Editorial comments

This edition of the ENT UK newsletter features views on the EWTD from a couple of angles, as well as a view on training. There is also news on the intercollegiate examination. We take a look at the Scottish Society of Otolaryngology, in this, its centenary year. I hope this will be the start of a series of articles on our regional societies. By now, most of us will have heard of the axing of the department of health funding for the ENT E-learning for health project and Victoria Ward updates us on the situation, as it stands, with this worthwhile and important venture.

Gerard Kelly, editor

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Last chance saloon

Ray Clarke
Associate Dean Mersey

Eighty government-sponsored reports have a habit of languishing on shelves in Whitehall. I suppose the modern equivalent is some form of repose on a defunct website, or taking up a few kB on a hard drive in Westminster. I hope that isn’t the fate of the Temple review on the impact of the European Working Time Directive (EWTD) on training (1).

Sir John Temple was asked to gather evidence, consult widely, and come up with firm recommendations on how we maintain high standards of training for our young colleagues given the undoubted constraints that the EWTD imposes.

I am acutely aware of the heartsink that mention of the EWTD brings about for anyone who feels they are hampered on all sides in their attempts to provide a tip-top clinical service, i.e. most of us. The sense of frustration is especially evident in acute specialties and in the smaller units. In my deanery role I visit trusts; I talk to service leads, trainees, medical directors, human resources directors and clinical directors. I am universally greeted with tales of the impossibility of coping with maternity leave, sick leave, rest periods, rota gaps, unfilled posts and the unrealistic service burden that falls on worn-out, demoralised and marginalised trainees. Many of them have little or no direct contact with their supposed supervisors.

Rota gaps are incredibly destructive. The remaining trainees in a depleted ‘cell’ are prohibited from attending their day-time...
allocated sessions – often high quality training opportunities – and told to do an extra night on-call, usually at very short notice. They are then told they must take a rest period, again during what would have been a good training session with their consultant. The trainee feels cheated; the consultant ‘harrumphs’ and announces that the trainees are feckless time-wasters who know nothing about his patients and he wants no more to do with them. Morale plummets and sick leave makes the rota gap even worse.

Some Pythonesque practices have come about. These include frog-march doctors off the premises at the end of their shifts, making creative adjustments to recorded start and finish times, bizarre split shifts and in some trusts the hated ‘rota police’. This is a group of hapless administrators given the thankless task of ensuring EWTD compliance. Seemingly they snoop around places doctors are known to congregate, shooing recalcitrant trainees off the wards in case the trust incurs financial penalties and has to pay the dreaded ‘banding’ costs. They allocate doctors’ leave according to complex computer-generated matrices only they can fathom. You can’t blame trusts for doing this - a breach in the EWTD that triggers a banding change can easily cost £250K for a single small specialty. That is a lot of ITU nurses, a fair few ENT consultant sessions, and a sizeable chunk of your taxes and mine when replicated across the land.

It is a sorry tale and I am not unsympathetic. I do wonder though if it is simply a case of EWTD bad, consultants and trainees good, or a more complex mix of poor planning, outmoded thinking about training, and a failure to grasp what really was a fantastic opportunity to move models of care and service delivery forward to make them more in tune with the expectations and lifestyle choices of a new generation of both patients and doctors. Advance planning to accommodate the EWTD in many trusts involved unwavering adherence to the notions that all out of hours care had to be delivered by doctors in training, and that departments providing such care needed to continue to do so even though a more sensible arrangement might have emerged following dialogue with an adjacent unit. Given the austere financial conditions we all now face, you have to feel that some of the development and reconfiguration possibilities the EWTD gave us are now gone. Sir John makes some suggestions we can still implement, but they will need courageous re-thinking. More consultant-delivered emergency care, flexible working patterns for consultants – for which read more night work, less rigidity about which theatre sessions are yours and when you take your SPA sessions. It means more accountability about exactly how consultants are using their SPA time to support trainees. Even more contentious is the notion that ‘service requirements and training quality may mean that it is no longer feasible to train in all hospitals’. The historical reliance on the availability of doctors in training to deliver service is not guaranteed in perpetuity. ‘In small specialties and subspecialities, it may be necessary to focus training in one or two units in each SHA and combine training programmes across SHAs’. That sounds great, eminently sensible and really you can’t mount a serious argument against it, but what if he is talking about removing trainees from your unit? Which ENT department that now relies on trainees for a significant service load and an on-call rota will be the first to come forward and offer to ‘go solo’ with no trainees? I can see some tough times ahead. Despite shafts of hope from the new health secretary, the EWTD is not going away.

