

**M5 - THE SYSTEMS SET UP BY THOSE MANAGING
PAEDIATRIC CARDIAC SURGICAL SERVICES AT THE
BRI, TO ENSURE**

**(A) A REVIEW OF THE OUTCOME OF INDIVIDUAL
CASES; AND**

**(B) REVIEW OF THE OUTCOME OF SERIES OF
CASES.**

INTRODUCTION

The practice of audit within paediatric cardiac surgery was set up by the clinicians in that area and it was done on the basis of their interest, enthusiasm and commitment, not because of any management requirement. In this group there were cardiologists, radiologists, pathologists, anaesthetists and surgeons. The practice evolved and developed from the years prior to 1984 and throughout the period under review. Whether implicitly or explicitly there was always a desire both to review individual cases or sub groups of cases, as well as large series and the totality of patients operated on. The goal was always to improve the quality of the Service being offered.

The following audit activities took place within the paediatric cardiological and cardiac surgical service during all or part of the period under review by this Inquiry. I offer this in response to Mr Whitehurst's letter of August 6th, 1999.

1. CARDIAC SURGICAL AUDIT -

Cardiac Surgical Audit was formally instituted in 1990/91 in response to the White Paper. However, it evolved from pre existing activities which had been labelled educational but which did involve a significant element of audit. All the cardiac surgical staff, junior and

senior, attended this meeting which occurred once a month in term time. Initially it took place within our educational programme, later audit had its own programme and occupied two hours in whichever half-day it was timetabled. To begin with there was no minute of the meeting; a record of the meeting was made by the Sub-Directorate Audit Convenor which was submitted to the Trust Audit Committee.

The most common method of presentation of data was for each consultant's registrar to present the work of the previous month and to draw particular attention to any patients where there had been death or serious complication. This led to a discussion of those events which sought to establish whether any modification of clinical practice would be beneficial. Specific topics were also audited such as wound infection. The annual statistics were usually presented to this meeting for discussion.

In this forum there was emphasis on the review of individual cases, but series of patients were reviewed when 'topics' were audited, or annual statistics presented.

2. PAEDIATRIC CARDIOLOGICAL AUDIT

Paediatric cardiological audit was an activity undertaken principally by the paediatric cardiologists and paediatric cardiac surgeons together with the radiologists, the nurses, the catheter lab technicians and anaesthetists when they were able to attend; thus it was always multi-disciplinary in character. The meeting was once a month at lunchtime for about an hour and a half and in general a topic was reviewed. A record was made of the meetings by the Audit Convenor for Paediatric Cardiology and submitted to the Trust Audit Committee. The topics presented would include such items as the results of surgery for total anomalous pulmonary venous drainage, results of operations on children in the first year of life, and of course included cardiological topics and not only surgical ones. Following the publication of the contents of a paediatric cardiological audit in Private Eye, this audit programme lapsed for a time.