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Executive Summary

1. There is significant variation in practice and outcomes within the Northwest, North Wales and Isle of Man for children undergoing (Adeno)tonsillectomy.

2. Children referred for consideration of (Adeno)tonsillectomy should be referred and treated at the unit best placed to manage the entire pathway. This will ensure both consistency and reduce delays in the pathway.

3. Children with high risk factors should be managed in AHCH or RMCH, with consideration given to geography and where co-morbidity is managed.

4. Children under the age of 2 years without high risk factors should be managed in AHCH, RMCH or RPH.

5. All Children over the age of 2 years and without high risk factors can be managed in the nearest unit that is commissioned to perform adenotonsillectomy. Moreover, the group of children are suitable to be managed without the need for overnight post-operative stay, subject to local anaesthetic and surgical policy and governance arrangements.

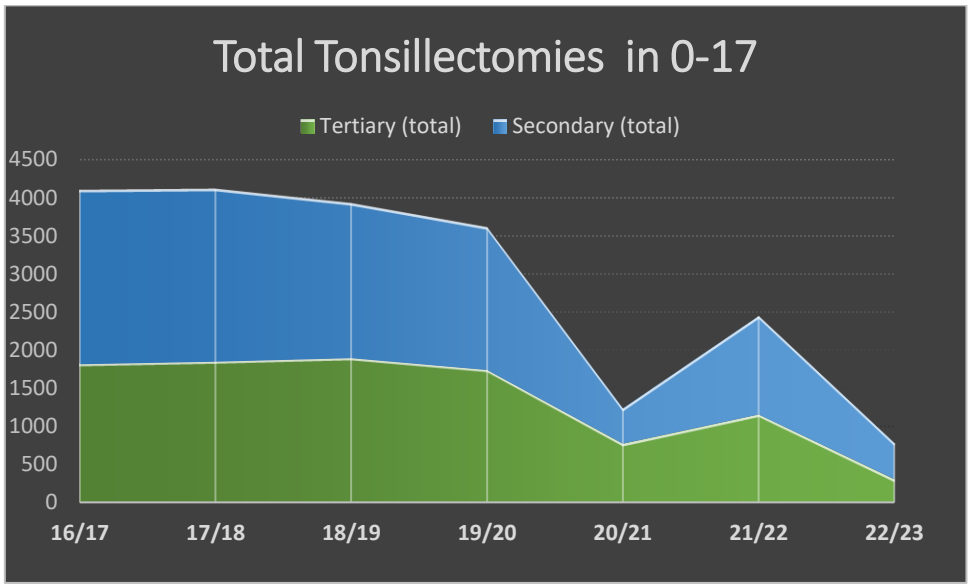
6. Overnight pulse oximetry is not routinely recommended as a tool to determine whether or not surgery is required.

7. Consideration should be given to intracapsular tonsillectomy that have demonstrably lower post-operative bleeding risks, particularly in younger children.

8. All units should conduct regular (at least quarterly) departmental M&M meetings and audit of outcomes against Model Hospital data, with sharing and review of practice to improve safety, quality, and performance and to identify and incorporate good practice.

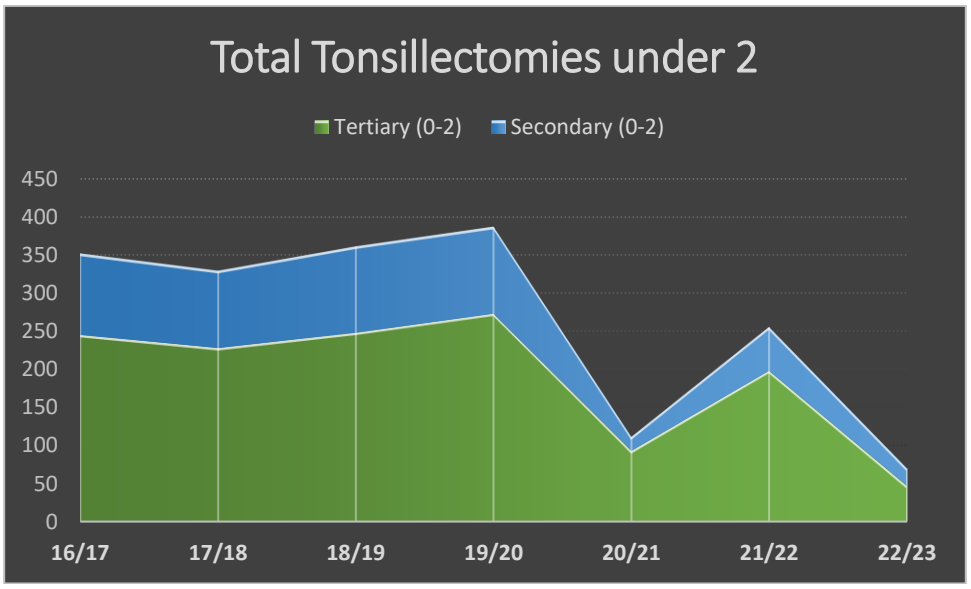
Introduction

(Adeno)tonsillectomy is a commonly performed ENT surgical procedure with approximately 25,000 performed annually in England, of which approximately 4000 were performed in the North West in 2019-20 (North Wales and IOM data not included). There had been a general trend toward fewer tonsillectomies leading up to the Covid-19 pandemic when activity in children was affected more in secondary care than in tertiary care.

