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Tonsillectomy

Costing approach learning extension (formerly CA1)

Version 1, March 2022

Tonsillectomy

Purpose: To ensure tonsillectomies are costed in a consistent way.

Objective

1. To improve the quality of cost data for tonsillectomies in all patients.[1]

Scope

2. This standard covers the costing of the inpatient episode only.

3. Take care to ensure the costs of pre-assessment and follow-up care are identified and separated appropriately. This care is normally delivered at outpatient attendances.

Overview

4. A tonsillectomy is a surgical procedure to remove the tonsils when these repeatedly become infected, or to treat breathing problems like heavy snoring and sleep apnoea.

5. The care pathway is likely to be divided into:
   - preoperative assessment
   - the inpatient episode (including the procedure)
   - aftercare and follow-up.

6. Different techniques may have different impact on cost, including time in surgery (which will be captured by Feed 13: Theatres) and surgical equipment/devices which are used. You should ensure that any material items

[1] Adults 18 years and over are now included in this standard.

are captured at patient level, or appropriate relative weight values applied where they are used.

7. The different techniques and terminology[2] for the procedure may include:
   - cold knife (steel) dissection, where the tonsils are removed with a scalpel – this is the traditional method
   - diathermy, where a probe is used to destroy the tissue around the tonsils, allowing them to be removed more easily; also called 'hot cauterisation'
   - coblation – similar to diathermy but at a lower temperature
   - radiofrequency ablation (RFA) – a probe is used to deliver a radiofrequency current to the required location, and remove tissue debris
   - intracapsular – surgery is performed within the fibrous capsule surrounding the tonsil, leaving it intact after removal of the tonsil
   - extracapsular – the capsule is removed along with the tonsil
   - unilateral or bilateral – removing one or both tonsils in one operation.

8. The inpatient episode of care normally consists of:
   - preoperative assessment
   - surgery (usually day case)
   - postoperative care:
     - overnight stay of one night (if not a day case)
     - the consultant may or may not assess the patient once on the ward; you need to establish this in discussion with clinical and service leads
     - if a day case, the length of recovery on the unit may be around four hours post-surgery.

Approach

9. Work with the ear, nose and throat (ENT) or paediatric service, depending on which delivers the care, to map the care pathways to inform the costing process.

10. Discuss with the service the difference between tonsillectomies for adults and for children and young people. You will have theatres information within the

[2] For more information see the Getting It Right First Time (GIRFT) report for ENT surgery

costing system that can also be used to understand different resource profiles for the procedure.

11. The healthcare resource groups (HRGs) specify under and over 19, but many services have their own protocols for age that is likely to have an impact on costing. For example:

    - Some differentiate between children under and over 12. This makes little difference to the surgery but does impact on anaesthesia input, particularly the pre and postoperative care. Children usually take longer to put to sleep and wake-up time is likely to be considerably longer for young children.[3] Anaesthetists may also use different equipment for children. Feed 13: Theatres will give you the procedure times in accordance with Standard CM5: Theatres and special procedure suites.
    - Different equipment may be used depending on the patient's age (or size). The same equipment will generally be used for all children, but as children enter adolescence (ie 12 to 15 years) adult equipment may be used instead.
    - Input from paediatric nurses may be driven by protocols around age (or by national standards). Patients aged up to 16 are likely to have paediatric nurse input as well as those older than 16 with learning disabilities.

Identifying the activity

12. The procedure mainly groups to HRGs CA60A (tonsillectomy, 19 years and over) and CA60B (tonsillectomy, 18 years and under). It may also group to CA61Z (adenotonsillectomy); this procedure involves removing the adenoid glands along with the tonsils and is more common in children.

13. These patients may be treated under treatment function codes (TFCs) 120 (ENT), 215 (paediatric ENT) or 420 (paediatrics).

14. Tonsillectomy activity is recorded on Feed 1a: Admitted patient care (APC).

15. Ward stay, diagnostics, theatres and medicines are recorded on the patient-level feeds.

[3] Using Feed 13: Theatres will ensure the time factor is reflected in the patient level costs.

16. Specialist nursing for admitted patients can be recorded on Feed 7: Supporting contacts, as a superior method.

17. Table CA1.1 is an excerpt[4] from Spreadsheet CP3.3 showing the resource and activity links to use for tonsillectomy.

Identifying the costs

18. Identify with finance colleagues all costs directly associated with the procedure. These costs fall into the following main areas:

Theatres

19. Work with finance colleagues who manage the cost centres for theatres, as well as the general managers for theatres, paediatrics, and ENT, to ensure the appropriate tonsillectomy information is captured on Feed 13: Theatres. Ascertain whether there is a dedicated or usual theatre for tonsillectomy, and the staffing for each session to ensure additional costs for this procedure are reflected in the PLICS.

20. Use the information on Feed 13: Theatres, to allocate staff costs.

21. Non-pay expenditure in theatres is significant. Identify use of any high-cost equipment or devices on Feed 15: Prostheses and high-cost devices, and match these to patients. See Standard CM21: Clinical non-pay items for more information. You should work closely with the theatre managers to establish whether there any standard packs of other non-pay items are used and use this information to inform relative weight values for the remaining clinical non-pay items used in theatre.

[4] Please note all excerpts in this standard are for illustrative purposes only. Use Spreadsheet CP3.3 to ensure you are using all the correct resource and activity links.

1. Table CA1.1: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for tonsillectomy inpatient stay costs

	Activity							
Resource	**Theatre care - general**	**Theatre – surgical care**	**Theatre – anaesthetic care**	**Theatre – recovery care**	**Ward care**	**Dispensing non patient-identifiable medicines**	**X-ray**	**Supporting contact 1:1 inpt unit**
Medical and surgical consumables	£X		£X		£X		£X	
Medical and surgical equipment and maintenance	£X		£X				£X	
Operating department practitioner	£X			£X				
Nurse	£X				£X			
Specialist nurse	£X							£X
Consultant – anaesthetist			£X	£X				
Medicines						£X		
Pharmacy technician						£X		
Radiographer							£X	
Medical physicist		£X					£X	

Pathology and diagnostic imaging

22. Use the information on the patient-level feeds and the relative weight values developed using Appendices 1 and 2 in Standard CP3: Allocating costs to activities, to identify the costs.

Medicines[5]

23. Medicines can be matched to the correct patients using Feed 10: Medicines dispensed. Any non patient-identifiable medicine costs used on the ward or in theatres are allocated using the medicines allocation methods in Spreadsheet CP3.3.

Specialist nursing

24. Paediatric nurses are likely to provide considerable input for children under 16. Costs for paediatric specialist nurses may be held in a separate cost centre in the standardised cost ledger from the paediatric ward. Work with the manager or team leader to determine whether they provide any care for these patients, especially for children with significant co-morbidities.

Other considerations

27. Some patient co-morbidities may affect procedure time, such as sickle cell disease, asthma and hypertension. This should be reflected in the theatre duration but may also require specialist nursing or additional medical staff input to the procedure or aftercare.

[5] For further guidance on the costing methods for pharmacy and medicines, see Standard CM10: Pharmacy and medicines.

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