

Health

National report



Access to care






Ear, nose and throat and audiology services

The Audit Commission is an independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high-quality local and national services for the public. Our work covers local government, health and criminal justice services.

Our national studies on the performance of health services examine services from a user's perspective and identify and promote examples of good practice. We also appoint auditors to all health authorities, primary care trusts and NHS trusts in England and Wales.

Our work focuses on:

- Whether there are firm foundations of good management to improve services to patients and provide value for money.
- How well organisations inside and outside the NHS work together to provide the best care for patients.
- How effectively key resources, for example, doctors, nurses, theatres, equipment and budgets, are managed.

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Preface

This is the report of the Audit Commission's study of waiting times in ear, nose and throat (ENT) and audiology departments. ENT was selected for study as it is one of the specialties with the longest waits. It is also less affected by emergency cases than other specialties, such as orthopaedics.

The study was carried out in collaboration with the NHS Modernisation Agency's programme *Action On ENT*. The two projects complement each other. The Audit Commission looked at what actually happened as patients travelled through the process of diagnosis and treatment in ten ENT services in 2001, analysed demand and capacity for all ENT services in England and sought the views of patients and general practitioners (GPs). *Action On ENT*, launched at the same time, focused on how to improve the delivery of ENT and audiology services. The *Action On ENT* programme published *Good Practice Guidance* in October 2002 (**Ref. 1**).

This study also complements the Audit Commission's broader review of waiting times which is being carried out in acute trusts in 2002/03 as part of the Acute Hospital Portfolio¹.

This report was prepared by Jane Laughton, Katerina Vardulaki, Deborah Causer and David Morgan. Statistical advice was provided by Daniel Smith and the study was directed by David Browning and Wendy Buckley. Supplementary papers explaining the methodology used in the study are available on the Audit Commission's website at www.audit-commission.gov.uk

The team is grateful for the support of the *Action On ENT* steering board, which provided advice throughout the project (**Appendix 1**) and for the co-operation of the study sites (**Appendix 2**).

¹ www.audit-commission.gov.uk/itc/acuteportfolio.shtml



Introduction and methodology

Waits for outpatients, elective surgery and audiology are a longstanding problem in ENT. The Audit Commission tracked the waits experienced by a sample of patients who received routine ENT and audiology treatment in 2001, analysed national data about ENT services in England, and sought the views of patients and general practitioners (GPs).

- 1 In nearly every year since the establishment of the NHS, the number of people who are waiting for hospital treatment has continued to rise, despite attempts by successive governments to reduce waiting lists (**Ref. 2**).
- 2 The Government set new interim and final waiting time targets for outpatients and elective operations for England in *Delivering the NHS Plan* in April 2002 (**Ref. 3**) (**Box A**).

Box A

Government waiting list targets for England

The Government has set interim waiting time targets to enable trusts to move towards the targets set out in *Delivering the NHS Plan*.

Target date	Maximum wait from receipt of GP referral to first outpatient appointment	Maximum wait from listing for surgery to admission for surgery
March 2003	5 months	12 months
March 2004	4 months	9 months
End 2005	3 months	6 months
End 2008	3 months	3 months (with an average wait of half this time)

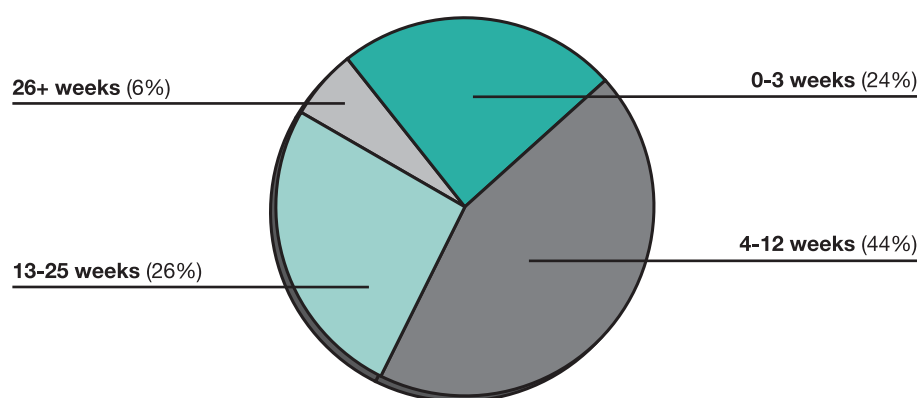
Bold type indicates targets set out in *Delivering the NHS Plan*. The others are interim targets.

Source: Department of Health

- 3 The Welsh Assembly Government has set targets and milestones for waits for each of the five health authorities in Wales. There are no national standards for waits for audiology services in England and Wales. Although waits for audiology are not monitored nationally, they are known to be very long at some trusts (**Refs. 4 and 5**).
- 4 Outpatient waiting times reported in the quarter ending March 2002 showed that, of the 186,000 patients seen in ENT departments in England, one-third waited over 12 weeks for their appointment [**Exhibit 1**].

Exhibit 1**ENT outpatient waiting times in England: length of wait for patients who were seen between 1 January and 31 March 2002**

One-third of new outpatients waited over twelve weeks.

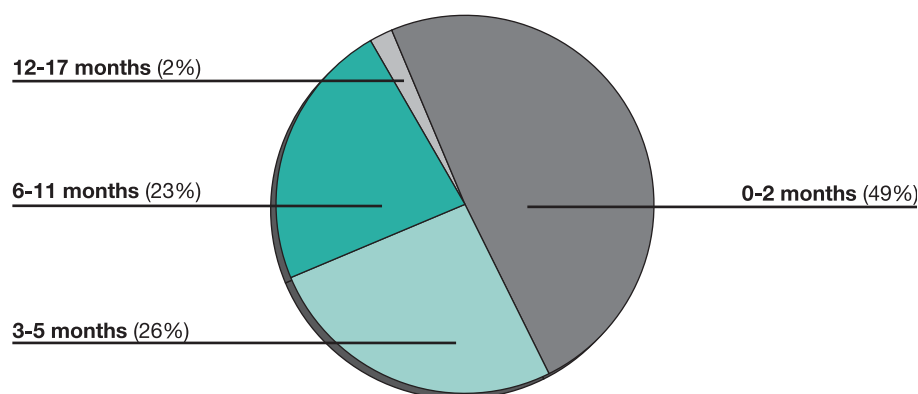


Source: www.doh.gov.uk/waitingtimes

- 5 At 31st March 2002 over 80,000 patients were still waiting for their operation in ENT in England, and one-quarter had already waited more than six months [Exhibit 2].

Exhibit 2**Waiting for an ENT operation in England: how long patients on the waiting list had been waiting at 31 March 2002**

One-quarter of patients had been waiting for more than six months.



Source: www.doh.gov.uk/waitingtimes

- 6 In Wales, ENT waiting times tend to be longer. A 'snapshot' of waiting lists on 31st May 2002 showed that over one-third of patients waiting for an ENT outpatient appointment, and over half of those waiting for an operation, had been waiting for over six months¹.
- 7 Reducing waits for ENT and audiology services poses a major challenge. The NHS Modernisation Agency, which supports improvement in the health service in England, launched *Action On ENT* in September 2000. *Action On ENT* focused on how to improve the delivery of ENT services and published *Good Practice Guidance* in October 2002 (**Ref. 1**).
- 8 In this study the Audit Commission worked alongside the NHS Modernisation Agency in its work on ENT services, looking at what actually happened as patients who received routine treatment for common conditions travelled through the process of diagnosis and treatment in ten ENT and audiology services in 2001. The Audit Commission also analysed demand, capacity and efficiency indicators for all ENT services in England, and sought the views of patients and GPs.

Methodology

- 9 The research for this study involved:
 - reviewing the case notes of patients who received one of three non-urgent procedures in ENT and audiology at ten trusts in England and Wales in order to track their waiting experience;
 - analysing comparative data on ENT services in England;
 - finding out what patients who received surgery for an elective procedure during a specific period at the study sites felt about their care by carrying out 'discovery interviews' and a postal survey; and
 - using a postal survey to get the views of over 400 GPs who refer patients to the study sites involved in this research.
- 10 For the case note review and patient interviews three groups of patients were selected:
 - children aged 12 and under who had a grommet inserted for the first time (usually a daycase procedure);
 - adults who had septal surgery (usually an inpatient procedure, but some are day cases); and
 - adults aged 60 and over who were having a hearing aid fitted for the first time (outpatient attendance at the audiology department).

- 11 All of the patients had their operations or were fitted with their hearing aid between January and October 2001. Those who had waited the longest had entered the system in 1999. The aim was for the patient groups to be as homogeneous as possible.
- 12 Further details of the methodology and statistical tests applied can be found on the Audit Commission website (www.audit-commission.gov.uk) as follows:
 - Supplementary paper 1: Methodology for collecting and analysing waiting times from case notes;
 - Supplementary paper 2: Methodology for surveying patients' views and a copy of the patient questionnaire;
 - Supplementary paper 3: Methodology for and the results of the GP survey; and
 - Supplementary paper 4: Methodology for grouping trusts into ENT services.



2



How long patients wait for ENT services

Comparisons between trusts showed wide variation in waits for both outpatient and elective surgery. Variations in waiting times between trusts cannot be directly explained by variations in demand and capacity. Even within some trusts, there are very wide variations in the length of time that patients wait. This suggests that access to services is not being actively managed by the department or by the hospital.

Variation in waiting times between trusts

- 13** This chapter describes the waits tracked for the first two groups of patients – children aged 12 and under who had a grommet inserted for the first time and adults who had septal surgery. The case note data were used to identify the following waits:
- the wait between the date on which the referral letter was written by the patient's GP or another clinician and the date the patient was first seen in outpatients (outpatient wait)^I;
 - the wait between the date that the patient was listed for surgery and the date on which they were actually admitted (wait for operation)^{II}.
- 14** The dates that the patient attended outpatients and was admitted for his or her operation were taken from documentation in the case notes. It was not possible to tell whether these dates were the first dates that the patients had been offered because 'did not attend' (DNAs) and appointments cancelled by patients or the hospital were not routinely recorded in the case notes. Department of Health (DH) waiting time measures take into account DNAs and cancellations^{III}. Comparisons between trusts were based on patients who only had one outpatient appointment before being listed for surgery.
- 15** There were wide variations between trusts in both waits for outpatients and for operations. These variations are statistically significant. Illustrations of the variations are shown below using the median. The median is the most valid way to describe the average length of wait for this type of data.



Web report – appendix 5

Patients having grommets inserted

- 16** The median wait for outpatients for grommet patients varied between 7 and 20 weeks. The variation in the median wait for an operation was greater – it ranged from 4 to 22 weeks. The trusts with the longest median outpatient waits also had long median waits for operations; for example, the median wait for patients at Trust I was 37 weeks from referral to treatment, whereas for patients at Trust F it was only 11 weeks **[Exhibit 3, overleaf]**.

^I This differs from the wait for first outpatient appointment currently monitored by the Department of Health (DH), which takes as its starting point the date that the referral letter is received by the hospital. This study took the earlier date because it more accurately reflects the wait experienced by the patient.

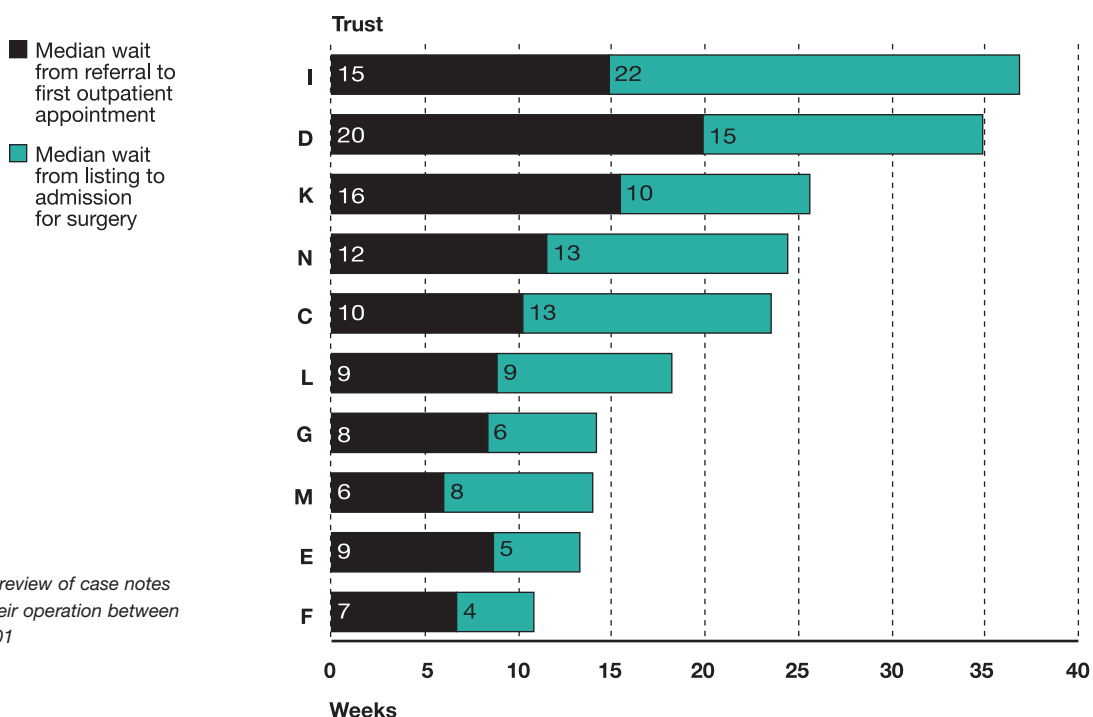
^{II} This is the same as the wait that is currently monitored by the DH.

^{III} DNA patients are taken off waiting lists, but DNA rates are monitored. Cancellations by patients are taken into account in measuring waiting times, so that the hospital is not penalised for decisions outside its control.

Exhibit 3:

Grommet patients: median waits for outpatients and operation

The trusts with the longest median outpatient waits also had long median waits for operations.



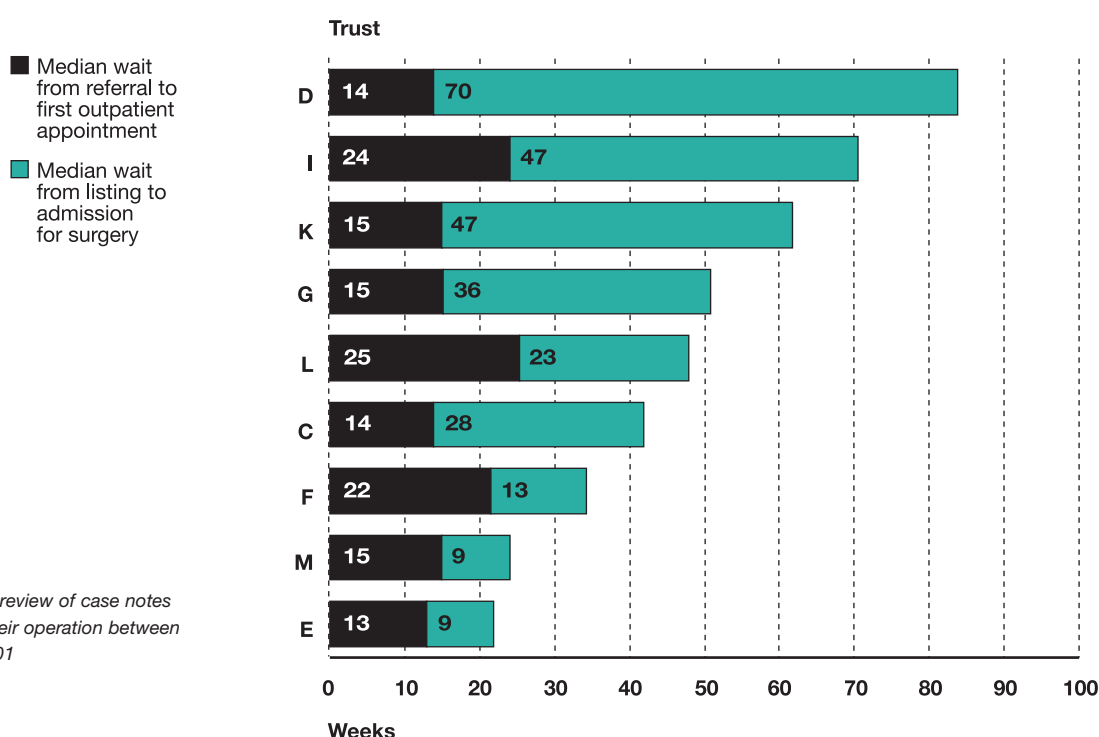
Source: Audit Commission review of case notes for 199 patients who had their operation between January and September 2001

Patients having septal surgery

- 17 Median waits for outpatients for septal surgery patients were generally longer than grommet patients' waits, but with less variation between trusts (13 to 25 weeks). However, there was wide variation between median waits for an operation. The median wait for operation at the trust with the longest wait was over 7 times greater than that at the trust with the shortest wait (range of 9 to 70 weeks).
- 18 The median wait for patients at Trust D from the date on which they saw their GP and were referred to the date on which they were admitted for surgery was 84 weeks. This is nearly four times as long as the median wait for patients at Trust E (24 weeks) [Exhibit 4].

Exhibit 4:**Septal surgery: median waits for outpatients and operation**

There was wide variation between trusts in the waiting times for an operation.



Source: Audit Commission review of case notes for 265 patients who had their operation between January and September 2001

Why do waits vary between trusts?

Variation in levels of demand, capacity and efficiency

- 19 The Audit Commission tested the hypothesis that long waiting times for outpatients and elective surgery are associated with relatively high levels of demand and relatively low levels of capacity. National data on ENT waiting times and a number of demand, capacity and efficiency indicators were compiled from DH and Audit Commission data (**Box B and Appendix 3**).
- 20 In order to make valid comparisons, all ENT departments in England were grouped into ENT services that provided both outpatient and inpatient services for a catchment population. This was necessary because some trusts' ENT departments see only outpatients, with the inpatient service being provided by a neighbouring trust. The catchment population of each ENT service was calculated from DH hospital episode statistics and population based data.



Box B

Demand, capacity and efficiency indicators calculated for ENT services in England

Demand	GP written referrals received per 1,000 population (2000/01) Admissions per 1,000 population (2000/01)
Capacity	GP referrals seen per 1,000 population (2000/01) Whole time equivalent (WTE) consultants per 100,000 population WTE junior doctors above senior house officer per WTE consultant Fixed clinic sessions ^{II} per WTE consultant per week Fixed theatre sessions per WTE consultant per week
Efficiency	Total outpatients seen per WTE consultant (2000/01) New outpatients seen per WTE consultant (2000/01) Theatre cases per WTE consultant (2000/01) New outpatient appointment DNA rate (2000/01) Follow-up outpatient appointment DNA rate (2000/01)

Source: Audit Commission

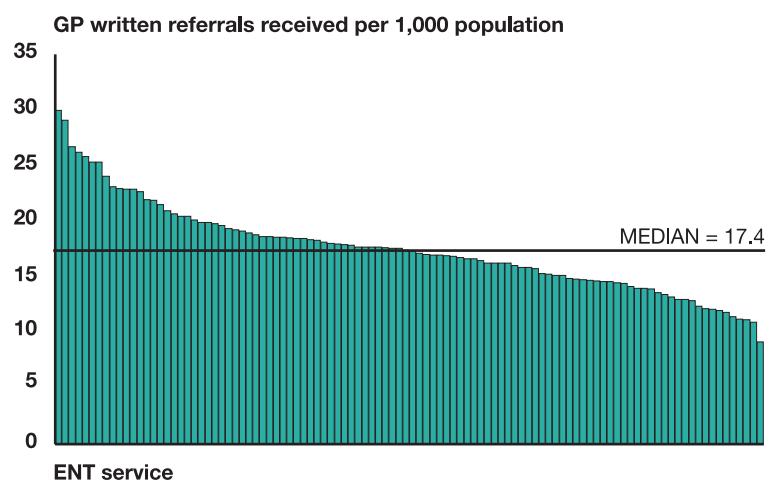
- 21 These indicators show wide variations between trusts in the level of demand and supply. For example, GP written referrals received per 1,000 population varied up to threefold and WTE consultants per 100,000 population up to fourfold [Exhibits 5 and 6]. The indicators are set out in full in Appendix 3.

I Consultant data at 31 March 2001.

II Fixed clinic sessions and fixed theatre sessions are the number of sessions set out in the consultants' job plan.

Exhibit 5**GP written referrals received by ENT services per 1,000 population**

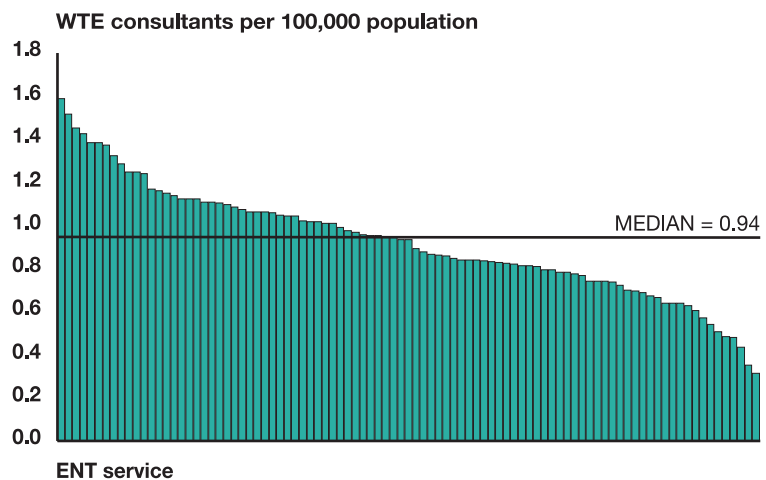
The level of demand from GP referrals varied up to threefold.



Source: Audit Commission trust groupings and populations; Audit Commission acute hospital portfolio data (medical staffing)

Exhibit 6**Whole time equivalent consultants per 100,000 population**

The number of consultants per 100,000 population varies up to fourfold.



Source: Audit Commission trust groupings and populations; Audit Commission acute hospital portfolio data (medical staffing)

- 22 Despite these wide variations, no correlations were found between demand and capacity indicators and the proportion of patients with very short or very long waits, as reported in the national waiting times data (**Appendix 4**). This does not mean that these factors are irrelevant. It does mean that waiting times alone should not be used to make resource allocation decisions. The NHS Modernisation Agency's work with trusts on waiting list management shows that the longest waits can be reduced by re-organising existing capacity and managing demand in different ways. Changes in the use of resources and additional funds should only be committed following analysis of demand, how well capacity is used to meet this demand and how well waiting times are managed.

Clinical priorities

- 23 One possible reason for the variation in waits between trusts is differences in opinion about clinical priorities between consultants at different trusts. Individual consultants assess all referrals made to outpatients when they are received in the ENT department and decide whether the patient should be seen as a priority or as a routine appointment[†]. A judgement is also made on priority when a decision is made that a patient needs surgery.
- 24 Differences of opinion between clinical teams may not be explicit. The NHS Modernisation Agency's Demand Management Team cites evidence that, in many areas, waiting lists are managed with little agreement on clinical priority, that is, what proportion of the patients who are waiting are urgent or routine, and how soon they need to be seen or treated (**Ref. 6**).
- 25 For this study common procedures were selected with the intention of excluding cases treated as being urgent. For grommets, however, there is an unusual lack of consensus among ENT consultants on priority. This was demonstrated by the results of a priority setting exercise facilitated by an independent consultancy (**Ref. 7**) (**Box C**). In one trust the ENT consultants considered that no grommet operations needed to be carried out within three months, and in another trust consultants thought that all grommet operations should be carried out within three months.

[†] Some departments operate three categories: 'urgent', 'soon' and 'routine', but the NHS Modernisation Agency has shown that using two categories can shorten maximum waiting times (Ref. 9).

Consultants were asked what proportion of grommet patients should be operated on within certain time periods (figures indicate the proportion of patients).

Source: Ref 7

Box C

Consultant views on the priority of grommet operations

ENT consultants differ in their view of the urgency of grommet operations.

	Within 1 month	1 to 3 months	Over 3 months
Trust X	20%	80%	0%
Trust Y	0%	20%	80%
Trust Z	0%	0%	100%

Variation in waiting time within trusts

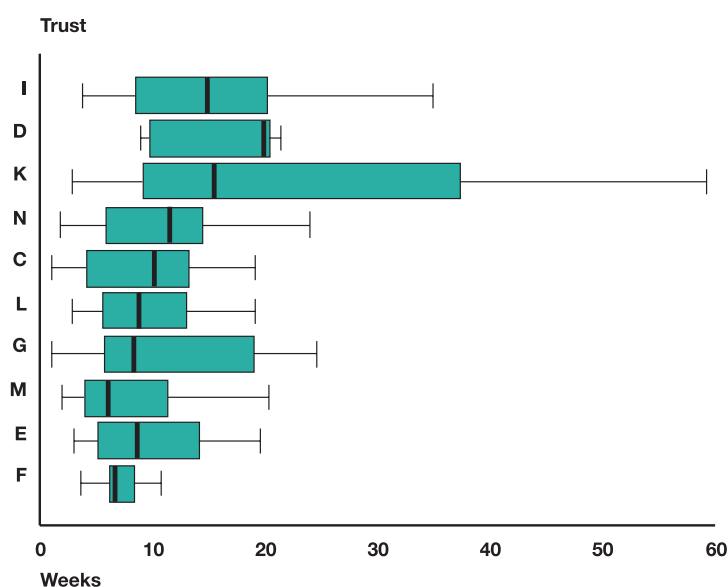
- 26 As well as variations between trusts, this study also found wide variation within trusts for patients undergoing the same procedure. Exhibits 7a and 7b, overleaf, show this variation both for outpatient wait and wait for an operation for grommet and septal surgery patients.

