NHS
Cheshire and Merseyside

# Clinical Commissioning Policy

## Tonsillectomy

### Category 2 Intervention - Only routinely commissioned when specific criteria are met -

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| Version: | 1 |
| Purpose | This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite. |
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| **Document control:** | | |
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| **Date:** | **Version Number:** | **Section and Description of Change** |
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# 1. Introduction

1.1 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

1.2 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined in Appendix 1.

1.3 At the time of publication, the evidence presented per procedure/treatment was the most current available.

1.4 This policy is based on NHS England's Evidence-Based Interventions (EBI) recommendations see link to programme below - accurate at the point of publication https://www.aomrc.org.uk/ebi/clinicians/tonsillectomy-for-recurrent-tonsillitis/.

# 2. Purpose

2.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

# 3. Summary of intervention

3.1 This guidance relates to surgical procedures to remove the tonsils as a treatment for recurrent sore throats in adults and children.

3.2 Recurring sore throats are a very common condition that presents a large burden on healthcare; they can also impact on a person's ability to work or attend school. It must be recognised however, that not all sore throats are due to tonsillitis and they can be caused by other infections of the throat. In these cases, removing the tonsils will not improve symptoms.

# 4. Policy statement

4.1 Tonsillectomy is not routinely commissioned for recurrent severe episodes of sore throat unless the following criteria (as set out by the SIGN guidance and supported by ENT UK commissioning guidance) are satisfied:

4.1.1 Sore throats are due to acute tonsillitis

**AND**

4.1.2 The episodes are disabling and prevent normal functioning

**AND**

4.1.3 Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year

**OR**

4.1.4 Five or more such episodes in each of the preceding two years

**OR**

4.1.5 Three or more such episodes in each of the preceding three years.

4.2 Tonsillectomy is also routinely commissioned at a lower threshold than above (4.1) if, after specialist assessment, any of the following criteria are satisfied:

4.2.1 Acute and chronic renal disease resulting from acute bacterial tonsillitis

**OR**

4.2.2 As part of the treatment of severe guttate psoriasis

**OR**

4.2.3 Metabolic disorders where periods of reduced oral intake could be dangerous to health

**OR**

4.2.4 PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis)

**OR**

4.2.5 Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous.

# 5. Exclusions

5.1 The following conditions are considered outside the scope of this policy:

5.1.1 Obstructive Sleep Apnoea / Sleep disordered breathing in Children

5.1.2 Suspected Cancer (e.g., asymmetry of tonsils)

5.1.3 Recurrent Quinsy (abscess next to tonsil)

5.1.4 Emergency Presentations (e.g., treatment of parapharyngeal abscess)

# 6. Rationale

6.1 Recurrent sore throats are a very common condition that presents a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the Scottish Intercollegiate Guidelines Network criteria are met.

6.2 The surgery carries a small risk of bleeding requiring readmission to hospital (3.5%). A previous national audit quoted a 0.9% risk of requiring emergency surgery to treat bleeding after surgery but in a more recent study of 267, 159 tonsillectomies, 1.88% of patients required a return to theatre. Pain after surgery can be severe (especially in adults) for up to two weeks after surgery; this requires regular painkillers and can cause temporary difficulty swallowing. In addition to bleeding; pain or infection after surgery can require readmission to hospital for treatment. The Getting it Right First Time ENT report is due late 2018 and will present updated figures on readmission rates in relation to tonsillectomy.

6.3 There is no alternative treatment for recurrent sore throats that is known to be beneficial, however sometimes symptoms improve with a period of observation.

# 7. Underpinning evidence

7.1 Rubie I, Haighton C, O'Hara J, Rousseau N, Steen N, Stocken DD, Sullivan F, Vale L, Wilkes S, Wilson The National randomised controlled Trial of Tonsillectomy IN Adults (NATTINA): a clinical and cost-effectiveness study: study protocol for a randomised control trial. Trials. 2015 Jun ;16:263. doi: 10.1186/s13063-015-0768-0.

7.2 SIGN (2010) Management of sore throat and indications for tonsillectomy A national clinical guideline

7.3 Osbourne MS, Clark MPA. The surgical arrest of post-tonsillectomy haemorrhage: Hospital Episode Statistics 12 years on. Annals RCS. 2018. May (100) 5: 406-408

# 8. Force

8.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

# 9. Coding

**SQL code**

```
WHEN left(der.Spell_Dominant_Procedure,4) IN
('F341','F342','F343','F344','F345','F346','F347','F348','F349','F361')
AND apcs.der_diagnosis_all not like '%G47%' AND apcs.der_diagnosis_all not like '%J36%'
AND APCS.Admission_Method not like ('2%')
THEN 'H_tonsil'
```

**Global cancer exclusion**

```
APC
apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (apcs.der_diagnosis_all not like '%C[0-9][0-9]%'
AND apcs.der_diagnosis_all not like '%D0%'
AND apcs.der_diagnosis_all not like '%D3[789]%'
AND apcs.der_diagnosis_all not like '%D4[012345678]%'
OR apcs.der_diagnosis_all IS NULL)
```

# 10. Monitoring And Review

10.1 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

10.2 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

# 11. Quality and Equality Analysis

11.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

# Appendix 1 - Core Objectives and Principles

# Objectives

The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

# Principles

This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

# Core Eligibility Criteria

There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

# Cosmetic Surgery

Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

A summary of Cosmetic Surgery is provided by NHS Choices. Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

# Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

# Clinical Trials

The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

# Clinical Exceptionality

If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy.