Clinical services capability framework
FAQs

Q1: **What is the CSCF?**

A1: The full name of the Queensland CSCF is the **Clinical Services Capability Framework for public and licensed private health facilities**. It outlines clinical and support services which hospitals can safely provide within their capability level.

Q2: **When was the CSCF introduced in the Queensland hospital system?**

A2: The CSCF (however titled) is not new in Queensland. The first iteration of the document was released in 1994, applicable only to the public sector. In 2002, a version applicable to the private sector was released. From 2004 onward, the CSCF has applied to both public and licensed private health facilities in Queensland.

Most Australian jurisdictions have a CSCF (however titled) and the first nationally applicable CSCF, the National Maternity Services Capability Framework (which supports the provision of safe maternity services in as many localities as possible across Australia in both the public and private sectors) was released by in 2011. The possibility of a national cancer care CSCF has been discussed for some time.

Q3: **How do I read the CSCF to best understand it?**

A3: The opening module of the Queensland CSCF is titled **Fundamentals of the framework**. This module outlines common features across all CSCF modules (clinical and support) so as to avoid unnecessary repetition in each individual module and therefore contain the volume of the CSCF.

The **Fundamentals of the framework** also contain a glossary, with a note at the beginning of the glossary stipulating certain terms used within the Queensland CSCF have been contextualised for the purposes of the CSCF. These terms are flagged by an asterisk (*). To best appreciate the CSCF, readers should familiarise themselves with these terms by referring to the glossary to gain a clear understanding of how terminology is applied within the CSCF.

Readers are also reminded the CSCF is intended for a broad audience of health professionals, not the public. The CSCF 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 in Queensland.

Q4: **Why isn't the CSCF a 'plain English' document?**

A4: The CSCF is a technical document prepared for health professionals, with certain terminology used within it intended to be specific to it. These specific terms, along with a definition of the term as it applies to (and should be used within the context of) the CSCF, are summarised within the glossary, contained in the **Fundamentals of the framework** or alternatively, may be described within module overviews of specific clinical services e.g. Mental Health services and Children's services modules.

Examples of frequently used terminology throughout the CSCF and subsequently defined within the glossary include but are not limited to:

Term	Definition
24 hour/s	Unless otherwise stated, refers to 24 hours a day, 7 days a week and may be written as 24/7.
Access / accessible	Ability to utilise a service (either located on-site or off-site) or the skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via a variety of communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach. **When this term is used, the individual does not necessarily need to be present on-site**.
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.
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. **When this term is used, the individual needs to be able to be present on-site**.
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.
Documented process	A process agreed to by all services involved. It may include a networking agreement, letter of agreement between relevant parties, policy arrangement, memoranda of understanding and/or contractual arrangements for retrieval and/or transfer of patients between facilities and outsourcing of services.
Health professional	A trained health professional who may or may not be registered with AHPRA.
On-site	Staff, services and/or resources located within the health facility or adjacent campus including third party providers.
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.
Scope of clinical practice	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.

An example of terminology specific to the Mental Health services module is "**dedicated pharmacy service**" which refers to a pharmacy service either based on a hospital campus ***or*** is a nominated pharmacy in the community with which a service agreement has been established for the delivery of mental health pharmacy services, with services delivered according to requirements outlined in the Australian Council on Healthcare Standards.

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. Some examples of undefined CSCF terms which have been questioned by readers include "emergency" and "training". Readers are encouraged to interpret the term within the context of the sentence in which it has been used.

Q5: **So how does the CSCF apply to health professionals working in public and licensed private health facilities?**

A5: The CSCF is intended for a broad audience of health professionals across both public and licenced private health facilities including clinical staff, hospital managers and health service planners.

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.

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

- established mandatory standards
- accreditation processes
- credentialing
- defined scope of clinical practice
- developing and organising workforce capability and capacity
- 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
- performance monitoring and accountability responsibilities
- determining the building structures and configuration requirements for health facilities
- prescribing service networks either at local, statewide or broader level
- service delivery processes.

