

**Royal Australasian College of Surgeons
Response to Tasmanian Department of Health and Human Services
Green Paper: Delivery Safe and Sustainable Clinical Services**

Executive Summary

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 and International Medical Graduates. 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.

RACS has carefully reviewed the Green Paper, Role Delineation Framework and supporting documents. We welcome the government's approach to the development of a clear plan for the delivery of health services to Tasmania on a statewide basis. We are pleased to offer this response in an effort to contribute to a White Paper that ensures Tasmania has a safe, high quality and sustainable health service going into the future.

Issues identified as important by the College are discussed in the following pages. Our position on these issues can be summarized as follows:

- **Volume Safety Equation.** This is a very complex issue and we have addressed this in detail below. Although there are minimum volumes that need to be achieved for complex surgery, it is not true that once these are exceeded the greater the volume, the better the outcome. Consideration of other factors must be given.
- **Clinical Advisory Groups.** The College supports the formation of CAGs. We believe the greatest value is gained from CAGs if they are representative of a broad range of relevant stakeholders. In Tasmania these must have statewide representation and members who are well informed of the issues affecting the whole health sector. The CAGs also need appropriate reporting structures to ensure a feedback loop to/from the government. It is also important the CAGs are careful in providing realistic expectations to stakeholders of what can be achieved.
- **Statewide Waiting Lists.** The College supports equity of access. There are many practical aspects to consider if this was to be implemented. We have also suggested a possible solution through the creation of a real-time information portal to enable General Practitioners, the public and others to view surgeon's waiting lists.
- **Agreed Data Definitions.** The provision of health information, including indicators of performance that are trusted is essential to a cohesive health system that engages clinicians in the future. We would be pleased to work with you more on this issue.
- **Funding of the health system.** We support the Activity Based Funding model proposed and agree having a block funding component is suitable for Tasmania. An increase in funding is required. Concerning health and federal roles, we support an integrated system.
- **Public and Private Services.** Co-dependence is inevitable in Tasmania. RACS supports exploration of public private partnerships to ensure access to high quality surgical services. It is important that capacity within the public sector is utilised prior to contracting out services to the private sector. Implications on training surgeons of the future must be considered.

- **Generalist Model of Care.** The College supports the principle of access to better care rather than access to any care when it comes to surgery. The creation of a rural training hub in General Surgery for Tasmania is already being developed through the College and relevant parties. We are developing a framework of support around extended scope of practice to support the development of generalist surgeons.
- **Trauma Role Delineation.** The development of the Role Delineation Framework is wholeheartedly supported. The College is supportive of an evidence-based and transparent approach to trauma services in all Australian states and territories. Such an approach requires the creation and maintenance of a Trauma Registry. This is an essential part of a mature healthcare system.
- **Sub-Specialty Role Delineation.** There is benefit in altering the Vascular Surgery Role Delineation Framework to better align to how services are currently delivered as this is of significant benefit to the patients. The scope of practice is appropriately determined by the relevant credentialing committee who may seek advice from the relevant sub-specialty as necessary. Time critical emergency services must be considered. Some additional reworking of the divisions between Level 4, 5 and 6 needs to be undertaken to reflect the availability of services that are essential in an emergency situation.
- **Sustainability.** Within a single Tasmanian Health Service, it is essential that Tasmania strengthen its interstate partnerships as proposed in the Green Paper. Duplication of services does not necessarily mean that they are of a lesser quality or more expensive. It is a matter for individual consideration in all of the circumstances. It is clear that services that are single person dependent are not sustainable in the long term. It is agreed that where possible these services need to be redesigned.
- **Practicalities of Travel.** The practicalities of travel need to be considered. If services are going to be relocated then it is essential that the necessary mechanisms be in place before that relocation occurs. Inherent in any process that requires travel or transfers is the risk of that travel or transfer in and of itself.

Greater collaboration with the community, patients, stakeholders and greater cooperation with the DHHS and between the major public hospitals is essential and its inclusion in the Green Paper is much welcomed.

