Victorian Quality and Safety Capability Framework

Safer Care Victoria

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VICTORIA
State Government

Contents

ACKNOWLEDGEMENT OF COUNTRY

Our office is based on the land of the Traditional Owners, the Wurundjeri people of the Kulin Nation. We acknowledge and pay respect to their history, culture, and Elders past and present. We acknowledge Aboriginal people as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we rely. We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches us. We embrace the spirit of reconciliation, working towards the equality of outcomes and ensuring an equal voice. For this land always was, and always will be, Aboriginal Land.

ACKNOWLEDGEMENTS

We extend our sincere gratitude to everyone who contributed to the development of this framework. The collaborative effort reflects the collective commitment to enhancing quality and safety for all Victorians. This framework is a testament to the power of collaboration, and we appreciate the commitment of all those who invested their time and expertise in its development, including:

- Members of the Victorian Quality and Safety Capability Framework Advisory Group
- Subject Matter Experts from SCV, academia and across the wider Victorian health sector
- Consumer representatives in the Victorian Quality and Safety Capability Framework consultation groups

CEO Forward

As a passionate advocate for quality and safety in healthcare, I am pleased to introduce this comprehensive Victorian Quality and Safety Capability Framework. This framework represents a significant step forward in our collective commitment to ensuring the delivery of the highest standards of care for everyone we serve.

In an ever-evolving healthcare landscape, the capabilities of our workforce are paramount. Just as Safer Care Victoria's updated Victorian Clinical Governance Framework underscores the essential systems, structures, and culture for quality care, this Capability Framework focuses on the individuals who bring that framework to life. It recognises that embedding a true culture of safety and quality requires a skilled and empowered workforce at all levels.

This framework provides a clear pathway for developing the necessary skills and behaviours to proactively manage risk, genuinely partner with consumers, cultivate a robust safety culture, and understand the complex systems within which we operate. It acknowledges that building capability is a journey, offering distinct levels of proficiency to guide individual growth and support organisational development.

By establishing a common language and understanding of the capabilities required for quality and safety, this framework aims to empower individuals to contribute meaningfully to a safer and more effective healthcare system. It highlights the critical role each person plays in identifying risks, collaborating with colleagues and consumers, and fostering an environment where learning and continuous improvement are embedded in our daily practice.

Ultimately, the success of our quality and safety endeavours rests on the capabilities of our people. I encourage every member of our healthcare community to engage with this framework, identify opportunities for growth, and embrace their role in creating a safer and more person-centred healthcare experience. Together, we can cultivate a workforce equipped to meet the challenges of modern healthcare and deliver exceptional care for all.

Ms Louise McKinlay
Chief Executive Officer, Safer Care Victoria
Chief Quality and Safety Officer Victoria

Introduction

The Victorian Quality and Safety Capability Framework outlines the essential knowledge, skills, and attributes required for individuals in the Victorian healthcare system to deliver consistently high-quality care and work to prevent avoidable harm and foster learning and improvement. The Capability Framework emphasises that quality and safety are a shared responsibility across all healthcare professions and consumer partners at every level of the system.

Structured around a set of core capabilities, the Capability Framework defines the expected level of proficiency through specific elements. These interconnected and interdependent capabilities reflect the complex nature of quality and safety in healthcare. We will regularly review and update the framework to incorporate evolving best practices, research, and changes in healthcare delivery. By fostering a shared understanding of the required capabilities, the framework aims to contribute to a more reliable healthcare system.

INTENDED USE AND AUDIENCE

This Capability Framework is intended to be used by all healthcare professionals and consumer partners at every level of the health system. We intend it to be adaptable and scalable, allowing healthcare organisations and individuals to tailor its application to their specific contexts and needs, including:

Common language for quality and safety: The Capability Framework establishes a shared vocabulary and understanding of the essential capabilities required for quality and safety. This common language facilitates communication, collaboration, and a consistent approach to delivering safe, timely, effective, efficient, equitable, and person-centred care (STEEEP).

Building individual development: Healthcare professionals and consumer partners can use this framework to assess their current capabilities in quality and safety, identify areas for growth, and guide their professional development activities. This process can be supported by the self-assessment tool found in Appendix 2.

Informing career development: The Capability Framework can be used to inform career pathways and progression within the healthcare system. It clarifies the quality and safety capabilities expected at different levels of responsibility and provides a roadmap for professional growth.

Supporting workforce planning: Healthcare organisations can leverage the Capability Framework to identify current and future workforce needs related to quality and safety capabilities. It informs training programs and succession planning, ensuring that the organisation possesses the necessary capabilities to deliver safe and high-quality care.

Facilitating team development: Teams can utilise the Capability Framework to facilitate discussions about shared responsibilities for quality and safety, identify collective strengths and weaknesses, and develop team-based improvement plans. It promotes a collaborative approach to problem-solving and enhance teamwork skills. This process can be supported by the self-assessment tool found in Appendix 2.

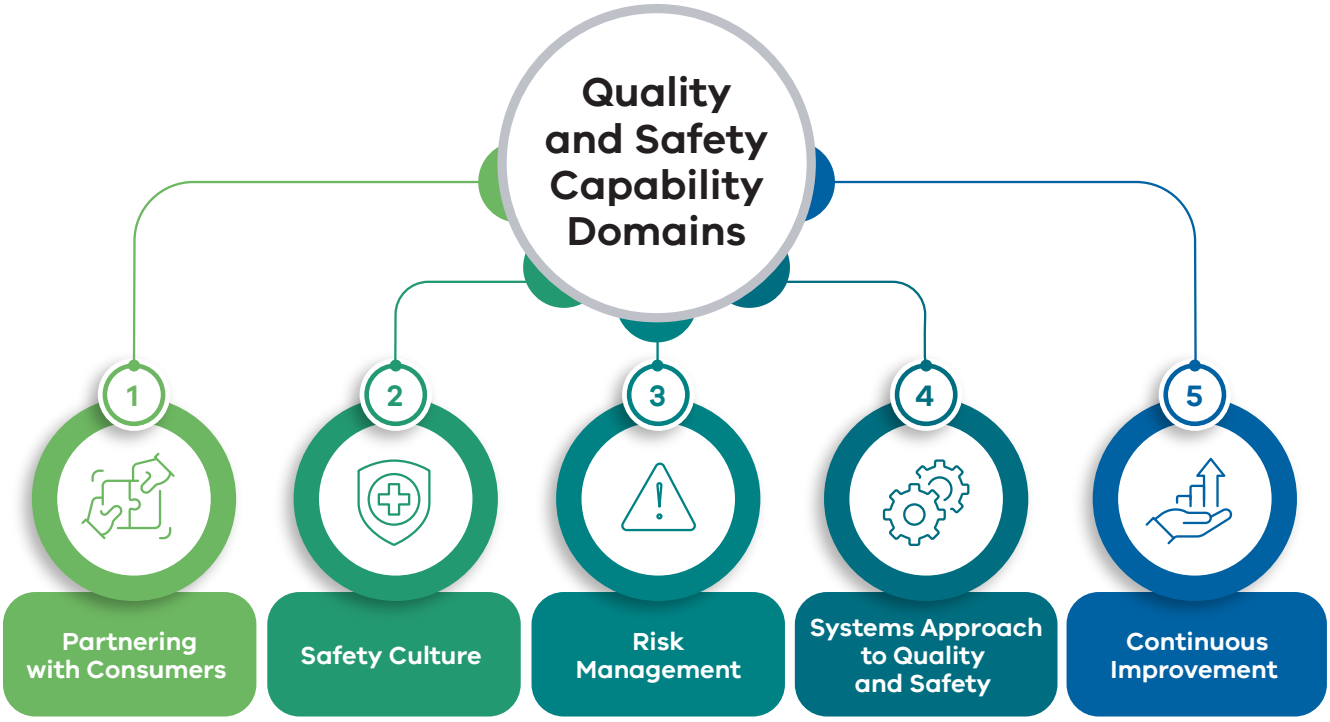
Capability Domains

We structured the Capability Framework around five core domains, each representing a critical aspect of quality and safety. The domains are:

- Partnering with Consumers
- Safety Culture
- Risk Management
- Systems Approach to Quality and Safety
- Continuous Improvement

Within each domain, we have defined a set of specific capabilities. This layered approach allows us to develop and assess the essential skills and knowledge required for a patient-centred, high-quality healthcare environment.

