



the
Lowitja
Institute

Australia's National Institute for Aboriginal and
Torres Strait Islander Health Research

**National CQI Framework for Aboriginal and
Torres Strait Islander Primary Health Care
2015–2025**

prepared for the Commonwealth Department of Health

November 2015

Draft for consultation

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ACKNOWLEDGMENTS

This report was commissioned by the Commonwealth Department of Health (Indigenous Health Division). The project was conducted by the Lowitja Institute and partner organisations supported by a Stakeholder Advisory Committee. The project team would like to thank all those who participated in the project, including key stakeholders who participated in individual interviews related to the development of the core components and in the mainstream general practice and policy workshops.

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Commonwealth Department of Health liaison and feedback

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Draft for consultation

ACRONYMS

AAPM	Australian Association of Practice Managers
ACCHSs	Aboriginal Community Controlled Health Services
ACRRM	Australian College of Rural and Remote Medicine
AHMAC	Australian Health Ministers Advisory Council
AIDA	Australian Indigenous Doctors Association
APNA	Australian Practice Nurses Association
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CFIR	Consolidated Framework for Implementation Research
CPD	Continuing Professional Development
CQI	continuous quality improvement
EHRs	electronic health records
EQHS-C	Establishing Quality Health Standards Continuation
GP	General Practitioner
IAHA	Indigenous Allied Health Australia
IOM	Institute of Medicine
IT	information technology
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHWA	National Aboriginal and Torres Strait Islander Health Worker Association
NGOs	non-government organisations
nKPIs	national key performance indicators
NPAs	National Partnership Agreements
NeHTA	National e-Health Transition Authority
PARIHS	Promoting Action on Research Implementation in Health Services
PCEHR	Personally Controlled Electronic Health Record
PDSA	Plan–Do–Study–Act
PHNs	Primary Health Networks
QAIHC	Queensland Aboriginal and Islander Health Council
RACGP	Royal Australian College of General Practitioners
RFDS	Royal Flying Doctor Service
RTO	Registered Training Organisation
VET	Vocational Education and Training

SECTION ONE

1.1 Introduction

The *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (Commonwealth of Australia 2013) clearly articulates that effective, high quality primary health care for Aboriginal and Torres Strait Islander people wherever and whenever they seek care is a national priority. Aboriginal Community Controlled Health Services (ACCHSs)¹ play a pivotal role in the provision of holistic, comprehensive and culturally appropriate primary health care for Aboriginal and Torres Strait Islander people. Non-Indigenous primary health care services, predominantly private general practices and state and territory government health centres also have a significant role in the delivery of services to Aboriginal and Torres Strait Islander people. At a system level it is important that both Indigenous and non-Indigenous services are capable of meeting the care needs of Aboriginal and Torres Strait Islander people.

Continuous Quality Improvement (CQI) is the central approach used by modern health care organisations (primary, secondary and tertiary) to improve health care quality (Colton 2000) along with other approaches such as accreditation and clinical and organisational governance. Over the past 10 years there has been increasing interest and activity in CQI in primary health care services for Aboriginal and Torres Strait Islander people. By improving the quality of their care, we are striving to improve health outcomes and close the gap in health status between Indigenous and non-Indigenous Australians.

Despite the increased interest and activity in CQI there has been no overall framework or coordination of investment or effort, in contrast to that for other quality approaches such as accreditation. Engagement in CQI by ACCHSs, private general practices and state/territory government services (collectively referred to in this document as **primary health care providers**) has varied from place to place and over time.

For this reason the Commonwealth Department of Health (the Department) commissioned a project to develop a **National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care**. This is that Framework.

1.2 Purpose of the Framework

The purpose of this **National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care** is to foster commitment and a coordinated approach to CQI in primary health care for Aboriginal and Torres Strait Islander people, wherever and whenever they seek care.

Recognising the central importance of cultural safety and competence in CQI, it provides guidance about where effort and investment is likely to achieve the best results. It does this by identifying the 'core components' necessary to embed CQI in everyday practice at the local level and what is required at local, regional, state/territory and national levels to support their implementation. It supports an approach to research, including monitoring, evaluation and knowledge translation that will enable stakeholders at all levels to build the evidence base for CQI in primary health care services for Aboriginal and Torres Strait Islander people and to translate new knowledge into evidence-based practice.

There are now approximately 150 ACCHSs providing services to an estimated 51 per cent (2011–12) of the Aboriginal and Torres Strait Islander population (NACCHO 2014). The Framework is intended for those services as well as the general practices and state and territory government health centres providing care

¹ Also called Aboriginal and Islander Community Controlled Health Services (AICCHSs) and Aboriginal Community Controlled Health Organisations (ACCHOs).

to Aboriginal and Torres Strait Islander people. Other non-government organisations (NGOs) and in some settings the Royal Flying Doctor Service (RFDS) are also key players, as are justice departments in the states and territories. The Framework builds on CQI activity in these sectors over the past 10 years.

1.3 Development Process

This Framework has been developed through a two-stage process. Through an approach to market, the Commonwealth Department of Health (the Department) commissioned a project to 'identify barriers and enablers in improvement and assess, develop and refine systems and capacity to support improved Primary Health Care for Aboriginal and Torres Strait Islander people. The project focused on CQI in ACCHSs but included some consideration of private general practices and state/territory government services with significant numbers of Aboriginal or Torres Strait Islander clients.

The project outlined two potential stages of work. Stage 1 required a synthesis and analysis of CQI activity and evidence 'to explore system wide national, regional and local enablers, barriers and linkages relevant to the development of a national CQI framework'. Depending on the findings and recommendations of Stage 1, the Department would decide whether to proceed with Stage 2 - the development of a national CQI framework.

Following wide consultation, Recommendation 1 from Stage 1 was that 'The Department should proceed with supporting the development of a national CQI framework for Aboriginal and Torres Strait Islander primary health care' (Lowitja Institute 2014). The Department subsequently commissioned the development of a framework exercising the option to continue with Stage 2. This is that Framework. It has been developed through a partnership between the Lowitja Institute, the National Aboriginal Community Controlled Organisation (NACCHO) and ACCHS state and territory peak bodies, Menzies School of Health Research, Flinders University, the University of Melbourne and consultations with state and territory government health departments, private general practice, health professional bodies and other stakeholders.

1.4 Framework Documents

On release of the Framework there are two relevant documents:

The **National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care 2015-2025** (this document) defines CQI and identifies the core components and key system attributes that are required to support successful implementation of CQI across the primary health care system, along with the expected early, intermediate and long term results for each component. It also provides a summary of the national and international evidence that underpins the Framework, including context issues, key system attributes and the core components.

Initial implementation of the Framework will be guided by the **National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care Implementation Strategy 2016-2019** which provides direction to stakeholders in developing the initial CQI implementation plans relevant to their organisation or sector.

1.5 Vision, Aims and Principles

Vision

Aboriginal and Torres Strait Islander people receive the highest attainable standard of primary health care wherever and whenever they seek care.

Aims

- All services implement CQI as a core part of their business
- Foster cultural safety and competence in the implementation of CQI
- Foster Aboriginal and Torres Strait leadership and participation
- Further develop CQI capacity
- Bring about and achieve efficiencies in the universal uptake, embedding, coordination and sustainability of CQI in everyday practice
- Ensure all primary care providers implement PDSA as a core part of their business
- Build the CQI evidence base and support knowledge translation.

Principles

- Draws on past experience and builds on momentum in CQI in primary health care, focusing on enablers
- Allows for flexibility in approaches and tools to meet the needs of local communities and services
- Incorporates evidence-based practice
- Recognises the need for partnerships and collaboration between primary health care service sectors
- Recognises the central importance of the ACCHS sector and its potential for leadership and guidance in implementation roles at all levels of the Framework
- Requires sustained commitment over a long timeframe.

The vision is being realised in the context of six issues that are outlined in **Appendix 1**. They are:

1. Health gaps between Indigenous and non-Indigenous populations
2. Comprehensive primary health care approach
3. Complex primary health care service sectors
4. Variation in organisational capacity
5. System reform
6. Evidence base

1.6 Audiences

Consistent with its vision for Aboriginal and Torres Strait Islander people to receive the highest attainable standard of primary health care wherever and whenever they seek care, this Framework has a number of primary audiences, including:

- ACHHSs and their representative organisations at regional, state/territory and national levels
- General practices
- State and territory health centres, districts and departments
- Primary Health Networks (PHNs)
- Other primary health care providers
- Professional peak bodies, particularly those representing GPs, practice managers and practice nurses; and those representing Indigenous doctors, health workers, nurses and midwives, and allied health professionals
- External data custodians, holders and analysts, such as the AIHW, ABS and Medicare Australia
- Government agencies and committees, and statutory bodies

- University and Vocational Education and Training (VET) organisations and institutions
- Research and development institutions
- Clinical information system and quality improvement resources providers
- Community organisations.

It is hoped that the Framework will foster among these players and others with an interest in primary health care a common purpose and commitment to CQI in services for Aboriginal and Torres Strait Islander people over the coming decade.

1.7 Aboriginal and Torres Strait Islander participation and leadership

Aboriginal and Torres Strait Islander participation and leadership is vital to the effective implementation of the Framework. The Framework's aims of fostering cultural safety and competence and Aboriginal and Torres Strait Islander participation and leadership are addressed by promoting **client and community centredness**. The Framework identifies a number of components that specifically address Aboriginal and Torres Strait Islander participation.

There is increasing recognition that the model of comprehensive primary health care that has been led by the ACCHS sector, with its emphasis on **culturally safe and appropriate care** is an important means of improving access and the quality and effectiveness of the care for Aboriginal and Torres Strait Islander people (Panaretto et al., 2014; AHCWA 2015). This Framework assumes that Australian and jurisdictional governments will continue their policy recognition and support of the ACCHS sector as the predominant service system for Aboriginal and Torres Strait Islander primary health care. This assumption remains pivotal to closing the gap and to ensuring that ACCHSs will, using CQI methodologies, creatively adapt, innovate and evolve their services in response to changing population health needs on an ongoing basis.

Another key assumption underpinning this Framework is the recognition that Australian and state/territory governments are encouraging non-Indigenous primary health care providers to also contribute more actively towards closing the gap. This will require these sectors to utilise the expertise and 'know-how' that have been acquired by the ACCHS sector over many years of service provision to strengthen their capacities to offer culturally safe and appropriate care for Aboriginal and Torres Strait Islander people.

SECTION TWO

2.1 What is CQI?

CQI is a continuous, forward looking, process of ongoing learning and sharing. It is underpinned by a philosophy that emphasises the importance of organisational commitment and whole team involvement to improve service systems and processes for delivering care. CQI encourages team members to continuously ask, ‘How are we doing?’ and ‘Can we do it better?’ (Edwards et al. 2008). A CQI environment is one in which data are collected and used to make positive changes – even when things are going well – rather than waiting for something to go wrong and then fixing it. High performance has been linked to the implementation of a CQI strategy (Shortell et al. 2009).

The term CQI does not refer to all quality improvement activities, but to those prospective processes that help organisations select and analyse objective data to achieve improvements in the delivery of services. First introduced into health care in the 1980s, organisations began moving away from retrospective reviews of health care processes and outcomes, known as quality assurance, to adopt the **proactive and forward-looking methods that make up CQI**. These methods are based on the idea that **improving service systems and care processes in a continuous ongoing manner can lead to better outcomes**. CQI has now evolved as a global approach for improving health care quality (Colton 2000, Sollecito & Johnson 2013).

Internationally CQI in health care is defined as:

A structured organisational process for involving personnel in planning and executing a continuous flow of improvements to provide quality health care that meets or exceeds expectations. (Sollecito & Johnson 2013:4)

Common characteristics of CQI

(after Rubenstein et al. 2013)

- Systematic data guided activities
- Plan–Do–Study–Act cycles
- Designing with local conditions in mind
- Aiming to change routine work processes
- Multidisciplinary teams
- Specific predefined aims
- Sets of specific changes
- Using evidence relevant to the problem
- Data feedback to implementers
- Creating a culture of quality improvement

This Framework recognises that CQI is a process nested within **clinical governance** which is in turn nested within organisational governance. It also recognises clear distinctions between CQI and accreditation. These relationships are outlined in **Appendix 2**.

2.2 Basics of the Plan-Do-Study-Act Cycle

The PDSA cycle is a key strategy used, particularly at the local service level, to undertake CQI. It involves teams identifying areas in the organisation and care processes that could be improved, and designing, implementing and testing strategies for improvement.

Many different techniques for conducting PDSA now exist in health care settings – they all share a common set of principles and practices (Langley and Nolan 1992).

Principles and practices for conducting PDSA cycles

- Take a simple approach
- Start small
- Help to plan, develop and implement change that can lead to improvement
- Involve the whole team in redesigning health systems and care processes to achieve improvements
- Engage teams in a continuous and incremental stream of improvements over time.

PDSA focuses teams on making small changes, adjusting these, observing the consequences of actions taken and documenting these so that learning can accrue. PDSA is conducted in rapid cycles which typically happen over short periods such as fortnightly or monthly cycles but longer cycles can also be used.

The steps in the PDSA cycle

Plan: Use data to identify what needs to be improved; discuss what changes could be made; prioritise, set objectives for action; and agree on what data and information are going to be reviewed to measure progress.

Do: Carry out the changes and collect data. During the 'Do' phase of the PDSA cycle, the team carries out the plan according to the detailed action plan developed in the planning phase. The team will need to support the implementation of the plan, making adjustments if necessary and monitoring the change process.

Study: At a meeting of the whole team, review results, reflect on data and discuss what might be contributing to the observed results as well as how the change process proceeded.

Team discussions facilitate processes of interpretation and action planning and should be concerned with the details of what performance indicator data show (e.g. What proportion of clients who are identified as having risk factors for chronic disease have had a brief intervention in the past 12 months?) Local knowledge on what is impacting a result is essential for interpreting what the data means and will help to inform whether an action or change process has been successful and/or whether a new action might be required to improve practice and if so, what that action/s should be taken.

Act: The team implements the new changes and decides on the next set of actions to be taken and (return to step one).

SECTION THREE

3.1 Essential building blocks for embedding CQI

There are fifteen building blocks considered essential for embedding CQI in everyday practice at the local level. These are the Framework core components. In total, they comprise the *essentials* but not necessarily the totality of what is needed to build an integrated system for high quality primary health care for Aboriginal and Torres Strait Islander people.

Core Components	
C1. Cultural safety and competence	C2. Client and community participation
C3. Access to CQI skills	C4. Clinical data infrastructure and functionality for CQI
C5. Clinical governance	C6. CQI Leads
C7. PDSA cycles	C8. Service support
C9. Managed CQI networks	C10. CQI Data sharing and sense-making
C11. Research and knowledge translation	C12. Professional training
C13. Government policy	C14. Organisational partnerships
C15. Coordination and facilitation of implementation of core components	

3.2 Core components at each level of the health system

Delivery of primary health care services takes place within a complex health system across **local, regional, state** and **national** levels. In order to embed CQI effectively in everyday practice at the local level, support must be provided across all four levels of this complex system. Furthermore, CQI practice must be underpinned by **five key attributes** that are described in **Appendix 3**. They are:

1. Client and community centredness
2. Leadership
3. Organisational culture for CQI
4. Team Functioning
5. Systems thinking

The wheel below (Figure 1) provides a graphic depiction of responsibilities for the 15 core components across the four levels. As shown, clients and communities remain at the centre of the Framework. *Responsibility* for most of the core components rests at more than one level. Stakeholders at particular levels may *participate* in a core component but not be *responsible* for implementing it. For example, local primary health care provider CQI leads will participate in CQI networks, but primary health care providers are not responsible for managing the networks as this is the responsibility of regional and state/territory support networks.

There is considerable but not complete overlap between state/territory and regional core component responsibilities; the differences between them will play out differently in the three sectors and may be strongly complementary. Where there are strong, culturally safe and competent regional organisations, they will be closer to services and therefore able to have more direct involvement. For example, state/territory ACCHS peak bodies will provide external support to their members for clinical governance and PDSA cycles, while regional ACCHS organisations might be more directly active in these areas at the service level. Such regional organisations have a central and important role to play in the future sophistication and sustainability of CQI including through their ability to broker regional solutions to local issues relating to Framework core components.

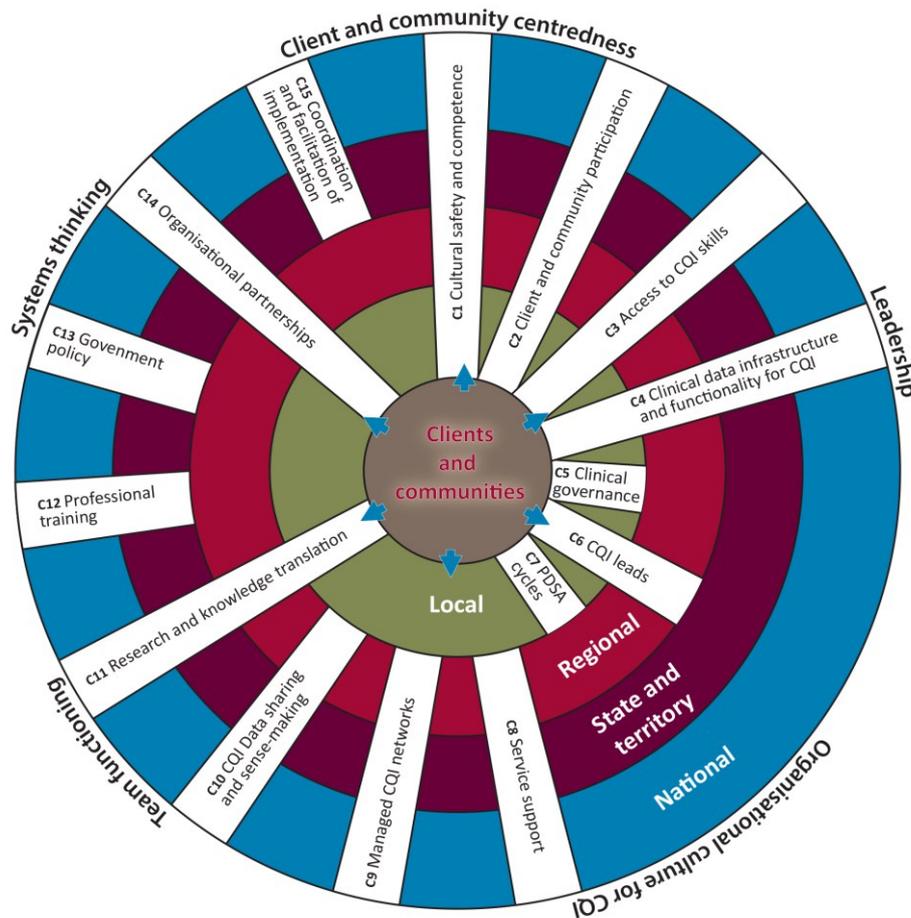


Figure 1: Core component responsibilities across the four levels of the health system and the five key attributes for effective CQI

3.3 How does this translate into practice?

All levels

The approach to planning and delivering care must be grounded in a culturally safe journey for Aboriginal and Torres Strait Islander clients, which is addressed by **cultural safety and competence (C1)** with responsibility across all levels of the system. Likewise the importance of appropriate Aboriginal and Torres Strait Islander participation is addressed by **client and community participation (C2)** across all levels. Stakeholders at all levels are also responsible for ensuring providers have **access to CQI skills (C3)**, for **clinical data infrastructure and functionality for CQI (C4)**, for conducting **research and knowledge translation (C11)** and for maintaining **organisational partnerships (C14)**.

Local level

At the **local primary care provider level**, the Framework includes three main sectors that deliver care to Aboriginal and Torres Strait Islander people – ACCHS, private general practice and state/territory government health centres. How the core components are taken up and implemented within and between these sectors will vary considerably. It is anticipated that over time, other relevant providers of primary health care services such as the RFDS, other NGOs and justice departments will adopt the Framework as they strive to deliver optimal care for their Aboriginal and Torres Strait Islander clients.

In *addition* to the core components common to all levels listed above, core components at the **local level** are **clinical governance (C5)**, recognised **CQI leads (C6)** and regular **Plan–Do–Study–Act (PDSA) cycles (C7)** focusing on service and community identified priorities.

Although there is value in applying PDSA cycles at all levels of the system, the focus of the Framework is on embedding CQI in everyday practice at the local level so it features PDSA cycles as a core component at the local level only.

Regional level

At the **regional level** key implementation stakeholders are regional ACCHSs, local health districts and PHNs, as well as the RFDS.

The *additional* core components at the **regional level** involve supporting primary health care providers by also having **CQI leads (C6)**, providing **service support (C8)**, coordinating **managed CQI networks (C9)**, and participating in **CQI data sharing and sense-making (C10)**.

State/territory level

At the **state/territory level** key stakeholders are ACCHS jurisdictional peak bodies and state and territory health departments; the jurisdictional Aboriginal Health Partnership Forums; and university and VET sector research and training institutions.

The *additional* core components at the **state/territory level** focus on stakeholders supporting primary care providers by also providing **service support (C8)**, coordinating **managed CQI networks (C9)**, participating in **CQI data sharing and sense-making (C10)**, developing **professional training (C12)**, implementing coherent **government policy (C13)**, and by sharing effective **coordination and facilitation of implementation of core components (C15)** with national stakeholders.

National level

At the **national level** key stakeholders include NACCHO; the Department of Health and other relevant Australian Government departments; professional organisations including the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM), the Australian Association of Practice Managers (AAPM), and the Australian Practice Nurses Association (APNA); and Indigenous-specific professional organisations including the Australian Indigenous Doctors Association (AIDA), the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) and Indigenous Allied Health Australia (IAHA).

In *addition* to the core components common to all levels, those at the **national level** focus on stakeholders providing **service support (C8)** through the provision of Continuing Professional Development (CPD) on CQI, coordinating **managed CQI networks (C9)**, participating in **CQI data sharing and sense-making (C10)**, providing **professional training (C12)** in CQI, implementing coherent **government policy (C13)**, and sharing effective **coordination and facilitation of implementation of core components (C15)** with national stakeholders.

SECTION FOUR

4.1 Core component summary results

Vision					
Aboriginal and Torres Strait Islander people receive the highest attainable standard of primary health care wherever and whenever they seek care					
Core Components	L	R	S T	N	Summary Result
C1. Cultural safety and competence					<ul style="list-style-type: none"> Organisations at all levels in all sectors are culturally safe and competent and implementation of Framework core components has been culturally safe.
C2. Client and community participation					<ul style="list-style-type: none"> Organisational structures, policies, processes and relationships embed community participation in implementation of Framework core components and local CQI. Client and community participation impact on policy, investment, service delivery, health literacy and community health action.
C3. Access to CQI skills					<ul style="list-style-type: none"> All primary health care providers have sustained access to personnel with the knowledge and skills necessary to embed CQI in everyday practice and there is a substantial body of evidence about the effectiveness of national, state/territory, regional and local strategies to help ensure primary health care provider access to personnel with CQI knowledge and skills.
C4. Clinical data infrastructure and functionality for CQI					<ul style="list-style-type: none"> All primary health care providers have access to flexible, user-friendly, clinical data infrastructure and functionality that supports PDSA and other CQI activities.
C5. Clinical governance					<ul style="list-style-type: none"> Clinical governance including CQI in primary health care providers that meets best practice standards is universal and there is universal ongoing uptake of best practice/evidence-based care.
C6. CQI Leads					<ul style="list-style-type: none"> Primary health care provider and regional CQI leads are well networked and supported and are respected and influential members of their organisations.
C7. PDSA cycles					<ul style="list-style-type: none"> PDSA cycles as a team function and incorporating all steps including service redesign, are embedded in the everyday practice of primary health care providers.
C8. Service support					<ul style="list-style-type: none"> State/territory and regional organisations are widely recognised as centres of excellence in tailored CQI and clinical governance support for primary health care providers, teams and individuals. National professional organisations are widely recognised as centres of excellence in CQI CPD
C9. Managed CQI networks					<ul style="list-style-type: none"> All key stakeholders participate in effective, managed CQI networks at regional, state/territory and national levels.
C10. CQI Data sharing and sense-making					<ul style="list-style-type: none"> CQI data sharing and sense-making within and between sectors by primary health care providers' regional, state/territory and national representative organisations results in widespread shared learning and underpins policy and investment and strategies for improvement at all levels.
C11. Research and knowledge translation					<ul style="list-style-type: none"> Co-creation of knowledge continually builds the CQI evidence base and knowledge translation routinely informs CQI policy, investment, support and innovation at all four levels.
C12. Professional training					<ul style="list-style-type: none"> The primary health care workforce is trained in CQI at undergraduate, professional and postgraduate levels. CQI career pathways are well established. Aboriginal and Torres Strait Islander health professionals are

Vision

Aboriginal and Torres Strait Islander people receive the highest attainable standard of primary health care wherever and whenever they seek care

Core Components	L	R	S T	N	Summary Result
					prominent in CQI leadership roles.
C13. Government policy					<ul style="list-style-type: none"> • There is ongoing coherent and complementary national and state/territory government policy and investment in Framework implementation. • There is a substantial body of evidence about the effectiveness of national and state/territory policy and investment in Framework implementation.
C14. Organisational partnerships					<ul style="list-style-type: none"> • Effective organisational partnerships engender trust and support implementation of Framework core components within and between service sectors at the local, regional, state/territory and national levels. • CQI is embedded in local and regional partnership models of care.
C15. Coordination and facilitation of implementation of core components					<ul style="list-style-type: none"> • Framework implementation steering committee is trusted and respected in leading the coordination and facilitation of implementation of Framework core components. • National and state/territory coordination and facilitation roles are effective in supporting the implementation of Framework core components. • A national CQI knowledge exchange mechanism is highly used and trusted source of information for ACCHS, GP, state/territory health department sectors and other stakeholders to support implementation of the Framework core components.

Draft for CQI

4.2 Core component early, intermediate and long term results

The following tables outline the rationale and identify the early, intermediate and long-term results within a 10 year timeframe for each core component, across the four levels of the health system. Throughout, 'local' refers to primary health care providers. Supporting information for each core component is summarised in **Appendix 4**.

C1. Cultural safety and competence			
Cultural safety and competence help providers and clients achieve the best, most appropriate care. Cultural safety centres on the experiences of the client as they receive care. Cultural competence focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.			
	Early results	Intermediate results	Long term results
Local, Regional and State/territory	Local, regional and state/territory organisations are implementing strategies to ensure they are culturally safe and competent, including in implementation of Framework core components.	National standards and measures for cultural safety and competence relevant for all sectors and all levels have been developed. Local, regional, state/territory and national organisations are meeting minimum standards of cultural safety and competence, including in implementation of Framework core components.	Local, regional, state/territory and organisations are culturally safe and competent, and implementation of the Framework core components at all levels has been culturally safe. Cultural safety and competence are routinely measured as part of Framework implementation at different levels of the system using agreed standards and measures.
	<p>Consultation has occurred across sectors to develop national standards for cultural safety and competence.</p> <p>Accredited cultural safety and competence training options appropriate for different sectors and levels have been identified/developed and endorsed.</p> <p>Resources to support organisations to achieve cultural safety and competence have been identified/ developed and made available through the national CQI knowledge exchange mechanism (see C15).</p> <p>National organisations have implemented strategies to ensure they are culturally safe and competent, including in implementation of the Framework core components.</p>	<p>Cultural safety and competence are beginning to be measured as part of Framework implementation at different levels of the system using agreed standards and measures.</p>	
National			

C2. Client and community participation

The importance of client and community participation in primary health care is increasingly recognised. Participation occurs when clients, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment, and the wellbeing of themselves and their communities.

	Early results	Intermediate results	Long term results
Local	<p>Opportunities for appropriately targeted client and community participation in primary health care provider CQI structures and processes have been identified and strategies implemented.</p>	<p>Client and community participation is becoming embedded in local CQI structures and processes.</p> <p>There is a developing body of evidence of the effectiveness of community participation in implementing Framework core components at the local level.</p>	<p>Client and community participation is embedded in local CQI structures and processes.</p> <p>There is a substantial body of evidence of the effectiveness of community participation in implementing Framework core components at the local level.</p>
Regional, State/territory and National	<p>Opportunities for community representatives to participate in regional, state/territory and national structures and processes for implementing Framework core components have been identified.</p> <p>Regional, state/territory and national organisational structures, policies, processes and relationships are supporting community representative participation in implementing Framework core components.</p> <p>Practical and efficient methods have been developed to measure the effectiveness of client and community representative participation at local, regional, state/territory and national levels.</p>	<p>Community representative participation is becoming embedded in regional, state/territory and national structures and processes for implementing Framework core components.</p> <p>There is a developing body of evidence of the effectiveness of community representative participation in implementing Framework core components at regional, state/territory and national levels.</p>	<p>Community representative participation is embedded in regional, state/territory and national structures and processes for in implementing Framework core components.</p> <p>There is a substantial body of evidence of the effectiveness of community representative participation in implementing Framework core components at regional, state/ territory and national levels.</p>

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C3. Access to CQI skills

Primary health care providers need access to personnel with the CQI knowledge and skills necessary to embed CQI in everyday practice. These include the concept of quality improvement; clinical data extraction, analysis and interpretation; managing group processes; best practice/evidence-based care; system redesign; change management; the social context of health; and client and community needs and attributes. Access may be affected by regional/local availability and/or capacity to hire personnel with appropriate knowledge and skills.

	Early results	Intermediate results	Long term results
Local	Local strategies to help ensure primary health care providers have ongoing access to personnel with the knowledge and skills necessary to embed CQI in everyday practice are being implemented.	Local, regional, state/territory and national strategies to help ensure primary health care providers have ongoing access to personnel with the skills necessary to embed CQI in everyday practice continue to be implemented and most primary health care providers have access to CQI knowledge and skills.	All primary health care providers have sustainable access to personnel with the knowledge and skills necessary to embed CQI in everyday practice. There is a substantial body of evidence about the effectiveness of local, regional, state/territory and national strategies to help ensure primary health care providers have ongoing access to personnel with CQI knowledge and skills.
Regional and State/territory	Regional and state/territory audits of primary health care providers access to personnel with the knowledge and skills necessary to embed CQI in everyday practice have been carried out within and between sectors. Regional and state/territory strategies to help ensure primary health care providers have ongoing access to personnel with the knowledge and skills necessary to embed CQI in everyday practice are beginning to be implemented.	There is a developing body of evidence about the effectiveness of local, regional, state/territory and national strategies to help ensure primary health care providers have ongoing access to personnel with CQI knowledge and skills.	
National	Knowledge and skills necessary for primary health care providers to embed CQI in everyday practice have been formally described. National strategies to help ensure primary health care providers have ongoing access to personnel with the knowledge and skills necessary to embed CQI in everyday practice are being implemented.		

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C4. Clinical data infrastructure and functionality for CQI

Primary health care provider teams need access to clinical data infrastructure and functionality that allow them to extract and use data in real time for PDSA cycles and other CQI activities.

	Early results	Intermediate results	Long term results
Local	Local strategies to help ensure primary health care providers have access to clinical data infrastructure and functionality that supports PDSA cycles and other CQI activities are developed and being implemented.	Local, regional, state/territory and national strategies to help ensure all primary health care providers have access to flexible, user-friendly clinical data infrastructure and functionality that supports PDSA and other CQI activities are being implemented.	All services have access to flexible, user-friendly clinical data infrastructure and functionality that supports PDSA and other CQI activities.
Regional and State/territory	<p>Clinical data infrastructure and functionality for CQI has been reviewed at regional and state/territory levels.</p> <p>Regional and state/territory strategies to help ensure all primary health care providers have access to clinical data infrastructure and functionality that supports PDSA cycles and other CQI activities are developed and being implemented.</p>	Most services have access to flexible, user-friendly clinical data infrastructure and functionality that supports PDSA and other CQI activities.	
National	<p>A national review of clinical data infrastructure and functionality for CQI has been undertaken.</p> <p>National guidelines for clinical data infrastructure and functionality for CQI have been developed.</p> <p>A nationally coordinated plan to improve clinical data infrastructure and functionality for CQI has been developed and is being implemented.</p>		

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C5. Clinical governance

Clinical governance is the means by which modern health organisations manage their quality and safety agendas. Boards and senior managers and clinicians need to act as champions and opinion leaders to drive a whole of organisation approach to CQI.

	Early results	Intermediate results	Long term results
Local	<p>Primary health care providers' organisational roles, structures and processes reflect commitment, involvement and accountability for clinical governance, including CQI.</p> <p>There are structures and processes in primary health care provider organisations to ensure ongoing uptake of best practice/evidence-based care.</p>	<p>Clinical governance including CQI in primary health care providers that meets best practice is widespread and there is widespread, ongoing uptake into practice of best practice/evidence-based care.</p>	<p>Clinical governance including CQI in primary health care providers that meets best practice is universal and there is universal, ongoing uptake of best practice/evidence-based care.</p>

C6. CQI leads

Evidence supports the importance of an individual within an organisation who is formally responsible for implementing CQI.

	Early results	Intermediate results	Long term results
Local and Regional	<p>All primary health care providers and regional organisations have access to an appropriately skilled, designated CQI lead.</p> <p>All primary health care provider and regional organisation CQI leads are internally recognised and supported in their roles.</p> <p>All primary health care provider and regional organisation CQI leads are becoming externally networked and supported.</p>	<p>Primary health care provider and regional CQI leads are respected and influential members of their organisations.</p> <p>Primary health care provider and regional CQI leads operate within established networks.</p>	<p>Primary health care provider and regional CQI leads are well networked and supported, and are respected and influential members of their organisations.</p>

C7. PDSA cycles

Plan–Do–Study–Act (PDSA) is an internationally recognised method for primary health care providers to systematically review their performance in meeting client needs, providing high quality care and improving client outcomes. It is a series of steps undertaken cyclically, that guides teams in the routine use of data as a basis for dialogue to identify priorities for action, develop and test strategies for improvement, and implement service redesign. Quality indicators are necessary for PDSA cycles.

	Early results	Intermediate results	Long term results
Local	<p>Regular PDSA cycles as a team function and incorporating all steps including service redesign, are being implemented in the everyday practice of primary health care providers.</p>	<p>PDSA cycles as a team function and incorporating all steps including service redesign, are becoming embedded in the everyday practice of primary health care providers.</p>	<p>PDSA cycles as a team function and incorporating all steps including service redesign, are embedded in the everyday practice of primary health care providers.</p>

C8. Service support

Support of primary health care providers, teams and individual primary health care professionals which is tailored to meet specific needs and different levels of CQI capacity, is needed to help embed CQI in everyday practice.

	Early results	Intermediate results	Long term results
Regional and State/territory	<p>Regional and state/territory support of primary health care providers, teams and individual health professionals to embed CQI in everyday practice is being provided including:</p> <ul style="list-style-type: none"> • Fostering leadership and commitment of Boards, CEOs and middle management • Board and staff training • Engaging the Aboriginal and Torres Strait Islander workforce in CQI • Mentoring for CQI leads • Assistance with extracting, interpreting and analysing data for PDSA cycles and other CQI activities • Access to CQI tools and resources • Support for clinical governance. 	<p>Regional and state/territory organisations are becoming recognised as centres of excellence in CQI and clinical governance support.</p>	<p>Regional and state/territory organisations are widely recognised as centres of excellence in CQI and clinical governance support.</p>
National	<p>Continuing professional development (CPD) in CQI is being provided to primary health care professionals by national professional organisations.</p>	<p>National professional organisations are becoming recognised as centres of excellence in CQI CPD.</p>	<p>National professional organisations are widely recognised as centres of excellence in CQI CPD.</p>

C9. Managed CQI networks

Formal networks are interconnected individuals, groups, or organisations that promote interaction to generate and share knowledge for achieving goals. Networks are important for CQI. Coordinators are essential to manage formal networks. Coordinators involve members, provide technical support, enhance functionality and maintain group processes, including supporting ongoing participation, sharing of quality information and knowledge translation. Face-to-face contact is an important aspect of network activity.

	Early results	Intermediate results	Long term results
Regional, State/territory and National	<p>Managed regional, state/territory and national networks that support CQI in the ACCHS, general practice and state/territory health department sectors are operational.</p>	<p>Managed regional, state/territory and national CQI networks are actively sharing knowledge, skills and resources with relevant key stakeholders.</p> <p>Managed networks demonstrate value to embedding CQI.</p>	<p>All relevant key stakeholders actively participate in effective, managed regional, state/territory and national CQI networks.</p> <p>Managed networks continue to demonstrate value to embedding CQI.</p>

C10. CQI data sharing and sense-making

Sharing of primary health care providers’ de-identified data at different levels within and between sectors allows their representative organisations to make contextualised comparisons, tailor support, demonstrate achievements, and highlight areas for improvement (sense-making). Quality indicators are necessary for data sharing and sense-making. Quality indicators are necessary for CQI data sharing and sense-making.

	Early results	Intermediate results	Long term results
Regional, State/territory and National	<p>Additional quality indicators that address the main health priorities are being developed.</p> <p>Approaches and data governance arrangements for primary health care providers’ regional, state/territory and national representative organisations to undertake CQI data sharing and sense-making within and between sectors have been established</p> <p>Strategies to ensure primary health care providers’ regional, state/territory and national representative organisations have access to information platforms that support CQI data sharing and sense-making are being implemented.</p> <p>Early CQI data sharing and sense-making outputs are available at regional, state/territory and national levels.</p>	<p>There is a bank of quality indicators covering all the main health priorities.</p> <p>CQI data sharing and sense-making at regional, state/territory and national levels within and between sectors is beginning to result in shared learning and underpins policy and investment and strategies for improvement at all levels.</p>	<p>CQI data sharing and sense-making at regional, state/territory and national levels within and between sectors results in widespread shared learning and underpins policy and investment and strategies for improvement at all levels.</p>

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C11. Research and knowledge translation

Co-creation of knowledge and knowledge translation through effective policy/practice–research partnerships at all levels will support development of the evidence base and uptake into policy and practice including through the development of innovative and refined approaches and resources for CQI.

	Early results	Intermediate results	Long term results
Local, Regional and State/territory	<p>Local, regional and state/territory organisations support co-creation of knowledge and knowledge translation through activities such as brokering practice–research partnerships, undertaking capacity building for research participation, and supporting opportunities for knowledge translation.</p> <p>Initial local, regional and state/territory CQI evidence needs have been identified and research that addresses those needs is being developed.</p>	<p>Co-creation of knowledge and knowledge translation are ongoing; there is a developing body of local, regional, state/territory and national CQI evidence; and knowledge translation is beginning to inform CQI policy, investment, support and innovation at all four levels.</p> <p>There is increasing sophistication of local, regional, state/territory and national knowledge translation structures and processes and a developing body of evidence of their effectiveness.</p>	<p>Co-creation of knowledge and knowledge translation are ongoing; there is a substantial body of local, regional, state/territory and national CQI evidence; and knowledge translation routinely informs CQI policy, investment, support and innovation at all four levels.</p> <p>There are sophisticated local, regional, state/territory and national knowledge translation structures and processes and a substantial body of evidence of their effectiveness.</p>
National	<p>A national Framework monitoring and evaluation plan that includes a formative evaluation is being implemented.</p> <p>Drawing on international best practice, a model for knowledge translation for CQI in Aboriginal and Torres Strait Islander primary health care has been developed.</p> <p>Initial national CQI evidence needs have been identified and research that addresses those needs is being developed.</p>		

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C12. Professional training

CQI training at undergraduate, professional and postgraduate levels is essential to ensure that CQI is embedded in everyday practice across primary health care. It is an area of expertise and should be recognised in career pathways. Aboriginal and Torres Strait Islander health professional leadership in CQI is central to the sustainability of CQI practice and to engaging clients and communities in CQI.

	Early results	Intermediate results	Long term results
State/territory and National	<p>Reviews of have been undertaken of university undergraduate and postgraduate and VET sector training for the primary health care workforce and opportunities for including CQI in courses have been identified.</p> <p>A review has been undertaken of CQI content in GP professional (registrar) training.</p> <p>Development of university postgraduate and advanced VET sector courses in CQI for GPs, Aboriginal and Torres Strait Islander health professionals, nurses, practice managers, and other health professionals has begun.</p>	<p>Guidelines for university undergraduate and postgraduate and VET sector CQI curricula content have been developed and curricula uptake promotion strategies are being implemented.</p> <p>Relevant university undergraduate and postgraduate and VET sector courses for health care professionals include CQI content consistent with the guidelines.</p> <p>University postgraduate and advanced VET sector courses in CQI in primary health care have been developed and there is good uptake of these courses.</p> <p>CQI career pathways have been developed, particularly for Aboriginal and Torres Strait Islander health professionals.</p> <p>Training in CQI is part of GP professional (registrar) training.</p>	<p>There is continuing good uptake of university postgraduate and advanced VET sector courses.</p> <p>The primary health care workforce is trained in CQI at undergraduate and postgraduate levels.</p> <p>CQI career pathways, particularly for Aboriginal and Torres Strait Islander health professionals, are well established.</p> <p>Aboriginal and Torres Strait Islander health professionals are prominent in CQI leadership roles.</p> <p>GPs are trained in CQI.</p>

C13. Government policy

National and state/territory government policy is needed to guide the system development and investment needed to embed CQI in everyday practice at the primary health care provider level.

	Early results	Intermediate results	Long term results
State/territory and National	<p>Endorsement of the Framework by key organisations and committees has been obtained.</p> <p>There are state/territory and national investment strategies to support implementation of Framework core components.</p> <p>State/territory and national government policies, programs and contracts that are levers for implementation of Framework core components are being influenced.</p>	<p>There is coherent state/territory and national government policy and investment for implementation of the Framework core components.</p> <p>State/territory and national government policy and investment in Framework core components reflect input from key stakeholders.</p> <p>There is a developing body of evidence about the effectiveness of state/territory and national policy and investment in Framework core components.</p>	<p>There is ongoing coherent state/territory and national government policy and investment for implementation of the Framework core components.</p> <p>State/territory and national government policy and investment in Framework core components continue to reflect input from key stakeholders.</p> <p>There is a substantial body of evidence about the effectiveness of state/territory and national policy and investment in Framework core components.</p>

C14. Organisational partnerships

Organisational partnerships are formal arrangements within and between service sectors at the local, regional, state/territory and national levels. Effective partnerships establish trust and provide the mandates, structures and processes that enable CQI to function effectively. They specify goals and share accountability between organisations.

	Early results	Intermediate results	Long term results
Local, Regional, State/territory and National	<p>Opportunities for local, regional, state/territory and national organisational partnerships to support implementation of Framework core components within and between the ACCHS, general practice, and state/territory government sectors and other relevant stakeholders have been identified.</p> <p>Local, regional, state/territory and national partnerships among relevant organisations have been formed and are beginning to provide the mandates, structures and processes to support implementation of Framework core components.</p> <p>Existing local, regional, state/territory and national partnership arrangements are beginning to provide the mandates, structures and processes to support implementation of Framework core components.</p>	<p>Local, regional, state/ territory and national organisational partnerships engender trust and effectively support implementation of Framework core components.</p> <p>CQI is becoming embedded in local and regional partnership models of care.</p>	<p>Local, regional, state/ territory and national organisational partnerships engender trust and effectively support implementation of Framework core components.</p> <p>CQI is embedded in local and regional partnership models of care.</p>

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C15. Coordination and facilitation of implementation of core components

National and state/territory coordination and facilitation of implementation of Framework core components are needed to help ensure there is consistent uptake across sectors and levels.

	Early results	Intermediate results	Long term results
State/territory	State/territory coordination/facilitation roles to support implementation of the Framework core components within the ACCHS, general practice and government sectors have been established.	State/territory ACCHS, general practice and government coordination/facilitation roles are effective in supporting the implementation of Framework core components within and between sectors.	State/territory ACCHS, general practice and government coordination/facilitation roles are respected leaders of Framework core component implementation within and between sectors.
National	<p>A national implementation steering committee has been established.</p> <p>National coordination/facilitation roles to support implementation of Framework core components within the ACCHS, general practice and government sectors have been established.</p> <p>National guidelines for clinical governance for the ACCHS sector have been developed.</p> <p>A national CQI knowledge exchange mechanism has been established to support implementation of Framework core components.</p> <p>A CQI resources audit and needs assessment has been undertaken and priority resources have been developed.</p>	<p>The steering committee is trusted and respected in leading the coordination/facilitation of implementation of Framework core components.</p> <p>National non-government coordination/facilitation roles are effective in supporting implementation of Framework core components within and between the ACCHS and general practice sectors.</p> <p>The national CQI knowledge exchange mechanism is an effective CQI support and knowledge translation entity.</p> <p>CQI resources continue to be refined and developed and are widely used.</p>	<p>The steering committee continues to be trusted and respected in leading the coordination/facilitation of implementation of Framework core components.</p> <p>National non-government coordination/facilitation roles are respected leaders of Framework core component implementation within and between the ACCHS and general practice sectors.</p> <p>The national CQI knowledge exchange mechanism is widely recognised as a centre of excellence in CQI support and knowledge translation.</p> <p>CQI resources continue to be refined and developed and are widely used.</p>

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APPENDIX 1 – CONTEXT

The vision is being realised in the context of six issues:

1. Health gaps between Indigenous and non-Indigenous populations
2. Comprehensive primary health care approach
3. Complex primary health care service sectors
4. Variation in organisational capacity
5. System reform
6. Evidence base

1.1 Health gaps between Indigenous and non-Indigenous populations

The life expectancy of Aboriginal and Torres Strait Islander people is around 10 years lower than for other Australians (ABS 2013). Aboriginal and Torres Strait Islander people are also more likely to experience disability and reduced quality of life because of ill health. Historical factors including dispossession, interruption of culture, intergenerational trauma, and racism are associated with this disparity (Dudgeon et al. 2010).

Ongoing access to quality health services is one important contributor to improving the health and wellbeing of Aboriginal and Torres Strait Islander people (AIHW 2011). However, due to their poorer health status, it is estimated that Aboriginal and Torres Strait Islander people need access to quality health services 2–3 times more than other Australians but use health services at a lower rate (AIHW 2011). Evidence also suggests that Aboriginal and Torres Strait Islander people receive fewer procedures and prescriptions than non-Indigenous Australians with the same health conditions (AIHW 2011).

Addressing such disparities requires widespread action at multiple levels of government and organisational and community action. The Australian Government has given a commitment to closing the gap in Indigenous life expectancy within a generation and halving mortality rates for children under five within a decade (COAG 2008). In the context of health care, this commitment shifts the policy and service environment to a greater focus on improving quality and a reliance on measuring and monitoring change in outcomes over time. CQI processes have an important role to play in achieving this.

1.2 Comprehensive primary health care approach

Because of the health gaps described above, and their social determinants, the comprehensiveness of primary health care services for Aboriginal and Torres Strait Islander people is central to the delivery of the highest attainable standard of care. Primary health care is the first level of contact individuals, families and communities have with the health care system. A *comprehensive* approach to primary health care includes, health promotion, illness prevention, treatment and care of the sick, community development, advocacy, rehabilitation, inter-sectoral action and population health approaches. The National Primary Health Care Strategy (DOHA 2010) recognised this broad approach to primary health care to better tackle the health challenges of the 21st century. Based on the 1978 WHO Alma-Ata Declaration, *the Australian Primary Health Care Research Institute defines comprehensive primary health care:*

Primary health care 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 in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other

sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation. (PHCRIS 2015)

While this definition is broadly accepted, the comprehensive primary health care approach adopted by ACCHSs is somewhat broader in scope than most other primary health care models in Australia. In addition to primary clinical care and preventive and health promotion activity, ACCHSs usually include education and development in relation to workforce training, and governance and community capacity building (Wakerman et al. 2008). Ensuring access to culturally safe, affordable comprehensive primary health care for Aboriginal and Torres Strait Islander people wherever and whenever they seek care underpins all aspects of this Framework. The provision of this calibre of health care requires an intimate knowledge of the community and its health problems (NACCHO 2015a).

1.3 Complex primary health care sectors

Aboriginal and Torres Strait Islander people need good access to both Indigenous-specific and mainstream primary health care services. The Framework will be implemented in primary health care sectors that have different governance, funding, administrative and workforce arrangements. These differences result in differing capacities in scope of care, with different focuses, accountabilities and reporting systems. There is also variation in the approaches to health planning and support for service improvement at regional and state/territory levels.

ACCHSs are not-for-profit non-government services governed by community boards and funded *primarily* through block grants from the Australian government and Medicare income.

They range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, which rely on Aboriginal health workers and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus. (NACCHO 2015a)

Initiated by communities in the 1970s, they were both a reflection of the aspirations of Aboriginal people for self-determination and a response to the urgent need to provide decent, accessible health services to Aboriginal populations (NACCHO 2015b). They are responsive to community health needs, maximise community empowerment through participation (Dwyer, Shannon et al. 2007) and foster Aboriginal community governance and action (Couzos & Thiele 2009). A holistic view of health and the delivery of comprehensive primary health care are the cornerstones of their philosophy. In 2015 there were over 150 ACCHSs across the country. The ACCHS sector comprises local, and in some areas regional, organisations and is supported by state/territory peak bodies and NACCHO, which are very active in sector and service development and advocacy and provide a platform through which Framework core components can be implemented. The sector has built up a considerable amount of knowledge and expertise in CQI, both independently and through participating in Australian Government programs such as the Healthy for Life program (Lowitja Institute 2014).

General practice 'provides person centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities' (RACGP 2015). General practices are usually small businesses, owned and operated by one or more qualified General Practitioners (GPs). There are also some corporate shareholder-owned companies providing general practice and a few other models of corporate governance. They work with a range of other medical and allied health professionals, sometimes employed in the same service, but more often through private and public providers. General practices are

funded primarily through fee-for-service payments, and can set their own fees to the patient, who then receives a rebate from Medicare. The practice can choose to receive the patient rebate as full payment for the service. There are some extra incentive payments, but activities for quality improvement in practice are usually unfunded, and undertaken voluntarily through College accreditation and education programs. The independent nature of GP services means that there is currently no single platform through which the Framework core components can be implemented. The RACGP sets quality standards for practice, which encourage quality improvement systems, and many practices voluntarily undertake this. In addition, the RACGP and ACRRM have programs of CPD, which include quality improvement activities. In addition, the Colleges (and broader general practice sector) seek to advocate for measures that improve the quality of patient care. The AAPM and the APNA perform similar functions for their respective professions. Medicare Locals have been active in some areas in promoting quality improvement, a role that will continue under the newly formed PHNs. PHNs will support General Practice in attaining the highest standards in safety and quality through showcasing and disseminating research and evidence of best practice. This includes collecting and reporting data to support continuous improvement.

Primary health care delivery by state and territory governments is funded by those governments (in some cases supported by Medicare income) and varies considerably in terms of philosophy of care and the scope of services provided. A common feature of states/territories is regionality in the form of local health districts, though the relationships between health departments and regional entities also vary within and between states. Local health districts provide existing regional structures through which Framework core components can be implemented.

Adding to this complexity are other important providers including the autonomous RFDS which operates regionally and other NGOs and state/territory justice departments delivering care in corrections facilities.

In terms of Aboriginal primary health care generally, and CQI in particular, the funding models for the three main sectors present major challenges to primary health care providers in terms of their capacity to respond to clients' needs and embed CQI in everyday practice. However, they also provide opportunities for funding mixes, including incentive payments that could help to address those challenges in the years ahead.

Partnership arrangements among all the players at local, regional, state/territory and national levels vary across the country. As well, the new Australian Government regional players – PHNs – will have a range of responsibilities for the coordination of primary health care and CPD, particularly in regard to practice support, as stated above. Other relevant professional groups include AIDA, NATSIHWA, CATSINaM and IAHA.

All of this complexity makes not only for great opportunities but also for significant challenges for the successful implementation of this Framework.

1.4 Variation in organisational capacity

Primary health care providers across the sectors vary in terms of their external and internal environments such as geographical location, demography, funding sources, infrastructure and workforce (Davies et al. 2009). Organisational attributes such as geographical location and access to human resource capacity are recognised as significant barriers to healthcare quality (Dwyer, Wilson & Silburn 2004). In the review of the Aboriginal and Torres Strait Islander Primary Health Care Program in 2003, Dwyer and others suggest population size of communities has influenced the range of services that can be provided locally not only because of high cost but also for technical and workforce reasons (Dwyer, Wilson & Silburn 2004).

Gardner and others found that governance arrangements, infrastructure, staffing levels and continuity, leadership and management styles, as well as the characteristics of the local communities also impact on implementation of CQI (Gardner et al. 2010). Perhaps not surprisingly, evidence also suggests that services with limited capacity have difficulty recognising the benefits of CQI initiatives (Baillie et al. 2013b).

In all three sectors, primary health care providers cover a very wide range of services. Some are large enterprises that have the capacity and capability to provide a comprehensive range of primary health care services. At the other end of the spectrum are small enterprises offering very limited services, sometimes on an episodic basis. Those struggling with capacity issues, for whatever reasons, will need development and support, without which they cannot be expected to perform at the same level as higher capacity organisations. The Framework offers an opportunity to take a considered and coordinated approach to differences in capacity for CQI and the development requirements they impose.

1.5 System reform

Australia rates well in health system comparisons of OECD countries (OECD 2013) but it also faces significant challenges in large increases in demand for and expenditure on health care, unacceptable inequities in health outcomes and access to services, growing concerns about safety and quality, workforce shortages, and inefficiency.

As in other countries, there has been a growing policy focus on the management of primary health care and on improving quality and outcomes for patients. In 2011, the National Health Reform Agreements set out the intention of governments to work in partnership towards improving health outcomes for all Australians, and to ensure the sustainability of the Australian health system (Scott 2013). Several structural reforms have taken place since signing these agreements including the introduction of activity based funding, and the establishment of the National Health Performance Authority (NHPA 2013) and PHNs whose purpose is to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improve coordination of care to ensure patients receive the right care in the right place at the right time (DoH 2015).

Other significant reforms for quality include the establishment of the Australian Commission on Safety and Quality in Health Care in 2006 which leads and coordinates health care safety and quality improvements in Australia (ACSQHC 2015); and the introduction of a National Health Performance Framework, and national targets for Indigenous health (AIHW 2014). The introduction of financial incentive payments to general practices to improve adherence to best practice for certain services, and efforts to develop the Personally Controlled Electronic Health Record (PCEHR), secure messaging, electronic prescriptions and national authentication service for health (NEHTA 2015) are significantly shaping the local service environment for quality improvement.

There has also been extensive, but uncoordinated, national and state and territory investment in quality improvement programs in Aboriginal and Torres Strait Islander primary health care services and general practices in the last decade. This has in part resulted in high levels of variability in CQI practice and outcomes within and between sectors and as noted in the Stage 1 Report (Lowitja Institute 2014) has resulted in poor coordination and inefficiencies in resource use.

The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (Commonwealth of Australia 2013) provides a foundation for reform in Aboriginal and Torres Strait Islander primary health care by highlighting the importance of health equality and human rights, community control and engagement,

partnerships, a culturally respectful and non-discriminatory health system, effective and clinically appropriate care and evidence based practice.

1.6 Evidence base

There is a growing, but still relatively small, body of international and Australian evidence on the *effectiveness* of CQI. It indicates that CQI programs *can* be effective in improving the quality of patient care and client outcomes but there is wide variability in impacts within and between programs and limited understanding of the effectiveness of different strategies for change.

Much of the published evidence of the effectiveness of CQI programs in improving services for aboriginal populations comes from a small number of programs in Australia and in the USA. From Australian programs, studies indicate there has been extensive interest among ACCHSs and other primary health care services in formal CQI programs over the last decade (Bailie et al. 2007a, Schierhout et al. 2013) but only a small amount of evidence on sustained engagement in programs over time (Gardner et al. 2010). Available evidence from the major programs shows promising short term improvements in service systems (Bailie et al. 2007a, Bailie et al. 2007b), the quality of care processes (Bailie et al. 2007a, Bailie et al. 2007b, Bailie et al. 2009, Marley et al. 2012, Panaretto et al. 2013, , Stoneman et al. 2014), and selected client outcomes (Bailie et al. 2007a, Bailie et al. 2007b, Marley et al. 2012, Stoneman et al. 2014) but more limited evidence from which to draw firm conclusions about the impacts of these formal CQI programs over time (Matthews et al, 2014, Marley et al. 2012) .

For the bigger programs, almost none of the evidence is specific to different sectors as ACCHSs and government services have been reported together. There is a significant knowledge gap about program impacts over time and until more is known, it will be difficult to determine success factors and to explore how programs might be improved to support services to sustain quality improvement strategies into the future. The inclusion in the Framework of research, including monitoring and evaluation, will help to build the evidence base for CQI. Key areas for research include the impact of policy and investment on the effectiveness of CQI programs, and the role and impact of knowledge translation strategies, training, networks, partnerships, service support, clinical governance and consumer engagement on improving capacity for embedding CQI in everyday practice, improving care processes and client outcomes. Over time, as the evidence about the effectiveness of different CQI strategies builds up, it will become increasingly possible to better understand how and in what circumstances CQI leads to improved care and outcomes.

APPENDIX 2 – CQI, CLINICAL GOVERNANCE AND ACCREDITATION

In this appendix the relationships between CQI and clinical governance and CQI and accreditation are discussed.

2.1 CQI and clinical governance

CQI is a process nested within **clinical governance** that is in turn nested within organisational governance. Clinical governance is defined as:

The system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers, and for continuously monitoring and improving the quality of clinical care. (ACHS 2004)

Clinical governance involves formal structures and processes that attend to corporate (Board) and organisational governance and leadership, workforce capacity and competence, clinical leadership, clinical integration and coordination, clinical monitoring and evaluation including CQI, and client and community participation (IUIH 2012). It is the mechanism through which service quality and organisational quality are linked together. Without formalised structures and processes for clinical governance, CQI cannot be effective or become embedded in everyday practice (Phillips et al. 2010). For this reason, clinical governance at the service level is a core component of the Framework (Core Component 13). An important driver of CQI, and quality in general, is consideration of the costs and revenues connected with clinical service improvements.

2.2 Differences between CQI and accreditation

The Framework recognises clear distinctions between CQI and accreditation. While both are concerned with quality, CQI is the primary mechanism for achieving forward looking, continuous improvements in the quality of health care, based on team review of service and other data for improving clinical care and client outcomes. There are existing, widely adopted structures and processes for accreditation in Australian primary health care. The greatly expanded uptake of both 'organisational' and 'clinical' accreditation in the ACCHS sector over the past decade (supported in part by Australian Government funding through the Establishing Quality Health Standards Continuation (EQHS-C) program) is part of the context into which this CQI Framework is introduced. The Framework seeks to build on this platform of accreditation through a broader quality agenda.

Table 1 summarises the critical differences between CQI and accreditation (Sibthorpe & Gardner, in prep. 2015). While both are internally driven processes, accreditation is assessed externally and focusses improvements in organisational and clinical administration. Accreditation undertakes retrospective analyses, and is assessed and achieved (or not) against a set of standards. While it is a developmental process, ultimately there is a yes/no outcome in accreditation – either an organisation is accredited against one or more sets of standards or not. Accreditation and re-accreditation happen over long cycles of several years (commonly three).

Table 1: Critical differences between CQI and accreditation

CQI	Accreditation (Organisational and Clinical)
Focuses on improving client care and outcomes	Focuses on improving organisational and clinical administration
Determined by local needs and priorities	Determined by national and international consensus
Internally assessed	Externally assessed
Prospective and ongoing review	Retrospective review
Data for dialogue	Data for certification
Measures, including quality indicators, with changeable targets	Sets of standards
Results vary over time	Yes/no result
Short cycles	Long cycles

CQI on the other hand is internally assessed and focuses primarily on achieving improvements in client care and outcomes. It involves prospective, frequent, routine and ongoing PDSA cycles and other CQI activities. A large number of measures, including quality indicators, are used to continually review care. These are determined both internally and externally and may include benchmarks (reference levels) or targets (aspirational levels) that change over time. CQI cycles do not have overall yes/no outcomes but track changes over time. Results will vary due to changes in many factors – for example, to a service’s catchment population, profile of regular clients, staff availability, availability of other services, environmental factors and definitions of what constitutes best practice. Data are used to inform an internal dialogue about service quality. CQI cycles typically happen over shorter periods.

Both CQI and accreditation are however concerned with systems and this is where the *link*, but *not overlap*, between accreditation and CQI occurs. The other important link between CQI and accreditation is that participation in formal CQI processes is increasingly required for primary health care services to obtain and maintain accreditation.

APPENDIX 3 – KEY SYSTEM ATTRIBUTES FOR EFFECTIVE CQI

Five key attributes for effective CQI in Aboriginal and Torres Strait Islander primary health care have been identified and are briefly addressed below. They are:

1. Client and community centredness
2. Leadership
3. Organisational culture for CQI
4. Team Functioning
5. Systems thinking

3.1 *Client and community centredness*

Client-centred care is defined as ‘an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families’ (IPFC 2010). It is widely recognised as an important principle in the provision of quality health care, particularly in relation to the care of people with chronic conditions (Rathert, Wyrwich & Boren 2013, Raven 2015:3). Rather than providing care ‘to’ or ‘for’ people, patient-centred care aims to provide care ‘with’ people (Health Foundation 2014a). It is about being respectful of and responsive to the preferences, needs and values of patients (clients), consumers, families and communities (IPFC 2011).

