PSCQ Strategic Plan

2022 - 2025

Patient Safety and Clinical
Quality Directorate

Government of **Western Australia**
Department of **Health**

Foreword

Since 2016, the Patient Safety and Clinical Quality Directorate (PSCQ) has developed triennial strategic plans. The 2016-2019 strategic plan focused upon the emerging role of the Department of Health as defined by the Health Services Act 2016, while the 2019-2022 strategic plan emphasised PSCQ's dual functions for assurance of the safety and quality of health services and clinician engagement.

In our 2022-2025 strategic plan, we have incorporated lessons learnt since 2016 and drawn from national and international best-practice for safety and quality. In addition to supporting the System Manager's assurance function; we have absorbed feedback regarding the role of the Department of Health in supporting clinicians and healthcare workers to improve care.

Experience elsewhere is that COVID has adversely impacted upon healthcare delivery, staff morale and psychological safety, and patient outcomes. We will be challenged by the need for contemporary clinically relevant data to guide our oversight of the health system; the need to adapt agilely to new systems and processes whilst maintaining the safety and quality of care; the need to support staff through patient safety cultures and to consider the PSCQ's regulatory functions.

This strategy outlines how the PSCQ will support the wider WA Health system in the face of pressures we will undoubtedly experience. The four pillars defined in our 2022-2025 Strategic Plan are directed towards providing the WA health system with data, resources, expertise, and quality improvement tools to drive changes locally. The pillars support robust clinical governance systems and patient safety cultures which focus on staff and patient experience and demonstrate PSCQ's ongoing commitment to high-quality services for all who access healthcare in WA.

We fully recognise the environment into which this strategic plan is being released. Considering the pressures which the WA Health system will face, it would be tempting to defer the work described in this strategic plan. However, the COVID-19 pandemic has highlighted the critical need for safe systems and commitment to high-quality health care. Thus, we have chosen to persist with the work outlined in this strategic plan. We accept that we may not meet our self-prescribed timeframes and that we may even fall short of our ambitions. What we cannot accept, is never taking these steps.

Dr Audrey Koay, Executive Director
January 2022

The PSCQ Management team

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The PSCQ Journey

PSCQ's function in promoting patient safety and clinical quality are part of well-established systems for clinical risk, governance, and consumer engagement which have been in place for many years in WA Health...

2016

The Health Services Act redefined the DOH's and HSPs' roles. In this context, PSCQ took an oversight function for safety and quality.

2016

At this time, the directorate comprised of the Patient Safety Surveillance Unit, the Licensing and Accreditation Unit, and a Quality Office

2018

In 2018, the Mental Health Unit and the Reproductive Technology Unit joined PSCQ, broadening its regulatory, quality and policy function

2018

The directorate expanded again, with the internal creation of the Medicines and Technology Unit and Healthcare Quality Intelligence Unit (formally commenced 2020)

2019

PSCQ developed its *PSCQ Priorities 2019-2022*

PSCQ Priorities recognised the importance of clinical engagement, and led work to support clinicians in understanding and addressing clinical variation and accessing clinical data

2020

2020 saw the release of the Safety and Quality Indicator Set, the WA Clinical Governance Framework, and the internal Patient Safety Strategy

2022

The *PSCQ Strategy 2022–2025* brings further intelligence, improvement, capability, and stewardship to the safety and quality landscape in WA healthcare

PSCQ contains a diverse range of teams who contribute specialist clinical, technical, policy, and governance expertise to support WA Health Service Providers and other non-government organisations to deliver safe, high-quality patient care as part of the Clinical Excellence Division, WA Department of Health.

Executive Office, Policies and Projects (EOPP)

EOPP assist the Executive Director to provide wider directorate-wide support for internal business functions and specific safety and quality programs.

EOPP administers the Clinical Governance, Safety and Quality Policy Framework; developing and providing assurance for several of the policies within the Framework.

In addition to this, EOPP supports specific time-bound safety and quality strategies and projects; and provides advisory, liaison, and work planning for Australian Commission on Safety and Quality in Healthcare in WA.

Reproductive Technology Legislative Review Unit (RTLU)

The RTLRU is a specific, time bound unit, created to support the review of the *Reproductive Technology Act 1991* and the *Surrogacy Act 2008*, through the various necessary stages, with new legislation to be implemented by 2024.

