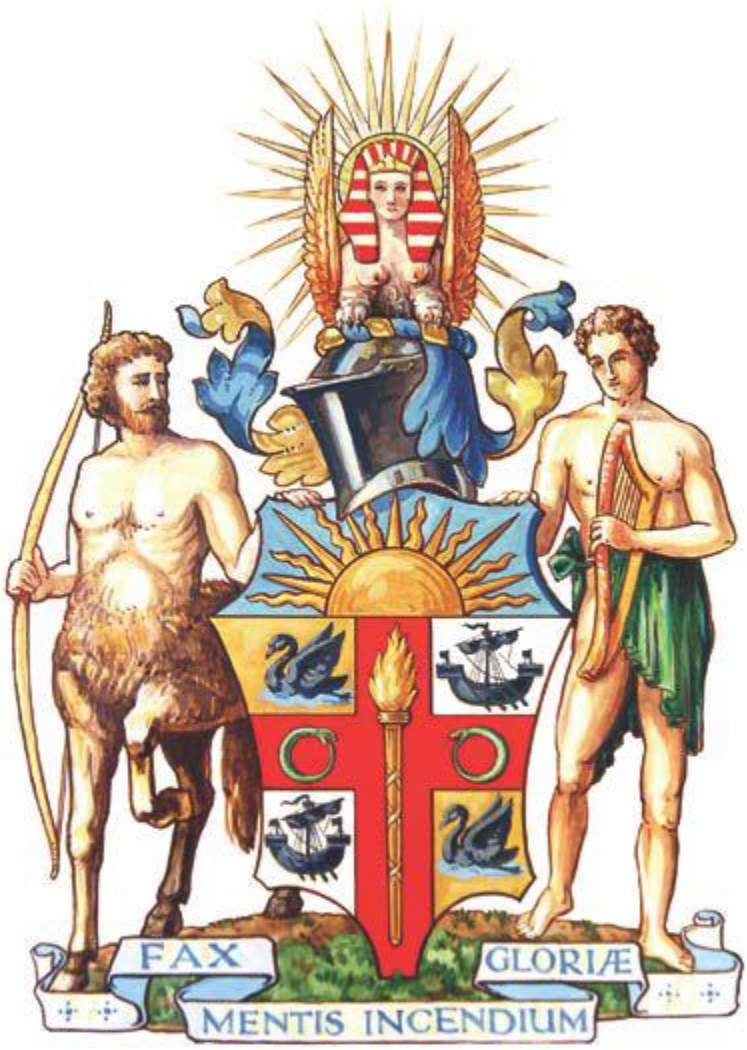

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

QLD STATE ELECTION 2015
POSITION STATEMENT

January 2015

Introduction

Prior to State and Federal elections, the Royal Australasian College of Surgeons provides an opportunity for political parties to outline policy positions on key issues relating to the delivery of surgical services. The College then distributes the responses to its membership and the broader community. This document outlines the areas of specific concern and relevance to the Fellows, Trainees and International Medical Graduates of Queensland in the lead-up to the forthcoming State election. The College believes that considered and informed policy positions will allow the Queensland Region of the College to advocate effectively to ensure the best outcomes for patients requiring surgical care in public hospitals of Queensland.

Background – Royal Australasian College of Surgeons

Established in 1927, the Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. The College is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees. There are nine surgical specialties in Australasia being: Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head-and-Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery. RACS also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. Approximately 95 per cent of all surgeons practising in Australia and New Zealand are Fellows of the College (FRACS).

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

Key issues

The Queensland Regional Committee has identified eight key focus areas relevant to this election. They are:

1. The **wait time guarantee** and associated outpatient lists.
2. Provision of **adequate specialist surgical training** opportunities and **appropriate working hours.**
3. **Expanded scopes of practice** - Nurse Endoscopy and Allied Health.
4. **Alcohol abuse** and its catastrophic impact on surgical trauma, as well as the community.
5. **No Fault care** after traffic accidents.
6. **PACS Digital Imaging**.
7. **Regional Surgical Services**.
8. Ongoing funding for the **Queensland Audit of Surgical Mortality**.

