ENHANCING CARE TOGETHER

Regional Outcome Review Initiative

PROJECT SUMMARY

This summary includes the background of the project and an overview of key activities with links to Implementation Toolkits.

These Toolkits provides a road map to implementing Joint Reviews, Collective Learning Forums, and a Panel Pool.

Originally set up for mental health, alcohol and other drugs, and suicide prevention services, the Implementation Toolkits can be applied to other health settings.

Contents

A note about language

This document will broadly use the term "**consumer**" to refer to people with Lived and Living Experience of mental illness, mental ill health or recovery. Similarly, the term "**families and support people**" will refer to carers, parents, siblings, spouses, friends, neighbours, nominated persons, and natural occurring supports.

While "**incidents**" are labelled differently across the sector, this document will use the term "**incident**" to mean any event or circumstance which could have or did lead to an unintended, unnecessary, undesirable, or unexpected harm to a person receiving care.

Defining what constitutes a "**Joint Review**" takes time, as each organisation may approach the criteria differently. This flexibility is intentional. Organisations are encouraged to adopt the principle of Joint Reviews which is to review incidents with relevant stakeholders who were involved with the consumers care around the time of the incident. While the exact process will vary, the commitment to learn together underpins the process.

Forword

The Regional Outcome Review Initiative, 'Enhancing Care Together', is a long-awaited development in the sector and one which we anticipate will be applauded by consumers and families and support people. The project promotes collaborative joint incident reviews amongst mental health, alcohol and other drugs (AOD) and suicide prevention services, so that learnings are shared, and harm is reduced. We know that when there's collaboration and integration between services, the consumer and their family are better supported, incidents are reduced, the consumer's treatment is more effective, and recovery can be a real possibility.

But so often, consumers and their families experience "things going wrong, horribly wrong", and there seems to be no appropriate redress. Or, if there is, it's disjointed, gets no traction, and the improvements identified fall by the wayside. When services "get on the same page", working together to create common processes, the consumer can receive quality, safe care, and confusion is reduced. Examples of excellence emerge from this, and these examples, too, are important learnings. The insights achieved in Joint Reviews, and Collective Learning Forums, can enhance collective learning and reveal system strengths and weaknesses. That understanding is crucial.

The Enhancing Care Together: Regional Outcome Review Initiative is a remarkable step forward in local mental health reform, providing a very real opportunity to build consumer and family confidence in the system.

Lynda and Denise
Lived Experience Representatives

Background

The North East Metro Health Service Partnership (NEM HSP) in collaboration with mental health, AOD and suicide prevention services in the eastern and north-eastern region of metro Melbourne, developed the Regional Outcome Review Initiative (RORI). Commencing in November 2022, RORI is our response to the question, how can we improve our ability to learn from incident reviews?

Five hospitals and seven community health services, and one non-governmental organisation, along with people with Lived Experience, Eastern Melbourne Primary Health Network have united in this important process of improvement, reform, and cultural change in our region's health system.

Drawing on principles from the Royal Commission into Victoria's Mental Health System and Safer Care Victoria, the shared principles ensure RORI provides safe learning environments, is connected and collaborative, and organised for safety and quality.

Participating organisations have piloted three key actions that have led to improvements in quality, safety, and clinical governance in integrated care. These are Joint Reviews, Collective Learning Forums, and a Panel Pool.

We have Implementation Toolkits for each of the key actions so you can implement part or all these actions within your own region. See the RORI website: **www.austin.org.au/rori/**.

What we learned

This has been a successful initiative to explore. RORI has demonstrated proof of concept with notable engagement and positive feedback. Within two years we have moved from initiative to business as usual (BAU) within most participating services. With cultural and attitudinal shifts leading to policy changes embedded into BAU, the data is showing early positive signs of success. Long term success outcomes are yet to be measured.

RORI had defined goals (*Figure 1*). Across the board, the experience of those involved is that we are meeting our aims. Ten services participating in the pilot study provided monthly data on the number of serious incidents occurring each month. Roughly 30% of those were suitable for a Joint Review and the number completed as Joint Reviews has increased. We are seeing the number of missed opportunities decline with 100% of appropriate reviews completed as Joint Reviews in the past three months (May, June, July 2024).

Information on methods of feedback is provided at the end of this document.

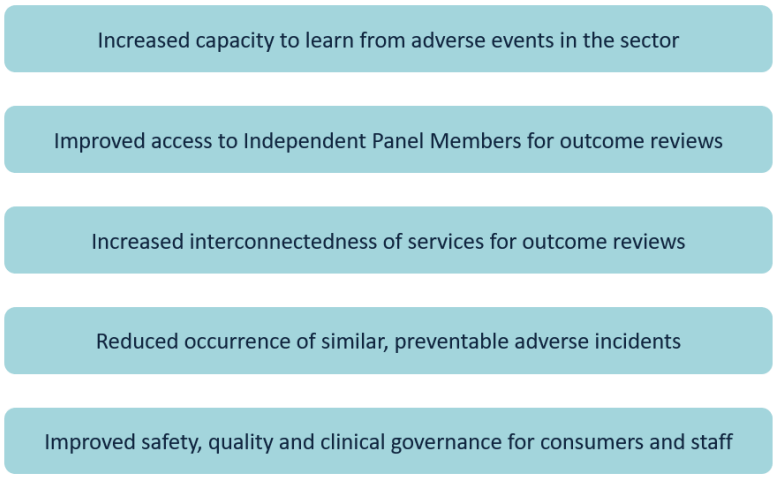

Figure 1: RORI Aims.

