International Journal of Surgery 12 (2014) S1–S4

Contents lists available at ScienceDirect

International Journal of Surgery

journal homepage: www.journal-surgery.net

Editorial

Surgical training in primary care: Consensus recommendations by the Association of Surgeons in Training

Keywords:
Primary care
Community care
Surgical
Training
Patient safety

A B S T R A C T

Health service reconfigurations may result in increasing numbers of minor surgical procedures migrating from secondary care in hospitals to primary care in the community. Procedures may be performed by General Practitioners with a specialist interest in Surgery, or secondary care Surgeons who are sub-contracted to perform procedures in the community. Surgical training in such procedures, which are currently hospital based, may therefore be adversely affected unless surgical training also takes advantage of these opportunities. There is potential for surgical trainees to benefit from training in the community setting. ASiT supports the development of formal surgical training in the community setting for junior surgical trainees, providing high standards of patient care and training provision are ensured. Anticipated problems relating to the migration of surgical services to the community relate to the availability and quality assurance of training opportunities in primary care, its funding, including exposure to issues of indemnity cover for trainees, and also the release of surgical trainees from hospital duties in order to attend these training opportunities. These consensus recommendations set out a framework through which both patient care and training remain at the forefront of these continued service reconfigurations.

1. Background

The face of minor surgery is changing. As a result of the introduction of General Practitioner (GP)-led Clinical Commissioning Groups (CCGs) in the United Kingdom, an increased proportion of surgical procedures may be provided in the primary care setting. Recently, a number of procedures, such as skin lump excision/biopsy, carpal tunnel decompression, vasectomy and simple hernia repair, have been performed in greater numbers in the community by General Practitioners with a Special Interest (GPwSI) in Surgery [1], or Consultant surgeons sub-contracted into the primary care setting. The Association of Surgeons in Primary Care (ASPC) has voiced support for further developments in this field, including robotic surgery and oncological surgery potentially being performed in the primary care setting [1]. ASPC is the formal national body whose aims include providing support, training and professional development, as well as auditing the surgical services provided in primary care (www.aspc-uk.net). This group is in dialogue with the Royal College of Surgeons of England, The Association of Surgeons of Great Britain and Ireland (ASGBI), and The Association of Surgeons in Training (ASiT) to ensure the challenges of surgery in primary care are met [2].

Although limited in depth and breadth, there is evidence that, with the right experience and equipment, the outcomes of hernia surgery performed by selected, experienced GPwSI in Surgery in selected primary care settings, can be comparable to those achieved in secondary care by Surgeons [3,4]. However, there are historical reports of a significant proportion of GP practices failing to meet minimum criteria for performing surgical procedures [5]. The constitution of many community surgical operating lists is akin to old-style SHO operating lists, and as such represent excellent prospects for development of the basic surgical skills, which are often overlooked by modern hospital-based training systems.

While financial constraints may provide impetus for an up-scaled migration of surgery from secondary to primary care, the cost analysis is far from simple, and there is no verdict as to whether it is justified [6,7]. The economical and political issues of whether a greater volume of minor surgical procedures should be performed in a primary care setting by GPwSI is outside the scope of this consensus statement, but suggestions have been made of a pilot programme utilising community surgery in the training of junior surgical trainees. We hope this document will inform with

Abbreviations: ARCP, Annual Review of Competency Progression; ASGBI, Association of Surgeons of Great Britain and Ireland; ASiT, Association of Surgeons in Training; ASPC, Association of Surgeons in Primary Care; CCG, Clinical Commission Group; GMC, General Medical Council; GP, General Practitioner; GPwSI, General Practitioners with a Special Interest; ISCP, Intercollegiate Surgical Curriculum Program; JCST, Joint Committee on Surgical Training; SAC, Specialist Advisory Committee; SHO, Senior House Officer; ShoT, Shape of Training.

http://dx.doi.org/10.1016/j.ijsu.2014.08.403
1743-9191/

regard to the trainee's position and help guide discussions with respect to the potential for provision of high quality training within a primary care setting.

2. Potential benefits

With a significant volume of minor surgical procedures already being performed by both secondary care consultants and GPwSI in Surgery in the community setting, the potential exists for surgical trainees to benefit from consequent training opportunities. There are anecdotal reports that trainees are attending operating lists in the community, supervised by their secondary care consultants, with good levels of experience gained. A growing range of procedures, spanning a number of surgical specialities, already exists in community surgical practice [1]. This presents a breadth of opportunity for trainees, whose speciality interests will be varied. ASPC represents an organised body of GPwSIs who have already expressed a willingness and enthusiasm to work with ASiT in the development of a scheme to facilitate surgical training in primary care. ASiT welcomes the opportunity for junior surgical trainees to develop knowledge and ability in the safe administration of, and operative skills under, loco-regional anaesthesia, or sedation. Operating in the primary care setting, without the availability for general anaesthesia, facilitates development of such valuable skills. This is of course providing the environment would be approved for this purpose, as recommended in the Shape of Training (ShoT) Review [8], and the trainer is continually assessed as competent to provide training. There are isolated reports of good clinical outcomes for patients in selected community settings [3,4], and it is ASiT's belief that, with appropriate expertise, investment and monitoring, good training outcomes could also be achieved. Of course, it must be remembered that Consultant surgeons also work in the community settings, and they may already be in a position to deliver the same level of training they already afford in Secondary Care.

