PATIENT SAFETY AND QUALITY IMPROVEMENT CAPABILITIES GROUP

CLINICAL EXCELLENCE COMMISSION

A SUPPLEMENT TO THE NSW PUBLIC SECTOR CAPABILITY FRAMEWORK

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Foreword

"High-performing health care organisations build in-house capacity for quality improvement and in so doing learn from others."

Ham, Berwick and Dixon (2015). *Improving quality in the English NHS - A strategy for action*. The King's Fund: London.

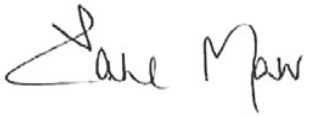
The Clinical Excellence Commission (CEC) seeks to promote and support improved clinical care, safety and quality across the NSW public health system. This is achieved by partnering with Local Health Districts (LHDs), Specialty Health Networks (SHNs) and other NSW Health agencies to help them to improve their services.

The CEC offers many programs of work to support safety management and quality improvement practices and to build a culture of safety across NSW Health.

For effective safety management and quality improvement, an organisation requires a workforce comprising individuals and teams with the right capabilities to ensure reliable, safe patient care and to continuously improve that care.

This document is a guide for Workforce and Clinical Governance teams in LHDs, SHNs and other NSW Health agencies to understand the capabilities (knowledge, skills and associated behaviours) needed at each level of an organisation to deliver patient safety and quality improvement outcomes.

Understanding the workforce capabilities required for effective patient safety and quality improvement will help Workforce and Clinical Governance teams recruit, develop and succession plan for the right capability mix and create sustainability in roles and teams throughout the organisation.



Carrie Marr
Chief Executive

Patient Safety and Quality Improvement Capabilities Group

The Patient Safety and Quality Improvement Capabilities Group complements the NSW Public Sector Capability Framework, which describes the capabilities and associated behaviours that are expected of all NSW public sector employees, at every level and in every organisation. The group comprises four new capabilities:

- Utilise Improvement Methodologies
- Think Creatively and Innovatively
- Manage Clinical Risk
- Manage Factors that Influence Human Performance

Most individuals will be familiar with capability statements from their position descriptions and performance development plans. However, capability frameworks support a much broader range of workforce and organisational development activities including:

- Providing role clarity
- On-boarding and induction
- Performance conversations
- Training needs analysis
- Learning and development
- Leadership development
- Workforce and succession planning
- Recruitment and selection

The Public Service Commission (PSC) designed the NSW Public Sector Capability Framework as a recruitment and capability development tool to be applied to all public sector roles. However, using the framework is not a required practice in NSW Health, and further is not designed to cover capabilities required uniquely by healthcare workers. One way in which health differs from the broader public sector is the high-risk, high consequence activities that represent our core business. To prevent patient harm and improve quality of outcomes, healthcare requires unique additional patient safety and quality improvement capabilities. Therefore, the CEC has consulted with NSW Health stakeholders and subject-matter experts to develop the Patient Safety and Quality Improvement Capabilities. This capabilities group complements the original 20 capabilities defined in the NSW Public Sector Capability Framework. The intended use of the Patient Safety and Quality Improvement Capabilities are to guide LHDs, SHNs and other NSW Health agencies on improving safety and quality capability development, role clarity and succession planning for their workforce.

The four new capabilities are based on NSW Health Clinical Governance and Patient Safety policies and well-known quality improvement theories and methodologies (see Appendix A for more detail on the basis of the four capabilities).

How to read this document

The new capabilities' definitions and behaviour indicators by level are outlined below. The behavioural indicators are a series of statements that illustrate the knowledge, skills and associated behaviours that an employee should ideally demonstrate. Behavioural indicators are organised into level descriptors. The five descriptors range from 'foundational' to 'highly advanced', reflecting a progressive increase in complexity and skill. Level descriptors are mapped to role type depending on the complexity and skill required for the role. For example, a Junior Medical Officer will require capability at a different level to the Executive Director of Medical Services.

Although this document focuses specifically on the new group of capabilities, it is important to recognise that many capabilities relevant to safety and quality are contained in the original PSC framework. For example, "be proactive to address risk" is included in the definition of *Demonstrate Accountability*. Similarly, the capabilities *Work Collaboratively* and *Communicate Effectively* are critical to building an environment of psychological safety where staff feel empowered to raise safety concerns. For this reason, the four new capabilities should only be used in conjunction with the 20 capabilities contained in the original framework.

