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## The patient, public and lay perspective



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*“Ultimately it’s the patient who takes the risk.”*

A comment made by a member of the NAP7 panel puts this whole project in context and Emma’s lived experience ([Chapter 1 Patient experience](#)) explains how it feels to be that person taking the risk.

### The patient, public and lay perspective

Perioperative cardiac arrest is a scary time for everyone involved. Clinicians may only rarely be involved in a perioperative cardiac arrest, if ever, and it can be a very traumatic experience. Although central to the event, the patient themselves may well be unaware or have little or no recollection of experiencing a perioperative cardiac arrest.

We have valued the opportunity to provide lay input to NAP7. Our role is to listen, question, comment and continually remind ‘the experts’ that the patient and their family are central to the improvements that NAP7 is aiming to make. We may not understand all the technical details but we are in the ideal position to see ‘the big picture’ and ‘ask the dumb questions’, so contributing to an improved outcome.

### Patient expectations prior to surgery

We know that 65% of patients have a fear of ‘not waking up’ and have lots of questions for the anaesthetist (Mavridou 2013). Patients preparing for a planned operation will have many concerns, alongside the continuing challenges of living with their condition. Most immediate may be:

- How long is the waiting list?
- Will the operation work?
- Could my operation be cancelled or delayed?
- Will I be in pain when I wake up?
- How long till I can go home?
- When can my family visit?
- and many more.

Patients who have emergency surgery will have similar concerns, although some may be more immediately experienced by friends and families.

Furthermore, everyone involved – patients and their families, anaesthetists, surgeons, other healthcare professionals and indeed the general public – all have a right to expect a robust organisational and governance structure, alongside an appropriate culture, which will maximise the likelihood of a successful outcome.

Patients and their families expect that the clinical staff looking after them will work as a cohesive team, be sufficient in number, training and experience and, when appropriate, be suitably supported and supervised by more senior colleagues. It is important to patients and their families that members of the clinical team feel valued, supported and able to achieve a good work–life balance.

Patients and their families will expect to receive a consistent high level of care, experience and outcome, whenever and wherever their operation happens, including time of day, day of the week, NHS or independent sector, north, south, east or west, integrated or standalone units. We welcome the recent publication of updated National Safety Standards for Invasive Procedures as a valuable resource in achieving this aim (Centre for Perioperative Care 2023).

### The bigger context – shared decision making about opting for surgery or not

It is a given that all the patients in NAP7 have had or intended to have a procedure while being cared for by an anaesthetist. However, for patients and their families, the initial decision whether or not to go ahead with the procedure is fundamental, although outside the scope of NAP7. In making this decision, patients need information both about the risks related to the

procedure and anaesthetic, but also, and very importantly, patients need to understand what is likely to happen if they decide not to have the procedure:

- The likely progress of their disease or condition
- Their future quality and quantity of life, especially pain and which activities they will still be able to do
- The eventual outcome and, for those patients with life threatening conditions, the nature of their end of life.

Our hope and expectation is that the decision whether or not to go ahead with any treatment will be given increased attention as a key aspect of holistic patient care, alongside the improvements we anticipate from NAP7.

## Lay members' experience of NAP7

As full members of the NAP7 steering group and panel during case reviews, we have been involved in almost all of the group meetings and review panels looking at individual case reports of perioperative arrests over a 12-month period ([Chapter 6 Methods](#)).

Our experience has been of a rigorous and comprehensive evaluation. Strong points included the number and variety of panel members: anaesthetists, anaesthesia associates, surgeons, trainee anaesthetists and fellows and lay representatives. All areas of clinical and research expertise were represented, from paediatrics through to frail elderly patients, and a wide range of specialties, including, cardiac, intensive care, neurology, obstetrics, vascular, and many more. There was good geographical representation and several members had experience of previous NAPs.

