QUALITY TIME
The value of consultants’ Supporting Professional Activities to the NHS
Foreword

Consultants are valued by their patients for many reasons, but foremost among these is the quality of care for which they are responsible. This is why it is an essential part of a consultant’s job to spend time thinking about how to make their services better – to take advantage of the latest scientific developments, to learn from proven innovations, to develop their skills, to extend scientific knowledge, to audit services for safety and quality, and to train others. Patients look to us not just to provide care, but also to lead and develop it.

However, the time in which consultants can undertake such work is now under serious threat. NHS organisations, increasingly squeezed financially and having to achieve more with less, are trying to reduce consultants’ Supporting Professional Activities (SPAs) in a search for ‘efficiency’. At its worst this can lead to pressure to treat patients as units of production rather than individuals engaged in a difficult journey at a testing time.

We also believe it represents a false economy. As many of the examples here show, when consultants have time to reflect on services and improve them, they frequently save the taxpayer significant sums of money. The NHS has been tasked with saving £20 billion by 2014, but this already Herculean challenge will become even harder if staff are denied time to stand back and consider ways of working more efficiently.

Preventing consultants from spending time on anything other than direct clinical care would represent a betrayal of what patients deserve from the NHS. Research shows very clearly that patients value quality of care very highly, and expect it to be delivered in all NHS organisations, not just a few centres of excellence.¹

We have gathered together here just a handful of examples of the work consultants undertake during their SPA time – ordinary consultants providing extraordinary services for patients throughout the UK.

Dr Mark Porter, FRCA
Chairman of the Consultants Committee
British Medical Association

¹ King’s Fund (2009) Choice at the Point of referral – Early results of a patient survey. London: King’s Fund. 04.11.10
www.kingsfund.org.uk/publications/choice_at_the_point.html
What are SPAs?

Under their standard NHS contract, full-time NHS consultants should typically have 10 hours (out of a standard 40-hour week) available for Supporting Professional Activities (SPAs). SPA time allows consultants to undertake a wide range of work, including the development of new services, research, clinical governance, training, and management. The remaining 75 per cent of consultants’ time is spent on direct clinical care. Variation from this standard split is subject to agreement between the employer and the individual consultant.

A UK-wide BMA survey of over 2,000 NHS consultants published in June 2010 indicated widespread cuts to the time available for such activities. Over a fifth (21%) said the number of SPAs in their job plan had been reduced since they transferred to the new consultant contract in 2004, or since they started. Only 7 per cent said the number of SPAs had increased. More than one in seven (15.1%) said their employer had reduced the standard number of SPAs for all consultants, and almost a quarter (23.8%) said their employer had reduced SPAs for newly appointed consultants. Nearly two thirds (65.4%) said the decrease to their SPA time was employer-driven. Areas identified as having already been affected by reductions, or at risk of being affected in future, included the training of junior doctors and Continuing Professional Development (CPD).

A separate Freedom of Information request in April 2010 found that a fifth of Trusts in England had reduced or planned to reduce SPA time.3

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2  BMA (2010) NHS at risk of ‘stagnating’ as BMA survey shows cuts to consultants’ time to develop services. London: BMA. 02.06.10

3  Santry, Charlotte (2010) NHS Trusts issue wake-up call on consultant productivity. Health Service Journal. 15.04.10
www.hsj.co.uk/news/workforce/nhs-trusts-issue-wake-up-call-on-consultant-productivity/5013540.article
Dr Idris Baker  
Consultant in Palliative Medicine  
Morriston Hospital, Swansea

Patients who get the right specialist care at the early stages of a life-limiting illness not only have higher quality of life but also survive longer. Yet access to palliative care on the NHS can be patchy, and is not always equitable. In his SPA time, Idris Baker who provides clinical leadership for the palliative care team at the Abertawe Bro Morgannwg University Health Board (ABM) in Swansea, Neath Port Talbot and Bridgend, has worked on an initiative that has resulted in more people benefiting from the care they need towards the end of life.

Initially, ABM’s palliative care service provided care to people with cancer, but when staff conducted a review they concluded it was unfair that the needs of other patients were not being met: ‘We’d come across patients in adjacent hospital beds, with frankly very similar problems, in terms of scale and nature,’ Dr Baker says. ‘There were a lot of people who were breathless because of lung cancer, and a lot who were breathless because of pulmonary fibrosis. They had similar symptom severity, but because of the diagnosis they had, we were saying “I’ll have you, but not you”. We decided we had to reduce that kind of arbitrary inequity.’ As a result of the review, the team turned a cancer-only palliative care service into one that provides care on the basis of need rather than diagnostic labels. And although out-of-hours access has also improved, there has been minimal additional cost to the NHS.

The review also yielded ideas for improving integration between services, making palliative care more central to the work of doctors in other specialties. As well as providing advice to colleagues on problems such as how to control their patients’ symptoms, Dr Baker’s team can offer tips on ‘short-cutting the bureaucratic nightmares’ they encounter when trying to arrange care at home for their patients, and is about to go live with an email advice service for GPs with questions about palliative care. Dr Baker says his colleagues have welcomed the additional support. ‘The fact is that most of surgeons’ experience and training isn’t so closely focused on how you meet the social care needs of someone with an inoperable disease. If you’re a patient under the care of that surgeon, you need them to know something about that. Patients are beginning to have better access to the support they need when they need it, and health professionals’ thinking is becoming more joined up across organisational boundaries.’

I can’t see how the NHS can improve services without the input of senior doctors, as well as lots of other people. Having that engagement doesn’t come without time. You can’t do it in five minutes between patients.
Dr Baker says the review could not have taken place without SPA time. ‘There’s no way I could have done it without it,’ he says: ‘I can’t see how the NHS can improve services without the input of senior doctors, as well as lots of other people. Having that engagement doesn’t come without time. You can’t do it in five minutes between patients. And in a sense you can’t separate SPA time from direct clinical care. The clinical service is strongly informed and developed by what we as a consultant body are able to do with our SPA time. I can only do something good clinically for patients because there are good things being done with the SPAs.’
Stephen Blair is used to seeing patients with a wide range of vascular problems, but the painful and debilitating nature of lymphoedema gave him the determination to use his SPA time to make a real difference to sufferers.

