

Guidelines for quality improvement committees seeking qualified privilege under the *Health Services (Quality Improvement) Act 1994*

These guidelines provide information for hospitals and health services within Western Australia wishing to obtain qualified privilege for their quality improvement committee under the *Health Services (Quality Improvement) Act 1994*. These guidelines must be read in conjunction with the *Health Services (Quality Improvement) Act 1994* (Appendix I), the *Health Services (Quality Improvement) Regulations 1995* (Appendix II) and the *Health Services (Quality Improvement) Act 1994 Standards* (Appendix III). All of these documents are also available from the State Law Publisher (www.slp.wa.gov.au).

1. Quality Improvement

Quality improvement or quality assurance is a process of continually reviewing and evaluating patient care and patient outcomes using a variety of data to identify where that care can be improved. The overall aim of quality improvement is to enhance the health care services provided to the community and to reduce the risk of adverse events.¹

Quality improvement encompasses a wide range of activities and includes remedial action following activities such as:

- review of patient deaths (mortality audits);
- review of patient outcomes (morbidity audits);
- review of current clinical practice and comparing this practice against standards (clinical audit);
- investigation of adverse events to identify the contributing or causative factor(s); and,

¹ An adverse event is an incident in which preventable harm is caused to a person receiving health care.

- monitoring the rates of selected adverse events and comparing them against expected rates.

2. The rationale for qualified privilege for quality improvement activities

Effective quality improvement processes require both open communication and an acknowledgment of where care processes and outcomes can be improved. This communication is best facilitated by referring to the experiences of individual patients and their particular episodes of care. Some health care professionals may be reluctant to engage in this process because they fear that:

- the information gathered for critical review may be used to pursue legal proceedings against them; and,
- participation in the assessment and evaluation of services provided by other health care professionals may result in legal action being brought upon them by those individuals.

In order to maximise the effectiveness of quality improvement, it has been argued that these activities should be conducted in an environment safe from the fear of litigation. Health care professionals need reassurance that the information they provide will not be used to attribute blame to them or their colleagues if the care provided resulted in, or almost resulted in, an adverse outcome. This non-punitive approach is consistent with the preferred 'systems approach' to health care safety and quality. Cases which involve deliberate harm or a deliberate breach of duty must not be managed via a quality improvement activity but rather via the appropriate authorities who are able to take suitable action.

Legislation has been passed in Western Australia, other states and territories and at the Commonwealth level which seeks to encourage health care professionals to participate in quality improvement activities by providing for:

- the confidentiality of some documents and proceedings of quality improvement committees;
- the protection of these documents and proceedings from being used in legal actions; and,
- the protection from legal liability for present and former committee members who were acting in good faith in carrying out their responsibilities.

3. Qualified privilege legislation in Western Australia

The *Health Services (Quality Improvement) Act 1994* (the *Act*) encourages health professionals to participate in quality improvement processes aimed at improving the quality of clinical care by prohibiting the disclosure of information that identifies, either directly or by implication, individual health care providers and/or patients. Individuals who acquire information solely as a result of the performance of the committee's functions are also protected from being compelled to give evidence, or produce identifying documents produced solely for the purpose of the committee activities in legal proceedings. Source documents that are not created specifically for the purposes of the committee (for example, medical records) are not protected by the provisions of the legislation.

The granting of privilege from disclosure in legislation is rare, and comes with certain duties and obligations, which are set out in the *Act* and referred to in these Guidelines. A declaration of approval therefore requires cogent reasons and is only made following an administrative process characterised by a very high degree of rigour to ensure that the public interest is appropriately protected.

The *Act* specifically excludes the operation of the *Freedom of Information Act 1992* in relation to the information and documents generated by declared quality improvement committees [see section 5 of the *Act*]. This exclusion

prevents the *Freedom of Information Act 1992* being used to obtain details, which although not admissible as evidence, could form the basis of a case prepared and supported by other materials. Primary and source materials, such as medical records, remain accessible through the freedom of information process.

4. Determining whether a committee requires qualified privilege

It is not mandatory for all committees undertaking quality improvement activities to seek a declaration under the *Health Services (Quality Improvement) Act 1994*. Many committees conduct quality improvement activities by discussing de-identified or aggregated information and do so in such a manner that the identity of a person (patient or health professional) cannot be inferred. In these circumstances the risk of medico legal proceedings is negligible and such committees are unlikely to need the protection afforded by the legislation. Committees only need to consider seeking protection if the granting of privilege from disclosure under the Act would facilitate quality improvement activities that would otherwise not occur if that protection were not provided.

A committee seeking qualified privilege must provide an explanation of how granting of the immunities and protections offered by the Act to the committee will facilitate the performance of the committee's functions,

5. Natural justice

A committee is to have regard to the rules of natural justice in so far as they are relevant to the performance of the functions of the committee [see *section 8(1) of the Act*]. The concept of natural justice encompasses various rules of procedural fairness to achieve two basic principles: persons whose interests will be affected by decisions must be given adequate opportunity to present their case; and the decision-maker is to be neutral and unbiased. These principles ensure that a fair decision making procedure is followed.

6. Meeting the public interest

There is clearly a strong public interest in ensuring that consumers receive health care of the highest possible safety and quality. If quality improvement activities are impeded because health care professionals fear their involvement may place them at risk of potential legal action, there is an important public interest aspect in addressing the potential consequences so that health care professionals feel confident to participate in these processes.

This is the basis on which it is argued that there is a public interest in protecting the confidentiality of information generated through quality improvement activities and restricting the ways in which it can be used.

On the other hand, it is generally accepted that people should have the ability to access information that is held, or generated, about them that relates to their health and the provision of health care services to them.

A declaration of approval under the Act is not to be made unless the MFH is satisfied that it is in the public interest to restrict disclosure of information compiled by that committee in the course of the performance of its functions [see *section 7(2)(e) of the Act*]. Consequently, a committee seeking qualified privilege must be able to provide cogent justification for qualified privilege. In particular, committees must provide a statement containing information that shows it is in the public interest to restrict disclosure of information compiled by the committee in the course of the performance of its functions. The statement may refer to the improvements in patient or client care likely to result if the committee is able to operate under the qualified privilege afforded by the Act.

7. Disclosure of information

Committees that are registered under the Act must comply with certain restrictions on the disclosure of information.

A person who acquires any information solely as a result of the performance of a committee's functions must not make a record of, divulge or communicate that information to any person, except for the purposes of the performance of the functions of the committee, or for the purposes of furnishing reports to the relevant governing body [see *section 9(1)(a) of the Act*]. Aggregated information can be disclosed in accordance with the Standards [see *section 9(1)(b) of the Act*]. Information that discloses the identity of an individual, either expressly or by implication, cannot be disclosed except with the written consent of the person to whom the information relates [see *section 9(1)(c) of the Act*]. Further guidance regarding disclosure of information can be found in the Standards (see Appendix III).

It is an offence for a person to make a record of, divulge or communicate information acquired solely as a result of the performance of the committee's functions other than in the prescribed circumstances under the Act. Any person who commits such an offence may be liable to a penalty of \$5,000.00 [see *section 9(1) of the Act*]. Protection under the Act extends to cover persons who are not members of a committee but who act under the instruction or at the request of committee members. For example, administrative staff can attend committee meetings to assist with minute taking even though they may not have the necessary training and experience appropriate to the services being assessed and evaluated. The committee may also request individuals to carry out investigations and submit reports but the ultimate responsibility for assessment, reporting and making recommendations to the governing body and monitoring the implementation of those recommendations will always rest with the committee.

In order to maintain the confidentiality provisions in the Act committees are required to adopt and maintain a written information management policy. This policy must provide guidance to committee members on the way relevant information is acquired, compiled and stored as well as what information can be disclosed.

If for any reason a committee ceases to be an approved committee, the provisions in the Act governing the disclosure of information continue to apply as if the committee were still an approved Quality Improvement Committee for the period that was covered *[see section 13(a) of the Act]*.

8. Information not to be given in evidence

A person who acquires information solely as a result of a committee performing its functions is neither competent or compellable in civil proceedings to divulge or communicate that information to any court, tribunal, board or person *[see section 10(1) of the Act]*.

A document that was created by or at the request of a committee, or solely for the performance of a committee's functions, is not subject to discovery and is not to be used in evidence in civil proceedings before any court, tribunal, board or person unless the document has been made available to the public or given to the Minister or to the governing body of the committee *[see section 10 (1)(a) of the Act]*. Discovery is a process that occurs before a trial whereby documents are provided to the other party for inspection.

This privilege ensures that persons who may have provided or have access to otherwise protected material (i.e. administrative staff, hospital administrators, medical records staff) will not be compelled to disclose the information in court and other proceedings. This privilege does not apply to a report which has been furnished, or information that has been made available, to a committee which does not disclose, either expressly or by implication the identity of an individual *[see section 10(2)(a) of the Act]*. This privilege does not apply to a

requirement made in proceedings in respect of any act or omission by a committee or by a member of a committee as a member [*see section 10(2)(b) of the Act*]. An act or omission refers to the doing or refraining from doing a thing, which attracts the operation of the law. Failure to act may constitute an offence in certain circumstances. For example, where a member of the committee breaches section 9 of the Act, a penalty may be imposed. A court may require a person who is a member of a committee to answer questions or produce documents that relate to a contravention of section 9 of the Act.

Pending a gazettal of the Minister for Health's approval, the actions of the committee are not protected under the Act.

Documentation² subject to privilege includes the minutes of a committee's meetings. Minutes should accurately reflect the members present, the deliberations of the committee, and all other business of the meeting. A committee is to keep accurate minutes at each meeting. The minutes of the meeting are to be submitted to the members of the committee for confirmation at the next meeting. When confirmed, the Chairperson or person presiding at that meeting shall sign the minutes [*See regulation 6*].

Any source data coming into control of a committee, independently of a committee requirement, is not protected. Source data may be stored and maintained within governing bodies, however, it will only be afforded protection under the Act if it discloses the individuals' identities and it came into existence to meet the committee's requirements.

A finding or recommendation by a committee as to the need for changes or improvements in relation to a procedure or practice is not admissible as evidence in any proceedings that the procedure or practice is, or was, careless or inadequate [*see section 11 of the Act*].

² Section 5 of the *Interpretation Act 1984* defines document to include any publication and any matter written, expressed or described upon any substance by means of letters, figures, or marks, or by more than one of those means, which is intended to be use for the purpose of recording that matter.

Committees are to have procedures in place to advise new members and regularly remind continuing members of the extent and limitations of the protection provided by the Act. These procedures may be included in a committee's information management policy, which can be attached to its Terms of Reference.

If for any reason a committee ceases to be an approved committee, the provisions under the Act governing information to be given in evidence continue to apply as if the committee were still an approved quality improvement committee *[see section 13(b) of the Act]*.

9. Storage of documents

A declared committee must make appropriate arrangements to ensure that any reports furnished to, information made available to, or documents used in the preparation of reports by the committee are kept in safe custody *[see regulation 7]*. Accordingly the storage area should be secure and fire and vermin proof. The range of security measures for consideration includes physical security, computer and network security, communications security and personnel security. Records are to be retained in accordance with the Patient Information Retention and Disposal Schedule (Version 2, 2000).

10. Reporting requirements

A declared committee is required to furnish annual reports to the Minister for Health, its governing body and the public detailing the activities of the Committee over the year. Annual reports to the Minister for Health and to the public will be aligned with the financial year (1 July to 30 June) and are due before 31st of August each year. In the event that a newly declared Committee has been operating for less than one full financial year, the Committee should report on the activity that has occurred since the date the Committee was officially declared.

The content of these reports are outlined in the Regulations accompanying the Act, and is also detailed below. Templates for these reports are available from the Office of Safety and Quality in Health Care.

10.1 Reports to the Minister for Health

Each committee is to furnish a report to the Minister for Health by the 31st of August each year, outlining the Committee's activities for the previous financial year. The purpose of the annual report is to provide justification for the Committee's ongoing protection under the Act. In order to do this, the report should contain sufficient details to illustrate the services that were evaluated by the Committee during the year. The report should also contain the results of action taken as a result of these evaluations or assessments, and the results of the action taken. The report should be adequately detailed to convey the minimum reporting requirements below.

The minimum reporting requirements to the Minister for Health are as follows:

- Details of the reports made available to the public during the relevant period and the manner in which the reports were made available. This includes detailing exactly where the report is located, and/or who the report has been distributed to. If the report is located on a website, please provide the internet address of the report.
- Details indicating whether or not the exercise of the functions of the committee has been and will continue to be facilitated by the provision of the immunities and protections afforded by the Act. In other words, explain how the protection has helped the committee to undertake quality improvement activities. The onus is on the committee to justify their ongoing protection under the *Act*.
- Details indicating whether or not it has been, and will continue to be, in the public interest to restrict disclosure of the information compiled by the committee in the course of the performance of the committee's functions.

In other words, explain how the public has benefited from the committee's activities under qualified privilege. It is important to use concrete, specific examples of the improvements that have ensued, or are expected to ensue, from the committee's activities under qualified privilege.

Where there is more than one committee in a health service (or hospital), it is recommended that the governing body coordinates the preparation of reports by individual committees and forwards them together to the Chief Medical Officer, Department of Health.

10.2 Reports to the governing body

Reports to the governing body are required as a condition of approval under the Act. Reports need only be submitted where the governing body has referred a matter to the committee. In addition, it is recommended that reports should be sent to the relevant governing body annually.

In practice, a report prepared by a committee in the public health system is to be sent to the Chief Medical Officer, Department of Health. Reports prepared by approved committees in the private sector will need to be sent to their respective governing body.

10.3 Reports to the public

A declared committee must provide an annual report to the public before the 31st of August each year, which outlines the committee's activities for the previous financial year. The purpose of this report is to convey to the public the benefits and improvements to health care achieved by the committee under qualified privilege.

The purpose of qualified privilege is ultimately to improve the safety and quality of health care. Committees operate under qualified privilege because protection from disclosure facilitates this process and therefore, it is in the public's best interest to do so. Quality improvement committees are obliged to

inform the public of what they have done to protect the public interest. In order to do this, committees need to report to the public on the improvements made to the safety and quality of health care.

The information contained in annual reports to the public can be described in general terms, but it must be sufficiently detailed to adequately convey the benefits that have resulted from the committee's activities under the protection of qualified privilege.

The minimum reporting requirements to the public are as follows:

- a) A description of the services which have been assessed and evaluated by the committee during that period;
- b) A description of any action taken as a result of the assessment and evaluation referred to in paragraph (a); and
- c) if known at the time of preparation of the report, any results of the action referred to in paragraph (b).

If paragraph (c) cannot be complied with, the approved committee is to make the results available to the public in the next annual report to the public.

The Committee's annual report to the public must be made publicly available. The onus is on the committee to ensure that the public have reasonable access to this report. It is generally sufficient for a report to the public to be displayed on a website administered by the relevant health service, provided that a hard copy is available at a designated place for those without internet access. In order to assist public access to committee annual reports, the Department of Health will, at the committee's request, post copies of annual reports from committees on the Office of Safety and Quality in Health Care (OSQH) website. If you would like to post your annual report to the public on the OSQH public website, please contact Ngaere Stewart on (08) 9222 2238 or email Ngaere.Stewart@health.wa.gov.au

11. Application process

Before applying for approval under the Act, committees must ensure that they understand fully both the extent of the protection provided by the Act and the duties and obligations of approved committees. The Minister for Health may declare a committee as an approved quality improvement committee for the purposes of the Act for a period not exceeding 3 years [see *section 7(1) of the Act*]. If the committee wishes to continue its operations with qualified privilege it must submit a subsequent application for approval.

Applications are made to the Office of Safety and Quality in Health Care (OSQH) on an application form that is to be read in conjunction with the Act. The OSQH assesses each application and seeks advice where appropriate from the Department of Health's Legal and Legislative Services Directorate to determine whether a committee meets the requirements for ministerial approval and warrants protection under the Act.

Before submitting an application, the committee should ensure the following requirements are met:

- The committee is established in accordance with the rules or official procedures of its relevant governing body [see *section 7(2)(a) of the Act*];
- Each member of the committee has the training and experience appropriate to the services to be assessed and evaluated [see *section 7(2)(b) of the Act*];
- The functions of the committee include –
 - The assessment and evaluation of the quality of health services, including the review of clinical practices;
 - The reporting and making of recommendations to its governing body concerning health services; and
 - The monitoring of the implementation of those recommendations [see *section 7(2)(c) of the Act*].

11.1 Establishing the committee

Committees cannot be declared under the Act unless the Minister for Health is satisfied that the committee is established in accordance with the rules or official procedures of its relevant governing body [see section 7(2)(a) of the Act].

In some instances, more than one established committee from the same organisation may seek approval under the Act. In these circumstances it is recommended, where possible, that hospital or health service management coordinates the preparation of individual applications. There is no restriction on the number of committees that may be approved under the Act.

A relatively formal resolution made by the relevant governing body of the committee is required to establish a particular committee. The resolution should identify the committee by reference to its name, its members and its functions. The resolution is to be recorded in the minutes of the meeting at which the resolution is made and any document that identifies the name, membership and functions is to be annexed to those minutes.

It is recommended that the following procedure be followed when establishing a quality improvement committee:

- The committee is to be constituted as a formal committee under the governing body;
- The committee is to have a written Terms of Reference;
- A chairperson is to be appointed and his/her duties described;
- The quorum for a meeting of the committee is to be established (minimum 50%); and
- Procedures are to be established for electing or appointing members of the committee.

11.2 Committee Members

A committee will not be declared under the Act unless the Minister for Health is satisfied that each member of the committee has training and experience appropriate to the services to be assessed and evaluated [see *section 7(2)(b) of the Act*]. The name, qualification, position (on the committee) and any relevant work experience of the committee members pertinent to the services being examined must be provided in the application.

In order to act in 'good faith' a committee member must make reasonable and genuine attempts to act fairly and properly when carrying out their function as a committee member [see *section 12 of the Act*];

Upon the ordinary principles governing the operation of a committee, members must act in concert and cannot delegate certain functions amongst themselves. If further clinical areas need to be protected under the Act, new committees need to be formed with their own distinct name, members and functions.

There is a legal distinction between a person becoming a new member of a committee and becoming a delegate to act as a substitute for a committee member. A quality improvement committee should not appoint a delegate to act in place of a permanent member.

A committee may alter its membership without hindrance to the operation of the committee. A change in membership does not require a further application for a declaration of approval however the Minister for Health is to be notified in writing of any changes in membership. Notifications are to be forwarded to the Minister via the Office of Safety and Quality in Health Care.

11.3 Delegates

A committee can delegate tasks to a non-committee member (delegate), provided that the task is directly related to the quality improvement functions

of the committee. For example, a committee seeking an expert opinion on treatment methodologies might delegate this task to a highly regarded specialist. Any information that the delegate generates during performance of the committee's functions is protected from disclosure.

It is recommended that the following procedure be followed when delegating a task to a non-committee member:

- The delegate is chosen carefully and has the relevant qualifications necessary to perform the task on behalf of the committee;
- The delegate has read a copy of the *Health Services (Quality Improvement) Act 1994*, and has been made aware of their obligations and requirements under the *Act*;
- Details of the task to be performed and the details of the person carrying out the task are documented by the committee and signed by the delegate; and
- Information given to the delegate to enable him/her to carry out tasks on behalf of the committee is limited to factual information obtained from the medical record or other non-privileged source documents.

11.3 Functions of the committee

A declaration of approval under the Act is not to be made unless the Minister for Health is satisfied that the functions of the committee include –

- The assessment and evaluation of the quality of health services, including the review of clinical practices;
- The reporting and making of recommendations to its governing body concerning health services; and
- The monitoring of the implementation of those recommendations [see *section 7(2)(c) of the Act*].

The functions should be outlined clearly in the committee's Terms of Reference. Alterations may be made to a committee's Terms of Reference however, such alterations cannot proceed beyond the scope of the functions set out in the document establishing that committee. For example, if a committee is to change its Terms of Reference so as to cover a different subject matter than expressed in its original committee functions, that committee is no longer the same committee. Accordingly, the establishment and a subsequent application for approval of a new committee must be made.

The Minister for Health is to be notified in writing of any changes or updates to the Terms of Reference of a committee. Notifications are to be forwarded to the Minister via the Office of Safety and Quality in Health Care.

12. Mortality Committees

The Act applies to and in relation to a Mortality Committee as if that committee had been declared a committee under the Act, the MFH were the relevant governing body for that committee and a report made under Part XIII A, XIII B or XIII C of the *Health Act 1911* was a report furnished to the relevant governing body [see section 14 of the Act];.


For the purposes of the Act, Mortality Committee means the Maternal Mortality Committee constituted under Part XIII A of the *Health Act 1911*, the Perinatal and Infant Mortality Committee constituted under Part XIII B of the *Health Act* and the Anaesthetic Mortality Committee constituted under Part XIII C of the *Health Act*.

13. Contact information

Committees intending to apply for qualified privilege under the Act are strongly encouraged to contact the OSQH prior to submitting an application.

Office of Safety and Quality in Health Care
Health Care Division

Department of Health
PO Box 8172, Stirling Street
PERTH WA 6849

 (08) 9222 4080

Fax (08) 9222 4234

 safetyandquality@health.wa.gov.au

APPENDIX ONE

HEALTH SERVICES (QUALITY IMPROVEMENT) ACT 1994

Part 1 – Preliminary

1. Short title

This act may be cited at the *Health Services (Quality Improvement) Act 1994*.

2. Commencement

This Act comes into operation on such day as is fixed by proclamation.

3. Object

The object of this Act is to encourage and promote the establishment of committees to review, assess and monitor health services with a view to improving the standard of health care in Western Australia.

4. Crown Bound

This Act binds the Crown.

5. Effect on other enactments

- (1) This Act has effect despite the *Freedom of Information Act 1992*.
- (2) If there is an inconsistency between a provision of this Act and a provision of any other written law, the provision of this Act prevails to the extent of the inconsistency.

6. Interpretation

In this Act, unless the contrary intention appears –

“**Committee**” means a committee that is declared, or is by section 14 taken to have been declared, to be an approved quality improvement committee under section 7(1);

“**governing body**” means the person or body (by whatever name called) having the general direction and control of, and overall responsibility for, the operations of –

- (a) a health service; or
- (b) an association, society, college, faculty or other body of professionals who provide a health service;

“**health service**” means –

- (a) any medical, hospital, ambulance, paramedical, dental, pharmaceutical, mental health, nursing home, palliative care, community health or environmental health service;

- (b) any service relating to or associated with the provision of a service referred to in paragraph (a); or
- (c) any other service relating to or associated with the maintenance or improvement of the health, or the restoration to health, of persons or the prevention of disease in or injury to persons.

Part 2 – Quality improvement committees

7. Approved quality improvement committees

- (1) The Minister may, by order published in the *Gazette*, declare that, for such period not exceeding 3 years as is specified in that order, a specified committee established by a governing body is an approved quality improvement committee for the purposes of this Act and by like order may amend or revoke the declaration.
- (2) The Minister is not to make a declaration under subsection (1) unless the Minister is satisfied that -
 - (a) the committee is established in accordance with the rules or official procedures of the relevant governing body;
 - (b) each member of the committee include has training experience appropriate to the services to be assessed and evaluated;
 - (c) the functions of the committee include –
 - (i) the assessment and evaluation of the quality of health services, including the review of clinical practices;
 - (ii) the reporting and making of recommendations to its governing body concerning health services; and
 - (iii) the monitoring of the implementation of those recommendations;
 - (d) the performance of those functions would be facilitated by the provision of immunities and protections afforded by this Act; and
 - (e) it is in the public interest to restrict disclosure of information compiled by that committee in the course of the performance of those functions.

8. Restrictions on Committees

- (1) A Committee is to have regard to the rules of natural justice in so far as they are relevant to the performance of the functions of that Committee.
- (2) A report furnished or information made available by a Committee, must not disclose, either expressly or by

implication, the identity of an individual who is a provider or recipient of a health service unless the individual has consented in writing to that disclosure.

9. Disclosure of information

(1) A person who acquires any information solely as a result of that person's membership of, employment by, or association with, a committee must not make a record of, or divulge or communicate that information to any person, except -

- (a) for the purposes of –
 - (i) the performance of the functions of the Committee; or
 - (ii) furnishing reports to the relevant governing body referred to in section 7(1);
- (b) in accordance with any standards, in addition to the restrictions imposed by this Act, that may be established by the Minister for the making available to the public or a section of the public or information that does not, either expressly or by implication, disclose the identity of an individual or individuals; or
- (c) with the written consent of the person to whom the information relates.

Penalty: \$5 000

(2) The Minister may from time to time determine, and publish in the manner prescribed by the regulations, standards for the purposes of subsection of (1)(b).

10. Information not to be given in evidence

- (1) Without limiting section 9, but subject to this section, a person who is or has been a member of a Committee is neither competent nor compellable in civil proceedings –
 - (a) to produce before any court, tribunal, board or person any document in his or her possession or under his or her control that was created by or at the request of, the Committee, or solely for the performance of the Committee's functions; or
 - (b) to divulge or communicate to any court, tribunal, board or person any matter or thing that came to his or her notice as such a member.
- (2) Subsection (1) does not apply to –
 - (a) a report which has been furnished, or information that has been made available, to a Committee which does not disclose, either expressly or by implication, the identity of an individual; or
 - (b) a requirement made in proceedings in respect of any act or omission by a Committee or by a member of a

Committee as a member.

11. Findings of Committee not evidence of certain matters

A finding or recommendation by a Committee as to the need for Changes or improvements in relation to a procedure or practice is not admissible as evidence in any proceedings that the Procedure or practice is, or was, careless or inadequate.

12. Personal liability of members

- (1) Anything done by a Committee, a member of a Committee or any person acting under the direction of a Committee, in good faith for the purposes of the performance of the Committee's functions, does not subject the member or person personally to any action, liability, claim or demand.
- (2) Without limiting subsection (1), for the purposes of section 354 of the *Criminal Code* –
 - (a) any statement made orally or in writing by a member of a Committee in good faith and in the performance of the functions of a member; and
 - (b) any report or other information published in good faith by the Committee,

is to be taken to be published for the information of the public and for the discharge of public functions.

- (3) The members of a Committee are, and are entitled to be, indemnified by the governing body that established the Committee in respect of any costs incurred in defending proceedings in respect of any action, liability, claim or demand against which they are protected by this section.

13. Continuation of protection

If for any reason a committee ceases to be an approved quality improvement committee under section 7(1) –

- (a) section 9 continues to apply to the making of a record of, or divulging or communicating of, information that was acquired when the committee was an approved quality improvement committee;
- (b) section 10 continues to apply to the competence or compellability of a person in relation to documents created when, or any matter or thing coming to that person's notice when, the committee was an approved quality improvement committee;
- (c) section 11 continues to apply to the admissibility of evidence that relates to a finding or recommendation made by the committee when it was an approved quality improvement committee; and

- (c) section 12 continues to apply to any action, liability, claim or demand that arose when the committee was an approved quality improvement committee,

as if the committee were still an approved quality improvement committee.

14. Mortality Committees

- (1) This Act, other than sections 7, 13 and 15(a) and (b), applies to and in relation to a Mortality Committee as if –
 - (a) that committee had been declared to be a Committee under section 7;
 - (b) the Minister were the relevant governing body for that committee; and
 - (c) a report made under Part XIII A, XIII B or XIII C of the *Health Act 1911* were a report furnished to the relevant governing body.
- (2) Regulations made under section 15, only apply to Mortality Committees where those regulations specify that they are to have that application.
- (3) In this section “**Mortality Committee**” means –
 - (a) the Maternal Mortality Committee constituted under Part XIII A of the *Health Act 1911*;
 - (b) the Perinatal and Infant Mortality Committee constituted under Part XIII C of that Act.
- (4) The provisions of this section are to be construed so as not to limit in any way the effect and operation of the provisions of Parts XIII A, XIII B and XIII C of the *Health Act 1911*.

Part 3 – General

15. Regulations

The Governor may make regulations prescribing all matters required or permitted by this Act to be prescribed or necessary or convenient to be prescribed for carrying out this Act and, in particular –

- (a) providing for the procedure of Committees and the manner in which they are to perform their functions;
- (b) permitting or requiring Committees to make specified information available to the public; and
- (c) permitting or requiring Committees to furnish reports concerning their activities to the Minister and governing bodies.

APPENDIX TWO

HEALTH SERVICES (QUALITY IMPROVEMENT) REGULATIONS 1995

1. Citation

These regulations may be cited as the *Health Services (Quality Improvement) Regulations 1995*.

2. Commencement

These regulations come into operation on the day on which the *Health Services (Quality Improvement) Act 1994* comes into operation.

3. Interpretation

In these regulations, unless the contrary intention appears –

“**Committee**” means a committee that is declared to be an approved quality improvement committee under section 7 (1) of the Act;

“**Department**” means the department principally assisting the Minister in the administration of the Act.

4. Application for approval as a quality improvement committee

(1) Where the governing body of a committee wishes that committee to be declared to be an approved quality improvement committee under section 7 (1) of the Act the governing body shall make application to the Minister.

(2) An application to the Minister under subregulation (1) shall be -

- (a) made in writing in a form approved by the Minister; and
- (b) accompanied by such further information as the Minister may require.

(3) For the purpose of ascertaining whether a declaration is to be made under section 7 (1) of the Act or for the purpose of determining the period for which approval is to be granted under that section the Minister may by notice in writing require a governing body making application under subregulation (1) to furnish the Minister, within such reasonable time as may be specified in that notice, with such information specified in the notice as that governing body may be able to give.

5. Publication of standards

Standards determined by the Minister for the purposes of section 9 (1) of the Act shall be –

- (a) published in the *Gazette*; and
- (b) made available free of charge at the offices of the Department during the usual hours of business of the Department.

6. Minutes

(1) A Committee is to cause accurate minutes to be kept of each meeting of the Committee.

(2) The minutes of a meeting shall be submitted to the members of a Committee for confirmation at the next subsequent meeting of the Committee and when confirmed shall be signed by the Chairperson or person presiding at that meeting.

7. Safe custody

A Committee is to cause any reports furnished to, information made available to, or documents used in the preparation of reports by, the Committee to be kept in safe custody.

8. Reports to governing body

Where a matter is referred to a Committee by the governing body by which it was established the Committee is to –

- (a) at the completion of the assessment or evaluation of the matter; or
- (b) at such earlier time as so directed by the governing body submit a report on that matter to that governing body.

9. Information available to the public

(1) A Committee is to make available to the public at least once in each period of 12 months, by such means as is determined by the governing body which established the Committee, a report containing the following information –

- (a) the services which have been assessed and evaluated by the Committee during that period;
- (b) any action taken (described in general terms) as a result of the assessment and evaluation referred to in paragraph (a); and
- (c) if known at the time of preparation of the report, any results of the action referred to in paragraph (b).

(2) If subregulation (1) (c) cannot be complied with the Committee is to make the results referred to in that subregulation available to the public in the report made under this regulation next following the time that those results are known to the Committee.

10. Reports to the Minister

Each Committee and each Mortality Committee (as defined in and for the purposes of section 14 of the Act) is to furnish to the Minister at least once annually or more often if so directed by the Minister, a report including the following information –

- (a) details of the reports made available to the public under regulation 10 during the relevant period and the manner in which the reports were made available;
- (b) a statement indicating whether or not the exercise of the functions of the Committee has been and will continue to be facilitated by the provision of the immunities and protections afforded by the Act; and
- (c) a statement indicating whether or not it has been and will continue to be in the public interest to restrict disclosure of information compiled by the Committee in the course of the performance of the Committee's functions.

APPENDIX THREE

HEALTH SERVICES (QUALITY IMPROVEMENT) ACT 1994

STANDARDS

ESTABLISHED BY THE MINISTER FOR HEALTH FOR THE PURPOSES OF SECTION 9(1)(b) OF THE HEALTH SERVICES (QUALITY IMPROVEMENT) ACT 1994

BACKGROUND

The aim of any quality improvement committee is to improve the quality of health care delivered to patients. Quality improvement committees registered under the *Health Services (Quality Improvement) Act 1994* (the Act) are required to fulfil a number of functions as outlined in section 7 (2)(c) of the Act. These activities include:

- the assessment and evaluation of the quality of health services, including the review of clinical practices;
- the reporting and making of recommendations to its governing body concerning health services; and,
- the monitoring of the implementation of those recommendations.

PURPOSE

These Standards are established by the Minister for Health for the purposes of section 9(1)(b) of the Act. The purpose of these Standards is to enable a person who acquires any information solely as a result of the performance of the Committee's functions to make a record of, divulge and communicate that information for the making available to the public or a section of the public of information that does not, either expressly or by implication, disclose the identity of an individual or individuals.

These Standards are in addition to the restrictions imposed by section 8(2) of the Act.

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DEFINITIONS

In these Standards:

“**Act**” means the *Health Services (Quality Improvement) Act 1994*;

“Committee” means a committee that is declared, or is by section 14 of the Act taken to have been declared, to be an approved quality improvement committee under section 7(1) of the Act;

“Department of Health” means the department principally assisting the Minister for Health in the administration of the Act and responsible for the State-wide administration of health services;

“family connection” means a connection identifying an individual by reference to members of their family. For example, by reference to a spouse/de-facto-partner/sister/grand-daughter of the person;

“governing body” means the person or body (by whatever name called) having the general direction and control of, and overall responsibility for, the operations of –

- a) a health service; or
- b) an association, society, college, faculty or other body of professionals who provide a health care service;

“health professional” means a person practising a particular discipline or profession in the health area and includes a medical practitioner, nurse, midwife, occupational therapist, osteopath, chiropractor, optometrist, pharmacist, physiotherapist, podiatrist, radiographer, psychologist;

“health section of the Public” means that section of the public comprising:

- (a) employees of the Department of Health;
- (b) employees of a health service;
- (c) health professionals;
- (d) members of an association, society, college, faculty or other body of professionals who provide a health services; and
- (e) employees of other Australian and international Government agencies responsible for the provision and administration of health services and health legislation.

“health service” means –

- a) any medical, hospital, ambulance, paramedical, dental, pharmaceutical, mental health, nursing home, palliative care, community health or environmental health service;
- b) any service relating to or associated with the provision of a service referred to in paragraph (a); or
- c) any other service relating to or associated with the maintenance or improvement of the health, or the restoration to health, of persons or the prevention of disease in or injury to persons;

“identifying feature” means any semi permanent or permanent physical identifying feature (eg. scar, excessive body mass index, skin colour);

“**information**” includes reports;

“**public**” means open to all persons;

“**Regulations**” means the Health Services (Quality Improvement) Regulations 1995; and

“**sentinel event information**” means information about the following events:

- Procedures involving the wrong patient or body part;
- Suicide of a patient in an inpatient unit;
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure;
- Intravascular gas embolism resulting in death or neurological damage;
- Haemolytic blood transfusion reaction resulting from ABO incompatibility;
- Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs;
- Maternal death or serious morbidity associated with labour or delivery;
- Infant discharged to wrong family or infant abduction; and
- Any other catastrophic event resulting in serious patient harm or patient death.

