1. **What the report is looking at**		A review of the care provided to children and young people undergoing emergency (non-elective) surgery under anaesthetic or sedation.	
2. **Countries are covered**		England, Wales and Northern Ireland	
3. **The date the data are related to**		All children and young people who underwent an emergency (non-elective) procedure between: Monday 17th June 00:00 to Sunday 30th June 23:59 2024 and Monday 12th February 00:00 to Sunday 25th February 23:59 2024.	
No.	**Recommendation**	**Evidence in the report which underpins the recommendation**	**Guidance available**
1	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 by: ▪ Formalising organisational networks[i] to define where children and young people are assessed and/or undergo an emergency procedure[ii], and to agree pathways of care based on age and condition. ▪ Formalising clinical specialist networks for advice as needed. *i Utilising existing operational delivery networks or equivalent where possible.* *ii For example, whether the procedure can be undertaken locally or whether the patient needs to be transferred to a specialist centre. This will require local and regional networks working together to ensure co-ordination of services.* ***Target audiences:*** Operational delivery networks or equivalent, commissioners and integrated care boards working with trusts/health boards.	**CHAPTER 3 PAGE 11** ➢ 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%). Data from the clinician survey showed that 313/564 (55.5%) clinicians transferred patients depending on hospital expertise. Fewer anaesthetists than surgeons stated that they would transfer children requiring emergency surgery due to age (140/257; 54.5% vs 157/272; 57.7%) (T3.2). ➢ As the reported hospital specialisation increased, the number of survey respondents willing to transfer children who required emergency procedures decreased (T3.3). ➢ Respondents to the clinician survey who worked outside of tertiary paediatric centres were asked about the levels of support they received from those centres. Anaesthetists reported feeling more supported than surgeons in the acceptance of referrals (123/135; 91.1% vs 126/153; 82.4%) (T3.4). However, this meant that 8.9% and 17.6% of anaesthetists and surgeons did not feel supported. ➢ Similar proportions of support from the tertiary centre was found regarding the provision of advice (surgeons: 137/161; 85.1% vs. anaesthetists: 141/155; 91.0%) (T3.5). The most	▪ 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.

		common reasons for not feeling supported were a lack of clear referral pathway and lack of beds in the receiving centre. **CHAPTER 4 PAGE 12** ➢ Only 190/512 (37.1%) patients were under the joint care of a paediatrician and surgeon (T4.6). This is particularly important in hospitals with no paediatric surgical specialists on site. The provision of joint care was unrelated to the operation performed and hospital type. ➢ The National Paediatric Early Warning System (NPEWS) was not used pre-operatively for 129/532 (24.2%) patients in our study; it was unknown whether they were used for 228/760 (30.0%) patients (F4.3). However, NPEWS has not yet been adopted by all hospitals. **CHAPTER 5 PAGE 14** ➢ Reviewers noted that only 287/629 (45.6%) patients were commenced on a dedicated pathway for emergency surgery in children and young people (T5.5) and that many of those who were not (83/255; 32.5%) should have been (T5.6). Reviewers also noted that the pathways for treating patients as a planned urgent procedure demonstrated good practice. ➢ It was reported that 92/143 (64.3%) hospitals had a specific protocol for the children and young people who may require emergency procedures under anaesthetic, but with variability in the content (F5.10). Notably, many did not include fasting requirements for surgery and importantly, arrangements around theatre access and escalation were often not included in protocols. **CHAPTER 7 PAGE 17** ➢ Clinicians who delivered surgical care to children and young people in tertiary paediatric centres commonly used both	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

		internal and external continuing professional development (CPD) opportunities, while those in university teaching hospitals and district general hospitals used them less frequently (F7.1). **CHAPTER 7 PAGE 18** ➢ The average number of emergency procedures undertaken per annum was 39 for surgeons and 58 for anaesthetists, with a median of 15 and 30 respectively. When asked whether they thought this was enough to maintain competency, 213/254 (83.9%) surgeons and 192/242 (79.3%) anaesthetists thought that it was. Consultants and resident doctors in less specialised hospitals tended to feel less confident about their competence (T7.1).	▪ 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
2	One or more co-ordinators should be in place to ensure that: ▪ Children and young people needing emergency surgery have timely access* to a theatre **NCEPOD classification of intervention* ▪ Patients who were not operated on within their prioritisation period are highlighted and the issue escalated to senior management with responsibility for patient safety/governance* **If there are regular breaches for urgent and expedited patients due to emergency operating demands exceeding available resources, then alternative ways of dealing with this should be considered (e.g. planned urgent lists (hotlists) to prevent recurrence of future delays).* ***Target audiences:*** Commissioners, integrated care boards working with their trusts/health boards.	**CHAPTER 5 PAGE 13** ➢ Reviewers reported that while the majority of patients had their procedures booked without delays, 131/853 (15.4%) patients experienced delays due to delays with/in the surgical team. ➢ Where grade could be determined the fact that some patients were booked by less experienced staff did not appear to affect delays in booking procedures (T5.4). However, patients undergoing less urgent procedures were more likely to wait longer from the decision to operate to the time of theatre booking (F5.5) suggesting these patients could be treated more effectively on non-urgent lists. **CHAPTER 6 PAGE 15** ➢ Lack of access to a 24/7 emergency theatre could lead to unnecessary delays in hospitals that provide emergency surgery for children and young people. Elective procedures were undertaken in emergency theatres in 22/119 (18.5%)	▪ Royal College of Anaesthetists, 2025. Guidelines for the Provision of Anaesthetic Services. Chapter 5, Guidelines for the provision of Emergency Anaesthesia Services. ▪ Royal College of Anaesthetists, 2025. Anaesthesia Clinical Services Accreditation standards ▪ NHS England. Urgent and Emergency Care ▪ GIRFT, 2021. Paediatric General Surgery and Urology