Training outside the hospital setting would also require protected training time for trainees in order to release them from their hospital-based duties, which may be facilitated by proposals to draw up separate training contracts as a result of the review into the European Working Time Restrictions, led by the President of the Rotyal College of Surgeons of England [9]. This may confer the benefit of being undisturbed by hospital service requirements, which frequently disrupt training time. Clearly, this would rely upon adequate cover for on-going service commitments in the hospital setting, without compromising patient care.

Benefits to both trainer and trainee exist in an era of revalidation and the need for maintenance of evidence of practice and competence. Opportunities for significant personal development and portfolio progress would be available for both parties.

3. Current concerns

Although ASiT promotes surgical training, this promotion is not at the cost of patient care. ASiT is vehemently against training in sub-standard centres. There is some evidence suggesting diminished levels of surgical quality and safety in the primary care setting [10], which may compromise the quality of patient care. We accept that some of this data is not contemporaneous, but in our opinion, the field is likely to suffer from significant publication bias towards good outcomes in primary care. Clinical quality assurance must therefore be undertaken prior to any primary care unit offering surgical training attachments. With respect to surgery in primary care, ASiT's main concern is the potential devolution of certain critical elements of basic training to centres that cannot be accessed by surgical trainees. Simple skin 'lump and bump' management and hernia repair exemplify these elements. This is similar to concerns voiced following the introduction of Independent Treatment Centre contracts, at which time ASiT also called for formalised, funded training in these centres [11].

ASiT believes that any surgical placement should have contemporaneous and complete surgical outcome data; and that trainers should be involved in a local surgical clinical governance group to ensure adequate clinical outcomes before a trainee is placed with them. This is in keeping with the National Medical Director's recommendations [12]. Furthermore, as it is currently configured, primary care is unable to support oncological surgery, which mandates a multi-disciplinary team discussion including a number of secondary care specialists; or robotic surgery which warrants highly specialised equipment and training. There is also evidence that oncological surgery may be inappropriate for GPwSI in Surgery [13]. If the future political desire is for these procedures to take place in primary care settings, Consultant surgeons would be better placed to perform such surgery.

Core surgical training is already a short and focused period, with considerable emphasis on achieving sufficient experience within a placement to obtain a competitive higher surgical national training number. We must be certain that diversion of a group of trainees from secondary care into the community will not be detrimental to their training as a whole, where they may lose valuable exposure to specialist clinics and procedures within the hospital, as well as decrease their exposure to the day-to-day care of complex post-operative outpatients. This is even more pertinent in view of the recommendations of the ShoT Review to shorten training further [8]. Training in minor surgery, especially for junior trainees, has long been construed as deficient in the hospital setting [13]. These valuable training opportunities should not be lost for the next generation of surgical trainees as a result of their migration into the remit of primary care.

While we accept the benefits for revalidation to trainees and trainers alike from the documentation of all training opportunities within the Intercollegiate Surgical Curriculum Programme (ISCP) website (www.iscp.ac.uk), ASiT strongly feels that this mutual benefit should be reflected in the funding of the process. Currently trainers in secondary care do not contribute financially to this valuable resource, despite the benefits to their own validation process, and we have concerns that trainers in primary care would continue this unfair practice. Steps should be taken to address this problem.

Crown indemnity currently provides significant protection against legal claims while working in a hospital setting. The indemnity cover outside of the NHS hospital setting requires clarification, particularly where patient care is being provided under the auspices of private contracts from commissioning bodies. Where the provision of surgical services in primary care is based on short-term or volume-based contracts, problems may arise in incorporating these into surgical training programmes when the duration or continuation of such training opportunities cannot be predicted or guaranteed.

4. Discussion and recommendations for surgical training in primary care

There is both political drive, and interest from Primary Care to provide surgical training within the community. If this is the direction of travel, the prerequisites of community surgical training should be the delivery of high-quality training from suitably qualified trainers with a proven track record, while providing high quality patient care. Based on these principles, ASiT have developed the following recommendations for surgical training in primary care. This resulting statement represents consensus opinion following extensive discussion and ratification by ASiT Council. This therefore