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 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".

Q6: **Is the CSCF applicable in other parts of the healthcare system like primary health care or aged care facilities?**

A6: The Queensland CSCF only applies to the planning and/or provision of acute and sub-acute health services. Typically, these are delivered from public and private hospitals and/or day hospitals.

Q7: **How should I read the CSCF to maximise my understanding of it?**

A7: Understanding the CSCF is best achieved by reading through the document following the suggested steps outlined below.

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 containing 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 and workforce requirements, service networks, and/or risk considerations unique to the module, where relevant), up to six service capability levels, and legislation and non-mandatory standards and guidelines applicable to the module.
4	Service (capability) level/s	Service (capability) levels describe the level of service offered (service description), service and workforce requirements by level, and specific risk considerations (where relevant).
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.

Once you have worked your way through these steps, you should be well positioned to appreciate the CSCF capability level relative to your service.

Q8: **What responsibilities do the public and private sectors have in relation to the CSCF?**

A8: As required by the *Hospital and Health Boards Act 2011*, a service agreement is in place between the Department of Health (DoH) and each Hospital and Health Service (HHS) for the provision of public health services. Within HHS service agreements, section 14—Hospital and Health Service Accountabilities—indicates:

- All facilities have undertaken a baseline self-assessment in September 2014 against the CSCF.
- DoH is notified when a change to the 2014 CSCF self-assessment occurs through the notification process established by the Patient Safety Unit (now known as Patient Safety and Quality Improvement Service).

Please refer to https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/hospitals/public/default.asp for details about the public sector requirements, templates to facilitate these requirements, and access to the most recent versions of CSCF HHS self-assessment summary sheets.

Under the *Private Health Facilities Act 1999* s12(1), the Chief Health Officer (CHO) is empowered to make standards for the protection of the health and wellbeing of patients receiving health services at private health facilities, with the required standards largely specified in s12(2) of the Act.

Ten private health facilities standards currently exist, some of which specify requirements in accordance with the CSCF e.g. management and staffing standard, minimum patient throughput standard, patient care standard and speciality health services standard (http://www.health.qld.gov.au/privatehealth/legislation/default.asp). To this end, licensed private health facilities are required to comply with the Queensland CSCF to either obtain licence approval and/or maintain their licence.

Thorough understanding of the CSCF is necessary by both public and private sectors when negotiating service contracts between sectors. The public sector should not expect patients be accepted by private sector partners where patient need is beyond the capability of the licensed private health facility. And the private sector should only enter into service contracts with the public sector within the scope of their respective licence.

Q9: **Can CSCF service levels ever change?**

A9: Yes. When facilities collaborate to create a service network and provide integrated services, the collective capability of these combined services may increase. For example, a rural hospital providing typical level 2 CSCF services such as emergency, maternity, medical and/or surgical services, could provide higher level CSCF services on an ad hoc (such as emergency presentation) or regular (clinic) basis with the support of higher level services via telehealth arrangements and/or during periods of visitation by specialist staff or the Royal Flying Doctors Service. A combination of the capabilities of the ‘host (home) service’ and ‘provider (visiting) service’ may temporarily change the capability level of the ‘host service’ due to establishment of consultation and/or advisory telehealth arrangements, or for the time the approved ‘provider service’ is on-site. Service networking is actively encouraged between all health facilities, ideally underpinned where practicable by documented processes agreed by all parties involved.

Other scenarios where a CSCF service level may increase include following recruitment of specialist staff, capital infrastructure improvements, adoption of new technologies, and equipment acquisition, among other factors. Alternatively, a CSCF service level may decrease if there is staff movement, decommissioning of a building, and/or the relocation of a service. These service level changes may be either temporary or permanent.

Q10: **How can I find out more about the Queensland CSCF?**

A10: If you have more questions about the Queensland CSCF you can email the Department of Health on **cscf@health.qld.gov.au** or telephone the Department of Health on **(07) 3328 9883** (for public sector inquiries) or **(07) 3328 9048** (for private sector inquiries).

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