Clinical Guideline: East of England Paediatric Tonsillectomy Provision

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For use in: EoE Paediatric Units, ENT Departments; Guidance specific to the care of children undergoing tonsillectomy.

Used by: ENT units, paediatric surgical departments, paediatric pre and post op wards, paediatric Pre-Assessment services.

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Change Log: additional pre-referral guidance, adaption of BAPO 2024 and GIRFT 2025 guidance, modification to ODN pathways: distance from hospital.

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Introduction:

The East of England (EoE) Tonsillectomy Provision Guidance initially published in December 2022 provided a regional guideline developed by the East of England Surgery in Children ODN to standardise paediatric tonsillectomy care across the region. It introduced 12 standards addressing patient selection, perioperative management, and discharge, aiming to increase day case surgery rates and keep care local for most children.

Following The British Association for Paediatric Otolaryngology (BAPO) guidance (February 2024) and Getting It Right First Time (GIRFT) Day Case Paediatric Adenotonsillectomy Pathway (Apr 2025) this document aims to enhance the EoE regional guideline in order to support best practice and a unified standard of care across the region with its geographical footprint, implementing the NCEPOD (2025) recommendation to agree pathways of care based on age and condition through formal networks.

Good Practice Guidance East of England Tonsillectomy Provision

Tonsillectomy is one of the commonest surgical procedures performed in childhood and makes up a significant proportion of work in both secondary and tertiary level care. This guideline has been produced to help standardise care across the region to reflect the ODN geographical footprint and provide best practice guidance to achieve:

1) The British Association of Day Case Surgery target of 80% of tonsillectomy case being performed as day case procedures ([1])
2) Reducing referral of routine tonsillectomy in otherwise healthy children to tertiary level services when care can be safely delivered locally, specifically repatriating the care of patients <2 years and <12 kg to secondary care ([7, 10]).
3) Promoting a day case by default approach for paediatric tonsillectomy.

Day Case Surgery Target
>80%
National benchmark for percentage of paediatric tonsillectomies performed as same-day cases.

Standard Eligibility Threshold
>2 yrs & >12 kg
Lower age/weight possible for day case in hospitals with enhanced support, given no other risk factors.

This guidance was produced following consultation with relevant parties throughout the East of England. The standards of practice outlined within this guidance have been agreed by consensus opinion following evidence review and formal discussion with ENT, Anaesthetics and nursing support teams across the region.

Decision Support Tool and Alternative Treatments

A key component of this guideline is the emphasis on using Evidenced Based Interventions via a Decision Support Tool and considering alternatives to tonsillectomy when appropriate. The ENT UK and NHS Treatment Choice Support Tool were developed as a national resource to improve decision-making for recurrent tonsillitis [(9)]. Clinicians should utilise this tool in practice, especially at the point of referral and initial assessment, adopting Advice and Guidance templates from Getting It Right First Time (GIRFT) [(10)].

Referral

A face-to-face assessment including the review of medical history and overall health should take place.

At referral, for recurrent tonsillitis use the NHS England Decision Support Tool: ‘Making a decision about recurrent tonsillitis’ to support shared decision-making (adults & children) [(9)]. Embed the link within EPR/templates.

Use day case as the default option

Treat every child as a potential same-day discharge unless specific contraindications exist (Table 1). Children <2 years or <12 kg should be managed in specialist units with planned admission. This is a modification to the BAPO guidance (Appendix 1).

In young children, the most common reason for tonsillectomy is sleep disordered breathing / obstructive sleep apnoea (OSA) rather than recurrent tonsillitis reflecting current practice where OSA drives referrals in paediatrics, in line with expert consensus and national trends.
If the history strongly suggests OSA or the severity is unclear, consider performing a sleep nasendoscopy to directly assess the site and degree of upper airway obstruction. Findings on nasendoscopy can guide surgical planning to determine whether an adenoidectomy alone or a combined adenotonsillectomy is the appropriate intervention. This targeted approach ensures that surgery addresses the specific cause of obstruction, improving outcomes.

Weight Management

If a child's BMI is above the 98th centile (obese), the team should offer lifestyle advice or weight management referrals before surgery [8, 9]. Considering an intracapsular tonsillectomy in obese or higher-risk patients to reduce complications [8]. The accepting team should request the primary referrer to instigate weight management at the start of the pathway rather than when seen in clinic (and thus BMI should be recorded on all referrals). Primary care should instigate weight management for patients with a BMI above the 98th centile along with a referral to ENT if they believe surgery will be necessary for patients. For sleep disordered breathing sleep apnoea there needs to be counselling in primary care that adenotonsillectomy may not be curative if a patient has a high BMI.
If there are concerns about caregiver ability, distance from a hospital or safeguarding, day case is not appropriate.

Section 1 Location of surgery

GIRFT (2025) provides updated Levels of Care Definitions:

- **Level 1a** - Includes 5-day units and ENT units with no paediatric inpatient beds, no 24/7 on-site paediatric service, or no 24/7 ENT on call cover.
- **Level 1b** - Hospitals that provide paediatric surgical care, typically as part of a mixed adult/paediatric surgery department, access to on-site paediatric inpatient beds, typically with 24/7 availability paediatric services and 24/7 ENT on call cover, but NO on-site Critical care/High Dependency Unit (HDU) beds.
- **Level 2** - Hospitals that provide paediatric surgical care, typically as a part of a mixed adult/paediatric surgery department, access to on-site paediatric inpatient beds, typically with 24/7 availability paediatric services and 24/7 ENT on call cover but still having a range of specialists AND provision of a paediatric High Dependency Unit (HDU).
- **Level 3** - Tertiary centres equipped to manage highly complex paediatric surgical conditions, with sub-specialist surgeons and a full range of support services available 24/7 with provision of a Paediatric Intensive Care Unit (PICU).

Source: GIRFT 2025 (Adenotonsillectomy Pathway)

Any centre performing these surgeries must have 24/7 ENT emergency cover arrangements or the ability with robust pathways to transfer to a unit that has 24/7 ENT cover (for those units with no facility for overnight stay - they also should have 24/7 paediatric support).

The level of care that can be delivered at each unit differs due to the staffing mix and out of hours provision. Patients undergoing tonsillectomy fall into 2 main groups

- the well child with recurrent tonsillitis or obstructive sleep apnoea (OSA),

- children with other comorbidities who require surgery for the same reason.

The vast majority of these children are otherwise well (please see section 6 for guidance on those with comorbidities) and can be treated in secondary care.

❑ **Standard 1**

For those units with appropriate anaesthesia provision [1, 2] in secondary care with overnight facilities – units should provide surgery in children 2 years and older with equivalent weight of 12 kg and above with no major comorbidities (as per table 1) regardless of indication for tonsillectomy.

For those units without appropriate provision for cases of 2–3-year-olds or without access to overnight stay, or no 24/7 ENT on call cover, a formal pathway should be established to local hub secondary care unit to facilitate surgery, or overnight admission.

Section 2 Planning of surgical lists

❑ **Standard 2**

To streamline workforce within the pre, peri and post-operative environments, departments should plan purely paediatric lists. It is recommended that anaesthetists' job plans reflect a regular commitment in staffing such lists, especially for children <5 years of age. National guidance is supportive of operating on otherwise well children aged >2 years in Level 1b and Level 2 units, and this should be undertaken where both appropriate anaesthetic availability and surgical expertise exist within each unit.

❑ **Standard 3**

Planned day case tonsillectomy should take place in the morning or early afternoon to provide adequate post-operative observation and thus support timely discharge. Departments should work with administration teams and theatre management teams to ensure access to regular morning operating lists. Where historical reluctance is a barrier, departments should review the evidence base and audit current practice to explore avenues for improvement. If necessary, discuss with the paediatric ENT and anaesthetic ODN workstream leads where required.

Section 3 Pre-operative assessment

❑ **Standard 4**

Thorough pre-operative assessment is critical. It identifies children unsuitable for day case (e.g. complex comorbidities, long travel distance, poor home support) in advance, ensuring overnight beds can be pre-booked if needed. This avoids last-minute admissions and winter bed crises and helps meet day case targets safely.

All children must undergo pre-operative assessment in accordance with the Association of Paediatric Anaesthetists of Great Britain and Ireland [5] guidelines and the network standard, ideally no later than 2 weeks before surgery and no earlier than 6 months prior to the surgery date.
Departments should screen patients at the point of listing for surgery to ensure timely referral to a higher-level unit where required. Each unit will have individual expertise and is therefore encouraged to develop a tailored screening questionnaire that incorporates Making Every Contact Count (MECC) principles.

Where pre-operative assessment takes place more than 6 months before the planned date of surgery, a focused re-check must be completed to confirm that there has been no interval change in the child or young person's clinical condition. This ensures that the assessment remains contemporaneous and aligned with APAGBI and GIRFT guidance on safe anaesthetic practice and appropriate patient selection.
Each department must also have a clear Standard Operating Policy (SOP) for the day case tonsillectomy pathway, covering pre-operative preparation through to discharge, which meets existing published standards [4].

❑ **Standard 5**

Pulse oximetry is a poor predictor of post-operative complications and is not routinely recommended for risk stratification (or clinical evaluation) of OSA cases [1]. Sleep-study severity alone does not determine day-case suitability; children <3 years with OSA should be assessed by an experienced anaesthetist and surgeon [7, 8].
Where doubt exists regarding the suitability of delivering safe care the unit should consider cardiorespiratory sleep analysis or formal polysomnography. It is recommended that children who are being considered for these studies be referred to a tertiary unit for overall management and surgery.

Section 4 Day of surgery

❑ **Standard 6**

Ward and recovery staff should be trained in the care of the post-tonsillectomy child, in particular counselling families on pain relief and recognising a post-tonsillectomy bleed.
Staff should be trained on team brief, WHO checklist and ensure the operation note includes clear Post Tonsillectomy Haemorrhage management instructions. GIRFT (2025) makes recommendations to consider non-sterile setup (mask/apron/gloves) and environmental impacts.

Section 5 Length of stay

The rates of day-case tonsillectomy vary widely across units. The GIRFT report (2019) found that levels of day-case surgery are not influenced by case mix; rather, effective planning of theatre lists and identifying suitable patients is key. Children should be discharged based on meeting agreed clinical discharge criteria (such as adequate oral intake, pain well controlled with oral analgesia, independent mobilisation appropriate for age, and absence of bleeding) rather than at a fixed or predetermined time. This aligns with GIRFT recommendations and is supported by RCN and BARNA principles, which emphasise safe, criteria-led discharge over time-based approaches.

❑ **Standard 7**

For well children >2 years old and >12 kgs with OSA or tonsilitis the aim should be to facilitate day case surgery whenever possible.

❑ **Standard 8**

Departments may wish to explore the use of the intracapsular tonsillectomy method during the surgical planning stage which is associated with lower rates of post-operative haemorrhage and quicker recovery [4, 5].

Section 6 Patients requiring treatment in tertiary unit

❑ Standard 9

Patients with the comorbidities documented in Table 1 should be referred to a tertiary unit. This list is not exhaustive and where required the lead consultant should discuss cases with an anaesthetist with onward referral if applicable. Such referrals should be treated in a timely manner (e.g. not join the back of the referral queue given children may waited for some time for surgery). The RTT information should be send to the tertiary centre to facilitate planning.

Section 7 Clear Discharge Criteria and Safety Netting

❑ Standard 10

Discharge following paediatric tonsillectomy should be patient-centred, safe, and based on clearly defined clinical criteria rather than arbitrary timeframes. All units should adopt a nurse-led discharge protocol aligned with the British Association of Day Surgery (BADS) standards and embed these criteria within the post-operative care plan for all suitable patients.

Review by surgeon and/or anaesthetist should take place if criteria are not met and/or patient not suitable for nurse-led discharge to determine suitability for daycase discharge. Maintain intravenous access until discharge and embed the national “unsuitable for discharge” list [7].

❑ Standard 11

Same-day discharge is contingent on the family being within a reasonable travel time of the hospital or having alternative arrangements within the network, and on an assessment of the home support situation or alternative arrangements. If these conditions are not met, overnight admission should be considered [7, 8].