Trainees may want to ponder the idea that employers need to ‘reappraise’ their current terms and conditions of service. The contracts they now have not only proved a strait-jacket for trusts but militate against good quality training because of the penal outcomes for rota ‘transgressions’.

I am as fond of trainees as the next man or woman. I do wonder though if paying some very junior and inexperienced ‘twenty-something’s’ -who have generous study leave allowances and to whom large chunks of deanery resources are allocated - more than we pay head teachers, senior police officers and mid-ranking civil servants is either wise or sustainable.

I await the deluge.


CORESS request

Claire Hopkins, ENT-UK representative to CORESS

The Confidential Reporting System in Surgery (CORESS) was officially launched in June, and is now on a drive to encourage submissions of case reports. We are looking for short reports of critical incidents, or near misses, in order to identify recurring events that could be preventable in future. All reports are rigorously anonymised before being passed to the CORESS Advisory panel, which publishes and disseminates important issues raised.

We will encourage submissions focused on particular topics roughly twice a year. We would like anyone with an incident relating to the use of any medical devices or implants (such as tracheostomy tubes, PEG tubes, cochlear implants) to submit a short case report via the website www.coress.org.uk. You will receive a certificate of reflective practice which will be useful for revalidation purposes.

Thank-you for your time, and support of this very worthwhile system.

The website is a useful resource for all surgical specialties. We are at particularly high risk of wrong side surgery when operating on paired midline organs (such as thyroid lobectomy), and extra caution is advised in such cases.
E-Learning for health project cut

Victoria Ward
Clinical Lead ENTUK e-LfH

As you may well know the ENT E-Learning for health (e-LfENT) launch was imminent (September 10th 2010), when we received confirmation from the Department of Health that the government, as part of the austerity measures, suspended the entire e-learning for healthcare programme on the 29th of July pending a review of technology enhanced learning and a means of saving some £25million pounds.

For ENTUK & the e-LfENT Project this could not have happened at a worse time as the executive, section editors and authors amongst you had been toiling to achieve real progress, ready for the launch. User acceptance testing undertaken by a representation of trainees from all regions proved extremely positive and validated the requirement and need for such a resource.

However, all is not lost. Professor Ramsden, myself and other Section Editors have been investigating the possibilities with the President of ENTUK, Alan Johnson, to provide an alternative means of delivering this worthwhile resource. We have to safeguard and realise all the hard work already undertaken and continue what has been started in the interest of the trainees and the specialty. We also have the opportunity to reapply for funding from the DH. Unfortunately I think the odds are somewhat stacked against us to obtain a slice of the now, rather diminished, pie. We are confident that with the continued support of all Section Editors, whose expertise and enthusiasm remains and you, the authors, to develop materials, we will ensure the survival of the project.

I look forward to announcing the results of the option appraisal put before council and outlining future plans for development after the meeting in September 2010 (the results of which may be known when you read this).

Thank you on behalf of the project executive to all contributors for your efforts to date and we look to you all for your further support.
**ENT-UK & the NHS Confederation**

**Andrew McCombe**  
ENT UK Assistant  
Honorary Secretary

The NHS Confederation is a charity. It describes itself as, ‘The independent membership body for the full range of organisations that make up the modern NHS’. Its membership includes ambulance trusts, acute and foundation trusts, mental health trusts and primary care trusts plus a number of independent healthcare organisations that deliver services on behalf of the NHS. Their stated aim is to support the NHS to deliver high-quality services and improve the nation’s health and well-being, and this is done by (sic):

Informing and influencing the development of healthcare policy.