Exhibit 7a

Variation in waits by patient – grommet insertion

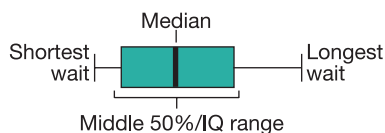
Even when looking at the middle 50 per cent of patients, there is considerable variation in waiting time within some trusts.

Outpatient wait



These graphs show the distribution of the waits for all patients in the sample. They show:

- the shortest and the longest waits (the ends of the thin line)¹;
- the middle 50 per cent of waits or inter-quartile range (the boxed area); and
- the median wait (the vertical line in the middle of the boxed area).



Source: Audit Commission review of case notes for 199 patients who had their operation between January and September 2001

¹ Excluding outliers defined as 1.5 to 3 box lengths from the upper or lower edge of the box. The box length is the inter-quartile range.

Wait for operation

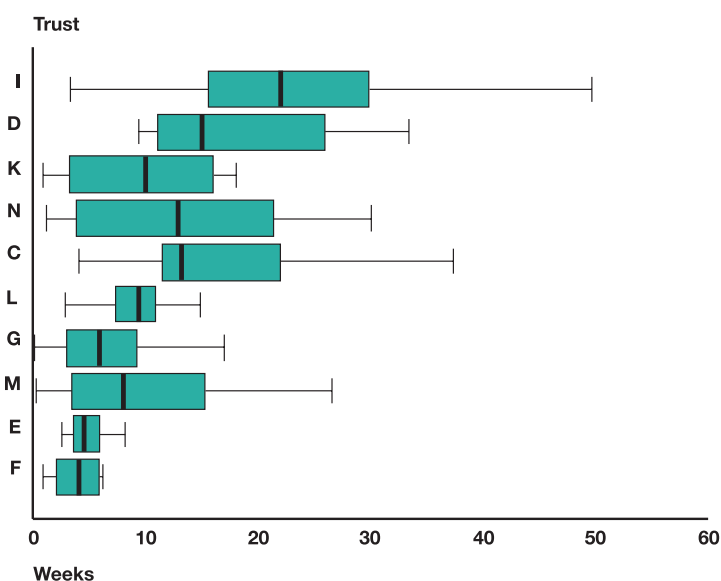
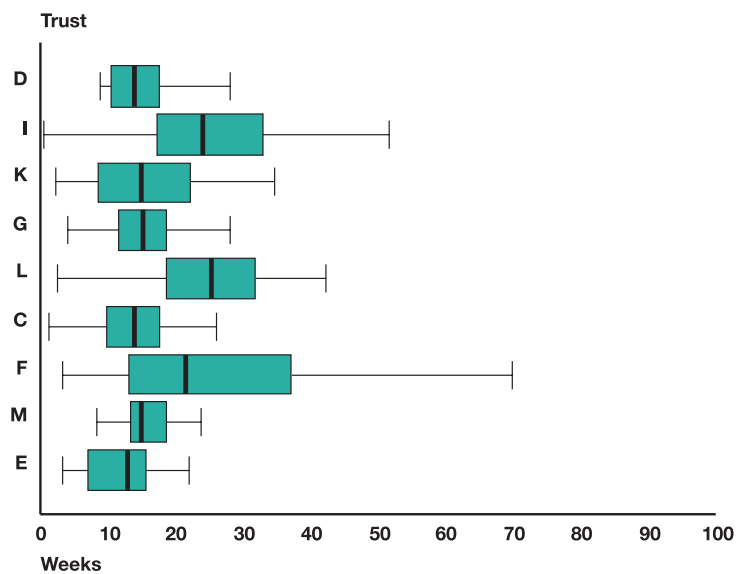
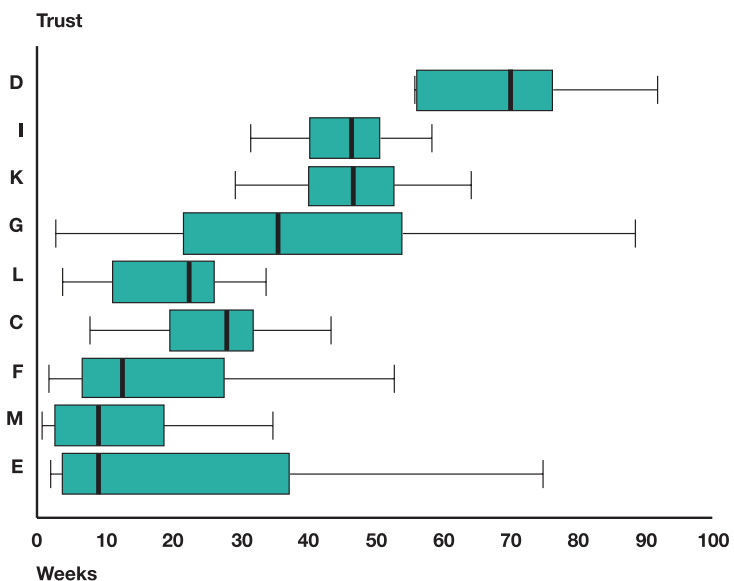


Exhibit 7b**Variation in waits by patient – septal surgery**

Even when looking at the middle 50 per cent of patients, there is considerable variation in waiting time within some trusts.

Outpatient wait**Wait for operation**

Source: Audit Commission review of case notes for 265 patients who had their operation between January and September 2001

- 27 Even when the patients with very short or long waits are excluded, and waits are described for only the middle 50 per cent of patients, there is considerable variation at some trusts. For example, at Trust I the middle 50 per cent of grommet patients waited between 9 and 23 weeks for an outpatient appointment, and then anything between 15 and 36 weeks for an operation.

Why do waits vary within trusts?

- 28 Established NHS policy on managing waits for elective care is that patients should be seen in order within clinical priority (**Refs. 6, 8 and 9**). If this policy is being followed, the distribution of waits experienced by patients within trusts for a particular procedure should be within a narrow range, although there may be some variation due to:
- individual differences between patients, such as social and economic circumstances and the effect that the patient's condition has on his or her everyday life. These may be taken into account in determining priority even though there may be no clinical reason for differentiating between patients;
 - unforeseen changes to demand or capacity, such as a possible acceleration of grommet and septal surgery cases during the period of this study because few tonsillectomy operations were carried out (due to a shortage of disposable instruments);
 - additional capacity created to 'blitz' waits in order to meet waiting times targets. This would mean that more recent entrants to the system would not wait as long as earlier entrants; and
 - rescheduling as a result of cancellations of planned operations by the trust or patient and patients not attending appointments.
- 29 The wide distributions and the very long waits found for the same procedure in some trusts suggest that some waiting lists are not being well managed. In particular there may be:
- a lack of agreed policies on clinical priorities and differences in judgements about clinical priority between different consultants at the same trust; and
 - queue-jumping, which results in patients being seen out of order. Accelerating a patient up the queue would be justified if the clinical priority of the patient changes because his or her condition changes. However, some services allow patients to jump the queue in response to enquiries or complaints about a long wait (**Box D**). Some services have an inadequate system for handling late cancellations, which means that cancelled slots are allocated to recent entrants to the queue.

Box D

Comments from patients in the Audit Commission survey

'I thought I may have been forgotten after six months so I rang. Funnily enough my appointment date arrived in a matter of days!'

'I only need to contact my consultant's secretary to get an earlier appointment.'

Source: Audit Commission survey of ENT patients – comments added by patients

- 30 Information on consistency of wait between patients with the same condition or patients waiting for the same procedure is not normally collected or reviewed by primary care trusts or acute trusts. The management of waiting lists with regard to fairness and efficiency is the subject of further Audit Commission work during 2002/03 at acute trusts as part of the Acute Hospital Portfolio¹.

Recommendations

- 31 Waiting times alone should not be used to make resource allocation decisions. Changes in resource use and additional investment should only be made after an analysis of demand, of how well capacity is used to meet this demand and of how well waiting times are managed.
- 32 The distributions of waits for outpatients and for routine procedures can be used to diagnose problems in waiting list management systems. Where distributions are narrow but waits long, local health commissioners and acute trusts should review capacity to identify whether resources can be used more efficiently or effectively, and whether there are shortfalls in resources.

¹ www.audit-commission.gov.uk/itc/acuteportfolio.shtml

3



Patients' views about their experience of ENT services

Patients who had undergone an operation were generally very satisfied with their experience. The most significant improvement patients would like is more information about their operation, especially recovery time and side-effects, and the ability to contact the hospital after discharge.



Web report – appendix 5

I This is difficult to evaluate, as a period of 'watchful waiting' or conservative medical management – such as nasal sprays for nasal blockage – can be clinically appropriate decisions. It is a valid concern if doctors are not communicating to patients that 'watchful waiting' is part of the treatment process. In the postal questionnaire, 59 per cent of patients said that they saw their GP two or more times before they were referred to outpatients.

II No questionnaire was produced for audiology patients because few had agreed to be interviewed, and those that did raised few concerns in the interviews. Most patients expressed satisfaction with the care and services that they received.

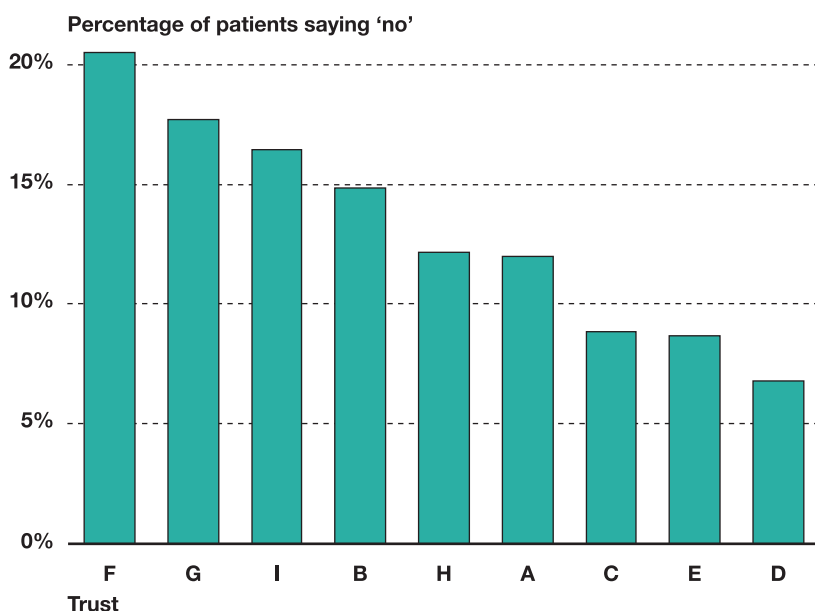
- 33 Patient views can be used to identify how services can be improved. The approach taken in this study was to:
- interview patients to discover their views on the service; and
 - use their concerns to draw up a postal questionnaire to send to a larger number of patients.
- 34 Seventeen one-to-one interviews were carried out with recent patients from the three groups reviewed in Chapters 2 and 4 – septal surgery patients, parents of grommet patients and hearing aid patients. The main areas of concern arising from the interviews were:
- difficulty getting a referral to secondary care^I;
 - a lack of information about who to contact to confirm or change appointment times, and to get information about when and where to attend;
 - difficulties contacting the hospital;
 - receiving conflicting information from different staff members;
 - inaccurate information about recovery time and side effects; and
 - not knowing who to contact after an operation for advice or to answer specific queries or problems.
- 35 A questionnaire was produced in order to quantify the concerns raised in the interviews. It was sent to 250 patients who had recently undergone ENT surgery in nine of our study sites (a total of 2,250 patients). Of the questionnaires sent out, 1,216 were returned, giving an overall response rate of 54 per cent^{II}. Examples of variation in responses between trusts are shown below [Exhibit 8, overleaf].

