Clinical services capability framework v3.2

Fundamentals of the framework

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Foreword

Queensland Health is committed to providing high quality, safe and sustainable acute health services to meet the needs of our communities. The *Clinical Services Capability Framework for Public and Licensed Private Health Facilities v3.2*, 2014 (CSCF) provides a set of minimum patient safety criteria by service capability level to inform health service planning and delivery.

The capability of any health service is recognised as an essential element in the provision of safe and quality patient care.[1] A systematic and robust approach to delivering safe and sustainable clinical services is necessary to meet the ever-increasing challenges for all health services. These include: an ageing population; a growing population, with increasing numbers of people from culturally and linguistically diverse backgrounds; an increase in preventable diseases; and workforce challenges; as well as the geographical spread of Queensland.

This version of the CSCF is a refinement of the *Clinical Services Capability Framework for Public and Licensed Private Health Facilities v3.1* (2012).[2] Historically, the CSCF has evolved over 20 years in Queensland, with the first iteration of the CSCF applicable to the public sector released in 1994, followed by publishing of a version applicable to the private sector in 2002. Since 2005, the Queensland CSCF has pertained to both public and private health care sectors.

The CSCF outlines the minimum service requirements, workforce requirements, risk considerations and support services for public and licensed private health services to ensure safe and appropriately supported clinical service delivery. When applied across the state, a consistent set of minimum standards and requirements for clinical services will safeguard patient safety and facilitate clinical risk management in public and licensed private health services.

Ian Maynard
Director-General

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Chief Health Officer

Acronyms

Acronym	Description
AA	Alcoholics Anonymous
AANMS	Australasian Association of Nuclear Medicine Specialists
ABMDR	Australian Bone Marrow Donor Registry
ACAT	Aged Care Assessment Team
ACCCN	Australian College of Critical Care Nurses
ACEM	Australasian College for Emergency Medicine
ACHS	Australian Council on Healthcare Standards
ACORN	Australian College of Operating Room Nurses
ACPSEM	Australasian College of Physical Scientists and Engineers in Medicine
ACRRM	Australian College of Rural and Remote Medicine
ADAWS	Adolescent Drugs and Alcohol Withdrawal Service
ADIS	Alcohol and Drug Information Service
AHPRA	Australian Health Practitioner Regulation Agency
AIR	Australian Institute of Radiography
ANZCA	Australian and New Zealand College of Anaesthetists
ANZICS	Australian and New Zealand Intensive Care Society
ANZNN	Australian and New Zealand Neonatal Network
ANZPIC	Australian and New Zealand Paediatric Intensive Care
ANZSNM	Australian and New Zealand Society of Nuclear Medicine
APAC	Australian Pharmaceutical Advisory Council
ARPANSA	Australian Radiation Protection and Nuclear Safety Agency
ART	Acute Response Team
AS	Australian Standards
ASA[1]	American Society of Anesthesiologists
ASA[2]	Australian Society of Anaesthetists
ASAPO	Australasian Society of Anaesthetic and Paramedical Officers
ASAR	Australian Sonographer Accreditation Registry
BiPAP	Bi-level Positive Airway Pressure
BPSD	Behavioural & Psychological Symptoms of Dementia
CAM Unit	Cognitive Assessment and Management Unit
CARI	Caring for Australians with Renal Impairment
CHIP	Community Hospital Interface Program
ChSS	Child Safety Services
CICM	College of Intensive Care Medicine
CKD	Chronic kidney disease
CL service	Consultation-Liaison service
CPLO	Child Protection Liaison Officer
CPAP	Continuous Positive Airway Pressure
CSANZ	Cardiac Society of Australia and New Zealand
CSCF	Clinical Services Capability Framework

Acronym	Description
CT	Computerised tomography
CYMHS	Child and Youth Mental Health Service
DABIT	Drug and Alcohol Brief Intervention Team
DAFU	Delirium and Falls Unit
ECG	Electrocardiogram/electrocardiograph
ECT	Electroconvulsive Therapy
ED outreach	Emergency Department outreach
EN	Enrolled Nurse
EQuIP	Evaluation and Quality Improvement Program
ERCP	Endoscopic Retrograde Cholangiopancreatography
ESKD	End-stage kidney disease
FACEM	Fellowship of the Australasian College for Emergency Medicine
FBC	Full Blood Count
FCU	Frail Care Unit
FCICM	Fellows of the College of Intensive Care Medicine
FRACS	Fellowship of the Royal Australasian College of Surgeons
GA	General Anaesthetic
GARU	Geriatric Assessment and Rehabilitation Unit
GATE team	Geriatric Assessment through eHealth team
GP	General Practitioner
GEDI	Geriatric Emergency Department Intervention
GEM	Geriatric Evaluation and Management
GEM Unit	Geriatric Emergency Medicine Unit
GEMITH	Geriatric Evaluation and Management in the Home
GRLS	Geriatric Referral Liaison Service
HADS	Hospital Alcohol and Drug Service
HHOT	Homeless Health Outreach Team
HITH	Hospital in the Home
ICU	Intensive Care Unit
IRSA	Interventional Radiology Society of Australasia
ISO	International Standardisation Organisation
JCCA	Joint Consultative Committee in Anaesthesia
LAN	Local Area Network
MATOD	Medication Assisted Treatment for Opioid Dependence [previously known as Queensland Opioid Treatment Program (QOTP)]
MDT	Multidisciplinary Team
MET	Medical Emergency Team, also known as Emergency Response Team and Medical Emergency Response Team, among others
MFM	Maternal Foetal Medicine
MHPPEi	Mental Health Promotion Prevention and Early Intervention
MRI	Magnetic Resonance Imaging
NATA	National Association of Testing Authorities
NGO	Non-Government Organisation
NHTP	Nursing Home Type Patient

Acronym	Description
NICU	Neonatal Intensive Care Unit
NOF	Neck of Femur
NP	Nurse Practitioner
NPAAC	National Pathology Accreditation Advisory Council
NSP	Needle and Syringe Program
PACS	Picture Archiving and Communications System
PACU	Post-Anaesthetic Care Unit
PCA	Postconceptional Age
PECC	Psychiatric Emergency Care Centre
PET	Positron Emission Tomography
PGY1	Postgraduate Year 1
PGY2	Postgraduate Year 2
PICC	Peripherally Inserted Central Catheter
PICU	Paediatric Intensive Care Unit
PoCT	Point of Care Testing
QAS	Queensland Ambulance Service
QIDDI	Queensland Illicit Drug Diversion Initiative
QMERIT	Queensland Magistrate Early Referral Into Treatment
QPHON	Queensland Paediatric Haematology/Oncology Network
QuIHN	Queensland Injectors Health Network
RACGP	Royal Australian College of General Practitioners
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCR	Royal Australian and New Zealand College of Radiologists
RCF	Residential (Aged) Care Facility
RCPA	Royal College of Pathologists of Australasia
RFDS	Royal Flying Doctor Service
RITH	Rehabilitation in the Home
RM	Registered Midwife
RN	Registered Nurse
ROMP	Radiation Oncology Medical Physicist
RRT	Renal replacement therapy
RSQ	Retrieval Services Queensland
SC	Surgical Complexity
SHPA	Society of Hospital Pharmacists of Australia
TGA	Therapeutic Goods Administration

