East of England ENT Programme Review Meeting
Victoria House, Cambridge
Thursday 19th and 20th February 2015

Present:

Mr A Bath FRCS	:	Chairman of S.T.C.
Mr A Hilger FRCS	:	Programme Director
Mr N Jamieson FRCS	:	Head of School of Surgery
Mr A Parker FRCS	:	SAC Liaison Member
Mr A Robson FRCS	:	Chairman of SAC

The purpose of this two day meeting was to investigate the strengths and weaknesses of the East of England Higher Surgical Training Programme in ENT. The SAC was invited to provide external input to the LETB-led review of the programme. The conclusions and recommendations were based on the following:

1. Trainee questionnaire coordinated by the TPD.
2. Hospital Application Form completed by the lead trainer.
3. Interviews with trainers and trainees.
4. JCST and GMC survey data.

This rotation comprises attachments at the following hospitals:

Addenbrooke's, Cambridge
Norfolk and Norwich (NNH), Norwich
James Paget, Great Yarmouth
Colchester, Essex
Chelmsford, Essex (Broomfield Hospital)
Lister, Stevenage
Peterborough
West Suffolk, Bury St Edmunds
Ipswich
Luton & Dunstable
Basildon (Mid Essex) within this region, but currently 'on loan' to North London and not used for training
Southend (trainees currently come from the North London rotation)
Bedford (subject to approval)

1. The meeting commenced on day one with interviewing trainees of various grades.

Trainee 1 – ST6

(1) Addenbrooke's

The on call was 1:6 or 1:7. There were Otology, Head & Neck and Paediatric blocks.

The Head & Neck timetable showed three theatre sessions per week. The other two showed 4 theatre sessions per week. There were 8-10 paediatric tracheostomies per year. On Friday afternoons, the Head & Neck clinic consultant was not in the unit, but the trainee was 'supported'. Theatre started at 08:15 and usually finished at 18:30 hrs. There was no cross cover of units whilst on call. The trainee said that having a clinical fellow in theatre improved training. There were 6 teaching ward rounds per month.

(2) Ipswich

The timetable had changed with theatre between 08:30 – 12:30 or to 17:30. Theatre was split with NNH (every other week) 16.5 hrs per week.

The trainee was complimentary about the variety of clinical material and research opportunities. However, in the attachment at NNH, they competed with other trainees one list in two.

Trainee 2 – ST7

The trainee, who was currently at Addenbrooke's Hospital, did not attend the programme review and their feedback scores were reviewed. Ipswich scored satisfactorily, but there was 'little opportunity' to undertake paediatric tracheostomy. The trainee was currently on an otology fellowship that trained to beyond the curriculum.

Trainee 3 – CCT award recommended

The trainee was in Ipswich last year and was now a post-CCT fellow at Addenbrooke's. The Ipswich job was divided into 3: otology, general & Head & Neck.

Otology was rated highly. Head & Neck was rated highly, but was split with NNH (once a fortnight). The general component was better suited for a 'junior' trainee. Rhinology was deficient and 'was not fantastic but a lot of FESS'. The post was good for DCR.

There was some competition with OMFS trainees for Head & Neck at NNH. The list was from 08:30 to 18:30, sometimes 19:00 hrs.

There was no cross cover on emergency takes, although the trainee could be on call for Colchester/patients transferred to Ipswich. The Ipswich on call was with Nurse Practitioners, which was reported to work well. There were a small number of septorhinoplasty cases due to commissioning problems.

Trainee 4 – Awaiting the award of CCT and is about to start as a locum consultant at Bury St Edmunds

(1) NNH

The trainee rated this as a 'very good job'. Theatre was sometimes 'crowded', e.g. with OMFS surgeons, but they obtained sufficient operating.

(2) Addenbrooke's

The trainee had a pre-CCT Head & Neck registrar timetable and there were two trainees at the same level in Head & Neck theatre. There was no on call cross cover and there were 2 teaching ward rounds per week.

Trainee 5 – ST6

(1) NNH

The timetable and theatre time were satisfactory and there was good MDT working. Head & Neck was 'fantastic'.

There were 3 x 4 month attachments. Despite the good operative exposure, the trainee would have preferred 6 month slots as they felt their training needs would be better served.

(2) Broomfield (Mid Essex)

There are four Mid Essex hospitals, with ENT centralised in Broomfield. The unit appeared to offer excellent operative experience, but clinics were just satisfactory. There was no formal on site teaching, but the trainee attended the regional study days.

