2013

Commissioning guide:

Tonsillectomy

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Commissioning guide 2013

Tonsillectomy

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Introduction

This commissioning guide comprises two pathways of care which culminate in tonsillectomy:

- Recurrent tonsillitis or its complications (e.g. quinsy) in children <16 and in adults
- Sleep disordered breathing in children <16

Recurrent acute sore throat is a very common condition presenting in primary care and tonsillectomy is one of the most common operations. It presents a significant burden of disease; in 2012 some 13,000 operations per year were performed in adults and 18,000 operations per year in children, incurring a cost of £51m across England.

There is an inequality of care demonstrated by widespread variation in the number of operations across the country; this makes an understanding of the pathway of care for this group of patients a commissioning priority.

For tonsillectomy there is good evidence addressing effectiveness in children; but limited evidence in adults.

1 High Value Care Pathway for tonsillectomy

This section provides two pathways:

1.1 High Value Care Pathway for recurrent tonsillitis or its complications (eg. quinsy) in children <16 and in adults

Primary care assessment

- Carefully assess (history and examination) a patient with sore throat symptoms and document diagnosis of significant sore throat or tonsillitis.
- Carefully assess and document impact on quality of life.

Referral

- Consider referral if SIGN criteria are met (i.e. 7 or more clinically significant, adequately treated sore throats in the preceding 12 months or 5 or more episodes in each of the preceding two years, or 3 or more in each of the preceding three years).
- There are a small proportion of patients with specific clinical conditions or syndromes, who require tonsillectomy as part of their on-going management strategy, and who will not necessarily meet the SIGN

guidance (e.g. those presenting with psoriasis, nephritis, PFAPA syndrome)

- Before referral to secondary care, discuss with patient/parents or carers the benefits and risks of tonsillectomy vs. watchful waiting. Information to be provided and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. This discussion should be documented.
- The impact of recurrent tonsillitis on a patient's quality of life and ability to work should be taken into consideration. A fixed number of episodes, as described above, may not be appropriate for adults with severe or uncontrolled symptoms, or if complications (eg quinsy) have developed.

Secondary care

- Confirmation of primary care assessment, fulfilment of SIGN criteria for tonsillectomy and impact on quality of life and ability to work/attend school.
- Consultation with patient about management options using shared decision making strategies and tools where appropriate.
- Management options: tonsillectomy, or referral back to primary care for on-going monitoring.

Surgical setting

- *Children*: Ideally within a paediatric surgical facility as a day case, although day case care may be contraindicated in the presence of significant sleep apnoea
- *Adults*: Ideally as a day case.

1.2 High Value Care Pathway: Children (<16) with sleep disordered breathing

Primary care assessment

- Carefully assess (history and examination) a child with symptoms of significant snoring and disruptive breathing patterns whilst asleep. Make note of large tonsils with or without nasal obstruction.
- Carefully assess and document impact on development, behaviour and quality of life.

Referral

- If sleep disordered breathing is suspected, refer to secondary care.

Secondary care

- Confirmation of primary care assessment, either on basis of history and examination or, if necessary, findings from further investigations (e.g. Sleep study)

- Consider impact on quality of life, behaviour and development.
- Consultation with parent/carers about management options using shared decision making strategies and tools where appropriate.
- Management options: tonsillectomy or adenotonsillectomy, or, if appropriate, referral to paediatrician or discharge back to primary care.

Surgical setting

- Within a paediatric surgical facility. Children with severe symptoms will need access to paediatric intensive care facilities.

2 Procedures explorer for tonsillectomy

Users can access further procedure information based on the data available in the quality dashboard to see how individual providers are performing against the indicators. This will enable CCGs to start a conversation with providers who appear to be 'outliers' from the indicators of quality that have been selected.

The Procedures Explorer Tool is available via the Royal College of Surgeons website.

3 Quality dashboard for tonsillectomy

The quality dashboard provides an overview of activity commissioned by CCGs from the relevant pathways, and indicators of the quality of care provided by surgical units.

The quality dashboard is available via the Royal College of Surgeons website.

4 Levers for implementation

4.1 Audit and peer review measures

The following measures and standards are those expected at primary and secondary care. Evidence should be able to be made available to commissioners if requested.

	Measure	Standard
Primary Care	Documentation of symptoms	Significant symptoms should be documented prior to referral
	Referral	Do not refer patients who do not fulfil criteria for referral unless exceptions as above.
	Patient information	Patients are provided with appropriate information prior to referral
Secondary Care	Patient engagement and information	Evidence of patient's engagement in shared decision making process and provision of written patient information
	Criteria for surgery	Evidence of appropriate documentation that patients fulfil criteria for surgery
	Criteria for non-day case decisions	Evidence of appropriate documentation supporting any non-day case decision
	Audit	Audit of: ▪ post-operative complications and morbidity ▪ appropriate peri- and post-operative management (pain control, post-discharge information, etc.)

