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From the Presidents desk

The sin of (C)ommission

I thought a few words on commissioning would not go amiss as this process is upon us for better or worse, albeit beset with confusion and accusations of conflict of interest at primary care level.

There are essentially two main areas at present: general commissioning for ENT and speciality commissioning for conditions and procedures which may cross several specialities. There have been a number of meetings on general commissioning, notably a multi-professional one held last week facilitated by the Royal College of Surgeons of England. Each speciality has been asked to identify 3 main areas for consideration in the first instance and for ENT we have chosen otitis media in children, rhinosinusitis and tonsillitis. Andrew McCombe elaborates on this in his piece later in this newsletter.

As clinicians it appears we are not to be trusted with the literature search of evidence and this is being done, presumably at some expense, by an external commercial organisation. This means that several wheels are being reinvented and even when thorough up-to-date evidence based reviews are available, unless they absolutely follow the dictated review process, they risk being rejected! Even when this process is completely adhered to, it is clear that commissioners may reject the advice given, although this can apparently be challenged by those sufficiently motivated to negotiate the byzantine complexity of the process. After all, this is about money and as there is a general perception in primary care that no-one ever died of a chronic ENT problem, why bother to pay for it!

Even more alarming in some ways was the rapid evolution of speciality commissioning which did not come on my radar until late last year. This applies to national commissioning for conditions or procedures, which occur <500 times/year. Five programmes of care had been created which covered 59 Clinical Reference Groups and was underpinned by several substantial guidance documents. However, it was immediately apparent that ENT per se had rather dropped out of the system although it was represented by specialised ear surgery, head and neck cancer and if one delved deeper, specialised ENT for children and cleft lip and palate. This meant that specialised benign rhinology and laryngology potentially had no input and I had a spirited email exchange early this year with James Palmer, a neurosurgeon in Plymouth who had just been appointed as the Chairman for Specialised Commissioning. We subsequently met with him in February and he has acknowledged this anomaly and offered to address in the next scoping
The latest DH guidance in decontamination of flexible endoscopes

Several years ago we were all being told that there would be an epidemic in progressive incurable neurodegenerative disease caused by prions that we had all been exposed to in the food chain. This potential risk had to be taken very seriously and disposable instruments were deemed essential for tonsillectomy. In addition to this, Infection Control teams were formed within hospitals to control MRSA and *C. difficile* infection within hospitals. It was not long before the focus of attention turned to the decontamination of flexible endoscopes and the British Gastroenterology...
Society were instrumental in the development of how this should be done. At the time, flexible endoscopes in ENT were being cleaned within the clinics with methods that included soap and water, alcohol wipes, immersion in fluids such as glutaraldehyde and chlorine dioxide wipes. Non of these methods complied with the more stringent gastroenterology guidelines, but little attention was given to the fact that most of our endoscopes differed from those in gastroenterology in that they did not have biopsy channels. However, microbiologists at the time were very much in the public view and their priority was to minimize all potential risk.

In 2005, ENT UK published its own guideline document that included advice and approval from a microbiologist who was a main DH advisors on infection control. One of the points of advice was to send the endoscopes for central decontamination after 3 hours: the time limit was suggested as sensible guidance simply because it was assumed that a clinic would last 3 hours: it was never intended to become a rigid cut-off that prevented an endoscope from being used safely once the time limit had expired.

As time went on, the drive for central decontamination increased and many of us became fearful of our clinical practice being severely disrupted. A revised endoscope decontamination document was therefore published in 2010, but attracted quite a lot of criticism because it did not include ‘stakeholders’ from microbiology: it was therefore not accepted by many Infection Control teams. However, this document did outline various models of decontamination practice together with the consequences and costs of each model.

A national survey on endoscope decontamination then took place that received a massive response, indicating the importance that this subject has to our clinical practice. The survey showed that many of us were still using the chlorine dioxide wipe system in clinic, although a good proportion had already gone over to central decontamination with automated endoscope washers. One of the key questions designed to assess the level of risk was whether each surgeon had any knowledge of harm being caused by cross contamination with an endoscope. From 475 responses, there were 13 positive responses to this question (3%) and most referred to cross contamination by MRSA. However, 97% ENT surgeons had no knowledge of any episode of cross contamination by a flexible endoscope.

