

ENT Clinical Audit Meeting

Royal College of Surgeons (Eng) Meeting

16th September, 1999

Introduction

We had more audit papers submitted this year than before and strict selection criteria had to be applied to reduce the number to six.

The main criteria for selection were that subject matter had to be current established practice and processes judged against a gold standard, rather than evaluating new practices – which properly belongs to research. In addition a full audit cycle had to be completed, and if more than one so that an audit spiral could be demonstrated, so much the better (Figure).

The papers are varied and the issues are as relevant to all our practices whether Professional Unit or District General Hospital (unlike much research). They are being presented in a logical order, examining the different stages of the process through which the patient passes from OPD to discharge back to GP.

Calman/Hine have given us our first National Strategic Framework for best practice in cancer management. An audit from Cambridge is presented which examines how to change practice to achieve outpatient Quick Early Diagnosis in patients with neck lumps.

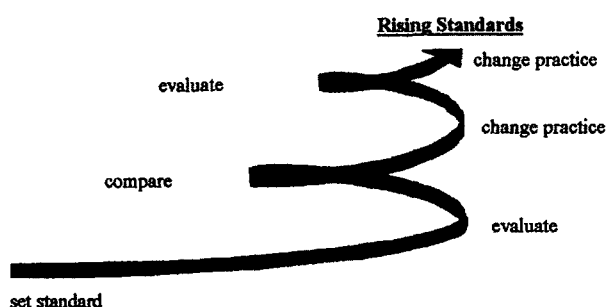
Still with outpatients, emergencies and urgent cases are often seen by the most junior members of the team without adequate supervision, and this is often worse during the day when people are busy. A Manchester team examines how restructuring can improve the service – and how the benefits can be overwhelmed by success!

Average Length of Stay in hospital has been falling dramatically. This has been changing our practice, not only allowing more day surgery to be carried out but also making us re-examine whether carrying out multiple procedures (in this case tonsillectomy and nasal surgery) necessarily increases the likelihood of complications (haemorrhage) and therefore the stay (Aberdeen). Audit also allows us to question whether the perceived wisdom that all day surgery should be carried out in dedicated Day Units maximizes efficiency for all specialities. Can we predict which cases are suitable for same-day discharge (Bath)?

The standard of communication between hospital and primary care, and vice versa, is almost universally poor. An attempt to improve matters through a protocol led discharge document is presented from Aberdeen, and the audit shows that just having such guidelines is not enough in itself.

No accurate comparative audit can be done without accurate clinical coding. This is the single most important matter that we have got to get to grips with early in the new millennium, or progress nationally and internationally will falter. The problem is not only *accurate* input and the issue of *who* should input, but also *what* coding system should be used if the current NHS standard OPCS-4 has a nomenclature that is lacking in specificity. The principles raised in this paper from Nottingham are discussed and audit data added to in the final paper from Milton Keynes.

Peter M Brown, F.R.C.S. Milton Keynes, ENT Clinical Audit Co-ordinator for Royal College of Surgeons (Eng.) Comparative Audit Service.



Research involves:

1. New Treatments
2. New Standards of Practice
3. Experimental techniques
4. New Technology

Audit involves:

1. Current Practice
2. Achieving accepted standards of practice
3. Observational techniques
4. Quality of clinical care

Audit of the Rapid Access Neck Lump Service at Addenbrooke's Hospital

O. D. Smith, F.R.C.S., P. Jani, B.D.S., F.R.C.S., P. D. M. Ellis, F.R.C.S., S. Briggs*

From the Departments of Otolaryngology and the Audit Department*, Addenbrooke's Hospital, Cambridge, UK.

Introduction

Prior to December 1997, a diverse referral pattern existed at Addenbrooke's Hospital for patients with neck lumps. Patients were seen by consultants across a range of disciplines, interspersed with other patients in their general clinics. Access time was very variable, and investigations were not standardized.

First change of practice

In December 1997 a dedicated neck lump service was established, held during the first hour of a general ENT clinic by a consultant with a head and neck interest.

