Editorial comments

This edition of the ENT newsletter goes to press just days before the general election on the 6th of May. When you read this, things will be different, in the country and undoubtedly in the NHS – which ever party (or parties) hold power. The expenditure on the health service this year will total £102 billion, this has grown 6% each year since 2000. The word for the next few years, apt for our profession, will be ‘cuts’. And the cuts will be deep. In this newsletter much space is devoted to some of our most eminent ENT UK members’ thoughts and musings and advice and predictions, for the future NHS.

Ray Clarke

The newsletter editor is a hard taskmaster. He insists on copy in good time, hence I write this as the Icelandic volcanic ash-cloud settles.

I have just hot-footed it from the Intercollegiate Examinations in Newcastle. We had to struggle on without Liam Flood who had a tortuous overland safari to repatriate his family following a Roman holiday. Kevin Gibbin showed the true Dunkirk spirit and arrived dapper and resplendent as ever having journeyed overland from Norway. A quiet week in Bridlington for Flood’s next break I hope! Say no more...

You are probably reading while basking in the June sunshine, incensed at the latest Department of Health missive demanding more and more for less and less. I write in ignorance of the outcome of the election but no doubt by now the ministers in the new administration have had a huddle with top civil servants and been briefed about just how severe the public spending cuts must be if we are to avoid national disaster. No matter how bad you thought things were, they will suddenly become much worse when your votes won’t be needed for another four or five years. Ministers will be aghast. They will appear on Question Time with long faces and ‘get tough on public spending’ agendas. The government spin machine will be in overdrive; newspaper editors will be softened up at Westminster dinners to help deliver the new austerity message. I remember a satirical television programme on Irish television when I was a student in the distant ‘seventies. The most celebrated character was ‘The Minister for Hardship’. A skeletal figure, dressed in a torn suit and frayed shirt, he would address the nation, admonish us all for our unrealistic expectations and explain how dire the public finances were. He would go on to exhort us to do some national belt tightening to prevent the national trousers from falling down around our ankles. I have little doubt the Minister for Hardship is due...
for resurrection and will be back on our television screens after the summer recess.

No serious observers or commentators now have any expectation that health care spending from direct taxation can ‘return’ to its pre-pandemic level. Nor do you accept that the NHS needs to be more cost-effective (yes, cheaper to you and me). Targets, commissioning, strategic health authorities, the purchaser-provider split and the various regulatory and advisory quangos that flourished during the last administration will be subject to intense scrutiny. In short, ministers, civil servants, health-care planners and –let’s be honest- the general public, want more for the taxpayers’ money than they are getting. As the working groups pore over balance sheets, end of year reports from SHAs and the findings from focus groups, what sort of bullet points do you think will find their way to the whiteboards and feedback sessions in the seminar rooms in Whitehall?

How about CEAs and SPAs?

What would be the consensus view from a focus group made up of hard-pressed taxpayers when presented with the following dilemma? A cadre of highly-paid doctors have a system whereby, on an annual basis, each of them can submit a request for a large and effectively permanent pay rise. This is on the basis that although they have a nationally agreed salary structure they feel they work well in excess of what might reasonably be asked of them, and have achieved more than their peers. The evidence is carefully sifted by a series of committees made up primarily of respected colleagues, and a predetermined number of applicants at each level deemed worthy of these pay hikes. The remainder nod sagely, console each other with tales of the unfairness of it all and regroup in readiness for the next round. The sums vary but can in the upper strata, amount for come lucky applicants to the salaries of some members of the focus groups might feel they are about as much value for money as duck ponds, second homes and decorative garden moats for the honourable members. Taxpayers can be right awkward folk when they get riled.

Notes from the SAC

by Tristram Lesser, Chair ENT SAC

CCT checklist

The formalisation of a CCT checklist has been invaluable in signing off CCT applications. Trainees should make sure they are aware of the points on the list and are keeping the relevant information in their portfolios. If you are not sure please ask your TPD or SAC Liaison Officer. Thanks to all those trainees who have sent in their CVs since January

MTI in ENT

The medical training initiative has started appointing Overseas Clinical Fellowships in ENT. These people are appointed to posts in the UK and work alongside local registrars. I am now looking for a UK registrar or team of registrars to lead on the National Meetings (two a year at the RSM) for the MTIs; any volunteers?

