How we do it: An audit of *Action on* ENT baseline standards in otolaryngology departments in England

Persaud, R.,* Hajioff, D.,† Georgalas, C.,‡ Bentley, M.,§ Silva, S.¶, & Narula, A.‡

*Departments of *Otolaryngology, Whipps Cross University Hospital, London, †Southmead Hospital, Bristol, ‡St Mary's Hospital, London, §West Middlesex University Hospital, London, and ¶Gloucestershire Hospitals NHS Trust, UK*

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Keypoints

- An internet-based audit was conducted to determine how well English otolaryngology departments apply *Action on* ENT baseline clinical and administrative standards.
- A total of 91% (97 of 107) departments responded.
- Only 8% of 97 departments met all 23 standards but the majority complied with most standards.
- Microsuction and outpatient endoscopy were almost universally available (99% and 97% respectively) and 98% monitored in-patient and day surgery activity.
- Compliance was poor (<60%) for three standards: common waiting lists for common conditions (51%), facilities to elicit patient feedback (56%) and the inclusion of a treatment plan in the notes (46%).
- More than one in four departments lacked dedicated facilities to treat children or a lead clinician for paediatric audiology, despite the Children Acts of 1989 and 2004.
- It is hoped that this audit will help sub-optimal units to correct their deficiencies.

The 10-year NHS plan, launched in July 1999, was promoted as an attempt to transform a 1940s health system into a service fit for the 21st century. According to the Department of Health White Paper 'The New NHS'[1] the main problems with the old system were as follows: (1) lack of national standards, (2) old-fashioned demarcations between staff and barriers between services, (3) lack of clear incentives and levers to improve performance, (4) over-centralization and (5) disempowered patients. Public consultation for the Plan showed that the public wanted to see more and better paid staff, reduced waiting times, higher quality care centred on patients and improvements in local hospitals and surgeries. A reduction in waiting times was the public's prime concern and this led to the establishment of a number of targets within the NHS, for example, by 2005 a reduction in waiting times for an outpatient appointment to a maximum of 3 months and a reduction in the wait for a hospital operation to 6 months, falling to 3 months by 2008, with an average wait of half this time. There were also targets for reducing waiting times in Accident and Emergency departments and General Practice.

However, shortly after the announcement of the NHS Plan it became apparent that some of the targets would be difficult to achieve in disciplines such as ENT, orthopaedics and dermatology. So as to amend the perceived shortcomings *Action on* ENT, *Action on* Orthopaedics and *Action on* Dermatology programmes were established. The brief for *Action on* ENT was to develop innovative facilities and methods for effective service delivery in England. Since the launch of *Action on* ENT in 2000, approximately £45 million has been spent on improving patient access and service infrastructure. There have been many pilot clinical projects that have demonstrated novel ways of providing higher quality, more convenient services with significant reductions in waiting times. For instance, one-stop clinics have been developed so that patients make fewer visits to hospitals. Details of other new practices were published in the *Action on* ENT Good Practice Guide in October 2002.[2]

So as to help deliver ENT care effectively, the steering board recommended a set of baseline clinical and administrative standards.[3] Using an internet-based questionnaire, we aimed to measure ENT departments' compliance with these standards in England, just over 2 years after they were first widely publicized.

Correspondence: R. Persaud, MPhil, MIBIOL, CBIOL, DOHNS, MRCS, Specialist Registrar in ENT, Head and Neck Surgery Whipps Cross University Hospital, Whipps Cross Road, Leytonstone, London E11 1NR, UK, Tel.: ????; fax.: ????; e-mail: ricardopersaud@yahoo.co.uk

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Methods

An email, with a hyperlinked web-based questionnaire (http://snurl.com/actiononent), was sent to ENT Specialist Registrars and Consultants in England using the ENT-UK database. Wales, Scotland and Northern Ireland have a devolved health service, not controlled centrally by the Department of Health in London, so the *Action on* ENT standards are not directly applicable.

The questionnaire assessed compliance with the clinical and administrative standards (Fig. 1a and b respectively); the questions were posed in a binary 'yes/no' format and took under 2 min to complete electronically. Our method made it very quick and easy for surgeons to return data from otolaryngology units while incurring virtually no cost. Missing data were obtained by phoning the Specialist Registrar at the particular hospital. Discrepant responses were re-assessed by telephone enquires.

Results

We achieved 97 responses from England's 107 ENT providers reported by the Audit Commissions (giving a response rate of 91%). Seven-six per cent of the replies were received electronically whilst the remainder were obtained by individual phone calls to the Specialist Registrar or middle grade surgeon at the particular hospital.

