Service for the surgical management of otitis media with effusion in children

Commissioning guide
Implementing NICE guidance

December 2008
Service for the surgical management of otitis media with effusion in children

This commissioning guide provides support for the local implementation of NICE clinical guidelines through commissioning, and is a resource to help health professionals in England to commission an effective service for the surgical management of otitis media with effusion (OME) in children.

The guide focuses on the surgical management of OME in children under the age of 12 years, including children with Down’s syndrome or cleft palate. The management of OME in children with other syndromes (for example, craniofacial dysmorphism or polysaccharide storage disease) and in children with multiple complex needs is outside the scope of this guide.

This commissioning guide should be read in conjunction with the following NICE guidance:

- NICE clinical guideline CG60 ‘Surgical management of otitis media with effusion in children’.

The clinical guideline covers clinical and cost effectiveness in detail and underpins the content of this guide. Implementation of the guidance noted above is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement this guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in the guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

The guide:

- makes the case for commissioning a service for the surgical management of OME
- specifies service requirements
- helps you determine local service levels
- helps you ensure corporate and quality assurance

The full text of this commissioning guide is accessed from the navigation menu on the right hand side of the screen. The associated commissioning tool is available until 25 June 2010 to primary care organisations in England who are already registered to use the tool. New registrations for the existing commissioning tool will not be possible after 31 March 2010.

From 1 April 2010 the new freely available commissioning and benchmarking tool can be downloaded here. There is no need to register.

We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please send us your ideas for future topic-specific guides or other comments.
Read the NICE disclaimer for information on the use and accuracy of content on the NICE website.

- **Topic-specific Advisory Group: service for the surgical management of OME**
Commissioning a service for the surgical management of otitis media with effusion in children

The directly standardised rate of insertion of ventilation tubes (grommets) for all primary care trusts (PCTs) in England in 2006/07 was 400 per 100,000 children under the age of 12 years. While it is not expected that implementation of NICE clinical guideline CG60 on surgical management of otitis media with effusion (OME) should not require a major change in what is already current practice in many areas, there is an eightfold difference in the rates of this type of surgery across England, suggesting that there is a need to standardise practice. Some commissioners may therefore need to review their adherence to care pathways for this procedure based on the NICE clinical guideline and/or to consider disinvestment where appropriate. Implementation of NICE clinical guideline CG60 on surgical management of OME should enable commissioners to make cost-effective and unbiased arrangements for the management of this condition, thereby giving maximum benefit to children while minimising the risks of intervention.

OME is a common condition of early childhood in which an accumulation of fluid within the middle ear space causes hearing impairment. The hearing loss is usually transient and self-limiting over several weeks, but may be more persistent and lead to educational, language and behavioural problems. It is most common in young children, with a bimodal peak at 2 and 5 years of age; 80% of children will have had at least one episode of OME by the age of 10 years. In most instances of uncomplicated OME, no intervention is required because the fluid clears spontaneously.

Care pathways for children with features suggestive of OME should ensure initial assessment, and referral for formal assessment if considered necessary. Formal assessment includes hearing testing appropriate for the child’s developmental stage and tympanometry. The persistence of bilateral OME and hearing loss should be confirmed over a period of 3 months before intervention is considered. This generally requires accurate audiometry at the beginning and end of this time, which may lead to an increase in referrals to paediatric audiology and may require better and more timely access to services than is currently available in some areas. The NHS in England: operating framework for 2007/08 identified the risks to delivery of the 18-week objective associated with audiology. Transforming services for children with hearing difficulty and their families: a good practice guide notes that, for many children, the maximum waiting period of 18 weeks will need to be much shorter in order to minimise the impact on their education and development. Currently there are significant variations in quality, models of audiology service, activity levels, workforce skill mix, productivity and costs. Most audiology services are located in NHS acute hospitals although some, in particular those for children, are provided on an outreach basis in the community.
Commissioners may need to ensure that there is timely access to surgical treatment and that the provision of hearing aids is available where surgery is contraindicated or not acceptable. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.

**Benefits**

The potential benefits of robustly commissioning an effective service for the surgical management of OME in children include:

- **reducing the risk of inappropriate surgical or medical management**, including antibiotic prescribing which may be high in some areas given the low clinical benefits.
- **providing timely and efficient clinical management** of OME in children by ensuring appropriate audiological assessment and surgical intervention when required.
- **improving clinical outcomes** such as improved hearing, reduced ear pain, reduced infection and improved reported speech and language development.
- **reducing the demand for ear, nose and throat (ENT) services** by improving GP access to paediatric audiology and agreeing and consistently applying referral criteria.
- **ensuring consistent and effective care** for children and their parents or carers.
- **reducing inequalities** by decreasing regional variations in the threshold for surgery and improving access to services for the surgical management of OME.
- **increasing patient choice**, improving partnership working and the experience and engagement of children and their parents or carers.
- **ensuring value for money**, by increasing the consistency of service provision across providers – this may include opportunities for clinicians to undertake local service redesign to meet local requirements in novel ways.

**Key clinical issues**

Key clinical issues in providing an effective service for the surgical management of OME in children are:

- **ensuring appropriate referral pathways are in place** to support the implementation of [NICE clinical guideline CG60 on surgical management of OME](#).
• ensuring there is access to, and sufficient capacity for, hearing testing appropriate for the developmental stage of children presenting with OME, and tympanometry
• identifying all children with OME who may benefit from surgery
• providing effective and efficient clinical care in line with NICE clinical guideline CG60 on surgical management of OME
• ensuring the service is integrated with other health and social services for children with OME to support holistic care
• providing a quality assured service

National priorities

National priorities and initiatives relevant to commissioning a service for the surgical management of OME in children include:

• High quality care for all: NHS next stage review final report identifies the need for locally-led, patient-centred and clinically driven change, including the work stream on children’s health.

• World class commissioning.


• National service framework for children, young people and maternity services and in particular the standard relating to hospital services for children Getting the right start: National service framework for children, young people and maternity services: standard for hospital services.

• The Care Quality Commission report on Improving services for children in hospital emphasises the standards required, including the hospital environment, training, surgery and anaesthesia.

• Joint planning and commissioning framework for children, young people and maternity services advocates effective joint planning as part of the Local Area Agreement, and commissioning as being at the heart of improving outcomes for children and young people.

• Commissioning framework for health and well-being.

• Delivering the 18 week patient treatment pathway.

• The Care closer to home initiative outlined in chapter 6 of the white paper ‘Our health, our care, our say’.

• Considering the impact of patient choice.

• A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services.

• Implementation of NICE clinical and public health guidelines. These are core standards, and performance against these
standards will be assessed by the Care Quality Commission in line with Standards for better health.

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.

References


Specifying a service for the surgical management of otitis media with effusion in children

Service components

The key components of a service for the surgical management of otitis media with effusion (OME) in children are:

- ensuring accurate assessment and diagnosis of OME in children
- ensuring appropriate specialist referral and management of children with OME
- developing a high-quality service for the surgical management of OME in children

Ensuring accurate assessment and diagnosis of OME in children

The diagnosis and general management of OME in children is described in detail in NICE clinical guideline CG60 on surgical management of OME. Ensuring that children with features suggestive of OME are accurately assessed, have the diagnosis confirmed and, where appropriate, are offered surgical management is important both in terms of good clinical management and in managing service demand.

OME may be overlooked because of the insidious nature of the condition, and suspicion of hearing loss in children must be acted upon effectively. Therefore, concerns from parents, carers or professionals about features suggestive of OME should lead to an initial assessment and subsequent formal assessment for confirmation of diagnosis if considered necessary. See the NICE clinical guideline CG60 quick reference guide for further information on care pathways, including initial and formal assessment. Commissioners should ensure that services provide a formal assessment, some of which may be provided in primary care or community settings.

NICE clinical guideline CG60 on surgical management of OME recommends that persistent bilateral OME and hearing loss should be confirmed over a period of 3 months before intervention is considered and that a child’s hearing loss should be re-tested at the end of this time. Commissioners will need to ensure there is timely access to, and sufficient service capacity for, hearing tests suitable for the developmental stage of children presenting with OME. Children may be placed on multiple waiting lists (for example, ear, nose and throat (ENT) as well as audiology) as GPs attempt to gain access to the service for their patients in the quickest possible way. The Department of Health report on Improving access to audiology services in England states that commissioners should carry out a rigorous needs assessment of the local population and review existing provision of audiology services to identify gaps and the potential for improvements. This may also provide the opportunity to review current practice and develop an integrated care pathway with clinicians and other health and social care professionals, for example, community
paediatricians, health visitors, school nurses and teachers. The pathway should identify clear criteria for referral and support consistent thresholds for surgical management of OME in line with NICE clinical guideline CG60 on surgical management of OME.