PMETB is dead, long live the GMC

April saw the end of PMETB and it moved offices to the GMC building. It is now up and running and has approved the current curriculum or most of it. There are various missives that emanate from their offices which we try and apply to training. Not all of these are as fixed as I first thought and the general principle is that the curriculum is submitted by us (the SAC) and the GMC decides which bits to approve.

The Deaneries (Schools of Surgery) and the Training Program Directors provide the training according to the approved curriculum. They are guided in how to achieve this by the various coloured Guides (Gold etc) and by the various standards set by such bodies as JCSCT. Oh! and the Quality Control of this is done by the SACs via their Liaison Officers as well as the GMC visits. Simple really.

The mystery of 16 months

A lot of people have been asking me about the number of months of ENT in Core Surgical Training for ENT trainees. There are 12 months of ENT in CT and 12 months of Allied Surgical Specialities. I would like to accept jobs that have 6 to 18 months of ENT and 6 to 18 months of allied surgical specialities (I had considered 16 months of ENT to be the maximum but now all agree 18 is a better number as there are 15 themed jobs which have 18 months ENT).

Why is this relevant? It is very important as ENT training is 2 years foundation, followed by 6 years of HST. There is no scope to extend this (unless competencies are not reached). The big jump in training is from CT to HST. The Person Specification and Selection Criteria are evolving to make this jump from CT to HST whilst the doctor still has other career options open. ENT is somewhat behind in this; for instance you are excluded from applying for Neurosurgical ST1 Training if you have done more than 18 months Neurosurgery. Orthopaedics selection does not exclude applicants but scores less for every month over 18 done in Orthopaedics. I will leave you to make your own conclusions.

National Selection and Intercollegiate Exams

Brilliant, both of them were full of really good trainees and I was uplifted to see the future of ENT in the British Isles. Well done all those who were selected and to those who passed...

PBA on the Web

There are a further 46 new PBAs being loaded onto the web as you read this. Do make use of them, why not impress a trainee by suggesting the next case you do with them is done as a PBA!

Surgical Simulation

The public want trainees to practice on simulators before we practice on them. Sounds reasonable. The SAC is devising a method of incorporating these into the curriculum, any suggestions would be gratefully received.
No one expects the Spanish Inquisition

1 M. Python et al

Adrian Drake-Lee

Very part-time ENT consultant and GMC associate

Before I expand on the title relating to visits, let me thank the executive committee of ENT UK for giving me an honorary membership and it was received gratefully. Monty Python sketches in series 2 had various historical and fictional characters burst in disruptively as a running gag and these images intruded repeatedly during my recent GMC visit to the West of Scotland Deanery. I kept my thoughts to myself.

I have only myself to blame for this being first a PMETB partner and then GMC associate. When on the SAC, I encouraged ENT surgeons to become PMETB partners because one thing I have learnt over the years, is that change must come from within. Even with all the changes in medical education, PMETB was here to stay. I hope I convinced Liam Flood, a notorious sceptic, about the externality being one of the five standards for Deaneries.

Now externality is one of the five College in the UK QA process as a part of the visiting team. Following this, there were planning and pre-visit meetings. The process did and does not comment on programmes and providers individually. If a patient safety issue arises, we take action and we found one issue on each visit. This suggests that there is something wrong with the present QA structure in the UK Deaneries.

I would like to highlight two points from my last visit, one relates to a specialty programme and the other to a provider. The ENT training was excellent but the SAC liaison member who comes from the Republic of Ireland did not do his job properly. It escaped my notice when I was SAC chairman. In my defence, the previous programme director should have let me know. On reflection, it questions the role of the Irish College in the UK QA process as training has become so different here. Tristram Lesser and his successor will have to resolve these thorny issues.

