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THE NEWSLETTER FOR ENT PROFESSIONALS

Editorial comments

In this edition of the ENT UK newsletter, we read two, quite different views of what we can expect from the post-2010 election NHS. It is clear that whatever the future holds, changes are happening and the NHS will be very different in just a few years compared to how it is today. Fellowships are a way of high volume, sub-specialised training and who can deny their worth but should we set our ENT sights on cleft palate fellowships? We also ask for your input for ideas for the ENT UK website, due to undergo a radial makeover.

Gerard Kelly, editor

The NHS post Lansley – an ex-parrot

Ray Clarke
Associate Dean Mersey

I started in the NHS in the Thatcher days and have lost count of the health service reforms, reconfigurations, white papers and their sequels that have come my way. Weary as I am, I was expecting a few yawns as I read the latest Lansley missive. ‘Liberating the NHS: Legislative framework and next steps’ was published in the run-up to Christmas and just before your editor’s deadline. It is a long (179 pages) detailed blueprint for a new approach to the funding, delivery and regulation of health care. There is many a yawn thrown in but make no mistake this will have a huge impact on how we all work. Much of it is aspirational; there are the expected platitudes about how wonderful the NHS is and how the principles that govern it are inviolate. Nevertheless many startling ideological shifts are buried in the text. The ‘ancien regime’ is set to disappear. This is the death-knell for the exasperating, lumbering but often lovable old health service in which many of us expected to see out our careers. Check it out on the DH website.

The White paper mantra ‘no decision about me without me’ has morphed into a sharp focus on encouraging competition between health care providers in the expectation that this will drive standards up. In practice, it looks like any organisation that feels it can deliver a service can tender for

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it. The decision making will be in the hands of the newly-empowered GPs, acting in ‘consortia’ and buying ‘packages’ of care from the various providers pitching for business. It doesn’t take a great business mind to predict what sort of ENT work will be most sought after – high volume, low morbidity surgery. Sound familiar? How loyal will your local GP consortium be to the ENT unit that served them well for the last thirty years, through the multiple reforms? How well equipped are your GPs to decide which ENT services are worth purchasing? If you have followed the recent debate re paediatric ENT surgery in the BMJ you will know that the world of GP is immersed in some fairly spectacular ignorance about what we do and why we do it. A selected few GP practices are already up and running – the fifty two ‘pathfinder’ consortia, in whom no doubt the DH will heavily invest and whose attainments will be lauded and ‘spun’ as an exemplary service.

When I trapse around the bull-barred WAG-style four-wheel drives and the named and neatly marked spaces– each used only three days a week – in my local GP surgery car-park, I shudder a bit when I reflect on who makes the decisions about what sort of referral I might need and who can provide it. The Quality and Outcomes Framework (QOF) has thrown up some fairly unseemly reminders of what does and what doesn’t influence GP behaviour patterns. Money talks.

There are always winners and losers in any reform. Surely it won’t be long before a few enterprising groups of CCT holders, struggling in the traditional job market-place, set up a series of ‘consortia’ of their own to sell their services to the new purchasers.

Who can blame them when they will be faced with an explicit government commitment to abandon hard-won NHS terms and conditions of service for staff? Lansley speaks for this is ‘The Government is committed to preserve (sic) employers’ ability to decide locally – in the spirit of determining what is best closest to the front line – whether to use national terms and conditions or to create local systems’.

When faced with stiff competition from the enterprising CCT holders down the street, how do you think a foundation trust will respond when faced with a department of say five surgeons with a smattering of local and national CEAs and fifteen SPAs between them, wanting to employ a new rhinologist? And how enthusiastically will they welcome surgeons in training, royal college input to the recruitment process, or ENT UK recommendations re minimum standards for job plans and departments?

It makes you wonder if the lessons of the dreaded ISDTCs and ISTCs have been learned. The companies that set them up are circling the decaying carcass Lansley has laid out before them. If you are a trainee, you may need to befriend some fairly unsavoury people. It’s an ill wind...

SAS group disquiet

Laurie Baxter
Chair ENT UK SAS Group

With the help of Janet Wilson, Tony Narula, Maurice Hawthorne and Ray Clarke, the ENT UK SAS Committee continues to try to ‘embrace’, include and encourage our sizeable group of ENT SAS across the UK. Manpower ‘miscalculations’, old-fashioned prejudice, lack of preparation and loss of self-confidence among the SAS doctors themselves have all contributed to my own failure to be able to increase the number of ENT UK SAS, much less motivate a committed SAS Committee. If you ask (as I do) the brightest and most successful ENT SAS across the 4 nations why they fail to get involved in ENT UK, the answer ranges from “it offers very little to its SAS” or “the attitude conveyed by some senior and junior medical staff, the lack of recognition or reward, the thoughtlessness of our group from agendas, invitations, committees, conferences is discouraging” to, “as a specialty, ENT treats its SAS badly, but locally I have earned the respect of my colleagues where it matters”.

