ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

2018 SOUTH AUSTRALIAN ELECTION

Election Issues

March 2018

Introduction

The Royal Australasian College of Surgeons (RACS) was established in 1927 and is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. RACS is a not-for-profit organisation representing more than 7,000 surgeons and 1,300 surgical trainees across nine surgical specialties. Approximately 95 per cent of all surgeons practising in New Zealand and Australia are Fellows of the College (FRACS).

RACS is committed to ensuring the highest standard of safe and comprehensive surgical care for the communities it serves and, as part of this commitment, strives to take informed and principled positions on issues of public health.

Prior to all government elections in Australia and New Zealand, RACS provides an opportunity for political parties to outline their policy positions on key issues relevant to the delivery of surgical services. RACS then distributes these responses to its membership and the public. This document outlines areas of specific concern and relevance to our membership.

KEY ISSUES

RACS has identified seven key focus areas relevant to the 2018 South Australian Election:

- Delivery of Surgical Services across the local health networks
- Clinician engagement
- Teaching, Training and Research
- Surgical Technology
- South Australian Audit of Surgical Mortality
- Alcohol Related Harm
- Recognition of Paid Parental Leave Entitlements and Diversification of Surgical Workforce

Background information on these follows, and RACS would like to have your party's responses to the questions posed.

Delivery of Surgical Services Across the Local Health Networks

Over the past four years the South Australian health system has undergone significant transformation. Despite the Government's 'Transforming Health' policy having concluded with the opening of the new Royal Adelaide Hospital, there is no question that further changes and adjustments are required to embed the appropriate long term structural models.
Since the consolidation of services under Transforming Health, the pressures that have been felt by metropolitan emergency departments have been well documented. These pressures have not only placed significant stress on staff and resources, but have also had flow on effects for other areas, such as outpatient appointments and elective surgery.

It is critical that any further reconfiguration of services is done in a planned manner, and at a pace and rigor that respects the interconnectedness of the hospital networks, but without compromising short term service delivery. Every effort must also be made to educate to members of the community on the extent of planned changes t in their local area. When changes are not fully understood this leads to increased numbers of hospital transfers, creating delays and jeopardising patient safety.

Northern Adelaide Local Health Network (NAHLN)

While there have been some enhancements at the Lyell McEwin Hospital, there is a perception that it currently does not have the adequate resources to be considered the central hospital that NALHN requires. The delivery of services across the network has been further complicated by a lack of clarity regarding the future of Modbury Hospital which has affected morale and led to difficulties in retaining senior clinicians.

RACS accepts that a fully functioning emergency department will not be restored at Modbury. However, we believe establishing a broader surgical case-mix should be explored as an option to alleviate pressure across the network. This would require additional investment to ensure that the hospital is resourced appropriately to support the acuity of care being delivered.

Q1. Will you commit to greater investment in our public hospital system, and in its workforce?

Q.2 What is your policy regarding the Lyell McEwin, Modbury Hospital and the delivery of services across NALHN?

Clinician Engagement

Whether perceived or actual, one of the greatest criticisms of Transforming Health was the lack of information flow and meaningful consultation throughout the reform process. Adding to the frustration was that when genuine concerns were raised, they were often met with responses such as; the reforms had 'the support of 95% of clinicans' (despite no supporting evidence to substantiate this claim) or that those raising the concerns were 'scaremongering.'

We appreciate that Surgeons, and other clinicians are working in increasingly high pressure and time poor environments, and that this can sometimes make consultation difficult. In order to utilise expertise and the good will of those on the front line it is essential that genuine engagement strategies are adapted to ensure that the input of clinicians is not removed from the management structures that govern them.

RACS and other peak medical bodies have an important role to play in contributing to policy development, and advocating on behalf of our patients and membership base. We were recently involved in the Transforming Health Surgical Advisory Group, which has now disbanded. The College recommends that a revised clinical advisory group is developed, which reports on statewide service delivery directly to the Chief Executive of SA Health.

Q 3. What is your engagement strategy to foster a culture of mutual respect and ensure that decision making is clinician-led?

Teaching, Training and Research

Support for surgical specialty training

RACS, together with its associated specialty societies, identifies training positions and ensure as many trainees as possible successfully complete its training program. While the College puts no cap on the number of trainees it accepts, positions are limited to the number of available surgical training posts in teaching hospitals.

In our 2014 election statement RACS called for increased funding for additional training places. In order for training positions to remain accredited Trainees must have exposure to an appropriate case mix, and demonstrate their ability to adequately perform a wide range of procedures. Due to the high volume/low acuity of care being performed at secondary hospitals, as well as the closure of the Repatriation Hospital accredited training positions have been lost. The loss of these positions has not been absorbed across the Local Health Networks meaning that there has been a net reduction in the number of training places in South Australia.

As well as this, the recent and substantial increase in the number of medical graduates entering the workforce means that there is now commensurate pressure on postgraduate training opportunities. South Australia – as a smaller state – must ensure that the number of training positions in surgery are maintained or increased to meet pressure created by an aged population (e.g. in areas of cardiac and vascular surgery including endovascular surgery, oncological surgery and renal access and transplant surgery). With a need for an increased number of surgeons in particular specialties, there is a requirement for a strong commitment from state governments to increase the number of, and funding for, additional training posts.

Q 4. What is your strategy to maintain and increase training posts within the public hospital system?

Q 5. How does your party plan to build the surgical workforce of the future to address South Australia's ageing population and health needs?

Surgical Technology

Robotic Surgery

Across Australia and internationally, surgical specialties are adopting new technologies and the evidence is increasingly showing demonstrated benefits to patients and cost savings for health systems. As the demand for minimally invasive robotic surgery grows and the capabilities of the technology increases, it is vital that an adequate surgical service delivery model exists to ensure that the highest quality of care is available to all patients in the appropriate setting.

