Outreach programme: consultant visits to rural hospitals

'To this day whether a child survives to his or her fifth birthday depends on where they are born.' – Mary Robinson, former president of Ireland.

BERNHARD GAEDE, ***MB BCh, MMed (Fam Med)***

Director: Centre for Rural Health, University of KwaZulu-Natal

Bernhard Gaede has worked for more than a decade at Emmaus Hospital in the Drakensberg of KwaZulu-Natal. His interests include clinical care, community-level services and the plural health care system. He is also involved with advocacy for rural health at local and national levels.

NEIL H MCKERROW, ***MB ChB, BA, DCH, FCPaed, MMed***

Chief Specialist & Head: Paediatrics & Child Health, Pietermaritzburg Metropolitan Hospitals Complex

Neil McKerrow is responsible for paediatric and child health services in Pietermaritzburg and the western half of KwaZulu-Natal. His major interests include clinical governance and health systems as well as the relationship between social circumstances and child wellbeing.

Correspondence to: Bernhard Gaede (besam@lantic.net)

Access to health care, like childhood survival, often depends on where one lives. Given the low population density and scarcity of infrastructure and resources, access to health care is not readily available to most rural communities. Furthermore, rural health care tends to provide a generalist service while specialist services are concentrated in larger centres. While this misdistribution is understandable in the light of available resources, access to services is often further compromised by a tendency to focus on those individuals who are able to attend health services rather than those who are dependent on such services. Limited access to specialist services in rural areas is a world-wide phenomenon not limited to resource-poor environments, although the feasibility of meeting this challenge is influenced by the local context and structure of the health care system.[1] In the resource-poor context, the idea of consultants visiting rural services is an obvious answer to improve the access to care. Given the diversity of the local context, 'consultant outreach' is a blanket term that covers a wide variety of activities.[2] There are a number of concepts that assist in developing a framework of consultant visits to rural services.

Limited access to specialist services in rural areas is a world-wide phenomenon not limited to resource-poor environments.

Primary health care (PHC), the district health system (DHS) and clinical governance

Primary health care (PHC) means health for all, not just health for those who can access care. Although the South African constitution recognises the right of all people to basic health care there are numerous problems in achieving this right. Since 1994 the National Department of Health has followed the precedent established at Alma Ata and in subsequent WHO documents promoting PHC as the philosophy and the DHS as the vehicle for delivery of health care.[3] This was recently re-affirmed[4] and is being strengthened in the strategic direction of the health service development. However, access to health services remains problematic, especially for the 43% of the country's population living in rural areas. In both KwaZulu-Natal and the Eastern Cape 54% of people live more than 30 minutes from their nearest health facility.[6] Furthermore, patients from urban areas still have much greater access particularly to specialised and high-technology services such as ICU or organ transplants than rural patients.

Many health care providers fail to appreciate that health care is delivered within a system in which all levels are mutually dependent. The nurse-run primary health care clinic depends on the doctor-run community health centre (CHC) or district hospital for supervision and support. In turn the CHCs and district hospitals require supervision and support from specialists based in the regional and tertiary hospitals. If a single level in the system is dysfunctional the impact is felt throughout the system as patients who could ideally be managed at a lower level of care swamp the higher level which is consequently unable to fulfil its core role. Specialist services are dependent on a functional primary care service to protect them from inappropriate problems and to provide a step-down facility in order to allow them to meet their core objective. The development and strengthening of primary care services is therefore a critical step in securing accessible specialist services. To achieve equity in access to the appropriate level of care, the following paradigm shifts are required in health care delivery within a DHS:

- shift of focus from the sick individual to the general population
- shift of focus from in-hospital population to community.

Underpinning these shifts is the recognition that a close relationship between components of the health system and a well-functioning referral system, with clear referral criteria, is key in actualising such an approach. However, there also needs to be a shift from movements of patients within the health system to the movement of capacity and resources up and down the health system. The advantage to the regional and tertiary services of such a system-wide approach is that the admissions to the higher level of care are much more appropriate.
In implementing the PHC approach through the DHS, the concept of clinical governance further assists in shaping the responsibility of the regional and tertiary level services in relation to the district level care. The need for active management of quality at all levels of the health care system has been identified as one of the more neglected aspects of the health care services through many studies and reviews.[5] Translating this into the concepts of taking responsibility for a catchment population, each clinical discipline at tertiary level shares the responsibility of quality of care with the peripheral services and needs to seek ways of

engaging with peripheral services to fulfil this mandate.

Approaches to consultant visits

In the past the visits by specialists to rural hospitals have often relied more on the personal relationships between individuals than on the requirements of the health system. Furthermore, these visits have often been once-off events, and while they may be encouraging in the short term, they have been unlikely to make any lasting impact on the overall clinical care. One exception is when a particular skill, e.g. operative technique or ultrasound skill, is being taught. However even then, ongoing support and follow-up would be needed to ensure adequate quality and ongoing learning, e.g. how to deal with the more complex presentations or complications of the technique.

