Queensland Health

Queensland Safety and Quality Improvement Framework

Mental Health Alcohol and Other Drugs Care

Queensland Government

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Queensland Safety and Quality Improvement Framework: Mental Health Alcohol and Other Drugs Care

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www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/guidelines

Contents

Acknowledgment of Country

Queensland Health acknowledges the Traditional and Cultural Custodians of the lands, waters and seas across Queensland, pays our respects to Elders past and present, and recognises the role of current and emerging leaders in shaping a better health system. We recognise the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination and commitment of Aboriginal and Torres Strait Islander communities in caring for the health and wellbeing of our peoples for millennia.

'First Nations' and 'Aboriginal and Torres Strait Islander' peoples are used respectfully within this document to refer to the first peoples of the lands known today as Australia who are living in Queensland. This is done with the acknowledgement that Aboriginal and Torres Strait Islander peoples maintain the right to self-determine the description of their cultural identity.

The term 'First Nations people' is used to describe when the focus is at the individual, rather than population level.

Recognition of Lived Experience

Queensland Health recognises people with lived experience of mental illness, problematic alcohol and other drug use, and/or mental health crisis and suicidality, their families, carers and support persons. Their contribution to driving and informing reforms to the mental health, alcohol and other drug service system is critical and valued.

A note about language

There are multiple terms used to describe people who access mental health and alcohol and other drugs care. To ensure this document is inclusive of the broad range of people with lived and living experience of mental illness, problematic alcohol and other drug use, and/or mental health crisis and suicidality the phrasing 'people receiving care, carers, families, and support persons' has been used when referencing people receiving care. The use of the term lived experience is used to be inclusive of both a lived and living experience of mental illness, problematic alcohol or other drug use, mental health crisis and suicidality when referencing the voice of individuals, carers, families and support persons.

Dedication

Queensland Health respectfully acknowledges the tragic death of Mr Manmeet Sharma which occurred on 28 October 2016. Mr Sharma was 29 years old when he died, and a widely respected member of the Punjabi community.

Queensland Health seeks to always remember Mr Sharma and the need to continually work towards improving the mental health alcohol and other drug service system and ensure community safety.

It is in this context that this Framework is dedicated in his memory.

We recognise the profound impact that the tragedy has had on Mr Sharma's family, the community and Queenslanders.

Glossary of terms and abbreviations

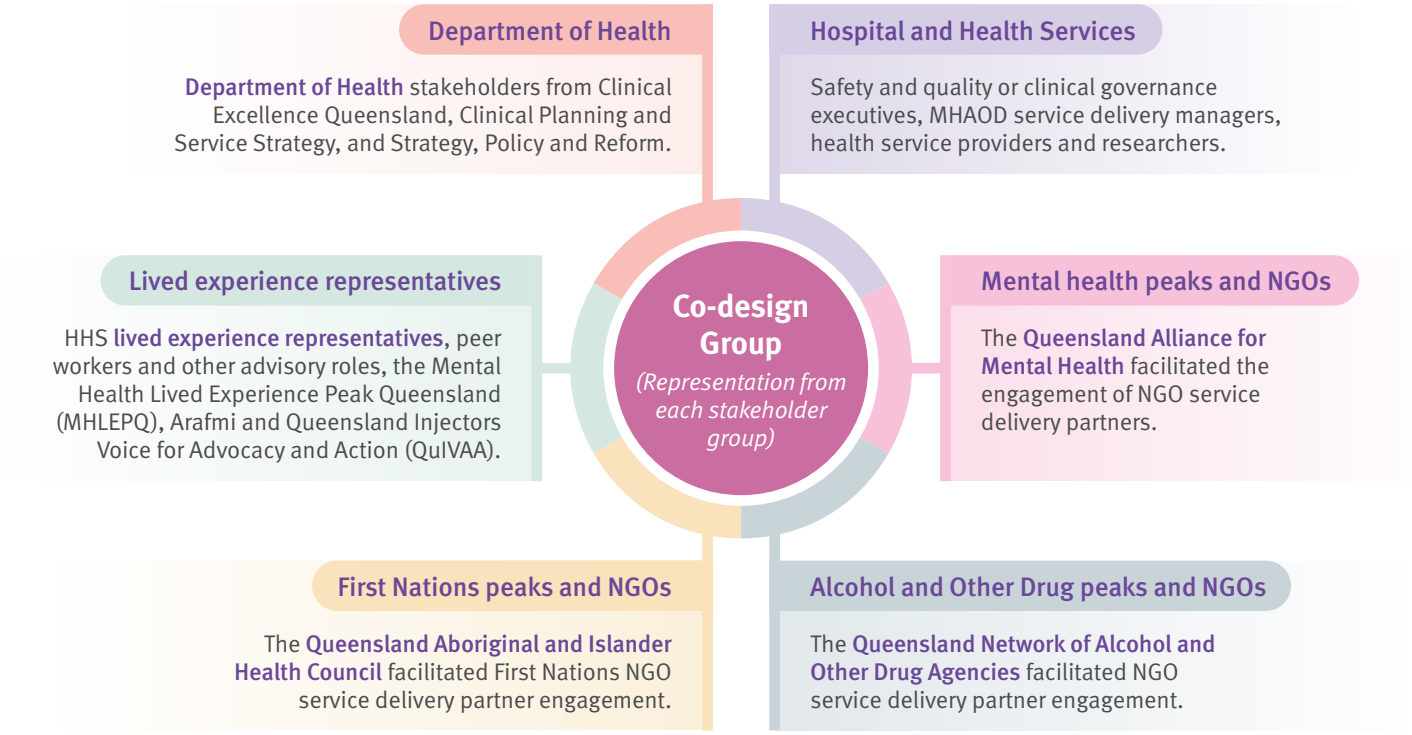
Term / abbreviation	Definition
Co-design	An approach where people receiving care, carers, families and support persons participate in designing solutions and are treated as collaborators with equally valuable contributions to the design process. This approach goes beyond just consulting with people and focuses on active and authentic collaboration between people affected by, or attempting to resolve, a particular challenge.
Evidence-informed	Reliance on up-to-date, reliable and relevant evidence from research, clinical experience, and individual's preferences to guide decision-making and the delivery of services.
Hospital and Health Services (HHS)	Healthcare services and facilities delivered by Queensland Health, including hospitals, health clinics, and community health centres, responsible for providing health services to specific geographical areas.
Improvement Science (IS)	The application of scientific methods and theories to understand and improve systems, processes, and outcomes.
Learning Healthcare System (LHS)	An environment in which knowledge generation processes are embedded into daily clinical practice in order to continually improve the quality, safety, and outcomes of healthcare delivery.
Mental Health Alcohol and Other Drugs (MHAOD)	The integrated treatment, care and support services provided to individuals experiencing mental illness, problematic alcohol or other drug use and/or mental health crisis and suicidality.
Non-Government Organisations (NGO)	A Non-Governmental Organisation (NGO) is a group that functions independently of any government with the objective of improving social conditions. NGOs are typically not for profit institutions.
Quality Improvement (QI)	The continuous process of identifying areas for improvement, implementing changes, and evaluating their impact to enhance the quality, efficiency, and effectiveness of healthcare services.
Safety and Quality Improvement (S&QI)	A focus on the delivery of safe and high quality services, whereby continuous improvement of services is at the forefront, driven by shared learning, evidence-informed practice and planning.
Services	State-funded services which provide mental health, alcohol and other drug treatment, care and support to individuals residing in Queensland. These services are delivered by Hospital and Health Services and non-government organisations.
Statewide improvement agencies and networks	State funded MHAOD services including non-government organisations, Hospital and Health Services, the Department of Health, the MHAOD Branch, peak bodies, service improvement agencies, clinical networks, training providers and other S&QI expert groups.
The Framework	Queensland Safety and Quality Improvement Framework Mental Health Alcohol and Other Drugs Care.
Theory of Change	A diagram or written description of the strategies, actions, conditions and resources that facilitate change and achieve outcomes.

Foreword

In an environment of ever-increasing demands and complexity it is important to continuously focus on ways to improve outcomes, experience, and quality of care in mental health alcohol and other drug (MHAOD) services. Safety and quality improvement (S&QI) is at the foundation of person-centred, efficient and effective healthcare. As a result, there has been increasing focus on S&QI internationally and across Australia.

Queensland has a well-developed healthcare system that provides high quality care. However, like all health systems, there is scope for further improvement. Service demand continues to grow across Queensland and people are presenting to services with increasing complexity. The pressure to respond to demand for MHAOD services has historically meant that challenges associated with access and availability of services have been prioritised. The increasing focus on S&QI reflects a recognition that, while access and availability remain essential goals, there needs to be further complementary work on optimising the safety and quality of services that are meaningful for people receiving care, carers, families, and support persons and the staff who support them. To support this focus, the involvement of the voice of lived experience is essential to gain valuable insights to drive meaningful change and improve the outcomes of care.

Figure 1. *Overview of stakeholder representation to support the development of the Framework*



Better Care Together: A plan for Queensland's state-funded mental health alcohol and other drug services to 2027 (*Better Care Together*) outlines Queensland Health's commitment to improve mental health and wellbeing outcomes for Queenslanders. Priority 4 of *Better Care Together* commits to *strengthening quality to reduce harm and improve outcomes*. A key action under this priority is to develop a systems-level framework for improvement, which articulates an agreed vision for clinical reform, an improvement agenda, and improvement methods for MHAOD treatment, care, and support.

The *Queensland Safety Priorities in Mental Health, Alcohol and Other Drugs Care* (the Safety Priorities) provides Queensland Health's position on safety and quality improvement activity in MHAOD services. The *Queensland Safety and Quality Improvement Framework Mental Health Alcohol and Other Drugs Care* (The Framework) complements the Safety Priorities to guide, optimise and integrate S&QI efforts by MHAOD services and statewide improvement agencies and networks to ensure clear direction and consistency of S&QI efforts.

The Framework articulates an agreed vision and structure to support services in achieving and maintaining a learning culture to drive S&QI in Queensland MHAOD services. Services across Queensland have varying capacities and capabilities in S&QI. The Framework provides guidance to support development and implementation of S&QI initiatives for healthcare improvement across the breadth of service settings, that are aligned with an agreed MHAOD healthcare improvement agenda and accreditation processes.

The Framework will inform the governance structure that will help drive safety and quality improvement across the MHAOD service system.

The Framework was developed through extensive engagement with people with lived experience, Hospital and Health Services, Department of Health, MHAOD and First Nations peak NGOs using a co-design methodology. The Framework recognises S&QI in individual services has been variable due to differences in systems, processes, and available resources. The Framework will be a living document that will be refreshed and revised to remain contemporary and will be influenced by developments in quality improvement, improvement science and broader system-wide influences. Broader system-wide influences may include but are not limited to coronial findings, legislative changes, public inquiries, royal commissions and emerging evidence.

Appreciation and thanks are extended to people with lived experience, representatives from Aboriginal and Torres Strait Islander community-controlled health organisations, MHAOD non-government organisations, advocacy groups and peak bodies, Hospital and Health Services and the Department of Health who participated in the design process for the development of the Framework.

Associate Professor John Allan
Executive Director,
Mental Health Alcohol and Other Drugs Branch

Background

Increasing focus on safety and quality improvement (S&QI) internationally and across Australia has driven a shift in the way people think about S&QI.

Initially, the focus of S&QI was primarily on safety, with efforts aimed at identifying and reducing adverse events, errors, and harm to individuals. This approach is known as Safety I and is essential to preventing incidents and ensuring patient safety. However, there has been a growing recognition of the need to include a focus on quality improvement to support healthcare outcomes. This shift is reflected in the Safety II approach, which recognises the complexity of healthcare systems and maintains a focus on what is working and the importance of a restorative just and learning culture in association with clinical incident management.

Two commonly adopted approaches which focus on safety and quality improvement are Quality Improvement and Improvement Science. Quality Improvement primarily focuses on improving safety, effectiveness and the experience of care through continuous improvement of specific processes, outcomes, or systems within services. Improvement Science focuses on the systematic study and application of methods to ensure the successful integration of evidence-informed practices in services. A successful MHAOD service system requires both approaches.

The *Queensland Safety and Quality Improvement Framework Mental Health Alcohol and Other Drugs Care* (the Framework) aligns with other national and statewide strategies and plans to support services, improvement agencies and networks to achieve their commitment to S&QI. It aligns with the national and state directions promoting healthcare improvement, including but not limited to, the MHAOD reform agenda as outlined in the policy, planning and information strategy documents detailed in Figure 2.

Purpose of the Framework

The purpose of the Framework is to support the implementation of S&QI initiatives in line with established governance structures, and through integration of approaches to evidence-informed care, consistent with relevant national safety and quality standards.

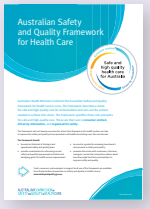
The Framework supports continuous improvement in state funded MHAOD services, improvement agencies and networks by promoting and providing guidance to services to adopt approaches to achieve and maintain a learning culture. The Framework does this by:

- articulating a shared vision and principles for S&QI in MHAOD services
- demonstrating a commitment to S&QI which aligns with the priorities outlined in the state and national MHAOD reform agenda
- supporting services, improvement agencies and networks to enhance their current S&QI approaches and adopt evidence-informed improvement methodologies
- promoting a system-wide culture of continuous improvement, learning and innovation, consistent with a learning healthcare system
- emphasising the importance of a restorative just and learning culture
- promoting awareness and engagement with people receiving care, carers, families, and support persons about S&QI
- building knowledge, capabilities and capacity of the MHAOD workforce and services within the system, to support continuous improvement and a learning culture.

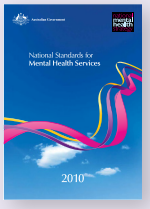
The Framework encourages a commitment from Queensland Health and all MHAOD services, staff, and partners, working in collaboration with people receiving care, carers, families, and support persons to the challenge of striving towards continuous healthcare improvement.

Figure 2. *Overview of national and state S&QI policy, planning and information strategy documents*

National

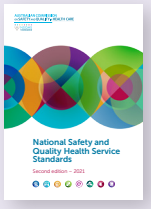


Australian Safety and Quality Framework for Health Care



National Standards for Mental Health Services

National Quality Framework for Drug and Alcohol Treatment Services



National Safety and Quality Health Service Standards

National Safety and Quality Mental Health Standards for Community Managed Organisations

The National Mental Health and Suicide Prevention Agreement

Queensland

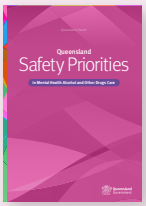
Better Care Together

Health Equity Framework

Mental Health Alcohol and Other Drugs Healthcare Digital Information Strategy

HEALTHQ32: A vision for Queensland's health system

Queensland Alcohol and Other Drug Treatment and Harm Reduction Outcomes Framework



Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care

Application of the Framework

The Framework recognises the complexity of the MHAOD service system, consisting of many independent but overlapping departments, organisations, and stakeholders with intersecting governance structures.

It is important to recognise that progress on S&QI in individual elements of the system has been variable due to differences in systems, processes, and available resources.

The Framework has been designed with this in mind and intends to offer guidance to services, improvement agencies and networks to build on their S&QI approaches in ways that can be adapted and applied based on the unique needs and circumstances of each service.

The Framework

The Framework provides a shared vision and set of principles to support Queensland state-funded MHAOD services, improvement agencies and networks to implement S&QI.

These principles form the essential building blocks of S&QI and include: embedding a learning culture; promoting collaborative partnerships; accountability and transparency; drawing on the evidence base and expertise of lived experience; monitoring and evaluation to support continuous improvement. These principles are further underpinned by enablers which are the resources, systems, and processes that will be used to achieve the vision and include leadership and culture; governance, roles and responsibilities; prioritisation of S&QI initiatives; data; and partnerships. The Framework recognises that while the enablers can operate separately, they also co-exist, and should work together to provide optimal support for MHAOD improvement efforts.

The Framework provides guidance on the systems, processes, approaches, tools, and resources that support the implementation of S&QI initiatives. The Framework also outlines approaches to provide guidance on the importance of monitoring and evaluation of S&QI initiatives to support continuous improvement. A visual summary of the Framework is provided on the following page.

Vision

Continuous evidence-informed improvement of safety and quality is at the forefront of Queensland mental health alcohol and other drug services, driven by service provider and lived experience leadership.

Principles

S&QI is most effective when it is undertaken in a way that:

- embeds a learning culture that promotes the sharing of ideas, outcomes, and learnings
- drives accountability and transparency through roles, responsibilities, processes, and outcomes
- draws on the evidence-base and lived experience to inform improvement initiatives and prioritisation of initiatives and programs of work
- prioritises ongoing monitoring and evaluation to assess progress and support continuous improvement
- promotes collaboration and stronger partnerships and recognises the voice of all stakeholders.

Queensland Safety and Quality Improvement Framework

Mental Health Alcohol and Other Drugs Care

Vision

Continuous evidence-informed improvement of safety and quality is at the forefront of Queensland mental health alcohol and other drug services, driven by service provider and lived experience leadership.

National and **State** level health service Safety and Quality Improvement frameworks and standards

Principles

- Embeds a learning culture that promotes the sharing of ideas, outcomes, and learnings
- Drives accountability and transparency through roles, responsibilities, processes, and outcomes
- Draws on the evidence-base and lived experience to inform improvement initiatives and prioritisation of initiatives and programs of work
- Prioritises ongoing monitoring and evaluation to assess progress and support continuous improvement
- Promotes collaboration and stronger partnerships and recognises the voice of all stakeholders

State and **Local** Safety and Quality Improvement drivers and influences

Enablers

- Strong leadership and learning culture
- Clear governance, roles and responsibilities
- Structured prioritisation of S&QI initiatives
- Meaningful data
- Collaborative partnerships

Implementation

Structured improvement methodologies to support the successful implementation, evaluation and continuous improvement of evidence-informed practices for safety and quality improvement.

Monitoring and evaluation

Monitoring and evaluation to support continuous improvement.

Enablers

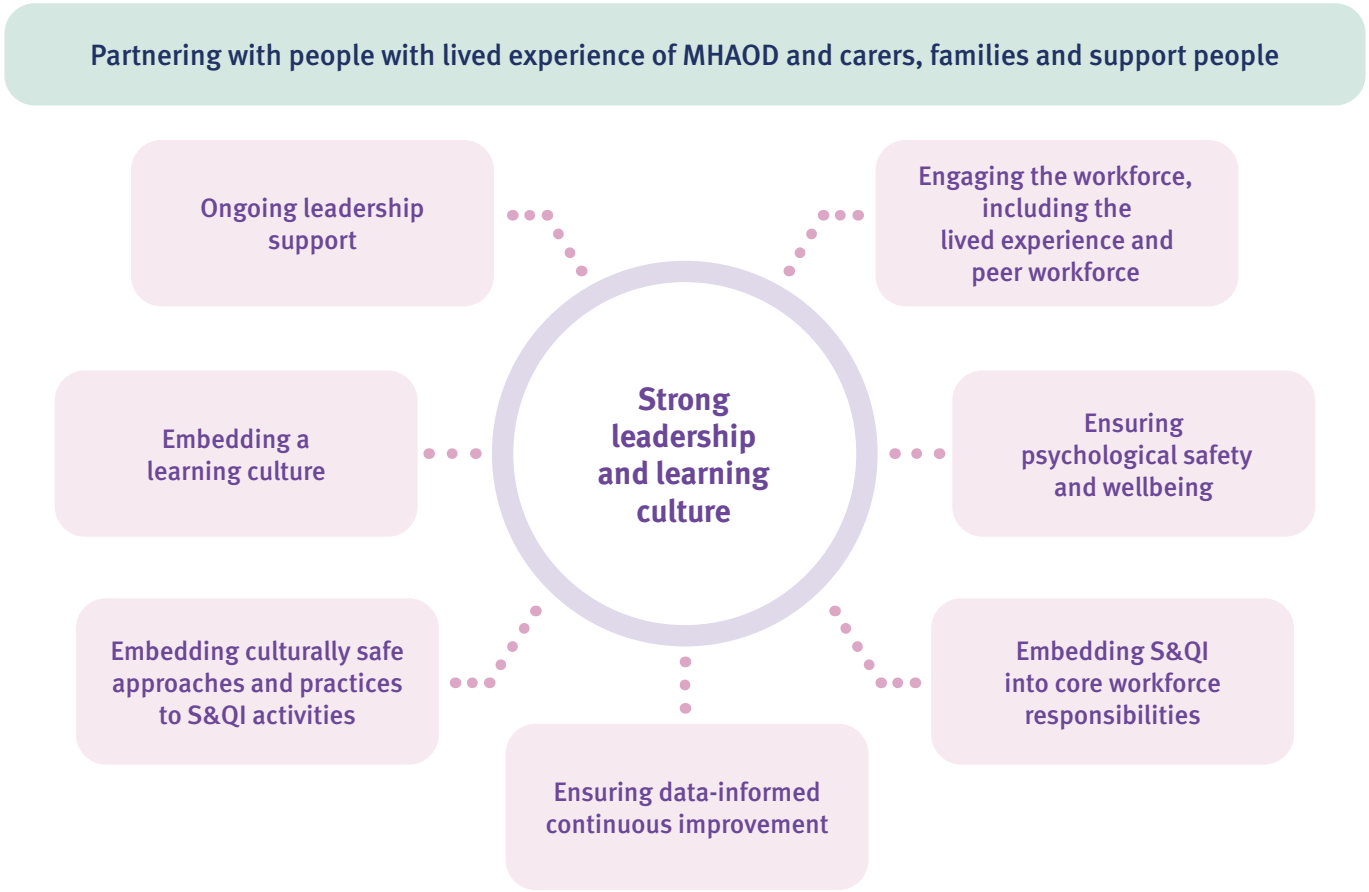
Enablers for S&QI include strong leadership and learning culture, clear governance, roles and responsibilities, structured prioritisation of S&QI initiatives, meaningful data and collaborative partnerships.

Strong leadership and learning culture

A culture of learning in MHAOD services can ensure S&QI is embedded across the organisation. It enables approaches to S&QI that are proactive to the needs of people receiving care, carers, families, and support persons and staff. A learning culture encourages shared accountability for S&QI and supports staff to share and apply learnings to identify and address S&QI opportunities.

Seven levers have been identified which strengthen a culture of learning and support S&QI and are shown in Figure 3. Partnerships with people receiving care, carers, families, and support persons are key enablers of these levers by ensuring that service culture responds to the needs and experiences of people accessing MHAOD services.

Figure 3. *S&QI learning culture levers*



The seven levers include:

- **Ongoing leadership support:** Leaders can support a culture of learning by promoting proactive approaches to S&QI, maintaining a commitment to learning and S&QI priorities, setting up the structures and processes for S&QI and establishing mechanisms for accountability.
- **Embedding a learning culture:** A learning culture that recognises the complex interplay of system issues in healthcare and builds trust and confidence between the workforce and the broader MHAOD systems. This is supported by restorative approaches to incident management and a restorative just and learning culture.
- **Embedding culturally safe approaches and practices to S&QI initiatives:** S&QI initiatives are designed and implemented in partnership with people with lived experience, Aboriginal and Torres Strait Islander people and in line with the Safety Priorities.
- **Ensuring data-informed continuous improvement:** This is supported by open communication, proactive planning, shared learnings and experiences, good-practice examples, and consideration of specific service delivery contexts.
- **Embedding S&QI into core workforce responsibilities:** Defining S&QI as part of core responsibilities through policy, orientation, training and support in relation to ongoing S&QI processes.
- **Ensuring psychological safety and wellbeing:** Enabling and encouraging people receiving care, families, carers, support people and staff to be empowered and supported to provide feedback and input on S&QI, including openness to new ways of working where S&QI opportunities are identified.
- **Engaging the workforce, including the lived experience and peer workforce:** Supporting the workforce at all levels to deliver services that focus on continuous improvement, are safe, high-quality, and culturally responsive through tools, clinical supervision, reflective practice, and training.

Applying restorative approaches to incident management

Using restorative approaches involves a shift away from a culture of blame towards a focus on repairing harm, promoting understanding, and cultivating a culture of growth. By adopting restorative approaches and a restorative just culture within a restorative just and learning culture framework, incidents can become opportunities for growth, healing, and building stronger relationships within services and with the community.

Partnering with people with lived experience

Empowering people receiving care, carers, families, and support persons to participate and have their voice heard and valued will contribute to:

- **Improved quality of services:** People receiving care, carers, families, and support persons have unique insights into the challenges they face, which can provide valuable feedback on the effectiveness of S&QI initiatives.
- **Accountability and transparency:** Involving people receiving care, carers, families, and support persons fosters accountability and transparency in the system. Their participation adds credibility and ensures appropriate decision-making.
- **Reduced stigma and discrimination:** People receiving care, carers, families and support persons participation in monitoring and evaluation of S&QI initiatives can challenge societal misconceptions and foster a greater understanding of MHAOD disorders and services.
- **Tailored and person-centred approaches:** Considering people receiving care, carers, families, and support persons unique insights ensures that the leadership and culture of S&QI contributes to the delivery of safe and high-quality improvement initiatives, promoting person-centred care, and improving outcomes.

Figure 4. *Roles and responsibilities of key stakeholder groups for S&QI*

Partnering and valuing the voice of people with lived experience at all levels of governance

Department of Health

- Enable a shared agenda for reform and create systems and processes that support a learning culture and adoption of S&QI initiatives.
- Support flow of information for statewide S&QI priorities.
- Oversight, identification and monitoring of statewide S&QI issues and opportunities.

Workforce and teams

- Identify and drive opportunities for S&QI.
- Participate in S&QI processes including in areas of professional development, and S&QI networks.
- Escalate concerns through existing clinical governance pathways.

