Royal Australasian College of Surgeons

Unleashing the potential of our workforce - Scope of Practice Review
Royal Australasian College of Surgeons (RACS)

About you

1. Which of the following perspectives best describes your interest in the Scope of Practice Review?

- ○ Aboriginal and Torres Strait Islander health practitioner
- ○ Aboriginal and Torres Strait Islander health worker
- ○ Allied health
- ○ Consumer
- ○ Government
- ○ Health administration
- ○ Insurer
- ○ Medical – GP
- ○ Medical - other specialty
- ○ Midwife
- ○ Nursing - enrolled nurse
- ○ Nursing - nurse practitioner
- ○ Nursing - registered nurse
- ○ Paramedic
- ◉ Peak body
- ○ Pharmacy
- ○ Practice manager
- ○ Professional association
- ○ Regulator
- ○ Student
- ○ Other

What is your postcode? 3000 Victoria

Benefits of expanded scope of practice

2. Who can benefit from health professionals working to their full scope of practice?

☑ Consumers ☑ Funders ☑ Health practitioners ☑ Employers ☑ Government/s ☐ Other

Other group(s) All of the above

3. How can these groups benefit? Please provide references and links to any literature or other evidence.

- When health professionals work to their full scope of practice consumers would benefit from prompt and high-quality care in coordinated manner.
- This rapid and timely provision of care would help decrease the burden of disease and associated risk factors, reduce unnecessary disability and premature death, and promote health equity.
- This would have downstream benefits for funders and government.
- Non-FRACS surgical practitioner should be able to work a lower scope of practice of surgery relative to a FRACS surgeon and covers basic procedures. Complex and advanced operations reserved for FRACS. The non-FRACS surgical practitioner must work in collaboration with FRACS so to ensure there is no scope creep and there is good continuity of care as a multidisciplinary team (MDT).
- The World Health Organization policy recommendations for rural health workforce recommend extended scope of practice for rural health workers. It benefits patients and it improves the attractiveness and professional satisfaction of health practitioners working in rural settings.[1,2]
- Reference: RACS collaborate for rural strategy paper [3]

Risks and challenges

4. What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice? Please give examples of your own experience.

When granted extended scope of practice, some practitioners can at times undertake procedures beyond their accredited scope (scope creep). Practitioners need to know when their scope ends. This needs to be governed well.

5. Please give any evidence (literature references and links) you are aware of that supports your views.

SA Fellow has personal experience only.

Real life examples

6. Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care?

- No
- Yes

7. Please give examples, and any evidence (literature references and links) you have to support your example.

- The Rural Generalist training program works in conjunction with Australian College of Rural and Remote Medicine (ACRRM) and Royal Australian College of General Practitioners (RACGP) and other non-GP specialist medical colleges has enabled GPs to work in an expanded scope of practice for minor surgical procedures providing care locally without having to displace the patient and minimising the pressure on urban hospitals (i.e., reducing the rate of tertiary hospital transfers).
- Australian and New Zealand College of Anaesthetists (ANZCA) have their own GP diploma.
- Nurses assisting in endoscopy[4] and urological procedures could be feasible with specialist nearby should the patient's condition deteriorate.
- From a consultation (outpatient) point of view, nurse practitioners are already trained to do consultations and could be expanded to incorporate defined protocols for diagnostic tests under the supervision of the medical practitioner.

Facilitating best practice

8. What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

Barriers:

- Regulators such as Australian Health Practitioner Regulation Agency (Ahpra) should be able to set the scope of practice of a practitioner linked to an endorsement model. The practitioner's scope of practice cannot always be set by the Medical Advisory Committee (MAC) especially since there are inconsistencies in how robust the governance structure of these Medical Advisory Committees (MAC) are.
- Clarity on what the criteria is for this expanded scope of practice.
- The facilities should be set up to support the scope of practice.
- funding for nurses to undertake training especially masters programs to achieve independent nurse practitioner status
- lack of Medicare Benefits Schedule (MBS) item numbers for these nurses to use in rural private practice (e.g. nurse practitioner led services should be accommodated for)

- Practice incentives for employing nurses exist for general practice by not specialist practice.
- Lack of clarity on the extent indemnity insurance will cover practitioners that work, with distinctions between public and private sectors.

9. What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

What we need from government is

- Funding. Fellowship subscription money to develop the program is very limited at present. ANZCA has just refreshed their diploma of GP anaesthetics and RACS may well examine an equivalent pathway with fully functional online portal for all activities. But RACS needs funding assistance from the government.
- We also need government funding for surgeons to travel to provide training in rural areas.
- Jurisdictions to develop policies for accounting for larger surgical services, so that there is a system's level pathway for GPs to maintain connection to larger units, as well as for example, continuing professional development (CPD) events, multidisciplinary cancer meetings, morbidity mortality and audit meetings.
- Re-introduction of adequately remunerated secondary telehealth or co-consulting (rural doctor and patient at one end, urban or regional specialist at the other end, these items were removed from MBS within the last 2 years, a retrograde step). This is so important for reducing travel for patients, efficient transfer of clinical information from doctor to doctor and shared decision making, maintaining clinical relationships and teaching rural doctor to then progressively take on more and more responsibility for providing care locally.

For GPs Ideally, RACS would have

- a GP surgical skills training program like ANZCA, ACEM and RANZCOG have skills courses, certificate and diploma courses, owned/operated by RACS in consultation with RACGP and ACRRM.
- A program with O&G Education and Training (OGET) and ACEM where obstetricians and FACEMs travel to rural areas to provide training to GPs and nurses to maintain their extended skills (these are government funded).
- A system for maintaining connection of rural generalists with extended skills in surgery with FRACS surgeons in hospitals along the referral pathway from the location where the GP practices.

For nurses,

- there is huge scope to develop a nurse workforce with extended skills in outpatient ENT, plastics, urology, general surgery (thinking breast care nurse, stomal therapists), mainly working as practice nurses or clinical nurse specialists under supervision of surgeons either local or remote (and we would need funding/item numbers etc)
- the same applies for independent nurse practitioners in many areas.

A collaborative MDT approach is essential to ensuring errors do not happen where decisions are not made properly.

Additional views

The broadest range of views will give the review a thorough foundation on which to consider new policy and regulation.

10. Please share with the review any additional comments or suggestions in relation to scope of practice.

This might be more relevant to nursing than medical since the GPs are utilising their full potential with certain exceptions of SIMG GPs with procedural capabilities until they get accredited.

RACS is very keen to remain involved in this process as key stakeholders.

[1] Increasing access to health workers in remote and rural areas through improved retention, Global policy recommendations, 2 February 2010 Report https://www.who.int/publications/i/item/increasing-access-to-health-workers-in-remote-and-rural-areas-through-improved-retention

[2] Retention of the health workforce in rural and remote areas: a systematic review Human Resources for Health Observer Series No. 25, 8 December 2020 Publication https://www.who.int/publications/i/item/9789240013865

[3] https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/interest-groups-sections/Rural-Surgery/4-Collaborate-for-Rural.pdf?rev=17e5072182304e1285410083b9e5937a&hash=82A289EC88C6DF614A50136403C0C944

[4] Nurse Endoscopy For Provision Of Colonoscopy Services In Australia Position Statement of The Gastroenterological Society Of Australia April 2021 https://www.gesa.org.au/public/13/files/Education%20%26%20Resources/Position%20Statements/GESA%20POSITION%20STATEMENT%20Nurse%20Endoscopy%2023Apr21(1).pdf