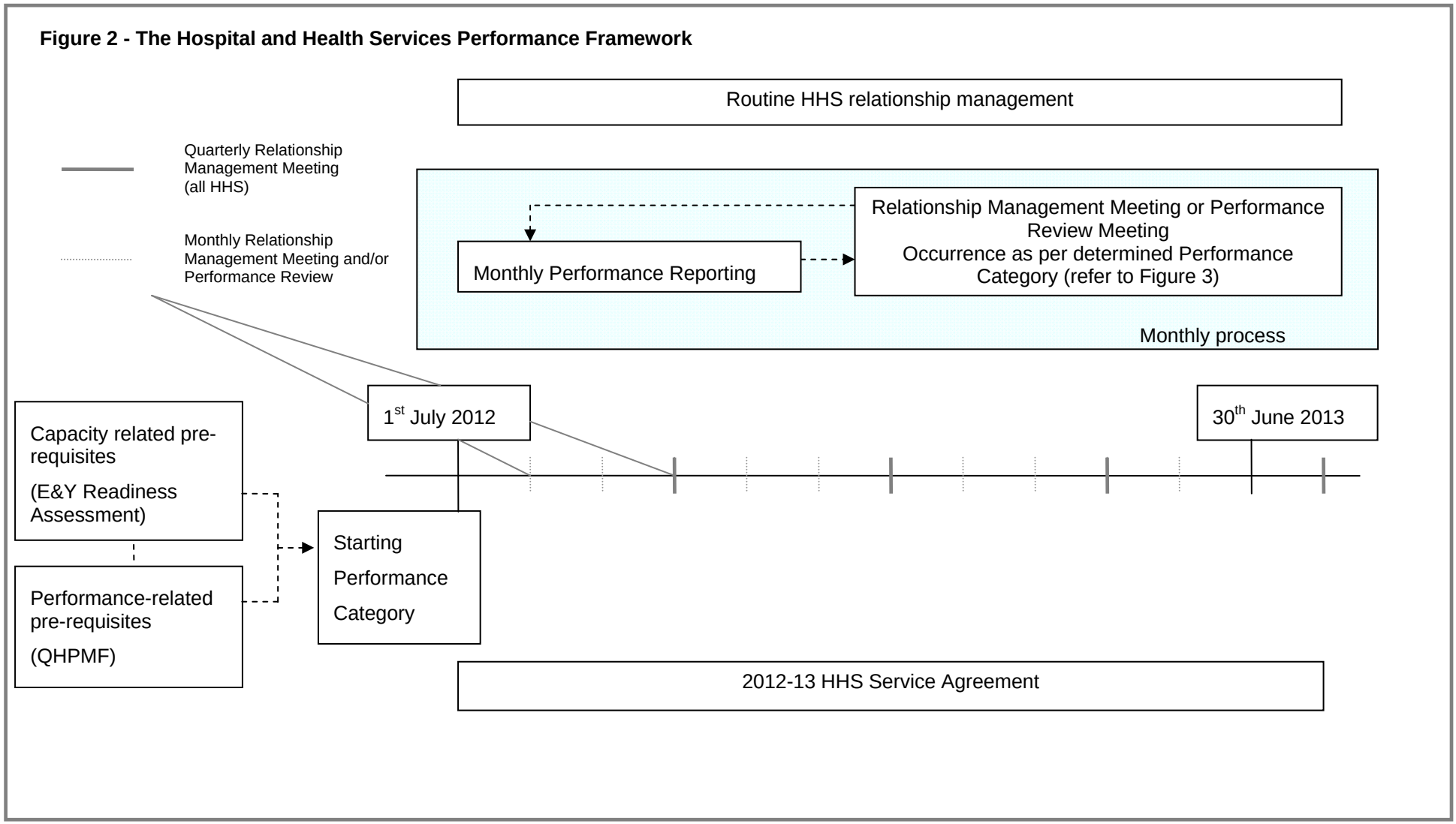
Figure 2 - The Hospital and Health Services Performance Framework



3.3.2 The Performance Review Process

The Performance Framework requires that the performance of all Hospital and Health Services and Mater Health Services against the targets contained within their service agreement be assessed. The System Manager will produce a monthly performance report for each HHS, based on the data submitted. This will include a dashboard report of each HHS's performance across the escalation KPIs within schedule 5 of the service agreement using a traffic light system (based on the traffic light methodology set out in section 3.2.3). This information will be submitted to the Director-General or nominated committee (see also section 3.2.4).

