



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND

Kupu Taurangi Hauora o Aotearoa

Review of the National Reportable Events Policy 2012:

Discussion document

10 November 2016

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How to respond to this document

The Health Quality & Safety Commission is asking for your help to shape the next National Reportable Events Policy. All ideas or comments are welcomed.

The timeframe for feedback runs from 10 November 2016 to 1 February 2017.

We invite responses from consumers/patients and families/whānau, individuals and organisations in the health sector, and others interested in the reporting of adverse events and health improvement.

This document has individual SurveyMonkey links embedded throughout. Please feel free to answer some or all of the questions. Each question will take about five minutes to complete.

Alternatively you can:

- email responses to: reportable_events@hqsc.govt.nz (note underscore reportable_events)
- post responses to:

National Reportable Events Policy review
Health Quality & Safety Commission
PO Box 25496
Wellington 6146

Attention: Kiri Rikihana

Please include the question/s you are responding to, if you are emailing or posting your feedback.

Purpose

The Health Quality & Safety Commission (the Commission) is carrying out a review of the National Reportable Events Policy 2012 (the policy). This discussion document:

- proposes potential changes to the policy, based on the findings of our literature review and stakeholder discussions¹
- seeks your views on the proposed changes.

This document is aimed at all health and disability organisations – including primary care, aged residential care, disability support services and secondary care.

After stakeholder engagement on this discussion document, we will release a new policy in early 2017.

Please note, this document goes into detail on all aspects of the existing policy. Providing feedback will take time but is important for three reasons: firstly, this is your opportunity to influence the direction of the policy; secondly, we will not be circulating the revised policy for consultation; and thirdly, we will not review the policy again for at least three years.

¹ See: www.hqsc.govt.nz/our-programmes/adverse-events/serious-adverse-events-reports/adverse-events-report-2015-16.

Introduction

The Commission works with health and disability practitioners, and people who use health and disability services, to improve the quality and safety of these services.

The policy is intended to guide organisations in developing their own policies on reporting, reviewing and learning from adverse events. It sets out the guidance and process for reporting a subset of adverse events to the Commission.

Context

The delivery and management of health and disability support services are becoming increasingly complex and challenging. To meet the changing demands facing the health and disability sector, we need to consider new models, approaches and attitudes. We now have a better understanding of safety for people who use services, and broader definitions of harm.

Emerging thinking suggests that, while we must continue to learn from adverse events, we should increasingly emphasise more proactive and positive approaches to safety.

This includes broadening the focus beyond past harm to a wider systems approach to build reliability and resilience. It is also important to recognise that 'one size does not fit all' – multiple safety strategies are needed to suit diverse health and disability contexts.

Background

Prior to this stage of the policy review, we completed an electronic survey of stakeholders and a literature review, and held initial meetings with stakeholders and people using services.

The work was discussed with our adverse events learning programme expert advisory group in August 2016, which has led to this discussion document.

The literature review and summary of our initial meetings are available on the Commission's website during the discussion period at: www.hqsc.govt.nz/our-programmes/adverse-events/serious-adverse-events-reports/adverse-events-report-2015-16.

Initial work suggests a need for the policy to focus more on facilitating learning from adverse events. Organisational changes can then be made to improve the safety and experience of care for consumers/patients. We found widespread support for policy changes to lift the quality of review (and recommended actions) and to make reporting easier.

We have identified the following five themes, or 'directions', for potential policy change.

Directions for policy change

1. Increase the focus on people who use services (consumers/patients).
2. Expand the purpose statement to clarify national and local roles and expectations.
3. Increase the focus on learning and action to strengthen implementation and monitoring of recommended actions.
4. Make it easier for organisations to report, and prioritise for national reporting.
5. Make the policy relevant to the whole health and disability sector and move to greater coverage over time.

Use of terms

This discussion document uses the term 'adverse event'. We acknowledge the terms 'consumer safety incident' or 'patient safety incident' may also be used in parts of the health and disability sector.

Question

1. Do you have a preference for the description of an adverse event? Would you prefer the term 'consumer safety incident', 'patient safety incident' or another description? Please state your preference and give reasons.

[Respond here](#)

Proposed policy changes

This section summarises the Commission’s suggested policy changes. A wide range of potential changes are canvassed under each of the five themes that resulted from our initial work.