Representing their members views and acting as advocates on their behalf - forming our responses based on what they tell us and ensuring their voices are heard at key stages of policy development and implementation. [Isn’t this the same as 1?]

Providing unique insight, analysis and guidance on national healthcare policy and its implementation and offering a valuable forum for NHS leaders and healthcare professionals to come together to discuss ideas and share learning.

Providing a source of fresh thinking and helping to shape the wider healthcare debate. It is in relation to this last point that ENT-UK has been approached.

Many of you will recall that our president, Alan Johnson, was a co-signatory (with a number of other senior surgical leaders) to a letter that was published in the Guardian drawing attention to the introduction of rationing on the sly! Following publication of this letter we were asked to a meeting with the NHS Confederation, ostensibly to discuss this letter and its contents. In fact, one of the reasons for the meeting (perhaps the real reason?!) was to invite ENT-UK and its members to participate in a project to identify areas where we could change our practice, to reduce costs, and yet maintain, or even improve, the quality of our service. A tall order?

A letter was sent by our President inviting ideas and a number of responses were received. We are still looking for more. So far however, the responses we have had have made suggestions along the following broad lines:

Referral guidelines. An enormous amount of our work is done in out-patients. A significant proportion of these referrals do not necessarily have to be seen by an ENT specialist, or perhaps could have more done prior to referral. Well devised guidelines may help with this. (Or perhaps just encourage more referrals as seems to happen to me every time I talk to GPs!)

More selectivity about the use of investigations. Examples for discussion include barium swallow in globus and MRI for otological symptoms. There is of course an element of risk to this strategy and perhaps we could be helped by guidance as to an acceptable level of risk, in terms of missing or mis-diagnosing?

Adherence to recognised treatment protocols and guidelines. SIGN for tonsillectomy, NICE for grommets, cochlear implants etc. This I believe most of us are doing anyway.

Improvement of the surgical day case rate. (One does wonder how much money this really would save at the end of the day).

A relaxing of the non-evidenced base requirement for instrument sterilisation (nasendoscopes), single use instruments, and non-essential, unhelpful mandatory courses, especially the recent requirement for teaching and training courses for which the educational “consultants” seem to be paid a small fortune.

It is hoped that a workshop can be organised (or may already have been, by the time this comes to press) which will include representatives from the NHS Confederation, the BMA and the Academy of Royal Colleges. Hopefully any conclusions can and will be fed back to the appropriate people in the DoH and thus afford us a small but tangible influence on future policy, especially as it pertains to the practice of ENT. Other ideas are still welcome as will the presence and involvement of individuals who feel strongly on any of these issues.
The SOS

Fiona MacGregor
Honorary Secretary & Treasurer of the Scottish Otolaryngological Society

The Scottish Otolaryngological Society held its first meeting in Edinburgh on the 11th November 1910. Excluding the war years the society has held two meetings every year in Scotland and celebrates its centenary this November. Initially the society was very much about establishing the specialty of otolaryngology within Scotland and meetings were where like-minded surgeons discussed challenging cases and new techniques. Amongst our early and founding members were such learned surgeons and authors as Arthur Logan Turner, Douglas Guthrie, Adam Brown Kelly and William Syme.

With time the society has inevitably become more involved in teaching, training and medical politics. It has been instrumental in setting up training programmes for ENT nurses and audiometricians. It has advised on training standards for doctors in ENT within Scotland, in audiological screening in children and it has been very active in establishing audit within our practice. Now that devolution has resulted in a separate health care system from the rest of the UK, we have an increasingly important part to play in advising the Scottish Government on issues related to otolaryngology and its provision of care. Currently our society has well over 100 members and is open to all those practising otolaryngology and audiological medicine in Scotland at the level of ST3 and above. The educational content of our meetings has expanded and developed and we now host the JLO RSM visiting professors during our early summer meeting in May each year. This is currently held over two days and provides an opportunity to hold an annual society dinner. Our one day winter meeting rotates around the country and is held in November. At both meetings we have a trainee section giving our junior members an opportunity to present their research and audit projects.