Trainee 6 – ST5

(1) Luton

Theatre and clinic timetables were satisfactory with an excellent Head & Neck and good emergency workload. On call was 1:5.

(2) James Paget

There were low scores on the questionnaire, but when operating lists happened, training was highly rated. Due to hospital management issues (since mid-December), the trainee had not operated for 8 weeks. There was no day case unit and there was not enough theatre time for 2 timetables (12-13.5 hrs per week, three lists per week). However, the trainee said that research was 'superb'.

Trainee 7 – ST5

(1) Bury St Edmunds

Training for ears and FESS was satisfactory and the timetable had changed to be SAC compliant. However, it was deficient on Head & Neck thyroids and the trainee was going elsewhere. On call was with the Addenbrooke's rota i.e. there was a split on call between the two centres, 30 miles apart. Every 8 weeks, the trainee had a week of looking after emergencies, but felt that this did not impair his training.

There were over one thousand cases per year through the department, so it was satisfactory for two trainees.

Trainee 8 – ST7

(1) NNH

3 x 4 month blocks. Timetables were satisfactory, operating was satisfactory and there were no problems with training.

(2) Luton

2 x 6 month posts: ears/noses and Head & Neck. Lists were 'fairly basic', but satisfactory. However, ears were 'few and far between'. A new consultant otologist was due to start and some lists would be taken away, although not from the trainees. The on call was split between Luton and Bedford and one consultant was on call for both units at the weekends.

Trainee 9 – ST7

(1) Peterborough

There were 3 trainees, two of whom were at same stage in their training. There were a couple of good trainers, although there was limited exposure to others and to clinical material because of bed/list closures. There were 370-400 cases/year, but the trainee felt they were not at his level so he was unable to progress.

Addenbrooke's

The ½ day list would be better as a whole day and there was not much emergency work. Two ST6 trainees doubled up in theatre sometimes and the trainee felt that two trainees and a core trainee would be appropriate. A new consultant appointment had revitalised training.

(2) Luton

This was the trainee's second time in the unit, but they felt it was good for further training. Busy on call and the post might not be EWTD compliant. This was discussed in detail above and was meeting training requirements.

Trainee 10 – ST5

(1) James Paget

There were 3 lists per week, 8 – 12:30 pm and 319 cases per year. For the first 3 months, they were the only trainee and got to do extra lists. Training was otherwise of 'very good quality'. The hospital closed at weekends.

(2) NNH

The timetable and training were satisfactory.

Trainee 11 – ST4

(1) Peterborough

The trainee had insufficient operating (n=250 per year) due to list cancellations, the consultant taking a lot of leave and lighter lists. There were 3-5 lists per week on their timetable. The trainee did not go to Addenbrooke's and did not give good feedback on the questionnaire.

The unit could support two trainees with consultant reorganisation.

(2) Stevenage

There were 4 clinics per week (one was supernumerary). One arm of the service had fewer than 4 lists per week, but the Monday list apparently went into the evening. The trainee said that they went to theatre in their free period.

Trainee 12 – ST3

(1) Ipswich (4-5 months)

There were 3 x 4 month rotations: 3.5 – 3.75 theatre lists per week between 09:00 – 12:30 hrs. The trainee attended theatre when they were free and had undertaken 212 operations (25 assisted) including 30 microsuction ears over the past year. They wanted more exposure to emergencies. The current timetable looked to be compliant. The on call was with nurses, which the trainee was happy with.

Trainee 13 – ST3

(1) NNH (4-5 months)

The trainee was well supported and was satisfied with their clinical exposure. They had undertaken 112 ops since 01/10/14.

Trainee 14 – ST3/4

(1) James Paget

The experience was very good when the trainee started, but they had not done much surgery since and 13 lists had been cancelled. The trainee had 3 lists per week, but they were supposed to last for 4-5 hours. The numbers of theatre cases were very low (n=80 since October 2014) and there was insufficient clinical material for two registrars.

Trainee 15 – ST3

(1) Bury St Edmunds

The timetable was satisfactory with 4 lists per week, although one was with an associate specialist. The trainee had undertaken 140 theatre cases in 4 months.

Trainee 16 – ST5

(1) James Paget

The trainee started in January 2014 after a period of biomedical research. This was a strong unit for otology, but the trainee said that they did not achieve their surgical targets. They felt that their numbers and exposure to cases were adequate and they had 3-4 theatre lists per week, although these could be 8am – 1 pm. The trainee could also be doubled up in theatre.

