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Professor Mark Cormack
The Independent Lead Reviewer for the Scope of Practice Review
Australian Department of Health and Aged Care

Email: scopeofpracticereview@health.gov.au

Dear Professor Mark Cormack,

RE: RACS Responses to Unleashing the Potential of our Health Workforce – Scope of Practice Review Issues Paper 2

The Royal Australasian College of Surgeons (RACS) is the leading peak body for surgical standards, professionalism and surgical education in Australia and Aotearoa New Zealand. We appreciate the opportunity to provide feedback on Issues Paper 2 of the Scope of Practice Review.

Given the Scope of Practice Review and Issues Papers have focussed on primary care settings, from a RACS perspective we provide commentary on regulatory changes in primary care that have flow on impacts to secondary care, and how primary care practitioners (such as rural generalists with extended scope of practice in procedural skills) may be impacted. We have taken this opportunity to provide an overarching written response in lieu of completing the survey questions on the Scope of Practice Review Issues Paper 2.

Overall, the reform options should not perpetuate fragmentation of healthcare system and works to ensure that clinical governance structures remain coherent, and models of care that are safe continue to be maintained.

The following provides commentary on the options outlined under the three categories for reform in the Issues Paper 2:

1. Workforce Design, development and planning
2. Legislation and Regulation
3. Funding and Payment Policy

1. Workforce Design, development and planning

Option 1: National Skills and Capability Framework and Matrix

In RACS previous submission to Issues Paper 1 it emphasised the lack of nationally consistent guidelines for determining the full scope of practice including nationally agreed terms and language usage. We would welcome the proposal to ask AHPRA and National Boards to undertake work to define and set guidelines for scope of practice at primary care or specialist level. Setting appropriate scope of practice is critical and should be embedded into registration framework in some way which it is not currently. Whilst we recognise that scope of practice is determined at institutional level, it is certainly our experience that many institutions look for guidance in this area, and whilst RACS and surgical specialty societies provide guidance, having clear limits on scope of practice e.g., rural generalists with extended scope of practice in procedural skills would be helpful if not essential as part of the registration process.

RACS would seek further clarification and detail on the proposed National Skills and Capability Framework and Matrix. Nationally consistent standard

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scope of practice and extended scopes of practice could be documented, including the pathways to developing and being recognised for extended or advanced scope of practice. For example, in a rural setting, an entry-level registered nurse would not have the provision to assist in surgical procedures, but it may for a more experienced registered nurse who has undertaken additional training.

Clear legislation, regulation and guidance from government and AHPRA is essential for indemnity insurers, employers and local credentialing committees to carry out their duty to ensure health practitioners are appropriately qualified and insured to provide safe quality care to patients. In the absence of clear guidance, indemnity insurers and credentialling committees will tend to default to the standard scope of practice and named profession titles.

Option 2: Develop primary health care capability

While RACS is not directly involved in primary health care training, we can acknowledge that learning opportunities are best placed in supervised clinical placements. This requires dedicated resources and funding. Most of RACS' senior Fellows provide pro bono work at their own time and expense when providing supervision to our Trainees and other health professionals, and at a level of uncompensated stress. Equitable funding and support are required to protect the valuable time of staff and to effectively assist them as supervisors in training and education.

Option 3: Early career and ongoing professional development includes multi-professional learning and practice

Training with and working in a team (local or distant) with relevant specialists is recommended. Employers can provide training in teams, rather than professional silos, to reinforce the effectiveness of team-based care. Examples include the RACS Safer Australian Surgical Teams, Definitive Surgical Trauma Care, Early Management of Severe Trauma and simulation courses (such as the rural obstetric emergency course). These concepts are discussed in detail in the RACS Rural Health Equity Strategy foundation paper on Collaborate for Rural.[1]

Appropriate training by RACS and/or the relevant surgical specialty society would ensure that primary care health practitioners with an interest in advanced procedural skills are educated based on a formal curriculum, meet many of the RACS competencies that are required for RACS Fellows, and that those competencies could be evaluated either via exit examinations or more likely workplace assessments to ensure those practicing at an extended scope of practice are safe for the public. For example, the best model would be for rural generalist with extended scope of practice in procedural skills is to work alongside a FRACS specialist surgeon who can mentor and supervise, or at the minimum, they have a defined link to a FRACS surgeon or to a surgical unit at a public hospital to ensure rural generalists are well supported. RACS can play a significant role in this program development and implementation with funding from government.

