Department of Health

Queensland rural and remote health service framework

June 2014

Great state. Great opportunity.

Queensland Government

This document has been prepared as a guide to assist Hospital and Health Services (HHSs) in partnership with communities and other service providers to undertake rigorous and transparent needs-based health service planning in rural and remote communities. Each community is unique and therefore planning should be tailored to community requirements.

Assistance is available to undertake the health service planning process for rural and remote communities.

Queensland rural and remote health service framework

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For more information contact:
System Policy and Performance
Department of Health
GPO Box 48
Brisbane QLD 4001

email statewide_planning@health.qld.gov.au, phone 07 3234 0461.

An electronic version of this document is available at www.health.qld.gov.au

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Contents

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- members of the Statewide Rural and Remote Clinical Network
- public, private and primary healthcare sector stakeholders from across Queensland who participated in the statewide consultation process
- Department of Health divisions and commercialised business units' staff
- Hospital and Health Services' staff.

Director-General's foreword

The *Queensland rural and remote health service framework* (the framework) has been developed to support Hospital and Health Services in their planning for and delivery of sustainable services to improve the health equity of residents living in rural and remote communities across the state.

Recognising the unique challenges of providing healthcare in rural and remote Queensland, the framework provides an overview of the health service mix, health service capability and workforce profile associated with rural and remote health facilities. Underpinning this new classification is the principle that health services at all levels operate within a health service network, providing timely access to quality and safe care aligned to patient need.

This framework will support achievement of the vision for rural and remote health services as articulated in *Better Health for the Bush: A plan for safe applicable healthcare for rural and remote Queensland.*

Developed by the Statewide Rural and Remote Clinical Network, a group that draws on the collective experience of rural clinicians across Queensland, *Better Health for the Bush* provides a roadmap for the future of rural and remote healthcare that is being backed by an increased investment in frontline service delivery and key enablers such as telehealth and new workforce models.

The framework lays the foundation for a supported approach to effective coordinated care, whilst enabling flexibility to recognise local circumstances.

I encourage those involved in the planning, funding or delivery of health services in rural and remote Queensland to familiarise yourself with both documents.

Ian Maynard
Director-General
Queensland Health

1. Introduction

Queensland is Australia's second largest state, covering 1,722,000 square kilometres. In rural and remote areas of the state the challenge of providing access to health services is magnified by geographical distance. In addition, no two communities are alike. Some rural communities are experiencing rapid growth associated with resource and mining development, while others have an ageing and diminishing population.

Limited and ageing infrastructure and higher costs associated with healthcare delivery are common challenges[1]. In this context it is essential that health services are well planned, with the capability to respond effectively to changes in the level and profile of health need.

As identified in the *Blueprint for better healthcare in Queensland* and *Better Health for the Bush*, improving access to a new generation of safe and sustainable health services for residents of small rural or remote communities is a priority. An example of this commitment is the increased investment in telehealth. Queensland has one of the largest managed telehealth networks in Australia and the benefits to patients and staff include:

- increased access to specialist clinical services through linkages with regional and Brisbane based specialist services, reducing the need for patients to travel and take extended time away from family and work
- increased support for local staff to manage emergency presentations while awaiting transfer to higher level health services
- improved networking and communication across health service networks including providers outside of the public health system
- increased access to professional development opportunities for rural and remote staff.

The telehealth network is continuing to expand and is supporting other innovative service responses in rural and remote areas. While larger rural communities are generally able to support a traditional hospital and specialised service models, increasing remoteness and diminishing population size and density demands innovative service responses. Emergent service models are increasingly based on a generalist workforce and involve strategic partnerships with other healthcare providers. These new models require public hospital services that are seamlessly integrated with the services of other healthcare providers including the Queensland Ambulance Service, private general practitioners, non-government providers, and community and aged care service providers.

Hospital and Health Services (HHSs) are responsible for leading local health improvements in partnership with local communities and other health and community service providers.

The *Queensland rural and remote health service framework* (the framework) supports planning and provision of health services in rural and remote communities across Queensland with the intent to:

- improve the health equity of Queenslanders living in rural and remote Queensland
- support people living in rural and remote Queensland to access a sustainable configuration of health services
- plan and operationalise locally determined health services that better meet the health needs of rural and remote communities.

[1] Australian Government, National Strategic Framework for Rural and Remote Health, 2012

2. Planning for health services in rural and remote Queensland

Factors that determine the local level of access to health services are complex. Planning processes need to support orientation of health services to better meet health needs while considering geographic location, health service networks (across HHS, regional and metropolitan areas), distribution of the population, transport networks, workforce supply, the availability of appropriate infrastructure and equipment, information communication technology requirements, and available funding.