Each month, every Hospital and Health Service will also be allocated an overall performance category, based on their performance against the escalation KPIs within schedule 5 of the service agreement. There are four performance categories:

- High performance
- Performing
- Underperforming (single or multi-dimensional)
- Serious underperformance (single or multi-dimensional)

Determining a Hospital and Health Service's Performance Category

A scoring system is used to allocate a traffic light rating (green, amber or red) against the escalation KPIs, as shown in Table 5. Each Hospital and Health Service's overall performance category is then calculated, using the rating triggers outlined in Table 6. For example, to be allocated the performance category 'performing', a HHS will need to perform at green or amber in all the escalation KPIs, including reaching the attainment scores for green within the NEAT and NEST targets and in the full year forecast KPI.

Changes to a HHS Readiness Assessment Level

The System Manager will undertake an assessment of the progress made by each HHS against the milestones identified within their DAP and RAP on a 6 monthly basis. Amendments to an HHS Readiness Assessment Level will be made where the level of progress indicates this is warranted.

Service Agreement Management

Whilst the Performance Framework focuses on a range of high level KPIs, the System Manager will also establish a service agreement management process. The service agreement management process aims to ensure that services are being delivered in accordance with the agreed purchasing intentions and service agreement rules which are set out in schedule 3 of the service agreement. It is also an opportunity for Hospital and Health Services to raise local issues for consideration e.g. proposed service developments or local capacity issues.

It is expected that the service agreement management process will be led through a Service Agreement Management team based within Healthcare Purchasing Branch[10]. Service agreement management will be an ongoing process, and includes a monthly analysis of activity undertaken and regular two way communication and discussion between each Hospital and Health Service and the System Manager. This process will apply to all Hospital and Health Services regardless of their overall performance category.

Any issues identified by either the System Manager or HHS through routine service agreement management may be raised or escalated to the Relationship Management Group if necessary (further information on the role of the Relationship Management Group is provided in 3.3.3).

[10] Structural arrangements are subject to confirmation through the pending restructure of the remaining Queensland Health departmental functions

3.3.3 Identifying performance issues and determining the appropriate response

In addition to the distribution of a monthly performance report and dashboard for each Hospital and Health Service, all HHS will be expected to attend Relationship Management Meetings with the System Manager. The frequency of Relationship Management Meetings is linked to both performance against the service agreement and progress against the DAP and in managing the risks identified in the RAP, as outlined in Figure 3 and Table 6. Relationship Management Meetings form part of the System Manager's routine processes for monitoring and understanding Hospital and Health Service performance and provide a shared opportunity for the HHS and System Manager to discuss a range of aspects of HHS (and system wide) performance.

Relationship Management Meetings will be held on a quarterly basis with HHS that are high performing both in terms of their performance against the terms of the service agreement and in their agreed DAP and RAP.

Meetings will be held on a monthly basis with HHS that are performing poorly either against the terms of their service agreement and/or in relation to their agreed DAP and RAP. Where significant risks and/or severe poor performance is identified more frequent Relationship Management Meetings may be established.

The frequency of meetings will be determined by the severity and/or risk of poor performance.

Terms of reference for Relationship Management Meetings are available on the Hospital and Health Service Service Agreement website which will be operational from July 2012.

Figure 3: Performance Management Matrix

		Readiness Assessment Level				
		5	4	3	2	1
Performance Category	High Performing	*Relationship Management Group*	*Relationship Management Group*	*Relationship Management Group*	*Relationship Management Group*	*Relationship Management Group*
	Performing	*Relationship Management Group*	*Relationship Management Group*	*Relationship Management Group*	*Relationship Management Group*	*Relationship Management Group*
	Underperforming (Single/Multi-Dimensional)	*Relationship Management Group*	*Relationship Management Group*	*Relationship Management Group*	*DDG to Chief Executive*	*DDG to Chief Executive*
	Serious Underperformance (Single Dimensional)	*Relationship Management Group*	*Relationship Management Group*	*DDG to Chief Executive*	*DDG to Chief Executive*	*DDG to Chief Executive*
	Serious Underperformance (Multi-Dimensional)	*DDG to Chief Executive*	*DDG to Chief Executive*	*DDG to Chief Executive*	*DG to Chair*	*DG to Chair*