ISSUES:

1. Volume Safety Equation

The Green Paper speaks very strongly in respect of a volume/safety or volume/quality equation. It is worth noting that while this has been clearly established to be the case for certain areas of highly complex surgery that this is not the case across the board^{1,2,3}. Although there are minimum volumes that need to be achieved for complex surgery, it is not true that once these are exceeded the greater the volume, the better the outcome. There are many other factors that play into the equation in addition to the volumes of surgery performed. This is one of the reasons that while NSW has gone down the track of establishing high volume centres for some procedures such as pancreatectomy and oesophagectomy it has not done so for most other procedures. Indeed the numbers chosen for any authorized centre are currently 6 or more cases per year, plus the involvement of multi-disciplinary meetings to make decisions about the care to be given. In NSW this process was also undertaken with significant involvement of the Royal Australasian College of Surgeons (RACS). In contrast Victoria has actively made the decision not to go down this path at all, though the discussions that have been engaged in do involve the RACS.

There is always a delicate balancing act where on one hand we are trying to increase the complexity of patients managed in the community by ensuring this experience is spread across a wider platform, while on the other hand we should select some conditions that are best concentrated in high volume centres.

Other factors that require consideration when talking about a volume/safety equation include:

- The volume of procedures undertaken by that surgeon in private as well as that in the public hospital; for some - particularly elective – procedures, the volumes in private will be significantly higher compared with the public sector. In some areas many of the same support staff will be involved in both sectors.
- The training and level of experience of the surgeon is also important. For example a surgeon who is trained as a generalist surgeon who has many years of experience may well be capable of producing superior results to those results produced by a less experienced surgeon in a unit with greater volumes. Whether or not this is the case can only be shown by careful audit that looks at in-hospital and long-term outcomes.
- A unit with greater volumes may well have lesser numbers of procedures performed by any individual surgeons within the unit, because they have more surgeons in comparison to a smaller unit. For example there are surgeons performing breast cancer surgery in Tasmania who would be considered very high volume surgeons by mainland standards although the total volume of cases through the unit is much smaller than many mainland units. Some research suggests that surgeon volume might be more important than hospital volume.⁴ What is important in these circumstances is the access to multidisciplinary meetings that influences the decision making that goes around the surgery rather than the surgery itself, as well as the provision of other modalities of therapy when appropriate. Unit volume is only one possible indicator of the quality of care that should not be considered in isolation.
- The Green Paper asserts that all four public hospitals in Tasmanian support a subspecialist model of care. From a surgical perspective, while the Royal Hobart Hospital does predominantly run a subspecialist model of care, the Launceston General Hospital, the Mersey Community Hospital and the North West Regional Hospital all run generalist models of care. The “subspecialist model” is therefore facilitated by general surgeons with subspecialty interests. For example, general surgeons with a specialist interest area such as breast or colorectal surgery. The orthopaedic surgeons manage all

orthopaedic cases but some offer a subspecialty interest such as spinal surgery. Another example is the general urologists with an interest in stone disease.

- If surgery in a particular area is concentrated in certain units on the basis of a perceived volume/quality relationship it is inevitable that those generalist surgeons will become deskilled in that area. This has implications for emergency surgical care, particularly when there are time critical emergencies. If the ability of a clinician is compromised by being deskilled, they may not be able to deal with that emergency with the result that a time critical patient may suffer a worse outcome due to the length of time it takes to transfer, usually several hours.
- In the case of Upper Gastro-Intestinal and Hepato-Biliary surgery such as pancreatectomy and oesophagectomy, which is specifically considered by the Green Paper, there is a significant loss of patients to the mainland to both the public and private sector. This occurs because the hospitals in Tasmania do not currently have the resources to deal with the number of patients requiring these services; the service exists but is insufficiently resourced to provide for the number of patients requiring surgery for what are time critical conditions and those patients are therefore referred to hospitals in Victoria.