Lymphoedema affects the limbs, causing them to swell up by up to two or three times their normal size, which has a huge impact on mobility – the heaviness caused by the build-up of fluid means many sufferers are unable to walk, or even bend their legs, and are often housebound. The condition affects 100,000 people in England and more than one in 200 people over 65. Mr Blair says that until 10 years ago little could be done to support patients, but now there are very simple treatments, such as special bandaging and massage, that can help to control the symptoms and minimise the impact. However, there is no set tariff for such treatments within the NHS, making it difficult for patients to get the specialist treatment they need. ‘With tools like the internet patients are becoming more aware that simple but effective care exists, and they get very upset when they realise that they may not be able to access it – depending on where they live,’ he says.

Four years ago Mr Blair and colleague Mr Martin Greaney decided to set up a primary lymphoedema treatment centre in the Wirral, the only one of its kind between Derby and Scotland. He employed two nurses using a research fund accumulated from donations and commercial research activities, which allowed them to receive specialist training. Mr Blair says his team is now able to provide courses of bandaging, during which patients can lose up to two stone in weight as a result of fluid being removed from their legs. This increases their ability to move easily, and to regain quality of life. Some of the patients are in their early 20s and, following treatment, many are able to enjoy the sort of social life they had thought impossible.

Left untreated lymphoedema can cause skin infections and weeping sores, resulting in expensive inpatient treatments that could be avoided. ‘In terms of the economics, it is madness not to treat this before complications arise,’ Mr Blair says. ‘If we let it get to a stage where people are being admitted to hospital for a number of weeks, or prescribed long courses of antibiotics, the bill for the NHS will be enormous.’ He says the cost to a patient’s wellbeing is also high, and could easily be avoided if NHS treatment were more accessible.
Mr Blair is proud of what he has achieved so far in his SPA time, and believes that without it he would have been unable to devote his time to drawing up business plans, or provide ongoing training for his staff. He believes the national trend for SPA time to be reduced would seriously damage innovation, encourage early retirement and act as a disincentive for newer consultants. ‘To take away a doctor’s ability to spend time improving services is totally counterproductive,’ he says. ‘The UK has always been at the forefront of research, innovation and the development of care and we would be risking being left way behind.’
When doctors and nurses in the breast surgery unit at City Hospital in Birmingham reviewed their service, they realised that a fundamental re-design could mean their patients getting home far more quickly. As a result, the average stay for women undergoing mastectomies and other breast cancer surgery has fallen from five days to less than one, and the Trust has saved an estimated £300,000 a year.

Consultant Surgeon Hamish Brown, part of the team that conducted the review with support from NHS Improvement, says increasing demand for beds meant they had to find more efficient ways of working: ‘Bed availability was increasingly tight, leading to delays and a risk of cancelled operations. The team had a series of meetings where we looked at our patient journey and redesigned it in an effective way so we could get all of our patients into hospital on the day of surgery, and home the next day.’

A closely audited pilot showed that it was safe to integrate much of the inpatient care into a pre-operative visit. ‘Under the traditional system patients were admitted to hospital and seen on a daily basis by the team, who monitored various aspects of their care, with preparations for discharge taking place during the admission,’ says Mr Brown. ‘Decisions about discharge were made by doctors, although nearly all patients had a predictable recovery. In the new pathway, they are seen by a pre-op team who teach them what to do when they go home, tell them what to expect, and give them all the necessary contact details. All patients are admitted on the morning of their operation and most are able to be discharged home in the evening by nursing staff.’

Within months, the majority of patients were being discharged within 24 hours. However, there was still a shortage of inpatient beds, prompting the team to make more changes to streamline the service. Further audit showed that other traditional aspects of post-operative care were unnecessary and even detrimental to the patient’s recovery. ‘It’s dogma that you do some things,’ says Mr Brown. ‘We found that patients who’d been given morphine felt too ill to go home, so we stopped using morphine and started using different painkillers. We also found that using a wound drain to reduce fluid build-up after the operation didn’t make any difference.’
There were some initial concerns that women would be uncomfortable leaving hospital so quickly, but audits of patient satisfaction have shown the opposite: ‘Most people said it was absolutely fantastic to go home the same or the next day,’ says Mr Brown. ‘Contrary to what everybody would normally think, the patients loved it. There’s this strange idea that people with breast cancer are terribly fragile, but they actually want to feel normal. People don’t like being away from their nearest and dearest, and they want to get home as quickly as possible.’

The initiative has now been picked up as national best practice and Mr Brown estimates that it could save the NHS millions if replicated across the country. Having demonstrated its value ‘in both a financial way and a patient-focused way,’ he and colleagues regularly give presentations across the country. However, he says it would have been very difficult without SPAs: ‘Service development takes up a lot of time. You need time to find consensus, to sit down and reflect on what you’re doing and what you’ve achieved.’
Mr Michael Davidson
Consultant Oral and Maxillofacial Surgeon
Taunton and Somerset NHS Foundation Trust

As Michael Davidson approaches the end of his career, he fears that without sufficient SPAs, younger doctors will not be able to dedicate the time to ‘non-core’ work that he has.

Mr Davidson deals with conditions of the mouth, jaw, skin and face, treating patients who could be suffering from mouth cancer, facial lesions, impacted wisdom teeth or facial trauma following an accident. He has used both his SPA and personal time to work on the www.tauntonmaxfax.net website, which provides information to doctors and patients about the work of his department. The initiative started life as a paper resource for GPs on how best to treat patients with maxillofacial problems, but now provides up-to-date evidence-based information online about maxillofacial health, as well as surgery and its possible complications. It also introduces the hospital team, explaining their roles to patients. ‘We’re finding that more and more patients look doctors up so if we can provide the information upfront, it will surely improve the patient journey and the profile of the Trust,’ Mr Davidson says.

As a result of donated funds and bequests, a web designer has been employed with the aim of making the site more user-friendly and dynamic. One of the biggest challenges is making sure it is accessible to everyone who needs it, and Mr Davidson spends a lot of his SPA time ensuring it uses language patients, as well as healthcare professionals, can understand.

Without sufficient SPA time Mr Davidson would be unable to develop and update the site. He believes Trusts are often happy to allow SPA time for management-related work, but need to acknowledge the value to the NHS of a wider range of activities. ‘There is some very valid work being done that doesn’t neatly fit into rigid categories,’ he says.

There is some very valid work being done that doesn’t neatly fit into rigid categories.
Northern Ireland consultant Carol Emerson has used her SPA time to develop a potentially life-saving sexual health outreach service that targets high-risk men who might otherwise slip through the net.