Relationship Management Group Meeting *or* Performance Management occurrence:

Quarterly (3 monthly)	Bi-Monthly (every 2 months)	Monthly

Note: Hospital and Health Boards will manage the performance of their HHS. The routine process will be for HHS executives to participate in Relationship Management Group Meetings with the system manager unless the matrix outlined in Figure 3 identifies that a performance review involving a higher level of executive is required. All HHS will provide progress reports to the system manager where escalation KPIs are not met, or where there are significant variances with DAP and RAP milestones and election commitments.

Performance Response

When a performance issue is identified, the System Manager will consider and determine the need for, and degree of, formal intervention required. In line with the principle of proportionality, this will depend on the nature and severity of the issue and an assessment of the Hospital and Health Service's capacity to resolve the issue. HHS who are placed in the 'high performance' or 'performing' categories will be given the opportunity to rectify the performance issue/s before formal performance management by the system manager is applied.

A range of interventions or levers may be applied in response to a performance issue. They include:

- Requirement to investigate, report and account for a performance issue
- Requirement to develop and submit a recovery plan (or turnaround plan for financial performance), with agreed milestones, to address a performance issue
- Increased frequency of monitoring
- Requirement for independent review/validation on the issue
- Appointment of external resources and expertise, including the requirement for a HHS to work with an external corporate mentor who will be responsible for providing assurance to the System Manager that development activities are progressing and any corporate risks are being managed effectively.
- Issuing of a direction in response to an audit, investigation or clinical review commissioned by the Director-General
- Appointment of external parties to the HHS
- HHS to 'show cause' as to why governance and/or management arrangements should not be changed
- Appointment of an administrator and/or replacement of Hospital and Health Board

Intervention responses for each performance category are applied as outlined in Table 6.

Escalation and De-escalation

In line with the principle of proportionality, before a proposed change to a Hospital and Health Service's performance category is confirmed, the HHS will be given the opportunity to respond to any concerns raised by the System Manager regarding their performance and to provide evidence of actions taken or proposed to recover performance to agreed standards and an explanation of the events or circumstances that contributed to the performance issue. This will be done through the Relationship Management Meeting with the System Manager. Where a routine Relationship Management Meeting is not scheduled for some time, an additional meeting will be called to facilitate a timely discussion of the issue/s.

Following this meeting, the System Manager will determine if a change in the Hospital and Health Service's performance category is warranted. The outcome will be confirmed in writing to the Hospital and Health Board Chair, along with any support and/or interventions that will be put in place.

The criteria and trigger points for escalation and de-escalation between performance categories are outlined in Table 6. For the purposes of the Performance Framework, escalation occurs when performance deteriorates.

3.3.4 Recognising and rewarding High Performance

A consistently high performing health system is one of the key goals of the System Manager. The importance of recognising high performance is reflected in the addition of a new performance category (high performance) which seeks to acknowledge consistent high performance. The System Manager will commit to working with Hospital and Health Services to develop meaningful ways of recognising and rewarding high performance during 2012-13, with a view to implementing the agreed outcomes from July 2013. This will include reviewing the criteria for allocation of a 'high performance' category, and the management of performance issues arising in Hospital and Health Services within this category.

Subject to a delegation by the Chief Executive under s46 of the *Hospital and Health Boards Act 2011*, the HHS may assume responsibility 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 Service.

