I think most of us would accept that today’s NHS can’t pro-
provide everything for everyone and that some kind of ration-
ing or prioritisation is necessary. However no political party
seems to have the courage to say as much. Instead we get
endless missives claiming that following a “review of evi-
dence” there are some procedures that are somehow of “limited clinical value”.
Andy Mc Combe & Janet Wilson clearly set out ENT UK’s position against the gov-
ernments recent statements with a number of well written and evidenced
“position papers” outlining the true benefit of intervention.
Also in this edition of the newsletter we are introduced to “CORESS” and the les-
sions we might learn from the aviation industry. With revalidation upon us we get
a helpful insight into how a pro-active and helpful secretary can help maintain a
consultants e logbook. Martin Burton outlines the new face of the “BSAO” while
Ricard Simo makes a strong case for those of us who perform thyroid surgery to
join the British Association of Endocrine surgeons and influence the association
from within.
The ENT.UK website is constantly being updated and is well worth
“bookmarking”, as it is a useful reference point for all things “ENT”.
As always your comments and contributions would be graciously received.

Tony Jacob Asst Editor

Advance Notice of Subscriptions Increase

In compliance with the requirements of the Direct Debit Guarantee, Members are formally notified that an increase in the annual sub-
scription was approved at the Annual General Meeting held on 5th February 2010. The increase will come into effect on 1 October
2010 when subscriptions at the new rate will be collected by Direct Debit. The approved increases are as follows:

Full Members: £380; Trainee Members: £175; Associate Members: £175;

The following subscription rates will remain unchanged:

Affiliate Members; £75 or £37; Corresponding Members; £75 or £37

A new category of Membership for Retired Members will be introduced and the subscription rate will be:

Retired Members: £75 or £37

From October 2010 credit cards and cheques will no longer be accepted for the payment of membership subscriptions for members
residing in the UK. The collection will be made by DIRECT DEBIT ONLY. If you do not have a Direct Debit mandate in place your
membership of the Association may be terminated.
Irrational rationing of the NHS

Andrew McCombe  Assistant Honorary Secretary  ENT UK

Despite various political promises of maintaining budgets for health and education, it cannot have escaped peoples’ notice that money is starting to get tight. There is a definite undercurrent of possible cuts to clinical services, although there never seems to be a reduction in the increasing tiers of management in the health service – at every level. Nor does there seem to be any reduction in spending by PCTs, SHAs and the Department of Health on management consultants. A recent report by McKinseys and commissioned by the DoH has suggested that Grommet insertion and Tonsillectomy are “ineffective” operations and can be reduced by 90%, with significant cost savings. Veiled in this report is also the implication that we as ENT specialists are remiss in suggesting such surgery to patients! Although the DoH have not gone on to accept the recommendations of this report, they have passed it on to the various PCTs and SHAs with the message that savings need to be made. You don’t have to be a rocket scientist to see what comes next!

As a strategic response to this, ENT-UK has been busy producing position statements on these two conditions. A huge amount of work has been done, in a very short time, by Janet Wilson and Peter Robb to produce these. You should all receive copies of these statements soon if you haven’t had them already? Copies have also been sent to the commissioning officers at all the PCTs around the country. Hopefully, this will help in any negotiations you may be forced to have with your various commissioners in the current contracting process.

In addition, a meeting was arranged between Andrew Lansley, shadow secretary for health, and our President, Alan Johnson. I went along as the President’s “wing man”. Our aim was to raise 3 key points with him:

1. Manpower and training
2. Negative impact of the EWTD, and particularly the loss of the old firm structure, and
3. The inequities of commissioning, particularly the “spin” on procedures as “less effective” rather than “not affordable”.

Not surprisingly for a politician who has been in the shadow health position for quite some time, he had a very good grasp of these issues and was (as you might expect at this time) quite sympathetic to these issues. He did suggest that a conservative government might be more focussed on “outcome measures” as a measure of a procedure’s therapeutic efficacy and benefit, and that commissioning would be likely to be based around such measurements. He also implied that there would be some bigger objectives given to local health care organisations and that they would be left to find their own ways of delivering to these targets with less micro-management.

Sounds good but I suppose we shall just have to see.......?

Finally, it would be very helpful for the executives if we could know about any such commissioning negotiations and their outcome. This will help to build up a better picture of what is going on around the country in this regard. So, if it’s happening to you, please let us know. (Don’t assume someone else will do it because they never do!) Either e-mail the office at ENT-UK, or me directly at amcco79794@aol.com.

The fight back!