Our teams

Reproductive Technology Unit (RTU)

The RTU provides oversight, regulation and advice regarding trends, new technologies and social issues relating to assisted reproductive technology practices in Western Australia.

RTU has legislative responsibilities, provides executive support for the WA Reproductive Technology Council, advises the Minister for Health and System Manager of WA Health, and provides information and support for community accessing reproductive technologies and surrogacy.

Patient Safety Surveillance Unit (PSSU)

PSSU are responsible for state-wide patient safety policy, data management and reporting. PSSU engages with a range of stakeholders across WA Health and externally to review consumer feedback and complaints, clinical incidents, clinical risk management and mortality review.

The PSSU administers the state-wide Clinical Incident Management and Consumer Feedback Systems (Datix CIMS/CFM), and provides data governance for each platform.

Mental Health Unit (MHU)

The MHU provides high-level expertise and advice to assist WA's mental health services to deliver an evidence-based, person-centred, trauma-informed, safe, respectful, and supportive mental health system.

The MHU administers the Mental Health Policy Framework; and co-ordinates reviews, monitoring, and improvement of safety and quality in public mental health services.

The MHU delivers the Mental Health Safety and Quality Indicator set; and is currently progressing a project in partnership with Consumers of Mental Health WA aimed at identifying quality improvement opportunities in the care of mental health consumers in ED.

Medicines and Technology Unit (MTU)

The MTU provides governance and expertise to facilitate the safe, cost-effective, equitable and quality use of medicines and health technology for WA patients.

The MTU coordinates the State-wide Medicines Formulary and the High Value Healthcare Collaborative, leads the response to the Sustainable Health Recommendation 16, and manages state-wide policies and projects relating to safety and quality for medicines and health technology.

Healthcare Quality Intelligence Unit (HQIU)

HQIU are a multi-disciplinary team with a mix of skills including ICT project management, business analysis, epidemiology, statistics, data analysis, research and quality improvement.

HQIU manages several programs of work, including:

- Safety and Quality Indicator Set
- WA Cardiology Outcomes Registry & National Cardiac Registry
- Cancer Multidisciplinary Activity Program
- Clinical quality registries

HQIU coordinates the WA Health Quality Surveillance Group, and works with clinicians and other HSP stakeholders to describe clinical variation in health outcomes to lead work to enable data-driven change.

Licensing and Accreditation Regulatory Unit (LARU)

LARU is the legislated regulator of health service accreditation as part of the Australian Health Service Safety and Quality Accreditation Scheme for both public and private hospitals.

LARU provides expert advice, investigations, reviews and makes responsive recommendations to areas of high risk or perceived non-compliance, to ensure health facilities are safe and provide an appropriate environment of care.

Our strategic approach

The PSCQ have defined four overarching system-level pillars supporting the PSCQ strategic direction. These pillars embody our approach and a shared mindset and are underpinned by collective goals shared among the PSCQ teams, which will be our core focus for the next three years.

Quality Intelligence

Apply data to support routine insights, safety and quality initiatives, and to improve overall clinical and health care

Quality Improvement

Leverage the latest improvement science approaches to drive quality and target clinical variation

Culture and Capability

Engage all clinical and health care staff to build and lead a positive safety and quality culture and improve system performance