The second point arises from my visit to Dumfries and Galloway Hospital where I met with the general surgeons. This is a remote and rural hospital that has difficulties attracting both senior and junior staff. Despite this the training is excellent with committed but overextended consultant trainers and enthusiastic trainees who love the surgical experience. As expected the EWTD rear its ugly head. The trainees are not pressured and will cover work as well as staying on voluntarily to finish cases that do not count as work. They work Band 3 but the managers try every trick in the book to not recognise this and alienate both the consultants and trainees in the process.

There is something missing from the QA process: good visiting with externality in most programmes, an essential part of good QA. I do not suggest we return to the days of SAC visits, but Deaneries could follow the example that Iain Swan and Sarah Thomas set in Yorkshire and I managed to set up in London where specialty and deanery representatives with both the programme director and SAC liaison member taking part. Pressure must be kept up within the GMC to ensure that the Deaneries do not act in self-interest and fudge the issues as may happen at present.

While a visit is not supposed to have an inquisitorial feel, it does engender fear. I wonder who came from the Monty Python team of cardinals, namely, Xi-menez, Fang and Biggles. As I go as a specialist and do little clinical work now, I must be fictional; so call me Cardinal Biggles!

ENTUK Annual Meeting
10th September 2010

This year’s annual meeting will attract a large and enthusiastic audience in the University Hospital, Coventry. Many delegates will choose to attend the annual CAPAG audit meeting, on Thursday 9th September. The meeting includes a number of innovations.

Firstly, President Alan Johnson hosts a champagne breakfast – (newly appointed consultants, and consultant retirees only). Cheers! Vinith Paleri, secretary of the ENTUK H+N, will provide the proceedings from the Evidence Based review on Oropharyngeal cancer. A time-efficient method of accessing a concise resume of the developments in this, the fastest growing primary head and neck cancer site.

The first full session is also an inaugural occasion. This is the first joint occasion on which the ORS and ENTUK and we acknowledged the flexibility and vision of the ORS Council and President, Iain Swan (who chairs the short papers). This is a very good opportunity for poster presentations, which are ensured a large and interested readership.

The delivery of the Lionel Colledge Memorial oration (a first), David Grant will update us on the evolution of minimally invasive head and neck surgery.

The external perceptions of ENT activity is a highly varied series of short presentations by very high quality speakers – content varying from the role of national audit to the place of snoring surgery.

The afternoon speakers are all likely to be known to many readers – Herman Jenkins from Colorado on the totally implantable hearing aid, our own Prof Leslie Michaels on the pathology of osteorosclerosis, followed by a dynamic presentation on patient safety – Tom Goddings and Guy Hirsh. As if all that were not enough the session closes with our director of education demonstrating the practical use of the e-logbook. In short you cannot afford to miss this excellent day – early bird registration now open on the ENTUK website. Please direct any queries to the ENTUK principal events co-ordinator, Julia@entuk.org.
Clinical Coding in ENT

Showkat Mirza

Clinical coding means money. That is, how much money we as surgeons bring to our departments and hospital trusts and is therefore becoming an increasingly important subject, concerning us as individuals within a department, as departments within a hospital trust, and as a specialty within the NHS.

Clinical coding is the process where information (diagnosis, operation, treatment, complications, co-morbidities) from the hospital casenotes is processed to produce a code with a payment tariff. The tariff is how much money the hospital receives for the patient’s admission and treatment/operation. Coding is usually performed after discharge to a strict deadline.

In ENT the main groups of operations are Mouth, Throat, Ear and Nose. Operations in each main group are sub-grouped; usually into minor, intermediate, major or complex procedures. The procedures in each subgroup eg. minor ear, will have the same tariff. A number of factors can modify the tariff. Co-morbidities and/or complications usually increase the tariff. For example, a myringoplasty in a diabetic patient adds £17. The tariff varies if the patient is less than 19y old or 18y old. So for example a patient who is less than 19y old with or without co-morbidities (doesn’t affect tariff in this case) who has a minor nasal operation eg reduction of fracted nose, creates a tariff of £569 (see table for examples).