(2) NNH

The trainee augmented their surgical experience by taking part in Saturday lists and did not feel compromised by other trainees in theatre.

2. Day two was spent interviewing consultant representatives/educational supervisors from each hospital.

(1) Mr G Fayad (Basildon)

There were 3 consultants and one LAS in the unit. The hub was Broomfield (Chelmsford), but the rotation included Harlow, Romford, Colchester and Southend.

The unit only provided day cases. The timetable was not SAC compliant with two theatre lists per week. There was some access to the Broomfield all day Head & Neck list. The figures given were approximate. Mr Fayad, who is not registered on the ISCP, felt that this post needed more development and an SAC compatible timetable needed constructing.

(2) Mr P Prinsley and Mr P Tassone (James Paget)

The unit had two whole time consultant equivalents.

The current trainees needed assistance with increasing their operative exposure and the logistical resolution of hospital theatre problems including plant failure and a post-Christmas bed crisis. The issues were being addressed at senior management level. Operative numbers were just adequate, but were probably high quality. The trainees who were deprived of operating were to be given theatre time at NNH.

The review team felt that if the situation continued, the unit should not be taking trainees and there was probably not enough operating when the theatres were running properly.

(3) Mr D Mc Ferran (Colchester)

The unit had no access to rhinoplasty or disordered sleep surgery. The trainee was sometimes in theatre with a consultant and an 'associate specialist' and training might be better with one trainee.

(4) Mr F Stafford (Chelmsford)

Mr Stafford was about to take up an appointment in Sunderland. The current trainee would therefore need a new educational supervisor and the hospital would have to bring in or appoint a new Head and Neck lead. There were also to be some LETB changes such that North London would relinquish placing trainees in this area. The trainee attended outpatients, but did not have a list booked and there were no defined arrangements for paediatric airways.

(5) Mr D McKiernan (Bury St Edmunds)

Surgical activity was adequate and the suggestions that the unit was not suitable for later stage trainees, as derived from the trainee questionnaires, were refuted. However, it was deficient in Head and Neck work (that for malignancy is undertaken off site).

The on call consultant cover was split site (with Addenbrooke's) and the hospital was not an admitting unit at weekends or out of hours during the week.

(6) Mr M Yung (Ipswich)

The unit had four consultants and three trainees. Lists could be doubled up with non-training grades, but the trainees took priority. One consultant sounded reluctant to let the trainees operate and, furthermore, was in a locum appointment which was not appropriate for long-term training.

(7) Mr A Qayyum (Peterborough)

There had recently been a School of Surgery visit, at which there was SAC representation, as a result of which one extra theatre session had been introduced and another was due to follow. The team reiterated the visit findings i.e. that there should be one core and 2 higher trainees in the unit, which was supported by the level of departmental activity.

(8) Mr A Bath (Norwich)

Surgical exposure was satisfactory, although four month attachments might be too short, especially in Head and Neck surgery. A recent alteration to the Head & Neck timetables had enabled all day theatre attendance.

There were currently three trainees, although there would be scope to train more, especially with an additional consultant. However, it was felt that this would reduce flexibility, although it could be useful to augment the training at James Paget.

(9) Mr B Fish (Addenbrooke's)

The unit currently had three trainees. The status of a fourth trainee (otology fellow) was uncertain, but the post did have a number which may have come with the incumbent. Complicated otology necessitated the employment of a fellow rather than relying on a trainee who could be very junior. A significant number of rhinology cases were undertaken by the Associate Specialist and by an incoming consultant from West Suffolk.

There were some disadvantages to a trainee spending one year in an otology post as it blocked the training position to others and it could amount to 'over-training' of a few individuals. One consultant wanted to go part-time with the appointment of another full time Head and Neck consultant. There were plans for another paediatric ENT surgeon, but there was no funding for the post as yet.

The Peterborough trainee attended theatre with another trainee, but this practice would stop if the Addenbrooke's trainee felt that it was adversely affecting their training. The unit had previously had a Head and Neck interface fellow, but there was not one currently.

(10) Mr Singh (Luton/Dunstable)

There was weekend on call cross cover with Bedford, i.e. there were two admitting units. Some trainees had rated major ear surgery training as poor, but this would improve with a new consultant appointment.

(11) Mr Mouchloulis (Lister, Stevenage)

Sometimes, theatre activity did not fulfil the SAC requirements of 16 hours per trainee per week, although this should be straightforward to organise as there were more than 16 theatre lists per week in the department.

