ENT UK Undergraduate Essay Prize 2024

"How can we overcome the challenge of excessively long waiting lists within ENT? What does the future hold for our specialty and what are the possible solutions?"

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(Excluding Captions and References)

1. Introduction

Waiting lists are a systemic issue in healthcare, exacerbated by the COVID-19 backlog.[1] ENT departments are particularly affected, with approximately 330,000 admissions and 2.8 million outpatient visits annually, with 960,000 involving outpatient procedures.[2] Of these, over 50% involve uncomplicated, non-surgical issues like ear infections and hearing loss, contributing to a doubling of the waiting list to 600,000 by 2022. The ENT surgical waiting list has also surged to 70,000, particularly affecting children awaiting tonsillectomies. Unfilled consultant posts further compound these issues.[3]

This persistent increase in waiting lists places immense pressure on ENT services, threatens timely access to care, and worsens patient morbidity and mortality.[4,5] Addressing this requires a structured, patient-centred framework that follows the patient pathway, identifying key points for intervention.

This essay proposes a three-pillar strategy to reduce ENT waiting lists: prevention and education, referral pathway optimisation, and hospital-level efficiency. Together, these pillars tackle root causes and present a cohesive approach to ensuring timely, effective care.

2. Primary Care

i. Prevention

Preventive care forms the foundation of the first pillar, prevention and education, in the strategy to reduce ENT waiting lists.

As the first line of defence in healthcare, preventive measures are successful and cost-effective.[6,7] Initiatives such as the UK's national Soft Drinks Industry Levy, commonly known as the sugar tax, have positively impacted dental hygiene.[8] Given the established links between poor oral hygiene, bad breath, and acute tonsillitis,[9] these improvements in public health alongside public education are likely to reduce the need for tonsillectomies. This integrated approach not only alleviates pressure on healthcare resources but also enhances overall quality of life for individuals.

Targeted campaigns could be designed to address common ENT conditions to build on this success. For example, sinus health awareness campaigns could emphasise the importance of managing allergens, maintaining hydration, and using saline nasal sprays to prevent the progression of minor sinus issues into chronic sinusitis.[10] By equipping individuals with practical, evidence-based strategies for sinus care, these campaigns could reduce the frequency of ENT consultations and enhance overall quality of life.

Similarly, smoking cessation programs are critical in addressing conditions such as chronic laryngitis and throat cancers, both of which place a significant burden on ENT services.[11,12] By reducing tobacco use, these programs could not only prevent serious ENT-related illnesses but also lower the incidence of milder conditions like recurrent throat irritation, which often require medical attention. These programs could integrate support for smokers through counselling, nicotine replacement therapies, and awareness of the long-term health benefits of quitting.[13]

Seasonal flu and vaccine awareness initiatives further underscore the role of prevention in ENT care. By promoting vaccinations and educating the public on the importance of immunisation, these campaigns can reduce the complications associated with influenza, which frequently lead to secondary infections such as otitis media and sinusitis.[14,15] Encouraging widespread vaccination uptake would decrease the demand for ENT consultations and interventions during flu seasons, easing the strain on healthcare services.

ii. Education

a. Medical Students

The adequacy of ENT training for medical students is crucial in reducing inappropriate referrals. For instance, as a UCL medical student, I observed that we receive only one week of formal ENT teaching. This seems insufficient, especially considering that around one-third of medical students become GPs,[16] and a significant portion of GP appointments are ENT-related (Figure 1).[17,18]

Expanding ENT training within medical curricula could address these gaps in knowledge and better prepare future doctors to diagnose and manage common ENT conditions effectively. Introducing comprehensive ENT modules that include practical sessions, simulated patient encounters, and critical thinking about referral thresholds could benefit their future competence. Additionally, teaching simple procedures like ear wax microsuction or nasal cauterisation during medical school could empower future GPs to handle such cases independently, thereby alleviating the burden on secondary care.