Other Specialties have moved on and now nurture their SAS. The payback in good working relationships and achievements at local, regional and national levels only highlights our specialty’s failure to do the same.

I’ve recently asked for a small change through the BACO Committee in our attitude toward our own SAS Colleagues. I have suggested that many of the BACO committee members know of good/outstanding SAS that could get involved with BACO and ENT UK—they need an invitation and encouragement.

We are all too well aware of the well-trained, highly skilled ‘time-expired’ SpRs / structured trainees in ENT who are not finding consultant posts. This is not because of SAS doctors, nor do these doctors threaten future consultant appointments. The SAS doctors are, for the most part, hard-working career grade ENT doctors who want to be very good at what they do with some acknowledgement of their contribution. At present, they are largely an untapped resource that will become increasingly rare as the Specialty Doctor appointments of very junior doctors replace the retiring experienced Associate Specialists. Please consider this change!
Money & Service changes

Tony Narula

In the October 2010 newsletter I referred to the need to ‘reconfigure’ services to take account of EWTD and also financial pressures. The latter are now really beginning to bite with cuts of several billion pounds over the next few years (in real not cash terms). The contraction of hospitals over the past 20 years will surely accelerate as the need for savings accelerates. However, less than half the total NHS budget is spent in the secondary sector and we should look at the bigger picture.

Andrew Lansley has put his faith in GP consortia taking over the commissioning of services. Some would say his faith in a government of self-employed practitioners is naïve. Or perhaps it is touching. We have been here before about 20 years ago with what was then called GP Fundholding. Certainly that led to some small but significant service developments but it also caused tremendous instability in the acute sector with poorly drafted contracts and Trusts unwilling to invest in new consultants etc. because of fears for their future income streams. Already this is beginning to sound rather familiar. What is less well remembered is that there were also abuses in the early stages with NHS funds being transferred to offshore companies by the first wave Fundholders. It is difficult to find people at the top in the DH who have any corporate memory of this era so I suspect many of the same mistakes will be repeated.

Perhaps a long hard look should be taken at the shape of primary care in the UK. We have large numbers of highly paid doctors who do little actual medicine for much of their working day. And at present many of them also provide no Out of Hours Service either. Perhaps the Darzi plan for NHS ‘polyclinics’ wasn’t such a bad one. With the proviso that the ‘specialists’ in these community based polyclinics should be GPs who can demonstrate at least one additional skill; i.e. a true group of GPwSIs working in groups. It is difficult to remember back to the late 1960s but one of the dreams of introducing Health Centres was exactly this kind of joined up working with Doctors and Allied Health Professionals. This concept needs to be updated for the 21st century.

What of secondary care? Much of our activity is hopelessly outdated. Clinic letters may be typed locally at great expense. Even when they are sent overseas (in digital format) there is often insufficient staff to actually print them off in a timely manner. Patient appointments are all still made by inefficient post instead of text / email. Many follow-ups could be done by email: especially when the results of tests are concerned.

Sir Phillip Green published a report into Government waste in mid 2010 pointing out the huge savings that could be made by co-ordinating purchasing decisions. I am sure we all concur that the NHS is very poor at this kind of thing. On the rare occasion it does get its act together enormous savings ensue. Most readers will recall the decision to go to digital hearing aids a few years ago. The negotiations were led by James Strachan from the RNID and resulted in massive unit cost reductions. So it is really possible. A similar overlooked area is the NHS Estate. Many community hospitals are under used and sitting in large tracts of land. This is all public money but where Foundation status has been granted, the individual organisations are able to develop, sell etc. and retain the proceeds. And they can then pay large bonuses to the managers present at the time (see the various reports on Mid-Staffs). Not exactly corrupt but certainly very dodgy.

Another area that politicians and the public are beginning to focus on is Consultants’ merit awards (or bonuses in journalese). These awards of £35,000 and upwards are hardly ever withdrawn; we may argue that this is because the process of selection is so rigorous that only the most worthy achieve them but it doesn’t sound so good when talking to the public. Already in 2010 we have seen Northern Ireland and Scotland halt the 2010/11 ACCEA round. In England in 2009/10 the number of National awards given was half that of the previous year. I think a pattern is developing which is clear to all of us.