Standard setting

Two standards were defined:

1. 100 per cent patients should be seen within two weeks of referral (as per the 1998 Government White Paper – 'The New NHS').
2. 100 per cent of primary investigations (ultrasound and guided core needle biopsy; full blood count; and chest X-ray) should be performed on same day as the initial consultation.

Evaluation of practice after December '97

Standard 1: 72 per cent of patients were seen within two weeks.

Standard 2: 89 per cent of patients underwent primary investigations in a single outpatient visit.

Comparison – reasons for failure to meet standards:

Standard 1:

- i) timing was calculated from date that referral letter was written, rather than date received;
- ii) some patients still referred to other consultants, who then referred on to the neck lump service;
- iii) lack of clinic time.

Standard 2:

Consultant Radiologists not always available to perform ultrasound and core needle biopsy.

Second change of practice

Standard 1:

- i) accurate recording of the date of receipt of referral letters;
- ii) publicizing the service in the Hospital Handbook;
- iii) creation of a dedicated Neck Lump Clinic – an entire half day 'session' dedicated to neck lump patients.

Standard 2:

Appointment of a consultant radiologist to the dedicated Neck Lump Clinic

Setting new standards

1. 100 per cent success in both standards desirable but perhaps unrealistic – aim to achieve at least 90 per cent success for both standards.
2. Set a third standard – that complex investigations be performed within two weeks of the initial clinic visit.

Re-evaluation

Outcome of the second change of practice will be re-evaluated against the new standards.

A Daily 'Open Access Clinic' Revisited

K. L. Howarth, M. A. Simmons, H. Wheatley, P. H. Jones, A. E. Camilleri

From the Department of Otorhinolaryngology, Wythenshawe Hospital, Manchester, UK

Introduction

Many daily 'emergency' referrals made to junior ENT staff are in fact urgent cases that can safely wait until the next day for attention. This audit chronicles the change in practice from seeing such cases *ad hoc* in a traditional 'ward treatment room' based service, through the introduction of a daily basic surgical trainee led 'open access clinic' specifically for this purpose, and onto the need for circulation of revised referral criteria.

First cycle

Set standard

The aim is to assess and manage emergency and urgent referrals from GPs, the accident and emergency department, other hospital departments and wards in an efficient and suitable environment and to provide experience and training for basic surgical trainees. Correspondence should be received by at least 80 per cent of referring clinicians.

Initial evaluation

A prospective study of all consecutive patients attending the treatment room during a two month period was performed. The referral pattern, type of referral, duration of symptoms and correspondence to the referring clinician were evaluated. A total of 130 patients were seen on an *ad hoc* basis requiring prior discussion with the on call junior staff. Any nursing support had to be provided by busy ward nurses and there were no dedicated secretarial support services. Otitis externa accounted for 25 per cent of all the referrals and 0 per cent of the referring GPs received a letter.

Comparison

Failed to meet any of the criteria.

Change of practice

A daily open access clinic was introduced with full clinical support services; this was led by a basic surgical trainee but the clinic ran concurrently with a consultant outpatient clinic.

Second cycle

Re-setting the standard

The aim of the clinic was to provide an easily accessible same or next day service for appropriate patients in an efficient, well designed clinic with clinical support services, to which patients can be referred directly without prior discussion with ENT staff. Correspondence to the referring doctor is provided.

Evaluation

The new clinic was evaluated using the same method for the evaluation of the old treatment room service. The clinic was shown to be very successful with an efficient use of resources and 83 per cent of referring clinicians gained feedback.

Comparison

A comparison of the daily open access clinic and the previous treatment room service and to the set standard was made. The set standard for communication for GPs was met. Telephone referrals and out of hours referrals were reduced and junior doctors were able to attend more clinics and theatre sessions.

Change of referral practice

Following the successful set up of the clinic it was noted that there was an increasing number of referrals being made from all GPs and departments. This was resulting in demand exceeding the service provision.