Building on the *Guide to health service planning (v2) 2012*, a new guide, the *Rural and remote health service planning process 2013* has been prepared to support local planning in rural and remote areas. These documents promote a consistent evidence-based approach to determining future rural and remote health service requirements aligned to the following principles:

- **Person focused services**—services are integrated across the health sector (including within and across public, private and non-government systems) to facilitate continuity of care.
- **Health outcome focused services**—improving the health and wellbeing of rural and remote communities.
- **Quality services**—promoting delivery of consistent clinical practice and models of innovative service delivery staffed by a flexible and skilled workforce.
- **Safe services**—providing consistently safe and appropriately supported health services.
- **Sustainable services**—developing, integrating and delivering services in a sustainable way, making efficient and effective use of limited resources.
- **Accessible services**—delivering safe and sustainable services as close as possible to where people live.
- **Culturally appropriate services**—considering cultural diversity and the health needs of specific groups.

The Australian Government has lead responsibility for primary healthcare in Australia. State and territory governments have lead responsibility for planning hospital care. These respective roles need to be considered when planning for the following service areas which are important to rural and remote communities:

- prevention, promotion and protection
- primary healthcare
- ambulatory care
- acute care
- sub-acute care
- maternity and child health
- mental health
- aged care.

The *Rural and remote health service planning process 2013* emphasises:

- community and stakeholder engagement to ensure a shared vision and understanding of health service issues and the changes required to address the issues
- aligning existing health service delivery arrangements with changing patterns of need—identifying and addressing the health needs of service users (or potential users)
- making the most effective use of available and future resources, including partnerships with other providers.

Health services need to be provided by an appropriate, skilled and well supported health workforce[2]. Sustaining a suitable clinical workforce in rural and remote areas has been challenging for many years. The following principles and issues need to be considered.

- **Ease of employment**—simplified engagement and remuneration arrangements that can be clearly articulated to current and potential employees. Arrangements that can sufficiently accommodate the differences in service delivery, balance between public and private work, deliver incentives for rural and remote, and provide sufficient employment security to attract and retain staff.
- **Flexibility**—employment arrangements that can adapt to a range of individual circumstances and service delivery needs.
- **Portability**—employment models and arrangements that facilitate continued mobility between urban and rural opportunities over the span of a career.

[2] Australian Commonwealth Government, National Strategic Framework for Rural and Remote Health, 2012

3. Application of the *Queensland rural and remote health service framework*

The framework:

- provides a consistent approach to the classification of public rural and remote facilities in Queensland as it relates to consistency of terminology
- describes characteristics that should be considered to support sustainable and safe levels of service provision in rural and remote communities
- provides a general overview of service mix, service capability and workforce profile for each classification of rural and remote health facility
- promotes health service networks with formal links between rural and remote health services and higher level services provided from regional and specialist services.

An underpinning assumption is that local care is provided within a broader service network. Health service networks provide essential service links to ensure continuity of care for patients and are necessary for safe and sustainable integrated care. The arrangement of health service networks is a local decision for clinicians and the HHS. The use of networking mediums, such as telehealth can be used at all levels and support different types of health service delivery.

Use of the framework should at all times be considered in conjunction with the *Clinical Services Capability Framework* (CSCF). HHSs must routinely refer to the CSCF regarding minimum service and workforce requirements, and implement mitigating risk strategies for delivery of safe and sustainable health care as required. HHSs must also be mindful of requirements as set out in relevant legislation, standards, guidelines and professional workforce requirements, credentialing and scope of clinical practice.

There will be occasions when health services will be required to respond to and provide short-term care beyond the capability level of a service for patients presenting with complex health issues or emergency presentations. Individual services and facilities need to be enabled to manage emergent situations. This includes training and communication systems and support for staff in the provision and management of imminent birthing—for facilities that do not provide planned birthing care—and adult, child and neonatal emergency resuscitation capability.

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 judgement 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 patients and their family. At these times, health service networks are essential in supporting local management of clinical care and facilitate (if necessary) the transfer of patients to an appropriate level of service to the patients' care needs.

4. Classification of rural and remote health facilities

To support consistent planning for health services, the framework applies consistent definitions to rural and remote health facilities—as opposed to health services within a facility—as follows:

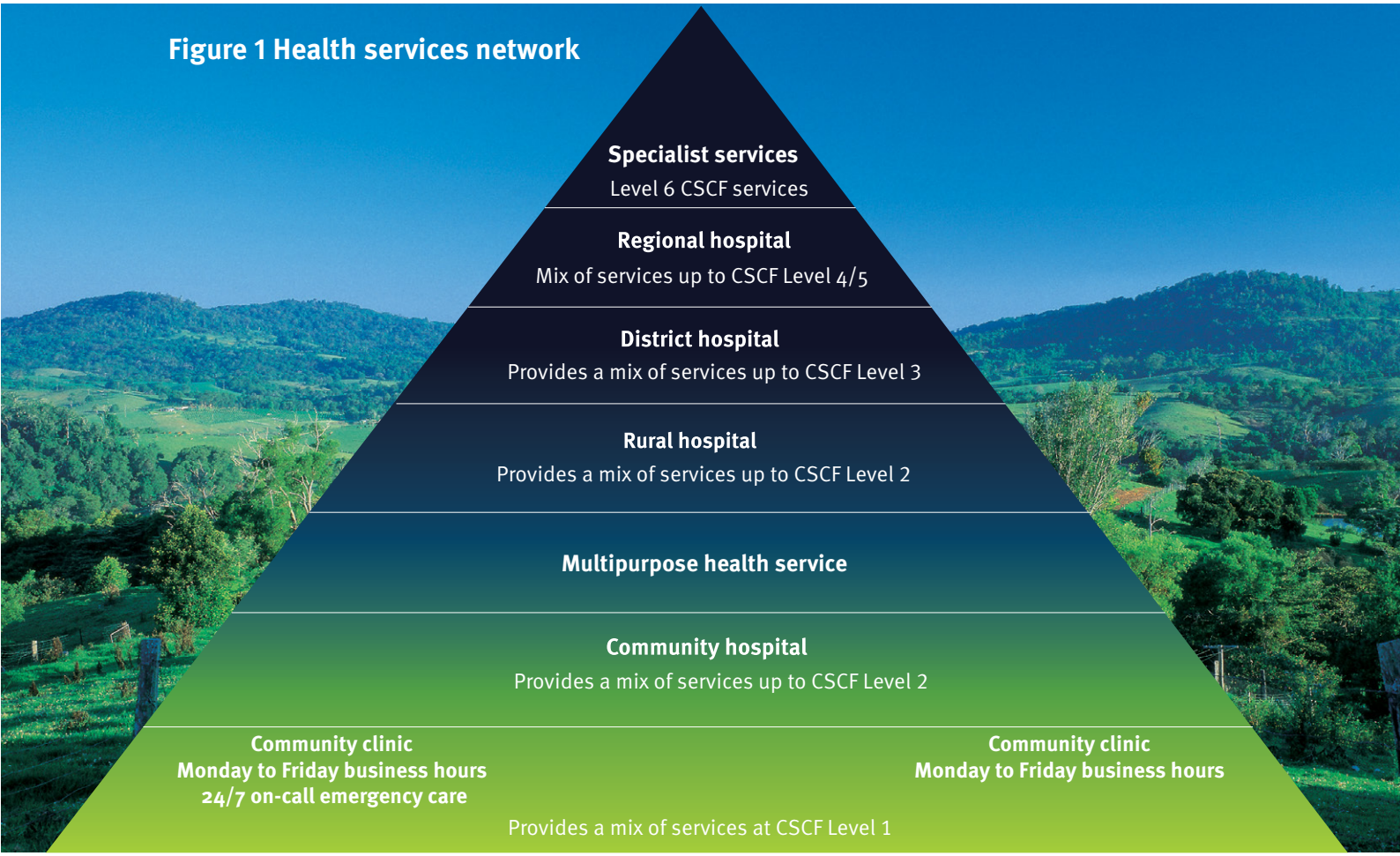
- **District hospitals**—generally serve populations of more than 4000 people and provide a comprehensive mix of CSCF Level 3 acute health services including medical, surgical, emergency and maternity. District hospitals may also provide a range of other primary, ambulatory, aged care and community services.
- **Rural hospitals**—generally serve populations of more than 2000 people and provide a comprehensive mix of CSCF Level 2 acute health services including medical, surgical, emergency and maternity. Rural hospitals may also provide a range of other primary, ambulatory, aged care and community services.
- **Multipurpose health services (MPHS)**—acute health services may be similar in mix and service capability to a rural or community hospital. MPHS also provide dedicated aged care and community care services.
- **Community hospitals**—generally serve populations with less than 2000 people and provide CSCF Level 2 acute services including medical and emergency. Community hospitals may also provide a range of other primary, ambulatory, aged care, surgical, maternity and community services.
- **Community clinics**—generally serve small populations in rural, remote and very remote locations within Queensland. Services provided at a community clinic include treatment and triage for lower acuity medical conditions and minor procedures plus life support and stabilisation prior to transfer to a higher level health service. They may also provide a range of other primary, ambulatory, aged care, prenatal care, postnatal care and community services. Community clinics have two types of operating hours for services:
  - a community clinic with after-hours emergency care is characteristically provided in locations that are a distance of more than 80 kms (or one hour where poor or no road access) from a higher level health service. These clinics provide services Monday to Friday with emergency on call 24 hours, 7 days per week. The ambulance service is provided by a registered nurse or paramedic in association with or from the clinic.
  - a community clinic that is characteristically within 80 kms (or less than one hour by road) from a higher level health service, will provide care between Monday to Friday during business hours only.

Regional and metropolitian health facilities are not in scope of the *Queensland rural and remote health service framework*. All facilities covered by the classifications noted above should operate as part of a larger health service network including regional specialist services and metropolitan specialist services provided at CSCF Levels 4, 5 and 6.

Collaborating across health service networks provides essential service links to ensure continuity of care and integrated levels of care for safe and sustainable services to meet community need. Refer to CSCF summary for generic descriptors of CSCF Level 1 to 6.