The topic-specific advisory group identified that it is useful for diagnostic reports from audiology to include the interpretation of results and an indication of whether onward referral is thought necessary. This can help to reduce the length of time on the patient pathway.

Transforming services for children with hearing difficulty and their families: a good practice guide advises that where possible initial hearing assessment should be carried out in a local hearing service with multidisciplinary and cross-sector working. Until local hearing services are fully developed, this may require collaboration with ENT services for access to expertise and facilities.

Ensuring appropriate specialist referral and management of children with OME

NICE clinical guideline CG60 on surgical management of OME states that persistence of hearing loss with adverse affects on the child will require further action, which may include surgery. Once a decision has been taken to offer surgery, it is important that there is a minimum of delay. Therefore commissioners will need to ensure that referral, assessment and access to surgery are timely. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.

Hearing aids should be offered to children with persistent bilateral OME and hearing loss as an alternative to surgical intervention where surgery is contraindicated or not acceptable. This may include children who have Down’s syndrome and OME with hearing loss.

It is anticipated that the implementation of NICE clinical guideline CG60 on surgical management of OME should not require a major change in what is already current practice in many areas. However, commissioners may need to consider that the management of children with OME can be complex and long term and requires specialist resources. There may also be resource implications in the non-surgical management of OME, particularly if a hearing aid is fitted.

Developing a high-quality service for the surgical management of OME in children

NICE clinical guideline CG60 on surgical management of OME recommends.

- Treatment and care should take into account children’s needs and preferences together with those of their parents or carers.
- Good communication between healthcare professionals and the parents or carers of children with OME is essential. This should
be supported by evidence-based written information tailored to the particular patient’s needs.

- During the active observation period, advice on educational and behavioural strategies to minimise the effects of the hearing loss should be offered.
- Hearing testing should be carried out by trained staff using tests suitable for the development stage of the child, and calibrated equipment.
- The care of children with Down’s syndrome who are suspected of having OME should be undertaken by a multidisciplinary team with expertise in assessing and treating these children.
- Hearing aids should normally be offered to children with Down’s syndrome and OME with hearing loss.
- The care of children with cleft palate who are suspected of having OME should be undertaken by the local otological and audiological services with expertise in assessing and treating these children in liaison with the regional multidisciplinary cleft lip and palate team.

Commissioners may wish to consider delivering a service for the management of OME in children in a number of different ways, and mixed models of provision may be appropriate across a local health economy. Examples include:

- joint clinics with paediatric audiology (this could be a community paediatric audiology service) and a consultant ENT surgeon or a paediatrician with expertise in developmental paediatrics and a special interest in audiology
- one-stop consultant-led primary care clinics
- direct surgical listing from paediatric audiology services.

The Shifting care closer to home: care closer to home demonstration site – report of the speciality subgroups identifies a hospital-based one-stop hearing and assessment service, where children no longer have to shuttle between hospital-based and community-based services. However, some care closer to home demonstration sites triage children aged under 5 years directly to secondary care, partly because of the need for more complex audiological testing and enhanced room facilities when assessing younger children. For further information on the requirements of audiology services, see also the quality assurance section for further information.

Surgical treatment of OME can be provided as day case surgery, but should meet the standards identified in the Healthcare Commission report Improving services for children in hospital, which emphasises the standards needed for children’s services, including anaesthesia. Surgery for children: delivering a first class service contains recommendations aimed at improving the quality of service, training, individual and team performance in children’s surgery.
Commissioners should ensure that the standards of care are in place for children with OME, who are often of pre-school age, and their parents or carers. The environment must comply with the requirements of the National service framework for children, young people and maternity services and in particular Getting the right start: National service framework for children, young people and maternity services: Standard for hospital services. Clinics that are known to be family-friendly will have higher attendance rates, thus maximising efficiency of the service and reducing waiting times[9].

Local stakeholders, including service users, should be involved in determining what is needed from a service for the surgical management of OME in order to meet local needs. The service needs to be child-centered and integrated with other elements of health and social care.