2. Clinical Advisory Groups

Clinical Advisory Groups (CAGs) have been convened or are in the process of being convened. The RACS supports the formation of CAGs but also recommends that they are truly representative and that their members are well informed of the issues affecting the whole health sector. The opportunity for clinical input into the way in which health services are delivered in Tasmania is welcomed, indeed it is essential.

Some concerns arise around how the governance structure of these CAGs is being implemented. Currently all of these groups perform an advisory role to the Health Council of Tasmania, which performs an advisory role to the Minister for Health. The manner in which the Health Council of Tasmania is constituted raises concerns about how it is able to determine priorities between competing clinical interests and in particular about whether precedence may be granted to the loudest group or those with the most cogent argument rather than the group with the greatest need in terms of providing for the Tasmanian patients.

CAGs have existed for a long period of time under various different names such as the Renal Network, the Cancer Care Network and a whole host of other identities. In the past they have been variably successful depending on the resourcing and favor of the administration and government of the day.

As the CAGs have currently been constituted, they are convened by Hobart based clinicians in all but one instance (where this was a preexisting committee chaired by a Launceston based clinician). There is also little evidence that there was an open and transparent process by which the members of these groups were chosen. There was not an advertised expression of interest and it sometimes appeared that the process was along the lines of a tapping on the shoulder of certain favoured individuals, rather than those who would have been truly representative.

For the CAGs to perform effectively there needs to be adequate representation from all jurisdictions around the state as well as all interested groups in terms of craft and background.

The governance structure needs to ensure that there is clinical input into the decision making for health services. If this does not occur the clinicians involved will rapidly lose interest as there are many competing demands for their attention, and it will be harder to re-engage them in the future.

3. Statewide Waiting Lists

It is clear that the Minister for Health is committed to the delivery of State Wide Waiting Lists as a means of providing equality of access to services across the state. The RACS supports equity of access.

The discussion paper on elective surgery remains silent on many of the practical details as to how State-Wide waiting lists will work.

If we consider the option of just contributing all of the patients into a central repository and each surgeon drawing their list from that repository then a number of issues arise:

- It is the position of the College that it is ideal if the surgeon providing the procedure is also responsible for the preoperative assessment, the consent and the postoperative care. This is because there are subtle differences in surgical decision-making or matching particular procedures to surgeons and their surgical outcomes. This does not obviate the need for a second opinion, consultation or multidisciplinary decision making for selected complex cases.
- Not all surgeons will operate in the same circumstances; there are different thresholds for operating amongst the surgeons even within the one craft group.
- Not all surgeons will perform the same operation in the same circumstances; what works for one surgeon may not be as effective in the hands of another surgeon.
- The ability of the State system to preoperatively assess everyone in outpatients is limited. Currently at the LGH 60% of the [public] waiting list is contributed from private rooms (as a single example). Were these patients to be seen in outpatients it would involve double handling many patients outpatient, preoperative assessment and decision making in an already overcrowded and overburdened system.
- One of the reasons that patients do not commence medico-legal action even when things go wrong is because of the pre-existing relationship with the doctor concerned. If a central waiting list is created then this relationship is lost and the surgeon becomes little more than a name on a bed card at the head of the bed.
- When complications occur if patients have travelled for their surgery then they may well occur when they have returned to their place of residence. This situation is then fraught as the emergency department and surgeon who are left to deal with the complication mostly won't have the operation note and where they do even the most comprehensive note will not convey all of the information that would be available to the surgeon who performed the procedure. Thus the options are either to transfer the patient at significant cost in terms of money, time and inconvenience or deal with the complication as best as one can. Obviously this is a less than ideal situation. There are many lessons to be learned in this space from the English NHS experience with contracting surgical activity to Spain. In those circumstances while the bureaucracy found this to be a successful experience the story was very different for many patients and clinicians.
- The costs of shifting a patient from their place of residence also need to be considered. This cost is not just in terms of the monetary cost of the travel although this is significant. Other costs are removing the patient from their support network of family and friends when they are undergoing a traumatic experience because although surgery is for us an everyday experience it is very different for the patient and this can significantly impact a patients' recovery.