Regulatory Stewardship

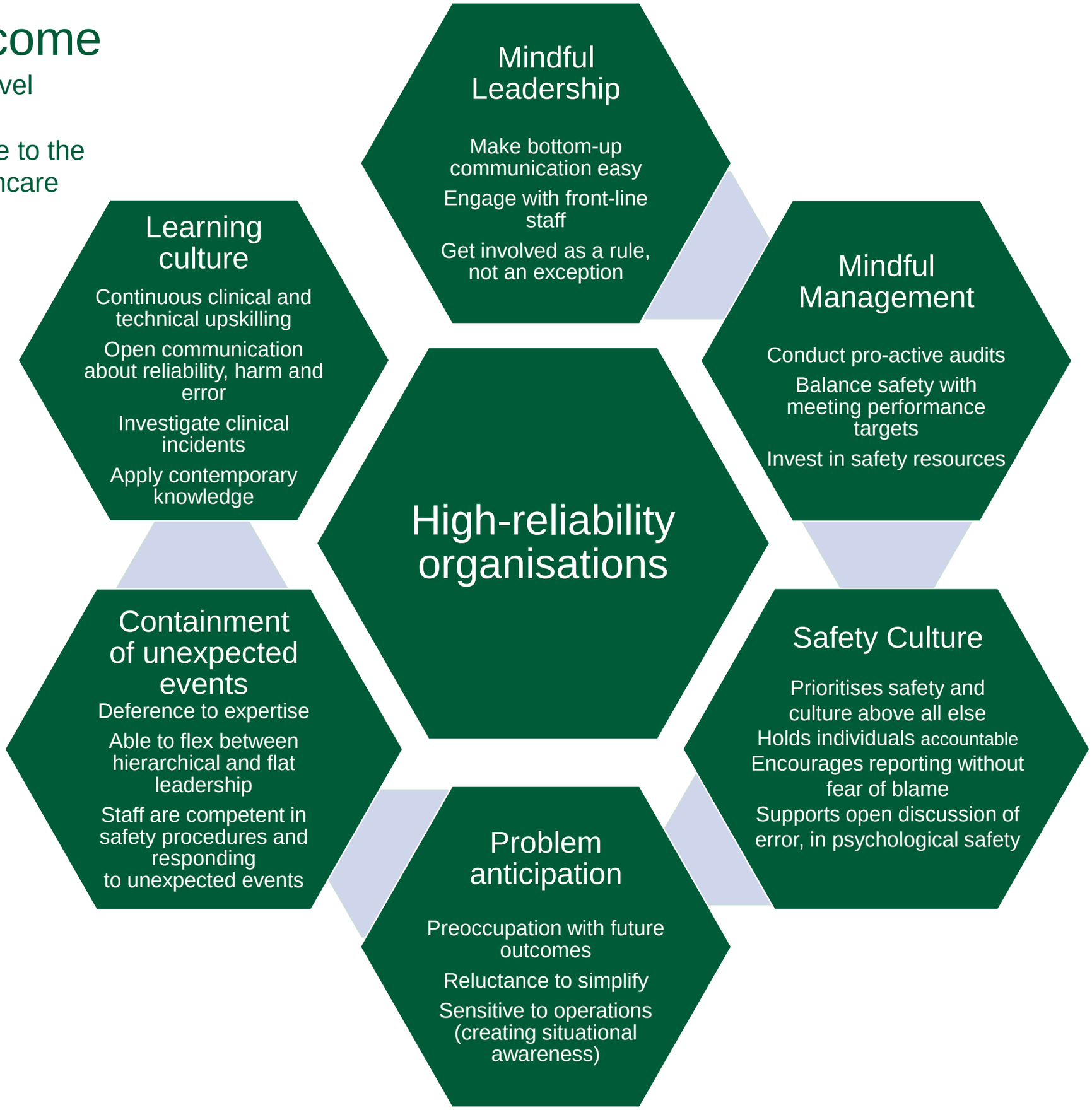
Promote a regulatory stewardship approach to ensure proactive, collaborative regulation, governance and reporting

Our Mission

To build high-reliability WA health organisations by providing stewardship and supporting clinical quality; and to maintain assurance for patient safety for the System Manager

Our intended outcome

The four overarching system-level pillars which support the PSCQ strategic direction will contribute to the creation of high-reliability healthcare organisations.



Quality Intelligence

What we will do

Translate health data to support clinicians, provide assurance for the System Manager, and to inform the community

How we will do this

Establish data sources, governance, processes, systems, and platforms to provide robust metrics and analysis for healthcare quality