A range of agencies from the public, private and not-for-profit sectors are likely to provide services at any one facility. In support of providing care as close to home as is safe and appropriate, levels of services can rise temporarily when local clinicians' provide more complex care, such as renal dialysis or chemotherapy, or visiting or outreach services are provided at the facility, such as mental health or surgical and anaesthetic services. For example, a rural hospital that generally provides CSCF Level 2 services could provide CSCF Level 3 or 4 services, on an ad hoc or planned basis with the support of higher level services and/or with visiting/outreach specialist services.
Figure 1 illustrates the health services network.

Figure 1 Health services network



The following sections more fully describe the characteristics associated with district, rural and community hospitals, multipurpose health services and community clinics.

Workforce profiles included in the charactistics do not provide staffing ratios, absolute skill mix, or clerical or administration workforce requirements. These are best determined locally in line with minimum standards.

5. District hospital

A facility named a district hospital provides a mix of CSCF Level 3 services. A clinical service may rise a CSCF level—temporarily—when local clinicians' provide more complex care or a specialist outreach service is provided.

Health services provided will be informed by:

- local patient and community needs and broader health service networks
- access to other health providers including HHSs
- the range of mediums to support face to face service delivery, including telehealth
- a facility's location—Australian Standard Geographical Classification (ASGC) remoteness area category—and proximity to higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

Note: HHSs must refer to the CSCF for detail regarding service and workforce requirements in the planning and delivery of safe and sustainable rural and remote healthcare services.

The following table outlines the core, enhanced, clinical and support, aged care services and workforce profile.

District hospital characteristics and services	
Characteristics: • serves rural population catchments of more than 4000 people • National Weighted Activity Unit (NWAUs) are categorised according to the Independent Hospital Pricing Authority and include — Group E hospital (1050-1499.9 NWAUs) — Group F hospital (1500-2649.9 NWAUs) — Group G hospital (2650+ NWAUs).	Core services: • emergency service • medical service • children's medical service • surgical service • children's surgical service • anaesthetics service • children's anaesthetic service • selected outpatient services • palliative care service • cardiac medicine service • mental health services • maternity service • neonatal service • peri-operative service including operating suite service, post-anaesthetic service • medication service • medical imaging service • pathology service.

District hospital characteristics and services
Enhanced services—in line with patient need: • medical oncology service • rehabilitation service • renal service • endoscopy service • cardiac diagnostic service.
Clinical and support services—in line with community health needs: • Aboriginal and Torres Strait Islander support services • alcohol tobacco and other drugs service • allied health service • chronic disease management service • community nursing service • dental/oral health service • general practice service • geriatric evaluation and management service • infection prevention and control program • population health service.
Workforce profile may include: • workforce to provide reliable 24-hour cover • registered medical practitioners who may have additional qualifications as a rural generalist, a general practitioner or advanced skills in areas required by the service • part of workforce may be provided by visiting registered medical practitioners • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • midwives and/or nurse midwives • radiographer/sonographer, radiographer onsite providing a full scope radiography service and supporting local X-ray operators • pharmacist onsite or via telehealth • laboratory scientist on duty/available • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • health care workers/personal carers • Aboriginal and Torres Strait Islander health practitioners—dependant on population need • expanded and new clinical roles such as physician assistants and non-medical proceduralists • clerical and administrative support • operational staff such as gardeners, cleaners, laundry and kitchen staff.
Aged care services may include: • residential aged care • home care packages • home and community care services.

6. Rural hospital

A facility named a rural hospital provides a mix of CSCF Level 2 services. A clinical service may rise a CSCF level—temporarily— when local clinicians' provide more complex care or a specialist outreach service is provided.

Health services provided will be informed by:

- local patient and community needs and broader health service networks
- access to other health providers including HHSs
- the range of mediums to support face-to-face service delivery, including telehealth
- a facility's location—Australian Standard Geographical Classification (ASGC) remoteness area category—and proximity to other higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

Note: HHSs must refer to the CSCF for detail regarding service and workforce requirements in the planning and delivery of safe and sustainable rural and remote healthcare services.

The following table outlines the core, enhanced, clinical and support, aged care services and workforce profile.

<table>
<tr><th colspan="2">Rural hospital characteristics and services</th></tr>
<tr><td>Characteristics:
serves population catchments more than 2000 people
NWAUs are categorised according to the Independent Hospital Pricing Authority and include:
— Group D hospital (675-1049.9 NWAUs)
— Group E hospital (1050-1499.9 NWAUs)
— Group F hospital (1500-2649.9 NWAUs).</td><td>Core services:
emergency service
medical service
children's medical service
surgical service
children's surgical service
selected outpatient services
palliative care service
mental health services
neonatal service
medication service
medical imaging service—ultrasound service may be provided
pathology service.</td></tr>
<tr><td colspan="2">Enhanced services—in line with patient need:
anaesthetic service
children's anaesthetic service
cardiac medicine service
maternity service
peri-operative service including operating suite service, post-anaesthetics service
medical oncology service
rehabilitation service
renal service.</td></tr>
</table>