Dr Emerson was concerned that the traditional Genitourinary Medicine (GUM) clinic at the Royal Victoria Hospital was not reaching large numbers of men at high risk of sexually transmitted infections. ‘Appointments at the clinic at the RVH are capped,’ she says. ‘We currently see around 30 men and 25 women in each of the morning and afternoon sessions. Up to 10 people per clinic are being turned away as we simply don’t have enough staff to see them, and people are also understandably frustrated at having to take a day off work to attend.’ This, as well as an outbreak of Hepatitis A in 2008, was the stimulus for Dr Emerson’s team to look at ways of working differently to improve the service, and to take it out into areas of Belfast where high-risk activity was occurring.

Having secured a small amount of grant money, Dr Emerson approached local venues, such as saunas, where high-risk activity was taking place. A sexual health clinic is now held every month rotating round the different venues. They are staffed by two doctors and a nurse and see a wide range of men, some of whom are married and would feel uncomfortable attending a hospital clinic. The Rainbow Project – a local organisation that works to improve the health of gay and bisexual men – advertises the clinics and meets the clients to explain the process to them. Frequently they have never even considered attending the clinic at the hospital. A sexual history is taken from each client, and ways of minimising risk of infection are discussed. Blood samples are taken for syphilis, HIV and Hepatitis, and vaccinations are available for Hepatitis A and B. Dr Emerson says the key to the success of the outreach scheme is discretion. ‘The only thing asked of clients is that they provide two forms of contact so that we can get in touch if necessary,’ she says. ‘Our service only works as it is totally confidential. We don’t judge.’

The clinics work well on many levels. The cost per patient to the NHS for a sexual health check, including tests and vaccines, is around £110. But the prevention of illness is hugely beneficial to both patients and the service. Since February 2009 multiple cases of syphilis and chlamydia have been identified, as have four HIV infections, which can now be managed in an outpatient setting, enabling clients to continue with their lives. Had they gone undetected, clients could have ended up in intensive care with AIDS-related illnesses.
Dr Emerson depends on SPA time to plan the clinics and keep up to speed with the latest developments in sexual health. Given that there are just 4.5 whole time equivalent consultants working in GUM in Northern Ireland, protected time is very important to enable her to share knowledge and ensure that high-quality, safe services are available. Recognition for the team’s work came in January 2010 through the Belfast Trust Chairman’s Award – the £10,000 prize money is going towards the purchase of new equipment. ‘I am passionate about my work and the need for high-risk men, who would not normally access health services, to get the right care,’ she says.
Dr David Flynn
Consultant in Emergency Medicine
Lincoln County Hospital

Swine flu headlines may now seem distant memories, but the pandemic flu plan drawn up by David Flynn during his SPA time is here to stay.

Dr Flynn, an emergency medicine consultant, was responsible for setting up systems to allow Lincoln County Hospital to deal with the swine flu pandemic. This involved assessing surge capacity and ensuring that the hospital would be able to deal with the volumes of patients that were expected if the pandemic became very serious. Plans were put in place to run two completely separate emergency departments – one dealing with flu and the other providing a normal core service. ‘If we have another pandemic, the protocols that myself and other colleagues put in place will be invaluable,’ Dr Flynn says.

He is now working on an alcohol reduction project based on a model developed in Cardiff, where clinical staff share information about alcohol-related facial injuries with the police. The initiative has helped police target hot-spots for alcohol misuse and violence, contributing to a 30 per cent drop in emergency admissions. Getting a similar project off the ground in Lincoln requires time, for example to nurture partnerships with local police.

Dr Flynn also uses his SPA time to raise awareness in the hospital about the importance of safeguarding children. The emergency department is often the first point of contact for many patients, and concerns among health professionals about children at risk are common. He chairs an A&E task group on safeguarding children, sits on the hospital young person’s committee, and encourages staff to access training in the protection of vulnerable children. ‘It’s important that doctors know how to spot families in trouble so that support can be found for them rather than let problems escalate,’ he says.

Without SPA time Dr Flynn believes many of the initiatives he has been involved with would not have happened. ‘There is a real move to get as much clinical work out of doctors as possible,’ he says. ‘But if doctors don’t have time to look at the factors underlying what they do, for example how to reduce alcohol-linked admissions, we won’t be as effective, we won’t improve quality and we won’t come closer to solving some fundamental health problems.’
Dr Sara Hedderwick
Consultant in Infectious Diseases
Belfast City Hospital

‘I just couldn’t believe that we expected patients to sit in a hospital bed for weeks just to get one or two injections per day.’ Having trained in Michigan in the USA, where discharging patients for intravenous (IV) antibiotic treatment at home was routine, Dr Sara Hedderwick was surprised to discover that there was no equivalent service in Northern Ireland.

As well as the obvious benefits to patients, there are benefits to the health service in terms of freeing up resources, including beds, money and staff.

Not long after taking up her registrar post at Belfast City Hospital she wrote to the clinical director putting forward her idea. Twelve years later, the home IV service is still going strong. After they are discharged, a district nurse calls patients to deliver the intravenous antibiotic at a convenient time. The service can be delivered anywhere in Northern Ireland, and one of the advantages is that patients are able to lead a normal life – attending school, going to work and taking part in sport.

‘As well as the obvious benefits to patients, there are benefits to the health service in terms of freeing up resources, including beds, money and staff,’ says Dr Hedderwick. ‘In fact, we estimate that the cost to deliver the IV service at home may be as low as £56 per day per patient. This compares well to a cost of £300-£500 per day for an inpatient stay.’ On top of this, the service reduces healthcare acquired infections. Many of the people Dr Hedderwick treats have MRSA, so discharging them for treatment at home reduces opportunities for infection to spread.

There are currently six to eight patients making use of the service at any one time but potentially around 50 in the hospital could be discharged home for part of their care. The team running the service at the hospital now consists of two consultants and three nurses, but Dr Hedderwick believes more staff – including an increase in the provision of trained district nurses – would be needed if the service were to expand in future.

The service depends on Dr Hedderwick having time set aside, and she says it could not have got up and running if she hadn’t had SPAs available. ‘I needed time to get nurses employed, develop policies and procedures, all of which take time to research and produce,’ she says. ‘I simply couldn’t have done it without SPA time.’ Her job plan now reflects the fact that she is the lead on the service. There is no specific amount of time allocated within her 2.5 SPAs for the home IV service, and she appreciates the fact that the amount of time she can spend on it each week is flexible. She describes as a ‘big mistake’ the UK-wide trend for reductions in SPAs: ‘A lot of useful work gets done in that period of time that is difficult to quantify. It will only be when it stops that you will realise how important it is.’
Mrs Scarlett McNally  
Consultant in Trauma and Orthopaedic Surgery  
East Sussex Hospitals NHS Trust

Consultant surgeon Scarlett McNally says much of her job is about communication: ‘It’s much more talking, and thinking and interacting and listening to what the patient wants than often people realise. It’s also a balance between operating, which is quite technical and quite precise, and talking and communicating and liaising with the team around me,’ she says.

