Commissioner's Guide to the NCEPOD Report 'Right Place, Right Time, Right Team'

INTRODUCTION

This review highlighted much good practice in **non-elective surgery undertaken in children**, but there is still room for improvement, in both district general hospitals and specialist centres. Many of the findings appear reassuring – there was no delay in arrival at the admitting hospital in over 92% of cases; 84% of hospitals are part of networks for non-elective procedures; and up to 90% of surgeons and anaesthetists in non-specialist hospitals feel supported by their local paediatric centres for the acceptance of referrals and provision of advice. However, this means that **around 10% of hospitals/surgeons/anaesthetists, are not utilising networks or feeling supported,** which could translate into thousands of patients potentially affected. We found that increased centralisation of elective surgical services for children has resulted in some healthcare staff in non-specialist units feeling less confident about providing emergency surgical care for critically ill children.

Please use this report to guide your commissioning of services, with emphasis on the areas highlighted here.

THE REPORT CAN BE ACCESSED HERE

KEY AREAS WHEN COMMISSIONING SERVICES

Networks were not always in place and there was an absence of structured pathways or procedures to transfer patients when needed, despite transfers being common.

Recommendation: Provide prompt access to emergency surgical and anaesthetic care by specialists with the relevant training and experience in providing care to children and young people.

- There were 19/143 (13.3%) hospitals not part of a network of care for non-elective procedures in children and young people. Most hospitals reported transferring patients out for surgery (133/143; 93.0%).
- Only 287/629 (45.6%) patients were commenced on a dedicated pathway for emergency surgery in children and young people. Many of the patients who were not, should have been (83/255; 32.5%).

Care was shown to be better in centres where an emergency surgery co-ordinator was available, but there was not always someone in this role and furthermore, theatre booking systems rarely highlighted breaches.

Recommendation: One or more emergency surgery co-ordinators should be in place to ensure that children and young people needing emergency surgery can access a theatre.

- Reviewers reported that while the majority of patients had their procedures booked without delays, 131 out of 853 patients (15.4%) experienced delays due to delays with/in the surgical team.
- Theatre co-ordinating managers or clinicians were only available in 60/143 (42.0%) hospitals.
- Only 52/143 (36.4) hospitals had a clinician responsible for assessing capacity in theatres on a daily basis.

Fasting was infrequently recorded in hospital policies for emergency procedures for children and young people, with many patients being fasted for too long prior to surgery.

Recommendation: Prevent children and young people who are waiting for emergency surgery from being fasted for any longer than necessary.

- In the opinion of the reviewers, 125/718 (17.4%) patients were fasted for too long, with those who underwent an expedited procedure most likely to be in this category.
- Pre-procedure preparation was adequate for most patients (798/853; 93.6%), however, fasting (10/55) was the most common area for optimisation.

SUPPORTING NATIONAL GUIDANCE AND REPORTS

- Royal College of Anaesthetists, 2025. Guidelines for the provision of Anaesthetic Services. Chapter 10, Guidelines for the provision of Paediatric Anaesthesia Services.
- Royal College of Paediatrics and Child Health, 2025. 5th Ed. Facing the Future: Standards for acute general paediatric services.
- Royal College of Surgeons, 2015. Standards for non-specialist emergency surgical care of children.
- GIRFT, 2021. Paediatric General Surgery and Urology
- GIRFT, 2022. Paediatric Trauma and Orthopaedic Surgery
- The Regulation and Quality Improvement Authority, 2019. Review of General Paediatric Surgery in Northern Ireland
- National Confidential Enquiry into Patient Outcome and Death, 2024. Twist and Shout
- NHSE, 2019 Paediatric Critical Care and Surgery in Children Review
- North East and North Cumbria Paediatric Critical Care and Surgery in Children Operational Delivery Network
- North West Surgery in Children Operational Delivery Network Guidelines
- East Midlands Surgery in Children Operational Delivery Network
- West Midlands Children's Network
- East of England Surgery in Children Operational Delivery Network Guidelines
- North Thames Paediatric Network Surgery in Children
- South Thames Paediatric Network Guidelines and resources
- South West Surgery in Children Operational Delivery Network Tools and resources
- Yorkshire and Humber Surgery in Children Network
- Royal College of Anaesthetists, 2025. Anaesthesia Clinical Services Accreditation standards
- NHS England. Urgent and Emergency Care
- GIRFT. Perioperative Care
- Centre for Perioperative Care: 'Sip til Send'
- EUROFAST trial 2025