SUMMARY

The benefits of day surgery were reviewed in the Audit Commission's report in 1990, *A Short Cut to Better Services: Day Surgery in England and Wales*. That report was based on visits to 11 District Health Authorities and analysis of computer data from 54 districts in four Regional Health Authorities. It was argued that a major expansion of day surgery was possible, at no cost to the quality of care. Local audits of day surgery followed in over 180 districts, each culminating in a report to the Health Authority or Trust Board.

The aggregated results of these local audits give a more comprehensive, up-to-date and reliable picture of the current state of day surgery. This report is published in parallel with the Royal College of Surgeons revision of its *Guidelines for Day Surgery*. Both publications provide updated information for managers and clinicians which can be used to develop day surgery services.

The audits showed that 95,000 patients in England and Wales could be treated as day cases rather than in-patients if all hospitals achieved minimum, conservative target proportions of day surgery. These targets were based on levels already being achieved by 25% of districts for 20 common procedures. Using alternative targets based on expert medical opinion of what is safely achievable, the number of patients who could be transferred to day surgery increased to 214,000. Both figures are higher than the estimates made in *A Short Cut to Better Services* and are derived from more accurate data. They confirm the earlier assessment that considerable further progress could be made.

To achieve these changes, the first requirement is appropriate day surgery facilities. Yet 25% of districts have no proper facilities for day surgery, and in such cases this should become an investment priority. There is already evidence that this is happening, and recently the government announced an increase in capital funding which is partly to be targeted at hospitals setting up day surgery units.

The remaining 75% of districts do have dedicated day surgery facilities, but the local audits revealed that these are significantly underused. Nearly all day surgery units have sufficient spare capacity for the extra patients that the audit results show to be feasible.

Improvement in the organisation and management of services will go a long way to optimising use of capacity. Services appear to be used more effi-
ciently if the day surgery is carried out in a dedicated operating theatre. Only a third of units have such an arrangement, but it should be a goal for all provider units.

Quality of care must not be compromised as day surgery activity increases. Many things can be done to improve patient selection and the information given to patients, both of which auditors often reported as being inadequate.

Monitoring the quality of the results is equally important. There should be systematic appraisal not just of the clinical outcome, but of the subsequent need for community and primary care services, and of the patients' views of their treatment.

Knowledge of potential day surgery activity levels will be valuable to purchasers who may try to negotiate a commitment to day surgery in contracts. More importantly, purchasers are in a position to raise quality by setting minimum standards for the care of day surgery patients.

INTRODUCTION

1 In October 1990 the Audit Commission published a report on day surgery, A Short Cut to Better Services: Day Surgery in England and Wales (Ref. 1). This confirmed the widespread opinion that day surgery is preferable to in-patient admission for appropriate procedures and properly selected patients.

2 Day surgery benefits patients through reduced waiting times, booked appointments, and care in dedicated facilities. It is also a more efficient use of resources; the cost of treating a patient who goes home the same day is less than if the same patient stays overnight in hospital.

3 The 1990 report identified several problems which have contributed to the slow uptake of day surgery in England and Wales:
   — lack of data to compare and monitor day surgery activity
   — lack of dedicated day surgery facilities
   — inefficient and ineffective use of facilities
   — clinicians' preferences for more traditional methods of treatment

4 Another problem, the risk for managers that more day surgery will result in an overall increase in activity within cash-limited budgets, should no longer exist. The recent health service reforms enable provider units to contract to receive more income if they treat more patients, especially for elective surgery.

THE AUDITS

5 Over the past year, audits have been carried out in most District Health Authorities in England and Wales. Auditors have followed a methodology, documented in the Commission's Day Surgery Audit Guide (Ref. 2) to:
   — assess day surgery activity
   — estimate the scope for treating increased numbers of patients in this way
   — look at the facilities available for day surgery patients
   — determine professionals' attitudes to day surgery
   — consider management arrangements for day surgery
   — investigate the organisation and running of dedicated day surgery units
   — assess whether spare capacity in such units is sufficient for the potential increase in activity

6 The Audit Commission identified a 'basket' of 20 common surgical procedures which account for about 40% of all surgery in the seven specialties represented and are considered to be suitable for day surgery when patients are properly selected. The procedures formed the basis of an assessment of day surgery activity and the potential for more day surgery.

7 Auditors were trained to collect data for this 'basket' of procedures from operating theatre registers, because of the doubts about the accuracy of routine procedure coding (Ref. 1). They then classified patients as day-cases or in-patients using hospital admission and discharge data.

8 Interviews were carried out with consultant surgeons, anaesthetists and managers. In hospitals with units dedicated to day surgery, data were collected on throughput of patients. Auditors interviewed sisters and other nursing staff responsible for caring for day surgery patients and running the facilities.

9 This publication brings together data from 187 audits and presents a comprehensive view of day surgery services in England and Wales.

10 Where there was more than one large acute unit in a district, they were frequently audited together. However, hospitals with Trust status were invariably treated separately.
11. The audits have increased our understanding of the problems identified in the first report, and provided further examples of good practice used to overcome them.

12. The paper is in four sections:

Section I describes day surgery activity for the 'basket' of 20 procedures and discusses the variation found by auditors.

Section II discusses the organisation and management of day surgery services as described in the audit reports.

Section III looks at quality of service and highlights areas where improvements can be made.

Section IV suggests a way forward as a result of a critical analysis of the audit returns.

13. This report is launched at the same time as the Royal College of Surgeons updated guidelines for day surgery (Ref. 3).

16. The upper quartile is an appropriate benchmark for setting targets for day surgery. For example, a quarter of hospitals carry out 49% or more of their laparoscopies as day cases – a realistic target for the others (Exhibit 2). Upper quartiles have been calculated for each 'basket' procedure, based on data collected in the audits. They can be found in the Appendix together with detailed profiles like those in Exhibit 1.

17. Although the audit did not involve looking at the use of day surgery by individual consultant surgeons, auditors were aware of considerable variation and noted that for some procedures – particularly inguinal hernia repair and cataract extraction – a high proportion of day surgery was very often due to the practice of a single consultant.

18. The pattern of variation in the use of day surgery changes with the age of
the patients (Exhibit 3). Targets should therefore be set separately for each age group.

Particularly wide variation in the amount of activity in the 0-15 age group confirms reports of consultant interviews where the case for treating children as day cases was often either challenged or supported with considerable strength. There is no overriding reason why day surgery should be any less suitable for children than for adults. Indeed, a recent report (Ref. 4) expresses the view that it is even more suitable for children, for whom it is especially important to minimise the time spent in hospital.

Exhibit 3
DAY SURGERY ACTIVITY FOR CYSTOSCOPY
The pattern of variation in the use of day surgery changes with the age of the patients.

POTENTIAL INCREASES IN DAY SURGERY
20 In each audit the percentage of patients treated as day cases in the three age groups for each procedure was compared with both:
— upper quartile percentages using interim computer data from 54 districts: the ‘conservative’ benchmark
— day surgery percentages reached by enthusiasts, reported in the literature and achieved in other countries: the ‘optimistic’ benchmark

21 This comparison enabled calculation of the potential number of existing in-patient treatments that could be carried out as day cases if either the ‘conservative’ or ‘optimistic’ benchmarks were achieved. The total of these for all 20 ‘basket’ procedures gives each district a realistic target.

22 Data from 187 audits identify a total of 95,000 cases which could be transferred from in-patient to day surgery, if conservative targets were reached; or 214,000 for the optimistic targets. And this is just for the 20 procedures examined by the auditors. Further transfers could almost certainly be made for other procedures.

SUMMARY MEASURES OF PERFORMANCE
23 The Audit Commission developed a District Standardised Performance Measure (DSPM) as an audit tool to give an overall measure of provider unit activity based on the ‘basket’ of 20 procedures. As well as case mix, the DSPM took into account the ages of the patients.

24 Auditors used the DSPM mainly to rank districts. It has proved to be of limited value because:
— it is difficult to interpret without knowing about performance for the constituent procedures. This problem applies to other summary measures including those in the Department of Health’s Health Service Indicators.
— it is of no value when setting targets, which should be based on individual procedures and age-group categories. This approach to target setting has been recommended in all audit reports.
— it is limited to the 20 procedures looked at by the Audit Commission and will not be useful as a standard for comparison when, as expected, providers develop their
own 'baskets'. With diverse 'baskets', overall comparisons or rankings will be meaningless.

2. ORGANISATION AND MANAGEMENT OF SERVICES

25 In some authorities, additional capital investment is required to achieve the potential identified in the audits. This is particularly true in those authorities with no facilities dedicated to day surgery. Also, in authorities where the capacity of an existing unit cannot accommodate higher levels of day surgery, investment will be needed to enlarge the unit. In most authorities, however, improving the way existing facilities are organised and managed will be sufficient to achieve the identified scope for more day surgery.

26 This section first summarises the facilities auditors found. It then examines the capacity available and the efficiency with which it is used. Finally, management arrangements are discussed.

FACILITIES

DAY SURGERY UNITS

27 Most hospitals have a dedicated ward or ward with theatre attached as their main day surgery facility (Exhibit 4). All units are sited in or next to a general in-patient hospital in contrast to practice in the USA where stand-alone units are common.

28 Auditors observed great variation in the structure, design and layout of day surgery facilities. All of these can have a marked effect on the efficiency and comfort with which patients progress through the unit. Units that have been custom-built rather than converted from existing facilities tend to have been planned with such factors in mind. Although there are also many excellent conversions some will have been forced into compromises by the structure of the original buildings. (Exhibit 5, overleaf).