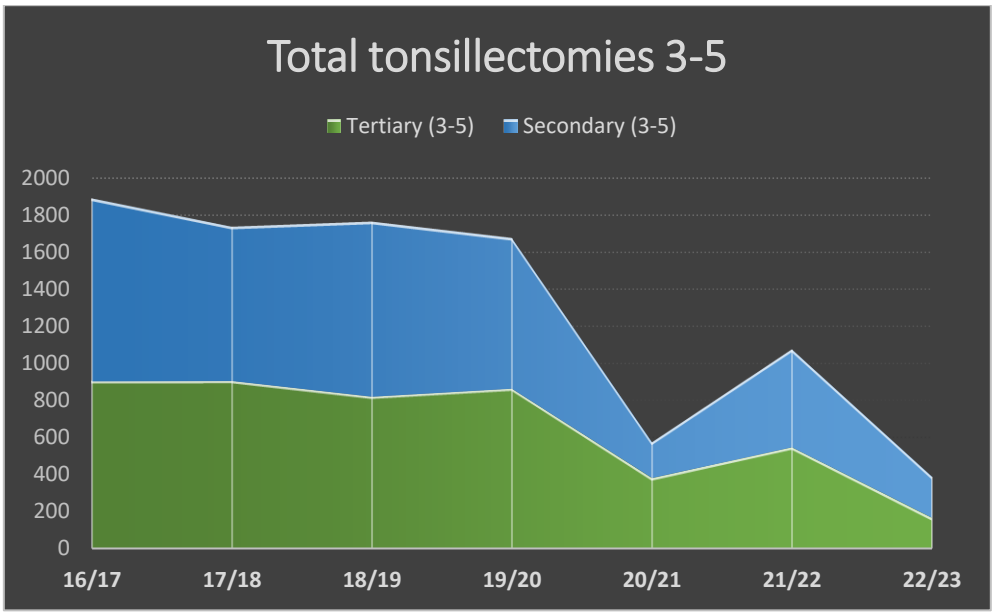


Factors that have influenced practice in recent years include

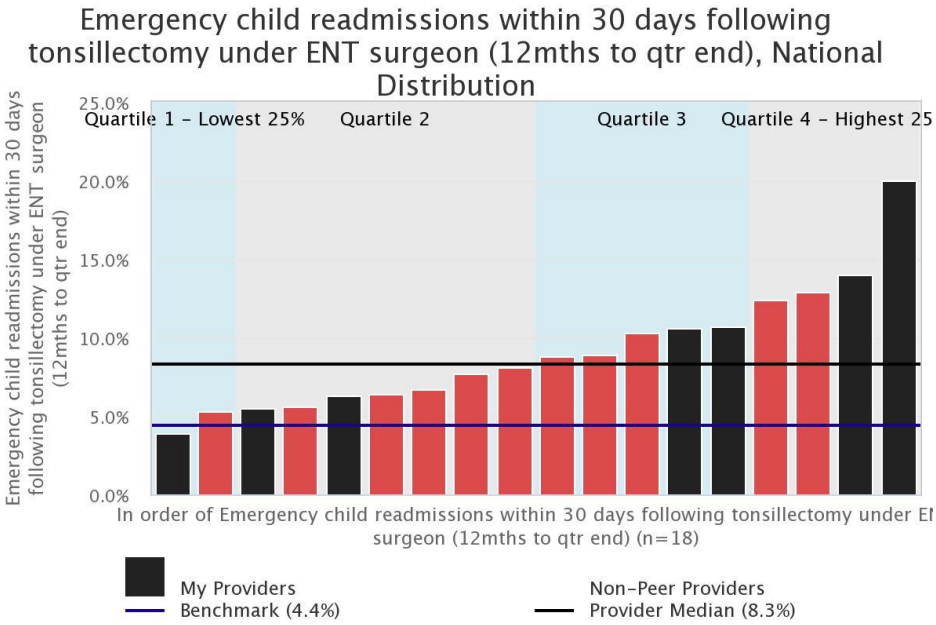
1. Changing demographics
    a. Greater proportion of cases are now for OSA (Obstructive Sleep Apnoea) than recurrent tonsillitis
    b. An increase in procedures performed in children up to the age of 2, with an increasing proportion of these performed in tertiary units.



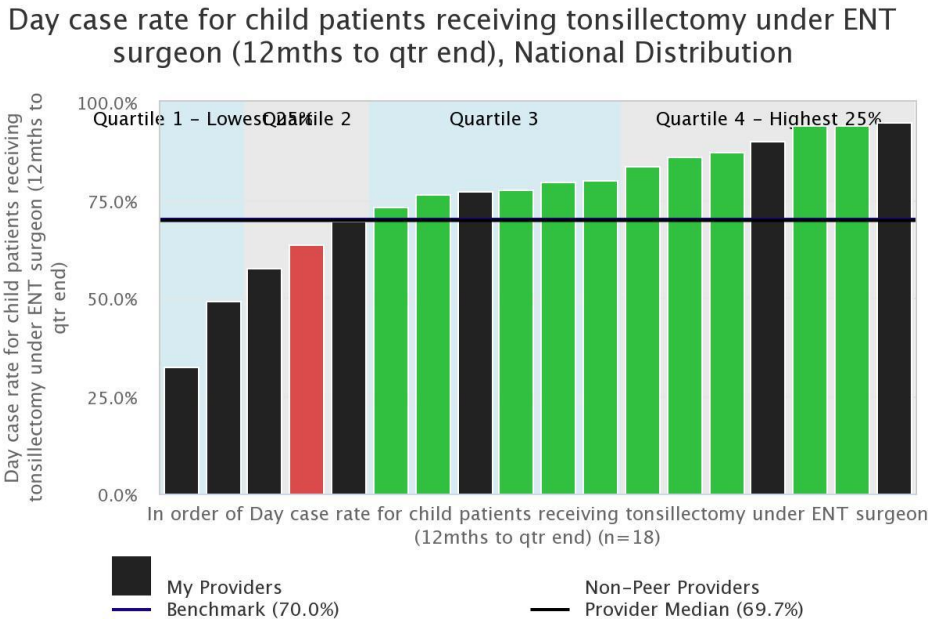
c. During and Post C-19, a greater proportion of the procedures in 3–5 year group were performed in the tertiary units suggesting slower recovery for children in the secondary centres.



