AMA Queensland Submission

Amendments to Clinical Excellence Queensland *Patient Safety Staff Escalation Pathway*

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AMA Queensland thanks Queensland Health for seeking our feedback on Clinical Excellence Queensland's Patient Safety Staff Escalation Pathway (the 'Pathway').

For some time now, doctors have been contacting AMA Queensland distressed about patient harm in our public hospitals. Most recently we have received calls from harrowed clinicians working in Redland, the Princess Alexandra and the Queensland Children's Hospitals. These dedicated health professionals want to protect their patients but are too frightened to report their concerns to their hospital management, the Department of Health or the Office of the Health Ombudsman (OHO).

Many advised this is a direct result of poor Hospital and Health Service (HHS) culture in which they have witnessed colleagues suffer retribution, discrimination or had their careers negatively impacted after speaking up. Several said the lack of HHS management accountability and fear of reprisal, from hospital executives or other colleagues, has even caused them to reconsider medicine as a profession.

AMA Queensland therefore supports Queensland Health's recognition of this issue by its proposed development of the Pathway. We also remain committed to working with Queensland Health to improve the culture within HHS' and between health professionals and the Department to support our workforce and protect patients.

To that end, AMA Queensland distributed the materials provided by Clinical Excellence Queensland (CEQ) widely via our member communication channels to give practitioners across Queensland an opportunity to provide individual feedback on the Pathway. As a result, we had some members contact us directly to provide more detailed input than was possible through CEQ's online Consultation Survey. This feedback is set out below and we would welcome an opportunity to discuss the Pathway further with CEQ.

Reporter confidentiality

Many of the concerns raised by practitioners related to the lack of confidentiality afforded by the Pathway. Of particular concern was that the reporter's escalation to the HHS/Hospital Patient Safety Steward (the 'Hospital Steward') or Department of Health Patient Safety Steward (the 'DoH Steward') would be notified to the reporter's line managers.

Practitioners felt this would be a disincentive to staff using the Pathway given cultural problems within hospitals, particularly where:

- the reporter raised the issue with one or both of the reporter's line managers but was dissatisfied with their response so escalated their concern to the next line manager, Hospital or DOH Steward; and
- the reporter bypassed their line managers and raised the issue direct with the Hospital or DoH Steward.

Doctors requested further detail about how confidentiality would be preserved to ensure reporters were not targeted or discriminated against by their line managers for escalating their concerns. AMA Queensland notes this is included under 'Policy/legislation required – Privacy/confidentiality provisions' in 'Supporting elements for successful implementation' on page 3 of the Proposed Approach. We submit Queensland Health must involve all health practitioners in the development of these policies and legislation.

Other practitioners also questioned whether such confidentiality was even possible given the difficulties experienced by practitioners who report patient harms to the OHO. Medical practitioners consistently advise they are reluctant to report other health practitioners to the OHO as it is relatively easy for reported practitioners to identify the reporting practitioner. This is because there are a limited number of health professionals who:

- work with a reported practitioner on a given shift, across any particular roster or specified time period;
- are involved with caring for an individual patient; and/or
- have the medical expertise needed to identify clinical errors by a particular practitioner.

Whilst AMA Queensland acknowledges the difficulties in preserving reporter confidentiality, doing so will be central to the success of the Pathway. Without such reassurance, clinicians are unlikely to use it. It is imperative that Queensland Health staff and peak bodies are consulted in the development of the associated reporter protections.

Patient Safety Stewards

Doctors wanted more detail about the proposed recruitment, induction and training for both Hospital and DoH Stewards (collectively 'Stewards'). AMA Queensland acknowledges CEQ has identified training and the Steward role as essential elements for the Pathway's implementation, under 'Supporting elements for successful implementation'. As such, we provide the following member questions to be addressed by CEQ when developing these elements:

- What professional backgrounds and experience will be required for employment as a Steward?
    - Will this be different for Hospital and DoH Stewards?
- Are there any current positions within Queensland Health which the Department believes are akin to the role of a Steward?
- How will Stewards be incorporated into the current governance structure within HHS'?
- Will the Department retain control of and responsibility for Stewards and not individual HHS'?
- What reporting framework will Stewards operate within?
- What recruitment process, including selection criteria, will be used to employ Stewards?
- What induction process will be provided to Stewards?
- How will Queensland Health ensure consistency of training for Stewards?
- How often will Stewards be required to undertake ongoing training?
- What input with Queensland Health staff have to the training requirements for Stewards?
- What training will be given to Queensland Health staff, including managers and those involved in clinical governance within HHS', about Stewards and the Pathway?
- How will staff receive feedback on the outcomes of their escalation?
- How will any recommendations/lessons learned that are more broadly applicable to the relevant clinical service (or other clinical services) be transparently communicated to all relevant staff to improve quality and patient safety?
- What evaluation will be undertaken of the training of Stewards and the effectiveness of the Pathway more generally?
- Who will undertake these evaluations?
- Will those evaluations be independent, transparent and released publicly?

'Supporting elements for successful implementation'

AMA Queensland notes the 'Supporting elements for successful implementation' included on page 3 of the Proposed Approach document. Doctors were particularly anxious for CEQ to provide much greater detail on the following elements.