Exhibit 8

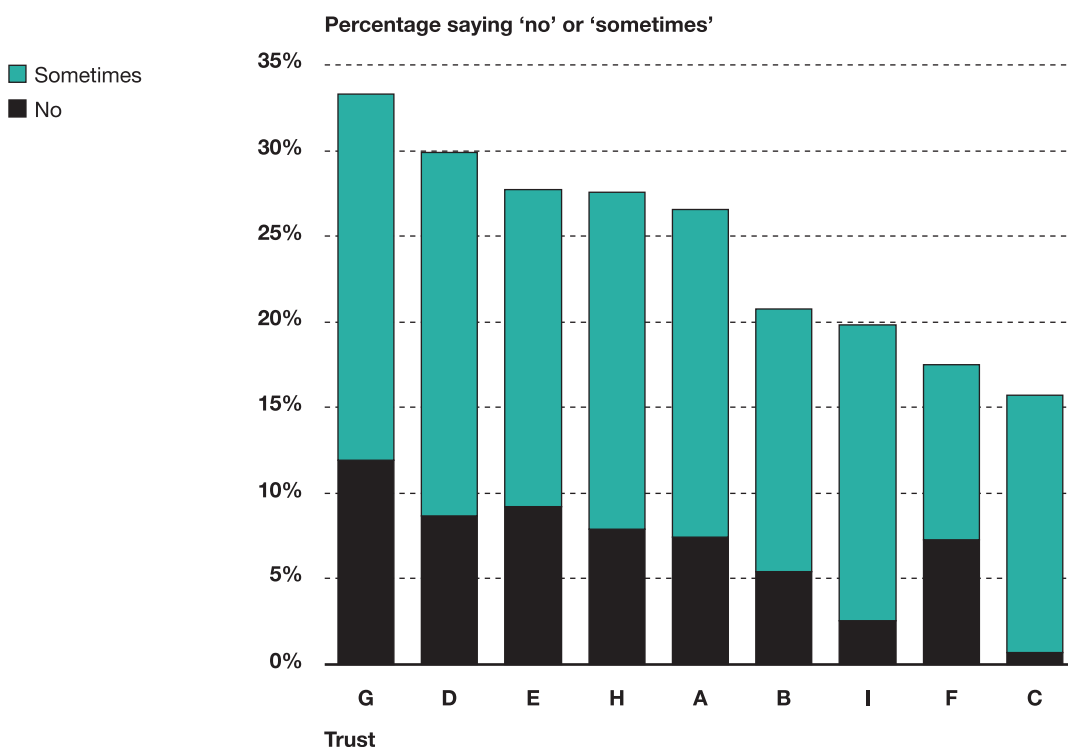
Variation in responses by patients at different trusts

Patients received more accurate information and found hospitals easier to contact at some trusts than at others.

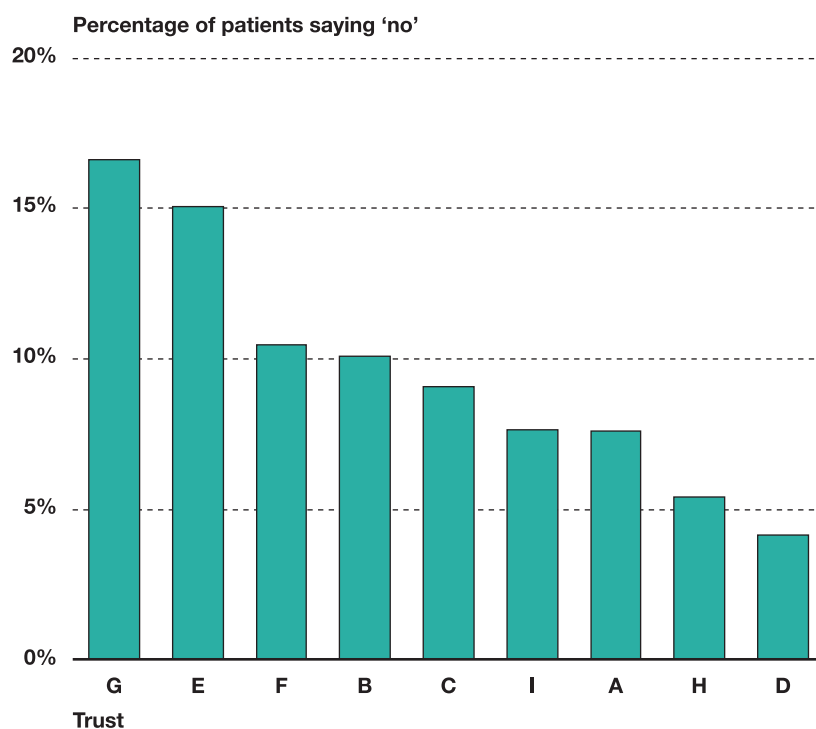
Did the hospital tell you whom to contact if you had any problems after your operation?



Thinking about the times you have phoned the hospital, was it easy to get through to the hospital on the telephone?



Were you told what to expect after your operation in terms of time to recovery?



Source: Audit Commission survey of 1,216 ENT patients, January – March 2002

- 36 The survey gave patients the opportunity to tell us anything further that they considered to be important. Patients were generally very happy with the care that they received (**Box E**).

Box E

Patient comments about the service that they received

The doctors and nurses were brilliant. They were very kind and polite.

I'm under a very good consultant, the best! The care and treatment I received has been first class.

Everyone, including the surgeon, made you feel like a person and not a number.

Altogether [the staff] are truly wonderful dedicated people...

I couldn't have asked for better treatment from Mr... and his team.

Source: Audit Commission survey of 1,216 patients, January – March 2002

- 37 A number of patients also expressed concern about aspects of their care that were not addressed in the survey. These responses are unlikely to be representative of all ENT patients and cannot, therefore, be used to estimate the prevalence of particular problems. However, the following themes were mentioned by a number of respondents:
- having to wait for their outpatient appointment while in hospital (not being seen at their scheduled time)...
- I had my appointment cancelled after waiting in hospital ALL day.*
- We were over two hours late seeing the consultant for approximately ten seconds.*
- ...and for their operation (patients having to wait for a long time to go in to surgery and/or being told of cancellation after arrival)
- I was sent home after waiting for two hours as there was no bed for me. I should have been told early morning to save me a lot of upset.*
- unhygienic or mixed wards
- The system of mixed wards is really unacceptable. Both my dignity and the dignity of the women on the wards were seriously compromised.*
- lack of information about the operation and possible side effects
- I would have liked to know more about the operation procedure.*
- lack of information and advice on self-care after discharge
- I was explained about the operation, but no advice was given about coping after the operation.*
- I didn't know about the recovery time until after the operation and had not organised any help.*
- concerns over being unable to understand doctors' accents
- I saw an SHO who had little grasp of English. I had difficulty understanding what she was saying.*
- 38 The Action On ENT steering board has already responded to these findings by incorporating the need for written patient information into their Recommended Baseline Standards (Ref. 10). Action On ENT has also funded the British Association of Otorhinolaryngologists and Head and Neck Surgeons (BAO-HNS) to produce patient information leaflets for common clinical conditions, and to develop the BAO-HNS website. A summary of approaches to patient involvement is in the Good Practice Guidance (Ref. 1).

Recommendations

- 39 ENT services should review the quality of information for patients about their operation, especially recovery time and side-effects, and provide a contact number after discharge.
- 40 Patients should be continuously involved in a dialogue about improving services. Surveys could be repeated at intervals to test whether patients report improvements.

4



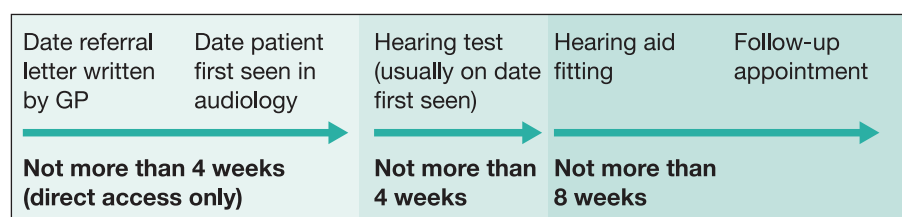
How long patients wait for audiology services

There are no national standard waiting times for audiology. Comparisons between trusts demonstrate wide variation in waits, and some are unacceptably long. The introduction of digital hearing aids and an ageing population are likely to increase demand for hearing aids. Within a few trusts, there are wide variations in the length of time that patients wait for hearing aids, suggesting that waiting lists are not always well-managed.

- 41 There are no government standards relating to waiting times for audiology services in England and Wales. Information on waits is not collated centrally, although individual departments may monitor their own waiting times. The Welsh Assembly Government is planning to introduce standards.
- 42 The Royal National Institute for Deaf People (RNID) has recently produced recommended best practice standards on waiting times for adult audiology services **(Ref. 11) (Box F)**. The RNID intends these standards to integrate with the new protocols being introduced in the Modernising NHS Hearing Aid Services Programme launched in England in 2000¹.

Box F

RNID Best Practice Standards for Adult Audiology (July 2002)



Source: Ref. 11

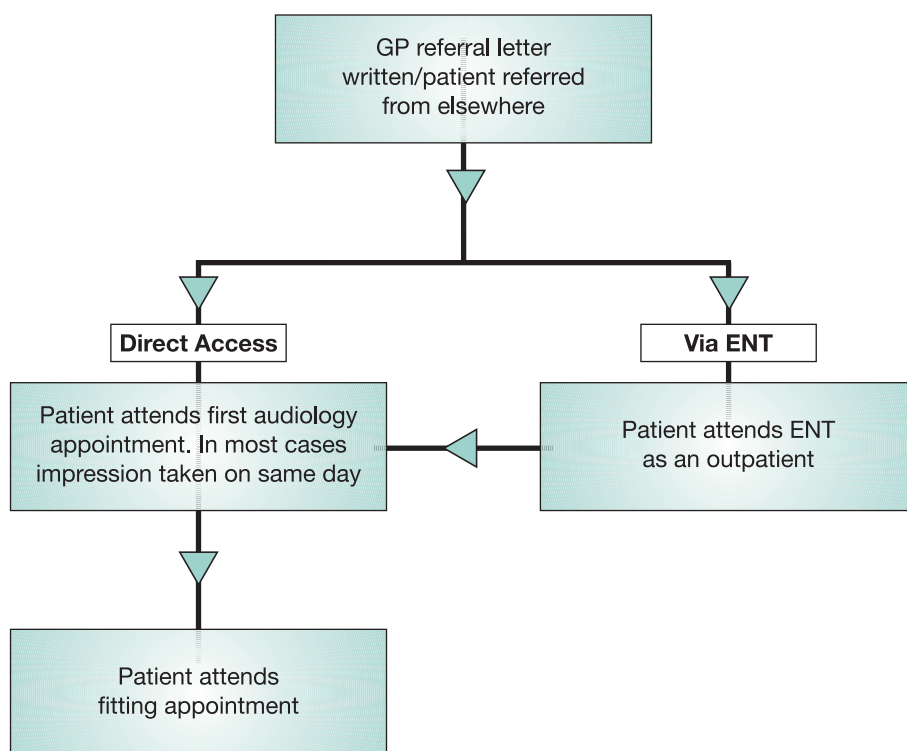
- 43 There are two main ways to access hearing aid services in the NHS – via an outpatient appointment at the ENT department or by ‘direct access’ to the audiology department **[Exhibit 9, overleaf]**. Since 1994, direct access has been the recommended practice for all patients who fulfil certain criteria **(Ref. 12)**.
- 44 Direct access is recommended for patients aged 60 and over and usually provides a quicker service, with the wait to see an audiologist normally shorter than the wait to see an ENT consultant. However, at one trust involved in this study the wait for a direct access appointment was longer than the wait for an ENT outpatient appointment. Patients who are referred to the ENT department will normally see an audiologist during the same visit.

¹ Both England and Wales have recently introduced programmes to modernise hearing aid services and improve the quality of service. This includes offering patients digital hearing aids rather than the analogue aids currently provided by the NHS. In England 20 trusts have piloted the provision of digital hearing aids and 30 more are due to offer them by the end of 2002 as part of the Modernising Hearing Aid Services Programme. According to the interim evaluation of the English programme, the modernised service improves hearing outcomes for patients (Ref. 13). Wales has a similar programme run by the Modernising Audiology Services Agency Wales (MASW) and all Welsh departments should be ready to offer digital aids by the end of 2002.

Exhibit 9

Routes to a hearing aid

Direct access is recommended for most patients and normally provides a quicker service.



Source: Audit Commission

- 45 The Audit Commission's survey of GPs showed that 15 per cent were unaware of direct access, despite the service being available in the trusts to which they referred. Some ENT consultants reroute patients from ENT to audiology after reading the referral letters and identifying that they would be suitable for direct access.