Strategic goal	What's involved? Target outcome	Key deliverables by when?	Who's involved?
Maximise the value of routinely collected data and new data sources for quality assurance and improvement	Source, collate, link, and refine safety and quality data; including development of data collection processes and tools to support acquisition of new data, and ongoing review of assurance measures across the system. E.g. Reproductive Technology Registers, Safety and Quality Indicator Sets (SQuIS - including mental health indicator sets); health service accreditation data; clinical quality registries such as WA Cardiac Outcomes Registry (WACoR) and Cubes of Cancer (CoCA); Medicines and Technology data; Clinical Incident data; opioid stewardship and sepsis data	Continuous function of all PSCQ teams	All PSCQ teams and external partners (E.g. Purchasing and System Performance)
Procure and manage information systems that support the storage and use of safety and quality data	Procure, commission, configure, and maintain systems to support data capture for patient safety areas such as medications safety, clinical incidents management and cancer care (including respective project and governance groups): • Datix CIMS/CFM (Clinical Incident Management/Consumer Feedback System) • WA Patient Information Approval System (WAIPAS) • State Medicines Formulary (Formulary One) • Multidisciplinary Team software for CanMAP project	DatixCIMS/CFM replacement (2024) SMF electronic platform replacement (end 2022) WAIPAS state-wide roll-out to WA Health (end 2022)	MTU, PSSU
Analyse data for internal planning and clinical practice improvement	• Apply data analytics methods and metrics (Eg. clinical variation measurement) to develop evidence-based indicators for clinical quality • Undertake robust data analysis to aid internal planning • Use data to explore clinical issues (eg. low-volume complex care, sepsis) • Compare and benchmark S&Q performance (including nationally)	Mapping and review: sepsis and LVCC data (end 2023); routine service comparison and benchmarking (scoping mid-2022); risk review for private facilities (annual)	MTU, RTU, EOPP, HQIU, LARU
Promote a culture of measurement for improvement across the WA Health System	• Encourage widespread use of data by delivering data literacy tools and training supported by the Institute for HealthCare Improvement • Engage clinicians through common facilitation model to assist review of data and encourage clinical practice improvement (using methods such as triangulation of soft and hard intelligence)	MH SQuIS indicators (commenced end 2021); additional indicators (2022-2025)	HQIU, MHU, MTU
Advocate for greater transparency of data to support patient safety and quality assurance	Build interoperable platforms for public reporting of health service accreditation, S&Q performance, patient experience and outcomes to: (1) promote transparency, visibility, and accessibility of data to improve quality of care at the state and clinical level (2) empower consumer choice in accessing healthcare	Accreditation results (2023); ART clinic reporting (scoping mid-2022, end-2025); Patient Safety dashboard (end 2022), public SQuIS (mid-2025)	HQIU, MHU, LARU, RTU, PSSU, MTU

Quality Improvement

What we will do

Undertake leadership and governance to foster the systems and environment for continuous quality improvement activities

How we will do this

Support quality improvement activities and quality systems across WA Health which align with PSCQ's remit for clinical quality

Strategic goal	What's involved? Target outcome	Key deliverables by when?	Who's involved?
Promote the ongoing success of the High-Value Healthcare (HVHC) model, and monitor and limit low-value healthcare treatments	• Provide coordination of high-value healthcare initiatives as per 'Recommendation 16' of the *Sustainable Health Review* (E.g. Choosing Wisely, Opioid Stewardship, Sepsis Management, Antimicrobial Stewardship, and other identified program areas) • Assist Health Service Providers to dedicate project resources and develop shared objectives to implement state-wide HVHC initiatives • Develop formal systems or defined approaches to advise and support WA Health to reduce low-value complex or unwarranted healthcare procedures; including through purchasing and commissioning practices	Opioid Stewardship engagement (end 2022) Choosing Wisely advocacy and support (ongoing)	MTU
Explore strategies to maximise the effectiveness of WA Health's existing quality improvement systems	Complete a scoping exercise to determine effective ways to support quality improvement in WA Health, including: • Reviewing best-practice models in other jurisdictions • Engaging with HSPs to determine current needs in supporting QI (mapping resources, local practices, training opportunities, supporting ICT infrastructure, and governance processes) • Conducting a prioritisation/ feasibility assessment to determine final goals	System-wide scoping exercise (end 2022); program implementation (commence 2023)	EOPP
Engage consumers and carers, clinicians, researchers, and HSPs to support state-wide clinical improvement initiatives	Undertake state-wide QI initiatives to improve patient outcomes in areas of identified clinical need (using the QI Collaborative model, and arising from data sources such as PSCQ and HSP priority areas and reported findings from the Australian Commission on Safety and Quality in Health Care) These areas may include projects to promote 'good care' in maternity and mental health	MHU QI activities commence (mid-2022); maternity activities commence (mid-2022)	MHU, EOPP, HQIU
Promote standardised guidance to support HSPs to deliver co-ordinated quality improvement activities	• Support training and local capability-building in methodologies for quality improvement • Provide system-wide access to online learning content provided by QI faculty and QI academies elsewhere in Australia and nationally • Promote the use of standard applications, tools, and frameworks to support QI activities across WA Health	TBC following scoping exercise (commence mid-2022)	HQIU, EOPP
Review the quality of PSCQ service delivery to ensure it meets stakeholder needs	Routine review of PSCQ performance in delivering robust, system-wide quality improvement support Seek annual feedback on regulatory inspection practices	(commence 2022, ongoing)	LARU, EOPP