Good communication, as well as SPA time, was central to an initiative that has cut the length of stay for the 400 patients admitted to Eastbourne General Hospital each year with a broken hip. Mrs McNally worked with colleagues to develop an integrated care pathway – guidance for staff which sets out exactly what care each patient needs: ‘They know exactly what’s going to happen at every stage,’ she explains. ‘For each patient there’s a booklet which provides prompts on what should happen. So for example, it reminds staff that the day after the operation, the patient doesn’t need an X-ray and can have their breakfast sitting up in a chair.’ The big advantage, she says, is that junior staff are empowered to make decisions without having to wait for instructions. ‘They can do things on a daily basis that they feel would help the patient. They can talk to the relatives and say what’s likely to happen at each stage.’

She says the pathway has proved ‘incredibly beneficial’ for hip fracture patients. ‘It’s reduced their length of stay – we get patients to the operating theatre more quickly, because everyone knows there are a finite number of things that could go wrong, and they look out for them and deal with them. These are elderly patients and they really are quite critically ill, but we do look after them very well and I think a lot of that is because of the team approach.’ There are also financial benefits to the Trust, which now has one of the best records in the country for survival following hip operations. Shorter stays for patients mean that beds and staff are freed up, and resources are used more efficiently. But Mrs McNally says the change would not have been possible had she not had time set aside for SPAs: ‘I needed time to go and talk to everybody involved. If I was doing clinics all the time, I wouldn’t have had that chance to go round and talk to people.’
Two years ago she became Director for Medical Education at her Trust, a role which involves ensuring that the 280 junior doctors at the Trust get the training, experience, and support they need. And various changes in the NHS mean that her clinical role is becoming more challenging and time-consuming: ‘I qualified 20 years ago but it’s become a lot more complex. The expectations of patients, staff and relatives are much higher, and there are more directives about how things should be done. In orthopaedics, a lot of the easy cases have gone to Independent Sector Treatment Centres so I’m left with a lot of complex cases without much time for working out the best way forward. With surgery you can’t afford to get it wrong – you have one go at it. But it does take a surprising amount of time, reading the journals, going to conferences, and keeping up to date and ahead of the game.’

She describes as ‘a very sad move,’ the national trend for SPA time to be cut: ‘There are a lot of consultants doing a huge amount of very good work. Medicine does keep changing so consultants are developing new initiatives, and that can take a huge amount of time.’
We have to let some of them die,’ says Dr Stephen Mather sadly. Fortunately the patients he’s talking about are made of latex and plastic, but it’s easy to see why the trainees at his Medical Simulation Centre soon forget that.

Dylan can be pre-programmed with a variety of conditions – so for example he can suffer an asthma attack while he’s being treated, and will become seriously ill if trainees do not respond quickly enough.

Dr Mather says that simulation provides a level of interactivity and immediacy that ‘you just don’t get in a lecture theatre’. One of the most popular courses at the centre allows trainees to test their life-saving skills on an interactive manikin while being driven round Bristol in a fast-moving ambulance, complete with siren and flashing lights. ‘It’s very realistic,’ he says. ‘When you’re in that ambulance, the suspension of disbelief is very powerful. It’s very immersive – some people get quite emotional.’

The project was born in 1996, when Dr Mather and colleagues set up a group to build the UK’s first Simulation Centre based on a computer-interfaced manikin developed at the University of Florida. The centre, which opened the following year initially consisted of a mock operating theatre housed in a derelict drill hall by the old Bristol General Hospital, and although it received a loan from the hospital’s Charitable trustees, it had to pay its own way by selling courses commercially, which it did with considerable success – in less than 10 years it was generating around a quarter of a million pounds a year.
Now most of the trainees who come through the centre are local NHS staff, including junior doctors, for whom opportunities for high-quality training are particularly important because of shorter training programmes and legal limits on working time. ‘There’s no evidence at all that the consultants we’re producing now are less competent, but they have seen less,’ says Dr Mather. ‘Simulation allows you to build confidence. They will know the theory and they may have watched a video, but if you do it six or seven times in a simulator, then you’re not so fazed.’

Initially, Dr Mather and colleagues had no protected time to develop the centre’s work: ‘In the early days, I was spending anything up to 10 hours a week on my own time,’ he says. ‘We’d sit there from six in the evening until nine trying to improve the simulators and the software models. None of that was funded.’

He is keen to praise his Trust for its decision in 2009 to take over ownership of the centre, which has meant that he and other staff working in the centre have their commitments more formally recognised. However, he believes this is not the case everywhere, and is concerned that cuts to SPA time could make it harder for the NHS to retain a motivated workforce. ‘Doctors are keen to do the things they do – they’ll still do the work, but not forever. People are motivated only in so far that they feel valued, and that’s why one of my colleagues pitched off to Canada. They offered her time and support to develop her ambitions, which at the time wasn’t possible locally. Unfortunately, it meant that her drive and enthusiasm were lost to the NHS.’
Mr Alastair Murray
Consultant Orthopaedic Surgeon
Royal Hospital for Sick Children, Edinburgh

Mr Alastair Murray has created a new service to treat clubfoot in South East Scotland, set up several departmental databases to audit quality of care, developed a core skills training course in orthopaedics, put in place a screening programme for hip dislocation, and set up a new children’s orthopaedic clinic in West Lothian.

SPA time also allows him to comply with national audit requirements, and to maintain a logbook of operations that can be used to inform patients of his experience. He also attends committee meetings in his role as a Regional Surgical Advisor for the Royal College of Surgeons of Edinburgh, which delivers support to trainees and consultants in Continuing Professional Development (CPD), and as a member of the Scottish Collegiate Committee for Children’s Surgical Services. SPAs also provide the opportunity to undertake essential research – Mr Murray has conducted research into hip dysplasia in children, with work aimed at identifying a marker for the condition to improve screening, and into Perthes disease, which affects the hip.

SPAs are not an allowance for the comfort of consultants, nor are they time away from the wards at the expense of patient care.

Mr Murray says: ‘In addition to developing and innovating services, consultants are expected to ensure that their skills and knowledge are up-to-date in order to ensure patient safety and to deliver a quality service to patients. CPD is an essential component of SPA time, as is preparation for revalidation and appraisal, which all doctors must undertake.

