



Best Practice Guidance

Preparation and Management of Children and Young People with Individual Needs requiring Surgery or Procedures



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1. Methodology

This guidance has been developed by an expert panel of health care professionals involved in the preparation and care of children and young people with individual needs who are presenting for surgery or other procedures. It draws on published evidence, presented evidence, existing recommendations and established good practice.

2. Purpose and Aims

This best practice guidance is designed to support the provision of services in any hospital or elective surgical hub which provides services for children and young people (0-18 years) with individual needs. It is intended to describe the necessary staffing, facilities and services which centres should have in place to deliver optimal care and experience for the children and their carers throughout the perioperative journey.

3. Definitions

For the purpose of this guidance:

Individual (Additional) Needs: A health or developmental difference that impacts on daily life and means the child/young person may need support beyond that which is typically provided. This term is used in this document to capture the range of conditions which may lead to the need for this additional support.

Autism: A lifelong individual neurodevelopmental state which presents challenges with social interaction and communication and sensory processing, along with restricted or repetitive behavioural patterns.

Attention Deficit Hyperactivity Disorder (ADHD): A neurodevelopmental condition which presents with persistent hyperactivity, inattention and impulsivity affecting development or functioning.

Learning Difficulty. A young person who presents with a reduced ability to understand new and complex information and develop new skills but has not been assessed to diagnose a disability.

Learning Disability: A lifelong condition which develops in childhood and presents with a reduced ability to understand new and complex information, develop new skills and function in complex social environments.

Reasonable Adjustments: changes that are made to reduce the challenges a child/young person may have in accessing a service.

Neurodiverse: a population level concept describing variation in human brains and cognition

Neurodivergent: describes an individual whose brain and cognition differ from the statistical norm

4. Introduction

Creating an inclusive healthcare culture is an important part of improving the healthcare experiences for children and young people, ensuring that they have equal access to care and that the teams and facilities available are specifically designed to meet their needs to achieve this. Children, young people and carers should be actively involved in the design of care pathways and any facilities.

Healthcare outcomes for neurodivergent people and those with disabilities are worse than for the general population. They are more likely to have co-existing medical complexities, require access to healthcare facilities more often than their peers [1] and have premature mortality [2]. Additionally, children and young people (CYP) growing up in areas of deprivation have worse health outcomes compared to less deprived groups [3].

Children and young people with ADHD are more likely to access healthcare due to accidents and injuries [4-5]. CYP with autism are more likely to experience higher levels of anxiety during preparation for their procedure [6], and more complications in the perioperative period [7] including higher levels of pain both in the immediate post-operative period and longer term [8-9].

CYP with individual needs are more likely to find interactions with healthcare staff and environments challenging, generating higher levels of anxiety and distress for themselves and their carers. This may manifest itself as significant uncooperative behaviour resulting in an inability of providers to deliver the required procedure or treatment, with subsequent postponement or abandonment of a procedure the child or young person needs [10].

The Equality Act 2010 places a legal duty on organisations to make “reasonable adjustments” to reduce specific barriers created by disabilities, thus allowing individuals to participate fully in services. This approach has also been adopted by the Care Quality Commission [11]. This inevitably requires individualised care plans developed collaboratively between children, young person, carers and the healthcare providers.

Failure to provide optimised care leading to a traumatic interaction with the healthcare team, will inevitably have long-term negative consequences on their future behaviour of individuals when interacting with healthcare.

This guidance is designed to support providers who deliver services for CYP with individual needs undergoing procedures or surgery. It should help achieve the following key objectives:

- Ensure equitable access to healthcare.
- Reduce the risk of delays or cancellations on the day of surgery.
- Improve patient and parent experience, reduce anxiety and help build confidence for future interactions with healthcare.
- Devise individualised care pathways in advance with reasonable adjustments to allow for a smooth perioperative journey.

5. Service Design and Leadership

- When creating and developing new or existing services, providers must consider how care of children and young people with individual needs can be integrated into services and pathway design.
- Providers must have a clear strategy for the early risk assessment and identification of CYP with individual needs as soon as they are identified as potentially needing healthcare interventions, so that reasonable adaptations can be put into place as early as possible in their healthcare journey.
- A multidisciplinary approach to care should form the framework for any reasonable adaptation strategy. This should include the involvement of:
 - The child/young person should remain at the centre of care.
 - Parents and carers
 - Professionals working with the family e.g. support workers, health visitors
 - General practitioners
 - Community nursing teams, care providers, teachers
 - Learning disability nursing teams
 - Paediatricians
 - Surgeons
 - Anaesthetists
 - Ward, ODPs, theatre and recovery staff
 - Play specialists.
- There should be clear strategies for education and preparation of CYP who require reasonable adaptations including the availability of appropriate resources to facilitate this.
- Providers should ensure that any pathways for care of CYP with individual needs address all aspects of the perioperative journey from referral and identification, to post operative care management.
- Providers where CYP undergo procedures should have access to play specialists and where appropriate paediatric clinical psychology to support the care of CYP with individual needs.
- Providers should nominate Autism and Learning Disability Champions to develop and facilitate the care of CYP presenting to hospital. These staff members should be easily identifiable and provide a link for families with hospital teams from booking to discharge.
- Providers should identify a link person within existing learning disability teams, to provide support for any CYP with LD presenting for surgery.
- Where CYP with individual needs undergo procedures under general or local anaesthesia, there should be a named senior medical and nursing lead within the perioperative team. Medical and nursing leads should have knowledge and experience of caring for CYP with a range of individual needs and gain training in relevant areas related to these roles. This should include communication skills, anxiety management, neurodivergent needs, learning

difficulties, consent issues. There should be an understanding of the Equality Act, deprivation of liberty policies and the delivery of safe clinical holding.

- Clinical leads should take responsibility for ensuring that suitable pathways have been developed and incorporate environmental adaptations, governance processes and service development strategies for meeting individual needs.

6. Training

- All staff involved in the care of CYP with individual needs presenting for surgery or a procedure should have specific training in aspects of care relevant to the care of individual needs patients. This must include but is not limited to:
 - Communication skills
 - Anxiety management
 - Consent
 - Clinical holding / Restraint
 - Reasonable adaptations
 - Learning disabilities, Autism and ADHD including sensory processing difficulties [12]
- Providers should ensure training of staff is part of a structured programme with annual updates.
- Preassessment nurses should be prioritised to complete this training as they will be the key team members interacting with the CYP with individual needs and their carers.
- Anaesthetists with regular paediatric practice should have specific training in caring for CYP with individual needs including anxiety management and neurodivergence, learning difficulties and clinical holding. Engaging with local charities and support organisations may be useful.

a. Communication Training

- Communication influences how CYP and their carers respond in healthcare settings. [10]. Communication training should include stigmatising language, deficit-based language (“disorder” or “deficit”) and non-verbal techniques. “Identity first” language is recommended. (i.e. an autistic person not a person with autism; sensory differences rather than sensory processing disorder).
- Sign language (e.g. Makaton) or imagery (symbol charts) e.g. picture exchange communication system (PECS), [Talking Mats](#), for the preparation and explanation of the planned events on the day should be available in areas that care for CYP, based on individual preferences determined at preassessment. This may include devices already owned e.g. VOCA (Voice Output Communication Aids).

b. Safeguarding Training

- Medical and Nursing leads for the individual needs service should attain Level 3 safeguarding training to support shared decision-making discussions within multi-disciplinary settings to determine the best interests of individuals in relation to the need to attend for surgery /procedure and the impact of delays in achieving this [13].
- There should be clearly documented Trust safeguarding policies readily available for all staff to consult if safeguarding actions are required.

c. Clinical Holding / Restraint Training

- All Providers should endeavour to develop individual care pathways which minimise the requirement for any clinical holding.
- All Providers where restraint of CYP may be required within a care pathway, should have a clear policy in place which should include:
 - Indications for restraint/clinical holding
 - Risks and benefits of restraint
 - Appropriate staffing and methods to facilitate restraint.
 - Process of consent for restraint usage.
 - Indications for abandonment of restraint.
 - Pathway for debriefing following events including debriefing with staff, patients, carers and families.

