Training Consensus Statement

Introduction

Breast Cancer Now, The Association of Breast Surgeons (ABS), and the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) are working together to urgently find solutions for the inequity in access to breast reconstruction services in England. Far from being an aesthetic choice, reconstruction procedures are an essential element of treatment and recovery from breast cancer.

All three organisations recognise that failing to build breast reconstruction teams across England/UK could have significant consequences for patients as demand continues to rise. Coupled with rising demand, there has been a trend of de-prioritisation for these essential procedures, as the plastics workforce are often pulled away to perform more "important" operations.

Generating more expertise in all types of breast reconstruction, particularly in the micro-surgery techniques needed for autologous procedures, is a fundamental step to ensure the future of these vital and life-changing surgeries following mastectomy.

Background

Currently breast and plastic surgeons make up the workforce in breast cancer surgery. Traditionally breast surgeons remove the cancer and, if indicated, the plastic surgeons then reconstruct the breast. There are different forms of reconstruction ranging from implants to using patient's own tissue to craft a new breast (autologous).

Increasingly breast surgeons perform implant-based and local tissue reconstruction (oncoplastic surgery) but not free-flap reconstructions (microsurgery). Plastic surgeons could perform all types of reconstruction including free tissue transfer using microsurgery, but they often do not get involved in implant only reconstructions. It is important to emphasise that symmetrising and revision surgeries can be performed by both and are often a core part of the patient's cancer journey.

However, the design of the surgical training curricula fosters a degree of separation in training. The General Surgery curriculum having "Breast surgery with oncoplastic reconstruction" as a Phase 3 specialty, but not including micro-surgery, and the Plastic Surgery curriculum syllabus being light on oncological procedures. Most plastics trainees do not get the opportunity for any practical experience of oncological procedures until post-CCT.

Currently the immediate deficit lies in patient access to the microsurgical forms of breast reconstruction. To increase capacity in delivering microsurgical reconstruction for patients following a mastectomy, we need more microsurgery trained Plastic surgeons that have a specialist interest in breast reconstruction.

The national Oncoplastic Breast Surgery Training Interface Fellowship (hereby referred to as the TIG Fellowship) is a well-established route to training surgeons in the techniques

required for the full spectrum of breast reconstruction procedures. The Joint Committee for Surgical Training (JCST) asserts that: "Fellows will be able to learn (or increase) their knowledge/aptitude in advanced breast conservation techniques involving volume replacement/redistribution, partial breast reconstruction and total breast reconstruction".

TIG fellowship places are limited (currently funding exists for 13 places nationally) but historically, a larger number of general surgery trainees take up the fellowship compared to plastics trainees. To illustrate, 11 out of 13 fellowships for the 22/23 round are occupied by general surgery trainees. Regardless of these TIG fellowship places, there is a lack of fellowships that focus specifically on microsurgery, and consequently numbers of plastic surgeons with this as a specialism are not large enough to support the volume of demand for free flap reconstructive work. Similarly, there is a lack of dedicated courses or support available specifically to develop both types of nurses who will support patients needing breast reconstruction (Breast Cancer Nurses and Breast Reconstruction Nurses).

With the projected continual increase in breast cancer patients, improved survival in the primary and secondary settings, as well as patients generally living longer which may necessitate revision surgery, the workforce must increase to meet demand.

Statements

In short, all three organisations have reached a consensus that there must be a coordinated drive to train more NHS surgeons and specialist nurses in all types of breast reconstruction. Further, the options must be discussed and offered to all patients with the necessary teams available that can provide the whole range of procedures, regardless of geography.

To this end, we collectively assert the following:

- ABS and BAPRAS should collaborate on implementing a system of coordinating and cross-referencing existing data collection to enable regular monitoring and reporting of capacity and demand for breast reconstruction. Working alongside the newly launched National Audit of Primary Breast Cancer.

- Plastics surgery trainees should be given ample opportunity to spend time with the breast surgeons - as stated in the curriculum, but not often realised in practice - promoted through coordinated messaging between ABS, BAPRAS and RCSEng.

- Explore the possibility of establishing a national microsurgery fellowship programme with the JCST and any relevant universities – seeking 3rd party sources of sustained funding (for example, Breast Cancer Now).

- Seek to secure funding for extra places on the breast TIG Fellowship, with the agreement that the new slots are specifically adapted for plastic surgeons focussing on the microsurgery techniques needed for reconstruction procedures.

- NHSE/ICBs must seek to expand training places in microsurgery (number per annum TBC).

- We need to better harness the more 'high volume' units and the opportunities they provide for trainees to experience micro-surgery techniques. Identifying and approaching these units as a collective is crucial to facilitate this.

- Increasing cross-exposure between breast reconstruction nurses and breast care nurses respectively as part of orientation and development. Fostered and facilitated through the Breast Cancer Now forums and networks.

- Every breast unit should have an oncoplastic MDT which should be attended by at least one plastic surgeon. This might be facilitated by joint appointments of plastic surgeons with some sessions (and funding) from a peripheral 'spoke' hospital where plastic surgery input is needed, and some sessions in the 'hub' plastic surgery centre. This could be formalised through NICE Quality Standards/Guidance or medical royal college best practice models.

- Promote best practice through encouraging job planning conversations - using learning sessions to showcase best practice and creating a co-badged "job plan template", with ring-fenced theatre time.

- Develop a Breast Reconstruction Toolkit for Breast Care Nurses (following the example of Fertility Toolkit).   To be potentially delivered by an app (see Kent Breast APP) Incorporating an agreed competency framework, PEGASUS principles, visual aids and animations.

- Encourage the development of a nationally accredited course on breast reconstruction for specialist nurse. Potentially created in-house and offered to a university who already run a relevant Master's degree, to either incorporate into existing course, or run as a stand-alone.

- The TIG fellowship needs to continue to be adaptable and consider growing surgery areas, such as breast conservation surgery – potentially using a modular system of training.