If the tone of this discourse seems rather depressing I would remind everyone that whatever the political aspirations of a particular Administration, our hard won NHS is very poor at this. Perhaps a long hard look should be taken at the shape of primary care in the UK. We have large numbers of highly paid doctors who do little actual medicine for much of their working day. And at present many of them also provide no Out of Hours Service either. Perhaps the Darzi plan for NHS ‘polyclinics’ wasn’t such a bad one. With the proviso that the ‘specialists’ in these community based polyclinics should be GPs who can demonstrate at least one additional skill; i.e. a true group of GPwSIs working in groups. It is difficult to remember back to the late 1960s but one of the dreams of introducing Health Centres was exactly this kind of joined up working with Doctors and Allied Health Professionals. This concept needs to be updated for the 21st century.

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New Interventional Procedures in ENT

Liam Flood, ENT-UK NICE Liaison and newly appointed member of IPAC

Amongst the less controversial guidance released by the National Institute for Health and Clinical Excellence (NICE) is the series of Interventional Procedure Guidances (327, few relating to ENT).

To quote NICE:

An interventional procedure is one used for diagnosis or treatment that involves one of the following:

- Making a cut or a hole to gain access to the inside of a patient’s body - eg, when inserting a tube into a blood vessel.
- Gaining access to a body cavity (eg the digestive system) without cutting into the body - for example, examining or carrying out treatment on the stomach using an instrument via the mouth.
- Using electromagnetic radiation eg, using a laser to treat eye problems.

Guidance relevant to us includes things as varied as endoscopic pouch surgery, suction diathermy adenoidecotomy or pillar implants for snoring (implants are up for review and they are particularly anxious to know if anyone in the UK is now doing the procedure, thanks to Joe Marais and John de Carpenter for info). Is anyone else doing pillar implantation for snoring, either in the NHS or privately and willing to share even their informal experience? Further, are there any other new techniques we could submit to NICE for appraisal?

They want things that are past the experimental stage, but are not yet mainstream practice. I wonder about intratympanic drugs for sudden sensorineural deafness and am grateful to Matthew Yung for preliminary information. Following on the guidance on balloon sinusplasty, we may now be submitting balloon Eustachian tube dilatation if I can get my pal Maurice to fill in the forms.

Existing guidance needs review, especially if obsolete or, conversely, there is new high-level evidence for efficacy. I am told that collagen for vocal cord injection is no longer available and that a hydroxyapatite product has replaced it (thanks to Shane Lester for that information). NICE will sometimes conclude that an interventional procedure is safe enough, but there is insufficient evidence for benefit. They then require ‘special arrangements for audit, consent and research’ if the procedure is undertaken and come back to us at ENT-UK to see if anything new has resulted. I would appreciate even the most informal suggestions as to what is new out there that a simple otologist might be missing.

A favourable review by NICE can be a great help in getting approval for innovative surgery from your trust and, at a time when we are all challenged by the de-commissioners of health care, can only help with funding!

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There has been a lot of debate about the standards that are required to enter Specialist Training and who should be interviewed. We have the capacity to interview nearly one hundred people and this year we are going to have 32 national training numbers. The competition will be tight both for the ability to be interviewed and for the posts that come up. We do hope to have some LAT posts available as well but it is too early to say how many of these are going to be available. A lot depends on how many people do get consultant jobs in the interim period and if there are still people going away on pre CCT fellowships next year. The short listing is being done online so the application forms are relatively limited in the information that is required and those who are invited for interview will be the hundred who score highest on this computer based marking. When this marking was modelling on last year’s CV’s, it short listed most of the people who were coming from themed core surgical training and most of the people who were one year after that i.e in the first year of a LAT. This should leave places for people who have come through alternative routes but as the criteria are the same no matter what route they have come through they will still need to be up to standard to get shortlisted. Once they are short listed then there will be six assessment stations, very similar to last year in Leeds and the top 32 people will be offered places according to their preferences and their ranking.

The assessment stations will be similar to last year in their lay out but not in their content. The portfolio station, the clinical management station, the general interview station and the communication station will all have more targeted questions and these are currently being written, assessed and validated to make sure they are fit for purpose when the time comes. National Selection is now run by a committee of eight people, jointly appointed from the National Association of Programme Directors in ENT (NAPDENT) and the Specialist Advisory Committee (SAC). Jeremy Davis who is the Chairman of NAPDENT chairs this National Selection Committee. The members of the committee have different responsibilities. Jeremy Davis Co-ordinates process and liaises with Deanery regarding placing successful candidates (top ranking candidate to get first choice etc) and leads on communication skills station. Tristram Lesser and Simon Hickey, short listing and portfolio stations; Tom Alun-Jones - Lead QA process and training on interview skills / avoidance of bias; Helen Cruickshank, leading practical skills station; Andy Reid, station lead, Derek Skinner - Scoring, Angoff score - spreadsheet for ranking and minimum appointability threshold; Nirmal Kumar and Rogan Corbridge, station leads.

