This document has been prepared as a guide to assist Hospital and Health Services (HHS) in partnership with communities, Medicare Locals 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.

Rural and Remote Health Service Framework
Published by the State of Queensland (Department of Health), June 2013

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

This rural and remote service framework was prepared by the Integrated Planning Unit, Policy and Planning Branch with the assistance of:

- 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 communalised business units’ staff
- Hospital and Health Services’ staff.
Introduction

Queensland is Australia’s second largest state, covering 1,722,000 square kilometres and occupying 22.5 per cent of the continent. Delivery of health services occurs in an increasingly dynamic environment, with ever changing community expectations, government priorities and technological advances. The budgetary setting is constrained however and there are ever increasing pressures and demands on the public health system to deliver safe, sustainable high quality services across the state.

In rural and remote Queensland the challenge of providing health services is complicated and magnified by geographical distance and unique community characteristics. Some rural communities are experiencing rapid growth associated with resource and mining development. In contrast, many communities have an: ageing population; low population density; limited and ageing infrastructure; and higher costs associated with health care delivery1. In this context it is essential that services are well planned, with the capability to respond to evolving changes in order to meet community need.

In recognising the unique characteristics and challenges of providing rural and remote health services the development of this document has been informed by:

- A definition of a rural model of health service delivery: A hub and spoke (service partner) model, March 2010
- Clinical Services Capability Framework for Public and Licenced Private Health Facilities Version 3.1 (CSCF), September 2012
- Safe applicable models of health care for rural and remote Queensland 2013.

The Queensland rural and remote health service framework—draft—(the Framework) aims to guide planning and provision of health services in rural and remote communities across Queensland with the intent of planning for the near and longer-term future 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 health needs of rural and remote communities.

As identified in the Blueprint for better healthcare in Queensland (www.health.qld.gov.au/blueprint), improving access to a new generation of safe and sustainable health services for residents of small rural or remote communities is a priority for the Queensland Government. Local Hospital and Health Boards—accountable to Parliament through the Health Minister—and their local community, are responsible for leading local health improvements. Enhancing local community, clinical and stakeholder input into how future services will be designed and delivered is a priority for the Queensland Government and Hospital and Health Services (HHSs). Developing equal partnerships—working together to plan services that are innovative, person focussed, safe and sustainable—is a priority.

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Queensland Health recognises it is not the only provider of health services in rural and remote communities and understands orientating health services to better meet local communities’ health needs is a priority for all local healthcare providers. Orientating health services to new service models can only be achieved if done at a sensible pace on a case by case basis in partnership with local communities and all providers.

The role of rural and remote hospitals has changed significantly over the last 15 years. 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 model options. Recognising a ‘one size fits all’ strategy will not work. Public hospital services must be orientated to complement and integrate with the mix of services provided by other services locally such as Queensland Ambulance Service, general practice, Medicare Locals and private and not-for-profit community and aged care service providers. This approach will reduce duplication and fragmentation, and maximise local partnerships and access to the provision of quality contemporary health services that better meet the specific health needs of each local community.

To improve health equity and support of rural and remote Queenslanders to live longer, healthier and more independent lives, a range of new service solutions are required. Services informed by innovative, contemporary best practice both within Queensland and in other Australian jurisdictions and internationally will need to be considered. Importantly new service models will be implemented to complement the network of health services that already exist. New models will consider opportunities to partner with other agencies including private general practices to work together developing a new generation of safe and sustainable health service models.

One innovative service solution that will be implemented immediately is an increased use of Telehealth. Queensland has one of the largest managed Telehealth networks in Australia in which more than 1000 systems deployed in more than 200 hospitals and community facilities support more than 40 clinical specialties and sub-specialties to provide Telehealth services across the state. Significant opportunity exists to further embed Telehealth in future planning and provision of public and private health services across Queensland. This will have a particular focus on enhancing health service delivery for rural and remote areas.