2. Variation in practice
    a. Referral from primary care- commissioning guidance
    b. Minimum age and weight criteria for safe surgery (and anaesthesia)
    c. Requirement for pre-operative sleep studies
    d. Day case criteria
    e. Triage of referrals, length of wait for outpatient assessment and length of wait on the surgical waiting list
    f. Criteria for referral to a tertiary unit. This sometimes leads to unnecessary referrals and therefore delay and excess travel for the children and their families.
3. Changes/ improvements in surgical and anaesthetic techniques
4. Variation in Outcomes
    a. Readmission rates in 12 months to quarter end Q4 2021/22 across NW providers (not incl North Wales and IOM)



b. Day case rates in NW in 12 months to quarter end Q1 2022/23 (not incl North Wales and IOM)



The aim of this pathway guideline is to enable standardisation of the pathway within the Northwest from referral to discharge to primary care, in order to ensure safe equitable care as close to home as possible.

The guideline is aimed at primary, secondary and tertiary care providers of adenotonsillectomy in children. It is also hoped that it will empower organisations to overcome barriers to change that will lead to improved care for this group of patients.

Methodology

This guideline is aimed at primary, secondary and tertiary care providers of adenotonsillectomy in children. It is envisaged that the guideline will enable standardisation of the pathway within the Northwest from referral to postoperative care, in order to ensure provision of safe equitable care as close to home as possible.

It is also hoped that it will empower organisations to overcome barriers to change that will lead to improved care for this group of patients.

The Guideline was developed by the (Adeno)tonsillectomy Working group. The group was drawn from representation from the NW, North Wales and IOM from multiple staffing groups from both tertiary and secondary units including ENT surgeons; anaesthetists; paediatricians, pre-admission teams, nursing staff; theatre staff; operational managers & the SiC ODN. In addition, primary care and ISC leadership representation was sought. The Terms of Reference for the (Adeno)tonsillectomy Working group are detailed in Appendix 1.

Declaration of Interests: No conflicting interests were declared by any Working Group members.

The pathway was mapped from referral from primary care to discharge from secondary care and the steps involved were detailed. Working group members were asked to comment on the steps to elucidate differences in practice, examples of good practice and standardisation. Data were obtained from Model Hospital and RAIDR to highlight variations in day case rates, readmission rates, and waiting lists. Recommendations from Ear Nose and Throat – GIRFT Programme National Speciality report (November 2019), ENT UK RCS Advancing Surgical Standards – Commissioning Tonsillectomy (2021) and Safe Delivery of Paediatric ENT Surgery in the UK: A National Strategy (2018) were also presented.

(Adeno)tonsillectomy Working group Meetings: An initial meeting was held in April 2022 at which the Terms of Reference were agreed, the purpose of the guideline discussed and some of the content debated and discussed. Comments were invited from all working group members prior to a follow up meeting in July 2022 where the comments were discussed, and consensus reached. Where consensus could not be reached because of paucity of robust evidence or contrary evidence, it was agreed that options would be offered, and a recommendation made to seek further evidence.

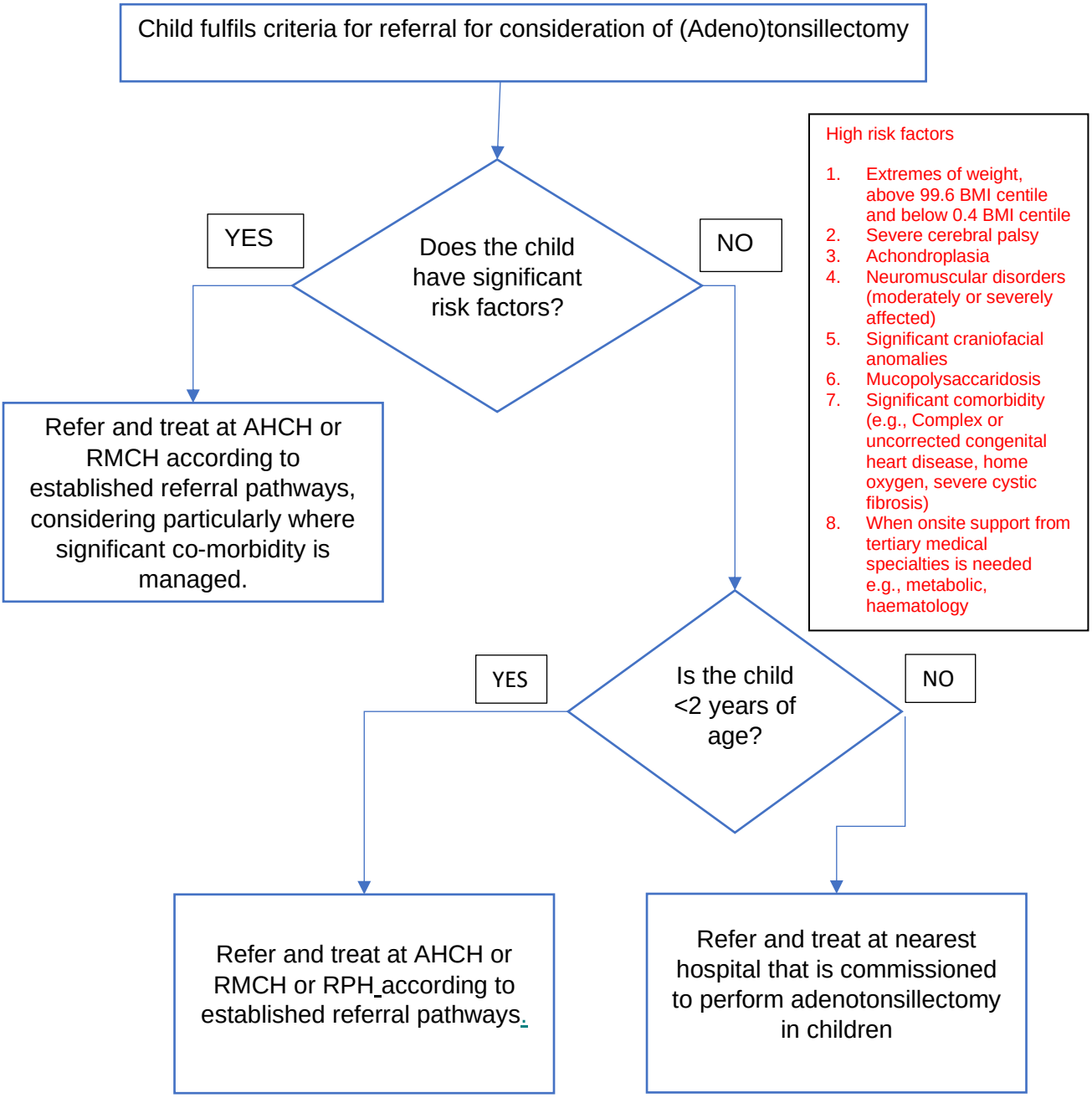
Patient/carer Representatives: Formal patient representation was not sought at the stage of guideline development but will be included in the stage of Stakeholder comments.