DISTRICTS WITHOUT DEDICATED FACILITIES

29 Twenty-five per cent of hospitals have no dedicated day surgery facilities. Some have plans to open units in 2 or 3 years' time in which case auditors have recommended interim measures so that day surgery levels can improve immediately. Wards which can be converted to day wards are almost always available.

30 New units are usually planned on the basis of allocation of sessions to consultants rather than on the number and type of procedures to be carried out. Audit reports give estimates of the achievable volume of day surgery work for the 'basket' of procedures and these can be used as a starting point to plan units of the right size. In one small authority, plans for a 20 bed unit were questioned after the audit identified a need for a dedicated ward of only 5 beds. As well as assisting with capacity calculations, auditors have also been able to pass on good practice advice concerning the day-to-day running of day surgery facilities.

31 At least a third of hospitals use 5-day wards open 24 hours a day, 5 days a week to accommodate day surgery patients. Many managers and consultants think that they are an acceptable alternative to using in-patient beds for the same purpose. But such practice does not result in the same quality of care and efficiency gains, and a 5-day ward cannot be considered a viable, long-term alternative to a dedicated unit.

32 Auditors often found that patients requiring 'basket' procedures were admitted to in-patient or 5-day wards the day before their operation. Another frequent finding was of consultants considering patients to be day cases simply because they went home the same day as their operation even

Exhibit 4
DAY SURGERY UNITS
Most hospitals have facilities dedicated to day surgery.

No dedicated facility
39%
Day surgery unit with theatre in main suite
6%
Day surgery unit with attached theatre
30%
Ward only
25%

Number of audits = 173

Source: Audit data
Exhibit 5

DESCRIPTIONS OF TWO DAY SURGERY UNITS
The design of a day surgery unit can affect patient care.

WELL PLANNED UNIT

The unit has its own reception area, nursing and administrative offices, staff changing and rest rooms, visitor lounge with television and refreshments, operating theatre, anaesthetic room, recovery area and ward. Patients use trolley beds and follow a simple circular route through the unit, minimising patient handling and transport.

POORLY PLANNED UNIT

The patient is admitted by the Admission Office near the entrance to the Hospital. Queuing delays are common. Patients walk the long distance to the day surgery ward. After medical assessment and tests the patient is taken to theatre which may be on another floor some distance away.

Source: Quotes from local audit reports

though there was no firm, prior intention to treat them as day cases.

33 Evidence shows that in such cases there is little incentive to adopt strict patient selection and discharge routines. Consequently both the patient and the hospital suffer: patients because they receive poor information and hospitals because patients who have not arranged to be collected have to spend the night in hospital although it is clinically unnecessary. Auditors often found high ‘stay-in’ rates for day surgery patients treated on 5-day wards. A sister on one ward estimated that almost half of all patients intended to be day cases were kept in overnight.

CAPACITY AND EFFICIENCY
THE EFFICIENCY WITH WHICH UNITS ARE USED

34 A frequent audit finding was that existing day surgery units are able to accommodate the potential increase in activity assessed for the ‘basket’ procedures, and still have spare capacity for other appropriate day cases. This is invariably true for conservative estimates of potential increase and only two units have so far been identified as having insufficient spare capacity to accommodate the optimistic estimates.

35 Therefore, in the short to medium term there is no major capital investment necessary where facilities already exist, unless ward-only units are to have an integral theatre added. In the long-term, managers will need to consider expansion based on targets and on consultants’ success in meeting them.

36 The Audit Commission's good practice benchmark is a throughput of
EXAM PLES OF PROCEDURES THAT DO NOT NEED, BUT OFTEN OCCUPY, A PLACE IN A DAY SURGERY UNIT:

- Upper gastrointestinal endoscopy
- Varicose vein injection
- Haemorrhoid injection
- Cervical laser treatment
- Ear syringeing
- Minor 'lump and bump' removal
- Minor pain relief
- Minor dental procedures

Full details of these and other similar procedures can be found in the Audit Guide/Data Collection File for Day Surgery (Ref. 2).

Source: Audit data

346 patients per bed per year. This is based on an assumption of approximately 1.5 patients per bed per day for 240 days per year. Few units achieve this level and their shortfall has been used as a measure of spare capacity.

37 Some procedures do not require the full facilities of a dedicated day surgery unit. They can be adequately performed in special facilities such as endoscopy rooms or sometimes even in out-patients (Box A). If patients requiring these procedures are excluded from the analysis, then throughputs are even lower and spare capacity correspondingly greater (Exhibit 6). This adjustment was made using data on the mix of procedures carried out in each day surgery unit.

38 Endoscopy can present a particular problem for day surgery units. Many units are used frequently for such patients, which is satisfactory as long as the ability to do more appropriate day cases is not constrained. As day surgery increases, monitoring will be essential to provide the information needed to maintain optimum use of resources. If capacity is limited because of endoscopy patients, consideration should be given to separating the two activities. Dedicated gastrointestinal endoscopy suites are recommended by The British Society Of Gastroenterology (Ref. 5).

REASONS FOR VARIATION IN THROUGHPUT

39 The appropriateness of the procedures carried out in a day surgery unit will affect the unit's throughput, as will the mix of day and half-day cases. Units where more patients undergo major day surgery procedures such as those in the 'basket', predictably have lower throughputs.

40 In units with dedicated theatres, throughput is usually higher than in units consisting of only a ward (Exhibit 7, overleaf). Fully integrated units make it easier for consultants to dedicate lists and improvements in organisation and management are easier to achieve.

41 As well as these reasons which relate to the types of procedures performed or the facilities available, audit reports suggest that many other factors can be responsible for the under-utilisation of units:

Preference for in-patient wards for day surgery patients. Some consultants prefer to admit day surgery patients to their in-patient beds because they perceive the day
Exhibit 7
THROUGHPUT IN UNITS WITH AND WITHOUT AN ATTACHED THEATRE
Throughput is higher in units with dedicated theatres.

Source: Audit reports

surgery unit to be badly staffed, organised or managed.

Inappropriate allocation of sessions or beds. Sessions and beds are usually allocated as a result of demand. The day surgery facility is perceived as 'available to consultants for day cases' rather than as an integral part of a properly managed service.

Some consultants told auditors that they would like access to beds or theatre time in the unit. But when those responsible for allocating sessions or beds were interviewed, they were unaware of this unmet demand. This could be solved by establishing clear communication lines and routine monitoring of session and bed use.

Preference for full-day admission. Some consultants are reluctant to admit any surgical patient for half a day. This is understandable if more complex procedures are being performed so that patients need a longer recovery period. But general anaesthesia alone, regardless of the procedure, is not a sufficient reason for avoiding half-day admission. In the best units, doing large numbers of 'basket' procedures, it is not unusual for both morning and afternoon general anaesthetic sessions to take place.

Restricted theatre time and mixed operating lists. When main theatres are used for day cases, theatre time may be a scarcer resource than beds. If so, beds will be underused.

Dedicated day surgery lists would help to alleviate the problem, but auditors found very few examples of consultants organising their work in this way. The reason usually given was that their day surgery workload is relatively light and does not warrant a regular dedicated day-case list.

A rotating list or shared list, successfully used by some consultants, helps to make best use of both theatre and ward. At one site, some consultants have pooled their day surgery lists with the result that dedicated sessions are fully used.

Inefficient booking procedures. Appointments for day surgery patients are often managed by individual consultants or their secretaries. Consequently no-one has an overall view of the use of the unit, or the responsibility for ensuring that it is used to capacity at all times.

This problem can be overcome if members of staff in the day surgery unit are delegated the tasks of booking appointments and calling up patients on waiting lists when there are unexpected places.

42 These reasons for under-utilisation highlight the need for well-managed, custom designed facilities if full advantage is to be taken of day surgery. Mixing day cases with in-patients, either on wards or in theatres, is likely to be disruptive and unsatisfactory for both patients and staff.

MANAGEMENT ARRANGEMENTS
LEADERSHIP

43 When there is a Director of day surgery he or she is usually a consultant surgeon or anaesthetist. This is appropriate to the tasks involved and the authority they need to carry with their colleagues. As more surgery is performed on a day case basis, this position will become increasingly important. Very few provider units remunerate consultants for their day surgery management role. (Exhibit 8). Those which do usually pay consultants for one half-day session (3.5 hours) per week.
Exhibit 8
DIRECTORS OF DAY SURGERY
32% of day surgery units have a consultant director of day surgery, less than a third of whom have paid sessions allocated to the task.

32%

Consultant Director

26%

Consultant Director with paid session

6%

No Director

5%

Director other than Consultant

Number of day surgery units = 168

Source: Audit Reports

44 The importance of the focus which a good Director provides cannot be over-emphasised. And yet most units do not have one. Directors are problem solvers for management issues, receive performance reports and act as convenors for users to agree policies and guidelines. They can also be instrumental in encouraging change at a local level amongst the consultant staff. In some cases, Directors were appointed as auditors took place and at one site the new Director acted as a focus for a discussion about appropriate procedures for the day surgery unit. The result was an agreed policy not to admit patients to the unit for unsuitable minor procedures.

45 Where a provider unit extends over more than one site, a Director of Day Surgery can take an overview of services and ensure consistency in policies and patient management across sites.