### Telehealth

Increasing the use of Telehealth for people in rural and remote locations will:

- increase access to a greater range of health services locally
- improve access to specialist clinical services—inpatient and outpatient—and advice through linkages with regional and Brisbane based specialist services
- reduce the need for patients to travel and take extended time away from family or work
- reduce the need for patients to travel for pre- and post-operative care
- support local clinical staff to manage complex emergency presentations while awaiting transfer to higher level services
- support staff to access education and learning
- improve networking and communication between staff across and within hospitals, HHSSs and private/non-government service providers—e.g. general practitioners.
Rural and remote health service framework

Across rural and remote Queensland, health services are described using terminology which is poorly defined and inconsistently applied. The rural and remote health service framework aims to:

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

Classification of rural and remote health facilities

Rural and remote hospital and health facilities—as opposed to services within a facility—will be described using the following terminology:

- **District hospitals**—generally serve populations of greater than 4000 people and can provide a comprehensive mix of Level 3 CSCF acute services including medical, surgical, emergency and maternity services. District hospitals may also provide a range of other primary, ambulatory, aged care and community services.
- **Rural hospitals**—generally serve populations of greater than 2000 people and can provide a comprehensive mix of Level 2 CSCF acute services including medical, surgical, emergency and maternity services. Rural hospitals may also provide a range of other primary, ambulatory, aged care and community services.
- **Community hospitals**—generally serve populations with less than 2000 people and can provide Level 2 CSCF acute services including medical and emergency services. Community hospitals may also provide a range of other primary, ambulatory, aged care and community services.
- **Community clinics**—generally serve populations with less than 1000 people. Services provided at a Community clinic include triage for lower acuity medical conditions and minor procedures and life support and stabilisation prior to transfer to a higher level service. Community clinics may provide a range of other primary, ambulatory, aged care and community services.
- **Multi-purpose Health Services (MPHS)**—provides a mix of acute, aged care and community services. Acute services may be similar in mix and service capability to a rural or community hospital.

The Framework does not describe regional hospital facilities as generally speaking they will provide services up to CSCF Level 4/5 which is outside the scope of this document. However all facilities covered by the classifications noted should operate as part of a larger service network including regional specialist services and metropolitan specialist services provided at CSCF Level 4, 5 and 6. Refer to Attachment 1 for generic descriptors of CSCF Level 1 to 6.
Collaborating across 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. A range of agencies from the public, private and not-for-profit sectors are likely to provide services however. For example, a Rural hospital—that generally provides CSCF Level 2 services—could provide up to CSCF Level 3 services, on an ad hoc and/or regular basis with the support of a higher level service. Figure 1 illustrates health networking arrangements and the CSCF Fundamentals of the Framework more fully expands this concept.

Figure 1: Health service network

Source: Integrated Planning Unit—Policy and Planning Branch, 2013

The following pages outline environmental characteristics—population and service acuity—National Weighted Activity Unit (NWAU) groupings—to determine the terminology to identify a facility. Once facility terminology is determined consideration turns to the level of service/s that may be provided at a facility. The service and workforce characteristics described in this Framework are to be used as a guide only and should not be seen as prescriptive. Workforce profiles do not provide staffing ratios, absolute skill mix, or clerical and/or administration workforce requirements as these are best determined locally in line with minimum standards.

HHSs undertake an annual CSCF self-assessment which identifies the mix and CSCF level of service/s facilities are actually providing. This information should be considered in conjunction with this Framework and the CSCF.
**District hospital**

Where a facility meets the following characteristics then that facility will be regarded/named a District hospital.

**Characteristics:**
- serves rural population catchments of greater than 4000 people
- NWAUs are categorised according to the Independent Health Pricing Authority and include:
  - Group E hospital (1050-1499.9 NWAUs) and greater than ASGC RA 2 or
  - Group F hospital (1500-2649.9 NWAUs) and greater than ASGC RA 2 or
  - Group G hospital (2650+ NWAUs)

Services that are provided by a District hospital will be informed/determined by and depend on:
- local health needs and broader health 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—ASGC remote area category—and proximity to other higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

A District hospital generally will provide a mix of CSCF Level 3 services. The following table outlines what that indicative service mix could be and is not prescriptive. HHSs must refer to the CSCF for detail regarding service and workforce requirements to support safe and sustainable rural and remote health care services.