Rural hospital characteristics and services
Clinical and support services—in line with community health needs: • Aboriginal and Torres Strait Islander support services • alcohol tobacco and other drugs service • allied health service • chronic disease management service • community nursing service • dental/oral health service • general practice service • infection prevention and control program • population health service.
Workforce profile may include: • workforce to provide reliable 24-hour cover • registered medical practitioner who may have additional qualifications as a rural generalist, a general practitioner or advanced skills in areas required by the service • part of workforce may be provided by visiting registered medical practitioners • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • midwives and/or nurse midwives • radiographer onsite providing a full scope of radiology services and supporting local X-ray operators • pharmacist provided from the hospital or the community—nurse supplied pharmaceuticals in collaboration with private pharmacy in town or district hospital • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • health care workers/personal carers • Aboriginal and Torres Strait Islander health practitioners—dependant on population need/ where Aboriginal population • expanded and new clinical roles such as physician assistants and non-medical proceduralists • clerical and administrative support • operational staff such as gardeners, cleaners, laundry and kitchen staff.
Aged care services may include: • residential aged care • home care packages • home and community care services.

7. Multipurpose health service

The multipurpose service program is supported by state, territory and Australian governments and aims to improve flexibility and integration of health and aged care services for small rural and remote communities. A multipurpose health service (MPHS) is generally established in populations not large enough to support a separate hospital, residential aged care and home/community care services and is characterised by:

- active community participation in planning services for their own care
- provision of quality aged care services within the local community, enabling people to be cared for close to friends and family
- opportunity to focus additional capacity/funding on addressing gaps in service delivery to meet community need
- streamlined assessment and improved communication between healthcare teams/staff
- improved opportunities for staff training, professional development and retention.

Acute services provided by a MPHS may be a similar mix and capability of health services as provided by a rural or community hospital and reference should be made to these tables and the CSCF when considering service and workforce requirements for safe and sustainable services.

8. Community hospital

A facility named a community hospital provides a mix of CSCF Level 2 services. A service may rise a CSCF level—temporarily— when local clinicians' provide more complex care or a specialist outreach service is provided.

Health services provided will be informed by:

- local patient and community needs and broader health service networks
- the range of other health providers including HHSs
- the range of mediums to support face-to-face service delivery, including telehealth
- a facility's location and proximity to higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

Note: HHSs must refer to the CSCF for detail regarding service and workforce requirements in the planning and delivery of safe and sustainable rural and remote healthcare services.

The following table outlines the core, enhanced, clinical and support, aged care services and workforce profile.

<table>
<tr><th colspan="2">Community hospital characteristics and services</th></tr>
<tr><td>Characteristics:
serves population catchments less than 2000 people
NWAUs are categorised according to the Independent Hospital Pricing Authority and include:
— Group A hospital (0-199.9 NWAUs)
— Group B hospital (200-374.9 NWAUs)
— Group C hospital (375-674.9) NWAUs).</td><td>Core services:
emergency service
retrieval service
medical service
children's medical service
surgical service
children's surgical service
selected outpatient services
palliative care service
mental health services
neonatal service
medication service
medical imaging service
pathology service.</td></tr>
<tr><td colspan="2">Enhanced services—in line with patient need:
anaesthetic service
children's anaesthetic service
cardiac medicine service
maternity service
peri-operative service including operating suite service, post-anaesthetic service
medical oncology service
rehabilitation service
renal service.</td></tr>
</table>

Community hospital characteristics and services
Clinical and support services—in line with community health needs: • Aboriginal and Torres Strait Islander support services • alcohol tobacco and other drugs service • allied health service • chronic disease management service • community nursing service • dental/oral health service • general practice service • infection prevention and control program • population health service.
Workforce profile may include: • workforce to provide reliable 24-hour cover • registered medical practitioner who may have additional qualifications as a rural generalist, a general practitioner or advanced skills in areas required by the service • part of workforce may be provided by visiting registered medical practitioners • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • midwives and/or nurse midwives • pharmacist provided from the hospital or the community or nurse dispenser—pharmaceuticals in collaboration with private pharmacy in town or district hospital • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • health care workers/personal carers • Aboriginal and Torres Strait Islander health practitioners—dependant on population need • X-ray operator • expanded and new clinical roles such as physician assistants, Aboriginal and Torres Strait Islander health practitioners and non-medical proceduralists • clerical and administrative support • operational staff such as gardeners, cleaners, laundry and kitchen staff.
Aged care services may include: • residential aged care • home care packages • home and community care services.

9. Community clinic

A facility named a community clinic provides a mix of CSCF Level 1 services. A service may rise a CSCF level—temporarily—when local clinicians provide more complex care or a specialist outreach service is provided.

Health services provided by a community clinic will be informed by and depend on:

- local patient and community needs and broader health service networks
- the range of other health providers including HHSs
- the range of ways to support face-to-face service delivery, including telehealth
- a facility's location and proximity to higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

Community clinics have two types of operating hours for services, depending on distance from a higher level service: community clinics with after-hours emergency care, and community clinics that operate between Monday to Friday during business hours only.

Note: HHSs must refer to the CSCF for detail regarding service and workforce requirements in the planning and delivery of safe and sustainable rural and remote healthcare services.

The following table outlines the core, enhanced, clinical and support services and workforce profile of a community clinic with after-hours emergency care.

<table>
<tr><th colspan="2">Community clinic with after-hours emergency care characteristics and services</th></tr>
<tr><td colspan="2">Community clinic with after-hours emergency care—clinic more than 80 km (or one hour where poor or no road access) from a higher level health service.
Clinic service—Monday to Friday business hours services
Emergency service on-call 24 hours, 7 days per week
Ambulance service provided by registered nurse/paramedic in association with or from the clinic.</td></tr>
<tr><td>Characteristics:
do not admit patients, may provide short term observation
are supported by higher level services
onsite or collaborative emergency response service.</td><td>Core services:
emergency service
retrieval service
medical service
children's medical service
selected outpatient services
mental health services
neonatal service
medication service
pathology service.</td></tr>
</table>

Community clinic with after-hours emergency care characteristics and services
Enhanced services—in line with patient need: • medical imaging service • maternity service—pre and post birth care • peri-operative service—pre-operative assessment • medical oncology service • palliative care service • rehabilitation service • renal service.
Optional clinical and support services in line with community health needs: • Aboriginal and Torres Strait Islander support services • alcohol tobacco and other drugs service • allied health service • chronic disease management service • community nursing service • dental/oral health service • general practice service • infection prevention and control program • population health service.
Workforce profile may include: • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • Aboriginal and Torres Strait Islander health practitioner • physician assistant • onsite paramedic • pharmacist provided from the community or nurse supplied—pharmaceuticals in collaboration with private pharmacy in town or district hospital • X-ray operator(s) • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • health care workers/personal carers • clerical and administrative officers • operational staff such as gardeners, cleaners, laundry and kitchen staff.

The following table outlines the core, enhanced, clinical and support services and workforce profile of a community clinic.

<table>
<tr><th colspan="2">Community clinic characteristics and services</th></tr>
<tr><td colspan="2">Community clinic—a clinic is within 80 kilometres (or less than one hour) from higher level health service, and provides care between Monday to Friday during business hours only.</td></tr>
<tr><td>Characteristics:
do not admit patients
are supported by higher level services.</td><td>Core services with Monday to Friday business hours:
medical service
children’s medical service
selected outpatient services
mental health services
medication service
pathology service
neonatal service.</td></tr>
<tr><td colspan="2">Enhanced services—in line with patient need:
medical imaging service
maternity service—pre and post birth care
peri-operative service—pre-operative assessment
medical oncology service
palliative care service
rehabilitation service
renal service.</td></tr>
<tr><td colspan="2">Optional clinical and support services in line with community health needs:
Aboriginal and Torres Strait Islander support services
alcohol tobacco and other drugs service
allied health service
chronic disease management service
community nursing service
dental/oral health service
general practice service
infection prevention and control program
population health service.</td></tr>
</table>

Community clinic characteristics and services
Workforce profile may include: • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • Aboriginal and Torres Strait Islander health practitioner • physician assistant • onsite paramedic • pharmacist provided from the community or nurse supplied—pharmaceuticals in collaboration with private pharmacy in town or district hospital • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • X-ray operator(s) • healthcare workers/personal carers • clerical and administrative officers • operational staff such as gardeners, cleaners, laundry and kitchen staff.

10. Further assistance

A range of additional resources are available to further support implementation of this framework and associated health service planning processes including:

- Blueprint for better healthcare in Queensland 2013*
- Better Health for the Bush 2014*
- Clinical Services Capability Framework for Public and Licenced Private Health Facilities*
- Guide to health service planning (v2) 2012*
- Rural and remote health service planning process 2013*
- Operational guidelines for multipurpose health services 2014*
- Consumer and Community Engagement Framework 2012*
- HHSs clinician engagement strategies and consumer and community engagement strategies (available on individual HHSs websites)
- National Strategic Framework for Rural and Remote Health 2012 (www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/NSFRRH-homepage).

*To view these documents go to www.health.qld.gov.au

11. Clinical Services Capability Framework summary

The *Clinical Services Capability Framework (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. 'Facility' refers to the physical structure or organisation that operates a number of services of similar or differing capability level.

Within the CSCF, clinical services are categorised into six capability levels with Level 1 managing the least complex patients and Level 6 managing the highest level of patient complexity (Figure 2).