In Aboriginal and Torres Strait Islander primary health care emphasis is placed on the importance of a family (community) centred focus and approach (Griew et al. 2007). Family-centred primary health care for Aboriginal and Torres Strait Islander people takes a life course approach focussing on establishing early life resilience and advantages in child development in an attempt to draw education and family welfare, usually considered to be part of the social determinants of health, into the foreground of primary health care practice (Griew et al. 2007, Australian Government & Closing the Gap 2013). Client-centred factors associated with successful local level primary health care interventions for Aboriginal and Torres Strait Islander people include:

- genuine local Aboriginal and Torres Strait Islander community engagement to maximise participation, up to and including full Aboriginal community control,
- a multidisciplinary team approach, including employing local community members, and
- service delivery that harmonises with local Aboriginal and Torres Strait Islander ways of life (Griew et al. 2008).

Several definitions of client and community-centred care reflect these and other factors as follows:

- Informing and involving clients,
- Eliciting and respecting client preferences,
- Engaging clients in the care process,
- Treating clients with dignity,
- Designing care processes to suit client needs, not providers,
- Ready access to health information, and
- Continuity of care (Robb & Seddon 2006, IAPO 2007).

Client-centred care and community participation are likely to be achieved differently in different sectors.

In Australia, the client and community centred approach to health care is now widely reflected, including in national service-level initiatives, strategies and policies such as the Australian Charter of Healthcare Rights (ACSQHC 2008a), the Fourth National Mental Health Plan (DoH 2009), the National Chronic Disease Strategy (DoH 2010), the National Safety and Quality Framework (ACSQHC 2010), the National Primary Care Strategic Framework (DoH 2013), and the Fifth Community Pharmacy Agreement (DoH 2014). The National Aboriginal and Torres Strait Islander Health Plan also reflects client-centred principles and a focus on family and community (Commonwealth of Australia 2013).

Benefits of a client and community centred approach include improvements in quality and safety of health care, reduction in health care costs, and increased provider and patient satisfaction (Stewart et al. 2000, IAPO 2007, IPFC 2010, Longtin et al. 2010). Other benefits associated with client and community centred care include decreased mortality (Schneider et al. 2001), fewer medication errors, lower infection rates (Arnetz et al. 2010), and improved clinical care (Glickman et al. 2010).

In the care of patients with chronic conditions, patient-centred approaches can improve disease management, increase both patient and doctor satisfaction, increase patient engagement and task orientation, reduce anxiety, and improve quality of life (Safran, Miller & Beckman 2006, Meterko et al. 2010, Boulding et al. 2011). Client and community centred care can also increase efficiency through fewer diagnostic tests and unnecessary referrals, and reduce hospital attendance rates (Safran, Miller & Beckman 2006, Meterko et al. 2010). Client and community centred care is therefore regarded as an integral component of preventative care (DiGioia III, Greenhouse & Levison 2007, Meterko et al. 2010).

3.2 Leadership

There is now a substantial literature that identifies the importance of leadership in the implementation of improvements both at the systems level (Greenhalgh et al. 2004, Best et al. 2012) and at the practice level (Grol & Jones 2000, Grol & Grimshaw 2003, Grol et al. 2013). The Stage 1 Report (Lowitja Institute 2014) identified the importance of leadership of different kinds at all levels, recognition of the leadership role played by the ACCHS sector in delivering primary health care to Aboriginal and Torres Strait Islander people and the development of leadership roles for Aboriginal and Torres Strait Islander health professionals.

Leading improvement across complex interdependent systems of care has been recognised internationally as a new and different role (Fillingham & Weir 2014). Both designated and distributed leadership are essential – that is, someone formally in charge of the change effort ('designated') and professionals and partner organisations who share responsibility for mobilising effort and delivery ('distributed'). Leadership commitment to quality improvement is necessary for 'health care to achieve and sustain the elusive goal of consistent excellence in safety and quality' (Chassin & Loeb 2011:566).

The actions of senior leaders create many of the conditions that constrain and enable lower-level leaders to act. Committed leaders can increase the staff perception of CQI as an important activity, and further motivate staff to participate by providing non-monetary rewards such as personal recognition for staff achievements, career promotion and skill development opportunities (Graber & Kilpatrick 2008). Clinical leadership is recognised as fundamental for driving service redesign and improving patient outcomes at the service level (Garrubba, Harris & Melder 2011, Zachariadis et al. 2013).

3.3 Organisational culture for CQI

There are a number of different ways to conceptualise organisational culture in health care. One common approach depicts organisational culture as a set of attributes that emerge from what is shared between

colleagues in an organisation, including their shared beliefs, attitudes, values, and norms of behaviour. That is, organisational culture reflects a common way of making sense of the organisation that allows people to see situations and events in similar and distinctive ways. In lay terms organisational culture captures 'the way things are done around here' (Davies, Nutley & Mannion 2000:112).

With respect to CQI, some features of organisational culture are seen as helpful for embedding quality and improvement processes (Shortell et al. 1995, Sun, 2008) whereas others are thought to mitigate against it. A participative, flexible, risk-taking organisational culture has been significantly related to quality improvement implementation in primary health care settings (Shortell et al. 1995). Conversely, key factors that appear to impede culture change across a range of sectors include inadequate or inappropriate leadership, constraints imposed by external stakeholders and professional allegiances, perceived lack of ownership, and cultural diversity within health care organisations and systems (Scott et al. 2003).

It may be possible to cultivate organisational conditions that 'enhance the possibility of innovation occurring and spreading' (Greenhalgh et al. 2004). Research has shown that some sort of quality 'council' made up of the institution's top leadership, a link to key elements of the organisation's strategic plan, personnel policies that motivate and support staff participation in process improvement, training programs for personnel, and staff support for process analysis and redesign are essential elements (Sollecito & Johnson 2013). Institutional commitment rather than ad hoc support (Lowitja Institute 2014) and at the practice level, a culture that allows risk taking and supports a 'no-blame' systems thinking approach (see 3.5 below) are seen as critical features.

3.4 Team functioning

CQI is underpinned by a philosophy that emphasises the importance of organisational commitment and whole team involvement to improve service systems and processes for delivering care. Teams are necessary to deliver comprehensive primary health care, especially for chronic disease. In the area of quality improvement, the team is the primary vehicle through which problems are analysed, improvements are generated and change is evaluated (Sollecito & Johnson 2013).

Qualitative studies cite the presence of strong CQI teams and collaborative teamwork as crucial factors in successful programs (Fox et al. 2007, Chin et al. 2008, Gardner et al. 2010, Lob et al. 2011). Likewise, lack of teamwork is a barrier to CQI (Lowitja Institute 2014). Formation of process improvement teams with an emphasis on the importance of empowering people to deal with existing problems and opportunities is needed (Sollecito & Johnson 2013).

3.5 Systems thinking

CQI has a system focus. It is distinguished by its emphasis on avoiding personal blame and its focus on the managerial and professional processes associated with a specific outcome (Sollecito & Johnson 2013). CQI places responsibility for ownership of a process in the hands of its implementers, since it is the people involved in the process who are regarded as best able to identify how to approach a problem and to develop and become part of a solution, but management is ultimately responsible for change.

Systems thinking 'involves in-depth consideration of the linkages, relationships, interactions and behaviours among the elements that comprise a complex adaptive system—i.e., one that self-organises, adapts, and evolves with time' (De Savigny & Adam 2009) It is defined as:

the ability to recognize, understand, and synthesize the interactions, and interdependencies in a set of components designed for a specific purpose. This includes the ability to recognize

patterns and repetitions in the interactions and an understanding of how actions and components can reinforce or counteract each other. These relationships and patterns occur at different dimensions: temporal, spatial, social, technical or cultural. It is fundamental to undertaking specific methodology or strategies to explore and redesign a set of components comprising a whole. (Dolansky & Moore 2011: 5)

System effectiveness is a priority of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (Commonwealth of Australia 2013).

Draft for consultation

APPENDIX 4 – CORE COMPONENT SUPPORTING INFORMATION

Below is a **brief** summary of the international and national literatures (journal articles and reports), extensive consultations in Stages 1 and 2 of Framework development (through workshops and key informant interviews) and the combined knowledge and experience of the project team.

C1. Cultural safety and competence

Cultural safety and cultural competency are related but different concepts. Cultural safety aims to improve the health outcomes of Indigenous and diverse populations (Johnstone & Kanitsaki 2007). It developed as a concept in nursing practice in New Zealand with respect to health care for Maori people (Wepa 2015) and is defined as,

[A]n environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening. (Williams 1999: 213)

Cultural safety centres on the experiences of the client (AIDA & RACP 2004). It develops the idea that to provide quality care for people from different ethnicities and cultures, health practitioners should reflect on their own cultural identity and recognise the impact their culture has on their own health practice. As such, cultural safety is about educating the health practitioner to become open minded and non-judgmental; to understand, rather than blame, the victims of historical and social processes for their current situation; and to encourage a better understanding of poverty and its impact on people (Ramsden 1992, Jeffs 2001).

Cultural competence, on the other hand, has its origins in the USA (Betancourt et al. 2005) and is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services (NHMRC 2005).

A health system that is culturally safe and competent:

- Helps health providers and consumers to achieve the best, most appropriate care and services
- Enables self-determination and ensures a commitment to reciprocity for culturally and linguistically diverse consumers and their communities, and
- Holds governments, health organisations and managers accountable for meeting the needs of all members of the communities they serve (NHMRC 2005).

Unfortunately, published evidence of the benefits of cultural safety is scarce (Brascoupé & Waters 2009). The most concentrated investigation of the applicability of culturally safe practice is found in literature from the New Zealand and Australian health care field, largely focused on nursing. Even here, the evidence is largely qualitative and anecdotal. The body of literature examining wider issues of culture in health care delivery, focusing in particular on cultural competence, is more extensive and shows that cultural consideration improves health outcomes (Brascoupé & Waters 2009).

There is a great deal of existing work in this area to build on. A national cultural respect framework is currently being updated and most of the key stakeholder organisations already have cultural safety frameworks of some description. Many of these will already fit-for-purpose in terms of this core component, while some may need to be modified. An important contribution to consistency in approach and assessment of effectiveness through the Framework will be the development of national standards and measures for cultural safety and competence. As well, national identification/development and

endorsement of accredited cultural safety and competence training options appropriate for different sectors and levels and the development of resources to support organisations to be culturally safe and competent are identified as early results. All organisations at all levels are expected to implement strategies to ensure they are culturally safe and competent, including in implementation of Framework core components.

C2. Client and community participation

Aboriginal and community participation is central to the successful implementation of this Framework.

The importance of client and consumer participation in primary health care was recognised many years ago in the Declaration of Alma Ata and the Ottawa Charter for Health Promotion (WHO 1978, 1986). In Australia, client and community participation is reflected in the National Safety and Quality Health Service Standards, accreditation requirements and the National Aboriginal and Torres Strait Islander Health Plan (ACSQHC 2011, Australian Government & Closing the Gap 2013). While there is policy support for client, public or community participation in health services in Australia, it is unclear at the local level how participation is enacted and about the role of community, consumer or user representatives in health service processes. There also appears to be differences in perspectives between staff and health service-users about the purpose and scope of client and community participation (Rutter et al. 2004).

Research demonstrates that people become involved in safety and quality in health care in the following areas (ACSQHC 2008b):

- Individual care – where clients are involved in their own individual care
- Program, institutional or departmental involvement – where clients, carers, consumers and community members are involved in decision making about health care service or institutional redesign and safety and quality improvement. This involvement is at the program, institutional or organisational level rather than the individual level, and
- Setting the strategic direction/governance – where clients, carers, consumers and community members are involved in setting the strategic direction and the governance of safety and quality issues across the health system.

There are five levels of involvement ranging from low-level involvement (Level 1) and influence to high levels of involvement and influence (Level 5). The levels of participation needed to embed CQI in primary health care includes:

- Level 2 – gather information, for example establishing a consumer advisory committee
- Level 3 – discuss, for example establish a panel of consumer experts to discuss CQI strategies
- Level 4 – engage, for example public consultation processes, and
- Level 5 – partner, for example partnerships with consumer organisations.

A small but significant body of evidence demonstrates client and community participation in primary health care is associated with improved health outcomes (Bath & Wakerman 2013). In activities where client and community participation was a means to achieve a defined end there was reported reductions in neonatal mortality (Manandhar et al. 2004, Bhutta et al. 2008), a reduction in perinatal mortality and child growth faltering (O'Rourke, Howard-Grabman & Seoane 1998, Warchivker & Hayter 2001) and an increased utilisation of antenatal and perinatal care and diabetes mellitus prevention (Kibria et al. 2011, Oba et al. 2011). In activities where there was substantive client and community participation (i.e. where community

members are actively involved in determining priorities and implementing solutions), there appears to be an association with improved health outcomes (Sare & Kirby 1999, Hancock et al. 2001, Nikniaz & Alizadeh 2007, Draper, Hewitt & Rifkin 2010), service quality (Uddin et al. 2001), and access (Tyrrell et al. 2003). In terms of client and community participation, much of the literature documenting this type of participatory mechanism comes from the Aboriginal community controlled sector and is associated with improved health outcomes (Chandler & Lalonde 1998, Rowley et al. 2000, Lavoie et al. 2010).

The approach taken within the Framework is for participation at the national, state/territory and regional levels to focus on the participation of community representatives in relevant structures and processes, while at the local primary health care provider level the focus is on participation of clients and community members.

C3. Access to CQI skills

Workforce access has two aspects: access to the staff needed to deliver a quality service; and access to personnel with the skills necessary to continually assess the quality of the service being delivered (undertake CQI). With respect to the first aspect, it is acknowledged that organisational attributes such as geographical location and access to human resource capacity are significant barriers to quality healthcare (Dwyer, Wilson & Silburn 2004) and primary health care providers struggling with such issues will need capacity development and support, without which they cannot be expected to perform at the same level as higher capacity organisations. However, this core component is primarily about the second aspect – primary health care providers having access to the knowledge and skills necessary to embrace CQI and embed it in everyday practice.

Within hospitals, research suggests that a lack of knowledge and skills among clinicians and managers is a significant barrier to improving quality in healthcare (Devitt & Murphy 2004, Audet et al. 2005, Neale, Vincent & Darzi 2007). CQI is a team function, so embedding CQI in everyday practice requires everyone – health professionals, managers, leaders and administrative and support staff – to learn and apply new knowledge and skills. To work efficiently, CQI teams need diversity: people with different skills, experience, knowledge and viewpoints. PDSA cycles require knowledge and skills in the concept of quality improvement; clinical data extraction, analysis and interpretation; managing group processes; best practice/evidence-based care; system redesign; change management; the social context of health; and client and community needs and attributes. In turn, CQI is a part of clinical governance which involves clinical audits, guidelines, quality improvement frameworks, performance management approaches, incentives and organisational governance and leadership.

The core competencies deemed necessary to embed these techniques and processes range from practice-based learning and improvement, systems-based practice, patient-centred care, teamwork and collaboration, evidence-based practice, quality improvement, safety and informatics (Djuricich, Ciccarelli & Swigonski 2004, ACGME 2008, Barton et al. 2009, Preheim, Armstrong & Barton 2009, Spencer 2009, Wittich et al. 2010). The Institute for Healthcare Improvement also describes eight domains of quality improvement knowledge: customer/beneficiary knowledge; healthcare as process/system; variation and measurement; leading and making change in healthcare; collaboration; developing new, locally useful knowledge; social context and accountability and professional subject matter (Batalden et al. 1998).

All the personnel who are directly involved with the health issue under study should be involved in PDSA processes, and in some cases expertise might need to be co-opted. For example, a PDSA on hearing health may need input from an audiologist or ENT specialist from outside the centre.

Of all the skills listed above, clinical data extraction, analysis and interpretation for CQI received the greatest amount of attention in the Stage 1 consultations and anecdotal evidence indicates that it is a major barrier to CQI across all three sectors. Consequently there is a very considerable amount of skills development needed in this critical area. This development, as well as development of the other knowledge CQI skills, will need to occur through a combination of professional training (C12), continuing professional development (CPD) through service support (C8) and experiential learning on the job.

