Queensland Health
Health Service Investigation Report

9 September 2024

1 Executive Summary

1.1 Introduction

1 On or about 13 May 2020, former Director-General of Queensland Health (**QH**), Dr John Wakefield, commissioned this investigation pursuant to Part 9 of the *Hospitals and Health Boards Act 2011* (Qld) (**HHBA**) to investigate and report on matters relating to the management, administration and delivery of public sector health services:

(a) at Redland Hospital[1] arising from concerns raised about the standard of endoscopies undertaken by Surgeon 1 and Surgeon 2, and the clinical management of bowel related procedures undertaken by Surgeon 1, regarding the outcomes for patient cohorts treated during the approximate period of 2008 to 2018; and

(b) relevant to clinical governance, identification of issues, escalation of issues, operational management of issues, accountability for issues, quality assurance and other practices identified locally, which could be implemented state-wide to the extent they apply to the public sector health system more generally, to ensure appropriate surveillance of the quality of clinical practice of individual practitioners, against established guidelines and key performance indicators;

(**Investigation**).

2 Redland Hospital serves Redland City[2] which is an area with a rising population. Redland Hospital is part of the Metro South Hospital and Health Service (**MSHHS**)[3] which was established in 2012 under the HHBA. Any actions or failure to act prior to 2012, cannot be attributed to the entity that is MSHHS. In addition to Redland Hospital, the MSHHS hospital network includes Logan Hospital, Princess Alexandra Hospital (**PAH**) and Queen Elizabeth II Jubilee Hospital (**QEII**).

3 As part of this Investigation, the Health Service Investigators (**Investigators**) were informed by the report of a Clinical Review, delivered to them on 26 February 2024.

4 The Investigators also sought information from organisations and individuals. Given the period of time under Investigation, thousands of documents were disclosed to the Investigators. Where they could be identified and located, individuals were also interviewed about the matters under Investigation.

5 Organisations and individuals were afforded an opportunity to respond to concerns expressed by the Investigators, and these responses were

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1 Prior to 2012, Redland Hospital was a part of the Bayside District Health Service. With the introduction of the HHBA, in 2012, Redland Hospital became part of MSHHS.
2 Known as “the Redlands” or formerly, the Redland Shire.
3 The Investigators acknowledge MSHHS now refers to itself as Metro South Health. For the purposes of this report, Metro South Health is MSHHS.

considered by the Investigators when coming to their findings and recommendations set out herein.

6 Through the efforts of the Clinical Reviewers, the Investigators acknowledge that the care of some patients at Redland Hospital fell below an accepted standard. However, overall, the Investigators were of the view that the staff at the hospital had worked hard to provide safe and patient centred care to a rapidly growing local population, and a busy Emergency Department.

7 In the period since this Investigation, most of the Investigators' concerns expressed in this Health Service Investigation Report (**Report**) have been addressed. The Investigators acknowledge that significant changes have been made from an organisational perspective since the period under review, which they have accounted for when coming to their conclusions and making recommendations. It is well recognised that most clinical incidents are identifiable at the time of an event and, like MSHHS, most health services in Australia have well-documented processes for reporting those incidents. Similarly, in the Investigators' experience, most staff who work in health services are aware of their obligations to report a clinical incident and are generally aware of the local processes for doing so. As this Investigation shows, MSHHS is no exception.

8 There is a particular challenge to the incident reporting culture when important pathology is found at a second endoscopic procedure, that could or should have been reported at the first examination. Recognising the importance of such a finding can usually only sit with the endoscopist. In the right culture, a specialist endoscopy nurse might raise the question. The Investigators consider this is less likely in the case of a rotating general operating theatre nurse, who might not believe they have specialised experience in the area, to do so.

9 The practical reality is that the occurrence of clinical incidents continues to be underreported in Australia and internationally. Much research has been done and will continue to be done to identify and rectify barriers to timely clinical incident reporting. The Investigators have, throughout the course of this Investigation, attempted to uncover the barriers which might have impacted the ability of MSHHS and its staff to report clinical incidents which occurred between approximately 2010 and 2018.

10 Unsurprisingly given the passage of time, memories have faded, and timelines have become irreconcilably blurred rendering those attempts largely unsuccessful.

11 What the Investigation reveals is an obvious consequence of underreporting of clinical incidents, ie that opportunity for earlier assessment, thorough review, intervention (remedial or otherwise) and remedy is delayed or lost, at a cost to patients, staff and the organisation. The Investigators do not make this observation as a criticism of MSHHS or any individual, but rather as a general observation which was only capable of identification by them when the pieces of the puzzle were known and assembled.

12 Clear and consistent communication with all interested persons, decision-making and documentation of those matters might have enhanced MSHHS' management of the matters the subject of the Investigation, and supported an ability to intervene earlier and in more meaningful ways.

