Submission No 29

INQUIRY INTO THE MANAGEMENT OF HEALTH CARE DELIVERY IN NSW

Organisation: Royal Australasian College of Surgeons

Name: Dr Raffi Qasabian

Position: NSW Chair

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The Chair
Mr Bruce Notley-Smith MP
Public Accounts Committee
Parliament House
Macquarie Street
SYDNEY NSW 2000

Subject: Inquiry into the Management of Health Care Delivery in NSW

Dear Mr Notley-Smith,

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. RACS is a not-for-profit organisation representing more than 7,000 surgeons and 1,300 surgical trainees. Approximately 95 per cent of all surgeons practicing in Australia and New Zealand are Fellows of the College (FRACS).

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

The NSW RACS Committee not only represents the College in NSW, but has the privilege of representing almost 2000 Fellows and 450 Trainees as well as a number of International Medical Graduates on behalf of the College to key stakeholders throughout our state.

The NSW RACS Committee greatly appreciates the opportunity to make a submission to the “Inquiry into the Management of Health Care Delivery in NSW”. The Committee has been involved with NSW Health and the NSW Ministry for some time and we appreciate the interaction and opportunities to benefit not only surgery but also patient care in our great state.

From a surgical perspective regarding the current performance reporting framework for monitoring the effectiveness and efficiency of health care service delivery in NSW there are variances between hospitals with regards to the sharing of information, one example being around in-house Mortality and Morbidity audits, when in place this is a valuable tool for maintenance and development of standards.

RACS is also fortunate to support the Clinical Excellence Commission’s (CEC) Collaborating Hospitals’ Audit of Surgical Mortality (CHASM), (*http://www.cec.health.nsw.gov.au/incident-management/mortality-review-committees/chas)*. RACS has a requirement for all Fellows undertaking Continuing Professional Development "to participate in the Australian and New Zealand Audit of Surgical Mortality if a surgeon is in operative-based practice, has a surgical death and an audit of surgical mortality is available in the surgeon's hospital."

The Bureau of Health Information (BHI) regularly collects data regarding admissions and elective surgery, which is a useful tool for evaluating the ongoing efficiency of hospitals for admissions to emergency departments and waiting lists for elective surgery through their publication of “Healthcare Quarterly”. The snapshot gives a clear guide as to hospital performance regarding admissions, elective surgeries and other areas relevant to the larger medical community.

College of Surgeons of Australia and New Zealand ABN 29 004 167 766

Suite 1, Level 26, 201 Kent Street, Sydney NSW 2000 Australia
Telephone: +61 2 8298 4500
Facsimile: +61 2 8298 4599 **Email:** college.nsw@surgeons.org
Website: www.surgeons.org

The Surgical Services Taskforce (SST), under the Agency for Clinical Innovation (ACI) was established to "optimise access to elective surgery for patients within the NSW Health System" (*https://www.aci.health.nsw.gov.au/networks/surgical-services-taskforce*). The RACS NSW Committee has representation on the SST and this has proved a positive conduit for accessing and sharing information in regards to the effectiveness and efficiency of surgical care in NSW.

The SST is supportive of various initiatives including the National Surgical Quality Improvement Program (NSQIP) which was developed by the American College of Surgeons and enhances a hospital's ability to zero in on preventable complications. The SST has established a NSQIP Steering Committee to assist hospitals with implementation in NSW.

As is obvious from the above, RACS in NSW is both a supporter and advocate for the current performance reporting framework for monitoring the effectiveness and efficiency of health care service delivery in NSW. We feel that it is important to emphasise that there are opportunities for development through the standardisation of data collection at both a hospital level and also at a Local Health District level (LHD), thus reducing the risk of inaccuracy.

As to the extent to which efficiency and effectiveness is sustained through rigorous data collection, monitoring and reporting, it can be seen from the response to the first terms of reference that the NSW Committee is fully supportive of rigorous data collection, but this data needs to be collected uniformly and utilised in a prescribed manner. There is a strong need to maintain ongoing data collection, monitoring and reporting, not only to justify the high standards that we set for our profession, but to also aim for world class patient care as an ongoing expectation.
An issue that may arise is over reporting or misreporting of patient issues across various departments, e.g. an incident or outcome, recorded as an individual incident, or recorded twice or more as a patient is moved throughout a hospital and testing environment. Consequently we would emphasise the need for clear access to patient records, not just during their time in hospital, but post-discharge. This is an ongoing risk for data collected across differing methods.

The BHI, CEC and the ACI are clearly aware of these issues and are indeed addressing these concerns, but it is important to highlight them none the less.

Regarding the adequacy of the provision of timely, accurate and transparent performance information to patients, clients, health providers and health system managers we would propose that this is an area that can be developed further resulting in positive outcomes. Providing timely relevant data to stakeholders can be difficult, but adding in an easily found and utilised path for the public is another issue. From a medical professional perspective the LHDs and hospitals should be circulating the information so that it can be utilised. This should go beyond who the LHD and the hospitals see as key stakeholders in the area of patient care, rather the data and outcomes should be accessible for other medical practitioners who may be in a position to treat the patient in the future or concurrently.

Information and communication of information should be relevant to the target stakeholder and as stated above there is a need for access to treatment across differing spheres within the medical environment. The patient should receive the highest quality of care offering optimum results and they should feel confident that this is what they are receiving along with clear disclosure as required by law.

Health providers and health system managers should know that they are getting economic efficiency and value.

As can be seen from the above there is the need for pertinent timely data in varying formats to various stakeholders.

The current framework drives positive change, but we feel that more could be achieved though the collaboration over other key areas associated with the provision of healthcare such as access to surgery in the rural setting or appropriate follow-up care data, access to comparative data on public versus private numbers and outcomes and data around the effectiveness of academic surgery in relation to increases in quality.

Finally we would raise some points that we feel have relevance to this discussion. An area that RACS as a whole has been addressing, not just in NSW, is the issue of bullying and harassment, across training and with colleagues.

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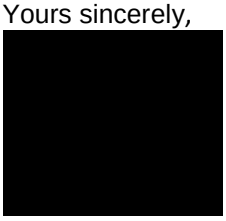
RACS has developed a plan entitled “Building Respect, Improving Patient Safety” (*http://www.surgeons.org/about-respect/)* to address this issue that has previously been highlighted within our College, and subsequently across other Colleges and health organisations. Key to this is the acknowledgment that these negative traits affect patient safety and quality of care. Consequently having data that can be shared with appropriate stakeholders would prove valuable and beneficial.

As a Committee of RACS we regularly have to address the ongoing need from more surgeons in the rural setting and the difficulties associated with achieving this. We regularly discuss these issues with the Ministry and the Pillars and having data to guide in our approach and discussions would prove most valuable.

In summing up we fully see the need for ongoing data collection and evaluation if we are going to maintain high standards, reduce risk and ensure a sustainable health service for the residents of NSW. The importance of shared accurate information is a prerequisite of offering the highest quality in surgical care as well as training the highest standard of surgeons which are key to RACS.

Yours sincerely,



Dr Raffi Qasabian

Chair, NSW Regional Committee

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