Access to personnel CQI knowledge and skills might be compromised because personnel with the required skills are simply not available in the regional or local area, primary health care providers do not have the financial capacity to hire them, or they can hire them but they do not stay. Staff turnover has been identified as a particularly important barrier to CQI in Aboriginal and Torres Strait Islander primary health care services (Chin et al. 2008, Gardner et al. 2010). A practical solution to problems of availability and/or capacity to hire might involve pooling of funds and shared positions, within and possibly between sectors.

C4. Clinical data infrastructure and functionality for CQI

The quest to use health information technology (IT) specifically electronic health records (EHRs), to improve the quality of health care throughout the health care delivery continuum is a consistent goal of health care providers, national and local policy makers, and health IT developers. The seminal Institute of Medicine (IOM) report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM 2001, Bloom 2002), was a call for all health care organisations to renew their focus on improving the quality and safety of patient care in all health care delivery settings. Since the IOM report, the health care industry has emphasised the design and implementation of health IT that supports quality improvement and quality monitoring mechanisms in all levels of the health care delivery system.

Measurement is a fundamental part of CQI and review of data is a critical, non-negotiable step in PDSA cycles. EHRs are essential. EHR software and extraction tools need to allow members of health care teams to readily interrogate their clinical data on a day-to-day basis to review care and outcomes and to have user-friendly reports that can be a basis for dialogue in clinical teams and with others in the organisation, from Board members to support staff.

Further, evidence suggests that high performing primary health care organisations monitor progress by using data systems for clinical care, operational performance and client experience. For example, how well EHRs link to other service data is a strong influence on what can be achieved in relation to delivery of good chronic illness care. A supportive IT system is a key pillar of the evidence-based Chronic Care Model (Wagner et al. 2001), endorsed by several Australian health departments and other agencies.

Within the sectors and primary health care providers delivering care to Aboriginal and Torres Strait Islander people there are very significant problems relating to clinical data, structure and functionality for CQI. These include a range of different software packages with different ways of capturing and coding information, variations in the extent to which EHR data link to other service data such as billing data, variations in the user-friendliness of extraction tools, proliferation of home-grown modifications to data bases and extraction tools, and limitations in the ease of interpreting data extraction outputs. The Framework should drive improvements in clinical data infrastructure and functionality to support CQI and achieve efficiencies in reform. A national review of clinical data infrastructure and functionality for CQI, national guidelines and a nationally coordinated plan to improve clinical data infrastructure and functionality for CQI are Framework early results. These will help ensure some consistency in reform of interoperability, data capture, data extraction and reporting and help reverse the current inefficient

dilution of knowledge and skills as staff move between EHR systems and extraction tools within and between sectors. Effective relationships with software and extraction tool providers will be keys to success, as will the involvement of the National e-Health Transition Authority (NeHTA).

Having effective and efficient EHRs and data extraction tools is one thing, while ensuring they are used effectively is another. It is widely recognised that a considerable amount of work needs to be done to improve staff skills in data entry, extraction analysis and interpretation. This core component therefore has strong links to professional training (C12) and service support (C8).

C5. Clinical governance

Clinical governance is promoted as the systematic and integrated approach to assuring safe, good quality care (Phillips et al. 2010). It acknowledges the importance of clinical leadership but also makes explicit the importance of broader dimensions described in the health care improvement literature. However, the way change at the practice, or micro, level can best be supported by actions at the meso and macro levels to facilitate a coherent approach to clinical governance is yet to be explored (McDonald et al. 2007, Gardner et al. 2010, Gardner et al. 2013).

Clinical governance is defined as the:

system by which the governing body, managers and clinicians share responsibility and are held accountable for client care, for minimising risks to [clients], and for continuously monitoring and improving the quality of clinical care. (ACHS 2004:4)

It includes formal structures and processes that attend to corporate (Board) and organisational governance and leadership, workforce capacity and competence, clinical leadership, clinical integration and coordination, clinical monitoring and evaluation including CQI, and client and community participation (IUIH 2012). Elements of clinical governance commonly include education, clinical audit, clinical effectiveness (evidence-based practice), risk management, research and development and openness (RACGP 2010).

Clinical governance is the mechanism that links organisational governance and management with clinical care; accreditation with CQI. Through clinical governance, Boards and senior managers and clinicians can act as champions and opinion leaders to drive a whole of organisation approach to quality including CQI. The processes of clinical governance can be supported by effective integration with financial governance processes including collaboration between professional staff in lead clinical roles and others such as practice managers with responsibilities for tracking income and expenditure.

There is no published evidence about the extent to which formal clinical governance has been taken up in the ACCHS sector but all the anecdotal evidence indicates that it is relatively underdeveloped, except in a few places. A trend seems to be developing of services and regions that have CQI firmly embedded in everyday practice moving on to formalise clinical governance structures and processes – in this way clinical governance can be seen as a measure of increasing sophistication of an organisation's quality agenda. Since many ACCHSs undergo clinical accreditation against RACGP standards, an important driver for clinical governance is the Clinical Governance criterion (Section three: Safety, quality improvement and education; Criterion 3.1.3; RACGP 2010).

While clinical governance is shown as a primary health care provider responsibility, it is recognised that in some cases regional organisations might have quite direct involvement in clinical governance, for example through management of networks of lead clinicians. As well, they might provide more indirect support for

clinical governance. Support will be critical to embedding both clinical governance and CQI in everyday practice over the coming years so this core component has strong links with service support (C8), both a regional and state/territory level responsibility. An early result for coordination and facilitation of implementation of core components (C15) is the development of guidelines for clinical governance for the ACCHS sector to facilitate progress in this important area.

An important driver of CQI, and quality in general, is consideration of the costs and revenues connected with clinical service improvements. An example is the relationship between Medicare Benefits Schedule (MBS) items and strengthening the quality of client care. The use of Health Assessments, GP Mental Health Treatment Plans and Chronic Disease Management items enable high quality health care while adding to the revenue of the primary health care provider. A primary health care provider could use CQI feedback processes and population health data to better identify the extent to which it is reaching its catchment population and effectively utilising MBS items. The provider could then make changes to its service model, which could result in increased episodes of primary care and MBS income. MBS income can then be reinvested in the service for expansion or improvement in systems and service delivery.

C6. CQI leads

Implementation of complex interventions requires leadership at multiple levels of the health care system. Both designated and distributed leadership are central to the successful implementation of system-wide improvement efforts, as has been highlighted elsewhere in this Framework.

Good leaders help to foster teamwork by clearly defining roles, responsibilities and objectives for team members, setting structured time aside for CQI activities and motivating teams to participate in CQI activities (Wang et al. 2004, Gardner et al. 2011). Clinician champions can also play a critical role in motivating staff participation as can dedicated clinic managers or administrative staff who help support CQI teams by ensuring that service priorities are translated into actions, and by holding the team accountable for CQI processes (Wang et al. 2004, Bray et al. 2009, Gardner et al. 2010).

Appointment of designated quality leads, whether at the individual primary health care provider level and/or at the regional level aims to ensure that CQI activities have a 'driver' and can be embedded into routine practice over time. Quality leads need to be highly respected, internally recognised and externally networked so they have authority among their peers and in the system more broadly to implement CQI. Aboriginal health professionals being in quality lead roles can help to ensure cultural safety and competence (C1), client and community participation (C2) and sustainability of CQI since they are often among the more stable, long-term employees. This core component also has links with service support CPD (C8) and professional training (C12).

C7. PDSA cycles

At the service level, many different strategies are used in CQI programs but the key is the PDSA cycle which involves CQI teams in using measurement and problem solving strategies to identify sources of variation in care processes and to design, implement and test strategies for improvement. The original PDSA model was developed in the 1920s by Walter Shewhart, a quality engineer who studied variation in practice (Shewhart 1931). He determined that by standardising procedures, unacceptable variation could be minimised.

Although many different techniques for conducting PDSA now exist in healthcare settings, they share a common set of principles and practices, articulated by Langley and Nolan (1992), in their basic

improvement model. All other models are now based on this successful model. Use of this model enables services to:

- Take a simple approach,
- Start small,
- Plan, develop and implement change that can lead to improvement,
- Involve the whole team in redesigning health systems and care processes to achieve improvements, and
- Engage teams in a continuous and incremental stream of improvements over time.

PDSA focuses teams on making small changes, adjusting these, observing consequences of actions taken and documenting these so that learning can accrue. PDSA is conducted in rapid cycles which typically happen over short periods such as fortnightly or monthly cycles but longer cycles can also be used. Existing CQI programs employ both short and long cycles: for example, APCC uses rapid cycles and One21Seventy audit tools are based on annual cycles of data collection, systems assessment and action planning. Short PDSA cycles can be effectively nested within longer cycles of comprehensive file audits, such as those of One21Seventy. For example, One21Seventy audits can highlight the areas needing improvement through PDSA cycles. Some services currently use both programs and there is further scope for services to use such a combination of methods for different topic areas.

The steps in the PDSA cycle are described below:

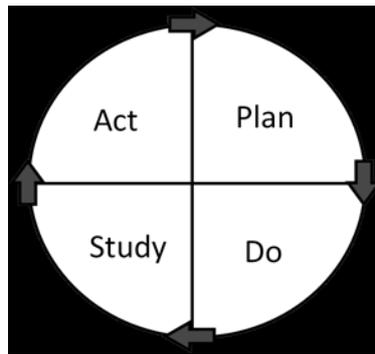
The first step in implementing a PDSA is **Plan: use data to identify what needs to be improved; discuss what changes could be made; prioritise, set objectives for action; and agree on what data and information are going to be reviewed to measure progress.**

The second step is **Do: Carry out the changes and collect data.** During the 'Do' phase of the PDSA cycle, the team carries out the plan according to the detailed action plan developed in the planning phase. The team will need to support the implementation of the plan, making adjustments if necessary and monitoring the change process.

The third step is **Study: At a meeting of the whole team, review results, reflect on data and discuss what might be contributing to the observed results as well as how the change process proceeded.**

Team discussions facilitate processes of interpretation and action planning and should be concerned with the details of what performance indicator data show (e.g. What proportion of clients who are identified as having risk factors for chronic disease have had a brief intervention in the past 12 months?) Local knowledge on what is impacting a result is essential for interpreting what the data means and will help to inform whether an action or change process has been successful and/or whether a new action might be required to improve practice and if so, what that action/s should be taken.

In this phase **Act: The team implements the new changes and decides on the next set of actions to be taken and (return to step one.)**



After having reviewed all the information collected, the team will decide whether to adopt the change, whether to adapt the change or whether to abandon it altogether. If changes are to be adopted, there will usually be a focus in this stage on making the change a part of routine practice or rolling the change out more broadly or on a larger scale.

A range of measures, including quality indicators will be used during PDSA cycles. Over time it will be important to have a bank of quality indicators that cover all the main priorities in Aboriginal and Torres Strait Islander health care (see C10 CQI data sharing and sense-making).

Within the Framework, PDSA cycles are the responsibility of primary health care providers, but they may also be usefully integrated into the CQI activities of organisations at other levels to support effective implementation of Framework core components.

C8. Service support

International evidence demonstrates that CQI can achieve significant improvements in care and outcomes for Indigenous and underserved populations (Chin et al. 2004, Din-Dzietham et al. 2004, Hupke et al. 2004a, b, Wang et al. 2004, Chin et al. 2007, Fox et al. 2007, Landon et al. 2007, Grossman et al. 2008, Lob et al. 2011). However, CQI is a complex intervention that requires individuals, teams, services and organisations to work at multiple levels of the health care system to achieve improvements. As a consequence, many health improvement efforts struggle to achieve their goals, in part because of contextual factors or technical problems that impede implementation but also because such projects face adaptive challenges that are difficult to address (Pronovost & Jha 2014). Adaptive challenges are those that can only be addressed through changes in people's priorities, beliefs, habits and loyalties (Heifetz, Grashow & Linsky 2009). Translating evidence into practice and embedding CQI in everyday practice are two such challenges, requiring institutions, organisations, services, teams and individuals to work together with patients and technologies across existing boundaries to redefine work processes and care pathways. Challenges in engaging partners, surmounting multi-organisational disconnects, unstable professional legitimacy, ambiguous information and information systems, workforce turnover and shifting needs point to the importance of relational, organisational and institutional strategies for supporting CQI and building capacity within services to embed it in everyday practice.

With respect to CQI in ACCHSs, multiple barriers to implementation have been observed: at the macro level, resource constraints (workforce issues) and inadequate access to project support (CQI coordinator); at the meso level, senior level management and leadership for quality improvement and organisational readiness; at the micro level, knowledge, attitudes and need for assistance with data entry, information systems and technical expertise for data analysis and synthesis and lack of team tenure are important barriers (Newham et al. 2015). At the local ACCHS level, ownership of the CQI process, timely data collection, openness to admitting deficiencies and willingness to embrace change facilitates CQI practice

(Stoneman et al. 2014). In general practice settings, local support of practice teams is instrumental for improvement and enthusing, and training and resourcing practice teams is key to rapid change (Knight et al. 2012).

Services have different levels of capacity to mobilise resources to support implementation, and there is great variation between primary health care providers in governance arrangements, infrastructure, staffing levels and continuity, leadership and management styles, as well as in the characteristics of the local communities served (Gardner et al. 2010). Building capacity requires different forms of leadership, organisational linkages and collaborations as well as data know-how, operational clinic teams and a mandate from senior management. Support of organisations, primary health care providers, teams and individual health professionals that is tailored to meet specific needs and different levels of CQI capacity, is therefore essential for supporting services to embed CQI in everyday practice.

International studies show that services with more established CQI programs appreciate continuous guidance and follow-up from the CQI program/research teams (Fox et al. 2007, Lob et al. 2011). In addition to providing expert feedback, CQI program teams gave substantial support in the form of training in CQI activities, technical assistance with patient information systems, assistance with analysing and understanding data, providing new tools (such as patient registries or guidelines), and facilitating collaboration between new services and other services with more experience in CQI.

Adequate training for staff is a key requirement and is cited as a critical element for sustained CQI success in the Stage 1 Report (Lowitja Institute 2014) and in the international literature on CQI. Most CQI programs provide initial training sessions as well as ongoing training sessions for staff, but it is also suggested that staff should be cross-trained so that people on different teams are able to carry out different CQI activities such as entering data and leading PDSA cycles (Wang et al. 2004, Lemay et al. 2010). Regular training sessions provide staff with access to the knowledge of more experienced CQI teams from other services, which can accelerate learning and generate new ideas. Training is an essential element of service support and has been highlighted in consultations undertaken during Stage 1 and in interviews conducted for this stage of Framework development. It can be offered as ongoing informal support for individual capacity building, as CPD (C8) and as part of professional training (C12).

Other areas highlighted by key CQI support staff in the ACCHSs emphasised the importance of:

- Fostering leadership and commitment of Boards, CEOs and middle management,
- Board and staff training,
- Engaging Aboriginal and Torres Strait Islander workforce in CQI,
- On-ground support for CQI leads,
- Access to tools and resources,
- Assistance with extracting, interpreting and analysing data and using it to drive service improvements, and
- Structured, planned and purposeful data sharing to build engagement and knowledge for CQI.

Within the Framework, regional and state/territory representative organisations, as well professional organisations all have key roles to play in service support.