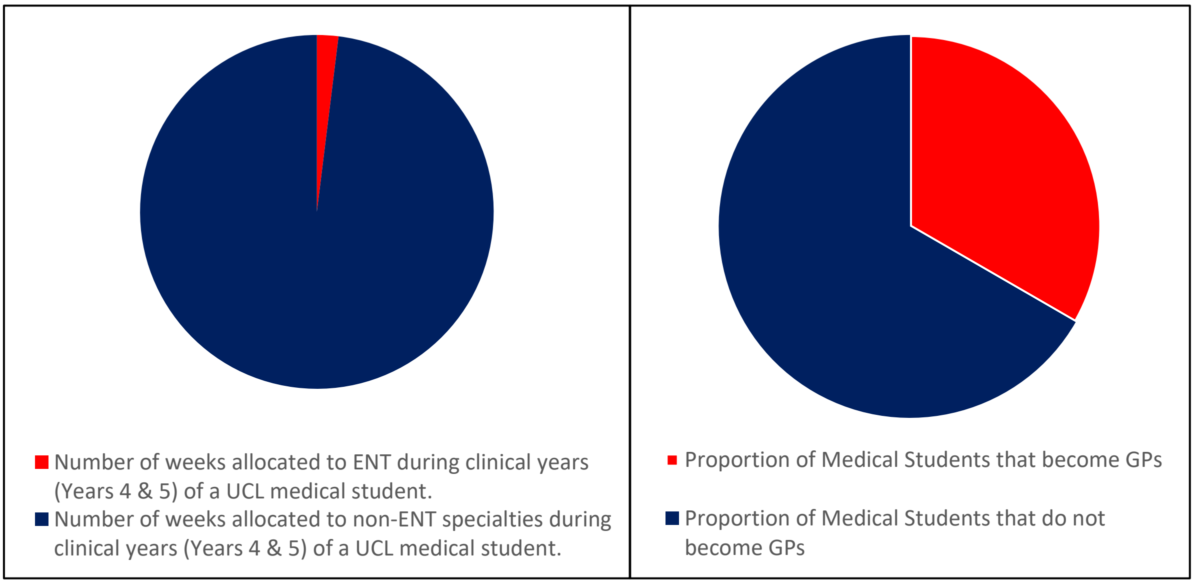

Figure 1. *Pie charts illustrating the disparity between formal undergraduate ENT clinical teaching, versus the proportion of students who become GPs (who have high ENT-related workload).*

b. General Practitioners (GPs)

GPs are gatekeepers to secondary care, managing initial diagnoses, referrals, and patient follow-ups. Their decisions significantly influence the flow of patients and the length of waiting lists for ENT specialists, cutting the costs associated with secondary care services.[19] However, limited training may leave GPs underprepared to manage ENT conditions effectively, leading to unnecessary referrals. A recent survey revealed that 75% of GPs desire additional ENT training,[20] highlighting the need for enhanced educational resources.

Improving ENT education in primary care through CPD courses or integrating more comprehensive ENT training into the GP curriculum could significantly reduce inappropriate referrals, thus alleviating pressure on specialist services.

Some key areas where GPs could benefit from further education include the management of conditions like TMJ dysfunction, which can mimic ear pain, and otitis externa, a common ear infection which can be treated in primary care. Additionally, conditions such as adenoid hypertrophy and chronic rhinosinusitis, which can present similarly to other ENT issues, may not always require specialist intervention. Understanding how to differentiate and manage vertigo, particularly benign paroxysmal positional vertigo (BPPV) versus postural hypotension, is also crucial. In addition, GPs could be trained and incentivised to facilitate microsuction clinics for impacted ear wax removal.[21]

iii. Resources

When GPs are unsure of a patient's next steps, they must have access to reliable resources to guide their decision-making process.

a. Advice & Guidance

One such resource is the "Advice & Guidance" scheme, which is pivotal in managing patient referrals and supporting GPs handling many patients.[22] This scheme allows clinicians to seek specialist advice, ensuring that only clinically appropriate patients are referred to specialist clinics. This reduces unnecessary appointments and optimises clinical resource use, freeing up slots for patients who genuinely need specialised care alongside helping junior practitioners make more informed decisions. This resource enhances the quality of care across the board by minimising delays due to patient redirection and ensuring that patients are seen in the right place with the appropriate urgency, thereby improving the overall efficiency of the healthcare system.

b. Screening Tools

Screening tools can be instrumental in reducing waiting times and unnecessary referrals in ENT services. A prime example is a questionnaire designed to assess the risk of sleep apnoea hypopnoea syndrome, coupled with home oximetry when appropriate. This approach has proven highly effective, reducing sleep study waiting times by 90 days, reducing waiting times for CPAP trials by 32 days and cutting ENT appointments in half without increasing respiratory clinic workload.[23] Given its cost-effectiveness and efficiency, this method could be adapted to other areas within the speciality, potentially yielding significant improvements in patient management and resource allocation.

c. Clinical Photography

Integrating clinical photography into the triage process offers a promising solution for optimising resource allocation within ENT services. A 2023 study demonstrated that clinical photography significantly reduced the need for face-to-face consultant appointments.[24] This innovation streamlines patient management, enabling the early detection of serious conditions like tympanic membrane perforations and cholesteatomas, thereby improving patient outcomes (Figure 2). Expanding this service to include nasal cavity and oropharyngeal lesions could reduce pressure on outpatient clinics and ensure that urgent cases receive timely care.

d. Clinical Audits

Regular clinical audits should be conducted to ensure that resource allocation strategies are effective. These audits would assess service usage, waiting times, and whether the set goals for resource allocation are being achieved. Continuous monitoring and evaluation would allow adjustments as needed, ensuring that improvements in patient care and resource efficiency are maintained.