Evaluation

This led to a prospective study of the number of consecutive patients attending the open access clinic during a comparable period to the previous two audit loops. The appropriateness of referrals made was assessed using a four point scale based on a protocol used for consultant clinic and emergency referrals. The number of new patients attending the clinic more than doubled in comparable months from 1996 to 1998. A third of all referrals were deemed to be inappropriate while up to 50 per cent of referrals from GPs were inappropriate, therefore the standard required re-setting with the aim of reducing inappropriate referrals.

Change of guidelines

The demand for the open access clinic has expanded rapidly and has far exceeded that of the previous ward-based service. New guidelines for the use of this service have been introduced outlining the appropriate conditions, duration of symptoms and referral timing of patients, with the hope that this would reduce inappropriate attendances allowing efficient use of hospital resources and increasing the quality of patient care (Appendix I). The clinic will continue to be evaluated and further changes instigated if the outcome fails to meet the set standard including adherence to guidelines for referral.

Appendix I

DEPARTMENT OF OTORHINOLARYNGOLOGY HEAD
AND NECK SURGERY SOUTH MANCHESTER
UNIVERSITY HOSPITALS NHS TRUST

THE OPEN ACCESS CLINIC GUIDELINES

A&E patients and other hospital departments who do not need to be seen immediately but who would benefit from an early appointment.

GP referrals with urgent and/or painful conditions which can wait until the next day to be seen.

THE FOLLOWING ARE SUITABLE REFERRALS:

Otitis externa
Acute otitis media
Severe otalgia
Acute trauma to the outer ear
Foreign bodies in the ear, nose or throat
Sudden hearing loss
Nasal fractures
Routine epistaxis, especially in the younger patient
Sore throat or quinsy
Palatal or tongue trauma
Acute sinusitis

IT IS NOT SUITABLE FOR:

Chronic conditions and currently asymptomatic patients with recurrent conditions
Long-term hearing loss
Chronic ear disease
Tinnitus
Vertigo and Meniere's syndrome
Bat ear
Recurrent ASOM
Glue ear
Perennial rhinosinuitis
Long-term nasal deformity requiring septoplasty or septorhinoplasty
Dysphonias including hoarseness
Dysphagia and globus sensation (lump in the throat) (see below)
Hearing aid patients

Dysphonia and dysphagia patients including globus should be referred to the South Manchester Voice Centre by phoning the Extended Vocal Assessment Clinic Administrator, Mrs Carys Walker on 0161 291 2864 for an urgent appointment.

Audit of Post-Tonsillectomy Bleeding in Patients Undergoing Synchronous Nasal Surgery

H. El-Hakim*, D. Murray, F. Ashan, D. A. Nunez
From the Departments of Otolaryngology, Ninewells Teaching Hospital* and Aberdeen Royal Infirmary, UK.

Aim

The incidence of post-operative bleeding and the hospitalization time was audited in patients undergoing synchronous nasal surgery and tonsillectomy.

Standard setting

The incidence of post-tonsillectomy bleeding and the duration of hospital stay was recorded in 398 patients undergoing tonsillectomy alone within the Grampian University Hospitals for a one year period July 1998 to 1999. 4.7 per cent (95 per cent CI, 2.4–6.2 per cent) had a post-operative bleed and the mean hospital stay was three days.

Evaluation

Seventy-one adult patients who underwent synchronous tonsillectomy and nasal surgery over an eight-year period (1991–1998) were identified from one unit. 12.6 per cent (95 per cent CI, 4.8–20.4 per cent) of these patients had post-tonsillectomy bleeding. The rate of bleeding was significantly different from the standard group ($p < 0.01$). There was no statistical difference in the duration of stay between the groups.

Conclusion

The practice of synchronous tonsillectomy and nasal surgery did increase the post-operative morbidity significantly and a change of practice is indicated. The impact of this change in practice will be audited prospectively.

Suitability for Day Surgery Audit

C. Hopkins, D. Gardner-Thorpe, A. Toma, R. Slack
From the ENT Department, Royal United Hospital, Bath, UK.

Introduction

As the trend towards day case surgery increases we set out how to better predict our requirements for inpatient and day case beds, and make better use of available resources.

