



**NATIONAL CQI FRAMEWORK
FOR ABORIGINAL AND TORRES STRAIT ISLANDER PRIMARY HEALTH CARE
2015- 2025**

ENSURING LONG TERM SUSTAINABILITY:

NACCHO POSITION STATEMENT

The original version of this Position Statement was endorsed at the Strategy Workshop convened for Directors of the NACCHO Board and CEOs of jurisdictional Affiliates, Adelaide 5-6 August 2015. The Position Statement was subsequently endorsed by the NACCHO Board of Directors in Canberra on 16 September 2015.

NACCHO Welcomes a National Vision of Quality Improvement

NACCHO welcomes the Australian Government's commitment to introduce, via the Department of Health (DoH), the National Continuous Quality Improvement (CQI) Framework for Aboriginal and Torres Strait Islander Primary Health Care. This 10 year multi sector and intergovernmental strategic reform imbeds an operational vision of partnership at national, state/territory, regional and local levels to achieve ongoing quality enhancements to the direct clinical service, policy and planning contexts of primary health care provision for Aboriginal and Torres Strait Islander people. NACCHO welcomes also the investment of additional new funds to ACCHOs through the *Healthy for Life* program to assist them prepare local CQI action plans; as well as the complementary investments in jurisdictional Affiliates to enable them to provide support and assistance to ACCHOs.

Acknowledging a Consultative Development

The open approach of the two responsible portfolio Ministers The Hon Sussan Ley MP, Minister for Health, and Senator the Hon Fiona Nash, Assistant Minister for Health, and their Department to developing and introducing the Framework in a highly consultative manner with all the key stakeholders is appreciated. Extensive engagement with the ACCHO Sector has occurred encompassing NACCHO, jurisdictional Affiliates and Services. In fact constructive conversations between DoH, the Lowitja Institute and stakeholders in all sectors about the content and implementation of the Framework is ongoing and has been the principal reason why NACCHO had not earlier released a position statement on this important reform.

Ensuring the Framework's Long Term Sustainability

DoH has advised that there will be a consultation process concluding during September 2015 to address the implementation structure of the Framework. NACCHO supports this approach but also believes it is appropriate during this time to make some fine tuning adjustments to the CQI architecture. The Framework has a 10 year operational horizon and the fine tuning proposals should assist its long term sustainability. One important reason for fine tuning of the Framework is that more analysis is required on preferred steps for its application to *the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan (2013-2023)*. Other reasons are outlined below.

The Position Statement

This document summarises NACCHO's views and assessment of the draft National CQI Primary Health Care Framework documentation ("the Framework") at 30 July 2015 prepared by the Lowitja Institute as the academic body commissioned by DoH to produce the Framework, together with other draft materials prepared by DoH and additional issues emerging from the ongoing consultative dialogue.

NACCHO's Lens of Viewing the draft National CQI Framework

NACCHO's observations and analysis about the draft Framework derive from several pivotal sources including firstly the network of our 155 Member Services on the ground, secondly advice from Affiliates (ie the ACCHO state/ territory peak bodies) and thirdly NACCHO's own involvement in the Framework's development as an active participant of the project management committee, related task groups and other processes.

Clarity about the Characteristics and Definition of the ACCHO Sector

NACCHO's lens for viewing the Framework reflects the essential character of the ACCHO Sector which is encapsulated in the following reality focussed description.

(i) The Leading and Preferred Provider

In 2012-2013 the 141 ACCHOs provided over 2.4 million episodes of care services to over 316,000 clients, about 252,000 of whom were Aboriginal or Torres Strait Islander: a figure representing 34.6 percent of the Aboriginal and Torres Strait Islander population.

The ACCHO Sector, which is principally funded by DoH, is the leading and preferred provider of culturally safe and comprehensive multidisciplinary primary health care to Aboriginal and Torres Strait Islander clients, families and communities including targeted actions to Close the Gap, and is the foremost holder of expert knowledge and 'knowhow' for these purposes.

A recent important exploration of ACCHOs' performance verifying these attributes was published in the June 2014 Medical Journal of Australia. [Aboriginal Community Controlled Health Services: Leading the Way in Primary Care. KS Panaretto, M Wenitong, S Button, IT Ring. Medical Journal of Australia, 200(11) 16 June 2014.] This study of ACCHOs' activities in Queensland, derived from data collated in QAIHC, generated a range of pivotal evidence based findings including:

- Remarkable ACCHO access indicators that convey greater population market penetration than mainstream General Practice such as:
 - the number of Aboriginal patients making one visit in two years to a regional ACCHS is higher than the resident Indigenous population for
 - (i) the Service's surrounding geographic catchment (as defined by drive time and local government area).
 - (ii) In the case of 11 of 17 regional ACCHOs, over 60% of Aboriginal people living within a 30-minute drive had visited the Service in two years, while for six of the most remote of these ACCHOs 100% of Indigenous people resident within a 30 minute drive used the Service in a two year time-frame plus many additional visits from people travelling longer than 30 minutes.
- Treatment methodologies and care outcomes for chronic disease prevention and management compare favourably with private General Practices and out-perform the mainstream in such areas as cardio-vascular and diabetes risk management, best practice medication approaches and diagnostic coding.
- Models of comprehensive primary care are consistent with the patient-centred medical home mode advocated by mainstream medical reformers and demonstrate ongoing performance improvements on the range of best practice care indicators

(ii) Unique Models of Care

The culturally safe and multidisciplinary models of comprehensive primary care provided by the Sector that have evolved over the last forty years represent its enduring and continuously innovating strengths. These are distinctive mixes of local community and cultural authority blended with a broad span of service responses from the promotion of healthy life choices, chronic diseases prevention and management to enabling personally empowered and smooth client/ patient journeys supported by comprehensive electronic health records. The unique syntheses of these community controlled care models cannot be replicated in public or private- for profit mainstream systems of primary health care.

(iii) The ACCHO Sector Expertise and Market Challenge

This national client service system functions with strong community engagement, performs at high levels of clinical competence, possesses sophisticated professional expertise and operates with cost efficient administration to direct service ratios, and has remarkably high levels of market penetration within its surrounding population catchments. Its market challenge is to extend the supply of its proven models of care to those Aboriginal and Torres Strait Islander Peoples who currently do not have ready geographic access to ACCHO services.

(iv) ACCHO Partnerships with Mainstream Services

Sector engagement with mainstream health services/systems occurs **firstly** to enable smooth referral pathways for client/patient journeys/care plans coordinated and managed by ACCHO clinical teams and **secondly** to enable the Sector's expert knowledge and 'knowhow' to be applied for clinical change management activities which make the mainstream more Indigenous friendly.

(v) Empowered Client/Patient Journeys and State and Territory Departmental Interfaces

Facilitating smooth referral pathways for Aboriginal and Torres Strait Islander clients/ patients whose assessed needs in ACCHO care plans require clinical treatment or other professional support from mainstream health services is a critical success factor for these journeys. This includes the timely acceptance of, treatment and finalisation (discharge) of these referred episodes of care by mainstream providers. Cooperation between the ACCHO Sector, DoH, State and Territory Departments, the networks of public mainstream hospitals and health services the States/Territories auspice and Primary Health Networks (PHN) is required to ensure episodes of mainstream referred care for Aboriginal and Torres Strait Islander clients/patients are effective. These referred care steps need to proceed with cultural safety, clinical soundness, and with timely decision making communication between the client/patient, their families and mainstream and ACCHO clinicians to support optimal care planning and plan management. The use of the PCEHR/MyHealth is an important tool to achieve these goals.