Glossary

*** = definitions contextualised for purposes of CSCF v3.2**

Term	Definition	Source
24 hour/s	Unless otherwise stated, refers to 24 hours a day, 7 days a week.	CSCF v3.1 2012*
Access / accessible	Ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.	CSCF V3.2, 2014*
Acute care	Healthcare in which patients treated for acute (immediate and severe) episodes of illness; for subsequent treatment of injuries related to accidents or trauma; or during recovery from surgery. Usually provided in hospitals by specialised personnel using complex and sophisticated technical equipment and materials. Unlike chronic care, it is often necessary only for a short time.	Forster, P. Queensland Health Systems Review: Final Report. Brisbane; 2005
Admitted patient	A patient who undergoes a hospital's formal admission process to receive treatment and/or care. 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 patient).	Australian Institute of Health and Welfare. Definitions for terms used on page 'Hospitalisation'. AIHW.
Advanced life support	Advanced life support (ALS) is basic life support with the addition of invasive techniques (e.g. defibrillation, advanced airway management, intravenous access and drug therapy).	Australian Resuscitation Council (2006) Guideline 11.1 p1
Ambulatory care	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.	Australian Institute of Health and Welfare. Australia's Health. Canberra: AIHW; 2008
Ambulatory setting	Non-inpatient setting where patients do not require a hospital bed and are freely able to walk around/mobilise during treatment.	CSCF v2.0 2005
Available	Ability to seek and obtain advice and physical intervention from a suitably qualified person who is deemed, is rostered, is on-call / standby or has nominated to be contactable and immediately available to a clinical unit. Individual facilities may define specific availability requirements of medical practitioners and/or other health practitioners in local policy or work arrangement, or under their by-laws.	CSCF v3.1 2012*
Back-transfer	The process that occurs when higher level services transfer patients back to service/s closer to their place of residence (may involve transfer from service/s with higher to lower capability).	CSCF v3.1 2012*
Basic life support	Basic life support (BSL) is the preservation or restoration of life by the establishment of and/or the maintenance of airway, breathing and circulation, and related emergency care.	Australian Resuscitation Council (2006) Guideline 11.1 p1

Term	Definition	Source
Business hours	Commonly defined as 9 am to 5 pm Monday to Friday or as determined by the individual service.	CSCF v3.1 2012*
Case management	The activities health professionals normally perform to ensure coordination of health services required by a patient. When used in connection with managed care, it also covers all the activities of evaluating the patient, planning treatment, referral, and follow-up so care is continuous and comprehensive, and payment for the care is obtained.	Victorian Government. Better Health Channel. Melbourne; 2009 (modified)
Chronic diseases	A diverse group of diseases (such as heart disease, diabetes and arthritis) which tend to be long-lasting and persistent in their symptoms or development. Although these features also apply to some communicable diseases (e.g. infections), the term is usually confined to non-communicable diseases.	Australian Institute of Health and Welfare. Australia's Health. Canberra: AIHW; 2008
(Local) Clinical governance arrangements	Means the policies, processes and accountabilities for improving patient safety and the quality, effectiveness and dependability of services provided by a Service.	Hospital and Health Boards Act 2011, Schedule 2
Clinical pathway	Standardised, evidence-based multidisciplinary management plan, which identifies an appropriate sequence of clinical interventions, time frames, milestones and expected outcomes for a homogenous patient group.	Queensland Government. Queensland Health Implementation Standards: Clinical Pathways. Queensland Health; 2007
Close observation care area	Designated area which may be located in a general ward for patients who have increased dependence on nursing support, including additional monitoring above general ward baseline resources. Close observation care areas in general wards have designated floor space to accommodate one or more beds and any necessary equipment required to manage patients requiring increased observation. Does not include care for patients requiring invasive ventilation or dialysis (with exception of dialysis in a dedicated renal unit). Patients requiring invasive monitoring should be cared for in a close observation care area only when there is an ICU or appropriately credentialed registered medical practitioner on-site for consultation and intervention, if required. Patients requiring more than one system of invasive monitoring are normally cared for in a higher-resourced area unless otherwise agreed by qualified registered medical specialist.	CSCF v3.1 2012*
Comorbidity	When a person has two or more health problems concurrently.	Australian Institute of Health and Welfare. Australia's Health. Canberra: AIHW; 2008
Continuity of care	The provision of barrier-free access to the necessary range of healthcare services over any given period of time, with the level of care varying according to	World Health Organization Centre for Health Development. A

Term	Definition	Source
	individual needs.	glossary of terms for community health care and services for older persons. Kobe: WHO; 2004
Credentialing	Formal process used to verify qualifications, experience, professional standing and other relevant professional attributes for the purpose of forming a view about a clinician's competence, performance and professional suitability to provide a safe, high quality healthcare service within specific environments.	Directive # QH-HSD-034:2014, Credentialing and defining the scope of clinical practice
Cultural competence	A system where a person's cultural background, beliefs and values are respected, taken into account and incorporated into the way healthcare is delivered to that individual.	Australian Government Department of Health and Ageing. National Mental Health Policy 2008: Glossary. Dept of Health and Ageing; 2009
Cultural respect and safety	The recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples and other cultural groups.	Australian Government Department of Health and Ageing. National Mental Health Policy 2008: Glossary. Dept of Health and Ageing; 2009
Designated (in the context of a service)	Specifically defined hours, equipment (e.g. beds) or infrastructure (e.g. ward or unit) are available for providing the service. Includes a routine/regular caseload.	CSCF v2.0 2005*
Documented process	A process agreed by services involved. It may include a networking agreement, letter of agreement between parties, a policy arrangement, memoranda of understanding and/or contractual arrangements for retrieval and/or transfer of patients between facilities and/or outsourcing of services.	CSCF v3.1 2012*
Episode of care	Period of admitted patient care between formal or statistical admission and formal or statistical separation, characterised by only one care type.	Australian Institute of Health and Welfare. Australian Hospital Statistics 2003-04. Canberra: AIHW; 2005
Exclusive rostering	Where mention is made to clinicians being "exclusively rostered to a unit", this requirement is relevant only when services are operational, and does not prohibit them from leaving their immediate work area to attend work-related matters, on the proviso they are readily contactable and able to return promptly to the unit if required to do so.	CSCF v3.2 2014*
Extensive experience	Over 5 years (full time equivalent) of relevant clinical experience commensurate with the position.	CSCF v3.1 2012*
Health professional	A trained health professional who may or may not be registered with AHPRA.	Department of Health, Credentialing and defining the scope of clinical practice, Policy # QH-POL-390:2013

Term	Definition	Source
Hub and spoke model	Typically involves arrangements whereby one site acts as a principal base providing centralised support or activities to satellite sites connected to the principal site. Hub and spoke arrangements can vary within health care depending on the nature of organisations involved and types of services provided.	A definition of a rural model of health service delivery: A 'hub and spoke' (service partner) model. Queensland Department of Health, March 2010
On-site	Staff, services and/or resources located within the health facility or adjacent campus including third party providers.	CSCF v3.1 2012*
Performance indicator	Measures the efficiency and effectiveness of health services (hospitals, health centres, and so forth) in providing healthcare.	Australian Institute of Health and Welfare. Australia's Health. Canberra: AIHW; 2008
Primary health 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.	Forster, P. Queensland Health Systems Review: Final Report. Brisbane; 2005
Qualification	May include formal qualification/s from a higher education institution such as a university, at either under-graduate or post-graduate level, or informal qualification/s obtained as part of an ongoing professional development program, employer-based in-service program, College and/or Professional Association membership, etc.	CSCF V3.2, 2014*
Referral pathways	Provide the process or series of steps to be taken to enable timely referral of individuals to services that will best meet their needs. The referral pathway is ideally developed through a comprehensive and inclusive approach involving all local health services. It may be part of a clinical pathway.	General Practice Queensland. Chronic Disease Matrix. GP Queensland; 2009
Scope of clinical practice	The extent of an individual practitioner's approved clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability and needs and capability of the organisation to support the practitioner's scope of clinical practice.	Directive # QH-HSD-034:2014, Credentialing and defining the scope of clinical practice
Service network	Formalised and clearly defined links of health services across a range of sites and settings to provide an appropriate, effective, comprehensive and well-coordinated response to health needs.	CSCF v3.1 2012*
Shared care	Establishment of pathways through which clients and health professionals in hospital and community settings can collaborate in developing a therapeutic plan to meet clinical and functional needs of the client.	CSCF v3.1 2012*
Statewide service	Queensland-wide services provided from only one or two service bases as self-sufficiency in these services cannot be maintained due to the inadequate volume of cases. The service could include a statewide regulatory, coordination and/or monitoring role.	CSCF v3.1 2012*

Term	Definition	Source
Superspecialty service	Services with a high level of clinical complexity and include the pre- and post-procedural care associated with highly specialised, high-cost, low-volume procedures. They require a critical mass of highly specialised and often scarce clinical expertise.	CSCF v3.1 2012*
Telehealth / Telepharmacy	The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information sharing across distance. Telehealth may include but is not limited to telephones, facsimile machines, electronic mail systems, live interactive video links and remote patient monitoring devices used to collect and transmit patient data for monitoring and interpretation.	CSCF v3.1 2012*

Table note: Not all terms used in the CSCF have been defined. In the absence of a defined CSCF term, readers are encouraged to defer to 'plain English' interpretation relative to these words.

1. Purpose

The CSCF has been designed to guide a coordinated and integrated approach to health service planning and delivery in Queensland. It applies to both public and licensed private health facilities and will enhance the provision of safe, quality services by providing health service planners and service providers with a standard set of minimum capability criteria.

The CSCF's purpose is to:

- describe a set of capability criteria that identifies minimum requirements by service level
- provide a consistent language for healthcare providers and planners to use when describing and planning health services
- assist health services to identify and manage risk
- guide health service planning
- provide a component of the clinical governance system, credentialing and scope of practice of health services
- instil confidence in clinicians and consumers services meet minimum requirements for patient safety and guide health service planning.

The CSCF is intended for a broad audience including clinical staff, managers and health service planners. It is not intended to replace clinical judgment or service-specific patient safety policies and procedures, but to complement and support the planning and/or provision of acute and sub-acute health services.

2. Structure

The CSCF is presented in modular form. Each module must be read in conjunction with this section, the *Fundamentals of the Framework*, and, where relevant, other modules.

The module overview details module-specific criteria and, where relevant, service networks, service requirements and workforce requirements. Each module identifies specific minimum service-level capability criteria. Some modules include sections.

Legislative and non-mandatory information relating to all modules has been listed in Appendix 1 and 2 of the *Fundamentals of the Framework*. Each module lists additional legislative and/or non-mandatory information specific to the module.

A glossary and acronym list is included to define terminology used in the CSCF. These are important references to ensure terminology used in the modules is interpreted correctly.

Please refer to Figure 1 to assist with reading and understanding the CSCF.

Figure 1: Reading and understanding the CSCF v3.2

Step	What to read	Why
1	Fundamentals of the Framework	This document underpins the CSCF, containing information common to all modules and is pivotal to understanding the CSCF.
2	Preamble (where relevant)	Children's and Cancer Services are preceded by a Preamble. A Preamble contains information common to the specific group of modules it precedes and is essential to fully understanding those relevant modules.
3	Relevant service module/s	Each module contains an overview of the service including underpinning requirements (such as service networks, service and workforce requirements and/or risk considerations unique to the module, where relevant), up to six service levels, and legislation and non-mandatory standards and guidelines applicable to the module.

Step	What to read	Why
4	Service level/s	Service levels describe the level of service offered (service description), service and workforce requirements by level, and specific risk considerations (where relevant). Service levels build on each other i.e. a Level 2 service entails all Level 1 requirements plus Level 2 requirements, etc (except for adult Emergency Services).
5	Relevant identified support module/s	Each module lists support services requirements by level. It is crucial to refer to the identified support services modules to determine capability factors of those services.

3. Historical background

The timeline below shows the significant publications and/or legislation contributing to and providing impetus for developing the current version of the CSCF.

1994: Guide to Role Delineation of Health Services (Queensland Health 1994)—public sector only.

1999: *Private Health Facilities Act 1999*.

2002: Guidelines for Clinical Services in Private Health Facilities (Queensland Health 2002)—private sector only.

