Delivering day surgery as 'the default'

There is a need for day surgery to become the default pathway, wherever possible, but the message must be communicated early on and there needs to be a better understanding of which types of procedures can be performed. The British Association of Day Surgery argues that hospitals need to adopt an 'inclusion' rather than an 'exclusion' philosophy.

The British Association of Day Surgery recently hosted a series of virtual conferences highlighting the need to move to day case surgery as the 'default' position, wherever possible. As NHS Trusts battle with a backlog of elective surgery, in the wake of the pandemic, day case pathways will be key to NHS recovery. However, avoiding hospital stays and sending patients home on the same day offers other important benefits – both in terms of patient satisfaction, reducing the risk of healthcare-associated infections, and improving outcomes.

Dr. Mary Stocker, past president of BADS, and consultant anaesthetist and recent director of Torbay's Day Surgery Unit, addressed some of the misconceptions with regards to 'what constitutes day case surgery', providing an insight into which patients are eligible, the types of procedures that can be performed, and the key considerations to ensure successful outcomes.

Speaking at *Day Case Major Knee Surgery: ACL reconstructions to Total Knee replacements*, she commented: "Initially day case surgery was 'a planned procedure', but it isn't just about elective surgery anymore," she commented. "We are trying to push more and more urgent surgery into the day case arena."[1]

She pointed out that day case surgery must be the 'intention' in order to meet the definition: "If a procedure is not planned as a day case, it does not count as a day case," she explained, adding that the term "23-hour stay" does not refer to day surgery. To be a day case the patient must be admitted, operated upon and discharged on same calendar day.

Dr. Stocker emphasised that it is important that booking, pre-op assessment, admission, surgery and discharge are managed by a dedicated day surgery team, in order to achieve high quality outcomes. She outlined the pathway as follows:

- GP referral for procedure
- Surgical outpatient appointment
- Patient Selection
- Booking
- Pre op assessment
- Admission
- Surgery
- Discharge
- Recovery at home

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Dr. Stocker went on to highlight the *BADS directory of procedures* which lists over 200 procedures that can now be performed as day case surgeries.[2] However, she raised the question: 'how much awareness is there at the start of the pathway of the types of procedures that can be performed?'

She pointed out that raising awareness among GPs is vital to ensure that primary care colleagues know which procedures can be considered for day case surgery and that they communicate the 'day surgery message' early on to patients.

"GPs need to know that hip replacement, knee surgery and hysterectomies can be performed as day cases, otherwise the GP might tell the patient they are referring them for surgery and they are likely to be in hospital for three days. The patient will then have this expectation and, once they have this in their mind, this is what is likely to happen," said Dr. Stocker. Effective communication with primary care colleagues is therefore required to ensure GPs know which patients are ▶

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appropriate and that they ensure the patient is 'fit to be referred' – including diabetes management, for example.

She pointed out that the situation is very similar with surgical outpatient clinics. "We need to ensure all of our surgical colleagues are singing from the same hymn sheet. They need to know which procedures are suitable; which patients are appropriate; and they need to recognise when a patient may require optimisation before listing. They also need to reinforce the day surgery message," she explained.

"We want the surgeon to confirm day case management intention and default suitable procedures to day case surgery. It is also important to remember, that if a patient is not fit for day surgery, they are probably not fit for elective surgery. Patients need to be optimised to get them as fit as they can possibly be, to ensure they are considered appropriate," Dr. Stocker continued.

In 2001, the Audit Commission's 'Basket of Procedures' listed 25 procedures that could be performed as day case surgery, but Dr. Stocker pointed out that a great deal has changed since then; today, the following surgical criteria need to be considered:

- Can the patient be reasonably expected to manage oral nutrition post-operatively?
- Can the pain of the procedure be managed by simple oral analgesia supplemented by regional anaesthetic techniques?
- Is there a low risk of significant immediate post-operative complications (eg catastrophic bleeding)?
- Is the patient expected to mobilise with aid post-operatively?

She advised that surgical teams should evaluate existing inpatient procedures with a short length of stay, then consider: what would we need to change in the pathway to enable them to become a day case?

"Traditionally, we were told that procedures lasting longer than 60 minutes shouldn't be undertaken as a day case, but this has changed," she commented, highlighting findings by Skues (2011)[3], which showed no statistical difference in unplanned admissions following day-case procedures lasting less than 60 minutes, compared to procedures lasting greater than 60 minutes.

Dr. Stocker added that the US has been ahead of the UK for some time – procedures lasting 3-4 hours are now routinely performed on an ambulatory basis.[4]

She pointed out that nearly ALL surgery should be day or very short stay, and this now includes fairly complex surgery, such as:

- laparoscopic nephrectomy
- prostatectomy
- laparoscopic hysterectomy
- vaginal hysterectomy
- thyroidectomy
- mastectomy
- shoulder surgery
- anterior cruciate ligament
- lumbar discectomy
- abdominoplasty

With the publication of the *Sixth Edition of the BADS Directory of Procedures*[2], the list has been extended even further to include more complex surgery such as:

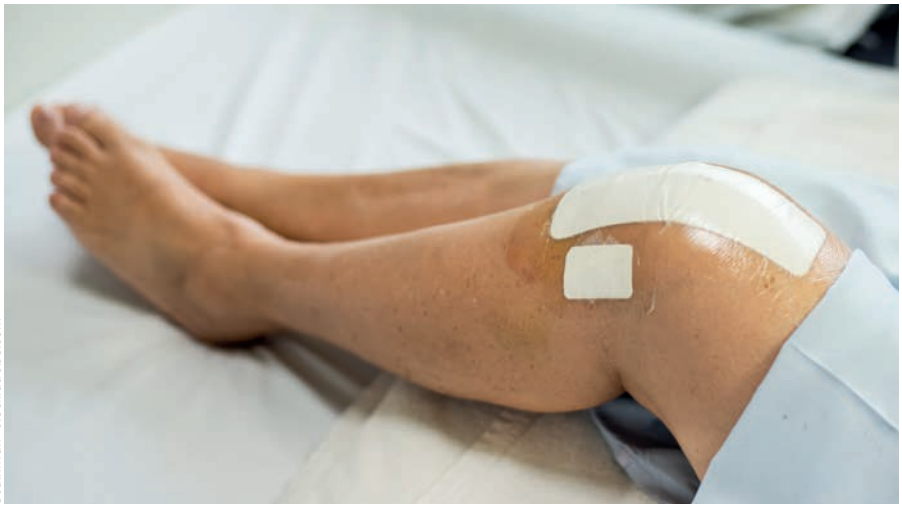
- Craniotomy
- