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12 September 2024

Adjunct Professor Jackie Hanson
Chief Executive
Metro North Hospital and Health Service

By email: [redacted]

Subject: Caboolture Hospital ED SMO Concerns

Dear Adjunct Professor Hanson

Senior medical officers (SMOs) at Caboolture emergency department (ED) have written to AMA Queensland raising serious concerns about ongoing executive interference in clinical decision making at the hospital. Extracts from the SMO correspondence are set out in the enclosure.

There are 11 core issues of particular concern to the ED SMOs with requested actions for Caboolture Hospital executives to implement as a priority. These are summarised in the below table (please refer to the enclosure for more detail).

Issue	Requested Action
1. Interference in clinical prioritisation to 'game' ambulance ramping KPIs	• No interference by executives or other non-clinical staff • Senior clinicians to determine based on clinical need
2. Interference in individual patient triage, diagnosis and level of care	• As above
3. Interference with patient location	• As above
4. Interference with staff location	• As above
5. Interference in access to ward beds	• As above
6. Interference in staffing arrangements	• As above
7. Diversion of ED staff to satellite hospitals	• Satellite hospitals responsible for own recruitment and rostering shortfalls
8. Lack of crisis support	• Surge response escalation pathway • Business continuity plan • Emergency plans able to be triggered 24 hours, 7 days a week
9. Obstruction of recruitment processes	• No obstruction by executives • Provision of timely, predictable recruitment support services
10. Lack of collaboration and codesign in changing and implementing models	• Collaboration and codesign with senior clinicians
11. Complaints mismanagement	• Senior clinicians to manage clinical complaints • Management to manage system complaints • Implementation of a mature complaints management process

We note we raised several of these issues, particularly 1-6, on behalf of our members with the Director-General in July and during subsequent meetings, including with yourself. Despite this, doctors report there has been no genuine action by the Hospital's executives to resolve their concerns.

We are also concerned that these actions demonstrate Metro North Hospital and Health Service and its Board may not be fulfilling their legislative obligations to provide a psychologically safe workplace. The prioritisation of patients on factors other than clinical need could also breach requisite obligations under the *Hospital and Health Boards Act 2011* (Qld) and the National Health Reform Agreement and we ask you to respond on those specific concerns.

We acknowledge that you recently offered to convene a meeting between the Hospital's senior executives and SMOs and AMA Queensland. We thank you for that offer and ask that this meeting be arranged as a priority given the ongoing and still unresolved issues. We have availability during early October and Executive Assistant [redacted] can assist to identify a mutually suitable time (please email [redacted]).

We look forward to hearing from you.

Yours sincerely

[redacted]

Dr Nick Yim
President
AMA Queensland

Dr Brett Dale
Chief Executive Officer
AMA Queensland

Copied to:
The Hon Shannon Fentiman MP, Minister for Health, Mental Health and Ambulance Services, Minister for Women, [redacted]
Mr Michael Walsh, Director-General, Queensland Health, [redacted]
Ms Karlene Willcocks, Executive Director, Caboolture, Kilcoy and Woodford Clinical Directorate, Metro North Hospital and Health Service, [redacted]
Mr Bernard Curran, Board Chair, Metro North Hospital and Health Service, [redacted]

ENCLOSURE: ED SMO Concerns with Caboolture Kilcoy Woodford Senior Management

Lack of crisis support

At times the ED cannot provide a safe level of care. There have been numerous requests over years for a surge response escalation pathway. The lack of a planned response contributes to adverse outcomes, delayed diagnoses, unnecessary patient suffering and an unsafe work environment for staff. While the timing of extreme surges are unknown, their frequent [sic] *of occurrence is entirely predictable.*

Requested action

- *Staff require a business continuity plan, for when a surge in patient arrivals outstrips the ability of the ED to provide an acceptable level of care. This requires a hospital wide +/- health service response.*

Occasionally there are perfect storms of high inflow of critically unwell patients + low staffing + low skill mix + hospital overload; during these times there have been requests for a code yellow response. According to MNHS, code yellow is 'an internal event that significantly affects service delivery or the safety of staff, patients or visitors'. The response to requests has been 'no, there is no tolerance for this to occur', without any risk assessment, or meaningful alternative actions and no post-event review.

Requested action

- *Senior clinicians need an achievable crisis response. Emergency plans which cannot be enacted, are of no use. They need to be able to be triggered 24/7.*

Interference with patient locations

Staff are being directed to move individual patients to suboptimal care locations. Eg. You must move them to the waiting room, or out of the mental health area. This is not based on patient need or clinician advice, but in order to help senior managers achieve KPIs related to certain locations.

Requested action

- *Senior clinicians need to be able to manage patient location, based on clinical need, without interference.*

Interference with staff locations

Staff are being moved away from certain areas, not based on the needs of patient groups, but in order to enhance senior managers' KPI performance.

Requested action

- *Senior clinicians need to be able to manage staff, to meet the greatest healthcare needs, within the whole ED, without interference.*

Access to ward care

Staff are being directed to prioritise access to ward beds, for patients who will enhance senior manager's KPIs. While simultaneously blocking access to ward care, for those who will not help them achieve their KPIs. This is both using public resources for personal gain and creating inequitable access for patients to ward care. Patients awaiting ward care, from the short stay unit are not getting fair access to ward level care.

Requested action

- *Access to ward beds needs to be based on clinical need, with fairness and equity.*

Prescriptive staffing, removing flexibility

Directive to staff Paediatric area in a specific way, with no codesign or appetite to negotiate. This has been done at the cost of providing care to other patients and is not related to clinical need. It has removed the ability of senior clinical staff to manage their staffing resources, to meet needs for emergency care. It reduces in-shift flexibility to respond to the changing needs in ED and removes options to flex space up and down based on patient need.

Requested action

- *Senior clinicians need to be able to manage their staff and space, in a dynamic manner, based on the clinical need of patients.*

Disabling recruitment efforts

Interference and delaying ED's ability to recruit doctors. Repeated requests for authorisation, (for routine recruitment methods) are being delayed until numerous recruitment windows have passed, despite escalating requests and warnings. Eg. Not authorising advertisements, so vacancies are not being advertised. Eg. Not signing locum extension contracts, so the locums leave, despite wanting to stay. Eg. Reneging on verbal agreements to provide 'attraction incentives' for junior doctors. Eg. Stopping recruitment advertisements which mention incentives (how will prospective doctors know or be attracted?) Eg. Requiring lengthy slow recruitment processes, which no other MNHS ED is directed to do. These disablers and blockers are making it unnecessarily hard to recruit doctors to ED.

Requested action

- *Senior clinicians need to be able to recruit and retain doctors, enabled by predictable support services and quick processes.*
- *Disabling and unnecessary steps, need to be removed promptly.*

Diverting ED staff to work elsewhere

Staff are being directed to work in other parts of the health service, when ED is in a staffing crisis.

A significant part of the current staffing crisis is related to staff taking positions at the two new satellite hospitals, at the same time as the moving into a new Caboolture Hospital Clinical Service Building (with increased staffing

requirements). This has removed large numbers of staff from the ED pool. Senior management was warned of this risk beforehand. It is an avoidable senior management created problem, which has left ED short staffed and with low skill mix.

In addition to this, some remaining ED staff are being directed away from ED at short notice, to cover roster shortages at the satellite hospitals. Eg. ED Physios. This is not related to patient need, not related to value for the community, but to optimise senior manager KPIs and manage fears of adverse political comment. This leaves ED with low a base of low staffing numbers and skill mix, which is then further depleted to unsafe levels, creating harm to the community. Elderly patients wait for extremely long times to be seen in ED (with associated adverse outcomes), in order to help senior managers minimise adverse political problems related to the satellite hospitals.

<u>Requested action</u>

- *The satellite hospitals need to be responsible for their own recruitment.*
- *Where there are staff shortages creating unacceptable health outcomes, staff placement needs to be prioritised to the areas where health outcomes will be improved the most.*
- *If CKW cannot safely staff both the ED and satellite hospitals, then a directorate or MNHS response is required.*

Interfering in clinical prioritisation

Directing that individual patients skip the queue to get beds, in order to game ambulance offload KPIs. Disadvantaging patients who are a lot sicker and have higher needs for a bed. This creates perverse incentives, where frequent ED attenders learn to call an ambulance, instead of arriving by their own transport, further lengthening offload times.

Directing that individual patients be moved from the ambulance waiting area, straight to the short stay unit in order to game ambulance offload times. This places patients without an ED assessment in a low acuity area, with inappropriate staff and inappropriate equipment.

Directing that patients who are nearing 24 hours in ED, are moved to the short stay unit, where their 'clock is stopped', to game their 'time in ED' KPI. The move is not for clinical need, it is to game their 'time in ED' KPI. The patients then stay for up to 6 days in ED, unable to access the specialised care they require on the wards.

<u>Requested action</u>

- *Senior clinicians need to lead the provision of healthcare for individuals.*
- *KPIs need to be seen as an output measure of the care provided, not a gaming tool where hospital function is falsely represented, to accountable authorities.*

[sections redacted]

Lack of collaboration and codesign

Senior managers are imposing changes on frontline clinicians, which are being formed without understanding of how good emergency care can be provided. There are increasing examples where a lack of collaboration and codesign is causing slowed patient flow and barriers to good care.

Eg. Requiring IHT forms be filled for transfers to Caboolture Private Hospital; no other facility does this, it slows patient flow, in order to make the workload of non-clinical roles easier to control (tail wagging the head). There was no collaboration, consulting or codesign with people affected by the change.

Eg. ED models of care being formed by people who do not work in ED and do not understand how good emergency care can be provided.

Eg. The majority of issues listed in this document have occurred without collaboration, consultation or codesign, by senior managers who do not have a deep understanding of good emergency care or the impacts on patients or the implications for staff.

Requested action

- *Senior clinicians need to be involved in the codesign of processes impacting patient care or the staff they supervise.*
- *Codesign needs to involve all the impacted professional disciplines, including doctors. It needs to involve staff who understand the clinical area in detail.*

Complaints system mismanagement

There is an increasing number of complaints from patients and relatives. The majority relate to long wait times. While these events occur in the Emergency Department, the cause and solutions lie outside of ED. There have been requests for a mature complaints management process, where complaints are prioritised and the responsibility for managing the response lies with the role which can resolve the complaint topic. The response has been 'we have no appetite for this', without an alternative being provided. This results in ED staff having daily tense conversations with family members, apologising, yet unable to resolve or prevent occurrence of the same events occurring again in the future. It is an exercise in futility, which consumes large amounts of time and erodes morale and is not aligned with a good quality system. It stops healthy feedback loops and contributes to even longer patient waiting times.

Requested action

- *Senior clinicians need to be able to manage clinical complaints, as part of providing good patient care (with accountability as part of usual line management).*
- *Managers need to be responsible for managing complaints relating to system problems, within their area of responsibility.*
- *A mature CKW complaints management process needs to be formed, with the focus on improving (past and future) patient care.*

The above issues have been raised on numerous occasions with CKW senior managers, with failure to address or progress.