Theme 1: Increase the focus on consumers/patients

Our initial work supports taking a more consumer-/patient-centred approach to adverse event reporting. The approach should consider an adverse event in the context of the whole care experience. Providers need to acknowledge the effects of an adverse event on the consumer/patient and their family/whānau, and assure them action has been taken to change the system to reduce the chances of future harm.

We propose adding a new section to the policy on the role of consumers/patients and their families/whānau in adverse event reporting. The section would state the benefits of involving people who use health and disability services, such as:

- providing new information to complement a provider perspective
- helping services to identify and prevent problems at an earlier stage.

Proposed change 1: Expectations for consumer/patient involvement

We plan to introduce a set of expectations for involving consumers/patients and their families/whānau in reporting and learning from adverse events (listed in the table below). These expectations will be encouraged – not mandatory – to recognise organisational diversity and flexibility. Consumers/patients and their families/whānau may not always want to be involved, but we believe they should be given the option.

Expectations for consumer/patient involvement

Proposed expectations	Detail on the expectations
Open communication	Communicate openly with the affected consumer/patient and their family/whānau from as early as possible after an adverse event is identified, and throughout the process of a review and its outcomes.
Start with the consumer’s/patient’s story of what happened	Invite the consumer/patient and their family/whānau to tell their story of their care experience and perceptions, and how the experience has affected them, including emotional harm.
Support consumers/patients	Encourage organisations to identify and respond to the support needs of consumers/patients and their families/whānau – for example, referral to social work or cultural support.
Opportunity for consumer/patient review of draft report	Invite the affected consumer/patient and their family/whānau to comment on the draft report and recommended actions.
Share the report and outcomes with the consumer/patient	Share and discuss the report and outcomes with the affected consumer/patient and their family/whānau. Keep communicating openly so consumers/patients can see evidence of change.

Adapt the review process to include consumer/patient perspectives	Consider priority concerns for consumers/patients, such as communication, privacy concerns, the expected process of care and next steps.
Have independent consumer representation	Appoint an independent consumer representative, who is not involved in the adverse event, to the review team for reviews of serious adverse events.
Involve the consumer/patient in learning from adverse events	Encourage consumer/patient involvement in the identification and development of Open Book reports.
Measure consumer/patient involvement	Measure consumer/patient engagement and satisfaction with the review process.

Questions

1. How could consumers/patients be more effectively engaged in reporting and learning from adverse events?
2. Do you support the proposed expectations for involving consumers/patients? Why/why not?

[Respond here](#)

Other changes to consider

- Consider the potential for enabling people who use health and disability services, and/or family/whānau members, to report adverse events. This happens in several overseas contexts, such as the United Kingdom, Denmark, British Columbia (Canada) and some European Union countries. Options could include:
 - a. introducing an online consumer portal as a parallel system for reporting adverse events
 - b. a consumer-designed survey to report adverse events. It would be important to reduce any potential duplication or confusion with the Health and Disability Commissioner's (HDC) complaints system, which serves a different purpose.
- Provide advice on how to tailor reviews to better suit Māori, Pacific peoples, Asian and other population groups. This could include, for example, guidance on improving open communication with Māori whānau, and/or guidance on including ethnic-specific representatives in reviews of serious adverse events.
- Amend the Commission's reporting template to collect information on the ethnicity of consumers/patients who are involved in adverse events in Part A of the Reportable Event Brief (REB). The information needs to be completed and classified consistently, based on self-identification (consistent with the consumer's health record).

Questions

1. What needs to be taken into account when designing a consumer-initiated reporting system?
2. How could the policy best support culturally appropriate review practice at a local level?
3. Would consumer-initiated reporting be useful?

[Respond here](#)

Theme 2: Expand the purpose statement

Our initial work highlighted the need to strengthen the purpose statement of the policy. Stakeholders said the policy needs to be more explicit about national and local roles, and about what the Commission expects from local organisations across the whole health and disability sector.

Proposed change 2: Expanded purpose statement

We suggest the following draft purpose statement, and information on national and local roles.

Draft section for policy: Purpose statement and expectations

Policy goal: To improve quality, safety and experience of health and disability services by ensuring that adverse event reporting leads to learning and action to prevent harm to those who use services.