Figure 1. SCV Capability Domains



Capability Levels

The four distinct capability levels range from general understanding to advanced. These descriptors reflect a clear progression in knowledge, skill, and mindsets, signifying a tangible uplift in individual capability. Recognising that individual capabilities can vary across different quality and safety domains; this framework supports a flexible approach to tailored capability development.

Our framework recognises that a thriving quality and safety environment is enabled by **strategic decision-makers**. Individuals at this level are system-level leaders. They possess a strategic understanding of how quality and safety are integrated across the entire organisation and within the broader healthcare system. They lead significant organisational change, driving sustained improvement in patient outcomes and safety at a systemic level. They may also engage in external collaborations to advance quality and safety across the sector. Strategic leaders do not necessarily possess expertise in all domains, however, operate at a system-wide level to champion and enable a culture of quality and safety across the organisation.

General understanding

Individuals possess a basic awareness and introductory knowledge of quality and safety principles, methodologies, and tools. They can recognise the importance of these elements in healthcare delivery but may have limited practical application or in-depth understanding. They are beginning to learn about relevant terminology, guidelines, and reporting mechanisms within their immediate work environment.

Foundational

Individuals demonstrate a broader understanding of quality and safety principles, methodologies, and tools. They can identify and analyse common quality and safety issues and apply learned concepts in their work. They are beginning to identify potential risks and contribute to quality improvement initiatives.

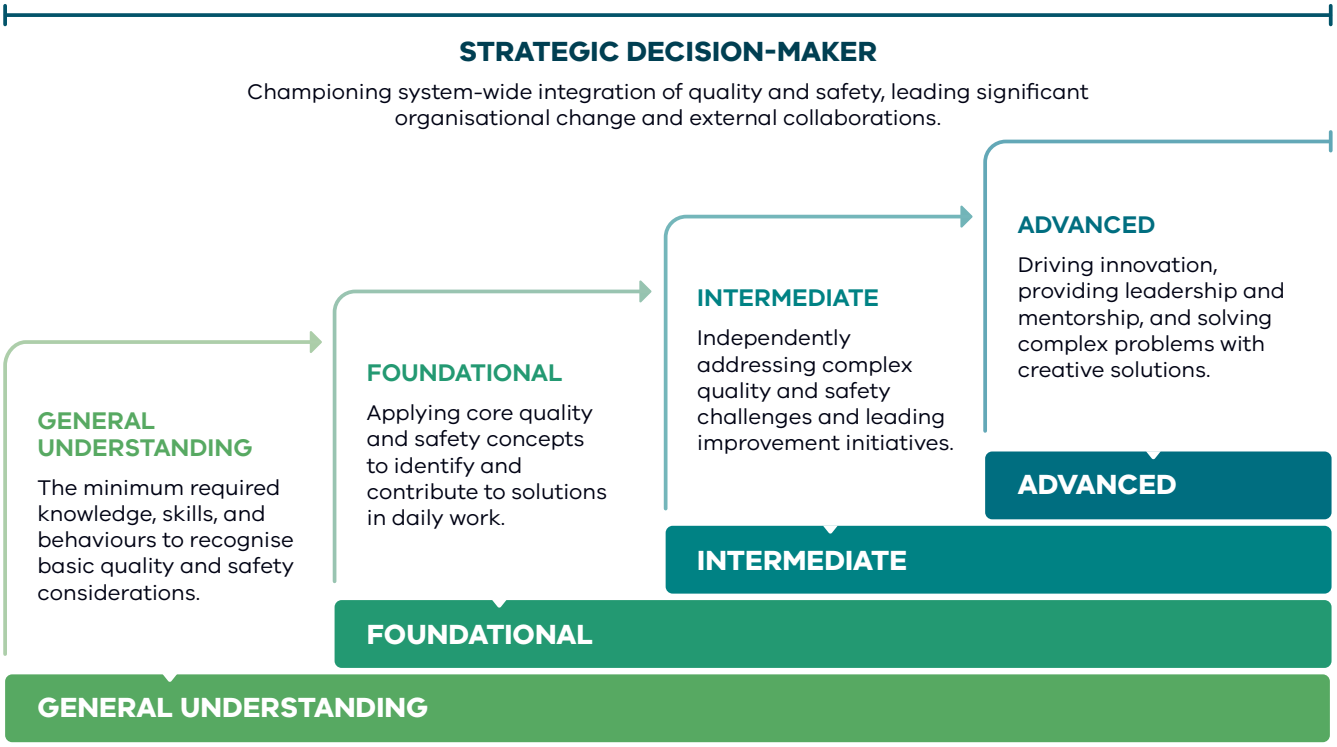
Intermediate

Individuals possess a core understanding of quality and safety principles, methodologies, and tools. They can independently identify, analyse, and address complex quality and safety challenges. They contribute to quality improvement initiatives and lead projects. They demonstrate a commitment to continuous learning and staying current with best practices.

Advanced

Individuals possess comprehensive understanding of quality and safety principles, methodologies, and tools. They provide leadership, mentorship in the field, driving innovation and shaping organisational quality and safety culture. They analyse and solve complex problems and address challenging issues bringing creative and innovative solutions.