Our democratically elected chairman and council represent all aspects of the specialty and all geographical areas within Scotland. The principal responsibilities of the council are to ensure that all the educational and advisory requirements are carried out with regard to all of the members’ wishes. This advisory role extends not only to our government but to many institutions including the royal colleges, health boards and ENT UK. It is imperative that the society continues a healthy dialogue with the Scottish Executive with regard to service provision but at the same time maintains a united front with ENT UK and regional societies elsewhere in the country.

Many distinguished figures have been active members of our society over the years and the society has played host to a very impressive list of internationally renowned otolaryngologists who have come to Scotland to give our Guthrie Lecture. Our Guthrie Fund assists trainees in funding research and audit projects in addition to travel to and participation in overseas fellowships. Our society meetings are an ideal forum for friends and colleagues to meet, share ideas and work together to face the many challenges that lie ahead.

We look forward to celebrating our centenary in Edinburgh later this year with a two day meeting at the Royal College of Surgeons Edinburgh and a Centenary Ball at the Balmoral Hotel on the 11th November, exactly 100 years to the day from our first meeting. We then look forward to the next 100! Honoray Secretary and Treasurer

Further information and updated programmes will be available on the SOS website at http://www.scottish-otolaryngological-society.scot.nhs.uk/

You can register online for the centenary meeting at www.regonline.co.uk/sos_centenary

For queries e-mail sos@execspace.co.uk or Fiona.macgregor@ggc.scot.nhs.uk
Is it time for an EWTD rethink?

*Tony Narula*
Consultant at Imperial Healthcare

The Royal College of Surgeons 2-year campaign against the pernicious effects of the EWTD seem to finally be receiving a sympathetic hearing. On Sunday August 1st the DH issued a response to Channel 4 News saying that this directive had caused a lot of problems in healthcare and that the new Coalition government were working to modify it. This followed a July online survey carried out by the RCS over a 10-day period which had almost 1000 responses. This statement represents a major volte face for the DH which has always taken the line that the reduced working hours were perfectly manageable. The majority of respondents to the RCS survey stated that the new regulations had led to decreased training opportunities and increased dissatisfaction. The situation had also deteriorated since the previous survey in October 2009. All round the country we see individual departments struggling to staff the shift work rotas that EWTD requires. This either leads to rota gaps which often have to be filled by internal locums (thus defeating the object of the exercise) or by ‘networking’ between departments which really means closing some services and transferring them to a distant site. The latter is fine for patients who live near the surviving site but not so good for those who live near the other.

Transferring services also threatens the viability of district general hospitals. These have been one of the great unsung success stories of the NHS. Before 1948, there were a small number of highly regarded teaching hospitals and a large number of DGHs with very variable services. Since 1948 the standards have been raised such that the public have found high standards almost everywhere. Now as services are transferred out – often without strategic thinking but for short-term reasons – it becomes impossible to provide a full service. An example of this is a recent Care Quality Commission survey of paediatric services which suggests that not all current paediatric departments are viable. They even looked at travelling times between departments. It is clear what is being considered here.

The reduction in training time has led to a decline in total training hours for surgeons. In 2004 a 58 hour week and a 42 week effective working year provided 2,436 working hours/year. A 48 hour week now provides 2,016 working hours/year. Over a 6 year SpR scheme this is a reduction of 2,520 hours. Of course not all the time at work is spent training. But a reduction on this scale can only be accommodated if accompanied by a dramatic change in how the NHS functions. Not only has this failed to take place, during the past few years the constant pressure on waiting time targets has led to less time for trainers to give to their trainees – especially in the operating theatre.

Interestingly the new president of the RCP has also stated publically that this has been a disaster for medicine. It seems we have allies at last.