For each procedure there are a number of possible operation codes but in general they all occur in the same subgroup and therefore result in the same tariff. For example for benign parotid surgery the possible procedures include ‘excision of parotid gland’, ‘excision of lesion of parotid gland’, ‘other specified excision of salivary gland’ and ‘partial excision of parotid gland’. All four procedures codes feature in the major mouth subgroup and give a tariff of £1837. In general, additional procedures do not increase the tariff. For example, adding submucosal diathermy to inferior turbinates in a septoplasty does not bring a higher payment than septoplasty alone. Also, revision procedures do not attract a higher tariff. For example a revision mastoidectomy has the same tariff as a mastoidectomy.

In addition to the financial role, clinical coding data may be used in audits and for planning healthcare resources.

Accuracy of Coding

The accuracy of clinical coding is important to ensure departments

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New office space for ENT UK
Andrew Swift

For any of you who have ventured into the labyrinth of the Royal College of Surgeons, found and entered the office that is the nerve centre of ENT UK, you would be instantly aware of how tight and cramped the space really is. This long narrow room is generally a hive of activity with computers and telephones constantly in action and where our stalwart staff have toiled for long years. However, the amalgamation of BADL-HNS with BACO and the increased intensity of modern day work now mean that the old office is no longer fit for purpose. At present, the current single office houses Barbara, Julia, Judi, Jo, Lidija and Nchama, our administrative manager. We have therefore been keen to seek new accommodation and last year we had the offer of a suite of 5th floor rooms in the Nuffield building.

Although the offer of the new accommodation from the College has been very much welcomed, it is quite old and shabby and it would not be unfair to say that it is in need of a lot of attention. This new suite of 5 rooms will however offer a large spacious office, a large meeting room, 2 smaller individual offices, and a storage room.

Currently, we have a window of opportunitly in which we can fully refurbish the new accommodation whilst operations still go on in the old office. We have therefore been in discussions with a team of professionals who deal specifically with office space design and project management. This firm is called ‘Workplace’. Their plans should ensure that each of our staff has a bright spacious comfortable work environment that will be impressive to any visitors and to new potential staff.

The new department will be entered by a new impressive glass door and our past-presidents’ portraits will line the specially illuminated corridor between the rooms. Our own meeting room will be designed so that it can also be utilised as a seminar room for presentations and educational events. The potential of having a meeting / educational room should be an extremely bright spacious comfortable work environment that will be impressive to any visitors and to new potential staff.

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The refurbishment work is due to start in the near future and should hopefully be complete before the next academic term begins. Although such a development will be quite expensive, we are confident that this will be a very positive move that will be completely justified by the benefit of the new amalgamated organisation for years to come.

Minor Moust Procedure
Suture of Lip
Tariff 436 Outpat proc 119

Intermediate Moust Procedure
Nasendoscopy + Biopsy of Post nasal space
Tariffs 680 Outpat proc 119

Oesophagoscopy
Tariff 641 Outpat proc 143

Major Moust Procedure
Laser Microendoscopy
Tariff 1080

Intermediate Ear Procedure
Grommet
Tariff 1098

Myringoplasty
Tariff 1896

Major Ear Procedures
Combined Approach Tympanoplasty
Tariff 2283

Minor Ear Procedure
Operations on Endolymphatic sac
Tariff 644 Outpat proc 119

Intermediate Ear Procedure
Polytectomy
Tariff 1139 Outpat proc 154

Major Nose Procedure
Septorhinoplasty
Tariff 1453

Intranasal ethmioedectomy
Tariff 1434

Other specified operations on the external nose
Tariff 1434

Total rhinoplasty
Tariff 23648

Bone Anchored Hearing Aid
Tariff 1821
are correctly paid for the work they carry out. For example if a procedure is coded as 'other operations on larynx unspecified' (Intermediate mouth procedure) instead of 'microtherapeutic excision of lesion of larynx using laser' (Major mouth procedure) then the trust will lose £1193. The excellent paper by Nouraei et al. (2009)9 detailed an audit of clinical coding and found coding errors resulting in a projected annual loss of over £400 000 for the ENT Department. Improved documentation, typed operative notes, greater collaboration between coders and clinicians4,4 and direct clinician participation in the process of clinical coding may all improve the accuracy of coding and bring in more money.

**Representative Coding**

Relatively new procedures may not have accurate procedure codes (eg endoscopic Lothrop procedure). The process for amending and adding procedures codes is through the Information Centre for Health and Social care (www.ic.nhs.uk).