- Surgery is a complicated experience. As a surgeon it is difficult to manage patient expectations on many occasions. There is a risk that we may create a system that increases the chances of raising patient expectations to a level that is beyond that which can be delivered.

It is possible to consider whether a pooled central waiting list may work for a limited range of procedures but again a lot of the same issues will arise. Alternatively patients could be approached to see whether they would be interested in receiving care in an alternate location. Unfortunately, this approach would also not alleviate many of the risks discussed above.

Perhaps a way of delivering Statewide Waiting Lists is to publish to the public, the Primary Health Care sector and in particular the General Practitioners (who are responsible for referral of patients to surgeons) all of the details about different surgeons waiting lists. This could be done on a regular basis or a live IT portal could be created such that waiting list information could be visualized in a totally transparent manner in real time. This would enable General Practitioners and patients to make informed decision around to whom and to where they were referred.

4. Agreed Data Definitions

An area touched on in several aspects of the Green Paper but needing further development, is the establishment of agreed data definitions and dates for drawing of that data. The College would welcome working with Tasmanian Health Ministry on this important topic.

We would also be willing to provide advice on the interpretation and governance of data. The provision of health information, including indicators of performance that are trusted is essential to a cohesive health system that engages clinicians in the future.

5. Recognising Current Success

It is clear that there are areas in which the Tasmanian Health system can be improved. It is also clear to those of us who work at the coalface that there are many areas where the delivery of health care is already of a high standard. It is therefore important that in reforming the system that we do not throw the baby out with the bath water and destroy those aspects of the health system, which is functioning well.

It is essential that we reform those areas that require it, retain those areas which are functional and do so with as much consensus as possible.

6. Funding of the Health System

It is acknowledged that the Tasmanian Government is in a difficult financial position as is clearly stated in the paper on sustainability supporting the Green Paper. It will always be difficult for a smaller state or territory to be self-sustaining.

We support the Activity Based Funding model proposed and agree having a block funding component is suitable for Tasmania.

However, further funding is required over the long term. Without that additional funding health care rationing will be required as the efficiency gains will be insufficient to address the shortfall. The planning and implementation must be open, transparent and practical.

7. Integration of State and Commonwealth Services

As discussed in the Green paper we are subject to the dysfunctionality thrust upon us by the divisions between a Federal and State Health System. This does lead to a duplication of services which can be inefficient. We support an integrated health system.

8. Public and Private Services

In Tasmania there is an inevitable co-dependence between the private and public sectors. This is well recognized in the Green paper and RACS supports exploration of public private partnerships to ensure access to high quality surgical services.

The private sector depends on the public sector to supply the high-end complicated services and the public sector depends on the private sector to undertake a volume of work that the public sector could not accommodate both from a volume and fiscal point of view. There may also be capacity in the private sector to help manage patients on the public elective surgical waiting list.

It is important to recognise particularly in surgery that the specialist workforce for the public sector is in many cases the same workforce as the private sector. As the private sector is more lucrative and provides access to greater volumes of work, it is this aspect of practice that allows recruitment of adequate numbers of specialists. In surgery it is important to appreciate that staff specialist models of care do not always work as it may well not be possible to occupy a full time staff specialist for an adequate number of hours per week unless less specialists are employed, thus reducing an ability to staff an on call roster.

In assessing a surgeon's volume it is essential to consider their throughput in the private sector as well as that in the public hospital. For a number of procedures the volumes in private will be significantly higher in private compared with the public sector. This may well make services viable that would not be viable on a public volume alone.

It is encouraging to see that the Green Paper seeks to develop further synergies between the public and private sectors although it is important that capacity within the public sector is utilised prior to contracting out services to the private sector as training opportunities are in general better able to be utilised in the public sector as evidenced by the training programs run by the RACS throughout Australia. It is essential that we maximise our training opportunities as training registrars are often the source of our consultant staff in the future and to say that for most surgical specialties we are in a highly competitive market understates the difficulties in recruiting significantly.