Key elements of success have included:

- Having the right people in the room: senior executives, clinical and medical directors and quality and safety staff representing their organisations. Decision makers and people who can enact and embed the changes.
- Leading through example: it takes vulnerability, bravery and trust to share serious incidents. Having our first Collective Learning Forums being led by those willing to step into this space was the central element that set up a culture of openness, trust, transparency and led to a safe learning environment.

"It (RORI) manages risk, enhances the safety for everyone, and enriches the services as well"
Steering Committee member

"Clinical governance, notification processes, and quality reporting at our organisation have reviewed and improved as a direct outcome of RORI"
Steering Committee member

"It's (RORI) proactive rather than reactive and it's very person-centred"
Lived Experience member

Joint Reviews

What?

When more than one service was involved with the consumer at the time of an incident a Joint Review is indicated. The involvement could have been either consecutive or concurrent. A Joint Review occurs when the service organising the incident review invites other stakeholders involved in the care to participate in the review rather than completing the review by themselves. This includes contributing to the timeline and contributing to the discussion as panel members.

Why?

Joint Reviews offer a comprehensive understanding of incidents and promote a holistic approach to addressing challenges and improving service delivery. Completing Joint Reviews fosters a culture of learning, collaboration, and continuous system improvement. Joint Reviews also improve consumer, family, and carer confidence that their journey has been seen as a whole.

How?

Any service can embed Joint Reviews within their processes and policies. Exactly how this process looks will differ from organisation to organisation. The principles of collaborative review of incidents, fostering a Just Culture – which emphasises learning and accountability rather than blame – and focusing on system improvement can be adopted by any service.

Further to updating processes, organisations can embed within their partnership agreements, a clear process regarding how incidents will be reviewed together. This paves the way for streamlined processes and clear expectations.

Our Learnings

Joint Reviews have strengthened our ability to learn from incidents, address shared challenges, enhance communication and trust between services, develop comprehensive findings and recommendations, enhance clinical governance and safety, increase consumer confidence, and improve closure for consumers, families and support people. Together, the RORI services have fostered a more comprehensive, collaborative, and effective approach to incident reviews.

"Joint Reviews will bring more closure to families"
Lived Experience member

"We have seen Joint Reviews undertaken in different states… …as a direct result of the focus and importance placed on Joint Reviews through the RORI initiative"
Steering Committee member

Joint Review Toolkit available on the RORI website

"Improved collaboration with other agencies will work to reduce incidents occurring at points of care transfer"
Steering Committee member

Collective Learning Forums

What?

Collective Learning Forums facilitate the sharing of potential risks, best practices, and strategies for improvement across the region. Each month, one organisation presents de-identified key learnings from a relevant incident, opening valuable discussions on system challenges, issues, and opportunities for system wide improvement.

Why?

Sharing the learnings from local incident reviews enables all organisations to enhance their processes, systems, and overall service. It also enables the focus to shift from individual incidents to broader system-level improvements.

Importantly, Collective Learning Forums create a space for regional relationship building. They unite stakeholders by cultivating a culture of openness, curiosity, and ongoing improvement.

How?

Any service can set up a Collective Learning Forum by inviting others to attend a regular community of practice meeting. A key element is having one or two services bravely present first, setting up the culture for openness and transparency.

Our Learnings

All services feel that understandings gained through the Collective Learning Forum will reduce the occurrence of similar, preventable adverse incidents. Therefore, despite the initial discomfort at sharing findings and recommendations from incident reviews, our services have shown great vulnerability and respect in the presentation and discussion of incidents. This has increased their interconnectedness and confidence to collaborate with each other for Joint Reviews and beyond the scope of RORI. Trust and communication have increased and facilitated a space for learning and change. Some services have already adjusted their policies and procedures due to their learnings while others report their learnings have already prevented adverse incidents.

"It has been instrumental in forming work by validating goals or shining a light on what is critical"
Steering Committee member

"The opportunity to get to know members of the steering committee is very important and facilitates shared learning, collaboration and partnerships across the region"
Steering Committee member

Collective Learning Forum Toolkit available on the RORI website

"Sharing the learnings gives all organisations the opportunity to put in place learnings before a similar adverse event occurs in the service – a way of improving practice and therefore safety for all consumers across the sector"
Steering Committee member

Panel Pool

What?

The Panel Pool is a list of organisations who have staff with the experience and expertise to be Independent Panel Members to incident reviews. There is also opportunity for those developing their skills to act as a Learner Observer.

Why?

