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By upload: Engage Victoria website

Consultation on *Victorian candour and open disclosure guidelines* and proposed model for clinical incident review protections

Thank you for the opportunity to provide further input into the Department's consultation on a statutory duty of candour. Thank you also for the meeting we were involved with in early March 2021.

Avant is Australia's largest medical defence organisation, providing professional indemnity insurance and legal advice and assistance to more than 78,000 healthcare practitioners and students around Australia.

In addition to assisting members in professional conduct claims, coronial inquiries and civil proceedings, Avant regularly provides members with advice, information, education and support about open disclosure and open disclosure processes.

Avant has long supported open disclosure in accordance with the Australian Open Disclosure Framework.[1] Avant has been involved in the development of open disclosure policies and procedures and in informing and educating our members about open disclosure.

It is with this background that we provide the following comments about the *Victorian candour and open disclosure guidelines* (the 'guidelines') and the proposed model of protections for clinical incident reviews.

Please contact me on the details below if you require any further information or clarification of the matters raised in this submission.

Yours sincerely

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[1] Avant Open Disclosure Position, 2013

Avant submission to Consultation on *Victorian candour and open disclosure guidelines* and proposed model for clinical incident review protections

The *Victorian candour and open disclosure guidelines*

Overall, Avant is supportive of detailed guidelines which underpin high level primary legislation. We support the content outlined in the Expert Working Group's report in Appendix D.

Healthcare practitioners will rely upon these guidelines more than the primary legislation and therefore we would recommend wide consultation and rigorous testing with practitioners before they are finalised.

As outlined in our submission to the Expert Working Group's consultation on the proposed statutory duty of candour, the statutory duty should align with and complement existing open disclosure standards and policies. We noted our concern that there may be confusion about whether the statutory duty or the open disclosure policy/procedure should be followed. This also applies to the guidelines: in our view, to reduce the risk of confusion the guidelines should be consistent with the current open disclosure framework.

The guidelines should be in a form that is easy to understand and apply. Examples of recently published guidelines which have resonated well with our membership are Ahpra's guidelines for mandatory notifications about registered health practitioners and its advertising guidelines. These guidelines are written and designed with the user at the front of mind. The language is succinct and simple to understand. The design is clean, not text heavy and the use of flowcharts and case studies is helpful for health practitioners and others.

The use of flow charts and decision-trees would be particularly beneficial when describing when the statutory duty of candour would apply and when open disclosure should be undertaken (for incidents that may not reach the thresholds established for the statutory duty of candour, but which otherwise warrant an open disclosure process). The requirements to meet the duty and what is expected from the framework could also be included in these flowcharts/decision-trees.

When describing how health entities will discharge the mandatory requirements, and when providing non-mandatory best practice approaches, examples and case studies would be helpful for health practitioners and others implementing these policies at a local level. Case studies would also be particularly useful to highlight considerations for specific cases – for example, disclosures involving multiple patients, or disclosures regarding events across multiple services. Templates may be useful for documentation of compliance with the statutory requirements.

If it is not considered appropriate to include information in this way in a legislative instrument, it could be appropriate to include it in supporting policy documents.

We agree that the guidelines should address how qualified privilege impacts on the open disclosure process. We agree with the Expert Working Group's findings that there is confusion within the healthcare sector regarding when qualified privilege does and does not apply.

In our view, the relationship between open disclosure and incident investigation, including clinical incident review, needs to be considered holistically. The entire process, including open disclosure, incident investigation and clinical incident reviews, should attract qualified privilege. This will reassure practitioners that they are not exposing themselves to liability and will encourage a just culture where lessons are learned from adverse events. This would encourage the free flow of information in order to improve the quality of health care, a goal of this proposed legislation.

Proposed model for clinical incident reviews protections

Avant supports clinical incident reviews consistent with the approaches taken in New South Wales and Queensland. Each of these states have statutory protections for the clinical investigations of serious incidents, when conducted in accordance with the relevant legislation.

Avant supports a flexible approach to the methodology used to review clinical incidents, where appropriate. Clinical incident review via root cause analysis (enshrined in legislation) has been in place for many years in NSW and was the subject of a review in 2015 by the Clinical Excellence Commission. Following that review the legislation has been amended to ensure that there is flexibility in terms of the methodology used for a review. The Queensland approach also allows for flexibility.

In the spirit of quality improvement, there should be a mechanism to disseminate learnings and/or recommendations from incident review processes. Careful consideration must be given to how this information is disseminated and efforts should be made to deidentify the clinical incident as much as possible. The dissemination of learnings or recommendations should not breach the privacy of practitioners involved in the clinical incident or the review process, nor seek to blame practitioners for the outcome.

In our experience of assisting members around Australia, practitioners are generally open in these reviews, but we have assisted practitioners who have been referred to medical regulators where the reason for the referral is the findings of the root cause analysis. This does not assist in encouraging a just culture. A blame culture in healthcare is a barrier to transparency. The purpose of the review and the use to which any reports may be put need to be clear. We strongly support the proposal that reports of clinical incident reviews are not to be admissible in court. They also should not be used to the form the basis of or background for expert opinion in any legal proceedings.

For incidents that are serious but do not appear to the entity to meet the threshold for a protected incident review process, we agree it would be appropriate to include a mechanism to refer to Safer Care Victoria to determine the classification of the incident. This should help create certainty and consistency in the classification of incidents across Victoria and would help to mitigate any unintended impact on decisions by health service entities about how incidents are classified. There is such a mechanism in the Queensland legislation.

The purpose of a clinical incident review is to identify how organisational systems in health service entities can cause or contribute to clinical incidents. We acknowledge that, from time to time, the statutory incident review team may identify concerns about the actions of a specific practitioner. There needs to be a clear process by which these concerns can be addressed by the health entity in a manner that is fair to the practitioner.

In the first instance, it would be appropriate for the review team to inform the entity that employed or engaged the practitioner. The entity can then decide whether it is appropriate for it to review the practitioner's conduct or whether to notify the regulator.

The model creates obligations on entities and, in keeping with that, any obligation to notify regulators should rest with the entity rather than specific members of the review team. We do not believe that it should up to members of the review team to make these reports.

Incident review protections should include personal protection for those conducting or participating in a statutory incident review process. For example, in Queensland and New South Wales members of statutory incident review teams are protected from liability for things done in good faith as part of their role as team member, specific privilege in relation to claims of defamation, and entitlements to be indemnified for costs incurred in defending themselves from liability against which those provisions protect them. In Queensland there are also protections for those who provide information to a statutory incident review team, so they are not exposed to disciplinary action or a defamation claim in relation to their provision of information to the team.

Avant strongly supports similar protections be put in place for health practitioners involved in clinical incident reviews in Victoria. To help practitioners participate openly and candidly in the process, and for the reviewers to gain the most transparent accounts, protections are necessary. Any disincentives to open and honest communication will hinder the efforts to improve quality and safety in healthcare.

Please contact us on the details above if you require any further information or clarification of the matters raised in this submission.

We would appreciate the opportunity to be consulted further once the proposed legislation and guidelines have been drafted.

Avant Mutual
9 April 2021.