CSCF

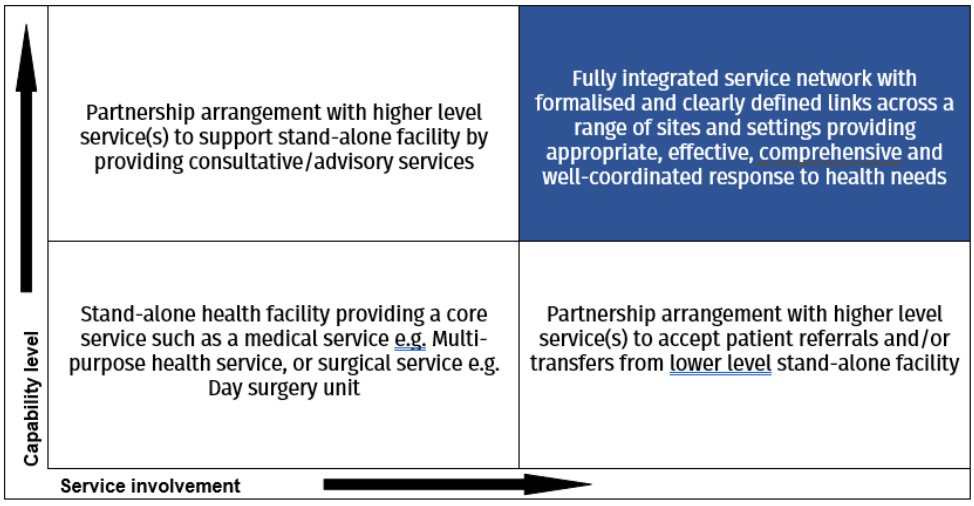
Fact sheet 6 – Service networks

The Clinical Services Capability Framework (CSCF) for public and licensed private health facilities has been designed to guide a coordinated and integrated approach to health service planning and delivery in Queensland. It is intended to work along with and inform other frameworks, systems or mechanisms supporting the provision of safe and high-quality health services.

Service networking by health facilities is fundamental in providing essential service links across a range of sites and settings, ensuring continuity of care and integrated levels of care for safe and sustainable services to meet community need. This is particularly important in parts of Queensland where health service provision is complicated by geographical distance, low population size and density, and limited health service options.

Health services are provided by a range of agencies from public, private and not-for-profit sectors. When agencies combine to create a service network and provide integrated services, the collective capability of these combined services increase. For example, a rural hospital generally providing CSCF level 2 services such as emergency, medical, surgical and maternity services, could provide higher CSCF level services, on an ad hoc or regular 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. Figure 1 illustrates the potential impact on CSCF capability using service networking arrangements.

Figure 1 Health service network



When addressing service gaps through service networking, consideration needs to be given to the most efficient and effective method of addressing them. Potential options for addressing service gaps are summarised in Table 1.

Table 1 Options for addressing service gaps

Options	Description
1.	Establishing a local stand-alone service.
2.	Determining whether another service provider is more appropriate to provide the service.
3.	Providing a virtual service via telehealth.
4.	Bringing the service to the health consumer via set up of an outreach service.
5.	Taking the health consumer to the service via referral arrangements.
6.	Emerging service delivery models/arrangements/modalities.

Efficient and effective service models are dependent on available supports and the number of people requiring the service, aiming to balance quality service provision with patient throughput and cost.

The CSCF does not prescribe, either at a local or statewide level, the configuration of service networks, as this is a local decision. However, the use of networking mediums, such as telehealth, outreach services and/or public-private partnerships, is actively encouraged at all CSCF capability levels.

Service networks also enable a number of possible transfer pathways. Patients may need to be transferred to services with a higher capability for ongoing management. Conversely, patients may be transferred from services with higher capability to services closer to their place of residence, for instance, where the care required is less complex and therefore may operate at a lower service level. Service network arrangements can be established between services for routine transfers, patient retrieval and/or outsourcing of services, among other arrangements.

To facilitate and integrate patient management and/or governance arrangement at each service level, links between health services are actively encouraged, ideally underpinned where practicable by documented processes agreed by all agencies involved. Documented processes could cover:

- defined communication pathways between registered health practitioners
- trigger mechanisms for local emergency health interventions
- clinical criteria for referral and transfer of patients to and from services
- referral and transfer processes including review of patient transfers and back-transfers
- safety and quality indicators of the agreed documented process e.g. emergency presentations requiring transfer out, number of referrals, number of consultations, number of back-transfers, among others.

Any partnership arrangements, whether formal or informal, should be reviewed by all services at least every three years, or more frequently if necessary.

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

Multidisciplinary team care underpins best practice. Service networks can enhance the composition of the multidisciplinary team. Multidisciplinary team members typically include medical, nursing and allied health professionals. The allied health professional workforce is vast and typically includes, but is not limited to, audiologists, clinical measurement scientists, dieticians, exercise physiologists, leisure therapists, medical radiation professionals, music therapists, occupational therapists, optometrists, orthoptists, orthotists, pharmacists, physiotherapists, podiatrists, prosthetists, psychologists, rehabilitation engineers, social workers and speech pathologists.