**District hospital service mix**

<table>
<thead>
<tr>
<th>Acute services: Note: A service may rise a CSCF level—temporarily—when a specialist outreach service is provided.</th>
<th>medical services for adults and children</th>
</tr>
</thead>
<tbody>
<tr>
<td>surgical services for adults and children</td>
<td>emergency services for adults and children provided on site 24-hours 7 days-a-week by nursing staff with a doctor available 24-hours per day (on-site or close proximate on-call) including: resuscitation, ventilation, life support and stabilisation prior to transfer to a higher level service</td>
</tr>
<tr>
<td>retrieval services—transfer based on patient care needs</td>
<td>selected outpatient services (including procedures, medical consultation, stand-alone diagnostic, mental health and allied health and/or clinical nurse specialist intervention)</td>
</tr>
<tr>
<td>palliative care services according to Australian guidelines</td>
<td>cardiac medicine services including immediate cardiac care</td>
</tr>
<tr>
<td>mental health services—ambulatory and inpatient—voluntary</td>
<td></td>
</tr>
</tbody>
</table>
## Maternity and neonatal services may be provided up to Level 3 CSCF:

- reliably provide acute and inpatient services including 24-hour emergency and operative obstetric coverage
- care may be delivered in primary healthcare environment
- maternity services for low risk pregnancies, birthing and postnatal care (planned birthing of ≥ 37/40 weeks gestation)
- neonatal services—well baby care (≥ 37/40 planned delivery) and manage infants with minor feeding and oxygen requirements and infants back transferred from regional and metropolitan centres
- prenatal care

## Clinical support services generally include services that support a particular CSCF level:

- anaesthetics services for adults and children
- peri-operative services including operating room, recovery and, endoscopy facilities
- medication services available during business hours
- medical imaging full or limited scope—point of care ultrasound service may be provided
- pathology services (access to level 3)—a limited range of approved tests including istat, O negative blood and Emergency Donor Panels and the ability to have timely transfer of emergency specimens

## Other clinical and support services may include (but not be limited to):

**Note: in-line with community health needs**

- medical oncology services—administration of chemotherapy and treatment of febrile neutropenia supported via telehealth (by higher level cancer service)
- rehabilitation services
- renal services—in centre/self-managed and support for home dialysis
- Aboriginal and Torres Strait Islander support
- alcohol tobacco and other drugs including withdrawal management support
- allied health services
- chronic disease management
- community nursing
- dental/oral health services
- general practice services
- geriatric evaluation and management
- infection prevention and control program
- population health

## Workforce profile may include:

**Note: nursing and midwifery profile will be informed by the Business Planning Framework**

- rural generalist/medical officer (potentially with right of private practice)
- rural generalist should have advanced skills and credentialing in areas required by the service such as: anaesthetics; obstetrics; and surgery (workforce to provide reliable 24-hour cover) may be provided by visiting medical officers
- general practitioners admitting private patients
- nursing staff including registered nurses, midwives and enrolled nurses
- midwives and/or nurse midwives able to provide 24-hour cover
- assistants in nursing
- radiographer/sonographer; radiographer on site providing a full scope radiography service and supporting local X-ray Operators
- pharmacist on site or via telehealth
- laboratory scientist on duty/available
- allied health including (not limited) to physiotherapy, dietitian, occupational therapy services, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service)
- Aboriginal and Torres Strait Islander health workers—dependant on population need
- expanded and new clinical roles such as physician assistants, Aboriginal and Torres Strait Islander health practitioner, nurse practitioner, and non-medical proceduralists when available
- allied health assistants
- non clinical workforce
- clerical and administrative support
- operational officers such as gardeners, cleaners, laundry, kitchen etc

| Aged care services may include: | residential high and/or low care  
|                              | home care packages  
|                              | home care services |
Rural hospital

Where a facility meets the following characteristics then that facility will be regarded/named a Rural hospital.

**Characteristics:**
- serves population catchments greater than 2000 people and
- NWAUs are categorised according to the Independent Health Pricing Authority and include:
  - Group D hospital (675-1049.9 NWAU) or
  - Group E hospital (1050-1499.9 NWAUs) or
  - Group F hospital (1500-2649.9 NWAUs)

Services that are provided by a Rural hospital will be informed/determined by and depend on:
- local health needs and broader health networks
- the range of other health providers including HHSs
- the range of mediums to support face to face service delivery, including tele-health
- a facility’s location—ASGC remote area category—and proximity to other higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

A Rural hospital generally will provide a mix of CSCF Level 2 services. The following table outlines what that indicative service mix could be and is not prescriptive. HHSs must refer to the CSCF for detail regarding service and workforce requirements to support safe and sustainable rural and remote health care services.