The service specification needs to consider:

- the required competencies of, and training for, staff responsible for providing the service
- the expected number of children (this should take into account how quickly any changes in service provision are likely to take place)
- ease of access, including access to interpreting services for audiology services and service location; commissioners should engage with parents and carers and other relevant individuals and organisations locally
- care and referral pathways, including audiology for GPs and other health and social care professionals, and by direct access as parents should be able to refer their own child if they have concerns about his or her hearing[9]
- information and audit requirements, including high quality information systems that enable children’s progress to be tracked across agencies; this is crucial in ensuring a seamless journey across complex pathways
- planned service improvement, including redesign, quality, equitable access, and referral-to-treatment times according to the 18 week patient pathway or equitable waiting times locally for those services currently outside 18 weeks
- service monitoring criteria

Useful sources of information may include:

- Delivering the 18 week patient pathway: audiology commissioning pathways – glue ear in children.
- Transforming services for children with hearing difficulty and their families: a good practice guide provides advice for commissioners and service providers on changing the way services for children with hearing difficulties and their families are commissioned and delivered, and on reducing waiting times.
• The Map of medicine provides an information resource that visually organises the latest evidence and best practice guidelines.

References


Determining local service levels for the surgical management of otitis media with effusion in children

_Benchmarks for a standard population_

Available data suggest that the standard benchmark rate for surgical management of otitis media with effusion (OME) is 0.4%, or 400 per 100,000, children under the age of 12 years per year. Approximately 15% of the population in England is under the age of 12 years.

For an average primary care trust population of 300,000 (with around 45,000 children under the age of 12 years), the average number of children requiring surgical management of OME would be 180 per year (0.4% of children under the age of 12 years).

For an average general practice list size of 10,000, (with 1,500 children under the age of 12 years), the average number of children requiring surgical management of OME would be 6 per year (0.4% of children under the age of 12 years).

Examine the assumptions used in estimating these figures.

Surgical management of OME is likely to fall under the programme budgeting category 209X (problems of hearing).

Use the service for the surgical management of otitis media in children commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

_Further information_

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- Annex A of the Commissioning framework for health and well-being outlines the process and data needed to undertake a joint strategic needs assessment.
- Department of Health Delivering quality and value – focus on benchmarking.
- NICE Health equity audit – learning from practice briefing.
- Delivering the 18 week patient pathway: 18 week commissioning pathways.
- The No delays achiever provides access to service improvement tools aimed at reducing time between referral and treatment.
Assumptions used in estimating a population benchmark

The assumptions used in estimating a benchmark for the surgical management of otitis media with effusion (OME) in children are based on the following sources of information:

- **epidemiological data** on the prevalence of OME
- **activity data** to establish the current rate of surgery
- **expert clinical opinion** of the topic-specific advisory group, based on experience in clinical practice and literature review.

**Epidemiological data**

Currently there is limited availability of epidemiological data on which to estimate the optimal rate of surgical management of OME in children. Therefore it has not been possible to develop a benchmark based on the prevalence, severity and persistence of OME in children.

**Activity data – ‘Hospital episode statistics’**

The ‘Hospital episode statistics’ (HES) database contains details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. The classification system used to code procedures within HES is the Office of Population, Censuses and Surveys: classification of interventions and procedures, 4th revision (OPCS4).

For the purpose of determining this benchmark for the surgical management of OME, we have used HES data extracted on the basis of the OPCS4 code D15.1: myringotomy with insertion of ventilation tube (grommet) through the tympanic membrane. Data have been extracted where the code occurs either as the main procedure or in one of the 14 secondary procedure fields. In a proportion of cases, insertion of ventilation tube may occur alongside other procedures for example adenoidectomy. Restricting the analysis to data for coding only under the main procedure significantly underestimates activity levels and overestimates regional variations in rates.

Please note: all following mentions of rate(s) per 100,000 children refer to the rate(s) per 100,000 children under the age of 12 years.

Analyses of the data indicate that the rate of procedures has decreased significantly since the early 1990s. There has been a decrease in rates from around 700 per 100,000 children in 1989/90 to around 400 per 100,000 children in 2006/07. This is an overall decrease in procedures of around 40%. This may be linked to information published in the early 1990s.
that questioned the use of ventilation tubes\cite{1}. The rate of decline has slowed in more recent years (see figure1).

The mean directly age-standardised rate of surgery for all primary care organisations in England in 2006/07 is 400 per 100,000 children. This estimated standardised rate of surgical management of OME is higher than the estimate used in the NICE costing report on surgical management of OME. This is because the costing report used data based on the coding of the procedure as the main procedure.