13 The Clinical Review revealed nine patients where interval cancers had already been detected and managed by the time of the 2015 recall of Surgeon 2's endoscopy patients. The Investigators concluded this recall was conducted on a select group of patients for the purposes of ascertaining whether any cancers had been missed. Only 1 cancer was detected in this cohort which the Investigators agreed was not, of itself, concerning. The Investigators found that results of the recall reassured relevant MSHHS Executives. The recall results were, however, only 1 piece of the puzzle and not the whole picture. MSHHS has advised the Investigators that the organisation would change how a recall would be conducted, should it happen today. These changes were evidenced in the 2019 recall. MSHHS indicated that there would be reporting of relevant information to QH, in addition to the MSHHS Board (**Board**). The Investigators support such changes and improvements.

14 The individuals who participated in the Investigation generally impressed the Investigators as insightful and had reflected on their own practices and areas for improvement. Information provided to the Investigators demonstrated that individual and organisational practices had been enhanced by learnings from this experience, which the Investigators believe will be built on in the future.

15 The Investigators would like to extend their thanks to all who engaged with the process.

1.2 Summary of Findings[4]

16 Based on a review of the documents and information provided by QH, MSHHS, individuals, relevant national and international standards and guidelines and interviews conducted with relevant QH and MSHHS officers and consumers, the Investigators find the following:

Endoscopic Services

(a) The Investigators acknowledge the vital role of general surgeon endoscopists, performing procedures in regional areas. To enhance quality and safety, there is a need for linkage of these practitioners to larger centres to:

  (i) avoid isolation;

  (ii) support them in remaining up to date with developments in the area; and

  (iii) provide them with meaningful access to more complex procedures and specialist endoscopists to enhance learning opportunities.

[4] This section represents a summary of findings of the Investigation. Please refer to each section, under the heading '*Conclusions and Commentary*', for the full findings of this Investigation.

(b) In these circumstances and whilst the Investigators accept that there were valid operational reasons for postponing consideration of an Endoscopy Stream in MSHHS in around 9 September 2014, it would have been beneficial for an Endoscopy Stream (or Network) to have been considered later.

(c) As technology and the ability to collect data improves, more rigorous programs of key performance indicator (**KPI**) collection, tighter local clinical leadership, mandatory re-education and recertification directed specifically to endoscopists is also likely to supplement the stream (or network) now in place.

(d) Collaboration between the services operating within MSHHS is required, irrespective of whether this is done by way of an Endoscopy Network or the broader Gastrointestinal Endoscopic Quality Framework of 2022 (**GEQF**), to:

  (i) ensure the endoscopists in the smaller centres are acquainted with the recent advances and level of standards;

  (ii) provide consistency in the care provided across the HHS; and

  (iii) establish relationships (enabling collaborative, multi-disciplinary and informed care).

Surgical Services

(e) Whilst the reasons for the decision to extend the scope of service to perform right-sided hemicolectomies at Redland Hospital were admirable and understandable, it was wise to exercise real caution before doing so.

(f) Absence of an Intensive Care Unit (**ICU**) and ability to perform surgery after hours (other than in exceptional circumstances) at the hospital meant that if adverse events occurred, it was likely patients would need to be transferred.

(g) At the relevant time, the transfer system was not streamlined enough to enable the rapid transfer for patients should they deteriorate.

(h) The Clinical Reviewers identified a lack of formal documented handovers or care plans for escalation to a consultant, meaning that junior staff did not always have had the level of direction and experience required to manage these deteriorating cases.

(i) Several circumstances argued against the decision to perform right-sided hemicolectomies at Redland Hospital, including the Investigators' observations regarding:

  (i) the relative experience and capabilities of junior staff;

  (ii) lack of documentation of handovers/plans should patients deteriorate;

  (iii) lack of an ICU; and

  (iv) limited availability for after hour surgery.

(j) In combination and with the benefit of hindsight, the institutional decision in 2012 to allow elective laparoscopic right hemi-colectomies to be performed, even in low-risk patients, was not optimal.

(k) There was also evidence of creep of scope, meaning some patients operated upon fell outside the agreed criteria for performance of colonic resection at Redland Hospital. Once these cases were identified, an earlier decision should have been made to more critically review the performance of colectomies at Redland Hospital, and it would have been preferrable for the prior approval decision to have been paused until such a review could be undertaken.

(l) Since 2019, planned surgery at Redland Hospital has been limited to patients who were expected to be discharged on the same day or on the following morning. With the benefit of hindsight, this should have been the model of surgical care in operation at Redland Hospital for the whole period under Investigation.

Consumer Partnering and Engagement

(m) There was considerable improvement in MSHHS' consumer engagement practices over the period under Investigation, and particularly subsequently. MSHHS should be commended for this.

(n) During the period under Investigation, post-procedure patient surveys were commonly used as a follow-up process to ensure issues arising from the delivery of care were addressed. However, these are not a substitute for true consumer engagement.

(o) There was an early opportunity to engage with consumers by appointing relevant consumers to an audit committee in relation to endoscopy KPIs in 2014. This could have provided another lens on the operation of this area and earlier consideration of processes/procedures to support true consumer engagement.

(p) True consumer engagement of this kind occurred with the establishment of new endoscopy guidelines for nurses. These guidelines were patient focused, patient-centred and consistent with the principles outlined in Standard 2 of the National Safety and Quality Health Service Standards. (**NSQHSS**).