Figure 2. SCV Capability levels

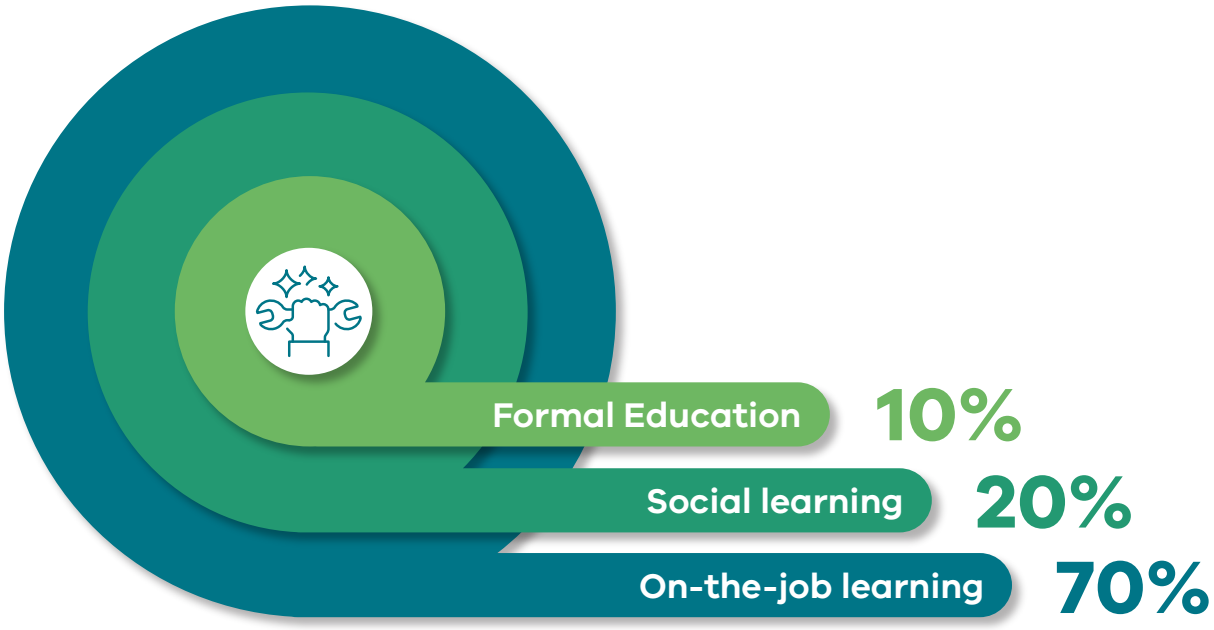


Achieving success and capability building

Individuals and organisations can measure individual and team growth in quality and safety capabilities. Individuals progress through capability levels by applying learned skills in real-world scenarios and committing to ongoing learning, which fosters a culture of continuous development.

The framework supports individual growth in quality and safety capabilities by blending formal, informal, and on-the-job learning, grounded in the 70:20:10 principles.[1]

Figure 3. Capability development, 70:20:10 model



On-the-job learning:

Participation in improvement projects

Reflective practice

Active feedback seeking

Social learning:

Mentorship programs

Peer-to-peer learning initiatives

Internal coaching programs

Cross-functional collaborations

Formal Education:

Short courses and workshops

Internal organisational training programs

Specialised higher education opportunities

1. Lombardo, M.M. and Eichinger, R.W. (2015).

Capability Statements

This section details capability statements across the five quality and safety domains. We illustrate the step-by-step development of knowledge, skills, and behaviours, moving from general understanding through foundational, intermediate and advanced. Strategic decision-makers, while not necessarily possessing the deepest expertise in all domains, operate at a system-wide level to champion and enable a culture of quality and safety across the organisation.

Each statement outlines the capabilities you should demonstrate at each level. We built these capabilities through a structured progression, ensuring a clear path for professional development. When you demonstrate capabilities at higher level, it indicates you've mastered the preceding levels, and we recognise that capability levels can differ across various domains.

PARTNERING WITH CONSUMERS:

Definition: Collaborating with consumers in all levels of the healthcare system to prevent harm and improve quality and safety outcomes

Description: This domain emphasises building collaborative and meaningful engagement with consumers to inform and improve the delivery of quality care. By prioritising consumer engagement, healthcare professionals and consumer partners can work together to create a patient centred, responsive and effective system that enhances patient safety. The capabilities outlined in partnering with consumers domain have been aligned with SCV's Partnering in healthcare framework (2019).[2]

	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Personalised and holistic care	Recognise that partnering with consumers is essential for improving outcomes and responding to individual needs.	Partner with consumers to deliver personalised and holistic care that considers their needs and preferences including physical, cultural, and language requirements.	Promote and facilitate person-centered care planning, addressing barriers and leading initiatives to integrate holistic considerations into care pathways.	Develop evidence-based personalised care models incorporating technologies and tools to support tailored care delivery.	Establish organisational vision and strategy that embeds partnerships as the standard of care in the organisation.
Meaningful consumer engagement	Demonstrate an understanding of the value of meaningful consumer engagement in their organisation.	Actively seek opportunities to engage consumers meaningfully in their work to improve quality and safety outcomes.	Promote and facilitate meaningful consumer engagement in their work and in improvement activities. Identify barriers to meaningful consumer engagement and implement potential solutions.	Provide expert guidance on best practices for engagement across diverse settings. Evaluate the impact of engagement initiatives on system performance and consumer outcomes. Identify and address system-level barriers to meaningful consumer engagement.	Develop and implement strategies and resources that enhance consumer engagement into organisational governance and strategic planning.
Accessible health information	Demonstrate an understanding of the value of accurate and timely information sharing with consumers. Recognise that there are varying levels of health and health system literacy.	Provide accurate and timely information to consumers. Adjust communication by using plain language and avoiding jargon when interacting with consumers. Check consumer understanding and uses strategies to confirm comprehension.	Promote and support access to resources and tools to support information sharing with consumers. Select appropriate communication tools and resources (e.g., visual aids, written materials) to enhance accessibility and comprehension for diverse populations.	Design and evaluate diverse communication materials (e.g., plain language summaries, visual aids, translated documents, multimedia resources) that cater to different levels of health and health system literacy.	Integrate systems and resources to effectively address the diverse health and health system literacy needs of all consumers.

2. Safer Care Victoria (2019) *Partnering in healthcare for better care and outcomes.*

	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Statutory duty of candour (SDC)	Demonstrate an understanding of SDC and that there is an expectation to communicate consumers when something has gone wrong in their care.	Understand the principles and goals of SDC (e.g., honesty, apology, explanation). Participate in SDC conversations under direct guidance and supervision within the role accountability. Escalate appropriately when the SDC process cannot be completed within their level of authority or expertise.	Facilitate SDC conversations, providing clear and accurate information, expressing empathy, and acknowledging what happened within the role accountability.	Lead SDC meetings for more complex incidents, ensuring a respectful and supportive environment for consumers and staff. Provides support and guidance to colleagues involved in the SDC process. Develops and implements organisational policies, and training programs to ensure consistent and high-quality SDC practices.	Promotes a culture of transparency, honesty, and learning from adverse events.
Consumer rights autonomy and decision making	Demonstrate an understanding of rights of consumers to make informed decisions about their own care, including the principles outlined in the Australian Charter of Healthcare Rights.	Respect and support consumer autonomy in daily practice, ensuring that consumers are informed and engaged in decision-making.	Promote the protection of consumer healthcare rights including consumer autonomy. Adapt shared decision-making approaches ensuring alignment with the Australian Charter of Healthcare Rights.	Provide expert guidance on complex issues related to consumer decision-making. Design and evaluate evidence-based guidelines, frameworks underpinned by consumers' rights to informed decision-making.	Ensure that strategic priorities, resource allocation, and governance structures align with the principles of the Australian Charter of Healthcare Rights. Identify and address systemic barriers that prevent consumers from exercising their rights.
Equity and inclusion	Demonstrate an understanding that the environment and conditions can impact effective consumer engagement. Recognise there are different levels of power in the health system between consumers and clinicians which can have an impact on consumer experience.	Adjust the environment and conditions to meet the individual needs of the consumer to enable effective engagement. Recognise how power imbalances affect quality, and safety takes steps to mitigate.	Promote and facilitate strategies that make assessments and adjustments to enable effective consumer engagement including environment, working conditions and power dynamics.	Provide expert support to staff to optimise equitable and culturally competent consumer engagement. Develop and evaluate cultural competency care models and training programs to address systemic environmental and power disparities.	Lead organisational improvements and environmental design to create inclusive and accessible environments for all consumers. Ensure cultural competency principles are embedded into organisational governance and strategic planning.
Measure and evaluate consumer experience	Recognise the importance of measuring and evaluating consumer experience to improve care.	Actively participates in collecting consumer feedback through established methods. Contribute to improvement activities based on consumer experience data.	Promote and support the collection and analysis of consumer experience data within their team or service area. Identify trends and areas for improvement based on consumer experience data.	Provide expert guidance in various methodologies and strategies for measuring and evaluating consumer experience. Design and lead system level quality improvement initiatives based on consumer experience data.	Establish organisational strategy for measuring and evaluating consumer experience as a critical driver of quality and safety. Use consumer experience data to inform strategic decision-making.

