

Pennine Acute Hospitals NHS Trust *and* Christie NHS Foundation Trust, Training Interface Group fellowship post in Head & Neck Surgical Oncology



## ***Introduction***

The fellowship programme is run through the Joint Committee on Surgical Training (JCST).

Fellowship posts are open to all higher surgical and where appropriate, non-surgical trainees, that meet the person specifications. Details of eligibility are found through the [JCST](#).

Any unit applying to host Training Interface Group fellows must have trainer representation from all parent specialties.

Applicant units are required to be able to deliver the TIG curriculum and adhere to the quality indicators (QIs). The curriculum can be found on the [ISCP website](#) in the curricula of the most relevant parent Specialties (as mentioned above) and the QIs are listed on the [JCST website](#).

The data included in the form below is an extract of the data submitted by the unit in their application to become a TIG unit.

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***Unit Lead Trainer:***

Name
<b>Mr Panos Kyzas</b>

***Local Educational Provider (LEP)***

Main hospitals/trusts involved with teaching (base units):

	<b>Hospital/Trust A</b>	<b>Hospital/Trust B</b>	<b>Hospital/Trust C</b>
Name of Trust	Pennine Acute Hospitals NHS Trust	Christie NHS Foundation Trust	
Address of Trust	The Pennine Acute Hospitals NHS Trust Trust Headquarters North Manchester General Hospital Delaunays Road Crumpsall M8 5RB	The Christie NHS Foundation Trust Wilmslow Rd Manchester M20 4BX	

Peripheral units (if to be visited by trainee):

	<b>Hospital/Trust N</b>	<b>Hospital/Trust O</b>	<b>Hospital/Trust P</b>
Name of Trust	Pennine Acute Hospitals NHS Trust	Pennine Acute Hospitals NHS Trust	
Address of Trust	Fairfield General Hospital Rochdale Old Rd Bury BL9 7TD	Whitehall St Rochdale OL12 0NB	

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### ***LEP Consultants / Trainers***

Primary Educational Supervisor (may be a trainer):

#### **Main Trainer(s) involved with fellowship:**

*A main trainer must undertake more than five programmed activities (PA) in their job plan and they must also be a surgeon primarily in the relevant sub-specialty area and recognised by the GMC as a trainer. At least one trainer from each specialty must have five years full time experience in the NHS.*

List of parent Specialties of main trainers:

Parent Specialty	Number of main trainers from this Specialty
OMFS	5
ENT	2
Plastics	2

#### **Other Trainer(s) involved with fellowship:**

Parent Specialty	Number of other trainers from this Specialty
Oncology	2
ENT	2
Plastics	3

Any other Specialties who are members of the multidisciplinary team not already mentioned as appropriate to the TIG:

Specialty	Trust A (numbers)	Trust B (numbers)	Trust C (numbers)

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### ***Indicative Timetable***

The fellow should be based at the main hospitals/Trusts for most of their educational activity but one session (professional activity) may occur outside these units each week. A trainee may work for 48 hours per week and if there is no on-call, all this time may be used for training.

Below is an indicative timetable that indicates the type of proposed activity and includes supporting professional development (SPD). SPD should be one half day each week. Please note that the timetable must be compatible with the Quality Indicators specific to the relevant TIG. All Quality Indicators may be found online at: <https://www.jcst.org/training-interface-groups/quality-processes/>

### **Types of activity**

Combined outpatient clinic (COC)

Other outpatient clinics (OOC)

Operating theatre (Th)

Multi-disciplinary team meeting (MDT)

Supporting Professional Development (SPD)

Teaching ward round (WR)

Research activities (RA)

Please indicate the activity and the trust, for example, MDT (A) or Th (B).

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	Th (Pennine)	Th (Christie)	Th (Pennine)	MDT (Pennine)	WR (Pennine)	RA	
Afternoon	Th (Pennine)	Th (Christie)	Th (Pennine)	COC (Pennine)	SPD		
Evening	Th (Pennine)		Th (Pennine)	MDT (Pennine)			

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**The above timetable is only indicative – there are several training opportunities per day, and a final timetable will be tailored on the individual fellows’ needs.**

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*Training Delivery*

Please an overview of the Unit's TIG Fellowship Training Delivery plan:

**The TIG H&N fellow in our unit will have the opportunity to be involved in a holistic approach of managing H&N Cancer patients. The fellow will follow the patient from the time of diagnosis, through the MDT discussion and combined multidisciplinary clinic, attend the surgical resection and reconstruction planning sessions, be involved in the surgical procedure and post-operative care, ensure the implementation of our enhanced recovery pathway, and follow up the patient in the clinic. This applies to all the sub-categories below.**

Tumours of the larynx

The TIG fellow will have the opportunity to attend MDT clinics and surgical sessions under the supervision of ENT surgeons for the management of tumors of the larynx. We offer transoral laser resection, or radiotherapy, for early stage laryngeal tumors (whichever is more appropriate for the best functional voice outcome) and we offer laryngectomy either as primary modality for advanced tumors or (more often) as salvage procedure following radiotherapy.