Summary Description of the Framework

Multi Sectoral and Intergovernmental

The National CQI Framework being introduced by the Commonwealth consists of two related documents: a Framework Report 2015-2025 prepared by the Lowitja Institute and an Implementation Strategy 2015-2017 also prepared by the Lowitja Institute. The Framework intends to provide a common platform to facilitate Continuous Quality Improvement for Aboriginal and Torres Strait Islander Primary Health Care across a number of health care service Sectors together with other stakeholders including professional health colleges and associations, tertiary educational and research institutions, and accreditation bodies.

The main Australia-wide *health service Sectors* identified in the Framework are:

- 1) The ACCHO Sector ie Aboriginal Community Controlled Health Organisations as the service delivery system and jurisdictional Affiliates and NACCHO as representatives of the system's managers
- 2) State and Territory Government Auspiced Services including the public primary care services provided by government departments and hospitals and health services networks including community health centres
- 3) Private General Practice

Other *service provider streams* that the Framework applies to include:

- 4) Non-government organisations such as the Royal Flying Doctor Service.
- 5) Aboriginal owned and managed organisations that are not ACCHOs,
- 6) The Framework is also intended to inform the work of Primary Health Networks (PHNs).

Consequently the National CQI Framework can be accurately depicted as Multi Sectoral and Intergovernmental.

PDSA Methodology

The Framework's principal CQI methodology proposed to improve quality at the local level is the use of Plan -Do -Study -Act (PDSA) cycles. These cycles focus on reviewing local service activity and population health data and, with the insights gained, making improvements to the quality of client/patient service provision such as the care plan journey and community based prevention and health promotion. PDSA cycles have been prominent in the total quality improvement (TQI) domain for at least 40 years, originating in for-profit commercial operations in major manufacturing economies.

Flexible Implementation by Each Sector

Responsibility for implementing the CQI Framework will rest with each of the three participating Sectors enumerated above. This implementation will occur on a flexible basis to address the CQI needs of each Sector. Moreover, roll-out responsibilities are intended to be defined within each Sector at national, state/territory, regional and local levels plus appropriate cross-Sector engagement. A high level generic implementation strategy for the period 2015-2017 has been prepared to help guide the roll-out by Sector.

ACCHO Sector Roll-Out

The Framework also acknowledges the increasing national evidence and multi- sector recognition of the ACCHO Sector as the benchmark service system for providing effective primary care for Aboriginal and Torres Strait Islander People and holding the expert knowledge about how this is done.

DoH is allocating in excess of \$40M over 3 years for roll-out of the Framework in the ACCHO Sector.

This will support Service-level (ACCHO) CQI action plans and the conduct of CQI activities focused on PDSA cycles. DoH is requiring Service-level action plans to be prepared by 31 December 2015, with the first annual progress report due on 15 August 2016. It is NACCHO's view that this CQI initiative has to cover on the ground service provision arising from all sources of Commonwealth Primary Care funding to ACCHOs including social and emotional wellbeing (mental health) program funds from the Department of Prime Minister and Cabinet.

NACCHO, in partnership with jurisdictional Affiliates and Member ACCHOs, will carry forward and shape the implementation process to address the CQI priorities of the ACCHO Sector. This will involve collaboratively preparing and operationalising a national level ACCHO Sector CQI Plan which mutually informs and is strengthened by interlocking Sector plans and CQI actions at state/territory (Affiliate), regional and local levels. It will also take into account the range of ACCHO CQI initiatives that are already defined and have been in place for a number of years.

NACCHO is convening a Sector 'Round Table' during September 2015 to review in detail the Framework and scope a Sector roll-out plan.

The National CQI Framework

Set out on the next page is a diagrammatic summary of the Framework .

15 Core Components Common to the Three Service Sectors- ACCHO, Private General Practice, State/Territory Governments

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

The 15 core components of the schema apply in common to the three main health service sectors identified in the Framework eg **ACCHO, Private General Practice** and **State/Territory Government Auspiced Services**.

The Framework identifies four geographic levels being national, state/territory, regional and local for having main implementation responsibility for a specific core component. Some components are exclusively assigned to a single level while other components are assigned to multiple levels.

