Mr. Brian Bingham  
*President, ENT UK*

**From the President’s Desk**

The ENT UK autumn meeting in London was excellent. We had a great mix of speakers, achieving our aim of producing a meeting with something to interest most in our eclectic mix of subspecialties. The standard of presentation was very high with one the most appreciated being the contribution by Peter Rhys Evans with a Horizon-like, anthropology based lecture of the ear nose and throat.

If you missed that meeting then the next eclectic mixture meeting is the Spring ENT UK meeting at York racecourse on 23rd March 2018. We have spaces for only 140, so you may have to book early. There will be research presentations from BOARS (our ENT research society). Andy Marshall will give an update and presentation on GIRFT (getting it right first time). Indications for septoplasty and day case opening hours may figure. Incidentally, no-one in ENT came up with the acronym GIRFT!

The AGM with update on CQC and the preliminary thoughts from a working party on revalidation needs for ENT surgeons. After lunch we learn about emotional resilience for ENT surgeons followed by a lecture on burnout by the excellent Prof. John Macfie, immediate past president of the Federation of Surgical Specialty Associations.

Our own Paul Spraggs, from the SAC in ENT, will explain the new GMC standards that are due to come into play in 2018. These new GMC standards have significant implications for both trainees and trainers. For those among us who are challenged by difficult airway problems then the late afternoon sessions are perfect. Firstly we look at strategies of airway management and support and then we consider the history of FONA, cricothyroidotomy and our place in their training and delivery.

This autumn the Confederation of British Surgery came into being. This is a trade union and it will be able to negotiate with employers in similar way to the BMA. At present the articles of association are being written.
As a member of ENT UK, through the Federation of Surgical Specialties, you should have access to this trade union. The Confederation of British Surgery may have a significant role to play in future contract negotiations particularly if weekend working/7 day working is the political negotiating chip!

On your behalf, I recently attended a joint colleges surgical forum on junior doctor morale. Most of the answers to this problem are reasonably well known, but getting them into practice seems to be difficult! The answers are that the on call rota should be provided at least 2 months in advance; time off for a wedding or similar event being confirmed by managers at many months notice; re-introduce the hospital mess; a rest bed available before having to drive home after an all night shift; a good team system where both juniors and consultants communicate. There is a document on our ENT UK website going into the morale factors and their amelioration in better detail.

This autumn was the last Intercollegiate Fellowship Examination for John Hill as Chairman of the intercollegiate board of Otolaryngology. John has led our examination process extremely well over the last three years. Quentin Gardiner follows as chairman and we wish him well for the next three years.

I also called my time on the intercollegiate examination process. For the last three years I have been an assessor of the fellowship examiners and their exams! This has involved me attending other surgical specialty examinations. The experience of other examinations has given me a perspective on our own exam and its potential shortcomings. The standard of examination in Otolaryngology is extremely high, and our group of examiners have to be congratulated. It is extremely stressful to sit the intercollegiate examination but our examiners make tremendous efforts to deliver a fair, repeatable and valid examination. We also, have a commendably diverse group of examiners compared to other surgical specialties although undoubtedly Quentin will push our diversity further in the next three years. I include a photograph of our examiners attending John Hill's thank you dinner.

In November I held a meeting with representatives/presidents of the sub-specialty associations to help with the smooth running between the different organisations. This meeting went well and is planned to be an annual event. In 2018 there may be a similar ENT UK type meeting with representatives of the devolved nations to facilitate co-operation and communication. This proposed meeting, however, will not happen during the 6 nations rugby.

The standards CQC survey is currently with CQC organisation for their views and their revision. Thank you to all the sub-specialists and individuals who contributed to the creation of the document. Hopefully the CQC survey will go live in early 2018 and be delivered to all NHS employers in England via survey monkey. We have a number of individuals poised to become CQC inspectors. If the CQC survey process is successful then I will ask the devolved nations if they would also like to participate.

Wishing you all a happy festive season.
Specialist Advisory Committee Update

The SAC has made significant progress over the summer. We have completed a major curriculum review which is in the final stages of submission. Within the specialty the main change will be defining a number of special interest areas. It has long been the case that trainees are expected to demonstrate an area of special interest when applying for certification, and this is assessed at their final ARCP. However, the definition of a special interest area has been left to the discretion of the assessors without any detailed benchmarking. Paul Spraggs, as Curriculum Lead, has led the development of six special interest areas: Otology, Head and Neck, Advanced Rhinology, Laryngology, Thyroid and Parathyroid, and Paediatric Otolaryngology. It is anticipated the new curriculum will start in 2018, but for the first 1-2 years senior trainees will follow the current curriculum. The other significant change across all surgical specialties within the curriculum is the assessment of nine Capabilities in Practice covering diverse areas of practice including the ability to supervise and manage a ward round, outpatient clinic or undertake research. These skills required for consultant practice will be taught and assessed.

The run through pilot project has advanced. I am optimistic that the first applications to this run through pilot will take place at the end of this year with ST1 trainees in Otolaryngology starting in August or October 2018. There have been a number of approvals and hurdles, but we remain on track to deliver the pilot programme in 2018. We believe that there will be significant advantages to trainees in following a run through programme at a time when surgical recruitment is less competitive than it used to be. We need to attract the best young surgeons to our specialty. At the time of writing it is likely that places will be available in NW, Yorkshire and Humber, West Midlands, London and KSS LETB’s.

All Specialty Registrar posts need to comply with the JCST quality indicators (QIs). These have been updated to include the need for a daily consultant-led board or ward round to cover emergencies, and can be found here. Please work with hospital management teams to ensure that StR training posts meet these QIs. Where a post does not meet the required standard, our liaison members and training programme directors have been asked to flag these to the SAC so that we can liaise to help units meet the training requirements. The ward or board rounds issue is one of patient safety; ENT has long been seen as an outlier with regard to consultant led ward rounds in the GMC survey.

All trainers at Educational Supervisor level and above now need to be recognised by the GMC. Some trusts have been very careful to implement this new requirement, but others are not so far advanced. Further information can be found on the GMC website here. Individual deaneries and LETBs will have slightly differing criteria for recognising a surgeon as an educational trainer. However, if you are acting as an Educational Supervisor or more senior, it is essential that you are recognised by the GMC. If you are not certain whether you have this recognition, please talk to your Director of Medical Education or equivalent, who should be able to advise you.

Finally, I would like to thank the very hard working members of the SAC and the training programme directors for delivering excellent ENT training. It is essential we continue to support and encourage trainees at all levels to join our profession. I would like to say a special thank you to Andrew Robson for his work with medical students as Director of Education for ENT UK, encouraging individuals at this early stage to view the specialty as an ideal career pathway.
Mr. Andrew Robson  
*Director of Education, ENT UK*

**Education and Training Update**

The education directorate have had a busy few months. Here, I will expand on areas that may interest the readership and are worth publicising.

**Student and Foundation Doctors Group (SFOUK)**

This is a really important group, arguably the most important within the umbrella of ENT UK. Its aim is to disseminate information about ENT as a career to medical students and foundation doctors so that we can encourage as many people into ENT as possible. This is particularly relevant now that we are piloting run through training so the more good students know about ENT early on the better. Jay Doshi is chair of the group and is doing a fantastic job leading a vibrant committee that includes student and junior doctor reps. They ran a successful annual meeting in Birmingham that attracted 83 delegates with excellent feedback, and have sent representatives to careers fairs at universities.

**What can you do to help?** Most members have contact with students and foundation doctors. Make ENT into an attractive career by welcoming them, act as a good role model and show them what an interesting speciality it is. Offer an SSC. If you hear about careers fairs, surgical society meetings, offer to speak, or let Jay and his team know, someone may be able to attend. Leaflets on ENT as a career are available from ENT UK, as are various ‘freebies’ and a pop up stand.

**Emergency Skills for Consultants Course (ESSC)**

We have now run two pilot courses, in Manchester and Bristol, for Consultants and SAS doctors who cover emergencies whilst on call. This is a blended course with case based scenarios and cadaveric dissection to update ENT surgeons in the management of ENT emergencies. A total of 34 delegates attended the course and provided excellent feedback, increasing their confidence in the surgical and non surgical management of common emergencies. We will be developing pre-course material and aiming to run more such one-day courses around the country as part of ENT UK’s commitment to providing resources to help ENT surgeons remain emergency safe and provide robust evidence to support this at appraisal. Lectures will be available on elefENT. There is a cadaveric session dedicated to ENT emergency management at BACO in 2018. Philip Clamp from Bristol is leading the development of related material. This is another tangible benefit of membership of ENTUK.

**Webinars**

In conjunction with RCSEd, ENT UK is organising a series of webinars in 2018 with an emergency theme. This will be suitable for Consultants, SAS doctors and trainees, and will be one hour lectures beamed out in the evening. We have some excellent speakers and chairs moderating questions submitted during the course of the talk. The topics are Blunt and penetrating neck trauma, Laryngeal and pharyngeal trauma, Airway emergencies, Epistaxis, Complications of Rhinosinusitis, Sudden sensorineural hearing loss and facial palsy, Complications of Otitis Media, Paediatric Airway emergencies, Non accidental injury in the Head and Neck.

These will be advertised through ENT UK and RCSEd. The plan is for these webinars to be archived for ENT UK members on elefENT, and for RCSEd members on the college website. This is another way of demonstrating evidence of updating oneself on emergency competencies.
Run Through Pilot in Otolaryngology

Run through training is a programme whereby trainees appointed to ST1 posts in the specialty will continue through to ST8 and certification without further competitive interview or recruitment processes, provided they meet the requirements of the programme and curriculum. This includes meeting examination and other requirements which are similar to the current training pathway. Trainees who have decided early in their training that they wish to pursue a career in Otolaryngology may benefit from the opportunity to undertake run through training because there will be assurance that the trainee will receive all their training in a defined programme and therefore geographical location; assurance that the posts offered in the first two years (ST1 and ST2) are likely to be particularly suitable to a future ENT surgeon, and assurance that subject to satisfactory progress, the trainee will be successful in pursuing a career in ENT, allowing early engagement with ENT UK and the various subspecialty ENT organisations, gaining access to the learning resources these organisations provide.

In the first year the run through pilot programmes will be offered as an option within national core recruitment. Several LETB’s have agreed to take part, with a good geographical distribution in England. There are no current plans for programmes outside England, but that may change in the future. In the LETB’s that will offer these posts there will be a “mixed economy” in that the posts will run in parallel with core training posts. The number of posts in each LETB will be approximately half of the core posts in otolaryngology. The posts will come under the purview of the Core Training Programme Director but we hope to have early years leads who are ENT surgeons to support these trainees in each LETB. The GMC has approved these posts and programmes on condition that they are evaluated closely and this pilot will run for 3 years, in the first instance.

Tony Narula
Past President, ENT UK

MediX: A new development for Surgeons

We surgeons tend to be asset rich but time poor. The majority of us buy our day to day household and general insurance policies on an individual basis and thus fail to take advantage of the considerable buying power inherent in the fact that there are more than 10,000 of us in the UK. This is a significant lost opportunity from which we could all benefit. There already exist some modest broker-organised insurance schemes for surgeons, mainly offering medical indemnity rather than personal insurance, which demonstrate that the concept of buying power in insurance is not new and can be successful. However, although notionally constructed for the benefit of surgeons, these schemes are commercial enterprises mainly benefitting brokers rather than the surgeons they are supposed to serve. With the support of the FSSA (Federation of Surgical Specialty Associations) a new company, MediX Cover Limited has been launched. The opportunity is being taken to
create an offering/organisation for surgeons from all of the ten specialty associations and other related medical professionals. The offering is spearheaded by three past and present specialty association Presidents, of whom I am one, and will be designed specifically with our needs in mind and priced on attractive terms, thus providing us with greater control and convenience in our insurance spend. By acting together, we can collectively achieve better outcomes than would be available to us as individuals.

FINANCIAL BENEFITS:

When we operate together, a collection of people such as ourselves has valuable characteristics:

Affinity group: to use insurance parlance, surgeons are a valuable affinity group. We share characteristics, meaning behaviour prediction is relatively easy. Our policies can be priced easily and more cheaply by the insurance companies. This is especially the case when we subscribe together to a specially tailored scheme.

HNW: we surgeons are high net worth individuals, and our demographic is known to deliver fewer claims and better loss ratios than the general public, a phenomenon which can be factored in to the premium negotiations.

Scale: the addition of family members and the potential for “bundled” coverage of more than one policy (e.g. home + car + disability + travel) would generate greater volume and allow the savings to be even greater.

Low churn: members trust their own organisations to deliver fair value and tend not to shop around. Insurers value loyalty and if asked, will reduce premiums for repeat customers. Long term policyholders have the best chance of keeping premiums down if they work in concert through an enthusiastic and knowledgeable intermediary.

Taken together, these characteristics represent a real opportunity to look for lower premiums in our insurance policies. Medix will enable surgeons to unlock the considerable value contained within the volume of insurance premiums we pay every year.

COVERAGE BENEFITS:

Medix will be managed with the interests of surgeons in mind, and thus will be able to determine what coverage is most appropriate for us in the policies it designs. This means that over time policies can be made more and more bespoke to our needs as surgeons, individually and collectively. For example:

- Many of us are lucky enough to own multiple homes, which we guard carefully
- Even more of us own multiple vehicles, but we are usually careful drivers
- We travel frequently, on business and holiday
- We have specialist personal needs, e.g. protection against injury to hands and eyes
- Some of us have specialist business needs e.g. to insure premises and employees

CONVENIENCE BENEFITS:

MediX will design policies to offer solutions that are not available from standard insurers and which individual surgeons might not think to ask for individually. A MediX policy may also make life easier in other ways, for example, by replacing the burden of multiple annual renewal dates with a single policy covering all of our risks on a continuous monthly basis.

CURRENT STATUS:

The company has been registered and I am included among its directors. We are working with an independent advisory firm, Resolution Partners, and are well on the way to selecting an insurance broking partner who will orchestrate the technical aspects of MediX activities. The intention is to launch the first insurance product in early 2018. MediX expects to provide policies with an attractive balance between the premium paid, the covers offered and the attitude of the insurer to pay out claims. A small amount of the money saved will also be returned to our Association to our mutual benefit. I look forward to updating you all in the New Year. But in the interim I would be delighted to hear from any member who wishes to have more information at this stage.
Arnold Maran came from Italian stock, retained a southern European temperament, and had outstanding energy and drive, tending to find routine boring. He made his mark nationally and internationally on several aspects of otolaryngology and in surgical affairs. He graduated from Edinburgh University in 1959, and carried out junior hospital appointments in the Royal Infirmary of that city. He obtained his FRCSEd in 1963 and MD with a thesis about vestibular function in 1967. He then spent a year at the University of Iowa learning head and neck surgery. On his return to this country, he was appointed to a consultant post in Dundee for a few years before returning to Edinburgh with a special interest in head and neck oncology.

In collaboration with Professor Philip Stell of Liverpool, the Stell and Maran courses and textbook on head and neck surgery became extremely popular and highly esteemed. In the 1980’s Arnold’s interests moved on to endoscopic sinus surgery and in the 1990’s to the pathology and treatment of voice disorders. Arnold was always creative academically, publishing many papers and editing several textbooks. He was a clear and concise teacher and attracted many international post graduate students to the department. He was appointed to a personal chair in otolaryngology in 1988. Simultaneously he became deeply involved in the affairs of the Royal College of Surgeons of Edinburgh serving consecutively as treasurer, secretary and finally in 1997 as president. After such an outstanding career he received honorary fellowships from several colleges of Surgeons, was the president of the laryngology section of the Royal Society of Medicine and was particularly proud of a D.Sc from the University of Hong Kong. Outside medicine and in his retirement, Arnold played golf and was a curler, he was a popular after-dinner speaker, and wrote books on such diverse subjects as the mafia, the singing voice and golfing at the North Pole. He was both knowledgeable about opera and played in several jazz bands.

Dr Bryan Dale

Professor Maran enjoying his 80th birthday with colleagues, June 2016 (photos thanks to Mr. James Patience)
The National Epistaxis Audit has been developed to address priorities identified by the British Rhinological Society (BRS), ENT trainees and patients. The aim of this ENT UK sponsored audit was to improve outcomes for patients with epistaxis by standardising care and enhancing the evidence-base for managing this common condition.

**INTEGRATE WEBSITE**

The audit has been developed by INTEGRATE (the National ENT Trainee Research Network), a trainee-led initiative created to promote regional collaborative research and deliver an annual research or audit project of national significance.

Epistaxis is the most common acute disorder managed by ENT services in the UK, with over 25,000 acute presentations to NHS hospitals every year. Despite this high incidence, prior to this initiative there were no nationally accepted guidelines for its management, with significant variation in existing treatment between hospital trusts. A national consensus event took place in May 2016, where trainee-generated, systematic reviews of the literature were considered by an expert panel to form consensus statements on the optimal management of epistaxis. These statements then formed the standards for the subsequent national audit.

Prospective data collection for the first 30-day audit cycle is now complete with 113 sites across England, Wales, Scotland and Northern Ireland submitting data on over 1826 cases to our secure online data collection system. The systematic reviews, national management guideline and audit findings will be published this month (December) in a dedicated edition of the Journal of Laryngology and Otology.

Mr Richard Williams
Chair, INTEGRATE