Standard setting

It has been suggested that up to 50 per cent of all surgical procedures could be undertaken on a day case basis (Burn, 1983; Royal College of Surgeons of England, 1992; Report of the NHS Management Executive Day Surgery Task Force, 1995), and this was therefore used as our aim. Prior to the first loop of the audit 10 per cent of cases were undertaken in the day care unit. Royal College recommendations for safe day case surgery state that less than three per cent of patients undergoing any day procedure should require admission to an inpatient facility.

Evaluation

The first loop of the audit was completed in 1995 over a six week period. All patients including children admitted to the inpatient wards were assessed using a questionnaire with regards to their suitability for discharge on the day of surgery. The reasons for overnight admission were classified as medical or social. Two hundred and seventeen patients underwent inpatient surgical procedures during the audit and of these 32 per cent were

subsequently discharged that day. This represented a total of 39 per cent of patients undergoing surgery on an ambulatory basis. Of those admitted five per cent were for social reasons.

Change in practice

While the audit results were encouraging, it was felt that we could further improve our throughput of day cases. The audit highlighted that certain procedures are ideally suited to the day case unit, and as a result of evaluation the day case unit increased allocation of beds for such ENT procedures. Of the remaining procedures we are unable preoperatively to predict those which will require overnight admission, therefore, we could not increase the range of procedures being undertaken in the day case unit without transgressing the safe limits defined by the Royal College. However, complications including haemorrhage invariably take place within hours of surgery, and a number of patients are fit for discharge on the day of surgery without an increase in the complication rate. The audit assisted a change in attitude allowing same day discharge for those well enough.

Re-evaluation

We repeated the audit during a six week period in June and July 1999. Thirty per cent of ENT procedures, where there is certainty of same-day discharge, are currently undertaken through the day case unit. Of those undergoing surgery through the inpatient facility (largely uncertain discharge time), 43 per cent were discharged on the day of surgery (see Appendix II). None of these patients were readmitted with complications. This represents a total of 60 per cent of procedures performed as day cases. Most lists were held in the morning.

Consequences of the change of practice

We have achieved our aim of increasing the proportion of patients having operations on a day case basis (60 per cent vs. 39 per cent) and increased the number admitted directly to the day surgery unit (30 per cent vs. 10 per cent). We had also hoped to reduce the number of patients admitted to the ward who were fit for discharge on the day of surgery, however, this number has increased largely because we are unable to accurately identify preoperatively, which patients will be fit for discharge. Most importantly we can now anticipate that up to 40 per cent of inpatients may be fit for discharge on the day of surgery. This allows us to better predict our bed occupancy overnight and thus optimize provision of services.

References

- Burn, J. M. B. (1983) Responsible use of resources: Day surgery. *British Medical Journal* **286**: 492–498.
- Canter, R. J., Rogers, J. (1985) Tonsillectomy: home after 24 hours? *Journal of Laryngology and Otology* **99**: 177–178.
- Report of the NHS Management Executive Day Surgery Task Force (1995).
- The Royal College of Surgeons of England (1992) Guidelines for Day Care Surgery.

Appendix II**Breakdown of Ratio of all Patients Through the In-Patient Ward Admitted Overnight/Going Home on Day of Surgery by Case Type**

Operation	Admitted Overnight	Discharged Same Day
Ossiculoplasty	0	1
Stapedectomy	2	0
Meatoplasty	0	3
Otoplasty	0	2
Mastoidectomy	1	0
Myringoplasty	2	0
Grommets	0	3
EUA Ears	0	3
Wedge Resection Pinna	0	1
Endoscopic DCR	0	5
SMD	0	1
SMR	0	4
Turbinectomy	1	1
Polypectomy	4	1
EUA/Biopsy Nose	1	2
FESS	5	0
Rhinoplasty	5	0
Septoplasty	0	2
Tonsillectomy	10	5
Ts + As	3	0
Parotidectomy	2	0
Submandibular Gland Ex.	2	0
Pharyngeal Pouch Ex.	2	0
Lymph Node Ex.	1	3
Superficial Lesion Ex.	0	2
Pharynx/larynx/Oesophagoscopy	3	3
Dilation Stricture	1	0
Biopsy Tongue	0	1
Totals	49	46

Paediatric Otolaryngology Discharge Document – An Audit of a Change of Practice

M. S. W. Lee, D. A. Nunez, J. Rollo*, H. Lamont*
From the ENT Department, Aberdeen Royal Infirmary and the Department of General Practice*, GP Audit Team, University of Aberdeen, UK.