The Expert Working Group for Mouth, Head, Neck and Ear procedures, chaired for the last time by Mr Ken Pearman recently, has improved the codes over the last few years within the parameters allowed but there are areas for further work. Clinical coding involves a complex system and inevitably some of the tariffs do not seem to accurately reflect the complexity, length of procedure, and equipment involved. Examples include the tariff for a mastoidectomy (£1896) being similar to that for a uvulopalatoplasty (£1837) and the tariff for an endoscopic medial maxillectomy (£1434) being less than that for an excision of submandibular gland (£1837). A submission to change the tariff for a mastoidectomy then the trust will lose £1833, greater collaboration between coders and clinicians4,4 and direct clinician participation in the process of clinical coding may all improve the accuracy of coding and bring in more money.

**Conclusion**

In the future, hospital trusts may look at the income generated by individual departments and consultants. Therefore the coding tariff system needs to accurately reflect the work being carried out and accurate coding is necessary to optimise generated income.

**References**


**Healthy Economics 2010**

**Tony Narula**

As I write this just before the 2010 general election, I have been re-elected to the Council of the Royal College of Surgeons for four more years. My thanks go to all members of ENT UK who supported me. Readers may be aware that I became Hon Treasurer in 2008 and following this election, I have the honour of being the first Treasurer elected by Council, not appointed by the President. Accordingly it behoves me to have an interest in general economic issues so here goes...

In August 2008 the British people saw the first 'run' on a Bank in about 60 years (Northern Rock): many people had no concept of the idea that Banks do not keep our money but rather lend it out, so they actually can never redeem all the deposits without a crisis developing. While this happened many times in the 1930s, none of us had seen it. Indeed during the Great Depression, hundreds of US Banks went bust and the Federal Deposit Insurance Scheme (protecting deposits of up to £100,000) was born. The Americans also introduced the Glass-Steagal Act which separated retail banking (high streets) from Investment Banking. These changes were mirrored in the UK. There were problems in the early 1970s but the Bank of England which was in charge of regulation organised a 'lifeboat' to save several secondary banks and individuals didn’t suffer.

In the early 1990s the Clinton administration repealed the Glass-Steagal Act and the British Government did the same sometime later. In 1999 the Clinton administration also put pressure on the major home loan corporations (Fannie-Mae and Freddie-Mac) to widen housing for low income groups. Sadly in time these loans became known as NINJA mortgages (no income and no job). A similar explosion of lending in the UK led to the implosion of Northern Rock and later of the Lehman Bros.

We all know that Western governments spotted the risks to the financial system and following the lead of Gordon Brown relaxed fiscal policy. This process is now known as Quantitative Easing (or Printing Money). So far we have staved off collapse but not all countries have been so lucky. Iceland and Greece are effectively bankrupt. Ireland introduced savage cuts in spending which have given them a respite but at great social cost. Here in the UK it seems to be living in a dangerous dreamland where everything will turn out OK in the end.

I envisage a severe public spending cutback by the new government, with probably several rounds of belt tightening as the cuts will be too severe for the public to accept in one go. The pound is likely to drop making imports more expensive (including food & oil) and overseas trips prohibitive. Regardless, the huge expansion of the money supply in 09/10 is bound to lead to a price hike. Inflation is already running above the official target of 2% and in my opinion will deteriorate further. This (with public sector wage cuts) will lead to a drop in living standards and the value of cash savings. As interest rates rise to curb inflation, borrowers will come under severe pressure but of course the value of the underlying loans will drop in real terms making eventual repayment easier.

Remember inflation in the 1970s? It takes money to bring it down than one might think and the impact hits everyone. The general rule is that when nominal prices are going up, you need to hold real assets not cash in the bank. So keep your savings ratio low and purchase things like more property. Indeed if you can afford increased repayments, increase your loans as they will cost less to repay in due course. Shares tend to have a topsy-turvy time as they tend to lead actual economic activity: so the Stock Market will fall when the inflation penny finally drops and then move up rapidly when it starts to look as if things are improving. For Treasurers of charities, learned societies etc. my advice is to tighten your belts now and reduce your outgoings while pushing growth. Investments are for the long term: so please don’t be swayed by quarterly returns. Dipping in and out of the market to catch the exact timing of index moves is impossible.