Table 5: Escalation KPI traffic light ratings

		Attainment Score		
KPI No.	**Escalation KPIs**	**Green**	**Amber**	**Red**
	Safety and Quality	Target		
E1	Never events	0	n/a	> 0
E2	Hospital acquired 3rd and 4th stage Pressure Injuries	5.0% of 2010-11 actuals	> 5.0% - 25.0% of 2010-11 actuals	> 25.0% of 2010-11 actuals
E3	Healthcare-associated Staphylococcus aureus (incl. MRSA) bacteraemia	20.0% of 2010-11 actuals	> 20.0% - 40.0% of 2010-11 actuals	> 40.0% of 2010-11 actuals
	Access	Target		
E4	National Emergency Access Target (NEAT): % of ED attendances who depart within 4 hours of their arrival in ED	2012: > 70.0% 2013: > 77.0%	2012: 69.9% - 65.0% 2013: 76.9% - 70.0%	2012: < 65.0% 2013: < 70.0%
E5	Emergency Department: % seen within recommended timeframe: Category 1: within 2 minutes Category 2: within 10 minutes Category 3: within 30 minutes Category 4: within 60 minutes Category 5: within 120 minutes	80% of all categories Cat. 1: 100% Cat. 2: > 80.0% Cat. 3: > 75.0% Cat. 4: > 70.0% Cat. 5: > 70.0%	 Cat. 1: 99.9% - 90.0% Cat. 2: 79.9% - 70.0% Cat. 3: 74.9% - 65.0% Cat. 4: 69.9% - 60.0% Cat. 5: 69.9% - 60.0%	 Cat. 1: < 90.0% Cat. 2: < 70.0% Cat. 3: < 65.0% Cat. 4: < 60.0% Cat. 5: < 60.0%
E6	Patient Off Stretcher Time (POST): < 30 mins (%)	> = 90.0%	< 90.0% - 85.0%	< 85.0%
E7	Elective Surgery: % treated within the clinically recommended timeframe for their category (National Elective Surgery Target (Part 1))	2012: Cat. 1: 89.0% Cat. 2: 81.0% Cat. 3: 91.0% 2013: Cat. 1: 100% Cat. 2: 87.0% Cat. 3: 94.0%	2012: Cat. 1: 88.9% - 85.0% Cat. 2: 80.9% - 78.0% Cat. 3: 90.9% - 87.0% 2013: Cat. 1: 99.9% - 96.0% Cat. 2: 86.9% - 83.0% Cat. 3: 93.9% - 90.0%	2012: Cat. 1: < 85.0% Cat. 2: < 78.0% Cat. 3: < 87.0% 2013: Cat. 1: < 96.0% Cat. 2: < 83.0% Cat. 3: < 90.0%
E8	Elective Surgery: Number of patients waiting more than the clinically recommended timeframe for their category: Category 1: within 30 days Category 2: within 90 days Category 3: within 365 days	0 for all categories Cat. 1: 0 Cat. 2: 0 Cat. 3: 0	HHS specific Cat. 1: > 0% - 5.0% Cat. 2: > 0% - 5.0% Cat. 3: > 0% - 5.0%	HHS specific Cat. 1: > 5.0% Cat. 2: > 5.0% Cat. 3: > 5.0%
E9	Activity: variance between purchased ABF activity and YTD recorded ABF activity, by Service Group (Inpatients, Outpatients, ED, Mental Health, Critical Care and SNAP)	0% to +/-1%	Within tolerance as per detail in Schedule 3 (part C) contained in the Service Agreement	> tolerance as per detail in Schedule 3 (part C) contained in the Service Agreement
	Efficiency and Financial Performance	Target		
E10	YTD Operating position	Balanced or surplus	0 – 1.0% unfavourable variance to budget	> 1.0% unfavourable variance to budget
E11	Full year Forecast Operating position (Agreed position between System Manager and HSS)	Balanced or surplus	0 – 1.0% unfavourable variance to budget	> 1.0% unfavourable variance to budget
E12	Own Source Revenue Budget	Balanced or surplus	0 – 1.0% unfavourable variance to budget	> 1.0% unfavourable variance to budget
E13	YTD average FTE (MOHRI head count)	HHS specific as per detail in Schedule 3 (part B) contained in the Service Agreement	0 – 1.0% unfavourable variance to budget	> 1.0% unfavourable variance to budget
	Closing the Gap			
E14	Performance domain target: Achievement of Closing the Gap escalation	0 escalation KPI red *and* > = 2 escalation	1 escalation KPI red in any quarter	> = 2 escalation KPIs red in any quarter