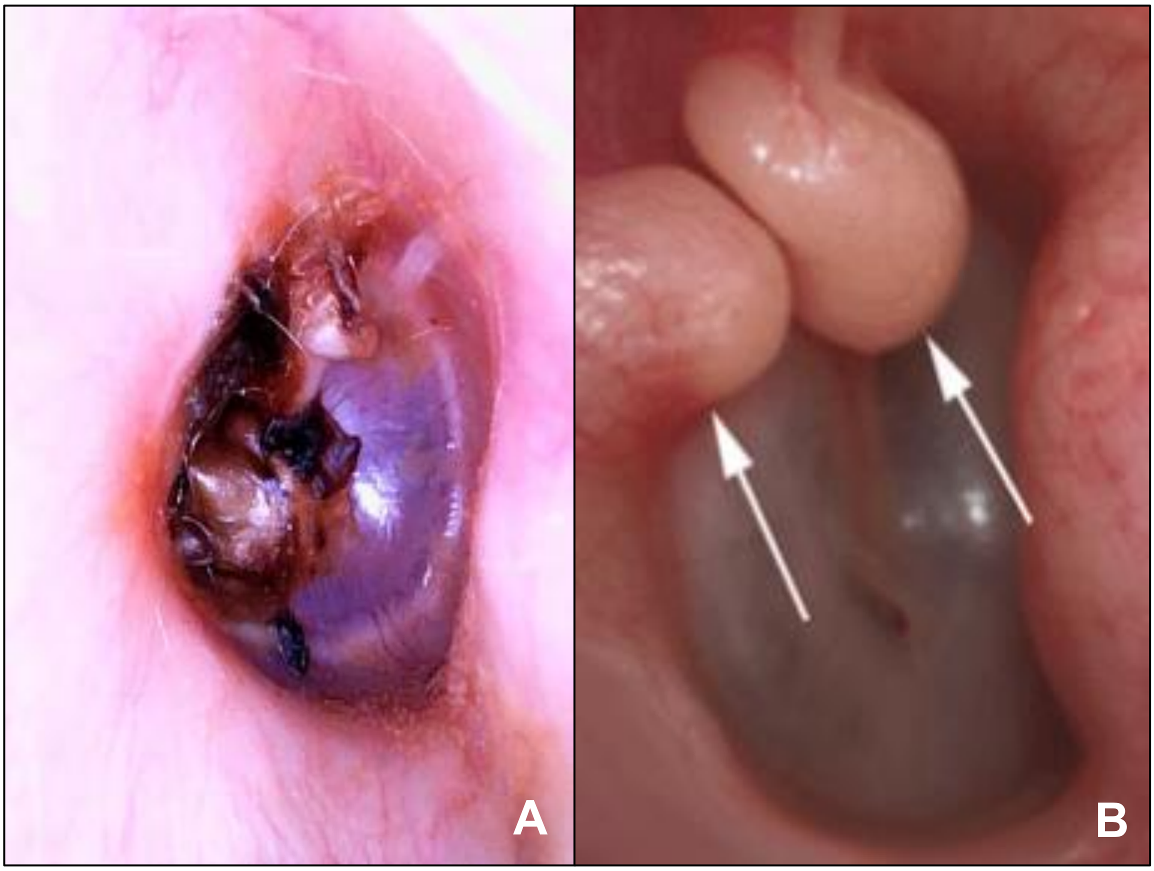

Figure 2. *A. Clinical photograph of a cholesteatoma, demonstrating the utility of such imaging in expediting urgent care.[24] B. Two external auditory canal exostoses (marked by arrows): clinical photography allows patients with this condition to be referred back to primary care in selected cases.[25]*

e. Allied Healthcare Professionals

Many ENT clinic referrals can be managed safely by allied healthcare professionals, such as audiologists, physiotherapists, and specialist ENT nurses. Specialist nurse-led clinics may reduce average waiting times by 70% and cut inappropriate referrals in half.[26] Additionally, involving healthcare professionals like dentists as the first point of contact for specific conditions helps identify red flags early, ensuring only those needing specialised ENT care are referred. These strategies streamline the referral process and further decrease waiting times.

In summary, we can reduce unnecessary referrals and optimise primary care by improving preventive care, enhancing GP education, and leveraging allied healthcare professionals. The next challenge is ensuring these referrals are managed efficiently through streamlined pathways.