46 Sisters on day surgery units have, for the most part, a specific managerial role with responsibility for day-to-day running of units. Sometimes, however, they reported problems arising because:

- important duties, for example discharge of patients, are not formally delegated or acknowledged. Delegation assists with the smooth running of patient care but must be within the framework of criteria which have been agreed and documented in an operational policy
- they have no clearly defined forum where their experience and views about day surgery services can be expressed and taken into account. Nurses in day surgery units are in a prime position to recognise quickly any short-comings of the service and their input to decision-making is invaluable

OPERATIONAL POLICIES

47 It is usual for an operational policy to be written when a day surgery unit opens and auditors confirmed that most units have a policy. However, examples of good policies were rarely reported because few include all the important details relevant to running a unit, such as patient selection, suitable procedures and staff responsibilities. The problem is compounded because few policies have been updated since they were first written.

STAFF IN DAY SURGERY UNITS

48 The Audit Commission has not recommended nurse staffing levels for day surgery units because there are many local factors such as staff availability and layout of wards which determine appropriate levels.

49 If a unit has an attached operating theatre, nurses do not have to transport patients long distances to theatre suites. Similarly, if a unit employs clerical staff, nurses are spared some administrative tasks.

50 A recent study found that other professionals in a hospital perceived day surgery work as low status (Ref. 6). Nevertheless audit reports confirm low turnover and high levels of morale amongst nurses and other staff working in well-run day surgery units.

51 Even in dedicated units which are properly managed and staffed, the quality of the service provided can vary greatly. The next section discusses some audit findings which shed light on quality of care.

3. QUALITY OF SERVICE

52 A number of factors contributes to the quality of service received by day surgery patients. The main ones raised in the audit reports were selection and assessment of patients, information for patients, treatment outcome and patients' views.

SELECTION AND ASSESSMENT OF PATIENTS

53 Selecting suitable patients is essential if they are not to be refused
treatment on the day of their operation or to have to stay in hospital overnight after it. Cancelling the treatment of a patient who has turned up is poor quality care for that patient and inefficient – another patient on the waiting list could have been treated. If a day surgery patient has to stay overnight, a bed is blocked and possibly another in-patient cancelled. Auditors frequently reported disruption to the day surgery routine because of cancellations which were the result of unsatisfactory patient selection. All of these problems are avoidable.

Use of a standard questionnaire leads to the early identification of patients who may be unsuitable for day surgery for medical or social reasons. Many units do not have such a questionnaire because consultants and anaesthetists have not discussed and agreed guidelines for patient suitability. The result is that key people in the treatment of day surgery patients have different selection criteria and, inevitably, details which should be checked at the outset are overlooked until the last minute.

The Royal College of Surgeons new guidelines include a proforma for assessing patients which is recommended either for immediate use or as a starting point for units which want to develop their own.

More often than not, patients are assessed by consultants in out-patient departments where time constraints prevent a thorough evaluation of their suitability. There appears to be a reluctance to delegate this responsibility to nurses on the day unit who could carry out the assessment on the same day as the out-patient consultation.

When criteria are understood and agreed, nurses are able to assess patients properly and they often have more time to identify the less obvious problems. In units where assessment is delegated, improvements in the service have been quickly identified by both consultants and nurses.

INFORMATION FOR PATIENTS

There is a dearth of good quality written information as well as a common belief that detailed information specifically for day surgery patients is unnecessary. Giving patients the standard admission details is often thought to be sufficient. However, these would not include information specific to the procedure being undertaken, and sometimes do not even give clear directions on the location of the day surgery unit.

Poor information leads to such problems as patients arriving late, or having had something to eat or drink, making them unsuitable for general anaesthetic. Although staff accept that occasional lapses in understanding will occur, many units have minimised problems by giving patients detailed written information, backed up orally.

If patients do not attend for treatment, one of the reasons can be because they have not been given proper, written information. Did-Not-Attend (DNA) rates need not exceed 5%, but in half of the units for which information is available, higher rates were reported (Exhibit 9). High DNA rates result in wasted resources.

The Department of Health's Value for Money Unit in its recent report Day Surgery: Making it Happen (Ref. 7) contains many examples of good patient information which units can use as a starting point in developing their own. Just for the Day (Ref. 4) also contains examples of good information for children.

OUTCOME

'STAY-IN' RATES

The stay-in rate, or percentage of planned day-case patients who are...
mitted overnight, should not be higher than 1% but in many units it is (Exhibit 10). Auditors report that where stay-in rates are higher than 1%, it is often in units where it is easy to keep patients in overnight, and so the intention for many of the patients is not really to treat by day surgery.

62 When patients are kept in on good clinical grounds it is nearly always because they are not fully recovered from procedures, for example cataract extraction, are seen the next day either in the home or at the hospital. But only a few units routinely use community nurses for all such patients. Where the use of routine community follow-up has been monitored it has been found unnecessary and has usually been discontinued.