2004: Clinical Services Framework v1.0 (2004).

2005: Clinical Services Capability Framework for Public and Licensed Private Health Facilities v2.0 (2005).

2006: *Health Quality and Complaints Commission Act 2006*.

2011: Clinical Services Capability Framework for Public and Licensed Private Health Facilities v3.0 (2011).

2012: Clinical Services Capability Framework for Public and Licensed Private Health Facilities v3.1 (2012).

4. Distinguishing ‘service’ from ‘facility’

The CSCF describes the services health facilities may provide. The word ‘service’ refers to a clinical service provided under the auspices of an organisation or facility. The word ‘facility’ usually refers to a physical or organisational structure that may operate a number of services of a similar or differing capability level.

5. Module review and development processes

Considerable work and extensive consultation has occurred throughout the history of the Queensland CSCF (however titled) since it was first developed and released in 1994. All developmental, revision and/or editing work has been conducted in accordance with project governance arrangements in line with best practice project management standards to support consistency and effectiveness of project related decisions.

CSCF v3.2 evolved from a functional assessment of CSCF v3.1, with the aim of ensuring user-friendly, minimum capability criteria applicable to health service planning and the delivery of safe and appropriate health services in Queensland public and licensed private health facilities to uphold the safety of the public. Diverse stakeholder groups including clinicians, health service administrators, clinical academics, and other representatives from public and private sector metropolitan, regional, rural and remote services were invited to provide feedback.

Only necessary amendment has been made in CSCF v3.2 by way of minor re-wording and/or clarification. Further developmental work to the Queensland CSCF may become a separate body of work into the future.

6. Parameters of the CSCF

6.1 Scope

The CSCF is applicable to public and licensed private health facilities in Queensland.

6.2 Principles

The CSCF is guided by a set of principles governing the way it is applied and defining how its purpose is achieved. These principles are:

- best available evidence underpins the delivery of safe and quality health services
- there is alignment with legislation, regulations, non-mandatory standards, guidelines, benchmarks, policies and frameworks, and relevant college standards
- the CSCF applies regardless of models of care adopted by health facilities
- services will be linked with services of lower, the same, or higher service capability levels resulting in the formation of service networks
- service networks facilitate transfer and management of patients appropriate to their care needs
- managing complex health conditions will require a combination of services, links to service networks, and multidisciplinary collaboration.

6.3 Assumptions

Assumptions underpinning the CSCF are health facilities comply with:

- relevant legislative requirements, standards, guidelines and benchmarks including organisational policies such as informed consent, fatigue management, infection control and quality processes
- health professional workforce requirements such as professional registration, codes of conduct, and the health and safety of employees, contractors and visitors
- relevant health professional credentialing and scope of clinical practice
- other policies, procedures and frameworks relevant to the sector
- culturally safe and capable service provision guidelines, including interpreter services (for language and/or sign language), as the foundation for providing the minimum standards of clinically safe and accessible healthcare to:
  - Aboriginal and Torres Strait Islander peoples
  - culturally and linguistically diverse people
  - people with sensory impairment.

6.4 Context

The CSCF complements national and state government health reform initiatives aspiring to deliver substantial health service improvements. These include the education and training reforms of the Council of Australian Governments, National Partnership Agreements and changes to health professional registration.

The CSCF supports public and licensed private health facility strategic, business-level and operational management by providing a guide for coordination and integration of health service planning and delivery in Queensland. It is intended to work along with and inform other frameworks, systems or mechanisms supporting the provision of safe and quality health services. Prevention, screening and early detection services are not in the scope of the CSCF.

The CSCF does not replace, nor does it amend requirements relating to:

- established mandatory standards (e.g. National Safety and Quality Health Service Standards and/or standards developed under the *Private Health Facilities Act 1999*)
- accreditation processes

- credentialing—as there are documented processes in both the public[3] and private sectors for verifying and evaluating the qualifications, experience, professional standing and other relevant professional attributes of registered medical and other health practitioners within specific organisational settings
- defined scope of clinical practice—the capability level of a service is one of a number of factors assisting in delineating the extent of an individual registered health practitioner's practice within a particular service
- developing and organising workforce capability and capacity—such as creating training capacity, improving clinical education and training, and, where relevant, aligning with state and national initiatives
- defining the service models best suited to local areas and population needs, and specific geographical, social, economic and cultural contexts differentiating metropolitan, regional, rural and remote communities
- clinical judgement
- managing health facilities' business practices, clinical process redesign and business process re-engineering
- developing risk management processes—both the public[4] and private sectors should have separate risk management processes in place to identify, analyse, prioritise and manage risk through continuous improvement and performance management strategies
- performance monitoring and accountability responsibilities
- determining the building structures and configuration requirements for health facilities such as legislative building requirements and facility guidelines
- prescribing service networks either at local, statewide or broader level—this is a clinical decision
- service delivery processes such as:
  - adherence to documentation requirements relating to patient admission, management, discharge, transfer and back-transfer policies, mutual agreements with higher-level service providers to facilitate ongoing patient management of more complex conditions at a host service level, and to enable timely transfers as required
  - compliance with auditing and reviewing clinical service and quality activities including evidence of internal and external clinical audits and reviews; review of all sentinel events; review of all incidents and complaints relating to an adverse event; and service-based educational activities reviewing best practice evidence
  - reviewing processes established between facilities and/or services for patient transfers including back-transfers
  - providing relevant clinical indicator data to satisfy accreditation and other statutory reporting obligations.

6.5 Essential considerations

When applying the CSCF, all services should deliberate on the essential considerations listed below. These are essential to safe, quality, coordinated and integrated health service planning and delivery in Queensland.

6.5.1 Culturally safe service provision

Studies have shown culturally safe and competent health care improves outcomes, access to services, and successful engagement in clinical treatment and care for Aboriginal and Torres Strait Islander patients, and culturally and linguistically diverse patients.[5, 6]

A lack of cultural understanding and communication has been linked to adverse experiences in mainstream health settings. These limitations have been found to compromise the safety and quality of care received by Aboriginal and Torres Strait Islander patients and by culturally and linguistically diverse patients.[7, 8]

The provision of services should be in accordance with recognised Queensland Health cultural capability frameworks. The Aboriginal and Torres Strait Islander Cultural Capability Framework and Queensland Health "Five Cross-Cultural Capabilities" set expectations and direction for staff on how to deliver culturally capable services to Aboriginal and Torres Strait Islander, and culturally and linguistically diverse, consumers, families and communities. In order to plan and deliver these services, the Queensland Health Organisational Cultural Competence Framework[9] should be used to identify the systems and service level workforce requirements. Other services such as interpreter services should be considered when providing services for Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse people and/or people with sensory impairment.

6.5.2 Service networks

Service networks provide essential service links to ensure continuity of care for patients. They are necessary for safe and sustainable integrated levels of care. Conceptually, they are similar to the 'hub and spoke' models of care and integrated multicampus service models. The CSCF does not prescribe, either at a local or statewide level, the configuration of service networks as this is a local decision. However, the use of networking mediums, such as telehealth, is actively encouraged at all levels.

Service networks enable a number of possible transfer pathways. Patients may need to be transferred to services with a higher capability for ongoing management. Conversely, patients may be transferred from services with higher capability to services closer to their place of residence, for instance, where the care required is less complex and therefore may operate at a lower service level. There may be statewide, interstate and/or international agreements between services for routine transfers.

To facilitate and integrate patient management at each service level, links between health services are required for referral and transfer of patients. These links should be underpinned by documented processes, which are reviewed by all services at least every 3 years or more frequently if necessary.

Such documented processes should include:

- defined communication pathways including level of registered medical specialist
- trigger mechanisms for local emergency health interventions
- clinical criteria for referral and transfer of patients to and from services
- referral and transfer processes including review of patient transfers and back-transfers
- safety and quality indicators of the agreed documented process.

Some modules have included additional information or requirements for consideration when managing patient complexity and transfers. Service providers such as General Practitioners, non-government organisations, Queensland Ambulance Service, Retrieval Services Queensland, Queensland Police Service and the Royal Flying Doctor Service are integral to safe and quality service networks.

6.5.3 Outreach services

Outreach services may require a multidisciplinary mix of staff and deliver ambulatory care, consultation services, planned procedures and/or health information such as 13HEALTH. These services require the necessary infrastructure, clinical support services and service networks to deliver safe and quality care at a specific service level, and are referred to as the 'provider service'.

The term 'host service' is used to describe the service the provider service is visiting or assisting. Provider services may visit host services on a regular (clinic) or *ad hoc* (emergency) basis, or assist them through telehealth and/or other mechanisms.

'Provider services' can affect service levels of 'host services'. A combination of the capabilities of the 'host service' and 'provider service' may temporarily change the capability level of the 'host service' for the time the approved 'provider service' is on-site.

If planned procedures require after-care (e.g. post-operative observation beyond the capability level of the 'host service'), the 'provider service' is required to remain at the 'host service' for the necessary period of time to ensure all care is safely managed.

6.5.4 Multidisciplinary teams

Studies indicate collaborative multidisciplinary team work in the delivery of comprehensive patient-centred care results in improved health outcomes.[10, 11] Multidisciplinary team care underpins best practice.[12]

The composition of multidisciplinary teams reflects the specialty area. As care complexity increases, the need for increasingly advanced knowledge and skills within the multidisciplinary team increases. Multidisciplinary team members typically include medical, nursing and allied health professionals. The allied health professional workforce is vast and difficult to define. As a general guide, within the CSCF the allied health professional workforce typically includes, but is not limited to, audiologists, clinical measurement scientists, dieticians, exercise physiologists, leisure therapists, medical radiation professionals, music therapists, occupational therapists, optometrists, orthoptists, orthotists, pharmacists, physiotherapists, podiatrists, prosthetists, psychologists, rehabilitation engineers, social workers and speech pathologists.

Each module indicates who should be considered as part of the multidisciplinary team for the particular service and service levels.

6.5.5 Research, teaching and education

Research, teaching and education is undertaken in all health services in order to provide current evidence-informed care. The degree of involvement in research, teaching and education is expected to increase with service level. As a general case, the following should apply:

Level 1 to Level 4 services:

- may have some research commitment/s by an individual clinician or the health service
- may provide clinical placements for health students and/or supervised practice for health professionals.

Level 5 services:

- have some research commitment/s by either an individual clinician or the health service through one or more university or other relevant affiliation/s
- have clinical placements for health students and/or provide supervised practice for health professionals.

Level 6 services:

- have major research commitments by either an individual clinician or the health service in local service-based and multicentre research
- have a major role in providing clinical placements for all health students and/or supervised practice for health professionals.

Research must be conducted ethically at all times within relevant legislative frameworks and guidelines, and be approved by relevant research ethics committees.

Staffing for teaching and education must reflect the corresponding service level requirements. For example, where clinical placement is provided for health students and/or supervised practice for health professionals in a Level 1, 2, 3 or 4 service, staff with relevant clinical knowledge and/or qualifications are required to supervise clinical practice, while Level 4, 5 and 6 services may have access to educators and/or clinical supervisors for all health professionals, particularly for Level 6 superspecialty services.

6.5.6 Risk management

Where minimum requirements for a particular service level are unable to be met, timely risk management strategies should be developed, documented and implemented. Particular attention should be paid to risk management strategies where there are identified risks to service sustainability, such as a service that relies on a sole practitioner in a given specialty or subspecialty. The risk management response needs to be in accordance with relevant health sector policy statements and standards, and endorsed by the appropriate health service chief executive or delegate.

The Queensland Health Risk Management Policy [4] is the overarching governance policy for the management of risk in public sector healthcare services. This policy is supported by an Implementation Standard and Risk Assessment and Treatment Procedure.

In the private sector, the Management and Staffing Standard requires a risk management plan to be developed and implemented,[13] while the Continuous Quality Improvement Standard requires compliance with legislative provisions and establishment of processes and mechanisms to ensure ongoing improvements in the quality of care.[14]

A risk management strategy regarding risk mitigation processes must be documented.

6.5.7 Planned and emergency care

Planned care includes elective surgery and non-emergency patient care. Under the CSCF, patients should receive planned care where the capability of the service level provides a safe and quality service. There will be occasions when services will be required to respond to and provide short-term care beyond the capability level of the service for patients presenting with complex health issues including emergency presentations.

On these occasions, a decision should be made about whether the patient can be managed safely at a lower level service for a period of time, and if and when the patient should be transferred to a higher level service. The decision is based on clinical judgment and requires a risk management response. The decision involves assessment of local capability and capacity, and multidisciplinary consultation with a higher level service and other appropriate stakeholders including the patient and their family/carer.

Possible clinical management processes include:

- transfer to a facility providing a higher level service
- management at that level, applying risk management procedures
- shared management through consultation with a higher level service
- transfer and/or shared management with a similar level service with higher capabilities.

6.5.8 Occupational health and safety

Underpinning the delivery of safe and accessible clinical services is the integration of workplace health, safety and injury management into all management systems and core operations. Health services are required to implement and maintain an effective occupational health and safety management system including the key elements of policy, planning, implementation, measurement and evaluation, review and improvement, and workers' compensation and injury management.

Particular occupational risks to be managed within healthcare environments include, but are not limited to:

- infection control and biological exposures
- chemical exposure and hazardous and dangerous goods
- manual handling and healthcare ergonomics (e.g. manual handling of patients including bariatric patients)
- occupational violence
- fire, electrical and radiation hazards.

6.5.9 Children's services

Child-friendly environments and facilities for children, families and carers are essential where children are cared for on a routine basis. Where children are treated in an adult health service environment, the service must:

- comply with the relevant components of the children's services CSCF modules
- ensure all medical staff have credentials and a defined scope of practice enabling them to provide services to children, and demonstrate currency of practice, which must be noted on their privileging document

- ensure all health workers are aware of the need to report any reasonable suspicions of child abuse and neglect to the Department of Communities, Child Safety and Disability Services
- ensure a clear documented process for child protection reports, including local guidelines and a link to, or contact with, a child protection liaison officer (CPLO)
- ensure access to a Child Protection Advisor at all times
- ensure all other staff involved in the care of children have qualifications and experience commensurate with the service being provided.

Where services are provided to children who require sedation, paediatric resuscitation equipment must be available and clinicians must be competent with its use.

For the purposes of the CSCF, ages identified are assumed to be the age on the day of the birthday. Age groups are consistent except where otherwise stated, such as within the *Children's Cancer Services* and *Mental Health Services* modules (specifically *Child and* Youth and *Older Persons Services*). Age groups are identified as follows:

- 0 to 1 year – infant
- older than 1 year and up to 14 years – child
- older than 14 years and up to 18 years – adolescent
- older than 18 years – adult.

6.5.10 Rural and remote services

The provision of services to rural and remote areas differs from the provision of services in urban or regional areas due to various factors including workforce availability, issues associated with accessibility and sustainability of services, and different patterns of health need. The planning, design and delivery of quality, contemporary health care in these communities needs careful planning, recognising these differences.[15]

Health services are characteristically provided by a combination of rural medical generalists, a range of nurses and midwives, allied health staff and often, visiting specialist health professionals. These professionals may make periodic visits of varying frequency, or be accessible as required, for example, through telehealth. In smaller rural communities, doctors and nurses have traditionally worked alone. Arrangements where these health professionals are supported by a local colleague or by telehealth, and provided adequate leave coverage are necessary to sustain the service. Community information about the service capability needs to be available to the public.

Key considerations for the delivery of safe health services in the rural and remote context are:

- local staff are supported (as individuals and/or teams) to maintain existing, and develop new capabilities, allowing them to provide services in line with their full scope of practice
- services are embedded within a network of services with planned and dependable access to higher level services
- emergency services are supported through 'real time' access to specialist advice via communication technologies and pre-determined protocols
- visiting specialist services are predictable and coordinated, and recognise the role of local staff in ongoing management of the patient
- safe practice is supported by the physical environment in which staff provide services and the technologies supporting reliable diagnosis and accurate treatment
- clinical support services, for example, pathology, medications and radiography, are locally available or can be accessed in a timely way to support diagnosis and high quality treatment
- collaborative service delivery with providers from the private sector (for example, the community pharmacist) and not-for-profits is the norm rather than an exception and safety discussions need to encompass consideration of the capabilities and clinical governance that applies to these other providers.

7. Core components of the CSCF

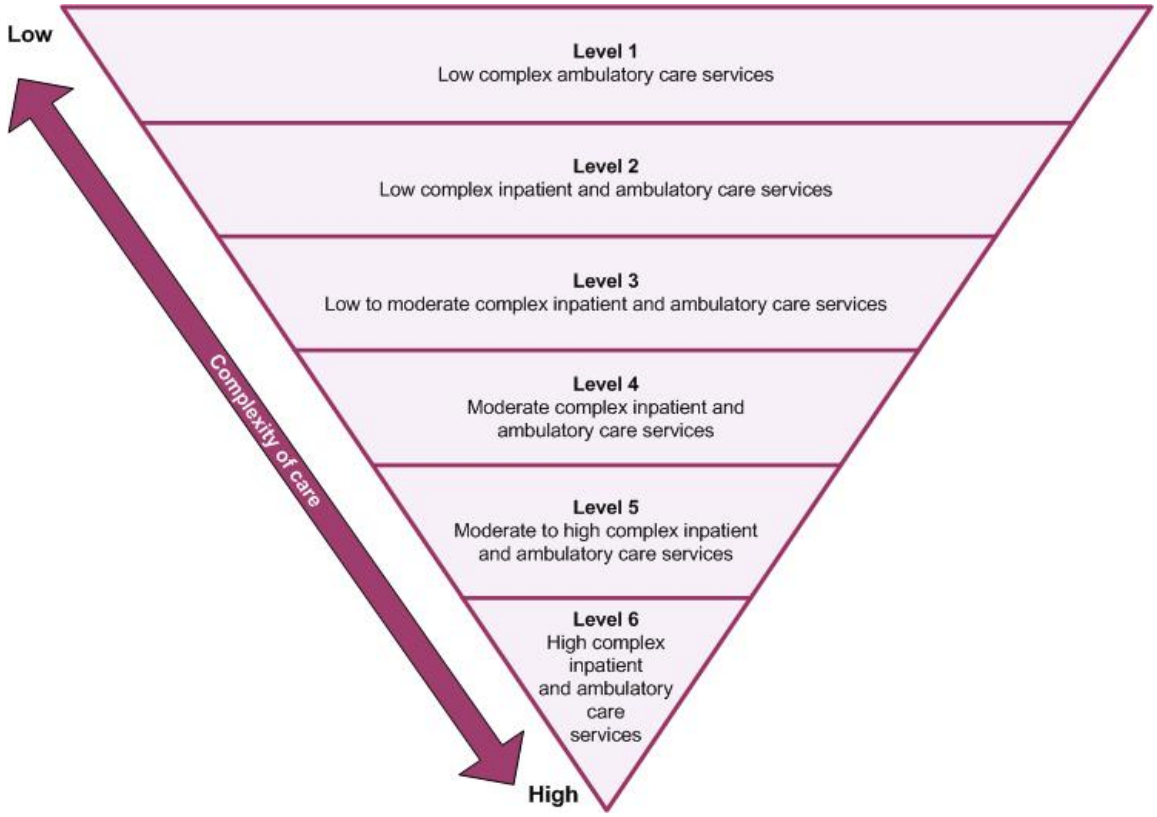
7.1 Fundamentals of the Framework

The Fundamentals of the Framework provides the foundation for the application of the CSCF. It is essential staff read and apply the necessary prerequisites found in the Fundamentals of the Framework before and during all stages of planning and coordination of safe and quality care at all service levels.