3. Streamlining Referral Pathways

Referral pathway optimisation forms the second pillar of the three-pillar strategy to reduce ENT waiting lists. By improving the efficiency of patient flow, this pillar ensures that individuals receive timely care at the appropriate level, reducing bottlenecks in secondary care and freeing up resources for complex cases.

Direct-to-service referral pathways can significantly reduce ENT waiting times by allowing patients to bypass initial consultations and receive timely care from allied health professionals. This approach streamlines patient management, reduces the burden on ENT clinics, and ensures faster access to complex interventions.[27]

a. Direct to Audiology Clinic & Advanced Audiologists

Direct referrals to audiology clinics, especially for children, can notably decrease waiting times.[28,29] Advanced audiologists, when provided with additional training, can further expedite care by independently conducting diagnostic evaluations, facilitating quicker surgical decisions, and managing early discharge planning. This shortens waiting lists and maintains high levels of parent satisfaction,[30,31] showcasing the potential for audiology-led initiatives to handle a broader scope of otological cases effectively.

b. Acute Vestibular Assessment and Rehabilitation Clinic

Dizziness, which accounts for 2% of GP consultations and is prevalent in 30% of patients over 65,[32,33] presents a significant workload and potential for misreferrals. Direct referrals to a multidisciplinary balance disorder clinic can safely discharge half the patients, significantly easing outpatient waiting lists (Figure 3).[21]

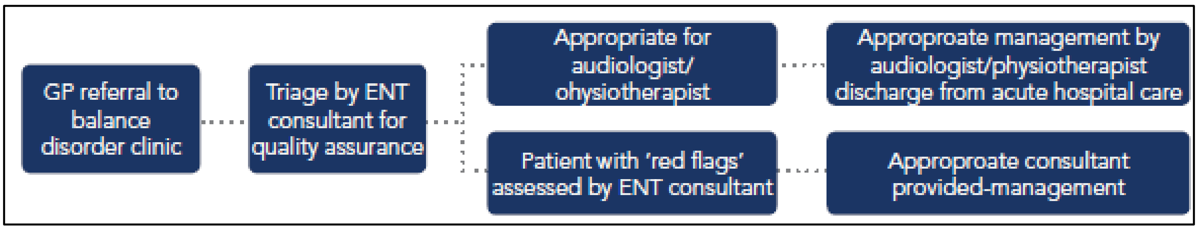

Figure 3. *An optimised specialist vestibular rehabilitation pathway*[21]

c. Rapid Direct Access to SLT

Speech and Language Therapy (SLT) teams equipped with Fibreoptic Endoscopic Evaluation of Swallowing (FEES) and videofluoroscopy can play a pivotal role in managing dysphagia. Direct referrals to SLT services enable prompt diagnosis and treatment, helping to prevent complications like aspiration pneumonia alongside shortening hospital stays and cutting waiting times.[21]

d. Paediatric ORL-HNS Clinic (for assessment of obstructive sleep apnoea)

Children awaiting tonsillectomy are among the largest groups on long-term surgical waiting lists, with many suffering from obstructive sleep apnoea. This condition can lead to severe cardiorespiratory and cognitive complications if untreated. Establishing dedicated paediatric otorhinolaryngology clinics with sufficient resources and personnel would streamline triage, prioritise cases with high medical urgency, and improve access to surgical interventions. These clinics could also support early interventions for milder cases, reducing the need for surgery and enhancing long-term outcomes.[21]

e. Direct Booking System for Tonsillectomy

Tonsillitis assessments account for approximately 20% of patients on ENT surgical waiting lists, often involving unnecessary initial consultations. Implementing a direct booking system for tonsillectomy based primarily on patient history and established clinical criteria could alleviate this workload efficiently and safely. This approach would free up valuable clinic time for more complex cases whilst ensuring that eligible patients proceed to surgery without delays (Figure 4).[21,34]

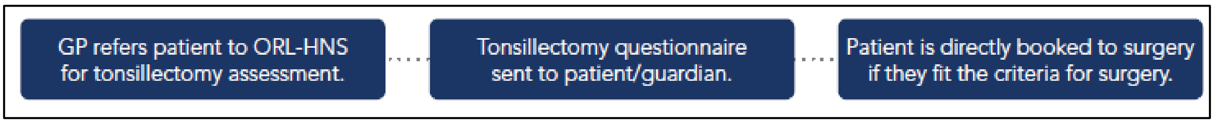

Figure 4. *A direct booking pathway for tonsillectomy[21]*

Whilst innovations in referral pathways address the initial stages of patient care, they must be complemented by strategies at the hospital level to maximise the overall efficiency of ENT services. The following section explores solutions to improve surgical throughput, reduce readmissions, and address workforce challenges.