This restraint/clinical holding policy should be available for review by all multidisciplinary team members including families, carers and patients and should be presented in appropriate forms to facilitate this review.

- Any staff involved in clinical holding must have attended an initial Trust training programme followed by regular training updates in safe restraint techniques.
- Any staff involved in the restraint of CYP should understand the legal frameworks relevant to the restraint and how to seek support and guidance through escalating within the organisation.
- There should be clear understanding of the clinical law in relation to clinical holding of children < 16 years old, who are or are not competent to consent.

7. Facilities/Environments

The facilities and environment are an important part of any strategy for minimising anxiety or distress in children and young people attending a healthcare setting. Care environments should offer the following facilities to support CYP with individual needs, and particularly those with sensory processing differences [14].

a. Ward Areas / Day case units

- Wards or day care units should ideally have access to at least one quiet area or side room to accommodate CYP who require this as part of their care. [15-16]. Quiet areas should be equipped with comfortable seating, dimmable lighting, and low-stimulation decor, creating a calming atmosphere that can be customised to the needs of the CYP. [17].
- All spaces should meet accessibility standards for all children, young people and carers regardless of mobility or age, with adequate space for parents or caregivers to accompany the child.
- Children with individual needs should ideally be recovered in an area with lower levels of noise and lighting and a familiar person, such as a parent or their carer, present as early as possible in the process [18].
- Clear and accessible information in a variety of formats (visual, written and tactile) should be available to guide children and families through the hospital. Information should be simple, clear, and placed at appropriate heights for children to see. [10, 19-20]

b. Sensory rooms and Equipment

- Children and young people should have access to a sensory room or sensory equipment to meet their specific needs. Although co located sensory rooms are a gold standard, cubicles can be used for this purpose, customised using sensory trolleys or boxes. [21-22].
- Sensory rooms should have adjustable lighting, soft furnishings, calming colours, and non-intrusive sounds to create a safe and comforting space for children who have sensory needs. A variety of sensory equipment should be available which may include visual or audio aids or projectors. [23].
- If a sensory room is not available a variety of sensory equipment that caters to different sensory processing needs should be available from admission to discharge. This might include noise-cancelling headphones, sunglasses, fidget toys, stress-relief balls, weighted blankets, or tactile sensory aids [2, 22].
- Sensory cards, information booklets and other resources in a variety of formats should be available to help children and young people understand their theatre journey.

- Departments should ensure that there are appropriate distraction devices to reduce stress for children and young people to use whilst they are awaiting surgery. This may include tablets, games consoles, toys, craft activities etc.
- A sensory check of each environment is recommended to ensure appropriate environments available within the whole pathway, and that smooth transition between them can be achieved.

c. Quiet routes to hospital areas/parking

- Providers should identify quiet routes into key hospital areas such as wards, days units and radiology departments. Routes should avoid high-traffic areas, bright lights, loud noises, and overwhelming stimuli.
- There should be clear, visible, and accessible signage to guide CYP and carers along quiet, less stimulating routes from parking areas to key hospital spaces.

d. Decompression areas

- Specific areas within wards that care for CYP, should be considered for children to decompress or deescalate if they are experiencing a period of high anxiety. These should be separate from high-traffic spaces and should provide an environment where CYP can retreat when overwhelmed [2]

e. Signage

- Consideration should be given to implementing customisable signage for specific patient needs. E.g. a visual guide for a child with autism might highlight which areas of the hospital they are likely to visit or give step-by-step directions to specific departments [15].