SAFETY CULTURE

Definition: The shared values, attitudes and behaviours that drive a culture of quality and safety, supporting consumers and employees to confidently raise concerns, learn from experiences, and contribute to continuous improvement.

Description: This capability domain highlights that a strong safety culture is essential for enhancing quality of care and used as lead indicator for preventing patient harm. It requires a shared responsibility, where individuals actively prioritise the safety of themselves and their colleagues. The capabilities in this section are aligned with SCV's (2024) Safety Culture Conceptual Framework as outlined in the Victorian Safety Culture Guide.[3]

	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Fostering a safety culture	Demonstrate understanding of the concepts of safety culture. Recognise that a strong safety culture improves patient and staff outcomes. Recognise individual responsibility to report safety risks and adhere to established safety protocols.	Apply safety culture principles by: • reporting risks, • adhering to safety protocols, • identifying improvements to organisational systems to reduce harm and, • engage in quality and safety improvement.	Integrate safety culture principles into daily practice and begins influencing team behaviours by: • proactively identifies risks, system gaps or improvement opportunities. • lead quality and safety improvements.	Lead and embed a culture of safety and continuous improvement within the organisation. Develop and implement system-wide improvement strategies to embed safety culture principles into policies and processes.	Use safety culture at scale to drive excellence in quality and safety. Ensure that organisational systems and leadership behaviours reinforce safety culture principles. Hold both individuals and the system accountable in proactively managing risks to achieve a high reliability organisation.
Measuring safety culture to drive improvements	Recognise the value of measuring safety culture to drive improvements. Participate in staff surveys, focus groups, pulse checks.	Actively participate in data collection and improvement activities within the work area relating to safety culture. Understand that data around safety culture supports safety and quality.	Design, implement and evaluate improvement initiatives in their work based on analysis of safety culture measures. Contribute to identifying areas for improvement including the triangulation of data with other sources e.g. reporting culture, consumer feedback, workforce metrics.	Lead organisational safety culture measurement and action planning. Use a mix of qualitative and quantitative data to support analysis of safety culture measures including triangulation of data and information. Recommend and support interventions to drive measurable improvements in safety culture.	Embed the measurement of safety culture as a key driver for strategic decision-making. Promote a culture where safety culture is continuously monitored and proactively improved. Benchmark and sharing of practices across service and regions.

3. Safer Care Victoria (2024) *Victorian Safety Culture Guide*, Safer Care Victoria.

	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Psychological safety	Recognise that a just culture supports psychological safety, where contributing involves open communication, respectfully listening to different ideas. Recognise that mistakes are opportunities for learning personally and collectively.	Contribute to psychological safety within their team or work area by: • participating and encouraging open communication • respectfully challenging ideas. Understand how learning from mistakes is essential within a just culture that focuses on system improvement.	Foster psychological safety within their team or work area by: • creating opportunities for team members to share concerns • supporting a just culture where errors are viewed as learning opportunities and improvement drivers • recognising the direct and indirect link between individual and team well-being and consumers.	Ensure that organisational structures, policies, and leadership behaviours actively promote open communication and a culture of learning from mistakes. Develop policies and procedures to ensure a consistent approach to fairness and learning, fostering an environment where all staff feel safe to speak up and contribute to continuous improvement.	Establish a culture of psychological safety across the organisation, embedding practices of open communication, respectful challenge, and learning from mistakes within a robust just culture framework. Address variation in psychological safety between teams, departments and across an organisation.
Employee wellbeing and engagement	Recognise the importance of self, team /staff well-being and engagement to consumer safety and quality of care.	Develop a sense of their personal well-being and understand when and how to access available support. Actively participate in team activities that promote engagement and contribute to a positive work environment.	Promote employee wellbeing within their work or team as a key driver of safety and quality.	Develop and implement strategies to enhance staff well-being. Integrate employee wellbeing feedback into quality and safety improvement initiatives.	Monitor key indicators of staff well-being and engagement and use this data to inform strategic decision-making aimed at improving safety and quality of care outcomes.
Communicating for quality and safety	Demonstrate an understanding of communication methods (verbal, written, digital) used in healthcare and the importance of timely escalation of risk. Recognise the existence of communication and escalation procedures in their organisation.	Communicate effectively by selecting the appropriate communication method to share information to prevent harm and improve safety. Escalate risk to the correct individual or team according to organisational procedures.	Facilitate and promote the use of appropriate methods for sharing complex and sensitive information and escalating risk promptly and effectively. Contribute to the review and improvement of local communication and escalation practices.	Develop and implement organisational communication and escalation procedures to prevent harm and improve safety. Measure the effectiveness of communication and escalation strategies at an organisational level.	Integrate sharing of critical information and complex risk within the organisation, governing board and regulatory bodies for informed decision-making.

RISK MANAGEMENT

Definition: Managing clinical and non-clinical risk at all levels of the healthcare system. Implementing strategies and processes to minimise the likelihood and impact of adverse events and improve overall quality and safety outcomes.

Description: This domain outlines the capabilities required for effective risk management across all levels of the organisation, encompassing the identification, reporting, analysis, mitigation, and learning from both clinical and non-clinical risks. Embedding a proactive and learning-oriented approach to risk management.

	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Identify and report risk	Identify and reports all clinical and non-clinical risks within their work environment accurately and timely.	Identify and proactively escalate potential emerging risks.	Promote and support team to proactively identify and address potential risks. Contribute to the development of policies and procedures.	Provide expert guidance on identifying complex or emerging risks. Analyse risk data to identify trends and inform proactive risk mitigation strategies. Develop and evaluate system-wide risk reporting frameworks, tools and resources.	Use risk reporting data for strategic decision-making and resource allocation to enhance safety. Drive organisation wide risk management and system-level improvements in safety by embedding system-wide risk reporting frameworks and tools.
Organisational clinical and non-clinical risk management procedures	Apply the organisational clinical/non-clinical risk management policy and procedures.	Identify areas for potential improvement based on their practical experience, offering suggestions for procedure enhancement.	Participate in the review and implementation of clinical/non-clinical risk management policies within their area.	Develop, implement and monitor clinical/non-clinical risk management policy and procedures. Ensure policies and procedures are aligned with relevant legislation and best practice.	Establish the strategic direction for organisational clinical and non-clinical risk management. Monitor organisational adherence and effectiveness in mitigating risks. Contribute decision making to organisational risk appetite.
Legislation and mandatory reporting	Understand that there are relevant legislation and mandatory reporting requirements within their work and scope.	Apply relevant legislation and mandatory reporting requirements, including identify and apply potential breaches within their role.	Apply legislation and mandatory reporting requirements including develop and implement strategies to continuously improve within their role or team.	Develop and review organisational policies and procedures to address legislation and mandatory reporting requirements. Proactively identify potential breaches across various aspects of the organisation.	Ensure the organisation demonstrates accountability for legislative and mandatory reporting requirements. Ensure effective systems are in place for identifying, managing, and reporting potential breaches at all levels of the organisation, with clear lines of accountability.