(12) Mr Barnes (Southend)

Mr Barnes took junior trainees from London. The unit had three consultants, 23-hour stay arrangements and good facial plastics services. There was one full-day list in Broomfield once a fortnight and no weekend or evening cover at the base unit. Training was fragmented by geography.

(13) Mr T Hoare (Bedford)

Bedford was currently a three consultant unit with close links to Luton, e.g. joint MDT working. Major surgery went to Luton and the unit had day case lists only. Although there was access to inpatient beds, there was no defined ENT ward. The unit used to be on the Oxford registrar rotation, but the number of trainees was cut when one consultant retired.

The timetable was not SAC compliant for theatre lists (less than four per week) and the on call was across two sites. Bedford was currently under review and might join with Addenbrooke's and the preference would be for earlier stage trainees to be sent to the unit.

CONCLUSIONS AND RECOMMENDATIONS

The rotation delivers the requirements of the curriculum with no serious deficiencies. The new training programme director is enthusiastic and committed to developing the programme and relations with the SAC have improved dramatically since his appointment.

This review confirms that within the rotation there is sufficient operative, emergency and outpatient work to support the number of trainees.

The review team has made 12 recommendations as detailed below:

1. The training arrangements at Basildon Hospital are not acceptable currently to take trainees. We recommend that trainers at this hospital need to provide definitive timetables and there needs to be liaison with the adjacent Essex Hospitals (see below).

2. The present arrangements at James Paget Hospital (Great Yarmouth) are not suitable for training as a result of hospital logistics. **The timetables are not compliant with the curricular requirements.** The two current trainees are deficient in operating, which could be resolved by linking them in with NNH. In the case of one trainee this is critical and additional operative exposure should be obtained forthwith and on an urgent basis at NNH. The situation would be easier if just one trainee was attached to this hospital and this latter aspect needs careful monitoring. It is acknowledged that the quality of training is of a very high standard.

3. There is an issue with the on call at Luton/Dunstable and the Bedford Hospital in that cross cover could enable the trainee to be unsupervised at times. These posts may not in themselves be EWTD compliant. Arrangements need to be made to ensure the trainees have supervision at all times when on call.

4. At the hospital in Bury St Edmunds, the on call is cross covered with Addenbrooke's and is not appropriate for trainee supervision. However, as there are no admissions to that unit out of hours and at weekends, arrangements are compliant.

5. The hospital in Ipswich offers good training, but there is a locum consultant currently in post. This situation is not appropriate for long-term training in respect of any trainee attached to this unit and plans should be made for a full-time substantive appointment to support training.

6. The problems in relation to training in the ENT unit at Peterborough Hospital have been addressed in a previous report. We note that an extra theatre session per week has now been introduced and that another one is due to follow. The recommendation is that the unit can support one core and two higher trainees at appropriate training levels. Under these arrangements, the Peterborough trainee need not attend the Addenbrooke's theatre list.

7. NNH could support another trainee, but it was felt that this would reduce flexibility although it could be useful to augment training at James Paget. Consideration needs to be given to basing the James Paget trainees at NNH. There needs to be enhancement of some components of these attachments for the trainees to attend special interest clinics.

8. The otology fellow post in Cambridge actually has a training number attached to it and consideration needs to be given to this being incorporated into the East of England ENT training programme. If the time spent in this post was six months instead of twelve, this would rectify the concern expressed that a significant proportion of East of England trainees coming through Addenbrooke's currently may not have had adequate otology exposure. (Post meeting note: a letter has been drafted from the School of Surgery to confirm that all posts badged for higher specialist training will be available for trainees from within the rotation).

9. At Stevenage Hospital, theatre time is just below the cusp for four theatre lists/16 hours of operating time a week per trainee and needs resolving. New timetables should be submitted to ensure these are compliant.

10. In Chelmsford, one trainer is leaving and a replacement educational supervisor/surgical training committee member should be nominated. We recommend that all three trainees in the Essex attachments (i.e. Broomfield, Southend and Basildon) should be based at this hospital rotating to peripheral units if there are appropriate training opportunities that enhance training.

11. We would encourage joint timetables and on call rotas for the trainees in the Mid Essex Hospitals. The training is currently fragmented and could be rationalised, e.g. by centralising services in Broomfield Hospital. This would produce a critical mass (three posts) for higher trainees and enhance their professional development.

12. The application of the ENT unit in Bedford to take a trainee or trainees has been considered. The problems in respect of cross cover with Luton (as detailed above) need resolving and, if they are resolved, we feel that the unit will provide satisfactory training, ideally for a ST3-4 level trainee.

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