The wait time elective surgery guarantee and outpatient lists

It is pleasing to see that elective surgery and outpatient waiting lists are receiving long overdue structural reform. It is evident that in the past, funding had been dedicated to improving wait times but at best this only resulted in short term gains. Reduced wait times on the elective surgery waiting list have been achieved by deferring patients on the outpatient list, meaning any meaningful action to reduce wait times must address both lists cohesively.

Q1: How will your party manage the elective and outpatient waiting lists in a cohesive manner?

Under the existing Government's policy, patients will need to be transferred between public and private facilities to ensure the Wait Time Guarantee (WTG) is met. Surgeons working across both the public and private services will be required to meet the elective surgery demand created by the WTG.

The College is concerned about how the elective surgery WTG, or any other policy to address wait times, will operate. Presumably any elective surgery that cannot be accommodated within the specified Hospital Health Service (HHS) will be transferred to another HHS in the first instance; then outsourced to the private sector if no HHS is available.

It is the College position that systems should be structured to maximise the efficient throughput of public outpatients to match the public elective operating capacity to reduce wait lists in both sectors. Outsourcing should be the last option to avoid excessive costs to the taxpayer and disproportionate diversion of HHS funding.

In the past, any surgery outsourced to the private system has been offered first to surgeons with a public appointment. The College seeks confirmation that this principle still remains. The benefits of this principle are that surgeons with a public appointment:

1. Have already shown commitment to the public sector.
2. Are more likely to have knowledge of the patients.
3. Are more able to involve trainees.
4. Have been through a thorough appointment process and renewal, meaning their surgical credentials can be verified.

Where contracts with private providers are granted, the need to train registrars must be considered within the contract service provision arrangements.

Q2 Does your party commit to the engagement of surgeons and surgical services as outlined above; with a similar commitment to including training opportunities for registrars?

Several new hospitals have been constructed and additions have commenced or been completed in public hospitals all over the state. Substantial infrastructure capacity now exists (theatres, beds, ED department space), which is under utilised in the system, particularly on the Gold Coast. Improvements to hospitals on the Sunshine Coast and throughout regional Queensland (Cairns, Townsville and Mackay in particular) will add to this capacity.

Q3 How will your party address latent capacity in our public hospitals? Will funding be provided to allow unused facilities to be opened and operational to clear waiting lists?

Specialist Medical and Surgical Specialty Training and appropriate working hours

An effective surgical service requires appropriate clinical loads, active clinical teaching, continuing professional development and robust audit and peer review, guaranteeing patient safety and the highest possible standards of care. Such a culture of excellence can only be sustained if these specific needs are met. Significant financial, infrastructural and cultural support from governments and health authorities is required to train and maintain the surgical workforce of the future.

A substantial increase in the number of medical graduates has led to an acute shortage of post-graduate training posts – both internships in our hospitals and places in the specialist medical colleges.

The College, together with its associated specialty societies, strives to identify 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.

Surgical trainees usually have a formalised working schedule set out by hospitals in relation to overtime shifts and daily working hours. The number of rostered working hours will depend on whether the work occurs mainly during the day or at night. Trainees are also required to fulfil the minimum training requirements of the Surgical Education and Training program of the College, and hospitals must recognise this requirement and facilitate completion of the training program.

With a standard 38 hour work week in many hospitals, significant penalty rates are applied to hours worked above this. Hospitals are cutting back on the rostered hours of trainees due to cost cutting measures, which then affects the experience the trainee is able to gain to meet the requirements of the surgical education program.

It is the College's position that:

- The community is best served by having appropriate numbers of well-trained surgeons with adequate training and exposure to a variety and varying intensity of clinical experiences within high-quality healthcare institutions.
- The College and its associated specialty societies can only approve training positions in centres that maintain high standards of care, adequate clinical exposure for training, and support for trainees and trainers within the context of a structured program of education over a period of time, and aims to approve as many suitable positions as are available.
- As direct funders of public teaching hospitals and hospital services throughout Queensland, and as a key stakeholder in the development of trainee and trainer employment contracts, the Queensland Government must support the infrastructure and workplace arrangements that facilitate postgraduate specialist training and surgical education.
- The Queensland Government must continue to support trainers, ensuring protected time and appropriate environment for training by ensuring adequate staffing levels.
- The College does not wish to lengthen the time for surgical training. It believes a 55-65 hour work week is appropriate for trainees to gain the knowledge and experience required by the training program. Overtime should be rostered but affordable.
- Surgical and other procedural trainees need to be rostered for appropriate working hours compatible with service provision, continuity of care and quality of specialist training.