NSW Public Service Commission Capability Framework

Personal Attributes

Display Resilience and Courage	Act with Integrity	Manage Self	Value Diversity

Relationships

Communicate Effectively	Commit to Customer Service	Work Collaboratively	Influence and Negotiate

Results

Deliver Results	Plan and Prioritise	Think and Solve Problems	Demonstrate Accountability

Business Enablers

Finance	Technology	Procurement and Contract Management	Project Management

People Management

Manage and Develop People	Inspire Direction and Purpose	Optimise Business Outcomes	Manage Reform and Change

Patient Safety and Quality Improvement

Utilise Improvement Methodologies	Think Creatively and Innovatively	Manage Clinical Risk	Manage Factors that Influence Human Performance

Utilise Improvement Methodologies

Able to understand and utilise appropriate improvement, research and/or applied science methodologies to achieve change for improvement.

Foundational

Be aware of the concepts of improvement in healthcare

Know where to find more information about the improvement resources available within the organisation

Raise change ideas for improvement with their manager

Take responsibility for raising and fixing issues they encounter in their work, where appropriate

Intermediate

Be aware of improvement methodologies/approaches and available improvement resources

Possess a solid awareness of what constitutes good aims and measures in improvement initiatives

Participate in the organisation's culture of continuous improvement

Understand risk to improvement initiatives

Read and interpret data presented in quality improvement tools, e.g. driver diagrams, run charts, etc.

Be able and willing to participate in an improvement project that is underpinned by improvement methodologies/approaches

Recognise the importance of 'spread' of quality improvement initiatives and participate in this process

Adept

Understand improvement methodologies/approaches and improvement resources available

Identify the difference and importance of Outcome, Process and Balancing Measures

Participate in and support difficult conversations about improvement change ideas with teams

Provide structure to support improvement initiatives

Help to remove barriers to change for improvement

Drive a culture of continuous improvement

Critique improvement work as it relates to the organisation's strategic and operational plans and outcomes

Lead spread of quality improvement initiatives

Understand the need for appropriate diversity within interdisciplinary quality improvement teams (e.g. consumers, experts, etc.)

Provide guidance to others, including how to access resources

Advanced

Possess solid knowledge about improvement methodologies/approaches and a variety of quality improvement tools

Use and apply those tools to suit the context of the improvement needed

Lead improvement projects by applying a variety of quality improvement and project management techniques

Facilitate productive discussions and meetings about change for improvement projects

Lead and participate in difficult conversations about change for improvement

Act as a change agent for improvement within the organisation

Help to remove barriers to change for improvement

Lead a culture of continuous improvement

Ensure there is appropriate diversity within interdisciplinary quality improvement teams (e.g. consumers, experts, etc.)

Coach teams and individuals that are working on improvement initiatives using an Advanced level of expertise

Highly Advanced

Possess expert knowledge about improvement methodologies/approaches and a variety of quality improvement tools

Teach others how to use and apply, where appropriate, the available quality improvement tools and data interpretation techniques

Apply appropriate change management strategies to suit the circumstances

Use change management strategies expertly to inspire others to come along on a change journey

Possess strong systems' thinking capability and can apply it to improvement work within the organisation

Lead and participate in difficult conversations about change for improvement

Provide the expert rationale and advice for what good continuous improvement culture looks like

Coach teams and individuals that are working on improvement initiatives using a Highly Advanced level of expertise

For each level of capability, the individual must also demonstrate the expected behaviours of each lower level of capability.

Think Creatively and Innovatively

Develop, implement and test novel ideas for improvement.

Foundational	Intermediate	Adept	Advanced	Highly Advanced
Try new things to improve their own work	Confident to push boundaries and take risks when appropriate	Understand principles of change management and is able to apply them	Understand the importance of allowing staff to think creatively and innovatively	Promote the importance of allowing staff to think creatively and innovatively
Show a “can do” attitude	Offer novel ideas comfortably about change	Build enthusiasm for creativity and innovation in others	Facilitate idea generation through multiple channels	Create a culture that supports new ideas and thinking
Offer novel ideas in group discussions on improvement	Be able to apply learning from other contexts	Identify patient safety/governance principles that might impact creative and innovative ideas and vice versa	Drive a culture that supports new ideas and thinking	Invest organisational resources and time into testing new ideas for improvement
Can identify where to go for support if they have a novel idea	Engage others to collaborate on new ideas	Interpret when novel ideas pose risks/introduce new harms	Establish networks that support developing new ideas and thinking	Actively facilitate idea generation through multiple channels and with various stakeholders/points of view
	Can test their ideas to demonstrate their worth	Coach others to come up with novel ways to change for improvement	Provision resources to support creative and innovative thinking	Endorse projects that are creative and innovative and are underpinned by sound research, measurement and evaluation
			Support/give permission to think creatively and innovatively to others	Remove organisational barriers that prevent creative and innovative thinking

