RECOMMENDATIONS

- Trusts and hospitals must establish systems to ensure that all patients' **medical records** are always available to clinicians. The inability to trace the notes, or parts thereof, of patients who have died, thus preventing surgeons and anaesthetists from completing returns to NCEPOD, is unacceptable (page 14).

- In two of every five hospitals in which patients die following surgery there is no **high dependency unit** (HDU). Although the provision of essential critical care facilities has increased greatly since 1990, the absence of an HDU in an acute surgical hospital is detrimental to patient care. It places unreasonable pressure on surgeons and anaesthetists in their decision making and impedes a flexible and graduated use of expensive critical care resources (page 40).

- The urgent and emergency workload in anaesthesia being undertaken by **non-consultant career grade (NCCG) doctors** is of considerable concern. These NCCGs are mainly staff grade anaesthetists, many of whom do not possess the Fellowship in Anaesthesia, and who are not receiving adequate consultant support. There are indications that the problem of unsupervised SHO anaesthetists, identified in previous NCEPOD reports, is being replaced by one of inadequately qualified, unsupervised NCCGs (page 51).

- Despite the resources that have flowed into **audit** activities over recent years, anaesthetists reviewed less than a third of perioperative deaths at local meetings; this percentage has remained unchanged since 1990. Surgeons overall now review three-quarters of deaths at local audit meetings, but there are wide variations between the surgical specialties, from a minimum of 13% to a maximum of 82%. It is sometimes stated that studying expected perioperative deaths, most often in old and very ill patients, contributes little. The experience of NCEPOD in examining these deaths nationally does not support this contention; there is much that can be learnt from their careful examination. It is a professional responsibility to examine one's practice and seek ways to improve surgical and anaesthetic management. Clinicians must strive to achieve an audit record for all deaths if professional education, credibility and public support are to be maintained (pages 39 and 72-73).