We do need consultants to come and help as assessors on the three days: the first day is training the next two days are assessments and Jeremy Davies would be delighted to receive offers of help. The only qualifications are that they should be an NHS consultant and have had equal opportunities training within the past two years (most Trusts now have this on line as part of their mandatory training). Reasonable expenses for attending are paid through the Yorkshire and Humberside Deanery – and accommodation in Leeds is arranged.

The Midlands Institute of Otology (MIO) is one of the regional ENT societies in the United Kingdom, which are actively involved in promoting teaching and research in ENT. The origins of the Midlands Institute of Otology date back to 1947 when Williams Stirk Adams [ENT surgeon at the Queen Elizabeth Hospital in Birmingham] initiated the formation of the institute and played a vital role in establishing the institute during the early years. Mr Stirk Adams served as the president of the institute from 1947 to 1977. Upon his death he generously bequeathed his residence in Edgbaston to the institute.

The full membership of the institute is open to all ENT consultants within the East and West Midlands regions and to those ex-trainees from the midlands who become consultants elsewhere. All otolaryngology trainees within the Midlands region are offered associate membership. Since 1949 the institute has held clinical/educational meetings twice a year – a winter meeting and spring meeting. The institute collaborates with ENT departments within the region to organise these meetings. On three occasions, these meetings were held outside the region – in 1977 hosts were the Royal Hospital, Wegberg, Germany, in 1987 the Free University, Amsterdam and in 1991 the meeting was joint with the West Midlands Surgical Society and held in Florence, Italy. Several of these meetings have included participation and lectures by eminent experts of both national and international standing. Since 1980, the most prestigious annual lecture has been dedicated to the memory of W Stirk Adams. The Stirk Adams lecture had been delivered by several eminent international speakers including Prof M Remacle, Prof H Stammberger, Prof William Wei and Prof Gregory Weinstein. During the past few years, Royal Society of Medicine visiting professors have given lectures during the spring meeting of this Institute.

Since 1984 educational bursaries have been awarded. Initially this was to attend the Advanced Otology course in Nijmegen but in recent years these bursaries fund educational course attendance in all aspects of ENT. During the year 1984 and 1985, the institute joined with the TWJ foundation to fund fellowships to enable a senior trainee to work and gain experience in otology in Toronto. The Institute has awarded fellowships to trainees from outside the EU to attend the British Academic Conferences in Glasgow, Dublin and Liverpool.

In addition to clinical meetings, the Institute has also helped to sponsor the Toynbee memorial lecture held at the Royal College of Surgeons of England for several years. It has also supported numerous research projects by consultants and trainees, provided travelling expenses to attend and present in various international meetings and supported the establishment of a Chair in Otolaryngology at the University of Nottingham. More recently, the Institute has pledged it support for the establishment of an academic unit within the West Midlands region. The records of the Institute are very detailed and include discussion of clinical problems very different from the present years. Some of the clinical discussions include treatment by suppositories of bismuth (1947), the survey of a poliomyelitis epidemic and a clinical trial of the treatment of persistent Eustachian tube obstruction by the insertion of radium carrying applicators to the nasopharyngeal orifice of the Eustachian tubes!

Currently, the institute holds two meetings per year. Trainees are encouraged to present their work in these meetings. The abstracts of the presentations in future meetings at the MIO will be published in the journal ‘The Otorhinolaryngologist’. Recent speakers at the Institute’s 2010 meetings include Prof John Rutka from Toronto, Canada (Stirk Adams lecture) and Prof Hans Zijlstra from the Netherlands. The current president of ENT UK Mr Alan Johnson was the immediate past president of this Institute. The details of various bursaries and fellowships available from the institute may be accessed through the Institute’s website: www. mio.org.uk

The National Selection for ENT training numbers in is going to take place on the 17th, 18th and 19th of May in Leeds. Like all other specialties, ENT is now undertaking nationally co-ordinated selection by Joint Specialty Deaneries. Wales, Scotland and Northern Ireland have separate national selections. Being a relatively small specialty ours is being done in one or possibly two rounds. Candidates should be preparing their CV’s and applications forms for May 2011.
Cosmetic and Reconstructive Interface Fellowship

Tristram Lesser

The cosmetic and reconstructive fellowship group is one of the three training interface groups. This fellowship is a pre-CCT fellowship that occurs in the UK and is funded by the Department of Health. The cosmetic and reconstructive post is interesting because it came about due to the need to train people who were doing cosmetic surgery both inside and outside the NHS. It was felt by the government that aesthetic surgery was not necessarily covered pre CCT and they wanted to regulate cosmetic surgery. This coincided with a change in the regulations that meant that people wanting to do cosmetic surgery had to be on a relevant specialist register. I have been on the committee representing initially ENT UK and then the SAC since it started and have watched these cosmetic fellowships evolve over time. They have been running for three years. Initially these were unfunded and there was uncertainty over their future but finally funding came from the Department of Health. Professor Sandhu from the Severn Deanery administers these fellowships and he runs this extremely well. The chairperson is currently a plastic surgeon from Nottingham who has worked tirelessly to make these posts a success. It has been a great pleasure to serve on this committee. Meetings which take place the night before the interviews are informative and efficient. The only complaint is that the bar bill is not part of the expenses and can be considerable!