For each level of capability, the individual must also demonstrate the expected behaviours of each lower level of capability.

Manage Clinical Risk

Identify, communicate and prevent circumstances that put patients at risk of harm.

Foundational

Be aware of clinical incident investigation processes, risk analyses methods and Just Culture principles

Speak up about clinical risks, hazards or 'near misses' and escalate if required

Uphold a Just Culture by actively learning from mistakes, rather than assigning blame

Recognise and report incidents, 'near misses' and hazards to the appropriate manager and in the incident management software

Intermediate

Possess awareness of patient safety concepts, investigative methodologies, and risk management/analysis methodologies

Possess understanding of legislation, regulatory processes, policies and insurance laws relevant to clinical investigations and risk management and monitor that requirements are met

Participate in clinical investigations following non-serious incidents and 'near misses' and complete risk analyses of local work environment

Lead local investigations and risk analysis in a professional manner

Support learning, openness, transparency, and accountability aligned with Just Culture principles while participating in an investigation or review

Participate in Open Disclosure following patient safety incidents, including reporting, timely acknowledgement, transparent and truthful communication and care for patients, support persons and those providing care where relevant

Participate in difficult conversations about individual patient incidents and how that might impact organisational patient safety risks

Adept

Possess solid awareness of patient safety concepts, investigative methodologies, and risk management/analysis methodologies

Possess understanding of and explain to others the legislation, regulatory processes, policies and insurance laws relevant to clinical investigations and risk management and monitor that requirements are met

Participate in investigations following incidents and conduct risk analyses

Demonstrate understanding of clinical risk management concepts

Ensure clinical investigations and reviews occur in an environment that encourages learning, openness, transparency, and accountability aligned with Just Culture principles

Actively commit to Open Disclosure for all patient safety incidents, including reporting, timely acknowledgement, transparent and truthful communication and care for patients, support persons and those providing care where relevant

Facilitate and participate in difficult conversations about individual patient incidents and how that might impact organisational patient safety risks

Advanced

Possess advanced knowledge about patient safety concepts, investigative methodologies, and risk management/analysis methodologies

Possess advanced understanding of and coach others on the legislation, regulatory processes, policies and insurance laws relevant to clinical investigations and risk management and monitor that requirements are met

Lead clinical investigations following serious incidents and conduct risk analyses, establishing appropriate teams to conduct these processes

Lead investigations and risk analyses in a calm, logical and reflective manner

Demonstrate understanding of clinical risk management concepts and their relationship to enterprise risk management and operational planning

Generate and monitor recommendations and clinical risk management strategies

Ensure clinical investigations and reviews occur in an environment that encourages learning, openness, transparency, and accountability aligned with Just Culture principles

Ensure systems, processes and resources are in place for all staff to identify and report when a patient safety incident has occurred, so that Open Disclosure can be initiated

Facilitate and participate in difficult conversations about individual patient incidents and how that might impact organisational patient safety risks

Highly Advanced

Possess expert knowledge about patient safety concepts, investigative methodologies, and risk management/analysis methodologies

Ensure the organisation upholds legislation, regulatory processes, policies and insurance laws relevant to clinical investigations and risk management and ensure that requirements are met

Provide expert guidance/advice to teams completing investigations and risk analyses

Incorporate clinical risk management into strategic and operational planning

Embed clinical risk management concepts into enterprise risk management processes and operational planning

Assess appropriateness and monitor effectiveness of recommendations and clinical risk management strategies from investigations and risk analyses

Promote the management of all clinical risk through learning, openness, transparency, and accountability aligned with Just Culture principles

Ensure all staff understand their responsibilities for Open Disclosure and provide necessary training, resources and guidance

Facilitate difficult conversations about individual patient incidents and how that might impact organisational patient safety risks

For each level of capability, the individual must also demonstrate the expected behaviours of each lower level of capability.