Culture and Capability

What we will do

Contribute to building a culture of continuous improvement supported by strong workforce capability for patient safety

How we will do this

Partner with HSPs and private providers to develop system-wide skills and workforce capability for safety and quality

Strategic goal	What's involved? Target outcome	Key deliverables by when?	Who's involved?
Review safety and quality culture and capability across WA Health and private providers	• Work with national partners to assist HSPs to self-administer S&Q maturity assessment and clinical governance stock-take to assess areas for improvement within HSP processes and systems • Develop and implement safety and quality capability frameworks, based on WA Public Sector Commission Capability Profiles, to assess and baseline the skills and knowledge of all WA Health staff	HSP maturity assessment (End 2022); S&Q Capability Framework (2025)	PSSU
Provide tailored, system-wide training and capability-building opportunities for safety and quality	• Work with national partners to build greater safety and quality capability for HSP Boards, managers, and clinical staff • Engage tertiary partners to deliver S&Q curricula as part of health professions training • Where appropriate, support education and training packages for consumers, private providers and contracted entities	Delivery of education sessions for ART (End 2022); S&Q L&D Program (mid-2025)	PSSU, RTU, LARU, MTU, HQIU
Promote platforms, resources, and knowledge systems to support S&Q capability	Promote positive patient safety culture (Safety II, Safe Systems, Human Factors) through: • Development of web content, online resources and guidelines, and a collaborative platform for clinical staff and S&Q professionals • WA Health Communities of Practice for networking and the sharing of information and expertise for safety and quality • Informational resources to support clinicians and consumers understand patient safety roles, responsibilities, and expectations	Clinical Incident Management resources and web content updates (end 2022); clinical guideline updates (end-2023)	PSSU, HQIU, EOPP
Build sector capability for regulatory function through legislative review	Develop and implement best-practice contemporary legislation to support capability in the private health facility sector. This will: • Align with the WA Government *Better Regulation* practice standards to achieve transparency, accountability targeting, consistency and proportionality within legislative frameworks • Respond to recommendations outlined in recent review reports and stakeholder engagement activities • Involve the provision of education opportunities to support introduction of legislation	*Private Hospitals and Health Services Act* legislative reform process (mid-2024); *Human Reproductive Technology* and *Surrogacy Acts* (end-2024); supporting education (end-2025)	LARU, RTU, RTLRU
Adopt a systems approach to S&Q capability driven by ACSQHC guidance	Expand existing secretariat function of Interjurisdictional Council for the *Australian Commission for Safety and Quality in Health Care* to improve information-sharing and support state-wide program alignment with *National Safety and Quality in Health Service Standards* and Clinical Care Standards	Continuous function of all PSCQ teams	Led by EOPP, LARU, MTU

Regulatory Stewardship

What we will do

Provide proactive, collaborative regulation and assurance to the System Manager for patient safety in private and public health facilities

How we will do this

Flexibly combine effective risk-based regulation (governance, standards, policies, and processes) with a stewardship approach (functional expertise, case-management, and outcomes-focused support)

