Royal Australasian College of Surgeons

Outreach Surgery in Regional, Rural and Remote areas of Australia and Aotearoa New Zealand

POS-3199

RURAL HEALTH EQUITY

Outreach means providing services at locations distant from a surgeon's main practice location.

The RACS Rural Health Equity Strategic Action Plan[i] aims to improve rural health equity by increasing access to safe, quality surgical services, delivered as close to home as possible for remote, rural, and regional people (hereafter, collectively referred to as rural). Outreach is a key component of increasing access to surgical services for rural people and improving rural health equity. Advocating and working for better access for those living in rural and remote areas, including through outreach, is a positive behavioural marker in the RACS Surgical Competence and Performance Framework and Professional Skills Curriculum.

Ideally, outreach surgery responds to community need, is context sensitive, culturally appropriate, and culturally safe, adds value to existing services, and is viable and sustainable.

In addition to the inherent value of providing services to patients, outreach services reduce the time and cost of travel for patients and their families and contribute positively to local communities and economies. Rural patients consider receiving care close to home an important part of their perception of quality of care.

PLACE-BASED OUTREACH SERVICES

RACS provides these guidelines for quality outreach services, while also encouraging flexibility to develop place-based services relevant to the context and needs of individual rural communities and surgical disciplines.

Rural communities are diverse; they are not one-size-fits-all. An individual rural facility can vary over time in its ability to provide care, depending on available medical practitioners and nursing staff in the perioperative team. Surgeons engage in rural contextual decision making, taking into consideration patient and place: local infrastructure, perioperative team availability and skills, patient factors and procedure factors to ensure the patient receives care in the right place. For outreach surgical services to be safe, an individual risk assessment and risk management plan is essential.

REMOTE, RURAL AND REGIONAL ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES AND MAORI

In planning and participating in surgical outreach services, surgeons should consider the unique context of Remote, Rural and Regional Aboriginal and Torres Strait Islander Peoples and Māori.

Key themes include:

- Indigenous holistic concepts of health, as not just the physical wellbeing of an individual but as the social, emotional, and cultural wellbeing of the whole community and of Country; and tikanga Māori values, holistic models and concepts of health and healthcare.
- The importance of family connections and relationships, and connection to Country and the natural environment for Aboriginal and Torres Strait Islander Peoples. The importance of Whakapapa for Māori: connection to iwi, hapu and family/whānau and to land/whenua.

- The effectiveness of Aboriginal and Torres Strait Islander and Māori health care workers, interprofessional healthcare teams and healthcare facilities, in enhancing patient outcomes.
- Principles of self-determination, partnership, community ownership, consultation, capacity building, reciprocity and respect in health care delivery and health service design.

Ideal outreach practice demonstrates:

- Cultural competence and cultural safety principles, cultural humility, and cultural agility, in caring for patients and their families/mob/whānau, and in working with and supporting Aboriginal and Torres Strait Islander colleagues in training, surgery and health workforce in general.
- Knowledge of
    - the values, cultural practices, languages, Country and land of the local Aboriginal and Torres Strait Islander community or Māori community
    - local population health issues and their impact on Indigenous people,
    - how cultural practices and responsibilities may impact on healthcare pathways.
    - health resources available in the healthcare team, Aboriginal and Torres Strait Islander and Māori liaison team, Aboriginal and Torres Strait Islander and Māori health services, family and community.
- culturally safe integration of the patient's family/mob/whānau and other community resources in assessment and management.
- Provision of access to interpreters in person or virtually, where language barriers exist between the medical team and the patient and their family/whānau, and of culturally appropriate and relevant patient information.
- The value of delivery of healthcare in place, on Country or as close to home as possible
- Collaboration with Aboriginal and Torres Strait Islander and Māori health care workers, interprofessional healthcare teams and healthcare facilities, to enhance patient outcomes.
- Reflective practice and clinical quality activities, including evaluating service acceptability and accessibility, and patient outcomes, with an equity lens.

In addition to the requirement for all surgeons to undertake cultural competence and cultural safety education and training, Surgeons providing outreach services to Aboriginal and Torres Strait Islander and/or Māori people and communities should ensure such training is relevant to the particular community they intend to serve and is acceptable to the community receiving the outreach services.

OUTREACH SERVICES EMBEDDED IN HEALTHCARE SYSTEMS AND NETWORKS

RACS strongly advocates for outreach services to be embedded in public healthcare systems and networks and commits to collaboration with rural communities, jurisdictions and specialty societies to achieve national and regional systems of surgical outreach.

Outreach services embedded in and resourced by health system networks contribute to the continuity, sustainability and longevity of outreach services.

Embedding outreach services in health systems, with service agreements between urban and rural facilities, enables services to be maintained by a team of surgeons, with reliable funding, staffing, leave cover and longevity of service, rather than relying on an individual surgeon’s availability. Systemic approaches to outreach services should be driven by data, including community need for surgical services and workforce planning, and should be combined with funding for infrastructure for rural facilities and ongoing funding for service provision.