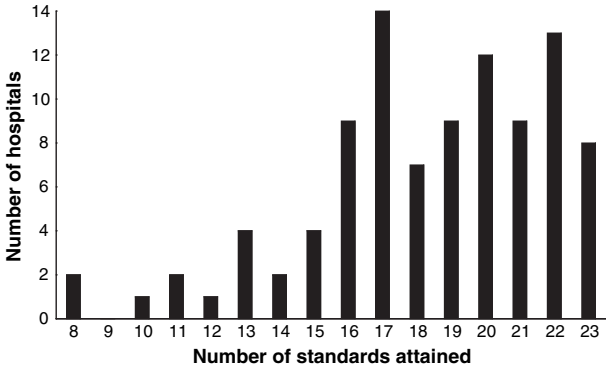

Fig. 2. Number of *Action on* ENT standards met by ENT departments.

Only 8% of the 97 ENT departments met all the recommended baseline standards while 31% met at least 21 out of 23 (91%) of the standards (Fig. 2). Regarding the clinical standards, microsuction and fibre-optic endo-

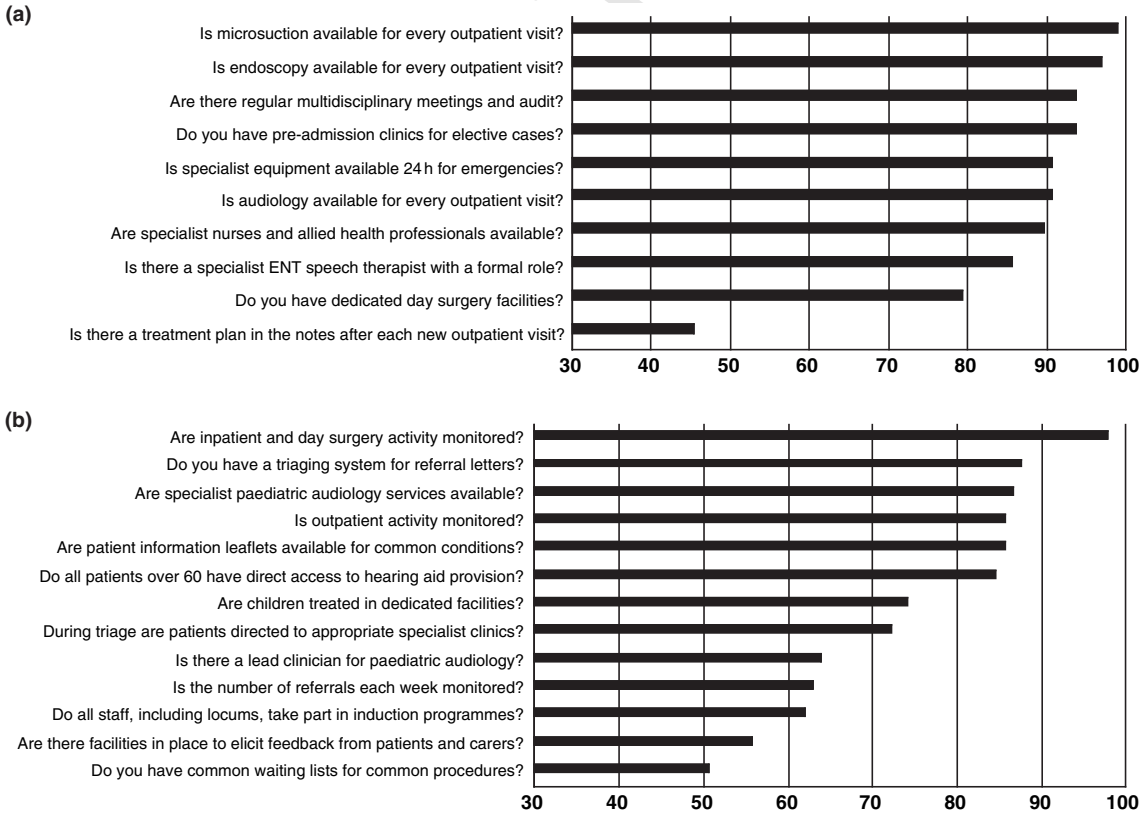

Fig. 1. (a) Percentage compliance for individual *Action on* ENT baseline clinical standards. (b) Percentage compliance for individual *Action on* ENT baseline administrative standards.

scopy were available almost universally in outpatient departments. Regular multidisciplinary meetings, including audit, and pre-assessment clinics for elective cases, were also frequent at 94%. However, the recommended inclusion of a treatment plan in the clinical notes had the poorest compliance rate (46%) of all the standards. Twenty per cent of the 97 ENT hospitals did not have dedicated day surgery facilities. Of the administrative standards, monitoring of inpatient and day surgery activity was nearly universal (98%) but relatively few departments had common waiting lists for common conditions (49%).

Although it appears that few hospitals complied with all the recommendations, most of the standards were common practice in the vast majority of hospitals. There were only three standards with relatively low compliance (below 60%): two were administrative (common waiting lists for common conditions 51%, and facilities to elicit patient feedback 56%) and one clinical (inclusion of a treatment plan in notes 46%). Other areas of deficiency included failure of all staff (including locums) to take part in induction programmes (38%); absence of dedicated facilities to treat children (26%), lack of a lead clinician for paediatric audiology (36%); lack of weekly monitoring of referrals (37%); lack of direct referral to specialized clinics during triaging (27%); lack of direct access to hearing aid provision in patients over 60 years (13%) and absence of patient information leaflets for common conditions (14%). Figure 1a and b illustrates the results graphically.