65 Despite this, some consultants cite a lack of services for community fol-

Exhibit 10
'STAY-IN' RATES IN DAY SURGERY UNITS
Some units have high levels of 'stay-in' rates for day surgery patients

<table>
<thead>
<tr>
<th>Number of units</th>
<th>% of patients who stay in overnight</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>1%</td>
</tr>
<tr>
<td>14</td>
<td>2%</td>
</tr>
<tr>
<td>12</td>
<td>3%</td>
</tr>
<tr>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>8</td>
<td>5%</td>
</tr>
<tr>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>0</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: Audit Reports

the anaesthetic. Consultants and nurses blame this on bad scheduling rather than on patients being selected who were unsuitable for day surgery.

63 Wards which close early invariably have problems because patients are not ready to go home. In one, a stay-in rate of 18% was attributed to this cause.

COMMUNITY FOLLOW-UP

64 No units routinely follow-up all day surgery patients after discharge. Arrangements are nearly always made for children to be seen post-operatively and patients undergoing certain low-up as their main reason for not performing more complex procedures as day cases. Where this is the case, managers should consider resourcing a community service as encouragement. The use of such a service should be closely monitored to provide information about its continuing value.

66 General practitioners should be consulted about planned increases in activity. If they express concern about increased demand on their practices and practice staff, including nurses, monitoring arrangements should be made.

67 One auditor carried out a postal survey of all general practitioners in a district which had seen a recent rise in day surgery activity following the opening of a new unit. Almost half of the general practitioners responded and their comments were very positive. They reported that the increase in day surgery had had only a slight effect on their workload.

CLINICAL AUDIT

68 Auditors confirmed that, at current levels, most consultants consider that the clinical outcome of day surgery is the same as for in-patients. But some consultants are still concerned about the quality of clinical outcome.

69 There was no strong evidence that day surgery is the subject of multi-disciplinary clinical audit but this could be one way of informing and reassuring consultants who have such concerns.

PATIENTS' VIEWS

70 Auditors report that some day surgery units have carried out surveys to find out what patients think about the treatment they receive. Data from such surveys can provide valuable information to managers, clinicians and nursing staff who are involved in providing the service and planning its future.

71 Monitoring patients' views should be on-going and the Audit Commission's patient perception questionnaire is now available as a tool for professionals to learn about the patients' point of view (Ref. 8), together with microcomputer software to assist with the analysis. To date, 39 day surgery units are using the questionnaire.
4. THE WAY FORWARD

72 In general, the attitudes of consultants, managers and nurses are positive. However, day surgery has developed, in all but a handful of places, in an ad hoc fashion with very little co-ordination of effort or standardisation of policies and procedures. Often the result is a poor service and this report has concentrated on some of the reasons why. To ensure the delivery of a high quality service in the future, both providers and purchasers of day surgery can act to improve patient care.

PROVIDERS

73 Managers of provider units have a responsibility, together with consultants, to deliver efficient and effective day surgery services. Recent publications (Ref. 1,4,7,8) together with this report and the Royal College of Surgeons updated guidelines, should provide sufficient building blocks to achieve a complete, well-managed service. In addition, the local auditor's report is available in most districts.

DEVELOPING A STRATEGY

74 Auditors reported that the development of day surgery can be hampered by the lack of a strategy agreed by both managers and clinicians. Whether to treat more patients or make financial savings – and this essentially means closing a ward – together with decisions about targets for day surgery, are issues that require resolution at the local level.

75 Substituting day surgery for in-patient capacity to treat more patients, resulting in an increased workload. Consultants must be involved in decision-making if they are to co-operate in achieving targets.

76 In spite of widespread clinical support for day surgery, a minority of consultants still feel that it is being pursued only as a cost-cutting exercise. One way to overcome the problem is to agree that at least some of the resources released as a result of increased day surgery activity are made available to the specialties making the change, for investment in ways decided by the clinicians.

PROVIDING A SERVICE

77 Making resources available for day surgery is necessary if the service is to keep up with changes in techniques, technology and activity. Managers should be sure that:
- suitable facilities are available
- a comprehensive operational policy is agreed
- systems are in place for setting, monitoring and reviewing targets
- consultants take part in continuing professional development programmes leading to acquisition of appropriate skills and knowledge

CONSIDERING PATIENTS FOR DAY SURGERY

78 For individual consultants to change their approach to day surgery, the first step is to consider all patients as candidates for day surgery. Assessing patients' suitability, both medically and socially comes next.

79 At one site the auditor reported that 'the specialties using the Day-Case Unit routinely consider patients for day surgery and will only admit them as in-patients if there are good medical or social reasons.' Consultants will be more likely to consider all patients if they have first agreed procedure-based targets for day surgery.

80 Monitoring the reasons why patients are unsuitable is essential if day surgery targets are to be realistic and achievable. Setting low targets as a result of monitoring information about selection, outcome and patient satisfaction is acceptable; achieving only low activity because of failure even to consider patients for day surgery, is not.