Hybrid Operating Theatre

Prior to its opening, RACS advocated for the inclusion of a hybrid operating theatre at the Royal Adelaide Hospital (RAH). While we were disappointed that the theatre was not included at the outset, we have been heartened by discussions with both major parties who have indicated their commitment to retrofitting the theatre now that the hospital has opened.

Earlier this year members of the RACS SA Regional Committee toured the RAH where we were shown an area that will potentially be retrofitted to become a hybrid operating theatre. We have also been advised that SA Health are investigating the possibility of a second hybrid operating theatre at the Flinders Medical Centre, which would be of significant benefit to clinicians and patients in the Southern Adelaide Local Health Network.

Q 6. What will your party do to ensure that public patients have access to the highest quality surgical technology?

Q 7. Does your party remain committed to the development of a hybrid operating theatre at the RAH, and if so are you able to provide a timeline for when the facility will be available?

Q 8. What is your party's position on the development of a second hybrid operating theatre at Flinders Medical Centre?

South Australian Audit of Surgical Mortality

The South Australian Audit of Surgical Mortality (SAASM) involves the clinical review of all cases where patients have died while under the care of a surgeon. By assessing surgical deaths in South Australia the audit is able to provide feedback to hospitals and the Government on systemic issues within the public and private sector. It currently covers surgery in all public hospitals, some private hospitals and a number of day surgery hospitals. This independent approach, in a qualified privilege environment, is greatly supported by South Australian surgeons, as it encourages greater participation and ultimately better health outcomes for patients.

As an example, since 2013 there has been a consistent downward trend in the number of surgical deaths (excluding terminal cases), from 583 in 2013 to 481 in 2016. Over the past year there has also been a considerable reduction in the proportion of surgical deaths with serious clinical management issues identified by assessors, from 10.2% (49/482) in 2015 to 6.9% (30/432) in 2016. The most marked reduction has been in adverse events, which is the most serious category of clinical management issues. The total annual number of adverse events has decreased from 26 in 2015 to 4 in 2016. (*Note: a small number of assessments from 2015 and 2016 are still in progress so the numbers may change slightly*).

Q 9. The mortality audit program is part of an effective quality assurance activity aimed at the ongoing improvement of surgical care. The current contract expires at the end of December 2018. RACS seeks a commitment from your party that a further three years funding will be supported.

Alcohol Related Harm

RACS has advocated against the harmful use of alcohol for many years, not only because of adverse effects that it has on our patients, but also for the broader ramifications that alcohol-related harm has on our health system and society as a whole. RACS endorses preventative measures as the best way to reduce alcohol-related harm by restricting the physical and economical availability of alcohol. This can be achieved by reducing the trading hours of both on and off licences, restricting liquor outlet density, and imposing a volumetric tax on alcohol.

RACS has an established position on alcohol related harm, and in the last two years we have provided a submission and supplementary submission to the Review of the SA Liquor Licensing Act 1997. Despite advocating for stronger recommendations, overall RACS was pleased with the considered analysis undertaken in the Independent Review by Justice Tim Anderson, and believe that harm minimisation remained a central consideration when presenting his report. While several of Justice Anderson's recommendations were adopted in the amended legislation many were not, and RACS believes that there is still considerable scope to strengthen existing legislation. As an example, RACS was disappointed that a recommendation to enforce cease in trade for three hours between the hours of 3am and 8am for all venues licensed to trade during these hours was not accepted.

Recently the Northern Territory Government undertook a similar review of its liquor framework. The Government has yet to prepare a formal response to the Review, but so far has accepted in principle 219 of the 220 recommendations put forward. The NT opposition has also pledged bipartisan support and to work constructively with the Government to implement the recommendations. If the recommendations in the Review become formal legislation, the NT will set a new benchmark for effective alcohol harm reduction measures in Australia. RACS encourages similar leadership in South Australia.

Q 10. What are your party's policies to address alcohol-related harm?

Recognition of Paid Parental Leave Entitlements and Diversification of Surgical Workforce

There is a significant problem accessing paid parental leave within state and territory health services for our surgical registrars as they progress through their surgical training, particularly but not exclusively for female trainees. This is one of many factors about surgical training that discourages women choosing surgery as a career.

Many of the smaller surgical specialties require interstate and even trans-Tasman moves for broad exposure during surgical training. This particularly affects paediatric, vascular and urology trainees. At present, each state and territory has separate policies determining eligibility for paid parental leave, mostly requiring 12 months' continuous service in that jurisdiction. This means that if these trainees have to move interstate whilst pregnant, the trainee is no longer eligible for paid parental leave.

As RACS tries to improve diversity within its training and within its membership this is a stumbling block. The stark reality is that only 12% of Fellows in Australia and New Zealand are women. Approximately 30% of SET Trainees now are women but they drop out at twice the rate of male trainees. We are committed to removing barriers that may inhibit women entering the surgical profession and we need the government's help to make this happen.

This also includes taking proactive steps to enable and normalise flexible training for male and female surgical trainees. We recognise there are multiple players involved in making this happen, including the College's Specialty Training Boards, hospitals and jurisdictions. Flexible training models that enable part-time work and training supplemented by unaccredited registrars may be a viable option.

We need a surgical workforce that is reflective of the communities we serve and we believe this will lead to better patient outcomes.

Q 11. Will you commit to raising this matter at COAG to assist in gaining agreement that all states and territories would commit to recognising 12 months' of continuous service in the public hospital system in Australia for eligibility to paid parental leave, rather than service in any one particular state or territory?

Q 12. Will you work with hospital and health services to create an environment conducive to flexible training for surgical trainees?