RECOMMENDATIONS

Clinical

- There is a need for a system to assess the severity of surgical illness in **children** in order to gather meaningful information about outcomes. The ASA grading system is widely used by anaesthetists but, as a comparatively simple system, does have limitations for use in children (see pages 31-33).

- Anaesthetic and surgical trainees need to know the circumstances in which they should inform their consultants before undertaking an operation on a **child.** To encourage uniformity during rotational training programmes, national guidelines are required (see pages 39-41).

- The death of any **child,** occurring within 30 days of an anaesthetic or surgical procedure, should be subject to peer review, irrespective of the place of death (see page 47).

- The events surrounding the perioperative death of any **child** should be reviewed in the context of multidisciplinary clinical audit (see page 47).

- Fluid management in the **elderly** is often poor; it should be accorded the same status as drug prescription. Multidisciplinary reviews to develop good local working practices are required (see pages 68-71).

- A team of senior surgeons, anaesthetists and physicians needs to be closely involved in the care of **elderly** patients who have poor physical status and high operative risk (see pages 58-59, 62, 80).

- The experience of the surgeon and anaesthetist need to be matched to the physical status of the **elderly** patient, as well as to the technical demands of the procedure (see pages 62, 74, 81, 86).

- **Elderly** patients need their pain management to be provided by those with appropriate specialised experience in order that they receive safe and effective pain relief (see pages 75-76, 78-79).

- Surgeons need to be more aware that, in the **elderly**, clinically unsuspected gastrointestinal complications are commonly found at postmortem to be the cause, or contribute to the cause, of death following surgery (see page 102).

Organisational

- The concentration of **children's** surgical services (whether at a local or regional level) would increase expertise and further reduce occasional practice (see page 26).

- A review of manpower planning is required to enable anaesthetists and surgeons in various specialties to train in the management of small **children** (see page 26).

- In the management of acute **children's** surgical cases a regional organisational perspective is required. This particularly applies to the organisation of patient transfer between units. Paediatric units have a responsibility to lead this process (see pages 43-46).

- All Trusts should address the requirements of the framework document on **paediatric** intensive care. Most children's hospitals have a good provision but many district general hospitals are deficient (see pages 35-36, 46).

- There is a need for central guidance to ensure the uniformity of data collection on surgery in **children** (see page 16).

- If a decision is made to operate on an **elderly** patient then that must include a decision to provide appropriate postoperative care, which may include high dependency or intensive care support (see pages 61-62, 70).

- There should be sufficient, fully-staffed, daytime theatre and recovery facilities to ensure that no **elderly** patient requiring an urgent operation waits for more than 24 hours once fit for surgery. This includes weekends (see pages 61-63, 82).

- Clinicians are still unable to return data to NCEPOD as a result of missing patient records. Action is required to improve hospital record systems; this is within the remit of **clinical governance** (see pages 11-12).

- NHS Trusts must take responsibility for ensuring that all relevant deaths are reported and questionnaires returned to NCEPOD as part of their **clinical governance** duties (see page 3).