Surgery for Children and Young People
South Tees Foundation Trust

Lessons from NCEPOD and local feedback October 2012

Suggestions for development 2012 - 2013

Information to parents

A very common source of parental concern and complaints are regarding conflicting information amongst a team (Specialty trainee and Consultant surgeon) and amongst specialties (Surgery and Paediatrics). The ideal would be for a clear plan to be decided amongst specialties away from the bedside in line with the current evidence base for that condition. Examples include length and route of administration of antibiotics post appendicectomy or for a septic joint.

Audit

Each consultant already keeps a logbook of their surgical cases and outcomes related to childrens' surgery. We hope that having a forum for open discussion will encourage the presentation of interesting or challenging cases with the emphasis on improving surgical care and knowledge. Ideally the forum should be linked with our Paediatric colleagues.

It is suggested therefore that we could attend and collaborate with the current 3 monthly Paediatric and Emergency Department joint meetings. We would aim for 2 of those sessions to have a Paediatric and Surgery slant; the remaining two a Paediatric and Emergency department slant. Trauma cases would remain relevant for any of these sessions particularly with the formation of the major trauma centre.

Venue:	Women and Childrens Conference Room
Organiser:	Dr Thwaites (with collaboration from all specialities)
Day:	Wednesday afternoons
Frequency:	3 monthly

Morbidity

The outcomes following childrens surgery here at South Tees appears to be very good, with a number of surgeons offering surgery not available in some tertiary paediatric centres. A transparent and supportive environment for discussing challenging cases or those that have not gone well already seems to be present within specialities. Often lessons of relevance to all can be learnt from these cases and so presentation of them to the audit meetings could be useful to all.

If there are concerns regarding outcomes of a childs care, these can firstly be taken up with the surgeon themselves who will in almost all cases provide the additional information needed to explain the deviance in outcome. Concerns beyond this point can be discussed with the Clinical Director for that specialty as the ideal first port of call or Dr Mike Tremlett.

Mortality

Elective

Thankfully, deaths following elective surgery are very rare. There are clear processes in place, led by our Paediatric colleagues, should this occur. The order is as follows:

1. In house review – those involved in the case will meet to discuss all aspects of the childs care. This could raise a range of issues which compounded the event with clear aims of improving the service and learning from the event if there are areas highlighted
    a. The NCEPOD report highlighted the need for this discussion to occur within the first month with a clearly documented summary in the clinical notes as to the cause of death and information gleaned from the discussions.
2. Child Death Review Panel – this panel meet to review the report submitted from the in house review. They invite relevant clinicians and other parties (e.g. school, social worker, psychiatric team) to attend for a discussion of the case
3. Local Children Safeguarding Board – they report to the government on any child death and have the remit (and ability) to remedy situations which led to the death (e.g. railings along roadsides to reduce cyclist injury). They will decide if a childs death is expected or not –expected.