C9. Managed CQI networks

Internationally, there is a growing interest in networks as a mechanism to support improvement in health care:

Properly designed, improvement networks provide an in-built mechanism to spread successful change quickly, leveraging the power of social and professional connections rather than relying on the formal chain for command of a hierarchical organization. (Health Foundation 2014b: 4)

To date there has been limited *systematic* support for networks as a mechanism to support quality improvement in Aboriginal and Torres Strait Islander primary health care. This has meant that networks that have been established have been difficult to sustain. It has also meant that their scope has necessarily been directed by the requirements of funders or auspicing organisations. For example, some CQI networks in Aboriginal and Torres Strait Islander primary health care have focused on the needs of a specific sector or group, whilst others have had a research focus. It is difficult for these kinds of networks to provide a neutral environment for collaboration across different constituencies and disciplines. From the consultations, front-line service providers who had been part of 'collaborative' efforts (such as those run by Aboriginal Medical Services Alliance of the Northern Territory, AMSANT), highlighted that peer-to-peer sharing supported by networks has been particularly valuable in relation to CQI. There was hope expressed that a national framework would profile this function, and extend it to other regions and levels of the system.

Distinctive features of networks for improvement have been described (Figure 2). International evidence suggests that not all CQI networks function equally well. Effective networks have a common purpose, a cooperative structure, critical mass, collective intelligence and community building (Health Foundation 2014b). In the CQI context, networks need to be 'managed' networks, not 'natural' networks (these will exist anyway), and they need to be well supported and resourced, with an identifiable network leader and protected staff time. The network must develop a well-organised work plan with identified deliverables or targets, and there is a need for ongoing monitoring and evaluation of performance. More effective networks also have resources to bring network members together through regular meetings, preferably with some face-to-face meetings. Resources are also required to achieve work plans. They have strong, effective communication and engagement across members and stakeholders, as well as brokerage and bridging roles to ensure dissemination of information in and out of the network. Effective CQI networks will also need to engage with clinical experts and researchers to ensure that their work is cutting-edge and evidence-based. The networks should include consumer representation and multidisciplinary clinical and non-clinical (e.g. organisational or service planning) representation. Clear articulation of the core purpose and activities of networks at different levels will help to guide decisions about the appropriate structure and governance of the networks (Health Foundation 2014b).

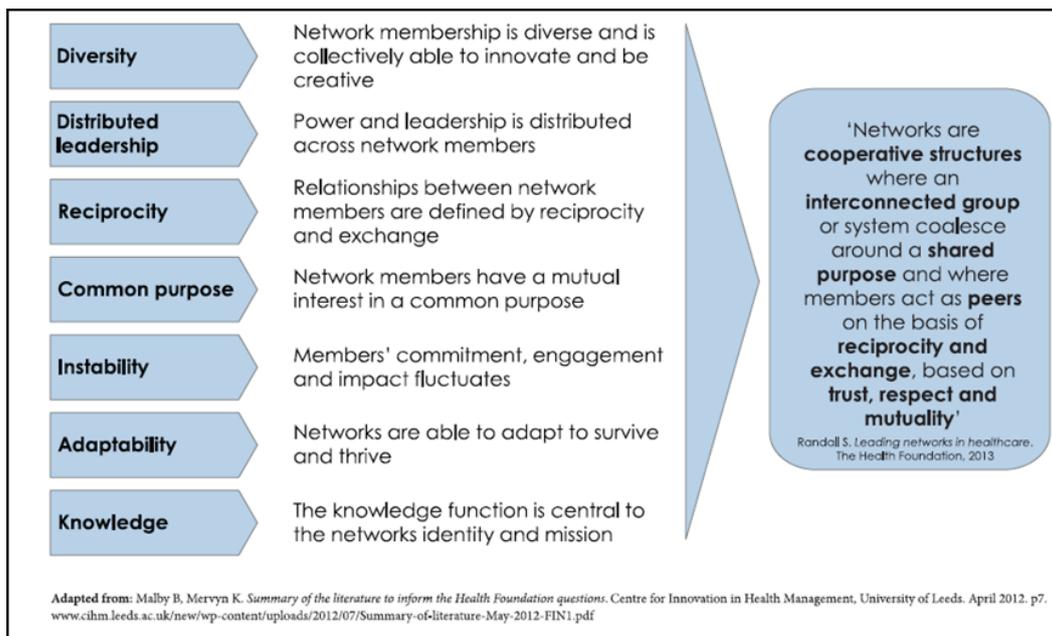


Figure 2: Distinctive features of networks for improvement

Given the diversity in the Framework implementation environments within and between sectors, multiple networks will be needed at national, state/territory and regional levels. Networks for improvement typically operate at different levels, and in relation to different enablers (The Health Foundation 2014b).

The importance of network members (as well as wider groups) being able to periodically meet face-to-face was emphasised repeatedly during Stage 1 and Stage 2 of Framework development. In the context of CQI in primary health care, the benefits of face-to-face contact cannot be overstated. It helps in the development of network relationships and provides multiple, layered opportunities for share learning. A significant corollary of this, mentioned by all relevant stakeholders, is the need for adequate resourcing of face-to-face meetings which needs careful consideration. In addition to the costs of host and forum and travel for participants, a barrier to face-to-face contact sometimes cited was failure of organisations to release staff to attend, which is also sometimes a resourcing issue. Organisations with embedded CQI maturity are more likely to see value in releasing staff to participate in such networks. Consideration could also be given to linking participation in managed networks with CPD points as part of professional training (C12). Examples of existing network meetings are the annual quality improvement forums run by ACCHS state/territory peak bodies. There are many other examples in the periodic forums held by national professional groups.

The flip side of the face-to-face contact stories were the accounts of the difficulties encountered in trying to maintain networks through the use of technologies such as teleconferences, webinars and online discussion forums. These rely on access to *reliable* telecommunications infrastructure which is not available in many areas, are not nearly as effective at establishing new relationships and are far from ideal mechanisms for communication for people for whom English may be a second or third language. Some mix of face-to-face and technology-based communication is necessary, but all stakeholders emphasised that the latter cannot be a complete substitute for the former.

C10. CQI data sharing and sense-making

Primary health care providers are involved in sense-making on a daily basis, but sharing of de-identified data *between* services at different levels can lead to value adding across the system. It allows representative organisations to make contextualised comparisons, tailor support, demonstrate

achievements, and highlight areas for improvement (sense-making). At the regional level, data sharing and sense-making can be a solution to difficulties faced by health services in developing meaningful improvement strategies based solely on their own data (Allen & Clarke 2013). It also opens doors to dialogues about solutions that can only be achieved at regional, state/territory or national levels.

At the local level, services have access to many thousands of data items in their EHRs that might be reviewed in PDSA cycles and other CQI processes. These are **measures**. Only a relatively small proportion of this data will be extracted and pooled for data sharing and sense-making. What gets pooled, what gets analysed, and what gets done with the results – as well as who and how all these things are decided – determine the extent to which the process is trusted and the outputs respected, and therefore how useful they are for CQI.

A subset of the data pooled and analysed by primary health care providers' representative organisations at regional, state/territory and national levels will be **quality indicators** that are based on best/evidence-based practice. There are important differences between CQI networks assessing their own performance against quality indicators to support and promote strategies for improvement and performance management systems reporting on performance indicators for public accountability. While both systems use indicators to measure change, they have different philosophical bases and different types of incentives used to promote change and therefore different impacts. Nevertheless, both performance reporting and CQI play an important role in improving quality in health service delivery. The critical differences between the two systems are highlighted in Table 4 (Sibthorpe & Gardner in prep. 2015). While quality indicators can also be used as performance indicators (and vice versa) this requires a high level of trust, collaboration and philosophical and technical alignment. The Framework offers opportunities for this to be achieved over coming years.

Table 4: Critical differences between CQI and performance reporting

CQI	Performance reporting
Quality internally assessed	Performance externally assessed
Data for dialogue and action	Data for external accountability (+/- ranking and league tables)
Data published internally, shared among networks	Data published by external agencies
Quality indicators +/- informal, changeable targets and benchmarks	Performance indicators +/- official, fixed targets and benchmarks
Addresses any health issue	Addresses only priority health issues
Incentives: <ul style="list-style-type: none"> • Quality of care and outcomes • Clinical and client satisfaction • Collegial competition between clinicians and services • Service reputation 	Incentives: <ul style="list-style-type: none"> • Earned autonomy • Access to competitive funds • Pay for performance

Quality indicators are essential for data sharing. Some quality indicators for the key conditions managed in Aboriginal and Torres Strait Islander primary health care are available and others are being developed. This process needs to continue so that over time a comprehensive bank of quality indicators is available for primary health care providers (for PDSA cycles) and their representative organisations (for data sharing and sense-making) to choose from. To date the development of quality indicators has not been well

coordinated so different sectors and jurisdictions have developed indicators independently. A coordinated, national approach to this is needed.

There is widespread support for data sharing and sense-making in the ACCHS sector (e.g. see NACCHO Strategic Plan 2011–2014). There is some support for it in general practice as well and also examples of cross-sector data sharing between the ACCHS, state/territory and general practice sectors. In the Northern Territory government and community controlled services report on a common set of indicators (albeit key performance indicators).

Suitable governance arrangements and technical infrastructure and data extraction capabilities are necessary for data sharing and sense-making. Seminal principles are the National Aboriginal and Torres Strait Islander Data Principles endorsed by the Australian Health Ministers Advisory Council (AHMAC) in 2006 and available via the Australian Institute of Health and Welfare's website.

Framework implementation provides an opportunity for significant gains to be made in this important area in coming years. It also provides an opportunity for better integration of CQI data sharing and the current national reporting of the Aboriginal and Torres Strait Islander primary health care national key performance indicators (nKPIs). The nKPIs are an important source of information for government and will continue to inform future policy. Currently, the AIHW provides six-monthly reports on nKPIs to participating providers, which can be used for sense-making at the local level. Further work on how nKPI reports can be used in CQI would be valuable. This core component has links with clinical data infrastructure and functionality (C4) and service support (C8).

C11. Research and knowledge translation

Research and knowledge translation can support CQI in primary health care in the following three ways:

1. Instrumental use involves the concrete application of research findings to make specific decisions or changes
2. Conceptual use is about changing people's way of thinking, and
3. Symbolic use reflects political uses of research findings (Ginsburg et al. 2007).

Research is about the discovery or the creation (i.e., primary research), distillation (i.e., the creation of systematic reviews and guidelines), and dissemination (i.e., appearances in journals and presentations) of knowledge. Knowledge translation is:

a dynamic and iterative process that includes synthesis, dissemination, exchange, and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the health care system. (CIHR 2014)

To enhance the uptake, use and impact of research outcomes in practice, research institutes and academics engage and/or involve different stakeholders throughout the research process and use various dissemination strategies. However, there is growing concern about the continual failure of research findings and evidence to rapidly affect or have an impact on clinical practice and health outcomes. Some of these failures include limited use of system-wide committees, lack of a library, information not compiled in one place, too many journals, and difficulties with the information format (Davis & Taylor-Vaisey 1997, Shortell, Bennett & Byck 1998, Davis et al. 2003, Glasgow, Lichtenstein & Marcus 2003, Lenfant 2003, Feifer et al. 2004, Glasgow et al. 2004, Majumdar, McAlister & Furberg 2004, Narayan et al. 2004, Solomons & Spross 2011).

Knowledge translation is an umbrella term that encompasses several other terms including knowledge transfer, knowledge mobilisation, knowledge exchange, and knowledge brokering (Barwick et al. 2014). There are also many proposed theories, frameworks, and models for achieving knowledge translation that can be confusing to those responsible for it. Conceptual frameworks and models are recommended as a way of preparing for the multiple, dynamic and interactive factors that influence the uptake of evidence in practice (Rycroft-Malone 2004, Eccles et al. 2005, Damschroder et al. 2009).

A knowledge translation framework for CQI in Aboriginal and Torres Strait Islander primary health care offers a frame of reference for organising thinking, a guide for action and interpretation. Potential benefits from applying such a framework include making the process of knowledge translation more systematic, with greater likelihood of changed practice and spread of evidence (Eccles et al. 2005, Helfrich et al. 2010, Rycroft-Malone & Bucknall 2011, Tabak et al. 2012, Ilott et al. 2013). Several conceptual frameworks that may be drawn on to develop a knowledge translation model for CQI in primary health care include Promoting Action on Research Implementation in Health Services (PARiHS) (Rycroft-Malone, Gill & Kitson 2002, Rycroft-Malone 2004) the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al. 2009) as well as the Knowledge to Action (KTA) Framework (Graham et al. 2006). The development of such a Framework is a Research and Knowledge Translation (C11) an early result at the national level.

Approaches associated with improved knowledge translation for CQI in primary health care include initiatives that facilitate and support front line learning; opportunities for researchers and practitioners to collaborate and co-produce research knowledge and knowledge translation, such as practice-based networks and health provider–university collaborations; and strategies that facilitate and support health providers to measure the application of knowledge (impact) (Lurie et al. 2002, Mills, Weeks & Surott-Kimberly 2003, Mold & Peterson 2005).

C12. Professional training

Successful uptake, embedding and sustainability of CQI across the system will be largely determined by the level of competence and commitment of the staff at the local service level which engage with Aboriginal and Torres Strait Islander clients on a day to day basis. In the Australian context, CQI has often been the responsibility of external ‘facilitators’ rather than of the staff managing clinical care within health services. This can be attributed in part to the fact that those staff (predominantly GPs, nurses and Aboriginal Health Workers) as well as others who make up service teams including managers, and IT and other support staff receive little or no training in CQI in their university or VET sector training.

While this is widely understood to be true, it has not been documented in the literature. The reasons for this becomes obvious from a brief search of the *MyUniversity* website for undergraduate and postgraduate courses (<http://myuniversity.gov.au/PostgraduateCourses>). At the undergraduate level searching on ‘health care’, ‘medicine’ and ‘nursing’ brings up over 1,500 degrees. Similarly, at the postgraduate level there are over 1,800 courses. In the VET sector the *Community Services and Health Industry Skills Council* health training package lists around 40 courses for ‘primary health care’ (including many courses relating to Aboriginal and Torres Strait Islander primary health care) and around 25 for ‘nursing’. Two examples highlight the training issues. The Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) (HLT52107) does not include any units on CQI. It is the fourth of a series of courses in Aboriginal/Torres Strait Islander primary health care practice that commence at Certificate II level. None of the earlier courses include units on CQI. The Diploma of Practice Management (HLT52012) has two potentially relevant units, ‘Lead a Quality Audit’ and ‘Report on a Quality Audit’. Audit is a necessary but small

component of CQI and these units are designed to meet the needs of a range of Diploma courses including Diploma of Public Safety (Explosive Ordnance), Diploma of Government (Road Transport Compliance), and Vocational Graduate Certificate in Radiation Safety.

The training gaps can be partly explained by the fact that CQI is relatively new in health. They result in attitudinal as well as skills deficits for CQI. Research has shown that team members are not always fully engaged with CQI, with some staff reporting that there was a perception that CQI was a low priority, temporary activity. Where key staff such as clinic managers or GPs did not perceive CQI as important, CQI activities could be particularly hard to implement (Chin et al. 2008; Graber et al. 2008). Similarly, without strong support from the executive, staff do not receive adequate time, resources and administrative or technical support for CQI activities, and again may feel that CQI is not considered a high priority activity (Chin et al. 2008, Graber & Kilpatrick 2008).