<table>
<thead>
<tr>
<th>Rural hospital service mix</th>
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</thead>
<tbody>
<tr>
<td><strong>Acute services:</strong></td>
</tr>
<tr>
<td>Note: A service may rise a CSCF Level—temporarily—when a specialist outreach service is provided.</td>
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<tr>
<td><strong>Maternity and neonatal services may be provided:</strong></td>
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</tbody>
</table>
Clinical support services generally include services that support a particular CSCF level:

- anaesthesics services for adults, children and maternity if in place
- medication services—on-site pharmacy available during business hours or provided by local chemist (covering inpatient, emergency, OPD)
- medical imaging—limited scope—point of care ultrasound service may be provided
- pathology services—on site including Point - of-Care instrument (iStat), O negative on site, Emergency Donor Panels (if obstetric service). Ability to store and monitor blood products. Venepuncture pathology collection and transfer out within 24 hours
- emergency services—resuscitation, ventilation, life support and stabilisation prior to transfer to a higher level services

Other clinical and support services may include (but not limited to):

Note: in-line with community health needs

- medical oncology—administration of chemotherapy and treatment of febrile neutropenia supported via telehealth (by regional cancer centres)
- rehabilitation services
- renal service—in centre/self-managed and support for home dialysis
- Aboriginal and Torres Strait Islander support
- alcohol tobacco and other drugs including withdrawal management support
- allied health including but not limited to: physiotherapy; dietitian; occupational therapy services—may be provided from community or non-government service geriatric evaluation and management
- chronic disease management services
- community nursing
- dental/oral health services
- general practice services
- infection prevention and control program
- population health

Workforce profile may include:

Note: nursing and midwifery profile will be informed by the Business Planning Framework

- rural generalist Medical Superintendent plus Senior Medical Officer(s)
- rural generalist/medical officer, often with right of private practice or Medical Superintendent Right to Private Practice plus Medical Officer(s)
- Right to Private Practice
- rural generalist anaesthetists and/or rural generalist obstetricians and/or medical officer and/or visiting medical officers—workforce to provide reliable 24-hour cover
- rural generalist should have advanced skills and credentialing in areas—e.g. surgery— required by a service
- a registered medical practitioner (general practitioner) with extensive experience in anaesthetics may provide anaesthesia for elective surgery applicable to the level of service
- nursing staff including registered nurses and enrolled nurse each shift—may be nurse practitioner or RIPRN trained or generalist nursing qualification
- nurse practitioner with relevant advanced training (optional)
- midwives and/or nurse midwives able to provide 24-hour cover, if required
- radiographer on site 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: physiotherapy; dietitian; occupational therapy—may be provided from community or non-
<table>
<thead>
<tr>
<th>Government service</th>
</tr>
</thead>
<tbody>
<tr>
<td>• allied health assistants on site where high Aboriginal and Torres Strait Islander population</td>
</tr>
<tr>
<td>• Aboriginal and Torres Strait Islander health workers—dependant on population need/where aboriginal population</td>
</tr>
<tr>
<td>• expanded and new clinical roles such as: physician assistants; Aboriginal and Torres Strait Islander health practitioner; and non-medical proceduralists when available</td>
</tr>
<tr>
<td>• assistants in nursing and allied health assistants</td>
</tr>
<tr>
<td>• clerical and administrative support</td>
</tr>
<tr>
<td>• operational officers such as: gardeners; cleaners; laundry; kitchen etc.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Aged care services may include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• residential high and/or low care</td>
</tr>
<tr>
<td>• home care packages</td>
</tr>
<tr>
<td>• home care services</td>
</tr>
</tbody>
</table>
Community hospital

Where a facility meets the following characteristics then that facility will be regarded/named a Community hospital.

**Characteristics:**
- serves population catchments less than 2000 people
- NWAUs are categorised according to the Independent Health 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)

**Services that are provided by a Community hospital will be informed/determined by and depend on:**
- local health needs and broader health 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 other higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

A Community hospital can generally provide a mix of CSCF Level 2 services. The following table outlines what that indicative service mix could be and is not prescriptive. HHSs must refer to the CSCF for detail regarding service and workforce requirements to support safe and sustainable rural and remote health care services.