Figure 2 Clinical services levels by complexity of care

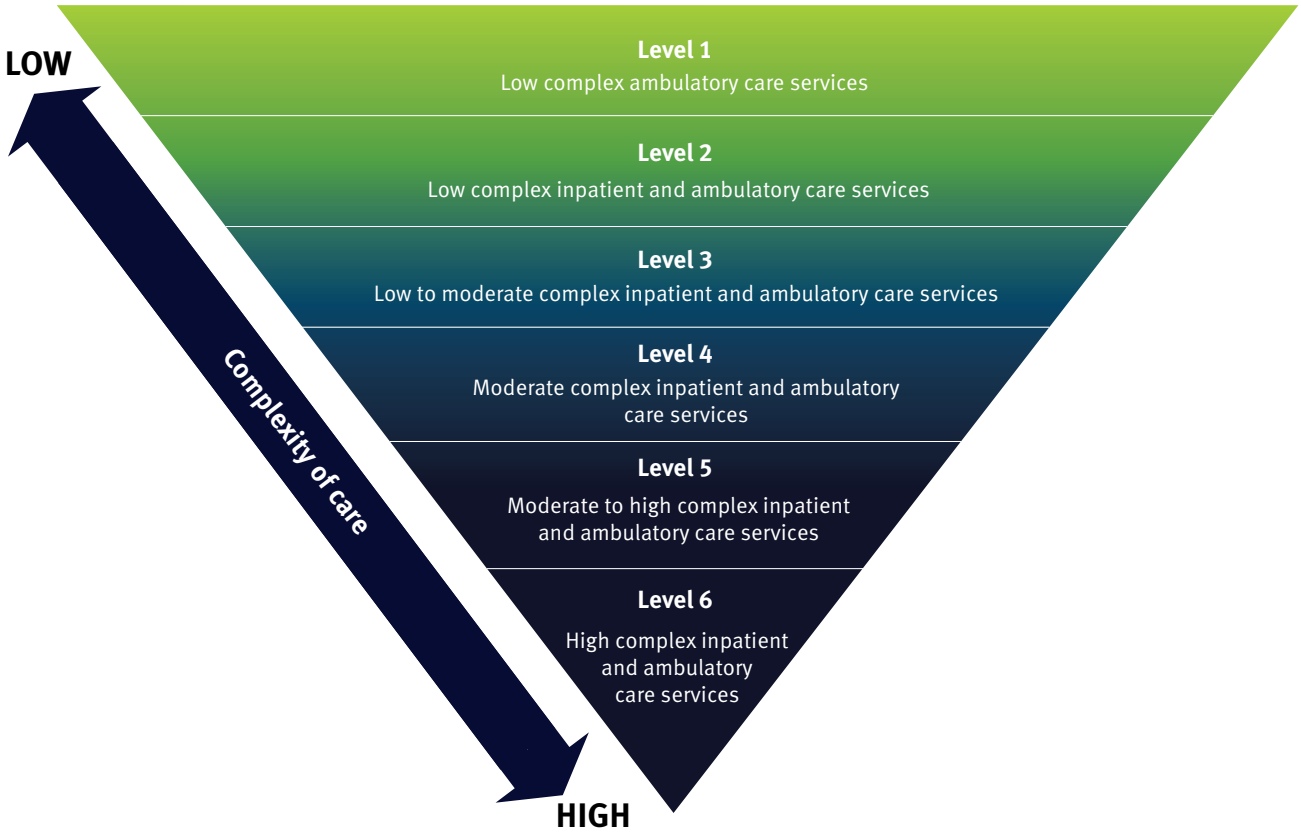


Figure 2 source: *Clinical Services Capability Framework for Public and Licensed Private Health Facilities*

As a general rule, service levels build on previous service level capability. For instance, service Level 6 should have all the capabilities of services up to Level 5, plus additional capabilities resourcing the most highly complex service. Each service level provides the additional capabilities that represent the minimum requirements for that level. A summary of the service levels appears below.

Levels of service

Level 1 service: A Level 1 service will provide a low risk ambulatory care service only, predominantly delivered by health providers (registered nurse and/or health worker) other than a registered medical practitioner. A visiting registered medical practitioner may intermittently provide a medical service and patients requiring a higher level of care can be managed for short periods before transfer to a higher level service.

Level 2 service: A Level 2 service will provide a low risk inpatient and ambulatory care service, delivered mainly by registered nurses and registered medical practitioners with admitting rights to the local hospital. There will be some limited visiting/outreach allied health services provided. A Level 2 service will manage emergency care until transfer to a higher level service. A Level 2 service may have a university affiliation including an education and teaching commitment.

Level 3 service: A Level 3 service will provide a low-risk inpatient and ambulatory care service with access to limited support services. A Level 3 service will predominantly be delivered by registered medical practitioners (available 24 hours, 7 days per week but not necessarily onsite) and registered nurses (including midwives and or nurses with speciality qualifications) with visiting day-only specialist services. Day-only specialist services may include low risk surgery, minor procedures and an education and training role (longer than day-only may be arranged). A Level 3 service will manage emergency care and will transfer to a higher level if required. A Level 3 service will have no access to an intensive care unit or high dependency unit although the service may have access to a monitored area. A Level 3 service may have a university affiliation including an education and teaching commitment.

Level 4 service: A Level 4 service will provide a low and moderate risk inpatient and ambulatory care service delivered by a variety of health professionals (medical, nursing, midwifery and allied health) including resident and visiting specialists. Medical staff will be onsite 24 hours per day, 7 days per week and an intensive care unit (may be combined with a cardiac care unit) with related support services will also be available onsite (size to be determined with review of the intensive care module). If higher level or more complicated care is required, patients may need to be transferred to a Level 5 service. Some specialist diagnostic services will also be available. A Level 4 service will have a university affiliation including an education, teaching and research commitment.