‘SPA time is vital – it allows us to develop services and ourselves in ways that may not produce immediately tangible results for individual patients but lead to vast improvement in the service in the long run. SPAs are not an allowance for the comfort of consultants, nor are they time away from the wards at the expense of patient care. Rather, they are vital in allowing consultants the time and space to develop their skills, train junior staff and maintain and improve services and techniques which directly benefit patient care and safety.’
It’s a field of science that can identify the risk of a disease years before it happens, allowing patients and their doctors to take action that is frequently life-saving. But Dr Alexandra Murray says genetic medicine still carries negative connotations. ‘Genetics is a scary word for the general public – there’s a lot of stigma attached and a lot of fear.’ Partly to address these fears, the Cancer Genetics Service for Wales, part of the All Wales Medical Genetics Service, works hard to base its services and research activity around the needs and concerns of patients, which depends on Dr Murray having SPA time available.

Most of the 26,000 people who have been referred to the service since 1998 come because a relative has been diagnosed with cancer, but Dr Murray also sees patients who have themselves discovered they have the disease. In most cases, the first step is for her team to work with patients to construct a ‘family tree’ detailing which cancers have affected relatives, and whether there are significant trends which warrant screening or genetic testing. By taking DNA samples from family members, they are able to identify mutations that indicate a genetic cause of cancer, which allows the risk for relatives to be predicted with surprising accuracy: ‘Once you’ve found a mutation in the family then you know what you’re looking for,’ says Dr Murray. ‘Then anyone else in the family can find out for definite if they have the mutation or not. It depends on the different genes and the different cancer but we know that with the BRCA genes, for example, if you’ve got a mutation, you’ll have up to an 85 per cent chance of developing breast cancer in your lifetime.’

While the whole process is obviously traumatic, Dr Murray points out that testing positive for a mutation is not the same as getting a cancer diagnosis, and often means that the patient or their doctor can take positive action: ‘There are people who are being monitored because a mutation has been identified in the family, and that leads to a cancer being picked up at a stage that allows it to be treated early enough, so you’ve effectively saved their lives.’ In many cases, the first step after a positive genetic test is to undergo screening, but she says that many people want to do more to manage their risk: ‘Patients are very different and some are happy just to go for a mammogram every year. But some want to be more proactive – for example they’ll choose to have their ovaries removed or have a mastectomy.’

Building on a tradition of research innovation at the Institute of Medical Genetics – it has discovered a number of disease genes and trained many eminent geneticists – the Cancer Genetics Service for Wales has in recent years developed a reputation for ‘patient-centred’ research, for example patients can feed in their ideas for
future research activities. ‘Patients get the opportunity to have their voice heard right back where it matters,’ says Dr Murray. ‘The researchers aren’t just interested in getting their names on papers – they want their research to be translated back into improving the patient’s experience.’

Other activities have included newsletters about the team’s activities, and open days, where patients can learn more about familial cancer and have one-on-one advice from clinicians. One of the current projects is Storybank – an online archive of stories told by people who have benefited from the service. As well as helping address new patients’ fears about genetic testing, Dr Murray hopes it will support people with specific dilemmas. ‘For example, when do you tell your kids there’s a gene in your family that means they might be at risk of getting cancer? What’s the right age to tell your daughter she might need to have invasive tests every two years of her life? Or what does it feel like to have your breasts removed? It’s those kinds of questions that people want to talk to other people about. I hope it’s something that patients will be able to turn to, to make the whole process less scary.’

She believes Storybank, and much else that the team does, would be impossible if SPA time were reduced: ‘I couldn’t stop training junior doctors or teaching, so something else would have to give. My concern would be that I wouldn’t be able to do these things that are dear to my heart because they’re about patients.’ She feels ‘incredibly fortunate’ compared to colleagues elsewhere and is concerned about the UK-wide trend to ‘squeeze consultants’ time: ‘I think it’s a false economy and I think it’s short-sighted. Of course doctors are under the same pressures as everyone else, but the thing I see changing is a trend towards outcomes and measures. If you look back to Bevan’s mission statement, it wasn’t about numbers of patients or how quickly you see them. That’s not what quality is, and hopefully the work we do looks at what patients want, and not just what people think they want.’
Dr Cliona Ni Bhrolchain
Consultant Community Paediatrician
Child Development Centre, Clatterbridge Hospital, Wirral University Teaching Hospital NHS Foundation Trust

They provide specialist care for the hundreds of thousands of children with disabilities and long-term conditions, as well as those who are looked after by local authorities, and have a vital role in public health work such as childhood immunisation. But, there is still a serious shortage of doctors working in community paediatrics, a problem that Dr Cliona Ni Bhrolchain has worked to address in her SPA time.

‘Each time we do a census, numbers of general paediatricians working in hospitals have gone up, but numbers of community paediatricians haven’t. So we’re holding our own but we haven’t really seen an increase over the last 10 years.’

Reduced hours for junior doctors have made it even harder to plug gaps in the service says Dr Ni Bhrolchain, who believes that children may be waiting longer for care as a result. ‘It’s difficult to get accurate figures, but we believe that nationally many disabled children don’t comply with the 18-week target between referral and treatment.’ The other area she believes could be suffering is the safeguarding of children: ‘There does appear to be a national shortage of expert witnesses in child protection cases, and part of that is a lack of community paediatricians.’

Hence Dr Ni Bhrolchain has devoted much of her SPA time to finding innovative solutions to the recruitment challenges facing her specialty, with highly successful results. One approach has been to make more efficient use of the workforce available, for example by training nurses to run a follow-up clinic for children with Attention-Deficit Hyperactivity Disorder (ADHD) – a condition which accounts for around a third of outpatient follow-up appointments at her Child Development Centre at Wirral University Teaching Hospital NHS Foundation Trust. She says it is still quite rare for an ADHD clinic to be led by nurses, but nurse-led services are popular with children and young people: ‘they don’t usually like talking to doctors because we’re authority figures, but they appear to find nurses much less threatening.’ The initiative has also freed up medical staff to take on other work: ‘By using nurses, we’ve been able to use our budget to its maximum benefit, because there’s only a limited amount,’ says Dr Ni Bhrolchain.
She has also used her SPA time to draw up a re-entry programme for a paediatrician returning to the UK after a 10-year absence, allowing the Trust to maintain the service at a time when it was struggling with gaps on the rota (the doctor has now returned to the workforce as a community paediatrician). And in 2007 she collaborated on a project to expand specialist training in community child health, so that more junior doctors could be trained. Three years later, nearly all the consultant vacancies in her area have been filled, in contrast with others, which are still experiencing recruitment problems.