STANDARD 1: Reports made by a Committee to the Minister for Health and the public in accordance with the Regulations

In accordance with regulation 9 of the Regulations, a Committee is to make available to the public at least once in each period of 12 months, by such means as is determined by the governing body which established the Committee, a report containing the following information –

- (a) the services which have been assessed and evaluated by the Committee during that period;
- (b) any action taken (described in general terms) as a result of the assessment and evaluation referred to in paragraph (a); and
- (c) if known at the time of preparation of the report, any results of the action referred to in paragraph (b).

In accordance with regulation 10 of the Regulations, a Committee is to furnish the Minister for Health at least once annually and more often if so directed by the Minister, a report containing the following information:

- (a) details of the reports made available to the public under regulation 9 during the relevant period and the manner in which the reports were made available;
- (b) a statement indicating whether or not the exercise of the functions of the Committee has been and will continue to be facilitated by the provision of the immunities and protections afforded by the Act; and
- (c) a statement indicating whether or not it has been and will continue to be in the public interest to restrict disclosure of information compiled by the Committee in the course of the performance of the Committee’s functions.

The reports provided under regulations 9 and 10 of the Regulations shall not disclose in relation to an individual or individuals the following information: names, address, dates of birth, age, family connection, occupation, qualifications, membership of a professional body, home or workplace location or region, religious denomination, cultural background, ethnicity, nationality, gender, gender

history, sexual orientation, sexual orientation history, marital status or an identifying feature.

STANDARD 2: Release of information by a Committee or the governing body to the health section of the public

Information which may be made available by a Committee or the governing body to the health section of the public may include information on:

- the assessment and evaluation of the quality of health services, including the review of clinical practices;
- the reporting and making of recommendations concerning health services; and,
- the monitoring of the implementation of those recommendations.

In particular, this standard applies to the provision of sentinel event information to the Department of Health as outlined in Operational Circular OP 1679/03 and the statewide sentinel event policy.

The information provided to the health section of the public shall not disclose in relation to an individual or individuals the following information: names, addresses, dates of birth, home or workplace location, religious denomination, nationality or marital status.

The age of the recipient of the health service should only be disclosed where it is relevant to the health condition of the recipient. If the age of the recipient of the health service is over 95 years of age, then that person should be referred to as a person in the centenarian age group.

The family connection of the recipient of the health service should only be disclosed if the medical history or family history of the recipient of the health service is relevant to the assessment, diagnosis and treatment of an individual's medical condition (eg. maternal history of diabetes, family history of genetic disorders).

The occupation, qualifications, membership of a professional body, cultural background, race or ethnicity of the recipient of the health service should only be disclosed where it is relevant to the health condition of the recipient of the health service or relevant to an understanding of the health services being assessed and evaluated (eg. requirement for interpreting services).

The gender, gender history, sexual orientation, sexual orientation history or an identifying feature of the recipient of the health service should only be disclosed where it is relevant to the health condition of the recipient of the health service or where it would be inferred from the particular health condition or procedure undertaken (eg. pregnancy, prostate cancer, gender reassignment).

The occupation, qualifications and membership of professional bodies of the provider(s) of the health service should only be disclosed by identifying them as being a health professional (eg medical practitioner, nurse) or as a member of a specialty grouping (ie. surgeon, anaesthetist, psychiatrist, obstetrician, midwife, community nurse, paramedic) and then such disclosure should only be made where it is relevant to an understanding of the health services being assessed and evaluated (eg. the performance of particular operation by a surgeon) or to identifying a class of health professionals to whom recommendations should be directed (eg. medical practitioners, nurses).

The cultural background, race, ethnicity, gender, gender history, sexual orientation or sexual orientation history of the provider(s) of the health service

should only be disclosed where it is relevant an understanding of the health services being assessed and evaluated or to identifying a class of health professionals to whom recommendations should be directed (eg. male or female medical practitioners, male or female nurses).

A region of Western Australia may only be described by use of the terms 'metropolitan' or 'rural'.

STANDARD 3: Sharing of information within the health section of the public

Where persons within the health section of the public have been provided with information under Standard 2, they may further share that information in the form of safety alerts, newsletters, bulletins, reports, data and the like with other persons within the health section of the public for the purpose of improving the quality of health services.

STANDARD 4: Release of information by the health section of the public to the public

The health section of the public may release information provided under Standard 2 to the public.

This information shall not disclose in relation to an individual or individuals the following information: names, address, dates of birth, age, family connection, occupation, qualifications, membership of a professional body, home or workplace location or region, religious denomination, cultural background, ethnicity, nationality, gender, gender history, sexual orientation, sexual orientation history, marital status or an identifying feature.