Janet Wilson  Honorary Secretary ENT UK

As Andrew has alluded to above, ENTUK has now launched a series of five position papers on key elective surgical procedures. The background to this activity is as follows - as disease demographics and patient
expectations have changed, so has the volume of elective ENT surgery in the UK. Surgical intervention rates for childhood glue ear have fallen steadily over the past 15 years.

Adenoidectomy in England fell by almost 60% from over 16,000 procedures per annum in the late 1990’s, to under 6000 in 2008-09. Childhood grommet insertion fell by over 40% from over 43,300 operations in 1994-95 to under 25,300 in 2008-09, largely due to the better understanding of the natural history of glue ear and the role of ‘watchful waiting’. Similarly, in the last 15 years the rate of tonsillectomy in England has decreased in all age groups from 77,604 in 1994-95 to 49,187 in 2008-09, a 37% reduction, due partly to surgeons refining the indications for surgery and almost certainly a reduction in the number of referrals received.

Against this evolution of more considered surgery, it was shocking to see that, with the stroke of a well pushed pen, a group of nonclinical management consultants should float a scam under the banner “Up to £700m could be saved if PCT’s decommissioned some procedures”. The 2009 report by McKinsey management consultants commissioned by the DH, was reported in the Health Service Journal, 10 Sept 2009.

Among the proposals was a 90% reduction in tonsil and grommet surgery saving £67 million. Basically what this ludicrous proposal claims is that we could spend less on healthcare if we delivered 90% less healthcare!! It may come as no surprise that in 2009, the NHS paid members of the Management Consultants’ Association £300 million, enough money to buy all tonsil operations for over 5 years.

Although the Health Services Journal report was not widely circulated, the rationing of interventions continues to be pursued on a wholesale basis – under the banner of “Procedures of limited Clinical Value” or “Low Priority procedures”.

The designation of a procedure to be of limited clinical value is an apparently arbitrary process. If you want to find out what is on your local list then simply google ‘Procedures of limited clinical value’ and find out what is operating in your region.

ENT UK is planning a press launch to deliver a proactive statement outlining the benefits of ENT surgery

The NHS Networks website offers a guide to productivity metrics. One such metric is the “standardised rate of surgery for a basket of surgical procedures where there is evidence that surgery may often not be effective”. There are 2 ENT procedures in the basket; Myringotomy with / without grommets and Tonsillectomy. At EN'TUK we have been shown documents from different areas of the country, citing additional operations to be of “limited clinical value”. Examples include surgery for congenital ear deformities, pinaplasty and septoplasty.

The five current EN'TUK position statements have been sent to the SHAs and are available for your own use – but their existence alone is insufficient. Andrew McCombe is planning an EN'TUK press launch to deliver a proactive statement outlining the benefits of ENT surgery.

Meanwhile, ironically you might think, your President has been approached by the conference wing of the Health Service Journal to participate in a joint meeting with administrators, purchasers and managers on ENT Services. This meeting is on the 20th May 2010 in London and I am pleased to say that several EN'TUK members are now scheduled to speak at this important event, which will be opened by Alan Johnson. EN'TUK members have been offered a promotional registration fee. If you are unable to attend we shall feed back on the outcome of this meeting in the summer.

Finally, if meeting the manager is not your cup of tea, you may, if you are a consultant, prefer to join clinicians in other disciplines who have the clinical standards of NHS interests at heart. Details of the NHS Consultants Association are available from nhsca@pop3.poptel.org.uk. Of 700 NHSCA members, only 8 of us to date are otolaryngologists.
CORESS Confidential Reporting System in Surgery

Alan Johnson President - ENT UK

This system has been devised by an interested group of surgeons and is hosted by the Association of Surgeons of Great Britain and Ireland.

The website address is www.coress.org.uk and there is a clear description of the organisation, its structure and how to use the system there. The idea originated from the “no blame” near miss reporting system that is used in civil aviation and now the maritime industry too – CHIRP – Confidential Human factors Incident Reporting Programme – www.chirp.co.uk.

The idea for these organisations is based on work looking at accidents. We already know that for every accident that happens, in aviation, in surgery and in every other field of human activity, there are larger numbers of near misses. The principle behind CHIRP and CORESS is that there are lessons to be learned from the near misses as well as the accidents, and if we are prepared to learn from the near misses, accidents may be prevented. These organisations do not investigate or report on serious incidents and accidents – in the aviation industry these are investigated by the Civil Aviation Authority and in healthcare, they are investigated through the NHS.