Primary care services

- Identify and drive opportunities for S&QI.
- Actively participate in S&QI processes.
- Work collaboratively with Department of Health and other state-funded services on S&QI and share learnings.

Clinical Networks

- Inform and agree agenda of priorities for statewide S&QI initiatives.
- Provide integrated statewide leadership, expertise and direction for S&QI.
- Progress agreed statewide priority initiatives.
- Work collaboratively with partners to share priorities and S&QI learnings.

PHNs

- Work collaboratively with the Department of Health, HHSs, NGOs and community-controlled services to identify and address S&QI issues and opportunities.

Other state-wide services

- Work collaboratively with Queensland Health funded services to support a consistent approach to S&QI.
- Address local S&QI priorities.

Groups with a statewide reach and training providers

- Respond to identified statewide priorities.
- Support consistent approach to S&QI.
- Build capability in S&QI methodologies, tools and approaches.

Statutory authorities and Coroners

- Provide an independent assurance function.
- Conduct reviews to identify gaps and areas for systemic improvement.

HHS and NGO MHAOD services

- Establish local S&QI governance.
- Inform and agree agenda of priorities for shared S&QI initiatives.
- Address local S&QI priorities.
- Work collaboratively across all levels to support S&QI.
- Ensure workforce has access to ongoing S&QI training.

Continuous engagement and collaboration across system stakeholders

Clear governance, roles and responsibilities

The roles and responsibilities of Queensland state-funded MHAOD services, improvement agencies and networks, should be defined to clarify their role and governance mechanisms relevant to S&QI activities. The voice of people receiving care, carers, families, and support persons is included and recognised in all levels of governance of S&QI initiatives in MHAOD services.

Roles and responsibilities of key stakeholder groups outlined in Figure 4 align with those set out in the *Australian Commission on Safety and Quality in Health Care National Model Clinical Governance Framework*. It is recognised that services will have their own established governance structures and process for S&QI. However, services are encouraged to use statewide governance processes to promote collaboration and sharing of learnings across the sector in a way that moves the system towards a cohesive and consistent approach that is informed by people with lived experience, families, carers and support persons, the workforce, community and understanding of the evidence.

Components of effective governance

Effective governance and leadership of S&QI in MHAOD services supports responsible and accountable decision-making and prioritisation of improvement initiatives.

There are several components of effective governance to consider. Table 1 provides an overview of components of effective governance for MHAOD services to consider supporting their commitment to S&QI. The features include consideration of governance structures, accountability, leadership, integrity, and engagement.

Table 1. *Components of effective governance for S&QI within MHAOD services*

Structure	
Structures	**Documentation and processes**
• Fit-for-purpose governance structures that are aligned with the broader service system and service roles, and responsibilities appropriately matched to scope and authority of position/s and agencies involved. • Governance roles that are complementary and minimise overlap or conflict. • Appropriate committees including clinical networks and linked governance structures including subcommittees and communities of practice. • Optimum balance of flexible guidance and responsibility at all stakeholder levels.	• Clear and cohesive governance charters with supporting documentation. • Well defined service agreement and contractual arrangements.
Accountability	
Roles and responsibilities	**Decision-making**
• Clear roles and responsibilities of key agencies, committees and of managers and leaders and others at all levels. • Responsibilities for S&QI are appropriate for the broader authority and accountability of the roles tasked to hold them. • Effective identification and management of risks and accountability for taking action to progress improvements.	• Clear decision-making authority, accountability, and scope. • Involvement of the right stakeholders with appropriate expertise and authority in shared decision-making and prioritisation. • Evidence-informed decision-making processes where decisions are made as close as possible to where the critical/relevant information is understood best. • Alignment of organisational values and decision-making.

Continued over page...

Table 1. *Components of effective governance for S&QI within MHAOD services (continued)*

Leadership	
Direction setting and alignment • Proactive modelling of a culture of S&QI. • Collaboration and shared decision-making across levels to inform prioritisation of S&QI initiatives ensuring effective communication at all levels. • Statewide S&QI initiatives are identified in line with statewide and local priorities. • Active prioritisation of S&QI initiatives. • Alignment of effort across services and NGOs with the agreed direction.	**Capability** • Ability to provide strong, ethical leadership. • Lead, promote, advocate and drive S&QI initiatives.
Integrity	
Governance conformance • Adherence to policies and procedures. • Proactive and efficient management of external compliance obligations. • Obligations regarding reporting and transparency.	**Monitoring and evaluation** • Clear mechanisms to guide development and implementation of S&QI initiatives. • Clear monitoring and evaluation mechanisms to support realisation of benefits from improvement initiatives. • Collection, use, and reporting of data, upholding privacy and confidentiality.
Engagement	
Voice of lived experience • People with a lived experience and those receiving care, carers, families, and support persons are supported to be partners in the co-design and co-production of planning, delivery, measurement, and evaluation of S&QI initiatives.	**Collaboration and learning** • Effective collaboration and engagement with relevant stakeholders. • Clear communication and feedback loops to ensure meaningful engagement and sharing of learnings. • Stakeholders have their voice heard and valued.

Structured prioritisation of S&QI initiatives

Drivers for prioritising S&QI initiatives

There are wide ranging opportunities for S&QI in the MHAOD landscape. Establishing a prioritisation of initiatives helps services to clearly identify which of the competing priorities should be a key focus at a particular point in time. Effective prioritisation allows for adequate planning of capacity and capabilities in response to service demands and S&QI opportunities. A process for prioritisation will consider both internal and external drivers.

S&QI priorities in MHAOD services will vary at national, statewide and local levels given the different contexts and drivers and competing priorities. The Safety Priorities provide a framework to guide safety improvements in the years ahead and are a statement of collective intent to focus improvement efforts of government, system administrators, and Queensland publicly run, funded, and licensed MHAOD care providers.

Figure 5 identifies factors to consider when determining the relevant priorities of S&QI initiative opportunities. These are not static, at times some will have more influence over prioritisation than others. The eight factors for consideration that provide all stakeholder levels with a transparent and objective way to prioritise S&QI initiatives are:

- **Cultural safety**, responding to cultural needs and ensuring MHAOD services are culturally safe, appropriate, responsive, and accessible.
- **Systems performance**, considering the effectiveness of service processes and the capacity and readiness for organisational change.
- Meeting **national standards**.
- Responding to **community and local needs** as they emerge and evolve, including social determinants of health through partnerships with other services, such as housing services.
- **External drivers**, such as legislation, regulation, policy and community concerns.
- **Evidence-base and data** relating to S&QI initiatives, impact, and feasibility. Interpretation and implementation of evidence should consider the context of local service environments.
- **People with lived experience, carer, family, support person and staff engagement**, which should be supported by opportunities to escalate S&QI priorities and implement S&QI strategies.
- **Care outcomes and experience**, such as immediate risks, responding to and learning from adverse events, and identifying opportunities to improve care outcomes and experiences and to reduce stigma and discrimination.

Figure 5. *Factors to consider when determining the relevant priority of S&QI activities*

Approaches to prioritise S&QI initiatives

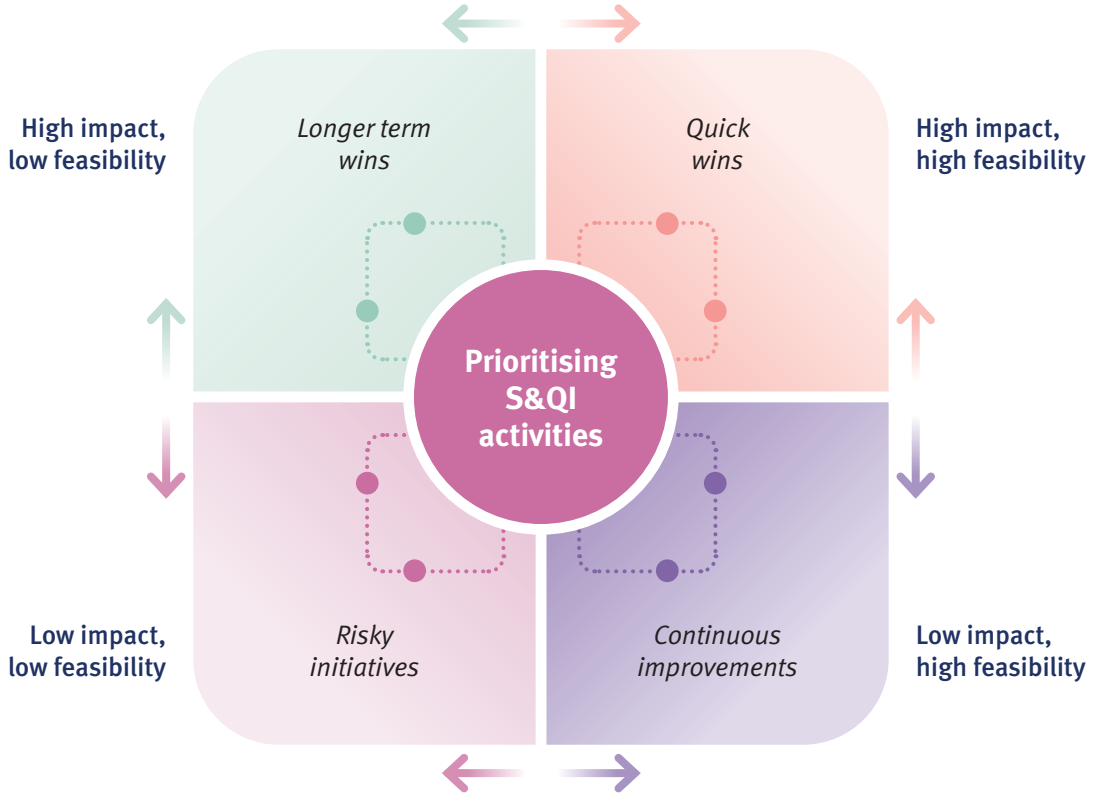
Some activities will need to be prioritised in response to legislation, statewide policy and organisational strategic landscapes. Services may consider categorising other S&QI opportunities against their impact (how they respond to the drivers listed above) and the feasibility of implementation. This can help to identify immediate quick wins and longer-term wins to inform allocation of capacity and capabilities within the service. Prioritisation exists within resource management demands.