The blue shaded boxes of the Table indicate which levels ie national, state/territory, regional and local have implementation responsibility.

In the ACCHO Sector these levels equate with NACCHO, Affiliates, RAICHOs and ACCHOs.

9 Core components assigned to the local level are intended to form the basis of CQI plans for ACCHO services. DoH has prepared some draft and non prescriptive templates for trialling to assist in the flexible development of these plans and CQI activities.

Although not shown each core component has a range of descriptors which define its general characteristics, implementation actions and intended results. The intended results from a 10 year high level implantation strategy are at the next page.

Proposed Results -10 year High Level Implementation Strategy

Core Components	N	S T	R	L	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. Government policy	■	■	■	■	<ul style="list-style-type: none"> There is ongoing coherent and complementary national and state/territory government policy and investment for CQI in primary health care services for Aboriginal and Torres Strait Islander people. There is a substantial body of evidence about the effectiveness of national and state/territory policy and investment for CQI.
C3. Coordination and facilitation of implementation of core components	■	■	■	■	<ul style="list-style-type: none"> Framework Implementation Steering Committee (FISC) is a trusted and respected committee 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 Hub is highly used and trusted source of information for ACCHS, GP, state/territory government and other stakeholders to support implementation of the Framework core components.
C4. 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.
C5. 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.
C6. 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 Health Professionals (AHPs) are prominent in CQI leadership roles.
C7. Access to CQI skills	■	■	■	■	<ul style="list-style-type: none"> All services/practices/centres have sustained access to 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 CQI knowledge and skills.
C8. Clinical data infrastructure and functionality for CQI	■	■	■	■	<ul style="list-style-type: none"> All services/practices/centres have access to flexible, user-friendly, clinical data infrastructure and functionality that supports PDSA and other CQI activities.
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 at all levels and sophisticated and effective knowledge translation results in refinement and innovation in policy, investment, support and practice.
C12. Service support	■	■	■	■	<ul style="list-style-type: none"> Regional, state/territory and national organisations are widely recognised as centres of excellence in tailored CQI and clinical governance support for primary health care providers, teams and individual primary health care professionals.
C13. 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 into practice of best practice/evidence-based care.
C14. CQI Leads	■	■	■	■	<ul style="list-style-type: none"> Primary health care providers and regional CQI Leads are well networked and supported and are respected and influential members of teams.
C15. 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.

Areas for Fine Tuning the National CQI Framework

A national multi-service Sector and intergovernmental reform strategy with a 10 year horizon such as this Framework will obviously have a range of implementation issues to be resolved and refined as it is rolled-out over time. NACCHO has invited Member Services and jurisdictional Affiliates to explore in depth the range of issues presented in this Position Paper at the September 2015 CQI National Round Table, so that their perspectives can contribute to the fine-tuning analysis.

At this point, NACCHO has identified some pivotal issues with the CQI architecture that require modification or elaboration to ensure the Framework is successfully carried forward. They are detailed below.

1. Mediating Clinical and Financial Risks – Financial Governance as a Core Component.

The Lowitja Institute's literature searching incorporated into the Framework's narrative clearly shows CQI's strong history within commercial industry prior to its introduction into healthcare. The companies that adopted CQI did so for a competitive advantage – they judged that the investment in CQI systems and processes would generate greater revenues from sales than the costs of putting the systems and processes in place and maintaining them, or would reduce the costs of production.

There has always been this connection in the real economy between CQI on the one hand, and revenue maximisation and cost efficiencies on the other hand.

The dominant if not the only outcome focus from DoH for the national CQI Framework is to strengthen ongoing quality in service provision at the level of the ACCHO clinics and population health/health promotion programs. This is a laudable but an entirely too narrow a focus for a national CQI Framework.

