Victorian Healthcare Association
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Member briefing

25 February 2022

What does the Health Legislation Amendment (Quality and Safety) Bill 2021 mean for your organisation?

The Victorian Government has just passed the Health Legislation Amendment (Quality and Safety) Bill 2021 (the Bill) in the Victorian Parliament. The legislation will lead to major changes for members – the VHA has developed this resource to help members understand the Bill and provide suggested next steps.

Who: Public health services, ambulance services and mental health service providers

What: The Bill creates a new Chief Quality and Safety Officer, and establishes the need for quality and safety reviews, serious adverse patient safety event reviews and a duty of candour

When: The legislation is in Parliament and expected to come into effect on 30 November 2022

Why: Delivering on the final recommendations from the *Targeting Zero* report

Context

The Bill marks final step in the delivery of the recommendations from the 2016 *Targeting Zero* report. *'Targeting zero, the review of hospital safety and quality assurance in Victoria'* was commissioned by the-then Minister for Health following the discovery of a cluster of perinatal deaths at Djerriwarrh Health Services.

This Bill supports some key reforms from the report, including the authorisation of Safer Care Victoria to inspect and audit hospitals, as well as establishing a statutory duty of candour and associated apology protections. The Bill passed in the Victorian Parliament on 24 February and is set to come into effect on 30 November 2022.

The Department of Health launched a consultation on the proposed duty of candour in late 2020. The VHA developed a submission that, while supporting the proposed law, expressed concerns around its implementation.

VHA response

The VHA welcomes the Health Legislation Amendment (Quality and Safety) Bill 2021 and its proposed changes, which will mark the completion of the reform intended by *Targeting Zero*.

Key recommendations from the VHA's submission are reflected in this legislation, particularly around the potential impact of reviews on clinicians and the need for personal protections for those involved.

However, there are still parts of this reform that need to be clarified. For instance, it is uncertain how these new requirements will interact with existing obligations, while it is not clear how services will be supported to implement these changes. A key concern is whether services will be funded to deliver the increased governance and investigation demands stemming from these changes.

This uncertainty inhibits the ability of services to prepare for these changes, especially during a period of high-demand, as currently experienced due to the COVID-19 pandemic. The majority of the VHA's initial recommendations are still relevant to support this process.

Health Legislation Amendment (Quality and Safety) Bill 2021

The Bill creates the following:

A Chief Quality and Safety Officer

- The Chief Quality and Safety Officer will conduct quality and safety reviews of health services and their care, and will have broad powers to do so.
- They will also be able to create authorised quality and safety officers to carry out their duties. The Officer will be part of Safer Care Victoria.

Quality and safety reviews of health services

- The reviews can be established if there are performance concerns, opportunities for improvements or if there are felt to be systemic issues at a health service or within the wider system.
- The reviews will either be standard or protected. The protected status ensures greater protections on the information if the Chief Quality and Safety Officer thinks it is required to ensure open and honest engagement.
- Health service staff are expected to give 'reasonable assistance' but do have protection against self-incrimination and are not liable for any information provided in a review.

Serious adverse patient safety event reviews

- A serious adverse patient safety event (SAPSE) is an event that results in harm to a patient or patients, which will be prescribed in the regulations. **Events with Victorian Health Incident Management incident severity ratings (ISR) of 1 (severe death or harm) and 2 (moderate harm) are expected to constitute the 'trigger' for the SAPSE**. Services will be expected to undertake these reviews in response, and can also be directed to undertake one by the Secretary.
- The SAPSE reviews will be undertaken by independent SAPSE review panels, appointed by health services. The review will establish the facts of the event, analysing the situation, and highlighting any remedial or preventative measures.
- The Bill provides protection from liability for any person who gives information, with any liability moving to the service, while there is also protection around not divulging any information relating to the SAPSE review in any legal process or under any Act.
- Health services are obliged to provide the SAPSE review report to the Secretary, if requested. In addition, the health service entity must offer a copy of the SAPSE review report to the patient or any associated person.