Policy objectives:

- a. To facilitate learning and quality improvement action from reporting and reviewing adverse events, at both national and local levels.
- b. To encourage a consumer-centred approach to reporting and learning from adverse events in the context of the wider care experience.
- c. To provide national analysis and overview of serious adverse events and learning, and to share this learning widely.

Principles: Open communication, systems approach, safe reporting, just culture.

[Note that the term 'open communication' is preferred over 'open disclosure' because it is more proactive and implies two-way communication.]

Audience: This policy is aimed at a wide audience involved with health and disability services, including consumers/patients, families/whānau, provider organisations, health and disability practitioners, managers and governance bodies.

Benefits of taking part in adverse event reporting and learning: Reporting and learning from adverse events has several key benefits, such as:

- a. providing information on learning and evidence of change to affected consumers/patients and their families/whānau
- b. ensuring public trust through openness and accountability
- c. improving the quality and safety culture within organisations
- d. saving organisations time and money, because they have safer systems and fewer adverse events.

Who has to comply with this policy? This policy covers the whole health and disability sector. District health boards (DHBs) are required to comply with this policy under the Health and Disability Services (Safety) Act 2001. Accountability is through two mechanisms: DHB contract (and through DHB contracts with other providers), and accreditation or certification standards. The Commission encourages all organisations to participate.

Scope: This policy includes both clinical and non-clinical adverse events, and 'near misses'. Although only Severity Assessment Code (SAC) 1 and 2 adverse events need to be reported to the Commission, the policy and attached guidance includes reporting all adverse events rated SAC 1–4.

Lower-level events, including near misses with learning potential, should be reported at the local level and may also be reported to the Commission.

The policy excludes occupational health and safety events, employee relationship issues or employee events. These are managed by other processes (eg, health and safety, and employment relations legislation).

Proposed roles and expectations at local and national levels

What is expected of local organisations?

- Local ownership of reporting, reviewing and sharing learning from adverse events.
- Commitment from the organisational leadership, governance and clinical leaders to prioritise a safety culture.
- Implementing and monitoring recommended actions from adverse event reviews.
- Taking part in a common approach to reporting and learning from adverse events.
- Taking action to improve safety and reduce the possibility of event recurrence.
- Sharing learnings nationally where appropriate.

What can local organisations expect of the Commission?

- Provision of clear expectations on what organisations need to do and how to involve consumers/patients and their families/whānau.
 - Custodianship of information on SAC 1 and 2 adverse events and selected lower-level events with national learning potential.
 - Analysis of aggregated data to identify trends and key national learnings.
 - National integration and sharing of learning from adverse events across agencies and sectors, including sharing information about preventive actions taken.
 - Assistance to provider organisations to help disseminate learning.
 - Guidance on how to carry out high-quality reviews and multi-organisation reviews, and how to disseminate learnings across settings.
 - Reporting publicly on the themes and learnings from adverse events (SAC 1 and 2 events, and other events with national learning potential).
-

What is the Commission's role in relation to other national reporting systems?

Various other national-level reporting systems are in place, such as the Medication Error Reporting Programme (MERP) and reporting systems led by various practitioner colleges.

The Commission's role is to share learnings from our reporting system, rather than to duplicate what others are doing. We aim to work closely with existing systems to collaborate and share learnings.

Questions

1. What comments do you have, if any, on the draft purpose statement?
2. What comments do you have, if any, on the proposed local and national roles?
3. What other national-level reporting systems are you aware of that may assist the New Zealand system?

[Respond here](#)

Theme 3: Increase the focus on learning and action

Increasing the focus on learning and action was a major theme in the literature review and initial stakeholder meetings. We have divided this theme into four:

- improve the quality of reviews
- act upon reporting
- encourage more reporting of lower-level events and near misses
- increase the focus on supporting staff.

Improve the quality of reviews

Many stakeholders said that, in general, the quality of reviews is variable. To encourage and support high-quality reviews, we propose the following changes.

Proposed change 3: Additional support to improve quality of reviews and recommended actions

We will provide new guidance, attached to the policy, to help organisations carry out high-quality reviews and make recommended actions for effective change. This will include the elements needed for a good review, a human factors template with system-level prompts, and a 'hierarchy of effectiveness' tool to help providers develop strong recommendations.