RACS strongly advocates for collaborative models of surgical care, combining virtual healthcare in geographically dispersed healthcare teams with inreach, outreach and locum services.

Networks with strong links between urban and rural facilities enables the benefits of dispersed and centralised models of healthcare to be realised; facilitating patients to access quality surgical care delivered as close to home as possible and when needed, the referral or transfer at the right time to the right facility for the right care.

Systems of surgical outreach, with collaboration between urban and rural surgical units, also facilitates the movement of staff bidirectional movement of surgeons between rural and urban facilities, for maintaining skills, continuing professional development and locum relief. This includes the ability to include Trainees in outreach surgical services, providing teaching and learning environments for the development of skills in outreach practice during Surgical Education and Training. The RACS Remote, Rural and Regional Professional Skills Curriculum and eLearning Course includes outreach surgical services.

RURAL FOCUSED URBAN SURGEONS RUFUS

Urban and rural surgeons engage in outreach. Rural Focused Urban Surgeons (RUFUS) engage in work that benefits rural patients and rural surgeons through:

Caring for remote, rural and regional patients through:

- Outreach: travelling to provide direct patient consultations and/or procedures
- Inreach: from an urban base, providing
    - Onsite care for rural patients travelling for treatment.
    - Virtual healthcare or telemedicine
    - Collaborative care in geographically dispersed teams.

Supporting rural generalism

Rural Generalists are rural general practitioners trained, registered and credentialled for broad scope or top-of-scope practice, emergency medicine and additional advanced specialist training in once of 13 areas, including rural generalist anaesthesia and surgery. Rural nurses and allied health practitioners have broad or top-of-scope practice, and may develop subspecialist, extended or over-lapping scopes of practice to meet community need. Rural health multidisciplinary teams include rural generalists, nurses and allied health practitioners with broad, extended and overlapping scopes of practice, collectively meeting their community's healthcare needs.

Rural Surgeons working in areas too small to support a full range of surgical specialties and subspecialties develop extended scopes of practice in response to community need.

Urban subspecialists and subspecialist societies can amplify their impact and ensure rural patients benefit from specialist and subspecialist care through collaborative models of training and healthcare with rural surgeons, rural generalists and rural health multidisciplinary teams.

Collaboration in geographically dispersed teams can include:

- Collaborative care for patients, remote decision support, and virtual multidisciplinary treatment planning meetings.
- Supporting rural surgeons and rural generalists to develop and maintain extended or subspecialty scopes of practice.
- Collaborative audit, peer review of practice and other quality assurance and quality improvement activities.
- Contributing to on call, locally or virtually. Rural surgeons have higher on call demands and outreach surgeons can reduce this load by contributing to the on-call roster on multi-day visits and be mindful of the added burden on rural surgeons of delegating post-operative care.

- Supporting rural surgical training: onsite and remote supervision of SET trainees and teaching, mentoring, and recruiting rural early career doctors and medical students to surgery.
- Supporting rural facilities by maximising use of local resources and building the capacity of local healthcare teams.

AFTER CARE, RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION, AND DELEGATION

Safe, quality care requires that, following a procedure, the surgeon should not leave the local area until the patient is in a stable condition and unlikely to need their immediate care. If a surgeon will not be available locally during the whole hospital admission or period of recovery from surgery, a documented plan of delegation must be in place. After discharge from hospital, patients need to know who will care for them, and when and how to seek help.

In most cases, the delegate should be a specialist medical practitioner capable of recognising and responding to clinical deterioration[ii]. AHPRA defines a specialist medical practitioner as a medical practitioner who has been assessed by an Australian Medical Council-accredited specialist college as being eligible for fellowship of that college, including surgeons, anaesthetists, emergency physicians, physicians and general practitioners (with fellowship of the Australian College of General Practice RACGP or the Australian College of Remote and Rural Medicine ACRRM).[iii]

While Prevocational and Vocational doctors (including RACS SET trainees) may be involved, they must be supervised by a Specialist Medical Practitioner, who is available to attend on site. Exceptional arrangements may be considered, where senior career medical officers are in place and hospitals are closely networked, with remote specialist supervision and fail-safe transfer mechanisms of less than one hour travel distance.

There must be predetermined pathways for transfer to definitive care for a deteriorating patient, with clinician-to-clinician and facility-to-facility level agreements in place. A formal surgeon-to-delegate handover must occur for each patient, and should be documented in the medical record, including who is responsible and how they can be contacted.[iv] The availability of the delegate should be confirmed before commencing the surgical procedure. Ideally, a delegate may be involved in the procedure as anaesthetist or surgical assistant.

OUTREACH RISK ASSESSMENT

Careful planning will maximise the benefits and reduce the risks of outreach surgical services. Planning outreach surgical services for a specific rural facility should consider:

- Community need: conducting a needs analysis; balancing the benefits to the community and local health workforce of outreach surgery with the risks of delivering care differently, while also keeping in mind the risk to the community and to individual patients of having no service.
- Jurisdictional surgical and anaesthetic capability frameworks and the specific capability level of the rural facility for adult and paediatric patients.
- Responding to clinical deterioration. For the proposed scope of surgical practice consider:
    - The type and frequency, and time-period within which complications requiring emergency management may arise.
    - The skills, knowledge, and infrastructure required to recognise and respond to clinical deterioration, with stabilisation and then definitive management or transfer.
    - The local health workforce: who has these skills or could be trained.
    - Real world transfer times to a facility capable of responding to postoperative complications.