	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Responding to adverse patient safety events	Demonstrate an understanding of the organisation's process for reviewing adverse patient safety events and non-clinical incidence. Recognise the relevant incident severity rating to classify adverse patient safety event.	Contribute to data collection and information sharing within the organisations review processes for adverse patient safety events and non-clinical incidences. Apply incident severity rating classification for adverse events within the accountability of their role.	Facilitate in-depth adverse patient safety event reviews and incident review protocols for non-clinical incidences. Implement recommendations to support effective system-wide safety improvements. Assess risk and develop risk management plans for their team or unit.	Provide expert guidance on adverse patient safety events review methodologies. Lead and facilitate in-depth complex adverse patient safety event reviews and incident review protocols for non-clinical incidences. Develop system-wide safety improvement recommendations based on evidence and best practice.	Allocate resources (financial, human, and technology) to enable thorough and impactful adverse safety event reviews and incident review protocols for non-clinical incidences. Establish clear accountability structures to support the effective implementation and oversight of the adverse event review system.
Learning culture	Understand the value of learning from clinical and non-clinical incident reviews and activities.	Contribute to learning from clinical and non-clinical incident reviews and activities by: • participating in case discussions • identifying potential contributing factors, and • suggesting areas for improvement.	Facilitate adverse patient safety event reviews and learning activities such as Morbidity and Mortality (M&M) meetings. Ensure that lessons learned are translated into actionable changes in practice and protocols within their area of responsibility.	Provide expert guidance on learning methodologies applied to adverse patient safety event and non-clinical incident reviews. Develop and implement frameworks for learning activities to drive continuous improvement in patient safety and quality of care. Proactively keeps up to date best practice and sector recommendation/ reports/learning.	Drive organisation strategic direction/planning based on best practice and evidence. Promote an organisational learning culture that: • translates lessons learned into tangible changes • minimises future risk and builds resilience • ensure ongoing adherence with National Safety and Quality Health Service Standards. Share systems-focused safety recommendations from professional bodies and regulators.

SYSTEM APPROACH TO QUALITY AND SAFETY

Definition: Understanding the different parts of the healthcare system, including its people, structure, functions, and processes, and how they interact and contribute to quality and safety outcomes.

Description: This domain highlights the effective communication and collaboration practices among healthcare professionals and consumer partners enhances consumer safety and minimises harm. This domain emphasises that information exchange, understanding different perspectives, and fostering partnerships across the system is vital for the delivery of a safe, timely, effective, efficient, equitable and person-centred care.

	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Clinical governance in quality and safety	Demonstrate understanding of the clinical governance framework in their organisation and how it supports their role in quality and safety.	Contribute to the clinical governance structures and processes in their role by: • applying relevant policies and procedures in daily work, and • adhering to established quality and safety standards • identifying and participating in improvement activities.	Promote and support application of clinical governance activities in their role or team by • facilitating incident reviews • leading improvement projects • contributing to quality and safety committees.	Develop and evaluate clinical governance frameworks within their organisations to support the delivery of quality and safe care. Conduct assessments and formulate actionable recommendations to enhance clinical governance.	Establish and maintain a clinical governance framework and use the processes within the framework to drive improvements in safety and quality. Ensure clinical and organisational review outcomes are used to inform strategic decision-making.
Applying systems thinking	Demonstrate knowledge that effective decision-making involves the integration of information from multiple system levels.	Recognise that changes in one part of the healthcare system might have unintended consequences in other areas. Identify key areas within the system (e.g., consumer, team, department) and explains how information from each level might inform decision-making.	Apply systems thinking tools to analyse how their team's work and decisions affect other parts of the wider healthcare system. Use information from multiple areas to inform decision-making within their area of responsibility.	Apply a variety of systems thinking tools to effectively analyse and simplify complex, systems-wide problems to drive long-term sustainable change. Use information from multiple system levels to inform effective decision-making.	Enable and drive a systems-thinking culture in the organisation. Analyse interrelationships between healthcare systems and processes to inform and recommend wider sector system changes.
Problem solving	Recognise the value of systematic problem-solving in identifying and addressing improvement opportunities.	Apply, with support, basic problem-solving and critical thinking techniques such as: • identifying issues, gathering relevant data, and contributing to solutions • identifying assumptions, considering different perspectives • evaluating evidence to enhance safe decision outcomes.	Proactively apply critical thinking techniques, to different contexts and situations to enhance safe decision outcomes by using: • structured problem-solving methods to analyse contributing factors • test potential solutions, and refine approaches based on evidence.	Provide expert guidance on complex problem-solving efforts by integrating data, systems thinking, and improvement methodologies to drive sustainable change.	Drive innovative problem-solving and critical thinking approaches at a system level, influencing policy and strategic direction to enhance safety and quality across the healthcare system.

	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Creative thinking	Recognise the value of creative thinking and diversity of views in problem-solving and improvement.	Identify and contribute creative ideas to problem solving and improve existing solutions within their work or scope.	Apply creative thinking techniques to develop innovative solutions. Actively seeks diverse viewpoints to enhance problem-solving and improvement processes within their work or team.	Provide expert guidance and innovative solutions that address complex challenges and improve organisational outcomes.	Foster a system-wide culture of creative thinking, integrating diverse perspectives and applying adaptive leadership principles to influence improvements across the healthcare system.
Safety principals	Demonstrate a basic understanding of reactive safety principles (incident reporting, investigation) and proactive safety principles (risk assessment and management)	Understand and apply basic Safety-II principles in conjunction with Safety-I to analyse incidents and identify contributing factors beyond individual error, thus recognising the importance of the system.	Lead the application of Safety-II principles to proactively anticipate, adapt to, monitor, and respond to risks within their work or team.	Develop, implement and provide expert guidance on comprehensive frameworks that embed Safety-1 and Safety-II principles into organisational safety management system.	Drive the integration of Safety-II principles into system-wide safety strategies and policies. Influence strategic direction to foster a culture of resilience and proactive safety across the healthcare system.
Human factors principles	Demonstrates a basic understanding of human factors, including how people, tools, technology, tasks, the organisational and internal environment affect quality and safety outcomes.	Apply basic human factors principles to identify and mitigate potential risks within their immediate work environment, including considering user needs and workflows.	Lead the application of human factors principles in their work or team by: • conducting risk assessments and process redesign • developing and implementing strategies to optimise workflows and • enhance user experience to improve safety and quality.	Analyse complex interactions between people, tools, technology, tasks, organisational factors, and the environment to identify root causes of safety issues and develop risk mitigation strategies that optimise human performance and system resilience. Provide expert guidance on human factors principles in service improvement projects within their organisation.	Integrate human factors principles into the organisation's strategic direction by allocating resources to build expertise and strengthen staff capabilities in Human factors principles, tools, and methodologies, emphasising their value in healthcare design and service delivery.
Cognitive bias	Demonstrate a basic understanding cognitive biases and their potential influence on decision making.	Identify common and personal cognitive biases in their work environment and actively work to mitigate them.	Identify cognitive biases in team decision-making and work to address them.	Develop and implement evidence-based strategies, tools and training to minimise cognitive bias influence in critical organisational decision-making processes.	Integrate evidence-based strategies to limit risk of harm from organisational and system biases.