<table>
<thead>
<tr>
<th>Community hospital service mix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute services:</strong></td>
</tr>
<tr>
<td>Note: A service may rise a CSCF Level—temporarily—when a specialist outreach service is provided.</td>
</tr>
<tr>
<td>- medical services for adults and children (including immediate cardiac care)</td>
</tr>
<tr>
<td>- emergency services for adults and children provided on site 24-hours, 7 days-a-week by nursing staff with a doctor available 24-hours per day—on-site or close proximate on-call</td>
</tr>
<tr>
<td>- resuscitation, life support and stabilisation (including neonatal) prior to transfer to a higher level service</td>
</tr>
<tr>
<td>- retrieval services—transfer based on patient care needs</td>
</tr>
<tr>
<td>- peri-operative assessments for adults and children including via telehealth</td>
</tr>
<tr>
<td>- selected outpatient services including: procedures; medical consultation; stand-alone diagnostic; mental health and allied health and/or clinical nurse specialist intervention</td>
</tr>
<tr>
<td>- palliative care services according to Australian guidelines</td>
</tr>
<tr>
<td>- mental health services—ambulatory and telehealth counselling</td>
</tr>
</tbody>
</table>

| Maternity and neonatal services may be provided: |
| - maternity services for low risk pregnancies, birthing and postnatal care (planned birthing of ≥ 37/40 weeks gestation) |
| - pre and postnatal care may be delivered in the primary healthcare environment |
| - neonatal services—well baby care (≥ 37/40 planned delivery) and manage infants with minor feeding and oxygen requirements and infants back transferred from regional and metropolitan centres |
| - Surgical services as required for maternity service |
## Clinical support services generally include services that support a particular CSCF level:
- anaesthetics services for adults, children and maternity
- medication services
- medical imaging provide a limited scope of radiography service; limited scope-point of care ultrasound service may be provided
- pathology services—on site including Point—of-Care instrument (istat), O negative on site, Emergency Donor Panels (if obstetric service)  
  Ability to store and, monitor blood products. Venepuncture pathology collection and transfer out within 24 hours

## Other clinical and support services may include (but not be limited to):
**Note: in-line with community health needs**
- medical oncology—administration of chemotherapy and treatment of febrile neutropenia supported via telehealth (by higher level cancer services)
- renal services—in centre/self-managed and support for home dialysis
- Aboriginal and Torres Strait Islander support
- alcohol tobacco and other drugs including withdrawal management support
- allied health including but not limited to: physiotherapy; dietitian; occupational therapy—may be provided from community or non-government service
- chronic disease management services
- community nursing
- dental/oral health services
- general practice services
- infection prevention and control program
- population health

## Workforce profile may include:
**Note: nursing and midwifery profile will be informed by the Business Planning Framework**
- rural generalist Medical Superintendent  Right to Private Practice usually with Medical Officer Right to Private Practice
- General practitioner preferably co-located
- Rural generalist/medical practitioner should have advanced skills in appropriate areas—e.g. surgery and/or obstetrics and/or anaesthetics
- Workforce nurse practitioner with relevant advanced training
- nursing staff including registered and enrolled nurses (may be nurse practitioner or RIPRN trained) each shift
- 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: physiotherapy; dietitian; occupational therapy—may be provided from community or non-government service
- Aboriginal and Torres Strait Islander health workers- dependant on population need
- X-ray operator
- expanded and new clinical roles such as: physician assistants; Aboriginal and Torres Strait Islander health practitioner; and non-medical proceduralists  when available
- assistants in nursing and allied health assistants
- clerical and administrative support
- operational officers such as: gardeners; cleaners; laundry; kitchen etc.

## Aged care services may include:
- residential high and/or low care
- home care packages
- home care services
Community clinic

Where a facility meets the following characteristics then that facility will be regarded/named a Community clinic.

**Characteristics:**
- do not admit patients
- are supported by higher level outreach services
- located in ASGC Remote Areas: RA3—Outer Regional or RA4—Remote or RA5—Very Remote.

Services that are provided by a Community clinic will be informed/determined by and depend on:

- local health needs and broader health networks
- the range of other health providers including HHSs
- the range of mediums to support face to face service delivery, including tele-health
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

A Community clinic generally provides a mix of services at CSCF Level 1. The following table outlines what that indicative service mix could be and is not prescriptive. HHSs must refer to the CSCF for detail regarding service and workforce requirements to support safe and sustainable rural and remote health care services.