Figure 2 is a funnel plot that shows the variation in the directly age-standardised rates of surgery across England in 2006/07. Rates vary by primary care organisation from around 100 per 100,000 children to 800 per 100,000 children. Thus there is over an eightfold difference in rates across England. Funnel plots illustrate variation in activity, and can be used alongside local knowledge to understand variation around the mean. Please see the Association of Public Health Observatories technical briefing (APHO) Statistical process control methods in public health intelligence for further information on funnel plots.

Smoking among parents and/or carers is a risk factor for OME in children\cite{2}. Some of the variation in rates observed may be related to the prevalence of smoking but there are likely to be other factors involved, such as referral criteria and service capacity. Clinical experts have suggested that those primary care organisations with very high or very low rates of procedures may not be operating within expected referral criteria.

It is not expected that the mean rate of surgery nationally should change significantly with the implementation of the NICE clinical guideline CG60 on surgical management of OME. Therefore, the current rate of surgical management of OME based on the national average of 400 per 100,000 children under the age of 12 years per year is considered appropriate as an indicative benchmark. Commissioners may wish to benchmark their activity against this figure and age-adjusted rate of their neighbouring or other primary care organisations. Directly age-standardised rates of surgery for all primary care organisations can be found in table 1.

**Expert clinical opinion**

The topic-specific advisory group suggests, based on emerging research, that on average, children with OME in England are likely to be receiving surgical intervention appropriately, and hence support the indicative benchmark of 400 per 100,000 children under the age of 12 years based on the national average.

Commissioners should take into account parental smoking because areas with a higher than average prevalence of smoking may have a greater need for surgical management of OME in children.
Conclusions

Based on the data above, it is considered that a benchmark rate for surgical management of OME is 0.4%, or 400 per 100,000, children under the age of 12 years per year is appropriate. This is based on the following assumptions:

- the national mean rate of surgical management of OME is around 400 per 100,000 children per year
- there may be areas with rates of surgery that may need to increase or decrease; the mean average rate nationally is not likely to change significantly with the implementation of the NICE clinical guideline CG60 on surgical management of OME.

Therefore the benchmark for surgical management of OME is estimated to be approximately 0.4%, or 400 per 100,000, children under the age of 12 years per year.

Use the service for the surgical management of otitis media with effusion in children commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

References


The commissioning and benchmarking tool

**Download the service for the surgical management of otitis media with effusion (OME) in children commissioning and benchmarking tool.**

Use the service for the surgical management of otitis media with effusion (OME) in children commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below.

**Identify indicative local service requirements**

The indicative benchmark based on the national average for the surgical management of OME in children is 0.4%, or 400 per 100,000, children under the age of 12 years per year.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population is significantly younger or older than the average population, or has a smoking prevalence different from the national average, you may need to provide services for relatively fewer or more children.

**Review current commissioned activity**

You may already commission a service for the surgical management of otitis media with effusion (OME) in children for your population. You can download your own up-to-date secondary care activity data into the tool and data specifications and user notes are provided to help. You can review and amend the downloaded data for your population to calculate the service levels and cost of the service you currently commission. When commissioning outpatient appointments or activity outside of secondary care the tool provides you with tables that you can populate to help you calculate your total current commissioned activity and costs.

**Identify future change in capacity required**

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

**Model future commissioning intentions and associated costs**

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level, and to model the required changes over a period of 4 years.
Use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which the service for the surgical management of otitis media with effusion (OME) in children may be provided, comparing the costs of commissioning the service across the various settings. The tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.
Ensuring corporate and quality assurance

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for patients. Commissioners need to set clear specifications for monitoring and assuring quality in the service contract.

Commissioners should ensure that they consider both the clinical and economic viability of the service, and any related services, and take into account the views of children and their parents or carers and those of other stakeholders when making commissioning decisions.

A service for the surgical management of otitis media with effusion (OME) in children needs to:

- be effective and efficient
- be responsive to the needs of children and their parents and carers
- provide treatment and care based on best practice, as defined in NICE clinical guideline CG60 on surgical management of OME
- deliver the required capacity for the assessment and management of children with OME
- be integrated with other elements of health and social care for children with OME
- define agreed criteria for referral, local protocols and the care pathway for children with OME
- be child-centred and provide equitable access, ensuring that children and their parents or carers are treated with dignity and respect, are fully informed about their or their child’s care, and are able to make decisions about their child’s care in partnership with healthcare professionals
- audit surgical management of OME to ensure improvement in patient outcomes
- demonstrate how it meets requirements under equalities legislation
- demonstrate value for money.