Filling the gaps at both university undergraduate and postgraduate and VET sector levels will be critical to embedding CQI in everyday practice for Aboriginal and Torres Strait Islander primary health care, and for the system as a whole. National coordination of CQI training and alignment of competencies will result in stronger, more coherent CQI practice and the impacts of staff turnover will be greatly reduced. Understanding the scale of the problem, deciding on where training should sit, developing curriculum content and courses targeted for different professional groups, training people who then graduate and enter the workforce in significant numbers will take many years. Properly developed, training should lead to a universal set of basic knowledge and skills all the way through to specialised career pathways for CQI in primary health care. This core component will have a very long lead time and there will be a heavy reliance on developing CQI knowledge and skills in the existing workforce in the short-term through service support (C8) while professional training is implemented. The future workforce will graduate with the necessary knowledge and skills which can then be strengthened through on-the-job learning.

In keeping with the vision defined in the *Review of Higher Education Access and Outcome for Aboriginal and Torres Strait Islander People* (Australian Government 2012), training should enhance opportunities for leadership roles for Aboriginal and Torres Strait Islander people working in senior positions in the primary health care sector (Allen & Clarke 2013) and the national appraisal of CQI in Aboriginal and Torres Strait Islander Primary Health Care (Wise et al. 2013) identified gaps in the Aboriginal and Torres Strait Islander quality improvement workforce including a need for increased Aboriginal and Torres Strait Islander leadership and practitioner involvement in CQI. One way to do this is to focus on support for transitions from VET sector to university training. As found in the Higher Education Review,

more Aboriginal and Torres Strait Islander people will need to be supported to enter the higher education system through other pathways, particularly the workforce and VET system. [...] To improve pathways from the VET sector to university, VET students need to be encouraged and supported to enrol in higher-level VET courses (Certificate IV and above) as they can act as a pathway to higher education. (Australian Government 2012: xii)

One way to achieve this is for courses to be offered by a Registered Training Organisation (RTO) that can deliver articulation, such as 'dual provider' universities and non-university RTOs with existing university linkages.

C13. Government policy

Australia rates well in health system comparisons of OECD countries (OECD 2013) but it also faces significant challenges in addressing variations in clinical practice between clinicians, services and

geographic locations that are leading to variable patient outcomes and quality of care (ACSQHC 2013, ACSQHC & AIHW 2014, Horvath 2014). There are significant challenges for governments in promoting quality goals that are acceptable to multiple stakeholders (professions, providers and communities and overcoming difficulties associated with using data to promote improvement (Freeman 2002). In a policy environment, there are ongoing tensions between supporting governance development, enabling providers to tackle the complex issues faced in implementing improvements, performance and accountability.

There is now considerable evidence showing that health care system performance may be improved with policy emphasis on areas such as primary care, quality improvement, and information technology. In 2014, Gault and others sought to investigate the extent to which policy makers in seven countries, including Australia, are emphasising these areas (Gault et al. 2014). Their findings suggest that while all seven countries featured national institutes or agencies that aim to promote quality improvement activities or to report on national quality indicators, there were variations in the extent of government commitment to quality improvement.

In Australia, there is variation across jurisdictions in the models of CQI being implemented, level of understanding of different models and elements of CQI, access to infrastructure, and level of capacity and capability (Wise et al. 2013). A shared policy platform offers an approach to addressing the variation to CQI by:

- Supporting the development of an overarching strategy aimed at improvement that encapsulates primary care, quality improvement and information technology, and
- Enabling the development and implementation of cohesive strategies and a concerted approach to CQI.

These factors and others such as leadership, involvement of key stakeholders in policy and strategy development and alignment of interest are associated with considerable performance improvement (Oliver 2008, Bohmer 2009, Blackmore, Mecklenburg & Kaplan 2011, James & Savitz 2011).

Embedded in this Framework is the need for ongoing, coherent national and state/territory government policy and investment for implementation of the core components. Endorsement by relevant national and state/territory governmental departments and committees will also be important, as will the use of policies and programs and contracts as levers for implementation.

C14. Organisational partnerships

Partnerships are a type of collaborative arrangement, defined as,

a collaborative relationship between two or more parties based on trust, equality, and mutual understanding for the achievement of a specified goal. Partnerships involve risks as well as benefits, making shared accountability critical. (APPS 2009)

Partnerships may involve relationships at a variety of levels, between individuals in organisations, organisational management, and individuals and organisations (Haynes et al. 2014). Partnerships differ from other types of collaboration such as networks in that they involve a formal relationship between parties that is defined through a written agreement or contract.

Effective partnerships between mainstream and Aboriginal health services are perceived as a mechanism to improve Aboriginal life expectancy (AHMAC 2004) and there has been increasing focus at the state level for

strategic partnerships to improve Aboriginal health service access and outcomes (Taylor & Thompson 2011).

Partnerships between organisations offer the following potential benefits to enable CQI (Hunt 2013):

- Synergy created from working collaboratively results in greater accomplishments than each group working on its own
- Increased opportunities for client and community access and participation leads to increased community awareness
- Sharing of resources and expertise
- Effective representation allowing larger and broader sections of the community to be represented
- Decreased duplication and appropriate distribution of resources, and
- Pooling of resources.

There are multiple examples of partnerships between the Aboriginal primary health care sector and research institutions that operate to support CQI. Some of these operate at the local level on the basis of individual service negotiations with a local university, others are larger scale arrangements that have developed into more formal partnerships operating at regional, state and national levels over time. The ABCD National Research Partnership is a large scale partnership that has engaged with over 150 Aboriginal health services, both community controlled and government, in different states and territories over time to support and develop CQI practice (Menzies School of Health Research 2015).

At the state and regional levels, examples of knowledge translation partnerships that have been established by the ACCHS sector to support CQI include the Closing the Gap Collaborative, established by the Queensland Aboriginal and Islander Health Council (QAIHC) to evaluate and support its CQI program (QAIHC 2011) and at the regional level the collaboration between the Kimberley Aboriginal Medical Services Council and the Rural Clinical School of Western Australia (CAPTER 2011).

Taylor and Thompson (2011) suggest successful partnerships between Aboriginal and mainstream organisations require having a common goal (important for all successful partnerships), recognising tensions early and committing to working through them, allowing time to develop trusting relationships between staff and building linkage protocols, and having strong leadership. Partnerships at all four levels will be essential for the effective implementation of Framework core components. They are identified as *primarily* involving community representatives in organisational structures and processes at the national, state/territory and regional levels, and clients and communities at the local level.

C15. Coordination and facilitation of implementation of Framework core components

Since the 1967 referendum, there have been varying degrees of government commitment to improving the health and wellbeing of Aboriginal and Torres Strait Islander people (AHRC 2005, DoH 2013). This commitment was reflected in two key policy documents: the National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party 1989) and the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003). However, one of the significant challenges in implementing these plans, particularly the National Aboriginal Health Strategy, was the lack of concerted partnership approach to support implementation by all necessary stakeholders and the lack of commitment by Australian Governments (ATSIC 1994). Attempts to strengthen commitment and a cooperative approach by all stakeholders to improve Aboriginal and Torres Strait Islander disadvantage include the endorsement of Health Framework Agreements and COAG's whole of government approach (COAG 2008).

To date there are several examples of government-supported initiatives that have been shown to improve the quality and performance of primary health care services over the years. These include Practice Incentive Payments (PIPs), the former EQHS-C program to support service accreditation (EQHS Accreditation Agency 2015), the establishment of the Australian Commission on Safety and Quality in Health Care (ACSQHC), the rollout of electronic patient information systems and the strengthening of accountability of health care providers through the introduction of the national Aboriginal and Torres Strait Islander Health Performance Framework (DoH 2015). However, outcomes from consultations with local and regional level providers suggest the absence of a collective approach by all governments has affected the impact and sustainability of CQI initiatives that have demonstrated improvements (Wise et al. 2013).

Key mechanisms identified in the Framework to support coordination and facilitation of Framework core components are the establishment of a Framework implementation steering committee and appointment of national and state/territory CQI coordinators in the ACCHS and general practice sectors, and state/territory coordinators in health departments.

Additional key mechanisms are the national identification and development of resources to support implementation of Framework core components at different levels and the establishment of a CQI knowledge exchange mechanism. Such a knowledge exchange mechanism would rely on the strategic use of information technologies such as platforms, cloud computing and information architecture to help all users find information and complete tasks. A CQI knowledge exchange mechanism would also support knowledge translation by supporting the widespread implementation and uptake of evidence-based programs, practices, and policies by:

- Transforming scientific knowledge into actionable processes
- Developing appropriate supporting structures, and
- Disseminating evidence-based programs, practices, or policies to potential adopters.

The knowledge exchange mechanism would also support communities, primary health care providers and practitioners to adopt and have sufficient supporting structures and resources to effectively move toward action.

APPENDIX 5 – REFERENCES

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APPENDIX 6 – LIST OF PARTICIPANTS IN WORKSHOP CONSULTATIONS

Project team consultation with invited CQI champions Adelaide, 12 March 2015 Facilitated by Michael Tynan, the Lowitja Institute	
Bridget Carrick	Australian Government Department of Health
Kerry Copley	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Frances Cunningham	Menzies School of Health Research
Maureen Davey	Tasmanian Aboriginal Centre
Karen Gardner	University of NSW
Aiesha Grierson	Lowitja Institute
Bec Harvey	Pangula Mannamurna Inc.
Bruce Hocking	Wurli-Wurlinjang Health Service
Jenny Hunt	Aboriginal Health and Medical Research Centre (AH&MRC)
Margaret Kelaher	University of Melbourne
Louise Lyons	Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
Judy McKay	Pangula Mannamurna Inc.
John Mitchell	Njernda Aboriginal Corporation
Luella Monson-Wilbraham	Lowitja Institute
Richard Reed	Flinders University
Carolyn Renehan	National Aboriginal Community Controlled Health Organisation (NACCHO)
Paul Ryan	Aboriginal Health Council of South Australia (AHCSA)
Beverly Sibthorpe	Consultant
Michael Tynan	Lowitja Institute
Kyla Ulmer	Aboriginal Health Council of Western Australia (AHCWA)
Roderick Wright	Queensland Aboriginal & Islander Health Council (QAIHC)
Apologies: Ana Herceg (Winnunga Nimmityjah Aboriginal Health Service) Nadia Lusic (Victorian Aboriginal Community Controlled Health Organisation)	

General practice consultation workshop RACGP House, Melbourne, 27 April 2015 Presented by Project Partners together with the RACGP Facilitated by Sanchia Shibasaki	
Jason Agostino	National Aboriginal Community Controlled Health Organisation (NACCHO)
Leah Austin	Royal Australian College of General Practitioners (RACGP)
Gary Bourke	Bendigo & District Aboriginal Cooperative
Devin Bowles	Australian Institute of Health & Welfare (AIHW)
John Buckskin	Country North SA Medicare Local
Claire Caesar	Claire Caesar Consulting
Moira Campbell	Australian Government Department of Health
Mike Civil	RACGP Standards Committee
Helen Congoo	Cairns and Hinterland Hospital and Health Service
Lauren Cordwell	Royal Australian College of General Practitioners (RACGP)
Sophia Couzos	Australian College of Rural and Remote Medicine
Zell Dodd	National Aboriginal & Torres Strait Islander Health Worker Association (NATSIHWA)
Karen Gardner	University of NSW
Gerard Gill	Deakin University
Aiesha Grierson	Lowitja Institute
David Johnson	Aboriginal Health Council of South Australia (AHCSA)
Helen Kehoe	Australian Institute of Health & Welfare (AIHW)
Cate Kildea	Australian Government Department of Health
Alison Killen	Australian Government Department of Health
Teng Liaw	University of NSW
Nadia Lusic	Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
Luella Monson-Wilbraham	Lowitja Institute
Bronwyn Morris-Donovan	Australian Primary Health Care Nurses Association (APNA)
Diana Murphy	Country North SA Medicare Local
Karen Nicholls	RACGP National Faculty of Aboriginal and Torres Strait Islander Health
Linda Osman	Australian Association of Practice Management (AAPM)
Jacqui Poltera	Aboriginal Health, Tasmanian Medicare Local
Richard Reed	Flinders University
Carolyn Renehan	National Aboriginal Community Controlled Health Organisation (NACCHO)
Sarena Ruediger	Country North SA Medicare Local
Paul Ryan	Aboriginal Health Council of South Australia (AHCSA)
Vicki Sheedy	Australian College of Rural and Remote Medicine
Beverly Sibthorpe	Consultant
Ian Sinnet	Networking Health NSW
Samantha Smorgan	Inner North West Melbourne Medicare Local
Jennifer Thompson	GP, experience with CQI
Murray Towne	Far North Queensland Medicare Local
Michael Tynan	Lowitja Institute
Bambi Ward	GP Educator
Mark Wenitong	Apunipima Cape York Health Council
Apologies: Helen Congoo and Katrina Stafford (Cairns and Hinterland Hospital and Health Service)	

Policy consultation workshop The Lowitja Institute, Melbourne, 28 April 2015 Presented by Project Partners together with the Australian Government Department of Health Facilitated by Sanchia Shibasaki	
Margaret Banks	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Maria Barredo	Watto Purrinna Aboriginal Health Service
Devin Bowles	Australian Institute of Health & Welfare (AIHW)
Jacinta Bunfield	Centre for Aboriginal Health, NSW Department of Health
Moira Campbell	General Practice Support Section, Primary and Mental Health Care Division, Australian Government Department of Health
Vivian Casey	Watto Purrinna Aboriginal Health Service
Darren Clinch	Aboriginal Health, Victorian Department of Health and Human Services
Frances Cunningham	Menzies School of Health Research
Karen Gardner	University of NSW
Aiesha Grierson	Lowitja Institute
Hugh Heggie	Northern Territory Department of Health
Helen Kehoe	Australian Institute of Health & Welfare (AIHW)
Cate Kildea	Australian Government Department of Health
Alison Killen	Australian Government Department of Health
Robyn Mildon	Parenting Research Centre
Luella Monson-Wilbraham	Lowitja Institute
Richard Reed	Flinders University
Carolyn Renehan	National Aboriginal Community Controlled Health Organisation (NACCHO)
Paul Ryan	Aboriginal Health Council of South Australia (AHCSA)
Wendy Sexton	Torres and Cape Hospital and Health Services
Beverly Sibthorpe	Consultant
Narelle Smith	Tasmanian Department of Health and Human Services
Peter Sproules	Aboriginal Health, Victorian Department of Health and Human Services
Jessica Stewart	National Health Performance Authority
Deborah Stoffell	Torres and Cape Hospital and Health Services
Michael Tynan	Lowitja Institute
Apologies: Daniel Williamson (Health Commissioning Queensland, Queensland Health) Geri Wilson (Centre for Aboriginal Health, NSW Department of Health)	

Project team consultation The Lowitja Institute, Melbourne, 25 May 2015 Facilitated by Sanchia Shibasaki	
Bridget Carrick	Australian Government Department of Health
Kerry Copley	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Frances Cunningham	Menzies School of Health Research
Maureen Davey	Tasmanian Aboriginal Centre
Aiesha Grierson	Lowitja Institute
Jenny Hunt	Aboriginal Health and Medical Research Centre (AH&MRC)
Karen Gardner	University of NSW
Margaret Kelaher	University of Melbourne
Cate Kildea	Australian Government Department of Health
Louise Lyons	Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
Luella Monson-Wilbraham	Lowitja Institute
Richard Reed	Flinders University
Carolyn Renehan	National Aboriginal Community Controlled Health Organisation (NACCHO)
Paul Ryan	Aboriginal Health Council of South Australia (AHCSA)
Bev Sibthorpe	Consultant
Michael Tynan	Lowitja Institute
Roderick Wright	Queensland Aboriginal & Islander Health Council (QAIHC)
Apologies: Kyla Ulmer (Aboriginal Health Council of Western Australia) Ana Herceg (Winnunga Nimmityjah Aboriginal Health Service, joined via phone link for part of the meeting)	