The Guideline will be updated in 3 years or sooner if a significant change to practice becomes apparent before then.

There was no funding made available for development of this guideline and we acknowledge the time commitment that the Working group members have made.

Guideline

Flowchart



Recommendations

	Recommendation	Who
Referral from Primary Care	Refer as per recommended commissioning guidance standardised across the region (see appendix 3)	Primary care practitioner/ ICBs
	A. All children **<2 years of age without significant co-morbidity/ high risk factors** (see appendix 2) should be referred directly to Alder Hey Childrens Hospital (AHCH), Royal Manchester Children's Hospital (RMCH) or to the Paediatric ENT Lead at Royal Preston Hospital (RPH). B. All children regardless of age **with significant co-morbidity/ high risk factors** (see appendix 2) should be referred directly to Alder Hey Childrens Hospital, Royal Manchester Children's Hospital C. All children >2 years of age and without significant co-morbidity/ high risk factors (see appendix 2) should be referred to the nearest ENT unit (that accepts children and is commissioned to perform adenotonsillectomy in children)	Primary care practitioner
	Referral guidance should be embedded in 'choose and book'	C & B directory teams via surgical Operational Mangers
Referral Triage at secondary care	Triage to be seen in out-patients 'within 2 weeks' when there is a suspicion of malignancy, 'within 3 months' for children referred with obstructive symptoms (including choking) and 'within 12 months' for recurrent tonsillitis, with clinical discretion to decrease this time for all categories	ENT surgeons/ Operational managers
	Redirect referrals at source to AHCH, RMCH or RPH for patients <2 years of age or patients with high risk factors (appendix 2) as above.	ENT surgeons/ Operational managers
	Overnight pulse oximetry is not routinely recommended as a tool to determine whether or not surgery is required.	ENT surgeons/ Operational managers
ENT clinic assessment/ patient selection for listing/ pre-op data collection	All children should be assessed in an outpatient clinic by an ENT clinician (with a named ENT consultant), with suitable supervision and governance arrangements in place.	ENT surgeons/ Operational managers
	A. All children <2 years of age without significant co-morbidity/ high risk factors (see appendix 2) should be assessed and listed at Alder Hey Childrens Hospital (AHCH), Royal Manchester Children's Hospital (RMCH) or to the Paediatric ENT Lead at Royal Preston Hospital (RPH).	ENT surgeons/ Operational managers

	B. All children with significant co-morbidity/ high risk factors (see appendix 2) regardless of age, should be assessed and listed at Alder Hey Childrens Hospital, Royal Manchester Children's Hospital. Consider geography and where their co-morbidity is managed. C. All children >2 years of age and without significant co-morbidity/ high risk factors (see appendix 2) should be assessed and listed at the nearest ENT unit (that accepts children and is commissioned to perform adenotonsillectomy in children)	
	Consultation with parent/carers about management options should use shared decision-making strategies	ENT surgeons
	Consider virtual (video) consultations for highly selected patient groups e.g., patients already seen in secondary care referred for tertiary care, recurrent tonsillitis in an older child, follow up after a period of watchful waiting.	ENT surgeons
	Consider adenotonsillectomy in patients that fulfil criteria as in Appendix 2	
	Consider use of T14 PROM (pre-op and 3 months post op)	ENT surgeons
	Consent process should be started in outpatients at the time of listing	ENT surgeons
	Use Patient information leaflets (ENTUK, EIDO) can be tailored to individual units.	ENT surgeons
Listing for surgery	Suggested P codes- use clinical discretion P1: Acute airway obstruction ('hot tonsillectomy') P2: Suspicion of malignancy, choking P3: Obstructive sleep apnoea, recurrent tonsillitis with significant co-morbidity P4: Recurrent tonsillitis with no comorbidity	ENT Surgeons
	Pre-operative assessment is helpful in preparing patients and parents for surgery and in increasing efficiency by decreasing the likelihood of same day cancellations/ delays and should be utilised where possible	ENT/ Anaesthesia/ Theatre/ Post operative Childrens Ward Managers and Operational Managers
	Day case Surgery: Children over the age of 2 years with no high-risk factors can be listed as a day case subject to local anaesthetic, surgical policy and audit. (Recently published	Pre-operative assessment units, Anaesthesia, Theatre, Surgical

	National GIRFT guidance varies slightly from this, and can be read in conjunction with this guidance and subject to local policy https://gettingitrightfirsttime.co.uk/wp-content/uploads/2023/06/Day-Case-Paediatrics-Tonsillectomy-Pathway-FINAL-V1-June-2023-1.html)	Operational Managers
Anaesthesia and Surgery	Consider the use of an LMA if suitable for both surgeon and anaesthetist.	Anaesthetists, ENT Surgeons
	Encourage fixed team working	Surgical Operational Managers
	Minimise the use of long-acting opioids subject to local policy and audit	Anaesthetists
	Consider intracapsular tonsillectomy, particularly for younger children with obstructive symptoms. The ODN can provide support with training, business cases etc.	ENT Surgeons, Surgical Operational Managers
	Consider adenoidectomy using indirect vision (mirror) and suction diathermy/ ablation	ENT Surgeons
Post op care and follow up	Consider nurse-led discharge	Surgical Operational Managers, Paediatric Nurse Managers
	Written discharge advice should be provided to all patients/ carers, including a point of contact if there are post op queries or concerns.	Surgical Operational Managers, Paediatric Nurse Managers
	Day case units should have a formal written arrangement for unexpected delay to discharge/ requirement for inpatient facility.	Surgical Operational Managers, Paediatric Nurse Managers
	Consider use of technology to facilitate follow up and collection of outcome data (T14)	ENT Surgeons
Audit and Governance	Audit should be carried out at least annually (or quarterly if significant changes have been made to practice) to ensure low readmission rates and day case rates (Model Hospital Data)	ENT Surgeons, Anaesthetists

