Summary of the 1989 Report

(published June 1990)

Contents:

Sample group

The detailed sample for the 1989 Report was deaths of children aged ten years or under.

Recommendations

- The information systems, particularly clinical information systems, in the NHS should be considerably improved to provide accurate and timely information for audit and clinical quality assurance. All consultants should assist in achieving this improvement.
- Local audit meetings are essential to good clinical practice and all consultants should participate.
- Surgeons and anaesthetists should not undertake occasional paediatric practice. The outcome of surgery and anaesthesia in children is related to the experience of the clinicians involved.
- Consultants who take the responsibility for the care of children (particularly in District General Hospitals and in single surgical speciality hospitals) must keep up to date and competent in the management of children.
- Consultant supervision of trainees needs to be kept under scrutiny. No trainee should undertake any anaesthetic or surgical operation on a child of any age without consultation with their consultant.

Key points

- The overall surgical and anaesthetic care of children as revealed to this Enquiry is excellent.
- Few children die following surgery. Those who die have multiple congenital anomalies often not compatible with life, or malignant tumours, or suffer severe multiple trauma.
- Much surgery and anaesthesia for children is given by clinicians with a regular paediatric practice. However, this is not always so.
- While most children's surgery and anaesthesia is undertaken by, or under the direct supervision of, consultants on some occasions this supervision was lacking.
- The clinical competence of some locum appointees to care for the special needs of children must be questioned.
- The needs of children in single surgical speciality units are not always fully met. Whilst the natural dominance of surgical requirements (for neurosurgery and burns in particular) are paramount, an absence of facilities in intensive care for children and a lack of skilled paediatric anaesthetists, paediatricians and paediatric nurses were found in some units.
- Local audit meetings to review the management of children occur in 83% of cases. This is a considerable improvement on the situation reported in the report of a Confidential Enquiry into Perioperative Deaths (1987).
- The system established by NCEPOD for the collection of data worked well. Its success was ensured by the enthusiasm of the consultants who participated. NCEPOD has again demonstrated that consultant anaesthetists and surgeons are willing to review their performance (only 0.2% of consultants refused to participate).
- The data systems in the NHS are inadequate. Rates of events (admissions, operations and deaths) cannot be calculated because contemporary data are not available. Thus valid comparisons between hospitals, districts or regions cannot be made promptly enough to influence clinical practice.