Manage Factors that Influence Human Performance

Understand and apply knowledge regarding how the organisation, environment, technology, process teams and personal conditions impact human performance to achieve safe, reliable care.

Foundational

Self-assess if you are fit for work (i.e. aware of staff illness, medication, fatigue, stress etc.) and communicate this to their direct supervisor

Employ structured (e.g. ISBAR) and closed-loop communication protocols during handover of patients

Employ graded assertiveness techniques (i.e. PACE/CUSS) to communicate patient safety concerns

Intermediate

Understand basic safety concepts including the characteristics of high-reliability organisations, the elements of a safety culture, and markers of effective teamwork

Understand how the way team members think (i.e. situational awareness and decision-making) and feel (i.e. stress and fatigue) impacts patient safety

Ensure staff are fit for work (i.e. aware of staff illness, medication, fatigue, stress etc.) and act to care for staff and prevent negative patient outcomes

Lead team in use of structured (e.g. ISBAR) communication and closed-loop communication tools

Employ graded assertiveness techniques (i.e. PACE/CUSS) to communicate patient safety concerns and acknowledge the concerns of others

Adept

Understand and model the leadership behaviours and principles associated with high-reliability

Discuss key safety concepts and models within team, including the characteristics of high-reliability organisations, the elements of a safety culture, Safety I and Safety II, work-as-imagined versus work-as-done, the efficiency-thoroughness trade-off, hierarchy of interventional effectiveness, markers of effective teamwork, etc.

Understand and explain how the way that team members think (i.e. situational awareness and decision-making) and feel (i.e. illness, medication, fatigue, stress etc.) impacts patient safety and act accordingly to prevent negative outcomes

Discuss the interaction of safety and efficiency with team members

Encourage use of graded assertiveness techniques to communicate patient safety concerns and acknowledge the concerns of others

Advanced

Coach line-managers and supervisors to understand and model the leadership behaviours and principles associated with high-reliability

Understand and explain key safety concepts and models to a variety of audiences within the organisation, including the characteristics of high-reliability organisations, the elements of a safety culture, Safety I and Safety II, work-as-imagined versus work-as-done, the efficiency-thoroughness trade-off, hierarchy of interventional effectiveness, markers of effective teamwork, etc.

Support and promote the use of simulation resources for clinical practice re-engineering, quality improvement efforts, usability and systems testing as well as research, education and training

Consider and accommodate factors that influence human performance in organisational policies, procedures and guidelines

Lead discussions internally and externally about the interaction between safety and efficiency

Highly Advanced

Coach senior leaders and managers to understand and model the leadership behaviours and principles associated with high-reliability

Support and promote use of Human Factors principles, tools, and methodologies in organisational activities and projects, such as when considering the design or refurbishment of new facilities or evaluating emerging interventions, technologies or processes

Provide education on key safety concepts and models to a variety of audiences within the organisation, including the characteristics of high-reliability organisations, the elements of a safety culture, Safety I and Safety II, work-as-imagined versus work-as-done, the efficiency-thoroughness trade-off, hierarchy of interventional effectiveness, markers of effective teamwork, etc. with internal and external stakeholders in the organisation

Know how to access and utilise simulation resources for safety assurance activities including clinical practice re-engineering, quality improvement, usability and systems testing, research and non-technical skills training

Employ Human Centred Design to identify and accommodate factors that influence human performance

