

INTEGRATE-BAPO NATIONAL PAEDIATRIC ADENOTONSILLECTOMY AUDIT

INTEGRATE Head and Neck Subcommittee in collaboration with BAPO

Protocol Version	2.0
Date	01/6/2026
Steering Committee	Natalia Glibbery Ayla Tabaksert Chang Woo Lee Praveena Deekonda Yadsan Devabalan Vikash Dodhia Matt Donachie Vishak Muraleedharan Shylaja Matthew Zammit Jeremy Wong Amar Rajgor
Supporting Body	BAPO
Senior Advisors	BAPO council
Funding	None
Contact	tonsil@entintegrate.co.uk
Online Resource	https://entintegrate.co.uk/integrate-bapo-national-paediatic-adenotonsillectomy-audit

Summary

Full Study Title	INTEGRATE–BAPO Paediatric Adenotonsillectomy Audit <i>A National Audit of Current Practice and Outcomes</i>
Short Title	INTEGRATE–BAPO Paeds Ts & As
Funding	None
Steering Committee	INTEGRATE Head and Neck Subcommittee & BAPO
Support	BAPO
Study Design	Multicentre Retrospective Observational Study
Population	Paediatric patients undergoing tonsillectomy, adenoidectomy or adenotonsillectomy in a secondary care setting
Study Duration	2 months – March + April 2026
Aim	To evaluate indications, peri-operative pathways, and outcomes of paediatric tonsillectomy, adenoidectomy and adenotonsillectomy
Method	A multicentre, retrospective, observational study collecting objective data relating to paediatric patients undergoing tonsillectomy/adenoidectomy/adenotonsillectomy

Background

Paediatric tonsillectomy, adenoidectomy, and adenotonsillectomy are among the most commonly performed surgical procedures in children in the UK. The principal indications are recurrent tonsillitis and sleep-disordered breathing, including obstructive sleep apnoea. Although generally safe, these procedures carry recognised peri-operative risks, including postoperative haemorrhage, respiratory complications, pain, dehydration, and unplanned readmission. Appropriate patient selection, peri-operative management, and postoperative care are therefore essential to optimise outcomes and ensure patient safety.

National guidance from the British Association for Paediatric Otorhinolaryngology (BAPO) and the Getting It Right First Time (GIRFT) programme provides recommendations on patient selection, peri-operative assessment, day-case suitability, postoperative monitoring, and service configuration. These frameworks aim to support safe, high-quality paediatric ENT care while reducing unwarranted variation in practice.

Despite the high volume of paediatric adenotonsillar surgery performed in the UK, contemporary national data on current practice and outcomes remain limited. This limits understanding of variation in care and opportunities for service improvement.

This national audit aims to provide a contemporary overview of paediatric tonsillectomy, adenoidectomy, and adenotonsillectomy across the UK. The findings will establish a national baseline of practice, enable comparison with contemporary recommendations where appropriate, and support future service evaluation and quality improvement.

Aims

Primary Aim

To evaluate indications, peri-operative pathways, and outcomes of paediatric tonsillectomy, adenoidectomy and adenotonsillectomy across the UK

Secondary Aims

1. To describe the demographic and clinical characteristics of children undergoing tonsillectomy, adenoidectomy, and adenotonsillectomy in the UK.
2. To evaluate indications for surgery and time to surgery.
3. To evaluate peri-operative risk assessment and management of higher-risk patients.
4. To describe operative characteristics, including procedure type, surgical technique, and intra-operative management.
5. To evaluate postoperative care pathways, including admission, monitoring, length of stay, and HDU/PICU utilisation.
6. To describe postoperative medication prescribing, including analgesia and adjunctive therapies.
7. To evaluate postoperative outcomes, including complications, readmissions, escalation of care, and revision surgery.
8. To examine variation in practice, service delivery, and outcomes between centres.
9. To compare current practice with contemporary BAPO and GIRFT recommendations, where appropriate.

Study Design and Methodology

Overall Design

A multicentre, retrospective, observational study collecting objective data relating to management of paediatric patients undergoing tonsillectomy, adenoidectomy and adenotonsillectomy

Setting

Secondary or Tertiary care level Ear Nose and Throat, Head and Neck services across the United Kingdom.

Timeline

Audit start date: 16/9/26

Audit end date: 10/1/27

Data Collection Window

Data collection will be done for paediatric patients identified to have undergone tonsillectomy, adenoidectomy or adenotonsillectomy as per the inclusion criteria below, within the following time period:

Start date: 01/03/26

End date: 30/04/26

Registration

This project will be registered with local audit/clinical governance departments according to their individual policies prior to the initiation of any data collection.

Study Population

Inclusion Criteria

- Children aged ≤ 16 years at the time of surgery.
- Under the care of a participating secondary or tertiary ENT/Head and Neck service.
- Undergoing elective tonsillectomy, adenoidectomy, or adenotonsillectomy (primary or revision), with or without additional procedures, at a participating centre.

Exclusion Criteria

- Emergency tonsillectomy, adenoidectomy, or adenotonsillectomy
- Patients undergoing surgery at a non-participating centre, including those presenting only with postoperative complications following surgery performed elsewhere.

