Editorials

Day surgery:

implications for general practice

Technological developments have made it possible to undertake a diverse range of surgical procedures under local anaesthesia, ranging from those requiring only basic surgical skills to more operations that are complex. Most of these take place in the hospital setting. Increasing minor surgery rates in primary care and redistributing selected local anaesthetic procedures away from hospitals for delivery by GPs, GPs with a special interest (GPwSIs) in surgery, or hospital consultants in the community (Box 1 [R Dhumale, Association of Surgeons in Primary Care {ASPC}, personal communication, 2016]) would fulfil key aims of the Department of Health for the provision of care in 'more local, convenient settings'[1] and the *Five Year Forward View*,[2] which promotes the development of multispecialty community providers.

There is additional impetus for change in that secondary care capacity is not meeting demand and this gap is widening. Waiting list admissions (predominantly for surgery) over the last 5 years have increased by 13% (from 5.4 million in 2010–2011 to 6.1 million in 2014–2015) with an accompanying increase in average waiting times of 8% (50 days in 2010–2011 to 54 days in 2014–2015).[3] This pressure will continue in the current climate of further NHS efficiency savings. Notwithstanding potential to improve patient experience and outcome by promoting surgery provision in the community, little has taken place to instigate such service redesign and development. In 2011–2012, only 0.3% (that is, 15 000) of day cases commissioned by the NHS took place in primary care, despite reorganisation, infrastructure and commissioning changes that could support more level 2 (Box 1) procedures being performed safely in this setting (L Spooner, personal communication, 2016). This almost certainly reflects the challenge of initiating and implementing change by an overworked and increasingly financially-restricted primary care sector. Given the current situation, is it justified and feasible to increase community surgery activity?

There are definite benefits for patients having their surgery out of hospital. These include improved continuity of care, satisfaction, and access (for example, shorter journey times, free car-parking facilities, and reduced waiting times) with the added advantage of reduced non-attendance rates.[4,5] While costs savings should not be the primary driver for change, community surgery may create potential for financial gains as performing procedures away from hospitals is significantly less expensive; the tariff for primary care typically being 50–85% of that incurred by the former. Review of 31 healthcare resource groups across eight specialties by the ASPC and the British Association of Day Surgery in 2011–2012 showed 3 million finished consultant hospital episodes performed in day surgery or outpatient departments, which, with the exception of a few high-risk patients, could have been undertaken in the community if resource was available. Based on 2011–2012 tariffs, clinical commissioning groups could have avoided 1.5 million hospital-based episodes and saved £0.4 billion, which could have been diverted to primary care to support community surgical service.

Development of new models of care or adaptation of pre-existing service to increase community surgery rates necessitates identification of current and likely future local population demand and the capacity necessary to do so. This in turn may raise organisational issues that could be seen as impediment for change, such as those surrounding structural instability, changing accountabilities (for example, workforce and facility planning, training, outcomes assessment, and clinical governance), commissioning, and cost restructuring.[6] Current funding arrangements within and across the primary and secondary care sectors may present financial hurdles due to their complexity and fragmentation. For example, secondary care payment by results is a deterrent to consultant out-of-hospital working and low directed enhanced service tariffs may disincentivise surgical procedure development and innovation in the community.[7]

In terms of surgical workforce planning and training, any change to service encompassing level 2 procedures will require decisions as to whether resource is provided by GPwSIs in surgery, local hospital consultants, or both. Irrespective of this, with both options, issues are raised for how service backfill if either are taken out of 'usual' clinical practice to meet this demand. Integrating hospital consultants into community care models requires resolution of concerns surrounding out-of-hospital indemnity, clinical governance, and funding allocations.[6] The Royal College of General Practitioners run courses for minor surgery and advanced minor surgery but there is no standardised training in place for GPs who wish to develop a specialist interest. Unfortunately, recommendations produced by The Association of Surgeons in Training and the ASPC to promote the delivery and quality assurance of surgical training in the community only apply to surgical trainees, excluding qualified GPs or GP trainees who wish to develop their surgical skills.[4] There

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Box 1. Procedures suitable for community surgery

Level 1 procedures can be provided by GPs with basic surgical skills in a minor operation or treatment room

- Sebaceous cyst
- Lipoma less than 2 cm
- Ingrowing toenail
- Excision of small lumps and bumps
- Chalazion
- Injection of joints and bursae
- Cryotherapy
- Aspiration of cyst

Level 2 procedures can be delivered by consultants or GPwSIs in a modified treatment room or operating theatre

- Vasectomy
- Carpal tunnel decompression
- Ganglion of the wrist (dorsum)
- Zadek's procedure for ingrowing toenail
- Ligation of varicose veins
- Haemorrhoid injection
- Sigmoidoscopy
- Gastroscopy
- Cystoscopy
- Caudal blocks

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is also a lack of national agreement about accreditation and appropriate revalidation for GPs who perform level 1 and level 2 surgical procedures, with no clarity about who should take responsibility for this.

To ensure good, reflective, responsive surgical practice, process for data capture, collection (for example, surgical metrics and patient experience), and audit, including the infrastructure to support this, should be incorporated into service design. Currently there is no mandatory requirement to do so in the community setting, which contrasts with surgical standards in secondary care. This does need to be addressed as exemplified by discrepant reported rates of incomplete excision of skin cancers by GPs,[4,5] The ASPC has already initiated national prospective audits to monitor standards for hand surgery, non-scalpel vasectomy, and community-based surgery but participation at present is voluntary (R Dhumale, ASPC, personal communication, 2016).[5] The only existing national quality assurance evidence for outcomes in community surgery is The National Cancer Peer Review Programme for skin malignancy (www.ncin.org.uk), which is an excellent example of modelling multidisciplinary pathways between primary and secondary care but the obligatory data collection is the responsibility of linked hospital trusts. Community facilities available for the delivery of surgery also need to be fit for purpose and there are now nationally agreed minimum quality standards monitored by the Care Quality Commission.

The challenges associated with establishment of community surgery services are many and may appear at first review, insurmountable. However, there are practices where this has been implemented successfully (L Spooner, personal communication, 2016).[6] While there are still issues to be resolved at a national level, for example regarding training, this should not prevent exploration of local service development and this does not need to be complex. Simple methodology such as Plan, Do, Study, and Act (PDSA) cycles can be a very effective tool to initiate change as roles and views of all involved clinical and management resource groups are identified from the outset.[8] Here the *Plan* is the service change to be implemented (for example, initiating a level 2 community surgery service). This involves mapping the patient pathway to demonstrate all associated procedures and administrative processes surrounding patient management and thereby identify potential gaps, bottlenecks, and hindrances to change.[9] In doing so issues about meeting access targets, pre-booking of appointments, workforce, funding streams, facilities, multidisciplinary team protocols being in place, and the adequacy of patient information can be identified. The *Do* is carrying out the change to service; rather than introducing this 'wholesale' it should be tested with a few patients initially to assess impact. *Study* involves collecting data before and after implementation of the change to observe and learn from the consequences. *Act* involves determining what modifications should be made before full implementation takes place. Planning community surgery pathways should not be based around cost-cutting as experience has shown service costs may be increased if community capacity meets a previously unrecognised but clinically-relevant demand.[6] An integrated local anaesthetic pathway template that can be adapted for community surgery planning is available on the British Association of Day Surgery website.[9]

In summary, delivery of more surgery in primary care has potential for enhancing patient-centred management by promoting the development of multispecialty community providers and reducing length of hospital stay, as championed by the NHS *Five Year Forward View*.[2] However, this will only happen if appropriate resources (money and training) are provided to enable it.

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