<u>Definition of 'patient safety concern'</u>

This definition is critical to the Pathway's stated core purpose 'to enable staff to escalate quality and safety concerns they believe have not been addressed at a local level in a timely, proper, or sufficient way'. It must be broad and capable of capturing systemic issues that Queensland Health staff feel have

not been or cannot be adequately addressed through existing approaches. This includes those existing processes identified in CEQ's 'Background' paper, particularly that provided by the OHO and Ahpra. The Pathway must not duplicate existing avenues.

Once the definition is provided, CEQ must also seek feedback from Queensland Health staff and peak bodies on its suitability.

HHS Safety Steward Executive Committees

Doctors have requested far greater details including the membership, establishment, powers and governance structure of these committees. AMA Queensland also notes these 'Committees' could be limited to just two members, both being HHS or hospital executives (with one required to also be a clinician). Such limited membership is likely to raise questions about the legitimacy of the committees and the Pathway itself, particularly given the distrust many Queensland Health employees feel towards HHS/Hospital management.

AMA Queensland members suggested these committees should be external to all HHS'/hospitals. It was strongly felt that committees and their members (as well as those tasked with implementing committee recommendations) must be, and be seen to be by Queensland Health staff, as:

- trustworthy and a safe place for staff to take concerns, without fear of reprisal; and
- holding no conflict of interest with the relevant HHS – members said this would require these people to be external to the hospital/HSS.

Given practitioners feel HHS have historically ignored or played-down staff concerns, feedback must be sought from all Queensland Health staff and peak bodies on these details once provided.

'Enhancement of approach to strengthen patient safety culture in speaking up, listening up and responding to issues':

Medical practitioners have consistently reported they fear they will be targeted by their HHS/hospital management or Queensland Health for raising concerns about their workplace and patient safety. This has contributed to a culture of intimidation and secrecy. To counter this, Queensland Health must implement staff protections for speaking out, including publicly whether through online forums, advocacy groups or the media.

AMA Queensland notes multiple reviews have recommended the Queensland Government overhaul its whistleblower legislation and the Wilson Review is expected in April 2023. Queensland Health must likewise develop protections for its staff and implement any and all relevant recommendations following publication of that review.

Bias towards local resolution

The majority of the issues reported to AMA Queensland by members at hospitals such as Redland, the Princess Alexandra and the Royal Children's Hospitals stem from systemic issues within HHS' or across the entire health system, rather than at an individual hospital. Whilst AMA Queensland understands the preference for local resolution of individual patient or hospital concerns, this preference is unlikely to be suitable for system-wide systemic failures.

For example, doctors report the major causes of adverse patient outcomes, particularly for elderly patients, at Redland hospital are:

- Lack of an ICU, after-hours general surgery and inpatient orthopaedics, meaning patients needing those services must be transferred to another hospital.

- Severe delays in those patient transfers because Metro South HHS' inter-hospital transfer system is dysfunctional.[1]

- A failure by Queensland Health and Metro South HHS to:

    - work with the Queensland Ambulance Service to ensure ambulances do not bring patients clearly needing orthopaedic or after-hours surgery to Redland Hospital;

    - address ambulance ramping issues at the Princess Alexandra Hospital, causing ambulances to bring patients to Redland Hospital despite the lack of services to avoid wasting valuable ambulance time ramped at the Princess Alexandra Hospital; and

    - a failure by Queensland Health to communicate the limitations in onsite clinical services to the community, including local GPs, so patients are aware that they will need to be treated at a major hospital, such as the Princess Alexandra, if they require those services.

Given it is systemic failures members have raised with AMA Queensland as amongst their key concerns for patient safety, the Pathway's preference for and emphasis on local resolution needs to be reconsidered. It is suggested that CEQ develop more options for staff to escalate systemic, rather than individual patient or hospital, issues contributing to a patient safety concern.

[1] Members reported that Metro South HHS has failed to establish a 'single queue' for patient access to definitive/procedural and specialist care. Instead, bed managers at the Princess Alexandra and QEII hospitals facilitate admission and surgery for patients presenting at their EDs causing Redland patients needing transfers to be delayed for the very same care, despite the Redlands patients presenting to its ED earlier (sometimes by days) than those presenting at the other facilities. These issues are compounded by clinicians in other Metro South hospitals being unaware of the lack of relevant services at Redlands, in particular a High Dependence Unit. This means frequent deterioration of patients on wards which lack the necessary staffing and other elements normally present in an HDU to care for these seriously unwell patients.

Clarity

Members advised they found the materials provided by CEQ did not communicate the proposed escalation pathway clearly and succinctly. The documents were regarded as verbose and requiring significant concentration to understand. Practitioners felt this would be a barrier to staff using the proposed pathway.

Members also asked that 'Figure 1 – Patient Safety Staff Escalation Pathway' include the process beyond Step 3. For example, 'Step 3' on pages 2-3 of the proposed approach includes referral to the Chief Operating Officer, Department of Health and the Health Ombudsman but this is not indicated in Figure 1. It is also unclear what that referral process would entail. Doctors additionally requested the resolution timeframes for each stage and option be clearly articulated and mandated.

AMA Queensland submits these details be provided and Queensland Health undertake an associated comprehensive consultation process with staff and peak bodies.