2. Legislation and Regulation

Option 4: Risk-based approach to regulating scope of practice to complement protection of title approach

There are wider implications for the regulation of the health sector at large should these reform options be implemented in their current form. RACS has previously stated that risk-based approach to regulation in a hospital care setting appears beneficial in rural, regional and remote settings. This should be adopted in a complementary manner to the named professional titles. Patients are reliant on professional titles to assess and understand their options for care. There is strong public

[1] Royal Australasian College of Surgeons. (2020). Rural Health Equity Foundation paper on Collaborate for Rural. https://www.surgeons.org/Resources/interest-groups-sections/rural-surgery/activities

understanding of the broad professional titles and their associated skillsets and trust that these are backed by sufficient training and quality assurance structures. In a recent example, the legislative changes to the use of title 'surgeon' aim to eliminate the confusion faced by patients and add a layer of safety when it comes to choosing a surgeon. A consistent approach to professional titles, similar to the recent legislative changes around use of the title 'surgeon' would be best, with an education campaign and explainer on the AHPRA website, that appears whenever a person searches for a practitioner. For example, health professionals should state their title/qualifications/extended scope of practice as - Primary qualification (e.g. physiotherapist/nurse/surgeon/general practitioner) with advanced practice skills in (e.g. vestibular/urology/breast surgery/procedural practice).

The implementation steps outlined on page 54 should not create additional bureaucracy. In RACS previous submission, we provided examples of where risk-based regulation could be applied. This included the use of appropriately trained registered nurses, perioperative nurse surgical assistants and nurse practitioners as surgical assistants. RACS has previously stated its in-principle support for these non-medical health professionals to assist as surgical assistants. Specialist surgeons are best placed to determine who can surgically assist with reference to the complexity of the procedure, the assistant's level of competence and available local workforce. While RACS does not have the authority to mandate training requirements and scope of practice of nurses as this responsibility lies with Nursing and Midwifery Board of Australia, RACS would welcome the opportunity to play a significant role in developing training, accreditation and credentialing of these surgical assistance programs with funding from government. This could also be applicable for nurses assisting in endoscopy and urological procedures with the specialist nearby. Similar arrangement could apply for the training of rural generalists for extended scope of practice in procedural skills.

Option 5: Independent, evidence-based assessment of innovation and change in health workforce models

It will require significant resources to implement the reform option to establish an independent national body which will be responsible for evidence-based advice on how the scopes of practice for health professionals will meet community need. The methodology to conduct evidence and research analysis should be rigorous, with consideration of randomised clinical trials and comparative studies.

Innovations using technology to complement traditional care, consultations with specialists via secondary telehealth, or even live streaming consultations and examinations with real time advice and guidance from a more senior surgical specialist should all be considered as ways to enable surgeons to work with primary care health practitioners such as rural generalists and nurses. Such initiatives must be supported by appropriate funding as MBS item numbers and remuneration.

3. Funding and Payment Policy

Option 7: Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice

RACS supports expanding MBS eligibility and other payment rates to professions for the delivery of identical services for specified activities falling within overlapping scope, as mentioned in our previous submission. Enabling health practitioners to access MBS item numbers for procedures and investigations relevant to their advanced practice area is important for to equity for patients and practitioners' financial sustainability. The billing payment models should be consistent with the complexity of the case and the skill and experience of the practitioner. Within public hospitals, salary support is considered as the best option as it mostly would be required in hospitals so practitioners could be paid a salary for working at their extended scope of practice. The location and remoteness as classified by the Monash Modified Model (MM2-7) should be strongly considered in MBS eligibility enable health practitioners working at an extended scope of practice in rural and remote areas

access to the MBS. This could prevent MBS claims by health practitioners in areas already well serviced by medical practitioners (such as in urban settings MM1).

Option 8: Direct referral pathways supported by technology

There should be considerations to accommodate more health professionals into the referral networks. This should be in alignment with the reinstatement and accelerated rollout of the referral algorithms that were previously developed, ensuring efficient and appropriate patient referrals for conditions such as back pain.

In some situations, access to MBS for the consultation or treatment is contingent on receiving a referral to see the specialist. Enabling MBS billing items for these practitioners to order investigations and make referrals in line with their area of advanced practice skill should allow more patients to access timely secondary care. However the variable usage of the My Health Record (and other technology) could hinder the communication, accessibility and storage of health information required for referrals between health professionals if the GP is not involved in the patient journey. It is important that any proposed reforms for direct referrals to non-GP specialists are clinically appropriate and do not unintentionally cause fragmentation of the patient journey.

4. Additional reform options which have not been considered or raised

Page 53 of Issues Paper 2 mentions the complexity surrounding professional medical indemnity insurance. Further reform options should consider how health practitioners working at their full of scope of practice are not discouraged due to their inability to get adequate indemnity coverage. Medical indemnity is an area that must be clearly defined should errors happen where decisions are not made properly. Clear guidelines on scopes of practice would provide insurers more certainty regarding what they will cover and what they want based on the practitioner's scope pf practice. The establishment of a sustainable indemnity model that upholds the highest standards of surgical practice while ensuring equitable access to care is paramount.