

EXPLANATORY STATEMENT

HEALTH INSURANCE ACT 1973

Health Insurance (Quality Assurance Activity – Top End Health Service Peer Review Clinical Audits of Surgical Mortalities and Morbidities) Declaration 2021

Authority

The *Health Insurance (Quality Assurance Activity – Top End Health Service Peer Review Clinical Audits of Surgical Mortalities and Morbidities) Declaration 2021* is a declaration made under subsection 124X(1) of the *Health Insurance Act 1973* (the Act).

Purpose of the Instrument

Part VC of the Act creates a scheme to encourage efficient quality assurance activities in connection with the provision of health services. Those activities help to ensure the quality of health services that are funded by the Government, including through the public hospital services. The scheme encourages participation in such activities by protecting certain information from disclosure, and also by providing some protection from civil liability to certain persons engaged in those activities in good faith, in respect of those activities.

Subsection 124X(1) of the Act provides that the Minister may, by legislative instrument, declare a quality assurance activity described in the declaration to be a quality assurance activity to which Part VC applies.

The purpose of the *Health Insurance (Quality Assurance Activity – Top End Health Service Peer Review Clinical Audits of Surgical Mortalities and Morbidities) Declaration 2021* (the Declaration) is to declare the Top End Health Service (TEHS) Peer Review Clinical Audits of Surgical Mortalities and Morbidities Activity (the Activity) to be a quality assurance activity to which Part VC of the Act applies.

The Declaration is a legislative instrument for the purposes of the *Legislation Act 2003*. The Declaration commences on the day after registration on the Federal Register of Legislation.

The Activity is undertaken by the TEHS. The quality assurance activity described in this declaration applies only to health services provided in Australia. The Activity is undertaken by the TEHS under the auspices of the Northern Territory (NT) Department of Health. The Activity is clinician-led and enables clinical review of cases to identify contributing clinical factors and make recommendations about changes or improvements in a policy, procedure or practice relating to health services to reduce the likelihood of, or prevent, the same type of event from occurring again. The Activity also includes the monitoring of those recommendations.

Staff involved in case reviews include specialist surgeons, anaesthetists and other clinicians who perform surgical operations and provide care for patients at the Top End Health Service, including patients admitted under the surgical team but who did not proceed to have an operation, with recommendations provided to the Executive Director Medical Service of the TEHS.

Review, analysis and assessment by clinician peers to the operational and clinical issues and factors which contribute to an unexpected event resulting in cases of death or substantial morbidity, are a regular feature of hospital operations. Most jurisdictions in Australia permit these activities to operate under qualified privilege. However, there is currently no legislation in NT to cover the Activity and accordingly, it is open for Part VC of the Act to apply to the Activity. Pursuant to s124ZC of the Act, Part VC of the Act will continue to apply to the Activity only to the extent to which any relevant NT law would not otherwise apply.

Under the Activity, the team(s) responsible for patients' clinical care meet to discuss the events and decisions that contributed to a complication or death. Clinical audit discussions provide a means for the sharing of information about clinical cases which have resulted in complications or death in an open non-punitive environment oriented towards learning from analysis of the event with the goal of improving patient safety.

Cases included in the Activity are those resulting in mortality and cases of substantial morbidity. Complications that have the potential for long-lasting disability after patient's discharge are included. Clinicians are encouraged to participate to promote system improvement rather than apportion clinician blame.

Key components of the Activity include:

- (a) A review of all deaths and substantial morbidity cases to identify whether a complication has occurred. The review is undertaken in an objective and reproducible manner and may result in recommendations to the Executive Director Medical Service of the TEHS about changes or improvements in a policy, procedure or practice relating to the provision of health services to reduce the likelihood, or to prevent the same or similar event from occurring again;
- (b) Case discussions and analysis amongst clinician peers, supported by professional evidence and literature;
- (c) Review of operational policies, procedures or practices and clinical issues and factors that contribute to the occurrence of an event;
- (d) From time to time and dependent on the circumstances of the event, the clinical practice and performance of individuals may be discussed;
- (e) The clinical audit report which is approved by the Executive Director of Surgery TEHS and its recommendations are forwarded to the Chief Operating Officer and Executive Director Medical Services TEHS and circulated within the hospital; and
- (f) Publication of non-identifying information to occur through the NT Health Annual Report, NT Health Clinical Quality and Patient Safety Surveillance Report and NT Audit of Surgical Mortality, the following specific information arising from the Activity:
 - (i) number of cases reviewed;
 - (ii) audit of attendance numbers at the TEHS Activity;
 - (iii) percentage of eligible cases audited;
 - (iv) a summary of themes that contribute to morbidity and mortality;
 - (v) high level details of particular cases;
 - (vi) recommendations made to improve policies, practices and procedures; and
 - (vii) a description of issues raised during M&M meetings that arise from assessing safety and quality systems and M&M meetings at the TEHS.