	Regular (at least quarterly) departmental M&M meetings with sharing and review of practice to improve safety, quality, and performance and to identify and incorporate good practice.	ENT Surgeons, Anaesthetists

Recommendation to seek further evidence via local audit and larger scale studies.

1. Anaesthetic techniques: It was felt that there is no single 'best' technique but that there would be value in sharing practice.
2. Surgical techniques: Intracapsular tonsillectomy was acknowledged as a safe technique with a significantly lower risk of primary bleeding and readmission than some other techniques. Consensus was not reached upon the age at which this technique should be offered, the long-term outcomes particularly in relation to recurrent tonsillitis and need for revision surgery and whether other techniques should be actively discouraged in children.
3. Role of overnight pulse oximetry "sleep studies": Although there was consensus that for the majority of children, pre-operative overnight pulse oximetry has no role in making the decision to perform (Adeno)tonsillectomy, there was less of a consensus on their role in risk stratification, determining urgency of intervention and their role in children with high risk factors/ comorbidities.
4. Training: Consider visualisation particularly for training with a microscope or a headlight with mounted camera. Courses are available for intracapsular tonsillectomy. All ENT trainees going through the North West ENT training programme will be trained to a competent level in this technique. However, established ENT surgeons would have to learn this as a new technique and a learning curve exists although further studies are required to determine how long this is and what level of mentoring/ supervision would be required.

Discussion of potential organisational and financial barriers to applying recommendations

a. Variation in minimum age/ weight criteria for general anaesthesia across different organisation-policy is determined locally despite national guidance. The ODN will support units in an effort to standardise the approach in keeping with RCOA guidance. Approaches include update courses, shared contracts, visiting anaesthetic personnel.
b. Variation in day case facilities particularly for children and young people.
c. Focus on waiting list backlog in DGHs on adult (oncology)- conflicting demands
d. Workforce pressures
e. Intracapsular tonsillectomy: cost implication relating to the equipment. Guidance can be provided with regard to business cases.

Good practice points

Areas of good practice should be identified and shared in order to be disseminated to the wider ODN. Examples of this include a day case unit model (walk-in walk-out), decreasing post op stay, analgesia protocols.

Reducing the risk of bleeding

INTRACAPSULAR TONSILLECTOMY REDUCES THE RISK OF BOTH PRIMARY & SECONDARY BLEEDING- PLEASE CONTACT THE ODN ON ADVICE ON TRAINING AND ADVICE RE BUSINESS CASES.

COLD STEEL & TIES TECHNIQUE IS ALSO ASSOCIATED WITH A LOW RISK OF SECONDARY BLEEDING

Reducing post-operative pain

INTRACAPSULAR TONSILLECTOMY REDUCES THE DURATION OF PAIN POST-OP.

POST-OPERATIVE ANALGESIA PROTOCOLS INCLUDE PARACETAMOL, IBUPROFEN, ORAL MORPHINE AND DIFFLAM.

Maximising Day Case Potential/ Efficiency

PREADMISSION REDUCES ON-DAY CANCELLATION

POST-OPERATIVE STAY CAN BE REDUCED DOWN TO 2 HOURS IN SOME CASES

USE OF A DEDICATED DAYCASE UNIT OR WALK-IN WALK-OUT MODEL IF THIS ISN'T AVAILABLE INCREASES THROUGHPUT

Clinical audit requirements with a suggested clinical audit tool.

1. All units should conduct regular M&M and audit- Model hospital data on readmission rates and day case rates is freely available. More detailed selective analysis should be performed at a more granular level, particularly if significant deviation from standards is found. This can be facilitated by the ODN.
2. Outcomes of tonsillectomy surgery have in recent years been reported in the literature using the T14 score to be recorded pre-op and 3 months post-op- this is recommended as a tool that will enable comparison

Appendices

Appendix 1: TOR

North West Surgery in Children (Adeno)tonsillectomy Working Group

Terms of Reference

Title	North West Surgery in Children (Adeno)tonsillectomy Working Group Terms of Reference
Author(s)	Lucy Allton - Lead Nurse SIC ODN
Co. Author	Joanna McBride Network Director
Target Audience	Membership of the North West Surgery in Children (Adeno)tonsillectomy Working Group Membership of the NW PCC, SiC and LTV Board
Ratified by	
Date Ratified	
Review Date	12.12.2024
Version	12.12.2022
Document Status	Final Review

Terms of Reference: North West Surgery in Children (Adeno)tonsillectomy Working Group

1. Introduction

The Surgery in Children Operational Delivery Network (SiC ODN) was established in 2021 following the SiC National Review. An Operational Delivery Network (ODN) brings together different parties (clinicians, providers, commissioners, patients) together to realise change across complex systems of care to improve care quality and outcomes. The formation of specialist working groups to focus on creation of pathways and guidelines for the region is essential to realising this change.

2. Vision

The vision for the (Adeno)tonsillectomy working group is for a range of clinical experts from across the NW, North Wales and the IOM region to work together to create evidence-based guidance for the (Adeno)tonsillectomy(adeno)tonsillectomy clinical pathway in children from referral to discharge.
This can then be adopted regionally to create a shared framework to provide equitable, high quality safe care as close to home for children requiring this surgery across the Northwest, North Wales and the IOM region.