Objectives

The project was designed to audit our existing and a newly implemented discharge letter. Aim to assess: (1) the extent to which the existing and the new discharge letters meet the selected criteria laid down by Scottish Intercollegiate Guidelines Network (SIGN), (2) what the general practitioners perceived as a good standard of practice. The audits of the two discharge summaries were run concurrently.

Standard setting

The SIGN protocol on Immediate Discharge Letter was used as the gold standard in combination with a survey of GP opinion (85 returns). The protocol includes a minimum data set which consists

of 21 fields for the immediate discharge letter (SIGN 1996 - see Appendix III). According to our survey, 1) the general practitioners in the Grampian region expect the discharge letters to be received in six days. 2) They wanted all 21 fields completed for ENT discharges. GP satisfaction, on five point scale, with handwritten discharge = 2.6, and with new proposed typed = 3.8. Preference was therefore in favour of change.

First cycle*Evaluation of old practice (handwritten discharge)*

The clinical records from 162 paediatric otolaryngology patients were studied. The letters are handwritten by the junior medical staff on the day of patients' discharge. The mean number of fields used were 13.7 ± 1.8 , and the time taken for the GP to receive the letter was four days (range 0-34).

Comparison

Failed to meet first standard (21 fields), but met second (>six days to receive letter).

Change of practice

Typed SIGN discharge letter introduced.

Second cycle*Evaluation*

Mean number of fields used were 12.2 ± 3.2 and time taken for GP to receive letter was 16 days (range 10-16).

Comparison

Failed to meet either standard. Worse than first cycle!

Second change of practice

There needed to be a change in organization and process to support the preferred SIGN discharge letter or the set standards could not be achieved. Changes: 1) Typed SIGN discharge only to be used; 2) Discharge letter to be dictated day before patient discharge; 3) Apply for funding for more secretarial support; 4) Letters to be sent first class mail; 5) If surgeon who dictated letter is not available, another signs to avoid delay.

Third cycle

This will be evaluated in due course to ensure that standards are now met as a result of the further changes.

Appendix III

The Minimum Data Set Recommended for GP Discharge Letters by The Scottish Intercollegiate Guidelines Network (SIGN)

1. Hospital
2. Patient Identification
3. G.P.
4. Consultant Identification
5. Ward/Department
6. Date of Admission
7. Date of Discharge
8. Reason for Admission/Transfer
9. Mode of Admission
10. Main Condition
11. Other Active Problems
12. Operations/Procedures
13. Medication on Discharge
14. Allergies
15. Other Plans on Discharge
16. Comment
17. Results Awaited Y/N
18. Further letter to follow? Y/N
19. Read & Approved
20. Contact Name
21. Signed

Audit of the Accuracy of OPCS4 and Theatre Clinical Coding

A. H. Marshall, N. S. Jones, N. Bateman
From the Department of Otolaryngology – HNS Queens Medical Centre, Nottingham, UK.

Introduction

OPCS4 is a classification, used nationally and locally, of surgical operations and procedures issued by the Office of Population Censuses and Surveys. In our hospital the clinical coding department analyses the clinical notes following the patient's discharge, and assigns the codes. In addition all operations performed at Queens have been recorded in a free text theatre register by the nursing staff. This system has now been computerized, with a locally designed coding system, which is unique to our hospital.

Aim

The aim of this study was twofold:

- 1) To assess the accuracy of the OPCS 4 codes assigned to patients undergoing rhinoplasty or septorhinoplasty over a four-year period.
- 2) To assess the accuracy of the transcription and allocation of operation codes into the computerized theatre coding system by the nursing staff for the same patients.