7.2 Service levels

Within the CSCF, clinical services are categorised into six service levels with Level 1 managing the least complex patients and Level 6 managing the highest level of patient complexity. However, complexity of care may vary between modules. The size of the service and diversity of health care managed at each level will be greater as service levels increase (Figure 2).

Figure 2: Clinical service levels by complexity of care



As a general rule, service levels build on the previous service level's capability (except for adult Emergency Services). For instance, service Level 6 should have all the capabilities of service Level 5 plus additional capabilities resourcing the most highly complex service. Each service level within the modules provides the additional capabilities representing the minimum requirements for that level.

7.3 Service level criteria

The service level criteria stipulated within the CSCF include:

- service description
- service requirements
- workforce requirements
- specific risk considerations
- support services requirements, if identified.

Minimum requirements for each criterion are defined in the service levels of the modules. The minimum requirements are based on best available evidence and requirements of the service. The minimum criterion requirements must be met at each level to provide safe and quality clinical services. A service level may exceed the minimum requirements but cannot claim subsequent service level status until the minimum requirements for the subsequent level are met.

7.3.1 Service description

Each module includes a brief description of the service including:

- service setting and general hours of service
- type of patient (e.g. multiple comorbidities)
- providers and subspecialties, where relevant.

Each level provides a more in-depth description of the service level capacity, which may not be covered in the module overview. Rights regarding patient admission to, and discharge from, inpatient care units are at the discretion of the relevant Health Service Chief Executive and/or licensee, and contingent upon relevant models of care and service delivery.

7.3.2 Service requirements

Each module provides additional detail and service-specific requirements including:

- type of service provided (e.g. particular interventions or treatment pathways, which could involve telehealth), specialty skills, specific hours and work-ordered timing of the service
- providers (e.g. specific expertise of the team/s)
- inter-service / inter-level relationships (e.g. service networking, referral pathways, transfer arrangements and interaction with other services, general practitioners, multidisciplinary teams and specialists).

Service requirements also list infrastructure, asset and equipment requirements, and each service level may have additional requirements. As the management of patient care becomes more complex, the service requirements of a service level may change. Infrastructure, asset and equipment service requirements include, but are not limited to:

- the health facility provides equipment suitable for the needs of the service (such as intensive care services) and/or the patients (e.g. children, bariatric or geriatric)
- all equipment and infrastructure is:
  - compliant with the manufacturers' instructions and relevant current national standards, in particular, the Therapeutic Goods Administration (TGA) regulatory guidelines and standards for medical devices
  - maintained in accordance with relevant Australian Standards
  - used in compliance with the manufacturer's intended purpose and instructions for use
- staff responsible for using the equipment are trained and competent in equipment use
- users of equipment and infrastructure have access to appropriate maintenance and support services, including biomedical engineering and technical services, information communications technology support, and building maintenance services
- all Level 6 services have access to on-site biomedical engineering and technical support services.

Reference to individual attributes of practitioners is listed under workforce requirements.

7.3.3 Workforce requirements

Workforce requirements describe the medical, nursing, allied health and other workforce specifications relevant to the levels within each module. These may be further defined within the service levels as the service level complexity increases.

The CSCF does not prescribe staffing ratios, absolute skill mix, or clerical and/or administration workforce requirements for a team providing a service, as these are best determined locally. Where minimum standards, guidelines or benchmarks are available, they should be considered as a guide for staffing requirements.

Minimum workforce requirements for employed staff include:

- must be suitably qualified for the role in which they are employed and only work within their scope of clinical practice
- must complete an orientation program, incorporating workforce cultural capability as relevant to the service
- must complete annual training related to occupational health and safety (e.g. manual handling, fire safety and infection control)
- must attend continuing education and skill enhancement programs
- must be competent in basic life support (clinical staff only)
- all healthcare workers caring for children must be competent in basic paediatric life support.

7.3.4 Specific risk considerations

This section identifies any service-specific risks not identified in the Fundamentals of the Framework under Section 6.5.6 Risk Management.

7.3.5 Support services requirements

Support services requirements identify the minimum suite of services needed to deliver a service at a particular capability level. Support service levels listed in the support services requirements table of each module, where necessary, are the required capability levels of the support service to deliver the specified CSCF level relative to each CSCF module. For example, a Level 4 surgical service may require an on-site Level 3 medication service whilst only requiring an accessible Level 4 rehabilitation service.

7.4 Legislation, regulations and legislative standards

Governments mandate minimum safety and quality standards under legislation, regulations and legislative standards that are applicable to the CSCF. Appendix 1 of the *Fundamentals of the Framework* lists legislation, regulations and legislative standards relevant to the CSCF. However, the list is not exhaustive and it is the responsibility of each service to comply with all relevant and current versions and revisions. The same applies to any legislation, regulations and legislative standards listed in modules.

It is assumed services comply with legislation and regulations pertaining to clinical staff registration (e.g. *Health Practitioner Regulation National Law Act 2009*) as these mandates are outside the scope of the CSCF and are considered a service management matter.

It should be noted that legislation and regulations may not specify what health professionals can and cannot do in relation to clinical practice. This dimension of their work may be more appropriately outlined in credentialing arrangements, position descriptions or other organisation-specific documentation.

7.5 Non-mandatory standards, guidelines, benchmarks, policies and frameworks

Non-mandatory standards, guidelines, benchmarks, policies and frameworks are usually developed by governing bodies and/or health professional colleges or equivalent (national and international) to inform safe practice by providing clear and transparent, safety and quality requirements and parameters for all healthcare providers. These should be referred to when reading the CSCF and are listed in Appendix 2 of the *Fundamentals of the Framework*. Additionally, modules list other non-mandatory requirements specific to the module. Services utilising these documents should comply with the most current versions and revisions.

8. Monitoring and reporting compliance with the CSCF

There are existing reporting mechanisms in both public and licensed private health facilities. For example, as outlined in service agreements between the Department of Health and Hospital and Health Services (HHS), Health Service Chief Executives are responsible for CSCF compliance, monitoring and reporting, provision of services within each service capability level, and notifying the Department of changes to previous CSCF self-assessments.

Under the *Private Health Facilities Act 1999*, the Chief Health Officer has the statutory responsibility for monitoring private health facility compliance with the CSCF.