3. Objectives

The objectives of the (Adeno)tonsillectomy working group are

- to establish a group of interested individuals and facilitate effective communication, thereby establishing strong working relationships
- to share current practice and guidelines from around the region
- to use best current evidence and existing guidelines / pathways to create new regional guidance for the clinical pathway for (adeno)tonsillectomy in children
- to share the guidance and pathway across the NW region for all areas to adopt
- to review the guidance and pathway every three years or when required

4. Term & Structure

The term of the working group will be six months, with an initial meeting and a meeting prior to stakeholder comment at 3 months. Progress between these two meetings will occur primarily by email with virtual meetings arranged ad hoc if required. The final version of the guidance and clinical pathway will be produced following consultation and presented to the NW ODN guideline

ratification group by 30 September 2022 by the SiC ODN leadership team. Information, evidence and current policies can be shared via ODN administrator or via MS Teams site for the group.

5. Reporting Arrangements

The (Adeno)tonsillectomy working group will report to the SIC ODN oversight group and the guideline ratification group.

6. Membership and Chair of the group

Membership of the group will be representation from the NW from multiple staffing groups from both tertiary and secondary units including ENT surgeons; anaesthetists; paediatricians, pre-admission teams, nursing staff; theatre staff; operational managers & the SiC ODN. In addition, primary care and ISC leadership representation would be desirable. The Group will be chaired by an ODN clinical Lead.

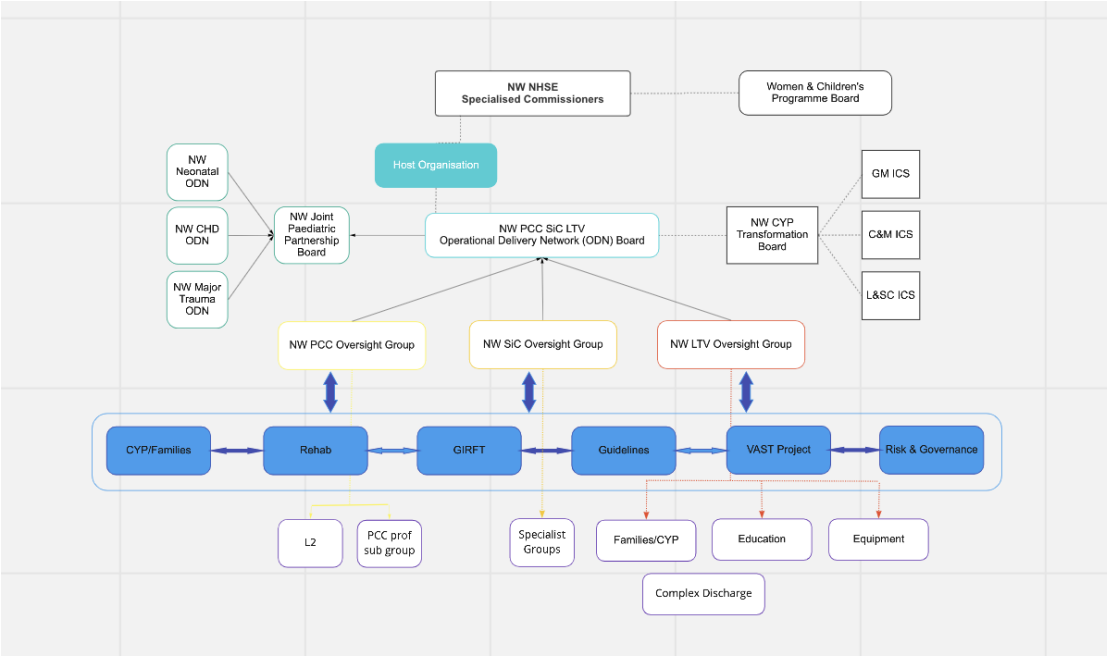
7. Relevant Documents

Ear Nose and Throat – GIRFT Programme National Speciality report (November 2019) https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/12/ENT-Report-Nov19-M.pdf

ENT UK RCS Advancing Surgical Standards – Commissioning Tonsillectomy (2021) https://www.entuk.org/_userfiles/pages/files/guidelines/Revised%20ENT%20UK%20Tonsillectomy%20commissioning%20guide%20edit%20to%20final%20(002).pdf

Safe Delivery of Paediatric ENT Surgery in the UK: A National Strategy (2018) Microsoft Word - Safe Delivery Paediatric ENT.docx (entuk.org)

8. Governance Structure


NW NHSE
Specialised Commissioners
Women & Children's Programme Board
Host Organisation
NW Neonatal ODN
NW CHD ODN
NW Major Trauma ODN
NW Joint Paediatric Partnership Board
NW PCC SiC LTV
Operational Delivery Network (ODN) Board
NW CYP Transformation Board
GM ICS
C&M ICS
L&SC ICS
NW PCC Oversight Group
NW SiC Oversight Group
NW LTV Oversight Group
CYP/Families
Rehab
GIRFT
Guidelines
VAST Project
Risk & Governance
L2
PCC prof sub group
Specialist Groups
Families/CYP
Education
Equipment
Complex Discharge

Appendix 2: High risk factors

1. Extremes of weight, above 99.6 BMI centile and below 0.4 BMI centile
2. Severe cerebral palsy
3. Achondroplasia
4. Neuromuscular disorders (moderately or severely affected)
5. Significant craniofacial anomalies
6. Mucopolysaccaridosis
7. Significant comorbidity (e.g., Complex or uncorrected congenital heart disease, home oxygen, severe cystic fibrosis)
8. When onsite support from tertiary medical specialties is needed e.g., metabolic, haematology

Appendix 3: Indications for (Adeno)tonsillectomy (Adapted from REF- commissioning guidance/ Pan Lancs

1. **For children with recurrent tonsillitis,**

   consider fulfilment of SIGN criteria for tonsillectomy and impact on quality of life and ability to attend education.