9. Generalist Model of Care

The RACS is currently investing a significant amount of time and effort in furthering the generalist model of care through establishment of rural and regional training hubs and growth of support around extended scope of practice to support the development of generalist surgeons. A summary of our principles are attached (attachment 1).

The College supports delivery of specialist surgical services to the whole population through a mix of specialist surgeons and surgeons covering a wide scope of practice. Surgeons working across a wide scope of practice are particularly necessary and effective in emergency surgery, rural and regional areas, military and humanitarian work. They are also increasingly desirable for the management of patients with multiple and complex conditions and presentations.

To deliver the maximum level and highest quality of service to patients, surgeons working across a wide scope of practice should have cooperative, easily accessible and mutually supportive relationships with more specialized colleagues and centres.

It is also very important that hospitals and health jurisdictions provide a supportive medico-legal framework to ensure surgeons who must extend their scope of practice in emergency situations are not penalized.

The support for a generalist model of care and for clinicians practicing and being supported to practice to the limits of their scope of practice that is presented in the Green Paper is welcomed and strongly supported.

10. Trauma Role Delineation

The development of role delineation and the Role Delineation Framework is wholeheartedly supported. The College's National Trauma Committee is supportive of an evidence-based and transparent approach to trauma services in all Australian states and territories.

Such an approach requires the creation and maintenance of a Trauma Registry. This is an essential part of a mature healthcare system. Without this, it is difficult to be objective. It is important to have an understanding of Trauma Triage tools in use by the ambulance service and existing trauma services and ensure this data is readily available and shared.

Retrieval Service data is also useful along with protocols in:

- Prehospital – hospital communication
- Hospital to hospital communication
- State wide Trauma Quality Assurance

Patients would greatly benefit from robust triage protocols including a triage hotline for GPs and others to use. This would not be a costly outlay for the government but would provide great benefit.

The College is more than willing to offer advice and expertise to the Tasmanian DHHS in setting up a Trauma Registry and supporting protocols.

The proposal in the Green Paper to transfer all major trauma cases from the North West Regional Hospital (NWRH) within 24 hours and from Launceston General Hospital (LGJ) within 72 hours must be on clinical grounds. Likewise the pathway for referral of patients to the appropriate trauma service should not be strictly on geographical and distance considerations. Urgency of treatment is behind the concept of the Golden Hour in terms of trauma treatment as taught in the Emergency Management of Severe Trauma (EMST) Course by the RACS.

It is important to consider that the patient may not benefit from the transfer if their definitive management has been completed and they are recovering. The patient may actually be harmed by the transfer if for example they have solid organ injuries that are being treated conservatively.

Essentially it is about having the right patient in the right place at the right time. A standard policy on transferring all patients is not the solution. Transfers must be based on the merits of the case to the right place – whether that is within Tasmania or to the mainland.

The current and immediate future capacity of the Royal Hobart Hospital in dealing with a likely significant volume of patients as a result of the proposed approach must also be considered. We are all aware of the upcoming capital works project which is likely to impact capacity for the next 3-5 years.

A collaborative approach between the four major hospitals would provide a greater benefit to patients and will likely reduce unnecessary costs to the system. Open communication and collaboration could ensure that those patients who will benefit from transfer are more easily able to be transferred and those who will either not benefit or potentially be harmed by the transfer remain where they are.

11. Sub-Specialty Role Delineation

Again the development of role delineation and the Role Delineation Framework is wholeheartedly supported. Some modification to the framework is required for better service delivery. Vascular Surgery in particular has a sense of urgency to it, and there is benefit in altering the Vascular Surgery Role Delineation Framework to better align to how services are currently delivered as this is of significant benefit to the patients.

The scope of practice for all sub-specialties is appropriately determined by the relevant credentialing committee who may seek advice from the relevant sub-specialty as necessary. Placing the Director of the Statewide Service in the position of deciding upon the scope of practice of surgeons outside of the RHH is placing the Director in a difficult position and may not provide for objective determination.