But of course we are in a privileged position: even if the Government decides it can’t afford the NHS at all, the Public will still need the services of ENT specialists. Who knows: maybe the whole thing would become more efficient if it was actually run by doctors!
A tale of three Cities

Liam Flood

It was only as we crossed the Swiss Alps that I first diagnosed the sleep apnoea of our Italian Taxi driver. His snoring, as we passed Milano, should have alerted me, but, at least then, his eyes had been open. Now, the Epworth score had caught up with him. Two packs of Marlboro, countless espressos and repeated cries from the back ‘we are all going to die’, could not stimulate his respiratory centres. We had done only half of the seventeen hour journey from Rome to Paris and it was getting dark. I confess, I was getting a bit anxious.

Five days in the four-star Hotel Arma and Leggio, as a getaway for the Flood family, after Easter, did appeal. On day four, the BBC suggested there might just be flight disruptions. By day five there was not a hotel room to be had in Rome (at least not at yesterday’s prices) and the queues at Rome’s central station, Termini, stretched across the coach park outside. On day six we belatedly joined a sixth hour, only to be told no trains north of Milan for a week. “Oh dear” I said. Well, something like that.

Car hire? No, you cannot take our cars out of Italy; those cars are long gone, but you can have an autoleggio. A harridan, who would have graced Act 1 Scene 1 of Macbeth, explained that this meant a luxurious Merc with a driver…for €4,600! A quick calculation of hotel costs, for four adults stuck in Rome, suggested even this seemed reasonable and I parted with my card. Twenty minutes later were back in our hotel and reception tells Elaine and me that we had reservations. It was near Besançon that our travel agent phoned to say a slight problem, as website had crashed and no reservations. One hour short of Paris and we finally had a hotel at least, convenient for Gare du Nord. That is a bit like saying ideal for King’s Cross; you are still in King’s Cross! I racked my brains to recall why the Rue St Denis was so familiar, but a glance on arrival reminded me; this is the red light district of Paris.

Banging on the hotel door we were greeted by a somnolent Senegalese chap, wearing a sleepy smile, a string vest (and little else), trying to scratch himself awake. The two fifteen year old lads spent the rest of the night leaning out the windows, watching the professional ladies, still at work three floors below.

Well, if you are to be stuck anywhere for five more days, Paris in the spring sunshine is not bad. Finally, we are settled on four scattered first class seats on the 0643, on Friday am, and I see my breakfast approaching. This idyll is interrupted by the tannoy; “If there is a doctor on the train etc” There is always someone worse off, as I found dealing with a 50 year old chap with dysphasia, an evolving right hemiparesis and loss of bladder control. Could I find an aspirin anywhere on the train? No. The Gallic version of what I took to be an F1 arrived, stared in horror and fled. A rather effete French oncolgist, wearing a bowtie, pronounced that a sugar cube be administered, but, even as a simple wax remover myself, I felt this unhelpful. A short stop at Lille and we were at last on our way. I did get a nice bottle of champagne from Eurostar, but where was my breakfast? Gone. London, Darlington, a little village next to the Moors proved easy stages after that. Over 180 e mails on return to work and the second one I opened reminded all staff that absences due to Iceland and we were to be at expense of annual or unpaid leave. Illegitimi.

There is always someone worse off. I think of my brother, cur- rently stranded in Bangkok, listening to explosions in the streets, with a departure date of May 3rd. I think back to the couple, with a Down’s Syndrome teenage daughter, in Rome, who needed a three bedroom room, but faced eviction as we left. But somehow, there are those who cruise through it all and somehow they inspire us. With her permission, let me share with you “our Valerie’s” (I am now an honorary Northerner, after 25 years oop here) account of a similar, but subtly different account of a similar journey. Quoted verbatim from her e-mail:

Dear Liam,

How funny! I think we were operating in parallel universes, a bit like ‘Sliding Doors.’