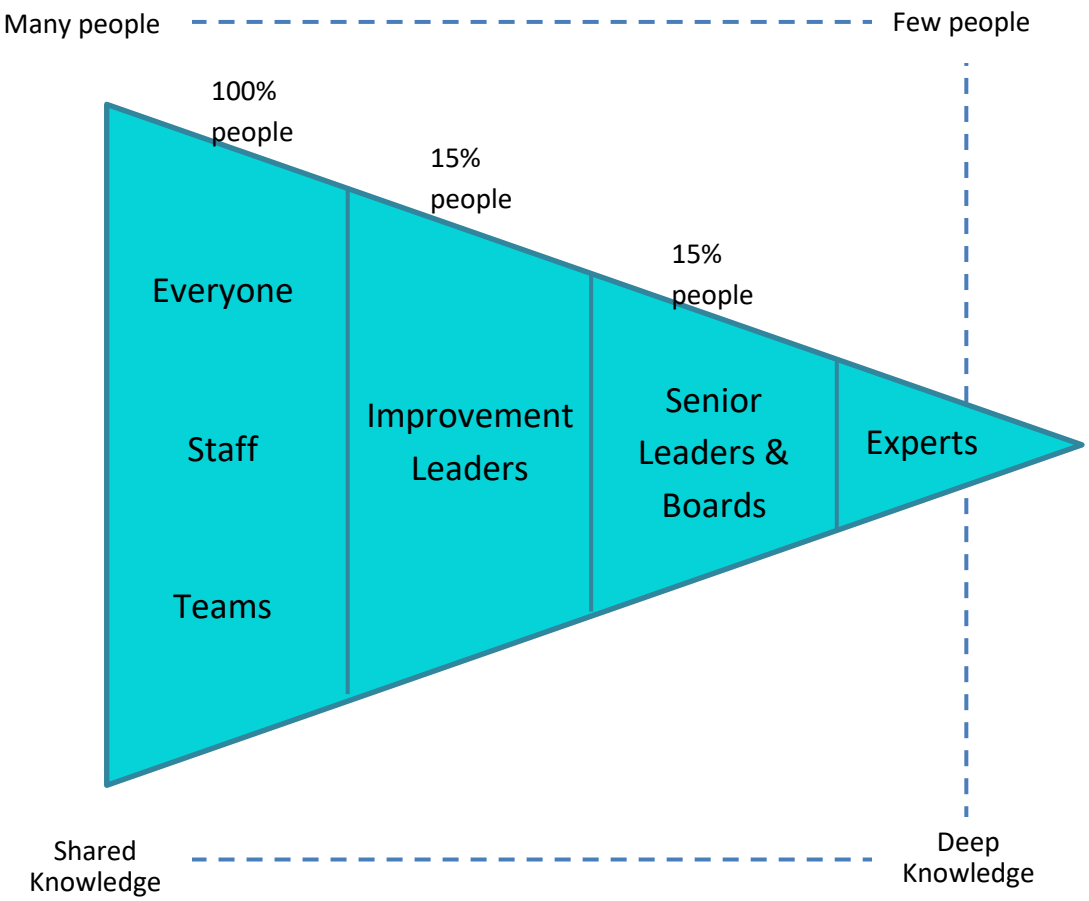
Educate the organisation about the relationship between efficiency, and production pressure on safety and quality

Building Organisational Capability

This document has outlined the capabilities needed across the NSW Health workforce to deliver effective patient safety and quality improvement. It is not feasible (or necessarily desirable) for every employee in your organisation to meet a highly-advanced level across all four capabilities. Instead, the goal is to develop both breadth and depth of capability across the organisation. A useful guide for the level of capability required across your organisation to achieve breadth and depth is provided by the Kaiser Permanente triangle of organisational capability shown below (Schilling, 2010).

There must be a small number of in-house Experts to guide and support the organisation's patient safety and quality improvement agenda. This group is empowered by Boards and Senior Leaders, who create the organisational conditions that are required for effective patient safety and quality improvement. To fulfil this critical role, Boards and Senior Leaders require a relatively high-level of capability, though not as complex as the Experts. Improvement Leaders are those middle-level managers and project leaders who either identify areas that affect patient safety and quality improvement, or are leading a group of staff who have identified such issues. They must also have a sophisticated level of capability, but may get assistance from Experts when needed. Finally, to create a shared understanding of everyone's patient safety and quality improvement responsibilities, all staff need a foundational level of capability.

What level of capability do you need across your organisation to have sufficient breadth and depth of skills in improvement?



Experts

Experts are those people in your organisation who have the highest level of knowledge, skills and abilities in patient safety management and quality improvement frameworks and methodologies. Their role is to teach, coach and support teams and individuals to improve the quality of their work to deliver safe, excellent care. This group serves a business support function and is usually, but not always, found in Clinical Governance Units. Organisations need patient safety management experts, quality improvement experts, quality assurance experts and data analytics experts. The capabilities needed for such expertise differ by each of these roles. Experts also require skills to work collaboratively to support managers and staff.