Web report – appendix 5

Variations in waits between trusts

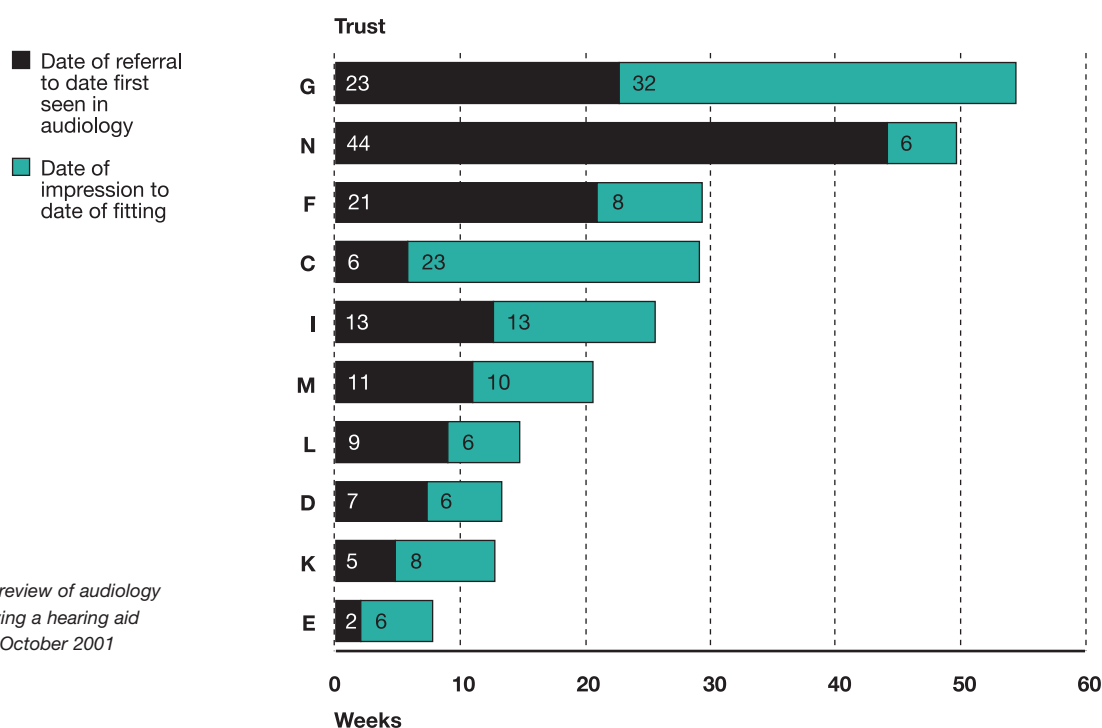
- 46 An analysis of audiology records was used to determine the waiting times experienced by a sample of patients at each of the study sites. The waits calculated were:
- the wait between the date on which the patient was seen and referred by their GP or another clinician to the date of their first assessment in audiology; and
 - the wait between the date on which the patient was assessed for a hearing aid and an impression taken and the date on which the hearing aid was fitted.

Exhibit 10 shows the median waiting times by trust for patients attending direct access clinics.

Exhibit 10

Median waits for hearing aid patients (direct access)

There is wide variation in waiting times for hearing aids – at some trusts waits are very long.



Source: Audit Commission review of audiology records for 353 patients having a hearing aid fitted between January and October 2001

- 47 There was greater variation between trusts in the length of waits for hearing aid patients than for septal surgery and grommet patients. The median wait from referral to first assessment in audiology varied between 2 and 44 weeks and the wait from impression to fitting between 6 and 32 weeks. At the trust with the longest total waits (Trust G) the median wait was 55 weeks from being referred to being fitted with a hearing aid.
- 48 This is consistent with the RNID's evidence of wide variation in waiting times cited in the Audit Commission report *Fully Equipped* (Ref. 4). A further survey by the RNID in March 2001 (Ref. 5) reported that waiting times had deteriorated further and that they still varied widely between trusts. It reported average waits for a hearing test in England of three months, with one in eight services keeping patients waiting for six months or longer.

- 49 The performance of the study trusts against the RNID best practice standards (Ref. 11) are reported in Box G.

Box G

Proportion of hearing aid patients meeting RNID best practice standards^I

Trust	Per cent of patients meeting RNID standard for first appointment	Per cent of patients meeting RNID standard for fitting
G	<5%	<5%
N	<5%	8%
F	<5%	<5%
C	23%	<5%
I	<5%	<5%
M	10%	6%
L	14%	33%
D	28%	8%
K	42%	<5%
E	96%	<5%

Source: Audit Commission review of audiology records for 353 patients having a hearing aid fitted between January and October 2001

Why do waits vary within trusts?

^I Ref. 11

^{II} For example, the service is not dependent on the availability of theatre capacity, beds, and so on. There is also less reason for variation in clinical priority.

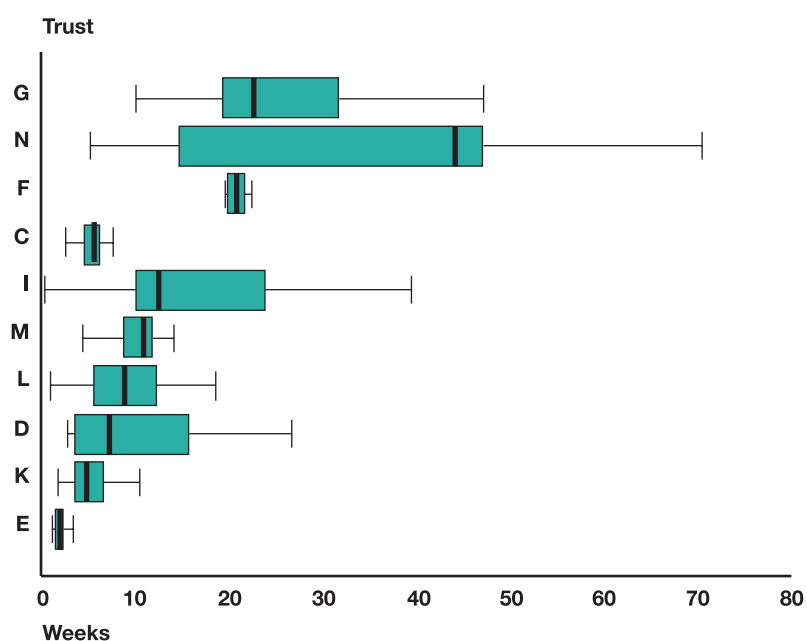
- 50 The assessment and fitting of hearing aids takes place in a less complex environment than ENT outpatients and operations, which should eliminate many of the causes of variation in ENT waits^{II}. [Exhibits 11a and b] show the extent of variation in the length of waits for patients attending appointments at the same trust; for example, there is very little variation in either wait for patients at Trust F. In contrast, there is a variation of over 21 weeks for both waits in the pathway at Trust G.

Exhibit 11a

Variation in waits by patient – hearing aids

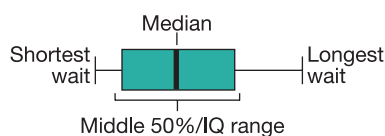
At some trusts there is very little variation; in others there is wide variation.

Wait for audiology appointment (direct access patients)



These graphs show the distribution of the waits for all patients in the sample. They show:

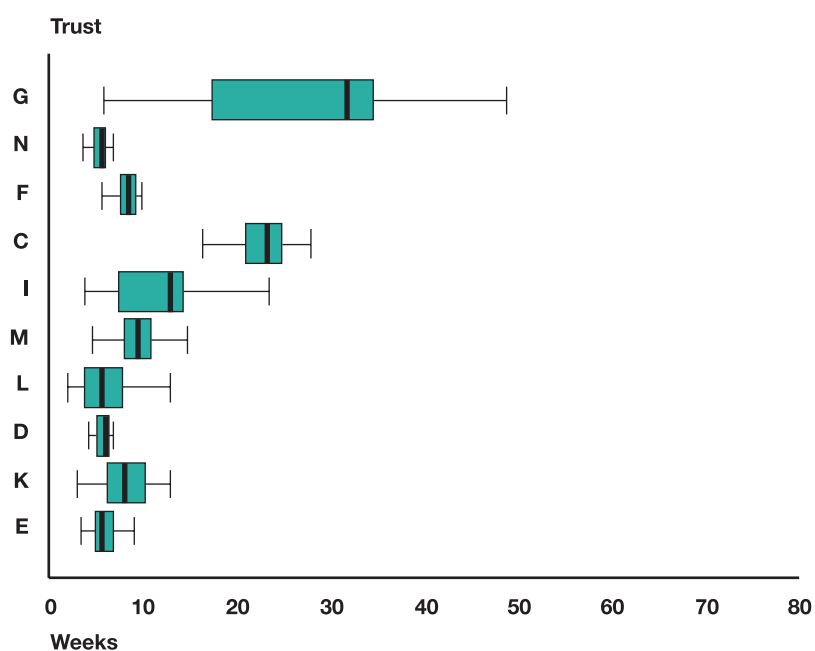
- the shortest and the longest waits (the ends of the thin line)¹;
- the middle 50 per cent of waits or inter-quartile range (the boxed area); and
- the median wait (the thick vertical line in the middle of the boxed area).



Source: Audit Commission review of audiology records for 353 patients having a hearing aid fitted between January and October 2001

¹ Excluding outliers defined as 1.5 to 3 box lengths from the upper or lower edge of the box. The box length is the inter-quartile range.

Wait for hearing aid fitting



- 51 At most of the study sites patient waits are within a narrow time band, indicating that patients are probably being seen in order. The distribution of waiting times alone, however, cannot demonstrate that capacity is being used to best effect. There may still be opportunities to use resources more efficiently and bring down waiting times. Analysis of demand and capacity will enable opportunities to be explored and specific resource shortfalls to be identified. In those trusts where there is an exceptionally wide distribution and some very long waits, management of waits is likely to be poor.

Demand, capacity and efficiency

- 52 Demand for hearing aids is not reported nationally. In *Audiology in Crisis* (Ref. 5), the RNID reported a 7 per cent increase in adult referrals in 1999/2000 over the previous year. Age-related hearing loss is likely to increase in future years as the number of older people increases. The introduction of digital hearing aids is also likely to increase demand.
- 53 Previous work has reported wide variation in staffing levels and efficiency in audiology departments. Data collected from the Medical Research Council (MRC) Institute of Hearing Research in 1996/97 and reported by the Audit Commission (Ref. 4) showed wide variation in the number of hearing aids issued per staff member. *Audiology in Crisis* reported a 'very wide variation in staffing levels' that was not related to the number of patients being referred (Ref. 5). At least one of the trusts with long waiting times involved in this study reported that a shortage of staff was causing long waits.
- 54 Staffing capacity is a major issue, as the modernisation programme requires audiologists to spend more time with patients, and the professional training period for audiologists is rising from two to four years. The MRC Institute of Hearing Research has estimated that an additional 400 audiologists will be required in England if the Modernising Hearing Aid Services¹ programme is rolled out to all adult audiology services (Ref. 14).
- 55 Some trusts that fit analogue aids report that the budget for hearing aids is insufficient to meet demand. Depending on how this is handled, it can lead to longer waits for all patients, or to longer waits for patients nearer the end of the financial year. Digital hearing aids are more expensive than analogue aids and this may add to financial pressures.

¹ See footnote on p 27.

Recommendations

- 56 National waiting time standards should be introduced for audiology and all NHS services where waiting occurs. These should be monitored by the DH, the Welsh Assembly Government, local health commissioners and trusts providing services.
- 57 Trusts should monitor the distribution of waits for audiology services to ensure that patients are seen in order.
- 58 Local health commissioning bodies and acute trusts should ensure that GPs and patients know about the availability of direct access clinics for audiology.

5



How to improve access to care

Local health commissioning bodies and acute trusts seeking to improve waiting times for patients in a particular specialty need to analyse demand and capacity in primary and secondary care. The analysis should be used to categorise demand and plan capacity to meet it, including redesigning services. Where waiting lists are necessary, local policies should be agreed to ensure that patients are generally seen in order. Demand, capacity and waiting time distributions should be monitored.

Analysing demand, capacity and efficiency

- 59 The Modernisation Agency has devised a number of tools to support primary care trusts and acute trusts in reviewing demand, capacity and efficiency. These include a step-by-step guide to improving outpatient services (**Ref. 8**) and a tool for matching capacity with demand (www.modern.nhs.uk/improvementguides/capacity).
- 60 Comparative information can help to diagnose potential problem areas in capacity. One source of such information is the Audit Commission's Acute Hospital Portfolio^I. By April 2003 this project will provide every acute trust in England and Wales with a tailored report on the relative fairness and efficiency of its waiting times (in outpatient departments and for admission) and its use of inpatient beds and operating theatres. This will be prepared by each trust's auditor using data collected from trusts earlier in 2002 and national sources. The data will be released to trusts during 2003.

Redesign: *Action On ENT*

- 61 The *Action On ENT* programme has provided funding and training for trusts to try different ways of providing ENT and audiology services. Ten regional pilot sites in England have used Modernisation Agency redesign tools and discovery interviews with patients to direct them in deciding how to improve their services. *Action On ENT* has also established four national pilots where several trusts work on the same aspect of redesign as part of a network. The national pilots have included various aspects of audiology, piloting the introduction of GPs with a special interest, communication between primary and secondary care and improving services for patients who have a balance disorder^{II}.
- 62 Case Studies 1 and 2 describe what two trusts have done to streamline and redesign parts of their ENT services as part of *Action On ENT*.

Tackling variations in waiting times within a trust

- 63 One trust addressed the problem of variation in waiting times by appointing a clinic co-ordinator to ensure that patients were being seen in order and that outpatient clinics were being used efficiently (**Case Study 1**).

Case Study 1

North Staffordshire Hospitals NHS Trust

North Staffordshire Hospitals NHS Trust is a regional pilot site for *Action On ENT*. It used some of its *Action On ENT* funding to appoint a clinic co-ordinator whose remit was to improve the running of outpatient clinics and reduce variations in waiting times.

^I www.audit-commission.gov.uk/itc/acuteportfolio.shtml

^{II} GPs with a special interest are doctors who are both qualified to provide the full range of GP services, and have additional, specialised training and expertise. They can take referrals in relation to their specialist interest from GP colleagues for the assessment and/or treatment of patients who would otherwise have been referred direct to a consultant in secondary care.

The ENT Department knew that patients were not being seen in order and that cancelled outpatient slots were being filled with patients who had recently joined the waiting list. Outpatient clinics were not being used efficiently – some weeks they were overbooked and other weeks they were underused, and there was variation in the time that patients waited to see their consultant.

The clinic co-ordinator actively manages the outpatient waiting list in the ENT Department. She compiles accurate information about who is on the list and how long they have been waiting. She manages the clinic lists and ensures that clinics are being used to capacity and that patients are being seen in order as far as is possible.

The Trust has combined this active management of outpatient clinics with various initiatives to identify which patients could be seen by other types of clinician. These include:

- audiologists following up children who have had grommet operations;
- lowering the threshold for direct access to audiology for patients with hearing loss from 60 to 50 years; and
- GPs with a special interest seeing some ENT referrals.

As a result of all of these strands of work the average waiting time for a routine outpatient appointment fell from its peak of 19 weeks in November 2001 to 11 weeks in April 2002. The number of patients waiting for over 13 weeks fell from 720 to 98 in the same time period. There is less variation in waiting time by consultant, with 70 per cent of referrals being allocated to a general (or pooled) waiting list.

The challenges for the Trust now are:

- to address the increased waiting times in the audiology department that have come about as a result of the redirection of work from ENT; and
- to sustain the improvements in ENT outpatient waits.

Source: Audit Commission fieldwork

Redesigning services to improve quality

- 64 Another trust redesigned its services to improve the quality of care for patients and to reduce pressure on doctors (**Case Study 2**).

Case Study 2

Blackburn Royal Infirmary

Blackburn Royal Infirmary is a regional pilot site for *Action On ENT*. After carrying out process mapping and holding discovery interviews with patients, the *Action On ENT* team decided to reconsider how outpatient clinics were used and organised. The department was under pressure to maintain outpatient waiting list targets and wanted to reduce the number of patients booked into outpatient clinics in order to give patients more time with the doctor.

It redesigned the pathways for certain groups of patients and used *Action On ENT* funding to employ a nurse practitioner to see patients who would otherwise have been seen by an ENT doctor. The nurse practitioner's activities include:

- a tonsil clinic. The consultants read all referral letters and pass relevant referrals to the nurse practitioner. She sees the patients, using an agreed protocol, and lists them for tonsillectomy if the patient wants the operation, or refers back to the consultant if necessary (only 2 per cent have been referred back to the consultant so far);
- telephone follow-up for nasal surgery patients. The nurse practitioner telephones patients three months after surgery and asks them questions from a questionnaire agreed with the ENT consultants. Patients are offered an outpatient appointment with the consultant within three weeks if they want one – so far only 9 per cent of patients have wanted to see the consultant; and
- an aural care clinic for routine mastoid cavity cleaning. The nurse practitioner sees all patients in this clinic. She received in-house training from the consultants.

Within ten months of being appointed, the work being done by the nurse practitioner has released over 1,000 outpatient slots. The number of patients seen in ENT outpatients has reduced from an average of 18 to an average of 13 patients per clinic per doctor. This reduction has improved the quality of the consultation. The department is able to see all outpatients within 13 weeks without holding so many waiting list initiative clinics.

Source: Audit Commission fieldwork

GPs with a special interest

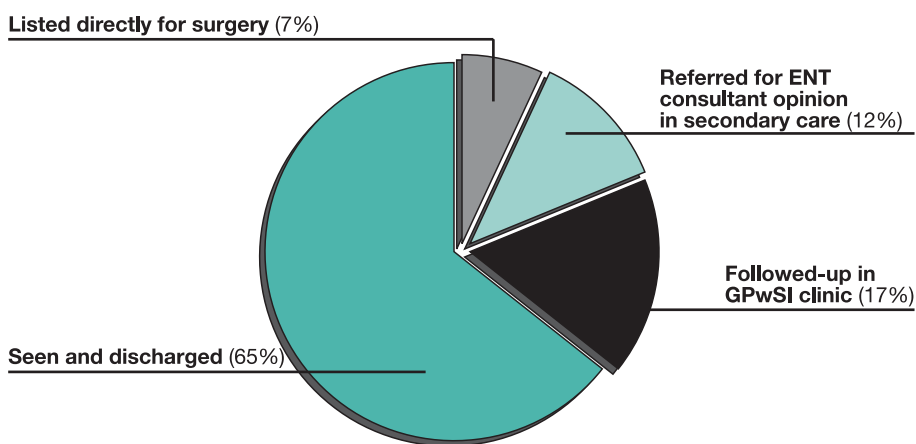
- 65 One of the national pilots established by *Action On ENT* explored the establishment of GPs with a special interest (GPwSIs). The reasons for developing GPwSIs are to:
- reduce the number of patients being referred to ENT outpatients, thereby reducing outpatient waits and enabling consultants to concentrate on seeing patients who need their skills;
 - give patients quicker access to a specialist opinion;
 - provide a more convenient service for patients – many GPwSIs see patients in GP surgeries or health centres; and
 - give GPs with an interest in ENT the opportunity to use their existing skills or to develop new ones.
- 66 Another potential benefit is improving the level of understanding between GPs and consultants. The Audit Commission's survey of GPs found that 45 per cent would like more training in ENT and 40 per cent said that clinics run in primary care by specialist GPs would help them to manage ENT patients better. Two-thirds of patients in our patient survey told us that they would not have minded seeing a local GPwSI rather than a hospital consultant.

- 67 GPwSIs can manage the patient themselves, refer patients for tests or for a second opinion and, in some cases, put them on the waiting list for an operation. Early results from one of the *Action On ENT* GPwSI pilots show the types of outcome for patients referred to a GPwSI. The Ipswich pilot began in January 2002 and the GPwSI saw 199 new patients in the first five months. This represented 34 per cent of all new referrals to ENT from one primary care trust (and another nearby large practice). Two GPwSI clinics were held each week, one of which had audiology support. All patients were seen within four weeks of referral. The majority of patients were discharged by the GPwSI [Exhibit 12].

Exhibit 12

Outcomes of referrals to *Action On ENT* GPwSI pilot in Ipswich

The GPwSI could deal with 88 per cent of referrals – only 12 per cent were referred for a consultant opinion.



Source: *Action On ENT GPwSI pilot in Ipswich*
Jan – May 2002

- 68 From this limited evidence it appears that there is scope for more specialist work to be carried out in primary care. There are, however, some concerns about GPwSIs:
- there may be increased demand from GPs for a second opinion because the GPwSI is easier to access than secondary care;
 - some patients could have an extra step in their pathway if GPwSIs refer them on to the ENT department for a second opinion;
 - there may be decreased capacity in primary care as GPs spend time in a GPwSI role instead of a GP role; and
 - the introduction of GPwSIs may distract from the need to carry out a more fundamental review of how many ENT consultants are needed.

- 69 A full evaluation of the *Action On ENT* pilot on GPwSI is underway and will be completed by autumn 2002. The *Action On ENT Good Practice Guidance* contains further details of the GPwSIs pilots (**Ref. 1**).

Seeing patients in order within clinical priorities

- 70 NHS policy is underpinned by the principles of fairness, openness, transparency and basing action on evidence (**Ref. 15**). Where waits for elective care are necessary, patients should generally be seen in order, except when their clinical priority requires them to jump the queue. Waiting list management systems should include for each specialty local policies on the clinical priority that will be applied to specific conditions and procedures. Such local policies should define the bands of time within which priority patients will be expected to be seen or treated, with most remaining patients waiting their turn. Where consultants have developed these policies in practice they have found that it matches patients' clinical needs better and shortens maximum waiting times (**Ref. 7**).
- 71 The development of local policies involves both clinical and resource decisions – choices between patients and choices about the use of scarce resources. For these reasons, policies should be developed by GPs, consultants and managers with the authority of their organisations. There should also be public involvement. The policies should be agreed by the local health commissioning bodies and trust boards, and should be communicated to the public and to all GPs who refer to the acute service. Explicit and transparent policies will assist NHS services in moving towards the requirement to offer booked admissions and patient choice as envisaged in *The NHS Plan* and *Delivering the NHS Plan* (**Refs. 15 and 3**).
- 72 Tools are available that can help trusts to improve waiting list management systems, to agree the shape of the desirable distribution of waits for each category of patients and to plan capacity to meet this agreed distribution. Examples include the Modernisation Agency's *Little Wizard*, at www.demandmanagement.nhs.uk and Checklist's urgency profiling and capacity planning tool at www.checklist.co.uk (**Refs. 9 and 7**).
- 73 One way of narrowing the band of time within which patients wait for the same procedure is to pool waiting lists for common procedures between consultants working in the specialty. Agreement on pooled lists can include the proportion of routine cases that will be treated by each consultant in each time period. Such local agreements should be included in the local policies agreed between the local health commissioning body and the acute trust with the GPs who refer to the service, and they should be explained to patients. Pooled lists are recommended in *Action On ENT's Recommended Baseline Standards* for ENT Departments (**Ref. 10**).

Recommendations

- 74 Waiting list management systems for outpatients and elective surgery should include local policies to ensure that patients are generally seen in order, except where their clinical priority requires them to jump the queue. Such local policies should define the bands of time within which priority patients can expect to be seen or treated, with most remaining patients waiting their turn. They should state how cancellations and other adjustments to lists should be administered to ensure that access is fair.
- 75 These local policies should be developed by GPs, consultants and managers, with the authority of their organisations and with public involvement. The policies should be agreed by trust boards and should be communicated to the public and to all GPs who refer to the acute service.
- 76 Capacity should be planned to support achievement of the agreed waiting time bands. How far the plan is being achieved should be monitored and adjustments made to stay within the plan.
- 77 Local clinicians, with the support of local commissioning bodies and trusts, should consider pooled waiting lists for common conditions and procedures. This will need to be agreed with the referring GPs and should be explained to patients.

Recommendations

1. Waiting times alone should not be used to make resource allocation decisions. Changes in resource use and additional investment should only be made after an analysis of demand, of how well capacity is used to meet this demand and of how well waiting times are managed.
2. The distributions of waits for outpatients and for routine procedures can be used to diagnose problems in waiting list management systems. Where distributions are narrow but waits long, local health commissioners and acute trusts should review capacity to identify whether resources can be used more efficiently or effectively, and whether there are shortfalls in resources.
3. ENT services should review the quality of information for patients about their operation, especially recovery time and side-effects, and provide a contact number after discharge.
4. Patients should be continuously involved in a dialogue about improving services. Surveys could be repeated at intervals to test whether patients report improvements.
5. National waiting time standards should be introduced for audiology and all NHS services where waiting occurs. These should be monitored by the DH, the Welsh Assembly Government, local health commissioners and trusts providing services.
6. Trusts should monitor the distribution of waits for audiology services to ensure that patients are seen in order.

7. Local health commissioning bodies and acute trusts should ensure that GPs and patients know about the availability of direct access clinics for audiology.

8. Waiting list management systems for outpatients and elective surgery should include local policies to ensure that patients are generally seen in order, except where their clinical priority requires them to jump the queue. Such local policies should define the bands of time within which priority patients can expect to be seen or treated, with most remaining patients waiting their turn. They should state how cancellations and other adjustments to lists should be administered to ensure that access is fair.

9. These local policies should be developed by GPs, consultants and managers, with the authority of their organisations and with public involvement. The policies should be agreed by trust boards and should be communicated to the public and to all GPs who refer to the acute service.

10. Capacity should be planned to support achievement of the agreed waiting time bands. How far the plan is being achieved should be monitored and adjustments made to stay within the plan.

11. Local clinicians, with the support of local commissioning bodies and trusts, should consider pooled waiting lists for common conditions and procedures. This will need to be agreed with the referring GPs and should be explained to patients.