Over the years a more systematic approach has evolved in many settings, attempting to systemise the consultant visits, rather than being an *ad hoc* arrangement.

A recent Cochrane review of specialist outreach clinics in primary care and rural settings noted the diversity of models and approaches that are practised – and that outreach services have been attempted in virtually all clinical disciplines.[2] Some of the variety is due to the differences in the health care systems and the funding constraints that influence the extent and scope of outreach programmes.

Most consultant visits can be understood in two broad approaches:

- Simple outreach visits in which clinical care is delivered by specialists outside their host institution. This makes specialist services more accessible to the patient population but does not address issues of equity or clinical governance. The focus of each visit is clinical services.
- Multifaceted outreach visits in which the primary focus is clinical governance. These visits focus on establishing relationships between components of the health system and the development of peripheral services in order to improve the standard of care and to ensure equity in access to specialist services. The content of each visit encompasses clinical services, staff development, supervision and support as well as various quality assurance (QA) programmes.

Primary health care (PHC) means health for all, not just health for those who can access care.

The multifaceted outreach model is evident in more recent consultant outreach programmes such as the consultant support for obstetric services in the Cape Town Peninsula, or the mental health services in Limpopo.

The outreach programme from Grey's Hospital in KwaZulu-Natal has formalised the consultant visit to the district hospitals in its catchment population. It covers all the major disciplines and particularly in paediatrics has formalised the visit into a number of important components. These include:

- clinical care – including a ward round where all patients in the ward are seen, and outpatient clinics to assess referrals from the district hospital and the follow-up of patients discharged from tertiary care
- clinical teaching – usually linked to the ward round, but also in the form of a presentation on a particular topic or approach to a clinical situation
- mortality audit and linked to a quality improvement process
- system and infrastructure development including motivation for appropriate equipment with the hospital management.

Through the experience of consultant visits in KwaZulu-Natal, personal relationships between the doctors and nurses at the district hospital are formed with doctors at the referral hospital. This in turn has led to much greater efficiency in managing patients across levels of care – improving both referrals and access to appropriate advice. The consultant visits are not only educational for the doctors at the district hospital, but also improve the understanding that the consultant has of both the capacity at the district hospital and the limitations in the context.

In some provinces the consultant support by regional hospitals to district hospitals has been made part of the official workload of consultants, and formal agreements at hospital level are signed regarding how much time the consultant has to spend at the district hospital. The role of overall management of the programme cannot be over-emphasised, and anecdotally it appears that the outreach service is more successful at district hospitals that are better managed. However, the outreach programme may well be part of a focused strategy to turn a struggling hospital around.

Running a consultant outreach service

When setting up or reviewing a consultant outreach programme the starting point is to define the purpose of the programme and whether a simple or multifaceted programme would best serve the participating disciplines. Exploring these issues is not a once-off process, but should take place in dialogue with the participating institutions. The planning process from the start is an ideal opportunity to develop relationships and ensure joint vision of the programme.

The more fundamental implications for the equitable access to an appropriate level of care need to be explored. These include:

- the need to define the catchment area of a health system
- identifying all health facilities in the health system
- defining the relationships and referral system of facilities within the health system
- the need to accept responsibility for the relevant catchment population of each institution
- the role of clinical governance in ensuring appropriate standards of care; this will include:
  - divorcing the concepts of level and standard of care
  - supporting the development and delivery of services – suitable infrastructure (facilities and equipment), staffing and skills, services
  - quality improvement and assurance programmes
- defining service elements
- monitoring and evaluating services and outcomes.

An obvious implication of such a re-orientation of the service is that the overall

outreach programme needs management and co-ordination at different levels of the service. It also implies that the consultant visit fits into a much larger context and should follow the referral system, i.e. the consultants responsible for the care of a given population should be involved with the outreach programme, rather than external consultants. Depending on the number of participating institutions and disciplines three levels of management and co-ordination are required, namely the overall management of the outreach programme, the management of the outreach within the specific participating disciplines, and the co-ordination of the outreach visits at the peripheral hospital (see Boxes 1, 2 and 3).

Box 1. Management of the outreach programme

This is best undertaken at the referral centre and needs to consider logistical issues and ensure that:

- Resources are allocated for outreach programmes
- The schedule of visits by different disciplines to each hospital do not overlap
  - Ideally each hospital should be visited on the same day each week so that they can structure the visits into their own routines
  - Different disciplines should visit each week but in the same week of every month, e.g. paediatrics on the second Wednesday of each month
  - Disciplines need to be grouped to ensure similar disciplines (medicine and psychiatry, paediatrics and O&G, orthopaedics and surgery) do not visit on the same day
- Transport arrangements cater for all disciplines

Box 2. Management of the outreach activities of the individual discipline

This requires a dedicated co-ordinator responsible for:

- Development of a structured programme for the visit which will encompass:
  - Site visits for the provision of:
    - Specialised clinical services
    - Teaching programmes
    - Quality improvement and assurance programmes
    - Infrastructure and systems development
    - Monitoring and evaluation
  - Ongoing support between visits
  - Attachment periods for district hospital staff to upgrade their skills in the referral hospital
  - Continuing education activities
  - Resource development and distribution
- Staff participation
  - Ensure all specialists participate in the programme
  - Link a dedicated specialist to each institution – this is essential for the development of a meaningful relationship and ongoing support between visits
- Logistical arrangements
  - Correspondence between the discipline and institutional management to outline the annual programme and provide feedback
  - Schedule of visits
  - Transport arrangements

Box 3. Co-ordination of the visit which needs to occur at the district hospital

- A dedicated administrative assistant (e.g. a secretary) to ensure arrangements are made such as transport or meals. This implies that there is buy-in from management. The administrative arrangements should not be the duty of clinicians
- Dedicate staff and time to the effort. In many institutions one doctor takes on the responsibility for the visit of one discipline, e.g. the doctor in maternity is responsible for the visit by the obstetrician. It is important to have the space to spend time and make the visits meaningful and for a relationship to develop
- Clarify expectations of the programme with the referring institution and visiting consultant, including the amount of time available
- Integrate review processes and audits that need to take place anyway, such as mortality audits, with the consultant visit. Allocate time for the preparation process and ensure that either management attends, or there is a clear feedback process to management on the visit, and from management on action taken
- Use the consultant visits to get feedback from referrals sent
- Think bigger than the visit – this is about a system of care

Ideally an outreach programme should strengthen the multidisciplinary team and include allied medical services and nursing support as well. Furthermore, as invariably management issues are raised as part of the clinical reviews, such as staff allocations and skills, medical equipment or infrastructure issues, management's involvement and responsiveness in the process is critical.

The development and strengthening of primary care services is therefore a critical step in securing accessible specialist services.

To ensure sustainability this support needs to be formalised and should include the following components:

- support to clinical services, both in- and outpatient services
- lobby for access to an equitable share of resources for the institution or specific domains
- promote the development of appropriate infrastructure
- ensure the ongoing development of personnel
- implement appropriate referral systems
- facilitate quality improvement and assurance programmes
- monitor and evaluate the health services and the health status of catchment populations.

The consequence of a well-run outreach programme includes the creation of good relationships between mutually dependent institutions, leading to appropriate advice or timeous referrals and accessible care and improved standards.

Conclusion

In the situations where strong personal links are formed, the outreach programme performs better – this is no different to working in any team, and the system should create conditions that make personal interaction possible.

The consultant visits are not only educational for the doctors at the district hospital, but also improve the understanding that the consultant has of both the capacity at the district hospital and the limitations in the context.

The Cochrane review on consultant outreach concludes that there is evidence that outreach programmes improve access to specialist services.[2] As part of the overall health care development, in line with the strategic imperatives of the Department of Health, consultant outreach programmes should be strengthened throughout the country with tertiary and regional services developing strong relationships with their referral hospitals. The provision of consultant support should not be seen as a nice-to-have but rather an integral part of how health care services are planned and funded. This is analogous with the support the district hospitals support the PHC clinic services and the community-level services in the catchment population they serve.

References available at www.cmej.org.za

IN A NUTSHELL

- There are two models for an outreach programme – simple with a focus on the peripheral delivery of specialist clinical services and multifaceted with a focus on both clinical care and clinical governance.
- Outreach programmes are thus a vehicle for clinical governance and improving standards of care.
- As such they foster relationships within a health system.
- They support the referral system.
- They promote equitable access to an appropriate standard of care.
- They require a commitment from both the referral and the referring centres.
- For sustainability the following is suggested:
  - allocation of a dedicated specialist to each hospital
  - regular scheduled visits on the same day of each month
  - a structured programme for each visit including clinical, training and quality assurance activities.
- A responsible person needs to be identified for logistical preparations and for the clinical programme.
- Annual review and feedback is critical.

SINGLE SUTURE

Swine flu returns

Europe and North America are braced for a surge in flu cases as schools resume after the holidays.

Schoolchildren are the main carriers of seasonal flu, and epidemics often reflect school schedules. The winter flu that is already pushing intensive care services to capacity in the UK has been dominated by the same swine flu virus that caused a pandemic in 2009.

While swine flu has now become a seasonal virus, and more people have immunity to it than in 2009, it still carries a sting in its tail. At least 36 people have already died of the virus in the UK this flu season and, as in most pandemics but unlike most seasonal flu, nearly all were under 65, while 40% had none of the risk factors that make flu deadlier, such as asthma.

Health agencies in Europe and North America are advising people in risk groups, such as pregnant women, to get vaccinated.

New Scientist, 8 January 2011.