This categorisation approach can be considered as:

- **High impact, high feasibility:** initiatives potentially delivering significant value with relatively low effort or change required.
- **High impact, low feasibility:** initiatives potentially delivering significant value but requiring relatively higher effort or change for implementation.
- **Low impact, high feasibility:** initiatives representing ongoing (and often less prominent) changes within services.
- **Low impact, low feasibility:** initiatives representing ongoing service commitments or overdue but necessary improvements to a service.

An example prioritisation matrix is provided in Figure 6.

Figure 6. *S&QI prioritisation matrix*



Meaningful data

Using data to inform S&QI is crucial as it enables evidence-informed decision-making, identifies areas for improvement, informs implementation of S&QI initiatives, monitors progress, engages stakeholders, and informs evaluation of initiatives. Each of these enablers are explored further below:

- **Evidence-informed decision-making:** Data provides objective and empirical evidence that helps drive decision-making processes. It allows services to identify areas of concern, understand trends, and make informed choices on where to allocate resources and implement improvements.
- **Identification of areas for improvement:** Data enables the identification of areas that require improvement. By analysing metrics such as person receiving care outcomes, feedback from people receiving care, staff feedback, adverse events, and process indicators, services can pinpoint specific problems or opportunities and where required develop targeted interventions to address them.
- **Implementation of S&QI initiatives:** Data provides information about the service context, such as workforce capacity and capabilities and workflows, as well as outcomes and experience of people receiving care, to understand the implementation and progress of S&QI initiatives.
- **Monitors progress against S&QI commitments and priorities aligned to the agreed reform agenda:** This may include monitoring of data such as outcomes and experience of people receiving care, service indicators such as wait times, clinical incidents, and measures of clinical quality.
- **Engages key stakeholders:** Data provides a credible and objective basis for engaging people receiving care, carers, families, and support persons, healthcare professionals, regulatory bodies, and policymakers. By presenting data on safety and quality outcomes, services can foster transparency, build trust, and solicit input from various stakeholders to drive improvement efforts collaboratively.
- **Evaluation:** An evaluation can be informed by qualitative and quantitative data and determines whether a S&QI initiative has been successful in achieving an anticipated outcome. Evaluation is a core element of continuous improvement and can support the scaling up of successful initiatives. See section Monitoring and Evaluation for further information.

Data lifecycle

Approaches to data handling are important to consider, ensuring that data are of high quality and provide a comprehensive overview of opportunities for S&QI within the service and the success of implemented initiatives. A data lifecycle provides a model to conceptualise the different actions taken at differing stages of using data to inform an improvement initiative. Figure 7 provides an example of a high-level overview of the data lifecycle.

Figure 7. *Overview of data lifecycle*

Considerations for each element of the data life cycle are explored further below:

- **Planning** is a critical step to ensure that the right data is collected, analysed, reported and linked where appropriate to inform continuous improvement. Consideration needs to be given to the purpose of collecting the data, the identification of specific measures, consistency of data definitions, and when to use the data.
- **Collection** of data to comply with informed consent requirements including that the purpose of data collection should be clearly articulated to people receiving care, that data is stored in secure systems and only collected for its intended purpose. Prior to collection it is important to identify what data is already collected and where there may be gaps. Targeted collection can supplement the use of existing data while reducing data collection burden. Where possible identify opportunities to codesign data collection methods with people with lived experience and consider successful methods utilised in other services and settings.
- **Analysis** of data provides an objective assessment of whether change has occurred and identifies opportunities for S&QI. Consideration needs to be given to what data analysis methods will be used to transform raw data into findings. Develop data and analytic capabilities within organisations to support staff to analyse and interpret data to inform S&QI initiatives.
- **Reporting** on data in ways that are clear, transparent, appropriate for the intended audience to maintain accountability for S&QI, and that acknowledges data limitations. Consider using standardised definitions so that data can be used to compare against similar services. Ensure that findings are accessible to people receiving care and meaningful to the community. Identify and participate in opportunities to showcase S&QI work at a local and statewide level.
- **Linkage** of data to identify broader S&QI issues, areas for innovation and improvement and to support collaboration. Ensure consent is obtained where required recognising the need to share data appropriately, within legislative contexts.

Measurement for improvement is an ongoing process and should be consistently reviewed to identify any gaps or additional opportunities for improvement.

Data sources and types

When planning for measurement and data collection, consideration needs to be given to specific inputs to data utilised in S&QI initiatives. Specific inputs include:

- **People receiving care, carers, family, and support persons**, including experience and outcome measures.
- **Clinicians and frontline workers**, including clinical notes, assessments, clinical interventions provided, measures of clinical quality, incident reporting and workforce wellbeing and engagement (e.g. absences, turnover).
- **Service delivery operations**, including workforce numbers, experience, roles, and responsibilities, where capacities and capabilities are prioritised, workplace culture, and workforce capability.
- **Operational and administrative data**, including service provision workflows, service activity data, wait times, and clinical incidents.
- **External partners and organisations**, including experience measures relating to transfer and continuity of care, referral processes, and collaborative processes.
- **Improvement activity data**, including data collected from monitoring and evaluating of individual S&QI initiatives.

Data improvement mechanisms

There are a range of opportunities for key stakeholders including people receiving care, carers, families, and support persons, MHAOD services, the Department of Health, service providers and researchers to utilise data for continuous improvement.

Some of these opportunities include, but are not limited to:

- People receiving care, carers, families, and support people contribute to planning and development of data approaches to ensure data is representative, meaningful, and accessible.
- MHAOD services use data to identify opportunities to improve, streamline and build data capabilities within services.
- The Department of Health and other funding bodies may lead the development of data frameworks, standardised reporting to support service delivery, and aggregate data to support services to compare S&QI opportunities and initiatives with other services operating in similar settings.
- Service providers and researchers lead the implementation and translation of evidence-informed S&QI initiatives into practice.

Collaborative partnerships

Effective partnerships are a genuine commitment between organisations and stakeholder groups to work towards a shared vision of S&QI. They are reciprocal, drawing on the strengths and expertise of each party to ensure the safety of people receiving care, carers, families, and support persons and staff and promote continuous improvement in service delivery.

Figure 8 provides an overview of the principles of effective partnerships.

It is important that the voice of key partners is strong and contributes to informing S&QI. Partnering with people receiving care, carers, families, and support persons is critical to understand needs and seek input on S&QI initiatives. This partnership needs to be genuine, and to recognise and address issues relating to power differentials between people with lived experience and services and funding bodies.

Partnerships will vary across services and contexts. Some services may have several active partners supporting them to deliver on their commitment to S&QI and others may still be building partnerships. Stakeholder mapping provides a useful tool to identify partners who may have an interest in the quality improvement initiative being undertaken and depending on the scope of the initiative stakeholders may be internal or external to the service setting.

Various stakeholder groups contribute to S&QI with numerous opportunities for different services and organisations to partner on S&QI. Services can partner to complement their capability and draw on other's expertise. Services and organisations may consider partnering on S&QI with service delivery partners and service development partners.