- Improve access to Independent Panel Members
- In line with best practice to increase rigour and objectivity of incident reviews
- Develop incident review skills
- Fosters regional relationship building

How?

The Panel Pool includes a list of participating organisations, a contact for each, and a list of Independent Panel Members areas of expertise. Organisations can request someone based on their expertise and experience through a single key contact who will connect them to an Independent Panel Member. The organisation providing an Independent Panel Member can also send a Learner Observer to the incident review panel. We developed criteria to determine if staff were appropriate to be Independent Panel Members or Learner Observers. Services also built into their processes the inclusion of an Independent Panel Member when setting up appropriate incident reviews.

Our Learnings

The Panel Pool increased services ability to access Independent Panel Members and allowed for the development of incident review skills for the Learner Observers. The inclusion of Independent Panel Members allowed for diversified perspectives. Having a direct contact at each organisation allowed for the ability to collaborate beyond the scope of RORI.

From the Panel Pool pilot, we learned that there was a gap in the training for incident reviews when it came to mental health, AOD and suicide prevention. The training available provided the theoretical underpinnings for how to complete incident reviews but lacked the complexity of the sector. In response to this we developed additional training which is available at www.austin.org.au/rori.

Panel Pool Toolkit available on the RORI website

"Having people from our organisation participating in reviews as Independent Panel Members and Learner Observers has been very valuable"
Steering Committee member

"The Panel Pool also held a symbolic function, messaging that we are all available to each other"
Steering Committee member

Acknowledgements

We thank the members of the Regional Outcome Review Initiative Steering Committee and the Implementation Working Group for their valuable contribution to this Initiative. This work is a testament to their commitment to improvement, willingness to be vulnerable, and the openness to building and strengthening relationships.

Thank you to all staff at participating organisations who have adopted the RORI aims and built them into your policies and processes. Because of you, these changes can live on beyond this project and support us to provide better care for those who access our services.

Regional Outcome Review Initiative Steering Committee

- **Naomi Capper**, North East Metro Health Service Partnership (Project Manager)
- **Dr Paul Katz**, Eastern Health (Clinical Lead, Nov 2022 – Mar 2024)
- **Dominika Baetens**, St Vincent's Hospital Melbourne (Clinical Lead, Apr 2024 – Nov 2024)
- **Lynda Watts**, Lived Experience Representative
- **Denise Damouni**, Lived Experience Representative (Jun 2023 – Nov 2024)
- **Greg den Hartog**, Lived Experience Representative (Jul 2023 – Sep 2023)
- **Dr Tamsin Short**, Access Health and Community
- **A/Prof Sophie Adams**, Austin Health (Nov 2022 – Jun 2024)
- **Emma Fitzsimon**, Banyule Community Health
- **Debbie Stanley**, Each (Nov 2022 – Aug 2023)
- **Nicholas Teo**, Each (Aug 2023 – Nov 2024)
- **Brooke Trevorah**, Eastern Health
- **Lynne Allison**, Eastern Health
- **Iftah Amith**, Eastern Health (Nov 2022 – Nov 2023)
- **Peri Boztepe**, Eastern Melbourne Primary Health Network
- **Alison Asche**, Eastern Melbourne Primary Health Network (May 2023 – Nov 2024)
- **Matthew Hercus**, Forensicare
- **Rosalyn Sandwell,** healthAbility (Aug 2023 – Nov 2024)
- **Anoushka Wootton**, Mind Australia
- **Mel Gregory**, North East Metro Health Service Partnership (Nov 2023 – Nov 2024)
- **Charlie McArthur**, North East Metro Health Service Partnership (Feb 2023-Oct 2023)
- **Rachel Meehan**, North East Metro Health Service Partnership (Nov 2022 – Jan 2023)
- **Di Nally**, Neami (Nov 2022 – Jun 2023)
- **Nadia Clarke**, Neami (Jul 2023 – Aug 2023)
- **Belinda Scott**, Northern Health
- **Brad Wynne**, St Vincent's Hospital Melbourne
- **Keryn Ralph**, Uniting (Jul 2023 – Nov 2024)
- **Jasmine Corbo**, Wellways
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- **Rebecca Bullock**, Northern Health
- **Karen Merlo**, Northern Health
- **Rebecca Janovic**, Uniting
- **Corey Eastwood**, Wellways
- **Apoorva Charukonda**, Your Community Health

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Feedback Methods

10 Steering Committee services actively participated in the pilot from July 2023-March 2024. These services provided monthly incident review data during the pilot period and provided 6 months of retrospective baseline data.

- How many ISR 1 and ISR 2 incidents occurred.
- How many of these incidents would be appropriate for a Joint Review.
- How many of these incidents had a Joint Review completed.

Collective Learning Forum attendance was tracked.

11 Steering Committee services completed online surveys that asked questions to see how RORI was progressing towards its aims (see *Figure 1* for RORI aims).

The RORI Project Manager had discussions with Steering Committee members whose organisation is not a direct provider of services.

The RORI Project Manager also met with Lived Experience groups to share the work and incorporate their feedback.