In 2012, ENT UK were asked to review an official document on decontamination of flexible endoscopes prior to its final publication, and although we did not believe that we would have much impact in the final version of this publication, we offered our advice. This publication is now complete and available, and amazingly contains an individual section on decontamination guidance for flexible endoscopes in ENT practice. **The key points within this document are that decontamination by wipe systems is acceptable although an endoscope washing device (EWD) is considered best practice; expensive special drying cabinets are no longer required but a simple cabinet that can be easily cleaned is acceptable; the 3 hour expiry time limit is no longer applicable and there is no longer a time limit beyond which the endoscope has to be sent for central decontamination.**

The latter guidance offers very sensible and practical advice that will no longer threaten ENT outpatient and emergency services. Sadly, this has almost come too late for many hospitals that have already adopted the central decontamination model with the high expense of having to purchase many new endoscopes, drying cabinets and endoscope washing devices.

Latest CFPP Publication

Derek Skinner  
ENT UK Director of Education

Report on the first Paediatric ENT Skills Course for consultants and non trainees

This course took place at the new Skill Centre at the Royal Albert Edward Infirmary, Wigan on 8th February 2013 and was conceived as a response to concerns over diminishing skills with paediatric endoscopy in non-specialist centres.

The course was a one-day event designed specifically to take a structured approach to the recognition of the seriously ill child where a methodology of rapid and structured clinical assessment was used to identify and treat acute paediatric airway problems including stridor and post-operative haemorrhage. The course included 16 delegates with a significant number of observers from other centres where similar courses using a similar methodology could take place. The teaching faculty included paediatric anaesthetists and paediatric otolaryngologists with a strong educational background.

The main topics covered included paediatric haemorrhagic shock, paediatric acute airway obstruction, paediatric tracheostomy and recognition of the seriously ill child. This was covered in short 20 minute tutorials, short lectures and four simulation stations using Storz paediatric endoscopy equipment and various sophisticated computerised mannequins. A high level of supervision and support was provided by the faculty. A further area covered, which was of significant benefit, included a short e-learning unit which was web-based, and included the human factors (or failings) involved with team working in acutely stressful tasks. For example, presentation of a young child with severe stridor. This allowed an objective insight into errors which can occur whilst concentrating on certain tasks when working as a team.

Overall, this was undoubtedly one of the best organised and the most educationally useful courses that many of us had undertaken as consultants. Although much of our knowledge and skills may be intact at the time of starting as a consultant, if these particular emergency-based skills are not used on a regular basis, then considerable degradation of knowledge occurs, often without much insight. This course undoubtedly addressed these issues and clearly there is a place for this course within the area of maintaining core emergency skills for consultant and non-trainee ENT staff, particularly where patients present to a relatively non-specialist paediatric ENT unit.

Several centres have now shown strong desire to help with this type of course, including Glasgow, Newcastle, Southampton, London, Bristol, Manchester and Birmingham and it is expected that later this year, these courses will take place. It is likely that these courses will take a very similar methodology to the most recent course, indeed a faculty building process is being undertaken, such that course material and course methodology/strategies are maintained and shared between the venues. Considerable thanks must go to the local organisers including Professor Nirmal Kumar, Professor Ralph McKinnon, Mr Michael Rothera and Mr Iain Bruce as well as other members of the paediatric ENT and anaesthesia network throughout the UK. ENT UK is very supportive of this activity as undoubtedly this will aid maintenance of consultant skills in the emergency environment, proof of which is required for appraisal and revalidation.

Please look out for further similar courses, which will appear in the next few months and should be well advertised through the ENT UK network.
The e-lefENT Project – 2013 update

In late 2008, ENT UK entered into a collaboration with the Department of Health’s “E-learning for Healthcare Strategy” to work on the e-lefENT project, a structured self-directed e-learning strategy for otolaryngology. This strategy was born out of the need for a solution for our trainees given the constraints of the European Working Time Directive (EWTD) and the introduction of Modernising Medical Careers (MMC) agenda. Its aim was to provide a web-based interactive training resource as part of a blended strategy designed and based on the ISCP Curriculum and ensuring national consistency of training standards. Unfortunately, the Department of Health withdrew its financial support in 2011 when the magnitude of the national debt became apparent, but out of the ashes the project has arisen Phoenix-like with the financial support of ENT UK. Its development is now a cornerstone of ENT UK policy and, following its launch at BACO 2012, we hope that it will be complete towards the end of this year.

The project is lead by Victoria Ward & Professor Richard Ramsden. We have over 275 active participants and hope to encourage and promote lifelong learning within the specialty for all ENTUK members, trainees, SAS doctors and consultants alike. We are continuing to develop materials in comprehensive learning zone sessions of which around 250 will place an emphasis on delivering the ISCP curriculum. In addition, comprehensive radiological and clinical image banks will provide quick spot diagnoses and self-assessment challenges for your revision and interest. The management guidelines section includes all the recently produced ENT guidelines and interactive self-assessment relating to each of these is also being developed. The assessment components are formative not summative and are only to provide the individual learners with a record of their performance to inform and enhance their learning. Records of completion & participation and certification are only accessible by the individual and any nominated third party, and access by regional trainers and programme directors will be at the discretion of the individual. ENTUK retains the copyright of all published materials and the ability to track activity and performance is not designed to be used for any other purpose other than to evaluate the impact of the project, identify popular materials and ensure high-quality materials are current, valid, and relevant.

An attempt to appeal to the different types of learners in the relevant sections has been considered and new developments will be ongoing, but the project needs enthusiastic engagement from the specialty. Whilst most of the main learning zone sessions are either complete or at various stages of development, there are still opportunities for members of the specialty to contribute, either to the remaining sessions or more immediately by contributing to the clinical or radiological image banks. Any interested member can obtain further advice and guidance by contacting either Victoria Ward or Professor Richard Ramsden. We welcome feedback and ideas, we encourage regional engagement of trainees, SAS Doctors and consultants alike and look forward to actively seek new content and contributions.

The strength of the project has always been the dedicated team of Section Editors, their content authors, whose work, imagination, experience, and authorship makes this feasible and a project the ENT community of the UK can be proud of. Do not hesitate to register at www.e-elfENT.org.uk and try it for yourself, or please do contact us at victoriammward@gmail.com or rramsden@quikmail.co.uk
Developing Commissioning Guidance

As of April this year there will be a new framework for the commissioning of clinical services. Newly formed clinical commissioning groups (CCGs) led by GPs will now be responsible for the commissioning of clinical services, rather than the PCTs of old. *La plus ca change*…..one might say.

Nevertheless, there have been problems with the commissioning of certain services in the recent past, particularly those labelled as “of low clinical effectiveness”. Essentially these are procedures performed usually for a non life-threatening condition and in which there is some variation in the rate of surgical intervention. This finding has been leap on by commissioners as an indication of clinical ineffectiveness and poor practice. With this has also come the suggestion that the lowest rate is probably the “best”, and efforts to achieve this will produce significant financial savings. There has been no effort to try and understand or explore the reasons for this variation and its occurrence. Nor has there been any effort to try and establish what might be the optimal rate for such surgical intervention. Unfortunately, many of our common ENT procedures fall into this category, as do a significant number of other surgical procedures.

As a result of this, the Royal College of surgeons have become involved, and along with the Department of Health RightCare team, have looked to try and develop clinical guidance to help inform and advise the “new” commissioning process.

The first step in this process has been the production of a guidance manual. This describes the process by which the clinical guidance should be produced. This manual is generic to all surgical specialities and has been supported by the Federation of Surgical Speciality Associations (FSSA). It has just receive NICE accreditation, meaning that any guidance produced to this format and standards should also receive NICE accreditation thus validating its value to any potential commissioner.

ENT UK has been very active and engaged in this process. We have suggested 3 care pathways as our initial contribution to this process: Otitis media with effusion (Glue Ear), tonsillectomy, and rhino-sinusitis. These pathways were chosen as their surgical outcome probably represents about two-thirds of our routine surgical activity.

The first meeting of the 3 working groups took place at the College in London on the 7th March. Representatives from all relevant stakeholders were invited: ENT, audiology, paediatrics, General Practice, Commissioners and patients, to provide a broad consensus view. The first part of the day involved a general introduction to the process and its purpose, including talks from Nigel Beasley representing RightCare and Simon Swift talking about available data and its analysis. In the afternoon session each working group appointed its chairman, devised a work plan and began to produce its guidance.

The timeline is tight, although much of the work has already been done. It is hoped that first drafts of the commissioning guides will be available for consultation by the end of April, with completion of some or all by June. Sir Bruce Keogh is pushing hard to see this through and, in the wake of the recent Francis report, there is certainly a strong political desire to see this delivered. Sadly, and most worryingly though, is the fact that despite all this CCGs are still able to commission services as they see fit for their local population. It is therefore possible that despite all this work, local commissioning arrangements may still see ENT procedures at risk. However, one hopes that it will be a very brave commissioner who will ignore National, NICE approved guidance, and not continue to commission ENT services to this specification. As soon as the guidance is produced we will share it with you in the hope that it may help those of you who may be engaged in discussions with your local commissioners.
It is the time of year for all of those striving for higher awards to complete CVQs. If you are thinking of applying, we’d like to advise you of a few key considerations.

1. Do make sure your appraisal for the last year is complete and has been signed off. Your Chief Executive or whoever will be reviewing your ACCEA application at your employer will need to have all your appraisal paperwork in place before they are able to process your ACCEA application.

2. If you already hold an ACCEA, you will need to demonstrate significant further achievements before you will be considered for another reward. Effectively, if you received an award last year, it’s unlikely that you will have accumulated enough evidence for another award in time for this year. Perhaps best to hold fire and wait ‘til next year (though the Awards may well not take place next year due to changes “in the system!”).

3. Quantify your achievements. The assessors will reject vague evidence of achievement: they are looking for quantified, well-evidenced applications that fit closely with each of the “domains” on the forms.

ENT UK is able to support members who are applying for these awards. If you are intending to apply for such an award and would like the support of ENT UK, I would be very grateful if you could let me know by Tuesday the 4th of April. You will need to send your CVQ (but this does not need to be your final CVQ at this stage). It is important to emphasise your personal contribution to ENT surgery, so that we can give you as much support as possible on behalf of the Society. ENT UK will consider all the applications received and will put forward recommendations to the ACCEA team.

Do also send in your application to the Royal College of Surgeons at cea@rcs.org as The RCS team will be putting forward their recommendations for the Awards for surgeons of any and all specialities. Because of the large numbers of applications they receive, they regret that they will not be able to give feedback about your application, other than to tell you whether or not they will be putting you forward for an Award.

The application form for a 2013 Clinical Excellence Award can be downloaded from ACCEA, here: http://www.dh.gov.uk/health/2012/11/clinical-excellence/

The time scale is tight so please act soon. We look forward to hearing from you.
A new organization – Fifth Sense

Introduction by Duncan Boak
Founder

Fifth Sense – a new organisation supporting smell and taste disorder sufferers including chronic rhinosinusitis

Of our five senses, smell is most frequently overlooked and undervalued. Our sense of smell is closely linked to memory and emotion – think of the feelings evoked by the sudden whiff of the fragrance worn by an ex-partner from a passer-by in the street, or how the smell of a particular meal cooking can return one to childhood, standing in grandma's kitchen whilst dinner is being prepared. Smell is intrinsically linked to so many aspects of our lives, yet we don't often stop to give it a second thought.

Lose your sense of smell, though, and what then? Life for many anosmia sufferers (as the condition is known) can become grey and barren; simple pleasures such as eating reduced to the perfunctory matter of sustaining oneself. Patients find themselves at risk from hazards such as escaping gas and spoilt food. The loss of the sense of smell, in contrast to blindness or deafness, has gone unsupported and unnoticed by the vast majority of the medical profession, with patients having nowhere to turn for support and advice, let alone treatment.

Fifth Sense was set up in 2012 by Mr Duncan Boak, who lost his sense of smell in 2005 following a head injury, to provide support and advice to fellow sufferers, act as a signpost to treatment, and raise awareness of not only the condition itself but also the huge role that the sense of smell plays in our lives. Whilst still a very new organisation, Fifth Sense is growing steadily and rapidly, with new members joining daily, and is supported by two experts in the field, Mr Carl Philpott and Mr San Sunkaraneni, the former who has set up the first specialist smell and taste clinic in the UK.

Fifth Sense wishes to connect with as many anosmia sufferers in the UK as possible to gain support for its campaign to the Department of Health to improve services and treatment options for patients. In addition to this, we need to raise awareness amongst ENT practitioners and indeed the medical profession as a whole of the huge importance of the sense of smell and how its loss needs to be taken seriously. It is hoped that in due course Fifth Sense will become a registered charity joining many other related organisations covering other ENT disorders.

With the increasing need for Public and Patient Involvement in Research (PPIRes) and in commissioning strategy, members of Fifth Sense will also be engaging with leading ENT academics to help with both researching funding applications (such as those being prepared by the Rhinology Research Group) and with helping to shape the future of ENT services with specific relation to chronic rhinosinusitis. It is hoped through the development of regional hubs that Fifth Sense will provide regional support to patients and clinicians both in coping with anosmia and in research and service development.

For further information, please email info@fifthsense.org.uk or call Duncan Boak on 07976 551796.

Find Fifth Sense online:

www.fifthsense.org.uk
Twitter: @fifthSenseUK
Facebook.com/FifthSenseUK