We will expand our current training programme to offer:

- advanced training in conducting adverse event reviews, targeted to more experienced practitioners
- training in conducting adverse event reviews for primary care and disability support providers.

The Commission will give more feedback to local organisations on the content of their reviews and recommendations. This could include regular feedback on the content, how reviews could be strengthened, and themes arising from reviews.

Questions

1. How could the Commission support organisations to increase the quality of reviews?
2. What comments do you have, if any, on our proposals to improve the quality of reviews?

[Respond here](#)

Act upon reporting

A strong message in our initial meetings with stakeholders was the need to strengthen the expectations for 'closing the feedback loop'. This involves organisations acting upon the learnings from adverse event reviews and monitoring the resulting actions.

Proposed change 4: Expectation that recommended actions are completed and monitored

We propose adding a new expectation that each organisation must have a follow-up process in place so recommendations are completed and the impacts of resulting changes are monitored.

Proposed change 5: Process for involving the governance body

Stakeholders reported that governance bodies (eg, boards) vary in their involvement with adverse event learning. Some have it as a standing item on their agenda, while others have little or no involvement in it.

We propose adding an expectation that each organisation has a process for regularly updating the governance body and encouraging its involvement.

Proposed change 6: Expectation of routine feedback to practitioners

We plan to introduce an expectation that organisations must routinely provide feedback to the practitioners (and other staff members) directly involved in an adverse event.

It is important that the people who have reported an event can see the changes made as a result. This will encourage future reporting. Learning should also be shared with frontline staff.

We will provide guidance in the policy for providing feedback to practitioners.

Question

3. Do you support the idea of the Commission reporting the numbers of completed reviews in the *Learning from adverse events* report? Why/why not?

[Respond here](#)

Proposed change 7: Sharing learnings by publishing adverse event reviews

We are considering the option of publishing anonymised, summary versions of serious adverse event reviews (ie, Part B summaries) on the Commission's website for national learning. Publication would require the permission of the consumer/patient and family/whānau involved.

We also propose encouraging more publication of anonymised adverse event reviews on local organisations' websites. This could include reviews involving exemplary care, to encourage learning from successes as well as from things going wrong.

The idea of publishing reports may be controversial. Anonymising reports can be difficult, particularly in small communities. Non-identification of the organisation, and guidance to help anonymise reports, would help mitigate this concern.

Question

4. Do you support the idea of encouraging more publication of anonymised adverse event reviews on local organisations' websites?

[Respond here](#)

Other changes to consider

- Encourage organisations across the sector to provide learning examples for the Open Book report series, which the Commission publishes regularly.

Encourage more reporting of lower-level events and near misses

Many stakeholders felt that important learnings are being missed because of the focus on serious adverse events. Learning from lower-level events and near misses is important because it encourages more proactive learning and prevention, rather than focusing only on harm that has already occurred.

The current policy encourages the reporting of 'near-miss incidents with a high potential SAC rating, or those adverse events rated as SAC 3 or SAC 4, where national learning can occur'. However, these events are rarely reported nationally.

The literature review strongly endorses the reporting of near misses at the local level. It contains less consensus on whether (or which) near misses should be reported nationally. National reporting of near misses happens overseas, for example, in Denmark, Scotland, British Columbia (Canada) and Germany.

Potential benefits of increasing the reporting of near misses at a national level include more opportunities for learning and sharing, and encouraging a more proactive approach. Risks include workload and capacity concerns if too many near misses were reported.

Proposed change 8: Encourage more learning from lower-level events and near misses

We propose strengthening the current policy wording to expect that near misses should be reported nationally when the organisation is willing to share the case in an Open Book report, for national learning.

Selected adverse events rated as SAC 3 or 4 should also be reported to the Commission if those events have the potential for national-level learning as Open Book reports.

The Commission will provide guidance to help organisations report these events nationally.

Question

5. Do you support the idea of the Commission encouraging more reporting of lower-level (SAC 3 and 4) events and near misses at a national level, where there is potential for national learning through an Open Book report? Why/why not?

[Respond here](#)

Other changes to consider

- Add an expectation that organisations have an internal process in place to manage lower-level events and near misses.
- Encourage regional and national collaboration to develop guidance for doing local reviews of lower-level events and near misses. Some regions are already working together to develop a common approach to managing and reviewing these types of events.