8. Preparation for surgery

- All CYP presenting for surgery or procedures should have an individualised plan which meets their specific needs to ensure that anxiety/distress are minimised, the procedure is successfully completed and that the positive interaction builds on coping strategies for future interactions with healthcare teams [24].
- Learning disabilities and neurodivergent conditions are commonly associated with other medical conditions or are part of known syndromes. Preparation pathways must be in place to facilitate appropriate investigation and optimisation of these conditions.

a. Booking

- All CYP listed for a procedure should have an early risk assessment as soon as practical following commencement of their procedural journey, to ensure triage to the most appropriate level of preassessment. [25]
- Information regarding any individual needs experienced by the CYP or carer should be highlighted to the wider multidisciplinary team and specifically the pre assessment team as early as possible. This should include information about how the CYP responded to previous healthcare interactions, communication preferences and any behaviours likely to pose a challenge to others. <https://www.rcemlearning.co.uk/foamed/behaviours-that-challenge/>
- CYP who are identified as having individual needs should have additional time allocated within pre assessment clinics to allow for shared decision making and discussions of individual anaesthetic plans.
- When booking appointments for CYP identified as having individual needs, the timing of appointments relative to their normal schedules should be considered to help reduce anxiety and minimise distress
- Providers should have a paper or electronic alert process for CYP previously identified as having individual needs and a way of accessing hospital passports and previous planning documents.
- There should be a process in place to consider the best care pathway for 16 -18-year-olds i.e. following a paediatric or adult pathway, especially those who have previously required reasonable adaptations to adult anaesthetic services.

b. Preassessment

- All CYP should be pre-assessed prior to the day of their procedure [25]. Ideally, this should occur prior to a date being offered for surgery with additional support closer to the date if needed. [26]
- Pre assessment should identify groups of CYP that may need additional preparation, reasonable adjustments and support e.g. CYP with neurodevelopmental, learning and/or behavioural needs [2, 27].
- Preassessment can be via telephone, virtual or face to face. Consideration should be given within departmental pathways to the best mode of assessment as telephone/virtual appointment may avoid a challenging additional hospital visit for the carers which may

increase anxiety in CYP. For others, a F2F meeting may provide the opportunity to familiarise the CYP with the environment and healthcare teams, which may ease anxiety regards the day of admission.

- CYP with any individual needs should be identified including any associated communication requirements (hearing, sight, speech) which need to be considered.
- All providers must have a planned care pathway that identifies whether reasonable adjustments and additional planning are required and how this can be facilitated. This should include assessment of the CYP's emotional/physiological needs as well as any other requirements for coexisting conditions [27].
- Staff should be enabled to view EHCP/hospital passports, previous medical/surgical notes, including those from other hospitals.
- Weight should be recorded. This may be available from documentation in other familiar environments e.g. school, community based services.
- Routine observations e.g. O2 sats, HR, BP should be recorded if possible. This may be obtained more successfully in a non-clinical setting away from the hospital on occasion and pathways should be in place to organise this.
- For some CYP, a multidisciplinary review or meeting will be essential to establish all their needs. Pathways should exist to facilitate this process in a timely fashion so that surgery is not delayed. Sometimes this process may involve visiting the CYP in a familiar environment such at school to aid the process of developing reasonable adjustment strategies.
- All CYP on the individual needs' pathway should have the opportunity to be reviewed in a consultant anaesthetic pre assessment clinic in order to collate information and discuss with the parents/carers a range of strategies and escalations to optimise the pathway on the day of admission. When a same day review is not practical efforts should be made to ensure appointments work around the normal routines of the CYP.
- After collecting all relevant information, the anaesthetist should discuss with the parents/carers at their preassessment appointment the significant aspects of admission on the day of the procedure through to discharge plans including pain assessment and management. There should a clear plan as to the optimal time for the CYP to be on the operating list to optimise delivery of all aspects of the care pathway and minimise distress.
- The anaesthetist or a senior member of nursing staff should agree and adhere to an Individualised admission plan with the parents/carers and the child and young person. This should include:

- Fasting durations and instructions – incorporating recent “sip til send” strategies for fluids may reduce distress
 - Pre hospital medication administration (regular and sedative)
 - Admission time and admission location (including parking and routes to wards if applicable). This includes planning parking outside of the theatre unit to enable admission directly from a car/ambulance.
 - Admissions may be staggered or adjusted from normal timings and may not always simply mean first on list.
 - Clothing (no metal for MRI cases)
 - What to bring (comfort blanket, familiar pillows/toys/cups/medicine syringes, tablet/phone, headphones).
 - Plan for observations, wrist bands and local anaesthetic cream.
 - Premedication plan – what and how and when this should be given
 - Listing plan including time, place and staffing arrangements. This should also include extra time on the list if this is felt necessary.
 - Induction plan including any potential need for restraint.
 - Recovery and discharge plan. This may include advance organisation of take-home medications to reduce waiting time after procedures and should include an agreed set of discharge criteria if not standard ones.
 - Post operative analgesic plan.
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- There should be a documented discussion regarding when to abandon attempts at anaesthetic management and when this would be appropriate.
 - If there is a potential need for the use of IM anaesthetic agents this should be discussed and documented in advance.
 - Consideration should be given during the planning phase and at preassessment for CYP with complex needs where other procedures may be possible under a single anaesthetic episode e.g. ECG, Echo, Bloods, dental examinations, immunisations (when practical), nail cutting etc. Co-ordinating this can be challenging and the time impact on the list needs to be factored in.
 - There should be a clear pathway for communicating the individualised care plan to all team members in advance of admission.
 - All care pathways should aim to give CYP autonomy over their admission as far as this is practical within the healthcare setting.
 - In common with other patients attending pre assessment there should be pathways in place for the identification of health needs such as smoking, obesity, dental hygiene etc and health optimisation in these areas which specifically consider children and young people with individual needs.

c. Information and resources

- Providers should have a variety of patient information resources including but not limited to:
 - Paper or web based general information and contact leaflets
 - Videos
 - Interactive preparation applications
 - Social story images and cards both in real life and widget form.
 - Story books
 - Equipment that can be taken away such as facemasks.
 - Information regarding therapeutic holding in written and picture formats
- A preparation strategy should be in place linking resources from home, hospital and the theatre play team so that preparation can be individualised to the specific needs of the CYP.
- Providers should offer play specialist sessions or clinics, real time tours/ visits and resources for home preparation tailored to the needs of the child.
- Providers should endeavour to offer desensitisation visits over weeks (or longer if needed) to help the CYP feel comfortable in the hospital environment and reduce the need for pharmacological interventions.
- Parents and CYP need to be aware that complication rates can be higher post operatively in CYP with individual needs and should have the opportunity to discuss these as part of the preoperative assessment. [28]

d. Consent

- All Providers should have detailed policies in place for:
 - Therapeutic holding and restraint
 - Escalation or termination of attempts at anaesthesia
 - Next steps should postponement be required.
- There should be a local policy for the consent of children and young people including:
 - Gillick competence
 - Assessment of capacity [29]
 - Definition of consent [30]
 - Safeguarding/ legal guardianship [13]

e. Play Specialists and Distraction

- All departments should have a play specialist responsible for assisting with the care of CYP [31]. This responsibility may extend to:
 - Preparing patients for theatre.
 - Organising and maintaining distraction equipment
 - Working with anaesthetic teams to manage the care of CYP within theatre.
- All departments should have distraction equipment available for use [32]. This may include some of the following:
 - Sensory toys
 - Projectors, light sources and electronic devices
 - Books
 - Weighted blankets and tubes
 - Games and art and craft activities

f. Premedication

- All departments should have a premedication policy. This should include directions on:
 - Types of medications, preparations and doses held for use in the department.
 - Side effects and contraindications
 - Methods of administration
 - Monitoring following administration
 - Length of stay following administration.
 - Parent information
- Children requiring complex premedication protocols should have access to a Consultant Anaesthetic pre assessment clinic so that shared decision making and consent can be considered prior to the day of surgery.
- Providers should have a policy in place for the administration of IM Ketamine should this be required. This should include:
 - Consent for use
 - Parent information
 - Administration – considering safety
 - Post administration monitoring
 - Care at home following use.