- Safe hours: outreach surgeons should schedule themselves to minimise the impacts of fatigue on work quality and personal safety, including driving.
- Viability: While nothing in this paper should be interpreted to reduce competition between commercial entities or medical practitioners, surgeons should consider how their outreach services may reduce the viability of mixed public/private local practices and hospitals, with risk of loss of services, resulting in reduced access and increased costs for patients. Models that may compromise viability of local services include private-only services and bypassing local services, where consultations happen close to home but local public and private hospitals with capacity to provide care are bypassed in favour of transferring patient care to an urban private hospital.

OUTREACH RISK MANAGEMENT PLAN

The team, including Directors of Medical and Nursing services, the outreach surgeon and local surgeons, anaesthetists, nurses, and rural generalist general practitioners can then negotiate:

- Scope of practice. What's in, what's out.
- Post operative care plan, for example:
    - The surgeon does not leave the local area until the patient is in a stable condition and unlikely to need their immediate care. The surgeon remains within proximity to the facility for a defined period after each operating list (e.g. within an hour of the facility for 24 hours) OR
    - A documented plan of delegation of post-operative care to a specialist capable of recognising and responding to clinical deterioration. The surgeon is available remotely by phone or video to advise. There is documented facility and surgical unit level agreements for transfer of deteriorating patients from the rural facility to a nominated regional or metropolitan facility OR
    - The surgeon undertakes procedures with very low risk of clinical deterioration requiring emergency care and can be available remotely by phone or video to assess and manage post operative concerns (e.g. excision skin lesions, hand surgery, insertion of ventilation tubes, upper GI endoscopy, cystoscopy).
- Capacity and capacity building. A gap analysis and plan for training and upskilling local medical and nursing staff.
- Coordination of rosters to ensure key staff are available at the time of surgical outreach visits. Before starting an operation list, the surgeon should satisfy themselves that the plan for post operative care is actionable in that facility at that point in time, taking into consideration availability of key staff. In small facilities, absence of key staff can reduce capability levels significantly.
- Handover. At the end of the operating list, a formal surgeon-to- delegate handover must occur for each patient, and should be documented in the medical record, including who is responsible and how they can be contacted.
- Clinical Quality Activities. A system for reporting clinical incidents, reviewing the agreed scope of practice and postoperative care plan, and updating as needed.

EVALUATION OF RRR OUTREACH SERVICES

Outreach services should be integrated into the quality assurance and quality improvement systems of both the local and distant healthcare teams and facilities.

Outreach services to remote, rural and regional communities should also be evaluated using agreed frameworks and benchmarks, for example the framework for evaluation of visiting health services in rural and remote settings by Healey et al. (2021)[v] (2) or principles for visiting healthcare services by

Carey et al. (2018)[vi](3). These frameworks combine healthcare quality with responsiveness to context and community need and collaboration and integration of local and outreach teams and services.

Carey et al.'s model includes seven domains: justification (response to community need), scheduling, co-ordination (collaboration between local and visiting stakeholders), scope (ability to meet community need), continuity, support (orientation to context including culture), review (of service and of community need). Healey et al.'s framework includes: feasibility (sustainable funding and capacity), justification (needs assessment, placed-based healthcare model), partnership (collaboration and integration with existing local services), scope (capacity and specificity of services in relation to meeting community need), scheduling (how well the frequency and duration of visits meet community need), continuity (consistency and reliability) and review (effectiveness and appropriateness, combining analysis of community need and evaluation of service provided).

COMPANION DOCUMENT

Outreach Surgery in Regional, rural and remote areas of Australia and Aotearoa New Zealand- Case Studies provides contemporary examples of the application of the principles in this position paper.

[i] Royal Australasian College of Surgeons. Rural Health Equity Strategic Action Plan [Internet]. 2022 [cited 2022 July 9]. Available from: https://www.surgeons.org/News/News/Rural Health Equity Strategic Action Plan

[ii] Medical Council of New Zealand Good Medical Practice 2021 https://www.mcnz.org.nz/assets/standards/b3ad8bfba4/Good-Medical-Practice.pdf

[iii] Australian Health Practitioner Regulation Agency https://www.ahpra.gov.au/Support/Glossary

[iv] Medical Board of Australia Ahpra. (2020). Good medical practice: a code of conduct for doctors in Australia. https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx

[v] Healy LJ, Beccaria G, McIlveen P. Revised model for evaluating visiting health care services in rural and remote settings. Aust J Rural Health. 2021 Oct;29(5):779–88.

[vi] Carey TA, Sirett D, Wakerman J, Russell D, Humphreys JS. What principles should guide visiting primary health care services in rural and remote communities? Lessons from a systematic review. Aust J Rural Health. 2018June;26(3):146–56.