This year the fellowships were available for four months and we appointed 14 people. These come from ENT, Maxillo-facial surgery, Plastic surgery, General surgery and Ophthalmology. Each year a number of ENT surgeons have been successful in obtaining these fellowships and progressing their careers in aesthetic surgery. Not only do successful applicants complete the fellowship but they also have the chance to go on the Royal College of Surgeons aesthetic surgery courses and learn about setting up a practice and a website etc. Anyone who is interested can have a look on the Severn Deanery website to see what the actual fellowships involve.

For anyone who is interested in having an aesthetic component to their practice when they become a consultant, I would recommend that they discuss this option with their Programme Director. The interviews are at the end of the year and the four month fellowship have to be taken before the end of the following year. So far the feedback over the last three years has been fantastic. Trainees who have had this fellowship are thus certificated. For those who want to take it even further, this certification, along with other experience they may have had in their training in general, can be used towards taking the American Boards of Facial Plastic Surgery exam.

I would highly recommend people apply for these fellowships as it is an opportunity that will not occur after they have obtained CCT in the same way. I am leaving the committee and being succeeded on behalf of the SAC by Merydd Harries and he will be able to give further information of where this is going in the future.

Endoscopes and Decontamination

Andrew Swift

At present, there seems to be nothing more emotive to ENT surgeons than interference with our normal clinical practice by rules and regulations set by those out with of our own profession. The decontamination of endoscopes is one such area.

Although we all aspire to have safe systems with minimal risk to our patients, we also experience the pressure to achieve a high throughput of patients within set time frames. Interest in infection has soared given the publicity of MRSA and C. difficile within the hospital environment. The various measures introduced into hospitals may seem excessive, but they have been effective and the risks of acquiring either of the above infections as a hospital inpatient are now very low.

The other risk factor of concern was prion transmission and CJD. Several years ago, this was predicted to rise to epidemic numbers but this has just not happened. The potential risk is still there however and must be taken seriously. Hospital Trusts have now set up infection control teams, decontamination committees and managers to focus on these problems. As a consequence, the methods used for cleansing both flexible and rigid endoscopes have come under scrutiny.

The issue was first addressed by ENUTK in 2005 when a working party consisting of Grant Bates, Phillip Jones and GL Ridgway, a microbiologist who was advisor to the DH, produced the first guidance document. However, there was a clinical need to review the subject and to try and produce clear practical advice on this subject: a further guidance document has therefore been published on the ENUTK website. The new document aims to delineate the advantages and limitations of the various methods of endoscope decontamination and the practicalities of applying them in clinical situations.

There has been much debate with the use of chlorine dioxide wipes, but it is likely that this is still the most common system being used in hospitals at present. However, decontamination committees are reluctant to accept this method because it is not automated and could introduce human error. Endoscope sheaths are another alternative but have not proved to be very popular so far. Decontamination committees will by nature favour methods that offer the optimum in cleansing or sterilising. The committee members will probably not include a representative from ENT and so will not understand the implications of the effect of their recommended systems on our clinical practice.

Hospital Trust Boards that move towards introducing systems of central decontamination need to consider all of the various factors before instigating the recommendations of their decontamination committees. Firstly, the risk of introducing infection from an endoscope that is cleaned by hand in the clinic is extremely low providing that clinic staff are trained appropriately and cleansing protocols are applied. Rigid endoscopes are suitable for central sterilising planning: this will require a large investment in buying additional endoscopes if this model is applied, especially if they have to be sent off-site. Flexible endoscopes pose an additional problem because they are considered by hospitals to be the same as gastroenterology endoscopes with their various channels and ports and as a consequence come under the same stringent guidelines for decontamination. Central decontamination by automated endoscope washers is therefore favoured. However, this requires a fast turned-around of endoscopes by the central decontamination unit; personnel to transfer the endoscopes to and from the outpatient clinic; a sufficient supply that might necessitate purchasing additional endoscopes; installation of drying cabinets within the clinic for endoscope storage throughout the duration of the clinic. The total cost of this model is therefore considerable and should be understood by the Trust board before the change is made.