g. Post operative Recovery and Discharge Care

- All Providers should have a strategy for the management of emergence delirium. As this is commoner in younger children, anxious children and those with ADHD, early identification and management planning is essential [33] to avoid potential complications following discharge [34].
- There should be a post operative recovery checklist linked to the individualise anaesthetic plan that should address:
 - Removal of unnecessary lines or other indwelling devices before fully awake, to avoid them being removed by the patient.
 - A strategy for pain control including specific assessment of pain for the individual CYP and a plan for maximal post-operative analgesia to mitigate worsening of behaviours initially [8]
 - Parental and CYP education pre and post operatively is important, as despite adequate analgesia children with ADHD can take longer to return to normal activities in the post-operative period e.g. school attendance.
 - Parental attendance in recovery as soon as is possible to normalise as much as possible for the CYP.
 - A plan for the provision of comfort items, clothing, food and drink.
 - A plan should the child have a “meltdown” (intense loss of behavioural control triggered by overwhelming sensory or emotional overload) in recovery and require clinical holding (see section 6c) or further support.
- There should be an individualised nursing discharge plan which may be different from standard discharge protocols. This allows nursing teams to swiftly discharge a CYP if they become distressed by the hospital environment if safe to do so, without the need to await formal medical review.
- Providers should have a policy for discharge medications so that discharge is not delayed whilst waiting for them to be dispensed.
- Providers should consider providing discharge information to the parent/carer whilst their CYP is in theatre so that they can focus on the information shared, rather than in a rush on discharge.
- All discharge information should include 24-hour contact numbers should the parent or carer need support following discharge.

9. Reviewing and Improving Services

a. Clinical Governance and Audit

- Practices within the service, particularly in relation to physical or chemical deprivation of liberty should be regularly audited and discussed. Examples include:
 - Governance – training compliance
 - Preoperative – screening process success, appropriate information provided, access to play
 - Day of surgery – premedication success, adherence to plan, comparative fasting times
- Time should be set aside regularly at departmental clinical governance meetings to discuss the care of patients with individual needs, provide education and address service directions.
- Regional collaboration should be sought, and links should be cultivated between healthcare, parent groups, schools and charities to ensure the service meets the needs of all its users.

b. Feedback

- There should be a clear method for obtaining and collating CYP and carer feedback and integrating this into future service developments
- Service users should be actively engaged in environmental and procedural developments so that the service meets local needs.

10. Regional networks

- Providers should work with other regional providers and surgery in children operational delivery networks to develop and standardise services across regions and ensure that all children and young people receive the highest standards of care.

11. Additional Resources

‘Supporting Patients with Additional Communication Needs’. Royal College of Anaesthetists 2025. <https://rcoa.ac.uk/sites/default/files/documents/2025-12/AdditionalNeeds2025.pdf>

[National Autistic Society: Learn](#). Supporting organisations and professionals to develop skills, confidence and inclusive practice which improve the lives and experiences of autistic and neurodivergent people

[Mencap: Resources for Healthcare Professionals](#). The resources will give you the tools to make sure you are making the adjustments needed to give great care to the people with a learning disability who come to you for support.

Council for Disabled Children: [Health and Systems Improvement](#). Supporting the health system and colleagues within it to understand how best to support disabled children and young people to live happy, healthy lives and prepare them for their future.

Autism Central. [National Peer Education Programme](#) for families and support networks of autistic people of all ages in England. The programme is delivered by Anna Freud and commissioned by NHS England.