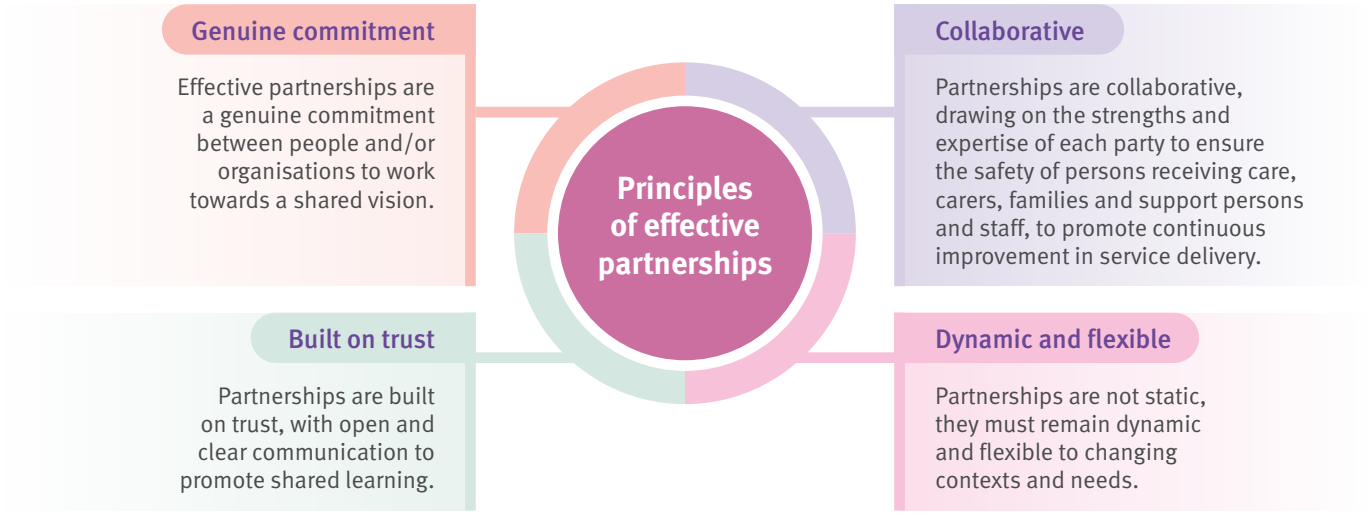
Service delivery partners include stakeholders who are part of the care continuum, such as:

- HHSs including other health care teams within or external to a HHS
- primary healthcare
- community services and NGOs
- peak organisations
- private service providers
- workforce including clinical, non-clinical and peer workforce across both MHAOD and non-MHAOD services
- non-health providers including education, housing services, legal and justice services, child protection organisations
- community leaders.

Service development partners include stakeholders involved in supporting S&QI processes at a systems level and whose expertise can be drawn on with regards to evidence-informed approaches such as:

- research organisations
- education providers including training providers, universities, TAFE
- other government departments' service improvement agencies
- clinical networks.

Figure 8. *Principles of effective partnerships*



Implementation

Implementation of S&QI initiatives needs to consider the system and/or local service context, capacity, and capabilities. Enablers of S&QI implementation include:

- existing systems and processes
- training and workforce development
- tools and resources.

Existing systems and processes

Services may leverage and/or strengthen existing systems and processes to support implementation of S&QI initiatives. Table 2 provides examples of systems and processes that support S&QI implementation.

Table 2. *System level and process considerations to support implementation of S&QI initiatives*

Transparency and shared understanding of roles and responsibilities	Confirming and communicating roles and responsibilities widely to support S&QI, including reviewing current roles and responsibilities and governance structures to ensure they are relevant, effective and suitable.
Mechanisms for engaging people receiving care, families, carers, and support people in S&QI	Reviewing feedback mechanisms or establishing reference groups to draw on the expertise of people with lived experience. Processes for engaging people with lived experience in S&QI initiatives will be confirmed and transparent.
Alignment of S&QI processes with service capacity and capability	Where there are limitations in capacity and/or capability, services may consider how best to address these, which may include: • prioritisation and re-allocation of capacity • workforce development • Artificial intelligence/digital technologies, digital service delivery • drawing on the expertise of partners across the system, including other services.
Prioritisation of S&QI initiatives	A shared understanding of prioritisation drivers for S&QI initiatives that considers local service contexts. Reviewing current activities against statewide priorities and local indicators of S&QI to confirm the priorities and establish processes to monitor and review priorities.
Available data collection and reporting mechanisms	Where possible, using existing data to support S&QI initiatives including local indicators and monitoring mechanisms, with more targeted data mechanisms developed only where there are data gaps that will compromise the success of the S&QI initiative.
Clear channels for communicating and sharing learnings	Communicating what S&QI looks like within the specific context of a service as well as broadly across services and establishing processes to share learnings across the services. Collaborative arrangements across services can support this.

Training and workforce development

Services can support S&QI through practice, training, workforce development, and continuous professional development processes. A strong understanding of S&QI methodologies supports:

- a culture of learning and continuous improvement
- innovation and faster translation of contemporary evidence into practice, and
- engagement of the workforce, people receiving care, carers, families and support people in S&QI initiatives.

Some services may have existing S&QI capabilities to support implementation while others may require training and workforce development to upskill workers in their S&QI knowledge and skills to apply evidence-informed approaches and methodologies in practice.

All stakeholders involved in MHAOD service delivery can benefit from training and workforce development to support capability in S&QI. Developing the workforce in S&QI approaches and methodologies has the following benefits:

- supporting the engagement and contribution of people receiving care, carers, families and support people in S&QI
- enhancing understanding and capability of service providers to identify opportunities for improvement and to lead and participate in S&QI initiatives
- enhancing leadership from those with knowledge and understanding of S&QI in planning and implementing larger S&QI initiatives, and
- supporting and maintaining a culture of learning and continuous improvement.

Table 3 provides examples of workforce development considerations to support S&QI.

Table 3. *Training and workforce development considerations to support uptake of S&QI approaches, tools and methodologies*

Training and workforce development opportunities	
S&QI methodologies can support service providers, managers, and leadership to identify gaps in improvement capabilities, and can support the application of new knowledge and skills into practice through effective management.	**Clinical supervision** provides service providers and peer workers regular opportunities to reflect on work and professional challenges and explore new ways of working, this may include external practice supervision. By supporting clinical supervisors to be upskilled in S&QI approaches and methodologies, supervisors will be able to assist supervisees to consider areas for S&QI and grow the supervisee's S&QI skill set.
Knowledge and skills development in S&QI methodologies can complement existing continuous development processes by preparing the workforce with skills for implementing and evaluating changes in practice.	**Buddying** by pairing new staff with staff experienced in undertaking S&QI initiatives to provide orientation to the service and S&QI processes and support connection with the workforce.
Service design can equip service providers, managers, and leadership to design and improve approaches to service delivery that meet the needs and preferences of people receiving care, carers, families and support people through methodologies such as co-design and human-centred design.	**Mentoring** using a mentoring approach involving senior professionals sharing knowledge and expertise with a mentee to support professional growth and learning.
Service user engagement can support service providers to draw on the perspectives of people receiving care, carers, families and support people with lived experience of MHAOD to inform best-practice and S&QI.	**Communities of Practice** can support shared learning for MHAOD stakeholders and provide a space to discuss S&QI initiatives in other services and contexts that may be adapted to local service environments.

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Table 3. *Training and workforce development considerations to support uptake of S&QI approaches, tools and methodologies (continued)*

Prioritising S&QI training and workforce development

Services can utilise the prioritisation matrix in the Framework to prioritise training and workforce development initiatives in relation to enablers of S&QI. Prioritisation can also be supported by:

- **Clearly defined roles and responsibilities of the workforce in relation to S&QI** which can support services to identify the skills and capabilities required and address any gaps through training and workforce development in the use of S&QI tools.
- **Regular review of roles and responsibilities and scope of work**, particularly when scope is influenced by new clinical practices or technologies.
- **Analysis of workforce knowledge and understanding of S&QI** approaches through feedback and surveys to identify gaps and opportunities for development.

Resources for S&QI training and workforce development

Services can encourage and support staff to undertake training in areas of S&QI related to their scope of work. There are a number of online resources that provide guidance for S&QI, including but not limited to:

- The Australian Council on Healthcare Standards (ACHS) Improvement Academy[1] provides free and paid courses to support service providers, managers and leadership with skills, knowledge and expertise in S&QI.
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP) offers a range of self-paced modules[2] on topics that support S&QI in mental health, such as Aboriginal and Torres Strait Islander mental health, leadership and management, quality improvement, evaluation and lived experience participation in service initiatives, and change management.
- Orygen, The National Centre of Excellence in Youth Mental Health has developed a service implementation and quality improvement[3] and introduction to implementation science resources.
- The University of Cambridge provides an online resource Improving Improvement: A toolkit for Engineering Better Care[4], which offers service providers detailed information on improving healthcare service delivery, including common methodologies and approaches such as IHI Model for Improvement, Lean Thinking, Six Sigma, and the Quality Enhancement Research Initiative (QUERI) Roadmap for Implementation and Quality Improvement[5].
- The Clinical Skills Development Service[6] online course Improvement Science[7] provides fundamental knowledge on how improvement science is used in the workplace to introduce sustainable, long term changes that result in improved care and outcomes.