A duty of candour

- If a patient suffers a serious adverse patient safety event in the course of receiving care, the health service responsible will owe a duty of candour to the patient.
- The duty of candour, which is also enacted under other Acts, applies to health services, ambulance services and mental health service providers.
- Under the duty, services will be required to provide the patient with:
  - a written account of the facts regarding the serious adverse patient safety event
  - an apology for the harm suffered by the patient
  - a description of the health service entity's response to the event
  - the steps taken to prevent re-occurrence of the event.
- An apology made in accordance with the duty does not constitute an admission of liability for death or injury, and is not admissible in any civil or disciplinary proceedings.
- The Bill enables the Minister to make guidelines, known as the Victorian Duty of Candour Guidelines, which services must comply with.
- A patient can elect not to receive the information that must otherwise be provided to them under this Division, but they can later reverse that decision. It is expected that the health services will prepare the material to comply with this requirement regardless.

Member impact

Only health services will be reviewed – more will have to be candid

The quality and safety reviews will only affect health services entities as defined in the *Health Service Act 1988* – this includes public health services, public hospitals and multi-purpose services. Registered community health services are not included.

The duty of candour requirement, which will also be enacted under other Acts, will apply to the health entities, ambulance services and mental health service providers, including Forensicare. 'Mental health service providers' refers to designated mental health services or publicly funded mental health community support services, which could include some community health services.

The Bill will establish further requirements on services and their boards

Under the Bill, the affected services will need to be prepared to:

- facilitate, comply with and respond to quality and safety reviews conducted by the Chief Quality and Safety Officer on their care, facilities and staff
- facilitate and comply with SAPSE reviews, conducted by independent panels that they appoint
- deliver on their duty of candour requirements.

All three of these key actions will require services to establish procedures and governance processes to ensure they can respond and deliver on each element.

All these actions will be in addition to current requirements on services, including the policy on adverse patient safety events and the Australian Open Disclosure Framework. This will lead to increased demand on services to respond to reviews and events. While there is limited public information on how many ISR1 and ISR2 events take place across the state, there were 859 ISR 1 events in Victoria in 2019-20, of which only 19 per cent were reported as a sentinel event. There is no mention in the Bill on how services will be funded to deliver these processes.

Services will face negative consequences if they fail to adhere to these changes

Failure to deliver on these proposed requirements will lead to repercussions for services. As an example, the Bill requires the Minister for Health and the Secretary for the Department of Health to take into account how services perform against the duty of candour when considering service's performance or whether to appoint a delegate to the board. There is also the risk of negative publicity through the release of a quality and safety review report, while the Minister can publicly name a health service if they are failing to comply with the duty of candour. The Bill also enables complaints to be made about any failure by a provider to comply with the duty of candour.

In considering establishing processes for these changes, services will need to ensure there is appropriate confidentiality. For instance, under the Bill it will be an offence for a health service, or a member of staff, to disclose the identity of a member of a SAPSE review panel.

Engagement is protected

The Bill is very clear on how the SAPSE reviews and duty are to be utilised, and provides a lot of protections for those involved in SAPSE reviews – but there are fewer protections for services.

The Bill provides protection from liability for any person who gives information, with that liability taken by the service. It is not clear what impact this may have on involved services, as there will be protection around not divulging any information relating to the SAPSE review in any legal process or under any Act. These protections are a response to concerns around the impact of these changes on the value of review processes, which the VHA has previously raised; they are meant to ensure health services and clinicians can fully engage with reviews so they include robust consideration of quality and safety risks and recommended improvements.

Similarly, the proposed duty of candour will have protections ensuring that any apology made in accordance with the duty does not constitute an admission of liability for death or injury, and is not admissible in any civil or disciplinary

proceedings. While services may still face court proceedings stemming from serious adverse patient safety events, any admission under the duty is not relevant.

Next steps

Services should:

- **establish whether they are affected by changes**, including whether they are subject to the quality and safety reviews or if they are only affected by the requirements around SAPSE reviews and the duty of candour
- **begin to consider how they may be impacted by these changes.** While there are still uncertainties around implementation of the reviews and the duty of candour, services can begin to consider how their processes will need to develop to accommodate these changes. Further advice and resources are expected from the Victorian Government, but this will be a major change affecting services, so preparation is essential.

The VHA is hosting a Lunch and Learn event on 27 April 2022 to support member understanding on this issue. The session will feature guest panellist Michael Gorton AM, Principal at Russell Kennedy Lawyers. Michael was appointed by the Minister of Health to Chair an Expert Working Group providing advice on the legislative reforms.

The VHA will explore the potential for further resources or advocacy to support members. We will also continue to monitor and engage with this reform as it progresses.

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