Discussion

Our audit shows that the majority of ENT departments comply with most of the recommended baseline standards, especially the clinical ones. This suggest that the standards are pragmatic in that it is realistic for most departments to achieve them, but at the same time they reveal frequent deficiencies, the correction of which would improve patient care in line with the principles of clinical governance.

The two most frequently deficient areas, i.e. the lack of common waiting lists for common conditions and the absence of treatment plans in notes, should be straightforward to correct but require a consultant-led change in culture. Common waiting lists for simple conditions (tonsillectomy, septoplasty and ventilation tube insertion) have been proven to be associated with more efficient use of resources, and any resistance to their implementation is difficult to justify. Similarly, the inclusion of a treatment plan in outpatient notes can improve continuity of care and reduce the need for frequent appointments.

It was alarming to note that 26% of departments lacked dedicated facilities to treat children. Furthermore, there was no designated lead clinician for paediatric audiology in more than one in three departments. The provision of health care to children in dedicated paediatric facilities is a requirement of the Children Acts of 1989[4] and 2004.[5] The recent document, Specialist Health Services for Children and Young People,[6] produced by the Royal College of Paediatrics and Child Health, noted that services should be both accessible and child friendly, with the whole family experiencing a 'seamless web' of care as they move through the constituent parts of the NHS, including ENT departments.

Thirteen per cent of departments lacked direct access to hearing aid provision in subjects over 60 years. This is surprising considering that the British Society of Audiology stated in 1992 that direct access to hearing aids is a cost-effective way to shorten waiting lists and improve access for older people.[7] A recent publication has suggested that direct referral hearing aid clinics may also be feasible in younger patients.[8]

We found that 14% of departments lacked patient information leaflets although this is a requirement of the Clinical Negligence Scheme for Trusts (CNST). Trusts complying with high standards in risk management make reduced CNST contributions.[9]

Most ENT departments (91%) have specialist emergency equipment available 24 h. However, it is worrying that 9% did not comply. This finding corroborates a recent survey, which showed that not all ENT units are appropriately equipped for services during unsociable hours.[10]

By achieving a response rate of 91%, we were able to minimize bias. Nevertheless, this audit may be criticized for not having more replies from an individual hospital. However, in this type of assessment, it is not necessary to have multiple replies from the same unit, providing the information received is correct. The respondents were Consultants, Middle Grade Surgeons or Specialist Registrars who were in post long enough to have a good knowledge of available facilities. Discrepant responses were verified by telephone. We believe that our audit provides fairly accurate information on baseline standards of majority of ENT providers in England.

In conclusion, we have successfully used a combination of an internet-based questionnaire and phone calls to obtain information rapidly and inexpensively. The web-based questionnaire proved to be a very efficient method to collect data (78%), both for the respondents and the investigators. Our audit found that ENT departments in England meet the majority of the clinical standards recommended by *Action on* ENT. However, there is room

for improvement in administrative standards. Purchasers of health care should be aware of these published standards and consider their local providers' varying levels of compliance. We hope that our findings will make otolaryngology departments more aware of their own deficiencies and that we may demonstrate an improvement by repeating the second cycle of this audit in 2 years.

Conflict of interest

None declared.

Acknowledgements

We thank all the surgeons who took part in this audit.

Part of this work was presented in poster format at the joint BAO, RSM and *Action on* ENT annual meeting in Liverpool, July 2004.

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Appendix: *Action on* ENT Baseline Standards

Clinical standards

1. At every outpatient visit, audiology, microsuction and endoscopy should be available.
2. A treatment plan should be in the notes.
3. Multidisciplinary meetings should be held regularly, including audit.
4. Specialized nurses and allied health professionals should be available.
5. All departments treating emergency cases should provide 24 h availability of specialized equipment
6. There should be a specialist speech and language therapist with a formalized role within the ENT team
7. There should be dedicated day case facilities and preadmission clinics for elective admissions.

Administrative standards

1. All patients aged over 60 years should have direct access for hearing aids.
2. Referral letters should be triaged and patients directed to specialized clinics where appropriate.
3. Common waiting list for common conditions should be encouraged.
4. Patient information leaflets should be available for common conditions.
5. Children should be treated in dedicated facilities by appropriate staff.
6. Specialized paediatric audiology services should be available within a child friendly environment
7. There should be a lead professional for paediatric audiology.
8. All staff, including locums, should take part in induction programmes.
9. Monitoring of number of referrals per week, outpatient department activity, inpatient and day case activities, number of patients added onto waiting list per week.
10. Mechanisms should exist for involving patients, carers and the public.

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