One issue that has occurred in parallel to these developments in decontamination is the instigation of effective traceability systems. This may be under-estimated by clinicians but could be of huge importance if an endoscope is used on a patient who is subsequently suspected of having CJD. The central guidance for this is still being considered but at present the rules state that an endoscope that is potentially contaminated must be held in quarantine, and if CJD is proven the endoscope must be destroyed.

The main message from recently experiencing the changes to a central decontamination model is that every change induces many other effects that need to be considered and anticipated prior to the event. The cost of introducing these changes is considerable. All hospitals are now acutely aware of infection control and decontamination and I would strongly advise that each ENT department offers a representative to sit on the decontamination committee. It would also be helpful to develop a good working relationship with a microbiologist who is involved in this area.
Policy making at the English College: ‘bottom up’ as opposed to ‘top down’?

Chris Milford

The fact that this article is appearing in the ENTK Newsletter reflects the fact that most ENT surgeons (including myself) working in this country ‘identify’ with our Specialty Association above the surgical Colleges where we are Members & Fellows. However, there are many common issues currently facing the profession which requires surgery coming together as one if we are to address them - and the relevant Surgical College may then be the appropriate ‘organisation’ to address those issues.

The ‘supporting surgeons in the workplace’ initiative recognises that the RCS is keen to respond to the views of all surgeons throughout the country and not just to be considered as London centric. Market research work carried out for the College last year indicated that this was a common view of fellows & members not based in London. The initiative involves raising awareness and improving communication about College support for surgeons working in England, Wales and Northern Ireland and attempting to develop an integrated strategy for regional surgical services.

Over the last decade, the College has developed a strong regional infrastructure which aims to support surgeons working and training in England, Wales and Northern Ireland. This has been achieved by investing in the development of effective regional roles and structures to support local training and education and professional affairs and a team of Regional Coordinators to help drive local implementation of College strategic aims on the ground. This support is in place for all surgeons regardless of College affiliation.

This regional College structure involves one Regional Council Member, one Director of Professional Affairs and a Regional Specialty Professional Advisor (RSPA) for each of the surgical specialties, this group making up the Regional Professional Affairs Board (PAB). This Board liaises with the Head of School of Surgery to support the development of the training and education environment, and is looking to develop an integrated strategy for regional surgical service provision. At a recent joint meeting of the South West and South Central PAB’s, the following were just some of the issues identified as major challenges we will face this year (and I am sure you will recognize these and similar issues in your local NHS):

Commissioning - although none of us have a clear idea of how this will happen in the brave new world, we need to be proactive in terms of looking at regional networks and how these regional networks might interlink with local. We need to do more work in this area in the hope we would be ready if a ‘regional’ arm of a national commissioning board comes into existence (the ASCGBI have already prepared a number of documents for each of the subspecialties on standards of surgical services in readiness for this). Increased ‘centralisation’ of services - it was suggested at that meeting that the College might usefully produce something on the Future of Surgical Provision - addressing issues such as the increasing need for part time training as we see the shift in the workforce to a majority of women in medicine and the need for provision of the consultant during their working lifetime (do older consultants continue to provide on call?), outcome data, minimum standards etc (the Vascular Society have produced a detailed document addressing some of these issues that has been used for Commissioning by SHA’s and in discussions with the NHS Employers Confederation. That is leading to a significant reconfiguration of vascular surgery in England). I forwarded this suggestion to the relevant Council members responsible for policy.

Although the majority of us are feeling ‘ground down’ by the system, if this ‘bottom up’ approach is to work, it requires your continued input/suggestions comments from you via your RSPA - please take the opportunity to influence College policy!

Should ENT Surgeons be primary cleft lip and palate surgeons?

Adrian Drake-Lee

Cleft lip and palate (CLP) surgery has come a long way over the past twelve years. At the start of this period there were a hundred and twenty-five surgeons including general paediatric surgeons undertaking cleft lip and palate surgery. This number has reduced to twenty-four and the service is organized in regional centres. It has been suggested that each surgeon does forty primary repairs a year but the figure is less than this with all doing over twenty and the service has been centralised around teams. The time of Mr Dickie Dabbler is past and so it should be as patients should get a surgeon who is experienced and accountable, and specialized. CLP surgery is one such career for consultant surgeon of the future and the way forward is by selective training.

The CLP teams include ENT surgeons who help manage the ear problems, mainly in childhood, and the nose and sinus problems, more common in adults. I was the ENT lead in the cleft team at the Queen Elizabeth Hospital in Birmingham, having set up the service at Birmingham Children’s Hospital. At present there are no ENT surgeons who are primary cleft surgeons. The paediatric surgeons do not want to be CLP surgeons anymore. In effect, the primary surgery is undertaken by plastic and oro-maxillofacial (OMF) surgeons. But there is still an opportunity for ENT surgeons to become one.