CONTINUOUS IMPROVEMENT

Definition: The use of a systematic, data-driven, and continuous process aimed at enhancing quality and safety at all levels of the healthcare system. Emphasises learning from results to ensure ongoing progress.

Description: This capability domain is dedicated to achieving lasting reductions in patient harm and sustained enhancements in quality of care. It emphasises empowering the healthcare workforce and consumer partners with the skills to utilise data and improvement methodologies to drive sustainable changes that enhance quality of care.

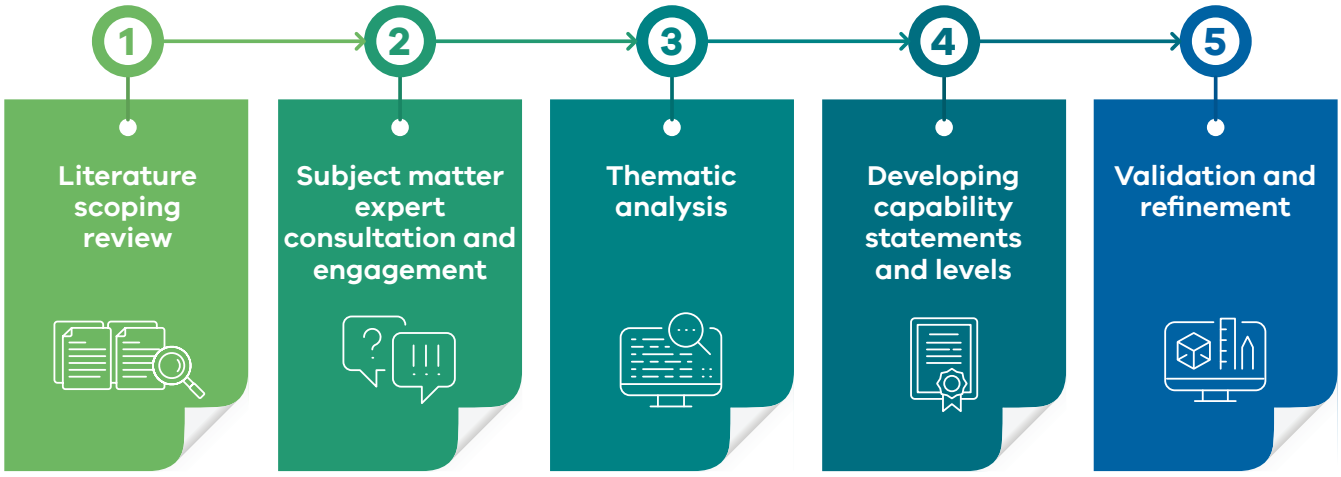
	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Improvement methodology	Demonstrate awareness of methodologies for continuous improvement used in their organisation. Recognise the need for continuous improvement to enhance quality and safety.	Apply continuous improvement methodology in small scale improvement activities. Identify opportunities for small scale improvement activities in their area of work based on varied sources of quality and safety data.	Apply continuous improvement methodology to lead improvement initiatives. Use varied quality and safety data to identify improvement opportunities. Support others to plan, test, and implement changes within their work area.	Develop and implement organisational continuous improvement frameworks. Provide expert guidance on how to apply improvement methodology in complex and evolving contexts. Identify and run large scale complex improvement activities.	Prioritise improvement activities across the organisation, allocating resources (time, funding, personnel) to those areas with the greatest need and potential for impact.
Using data for improvement	Demonstrate an understanding of the importance of qualitative and quantitative data for continuous improvement.	With support can accesses, visualises and interpret qualitative and quantitative data from various sources for the purpose of continuous improvement.	Analyse data (including control charts) to identify trends and insights and translate these insights into improvement actions.	Provide expert guidance on data analysis including building and analysing statistical and process control charts.	Utilise high-level data to monitor and report on performance across the organisation with the governing body and wider community. Uses high-level data to inform organisational strategy and critical decision-making.
Variation	With support can identify variations in healthcare service delivery and its importance in continuous improvement.	Understand and identify variation within healthcare, including inherent diversity in patient characteristics, care delivery processes, and patient outcomes.	Identify variation in their system and to understand the difference between common cause and special cause variation.	Use understanding of variation to monitor system stability & performance and determine appropriate actions to take in presence of both common and special cause variation.	Lead system-level decisions informed by an understanding of system variation and performance.
Structured measurement plans	Demonstrate awareness of the need to have a structured measurement plan (including process, outcomes and balancing) to support continuous improvement activities.	With support apply a structured measurement plan (including process, outcomes and balancing) in continuous improvement activities.	Develop and implement structured measurement plans (including process, outcomes, and balancing measures) for continuous improvement activities.	Design and mentor others to use a structured measurement plan (including data definitions, data collection plan and operational definitions) in complex continuous improvement activities.	Use strategic improvement measures to monitor and evaluate system wide improvement outcomes.

	General understanding	Foundational	Intermediate	Advanced	Strategic decision-makers
Testing ideas	Recognise the need for change and the value of generating and testing ideas for improvement.	Contribute, engage and support idea generation, building on existing evidence to suggest improvements. Participate in testing simple change ideas by helping to plan, observe, and reflect on outcomes to inform future actions.	Use a structured approach to develop and test change ideas and adapts those ideas based on what is learned in each testing cycle.	Develop innovative change ideas linked to system level improvement goals and targets, including forcing function. Provide expert guidance in testing methodologies, mentors others in applying iterative learning cycles. Ensure tests are rigorously designed, measured, and interpreted for effective improvement.	Foster a culture that values curiosity, learning, and disciplined experimentation. Embed testing approaches into governance, capability building, and strategic improvement efforts across the organisation.
People and change in Improvement	Recognise people are central to adopting and sustaining any change for improvement.	With support, apply a structured change approach, such as identifying potential challenges to a change and communicating the reasons for the change to colleagues.	Apply structured approach to change by assessing readiness, addressing resistance, and fostering commitment to improvement within their work or team.	Lead and facilitate the application of structured change methodologies across multiple teams or departments. Assess organisational readiness for complex changes, proactively addresses significant resistance. Develop comprehensive strategies to build widespread commitment and ownership of improvement initiatives.	Develop organisational capacity for effective change, fosters a culture of adaptability and continuous improvement.
Sustaining improvement	Understand the importance of sustaining improvements to achieve long-term impact.	Contribute to efforts to maintain improvements by documenting changes and reinforcing good practices. Understand and identifies human and system focused intervention.	Contribute to the implementation of sustainability strategies within their team or area, including adhering to standardised processes, participating in monitoring activities.	Lead and embed comprehensive sustainability plans for quality improvement initiatives, incorporating system focused interventions and strategies for ongoing capability building.	Establish the strategic direction for embedding sustainability across the organisation. This includes developing organisation-wide standards, implementing robust monitoring systems, and ensuring the provision of ongoing capability building programs to maintain and build upon quality and safety improvements for long-term impact.