		hospitals. However, this is not their intended purpose and the usage should be reviewed locally. Multidisciplinary emergency theatre handover meetings could facilitate better use of theatres, but these occurred daily in only 90/116 (77.6%) hospitals (F6.1). ➢ A theatre booking system was available in 135/143 (94.4%) hospitals, although six were unable to comment on this. Only 39/135 (28.9%) of those hospitals were able to confirm that the booking system flagged patients who breached their allocated timeframe to surgery. This indicates that most hospitals are unable to accurately identify when children and young people are waiting too long for surgery, which has implications, such as fasting and risk of deterioration for all patients awaiting emergency surgery. ➢ Theatre co-ordinating managers or clinicians were only available in 60/143 (42.0%) hospitals despite guidelines recommending this. When present there was still variation by hospital type with regard to the provision of a manager (F6.2). Only 52/143 (36.4) hospitals had a clinician responsible for assessing capacity in theatres on a daily basis (F6.3). ➢ Data from the real-time survey highlighted that not all patients had an emergency surgery co-ordinator involved in their care, with only 556/821 (67.7%) patients having one (T6.2). **CHAPTER 6 PAGE 16** ➢ Procedures were delayed less often when an emergency co-ordinator was involved (87/440; 19.8%) compared with when they were not involved (69/229; 30.1%) (F6.4). ➢ Reviewers reported delays from booking a case to the start of the procedure for 82/853 (9.6%) patients. This was more likely to affect patients who were booked for a more urgent	▪ GIRFT, 2022. Paediatric Trauma and Orthopaedic Surgery ▪ GIRFT. Perioperative Care

		procedure than those booked for a less urgent procedure (F6.5) and had an impact on the outcome for 6/82 patients. ➢ Clinicians reported that emergency procedures often displaced other emergency work and sometimes elective work (T6.6 and T6.7). These observations suggest that lack of organisation of emergency theatre workload often impacted on other patients and in particular patients were not operated on within the expected timeframe nor was there adequate escalation when this did not occur. ➢ Emergency procedures are the 'stress-test' of a system and can reveal areas where care could be improved. Auditing these procedures can help to ascertain whether the system is working. However, such audits were undertaken in only 45/108 (41.7%) hospitals.	
3	Prevent children and young people who are waiting for emergency surgery from being fasted for any longer than necessary. *In the absence of likely gastric stasis, 'Sip til Send' could be considered but note that this was not developed for emergency procedures nor in children and young people. There is new evidence around fasting in paediatric care e.g. the EUROFAST trial.* ***Target audiences:*** Commissioners, integrated care boards in discussion with their hospital trusts/health boards	**CHAPTER 4 PAGE 12** ➢ The majority of patients had a management plan written following their initial assessment (624/760; 82.1%) and while it was noted that fasting was commonly recorded, it was not part of the plan for 174/599 (29.0%) patients (T4.9). ➢ 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 (T4.10). **CHAPTER 5 PAGE 14** ➢ Pre-procedure preparation was adequate for most patients (798/853; 93.6%). However, fasting (10/55) was the most common response to the question about what should have been optimised. ➢ It was reported that 92/143 (64.3%) hospitals had a specific protocol for the children and young people who may require emergency procedures under anaesthetic, but with variability	▪ Centre for Perioperative Care: 'Sip til Send' ▪ EUROFAST trial 2025

		in the content (F5.10). Notably, many did not include fasting requirements for surgery and importantly, arrangements around theatre access and escalation were often not included in protocols. **CHAPTER 6 PAGE 16** ➢ Data from the real-time survey indicated that there was a delay in undertaking the procedure for 201/795 (25.3%) patients (F6.6). These data reflect those seen in the peer review (163/821; 19.9%). ➢ Where patient-related delays were identified, both the clinician real-time survey (11/39) and the reviewer assessment (9/30) identified lack of fasting as a cause of the delay to the procedure starting (F6.8 and F6.9).	