Another consequence of all this is that the SAC have now defined exactly what a trainee should have achieved before final sign off. This is to ensure standards are maintained but has attracted unfavourable comments from trainees who didn’t expect such a quantitative approach to their SpR years.

In many parts of Europe the EWTD is simply ignored. In Holland the law was changed to allow up to 60 hours. A similar process has occurred in some parts of Germany. ASiT have produced their own study and concluded that 60-65 hours is the best solution. However, this presumes that shift work is discontinued.

Changes in law take a long time. The Department for Business is the responsible body but one can see that even with political will, we may have 2-3 more years of this. The shape of our healthcare services may well have altered beyond recognition in that time as our trusts continue to attempt compliance with EWTD as well as compliance with financial restrictions. But what is clear is that a prolonged campaign based on hard facts is beginning to bear fruit. Perhaps the medical profession has not really lost its influence. Maybe we have just been afraid to put our heads above the parapet high enough to be noticed.
Training & selection: A plea for robust strategies & metrics

David Pothier
Neurotology Affiliate
Toronto General Hospital

For trainees there has been much to discuss of late. Selection has been very much in the news as have rapidly instituted changes to CCT requirements. Providing quality training is never easy, but there should be a consistent and robust system for doing whatever we decide is best at any period in time.

Selection
Getting selected used to be relatively straightforward – do lots of ENT in training positions and publish. And publish. We pretty much knew what we had to do. It could be argued that we did poor research for the sake of research, but at least we arrived relatively clinically experienced and with some academic background.

Unfortunately it seems that in an attempt to produce the perfect selection process, we have lost our way. Nobody appears to know what to do to get the post; even the Royal Colleges once said that research would not be a requirement for trainees and now we are penalizing candidates for being too good at ENT (at least, having too much ENT SHO experience).

What the correct tick boxes are can be debated forever, but it stands to reason that they should be consistent and not be formed in the image of the prejudices of those in power at the time.

We still need to select candidates that will take the specialty forward. There exists a system of Chinese whispers that trainees use to calculate how to make career progress. Would it not be a good idea to construct a set of values and goals that define our specialty and model selection around them? At least this could be used as a holding measure until we carry out the research required to find out what makes a good candidate. Could this be an extended role for ENT UK?

Assessment
Those of us who were lucky enough to secure a training position were subjected to training largely as it was envisioned by our local consultants with almost no real oversight by the SAC or College. Guidelines were flaunted, recommended training essentially ignored and the ‘best made of a bad situation’. Needless to say, no trainee dared to make a fuss for fear of being branded a troublemaker at their RITA; ironically, this was the same RITA where job compliance was supposed to be addressed. Insufficient operating was always the Achilles heel of any trainee as seen by the ‘Old Guard’. Interestingly, ‘not enough time in clinic’, largely service work, was never a big theme at a RITA. This is strange, given the perceived inexperience of trainees in the operating room. Perish the thought that the RITA committee would demand adequate training (or heaven forbid high-quality training) of their trainer peers. That would be most uncouth – we have other pressures, you know.

In fact, being a trainer requires no demonstration of skills, merely that the trainer is a consultant. No sanction is given to those providing appalling training – it is the trainee who bears the brunt of this neglect. It is fortunate that most trainers are very capable, as where there is a problem with a trainer, it seems no standards exist against which to judge them. Should there be a ROTA (Record Of Trainer Assessment)?

Now then. Fast forward to the end of training. A successful candidate will have been deemed ready to be a consultant by their Programme Director so as to sit their exam; will have been in receipt of six RITA C forms each implying the job they did each year was up to the training committee’s standards, and have a RITA G form stating that they are ready to receive a CCT. Suddenly these assurances are not enough; the candidate now has other burdens of proof with which to contend. Have enough on-calls been undertaken? Have there been enough specialist clinics and, irony of irony, has there been enough time spent in theatre. That’s right, the trainee who has been told, despite their rapidly-mutted protestations, they can’t be given more time in theatre, has to show the SAC that they were given enough operating time or fail to receive a CCT. No mention of trainers’ responsibilities here. Perhaps I’m being dramatic but is this not a bit like saying to a prisoner on the day of their intended release, “Prove your cell was 2 by 3 metres as specified by the Penitentiaries Act. Anything smaller and you have to start your sentence again”?