CHIRP was established in civil aviation in 1982 and in the maritime industry in 2003. In aviation, the publication it produces is read avidly by pilots and disseminates information about how accidents can arise and thus can be avoided. It has the support of the industry and is funded by it. All involved see the value in it and so it has become an important means of improving safety. It has independent status and funding and has achieved a genuine no blame culture and so pilots who have been involved in near misses are able to report them without fear of retribution. The independent structure of CHIRP is seen as important to preserve its impartiality.

Although there are distinct differences between flying aeroplanes and doing operations, the founders of CORESS felt there were enough parallels to explore the system to see if the benefits were transferrable to surgery. One of the lay members of CORESS, Mr Peter Tait, is the chief executive of CHIRP, and so he brings valuable experience of the system to the organisation. The CORESS board have concluded to date that the system is capable of improving safety in surgery. The current system produces publications that appear in CORESS newsletters produced by the ASGBI. They are also available on the CORESS website.

The process works by surgeons of any grade reporting an untoward incident which could have had serious consequences for a patient. There are instructions on how to do this on the CORESS website and the form is downloaded from there. The report is fully confidential and on receipt of it, CORESS carefully removes all identifiable details of the case before storing any data. The original is not copied and is returned to the author.

The untraceable data is sent to two or more surgeons who review the case and decide if it is suitable for publication. Each case is considered carefully to see if it has a lesson for surgeons that could improve patient safety. The incidents make interesting reading and their nature is very varied. They range from generic problems like patient identification to technical complications like vascular complications in laparoscopic surgery. Some are specific to the surgical specialty in which they arose, but some are generic in nature and many of the lessons learned have value for other specialties.

CORESS would now like to encourage more wide ranging use of the system across the surgical specialties. Already the first ENT cases are to be published. Claire Hopkins is the ENTUK representative, and Charlie Gid-
CORESS is hoping to become a fully independent organisation with charitable status to ensure its independence. Given the nature of the service in which we work and the increasingly litigious nature of our society, I suspect that financial and organisational independence and the ability to maintain anonymity in adverse incident reporting will become ever more important if this system is to be effective in preventing serious surgical accidents.

As part of a group from the Federation of Surgical Specialty Associations, (FSSA) I attended a presentation from the CORESS board in December. From what we heard and saw, I think that this system is achieving “no blame, near miss incident reporting” and I would encourage you to visit the website and read what is there. Having done so, I think you will see that the process is likely to improve safety in surgery by identifying issues and events that can arise in any theatre. If staff are aware of what can go wrong, the chances of adverse incidents must diminish. I felt that ENTUK should strongly support this system. If you are unaware of CORESS, please read about it. I would be most interested in your views and if you have a near miss incident to report that you think has a useful lesson for all of us, please consider using this system to educate your colleagues so that we can all avoid it.

The first report from CORESS

Claire Hopkins  Consultant ENT Surgeon & ENT UK Rep on CORESS

This quarters’ meeting contained two cases of particular relevance to ENT.

Firstly a historical case was reported where a patient was transferred to a tertiary centre for laryngectomy after a diagnosis of a large transglottic tumour was made, and squamous cell carcinoma confirmed by biopsy. However, definitive pathology on the laryngectomy specimen demonstrated laryngeal histoplasmosis, but no evidence of malignancy. Although with MDTs, this is much less likely to happen now, it highlights the importance of reviewing all original pathology specimens and imaging, and not just the reports, whenever care is transferred between hospitals, or even different services within the same centre.

The second case was of wrong side surgery performed when a trainee, via a midline incision, delivered the wrong testis, which was subsequently removed by the consultant. Pre-operative marking (which was subsequently covered by the drapes) and use of the WHO checklist perhaps created a false sense of security, and at the stage of organ removal, adequate steps were not taken to ensure correct side surgery. This could also potentially occur in thyroid surgery, accessed via a midline incision, particularly when there is no obvious asymmetry between lobes. It was suggested that an extra check is made prior to unilateral surgery of any paired midline organ (such as tonsils, thyroid, vocal cord) to ensure the correct side is treated.

There have been few reports from ENT to date (which is unlikely to be due to the absence of critical incidents in our specialty), so please could you all submit and relevant experiences, no matter how trivial they seem to be. Contributors to the site will be issued with a ‘certificate’ awarded CPD points for reflective practice that can be put in revalidation portfolios. By recognising recurring patterns in near misses we may prevent a critical incident. If even one life can be saved by preventing the same mistake occurring twice, then this must be a good thing. It may also save us all the angst of unnecessary complications and possible litigation.

For the next meeting the panel are particularly interested in events relating to MDTs, or problems arising from them.
On the 16th November licences to practice were issued by the GMC with the implication that these licences would have a time limit of 5 years and would not be renewed unless the doctor provides evidence of fitness to continue in practice.