Training has been structured around the fellowship programme based on six accredited units in the UK with two more seeking approval. The scheme is open to ENT, plastic and OMF trainees who are within their CCT. They are eligible to train for a minimum of twelve months and the CCT date is extended. This programme is organized through the Severn Deanery. The curriculum is approved by the GMC and these posts are in effect proleptic consultant posts as the number of fellowship posts are tailored to service retirements and are funded through the English Department of Health.

There are thorny issues around fellowship funding as Northern Ireland, Scotland and Wales do not contribute and trainees of these countries want to train in CLP surgery. In the past the English Department of Health recognised this and gave these countries special status. What about the eligibility of trainees in other European Countries including the Republic of Ireland to apply for these fellowships? When I went to the meeting of the Craniofacial Society of Great Britain that includes CLP surgeons from the Republic of Ireland, I was asked this question. At that time, other EU trainees were not eligible to apply for fellowships. The lead Dean consulted the Department of Health and this was confirmed as CLP is not a recognised specialty within the EU. Matters have moved on as the breast fellowship programme allows EU trainees to apply for posts as long as they have met the shortlisting requirements. As there could be a legal challenge, all training posts including CLP fellowships are now open to EU trainees. In effect the English Department of Health could fund the training of all EU trainees in CLP surgery including the Republic of Ireland. With the current financial state, this must be a good thing for some member states!

When I was chairman of the SAC I knew that a committee runs smoothly if the meetings are planned properly and the agenda are sorted first. These are much easier to do when the members are from within one’s own specialty. Dealing with two competing specialties is difficult as there are entrenched attitudes between two specialties added to the other common antagonisms that run through all specialties involving selection, training and service around the country. We have national selection for SLP fellows but as usual one training unit takes part when it feels like it and offers posts at other times to those it wishes to train.

I do have an agenda as I believe that doctors should be accountable for what they do to their patients. Quality assurance is difficult to manage across specialties and the curriculum should

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New Job Descriptions the 2.5 SPA:7.5 PA split

Chris Milford

Over the years the College has provided input to Trusts through the provision of advice on job planning and appointments. The College is concerned with promoting medical professionalism and maintaining the highest clinical standards, both of which impact on patient safety.

The role of the College in the job planning process is an advisory one i.e. any Trust can choose to ignore the views of the College regarding the job description for a new consultant post. The College has a statutory role to provide a representative for advisory appointments committees for non-Foundation Trusts, and has invested in selecting and appointing individuals to sit on advisory appointments committees to provide the highest quality service to trusts. This brings many benefits including ensuring that the standards of medical training and service are maintained, ensuring that the process is fair and open, and providing specialist expertise on the experience and skills of the candidates.

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The government has announced its intention that all trusts will become foundation trusts and enjoy the freedoms that this status brings. One of the freedoms is that foundation trusts are exempt from the statutory requirement to include a College/Faculty representative. Nevertheless the College continues to offer this service to all Trusts regardless of foundation status.

Job planning: balance of activities

We have seen an increasing trend over the last 12-18 months for trusts to move away from the agreed balance of activities in the Consultant Contract (7.5 Direct Clinical Care/2.5 Supporting Professional Activities) and towards a much higher proportion of direct clinical care. It is difficult to produce guidance that applies to all posts in all hospitals. However we have produced guidance, available on the College website, that explains in more detail the appropriate time required to undertake supporting professional activities.

Supporting Professional Activities (SPAs) reflect time spent undertaking teaching, training, education, CPD (including reading journals), audit, appraisal, research, clinical management, clinical governance, service development etc; activities that are essential to the long-term maintenance of the quality of the service but do not represent direct clinical care. SPA time is therefore critical in providing a safe clinical service for our patients. It is to the benefit of the trusts, patients and the healthcare system as a whole to allocate sufficient time for these activities.

Some provisional estimates suggest that in order to meet the requirements of revalidation (including CPD) each doctor will require the equivalent of 1.5 PAs per week. However, a contract that includes only 1.5 SPAs would have no time at all for other SPA work such as teaching, training, research, service development, clinical governance, contribution to management etc. It is unthinkable that a consultant could be employed with absolutely no involvement in these types of activities. A post that does not permit any involvement in service development or clinical governance would be contrary to the College’s concept of the consultant role.

We fully accept that a consultant does not receive an allowance of SPAs to do with as he or she wishes. Consultants remain accountable to their employer for the achievement of agreed objectives in both DCC and SPA time and will need to justify their SPA time at regular job plan reviews.

In view of this the College believes new consultant posts should continue to be advertised with a job plan including 2.5 SPAs with an expectation of a review in the first year when this time would need to be justified. Any job description that does not meet these criteria will not be approved by the College.