Dr Ni Bhrolchain believes her case is a clear example of investment in SPA time paying off: ‘There are two ways of looking at it. If I’m there doing the clinical work, the clinical work is getting done. But by using SPA time effectively, I have increased the resources available. If I hadn’t had the time I suspect we would still be struggling on – trying to manage with fewer juniors in clinic and certainly in the longer term we would have fewer community paediatricians. You do have to put the work in to start with, and that’s how you get your future workforce.’
Without time for reflection John Painter may never have come up with two ideas that have reduced waiting times for patients with serious gastroenterological conditions, and saved his Trust money. Using his SPA time, he devised simple mechanisms to help patients manage coeliac disease and dyspepsia – two of the most common digestive problems. Working with other health professionals Dr Painter set up dietitian-led coeliac review clinics alongside his gastroenterology clinic in Sunderland Royal Hospital, and community dyspepsia clinics run by pharmacists in GP surgeries.

Patients with coeliac disease are offered the opportunity to see a dietitian in the review clinic, which replaces a yearly follow-up appointment with a consultant. And patients with dyspepsia can visit the pharmacist in their local GP surgery for help with their condition. Both clinics free up Dr Painter’s time, allowing him to focus on patients with more complex health needs that require diagnoses and tests. The coeliac clinics are run under his supervision and to practical national guidelines, with patients seeing the practitioner who is best placed to help them understand how they can control their disease. Much of the advice for managing coeliac disease is related to a gluten free diet and the dietitian focuses on this, seeing patients every 12 to 18 months, answering their queries and directing them to a consultant where necessary. Dr Painter works with the two dietitians in the review clinics to ensure that annual blood tests are offered to all coeliac patients in a systematic way. ‘It’s about getting the right person to see the patient with the right problem,’ he says. The initiative means he is able to see more new patients a year, and reduces costs for the Trust, as less serious conditions are dealt with by dietitians rather than consultants.

Dr Painter has also set up community dyspepsia clinics run by prescribing pharmacists, held in GP surgeries. He trains the pharmacists – about 10 so far – so that they can offer patients with dyspepsia a first class service. They talk to patients about their medication, lifestyle and diet, and offer them a health check, which includes tests for high cholesterol and blood pressure.

‘Dyspepsia is extremely common, and it is just not feasible or practical in any way for all such patients to see GPs and definitely not hospital specialists,’ Dr Painter says. ‘We’ve tried to rationalise, make more efficient and improve upon care in the community for patients with dyspepsia.’ In line with best practice...
guidance, the pharmacists are also trained to give advice that ensures that patients are less likely to need referrals for further investigations. Dr Painter hopes that the approach can be rolled out with pharmacists in commercial pharmacies in the future. ‘They enable everybody to meet national criteria and free up doctors to see other patients who have more acute clinical needs,’ he says.
Fawzia Rahman says the best manager she ever had gave her some surprising advice. ‘She told me she didn’t want me to see a single patient in my first three months as a consultant. She just wanted me to go away and think.’

Dr Rahman has gone on to prove the value of consultants having protected time to generate ideas. The electronic patient information system she has developed has improved community paediatric services for children in Derby, and saved the NHS money by reducing rates of missed appointments. When she started her post in the community, there was no computerised system to keep track of appointments or provide detailed data about patients that could be used to improve the service. ‘The problem was there was no way to report activity’ she says. ‘We used to send back basic returns stating how many patients we’d seen in very broad categories, but I thought that wasn’t good enough – I wanted more detail on the patients I was seeing.’

She developed a personal database to record information about her patients, which proved so useful that she was given time to develop a new electronic information system for the whole service. ‘Now we have one of the best informatics systems in this area of work,’ she says. ‘We have a lot more information about the child’s background and why we’re seeing them – whether it’s a physical problem, a mental problem, a psychosocial problem, or whether there are child protection issues. Usually they’re referred for more than one reason – their needs are very complex.’

Having detailed data about patients also means that services can be shaped according to their needs. ‘From the child’s point of view, we’ve used the information to target services at children with the greatest needs,’ she says. ‘We can show for example that 45 per cent of the new patients we see are in vulnerable categories – they have special educational needs, or they’re adopted or being looked after by the local authority, or they’re the children of travellers or asylum seekers. We can demonstrate to commissioners that there’s a need for specialist services for these children.’

One of the problems better information-gathering has allowed the service to address is high rates of missed appointments (‘Did Not Attends’ or ‘DNAs’). Although this is a common problem in community paediatrics, particularly in deprived areas, Dr Rahman says she was sure it could be tackled. ‘I looked at the DNA rate and I was appalled,’ she says. ‘I thought we can’t have this.’ Using data from the informatics system, she devised an audit to find cost-neutral ways of reducing missed appointments. One of her findings was that patients were
more likely to miss an appointment if their child had been referred by a school nurse rather than a doctor. ‘People were less worried about not attending than if they’d been referred by a GP. So we’ve tried to change perceptions of referrals, because it costs the NHS a lot of money if the patient doesn’t attend. We now make sure that the appointment is necessary, that it’s been agreed by the parents, that the parents are convinced of its importance, and that admin staff ring them with a reminder.’ Measures such as this have resulted in DNAs dropping by around a third, with significant cost savings for the local NHS.

Leading informatics for her service is now part of Dr Rahman’s official responsibility, but she says she could not have got her ideas off the ground if she had not had SPA time available to begin with: ‘I am very fortunate to have a wonderful medical director, who has allowed me to be free with my time, which means I can generate ideas. If I’d just continued to do routine clinical work, I would never have had time to think we could be doing better. I would have just sat there and said “Another DNA – what can I do?” I’d just be a machine.’
Major obstetric emergencies, such as cardiac arrest during labour, are fortunately rare but this can mean staff being unsure what to do when they do occur.

Catherine Ralph has used her SPA time to develop simulated scenarios and lectures for all staff who may have to deal with obstetric emergencies. These monthly half-day events are open to midwives, obstetricians and anaesthetists who work in delivery rooms. Dr Ralph says the skills drills help staff deal better with both major and minor emergencies. ‘They have the confidence to communicate effectively with other staff and patients in emergency situations. Knowing the emergency drill saves lives and improves the quality of patient care.’

Having staff who are up to date with emergency systems also brings a financial benefit for the hospital, which saves money in insurance and litigation premiums, because it has evidence that staff are routinely trained to deal in the most effective way with an obstetric crisis.

