Safer Care Victoria
Reforms to foster an honest and open culture in health services
April 2021

Improve the mental health of communities
Royal Australian and New Zealand College of Psychiatrists submission
Reforms to foster an honest and open culture in health services

About the Royal Australian and New Zealand College of Psychiatrists
The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP Victorian Branch has almost 1700 members, including around 1200 qualified psychiatrists and more than 400 members who are training to qualify as psychiatrists. The RANZCP partners with people with lived experience, through the Community Collaboration Committee and our community member on the RANZCP Victorian Branch Committee. Carer and consumer representation is woven into the fabric of the RANZCP and helps to ensure the RANZCP considers the needs, values and views of the community throughout its work.

Introduction
The RANZCP Victorian Branch welcomes the opportunity to contribute to the Victorian government’s consultation on reforms to foster an honest and open culture in health services. It is critical that the government approach to health service reform is guided by input from clinicians working within the health system as well as people with lived experience and carers.

The RANZCP Victorian Branch broadly supports the introduction of a statutory duty of candour; however, we urge the government to consider the complex nature of psychiatric conditions when designing the statute. For example, if a consumer dies by suicide following assessment in a health service. There is evidence to suggest that it is not possible to assess suicide risk with sufficient accuracy to predict outcomes; therefore, not all suicides are preventable or result from an omission or mistake in care.

The recommendations contained within this submission are based on extensive consultation with the RANZCP Victorian Branch Committee which is made up of community members and psychiatrists with direct experience working in the mental health system. As such, the RANZCP is well positioned to provide assistance and advice about this issue due to the breadth of academic, clinical and service delivery expertise it represents.

It is noted the RANZCP Victorian Branch provided an earlier submission to the Expert Working Group on Statutory Duty of Candour. This submission is available on the RANZCP website.

Victorian candour and open disclosure guidelines
The guidelines will offer:
• detailed instructions to health services on apologies, explanations, and details of preventative action
• minimum requirements for compliance with the statutory duty of candour and open disclosure obligations
• guidance and information to support best practice.

1. Do you support the proposed content and format of the Victorian candour and open disclosure guidelines (noting they are a detailed legislative instrument underpinning high level primary legislation)?

YES / NO
2. Are there any matters which should be included or removed from the proposed content of the guidelines?

The RANZCP Victorian Branch recommends the Victorian Government develop guidance material, including scenarios, to illustrate when the statutory duty would apply. The guidance should include cases where the consumer lacks capacity and cases where consent to share information has been withheld.

3. Should the guidelines address how qualified privilege impacts on open disclosure process?

The RANZCP Victorian Branch believes there is a need to clarify the relationship between open disclosure and qualified privilege, in particular where one will end and the other begin (and their respective protections). We recommend that the Victorian Government develop detailed guidance material including scenarios to address this.

4. Are there other issues or unintended consequences that should be addressed or considered as part of the development of the guidelines? Please note a draft of the guidelines will be released with the exposure draft of the legislation (anticipated in 2021).

The RANZCP Victorian Branch does not have any comment on this question.

**Protections for clinical incident reviews - proposed model**

- Those involved in the clinical incident review and the commissioning health service entity are under a confidentiality obligation in relation to the clinical incident review
- The report and working papers from the clinical incident review are exempt from Freedom of Information requests and are not admissible in court
- Those involved in the clinical incident review cannot be required to give evidence about review documents and deliberations (e.g. interviews, discussions)
- Disclosure of the review report to specified third parties is allowed, including disclosure to a person whom the commissioning health service entity considers has a sufficient personal and professional interest
- Permitted disclosure does not make the report admissible in court or available under the Freedom of Information Act 1982
- Providing information to a review in good faith would not breach any professional ethics nor give rise to personal liability
- Health service entities are obligated to offer the clinical incident review report to consumers and to provide the report when consumers accept that offer. This aligns with duty of candour and mitigates against restrictions on consumer use of information.

1. Do you support the proposed model for clinical incident reviews?

**YES / NO**

2. Are there any unintended consequences or issues with the model that should be addressed or considered?

Further clarity is required around how this clinical incident review model will interact with the mandatory reporting scheme under the National Health Practitioner Regulation Law.
3. Should there be a mechanism to disseminate learnings and/or recommendations from incident review processes for quality and safety improvement purposes, including to those involved in the relevant case (although only relevant information may be provided to individual clinicians involved in the case)?

The Victorian Branch supports a mechanism to disseminate learnings and/or recommendations from incident review processes for quality and safety improvement purposes. With regard to mental health services, Safer Care Victoria, the Victorian Department of Health and/or the Office of the Chief Psychiatrist may be well placed to take on a role in disseminating learnings and/or recommendations.

4. To mitigate any unintended impact on decisions by health service entities about how incidents are classified, should there be a mechanism for a decision about an incident that does not meet the threshold for a protected incident review process and if so, what?

There should be a mechanism for a decision that an incident does not in fact meet the threshold for a protected incident review process, as is already present in the equivalent Queensland legislation.

The Victorian Branch would support the process proposed in the *Expert Working Group Report on A statutory duty of candour*, that in relation to certain kinds of incidents, a health service must consult with Safer Care Victoria about its categorisation before proceeding with the incident review [1].

5. What authorisations for information will ensure that protections for incident reviews do not restrict oversight and regulation of quality and safety, service delivery and professional conduct?

The RANZCP Victorian Branch does not have any comment on this question.

6. How and when should a statutory incident review team notify certain parties if they consider the incident to involve professional misconduct, unsatisfactory professional conduct, unsatisfactory professional performance or an impairment, to ensure there is clarity for services and practitioners?

It is important that notifications align with the National Health Practitioner Regulation Law definitions of professional misconduct, unsatisfactory professional conduct, unsatisfactory professional performance or an impairment. There should information available to the health practitioner and there should be processes in place to ensure the higher authorities in the organisations are involved in this process.

There should also be a clear pathway for the incident review team to notify the Australian Health Practitioner Regulation Agency, or any other relevant health complaints body, regarding any concerns or issues. It is important there is a clear relationship between the Statutory Duty of Candour legislation and the National Health Practitioner Regulation Law, particular in relation to mandatory notifications.

The Victorian Branch notes there is risk in continuing an incident review while a notification is made as the findings of the review may inadvertently influence the notification process. Effort should be made to ensure the process is as transparent as possible.

7. Should incident review protections include personal protections for those conducting or participating in a statutory incident review process in good faith?

The Victorian Branch would support protections for civil, criminal and administrative liability for those participating in a statutory incident review process in good faith.
References