Question

6. What could the Commission do to encourage more learning from lower-level (SAC 3 and 4) events and near misses?

[Respond here](#)

Increase the focus on supporting staff

Staff members who are involved in an adverse event need to be supported by their organisation. By staff we mean the affected practitioners as well as other staff who were involved in the event. Supporting the people on the review team is also important. The revised policy will acknowledge the impacts on staff of an adverse event and the ensuing review.

Proposed change 9: Mechanisms to support staff

We will include an expectation in the policy that organisations have a formal process in place to support practitioners (and other staff) involved in adverse events.

A range of existing support services could be drawn upon, such as the Employee Assistance Programme (EAP) and the Medical Protection Society (MPS). The Commission could also provide tools, in the guidance that supports the policy, to help organisations support staff directly involved in adverse events.

Question

1. What tools and services would help staff involved in adverse events?

[Respond here](#)

Theme 4: Make it easier for organisations to report and prioritise

Prioritise what is reported nationally

International experts recommend focusing on an agreed subset of adverse events for national reporting – to facilitate less reporting and more learning.

New Zealand's system currently prioritises by severity. We could consider prioritising further so that sufficient resources can be used for high-quality reviews, developing corrective actions and learning from adverse events.

Proposed change 10: Introduce a list of 'always report and review' events

An 'always report and review' list is a subset of highly preventable events that should always be reported and reviewed as serious adverse events, regardless of whether harm occurred.

The Commission will introduce an initial list at the national level. This policy change is strongly endorsed in the literature. We suggest the following list (see box below). We discussed the list with a small sample of stakeholders in 2014, who supported it.

The national list should be regularly reviewed and updated. In addition, we invite provider organisations to create their own list of events, to complement the national list. Additional events could reflect particular settings, such as primary care, aged residential care or disability support services.

The Commission prefers the term 'always report and review' over 'never events'. The new term gives a positive message for encouraging open learning, whereas 'never events' implies a more punitive approach. The term is also problematic because, unfortunately, 'never events' *do* happen.

Benefits and risks of a national 'always report and review' list

A national list could make it easier for organisations to decide which events to report and review. It could help to reduce uncertainty and increase standardisation. Reporting these events can help to raise their profile, and improve safety for those using services. It would also provide a focus on reducing and eliminating those events that can be prevented outright through strong clinical and organisational systems. An organisational culture that minimises or eliminates these events is also likely to reduce other preventable harm.

There are potential risks of producing a list. One risk is as insurance implications. Another is the introduction of confusion about reporting events that are not on the list (as the Commission would continue to expect reporting of serious adverse events or other events with national learning potential).

The national list could be based on the existing list from the Commission's 2014 consultation with the sector on 'always report and review' events, and recent lists from other jurisdictions.

Proposed criteria for selection of ‘always report and review’ events

(Note: all criteria need to be met)

- There is evidence that the event has occurred in the past and is a known source of risk.
- The event is preventable – if existing guidelines, protocols or professional standards are followed, the event can be prevented.
- Occurrence of the event can be easily identified and defined.
- The event may or does result in severe harm or death.

Proposed national list of ‘always report and review’ events

- Wrong consumer/patient
- Wrong procedure or implant
- Wrong site
- Blood component given to wrong consumer/patient
- Retained item
- Misadministration of radioactive or chemotherapy materials
- Child/infant abduction or discharge to the wrong family/whānau.

Additional locally defined event/s may be added to the above list, at the discretion of local provider organisations.

Questions

1. Do you agree with having a national list of ‘always report and review’ events?
2. If so, do you support our proposed list? Why/why not?
3. What else should be on the list?

[Respond here](#)

Proposed change 11: Triage all serious adverse events to determine the best review process

The current policy requires a full review using root cause analysis methodology for all SAC 1 and 2 events. A full review is not always needed or appropriate, however.

Some common adverse events may not always require a comprehensive review and can be learned from in other ways, such as desktop reviews or one review of a cluster of common events. Examples include more common events such as falls or hospital-acquired infections.

We propose changing the policy to encourage organisations to triage adverse events to decide whether a comprehensive review or concise review is required. The Commission already enables this for adverse events affecting users of mental health and addiction services.