The family should reside within approximately one hour’s travel time of a hospital with 24/7 ENT on-call cover and emergency theatre access. Considerations are given to the local geography, traffic conditions, and roadworks. If this criterion is not met, alternative arrangements (e.g. overnight hospital stay or temporary accommodation near the hospital) must be made.

While national guidance from GIRFT and BAPO recommends a 45-minute travel time threshold, regional best practice (such as that adopted by the South West SiC ODN) supports extending this to one hour. This adjustment reflects the geographical realities of the East of England and aligns with the need for equitable access to day case surgery across rural and semi-rural areas. Clinical teams should continue to assess travel feasibility on a case-by-case basis, taking into account local road conditions, transport availability, and the family’s ability to return promptly in the event of post-operative complications.

❑ Standard 12

Patient Information Leaflets must be made available outlining how post-operative complications are addressed, to include warning signs of complications (e.g. bleeding, poor oral intake, uncontrolled pain), ensuring families understand the need for regular analgesia for at least 10 to 14 days post-op and that pain often is at its worst between day 4 and 6 post op.

To minimise the risk of readmission for post-operative pain, all children undergoing tonsillectomy, regardless of surgical technique, should be advised to use regular alternating Paracetamol and

Ibuprofen at weight-adjusted doses (post operative pain), in line with BNFC or local policy. This analgesia should be administered regularly for a minimum of 5–7 days, and families should be advised that it may be required for up to 14 days post-operatively.

Parents should be provided with a clear written record of Paracetamol and Ibuprofen dosing and scheduling. Teams may want to provide additional Oramorph and should review a multi-modal approach to analgesia with consideration of Benzydamine throat spray for older children [8, 9].

Where possible, post-operative analgesia should be prescribed and dispensed by the hospital, either at pre-assessment or prior to discharge, to support safe and timely pain control at home. This approach is recommended as best practice by the East of England Surgery in Children Operational Delivery Network.

Where local policy or processes do not allow hospital dispensing of post-operative analgesia, weight-based dosing remains essential. In these circumstances, families must be provided with clear written discharge information, including explicit dosing instructions for each child, the volume of medicine to administer, and the concentration of each preparation, which should be clearly highlighted.

Families should be provided with emergency contact information and instructions for seeking urgent care, including safety-netting advice and a contact number for further advice following discharge.

Services should seek to gather feedback from children and/or their families regarding post-operative pain control, to assess whether the advice and analgesic strategies provided are effective and to support ongoing quality improvement.

In otherwise healthy children and young people follow-up or Patient Initiated Follow-Up (PIFU) is not recommended. Patients with comorbidities, especially obesity could receive a routine review or indeed PIFU - this should be discussed with the care givers [8].

Section 8 Departmental governance

- ❑ **Standard 13**

Departments should regularly audit their practice against these standards to facilitate a continuous opportunity for improvement and improved safety.