		Attainment Score		
KPI No.	**Escalation KPIs**	**Green**	**Amber**	**Red**
	indicators contained within Schedule 8 of the Service Agreement.	KPI green in any quarter	*or* > = 3 escalation KPIs amber in any quarter	*or* 1 escalation KPI red for > = 2 consecutive quarters
E14.1	CTG KPI 1 – Estimated level of completion of Indigenous status – specifically the reporting of 'not 'stated' on admission	'Not stated' is < = 1%	'Not stated' is > previous quarter but not meeting target	'Not stated' is > = previous quarter
E14.2	CTG KPI 2 – Percentage of in-scope separations of Aboriginal and Torres Strait Islander consumers from the HHS's acute mental health inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated (in person or via videoconference), was recorded in one to seven days immediately following that separation	> = 55% of in-scope separations of Aboriginal and Torres Strait Islander consumers	54.9% - 50.0% of in-scope separations	< 50.0% of in-scope separations
E14.3	CTG KPI 3 – The proportion of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice (DAMA)	< = HHS quarterly target (as per detail in Schedule 8 contained in the Service Agreement)	> previous quarter result but not meeting quarterly target	> previous quarter target
E14.4	CTG KPI 4 – Percentage of Aboriginal and Torres Strait Islander Cultural Practice Program participants by facility (based on staff numbers at beginning of financial year)	> = HHS quarterly target (as per detail in Schedule 8 contained in the Service Agreement)	> = 50.0% of quarterly target but not achieving quarterly target	< 50.0% of quarterly target
	Mental Health and Alcohol and Other Drugs			
E15	Performance domain target: Achievement of Mental Health & Alcohol and Other Drug Treatment Services escalation indicators contained within Schedule 9 of the Service Agreement. Listed below (where applicable):	Achieve target (listed below) in greater than 67% of the escalation indicators	Achieve target in 67% - 50% of the escalation indicators	Achieve target in less than 50% of the escalation indicators
E15.1	- Ambulatory service contacts	100% of ambulatory service targets	99.9% - 95.0%	< 95.0%
E15.2	- Ambulatory service contacts: Duration	100% of ambulatory service targets	99.9% - 95.0%	< 95.0%
E15.3	- Extended treatment facility and psychiatric hospital beds (Accrued patient days in block funded mental health facilities)	> = 95% of accrued patient day target delivered	94.9 - 90.0%	< 90.0%
E15.4	- Closure of ATODS Client intake	Closure period < 2 weeks	2 – 3 weeks	> 3 weeks
E15.5	- Number of dedicated hospital alcohol and other drugs withdrawal beds	> 95.0% open	95.0% - 85.0%	< 85.0%
E15.6	- Significant variation in number of dedicated residential alcohol and other drugs withdrawal beds	> 95.0% open	95.0% - 85.0%	< 85.0%

KPI attribute sheets for both escalation and monitoring KPIs will be available on the Hospital and Health Service Service Agreement website from 1 July 2012. A full list of KPIs is provided in schedule 5 of the service agreement.

Table 6: Performance Monitoring and Intervention

Performance Category *(NB 2012-13 starting category determined by results of readiness assessment and past performance)*				
High Performance	**Performing**	**Underperforming (single/multi dimensional)**	**Serious Underperformance (single dimensional)**	**Serious Underperformance (multi dimensional)**
Category Trigger				
For 12 continuous months: G green in 50% of escalation KPIs* (which must include NEAT, NEST and Full Year Forecast) with A amber in the remaining escalation KPIs*	**For each month:** G green or A amber in all escalation KPIs* which must include: G green in NEAT, NEST and Full Year Forecast	**For a consecutive period of 1 to 3 months (single dimensional):** R red in any of the escalation KPIs* contained within a single domain OR **For a consecutive period of 1 to 3 months (multi dimensional):** R red in escalation KPIs* occurring across multiple domains	**For a consecutive period of 4 or more months:** R red in any of the escalation KPIs* contained within a single domain	**For a consecutive period of 4 or more months:** R red in escalation KPIs* occurring across multiple domains
Routine Monitoring				
Quarterly, bi-monthly or monthly Relationship Management Meetings (frequency determined by readiness assessment level) led at Executive Director level Ongoing communication/liaison between HHS and System Manager at Service Agreement Manager level	Quarterly, bi-monthly or monthly Relationship Management Meetings (frequency determined by readiness assessment level) led at Executive Director level Ongoing communication/liaison between HHS and System Manager at Service Agreement Manager level	Bi-monthly or monthly Relationship Management Meetings (frequency determined by readiness assessment level) led at Executive Director or Deputy Director-General/Health Service Chief Executive level Ongoing communication/liaison between HHS and System Manager at Service Agreement Manager level	Monthly Relationship Management Meetings led at Executive Director or Deputy Director-General/Health Service Chief Executive level Ongoing communication/liaison between HHS and System Manager at Service Agreement Manager level	Monthly Relationship Management Meetings led at DDG/Health Service Chief Executive or DG/Hospital and Health Board Chair level Ongoing communication/liaison between HHS and System Manager at Service Agreement Manager level
Performance Interventions				
Recognition of achievement and sharing of good practice	Recognition of achievement and sharing of good practice	Health Service Chief Executive to provide formal advice on reason for the performance issue, action required to address and timeframe	HHS required to work with an external corporate mentor who will provide assurance to the System Manager that development	HHS required to work with an external corporate mentor who will provide assurance to the System Manager that development