Methods

A retrospective analysis of the clinical notes of all patients undergoing a rhinoplasty or septorhinoplasty from January 1992 until December 1996 was performed. The personal consultant held database of

all patients having had rhinoplasty or septorhinoplasty were used to identify the patients included in the study. The operation notes for all these patients (which we assume to be 100 per cent accurate) were examined to confirm what procedure had been performed (i.e. the gold standard). We also used the theatre computer to identify all cases which had been allocated the code of septorhinoplasty or rhinoplasty.

Setting standards

1. An acceptable accuracy rate of the OPCS 4 codes was thought to be 90 per cent or more.
2. An acceptable accuracy rate for the transcription and allocation of operation codes into the computerized theatre coding system by the nursing staff was also thought to be 90 per cent or more.

Evaluation of practice

1. Four hundred and sixty-eight patients' notes were examined. Only 352 (75 per cent) had the correct OPCS 4 code (E023 septorhinoplasty and graft, E024 septorhinoplasty and implant, E026 rhinoplasty). One hundred and sixteen were coded as another operation. Of these, 97 (21 per cent) were coded as 'other specified' (E028). This code was used by the coder as no OPCS 4 code exists for septorhinoplasty as the sole procedure. Of the remaining 19 (four per cent) cases eight were coded as septoplasty and 11 were coded as various ENT and non-ENT operations.

2. Four hundred and forty-seven (96 per cent) of the patients were allocated the correct operation code by the nursing staff in the computerized theatre coding system. Twenty-one (four per cent) of operations were not entered onto the computerized register as septorhinoplasty or rhinoplasty, which they should have been. In addition, 29 cases were identified by the computer as having had a septorhinoplasty or rhinoplasty, when this was not the case. All but seven of these 29 patients had undergone a septal procedure.

The clinical coding at source was therefore more accurate than remote coding by non-clinicians.

Change of practice

1. The coder responsible should discuss what codes to assign to specific operations if he is in doubt.
2. We will discuss with the coder exactly which codes he has used for the operations to be audited, so that we do not lose cases (here this meant that 21 per cent of our operations were not identified properly).
3. We will ask the nursing staff to check the operation code with the surgeon at the time of entry.

Re-evaluation

We will re-audit both the OPCS codes and the computerized theatre system against the gold standard after a further 12 month period following these changes.

Comment: What Coding System should we be using, and who should code? The need for a universal Minimum Data Set for Comparative Audit

Andrea Thirlwall, Peter Brown
Milton Keynes General Hospital.

Introduction

Coding is possibly the single most important issue for comparative audit. Without a simple and comprehensive coding system with good clinically recognizable nomenclature we cannot compare like with like.

OPCS-4 was designed to classify all operations and surgical procedures. It is currently mandatory to use this coding system for central statistical returns across the NHS in England. However it is recognized that there are serious problems with OPCS version 4, some of which are outlined below. Dr James Read developed his bottom up, clinically based, hierarchical coding initially for fellow GPs. The system he was developing seemed so superior to any other existing, that it was quickly bought out by the NHS and the Clinical terms Project was set up in all specialities. As a result, in April 1996, the Department of Health asked the NHS Information Authority (previously the NHS Centre for Coding and Classification) to look at the possibility of replacing OPCS-4 with an aggregation tool based on Read Coding.

The latest development took place in April of this year when the Department of Health announced an agreement between the NHS's Version 3 Clinical Terms (Read) and the main American (pathologically based) SNOMED-RT coding system. This will create a new world-standard for computerizing medical terminology, to be available in 2001, and is part of the thrust towards an Electronic Patient Record-EPR- (to exist at level 3 for all patients by 2005).

We have been using Read codes V 2 in theatre at Milton Keynes since 1993, run off a 'Theatreman' system. The main problem we have found is that it does not use a 'Windows' based search menu, and we tend to code off a hard copy.

Can Read coding really do better?

The main problem with OPCS-4 is its nomenclature, which is not easily recognizable by a clinician, and the lack of sufficient codes. In other words it lacks specificity and comprehensiveness. Because Read has been designed by clinicians it is recognizable to us, and can be regularly updated as new procedures are introduced. Such speedy upgrading is vital.

The study

To complement and add to the Nottingham paper we:

- 1) Compared the accuracy of a) OPCS-4 as coded by trained Coders, and b) Read as coded by surgeons, and c) Theatre Register as completed by nursing staff, for all patients undergoing rhinoplasty or septorhinoplasty between January 1994 and December 1998 (n = 108).
- 2) Compared the coding nomenclature for septorhinoplasty and rhinoplasty, and FESS across OPCS-4 and Read.

The written operative notes (n = 108) were used as the gold standard against which to compare.

Evaluation

1. Read Coding was capable of being 100 per cent accurate on nomenclature, but was only 94.4 per cent. The surgeon using a close but inaccurate nomenclature e.g. 'rhinoplasty' instead of septorhinoplasty' (5.5 per cent) miscoded six patients. This is similar to the Nottingham in-house theatre system, but better than their hospital coding system.
2. Our Coder's OPCS-4 nomenclature was only 21.3 per cent accurate – the same as the Nottingham figures. Sixty-nine patients (64 per cent) were assigned to a 'dumping' code used for 'septorhinoplasty' (EO28). Eleven (10 per cent) had a non-specific code for 'rhinoplasty' (EO26) when five patients had actually undergone 'revision rhinoplasty' and six had had 'augmentation'. This is a fault of the nomenclature, not of the Coders, whose accuracy more than matched that of the surgeons – only four of the 108 patients were miscoded (four per cent), but these errors tended to be very wide of the mark, for example 'submandibular gland excision' for 'rhinoplasty'! Nine Read Codes and five OPCS-4 codes cover this area, of which three are 'dumping'.
3. Our Theatre Register, kept by the theatre nurses, was the least accurate record (88 per cent), showing inaccurate recording in 18 cases (12 per cent).
4. 'FESS' was introduced into the UK about 15 years ago. There are 19 descriptive Read codes assigned to such surgery, but none specifically in OPCS-4. Read cross maps to OPCS-4 as one of four 'dumping' codes – 'Operation on internal nose' (EO8.8), 'non-specific operation on unspecified sinus' (E17.8), 'non-specific operation on sphenoid sinus' (E15.8) or 'intra-nasal ethmoidectomy' (E14.2).

Conclusion

These results support and add to the Nottingham audit by demonstrating:

1. The underlying weakness lies in the nomenclature of the OPCS-4 system, which lacks comprehensiveness, specificity and currency, rather than in any serious inaccuracy of the

professional Coders or Surgeons coding. Nurses do not record this data accurately without help. They have neither the training nor the interest, which lies elsewhere in theatre.

2. Coders should be assigned to specific specialities to gain sufficient in-depth knowledge, and they must be given a better coding system, whether Read V.3 or a merged Read/OPCS-4.
3. Surgeons should take the responsibility for coding, and Coders should, besides making the 'official' returns on behalf of the hospital, double check with the Clinical Director any conflicting coding – we believe such cross checking could achieve virtually 100 per cent accuracy.

The future

The move towards a common international user-friendly coding system by merging Read V.3 (Clinical Terms) and SNOMED-RT, and the move

towards the Electronic Patient Record (which will depend upon it) has been mentioned, and should be adopted as soon as possible. The British Association of Head and Neck Oncologists should agree their 'minimum data set' for Head and Neck Cancer with their relevant multidisciplinary craft associations (BAO-HNS, BAPS, BAOMFS) and code in Read. They will then be in a position to run a comparative audit for the first time – such is the power of an agreed coding.

We therefore would like to suggest that the future is with a modified Read V.3 and that it will be in all our best interests if we all start familiarizing ourselves with the system, and develop a culture of clinician responsibility for inputting codes. Only then can we start doing accurate and comprehensive comparative audit across all hospitals, and produce robust data on outcomes. This is the best way to counteract the attacks on the specialty that there is lack of evidence for efficacy of what we do.