Appendix 1:

Action On ENT steering board members

David Baguley
Consultant Audiological Scientist
Addenbrooke's Hospital

Valerie Day
Director of External and Corporate Affairs
Service Improvement Team
NHS Modernisation Agency

Wendy Gault
Action On ENT National Project Manager – Balance pilot

Hilary Harkin
Specialist ENT Nurse
Guy's and St Thomas Hospital

Gordon Hickish
General Practitioner representing Royal College of General Practitioners

Alan Johnson
Consultant Head and Neck/ENT Surgeon
University Hospital Birmingham NHS Trust

Robert Koefman
General Practitioner with a special interest in ENT

Liz Lawler
NHS Waiting and Booking Branch
Department of Health

Carol Limber (from April 2002)
Acting Programme Director
Action On ENT

John Low
Director of Technology
Royal National Institute for Deaf People

Linda Luxon
Academic Unit of Audiological Medicine
Great Ormond Street Hospital for Children

Pamela Marsh
Sensory Impairment and Environmental Support Branch
Department of Health

Lesley Mathieson
Speech and Language Therapist

Anthony Narula
Consultant Head and Neck/ENT Surgeon
St. Mary's Hospital, London

Heather Pitchford
Action On ENT National Project Manager – Audiology pilot

Derek Stewart
Patient Representative

Richard Wight
Consultant Head and Neck/ENT Surgeon
North Riding Infirmary

John Wilderspin (until April 2002)
Programme Director
Action On ENT

Appendix 2: Acute trusts involved in this study

Ealing Hospital NHS Trust

Gloucestershire Royal NHS Trust

Huddersfield Infirmary (Calderdale and Huddersfield NHS Trust)

Ipswich Hospital NHS Trust

Medway Maritime Hospital NHS Trust

North Staffordshire Hospitals NHS Trust

Oxford Radcliffe Hospital NHS Trust

Queen's Medical Centre, Nottingham University Hospital NHS Trust

Royal Preston NHS Trust

Singleton Hospital NHS Trust

St. George's Healthcare NHS Trust

Taunton and Somerset NHS Trust

Appendix 3: Comparative demand, capacity and efficiency indicators for ENT services in England

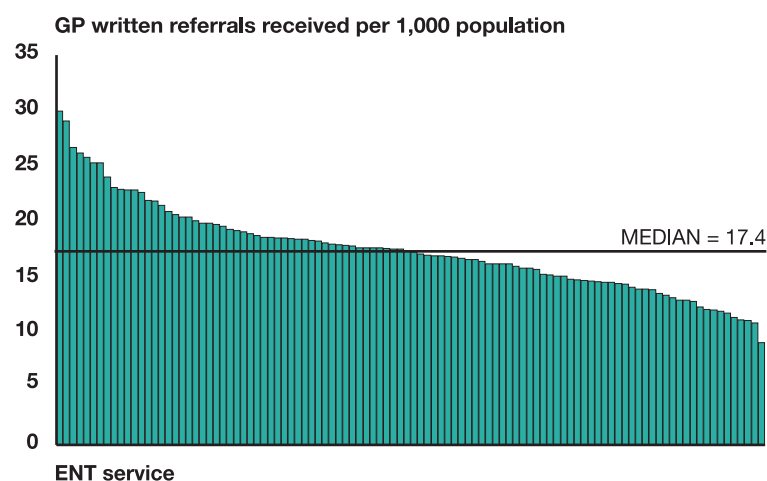
Demand, capacity and efficiency measures were calculated for all grouped ENT services in England. Services for which the data was incomplete or unreliable have been excluded. The sources of the data were Audit Commission trust groupings and populations, Audit Commission acute portfolio data on medical staffing¹ and DH hospital activity statistics. All data relates to 2000/01.



Web report – appendix 5

Demand indicators

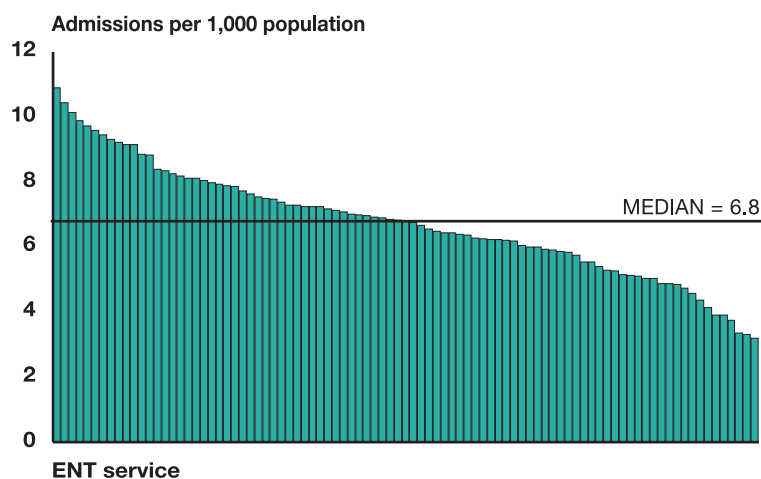
Appendix 3 Exhibit 1



Source: Audit Commission trust groupings and populations; Audit Commission acute hospital portfolio data (medical staffing)

¹ www.audit-commission.gov.uk/itc/acuteportfolio.shtml

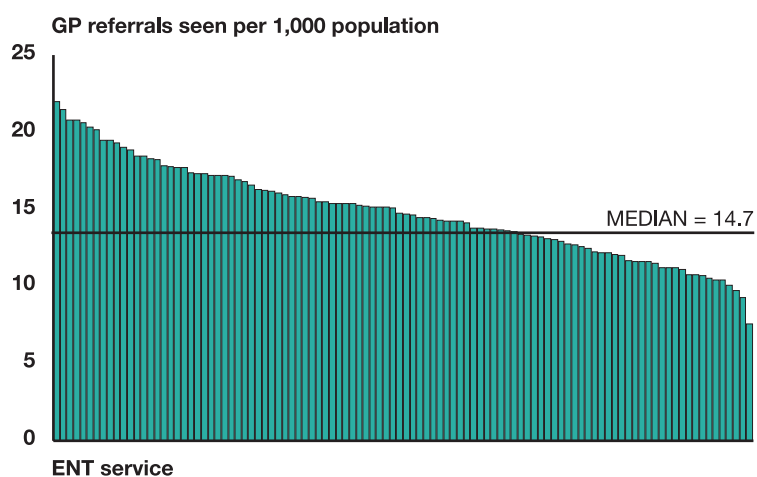
Appendix 3 Exhibit 2



Source: Audit Commission trust groupings and populations; Audit Commission acute hospital portfolio data (medical staffing)

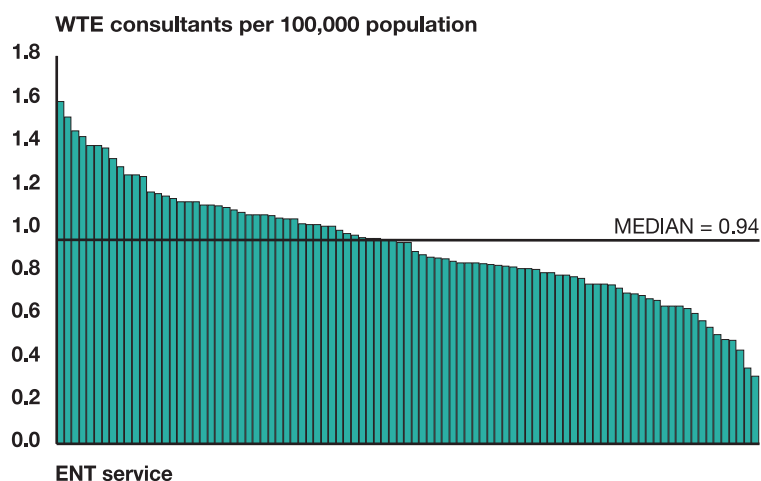
Capacity indicators

Appendix 3 Exhibit 3



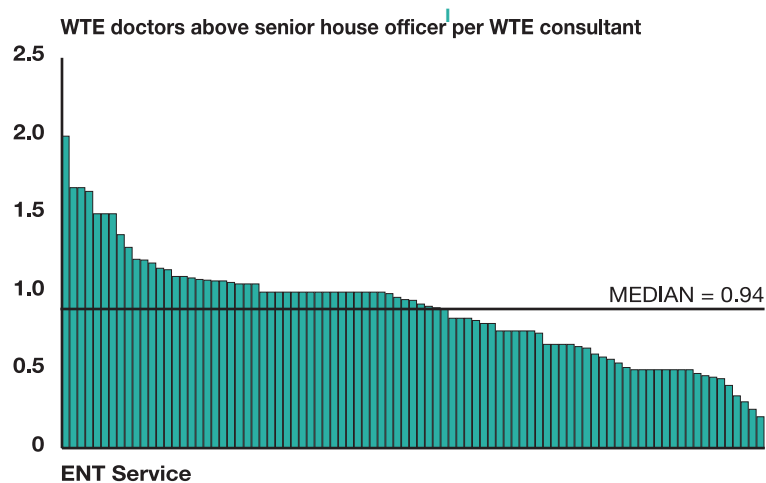
Source: Audit Commission trust groupings and populations; DH hospital activity statistics

Appendix 3 Exhibit 4



Source: Audit Commission trust groupings and populations; Audit Commission acute hospital portfolio data (medical staffing)

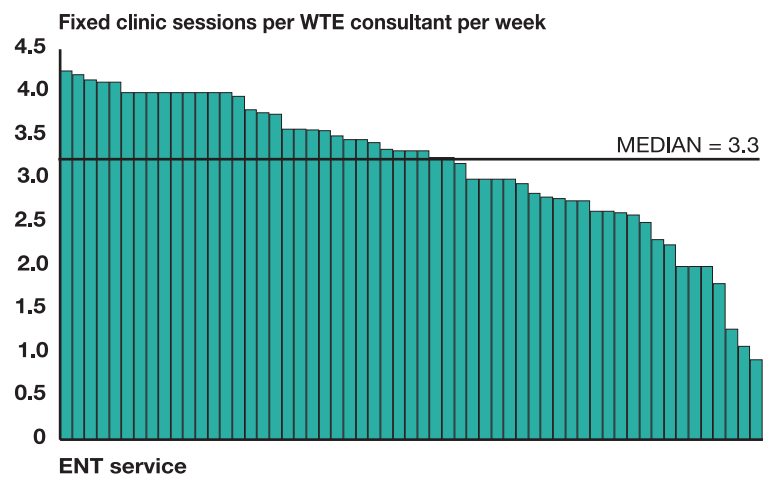
Appendix 3 Exhibit 5



Source: Audit Commission trust groupings; Audit Commission acute hospital portfolio data (medical staffing)

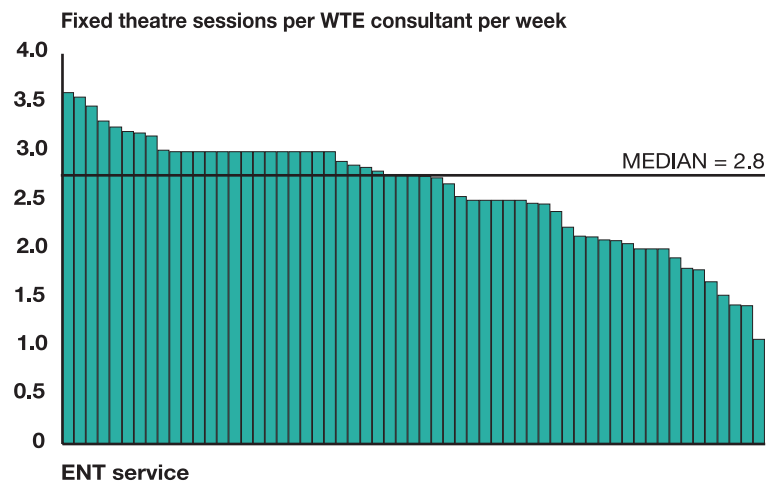
¹ Specialist registrar, associate specialist, staff grade.

Appendix 3 Exhibit 6



Source: Audit Commission trust groupings; Audit Commission acute hospital portfolio data (medical staffing)

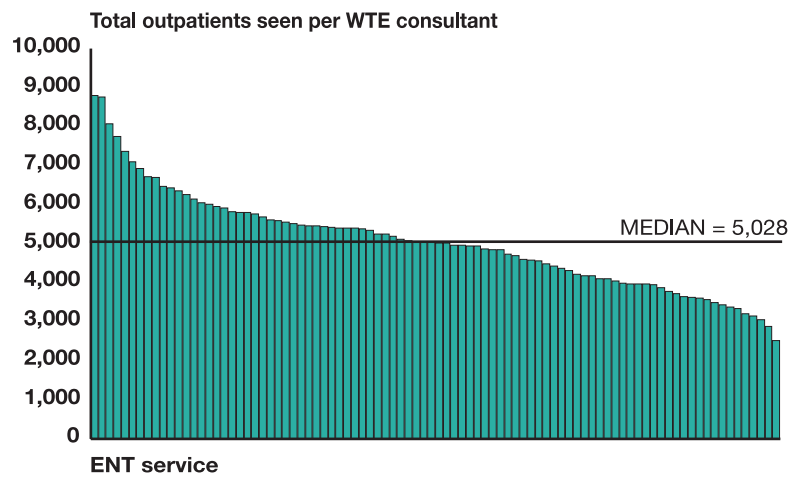
Appendix 3 Exhibit 7



Source: Audit Commission trust groupings; Audit Commission acute hospital portfolio data (medical staffing)