For the GMC, the error made at Cardiff Medical School last summer was a timely reminder that even an organisation that has been approving the provisional registration of doctors for decades can make mistakes. A failed medical student at Cardiff requested that his final examinations were re-marked and this was done. This discovered an error and the failed student was informed that there had been an error and he had actually passed. The remarking process brought to light another four students that had been registered at the GMC and had started their FY1 year. These four students had actually failed and through this error the GMC was forced to remove these “newly qualified” doctors from the register.

Clearly the GMC must have concerns that suddenly there will be hundreds of new organisations that will be testifying that medically qualified staff are fit to continue to practise. Whilst the planks of Appraisal, Audit, Continuing Professional Development (CPD) and Multi-source Feedback (MSF) will inform the responsible officer with reliable information there is a risk that the systems within the responsible officer’s organisation are not robust and reliable enough to reassure the GMC that the recommendations for revalidation are reliable and accurate.

The Department of Health (DoH) in consultation with the GMC has realised that External Quality Assurance of the organisations through which doctors must revalidate is a future requirement. These organisations are likely to be NHS Trusts, locum agencies, Deaneries and a range of other organisations. How these organisations will be quality assured and by whom is still to be clarified but it is likely that several pilot projects will be initiated first. It is now clear what form of evidence will be required of most ENT surgeons for revalidation. This evidence has to reflect the whole of a surgeon’s professional life. This will also include charitable work, sports medicine, medical management and medical education. For example, a doctor that regularly provides medical cover at a sporting event will need to show evidence of keeping up to date and skilled in this area of their practice.

The revalidation team at ENT-UK are developing guidance and a check list for the membership with additional guidance for those that practice in a subspecialty area.

At this stage to be prepared for the process, an ENT surgeon should be participating in audit, keeping a log of surgical activity, taking part in appraisal.

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Some Trusts are trialling multi-source feedback. We advise that members should take part in these trials. Should you choose to take part in an MSF trial I would be grateful if you could give feedback to the Executive of ENT-UK as to

Many of you surgeons reading this will be feeling a bit guilty about this e-logbook malarkey. You know you should be doing it – and soon the revalidation cops will be cruising the internet to confiscate your scalpels if you do not start to clock the ops. I thought it might help you get going if I explained how I as a consultant’s PA complete his e-logbook for him. Easier still here is an idiots guide that you can pass on to your secretary / PA to get him / her to do it for you.

"It is very simple to use the e-logbook - you register using your consultant’s GMC number and create a personal password.

If your consultant were to provide you with an operation list for the day with comments and notes annotated to it you can then proceed to enter data.

  choose "add operations"
  then enter hospital ID
  the hospital no and age.
  date of procedure
  type of surgery - elective or emergency
  ASA grade options e.g. fit and well etc
  responsible consultant
  state whether consultant performed or supervised procedure, operation side
  select procedure from the list.
  There are procedures that are performed often and these can be added to "favourites".

Then choose "hospital" and then if there are extra parts to the procedure there is a free text section for "operation notes/ complications".

Hit add and this is it saved. Back to the top and start again"

Happy to be contacted for any further questions!
Sadie.Sweeny@ggc.scot.nhs.uk

Sadie Sweeny PA
how successful these trials have been. Just write to me at the office or send me an e-mail to Maurice.hawthorne@iodem.co.uk

ENT-UK is slowly building up resource to assist the membership. It is hoped that very shortly the audit of chronic rhinosinusitis with the use of the SNOT 22 will be freely available as a national audit for the next three years. Peter Brown and his team are to be congratulated on their hard work in getting this off the ground. The e-log book accessible on the Royal College of Surgeons of Edinburgh website, as is the e-portfolio of the Royal College of Surgeons of England. Both these are more than just logbooks of surgical activity, they provide a record for CPD and other useful information can be recorded. All our trainees have to use the Edinburgh e-logbook because it is essential for trainers to be able to access trainees’ activity in one database and Adrian Drake-Lee has worked hard on developing and encouraging its use in conjunction with the e-log book team.

The recent pilot study undertaken by NHS Professionals does however indicate that locum doctors are not fully engaging and preparing for revalidation. This is a cause for concern and ENT-UK are currently considering ways of engaging this group in order to assist them prepare for revalidation. If you work as a locum in ENT, I would very much appreciate the opportunity to discuss this with you.

The British Society of Academics in Otorhinolaryngology - A new beginning

Martin Burton President BSAO

The British Society of Academics in Otorhinolaryngology was founded in 1993, its objects being 'to stimulate teaching and research of a high standard in the British Isles in Otorhinolaryngology and related disciplines including Audiology'. The membership was composed of salaried academics and individuals in charge of undergraduate otorhinolaryngology training as 'associate members'.

Over the years the membership changed. The distinction between ‘ordinary’ members and associates was blurred and in the last 12 months, trainees in academic posts (Academic Clinical Fellows, Clinical Lecturers and those doing funded post-doctoral research) were invited to join. The interests of the membership were predominantly in supporting the development of academic posts and individuals and trying to promote otorhinolaryngology within the undergraduate curriculum. There was a sense in recent times that this last ‘battle’ has - for the time being - been lost. More recently moves have been made to engage with medical students themselves to find out if they want ENT to be part of their curriculum. If so, can they help the specialty to highlight this in those medical schools where it has been dropped?

In early 2009 plans were formulated outside the BSAO (but by members of it) to encourage research in ENT by establishing a ‘Research Group’ within ENT-UK. Mindful that the object of ENT-UK, as provided by its Constitution is: “To assist in the advancement of public education and research in otorhinolaryngology and head and neck surgery”, the proposed aims of the research group were:

- to promote high-quality research in otorhinolaryngology and head and neck surgery (ORL-HNS) in the UK
- to liaise with local, national and international research bodies and agencies to achieve this aim
- to engage in activities to help prioritise research topics
- to involve and liaise with patients, health professionals and funders in decisions about research
- to advise ENT-UK Council on research matters within ORL-HNS.

At the meeting of BSAO held on 8th July 2009 during BACO in Liverpool, these proposals – for an ENT-UK Research Group – were presented and discussed. It was felt that these aims were sufficiently similar to those of BSAO that establishment of a new group was inappropriate. Rather, it was proposed that BSAO should take on this role. Furthermore, the suggestion was made that BSAO could become incorporated within ENT-UK and that such an arrangement
As a key tool for revalidation. There has been a gradual shift in who is doing thyroid surgery in the UK over the past 10 years. A survey in 2001 showed that only 15% of thyroid surgery in the UK was done by ENT H&N surgeons. Now, the proportion has significantly changed and it is believed to be up to 40%. However, the proportion of members of BAETS who are ENT H&N surgeons and furthermore the proportion of these ENT H&N surgeons contributing to the national audit is really minimal and represents only 7% of its contributions.

If ENT H&N surgeons want to be recognized and be at the “cutting edge” of the management of thyroid and parathyroid disorders, it is highly advisable if not imperative that they should join BAETS and contribute to their national audit process.

BAETS is the British Association of Endocrine and Thyroid Surgeons. The Association was originally called BAES but the executive committee recognized that “Thyroid” should be included in the title, as an increasing number of non-endocrine surgeons, especially ENT Head and Neck Surgeons, were practicing thyroid surgery and that this should be recognized. It was also felt that the association should be inclusive and open to these surgeons.

This year for the first time in its history, BAETS has elected an ENT surgeon, Professor John Watkinson as its president. John will lead the association for the next 2 years.

The aim of BAETS, just like any other professional medical association, is to promote and exchange the knowledge and skills in the management of endocrine, thyroid and parathyroid disorders. The Association is recognized by the Department of Health, the Association of Surgeons of Great Britain and Ireland and the British Association of Surgical Oncology. It advises the SAC and the Intercollegiate Board on the Curriculum for Training in Endocrine Surgery. It has contributed on the National Thyroid Surgery Cancer Guidelines and has produced its own guidelines on the surgical management of endocrine disorders.

The association has a very active annual programme with a yearly national meeting, which every 3 years is held abroad. It supports other multidisciplinary national and international meetings and runs a “masterclass”. It also regularly updates relevant guidelines.

It has also produced a unique web based national open audit tool, which allows all members to contribute data of thyroid, parathyroid and other endocrine surgery. This has now been recognized by the DOH as a key tool for revalidation.

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**Why join the British Ass. Of Endocrine & Thyroid Surgeons?**

**Ricard Simo**

*Committee member of BAETS*

**News just in …………**

We understand that it is very likely that major head & neck and skull base surgery will soon be removed from PbR, and the fees for this will be locally negotiated, with effect from 2010/2011.

For big trusts this will make a big difference - in the region of at least £1m per year on existing throughput. It is vital that trusts set realistic charges locally, as the DH will invariably review the charges set, and pick the lowest common denominator to re-set the tariff!

The last time charges were negotiated locally, some trusts set ridiculously low fees - this mistake was both costly for those underfunded services and damaging for UK H+N services overall. If anyone gets further news or updates as their local negotiations proceed please send them direct to BK on Admin@entuk.org

……..Janet Wilson