The Curriculum Framework for the Surgical Care Practitioner

A RESPONSE FROM
THE ROYAL COLLEGE OF SURGEONS OF ENGLAND PATIENT LIAISON GROUP

APRIL 2005

The Royal College of Surgeons of England

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Introduction

Page iii states the purpose of the consultation in the following two comments:

> *The SCP role has developed from many local initiatives by staff already in clinical roles and we are now seeking regulation of this protected title to ensure the safety of patients. To do this we need a very clear national curriculum framework, which states the standards that those using the SCP title will need to meet before entering practice.*
>
> *The proposed curriculum framework has been developed over a number of years and builds on the work of the RCSEng education and training programme for doctors and the NAASP core syllabus.*

The Patient Liaison Group of The Royal College of Surgeons of England have spent some considerable time over the last few years discussing and considering the role of the surgical care practitioner and welcome this opportunity to respond to this consultation.

The Curriculum Framework for the Surgical Care Practitioner as an Educational Programme

3.2 The principles of teaching and learning and the need for learning partnerships are supported. It is recognized that there is a need to move beyond the traditional approach of apprenticeship and the role of the consultant surgeon as clinical supervisor is essential – and is probably not something that every consultant surgeon would have the skills or time to be able to take on.

3.5.1

2 year programme represents min. period of training…

It provides for the understanding that some practitioners may need targeted training, which may extend this time.'

How will this be decided? Presumably there must be some mechanism to decide that some trainees will not be suitable to continue training as a SCP? This happens already with doctors training.

It is appreciated that a number of surgical practitioners will take a career break

What will the rules be about retraining before being able to practice again? Patients will want to know that the retraining is thorough and regulated.

3.6.3 Since existing SCPs will have entered their roles by a variety of routes it is important to ensure that they have always obtained the equivalent education and training. This links in with section 2.2 where it states that SCPs will abide by a 'voluntary' code of conduct until the regulatory framework is established. Patients are extremely concerned about accountability and quality and a *voluntary* code of conduct sounds inadequate, for however long it is used.

3.6.4 'Sufficient' needs to be defined in the table for registered ODPs and physiotherapists.

3.6.5–3.6.7 There would be concern initially about these two routes of entry and it would be prudent to ensure that the Type 1B worked well, before considering other routes. If other routes were to be considered in the future it would be important to define the type and duration of clinical experience required.

The Range of Knowledge and Skills in the Syllabus

> The core syllabus as listed covers the essential (minimum) theoretical skills, operative skills, clinical skills, equipment and educational processes.

> We would like to see communication skills included as a 'core clinical skill' rather than as an 'educational process'. Communication skills should be a vital aspect of SCP training. Patients want a formal recognition that good communication skills are at least as important as clinical expertise and have an impact on outcome. This must be reflected in excellent training. Trainees must be expected to pass an assessment. The training must be more than a short session that merely enables the trainers to tick the communication skills box on the list of SCP competences. It would be useful if patients were asked to assess communication skills as they are the recipients.

> Within 'educational processes' there should perhaps also be a section for time management.

> The detailed part of the syllabus is understandably focused on technical and operative skills, and there perhaps needs to be a bit more emphasis on some of the other skills that can be learned and applied, such as seeing patients in the outpatient clinic.

> Section 4.5 states that

…complex and major interventions not representative of a typical surgical facility would not fall within remit of specialty syllabus…This would be anticipated as part of a continuing professional development (CPD) process, rather than pre-qualification learning.

What does this mean? Are SCPs going to be involved in 'complex and major interventions'? This is where the definition of the SCP role and remit is so important, it must be very tightly defined. Patients would not be happy if SCPs were arbitrarily moving into 'major and complex interventions' by default.

Methods of Assessment

> We are supportive of the overall principles of assessment, which comprise formative and summative assessments, supported by a comprehensive portfolio of evidence. It is noted that appendix 3 shows a competency record for all core technical and operative skills and that level 4 should be reached by the end of training.

> It is also felt necessary for a similar criteria and standards document to be drawn up for other aspects of a SCP role such as in the outpatient clinic. There is concern that it may be difficult to assess when SCPs are competent to see patients in outpatient clinics. How can their competence be assessed? As with procedures/operative skills this would need to be focused on patients with specific conditions, eg hernias.