12. References

1. Jackson Brown, F · Guvenir, J. The experiences of children with learning disabilities, their carers and staff during a hospital admission. *Br J Learn Disabil.* 2008; 37:110-115
2. Brown S, Rabenstein K, Doherty M. Autism and anaesthesia: a simple framework for everyday practice. *BJA Educ.* 2024 Apr;24(4):129-137. doi: 10.1016/j.bjae.2024.01.002. Epub 2024 Feb 23. PMID: 38481418; PMCID: PMC10928310.
3. Thomas C, Pearse RM. Socioeconomic deprivation and health inequity: independently associated with postoperative outcomes, and does this matter? *Br J Anaesth.* 2025;135(5):1141-1143. doi:10.1016/j.bja.2025.07.002.
4. Ruiz-Goikoetxea M, Cortese S, Aznarez-Sanado M, et al. Risk of unintentional injuries in children and adolescents with ADHD and the impact of ADHD medications: protocol for a systematic review and meta-analysis. *BMJ Open* 2017;7:e018027. doi: 10.1136/bmjopen-2017-018027
5. Nigg, J.T., 2013. Attention-deficit/hyperactivity disorder and adverse health outcomes. *Clinical psychology review*, 33(2), pp.215-228.
6. Elliott AB, Holley AL, Ross AC, Soleta AO, Koh JL. A prospective study comparing perioperative anxiety and posthospital behaviour in children with autism spectrum disorder vs typically developing children undergoing outpatient surgery. *Paediatr Anaesth.* 2018 Feb;28(2):142-148. doi: 10.1111/pan.13298. Epub 2017 Dec 10. PMID: 29226493.
7. Tran J, Chen JW, Trapp L, McCormack L. An Investigation of the Long and Short Term Behavioural Effects of General Anesthesia on Pediatric Dental Patients With Autism. *Front Oral Health.* 2021 Aug 17;2:679946. doi: 10.3389/froh.2021.679946. PMID: 35048025; PMCID: PMC8757844.
8. Rosander S, Nause-Osthoff R, Voepel-Lewis T, Tait AR. A comparison of the postoperative pain experience in children with and without attention-deficit hyperactivity disorder (ADHD). *Paediatr Anaesth.* 2015 Oct;25(10):1020-5. doi: 10.1111/pan.12720. Epub 2015 Jul 22. PMID: 26200820.
9. Stickley A, Koyanagi A, Takahashi H, Kamio Y. ADHD symptoms and pain among adults in England. *Psychiatry Res.* 2016 Dec 30;246:326-331. doi: 10.1016/j.psychres.2016.10.004. Epub 2016 Oct 3. PMID: 27750114.
10. Short JA , Calder A, Anaesthesia for children with special needs, including autistic spectrum disorder, *Continuing Education in Anaesthesia Critical Care & Pain*, Volume 13, Issue 4, August 2013, Pages 107–112, <https://doi.org/10.1093/bjaceaccp/mks065>
11. CQC 2025. Services for autistic people and people with a learning disability - Care Quality Commission