   OR

   Acute and chronic renal disease resulting from acute bacterial tonsillitis

   OR

   Metabolic disorders where a period of reduced oral intake could be dangerous to health

   OR

   PFAPA (Periodic fever, apthous stomatitis, pharyngitis, cervical adenitis), Psoriasis exacerbated by acute tonsillitis, PANDAS

   OR

   Severe immune deficiency that would make episode of recurrent tonsillitis dangerous.

2. **For children with a clinical diagnosis obstructive sleep apnoea,**

   A. consider clinical history and examination and if available recording of child's sleep (smartphone video). Consider impact on growth and development, behaviour, and quality of life.

   B. Consultation with parent/carers about management options should use shared decision-making strategies

   C. If there is a history suggestive of allergy in a child > 4 years of age, consider allergy testing and appropriate treatment prior to a decision on surgery.

   D. Consider active monitoring prior to a decision on surgery for children with mild or improving symptoms- use clinical discretion.

3. **The patient has had more than one peritonsillar abscess (quinsy).**

4. **A history of acute choking episodes with large tonsils**

5. **Asymmetric tonsils/ ulceration or abnormal appearance of tonsils-**

   In the absence of an abnormal appearance of the tonsil AND/ OR B-symptoms OR a history of immunosuppression, tonsillectomy for histology is not indicated- *This decision to be made by ENT Surgeon

Appendix 4:

1. Patient Leaflets

[Helping you decide about tonsillectomy surgery for your child - NEW | ENT UK]

2. Audit Tools- T14

PAEDIATRIC THROAT DISORDERS OUTCOME TOOL (T-14)

Name

D.O.B ATTACH ID LABEL HERE

Hospital No

Below you will find a list of symptoms and problems that may be caused by your child's throat problems. We would like to know more about these and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information.

DATE OF COMPLETION: / /

Considering how severe the problem is when your child experiences it and how often it happens over the past **six months for your child**, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: If a certain question is not a problem for your child, please circle"0". Please try not to miss any questions.	No problem	Very mild problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as bad as it could be
1. Snoring loudly during sleep	0	1	2	3	4	5
2. Irregular or stopped breathing (apnoea) during sleep	0	1	2	3	4	5
3. Day time sleepiness	0	1	2	3	4	5
4. Noisy breathing during the day	0	1	2	3	4	5
5. Breathing through the mouth during the day	0	1	2	3	4	5
6. Problems with poor appetite, or poor eating habits (choking on food etc)	0	1	2	3	4	5
7. Frequent ear ache or ear infections	0	1	2	3	4	5
8. Repeated short-term throat infections that last less than 2 weeks	0	1	2	3	4	5
9. Constant, or chronic, throat infections that last more than 2 weeks	0	1	2	3	4	5
10. Many phone calls to the doctor or NHS direct	0	1	2	3	4	5
11. Many visits to the family doctor or A&E department	0	1	2	3	4	5
12. Taking antibiotics over and over for less than 2 weeks at a time	0	1	2	3	4	5
13. Taking antibiotics for more that 2 weeks straight	0	1	2	3	4	5
14. Missing school days due to sore throats	0	1	2	3	4	5

Please enter any further important symptoms that occur as a result of your childs' throat problems that we have missed from the list above, and give each a rating from 0 to 5 like the ones already listed:

.....

.....

.....

Appendix 5:
Membership of Working Group Including acknowledgement of Peer Reviewers and others who may have been co-opted in for a specific piece of work.

Alexandra Roper, ENT Consultant, Royal Bolton Hospital NHS FT
Andrea Collins Mid Cheshire Hospital FT
Andrea Davies Team Leader, Warrington, and Hatton Teaching Hospital NHS FT
Anwen Castleman, Theatre Manager, BCUHB – Wales
Catherine Doherty, Co Clinical Lead, NW SiC ODN
Corina Ichim ENT Specialist, Salford Royal NHS FT
Donna Deguzman, Southport & Ormskirk
Edward Flook Consultant ENT Surgeon, BCUHB – Wales
Emily Coup, Treehouse Children's Unit, Stockport NHS FT
Gerry O'Sullivan, Consultant ENT Surgeon, Wirral UTH NHS FT
Grace Khong, Consultant Paediatric ENT Surgeon, Alder Hey Children's NHS FT
Helen Beer, Consultant ENT Surgeon, Wirral UTH NHS FT
Ian Clegg, Co Clinical Lead, NW SiC ODN
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Janette Platt, Ward Manager, Day Unit, Wythenshawe – MFT
Joanna McBride, Network Director, NW PCC SiC LTV ODN
Karen Beirne, W&C, Nobles Hospital, IOM
Lawrence Azevedo, Lancashire Teaching Hospitals - Royal Preston Hospital
Lucy Allton, Lead Nurse, NW PCC & SiC ODN
Mark Children, Consultant Anaesthetist, Blackpool Teaching Hospital NHS FT
Mohammed Miah, Consultant ENT Surgeon, Pennine Acute, NCA
Moothedath Hariprasad
Neil Bateman, Consultant Paediatric ENT Surgeon, RMCH – MFT
Nicola Thorbinson, GP/Deputy Clinical Director Childwall and Wavertree Primary Care Network
Rachel Smith, Consultant Anaesthetist, Royal Bolton Hospital NHS FT
Shobha Ramakrishnan, Consultant Anaesthetist, BCUHB – Wales
Rishi Diwan, Consultant Paediatric Anaesthetist, Alder Hey Children's NHS FT
Sianedd Elliott, Consultant Anaesthetist, BCUHB – Wales
Sinead Clarke, Associate Medical Director for System Quality and Improvement Cheshire and Mersey ICS
Steph Haynes, Sister, Surgical Starlight Unit, Wythenshawe – MFT
Stephanie Bowler, Consultant Anaesthetist, East Lancashire NHS Trust
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Todd Kanzara, Consultant ENT Surgeon, Countess of Chester Hospital NHS FT
Tracy Denny, Manager, Children's Day Case Unit, RMCH – MFT