I went to Rome on Thursday am to give a lecture in the late afternoon, intending to return first flight on Friday. However, as soon as the situation started to unravel I got my Italians to get me on a train from Rome to Paris on Saturday and we collected the tickets Friday, spent the day sightseeing and eating, got an upgrade on the suite, had an Italian bodyguard to get me onto the train to circumvent queuing Brits, then my travel agent got me on the last Eurostar leaving EuroDisney on Sunday evening so spent a very pleasant night in Paris and a day in sunny Disney before coming back, all first class of course and at the Italians’ expense. We also had an emergency on the train but my next door neighbour on the train leapt up to help and the patient was off loaded at the Italian/French border! Similar but strangely different – would have made a good after-dinner talk at the exam.

You can punch me when we next meet.
Valerie xx

What is about some people that they can always come up smelling of roses? My wife has conjured up an image of a glamorous blonde celebrity, wearing shoes by Manola Blahnik, shades by Prada and a handbag by Bottega Veneta, escorted by her minders onto her private compartment. She did not even wave to us on Saturday am, in Rome Station, in our six hour queue!

Well, I can now emulate young Tony, who once, at an ORS meeting, introduced himself as “Narula, London and Leicester”. Next meeting, like Dell Boy, I can truly call announce myself as “Flood, London, Paris and Rome”.

Hill of an experience, but there is always someone worse off (or who breezes through the whole thing untouched)!

(with acknowledgements and thanks to Prof Valerie Lund, London and Rome)
Given that the median for rotas on a rota of 1:8 or less often.

responses indicated that 22% were mended 300 nights on call over this would allow for the recom-

1:7 rota or more frequent; and middle grade present at operating had less than three. However, 41%

operating lists per week, but 15% available in only 62% of posts. The
cists (eg skull base or voice) wereing less than three. Specialist clin-

responded. Other grades were not from all deaneries and all years training opportunities over 31

days. There was a 51% response rate estimated from all UK ENT training, how to avoid lawyers,

CCT. In other words if any assess-
ments or exams are taken whilst expected development: it would ap-
pear that any examination or as-
sessments taken while not in an approved training post cannot contribute towards the require-
ments needed for the award of a CCT. In other words if any assess-
ments or exams are taken whilst not in a formal training post they could only count towards CESR. The Royal Colleges are asking for clarification on this issue but it is expected that further FAQ’s will soon be added to the guidance section of the GMC site.

AOT Annual Conference - July
30th 2010

The annual conference of the AOT will be held this year in Lon-
don. We have hired the Trafalgar Studios for the conference, which is about 50 yards from Nelson’s Column in Whitehall. We have a
wealth of great speakers who will be delivering information that is impossible to find elsewhere. Top-
ics include consultant interviews, how to be a clinical lead, overseas training, how to avoid lawyers, work life balance and negotiating your consultant contract. As if that wasn’t enough there will be an evening dinner in the Great Hall at St. Bart’s Hospital. All AOT mem-
bers are welcome and also any trainees who are considering a career in ENT are encouraged to attend. Please see www.aotent.com for details, application forms etc.

I will be standing down as the President of the AOT this year and am grateful for the welcome and support offered and for all the tolerance I have been afforded.

Another Banking Crisis?

Chris Raine
Hon Treasurer, ENT
UK

Banks and their inefficient-
cies, bonuses and profits have been in the news for many weeks. Whilst we all have been affected by the recession in one way or the other our annual risk analysis required for the charity commission clearly identified reduced interest rates and capital depreciation as an area of con-
cern. One area which we thought was low risk was the collection of subscriptions by direct debit. What could theoretically be easi-
er? - set up the order and let the banks do the rest. Whilst the new rates had been tendered to the bank it transpired that delays in initiation where encountered. Whilst some banks honoured the request a month late we found that HSBC and Barclays refused to accept the BACS request. This left us with 297 members having to be contacted to pay by cheque and set up a new direct debit. If you are one of those – please help us resolve the problem with a prompt respond.
Independent practice
Threats and realities!

Tony Jacob
Member of IPC & Board member of FIPO.

The independent sector is facing a sustained challenge by insurers and hospital groups alike to create a managed care system akin to the much loathed American model. The profession in the UK has largely resisted this to date with associations such as FIPO promoting the fundamental principles of private practice, namely patient choice, high quality care and the maintenance of the consultant/patient contract. Their justification for the most recent onslaught is the economic crisis and they hide behind the view that corporate consumers are demanding better value for money. Find below some excerpts from a summary produced by the FIPO board, on a few of the current issues in the market place....

AXA PPP

Introducing a Fixed Fee Schedule for newly appointed consultants
In 2009 PPP stopped the recognition of new consultants for several months and then changed the Terms and Conditions for the recognition which means that these newly appointed consultants are locked into a contract with PPP and have no financial contract with their patients. These consultants are obliged to charge at the PPP Fixed Fee Schedule rate which is below the current BUPA rates. It is, of course, well known that the BUPA rates have hardly altered in the last 15 years during which time inflation has eroded their value by about 25%.

Trying to enforce a Fixed Fee Schedule on established consultants
Many established consultants have recently received a letter from PPP stating that as from the 1st April 2010, their fees will be fixed at a new lower level and asking these consultants to agree to adhere to these levels. There is a clear implication that failure to agree will mean that patients will be warned at preauthorisation that the consultant is “overcharging” and may then be diverted elsewhere to see another specialist. Up to now, PPP have never published a general fee schedule for consultants but have instead referred to “usual and customary” when discussing fees; this was different to the other insurers and left PPP in an unchallengeable position when they accused certain consultants of “overcharging”. This new PPP strategy is different from other insurers who have previously published lists of benefits that they give patients for consultant services because consultants are expected to adhere to the PPP schedule. Up to now it has always been accepted that consultants charge fees and insurers pay benefits and that the patient is ultimately responsible for the payment of their fees or shortfalls.

Delisting consultants for reasons often unclear
This PPP strategy has been built on a rather aggressive approach towards consultants about billing with the word “flaunting” being used by many consultants who were apparently charging over what PPP called “usual and customary” rates. Coupled with this has been the fact that PPP has withdrawn recognition from a large number of consultants and has told us that the delisting of consultants is “now a fact of life”. In addition, they say that they do not need to give reasons for delisting and will not engage in any discussions about delisted consultants.

Introducing Preferred Provider Networks with Hospitals
AXA PPP is also trying to introduce a new insurance product (The Corporate Health Plan Pathway) which they have launched with the help of the BMI Hospital Group. PPP state that the scheme will allow them to manage claims costs “by carefully selecting which providers are used to care for members’ treatment”. Essentially, any patient under this scheme will be directed to a BMI Hospital for treatment. The hospital will then choose the consultant from a limited list of those who have signed up locally (for an agreed lower than BUPA rated fee schedule) and will provide care plans for the patient’s admission.

The consultant will need to obtain consent from management to perform certain investigations and for referrals to colleagues or other hospitals. All billing will be through the hospital and nothing is allowed to go to the patient. This is a classical preferred provider network which removes patient choice, starts to impinge on clinical decision making and breaks the consultant/patient contract.

BUPA

Preferred Provider Networks
BUPA failed in its attempt to enforce a preferred provider network on ophthalmologists a couple of years ago due to the independent resolve action by the consultants. It was BUPA's intention to sweep up ophthalmology before moving on to orthopaedics. A new strategy has developed in which certain groups of orthopaedic surgeons have been offered a package deal for various procedures. The surgeon must then “buy in” the anaesthetist and the post-operative physiotherapist. Surgeons should be aware of all the implications of this package before accepting this offer as this would leave very little funding for post-operative care and physiotherapy. BUPA have been able to reduce the payments to physiotherapists and has withdrawn recognition from many. These various initiatives affect patient care as treatment time is reduced.

Non recognition of new consultants
Recently BUPA has stopped the normal recognition of newly appointed consultants. On the face of it this appears to be the same strategy as PPP, who did exactly this before introducing their new Terms and Conditions (a Fixed Fee Schedule). At a recent meeting Stephen Pink of BUPA said that recognition will be re-opened soon with “some modifications” that he wasn’t willing to divulge – watch this space!