



# ENHANCING CARE TOGETHER

## Regional Outcome Review Initiative

This Implementation Toolkit provides a road map to implementing a Panel Pool. It includes the background of the project and an overview of key activities with accompanying tools to support implementation.

Originally set up for mental health, alcohol and other drugs, and suicide prevention services, Panel Pools can be implemented in other health settings.

## PANEL POOL TOOLKIT

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## 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.

## Forward

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.

This Toolkit is to support you to implement a Panel Pool in your region. Other Toolkits and resources are available on the RORI website: [www.austin.org.au/rori/](http://www.austin.org.au/rori/).

# Panel Pool Implementation Toolkit

## 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](http://www.austin.org.au/rori).

“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*

## How to set up a Panel Pool

Organisations may choose to start a Panel Pool. This could grow from involvement in a Collective Learning Forum or through other connections. You can start small and grow the Pool over time.

1. Each organisation offers appropriate staff the chance to participate.
2. Using the [competency criteria](#), staff and supervisors determine which role is appropriate.
3. A key contact person from each organisation maintains a list of their participating staff. The key contact person ensures that the contact details for the organisation are up to date and that the expertise and experience of their members is reflected on the shared list.
4. When approached for an Independent Panel Member, the contact person will do their best to link an appropriate member to the requesting organisation.
5. Organisations that send an Independent Panel Member to an incident review may also send a Learner Observer.

## Administrative Tools

Each organisation should maintain a list of staff participating in the Panel Pool. Learner Observers should be encouraged to develop their skills and work towards becoming an Independent Panel Member.

Service A: Panel Pool Members		
Staff Member	Role	Experience and Expertise
Name A	Independent Panel Member	AOD, Psychiatry
Name B	Learner Observer	Aged Care Mental Health Nursing
Name C	Independent Panel Member	Safety and Quality

Table 1: Organisation Panel Pool List of Members

One organisation should maintain a list of all services involved in the Panel Pool.

Region Panel Pool		
Provider	Contact	Experience and Expertise
Service A	<b>Role:</b> <b>Phone:</b> <b>Email:</b>	AOD/ Psychiatry Aged Care Mental Health Nursing Safety and Quality
Service B	<b>Role:</b> <b>Phone:</b> <b>Email:</b>	

Table 2: Regional Panel Pool List

Examples of experience and expertise include but are not limited to:

- Lived Experience
- Allied Health
- Nursing
- Medical
- Safety and Quality Professional
- Psychiatrist
- Psychologist
- Experience working in Alcohol and Other Drugs
- Experience working in mental health
- Experience working in suicide prevention
- Experience working with children and adolescents
- Experience working with adults
- Experience working with older adults

## Independent Panel Member Competencies

The following criteria has been identified as central aspects to the role of an Independent Panel Member for incident review work in mental health, AOD and suicide prevention. The Independent Panel Member will provide an independent voice, fresh pair of eyes and objective view from outside the organisation(s) in which the incident occurred. They are encouraged to debrief with the Learner Observer after an incident review.

- Health professionals (medical, nursing, allied health), quality and safety professionals and, Lived and Living Experience workforce members who hold formal position at a Victorian public or private health service
- High level incident analysis skills
- Ability to identify findings coupled with recommendations
- Knowledge of a just culture
- Well-developed interpersonal skills such as emotional intelligence, collaboration, problem solving, building and maintaining relationships
- Nil Australian Health Practitioner Regulation Agency (AHPRA) notifications that remain open, any current legal or disciplinary proceedings or any current restrictions on practice
- Holds adequate insurance (needs to be cleared by each organisation's legal counsel)

## Learner Observer Competencies

The following criteria has been identified as central aspects to the role of a Learner Observer for incident review work in mental health, AOD and suicide prevention. A Learner Observer will work towards meeting the competencies of an Independent Panel Member. They are a silent observer in an incident review and are encouraged to debrief with the Independent Panel Member after attending an incident review.

- Health professionals (medical, nursing, allied health), quality and safety professionals, and Lived and Living Experience workforce members who hold a formal position at a Victorian public or private health service
- Emerging incident analysis skills
- Emerging ability to identify findings coupled with recommendations
- Knowledge of a just culture
- Building interpersonal skills such as emotional intelligence, collaboration, problem solving, building and maintaining relationships
- Nil Australian Health Practitioner Regulation Agency (AHPRA) notifications that remain open, any current legal or disciplinary proceedings or any current restrictions on practice
- Holds adequate insurance (needs to be cleared by each organisation's legal counsel)

## Incident Review Training

The following training topics are recommended but not required to perform the role of an Independent Panel Member. These are training opportunities for staff who want to build competency. It is not a comprehensive list and should not supersede internal training provided by your organisation. Readers are encouraged to look at Safer Care Victoria's [website](#) for the most relevant and up to date training modules.

### Training areas include:

- Fundamentals of Adverse Patient Safety Event Review: Human Factors and Systems Thinking
- Fundamentals of Adverse Patient Safety Event Review: Bias, Human Error, Safety Culture and Just Culture
- Fundamentals of Adverse Patient Safety Event Review
- Fundamentals of Adverse Patient Safety Event Review: The Sentinel Event Process
- Root Cause Analysis and Action
- AcciMap
- Engaging with Impacted Consumers
- Statutory Duty of Candour
- Statutory Duty of Candour: Perspectives
- Introduction to Open Disclosure
- SAPSE Reviews Including Protections

## RORI Incident Review Resources

- **From Incident to Improvement:** One page poster on the process of incident reviews.
- **From Incident to Improvement: Behind the Scenes of Incident Reviews** This video guides viewers through the processes around incident reviews in mental health, AOD, and suicide prevention services. Emphasising a 'no blame' culture and collaborative learning, the video aims to show how incidents become opportunities for learning and meaningful improvements.
- **From Incident to Insight: Navigating Complexities in Mental Health, AOD, and Suicide Prevention Incident Reviews:** This video explores the intricate world of incident reviews within mental health, AOD, and suicide prevention services. It addresses the unique challenges of conducting reviews in these high-stakes fields, where serious incidents are rare but have profound implications. Through expert insights, the video aims to demystify the review process, counter common fears and misconceptions, and shift the focus from blame to constructive learning. Emphasising the importance of collaboration and continuous improvement, it provides practical strategies for staff to better navigate and learn from incidents, ultimately fostering a culture of safety and enhanced patient care.

All resources and video links are available at [www.austin.org.au/rori](http://www.austin.org.au/rori).



# Acknowledgements

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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

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