Some additional reworking of the divisions between Level 4, 5 and 6 needs to be undertaken to reflect the availability of services that are essential in an emergency situation. This is because it is unreasonable to expect a generalist surgeon who has been deskilled by a restriction in his scope of practice to suddenly perform those procedures that he has not been performing recently in an emergency situation. This is particularly so where the LGH has a hybrid theatre available and many vascular emergencies are unable to be transferred in a manner that will allow for the pathology to be addressed in a timely fashion. These range from issues with bleeding to issues with ischaemia, where a part of the body has lost its blood supply. To restrict a scope of practice in this manner also goes against many of the principles expounded in the Green Paper that go to development of the generalist model of care and clinicians practicing the full extent of their scope of practice and being supported to do so.

It is noteworthy that there is currently an over supply of vascular surgeons in Australia and hence a resistance by vascular surgeons to train generalists in vascular techniques. This is in contradistinction to almost all other surgical subspecialties. In many cases the more recently trained vascular surgeons have significantly less experience in many aspects of open vascular surgery than those less recently trained generalists who practice with a vascular interest.

Similar issues arise with the Paediatric Surgery Role Delineation Framework, but in many ways they have already been able to be dealt with because of the collegiality and collaboration that exists between the surgeons both subspecialist and generalist. It would be advisable to address this in the Paediatric Surgery Role Delineation Framework so as to ensure that the documentation accurately reflects what is agreed and happens in practice.

12. Sustainability

The aim must always be to improve outcomes. This is not always achieved by concentrating services. Duplication of services does not necessarily mean that they are of a lesser quality or more expensive, in fact, services in some circumstances can be delivered more economically by having those services duplicated and providing more timely access to a service without the added cost of transfer; local access does not always mean poorer outcomes and the availability of many surgical services at every large hospital does not necessarily mean that patients wait much longer than clinically recommended. In contrast some services should not be duplicated as this makes them less efficient and may compromise quality. It is a matter for individual consideration in all of the circumstances.

Within a single Tasmanian Health Service, it is essential that Tasmania strengthen its interstate partnerships as proposed in the Green Paper. The concept that all elective surgical services must be provided on the island is unsustainable. The current reluctance to interstate transfer where it is appropriate must be overcome. In strengthening inter-state relationships there is an opportunity to further Tasmania's learning teaching and research through collaboration with larger institutions on the mainland.

It is clear that services that are single person dependent are not sustainable in the long term. It is agreed that where possible these services need to be redesigned. In some areas redesign can be achieved by promoting the generalist model of care that is discussed extensively in this document and in the Green Paper. In some areas single person dependency may be a necessary evil such that time critical problems can be addressed at least in the short to medium term and better alternatives may be established in the long term.

13. Practicalities of Travel

The practicalities of travel need to be considered. If services are going to be relocated then it is essential that the necessary mechanisms be in place before that relocation occurs. If this is not the case then patients will be compromised as they fall into the gaps. It is essential that capacity be created at the receiving location. This will require significant consideration as there is little spare capacity in any of the major public hospitals and the RHH is about to enter a major capital works project that will further impact on capacity.

Inherent in any process that requires travel or transfers is the risk of that travel or transfer in and of itself. This is well established in retrieval medicine. This includes the delay in treatment, perhaps less of an issue in the elective setting but definitely an issue in the emergency situation.

Again the practicalities of deskilling a generalist work force need to be considered as discussed above. This is particularly an issue in time critical situations.

References

1. Lauder CIW et al. ANZ J Surg 2010;317-323. Systematic review of the impact of volume of oesophagectomy on patient outcome
2. Finks JF et al. N Eng J Med 2011;364(22): 2128-2137. Trends in Hospital Volume and Operative Mortality for High-Risk Surgery
3. Birkmeyer JD et al. N Eng J Med 2002;346:1128-1137. Hospital volume and surgical mortality in the United States.
4. Brusselaers N. Mattsson F. Lagergren J. Gut. 63(9):1393-400, 2014 Sep. Hospital and surgeon volume in relation to long-term survival after oesophagectomy: systematic review and meta-analysis.