12. Oliver McGowan code of practice on statutory learning disability and autism training. <https://www.gov.uk/government/publications/oliver-mcgowan-code-of-practice>
13. RCPCH Intercollegiate document 2025. Safeguarding children and young people & children and young people in care: Competencies for health care staff. <https://child-health-safeguarding.rcpch.ac.uk/>
14. Wharton S, Hames A, Milner H. The accessibility of general NHS services for children with disabilities. *Child Care Health Dev.* 2005 May;31(3):275-82. doi: 10.1111/j.1365-2214.2005.00497.x. PMID: 15840147.
15. NICE 2021. Autism spectrum disorder in under 19s: support and management.
16. Selvey P, Stypulkowski K, Waisbren S. Surgical management of the patient living with autism. *Surg Open Sci.* 2019 Jul 12;1(2):90-96. doi: 10.1016/j.sopen.2019.06.006. PMID: 32754699; PMCID: PMC7391914.
17. Johnson M, Doherty M, Shaw SC. Overcoming barriers to autistic health care: towards autism-friendly practices. *Br J Gen Pract.* 2022 May 26;72(719):255-256. doi: 10.3399/bjgp22X719513. Erratum in: *Br J Gen Pract.* 2022 Jun 30;72(720):318. doi: 10.3399/bjgp22X720125. PMID: 35618467; PMCID: PMC9172244.
18. RCOA GPAS 2025. Chapter 10: Guidelines for the Provision of Paediatric Anaesthesia Services 2025 <https://www.rcoa.ac.uk/gpas/chapter-10>
19. RNIB. Accessible health and care information for patients. Accessible health and care information for patients | RNIB
20. National Institute for Health and Care Excellence (NICE). NICE guidance [Internet]. London: NICE; 2025. Available from: <https://www.nice.org.uk/guidance>
21. Unwin KL, Powell G, Jones CR. The use of Multi-Sensory Environments with autistic children: Exploring the effect of having control of sensory changes. *Autism.* 2022 Aug;26(6):1379-1394. doi: 10.1177/13623613211050176. Epub 2021 Oct 24. PMID: 34693744; PMCID: PMC9340127.
22. Pfeiffer BA, Koenig K, Kinnealey M, Sheppard M, Henderson L. Effectiveness of sensory integration interventions in children with autism spectrum disorders: a pilot study. *Am J Occup Ther.* 2011 Jan-Feb;65(1):76-85. doi: 10.5014/ajot.2011.09205. PMID: 21309374; PMCID: PMC3708964.
23. Sense. Multi-sensory impaired children in hospital. <https://www.sense.org.uk/information-and-advice/for-professionals/information-and-resources-for-healthcare-professionals/multi-sensory-impaired-children-in-hospital/>
24. Moreno-Duarte I, Brandsen S, Dawson G, Einhorn LM, Swaminathan M. Integrating tailored approaches in perioperative care strategies for neurodivergent individuals. *E Clinical Medicine.* 2024 Sep 26; 76: 102846. doi: 10.1016/j.eclinm.2024.102846. PMID: 39398495; PMCID: PMC11470177.

25. APAGBI 2022. Best Practice Guidance: Preassessment Services for Children undergoing Surgery or Procedures. <https://www.apagbi.org.uk/working-groups/paediatric-perioperative-care-p-poc>
26. GIRFT 2024. Closing the gap: Actions to reduce waiting times for children and young people. <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2024/08/UPDATE-Closing-the-gap-CYP-elective-recovery-August-2024.pdf>
27. Haydon C, Doherty M, Davidson IA. Autism: making reasonable adjustments in healthcare. *Br J Hosp Med (Lond)*. 2021 Dec 2;82(12):1-11. doi: 10.12968/hmed.2021.0314. Epub 2021 Dec 8. PMID: 34983215.
28. Yoon Y, Kennis M, Hale EW. Post-operative complications and ADHD. *Front Child Adolesc Psychiatry*. 2022 Nov 1;1:1032559. doi: 10.3389/frcha.2022.1032559. PMID: 39817278; PMCID: PMC11731803.
29. UK Gov 2005. Mental Capacity Act. <https://www.legislation.gov.uk/ukpga/2005/9/contents>
30. GMC 2017. GMC 0-18 years. <https://www.gmc-uk.org/professional-standards/the-professional-standards/0-18-years>
31. [NHS England » Play well – resources for health play services for England](#)
32. [Starlight | NHS Play Well Toolkit](#)
33. Reddy SK, Deutsch N. Behavioural and Emotional Disorders in Children and Their Anaesthetic Implications. *Children (Basel)*. 2020 Nov 25;7(12):253. doi: 10.3390/children7120253. PMID: 33255535; PMCID: PMC7759846.
34. Sung V, Hiscock H, Sciberras E, Efron D. Sleep problems in children with attention-deficit/hyperactivity disorder: prevalence and the effect on the child and family. *Arch Pediatr Adolesc Med*. 2008 Apr;162(4):336-42. doi: 10.1001/archpedi.162.4.336. PMID: 18391142.
35. 'Supporting Patients with Additional Communication Needs'. Royal College of Anaesthetists 2025. <https://rcoa.ac.uk/sites/default/files/documents/2025-12/AdditionalNeeds2025.pdf>