There is no doubt that providing quality training in the midst of very heavy service pressures is complex and a balance needs to be struck. I have certainly been lucky enough to have benefitted from some superb trainers maintaining very impressive levels of teaching despite crippling pressure to deliver a high volume service. Perhaps these trainers need to be supported by national standards, which can be shown to administrators. However, if minimum standards are negotiable to the benefit of hospital administrators and trainers, how can it be the trainee’s fault that they are not met?

Should we not lay down firm rules and then abide by them?
Invited review mechanism & ENTUK - FAQs

Janet Wilson
ENT UK Honorary Secretary

What is the Invited Review Mechanism? The RCSEng Invited Review Mechanism (IRM) covers all surgeons working in the NHS and private sector in England, Wales and Northern Ireland. The purpose is to assist hospitals in determining whether there is a problem with regard to the alleged unsafe, inappropriate and unsatisfactory performance of an individual surgeon or the delivery of a surgical service/team working within a unit. The aim is to provide a fair, independent professional review process to support:

a) existing local procedures and
b) individual surgeons and surgical teams through the early identification and resolution of problems.

The process is organised through an RCSEng Joint Standing Committee, chaired by Prof Norman Williams, on which the current ENTUK representative is Prof Richard Ramsden.

What if the problem concerns an ENT surgeon? The IRM coordinator will approach the committee representative, or the ENTUK President / deputy who will suggest whom from the ENTUK IRM team might most usefully undertake any required review.

Who carries out the review? The review is carried out by trained panel members. The ENT current panel members include Miss Kate Evans; Mr Andrew McCombe and Mr Andrew Parker. What reviews may be invited?

1. Individual Reviews assist hospitals in identifying whether there is a case to be answered with regard to alleged inappropriate or unsatisfactory surgical performance of a surgeon.
2. Service Reviews provide an independent expert opinion in relation to concerns about a specific surgical department/unit.
3. Case Note Reviews provide an independent expert opinion on whether the management of a specific case or series of cases has met the required College/Specialist Association standards.

Who needs to know that the IRM is in progress? All those involved with the review must agree; so that the review is carried out in an open and transparent manner and includes discussions with all parties. The surgeon(s) involved must not only consent to the review, but be fully informed of the terms of reference and the procedures to be followed.

Who or What triggers an IRM? The IRM will be initiated when an approach is made by a hospital Chief Executive/Medical Director to the Chairman of the Invited Review Mechanism at the College. Reviews cannot be instigated by a request, a visit and a report of a hospital or any other third party.

What happens after the review? An advisory report of the team’s findings is prepared for the hospital, with recommendations for the consideration of the hospital concerned. The report is the property of the hospital which remains entirely responsible for all decisions or subsequent actions, although it is a condition of the review that the report must be made available to all involved.

What records are held in ENTUK on an IRM request? Nothing is recorded by us on the outcome, just that there has been a request, a visit and a report. If you are interested in this opportunity, please contact the IR coordinator – see below.

How many people are on a reviewing team? The reviewing team comprises two clinical reviewers (surgeons), and one lay reviewer.

What should I do if I feel I might make a good reviewer? The College recruits, in open competition and against set criteria, a panel of reviewers who will be trained to undertake reviews on behalf of the College and ENTUK.

Where can I find out more?

Further information is available at www.rcseng.ac.uk
Or from Ms Simone Callender Invited Review Coordinator Professional Standards and Regulation Department The Royal College of Surgeons of England 35-43 Lincoln’s Inn Fields London WC2A 3PE
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Invited review mechanism & ENTUK - FAQs

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