4. At The Hospital

The third pillar of the strategy involves optimising in-hospital efficiency. This is critical to reducing ENT waiting lists by maximising surgical capacity, minimising delays, and addressing workforce challenges. These interventions can complement preventive care and referral pathway optimisation to ensure ENT departments deliver timely, high-quality care alongside alleviating systemic pressures.

i. Surgery

Consistent preoperative assessment is crucial to avoiding on-the-day cancellations, reducing costs and protecting theatre time.[21] By identifying and managing risk factors such as uncontrolled hypertension or poorly managed diabetes, these assessments help minimise perioperative complications and reduce the likelihood of readmissions,[35] supporting smoother surgical workflows.

A recent audit by the Royal College of Surgeons found that 69.4% of surgeries could be performed as elective day-cases,[36] highlighting a significant opportunity to streamline hospital operations. Expanding day-case procedures in ENT—such as tonsillectomies, septoplasties, and grommet insertions—can substantially increase surgical volume. For instance, tonsillectomies, a common ENT procedure, have proven safe and efficient as day-cases for well-selected patients.[37] Scaling up day-case capabilities not only reduces overnight bed occupancy but also generates significant financial savings, with an elective tonsillectomy overnight stay costing

FINANCIAL BENEFITS OF DAY CASE vs INPATIENT SURGERY OVER SIX MONTHS					
Procedure	Healthcare Resource Groups funding code	National average unit cost		Number of inpatient procedures	Day case savings
		Inpatient	Day case		
Insertion/removal of grommet	C01 (Ear procedures – category 1)	£820	£568	25	£6,300
Septoplasty/sub-mucous resection of septum	C22 (Nose procedures – category 3)	£979	£668	46	£14,306
Endoscopy	C24 (Mouth/throat procedures – category 3)	£889	£562	86	£28,122
Tonsillectomy	C24 (Mouth/throat procedures – category 3)	£889	£562	107	£34,989
				Total	£83,717

Figure 5. *The financial benefits of day case surgery are another significant reason to make the shift. Nearly £84,000 could have been saved on just these four procedures.*[38]

nearly £900 per patient (Figure 5).[38] This approach alleviates pressure on specialists and frees resources for emergency care, which continues to strain the system.[39]

To further enhance these efficiencies, dedicated surgical hubs offer an effective solution. These hubs act as centres of excellence for high-volume, low-complexity procedures like tonsillectomies and septoplasties, combining multidisciplinary teams under one roof to streamline workflows and reduce waiting times.[40] Recognising their value, the Labour government has allocated £1.5 billion to surgical hubs and scanners, aiming to deliver an additional 40,000 elective appointments annually.[41]

By integrating preoperative assessments, intraoperative care, and post-operative follow-ups, hubs enhance patient outcomes whilst minimising complications and readmissions. Crucially, separating elective care from emergency services safeguards productivity, shielding elective procedures from disruptions caused by hospital-wide pressures, such as COVID-19 surges or seasonal influenza.

In addition to improving service delivery, surgical hubs present a valuable opportunity to address workforce shortages by serving as advanced training centres. Concentrating surgical activities in hubs allows trainees to gain consistent, high-volume operative experience under the guidance of multidisciplinary experts, accelerating the development of key competencies. These centres could also incorporate simulation-based training and workshops on novel surgical techniques, fostering innovation and enhancing the surgical skillset across the workforce. By integrating education into their core function, surgical hubs not only improve current service efficiency but also ensure the long-term sustainability of ENT care.

ii. Reducing Readmissions & Follow-up

Effective post-operative care strategies are essential for minimising complications, reducing readmissions, and improving patient outcomes. Clear and concise patient education on surgical site management, wound hygiene, and recognising early signs of infection, such as redness, swelling, or fever, empowers patients to take an active role in their recovery alongside lowering the risk of complications.[21]

Incorporating telemedicine into routine follow-up care offers an innovative solution for monitoring recovery and addressing concerns. Virtual consultations, staffed by allied healthcare professionals, provide an accessible and convenient platform to identify complications early. This approach eliminates barriers such as travel, ensuring equitable access for patients in rural or underserved areas whilst maintaining high patient satisfaction.[42,43]

For procedures with predictable recovery trajectories, patient-initiated follow-up has demonstrated the potential to reduce healthcare workload without compromising outcomes.[44] This method fosters patient autonomy and trust, streamlining care by eliminating unnecessary routine follow-ups and enhancing overall satisfaction.

Timely communication between secondary and primary care is another crucial component of reducing readmissions. Ensuring GPs receive comprehensive discharge summaries enables optimal post-operative care in primary care settings, preventing avoidable hospital readmissions.