Q4 The College seeks both parties commitment to:

- **Affordable solutions to overtime hours worked by surgical trainees to maintain the timeliness and integrity of the training program.**
- **Advancing and maintaining the infrastructure that supports surgical training in public, private, metropolitan and regional hospitals throughout Queensland, including development and funding of appropriate educational infrastructure and surgical simulation training facilities to establish Qld as a centre of teaching excellence.**
- **Preserving dedicated time for teaching and training, including time for surgeons to develop their teaching skills.**

<u>Expanded scopes of practice – Nurse Endoscopy and Allied Health</u>

Throughout 2014 there has been considerable debate about nursing and allied health scopes of practice. The College supports a delegated model of care, not substitution. If allied health care

providers are to be substituted into roles currently held by doctors, they should be held to the same standard.

Some of the listed changes in scopes of practice are welcomed and some should be addressed with caution. Public safety is the prime concern and if changes in scope of practice are to occur there should be an emphasis on appropriate education and accreditation, delivery of services within a multi-disciplinary team, and collaboration. Delegation of accountabilities and responsibilities must be clearly defined and high clinical service standards and patient safety are paramount.

There should be no 'drop in standard' if a different profession delivers the service, and since health care is always interrelated and co-dependent, the College is not supportive of an independent practice model.

Q5 The College seeks your party's position on expanded scopes of practice and how it will encourage the nursing and allied health sectors to work closely and collaboratively with the Medical Colleges on these issues.

<u>Alcohol abuse and related violence and trauma</u>

Alcohol-fuelled violence leads to serious trauma, often requiring surgical intervention. Recent cases highlighted in the media have led to proposed changes of legislation to ensure stiffer penalties act as a deterrent. Whilst the College supports these moves, it believes that the root problem remains the inappropriate use of alcohol.

- 77% of Queenslanders believe more needs to be done to address alcohol-related harm, and two thirds (66%) have been negatively affected as a result of someone else's drinking.[1]

- Laslett et al (2010) found that an estimated 367 Australians died and nearly 14,000 people were hospitalised because of the drinking of others during 2005. Interpersonal violence resulted in 182 deaths, of which 42% (77 deaths) were estimated to be attributable to another person's drinking. A total of 277 deaths of people aged 15 years and over were estimated to be due to another's drinking and driving, with 31 of these being pedestrian fatalities.[2]

- Surgeons operating in jurisdictions that have introduced tougher measures to deter alcohol-fuelled violence including changes to hours and licensing such as the Sydney Entertainment Precinct and Newcastle have seen a significant reduction in the number of presentations to emergency departments with alcohol related injury, a reduction in the severity of alcohol related injury presentations, and an improvement in amenity for the residents in these areas. Only recently surgeons at Sydney's busy St Vincent's Hospital, which borders the notorious Kings Cross nightlife precinct, have cited what they call a huge reduction in extreme drug and alcohol-related injuries that they attribute to the NSW Government's lockout laws.

The ratings below are from the National Alliance of Action on Alcohol. The College notes that Queensland is in a poor position compared to many other states.

Rank	Jurisdiction	Total points achieved	Total possible points	Final score (%)
1	ACT	13.5	28	48
2	WA	12	28	45
3	NSW	11.5	28	41
4	VIC	11.5	28	41
5	TAS	10	28	36
6	QLD	9	28	32
7	NT	8.5	28	30
8	SA	8.5	28	30

[1] QCAA 2015 Election Platform (2014)
[2] Laslett, AM, Catalano, P, et al (2010) *The Range and Magnitude of Alcohol's Harm to Others*.

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Government agencies monitor and report incidents of alcohol-related harm and some of the costs associated in responding to alcohol abuse. However agencies do not monitor or report the total cost of alcohol abuse, which means the Queensland Government does not have a complete picture of the harm caused by alcohol in terms of its costs and consequences on society.

Raising the barriers on the purchase of alcohol is an effective means of reducing alcohol consumption and alcohol-related injury. The College's key messages are to tackle Hours - Outlets - Taxes or *HOT* issues.

Q6 The College is seeking your party's position on the following issues, as the current *Safe Night Out* strategy has not adequately addressed the *HOT* issues.