Patient Identification Process

Local management teams will identify new patients having undergone surgery within their departments during the data collection window (01/03/2026 – 30/04/2026).

Anonymisation of Patient Identifiable Information & Informed Consent

This is a retrospective observational study collecting objective data relating to each patient's reason for attendance, medical history, investigation, management and outcome. All collected data will be anonymised and no identifiable data will be collected by the steering committee. Therefore, there will be no impact on the management for individual patients and they will not be identifiable. As such, obtaining consent is not required.

Data Collection and Management

Dataset

The final sample size will depend on the number of sites taking part and submitting data for this study. There is no a priori estimation, but it is anticipated that at least 50 centres will submit data, based on previous INTEGRATE audit participation numbers.

Data Collection Tools

Anonymised data will be locally entered into data extraction forms on Microsoft excel (Redmond, WA, USA). The quality of the data entered will be controlled by limited data entry, drop-down options and predefined data formats. Range checks for chosen fields will automatically appear where data points are outside of a pre-specified range.

Data Handling & Record Keeping

Anonymised data will be submitted via an NHS email account to the Project Management Team. No patient identifiable information will be sent or stored by the Project Management Team. The Project Management Team will not request or be provided with the names, addresses, NHS numbers, medical record numbers (MRN) or identifiable dates for any patients.

Reporting and analysis will not identify individual cases in any subsequent reports, presentations or publications. Data flow will be one way, from the Data Discloser to the Data Receiver (i.e. Project Management Team). There will be no traceability from the data receiver database to local records. If any identifiable data is received, the files will be deleted and the site will be informed.

Anonymised data may be made available to applicants who submit a project proposal to the Project Management Team, and which receives approval from the Project Management Team, expert advisory group and INTEGRATE main committee.

Local data forms should be kept according to local data governance for 12 months following submission to allow appropriate local analysis and scrutiny from the Project Management Team. At the end of this period, local data forms should be destroyed/deleted in line with local data governance policy.

The anonymised collated data will be held by the Project Management Team for at least 5 years on an NHS server to allow for appropriate scrutiny and reanalysis.

Missing Data

The Project Management Team (PMT) will check submitted data for completeness and integrity. Where necessary, the PMT will contact local leads to encourage the completion of data where fields are deemed inadequate. If data is not available, the data point will be treated as null, and that record will be excluded from any relevant analysis.

Data Analysis and Statistics

Final statistical analysis will depend on the volume and quality of data received from participating centres. Statistical analysis will be conducted in RStudio (R foundation, Vienna, Austria).

Demographics will be summarised using mean and SD for continuous variables and counts and proportions for categorical variables. Analysis of categorical variables will be performed using the Chi-square or Fishers exact test to detect differences between two or more groups. Quantitative continuous variables will be analysed using descriptive statistics such as mean, median, quartiles, and range. Tests for homogeneity will be employed, with Student's test being used when homogeneity is confirmed, or the MannWhitney U, Kruskal-Wallis, Wilcoxon or Friedman tests used as appropriate when it is not confirmed.

Ethical Considerations

This project has been determined to be an audit using the HRA decision tool available at <http://www.hra-decisiontools.org.uk/research/>.

This project will report on the outcomes of investigative management that have already occurred. As there will be no deviation from the usual standard of care, formal ethical approval is not required. Data will be anonymised by the local site lead prior to submission. Due to this, no formal informed consent is required. The study will need the approval of the local Research and Development department at each site before data collection can begin.

Authorship Policy

Criteria for inclusion as a PubMed citable collaborator

Authorship will be in line with INTEGRATE policy on multi-centre collaborative projects. Each Centre will have a named Consultant Lead, Trainee Lead, and a Local Collaborator; who will be eligible for collaborative co-authorship of publications that result from the project. Additional team members across ENT departments within the same hospital can be added in discussion with the INTEGRATE Project Management Team and will also be included as citable collaborators. Authorship will be subject to meeting the minimum screening and inclusion numbers. A minimum of **20 patients** must be contributed by a collaborator to qualify for authorship, in accordance with the study authorship policy.

Acknowledgements

All individuals contributing to data collection will be acknowledged in any subsequent presentations and publications.

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References

1. British Association for Paediatric Otorhinolaryngology (BAPO). *Day Case Paediatric Adenotonsillectomy: Consensus Guideline*. 2024. Available at: https://www.entuk.org/_userfiles/pages/files/day_case_paediatric_adenotonsillectomy_consensus_guidelines.pdf (Accessed: 8 February 2026).
2. Getting It Right First Time (GIRFT). *Day Case Paediatric Adenotonsillectomy*. 2025. Available at <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2025/04/Day-Case-Paediatrics-Adenotonsillectomy-Pathway-April-2025-FINAL.pdf> (Accessed: 8 February 2026).
3. Marshall, A. (2019) *Ear, Nose and Throat Surgery GIRFT Programme National Specialty Report*. Getting It Right First Time (GIRFT). Available at: <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/12/ENT-Report-Nov19-M.pdf> Accessed: 8 February 2026).