The COVID-19 pandemic delayed the start of data collection for 12 months; however, the opportunity was taken to formally track and document the impact of COVID-19 on anaesthesia ([Chapter 7 COVID-19](#)). NAP7 was digitalised and although this was a big challenge, we are confident that the benefits of this process will be carried through to future NAPs. All submissions were completed and submitted online and the majority of project team meetings were held online, saving time and costs and enabling good debate of case reports. All documents were held on Microsoft SharePoint®, ensuring good governance once we all became comfortable with using the software.

## Learning from NAP7

The specialty chapters of this report describe in detail the clinical findings and recommendations from NAP7. Below are our observations from participating and listening as lay members, including what we see as essential for safe and effective practice, issues of potential concern and our recommendations for further action.

## Lack of information from the independent sector

We are disappointed that only limited input was received from the independent sector. This means that NAP7 is unable to make meaningful comparisons between patient experience and outcomes in NHS and independent hospitals. However, patients and their families considering surgery should be made aware of these observations as they are equally applicable to both NHS and independent healthcare settings.

## What is necessary for safe and effective patient care?

- A strong governance and organisational structure.
- A culture of caring, communication, learning and accountability.
- Sufficient and well-trained staff of the appropriate skill mix, who feel valued and supported.
- Timely shared decision making, involving patient/carers, surgeon and anaesthetist.
- An effective and well communicated plan for what to do when things go wrong: always remembering that *it is the patient who takes the biggest risk* and it is they and their family whose lives will change for ever if there is a poor or catastrophic outcome.

## Potential risks to be considered in advance of surgery

- Lone anaesthetists – for whatever reason.
- Isolated units, geographical or time wise, where support is not immediately available.
- Potential reduced services overnight, at weekends and bank holidays.
- Adequate medical provisions in case things go against you (eg appropriate blood availability).
- Patient transfer from anaesthetic room to theatre, to recovery and between units.
- NHS patients receiving care in the independent sector.
- Patients who are frail or elderly and those with special needs.

## Recommendations for further study

- Involvement of orthogeriatricians.
- 'Do not attempt cardiopulmonary resuscitation' recommendations – discussion prior to surgery, including suspension if appropriate.
- Communication between surgeons and anaesthetists.
- Choice of hospital in light of individual patient risk assessment.
- Empowering patients and all the clinical team to challenge 'the medical line' when necessary.
- Issues related to hospitals spread over more than one site.

- Transferability of NHS data to private and independent hospitals and between NHS organisations.
- Decision making between local and general anaesthesia and patient involvement, including the decision whether or not to go ahead with a procedure.
- When guidance is not followed and why (eg monitoring, Anaesthesia Clinical Services Accreditation standards, risk assessment, cost pressures, finishing the list, delaying surgery and taking short cuts).
- Workforce plan.
- Effective clinical transfer of patients between departments and hospitals. We have heard of three cases where the transfer notes were not referenced or read by the receiving department.
- Ensuring that clinicians communicate effectively and patients understand the level of risk, including referring patients to RCoA guidance which explains risk in layman's language. To reiterate, ultimately, the patient is taking all the risk and should be provided with all the necessary data and time to properly consent.

### Our biggest concerns

- All aspects of workforce planning and implementation.
- Getting preassessment right to avoid delays and complications later – at the right time for the right patients and with an enquiring and inclusive approach.
- Standards and recommendations should apply equally to the independent sector, although the sector has not contributed sufficiently to this report, which is a real concern to us.
- The patient's family must always be a priority and kept well informed and supported, particularly when things go wrong.
- Ensuring patients and families are empowered to challenge the 'medical line' when necessary.

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## References

Mavridou 2013: Mavridou P, Dimitriou V, Manataki A et al. 2013. Patient's anxiety and fear of anesthesia: effect of gender, age, education, and previous experience of anesthesia. A survey of 400 patients. J Anesth 27: 104–8.

Centre for Perioperative Care 2023: National Safety Standards for Invasive Procedures 2 (NatSSIPs). London: Centre for Perioperative Care. <https://cpoc.org.uk/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips> (accessed 20 May 2023).