In the past five years, ACCHOs and their regional organisations have increasingly been implementing a more sophisticated strategy that integrates CQI processes and systems with business systems for revenue maximisation and cost efficiencies that enables ACCHOs and their regional bodies to contribute to expansion of services and diversification into new markets. While a number of examples can be cited, perhaps the best documented and most prominent place-based example of this integrated strategy on a significant regional scale has been the Institute for Urban Indigenous Health in south-east Queensland, whose operations have been visited by Government Ministers, senior public servants, and many Service managers from within our Sector.

This integrated strategy includes the relationship between MBS Items and strengthening the quality of client/ patient care, and leveraging the increased self-generating income to diversify services and expand into locations of comparative market failure. The use of Health Assessments, GP Mental Health Treatment Plans, Chronic Disease Management items and the like have been able to enhance care while adding substantial revenues to an ACCHO or a private General Practice.

It is now evident that an ACCHO - or even a Private General Practice - could use CQI feedback processes to assess local service and population health data and better identify the extent it was:

- reaching its catchment
- effectively utilising MBS items which
- directly triggers improved episodes of primary care, and

-
- increases MBS income capacity for reinvestment in strengthened connectivity between client/patient information systems.

One of the emerging implementation solutions that is becoming attractive on the revenue maximisation side for entrepreneurial ACCHO Boards and CEOs is to formalise collaboration between professional staff in lead clinical roles and practice managers who have responsibilities for tracking income and expenditure.

Apart from the revenue maximisation solutions, there are cost reduction solutions that CQI action plans can address. Achieving cost saving efficiencies in the design of one type of client/patient service could enable an ACCHO to invest more in a higher priority service type identified via the PDSA process.

So it is now obvious that the processes of quality clinical governance in a primary health care Service such as an ACCHO can be reinforced by effective integration with financial governance processes.

NACCHO has arrived at the conclusion that ‘Financial Governance’ focusing on revenue maximisation and cost efficiencies needs to be introduced as a core component in the Framework.

Not to do so leaves our Member Services at considerable risk of:

- (a) pursuing clinical quality initiatives that cannot be sustained within appropriate cost, revenue and corporate fiduciary parameters; and
- (b) limiting the focused application of MBS items or other funding streams towards supporting CQI.

There are at least two ways of doing this. The preferred approach is to combine the two components related to “training” into a single component, and add in the “financial governance” component without thereby exceeding the existing total of 15 components. Practically speaking, this means combining Core Component 6: ‘Professional Training’ and Core Component 7: ‘Access to CQI Skills’ into a single core component ‘CQI Professional Training and Workplace Learning’. The only other approach would be to add “financial governance” as an additional, sixteenth, core component.

The amalgamation of these training and skills components seems compatible with other DoH healthcare training program strategies which promote the health care work place as a dynamic learning environment able to enhance relevant skills of health practitioners and undergraduate learners and also inform the curriculum content of tertiary qualifications training. Examples of such integration are DoH’s support of undergraduate level clinical placements for the health professions, and DoH’s history of engagement with GP vocational training.

2. COAG and Intergovernmental Policies

Two core components collectively address the need for a range of Commonwealth and State/Territory government policy coordination arrangements to enable the effective carriage of the Framework. They are Core Component 2: ‘Government Policy’ and Core Component 3: ‘Coordination and Facilitation of Implementation of Core Components’.

The *NIRA Based National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes* identifies important commitments by the Commonwealth and State and Territory Governments of coordination to support improved service provision for Aboriginal and Torres Strait Islander Peoples. These commitments address several service provision Outcome Areas that effectively impact on the National CQI Framework including ‘Fixing the Gaps and Improving the

Patient Journey', 'Primary Health Care Services That Can Deliver' and 'Making Indigenous Health Everyone's Business'. NACCHO believes that an updated understanding of the reported impacts of these agreements will substantially assist the endeavour of the three main service Sectors - ie ACCHO, Private General Practice and State and Territory Government auspiced services - in responding to the CQI Framework.