Tumours of the oro/hypopharynx

Our unit is signed up to start enrolling patients for the PATHOS trial, therefore the fellow will have the opportunity to get involved in TOLS of oropharyngeal/hypopharyngeal tumors. The fellow will also have the opportunity to attend planning sessions with our oncologists for the non-surgical aspect of treating this disease. HPV + oropharyngeal tumors are treated with primary radiotherapy +/- chemotherapy; however, there is a significant number of patients that have salvage surgery for residual or recurrent disease. These cases are commonly treated jointly between OMFS and ENT within our team, as most of them will need microvascular free flap reconstruction following ablation. Our salvage surgery outcome data have recently been submitted for publication and the fellow will be encouraged to further pursue this from a research perspective.

Tumours of the oral cavity including access procedures

Our MDT hosts one of the biggest OMFS H&N units in the country, having 5 OMFS/reconstructive surgeons. We perform around 100 ablative/reconstructive procedures, mainly for oral cavity tumors per year. There are two major three session lists per week that the fellow will be attending on a regular basis. We also provide access procedures (i.e. lip split mandibulotomy) for a number of allied specialties (i.e. vascular surgery) and for benign disease. The TIG Lead

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trainer in our team (Mr Kyzas) is a regular faculty member of a RCS accredited course for oral tumor resection techniques/planning. The fellow will be encouraged to be involved in the planning of the resection of the tumor using axial imaging and appropriate software. We cover a generally deprived population with advanced oral cavity disease being the norm in our patients' cohort (70% stage IV oral tumors).

### Tumours of the skin of head and neck

On average, within our team, we treat over 1000 patients with cutaneous H&N tumors. There is a local skin MDT attended by Plastic Surgeons, OMFS surgeons, dermatologists, histopathologist. We have over 6 LA lists per week treating patients with skin tumors that the fellow will have access to. The majority of patients on those lists will need reconstruction either with a local skin flap or skin graft – our linked dermatologists in primary care do simple excisions with primary closure.

The Christies melanoma team provides specialist treatment for H&N melanoma – the plastic surgery team can offer brilliant training for the fellow in terms of ablation and reconstruction.

### Reconstruction in head and neck oncology

The OMFS team provides all types of microvascular free tissue transfer and reconstruction within our MDT, with approximately 90 free flaps per year. Our team is leading nationwide in the number of hard tissue reconstruction (mandible, maxilla) using patient specific planning (PSP) and 3D software. Our laboratory has a 3D printer and licence for the Materialise software – we also accept and treat patients requiring composite bony reconstruction from outside the remits of our trust. There is an excellent research opportunity for the fellow, as the number of these cases is exponentially increasing. We also focus on the functional rehabilitation of our patients – all of them are seen and assessed by our restorative consultants and receive dental implant rehabilitation at the time of primary surgery, if appropriate.

We have an enhanced recovery pathway in place for these patients, and the fellow will be encouraged to participate in the regular data collection audit for this.

We also have a cohort of patients with stage III ORN that require and receive microvascular free flap reconstruction. The fellow will have the opportunity to appreciate the challenges related to these cases, in terms of addressing the vessel-depleted neck, functional considerations and quality of life.

### Thyroid disease

Three ENT surgeons offer treatment for benign and malignant thyroid disease in our trust and attend the thyroid MDT. The TIG fellow will have the opportunity to work with all of them and attend the thyroid MDT. There is an ample number of cases and not all lists are covered by StRs, therefore, there is a great opportunity for training in thyroid surgery. Thyroid cancer cases are discussed in the regional thyroid MDT but are also discussed in our trusts'

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H&N MDT.

### Salivary gland disease

Benign and malignant salivary gland tumors are identified via our neck lump clinic and treated by all MDT surgeons. Due to the high workload of malignant H&N cancer cases requiring ablation and reconstruction, the benign salivary gland tumors are being treated on separate lists by the responsible consultant, often without a trainee. Therefore, this is a great opportunity for the TIG fellow to increase surgical skills in salivary gland surgery. Achieving the indicative numbers for salivary gland surgery has been a nationwide issue for OMFS and ENT trainees recently; however, in our unit we have enough salivary gland workload to fulfil the training needs of our trainees and the fellow. Depending on the experience and previous exposure, there is an opportunity for the TIG fellow to teach more junior trainees in these procedures, and increase his skills as a surgical trainer

### Tumours of the nose and paranasal sinuses

Tumors of the nose/paranasal sinus that are involving the skull base are referred to the GM skull base MDT. Tumors amenable to major resection are treated jointly between ENT/OMFS within our MDT on our major lists. There is an excellent endoscopic surgery service (FESS) for benign disease, provided by our ENT surgeons that the fellow could attend to increase his understanding/skills in endoscopic nasal surgery.

### Management of facial nerve

Facial nerve grafting, alongside with dynamic (i.e. gracilis free flap transfer) and static reanimation is offered by the OMFS reconstructive surgeons within the team. Tumors requiring lateral skull base input are referred to the GM skull base MDT