Partnerships with external training organisations, such as those listed in the Partnerships section of the Framework, can support training of staff, people receiving care, carers, families and support persons to participate in S&QI activities. For example, research institutes, education providers, universities and TAFE.

1 https://www.achs.org.au/improvement-academy
2 https://www.ranzcp.org/training-exams-and-assessments/exams-assessments/self-paced-online-learning-requirements
3 https://www.orygen.org.au/getmedia/28fea641-7e2f-4ea3-b5ad-33422fa3d2c7/SIQI-A-Theoretically-Informed-Approach.aspx
4 https://www.iitoolkit.com/start/executive.html
5 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6750196/pdf/mlr-57-s286.pdf
6 https://csds.qld.edu.au/
7 https://central.csds.qld.edu.au/central/courses/390

Tools and resources

Many different approaches, tools, and resources are available to support services to implement S&QI initiatives. Tools and resources should be considered within the local service context to ensure they are appropriate to meet service needs. Services may also develop their own tools and resources to support staff to implement S&QI initiatives. Table 4 details some options for services seeking evidence-informed tools and resources that support S&QI and resources that support S&QI.

Table 4. *Tools and resources to support implementation of S&QI initiatives*

Structured improvement approaches can support S&QI. They have been widely used and there is evidence of their benefits in improving healthcare service provision. Examples include but are not limited to:

- *Clinical Redesign*[8] is a systematic approach used to improve safety and quality of care by reviewing and refining clinical processes, workflows, and pathways to enhance efficiency, effectiveness, and the outcomes and experiences of people receiving care. Services may use Clinical Redesign to identify and address challenges that impact the journey of people receiving care through the service. For example, mapping the journey, and related processes, from initial referral to intake and assessment can uncover challenges that may contribute to delayed service entry and can help services identity solutions.
- *Quality Enhancement Research Initiative (QUERI)*[9] *(QUERI) Roadmap for Implementation and Quality Improvement* provides a practical guide that aims to support frontline staff and clinicians in a learning health system in ensuring that effective practices are more rapidly implemented into practice. It is a practical guide consisting of three phases pre-implementation, implementation and sustainment involving multidisciplinary teams of clinicians, consumers, managers, and investigators working together to improve outcomes. The QUERI Roadmap uses the Knowledge to Action Framework to support the steps from creation of knowledge to the action cycle of implementation of knowledge into practice and utilises rigorous evaluation methods.
- *Institute for Healthcare Improvement (IHI) Model for Improvement*[10] provides a structured framework for making continuous and sustainable improvements in health services by focusing on clear aims, measurement and iterative testing of changes. The IHI Model for Improvement is better suited for specific challenges with solutions that can be refined over time. It can support services to achieve small and quick improvements that can be scaled up and refined over time. For example, MHAOD services implementing behavioural support techniques to reduce distress and restrictive practice may use the IHI Model for Improvement to assess outcomes and adapt these techniques accordingly.
- *Engineering Better Care: Improving Improvement: A toolkit for Engineering Better Care*[11], a framework for improvement based on a set of questions addressing people, systems, design, risk and management perspectives.

  Engineering Better Care uses a systems approach to health and care design and continuous improvement to accommodate developing something new or to improve an existing system. The approach focuses on using structured questions, activities and tools to move a system from its current performance to a future, measurably better state and across key stages of understand, co-design, deliver and sustain.

Continued over page...

8 https://www.mja.com.au/journal/2008/188/6/patient-journeys-process-clinical-redesign
9 https://www.queri.research.va.gov/tools/roadmap.cfm
10 https://www.ihi.org/resources/how-to-improve
11 https://www.iitoolkit.com/start/executive.html

Table 4. *Tools and resources to support implementation of S&QI initiatives (continued)*

Structured improvement methodologies can support implementation, monitoring and adaptation of S&QI initiatives. Examples include but are not limited to:

- *Lean Thinking*[12]: Focuses on streamlining processes by engaging the workforce to consider where value is delivered. It is a team process, which involves identifying non-value adding initiatives, reducing unnecessary steps, and improving allocation of capacity and capability to improve efficiency.
- *Six Sigma*[13]: Data-driven quality improvement methodology that aims to reduce variation and errors in processes. By utilising statistical analysis and problem-solving techniques, MHAOD services can identify and rectify sources of error or inefficiencies that risk service delivery quality. Six Sigma typically follows a standardised and systematic method known as Define, Measure, Analyse, Improve, Control (DMAIC). This process can be used to map cause and effect relationships to identify the root cause of a challenge and to measure the impact of improvements and modifications on outcomes. Lean Thinking and Six Sigma methodologies are often combined[14], recognising their complementary processes.
- *Plan-Do-Study-Act (PDSA)*[15]: An iterative four-stage problem-solving model used for improving a process or carryout change. It involves planning your change, carrying out the plan and observing, measuring, and recording the data, studying the data to summarise what was learned, and acting on the data to decide what changes you will make next. PDSA is embedded in the IHI Model for Improvement. It ensures the impact of changes are measured and acted on to contribute to continuous improvement.

12 https://www.iitoolkit.com/improvement/lean.html
13 https://www.iitoolkit.com/improvement/sigma.html
14 https://ontario.cmha.ca/wp-content/uploads/2019/06/B1-1-2pm-More-than-wishful-thinking-Ann-Barber.pdf
15 https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/model-for-improvement-and-pdsa-cycles

Table 4. *Tools and resources to support implementation of S&QI initiatives (continued)*

Other resources available to support implementation include:

- **S&QI leaders, both formal and informal**, may guide, support, and develop others to fulfil their roles in S&QI. S&QI leaders may be responsible for coordinating opportunities for identifying S&QI opportunities within a service and coordinating mechanisms for shared learning, i.e. regular S&QI meetings or forums.
- **Resources** that are available to services can support S&QI. Resources provided by Queensland Health include: the Clinical Excellence Queensland's Patient Safety and Quality Improvement Service[16], the MHAOD Branch Analytics, Improvement and Transformation Unit and the Department of Health's Statistical Services Branch (SSB)[17] which collects, processes, analyses and disseminated statistics on the health of Queenslanders and their use of health services. Services can request data from the SSB to inform S&QI initiatives and research.
- Within Queensland Health, Clinical Excellence Queensland the Health Care Improvement Unit (HIU)[18] works with Hospital and Health Services in co-designing new and innovative models of care with the aim of improving access to healthcare by improving capacity, capability and efficiency. The HIU offers a number of resources including health care evaluation.
- Further, the Allied Health Translating Research into Practice (AH-TRIP)[19] is a Queensland Health initiative which offers a wealth of available supports, tools and resources to support services in implementation science.
- There is also a suite of resources available more widely including through accreditation bodies such as SAI Global[20] and Quality Innovation Performance Limited[21].
- *Consumer and Community Engagement Framework*[22]: Provides a framework for best practice in engagement with consumers and communities in health.
- *A Guide for Health Staff Partnering with Consumers*[23]: Provides guidance to help health staff develop effective consumer partnerships.

16 https://clinicalexcellence.qld.gov.au/about-us/what-we-do/patient-safety-and-quality-improvement-service
17 https://www.health.qld.gov.au/hsu
18 https://qheps.health.qld.gov.au/caru
19 https://www.health.qld.gov.au/clinical-practice/database-tools/translating-research-into-practice-trip/about-us
20 https://www.saiglobal.com/en-au/standards_and_legislation/research/certification/
21 https://www.qip.com.au/
22 https://www.hcq.org.au/wp-content/uploads/2017/03/HCQ-CCE-Framework-2017.pdf
23 https://www.hcq.org.au/wp-content/uploads/2018/06/HCQ_StaffGuide.pdf

Monitoring and evaluation

The purpose of monitoring and evaluation is to understand whether S&QI initiatives are being delivered as expected (e.g. inputs, initiatives, and outputs), and how they are progressing towards desired intermediate and long-term outcomes.

Monitoring S&QI initiatives is important in determining:

- To what extent is the initiative being delivered as expected?
- How is it progressing towards achieving intended outcomes?
- What learnings can be applied to the implementation of the initiative going forward?