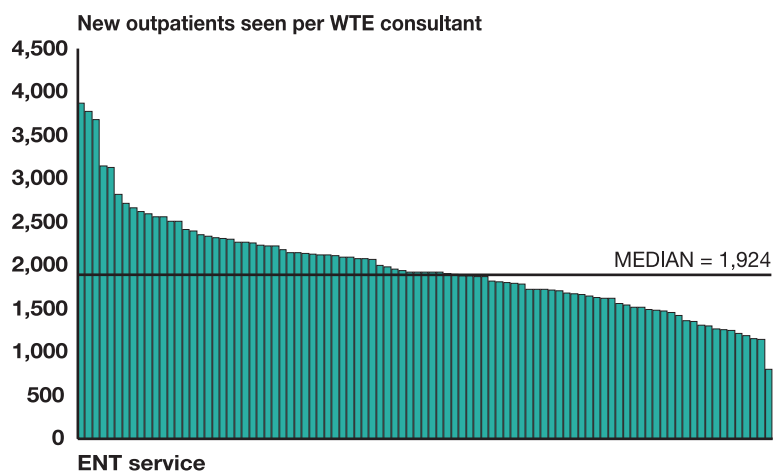
Efficiency indicators

Appendix 3 Exhibit 8



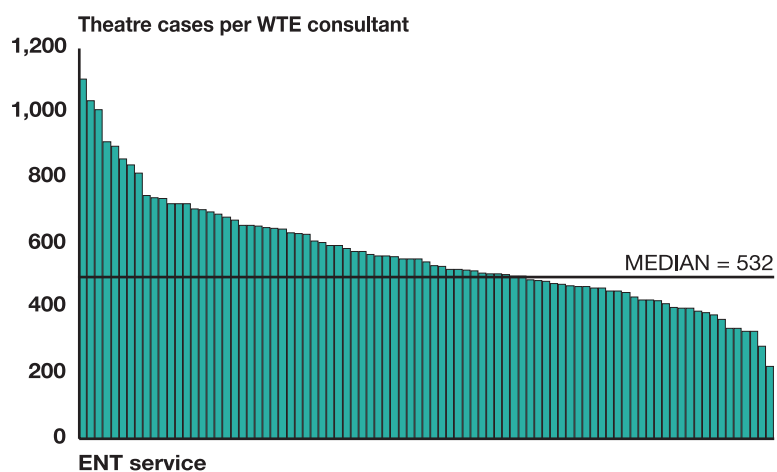
Source: Audit Commission trust groupings; Audit Commission acute hospital portfolio data (medical staffing); DH hospital activity statistics

Appendix 3 Exhibit 9



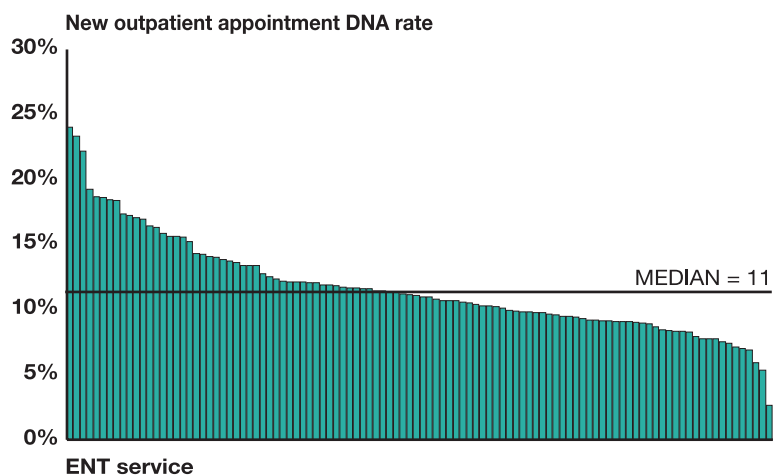
Source: Audit Commission trust groupings; Audit Commission acute hospital portfolio data (medical staffing); DH hospital activity statistics

Appendix 3 Exhibit 10



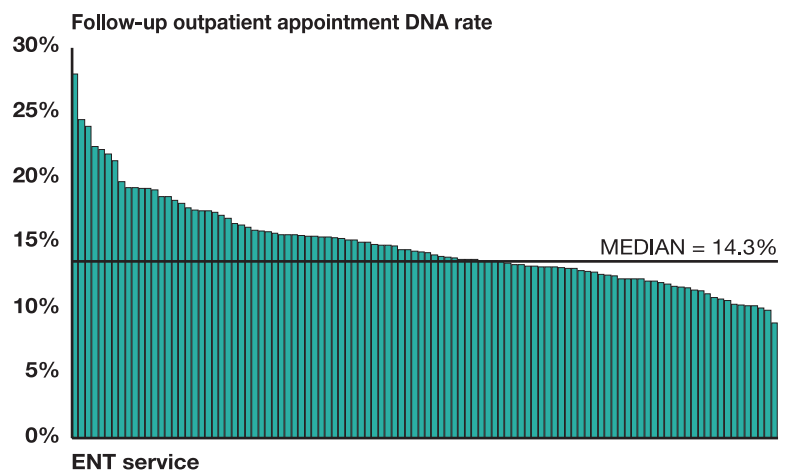
Source: Audit Commission trust groupings; Audit Commission acute hospital portfolio data (medical staffing)

Appendix 3 Exhibit 11



Source: Audit Commission trust groupings; Audit Commission acute hospital portfolio data (medical staffing); DH hospital activity statistics

Appendix 3 Exhibit 12



Source: Audit Commission trust groupings; Audit Commission acute hospital portfolio data (medical staffing); DH hospital activity statistics

Appendix 4: Correlations between waiting times, demand and capacity

The Department of Health's 2000/01 waiting times data were used to derive four dependent performance variables for ENT services in England (**Box 1**):

Appendix 4 Box 1

Percentage of outpatients who waited: Under 12 weeks

Over 26 weeks

Percentage of inpatients still waiting:

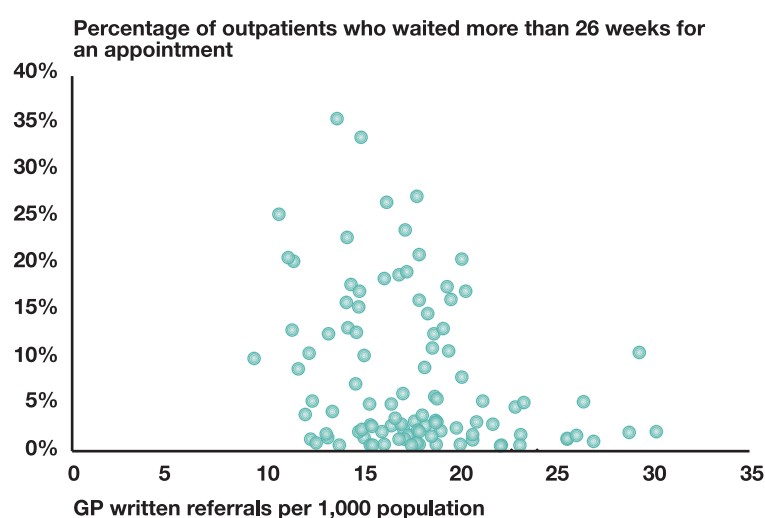
Over 6 months

Over 12 months

Key demand and capacity indicators from Appendix 3 were used as independent variables in linear regression analyses in SPSS. Appropriate inpatient or outpatient variables were used in all analyses. Multivariate analyses were also carried out to adjust for one or more variables that were thought might confound the outcomes.

None of the demand or capacity indicators listed below were correlated with the four dependent performance variables. All data relates to 2000/01.

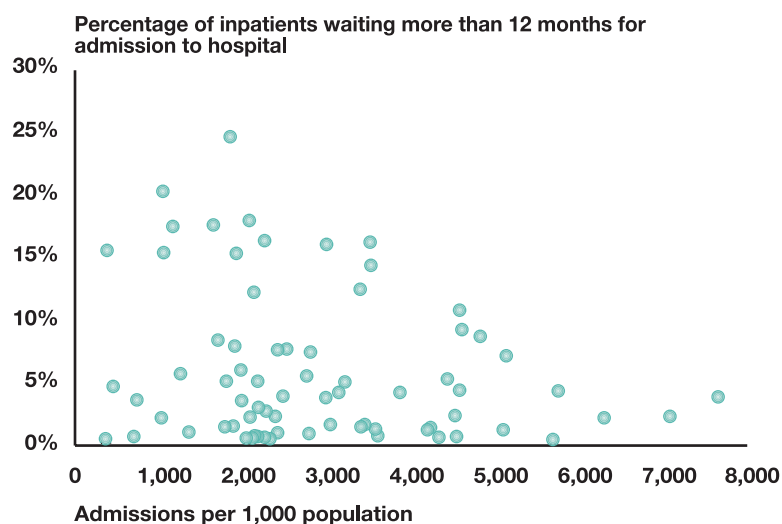
Appendix 4 Exhibit 1



Source: Audit Commission trust groupings and populations; DH hospital activity statistics; NHS waiting times data

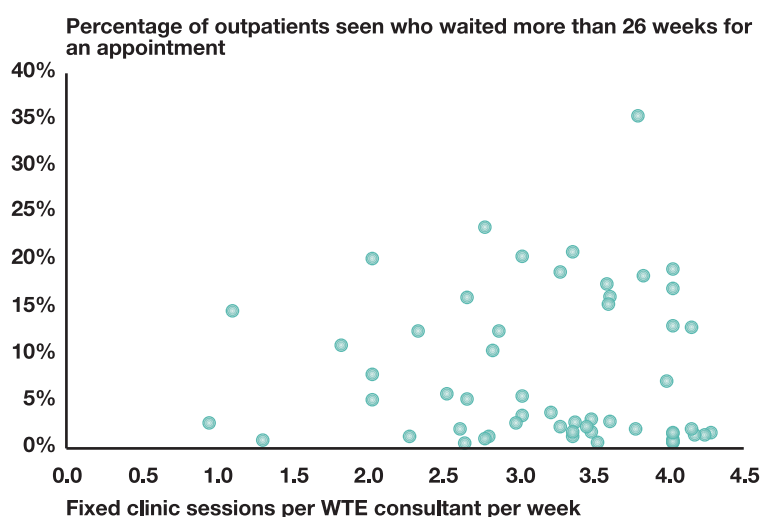
Source: Audit Commission trust groupings and populations; Audit Commission Acute Hospital Portfolio data (medical staffing); NHS waiting times data

Appendix 4 Exhibit 2

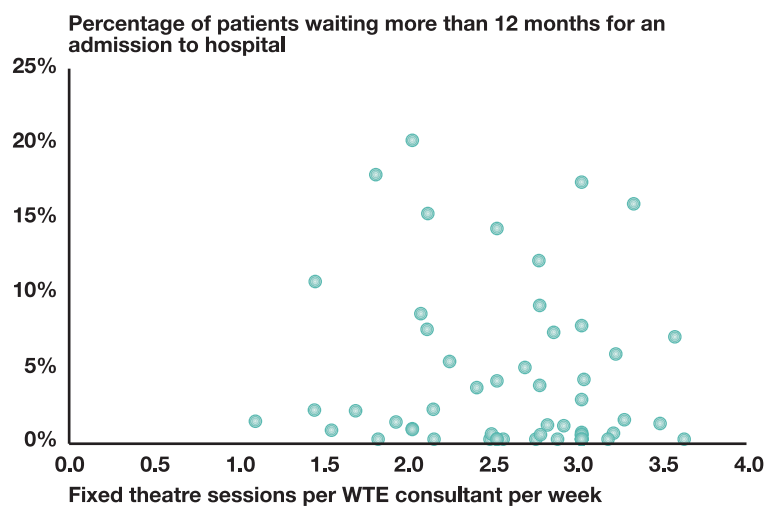


Source: Audit Commission trust groupings; Audit Commission Acute Hospital Portfolio data (medical staffing); NHS waiting times data

Appendix 4 Exhibit 3

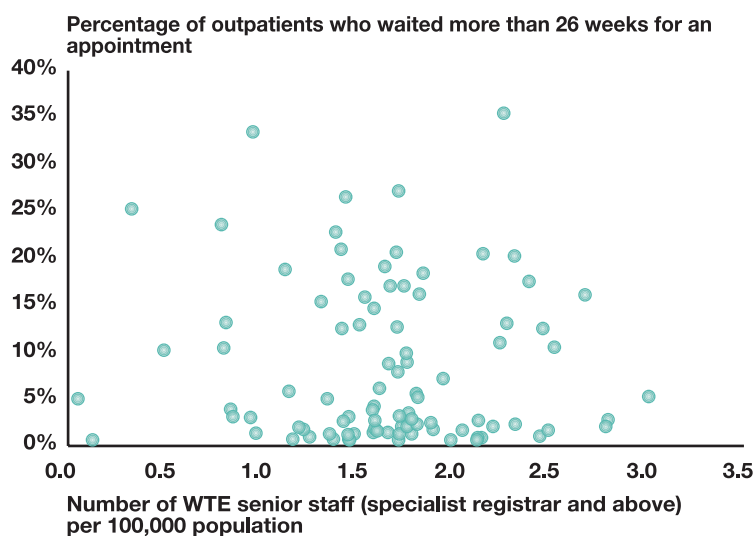


Appendix 4 Exhibit 4



Source: Audit Commission trust groupings; Audit Commission Acute Hospital Portfolio data (medical staffing); NHS waiting times data

Appendix 4 Exhibit 5



Source: Audit Commission trust groupings and populations; Audit Commission Acute Hospital Portfolio data (medical staffing); NHS waiting times data

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