Appendix 1. Methodology

To create the framework, we used a stepped approach. We worked closely with subject matter experts and the wider healthcare sector. This involved several key stages:

Figure 3. SCV Framework development methodology



Literature scoping review: We conducted a scoping review of relevant literature to identify existing capability frameworks, best practices, and research related to quality and safety in healthcare. This review provided a foundation for establishing the overarching domains and definitions that underpin the framework. We designed this framework to align with key existing resources, including Safer Care Victoria (SCV) documents and other established standards and best practices including:

- Safer Care Victoria (2024) Victorian Clinical Governance Framework (VCGF).
- Safer Care Victoria (2019) Partnering in healthcare: A framework for better care and outcomes.
- Safer Care Victoria (2024, Safety Culture Conceptual Framework as outlines in the Victorian Safety Culture Guide.
- The Canadian Patient Safety Institute (2020), The Safety Competencies The Safety Competencies 2ND EDITION Enhancing Patient Safety Across the Health Professions.
- Clinical Excellence Commission (2021) Healthcare Safety and Quality Capabilities: An Occupation- Specific Set for Healthcare Workers in NSW Health.
- Australian Commission on Safety and Quality in Health Care (2021) National Safety and Quality Health Service Standards (2nd).
- Australian Commission on Safety and Quality in Health Care (2017) National Model Clinical Governance Framework
- Health Quality & Safety Commission (2016) From knowledge to action A framework for building quality and safety capability in the New Zealand health system.

Subject matter expert consultation and engagement: We undertook extensive consultation to identify key themes and priorities in quality and safety capabilities. This involved a multi-faceted approach, including focus groups, surveys, and in-depth interviews. Our consultation engaged over 140 individuals, representing a broad cohort of Victorian subject matter experts including quality and safety leaders, quality improvement specialists, clinical educators, academics, and consumer representatives.

Thematic analysis: We conducted thematic analysis on data from our literature review, focus groups, surveys, and in-depth interviews. The resulting themes informed the development of the capability statements and proficiency levels within the framework. Our thematic analysis process involved familiarising ourselves with the data, coding relevant sections, generating broader themes from those codes, reviewing the themes against the data for accuracy, defining and naming the final themes, and presenting the findings.

Development of capability statements and proficiency levels: Based on the thematic analysis, we developed detailed capability statements for each identified domain. These statements describe the knowledge, skills, and attributes required for individuals to demonstrate competence in that area. We then defined proficiency levels for each capability, outlining the expected level of performance at different stages of professional development.

Validation and refinement: To validate and refine the capability statements we distributed it to the consultation groups and several key expert stakeholders. We then conducted validation workshops to gather in-depth feedback on its clarity and applicability. We analysed feedback and integrated the findings to finalise the framework, ensuring it accurately reflected the needs of the Victorian healthcare sector.

Appendix 2. Self-assessment Tool

We have designed a self-assessment tool for the Quality and Safety Capability Framework to support individual and team professional development and enhance the collective quality and safety capabilities within an organisation. **Self-assessment tool - Quality and Safety Capability Framework.**

This self-assessment offers you an opportunity to reflect on your current skills, knowledge, and behaviours in relation to five capability domains and proficiency levels. By evaluating your capabilities against the provided statements, you can identify your strengths and areas for potential growth.

HOW TO USE THIS TOOL

For individuals:

1. **Self-reflect**: read each capability statement within each domain and level in the Framework. Within the **Self-assessment tool - Quality and Safety Capability Framework**, mark the level that you believe best reflects your current capabilities, considering your recent experiences, knowledge, and consistent demonstration of the described behaviours in your daily work.
2. **Evaluate honestly**: strive to be objective and honest in your self-evaluation. It is important to be realistic about your current level, recognising both your accomplishments and areas for growth.
3. **Review your spider diagram**: once you have completed the assessment, the Excel tool will generate a spider diagram highlighting your strengths and areas for growth across the five domains. Use this visual output to inform your individual learning plans and professional goals.
4. **Identify opportunities for development**: with your individual spider diagram in view, pay close attention to the areas where your assessed level is lower, as these dips highlight potential development needs. At the same time, consider how you can leverage your areas of strength, as depicted in the higher points of your spider diagram, in your daily work and to support your colleagues' development in quality and safety practices. Focusing on both your strengths and areas for growth will enhance your overall capabilities and contribute to your professional development.
5. **Track progress**: You may choose to revisit this self-assessment periodically to track your progress as you gain new experiences and develop your skills.

For teams:

1. **Build shared understanding**: this tool can facilitate team discussions around quality and safety capabilities. Each team member can complete the self-assessment individually, and then the team can collectively review the results to identify shared strengths and development areas.
2. **Review aggregate spider diagram**: once all team members have completed the assessment, the Excel tool will generate a spider diagram highlighting your team's strengths and areas for growth across the five domains.
3. **Plan team development**: the aggregated team spider diagram can inform the development of team-based training, projects, and initiatives aimed at enhancing overall quality and safety performance.
4. **Identify expertise**: understanding the distribution of capabilities within the team can help identify individuals with specific strengths who can support others and lead quality and safety initiatives.
5. **Benchmark and set goals**: teams can use the self-assessment to benchmark their current capabilities and set collective goals for improvement over time.

Considerations and limitations:

While this self-assessment tool provides a valuable starting point for understanding your capabilities, it is important to acknowledge its limitations. Self-perception can sometimes be subjective, and individuals may either overestimate or underestimate their abilities.

For the most accurate and beneficial application of this tool, we strongly recommend that you discuss your self-assessment with your manager or other peers, mentors or team members who can provide constructive feedback and help verify your assessment through reflective questions or based on their observations of your performance. This collaborative approach will offer a more comprehensive and balanced understanding of your capabilities and support the development of targeted and effective development plans.

Appendix 3. Glossary

Australian Charter of Healthcare Rights	Outlines the key rights of patients when seeking or receiving healthcare services.[4]
Adaptative leadership principals	As described in the Victorian Clinical Governance Framework (VCGF). The six aspects of the adaptive leadership mindset: 1. Get on the balcony (obtain a high-level perspective) 2. Identify the adaptive challenge (assess and evaluate the situation) 3. Regulate distress (inspire and motivate change and monitor responses) 4. Maintain disciplined action (navigate conflicts as they arise) 5. Give the work back to employees (empower them to take a role in adaptive work) 6. Protect leadership voices from below (provide a platform for all voices to be heard).[6]
Adverse Patient Safety Event (APSE)	An incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event. (SAPSE and sentinel event are a subset of APSE.)[5]
Capability Domain	Represent the major areas of skills, knowledge, and behaviours needed to perform a job or role effectively.
Clinical	In this document, 'clinical' refers to the practical application of health professional knowledge and skills in any setting of care involving direct patient care or other related activities.[6]
Clinical governance	Clinical governance refers to the integrated systems, processes, leadership, and culture that are at the core of providing safe, timely, effective, efficient, equitable and person-centred care underpinned by continuous improvement. This applies to all care settings.[6]
Confirmation bias	The tendency to more easily accept and look for information that confirms existing beliefs. (includes related positive hypothesis testing, search satisficing, premature closure).[6]
Consumer	The term 'consumers' is inclusive and refers to patients, residents, clients, families, supporters, carers, those with lived and living experience (LLE) carers, advocates, representatives, and communities who may be past, current, or potential users of healthcare services.[7]
Meaningful consumer engagement	Meaningful consumer engagement occurs when individuals with lived and living experience are respectfully and equitably engaged with health services to improve health outcomes. Services partner with consumers in a range of processes and activities within a supportive and enabling environment which recognises lived experience as a valued form of expertise. By sharing decision-making and co-designing strategies, meaningful consumer engagement influences the quality, safety, efficiency and effectiveness of services and improves the experience for service users.[1]
Continuous improvement	Organisational process that engages all team members in planning and implementing ongoing improvement strategies and practices.[7]
Employees	This document defines 'employees' to include all individuals engaged or employed by the organisation to carry out specific roles and functions.[7]

4. ACSQHC (2020) *Australian Charter of Healthcare Rights (second edition)*, ACSQHC.
5. ACSQHC (2021) *Incident Management Guide*, ACSQHC.
6. Safer Care Victoria (2024) *Victorian Clinical Governance Framework*, Safer Care Victoria.
7. Safer Care Victoria (2019) *Partnering in healthcare for better care and outcomes*, Safer Care Victoria.