Indicators and measurement methodologies

Existing measures and indicators can inform monitoring of S&QI initiatives. However, some initiatives may require additional measures and indicators be developed depending on the existing measures within services.

The following components can be applied to support the identification or development of suitable measures to inform a monitoring approach. Suitable measures are:

- **Relevant and meaningful:** Measures reflect what the S&QI initiative is trying to achieve.
- **Attributable:** Measures can attribute change to the initiative.
- **Comparable:** Measures can be compared across time periods or with similar services or benchmarks.
- **Clear:** Measures are clearly defined and unambiguous.
- **Timely:** Collection and reporting of measures are timely to contribute to ongoing improvement and decision-making.
- **Efficient and feasible:** The collection of measures is efficient and feasible within available resources and time limits.

Qualitative and quantitative data to inform indicators can be collected using a variety of methods. Some examples of qualitative and quantitative feedback and improvement mechanisms are provided in Table 5.

Table 5. *Examples of qualitative and quantitative feedback and improvement mechanisms*

Qualitative mechanisms
• Experience surveys
• Feedback and complaint data
• Climate surveys
• Interviews
• Focus Groups
Quantitative mechanisms
• Service activity data
• Incident data
• Clinical indicators
• Feedback and complaint data
• Indicators reported in the Chief Psychiatrist Annual Report
• Surveys and repeated measurement assessments

The voice of lived experience in monitoring and evaluation

The voice of lived experience in monitoring and evaluation of S&QI may look different depending on the context. The following mechanisms may be considered to ensure their voice is heard and valued:

- **Lived experience advisory groups:** Lived experience-led advisory groups or committees which could participate in monitoring and evaluation processes. These groups can provide feedback, review data, and offer insights from their lived experiences to inform decision-making.
- **Surveys and feedback mechanisms:** Regular feedback and input from people receiving care, carers, families, and support persons through surveys or feedback mechanisms such as suggestion boxes or online platforms. This allows for sharing of experiences, opinions, and suggestions for improvement.
- **Focus groups and interviews:** Provide opportunities for people with lived experience to participate in focus groups or individual interviews to gather in-depth insights on experiences with MHAOD services. This qualitative data can provide valuable context and uncover specific issues or areas of improvement.
- **Lived experience researchers:** People with lived experience of mental health, alcohol, and other drug use either provide expertise through experience, researcher, peer worker, or mental health professional with lived experience to identify issues that are important to people with lived experience, carers, families, and support persons and identify opportunities for improvement. They can participate in monitoring and evaluation activities alongside services, bringing a unique perspective and evaluating services based on shared experiences.
- **Co-design and co-production:** Empower people receiving care, carers, families, and support persons to be involved in the design and development of monitoring and evaluation frameworks or tools. This ensures that the approach is accessible, relevant, and meaningful, making them active partners in the process.

Evaluation considerations and approaches

When thinking about evaluation of S&QI initiatives it is important to identify the suitability of the initiative for evaluation. Table 6 outlines threshold questions to assess suitability for evaluation.

The following evaluation approaches may be considered when evaluating S&QI initiatives:

- **Formative evaluation:** Conducted during initiative development or early implementation, formative evaluation focuses on providing feedback and insights to shape initiative design and improve its implementation. It helps identify strengths, weaknesses, and areas for improvement before full-scale implementation.
- **Process evaluation:** Assesses the implementation fidelity and delivery of an intervention. It examines how interventions were delivered, the adherence to prescribed protocols, and identifies factors that may have influenced outcomes.
- **Outcome evaluation:** Seeks to determine the extent to which the intended outcomes or impacts have been achieved and the effects of the initiative on people receiving care, carers, families, and support persons. Outcome evaluations go beyond measuring outputs or activities and instead examine the broader changes or benefits that have occurred because of the initiative.
- **Participatory evaluation:** Involves engaging stakeholders, including program participants, in the evaluation process. It recognises the value of different perspectives and promotes collaborative decision-making. Participatory evaluation ensures that the evaluation is relevant, credible, and has buy-in from those affected by the program.

Table 6. *Criteria and threshold questions to assess evaluation suitability*

Criteria	Threshold question
Scale and feasibility	• What is the scale of the program of work? • What are the limitations of evaluation in informing further improvement efforts or scaling of the program of work?
Complexity	• How complex is the initiative/program of work? • What will be required to evaluate the program of work? • What data is available to inform the evaluation? • To what extent will the evaluation be able to draw conclusions from available data? • To what extent will the findings be attributed to the program of work?
Clear outcomes and benefit	• Are the outcomes clearly defined? • What would be the benefit of undertaking an evaluation?
Interactions and dependencies	• What are the dependencies associated with achieving the outcome? • How compelling is the theory of change? • How directly are the outcomes attributable to the program of work?
Continuous improvement	• To what extent will the evaluation contribute to ongoing improvement? • How will the findings/learnings contribute to the future delivery of the program of work and ongoing improvement? • How will the findings/ learnings be shared more broadly?

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Appendix 1

Improvement methodology examples

The following provides three examples of improvement methodologies and how they might be applied.

Clinical redesign

What is it?

A systematic approach used to improve safety and quality of care by reviewing and refining clinical processes, workflows, and pathways to enhance efficiency, effectiveness, and overall consumer outcomes and experiences.

When can it be applied?

Clinical redesign may be used to identify and address challenges that impact the safety, experiences and outcomes of people receiving care. The approach can be used to determine the root cause of challenges and enables a service to implement evidence-informed solutions.

How should I use it?

A key component of clinical redesign includes mapping the journey and related processes to diagnose challenges and identify solutions including actions taken by people receiving care, their experiences and thoughts and feelings at each step. This requires collaboration with people receiving care, carers, families, support people, workforce and other health care partners.

Process and activities for clinical redesign

1 Initiation

- Identify goals, objectives and benefits
- Engage key stakeholders
- Identify key resources
- Establish project governance

2 Diagnostics

- Analyse data
- Undertake consultation with people receiving care, carers, families, support people and workforce
- Map journeys

3 Solution

- Explore existing solutions
- General solutions
- Prioritise solutions
- Understand enablers and barriers

4 Implementation

- Operationalise and implement solution
- Monitor and adjust as appropriate

5 Sustainability

- Ensure the solution is sustainable
- Evaluate the solution

Institute for Healthcare Improvement (IHI) Model for Improvement

What is it?

A structured framework for making continuous and sustainable improvements in health services by focusing on clear aim, measurement, and iterative testing of changes.

When can it be applied?

The IHI Model for Improvement can be applied to address specific challenges or improve processes and outcomes. The IHI Model sets clear goals for improvement and supports monitoring of outcomes to enable adaptations and scalability.

How should I use it?

The IHI Model for Improvement has two parts: three fundamental questions that can be answered in any order, and the Plan-Do-Study-Act (PDSA) cycle to test and adapt changes.

Diverse perspectives and expertise should be drawn on to answer the three questions to ensure ideas for change are effective and sustainable.

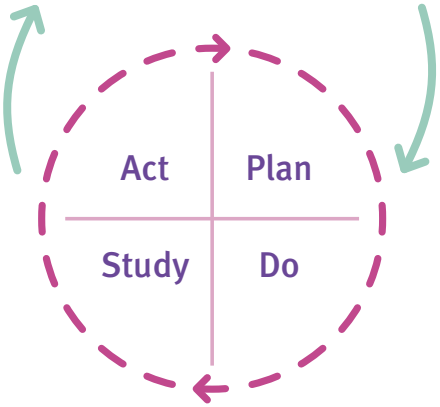
Implementation should start small, allowing for testing before scaling up. For example, beginning with one-patient or trialling a change for one-day first and measuring outcomes before scaling up.

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in an improvement?



Lean-Six Sigma

What is it?

Lean and Six Sigma are two complementary processes for S&QI. Lean Thinking focuses on streamlining processes by identifying and reducing non-value adding activities. Six Sigma is a data-driven quality improvement methodology, which aims to reduce variation and errors in processes.

When can it be applied?

Lean-Six Sigma may be used to improve efficiencies in service delivery to improve processes and quality of service delivery. Data can be used to identify the root causes of errors or incidents and changes can be implemented to enhance overall safety and quality.

How should I use it?

Identify and diagnose the challenge to be addressed, mapping out the root causes and considering where improvements can be made. Learnings from similar work in other services or from previous work can help identify potential solutions. Solutions may involve reducing the number of non-value adding activities and streamlining components of service delivery to reduce variation. The methodology follows a five-step process of Define, Measure, Analyse, Improve, Control (DMAIC).

Drivers for prioritisation of S&QI initiatives in MHAOD services

1. Define the problem or opportunity
2. Measure the problem or opportunity
3. Analyse and identify the cause of the problem
4. Improve – implement and verify the solution
5. Control and maintain the solution

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