Performance Category *(NB 2012-13 starting category determined by results of readiness assessment and past performance)*				
High Performance	**Performing**	**Underperforming (single/multi dimensional)**	**Serious Underperformance (single dimensional)**	**Serious Underperformance (multi dimensional)**
		HHS required to work with an external corporate mentor who will provide assurance to the System Manager that development activities are progressing and risks are being effectively managed. HHS required to produce a recovery plan (turnaround plan for financial performance), including timetable for resolution Time frame for recovery to be agreed by System Manager System Manager to provide monthly status report on progress against recovery plan to Director-General or nominated delegate	activities are progressing and risks are being effectively managed. System Manager to provide monthly progress reports to the Director-General Changes to the governance of the HHS may be required. This may include: ▪ System Manager assigns staff or resources to work with HHS to implement recovery plan ▪ System Manager takes on more direct involvement in HHS operations ▪ Director-General commissions independent review of HHS management and governance ▪ Director-General appoints a health service auditor to undertake audit of HHS performance ▪ Director-General issues directive to HHS, further to audit, investigation or review ▪ Minister dismisses Hospital and Health Board and appoints administrator/new Hospital and Health Board (Note: the Minister may determine additional requirements)	activities are progressing and risks are being effectively managed. System Manager to provide monthly progress reports to the Director-General Changes to the governance of the HHS may be required. This may include: ▪ System Manager assigns staff or resources to work with HHS to implement recovery plan ▪ System Manager takes on more direct involvement in HHS operations ▪ Director-General commissions independent review of HHS management and governance ▪ Director-General appoints a health service auditor to undertake audit of HHS performance ▪ Director-General issues directive to HHS, further to audit, investigation or review ▪ Minister dismisses Hospital and Health Board and appoints administrator/new Hospital and Health Board (Note: the Minister may determine additional requirements)

Performance Category *(NB 2012-13 starting category determined by results of readiness assessment and past performance)*				
High Performance	**Performing**	**Underperforming (single/multi dimensional)**	**Serious Underperformance (single dimensional)**	**Serious Underperformance (multi dimensional)**
Point of Escalation →				
Performance issue identified and not resolved following discussion between the HHS and System Manager	R red in any of the escalation KPIs*	**Single dimensional:** R red in any of the escalation KPIs* contained within a single domain for 4 consecutive months OR **Multi dimensional:** R red in escalation KPIs* occurring across multiple domains for 4 consecutive months	R red in escalation KPIs* occurring across multiple domains for 4 consecutive months	Not applicable
Point of De-escalation ←				
Not applicable	▪ All milestones in EY development action plan met ▪ Continuous 12 month period at 'performing' ▪ System Manager is confident that high performance is sustainable	▪ System Manager is confident that issue has been resolved and the HHS has achieved the rating trigger for 'performing' for 2 consecutive months	▪ System Manager determines performance is satisfactory for 3 consecutive months within single domain. ▪ Recovery plan milestones met/on track. ▪ There is demonstrable evidence that the HHS has the capacity to take full responsibility for the service	▪ System Manager determines performance is satisfactory for 3 consecutive months across multiple domains. ▪ Recovery plan milestones met/on track. ▪ There is demonstrable evidence that the HHS has the capacity to take full responsibility for the service

* When referring to 'escalation KPIs' for determining of performance categories for both the *Closing the Gap* domain and the *Mental Health & Alcohol and Other Drugs* domain, the performance domain 'KPI' is to be used, not the individual escalation KPIs contained within the domain (as per Table 5).

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Queensland Government