Strategic goal	What's involved? Target outcome	Key deliverables by when?	Who's involved?
Strengthen S&Q policy assurance	Support, standardise, and streamline PSCQ Mental Health and Clinical Governance Safety and Quality Policy Frameworks; transition PSCQ policy management to a supportive assurance function for S&Q-related and NSQHS-aligned policy processes in Health Service Providers and mental health facilities	Complete full implementation and review cycle by end 2025	EOPP, MHU, MTU, PSSU, LARU
Deliver and enhance clinical governance systems and legislated regulatory functions for public and private health facilities	Work with Health Service Providers to deliver strong clinical governance systems and effective patient safety reporting and review processes as defined by legislation and mandatory policy, including: • High-quality clinical incident management • Mortality review • Consumer feedback • External engagement, information, and advice Administer the legislative requirements for facility ownership and governance of private health care facilities in WA; and ensure and support legislative compliance and manage noncompliance, quality and safety risks across the sector	Continuous function of PSCQ regulatory teams	LARU, PSSU, RTU
Strengthen clinical governance in contract management for Contracted Health Entities	Work with contracted entities and Safety and Quality staff in HSPs to strengthen clinical governance processes for non-WA Health providers. This includes establishment of contracted health entity register for safety and quality purposes, informational materials, and an annual compliance review	Register (early 2022); Informational materials (mid-2022); Annual review (from early 2023)	PSSU
Review regulatory stewardship functions of the Reproductive Technology Unit and Council	Comprehensive review of RTU's regulatory functions, including recommendations to inform development of new legislation and supporting activities, and potential transition of regulatory function to LARU	Review complete (end 2022); implementation by end 2025	RTU, RTLRU, LARU
Promote stewardship through effective relationship building with public and private health facilities	Promote positive relationships with licensed private healthcare providers and an open and transparent regulatory culture using: • A case-management and support approach to regulation • Soliciting regular stakeholder feedback on licensing process • Reporting and publication of accreditation outcomes and disaggregated adverse events	Stakeholder feedback (end 2022); ART reporting (end 2022) Accreditation reporting (end 2025)	LARU, PSSU, RTU, MTU

Evaluating progress

Evaluation of the *PSCQ Strategic Plan 2022-2025* will be achieved through periodic monitoring of internally developed KPIs which include activity, performance, and outcome metrics.

Activity-based KPIs

- Development and deployment of new safety and quality systems (such as PowerBI dashboards for the Safety and Quality Explorer platform)
- Completed legislative reviews, ongoing policy review, and development and application of a framework for assessing relevance of PSCQ policies
- Development of clinically relevant data sets used by clinicians and health services for audit and QI, consumers to inform healthcare choices, and researchers for safety and quality collaborations
- Implementation of Safety and Quality Capability Assessment by all WA HSPs
- Provision of ongoing secretariat support to relevant committees and high-quality advice across the sector, by all teams

Performance-based KPIs

- Monitoring of delivery and deployment costs and timeframes for new activities
- Application of an effective and mature policy assurance process
- Positive feedback on internal PSCQ operations, S&Q platforms, and training and engagement programs from external consumers and stakeholders
- Adoption, usage, and efficacy metrics for reporting platforms and informational materials
- Compliance with PSCQ's legislated governance and regulatory requirements
- Nuanced metrics that recognise competing factors in risk-based and stewardship approaches to regulation
- Development of shared project objectives which demonstrate successful change management

Outcome-based KPIs

Acknowledging that PSCQ does not have a direct impact on patient outcomes, we will continue to monitor:

- The prevalence of low-value healthcare treatments and procedures in WA healthcare facilities
- The extent of unwarranted variation against key clinical indicators
- Dissemination of good safety and quality practices and High-Value Healthcare across the WA Health system
- Patient experience measures
- Staff experience measures
- Carer experience measures – national measures for mental health carers may be adopted for use in WA during the *PSCQ Strategic Plan* period 2022-2025

Building blocks to support the Strategy

To support PSCQ's strategic direction, PSCQ will undertake internal enabling activities including:

- A supported, directorate wide-implementation process with regularly reviewed internal KPIs and targets
- Strengthening of our management team to support cross-team collaborative goals
- Streamlined business support and administrative processes
- Continued high-quality training and learning opportunities to support professional development in patient safety and clinical quality for all PSCQ staff
- An ongoing strategic planning and review cycle as part of annual reporting
- Whole-of-directorate data to identify and respond to critical system-wide safety and quality issues, and inform work-planning

This document can be made available in alternative formats on request for a person with a disability.