The significance of having effective referral pathways from the ACCHO Sector into and from the State and Territory public mainstream systems has already been noted. The *AHMAC 2014 Report on the Aboriginal and Torres Strait Islander Health Performance Framework* provides extensive indicative evidence of service delivery areas which would benefit from systems and procedures around referral pathways that improve the patient journey, continuity of care, and ultimately health outcomes. Accordingly, NACCHO wants to see the CQI Framework being used to significantly strengthen Commonwealth Government led brokerage to install practical CQI referral systems and procedures between the ACCHO Sector and predominantly public mainstream systems at state, regional and local levels. The embryo for this potentially already exists in the form of jurisdictional-based Aboriginal and Torres Strait Islander Health Partnership Forums, but these have historically not been adequately leveraged by the Commonwealth.

We also believe in this context that the Australian Healthcare and Hospitals Association (AHHA) as the peak national body for the public healthcare domain requires a seat at the high level national Framework Implementation Steering Committee (FISC) which will guide Framework roll-out.

3. *Core Component 8 'Clinical Data Infrastructure and Functionality for CQI' and 'Core Component 10 CQI Data sharing and Sense-Making'*

The results descriptor in the Framework for core component 8 refers to

"All services /practices / centres have access to flexible, user-friendly, clinical data infrastructure and functionality that supports PDSA and other CQI activities"

while Core component 10 refers to

"CQI data sharing and sense-making within and between sectors by services '/practices'/ centres' regional, state/territory and national representative organisations results in widespread shared learning and underpins policy and investment and strategies for improvement at all levels".

References are made in the Framework to the *National Aboriginal and Torres Strait Islander Data Principles* endorsed by the Australian Health Ministers Advisory Council (AHMAC) in 2006.

Nevertheless, considerable further exploration is required to take into account a range of important community authority/permission/ protocol and data entry/storage issues for ACCHOs in collecting, coding, storing, releasing and sharing community population health and clinical service activity data within and outside the Sector to inform strategic developments. This also applies to the extended use of the PCEHR/MyHealth.

NACCHO considers these issues start with a recognition that a community's population health data is also a window into its history including its resilience and the adverse impacts experienced such as dispossession and Stolen Generations. They then proceed on a continuum of technical and epidemiological steps surrounding the aggregation, interpretation and practical use of data. NACCHO's Health Information Strategy is addressing these issues, nevertheless in this area the Framework appears to pass far too quickly over an array of complex matters in relation to

information management that require a lot more resolution before these Core Components acquire safe and reliable states of readiness.

4. Recognising the Good Work Already Being Done by Local Services

Many quality initiatives have been put in place by NACCHO Member Services across Australia. The service providers of the ACCHO Sector have been innovators in locally driven primary health service delivery for nearly 40 years with an unceasing ambition to improve the quality of life, health and wellbeing for the individuals and the communities to whom they are directly accountable. CQI is a formalisation of processes, aspirations and targets that consolidate existing learnings and experience, to share and build on what is working, and to guide future efforts by encouraging change to achieve better outcomes.

NACCHO is aware of an undercurrent of concern that the introduction of the Framework sends messages which reject or devalue the quality gains many local Services have made by dint of very hard and sustained work. Moreover they are worried that the Framework will force them into a major reorientation and approach to quality improvement when they have already established effective ways of doing business that fits well with their local resources and circumstances.

These concerns have been discussed by NACCHO with DoH and the Department has given assurances that a flexible, locally adaptive and non-prescriptive approach to the use of tools, templates and the conduct of local CQI planning will be a hallmark feature of this national reform. Recent Departmental advice prepared for local services has acknowledged the foundation of CQI established in the national ACCHO service system.

Even so these concerns identify the need for imbedding the ACCHOs' active corporate memory and systems orientated CQI archival capabilities in the Framework's implementation strategies which honour, value and practically draw upon the Sector's traditions of improvement, and ensure the cycles of CQI envisaged in this 10 year plan are not wheels of re- invention but deliver genuinely enhanced outcomes for the ACCHO models of care.