Royal College of Anaesthetists

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Dear Mr Irvine,

Re: Regulation 28: Report to Prevent Future Deaths in the matter of Surekha Pandharinath Shivalkar [redacted]

Thank you for giving the Royal College of Anaesthetists (RCoA) the opportunity to respond to your Regulation 28 Report highlighting your concerns regarding preoperative risk assessment and poor communication between the surgical team and the anaesthetist. We have based our response on the limited information available to us in your report; due to the limited information available we cannot comment on whether there is any further national learning that can be gained from this tragic case. We note that Mrs Shivalkar's death took place in September 2018 and new national guidance, detailed below, relevant to your concerns has been published since then. Our response is based on the current guidance, rather than that which was in place when Mrs Shivalkar died.

Your report noted the delay in transfer due to the remote location. Mrs Shivalkar's operation took place in a facility the RCoA would deem as a remote site. We define any location where general or regional anaesthesia is administered away from the main theatre suite and/or anaesthetic department, within or distant from the base hospital, as a remote site. The RCoA's Anaesthesia Clinical Services Accreditation (ACSA) standards set out in standard 1.1.2.1 that departments should have "policies for the anaesthetic management, including preoperative assessment, of adults and children in remote sites." It goes on to state that these should "include reference to how help will be summoned in an emergency." We do not have sufficient information to comment on whether there were appropriate mechanisms in place for the anaesthetist to summon help from colleagues or whether the prolonged period of hypotension was not deemed sufficient reason to utilise available mechanisms to summon assistance.

It would be expected that the remote policy would outline how patients would be triaged at preassessment to determine whether it is appropriate for the patient's operation to take place at that site. The Perioperative Quality Improvement Programme (PQIP) set a standard for all patients having major surgery to have an individualised risk assessment and identified individualised risk

assessment as one of the top five national improvement priorities in its 2017-18 and 2018-19 reports. Individualised risk assessments facilitate shared decision making and open discussion of risks between surgeons, anaesthetists and patients, as well as planning appropriate perioperative care.

In June 2021, the Centre for Perioperative Care, in partnership with many other organisations, published "Preoperative Assessment and Optimisation for Adult Surgery". This guidance was endorsed by the RCoA and clearly articulates recommendations for risk scoring and patient selection for enhanced care, critical care and surgical hubs:

- "All patients who are being considered for a surgical intervention should have their individualised risk assessed using objective measures, combined with senior, experienced clinical judgement."
- "A risk model which provides an estimate of mortality (rather than simply a score), which has been validated on UK patients and which combines patient health with magnitude and urgency of surgery is recommended: for example, the Surgical Outcome Risk Tool (SORT) and SORT-clinical judgement models (www.sortsurgery.com)"

The guidance goes on to recommend that "patients with >1% mortality risk should only be considered for surgical hubs if enhanced care facilities and access to critical care and/or perioperative medicine services are available on site." This recommendation would apply equally to any remote site.

Your report also commented that "poor communication between the orthopaedic surgical team and the anaesthetist led to a collective failure to identify a critically ill patient." Non-technical skills, which include clear communication and good multidisciplinary team working, are a core part of our curriculum for anaesthetists in training. We also recommend in our Guidelines for the Provision of Anaesthetic Services: The Good Department that "simulation-based learning techniques should be used to assist the department and organisation to identify areas of existing positive practice and areas requiring improvement, as well as supporting the development of technical and non-technical skills." The Academy of Medical Royal Colleges also highlighted the importance of clinical simulation for non-technical skills training in their report "Multi-professional team-working: The experience and lessons from COVID-19" (October 2021). Regular, multidisciplinary team training is one of the standards for our ACSA scheme. However, in practice, it is a standard that many departments find difficult to meet to an adequate level due to the pressure on theatre time.

In order to ensure that the clear guidance outlined above is embedded into practice we will:

1. Promote the use of individualised risk assessment scoring tools through our accreditation scheme and communication networks in partnership with other stakeholders, such as the Centre for Perioperative Care
2. Work with the Royal College of Surgeons of England and the Centre for Perioperative Care to develop common guidance on risk assessment, communication and the joint management of complex cases
3. Promote the use of simulation-based learning techniques to support the development of non-technical skills as part of the RCoA's Simulation Strategy
4. Work with stakeholders to highlight the importance of theatre teams having sufficient time to undertake essential multidisciplinary team training.

5. Work with the Centre for Perioperative Care and the Care Quality Commission to define perioperative care standards.

We hope that this action will satisfy you that we are taking appropriate steps to ensure that anaesthetists are aware of these issues, and that these steps should make future, similar tragedies less likely to occur.

We would be happy to respond to any questions that you might have.

Yours Sincerely

[redacted]

Dr [redacted]
President
Royal College of Anaesthetists