**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).