ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Patron: H.R.H. The Prince of Wales

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The Honourable Jack Snelling, M.P.
Minister for Health, SA Health
Citi Centre Building
Hindmarsh Square
Adelaide SA 5006

Dear Mr Snelling

Re: Response to the Delivering Transforming Health Paper, February 2015.

The Royal Australasian College of Surgeons (RACS) supports endeavours to improve the current South Australian (SA) healthcare service.

The Delivering Transforming Health paper which seeks to describe the future of health services in South Australia, is remarkably short on detail concerning implementation, time frames for change and how resource reallocation will occur.

As a peak body and leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand, RACS considers that the following points need to be embedded principles in any document which seeks to alter health delivery in SA:

- It is essential for the Level 1 Trauma Centre at the new RAH to have dedicated Trauma Surgeons. Trauma surgery as a specialty has not been mentioned in the Delivering Transforming Health document.
- Evidence shows that severely injured trauma victims regularly self-present to non-major Trauma Centres. The proposed reconfiguration of ED services across the state must take this into account.
- RACS is concerned that the enactment of many policy standards in the discussion paper will have implications for surgeon training, which need to be carefully considered when implementing changes.

- The foreshadowed closure and downgrading of services at Repatriation General Hospital and Modbury Hospital will have significant implication for training of the future surgeons of South Australia.

Implications for Hospitals:

- **Noarlunga Hospital**
  The concept of a single site elective day surgery centre is supported in principle by RACS. However the location of the hospital at Noarlunga raises significant issues related to the capacity of those in the lowest socio-economic groups, particularly from the north, to access this service. A more central location for such a facility would improve access for all.

- **The Queen Elizabeth Hospital**
  RACS supports the separation of elective and emergency surgery.
  There is little detail however in how referral of patients between local area health networks will be implemented. There is the capacity for serious risk to patients who are added to the waiting list at one site and operated on elsewhere. We believe that the likelihood of patients being cancelled on day of surgery is significantly increased if the operating surgeon has no or little opportunity to review the patient prior to surgery. The separation of elective and emergency surgery has implications for surgical training.

- **Repatriation General Hospital (RGH)**
  The closure of RGH has significant implications for Urology and Orthopaedic Services in the south. We emphasize that the current surgical service is a prime example of a service model which has successfully improved efficiency by separating elective and trauma surgery, consistent with the model espoused in Transforming Health.
  The dismantling of this service at RGH will in all likelihood result in loss of expertise rather than transfer.

- **Modbury Hospital and Lyell McEwin Hospital**
  Further information is required regarding plans for the current surgical services provided at Modbury Hospital. We expect that some movement of these services to the Lyell McEwin site is planned however this is not made clear in the document. We are uncertain as to the capacity of the Lyell McEwin hospital to absorb any or all of these and request information

about plans for expansion in order to meet the needs of those currently cared for at Modbury.

- **Women's and Children's Hospital**
  RACS supports the co-location of the Women's and Children's hospital in a purpose built facility at the new RAH site. Further clarification is required regarding the plans for the implementation of a statewide service for paediatric surgery. Current workloads in surgical units at WCH are such that there is limited capacity to provide outreach services for surgery. We have ongoing concern about the provision of paediatric surgical services at hospitals where there is no resident paediatric surgical staff.

The following table is in response to standards taken from the Delivering Transforming Health document, which are directly applicable to surgical services.

Point	Claim	Response
Page 6, Why do we need to change?	*Health care services should be offered seven days a week every week. Human and infrastructure resourcing should be aligned to achieve this*	We support quality patient care and recognise the need for 24/7 coverage of some acute health care services. Surgical workforce numbers and availability will need to be considered in addition to cost of staffing.
Page 8, Our vision for better health care	*Improved use of our specialist resources, such as x-ray machines, operating theatre departments and outpatient clinics, so that tests and treatments are available when needed*	We support improved access to timely investigations but note that any extension of the hours during which these services are available will have major cost implications
Page 25, Specialist centres for elective surgery	*Doctors in training can also attend these sites to become skilled in elective surgery procedures*	Throughout Australia training for surgeons is undertaken in accredited training facilities. Facilities need a range of clinical cases and facilities to attract training positions and accreditation. Stand-alone elective surgical hospitals are unlikely to meet standards for training requirements by themselves. It is possible that by rotating Trainees from larger emergency hospitals through elective hospitals, training in these facilities could occur. However this would

		have significant service implications in the emergency hospitals especially for smaller surgical subspecialties with low numbers of Trainees. This topic will require further consultation between hospitals, training and accreditation boards.
Page 25, Clinical Standards of care		
Point 92	*Nurse practitioners should be utilised across the surgical system to improve efficiency*	In some areas nurse practitioners have been proven to be effective in specific roles however the expectation that increasing utilisation across the entire surgical spectrum will decrease cost is not supported by evidence. RACS supports appropriate task delegation within well supervised clinical teams.
Point 161	*Where possible patients should be triaged based on need for surgery or not. Those definitely not requiring surgery should be diverted to non-surgical services such as allied health led clinics*	We consider that in certain limited instances this may be appropriate e.g. physiotherapists assessing joint pain, however RACS does not consider that this approach is broadly applicable across all surgical specialties. The decision to recommend for or against a surgical intervention lies with the surgeon.
Appendix 2 Clinical Standards of Care		
Overarching Standard Point 38	*Multidisciplinary criteria-led discharge should be established. Diagnostic and therapeutic support should be readily available for all disciplines to use when appropriate*	Discharge of surgical patients should be at the discretion of the surgical unit. Although this can involve task delegation to other health workers, it is reliant on good discharge planning or hospital in the home/community follow-up.
Bariatric Standard Point 271	*A bariatric service (surgeon with all support facilities) should perform at least 40 bariatric cases per year*	Bariatric surgery needs to be performed at a hospital with access to intensive care as 10% of patients will require high level support post-

		surgery.
Vascular Standard Point 284	*Patients requiring carotid endarterectomy should be allocated to the next available operating list (ideally within three days of referral).*	This standard applies to symptomatic patients with symptoms referable to carotid disease. Asymptomatic patients may not require treatment within the time frame stipulated
Vascular Standard Point 268	*Elective abdominal aortic aneurysm (AAA) repair should only be undertaken in hospitals where: there is a 24-hour on-site vascular on call roster every day covered by consultant vascular surgeons, there is a 24-hour critical care facility every day, and there are a minimum of 33 AAA procedures per year.*	The definition of repair should be clarified as AAA procedures encompass both open and endovascular approaches. To ensure the best outcomes appropriate angiographic facilities need to be available at call.

Yours sincerely

Dr Sonja Latzel
Chair, SA Regional Committee