Local quality assurance

Any mechanisms for quality assurance at a local level are likely to refer to the following.

- Service and performance targets, including estimated activity levels and case mix, waiting and referral-to-treatment times
(ensuring that children and their parents or carers do not experience unnecessary delays), complaints procedures.

- **Clinical governance arrangements**, including incident reporting.
- **Clinical quality criteria**: appropriateness of referral, consenting procedures, clinical protocols.
- **Audit arrangements**: frequency of reporting, reporting route and format, and dissemination mechanisms; arrangements should include auditing the proportion of eligible children with OME who are provided with care, and monitoring of patient outcomes and complications (see audit support for NICE clinical guideline CG60 on OME for further information).

- **Health, safety and security**: prevention of infection, infection control, waste management, confidentiality procedures, legislative requirements.
- **Equipment**: must be calibrated at least annually using acceptable methods. Calibration should meet national standards (BSA 2000). It is suggested that equipment should not be more than 5 years old. Audiology testing must be performed in soundproofed accommodation to ISO 8253-1 (1987) and ISO 8253-2 (1992) standards for acoustic test methods suitable for children and conform to standards outlined in the Department of Health Building Note (1994). It is possible to provide tympanometry in a GP surgery but equipment will require calibration and the service should be integrated with the local ear, nose and throat service and paediatric audiology service.

- **Accreditation requirements**: for some or all elements of the service, the premises and/or staff.

- **Patient satisfaction**: child and parent or carer perspective and perception of service provision, complaints.

- **Patient outcomes**: such as improved hearing, reduced ear pain, reduced infection and improved reported speech and language development. Reduced number of adjuvant adenoidectomies.

- **Staff competencies**: state registration requirements should be met for staff working in paediatric audiology services. Staff should also be specifically trained to work with children and have fully compliant child protection training and CRB screening.

- **Information requirements**, including both patient-specific information (NHS number, referring GP, provision of high-quality information to patients/parents/carers) and service-specific information (referral-to-treatment times, workload trends, number of complaints).

- **The process for reviewing the service with stakeholders**, including decisions on changes necessary to improve or to decommission the service.
• Achieving targets associated with equalities legislation.

Further information

General information on quality and corporate assurance can be obtained from the following sources:

• The National Patient Safety Agency (NPSA) oversees the implementation of a system to report and learn from adverse events and near misses occurring in the NHS. The publication ‘Seven steps to patient safety’ provides an overview of patient safety and gives updates on the tools that the NPSA is developing to support patient safety across the health service.

• NHS Alliance online resources. NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.

• The DH commissioning framework provides guidance on the commissioning process in the context of the NHS reform agenda.

• Delivering the 18 week patient pathway provides a range of resources to support the key NHS objective to deliver an 18 week patient pathway from GP referral to the start of treatment by the end of 2008.

• NHS Institute for Innovation and Improvement support for commissioners, includes Commissioning for Health Improvement products to accelerate the achievement of world class commissioning; The Productive Leader programme to enable leadership teams to reduce waste and variation in personal work processes, and Better care, better value indicators to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.

• 10 Steps to your SES: a guide to developing a single equality scheme. This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties, and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.

Specific information on quality and corporate assurance for a service for the surgical management of OME in children can be obtained from the following sources:

• Transforming services for children with hearing difficulty and their families: a good practice guide describes the indicators of high
quality care and notes that audiology assistants and associate audiologists can undertake some of the less expert, routine clinical tasks, with appropriate training

- **Quality standards in paediatric audiology – guidelines for the early identification and the audiology management of children with hearing loss**
- The Care Quality Commission report *Improving services for children in hospital*, which emphasises the standards needed for children’s services including anaesthesia
- **Surgery for children – delivering a first class service** contains recommendations aimed at improving the quality of service, training, individual and team performance in children’s surgery
- ‘**Better metrics**’ is a pragmatic project that provides clinically relevant measures of performance to support the development of measurable local targets and indicators for local quality improvement projects. See children and maternity metric, which is currently being updated.
- **Skills for health** works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services. See details of the *children’s services competence framework*. 
Topic-specific Advisory Group: service for the surgical management of OME

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

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