- **We need to maintain or reduce the number of 'Hours' alcohol is available (1:30am lockout and 3am last drinks).**
- **We need to maintain or reduce the number of 'Outlets' where alcohol can be purchased in our community.**
- **We need an effective alcohol taxation and pricing policy to bring about behavioural change.**

No Fault care after traffic accidents

The Australian Government is currently working with the States and Territories to develop the National Injury Insurance Scheme as a federated model of separate, state-based, no-fault schemes that provide lifetime care and support for people who have sustained a catastrophic injury, regardless of who caused the injury.

In Victoria, this is managed through the Transport Accident Commission. This system is regarded as an excellent model to provide much needed trauma services and is funded by an additional levy on the third party insurance component of car registrations. In Western Australia, the Government is currently considering public submissions on a Green Paper[4] on the "no fault" insurance approach, which provides an excellent analysis of the issues involved. If Western Australia introduces this legislation, Queensland will be the only state where an "at fault" system exists for catastrophic injuries.

Q7 What is your party's position on the "no fault" compulsory third party or CTP scheme?

PACS Digital Imaging

The College position statement on Digital Imaging states (in part) that, *'Diagnostic quality imaging is required for the planning and execution of operative approaches and delineation of the extent of pathological changes. It is dangerous, unsafe and unacceptable to plan or commence surgical procedures without access to images either in digital or hardcopy form'.*

Digital images are now provided to patients on CDs, but the use of multiple software platforms throughout public and private hospitals means that images may not be able to be viewed on hospital computers or monitors in operating theatres. Additionally, many hospitals do not have access to onsite radiology printing facilities. This situation compromises the ability of surgeons in their operative practice. Queensland Health is working on a cloud solution that may resolve the problem, and the College hopes that your party will support their efforts.

Q8 How will your party ensure the issue of digital imaging software incompatibility is resolved? Will your party agree to include a requirement in the licensing accreditation of private hospitals that ensures access to quality imaging?

[3] National Alliance for Action on Alcohol (2014) *National Alcohol Policy Scorecard*

[4] Insurance Commission of Western Australia (2014) *CTP Green Paper* - https://www.icwa.wa.gov.au/mvpi/greenpaper/mvpi_ctp_green_paper_intro.shtml

Regional Surgical Services

It has been difficult for regional hospitals to maintain a consistent number of Australian and New Zealand trained surgeons as part of their surgical workforce. Several factors contribute to this situation:

- The lifestyle attraction of working in a metropolitan hospital.
- The perceived preference for the employment of full time Staff Specialists in regional hospitals, rather than a Visiting Medical Officer (VMO) lead or contributing service.
- Surgeons enjoy contributing to training the next generations of surgeons. Often Registrar numbers are much lower in the regions, which acts as a deterrent to more experienced surgeons wishing to work in a regional hospital. The employment of extra Australian and New Zealand trained consultants (even in a VMO capacity) will lead directly to the potential creation of new Registrar positions in the regions.
- Isolation, or limited support in terms of, on call rostering, the difficulty in obtaining leave and access to Continuing Professional Development.

A well-resourced regional surgical service requires a supportive environment.

Q9 How will your party attract specialists, in particular young surgeons, to regional areas?

Ongoing funding for the Queensland Audit of Surgical Mortality

The Queensland Audit of Surgical Mortality (QASM) has been operating since 2007, and has shown that mortality is declining despite an increase in surgery. The Audit assesses surgical deaths in Queensland and provides 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 Queensland surgeons, as it encourages greater participation and ultimately better health outcomes for patients.

Since 2007 – 6,937 surgical deaths have been assessed and currently 83 hospitals notify QASM and are involved in the process.

Q10 QASM has guaranteed funding until 30 June 2016. Since the mortality audit program is part of a quality assurance activity aimed at the ongoing improvement of surgical care, the College seeks a commitment from your party that a further three years funding through to 30 June 2019 will be supported.

Conclusion: The Royal Australasian College of Surgeons Queensland State Committee is appreciative of your time in addressing these matters. We are acutely aware of the time frame presented by the short election campaign time and we look forward to receiving your response by 28 January 2015. This will enable us to inform our membership of your policy positions prior to the election on 31 January 2015.