- *Where do the Experts reside in your organisation?*
- *How do they support your organisation achieve its patient safety and quality improvement goals?*
- *How do they work together to provide expertise to the organisation? How do they work across other business support functions, e.g. organisational development and learning, operations, etc.?*
- *What percentage of your workforce are Experts?*

Improvement Leaders

Improvement Leaders are the group with the most diverse roles. Often they are middle managers, project leads or investigation team leaders within the organisation, whose work either identifies areas that affect patient safety management and quality improvement, or who are leading a group of staff who have identified such issues. They must also have significant capabilities, but may get assistance from experts when needed. They need to have the same level of knowledge as senior leaders, but also require the ability to coach their team through patient safety management and quality improvement work. This means helping to interpret data, identify problems, develop and implement strategies to prevent future harm or improve quality of service.

- *To what level do some middle managers and project leaders understand quality improvement and know how to use improvement methodologies? To what level do middle managers and investigation team leaders understand patient safety policies, procedures and methods? How do middle managers and team leaders proactively manage risk and prevent harm in their teams.*
- *How do these leaders drive safety and continuous improvement cultures and lead improvement and patient safety efforts in the organisation?*
- *What percentage of Improvement Leaders possess the required workforce capabilities to drive quality improvement and lead patient safety in their teams or areas?*

Senior Leaders

As key sponsors, senior leaders are the drivers of safety and continuous improvement cultures and endorse teams and individuals to deliver patient safety and engage in quality improvement work. Therefore they need a working knowledge of patient safety management and quality improvement concepts, tools, methods and measures. They need to be able to make good management decisions based off this information.

- *To what level do your Senior Leaders understand quality improvement? To what level do they understand patient safety policies, procedures and methods?*
- *How do they drive safety and continuous improvement cultures and endorse staff to improve their work and deliver safe patient care?*
- *What percentage of the Senior Leaders possess the required capabilities at their level?*

Board members

Board members need to agree on and understand the organisation's patient safety and quality improvement strategies and plans to guide the organisation. Therefore, to make best decisions for the organisation, they need to understand how data is used for patient safety and quality improvement measurement.

- *To what level do your Boards and committees understand the organisation's strategy and plans for quality improvement? To what level do they understand patient safety policies, procedures and methods?*
- *How do they make decisions that support safety and continuous improvement cultures and endorse staff to improve their work and deliver safe patient care?*
- *What percentage of the Boards and committees possess the required capabilities at their level?*

Everyone else

This is the largest group in your organisation. Everyone means 100% of your workforce. Therefore, all staff must have a general introduction to the knowledge, skills and abilities about patient safety and quality improvement. This facilitates shared understanding, helps identify more opportunities for change and is essential to building a culture of safety and improvement.

- *How does your organisation set and communicate the expectations for safe patient care delivery to every member of your workforce?*
- *How does your organisation set and communicate the expectations to improve their work for every member of your workforce?*
- *What percentage of your workforce at this moment possesses a foundational level of patient management and quality improvement capabilities?*

What level of capability is required by each stakeholder group?

Stakeholder group	Capability	Level
Quality Improvement Expert	Utilise Improvement Methodologies	Highly Advanced
	Think Creatively and Innovatively	Advanced
	Manage Clinical Risk	Adept
	Manage Factors that Influence Human Performance	Adept
Patient Safety Management Expert	Utilise Improvement Methodologies	Adept
	Think Creatively and Innovatively	Adept
	Manage Clinical Risk	Highly Advanced
	Manage Factors that Influence Human Performance	Advanced
Improvement Leaders[1]	Utilise Improvement Methodologies	Advanced
	Think Creatively and Innovatively	Advanced
	Manage Clinical Risk	Advanced
	Manage Factors that Influence Human Performance	Adept
Senior Leaders	Utilise Improvement Methodologies	Adept
	Think Creatively and Innovatively	Highly Advanced
	Manage Clinical Risk	Adept
	Manage Factors that Influence Human Performance	Adept
Board	Utilise Improvement Methodologies	Adept
	Think Creatively and Innovatively	Adept
	Manage Clinical Risk	Adept
	Manage Factors that Influence Human Performance	Adept
Everyone else	Utilise Improvement Methodologies	Foundational-Intermediate
	Think Creatively and Innovatively	Foundational-Intermediate
	Manage Clinical Risk	Foundational-Intermediate
	Manage Factors that Influence Human Performance	Foundational-Intermediate

[1] One Improvement Leader may not possess all capabilities at all levels required. Improvement Leaders need to develop teams where the capabilities are covered by multiple members.

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