It is fully understood that such a position will bring us into conflict with many Trusts. A local ‘escalation’ process has therefore been proposed in the hope of improving negotiation at a local level: Local escalation

In general, the advice of the RSPA is valued and well received, however on occasion some negotiation will be required to ensure that a suitably balanced job description is achieved. We recommend that the following process is followed.

RSPA reviews job description. If unhappy with the balance of activities, discusses directly with Clinical Director.

If the situation is not resolved, the matter should be discussed with the DPA who may approach the Medical Director. At this stage the Regional Council Member will be notified. If problems still persist, the matter should be referred to the College President via the AAC Trustee who will contact the chief executive of the trust.

Advisory Appointments Committees

Lack of approval of a job description will not prevent an employer advertising a post (as mentioned above, the role of the College in this process is purely advisory). At its meeting earlier this month, Council debated the issue of whether to send an assessor to an Advisory Appointments Committee if the job description had not been approved by the RSPA. Council voted that the College should participate in the appointments committee as this would, amongst other things, provide further opportunity for continuing dialogue and negotiation regarding the job-plan and ensure external specialty input into the suitability of candidates. We will be putting processes into place to ensure that any concerns that an RSPA has about a particular job description can be shared with the Assessor who will be attending the interview.

Through the provision of advice on job planning the College is primarily concerned with promoting medical professionalism and maintaining the highest clinical standards both of which impact on patient safety. We will continue to ‘argue’ this point of view at advisory appointments committees despite this ‘age of austerity’.
lead to sub-speciality status recognised by the GMC and revalidation of surgeons should be undertaken through the craniofacial society of Great Britain. This means an agreed logbook for training and recording practice, and a central collection of data that links into HES. Some of this is outside the remit of the CLP Fellowship programme but I can make sure that there is a common logbook and that the work based assessments are PBAs and case based discussions. This is underway at present. Each trainee has a mentor and we are in the process of involving the trainees more formally in the accreditation of training. In many ways, my post is similar to that of a programme director with some extra duties similar to those of the SAC chairman.

The most worrying part of being the chairman of the SAC was signing off every trainee for a three year period. I know that I will have let someone through who is below standard but hopefully will not be so poor that they are a danger to society. I relied on two people, the local programme director and the SAC liaison officer to help me make my decision. Each fellow had a mentor and may well go to a unit outside his or her own programme. I will have to sign each of the fellows off at the end of their specific training and this in turn will feed back into the system. It means that I have to understand the workings of both the training and service to be effective.

I have attended the Craniofacial Society of Great Britain, been to a number of meetings of the Cleft Development group, talked to the CLP Patients Association, sat on a consultant appointment committee, helped organize national selection and attended our committee meetings in order to develop a more integrated approach to the fellowship posts. So far there has been one ENT applicant for a fellowship post. ENT trainees are at a disadvantage as any applicant has to have experience in primary CLP surgery. Plastic and OMF trainees rotate through CLP units. I have been asked to intervene by one of the OMF committee members in registrar training in one region as their trainees are being excluded. This is a matter for the parent SACs and the regional programme directors to solve. If I intervened I would have to make sure that ENT trainees have similar opportunities and it is something, even if desirable, that I could not achieve. So ENT trainees wishing to undertake this fellowship have to seek experience, either at home or abroad and preferably both, to show comparability. Where they are able to shine is in academia something the OMF trainees find difficult. Again I have been asked to equate a degree in dentistry as a higher degree for short listing points. I cannot see why another undergraduate degree whether it be in immunology, health economics, languages or dentistry, should weigh more heavily. People come into medicine by different routes and it does not require a dental degree to be a CLP primary surgeon: they all count the same.

The last national selection resulted in much lobbying from the plastic surgeons as there were up to four posts for training. I was asked to change the rule so that they could shortlist their boys (all male) who did not meet the requirements. These are quite clear: every trainee requires the first part of the exit exam by the time the appointment committee is set up, and the second part before the fellowship takes place. I gave way to pressure from both OMF and plastic surgeon committee members as I had wanted both parts of the exam by application. Suffice it to say that the quality of the candidates at interview was very variable and we appointed one person only. Another round is taking place now and only exceptional candidates should be appointed.

Exceptional candidates are few and far between and it is much easier to worship the golden calf as seen by the number of applicants for facial plastic surgery fellowships from plastic, OMF and ENT trainees. Obviously if an ENT trainee wishes to undertake CLP surgery it requires a special commitment and dedication from ST4 at the very least. While such a person may exist, he or she needs to interview well and understand how CLP is treated around the world. Being a primary CLP surgeon would complement the skills of an ENT surgeon. Whether ENT trainees wish to undertake this type of career is up to them to decide but there may be some exceptional trainees out there.

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