For cases requiring multiple follow-up visits, such as benign paroxysmal positional vertigo (BPPV), nurse-led clinics offer a cost-effective, patient-centred alternative.[45] Expanding these clinics to manage other common conditions—such as chronic rhinosinusitis or post-operative tympanoplasty care—could enhance efficiency and accessibility across ENT services. By integrating patient education, virtual consultations, and specialised follow-up clinics, ENT services can improve care delivery whilst optimising resource utilization.

iii. Workforce Planning

Effective workforce planning is essential to ensuring that there are enough trained professionals to meet rising patient demand. This is not the case currently, with ENT registrar numbers remaining stagnant since 2018 despite rising competition ratios.[3] Although the increase in ENT applicants is promising, without a corresponding increase in training posts there is a risk of creating a bottleneck that could deter future candidates. The CESR programme, which enables experienced doctors outside traditional UK training pathways to achieve specialist registration, [46] offers a vital solution to fill workforce gaps and also attracts internationally trained doctors who bring diverse expertise to the NHS.

Fostering positive training environments and departmental cultures is also crucial, especially given the high rates of burnout in surgical specialities, which are even more pronounced among trainees.[47] This issue is further exacerbated by reduced theatre lists and the impact of industrial actions, limiting surgical exposure. To address these challenges, departments should prioritise initiatives such as structured mentorship programs, protected time for education, and engaging trainees in discussions about resource allocation – fostering a sense of ownership and commitment to their professional growth.

The 2021 competency-based curriculum introduced by the Intercollegiate Surgical Curriculum Programme offers a potential solution, allowing training deaneries to explore alternative methods for accelerating operative development, such as simulation training with animal cadavers, 3D models, and advanced technologies like virtual simulations and augmented reality.[48]

Despite growth in the ENT consultant body, vacancies persist, and the rate of consultant expansion is not keeping pace with increasing demand.[3,49] A rising percentage of consultants nearing retirement alongside stagnant registrar numbers, threatens succession planning and the sustainability of the ENT workforce. To address the impending retirement wave feasible options might include flexible retirement options, phased transitions, and expanding pathways like CESR to enable experienced staff to enter consultant roles efficiently. Together, these measures would ensure a resilient, well-trained ENT workforce capable of meeting future healthcare demands.

5. Conclusion

The critical state of waiting lists in ENT services calls for urgent and decisive action. Without swift intervention, growing care delays will continue to jeopardise patient outcomes and overwhelm healthcare providers. This essay has outlined a three-pillar strategy to tackle these challenges: preventive care and education, referral pathway optimisation, and hospital-level efficiency.

Implementing robust preventive measures and enhancing education for medical students and GPs addresses the root causes of demand, whilst innovative tools like the "Advice & Guidance" scheme and direct referral pathways ensure streamlined patient management. These efforts must be complemented by hospital-level strategies, such as expanding day-case surgeries, leveraging surgical hubs, and addressing workforce shortages, to maximise surgical throughput and sustain long-term efficiency.

Addressing these challenges with urgency is not just a matter of efficiency — it is essential for preserving quality of care and ensuring timely access to treatment for all patients in need. By advancing this three-pillar strategy, ENT services can meet rising demands and prevent further patients from suffering the harm of delayed treatment. The time to act is now.

6. References

1. *Office for National Statistics. Waiting times for cancer treatment across the UK. 2024. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/waitingtimesforcancertreatmentacrosstheuk/2024-08-23. Accessed 23 August 2024.*
2. *Getting It Right First Time (GIRFT). ENT Workstream. 2024. Available from: https://gettingitrightfirsttime.co.uk/surgical_specialties/ent-workstream/. Accessed 23 August 2024.*
3. *Nieto H, Lee J, Hall C, McDermott AL. The Otolaryngology Consultant Workforce in England: A Survey Update and Future Repercussions. Clinical Otolaryngology. 2024;49(5):682-6.*
4. *Bhattacharjee R, Kheirandish-Gozal L, Spruyt K, Mitchell RB, Promchiarak J, Simakajornboon N, et al. Adenotonsillectomy outcomes in treatment of obstructive sleep apnea in children: a multicenter retrospective study. Am J Respir Crit Care Med. 2010;182(5):676-83.*
5. *Dayan GS, Bahig H, Johnson-Obaseki S, Eskander A, Hong X, Chandarana S, et al. Oncologic Significance of Therapeutic Delays in Patients With Oral Cavity Cancer. JAMA Otolaryngology–Head & Neck Surgery. 2023;149(11):961-9.*
6. *Cohen JT, Neumann PJ, Weinstein MC. Does preventive care save money? Health economics and the presidential candidates. N Engl J Med. 2008;358(7):661-3.*
7. *Johnston RS, Stafford J, Jongenelis MI, Shaw T, Samsa H, Costello E, et al. Evaluation of a public education campaign to support parents to reduce adolescent alcohol use. Drug Alcohol Rev. 2018;37(5):588-98.*
8. *Sheiham A, James WP. A reappraisal of the quantitative relationship between sugar intake and dental caries: the need for new criteria for developing goals for sugar intake. BMC Public Health. 2014;14:863.*
9. *Alghamdi FA, Jawmin BA, Alghamdi MA, Almalki MA, Sabbagh YH, Aljemyie AA, et al. Prevalence of Acute Tonsillitis and Its Association With Oral Hygiene Among the Population of Taif City, Saudi Arabia. Cureus. 2024;16(3):e55801.*
10. *Rudmik L, Soler ZM. Medical Therapies for Adult Chronic Sinusitis: A Systematic Review. JAMA. 2015;314(9):926-39.*
11. *Stein DJ, Noordzij JP. Incidence of chronic laryngitis. Ann Otol Rhinol Laryngol. 2013;122(12):771-4.*
12. *Khalifeh M, Ginex P, Boffetta P. Reduction of head and neck cancer risk following smoking cessation: a systematic review and meta-analysis. BMJ Open. 2024;14(8):e074723.*
13. *Hersi M, Beck A, Hamel C, Esmaeilisaraji L, Pussegoda K, Austin B, et al. Effectiveness of smoking cessation interventions among adults: an overview of systematic reviews. Systematic Reviews. 2024;13(1):179.*
14. *Norhayati MN, Ho JJ, Azman MY. Influenza vaccines for preventing acute otitis media in infants and children. Cochrane Database of Systematic Reviews. 2017(10).*
15. *Marchisio P, Cavagna R, Maspes B, Gironi S, Esposito S, Lambertini L, et al. Efficacy of Intranasal Virosomal Influenza Vaccine in the Prevention of Recurrent Acute Otitis Media in Children. Clinical Infectious Diseases. 2002;35(2):168-74.*
16. *Pulse Today Editorial Team. How do UK medical school places translate to fully trained GPs? 2023. Available from: https://www.pulsetoday.co.uk/analysis/pulse-on-*

workforce/how-do-uk-medical-school-places-translate-to-fully-trained-gps/. Accessed August 25, 2024.

17. *Griffiths E. Incidence of ENT problems in general practice. J R Soc Med. 1979;72(10):740-2.*
18. *Donnelly MJ, Quraishi MS, McShane DP. ENT and general practice: a study of paediatric ENT problems seen in general practice and recommendations for general practitioner training in ENT in Ireland. Ir J Med Sci. 1995;164(3):209-11.*
19. *Wilson T, Roland M, Ham C. The contribution of general practice and the general practitioner to NHS patients. J R Soc Med. 2006;99(1):24-8.*
20. *Clamp PJ, Gunasekaran S, Pothier DD, Saunders MW. ENT in general practice: training, experience, and referral rates. J Laryngol Otol. 2007;121(6):580-3.*
21. *National Clinical Programme in Surgery (NCPS). Otolaryngology, Head and Neck Surgery: A Model of Care for Ireland. 2019.*
22. *NHS Digital. Advice and Guidance Overview for the NHS e-Referral Service (e-RS): NHS Digital; 2024. Available from: https://digital.nhs.uk/services/e-referral-service/document-library/advice-and-guidance-overview [updated June 18, 2024].*
23. *West B, Bennett JA, Deegan PC, Merry P, Watson L, Jones NS, et al. Reducing waiting times for sleep apnoea hypopnoea syndrome and snoring using a questionnaire and home oximetry: results of a second audit cycle. J Laryngol Otol. 2001;115(8):645-7.*
24. *Evans V, Llewellyn C, Clarke J. The use of clinical photography to aid in the triage of ENT patient referrals. Journal of Visual Communication in Medicine. 2023;46(3):143-6.*
25. *Adamo DA, Fender QA, Hyde B, Carlson M, Koeller K, Lane J. A Pictorial Essay of Middle Ear Pathology Correlating Temporal Bone CT and MRI with Archived Otoscopic Photographs. Neurographics. 2017;7:76-87.*
26. *Smyth C, Moran M, Diver C, Hampton S. Rapid access rather than open access leads to improved effectiveness of an ENT emergency clinic. BMJ Qual Improv Rep. 2013;2(1).*
27. *Payten CL, Eakin J, Smith T, Stewart V, Madill CJ, Weir KA. Outcomes of a multidisciplinary Ear, Nose and Throat Allied Health Primary Contact outpatient assessment service. Clin Otolaryngol. 2020;45(6):904-13.*
28. *Hall AE, Brandenburg C, Ward EC, Pokorny MA, Trafford K, Seabrook M, et al. Evaluation of health service outcomes for an audiology first point of contact retrocochlear clinic: a 6-year retrospective cohort study. International Journal of Audiology. 2023;62(7):617-25.*
29. *Katiri R, Sivan N, Noone A, Farrell E, McLoughlin L, Lang B, et al. Outcomes from 7 years of a direct to audiology referral pathway. Irish Journal of Medical Science (1971 -). 2023;192(3):1341-7.*
30. *Pokorny MA, Thorne PR, Whitfield BC, Lee AC, Wilson WJ. Can an advanced audiology-led service reduce waiting times for paediatric ear nose and throat outpatient services? J Paediatr Child Health. 2021;57(2):268-72.*
31. *Pokorny MA, Thorne PR, Lee AC, Whitfield BCS, Wilson WJ. Parental satisfaction with an advanced audiology-led triage service in paediatric ENT outpatient clinics. Int J Audiol. 2022;61(2):159-65.*
32. *Sloane P, Blazer D, George LK. Dizziness in a community elderly population. J Am Geriatr Soc. 1989;37(2):101-8.*
33. *Colledge NR, Wilson JA, Macintyre CC, MacLennan WJ. The prevalence and characteristics of dizziness in an elderly community. Age Ageing. 1994;23(2):117-20.*
34. *National Health Service in Scotland, Scottish Intercollegiate Guidelines Network. Management of sore throat and indications for tonsillectomy: a national clinical guideline*

[Internet]. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2010 Apr. Available from: http://resource.nlm.nih.gov/101609287
35. *Kuiper BI, Janssen LMJ, Versteeg KS, ten Tusscher BL, van der Spoel JI, Lubbers WD, et al. Does preoperative multidisciplinary team assessment of high-risk patients improve the safety and outcomes of patients undergoing surgery? BMC Anesthesiology. 2024;24(1):9.*
36. *The Royal College of Surgeons. ENT Waiting Lists. 2024. Available from: https://www.entuk.org/news_and_events/news/351/ent_waiting_lists. Accessed August 23, 2024.*
37. *O'Riordan I, Garry S, Wauchope J, Lehane H, Mitchell M, Heffernan C, et al. The Successful Implementation of Day Case Tonsillectomy. Ir Med J. 2022;115(1):518.*
38. *Bhutta M. Adult ENT day surgery: A case for expansion of services. Bulletin of The Royal College of Surgeons of England. 2006;88:314-7.*
39. *Bleach NR, Williamson PA, Mady SM. Emergency workload in otolaryngology. Ann R Coll Surg Engl. 1994;76(5):335-8.*
40. *Department of Health and Social Care. Over 50 new surgical hubs set to open across England to help bust the COVID-19 backlogs [press release]. UK Government, 26 August 2022.*
41. HM Treasury. *New funding to kickstart delivery of two million extra NHS appointments [press release]. UK Government, 28 October 2024.*
42. *Kruse CS, Krowski N, Rodriguez B, Tran L, Vela J, Brooks M. Telehealth and patient satisfaction: a systematic review and narrative analysis. BMJ Open. 2017;7(8):e016242*
43. *Klee D, Pyne D, Kroll J, James W, Hirko KA. Rural patient and provider perceptions of telehealth implemented during the COVID-19 pandemic. BMC Health Services Research. 2023;23(1):981.*
44. *Taneja A, Su'a B, Hill AG. Efficacy of patient-initiated follow-up clinics in secondary care: a systematic review. Intern Med J. 2014;44(12a):1156-60.*
45. *Reddy VM, Sargent HM, Prior M. Benign paroxysmal positional vertigo nurse-led follow-up clinic. European Archives of Oto-Rhino-Laryngology. 2011;268:829-32.*
46. *Willis D. CESR: a guide to survival. BMJ. 2013;346:f1228.*
47. *Balendran B, Bath MF, Awopetu AI, Kreckler SM. Burnout within UK surgical specialties: a systematic review. Ann R Coll Surg Engl. 2021;103(7):464-70.*
48. *Intercollegiate Surgical Curriculum Programme (ISCP). About the Surgical Curriculum from August 2021. 2021. Available from: https://www.iscp.ac.uk/iscp/surgical-curriculum-from-august-2021/about-the-surgical-curriculum/. Accessed August 25, 2024.*
49. *Wilmot VV, Davis JP, Carrie S. National ENT workforce planning in the United Kingdom; An increasing cause for concern? Clin Otolaryngol. 2019;44(3):213-8.*