In her own time Dr Ralph is conducting research into the use of intra-operative cell salvage in obstetrics – an innovative technique which allows women undergoing obstetric procedures to be treated with their own ‘recycled’ blood, which prevents anaemia and is safer than a blood transfusion. It also has the potential to save the Trust money – a unit of donor blood costs £140 whereas the cost of recycling blood through the cell saver machine costs less than £70.

Dr Ralph says if the Trust took away SPA time she would probably carry on doing the work unpaid but believes good will can only be pushed so far. ‘There are not enough hours in the day to do everything you want to do as a doctor,’ she says. ‘Without SPAs I am sure that the quality of patient care would be compromised.’
Dr Cait Searl
Consultant Cardiothoracic Anaesthetist
Freeman Hospital, Newcastle

SPA time is at a premium at Cait Searl’s Trust, making her achievements even more impressive. Her work introducing new technology, training colleagues and developing services has meant a huge amount to her patients.

Dr Searl first heard of the novalung interventional lung assist (iLA) device when she was researching ways of improving survival in patients with acute lung injury, and later travelled to Germany to learn how to use it. The iLA does not require a pump because the patient’s own circulation drives it, and Dr Searl says it is particularly useful in patients who have undergone a lung transplant: ‘The new lungs are often injured by the transplantation process and one of the issues is that you need to assist their function because any ventilation you do will worsen the injury. If you use the novalung very early you can decrease the time they are ventilated for and lessen the injury.’

Convinced the iLA could benefit her patients, Dr Searl sought support from her Trust Board and finance department. Once she had been trained and developed enough expertise, she set about convincing colleagues of its value but the results were so apparent that this was not difficult. ‘It’s a very intuitive piece of kit and once you’ve used it and seen how effective it is, very few people aren’t converted,’ she says. ‘We then had a steep learning curve in learning how to use the device most effectively, and I spent quite a lot of time developing information packs and teaching.’

Dr Searl has now developed a reputation as one of the UK’s experts in the iLA, and teaches staff across the country on how to use it. Although it is too early for a full audit, early results appear very promising, and the iLA has been approved by NICE. Its value to patients is obvious. One woman who was close to death survived to have a lung transplant because the device had been inserted, and now raises money for charity. Use of the iLA is limited for financial reasons, but Dr Searl is optimistic that the medium and long-term benefits to patients, and the increased efficiency it supports, will convince NHS managers that it will save them money in the long term.

Dr Searl has also used her SPA time to develop simulation courses for nurses and medical students. After a particularly traumatic intensive care week she sat down with the nurse educator and discussed how they could better prepare staff for emergency situations – from having to re-open the chest of a patient, to identifying...
faulty pace-maker function. What surprised everyone was just how convincing the simulations turned out to be. ‘Amazingly staff quickly forgot that it wasn’t a real person and the level of panic was exactly right!’ she says. ‘The feedback afterwards was “how could it be so real?”’

Given what she has achieved with her SPAs, it is not surprising that Dr Searl is disappointed that they are being cut elsewhere. ‘I think it is a shame to discourage people from spending time doing anything other than directly clinical work,’ she says. ‘One of the problems with decreasing consultants’ SPA time is that they won’t have time to innovate.’
Dr Bill Stephens  
Consultant Physician  
Trafford Healthcare NHS Trust, Manchester

‘If patients need the expertise of a consultant they should get it,’ says Bill Stephens. It seems a very simple idea, but isn’t always easy to deliver.

Dr Stephens works at Trafford Healthcare NHS Trust in Manchester, which is pioneering a new approach to healthcare delivery that gives patients better access to specialist care. The management of chronic diseases like diabetes usually takes place in the community, but much of the specialist expertise is located in hospitals. Generally patients only get to see a specialist when they have a problem or need to be admitted to hospital. The aim of this new system of healthcare delivery is to ensure that the hurdles of getting a referral from a GP are removed so that patients get to see the appropriate person at the appropriate time in an appropriate place.

Dr Stephens explains how the project came about: ‘We were sounded out by one of the senior managers at our PCT to try a new approach to chronic disease management. With the help of GPs, NHS managers and the Strategic Health Authority we set about devising a system of diabetes care that ensures that those who need intervention most get the care they need.’

Using a combination of his own time and SPA time Dr Stephens helped devise a system that fundamentally changes the way diabetes care is delivered. ‘Firstly we want to ensure that patients have all the information they need to understand their diabetes so they can better manage their condition,’ he says. ‘We have done this by introducing a structured formal education programme for patients diagnosed with Type 2 diabetes.’ The education of healthcare staff has also been improved, with all local district nurses now receiving mandatory training in diabetes.

But the critical innovation of the new system is the ease with which patients get access to the expertise of consultants. Nurses now have immediate access to consultants through virtual clinics and practice nurses can email questions to consultants, who can suggest treatment options or arrange to see the patient face to face. ‘We can now have an influence on patients’ care on the day they are seen by a practice nurse,’ Dr Stephens says.

The advantages for patients are clear, and the innovation is also expected to bring a long-term financial benefit. Diabetes, if not managed properly, can lead to very serious complications such as heart disease, eye problems,
kidney disease and even limb amputation. With patients educated to have a better understanding of their condition, and much closer involvement of consultants in their care, there are likely to be fewer complications, which will ultimately save the NHS money.

Dr Stephens is hopeful that the pioneering model can be applied to other chronic diseases. ‘We hope the diabetes model will be used as a template to improve the care of a range of other conditions. The Trust is already looking at rolling out this model of care in different areas of medicine.’
When Paul Tesha arrived at Lincoln County Hospital the area lacked a service to treat wet age-related macular degeneration – the commonest cause of visual loss in older people – so he built one from scratch.

‘There were some very good services up and running in Lincolnshire, but we lacked a local service for treating wet age-related macular degeneration,’ says Dr Tesha. ‘Patients were not able to receive treatment locally and had to travel to Nottingham, in the next county, to get the sight-saving treatment they needed. This obviously added an extra bit of stress to people already worried about their eyesight, and the travelling can be a challenge for older patients.’

Dr Tesha implemented a raft of plans as part of his SPA work to create an efficient and cost-effective service that aims to give holistic care to the patients. It included the development of new designs for an Ophthalmic Procedure Room to perform eye operations, which reduced waiting times from three hours to around 45 minutes. A new operation pack for injecting drugs into the eye will save his Trust an estimated £35,000 a year, while the introduction of monthly performance reports for wet age-related macular degeneration succeeded in reducing referral times to just one week.