> It is helpful to see the list of who the key personnel involved in the assessment process should be. In addition to this, it would be helpful to see other requirements such as dedicated time and some proven evidence of teaching/training effectiveness. For a clinical supervisor, being a RCS accredited surgeon and completing a recognized training course wouldn't necessarily make him or her an effective clinical supervisor hence the need for some evidence. This evidence may be available from either the individual's own portfolio or from a reference.

> Do clinical outcomes and patient response play any part in the assessment of SCPs and/or their role? It would be reassuring to think that an improvement in clinical outcomes was an essential long term goal for this new role.

> The Patient Liaison Group feel strongly that the assessment of completion of training should be twofold; firstly there should be the formative and summative assessments as described in the consultation; and secondly that The Royal College of Surgeons of England should produce a completion examination with award of a diploma for successful candidates. These would equate with the examination structure for junior trainee surgeons.

Appendix 4 – Specialty Specific Skills and Knowledge at Qualification

> In broad terms we agree that that level 4, knowledge of the principles would be required by qualified SCPs in the area in which they are specializing. Although the clinical/technical skills have been set at level one, it is recognized that for appropriately trained and qualified SCPs then level 2–5 may be achievable. Furthermore there will be additional clinical/technical skills that may be appropriate for some specialty SCPs and there should be some guidelines as to what procedures may be considered and under what circumstances.

> It is also noted that there are a number of spelling errors and odd ways of describing terms that should be corrected in the final document. These include:

1A Urology - 'neuropathic' instead of 'naturopathic'; 'hydrocoele' instead of 'hyrocoele'

2A Trauma & orthopaedics - 'antibiotic prophylaxis....' instead of 'antibiotics prophylaxis ...'

3A Cardiothoracic surgery - 'Swan Ganz' instead of 'Swanganz'

6B Paediatric surgery - 'Inguinal herniotomy' instead of 'inguinal hernitology'

7A Part I Core general surgery - 'Axillary' instead of 'axiall' relating to superficial abscesses; duplication of ingrown toenail surgery – suggest delete separate section on Great Toenail; 'Spighelian hernia' instead of 'Spegilan hernia'; reformat bullet point for 'loop' to include with other formation of stomas; 'bronchoscopy' instead of 'bronchoscope'.

7C Part II - 'laparoscopic splenectomy' instead of 'laparoscopic spleenectomy'; 'Hellers' instead of 'hellers'; not sure if 'training resection' is what is intended.

8B 'Loupes' instead of 'lupes'

9A 'hypo-pharynx' instead of 'hyper-pharynx'?; delete 'the' in 'Clinical Investigation of the otorhinolaryngology surgery'; 'laryngopharynx' instead of 'laryngoparynx'; 'otalgia' instead of 'otaligia'?

Appendix 5 – Triggered Assessment

> Does the word 'holistic' need to be included – as from the assessment it is clear that the whole process is being assessed?

> In the operative section of the example form, it should read, 'Performs part of/the whole procedure/operation according to specialty protocol' or something like that. There should also be space to specify which part of the procedure/operation is done.

Issues Around Supervision

- There is some confusion around the definition of the levels of supervision of SCPs in table 4 (section 4.3.3) and table 5 (section 4.3.4.2). Whilst it is recognized that these tables are from different sources, with table 4 being adapted from surgeon training and table 5 designed for SCP training, the fact that one has four levels of supervision and the other has five it would be helpful to show which levels in table 5 equate to which levels in table 4. For example does Level 1 supervision in table 5 mean 'Surgeon showing. SCP assisting?' Likewise if Level 4 supervision (table 5) is 'SCP doing: Surgeon within the theatre or clinic environment' there is concern that the crucial professional awareness 'has strong sense of limitations of practice and recognition of changing situations' etc is only included at Level 5. The table in appendix 4 seems to combine these two and we wonder if it would be more useful to include this in section 4 and move the existing tables 4 and 5 in section 4 to appendix 4?

- If an SCP is undertaking a surgical procedure under proximal supervision what are the procedures that are in place should an emergency arise and the supervising consultant is no longer immediately available? Some patients would have concerns about SCPs carrying out procedures in theatre without the supervision of a consultant surgeon.

- Section 6.2 states that consultant surgeons must accept overall responsibility for any duties that are delegated to a trainee or qualified SCP. It is vitally important for the public and patients to know this, particularly in light of media dis-information.