Appendix 1: Legislation, regulations and legislative standards

Public and private sectors

- *Aged Care Act 1997* (Cwlth)
- *Anti-Discrimination Act 1991*
- Australian Commission on Safety and Quality in Health Care (ACSQHC) (September 2011), National Safety and Quality Health Service Standards, ACSQHC, Sydney
- Standards Australia. AS/NZS 4187:2003. Cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of associated environments in healthcare facilities
- *Carers (Recognition) Act 2008*
- *Child Protection Act 1999*
- *Coroners Act 2003*
- *Crime and Corruption Act 2001*
- *Criminal Code Act 1899*
- *Disability Services Act 2006*
- *Environmental Protection Act 1994*
- *Family Law Reform Act 1969* (UK)
- *Guardianship and Administration Act 2000*
- *Health Insurance Act 1973* (Cwlth)
- Health Insurance Regulations 1975 (Cwlth)
- *Health Ombudsman Act 2013*
- *Health Practitioner Regulation National Law Act 2009*
- *Health Practitioners (Professional Standards) Act 1999*
- Health Regulation 1996
- Health (Drugs and Poisons) Regulation 1996
- *Hospital and Health Board Act 2011*
- Hospital and Health Board Regulation 2012
- *Information Privacy Act 2009*
- *Mental Health Act 2016*
- Mental Health Regulation 2016
- *National Health Act 1953* (Cwlth) [including Section 100]
- *Privacy Act 1988* (Cwlth)
- *Privacy Amendment Act 2004* (Cwlth)
- *Public Health Act 2005*
- Public Health Regulation 2005
- Queensland Development Code
- Queensland Health Drug Therapy Protocol: Isolated Practice Areas and Rural Hospitals – Registered Nurses (2009)
- Queensland Health Office of Health and Medical Research: Guidelines and Legislation
- *Radiation Safety Act 1999*
- *Right to Information Act 2009*
- *Therapeutic Goods Act 1989* (Cwlth)
- Therapeutic Goods Standards (Cwlth)
- *Transplantation and Anatomy Act 1979*
- Transplantation and Anatomy Regulation 2004
- *Water Supply (Safety and Reliability) Act 2008*
- *Workers' Compensation and Rehabilitation Act 2003*

- *Working with Children (Risk Management and Screening) Act 2000*
- *Workplace Health and Safety Act 2011*
- Workplace Health and Safety Regulation 2011
- *Youth Justice Act 1992*
- Youth Justice Regulation 2003.

Private sector only

- *Food Act 2006*
- *Private Health Facilities Act 1999*
- Private Health Facilities (standards) Amendment Notice (no.1) 2006
- Queensland Government. Private Health Facilities Act 1999 Credentials and Clinical Privileges Standard
- Private Health Facilities (Standards) Notice 2000
- Private Health Facilities Regulation 2000.

Note

- Queensland Government legislation is available from: www.legislation.qld.gov.au/
- Australian Government (Cwlth) legislation is available from: www.comlaw.gov.au/
- All legislation, regulations and legislative standards updated from time to time.

Appendix 2: Non-mandatory standards, guidelines, benchmarks, policies and frameworks (not exhaustive & hyperlinks current at date of release of CSCF v3.2)

- Association for the Wellbeing of Children in Health Care. Health Care Policy Relating to Children and Their Families. AWCH; 1999. www.awch.org.au/child-and-adolescent-health-policies.php
- Association for the Wellbeing of Children in Health Care. Policy Related to Provision of Play for Children in Hospital. AWCH; 1986, revised 2002. www.awch.org.au/hospital-play-policy.php
- Australasian Health Infrastructure Alliance. Australasian Health Facility Guidelines: Revision v4.0. AHIA; 2010. www.healthfacilityguidelines.com.au/guidelines.aspx
- Australian and New Zealand College of Anaesthetists. Professional Standard PS8: Recommendations on the Assistant for the Anaesthetist. ANZCA; 2008. www.anzca.edu.au/resources/professional-documents/
- Australian and New Zealand College of Anaesthetists. Professional Standard PS26: Guidelines on Consent for Anaesthesia or Sedation. ANZCA; 2005. www.anzca.edu.au/resources/professional-documents/ps26.html
- Australian and New Zealand College of Anaesthetists. Professional Standard PS45: Statement on Patients' Rights to Pain Management and Associated Responsibilities. ANZCA; 2010. www.anzca.edu.au/resources/professional-documents/ps45.html
- Australian College of Rural and Remote Medicine. Credentialing and Clinical Privileging for Rural and Remote Medical Practice. www.acrrm.org.au/
- Australian Commission on Safety and Quality in Health Care. www.safetyandquality.gov.au/
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- Australian Council on Healthcare Standards. Standards and Guidelines. www.achs.org.au
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- Australian Government. Cultural competency in health: A guide for policy, partnerships and participation. National Health and Medical Research Council; 2006. www.nhmrc.gov.au/
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- Australian Health Practitioner Regulation Agency (AHPRA). www.ahpra.gov.au/
- Australian Resuscitation Council. Standards for Resuscitation: Clinical Practice and Education. ARC; 2008. www.resus.org.au/clinical_standards_for_resuscitation_march08.pdf
- College of Intensive Care Medicine of Australia and New Zealand. Minimum Standards for Transport of Critically Ill Patients. CICM; 2003.www.cicm.org.au/policydocs.php
- Council of Australian Governments. National Partnership Agreement for Hospital and Health Workforce Reform. COAG. www.nhwt.gov.au/documents/COAG/National%20Partnership%20Agreement%20on%20Hospital%20and%20Health%20Workforce%20Reform.pdf
- Dental Board of Australia. http://www.dentalboard.gov.au/
- International Organisation for Standardisation. Standards and guidelines. www.iso.org/iso/home.htm
- National Standards for Mental Health Services, 2010.
- National Code of Conduct for Health Care Workers (Queensland). 1 October 2015.

- Nursing and Midwifery Board of Australia (NMBA). Registration standards. NMBA. www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx
- Nursing and Midwifery Board of Australia (NMBA). Codes, guidelines and statements. NMBA. www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements.aspx
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  www.health.qld.gov.au/atsihealth/documents/cultural_capability.pdf
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- Toolkit of resources to address domestic and family violence https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence
- Royal Australian College of General Practitioners. Standards for General Practices. RACGP; 2010. www.racgp.org.au/standards
- Workers Compensation and Rehabilitation Act 2003 – Workers compensation protocol for nurse practitioners.

Note

- All non-mandatory standards, guidelines, benchmarks, policies and frameworks updated from time to time.

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