Governance and Audit

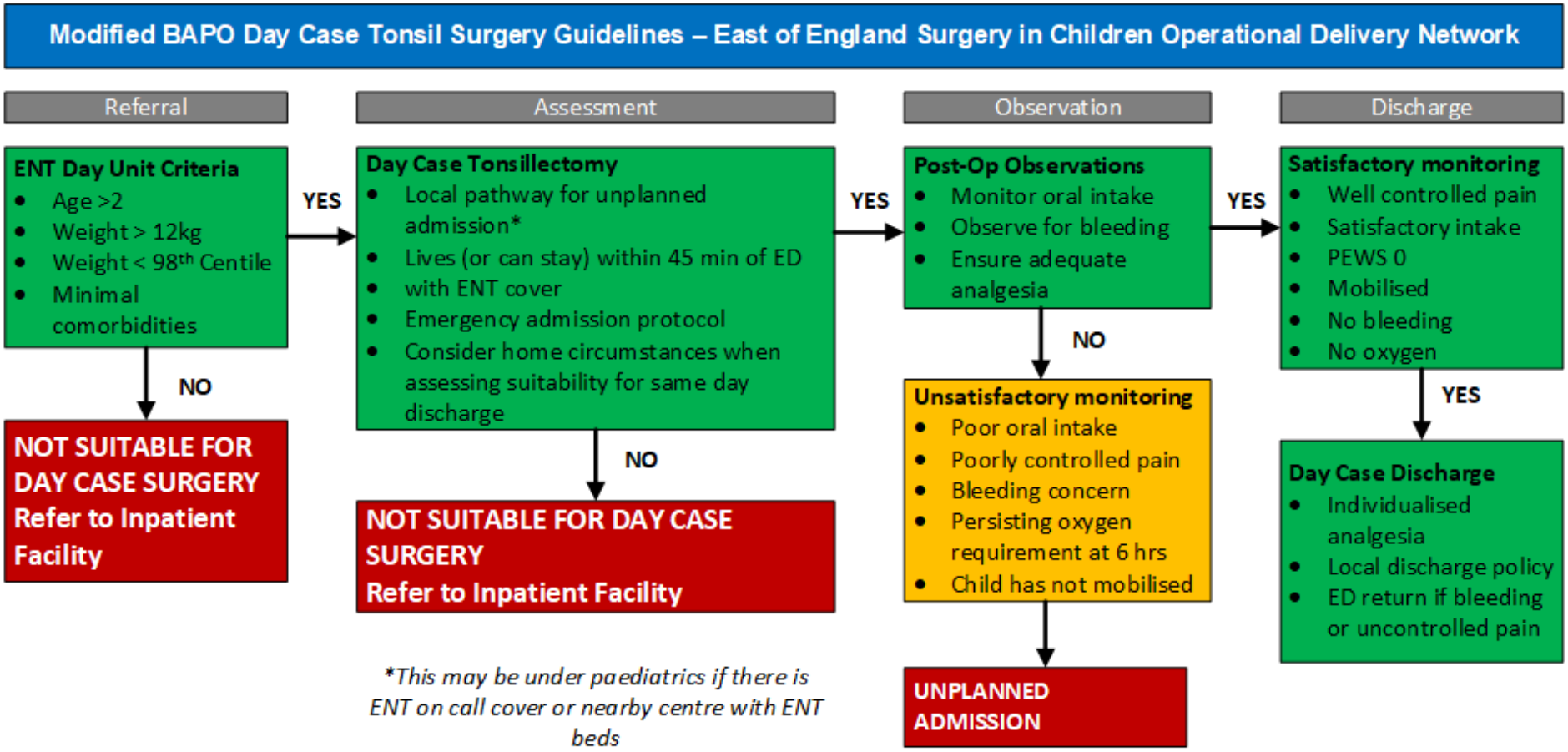
All centres within the East of England Surgery in Children Operational Delivery Network must undertake regular audits of their paediatric tonsillectomy pathways against the standards outlined in this guidance. The objective is to monitor compliance, identify variation, and drive continuous improvement in patient safety, quality of care, and operational performance across the region. Audit findings should be reviewed regularly through local governance structures and reported to the ODN Clinical Oversight Group at least yearly to inform regional benchmarking and quality improvement initiatives.

Additionally, metrics including day case rate %, unplanned admission rate, 30-day readmission rate (bleed/pain) should be reviewed. By undertaking internal deep dives and comparing with GIRFT/BADS benchmarks (e.g. aiming for ≥80% day case), the region can identify where further improvements are needed.

Table 1 Risk Factors
Severe cerebral palsy
Achondroplasia
Neuromuscular disorders (moderately or severely affected)
Down syndrome (Trisomy 21)
BMI >98th centile (extreme obesity); consider case-by-case for overweight below this threshold in combination with other risks
Significant craniofacial anomalies
Mucopolysaccharidosis
Significant comorbidity (e.g. Complex or uncorrected heart disease, home oxygen, severe cystic fibrosis)
When onsite support from tertiary medical specialities is needed e.g. metabolic, haematology

See also: BAPO (2024) and NCEPOD (2025) for further discussion on comorbidity considerations.

Appendix 1: Modified BAPO Day Case Tonsil Surgery Guidelines based on East of England Operational Delivery Network Guidelines



Modified BAPO Day Case Tonsil Surgery Guidelines based on East of England Operational Delivery Network Guidelines: British Association for Paediatric Otorhinolaryngology: day_case_paediatric_adenotonsillectomy_consensus_guidelines.pdf

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