(q) Whilst there was little documentary evidence provided to the Investigators regarding patient engagement at MSHHS, the Investigators noted a change in consumer engagement since 2018 and welcomed the efforts MSHHS and Redland Hospital had undertaken in this area.

Credentialing and Scope of Clinical Practice

(r) Evidence about what occurred at meetings regarding the credentialing of Surgeon 1 in 2010, were hampered by the passage of time and lack of documentation. Given this the Investigators considered information provided at interviews about what the 'usual practice' of the CC would have been.

(s) The Credentialing and Scope of Clinical Practice Committee (**CC**) were reassured that Surgeon 1 had been appropriately recruited with reference checks, and had been practicing as a surgeon at Redland Hospital on interim credentialling, with no issues. In that context and whilst those interviewed remain adamant that it would have occurred, the CC appears not have formally contacted Surgeon 1's past employer (a hospital) to investigate the practitioner's suspension from that organisation (for matters which Surgeon 1 says were investigated and that the practitioner was exonerated). Despite this, it is accepted that there was some discussion of the fact of that suspension during the CC meeting.

(t) Further and even if the CC had contacted Surgeon 1's past employer, noting that Surgeon 1 had been 'exonerated', it may have made no difference to Surgeon 1's credentialing and scope of practice.

(u) The same observations apply to Surgeon 1's re-credentialling in 2013 save that in accordance with policy at the time, CC discussions should have been documented in the Committee minutes. They were not.

(v) That there was no provision for recording significant discussion regarding applications which required them in the template minutes for the CC may have contributed to this. The design of the minutes format needed to be addressed to allow for more extensive documentation of these discussions, should they occur.

Performance Management

(w) Performance management processes such as Performance Appraisal and Development (**PAD**) and Senior Medical Officer Performance Reviews (**SMPR**) were not capturing significant performance concerns regarding Surgeons 1 and 2.

(x) The Investigators did not receive sufficient documentation or information to critically examine the performance management processes that would have applied to Surgeon 2.

(y) After concerns were raised about Surgeon 1's performance in 2015, there was no reference to them made in the practitioner's PAD. Endoscopy clinical indicators, available from 2015, did not feature in the PAD either.

(z) The SMPR was a broader-based tool than the PAD processes and should theoretically have provided a better way to capture and assess a Surgeon 1's performance, but it also did not capture significant clinical performance matters.

(aa) The apparent absence of any discussion regarding clinical performance matters in the PAD or SMPR processes around that time appeared to have instilled an unhelpful sense of reassurance about the overall significance of KPIs and clinical performance of Surgeon 1, both on an individual and organisational level.

(bb) As to Surgeon 1's performance, there was then limited information as to what was occurring between 2015 and 2016, other than monitoring of their KPIs. It was impossible to ascertain if there was any action was being taken between 2017 and 2018, except the collection of data pertaining to those KPIs.

(cc) The evidence suggests Surgeon 1 was not spoken to about performance concerns between 2015 and 2018, although their performance was being monitored, at least by way of KPIs. Surgeon 1 should have been made formally aware of performance concerns, in at least 2017.

Risk and Incident Management

(dd) The Investigators expressed concern that RiskMan reports on clinical incidents and near misses were not reported upon in some matters where reports should have been made. Had RiskMan reports been lodged for certain cases identified in 2015 and/or October or December 2016, this would have provided an additional alert to the care being provided by Surgeon 1, potentially leading to further action, or at least a conversation with the practitioner about the care being provided to patients.

(ee) The challenge for all endoscopy and surgical facilities is to ensure that local culture encouraged all staff to question whether:

(i) procedures were of the expected standard and thoroughness;

(ii) anything was missed; and

(iii) adverse outcomes from procedures could have been prevented.

(ff) The adequate protection of patient safety and quality required all functions of clinical governance to be conducted in a timely manner. From an organisational perspective, failure to identify and report clinical incidents and risks as they occur means that the opportunities to take timely corrective action are lost.

(gg) When a serious adverse event occurs and a patient suffered significant harm, it was incumbent to undertake a timely and efficient investigation so that the causes of the adverse event are identified, and corrective action and open disclosure initiated.

(hh) QH has made strong and clear recommendations in relation to risk and incident management, and there had already been improvements to MSHHS' own policies and procedures in this area.

(ii) The Investigators acknowledged and commended the steps made, and advances taken by MSHHS already, which had largely addressed the matters identified in this Investigation regarding risk and incident management.

Clinical Governance

(jj) It is important that critical information, like the fact of the 2015 recall of Surgeon 2's patients, is formally provided to the Australian Council on Healthcare Standards (**ACHS**) during their accreditation assessment, to support the ongoing integrity of the accreditation process. The nature and extent of what the ACHS was told about the 2015 recall during Redland Hospital's accreditation in 2015, is unclear. Redland Hospital did, however, pass accreditation. Similarly, and although there is evidence that the Board were aware of the fact of the recall, the nature and extent to which it was told about the recall in 2015 was also unclear. In relation to the recall of Surgeon 1's patients between 2018 and 2019, it was likewise unclear what the Board was told prior to 17 January 2020, after media coverage of the recall.

(kk) Whilst the 2015 recall had not been escalated to QH, the Investigators accepted that at the time, it was not usual practice to do so. If a recall such as this occurred today, policy changes meant that QH would be notified, which is appropriate.

(ll) At a high level, the Investigators were of the view MSHHS had developed an integrated and sophisticated safety and quality system with many appropriate metrics being collected and actions taken to improve the safety and quality of patient care during the relevant period.

(mm) Likewise, the Clinical Governance Operations Plans and Framework were excellent documents and covered the content regarding clinical governance well.

(nn) However, whilst these reports were detailed and comprehensive, clinical performance was not described in detail within these documents beyond references to credentialing and SoCP.

(oo) Where there are concerns regarding a practitioner's clinical practice, there needs to be a balance between confidentiality for the practitioner and providing the appropriate level of information to the Board and its subcommittees, as well as recording decision-making. In the Investigators' opinion, the balance struck was not always optimal.

1.3 Summary of Recommendations[5]

17 The Investigators acknowledged that during and since the period under Investigation, QH and MSHHS have taken many steps and instituted numerous system and safety improvements relevant to the circumstances leading to this Investigation, which will improve patient safety and service delivery both at the Hospital and Health Service (**HHS**) level, and throughout the state. These include:

[5] This section represents a summary of recommendations of the Investigation. Please refer to section '*The Way Forward – Consolidated Recommendations*', for the full recommendations of this Investigation.

For **QH**:

(a) introducing the GEQF to monitor endoscopy standards;

(b) improvement in the system for monitoring histology results;

(c) improved patient consent processes; and

(d) approval of an expansion at Redland Hospital to include six ICU and six High Dependency Unit (**HDU**) beds.

For **MSHHS**:

(e) establishing KPIs for endoscopy;

(f) improving bowel preparation protocols and purchasing high-definition endoscopy scopes;

(g) engagement of a specialist endoscopy nurse, and gastroenterologist as Clinical Lead, at Redland Hospital;

(h) development of a patient/procedure information sheet to accompany consent documentation;

(i) membership of the MSHHS Board to include a consumer advocate;

(j) improvements in the consent process at Redland Hospital as a result of NSQHSS audits;

(k) engagement with patients in endoscopy, with comprehensive guidelines for bowel preparation;

(l) released a Patient Safety and Quality Strategy 2024 to 2027 which was designed to ensure that care remained of high quality across MSHHS;

(m) creation of a Patient Safety Officer role;

(n) establishment of an Incident Management Forum;

(o) institution of the MSHHS Patient Safety and Quality Improvement community of practice;

(p) implementing processes as against the 16 Hospital Acquired Complications (**HAC**), developed by the Australian Council for Safety and Quality in Healthcare;

(q) requiring HACs to be reported to the Board Safety and Quality Committee, on a quarterly basis;

(r) reporting of SAC1 cases which are clinical incidents that have, or could have caused, serious harm or death that are attributable to health care provision (or lack thereof), to the Board on a monthly basis; and

(s) adopting the principles of High Reliability Organisations (**HRO**) to provide a framework for improvement in a challenging environment with constant change and variability.

18 Whilst there have been a number of excellent improvements during and since the events giving rise to the Clinical Review and Investigation, the Investigators

have made a number of recommendations which they believe could improve service delivery and patient safety even further, such as:

Endoscopic Services

(a) Redland Hospital continue with a quality endoscopy service led by a specialist gastroenterologist, supported by advanced practice nurses specialising in endoscopy.

(b) Redland Hospital continue to monitor performance, supporting improvement for underperforming endoscopists by offering training, upskilling, access to mentoring and workshops.

(c) Continue to foster a culture of teamwork and inclusiveness through regular department meetings where outcomes and improvements can be discussed openly, to promote a safe environment.

(d) Continue regular monitoring, management and replacement of endoscopy equipment.

(e) For any future recalls or audits, consider patient selection to ensure all relevant information and adverse patient outcomes (including those arising outside of the active recall for patients) are captured.

(f) Guard against over reliance on KPIs as an exclusive measure of the quality of endoscopies, to the exclusion of other factors.

(g) Consider the United Kingdom (**UK**) National Health Service (**NHS**) reforms such as the formation of Endoscopy Networks or an Endoscopy Training Academy, and to ascertain whether any are workable in the Queensland context.

(h) Consideration be given to the Royal Perth Hospital model, including forming an Endoscopy User Group.

Surgical Services

(i) Redland Hospital should continue to limit planned surgery to procedures that require day only/extended day only care, unless and until it acquires:

    (i) an ICU;

    (ii) the resources needed to be able to open an operating theatre out of hours to allow surgery to be performed:

        (A) on patients admitted via the Emergency Department with urgent surgical conditions that are otherwise within the agreed scope of practice of surgeons at Redland Hospital; and

        (B) on patients who develop complications following procedures at Redland Hospital that need operative correction (acknowledging that these patients may well also need ICU capabilities).