Level 5 service: A Level 5 service will manage all but the most highly complex patients and procedures. It will act as a referral service for all but the most complex service needs. This may therefore mean that highly complex high risk patients will require transfer or referral to a Level 6 service. A Level 5 service will have strong university affiliations and major teaching with some research commitments in both local and multi-centre research.

Level 6 service: A Level 6 service will be the ultimate high level service delivering complex care and acting as a referral service for all lower level services. A Level 6 service can also be a statewide super specialty service accepting referrals from health services across the state and interstate where applicable. This level of service will generally be provided at a large metropolitan hospital. This level of service will have strong university affiliations and major teaching and research commitments in both local and multi-centre research.

Glossary

Australian Standard Geographical Classification (ASGC)/Remoteness Structure/ Remoteness Areas	The Australian Standard Geographical Classification provides a common framework of geography which enables the production of statistics that are comparable and can be spatially integrated. The Remoteness Structure is part of the ASGS ABS Structures and provides a geographical standard for the publication of statistics by relative remoteness. It divides each state and territory into several regions on the basis of their relative access to services. The Remoteness Areas (RAs) divide Australia into broad geographic regions that share common characteristics of remoteness for statistical purposes. The classes of RA in the Remoteness Structure are: RA1—major city; RA2—inner regional; RA3—outer regional; RA4—remote or RA5—very remote.
Consumers	Consumers are people who use or are potential users of health services including their family and carers. Consumers may participate as individuals, groups, organisations of consumers, consumer representatives or communities. Source: *Health Consumers Queensland Consumer and Community Engagement Framework 2012*.
Community engagement	Community refers to groups of people or organisations with a common local or regional interest in health. Communities may connect through a community of place such as a neighbourhood, region, suburb; a community of interest such as patients, industry sector, profession or environment group; or a community that forms around a specific issue such as improvement to public healthcare or through groups sharing cultural backgrounds, religions or languages. Source: *Health Consumers Queensland Consumer and Community Engagement Framework 2012*.
Clinical Services Capability Framework (CSCF)	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 service planners and service providers with a standard set of minimum capability criteria. It is updated by the Department of Health from time to time.
Health service need	Health service need refers to the gap between what services are currently provided to a given population, and what will be required in the future to improve the health status of a community (and avoid a decline). Source: *Department of Health Guide to health service planning v2 2012*.
Health service planning	Health service planning aims to improve health service delivery and/or system performance to better meet the health need of a population. It encompasses the process of aligning existing health service delivery arrangements with changing patterns of need. Source: *Department of Health Guide to health service planning v2 2012*.
Model of care	A model of care outlines best practice patient care delivery through the application of a set of service principles across identified clinical streams and patient flow continuums. An overarching design or description of how care is managed, organised and delivered within the system.

National Weighted Activity Unit (NWAUs)	NWAUs refers to National Weighted Activity Unit determined by Independent Hospital Pricing Authority. Source: www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/nec-determination-2013-14~03-nec-hosptials~3-2-calculation-rural.
Nurse practitioner	A registered nurse with extensive clinical experience and expertise, whose registration has been endorsed by the Nursing and Midwifery Board of Australia as a nurse practitioner under section 95 of the *Health Practitioner Regulation National Law Act 2009*.
Physician assistant	A clinical practitioner, trained in the medical model who works as a member of a multidisciplinary team under the delegation and supervision of a medical practitioner.
Primary healthcare	Primary healthcare is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems. Comprehensive primary healthcare includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation. Source: *Australian Primary Health Care Research Institute Primary healthcare position statement 2005*.
Rural and remote community	Rural and remote communities are defined in this paper as those communities with an Australian Standard Geographical Classification (ASGC) Regional Area of RA2 and RA3—regional or Remoteness Area of RA4—remote or RA5—very remote. Source: *Australian Bureau of Statistics Australian standard geographical classification 2011*.
Rural Generalist	Through the Medical Officers' (Queensland Health) Certified Agreement (No. 1) 2005, rural generalist medicine was recognised by Queensland as a generalist discipline in May 2008. A rural generalist is defined as a rural medical practitioner who is credentialed to serve in: • hospital-based and community-based primary medical practice • hospital-based secondary medical practice: — in at least one specialist medical discipline (commonly but not limited to obstetrics, anaesthetics and surgery) — without supervision by a specialist medical practitioner in the relevant disciplines • possibly hospital-based and community-based public health practice-particularly in remote and Aboriginal and Torres Strait Islander communities.
Telehealth	Telehealth is an extension of the way we can communicate with patients, nurses, doctors and other specialists by using in most cases videoconferencing (that is basically a TV screen and a digital video camera). Telehealth allows patients in rural and remote locations to talk to and see a health professional from any hospital in Queensland, without the need to travel too far from home.

Department of Health
Queensland rural and remote health service framework

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