USERS GROUPS

81 It is not unusual for problems, especially those associated with patient selection and patient information, to have been identified by different groups in the hospital. Clinicians, anesthetists and nurses often agree that there is no forum for views to be aired and solutions found. Established groups, Theatre Users for example, are frequently used for discussing day surgery issues. This can be unsatisfactory because not all members of such groups have an interest; other topics take precedence and communication is hampered.

82 Day Surgery Users Groups are effective in provider units which have them, and managers can play a key role in ensuring that there is such a forum for discussing day surgery issues.

PURCHASERS

STIPULATING DAY SURGERY IN CONTRACTS

83 For purchasing authorities and fund-holding general practitioners, the cost of treatment for patients requiring
elective surgery is important. Both should find a properly delivered day surgery service the preferred alternative for suitable patients. If purchasers wish to stipulate day surgery in the contracts they place with providers, data such as those presented in the audits will provide a useful starting point.

At the time of the audits no provider unit was reported to be setting day surgery targets by specific procedures (although some were planning to do this) and no purchasing authority had stipulated day cases in its contracts. Both providers and purchasers should work together to agree how, if at all, day surgery treatment is best written into contracts.

The lower cost of treating a particular condition on a day basis will be increasingly attractive to purchasing authorities, but only if quality of care is not compromised. Purchasers have a strong incentive to increase day surgery activity not only to increase cost-effectiveness, but also because they can more easily stipulate and monitor the quality of service in day surgery units.

ROLE OF REGIONS

PROVIDING CAPITAL

Although audits identified one or two hospitals with high levels of day surgery despite not having dedicated facilities, such practice is inefficient. Also, the quality of patient care is difficult to maintain when there are no dedicated facilities or staff. In districts where there are no facilities dedicated to day surgery, Regional Health Authorities should expect an increase in demand for capital to provide them. Recent increases in capital funding for the NHS included a specific element to be targeted at hospitals setting up day surgery units.

AUDITING DATA

Accurate data are essential. Auditors found many examples of inaccurate manual and computer records, incomplete theatre registers and confusing ward diaries. In particular, patients who had been admitted and discharged on the same day were sometimes categorised as in-patients because of a failure to record the intention to treat them as day cases. Auditors were able to analyse the problem, take it into account and comment on it, but it is unlikely that data routinely used by managers would be subject to such scrutiny. Improving this situation could be enhanced by regional initiatives.

Inter-district comparisons, made in this report on the basis of manually collected data, will only be obtainable in future from computer records. Regional Health Authorities should be instrumental in ensuring they are available, complete and accurate.

ROLE OF ROYAL COLLEGES

The Royal College of Surgeons has positively endorsed day surgery, both in 1985 and now again in its revised guidelines. All Royal Colleges can now play an active role by:

- ensuring that clinicians carrying out surgical and investigative procedures have access to adequate training and professional development
- setting appropriate technical standards as equipment and techniques develop
- monitoring the quality of patient care by proposing systems for clinical audit

REFERENCES

3. Guidelines for Day Surgery, Royal College of Surgeons, 1992
5. Provision of Gastrointestinal Endoscopy and Related Services for a District General Hospital, The British Society of Gastroenterology, 1990
7. Day Surgery, Making it Happen, Department of Health Value for Money Unit, 1991
APPENDIX

The following pages give details of day surgery activity procedure by procedure obtained from data collected in the audits.

INGUINAL HERNIA REPAIR

<table>
<thead>
<tr>
<th>Number of audits</th>
<th>Number of audits</th>
<th>Number of audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
</tr>
<tr>
<td>% as day cases (0-15 years)</td>
<td>% as day cases (16-84 years)</td>
<td>% as day cases (65 years and over)</td>
</tr>
<tr>
<td>Median 20%</td>
<td>Median 2%</td>
<td>Median 0%</td>
</tr>
<tr>
<td>Upper Quartile 47%</td>
<td>Upper Quartile 6%</td>
<td>Upper Quartile 2%</td>
</tr>
</tbody>
</table>

EXCISION OF BREAST LUMP

<table>
<thead>
<tr>
<th>Number of audits</th>
<th>Number of audits</th>
<th>Number of audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
</tr>
</tbody>
</table>
| % as day cases (16-84 years) | % as day cases (65 years and over) |%
| Median 28% | Median 8% | Median 50% |
| Upper Quartile 50% | Upper Quartile 20% | Upper Quartile 75% |

ANAL FISSURE EXCISION

<table>
<thead>
<tr>
<th>Number of audits</th>
<th>Number of audits</th>
<th>Number of audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
</tr>
</tbody>
</table>
| % as day cases (16-84 years) | % as day cases (65 years and over) |%
| Median 53% | Median 50% | Median 53% |
| Upper Quartile 75% | Upper Quartile 82% | Upper Quartile 75% |

Audits with less than 10 cases (inpatients and day cases) in any age group have been excluded from that histogram. Histograms are not shown where the procedure is either unknown or very rare for the given age group.