(j) Once these capabilities are achieved, increase in the level of complexity for planned operative procedures (including colonic resection) should occur:

(i) consistent with the Clinical Services Capability Framework (**CSCF**);

(ii) undertaken with sufficient volume to ensure currency of practice; and

(iii) after wide consultation with anaesthetic staff and senior nursing staff of the operating theatre and the surgical ward, as well as with the surgeons involved.

Any such increase in complexity level should be closely audited.

(k) If this has not already occurred, local guidelines concerning the delegation of informed consent should be brought into alignment with QH guidelines, with planned reviews to ensure proper implementation.

(l) Clinical leadership at Redland Hospital should ensure that all incoming rotating medical officers are fully cognisant of the requirements of a valid consent process, including orientation/training sessions directed at this group as required (if this is not already occurring).

(m) Responsibilities of senior surgeons for patient care, communication with patients and staff, handover, audit, teaching and supervision should be spelled out explicitly in employment contracts and/or policy documents and handovers should be documented with clear instructions about any special circumstances or parameters of escalation to the consultant on call.

(n) For surgeons performing low volumes of procedures, or limited surgery in centres such as Redland Hospital, encouragement and opportunities should be given for dual appointments in larger hospitals within the HHS, to allow them to expand their experience and maintain their skillset.

(o) If an audit is proposed, there should be clear documentation as to who is responsible for following up the progress of the audit and its results, so that there is ownership of the process and the audit progresses in a timely way.

Consumer Partnering and Engagement

(p) Should the following not already exist within MSHHS, the Investigators recommend:

(i) MSHHS consider formulating KPIs to ensure consumer partnering and engagement is mandatory, including audit of compliance. The Investigators suggest introducing Patient Related Outcome Measures (**PROM**), in relation to a patient's improvement post-treatment and their experience in receiving the treatment of itself.

(ii) Each MSHHS hospital should regularly report to the Board regarding consumer partnering and engagement, by way of the Consumer Advisory Committee (**CAC**).

(iii) MSHHS consider engaging a 'pool' of recognised consumers who are appointed to appropriate committees within the HHS to ensure the voice of the consumer is heard.

(iv) More specific information and detail should be provided in the MSHHS Board's annual report about the actions taken within the organisation to ensure and monitor consumer partnering and engagement across the HHS.

(v) Although MSHHS says there is no broad consensus on the idea, MSHHS should consider the feasibility of appointing consumers to the Safety and Quality Committee, and the CC.

Credentialing and Scope of Clinical Practice

(q) To improve documentation of decision-making:

(i) CCs across Queensland should consider all relevant material regarding a medical practitioner seeking re-credentialing, including but not limited to significant incidents, serious complaints, and relevant KPIs and audits.

(ii) QH should ensure that the minutes of the CC contain not only the outcomes of deliberations, but also relevant discussions surrounding the decision-making. Meeting minutes should be re-designed to facilitate ease of documentation of the CC's decision-making.

(iii) QH CC members should be provided with the supporting business documentation in sufficient time for the members to be able to review and consider the information before the meeting.

Performance Management

(r) The Investigators recommend that:

(i) a performance appraisal process should incorporate critical analysis of the whole of a clinician's practice, particularly when there are significant concerns being addressed. The process should involve:

(A) clear communication of those matters with the clinician;

(B) clear communication of the expected development steps along with expected timeframes for completion and notification of ongoing monitoring of performance; and

(C) documentation of that communication.

(ii) QH should review current policies and practice in line with what is considered best practice for performance monitoring of senior medical officers (**SMO**) in other jurisdictions;

(iii) mandatory standards of practice should be introduced to ensure that performance reviews (whether PAD or SMPR) provide relevant information about the whole of a clinician's practice, including significant adverse events, any practice concerns, complaints and any remedial action documented;

(iv) the PAD form should be re-designed to allow for clinical concerns to be documented; and

(v) QH should consider deploying graded approaches to performance management and professionalism across Queensland, such as coffee chats and more informal approaches, including appropriate training for those involved in these approaches.

Risk and Incident Management

(s) The Investigators were of the opinion the current policy environment was adequate to guide HHS' to undertake appropriate identification, reporting and management of incidents, and the management of risks to patient safety.

(t) However, to refresh staff on their obligations to identify and report on risk and incidents arising within their practice, MSHHS ought to provide updated education on the principles of risk management, particularly risk and incident identification so that they are appropriately identified, reported in a timely fashion, and to foster the collaboration and partnership between the institution and the staff themselves.

Clinical Governance

(u) The Investigators recommend that:

(i) the Board introduce a policy mandating the confidential reporting of significant clinical practice concerns to its Safety and Quality Committee and the CC, with a view to improving the assessment of practitioner's clinical capabilities;

(ii) QH mandate, or reinforce any existing mandate, to ensure that relevant authorities (Boards, Office of the Health Ombudsman (**OHO**), Australian Health Practitioner Regulation Agency (**AHPRA**) and itself (in certain circumstances)) are informed of any significant recall of patients or other significant action resulting from concerns regarding a practitioner's clinical care of patients;

(iii) MSHHS implement a program of work to engage and empower senior clinicians in clinical governance processes, as partners with management; and

(iv) MSHHS continue to adopt the HRO framework to improve patient safety and service delivery in Redland Hospital.

