5 ENT

5.1 Bone anchored hearing aids

This commissioning responsibility has transferred to NHS England (http://www.england.nhs.uk/).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

5.2 Cochlear implants

This commissioning responsibility has transferred to NHS England (http://www.england.nhs.uk/).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

5.3 Grommets

Category	Restricted (prior approval required for East Kent CCGs' patients only; prior approval not required for other Kent and Medway patients)

Background

Grommets, also known as tympanostomy tubes or ventilation tubes, are small tubes that are surgically inserted in the ear drum to aerate the middle ear.

A grommet will help keep the eardrum open for several months. As the eardrum starts to heal, the grommet will slowly be pushed out of the eardrum and will eventually fall out. Most grommets will fall out within 6–12 months of being inserted.

The main indications for grommets are otitis media with effusion (OME), Eustachian tube dysfunction and Ménière's disease. OME is most common during childhood.

Resources

Patient leaflet on grommets for glue ear in children aged under 12 years developed by the NHS England EBI programme.

Policy

Adults

Grommets for adults are not routinely funded, except in the following circumstances:

- A middle ear effusion* causing measured conductive hearing loss and resistant to medical treatments where the patient has been managed and monitored for a minimum period of 6 months in secondary care before a decision is made to treat, *or*
- Persistent Eustachian tube dysfunction resulting in pain (e.g. flying), *or*
- As treatment for Ménière's disease, *or*
- Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma

**Unilateral effusion requires urgent assessment and is detailed as criteria on the Kent & Medway Cancer Network Head and Neck Cancer referral form. Patients should be referred and treated in line with agreed rapid access pathways.*

Continued overleaf

Prior approval is required for this procedure for East Kent CCGs' (i.e. Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG) patients only – see Appendix A.

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Children under the age of 18:

Grommets for children are not routinely funded, except in the following circumstances:

- Severe collapse (retraction) of the ear drum, *or*
- Progressive atelectasis of the tympanic membrane, *or*
- Otitis media with effusion (OME) in accordance with recommendations listed in NICE CG60[1] following formal assessment[2]

Adenoidectomy for otitis media in children is not routinely funded, except when combined with grommets in children who meet the criteria specified in NICE CG60.

[1]Although CG60 only pertains to people aged <12, this policy applies to people aged <18.

[2]Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

Prior approval is required for this procedure for East Kent CCGs' (i.e. Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG) patients only – see Appendix A.

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Policy exclusions:

Malignancy or suspicion of malignancy. Any suspicion of malignancy at any stage of the pathway should be managed and treated appropriately.

Rationale

The policy on grommets for children with OME is consistent with NICE CG60 (2008), NHS England EBI guidanceon glue ear in children (2018) and commissioning guidance on OME from the Royal College of Surgeons of England and ENT UK (2013).

Overall there is a lack of evidence for the insertion of grommets in adults. Clinical Commissioning Groups (CCGs) are currently under considerable financial strain and need to prioritise funding of procedures where there is good evidence to suggest they result in health gain. Consequently, watchful waiting is recommended for adults with OME for 6 months.

5.4 Prominent ears (surgical correction of)

Category	Restricted (prior approval not required)

Background

Ear prominence is very common. Although there are no functional problems associated with prominent ears, this condition can lead to low self-esteem and psychological morbidity, particularly in childhood and adolescence.

After the age of 6 months, surgical correction (pinnaplasty or otoplasty) is currently the only available method of addressing prominent ears.

Policy

Surgical correction of prominent ears is not routinely funded except where both of the following criteria are met:

- The person is aged <16 years at the time of surgery, *and*
- The child rather than the parents alone, expresses substantial psychological distress*.

** It is anticipated that in the majority of cases, GPs will be able to verify whether the patient is suffering from substantial psychological distress that would be relieved by pinnaplasty or otoplasty. If there is any doubt regarding psychological distress the child may benefit from referral for a psychological assessment.*

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

5.5	Repair of lobe of external ear
Category	Restricted (prior approval not required)
Policy	

Surgery to repair the lobe of external ear is not routinely funded except for completely split ear lobes as a result of direct trauma.

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

5.6 Rhinoplasty/ septorhinoplasty

Category	Restricted (prior approval required)

Background

Rhinoplasty is a procedure used to reshape the nose. Septoplasty is a surgical procedure to correct a deviated nasal septum. Septoplasty is sometimes combined with rhinoplasty (septorhinoplasty).

Policy

These procedures are not routinely funded by Kent and Medway CCGs except in the following circumstances:

- Objective nasal deformity caused by trauma, *or*
- Correction of complex congenital conditions, unless the commissioning responsibility of NHS England*

Prior approval is required (see Appendix A) for complex or severe cases of nasal septal deviation that is not post-traumatic. Applications for septorhinoplasty must demonstrate a clear clinical need for surgery and must be made by a consultant.

**Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.*

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

5.7 Snoring surgery for adults (in the absence of obstructive sleep apnoea [OSA])

Category Not routinely funded

Background

Snoring is a noise that occurs during sleep. It is caused by things such as the tongue, mouth, throat or airways in the nose vibrating whilst breathing. It happens because these parts of the body relax and narrow during sleep.

Snoring is very common. It is more common in people who are overweight, smoke, drink too much alcohol or sleep on their back.

Snoring is not usually harmful to health as long as it is not complicated by periods of apnoea (which is when the airways become temporarily blocked during sleep).

Conservative treatments include lifestyle changes such as weight loss, reducing alcohol intake, stopping smoking, sleeping on your side and over-the-counter stop-snoring devices and treatments for a blocked nose.

Resources

Patient leaflet on snoring surgery developed by the NHS England EBI programme.

Policy

Surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate for snoring are not routinely funded.

Policy exclusions:

This policy only applies to adults, and only to snoring in the absence of OSA.

Rationale

This policy is consistent with NHS England EBI guidance on adult snoring surgery in the absence of OSA (2018) which has been approved by ENT UK. NHS England EBI guidance notes that snoring surgery (in the absence of OSA) should not be routinely commissioned because the evidence suggests these procedures have limited to no long-term clinical effectiveness and carry a small risk of severe complications including bleeding, airway compromise and in rare cases death. There is also evidence that the majority of people who undergo snoring surgery experience persistent side effects including swallowing problems, voice change, globus (a persistent sensation of having a lump in the back of your mouth), taste disturbance and nasal regurgitation. A number of alternatives to surgery can improve snoring.

5.8 Tonsillectomies ± adenoidectomies

Category	Restricted (prior approval required for East Kent CCGs' patients only; prior approval not required for other Kent and Medway patients)

Background

Tonsillectomy is a surgical procedure where each tonsil is removed from a recess in the side of the pharynx called the tonsillar fossa. Tonsils are important lymph tissue that protects the upper airways; they tend to atrophy in early adulthood.

For children, the adenoids are usually removed at the same time as the tonsils, a procedure called adenoidectomy, or adenotonsillectomy when combined.

Resources

Patient leaflet on tonsillectomy for tonsillitis developed by the NHS England EBI programme.

Policy

Tonsillectomy ± adenoidectomy is not routinely funded by Kent and Medway CCGs except in people who fulfil the criteria outlined below:

- Recurrent tonsillitis: ≥7 well documented, clinically significant, adequately treated sore throats in the preceding year or ≥5 such episodes in each of the preceding two years or ≥3 such episodes in each of the preceding three years. Episodes of sore throat must be due to acute tonsillitis and must be disabling and prevent normal functioning, OR
- Peritonsillar abscesses (PTA): ≥2 episodes resulting in hospital stay or one episode resulting in hospital stay plus a history of recurrent tonsillitis, OR
- Tonsillar hypertrophy causing upper airway obstruction in people aged under 16, OR
- Sleep disordered breathing in people aged under 16 demonstrated by accepted method of diagnosis including sleep study, which impacts on development, behaviour or quality of life, OR
- Malignancy: Suspicion or evidence of malignancy. Patients should be referred and treated as appropriate, OR

Continued overleaf

- Other: People with specific clinical conditions that require tonsillectomy as part of their on-going management strategy (e.g. psoriasis, nephritis, periodic fever aphthous pharyngitis and cervical adenopathy [PFAPA] syndrome)

Prior approval is required for this procedure for East Kent CCGs' (i.e. Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG) patients only – see Appendix A.

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery.

Policy exclusions:

- Emergency presentations (e.g. treatment of parapharyngeal abscess)
- Suspicion of malignancy. Any suspicion of malignancy requires urgent assessment and should be referred using the Kent & Medway Cancer Network Head and Neck Cancer referral form. Patients should be referred and treated in line with agreed rapid access pathways.

Rationale

The most common indication for tonsillectomy is recurrent sore throat. Whilst the tonsils are considered to play an important role in the causation of chronic/ recurrent acute throat infections, they are probably not the only factor responsible. The indications for tonsillectomy within this patient group are therefore controversial and opinions vary greatly as to whether or not the benefits outweigh the risks. The eligibility criteria detailed in this policy are consistent with current SIGN guidance 117 on the management of sore throat (2010), NHS England EBI guidance on tonsillectomy for recurrent tonsillitis (2018) and professional society guidance (2013). There is no formal NICE guidance on indications for tonsillectomy. However, NICE have issued interventional procedure guidance (IPG) recommending that current evidence on the safety and efficacy of different tonsillectomy procedures appears adequate to support the use of these techniques.