Appendix 6: Glossary

Abbreviations	Definition
AHCH	Alder Hey Children's Hospital
PANDAS	Paediatric Autoimmune Neuropsychiatric Disorders Associated With Streptococcal Infections
APAGBI	Association of Paediatric Anaesthetists of Great Britain and Ireland
DGH	District General Hospital
ENT	Ears, Nose and Throat
GIRFT	Getting It Right First Time
GMC	General Medical Council
IOM	Isle of Man
IP	Inpatient
ISC	Integrated Care Systems
LMA	Laryngeal Mask Airway
NW	North West
ODN	Operational Delivery Network
OSA	Obstructive Sleep Apnea
PMC	PubMed Central
PROM	Patient Reported Outcome Measures
RAIDR	Rapid Actionable Insight Driving Reform
RCS	Royal College of Surgeons
REF	Reference
RMCH	Royal Manchester Childrens Hospital
RPH	Royal Preston Hospital
TOR	Terms of Reference
UK	United Kingdom

Appendix 7: Equality Impact Assessment Steps and Forms

This page outlines the steps to guide completion of the forms.
Please note that the term Policy is used throughout to describe Business Case, Guideline, Policy, Project, Service / Function, Review, Tender Specification, Transformation, Workforce Reorganisation or other key decision.

Step 1: Determine which of the following four categories best fits your policy.

Category 1: Existing policy	The changes to the policy are simply administrative, such as changing the name of the policy or contact details or expert clinician on the policy, or documentation change and the policy has an existing EqIA registration number.	Complete Form 1 including the existing equality impact assessment registration number and submit to the Equality and Diversity Team equality@mft.nhs.uk
Category 2: Existing policy	The changes to the policy are simply administrative, such as changing the name of the policy or contact details or expert clinician on the policy, or documentation change, but the policy does not have an existing EqIA registration number from the Former CMFT.	Go to Step 2.
Category 3: Existing policy	The changes to the policy are more than simply administrative; they are to do with the content of the policy.	Go to Step 2.
Category 4: New policy		Go to Step 2.

Step 2: Determine the relevance of the policy to equality as follows.

When considering relevance ask yourself whether the policy will affect patients, service users, communities or employees on the grounds of the protected characteristics.

Prompts to think about :

- Do different protected characteristics have different needs in relation to the policy?
- Is there any reason to believe that people with protected characteristics could be adversely affected by the policy?
- Could the policy disproportionately affect sub-groups with protected characteristics, e.g. different racial groups or different disabilities?
- Are there implications regarding the accessibility of a service?
- Is there an opportunity to foster good relations between people who share a protected characteristic and those who do not have that characteristic?

If you determine the policy is Not relevant		**If you determine that the policy Yes is relevant**
Please complete Form 1 and email the form together with the Business Case, Guideline, Policy, Project, Service / Function, Review, Tender Specification, Transformation, Workforce Reorganisation to the Equality and Diversity Team for quality assurance equality@mft.nhs.uk.		**Please Complete Forms 1, 2 and 3** and email the forms together with the Business Case, Guideline, Policy, Project, Service / Function, Review, Tender Specification, Transformation, Workforce Reorganisation to the Equality and Diversity Team for quality assurance. equality@mft.nhs.uk.

Step 3: The equality impact assessment will undergo quality assurance. You will be advised if there are:

a) Comments and/or recommendations for your consideration in which case you are invited to resubmit the revised equality impact assessment and policy, which will undergo final quality assurance before being given and equality registration number; or
b) There are no comments and/or recommendations for your consideration in which case you will be provided with an equality registration number.

Form 1: Record of the equality impact assessment screening decision

Form completed by:	Name:	Helen Blakesley
	Job Title:	North West Paediatric Critical Care, Surgery in Children & Long Term Ventilation Operational Delivery Network
	Hospital Site/MCs or Division or Directorate or Function:	RMCH Management Strategy and Networks
	Decision making group(s) or committee(s)	North West Surgery in Children Operational Delivery Network Oversight Committee
Equality impact assessment of	**Northwest, North Wales and Isle of Man Adenotonsillectomy Pathway/ Best Practice Guidance**	
	Yes - New Policy ☒	No - A Reviewed Policy ☐
Purpose	There is significant variation in practice and outcomes within the Northwest, North Wales and Isle of Man for children undergoing (Adeno)tonsillectomy. Children referred for consideration of (Adeno)tonsillectomy should be referred and treated at the unit best placed to manage the entire pathway. This will ensure both consistency and reduce delays in the pathway. This pathway sets out to ensure equity of access to services for children requiring (Adeno)tonsillectomy surgery.	
Was the decision reached to proceed to full equality impact assessment?		
Yes	Tick here and complete Forms 1, 2 and 3. ☐	
No Write in existing equality impact assessment registration number ion this box if there is one.	☒ Pathway /guidance has been developed to standardise pathways across the NW for access to (Adeno)tonsillectomy surgery. Its aim is to ensure equity of access to services and high-quality care.	
Do you have a deadline by which you need a response to		

this equality impact assessment?	

References

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ENT UK RCS Advancing Surgical Standards – Commissioning Tonsillectomy (2021)

https://www.entuk.org/_userfiles/pages/files/guidelines/Revised%20ENT%20UK%20Tonsillectomy%20commissioning%20guide%20edit%20to%20final%20(002).pdf

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https://www.apagbi.org.uk/sites/default/files/inlinefiles/Safe%20Delivery%20Paediatric%20ENT.pdf

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https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---0-18-years---english-20200211_pdf-48903188.pdf

APAGBI Best Practice guideline: Preassessment Services for Children undergoing Surgery or Procedures

https://www.apagbi.org.uk/file/preassessment-services-children-undergoing-surgery-or-procedures

Guidelines for the Provision of Anaesthesia Services for Day Surgery 2021

Chapter 6: Guidelines for the Provision of Anaesthesia Services for Day Surgery 2021 | The Royal College of Anaesthetists (rcoa.ac.uk)

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