- As has been emphasised elsewhere it is important that clinical supervisors during SCP training and consultant supervisors post-qualification, have the time to provide proper supervision and that this should be balanced with their other commitments. It is important that training for surgical junior staff is not compromised by the training of SCPs.

- Communication is viewed as vitally important by patients and the experience of some patients is that the communication skills of doctors and surgeons are not always as good as it might be. Involving yet another person in the patient's contact with the hospital would mean that communications, unless carefully handled, could fall between the cracks – and the presence of an SCP in the team would provide yet another relationship for the patient to deal with. This system would only work if professional communications within the team are excellent and the SCP is not just going to be a go-between messenger batting questions and answers between surgeon and patient.

Section 2.2.1 states

> *The dynamic nature of professional knowledge and the ability to work in this environment, requires the recognition of personal limits*

This is seen as crucial to and SCP role and should not be left to individual SCPs to decide – there needs to be formally decided and defined limits.

The Title of Surgical Care Practitioner

There are mixed views on the title and there is concern that the current title may confuse the public and patients and give the impression that the post-holder is medically qualified. It is acknowledged that there has been a previous public consultation document on this topic and the title that gained most support was a surgical care practitioner. The use of the term 'surgical' could be misleading for some patients, who may be under the impression the SCP is a surgeon. The use of the term practitioner has been viewed as being synonymous with a

medically qualified person, but there are operating department practitioners already. The use of the term 'assistant' or 'assisting' may be of benefit, although this may not be appropriate or acceptable for the highly-trained SCP. An alternative title which is offered for consideration is that of 'Practitioner in Surgical Care'.

Perhaps what is key is that for whatever title is agreed upon there needs to be good communication of the title and role:

> Amongst the public and the professions

> By SCPs to any patient they see, with an open choice to be seen or treated by them or by the surgeon. This choice needs to be given early so that the patient is not put in a difficult position at the time of treatment.

A definition of a SCP is set out in section 1.1 and the scope of their activity, 'who performs surgical intervention' is listed in section 1.5. It is also stated that the definition may change as the role develops. It is vital to make sure that the definition is specific and tight, if the definition of the role is so general that it is merely left to interpretation in day-to-day practice, this would be of great concern to patients. It is also felt that there should be no real need for the definition to change in that non-medical practitioners will always be working in and/or out of the operating theatre; and that although the range of surgical interventions may change, then that should always be under the supervision of a consultant surgeon. It should be stated that surgical care practitioners should never be allowed to pursue an independent practice.

Other Issues

> Although this document relates to the *Curriculum Framework for the Surgical Care Practitioner* it should be recognized that once trained and qualified, SCPs require the same degree of continuing education, supervision, appraisal and assessment as do other medically qualified surgical trainees. There is also the need to have clearly defined protocols for SCPs in whom it is appropriate to develop post qualification experience (*see* section 1.5). In the area of training for example, this should be tightly supervised and defined – and restricted to those specific areas of surgical involvement where the SCP has competent experience. Otherwise there may be a risk of surgical training becoming more and more diluted in depth as it is further delegated, with trainees receiving training without reference to a wider medical context.

> In the light of existing concerns about surgical training of medically qualified individuals, it should be stated somewhere in the framework document, that the educational and training requirements of surgical trainees should take priority over those of SCPs.

> Section 4.7 states that

Validation and evaluation are central parts of the quality assurance procedures. Those with appropriate knowledge and authority will carry this out….

The RCSEng should always be involved in this and this would be reassuring for patients. As consultant surgeons will always be supervising SCPs it is essential that any regulatory body subsequently established is under the jurisdiction of the RCSEng, rather than being independent. The need for a diploma to be granted by The Royal College of Surgeons of England at the end of training is again emphasised.

> This framework document has been developed by the RCSEng in conjunction with NAASP – can it be clarified if this will only apply to England and Wales or will it apply equally to Scotland and Ireland? Furthermore there needs to be standardization for any individual coming from outside the UK, than their previous experience would need to be proven equivalent and that they would be subject to the same processes of ongoing assessment, appraisal and continuing professional development.

Written by Mr Keith Rigg and Mrs Lesley Bentley

On behalf of the Patient Liaison Group, The Royal College of Surgeons of England

Published by the Patient Liaison Group
The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields
London
WC2A 3PE

www.rcseng.ac.uk/services/publications

First published 2005

The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields
London WC2A 3PE
T: 020 7405 3474
W: www.rcseng.ac.uk

Registered Charity Number 212808