‘There wasn’t one big reform,’ Dr Tesha says. ‘It was about many smaller elements being built from scratch and then integrated together so that we reduced costs, sped up treatment for patients and set up more efficient services. It was a real challenge, but having the ability to undertake this as part of my SPA work really helped. I did though do half the work in my own time, unpaid, just to make sure everything got off the ground in the right way.’

The innovation Dr Tesha is most proud of is the development of a post for an Eye Clinic Liaison Officer, a professional who offers information and support to people newly diagnosed with sight loss.

‘Losing your ability to see is a terrible occurrence and I felt it was important we put in place a knowledgeable, well trained person who bridged the gap between what happens when the treatment ends and when they return home,’ says Dr Tesha. ‘We did this with help from the local blind society and I really feel this aspect has made a big difference to how patients are treated.’
Dr Rani Thind
Consultant Radiologist
St Helens and Knowsley Teaching Hospitals NHS Trust

Rani Thind believes that in any profession you need time to step back and review what you’re doing, and ask yourself how the service you provide can be improved and expanded. This is what she has done with rapid access breast clinics at St Helens and Knowsley Teaching Hospitals NHS Trust in Merseyside. The clinics are expensive to run, as they make use of the time and expertise of a surgeon, radiologist, radiographer, specialist nurse as well as administrative support, and NHS targets increase the importance of using resources efficiently. ‘In order to meet the two-week target for all breast referrals doctors need to make sure that the capacity is used appropriately,’ says Dr Thind.

Working in her SPA time, Dr Thind audited the journey of women attending the rapid access breast clinic, interviewing some of them at the end of their appointment. She found that surgeons were referring patients they had seen in their non-urgent follow-up clinics because they needed urgent radiology intervention. This was problematic because two or three slots could be taken up in each clinic, creating problems with capacity. Instead Dr Thind arranged for these patients to be fast-tracked through the imaging department, releasing several slots every week for new patients in the rapid access clinics.

She also reviewed the patient journey of women under 30, who do not routinely have mammograms. They are now seen in a separate clinic, but still within the two-week target. As there is no need for radiographers or specialist nurses, this clinic costs much less to run.

Dr Thind says all of these changes have been developed during protected time. ‘Having SPA time meant that I was able to review and develop changes to the service within my working day,’ she says. ‘This has benefited the Trust as it has reduced the cost of delivering the required capacity, as well as helping to make the service better for patients by streamlining their treatment.’
When Julia Thomson took up her post she immediately set to work on creating a monthly newsletter to improve links with local clinical colleagues. The result was *Paediatric Pearls* and she quickly realised its value as an educational and communication tool.

A monthly publication in two editions, *Paediatric Pearls* provides guidance and advice to GPs in Waltham Forest, Redbridge and West Essex, and to junior doctors at Whipps Cross. Dr Thomson, who works on the publication in her SPA time, aimed to produce something accessible and useful: ‘It was a way of imparting information in an interesting bite-size way which would make people think “Oh that’s interesting”;’ she says. ‘I use it as a vehicle for communication – how to refer patients to paediatrics, for example, to make the pathways smoother for both GPs and patients.’

*Paediatric Pearls* has made a big impact in a short time, with local GPs, junior doctors, the head of the local primary care trust, senior nurses, practice nurses and the health visiting liaison officer all becoming regular readers. The local focus of the newsletter is what sets it apart – it deals with issues and cases that all medical professionals in the area find relevant. In turn, this makes the service more efficient and ultimately benefits the young patients and their families. Dr Thomson cites the example of infant tongue-tie release, where the child’s tongue is too firmly anchored in its mouth for it to breastfeed properly. Through her work on *Paediatric Pearls*, she has been able to clarify NICE (National Institute for Health and Clinical Excellence) guidance on what needs to be done, in particular, when the tongue ties need to be cut, and when a simple change in breastfeeding technique might be all that is needed. ‘I know who to refer the patients on to, and have more confidence that they’ll get a good and sensible service. My own patients definitely benefit,’ she says.

Dr Thomson invites regular feedback and requests for topics from her readers, and through sharing knowledge and best clinical practice, *Paediatric Pearls* provides a very important link with the local medical community. The newsletter helps to cut waiting times for children and avoid unnecessary referrals. Dr Thomson hopes, with the help of one of her current registrars, Dr Amutha Anpananthar, to expand and improve the newsletter in future, making it easier to access and even more useful to its readers. *Paediatric Pearls* is freely available online at www.paediatricpearls.co.uk.
The work is reliant on Dr Thomson having sufficient time, and as a paediatrician trying to make things smoother for children in Accident and Emergency, she worries about the national trend to reduce the amount of time allocated to SPA work. ‘I think to drop it down erodes the professional role of the consultant. It is hard to fit in all our work in the time allowed, and it’s unrealistic and misunderstanding the professional role of senior clinicians to just make us do practical and shop floor work. If they cut down the SPA time, the first thing to go would be *Paediatric Pearls* which would be a great pity because we all learn a lot from it, especially me.’
Mr Atef El-Kholy
Consultant ENT Surgeon
Trafford General Hospital, Manchester

When Atef El-Kholy, a surgeon at Trafford General Hospital, became aware that an integrated care pathway service was being developed between his hospital and the local primary care trust he decided to set up one for his specialty, Ear, Nose and Throat (ENT). Other specialties that have developed similar systems include respiratory disease, diabetes and care of the elderly.

Any cost savings generated by the initiative are reinvested back into the ENT service, and have allowed extra clinical services and specialist nurses to be funded.

He started by developing an ENT integrated care pathway that supports GPs in making the most appropriate treatment and referral decisions for their patients. For example, if a patient has globus sensation – a constant feeling of something stuck in the throat – GPs are directed to look for a range of specified symptoms, such as earache, difficulty swallowing, hoarseness or oral lesions. If any of these are present, the patient should be referred to hospital urgently to rule out cancer or another life-threatening condition. However, if none of the symptoms is identified, it may be more appropriate for the patient to be treated by the GP, as it might be a less complex condition, such as acid reflux.

Integrated care pathways ensure that patients receive the most appropriate treatment, and allow hospitals to deal with urgent cases more quickly. Any cost savings generated by the initiative are reinvested back into the ENT service, and have allowed extra clinical services and specialist nurses to be funded.

Without SPA time, Mr El-Kholy says he would have been unable to develop the integrated care pathway. ‘No way could I have developed the guidelines,’ he says. ‘They take time to develop as they have to be evidence-based. These pathways are about improving quality, flexibility and efficiency and ultimately safety for patients. Reducing SPA time would not be good for the NHS as this is when doctors do their creative work and develop new initiatives.’