Access to identifying information is limited to the Quality Assurance coordinator, lead reviewer, clinician peers participating in the audit activity, the Executive Director of Medical Services, Chief Operating Officer and NT Department of Health Legal Services.

Details of the Declaration are set out in **Attachment A**.

CONSULTATION

The TEHS, as the applicant for declaration of the Activity and the Australian Commission on Safety and Quality in Health Care was consulted in relation to the content of the Declaration.

The Declaration will not result in any direct or substantial indirect effect on business.

Section 1 – Name

This section provides for the Declaration to be referred to as the *Health Insurance (Quality Assurance Activity – Top End Health Service Peer Review Clinical Audits of Surgical Mortalities and Morbidities) Declaration 2021* (the Declaration).

Section 2 – Commencement

This section provides that the Declaration commences on the day after it is registered on the Federal Register of Legislation.

Section 3 – Authority

This section provides that the Declaration is made under subsection 124X(1) of the *Health Insurance Act 1973*.

Section 4 – Repeal

This section provides that the Declaration will be repealed when it ceases to be in force in accordance with subsection 124X(4) of the *Health Insurance Act 1973*.

Subsection 124X(4) of the *Health Insurance Act 1973* provides that a declaration of a quality assurance activity ceases to be in force at the end of 5 years after it is signed, unless sooner revoked.

Section 5 – Schedule

This section provides that the activity described in the Schedule is declared to be a quality assurance activity to which Part VC of the *Health Insurance Act 1973* applies.

Schedule 1 – Description of quality assurance activity

The Schedule provides that the name of the activity is ‘Top End Health Service Peer Review Clinical Audits of Surgical Mortalities and Morbidities’. It describes the quality assurance activity as a clinician-led activity that enables clinical review of identified cases to discuss and evaluate contributing clinical factors that led to an adverse outcome and the making and monitoring of recommendations about changes or improvements in a policy, procedure or practice relating to health services to reduce the likelihood of, or prevent, the same type of event from occurring again.

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Health Insurance (Quality Assurance Activity – Top End Health Service Peer Review Clinical Audits of Surgical Mortalities and Morbidities) Declaration 2021

This Declaration is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the Legislative Instrument

The *Health Insurance (Quality Assurance Activity – Top End Health Service Peer Review Clinical Audits of Surgical Mortalities and Morbidities) Declaration 2021* (the Declaration) declares the Top End Health Service (TEHS) Clinical Audit of Surgical Mortalities and Morbidities to be a quality assurance activity to which Part VC of the *Health Insurance Act 1973* (the Act) applies. Information known solely as the result of conducting the activity, or documents created solely for the purposes of the activity, will be covered by qualified privilege.

Human rights implications

This Declaration engages the right to health as set out in Article 12 of the International Covenant on Economic, Social and Cultural Right by assisting with the progressive realisation by all appropriate means of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The qualified privilege scheme established by Part VC of the Act is aimed at encouraging participation in quality assurance activities that help ensure the highest possible health care standards are maintained. The quality assurance activity described in this Declaration will provide participants with a greater degree of confidence and security that their participation is for the benefit of improving clinical management and delivery of care within the hospitals in the TEHS under the auspices of the Northern Territory (NT) Department of Health. .

This Declaration also engages, but does not limit, the right to privacy as contained in Article 17 of the International Covenant on Civil and Political Rights by involving the collection, storage, security, use, disclosure or publication of personal information. Data collected as part of the quality assurance activity will be subsequently de-identified to ensure that no individual or individuals are identified prior to analysis or disclosure of the information. Participants will publish a range of information relating to clinical and system factors that contribute to patient morbidity and mortality in the NT Health Annual Report, NT Audit of Surgical Mortality and the NT Health Clinical Quality and Patient Safety Surveillance Report.

Conclusion

This Declaration is compatible with human rights as it promotes the right to health and does not limit the right to privacy.

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