<table>
<thead>
<tr>
<th>Community clinic service mix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute services:</strong></td>
</tr>
</tbody>
</table>
| Note: A service may rise a CSCF Level— temporarily—when a specialist outreach service—out-patient only—is provided. | • medical services—access to triage for lower acuity medical conditions and minor procedures  
• children’s medical services—including, but not limited to, immunisation, hearing checks, developmental assessment  
• selected outpatient services  
• resuscitation, life support and stabilisation (including neonatal) prior to transfer to a higher level service  
• retrieval services—transfer based on patient care needs  
• peri-operative assessments for adults and children including telehealth  
• maternity services—pre and postnatal care may be delivered in the primary healthcare environment  
• mental health services—ambulatory and telehealth counselling |
| **Clinical and support services generally include services that support a particular CSCF level:** | • medication services—nurse dispensed or provided by local chemist  
• medical imaging—limited scope point – of- care ultrasound services; may be provided  
• pathology services—on site including point of care istat, O negative on site, Emergency Donor Panels. Venepuncture pathology collection and transfer out within 24 hours. Ability to store, monitor blood products |
Other clinical and support services may include (but not be limited to):

Note: in-line with community health needs

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• medical oncology services—assessment and transfer for complications</td>
</tr>
<tr>
<td>• renal services—in centre/self-managed and support for home dialysis</td>
</tr>
<tr>
<td>• Aboriginal and Torres Strait Islander support</td>
</tr>
<tr>
<td>• alcohol tobacco and other drugs services including withdrawal management support</td>
</tr>
<tr>
<td>• allied health including but not limited to: physiotherapy; dietitian; occupational therapy—may be provided from community or non-government service</td>
</tr>
<tr>
<td>• chronic disease management services</td>
</tr>
<tr>
<td>• community nursing</td>
</tr>
<tr>
<td>• dental/oral health services</td>
</tr>
<tr>
<td>• general practice services</td>
</tr>
<tr>
<td>• infection prevention and control program</td>
</tr>
<tr>
<td>• population health services</td>
</tr>
</tbody>
</table>

Workforce profile may include:

Note: nursing and midwifery profile will be informed by the Business Planning Framework

<table>
<thead>
<tr>
<th>Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>• registered nurse often RIPRN nurse or nurse practitioner or generalist nursing qualification, Physician's assistant</td>
</tr>
<tr>
<td>• enrolled nurses</td>
</tr>
<tr>
<td>• rural nurse with appropriate qualifications</td>
</tr>
<tr>
<td>• pharmacist provided from the community or nurse supplier—pharmaceuticals in collaboration with private pharmacy in town or district hospital</td>
</tr>
<tr>
<td>• X-ray operator/s</td>
</tr>
<tr>
<td>• allied health including but not limited to: physiotherapy; dietitian; occupational therapy—may be provided from community or non-government service</td>
</tr>
<tr>
<td>• supported by Queensland Ambulance Service staff</td>
</tr>
<tr>
<td>• clerical and administrative support</td>
</tr>
<tr>
<td>• on site paramedic</td>
</tr>
<tr>
<td>• expanded and new clinical roles such as: physician assistants; Aboriginal and Torres Strait Islander health practitioner</td>
</tr>
</tbody>
</table>
Multi-purpose health service

The Multi-purpose service program is a collaborative model supported by the State/Territory and Commonwealth governments and aims to improve flexibility and integration of health and aged care services for small rural and remote communities. A Multi-purpose health service (MPHS) is generally established in populations not large enough to support a separate hospital, residential aged care and home/community care services.

Where a facility delivers acute services—purchased by DoH—and is funded by DoHA to provide flexible aged care places then that facility can be regarded/named as a Multi-purpose health service. Generally the characteristics for a MPHS are:

- serves population catchments less than 3000 people
- less than 30 existing aged care beds in the community
- minimum average of three maintenance beds for past three years—acute services.

The NWAUs for acute services of a MPHS are predominantly categorised as:

- Group B hospital (200-374.9 NWAUs) or
- Group C hospital (375-674.9 NWAUs) or
- Group D hospital (675-1049.9 NWAUs).