4.2 Quality Specification/CQUIN

Measure	Description	Data specification (if required)
Length of stay	Provider demonstrates a mean LOS of <2 days	Data available from HES
Day Case Rates	Provider demonstrates day case is the expectation	Adequate justification for non day case rate
Unplanned readmissions within 14 days	Provider demonstrates low readmission rates within 14 days: up to 15% is acceptable for post-operative pain/bleeding)	Data available from HES

5 Directory

5.1 Patient Information for tonsillectomy

Name	Publisher	Link
Shared decision making tool	Right Care	http://sdm.rightcare.nhs.uk/pda/recurrent-sore-throat/
ENT-UK Patient Information leaflet on tonsillectomy	ENT-UK	https://entuk.org/ent_patients/information_leaflets
Tonsillitis	NHS Choices	http://www.nhs.uk/conditions/tonsillitis/pages/treatment.aspx

5.2 Clinician information for tonsillectomy

Name	Publisher	Link
Management of sore throat and indications for tonsillectomy ***A national clinical guideline***	SIGN	http://www.sign.ac.uk/pdf/sign117.pdf
Prescribing of antibiotics for self-limiting respiratory tract infections in adults and children in primary care	NICE	http://www.nice.org.uk/CG69
Clinical Knowledge Summary: Acute Sore Throat Management	NICE	http://cks.nice.org.uk/sore-throat-acute

6 Benefits and risks of implementing this guide

Consideration	Benefit	Risk
Patient outcome	Ensure tonsillectomy is only undertaken on patients with significant symptoms	As guidelines are well defined, some patients who might otherwise have benefitted from tonsillectomy will not have been offered the procedure (see section 1).

Patient safety	Patients receive appropriate information about their condition and treatment.	HES data indicate that as tonsillectomy rates have fallen in the UK there has been a corresponding annual increase in acute hospital admissions with tonsillitis and its complications.
Patient experience	Improve access to patient information	
Equity of Access	Improve access to effective procedures for those most likely to benefit	To deny access to some patients who might otherwise have benefitted from tonsillectomy.
Resource impact	Reduce unnecessary referral and intervention Reduce unnecessary societal costs of recurrent tonsillitis	Increased activity in primary and secondary care in managing acute sore throats. Costs of potential increased surgical activity

7 Further information

7.1 Research recommendations

- Research on development of a PROM for recurrent sore throat
- RCT of tonsillectomy in adults with recurrent tonsillitis
- Development of most clinical and cost effective peri and post-operative clinical protocols

7.2 Other recommendations

- Recommendation that PROMs for recurrent tonsillitis is developed and implemented.

7.3 Evidence base

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7.4 Guide development group for tonsillectomy

A commissioning guide development 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 and teleconference.

Name	Job Title/Role	Affiliation
Sean Carrie	Chairman	ENT-UK
Jonathan Hobson	Consultant ENT Surgeon	ENT-UK
Martin Burton	Consultant ENT Surgeon	ENT-UK
Anne Schilder	NIHR Research Professor and Professor of Paediatric Otorhinolaryngology	NIHR
Sarah Bird	Patient Representative	Patient Representative
Ian Williamson	General Practitioner	
James Rabbett	Patient Representative	Patient Representative
Juliet Martin	Patient Representative	Patient Representative
Tony Narula	Consultant ENT Surgeon	ENT-UK
Peter Robb	Consultant ENT Surgeon	ENT-UK
Andrew Brooks	Chief Operating Officer, Surrey Heath CCG	Surrey Heath CCG

7.5 Funding statement

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- DH Right Care funded the costs of the guide development group, literature searches and contributed towards administrative costs.
- The Royal College of Surgeons of England (RCSEng) and ENT-UK provided staff to support the guideline development.

7.6 Conflict of Interest Statement

Individuals involved in the development and formal peer review of commissioning guides are asked to complete a conflict of interest declaration. It is noted that declaring a conflict of interest does not imply that the individual has been influenced by his or her secondary interest. It is intended to make interests (financial or otherwise) more transparent and to allow others to have knowledge of the interest.

The following members declared interests:

Name	Job Title/Role	Affiliation
Mr Sean Carrie	Consultant ENT surgeon	▪ Received funds as co-worker on NESSTAC trial ▪ Work in acute NHS Foundation Trust ▪ Private ENT medical practice
Professor Anne GM Schilder	NIHR Research Professor, Professor in Paediatric Otorhinolaryngology, Director ENT Clinical Trials Programme, Ear Institute, UCL, London	▪ Supported by an NIHR Research Professorship to develop a programme for Clinical Trials in ENT
Mr Peter Robb	Consultant ENT surgeon	▪ MRC funding for nursing staff as part of the OME genetic study ▪ Athrocare UK Ltd as faculty member and advisor on coblation surgery ▪ Travel/accommodation at RSM as Section President ▪ Modest honoraria for speaking at various

		meetings e.g. BAPA
Mr Martin Burton	Consultant Otolaryngologist and Director, UK Cochrane Centre	▪ Employed by NHS Trust and work in private practice