13 The Way Forward – Consolidated Recommendations

777 A consolidated list of the Investigator's recommendations follows.

13.2 Endoscopic Services

778 Redland Hospital continue to service the region with a quality Endoscopy Service led by a specialist gastroenterologist, and supported by advanced practice nurses also specialising in endoscopy.

779 Redland Hospital continue to monitor performance and foster a culture of reporting incidents to support data collection/early identification of underperforming endoscopists and supporting improvement in underperforming endoscopists by offering training, upskilling, access to mentoring and workshops.

780 A culture of teamwork and inclusiveness should be fostered by having regular department meetings for all staff (should they not already be occurring) where outcomes and improvements can be discussed openly, to promote a safe environment to speak up if the clinician believed something was not quite right. This could be in the form of an Endoscopy User Group meeting, periodically scheduled, and minuted.

781 Replacement of old and outdated equipment should be regularly monitored and managed by the hospital Medical Equipment Servicing Unit. This is in acknowledgement of the increased care and maintenance requirements of endoscopy equipment due to their delicate nature which differentiates them from some standard surgical equipment.

782 For any future recalls or audits, consider the patient selection to ensure that all relevant information and adverse patient outcomes (including those arising outside of an active recall for patients having been identified as needing to be offered a recall procedure) are captured.

783 HHS' should guard against over reliance on KPIs as an exclusive measure of quality of endoscopies to the exclusion of other factors.

784 QH consider further review of the UK NHS reforms including the formation of Endoscopy Training Academy and Endoscopy Networks, aimed at connecting regional endoscopy units, to ascertain whether any are workable in the Queensland context.

785 Likewise, consideration be given to the Royal Perth Hospital model, and whether any aspects might be applied in Queensland.

13.3 Surgical Services

786 Redland Hospital should continue to limit planned surgery to procedures that require day only/extended day only care, unless and until it acquires:

(a) an ICU (the Investigators were informed by MSHHS in response to a NPAF that QH has approved expansion of Redland Hospital to include 6 ICU beds and 6 HDU beds);

(b) the resources needed to be able to open an operating theatre out of hours to allow operations to be performed:

(i) on patients admitted via the Emergency Department with urgent surgical conditions that are otherwise within the agreed scope of practice of surgeons at Redland Hospital; and

(ii) on patients who develop complications following procedures at Redland Hospital that need operative correction (acknowledging that these patients may well also need ICU capabilities);

(c) once these capabilities are achieved, increase in the level of complexity of planned operative procedures (including colonic resection) should be:

(i) consistent with the CSCF;

(ii) undertaken with sufficient volume to ensure currency of practice; and

(iii) performed after wide consultation with anaesthetic staff and senior nursing staff of the operating theatre and the surgical ward, as well as with the surgeons involved;

and any such increases should be closely audited.

787 If this has not already occurred, local guidelines concerning the delegation of informed consent should be brought into alignment with QH guidelines, with planned reviews to ensure proper implementation. This implies a greater involvement by the senior surgeon in this process as well as documented instruction of junior medical staff, or confirmation that junior staff have the requisite knowledge to provide fully informed consent on the relevant risks of more complex procedures.

788 Clinical leadership at Redland Hospital should also ensure that all incoming rotating medical officers are fully cognisant of the requirements of a valid consent process, including orientation/training sessions directed at this group as required, if this is not already done. This should include ensuring that junior medical officers are supported if they decline to complete the consent process if they feel uncomfortable about doing so.

789 The responsibilities of senior surgeons for patient care, communication with patients and staff, handover, audit, teaching and supervision should be spelled out explicitly in employment contracts and/or policy documents such as the attached as **Annexure J**, Responsibilities of the Admitting Medical Officer.[417]. Handovers should be documented with clear instructions as to any special circumstances or parameters of escalation to the consultant on call.

790 For surgeons who are performing low volumes of procedures or limited surgery in centres such as Redland Hospital, encouragement and opportunities should be given for dual appointments in larger hospitals within the HHS, to allow them to expand their experience and maintain their skillset. This would likely

[417] The Investigators have received permission to annex this document.

improve surgeon retention and/or attract surgeons in circumstances which otherwise might have been difficult.

791 If an audit is to be undertaken, such as the external audit into right-sided hemicolectomies, there should be clear documentation as to who is responsible for following up the progress of the audit and its results, so that there is ownership of the process and the audit progresses rather than *"falling through the cracks"* as appears to have happened in the circumstances described above. There should additionally be resources allocated to the audit in recognition of the fact that such processes impose additional burden on clinical staff.

13.4 Consumer Partnering and Engagement

792 Should the following not already exist within MSHHS, the Investigators recommend:

(a) that MSHHS consider formulating KPIs to ensure consumer partnering and engagement is mandatory, including audit of compliance. The Investigators suggest introducing PROM in relation to a patient's improvement post-treatment and their experience in receiving the treatment of itself;

(b) each MSHHS hospital should report regularly to the Board regarding consumer partnering and engagement, by way of the CAC;

(c) MSHHS consider engaging a "*pool*" of recognised consumers who are appointed to appropriate committees within the HHS to ensure the voice of the consumer is "*heard/addressed/considered*"; and

(d) in the MSHHS Board's annual report, more specific information and detail be provided as to the actions taken within the organisation to ensure and to monitor consumer partnering and engagement within each of the respective MSHHS hospitals.

793 Although MSHHS says there is no broad consensus on the idea, MSHHS consider the feasibility of appointing consumers to MSHHS' Safety and Quality Committee, and the CC.

13.5 Credentialling and Scope of Clinical Practice

794 MSHHS (and all) CCs should consider all relevant material regarding a medical practitioner seeking re-credentialing as required by QH policy, including but not limited to significant incidents, serious complaints, relevant clinical indicator data and audits.

795 QH should ensure that the minutes of CCs contain not only the outcomes of their deliberations but also relevant discussions surrounding the decision-making. This may require training of CC members to ensure they are aware of their obligations, and auditing of minutes to ensure the decision-making processes are being documented. This will ensure transparency and accountability, that decision-making can be appropriately assessed, and patient safety protected. Meeting minutes should be re-designed to facilitate ease of documentation of the CC's decision-making.

796 The QH CC members should be provided with the supporting business documentation in sufficient time for the members to be able to review and consider the information before the meeting.

13.6 Performance Management

797 The Investigators are of the opinion that:

(a) a performance appraisal process be developed that incorporates critical analysis of the whole of a clinician's practice, particularly when there are significant concerns being addressed. The process should involve:

(i) clear communication of those matters with the clinician;

(ii) clear communication of the expected development steps along with expected timeframes for completion and notification of ongoing monitoring of performance; and

(iii) documentation of this communication;

(b) QH should review current policies and practice in line with what is considered best practice for performance monitoring of SMOs in other jurisdictions, and implement those practices with appropriate training of managers should they represent improvement on the SMPR process;

(c) mandatory standards of practice should be introduced to ensure that performance reviews (whether PAD or SMPR) provide relevant information about the whole of a clinician's practice, including significant adverse events, any practice concerns, complaints and any remedial action documented;

(d) if the PAD form is to be used moving forward, it should be re-designed to allow for clinical concerns to be documented, and identification of training to be provided regarding documentation of these concerns; and

(e) as part of its review, QH should consider the deployment of graded approaches to performance management and professionalism across Queensland, such as coffee chats and more informal approaches, including appropriate training for those involved in these approaches.

13.1 Risk and Incident Management

798 The current policy environment is adequate to guide HHS to undertake appropriate identification, reporting and management of incidents and the management of risks to patient safety.

799 However, in an attempt to refresh staff on their obligations to identify and report on risk and incidents arising within their practice, QH and MSHHS ought to provide continuous education to all staff on the principles of risk management, particularly risk and incident identification so that they are appropriately identified, reported in a timely fashion and managed in the future, and to foster the collaboration and partnership between the institution and the staff themselves (should this not already be occurring).

13.2 Clinical Governance

800 Many organisations internationally are now adopting the principles of HROs to provide a framework for improvement in a challenging environment with constant change and variability. It is posited that HROs need to be constantly vigilant of failures with the following 5 characteristics to be kept in mind:

(a) preoccupation with failure – every failure must be followed up and addressed;

(b) reluctance to simplify – complex problems need complex solutions;

(c) sensitivity to operations – finding minor changes in operations and addressing them before they come serious;

(d) commitment to resilience – an organisation's capability to recognise errors quickly and contain them; and

(e) deference to expertise – the staff at the front lines, not management, are best placed to develop solutions.[418]

801 MSHHS has submitted to the Investigators that they have been implementing the HRO principles to improve clinical governance measures since 2018.[419]

802 The Investigators further recommend that:

(a) the Board introduce a policy that mandates the confidential reporting of significant clinical practice concerns to its Board Safety and Quality Committee and the CC, with a view to improve the assessment of practitioner's clinical capabilities;

(b) QH mandates, or reinforces any existing mandate, to ensure that relevant authorities (Boards, OHO, AHPRA and itself (in certain circumstances)) are informed of any significant recall of patients or other significant action resulting from concerns regarding a practitioner's clinical care of patients;[420]

(c) MSHHS implement a program of work to engage and empower senior clinicians in clinical governance processes, as partners with management; and

(d) MSHHS continue to adopt the HRO framework to improve patient safety and service delivery in Redland Hospital.

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[418] Chassin MR, Loeb JM, '*High Reliability Health Care: Getting There from Here*', (2013) *The Milbank Quarterly* 91(3): 459-490.

[419] Submission from MSHHS - Redland Hospital Health Service Investigation dated 27 September 2022 (IPI.MSHHS.008.00001).

[420] See the discussion regarding the Hot Issues Brief in paragraphs 755 and 757 of this Report.