Where relevant, the data have been divided according to patients' ages into 3 groups: 0-15 yrs; 16-64 yrs; and 65 yrs and over.

For combined age groups:

<table>
<thead>
<tr>
<th>Median</th>
<th>Upper Quartile</th>
<th>n(patients)</th>
<th>n(audits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>11%</td>
<td>23,613</td>
<td>186</td>
</tr>
<tr>
<td>27%</td>
<td>44%</td>
<td>14,609</td>
<td>186</td>
</tr>
<tr>
<td>47%</td>
<td>68%</td>
<td>4,476</td>
<td>158</td>
</tr>
</tbody>
</table>
VARICOSE VEIN STRIPPING OR LIGATION

For combined age groups:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Median</th>
<th>Upper Quartile</th>
<th>n(patients)</th>
<th>n(audits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicose Vein Stripping</td>
<td>6%</td>
<td>23%</td>
<td>15,645</td>
<td>184</td>
</tr>
</tbody>
</table>

CYSTOSCOPY, DIAGNOSTIC AND OPERATIVE

For combined age groups:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Median</th>
<th>Upper Quartile</th>
<th>n(patients)</th>
<th>n(audits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystoscopy</td>
<td>55%</td>
<td>67%</td>
<td>56,413</td>
<td>186</td>
</tr>
</tbody>
</table>

CIRCUMCISION

For combined age groups:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Median</th>
<th>Upper Quartile</th>
<th>n(patients)</th>
<th>n(audits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumcision</td>
<td>34%</td>
<td>55%</td>
<td>10,680</td>
<td>186</td>
</tr>
</tbody>
</table>
EXCISION OF DUPUYTREN'S CONTRACTURE

For combined age groups:
- Median: 8%
- Upper Quartile: 28%
- n(patients): 3,124
- n(audits): 133

CARPAL TUNNEL DECOMPRESSION

For combined age groups:
- Median: 68%
- Upper Quartile: 81%
- n(patients): 6,254
- n(audits): 174

ARTHROSCOPY, DIAGNOSTIC AND OPERATIVE

For combined age groups:
- Median: 37%
- Upper Quartile: 59%
- n(patients): 18,867
- n(audits): 180
EXCISION OF GANGLION

For combined age groups:
- Median = 72%
- Upper Quartile = 83%
- n(patients) = 3,924
- n(audits) = 166

Median 77%
Upper Quartile 87%

ORCHIDOPEXY

For combined age groups:
- Median = 9%
- Upper Quartile = 32%
- n(patients) = 3,704
- n(audits) = 160

Median 9%
Upper Quartile 39%

CATARACT EXTRACTION, WITH OR WITHOUT IMPLANT

For combined age groups:
- Median = 1%
- Upper Quartile = 7%
- n(patients) = 27,746
- n(audits) = 129

Median 0%
Upper Quartile 4%

Median 1%
Upper Quartile 7%
CORRECTION OF SQUINT

For combined age groups:
- Median = 0%
- Upper Quartile = 12%
- n(patients) = 4,242
- n(audits) = 124

MYRINGOTOMY, WITH OR WITHOUT INSERTION OF GROMMETS

For combined age groups:
- Median = 62%
- Upper Quartile = 82%
- n(patients) = 15,044
- n(audits) = 152

SUB MUCOUS RESECTION

For combined age groups:
- Median = 4%
- Upper Quartile = 13%
- n(patients) = 8,528
- n(audits) = 143
REDUCTION OF NASAL FRACTURE

For combined age groups:
- Median: 55%
- Upper Quartile: 80%
- n (patients): 3,500
- n (audits): 124

Number of audits

Median 76%
Upper Quartile: 87%

OPERATION FOR 'BAT' EARS

For combined age groups:
- Median: 14%
- Upper Quartile: 37%
- n (patients): 1,307
- n (audits): 33

Number of audits

Median 2%
Upper Quartile: 8%

DILATATION AND CURETTAGE

For combined age groups:
- Median: 50%
- Upper Quartile: 66%
- n (patients): 49,656
- n (audits): 182

Number of audits

Median 52%
Upper Quartile: 69%

Median 8%
Upper Quartile: 20%
LAPAROSCOPY WITH OR WITHOUT STERILIZATION

For combined age groups:

<table>
<thead>
<tr>
<th>Median</th>
<th>Upper Quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>19%</td>
<td>49%</td>
</tr>
</tbody>
</table>

n(patients) = 33,567
n(audits) = 182

TERMINATION OF PREGNANCY

For combined age groups:

<table>
<thead>
<tr>
<th>Median</th>
<th>Upper Quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>59%</td>
<td>80%</td>
</tr>
</tbody>
</table>

n(patients) = 24,630
n(audits) = 172