Employee feedback	These are structured ways to collect employee feedback, including insights, opinions, and experiences related to their work environment.[7]
Employee wellbeing	This covers all aspects of an employee's work life, such as their physical and psychological well-being, workload, job design, organisational structure, and support systems. Effectively addressing these factors creates a work environment that fosters meaning, purpose, and belonging, resulting in safe, healthy, satisfied, and engaged employees.[8]
Equity in healthcare	Equity in healthcare means all individuals receive safe, effective, and high-quality care tailored to their unique needs, culture, language, ability, experience, and preferences. This necessitates ensuring everyone's healthcare needs are met equally well by eliminating disparities in quality, safety, accessibility, and rights between different groups, rather than providing identical care.[8]
Health workforce	This includes everyone working within a health service organisation, such as clinicians, employed and contracted locums, agency staff, students, volunteers, and peer workers. It also encompasses individuals from medical companies who have assigned roles and responsibilities related to patient care, administration, support, or involvement within the organisation.[9]
High-quality care	The elements of high-quality care are safe, timely, effective, efficient, equitable and person-centred.[9]
Human factors	Human Factors is the scientific study of how people interact with their environment, considering cognitive, emotional, social, and physical aspects.[10]
Human centred design	Human-centred design is an approach to developing interactive systems that prioritises users and their needs to ensure usability and usefulness.[11]
Human and system focused interventions	Adapted from The Canadian Medical Protective Association, human-focused interventions tend to rely on individuals to effect change, whereas system-focused interventions focused on system level change.[11]
Just Culture	Just culture aims for a balanced accountability between organisations and individuals and uses systems-thinking to enable fair and just responses to adverse events, ultimately promoting learning and improvement.[12]
Learning culture	Adverse events and near misses are seen as opportunities for learning and changes are made as a result. It is an atmosphere where continuous learning and the pursuit to evolve, and grow are embraced.[12]
Lived experience	Consumers and carers who hold a personal experience of mental illness and the Victorian mental health system.[13]

8. Adapted from a *Victorian Safety Culture Guide*, Safer Care Victoria.
9. Adapted from the National Model Clinical Governance Framework.
10. Holden, R.J. et al. (2013) '*SEIPS 2.0: A human factors framework for studying and improving the work of healthcare professionals and patients*'.
11. Adapted from The Canadian Medical Protective Association. (2021, May). *Human factors*. https://www.cmpa-acpm.ca/en/education-events/good-practices/the-healthcare-system/human-factors#ref.
12. Reason, J. (1998). *Achieving a safe culture: theory and practice*.
13. Adapted from Partnering in healthcare: A framework for better care and outcomes.

NSQHS Standards (second edition)	Developed collaboratively by the Australian Commission on Safety and Quality in Health Care with the Australian Government, states, territories, consumers, and the private sector, the National Safety and Quality Health Service (NSQHS) Standards primarily aim to safeguard the public and enhance healthcare quality. These standards outline the expected level of care and the necessary systems for health service organisations.[14]
Organisation	Service where care is delivered, including public and private hospital settings, aged care, mental health services, ambulance, and custodial health settings.[14]
Organisational culture	The shared values, customs, and behaviours within an organisation shape its operations, employee relations, customer interactions, leader assessment, and performance metrics. This culture is a direct expression of the organisation's underlying values, norms, and behaviours, often summarized as 'the way things are done around here.[15]
Psychological safety	Psychological safety is the sense of confidence that allows individuals to speak openly, raise concerns, ask clarifying questions, and admit when they're wrong, all without the worry of negative repercussions.[15]
Quality improvement (QI)	Quality improvement (QI) in healthcare refers to a systematic and continuous process of using data, methods, and tools to enhance healthcare outcomes, patient experiences, system performance, and professional development.[15]
Quality improvement specialist	An individual who has completed advanced training in improvement methodologies, drives enhancements in patient outcomes, safety, and efficiency through strategic planning, implementation, and evaluation of quality initiatives.[16]
Safety I	A traditional approach to safety management with a focus on learning from clinical incidents or what went wrong and often uses a cause-and-effect methodology.[17]
Safety II	An understanding of safety management with a focus on positive outcomes including understanding of systems that support good outcomes despite high complexity. An understanding of what went right and why.[17]
Safety culture	The product of individual and group values, attitudes, and behaviours that determine the commitment to and practice of organisational safety.[18]
Sentinel event	Is defined in the Health Services (Quality and Safety) Regulations 2020 as an unexpected and adverse event that occurs infrequently in a health service and results in the death of, or serious physical or psychological injury to, a patient because of system and process deficiencies at the health service entity.[19]

14. ACSQHC (2023) *About patient safety culture. Australian Commission on Safety and Quality in Healthcare*.
15. NHS (2022). *Safety culture: Learning from best practice*.
16. Backhouse, A. and Ogunlayi, F. (2020) 'Quality Improvement into Practice', *BMJ*, p. m865. doi:10.1136/bmj.m865.
17. Bentley, S.K. et al. (2021) 'Debrief it all: *A tool for inclusion of safety-II', Advances in Simulation*.
18. Safer Care Victoria (2024) *Victorian Safety Culture Guide*, Safer Care Victoria.
19. Regulation 3A of the Health Services (Quality and Safety) Regulations 2020.

Serious Adverse Patient Safety Event (SAPSE)	A serious adverse patient safety event is defined, in section 3(1) of the Health Services Act 1988, as an event of a prescribed class or category that results in harm to one or more individuals. A prescribed class or category is an event that: l occurred while the patient was receiving health services from a health service entity; and l in the reasonable opinion of a registered health practitioner, has resulted in, or is likely to result in, unintended or unexpected harm (which includes moderate harm, severe harm or prolonged psychological harm) being suffered by the patient. To avoid doubt, this includes an event that is identified following discharge from the health service entity.[20,21,22]
Statutory Duty of Candour (SDC)	A legal obligation for Victorian health service entities to apologise to and communicate openly and honestly with patients, their families or carers when a SAPSE has occurred. It builds on the Australian Open Disclosure Framework currently used for all cases of harm and near miss. Statutory duty of candour is set out in section 128ZC of the Health Services Act 1988, section 22I of the Ambulance Services Act 1986 and section 637 of the Mental Health and Wellbeing Act 2022.[23]
Systems thinking	Systems thinking refers to the interacting dynamics between self, team, environment, and patient and how they work together to contribute to outcomes. It is based on the concept that a system, not any one individual, is responsible for both good and bad outcomes. A system's function is more than the sum of its parts (of which people are just one part) and is the product of its interactions.[24]

20. *Ambulance Services Act 1986*.
21. *Health Legislation Amendment (Quality and Safety) Act 2022*.
22. *Health Services Act 1988*.
23. Regulation 3A of the Health Services (Quality and Safety) Regulations 2020.
24. Bentley, S.K. et al. (2021) 'Debrief it all: *A tool for inclusion of safety-II', Advances in Simulation*.

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