The revised policy will also enable aggregated reporting from provider organisations, where providers report some adverse events to the Commission and review events as a group, instead of individually. Aggregated reviews could be done for clusters of similar events, whether common or rare. Numbers of cases would still be reported, as these reflect individuals impacted by each event, but the information could be grouped into one Part A form.

The policy change would need to be accompanied by communication to consumers/patients and the wider public to explain why some serious events do not always require a full review.

Question

4. Should the policy encourage organisations to have their own triage process to decide the level of review for all serious adverse events (SAC 1 and 2)? Why/why not?

[Respond here](#)

Proposed change 12: Enable a wider range of review methodologies

We would like to introduce more flexibility in the policy for organisations to use various review methodologies for events of any SAC rating, not only root cause analysis (RCA). Organisations can then decide what best suits the situation. Alternative methodologies are now in use, such as the London Protocol,² and an RCA process does not necessarily suit all situations.

The wording in the policy could be amended to 'RCA or similar methodology' (page 4 in the 2012 policy). Reviewing a cluster of similar events with one review should also be done where this makes sense.

The Commission will provide tools and templates to help the sector use various review methodologies. We encourage the use of newer approaches that aim to build the resilience of services and care settings.

Proposed change 13: Reduce duplication through a single adverse event review being used for various purposes

Many stakeholders said there was some duplication of reporting at present. Duplication was reported within the Commission (eg, between its adverse events learning programme a, its improvement programmes and the mortality review committees), as well as between the Commission and other agencies (eg, the HDC, Coronial Services, the Accident Compensation Corporation (ACC) and the Ministry of Health).

The Commission wants the adverse event review to be used for various purposes. For example, one single review, if done well, should be used across the Commission's work programmes and by other agencies to inform their investigations and reduce duplication.

Question

5. How could the policy support a single local review being used for various purposes?

[Respond here](#)

² And/or ALARME, a recently expanded version of the London Protocol (Vincent and Amalberti 2016).

Other changes to consider

Simplify the classification of severity and likelihood

Many stakeholders called for review and simplification of the SAC ratings system. Some said it was overly complex and confusing.

Views differed widely on how best to classify severity. Some favoured our current classification system, arguing it is best to retain it for consistency and comparability. Others suggested changes to how we classify the severity of events.

Stakeholders made the following suggestions.

- Amend the SAC matrix to reduce the number of categories (SAC 1–4) into two categories: reportable and not reportable (at the national level; events would still be reported and reviewed within local organisations).
- Adopt the three categories used in Scotland (permanent harm, temporary harm and near miss).
- Amend the SAC matrix to better reflect non-clinical events (such as communication breakdown, continuity of care problems, technology failures, privacy breaches or administration errors).
- Remove the likelihood table because it can cause confusion.

Questions

6. Does the SAC classification system need to be changed? If so, how?
7. Do you think the likelihood table should be removed? Why/why not?

[Respond here](#)

Work towards a single classification system across agencies

Some stakeholders said they wanted the national-level agencies, such as the Commission, the ACC, the HDC and the Ministry of Health, to work towards an integrated classification system and common reporting templates for classifying severity and adverse events. The Commission has a national leadership role in encouraging a more integrated approach to reporting.

We recommend aiming for a single classification system across agencies and organisations.

More broadly, some stakeholders raised the idea of working towards a cross-sector, integrated approach to event reporting and learning (ie, across all agencies). The Commission is keen to work with other agencies to discuss the development of, and the Commission's role in, a cross-sector approach to event reporting and learning.

Theme 5: Make the policy more relevant to the whole sector

Consumers/patients receive care from various parts of the sector, and most care now happens in primary care and community settings, not hospitals. Increases in long-term conditions and complex care needs mean that care is more often shared across providers and settings.

Some other countries, including the United Kingdom, Canada and Denmark, have national reporting systems that cover all care settings.

Our system is intended for the whole sector, yet in practice our policy has been designed mostly for secondary care. There is a small amount of reporting from other parts of the sector at present.

Stakeholders widely agreed, in principle, to work towards extending coverage to the whole sector, in a consultative, staged way. They expressed diverse views on how this should be done.

Proposed change 14: Work towards whole-sector involvement

The Commission is working towards a 'whole-sector' approach, in close collaboration with sector groups, for example, primary care, disability support services and aged residential care. We recognise that this will take time.