Glossary

Term	Explanation
ACG	American College of Gastroenterology
ACG Guidelines	ACG Practice Guidelines on the Diagnosis, Surveillance and Therapy of Barrett's Oesophagus
ACHS	Australian Commission on Healthcare Standards
ACSQHC	Australian Commission on Safety and Quality in Healthcare
ADR	Adenoma Detection Rate
AGA	American Gastroenterological Association
AGA Statement	AGA Medical Position Statement on the Management of Barrett's Oesophagus
AHPRA	Australian Health Practitioner Regulation Agency
ALOS	Average Length of Stay
AMC	Australian Medical Council
Barrett's Oesophagus	Changes in the cellular structure of the oesophagus lining
Board	Metro South Hospital and Health Board
CAC	Consumer Advisory Committee
CAPS	Communication and Patient Safety
CC	Credentialing Committee
CCCS	ACSQHC Colonoscopy Clinical Care Standard
CCRTGE	Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy in Australia
CIM CoP	Clinical Incident Management Community of Practice
CLG	Clinical Lead - Gastroenterology
Colonoscope	Flexible tube with a camera on one end
Colonoscopy	Non-surgical procedure performed using a colonoscope to visually examine the lining/inside of the rectum and colon
CoP	Community of Practice
CRH	Central Referral Hub
DMS	Director of Medical Services
DRE	Digital Rectal Examination
DRG	Diagnosis Related Groups
DVT	Deep Vein Thrombosis
Endoscope	Flexible tube with camera on one end used to perform endoscopies
Endoscopies	Gastroscopies and colonoscopies
EQuIP	Evaluation and Quality Improvement standards
ERCP	Endoscopic Retrograde Cholangiopancreatography
ESQ Committee	Executive Safety and Quality Committee - MSHHS
FOB	Faecal Occult Blood
FRACS	Fellowship of the Royal Australasian College of Surgeons
Gastroscopy	Non-surgical procedure performed using an endoscope used to visually examine the lining/inside surface of the digestive tract
GEQF	Gastrointestinal Endoscopic Quality Framework

Term	Explanation
GENCA	Gastroenterological Nurses College of Australia
GESA	Gastroenterological Society of Australia
GESIS	Gastrointestinal Endoscopy Services Policy and Implementation Standard
GP	General Practitioner
HAC	Hospital Acquired Complication
Helicobacter Pylori	Also 'H Pylori', a type of bacterial that infects the stomach
HHBA	*Hospital and Health Boards Act 2011* (Qld)
HHS	Hospital and Health Service
HDU	High Dependency Unit
HOA	*Health Ombudsman Act 2013* (Qld)
HQCC	*Health Quality and Complaints Commission Act 2006* (Qld)
HRO	High Reliability Organisations
ICU	Intensive Care Unit
iFOBT	Positive Immune Faecal Occult Blood Test
Interval Cancer	Cancer diagnosed after a negative screening or surveillance examination in which no cancer is detected and thereafter found before the date of the next recommended endoscopic examination
JAG	Joint Advisory Group on GI Endoscopy in the United Kingdom
KPI	Key Performance Indicator
Lynch Syndrome	Hereditary nonpolyposis colorectal cancer
MBA	Medical Board of Australia
M&M	Morbidity and Mortality
MSHHS	Metro South Hospital and Health Service (Metro South Health)
NHMRC	National Health and Medical Research Council in Australia
NHS	National Health Service in the United Kingdom
NPAF	Notice of Potential Adverse Finding
NSQHS	National Safety and Quality Health Service in Australia
NSQHSS	NSQHS Standards
NUM	Nurse Unit Manager
OHO	Office of the Health Ombudsman (Queensland)
Open Access	Also 'Direct Access'. Means by which a GP can refer a patient directly for an endoscopy
PAD	Performance Appraisal and Development
PAH	Princess Alexandra Hospital
PCCRC	Post Colonoscopy Colorectal Cancer
PHO	Principal House Officer
Prague Protocol	Also 'Prague Classification'. Standard for measuring the length of Barrett's oesophagus
PROM	Patient Related Outcome Measure
PSO	Patient Safety Officer
QEII	Queen Elizabeth II Hospital
QH	Queensland Health
RACP	Royal Australasian College of Physicians

Term	Explanation
RACS	Royal Australasian College of Surgeons
Retroflexing	Making a u-turn with the flexible part of a colonoscope
RMO	Resident Medical Officer
SoCP	Scope of Clinical Practice
Seattle Protocol	Biopsy protocol consisting of 4 quadrant jumbo biopsies with biopsies of mucosal abnormalities
Serrated Polyp	Polyp with a serrated or saw-like appearance
Sessile Serrated Polyp	Type of serrated polyp with flat or slightly elevated shape
SET	General Surgery Surgical Education and Training Programme
SMO	Senior Medical Officer
SMPR	Senior Medical Practitioner Review
SoCP	Credentialing and Scope of Clinical Practice
SPOT	Tattoo used to mark lesions in the upper and lower GI tract
SRMO	Senior Resident Medical Officer
SSRA	Small sessile serrated adenoma
TCT	Train the Colonoscopy Trainer
TSA	Traditional serrated adenoma, otherwise known as a neoplastic polyp of the colon
Withdrawal Time	Time taken to remove a scope from the digestive tract
VLAD	Variable Life Adjusted Display
VMO	Visiting Medical Officer
VTE	Venous thromboembolism