Therefore acute services provided by a MPHS may be a similar mix and capability of health services 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 to be delivered from a facility.

Planning for rural and remote health services

Recognising no two communities are alike a Rural and remote health service planning process has been prepared to complement this framework. This planning process will ensure the services outlined in this Framework are tailored to local requirements. The planning process provides an evidence-based consistent approach to designing future rural and remote health services. Future health services should be based on the following planning principles:

- **person focussed**—services are integrated across the health sector (including within and across public, private and non-government systems) to facilitate continuity of care.
- **improving population health outcomes**—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 health needs of specific groups.
Building on the Guide to health service planning (v2) 2012, the planning process supports services to respond to changing service demand, improved rural and remote health service delivery models, emerging trends in service delivery, and new policy initiatives. It encompasses the process of aligning existing health service delivery arrangements with changing patterns of need, making the most effective use of available and future resources including workforce. Importantly health service planning is based on identifying and addressing the health needs of service users (or potential users).

Factors that determine the local level of access to health services are complex. The planning process will support orientation of health services to better meet health needs whilst considering: geographic location; health service networks (across HHS, regional and metropolitan areas); dispersement of population; transport networks; workforce supply; the availability of appropriate infrastructure and equipment; information communication technology requirements; and available funding. Within this context, local services have the flexibility to determine the mix and breadth of service changes to better meet local health need.

Critical to the planning process is community and key stakeholder engagement to ensure a shared vision and understanding of service issues and the service changes required to address the issues. All involved must have a common understanding of: burden of disease; geographical environment; health data; current service activity and capacity; budgets; health systems regulations; human resources; and proposed solutions. HHSs will communicate with community and key stakeholders in a transparent manner in collecting quantitative and qualitative information during the planning process. Other health services such as general practice, Queensland Ambulance Service, Medicare Locals, local government and private providers’ information may also be shared.

Whilst HHS Chief Executives, Hospital and Health Boards and DoH will make the ultimate decision on service directions, active community engagement throughout the planning process helps ensure all parties consider potential service solutions and are also aware of the practical constraints of implementing such solutions.

Future services at the local level will be supported by higher level policy and planning directions that are developed at a HHS, regional, statewide and national level. Conversely, higher level policy and planning directions will also be shaped by local level services.

Service areas for consideration in the health service planning process include:

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

Local partnerships with a range of providers will be considered including (but not limited to):

- community
- general practice
- Medicare Locals
- Queensland Ambulance Service
- Royal Flying Doctor Service
- local government
- community controlled organisations
- private hospitals
- private providers
Partnerships will need to recognise the Commonwealth government has lead responsibility for system management, policy and funding for primary healthcare.

**Health workforce**

Services proposed through the health service planning process will need to be provided by an appropriate, skilled and well supported health workforce. New planned services will be complemented by innovative and flexible health workforce models. The planning process will ensure minimum workforce requirements are supported including:

- staff must be appropriately skilled, registered, credentialed where required
- staff are to be provided orientation to the service incorporating workforce cultural capability as relevant
- staff must complete annual training related to occupational health and safety (e.g. manual handling, fire safety and infection control)
- staff must attend continuing education and skill enhancement programs
- staff must be competent in basic life support (clinical staff only)
- all healthcare workers caring for children must be competent in basic paediatric life support.

Access to a suitable medical workforce in rural and remote areas has been challenging for many years and Queensland Health has sought to address this through its industrial relations framework. The following principles and issues need to be considered in any future changes to the industrial relations framework:

- 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
- 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

**Further assistance**

A range of additional resources are available to further support implementation of this Framework and the associated health service planning process including:


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• HHS clinician engagement strategy and consumer and community engagement strategy may be available on individual HHS websites
• HHS and Medicare Local. Protocols may be available on Medicare Local and HHS individual websites
• National Strategic Framework for Rural and Remote Health
• Queensland rural and remote health service process
<table>
<thead>
<tr>
<th>Key Term</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Australian Bureau of Statistics (ABS)</strong></td>
<td>The Australian Bureau of Statistics is the official and central statistical organisation for the Australian Government. The primary responsibility of the ABS is to provide official statistics that serve the needs of all levels of government.</td>
</tr>
<tr>
<td><strong>Accessibility/Remoteness Index of Australia (ARIA+)</strong></td>
<td>Accessibility/Remoteness Index of Australia (ARIA) was developed by the Commonwealth Department of Health and Aged Care and the National Key Centre for Social Applications of Geographical Information Systems. ARIA measures remoteness based on the physical road distance between a settlement and four classes of service centre. In 1999 a further revision of ARIA called ARIA+ was developed that incorporated more information on the location of service centres. ARIA+ was used to create the 2006 ASGC Remoteness Structure.</td>
</tr>
<tr>
<td><strong>Bed days</strong></td>
<td>The number of full or partial days of stay for patients who were admitted for an episode of care and who underwent separation during the reporting period. A patient who is admitted and separated on the same day is allocated one patient day.</td>
</tr>
<tr>
<td><strong>Consumers</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Consumer engagement</strong></td>
<td>Consumer engagement informs broader community engagement. Health consumers actively participate in their own healthcare and in health, policy, planning, service delivery and evaluation at service and agency levels. Source: Health Consumers Queensland Consumer and Community Engagement Framework (2012)</td>
</tr>
<tr>
<td><strong>Community engagement</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Criteria for success</strong></td>
<td>Criteria for success are used to demonstrate the achievement of outcomes of a planning activity in terms of accomplishing service directions or meeting the intent of the planning. Source: Department of Health Guide to health service planning v 2 (2012)</td>
</tr>
<tr>
<td><strong>Clinical Services Capability Framework v3.1 (CSCF)</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
### 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 v 2 (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 v 2 (2012)*

### Health service planning benchmarks

Health service planning benchmarks provide commonly agreed on methodologies to be used in determining future service requirements.

### Medicare Locals

Medicare Locals are local primary healthcare organisations.

### 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.  
Source: Department of Health *Guide to health service planning v 2 (2012)*

### National Weighted Activity Unit (NWAUs)


### Occasions of service

Occasions of service include any examination, consultation, treatment or other service provided to a non-admitted patient in each functional unit of a health service facility on each occasion such service is provided.

### Population projection

An estimate of the future resident population of a given area. The Queensland Government produces updated population projections for all Queensland on a regular basis.

### 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, and advocacy and rehabilitation.  
Source: *Australian Primary Health Care Research Institute Primary health care position statement (2005)*

### Queensland Hospital Admitted Patient Data Collection (QHAPDC)

The Queensland Hospital Admitted Patient Data Collection (QHAPDC) is the corporate repository for demographic and morbidity data on all admitted patients separated (an inclusive term meaning discharged, died, transferred or statistically separated) from both public and licensed private hospitals and private day surgeries in Queensland.  
The system used to collect data for QHAPDC in public hospitals is known as HBCIS (Hospital Based Corporate Information System). All patient separations and patient days (or occupied bed days) that occur in public hospitals are recorded via direct or indirect access to an operational HBCIS system.
<table>
<thead>
<tr>
<th>Rural and remote community</th>
<th>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)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service delivery model</td>
<td>Service delivery models are an adaptation of an organisation’s model of care and describe ‘where’ and ‘how’ work is carried out. Service delivery models suit the local environment and resources to best meet the overarching organisational requirements. Source: Department of Health Guide to health service planning v 2 (2012)</td>
</tr>
<tr>
<td>Service directions</td>
<td>Service directions describe the direction/s for the organisation to address the identified issues/needs. Service directions assist stakeholders to be clear about the intent for the future, and support strategy development targeted to meeting prioritised needs and resolving health service issues. Source: Department of Health Guide to health service planning v 2 (2012)</td>
</tr>
<tr>
<td>Service options</td>
<td>Service options describe the most appropriate service arrangements, configurations or models of care proposed to sustainably address future health service needs. Source: Department of Health Guide to health service planning v 2 (2012)</td>
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</table>
Attachment 1: Clinical Services Capability Framework V3.1

The Clinical Services Capability Framework v3.1 (CSCF) describes services that 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 Capability Framework v3.1 Levels

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, with the complete framework at www.health.qld.gov.au/cscf

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 general practitioner. A visiting general 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 general 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 general practitioners (available 24-hours, 7-days per week but not necessarily on site) 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 on site 24/7 and an intensive care unit (may be combined with a cardiac care unit) with related support services will also be available on site (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 across the state, hospital and health services 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.