Parts of the sector may already have, or prefer to develop, their own specific national reporting systems. Ambulance services, for instance, used to only report to the National Ambulance Sector Office, which would then provide a report to the Commission. Now ambulance providers report directly to both organisations using a common template. One report goes to both organisations so it is not extra work for the providers.

The disability support sector already reports nationally on critical incidents to the Ministry of Health. Inclusion of this reporting in the Commission's system would be desirable because national learning is important across the entire health and disability sector. A process for encouraging more integrated national reporting and learning should be discussed.

We propose having further discussions with various sector representatives, particularly those from primary care, disability support services and aged residential care, to talk about their potential involvement and the next steps. The cultural and organisational landscapes of each setting are unique, and differ significantly from the secondary care setting. These differences have implications for the development and adaptation of national reporting systems.

Questions

1. How could the Commission work with various parts of the sector (eg, primary care, disability support services and aged residential care) to enable reporting to us?
2. Should the Commission expect all SAC 1 and 2 events from the entire sector to be reported (or co-reported) to us? Why/why not?

[Respond here](#)

Other changes to consider

- Make the policy more relevant to the whole health and disability sector. For example, add examples from across the sector (and reduce the current secondary-care-specific language).
- Use common terms, shared language and broader methods (eg, the London Protocol is designed to be applicable to the wider health sector, including primary care).
- Expand Open Book reports to the wider sector, by publishing them on events in various settings and promoting them widely.
- Encourage shared commissioning of reviews, for example, between primary health organisations and DHBs. Provide guidance on how to complete multi-organisation reviews, for example, how to collaborate when two or more organisations are involved.

Mental health events

Background

Early adverse event reporting by the Commission included events relating to users of mental health and addiction services. After discussions with the mental health sector in 2011 the Commission decided the inclusion of these cases in the report was inappropriate. This was predominantly due to the complex nature of these adverse events and the contextual issues associated with them. The sector also advised the Commission there was a preference for using the London Protocol (or a comparable structured process of systematic analysis) because the framework for analysis to review cases was more suitable for services than the root cause analysis process.

In July 2012, the Commission board accepted recommendations from a working group about the process to follow for local review of adverse incidents involving users of mental health services. It was also agreed that DHBs would continue to report adverse events relating to clients of their mental health services to the Commission. We would work with the Office of the Director of Mental Health (ODMH) to publish these events in the ODMH annual report. This would align the reporting to similar events within this annual report. This has been the practice for the past four years.

Should mental health adverse events remain separate?

The Commission would like the same level of analysis and sharing of learnings of mental health adverse events as has developed in non-mental health adverse event processes. We have been discussing this with the ODMH, and it would be useful to get sector feedback on the best approach.

Some stakeholders have called for the new policy to be integrated, that is, to cover all events, including mental health events.

Questions

1. Do you agree that the new policy should cover all events, including mental health events? Why/why not?
2. Should there be wider sharing of learnings from reviews of mental health events?

[Respond here](#)

Referral of serious concerns to other agencies

In very rare circumstances, it is possible that a significant issue could be identified through our receipt of reports on adverse events. We have developed a referral policy for the rare situations in which information might come to our attention that raises concerns about the ongoing safety of a provider, whether an organisation or an individual practitioner. Potential concerns could be to do with an organisation's response, a cluster of events or another matter.

The revised policy will include our process for escalating these concerns. It is important to meet the public's expectation that, if we have knowledge of a concern, we will act on it.

The Commission may notify other agencies, but only in situations where this is needed to achieve our statutory objectives (to help improve the quality and safety of health and disability support services).

In circumstances where the Commission chief executive becomes aware of a matter that raises a concern about public health or safety, they will first discuss the issue with the individual or provider organisation.

The Commission's referral policy will honour the principles of just culture and transparency, and will be directed at organisations, not individuals.

Monitoring and evaluation of the policy

The Commission and its adverse events learning programme expert advisory group are responsible for monitoring and evaluating the implementation of this policy. This will be done on an annual basis by reporting in the *Learning from adverse events* report.

Date for the next review of this policy: The National Reportable Events Policy, supporting operational guidance and forms, will be reviewed at least every three years.

[If you have any further comments on any aspect of this policy review, please provide them here via SurveyMonkey.](#)

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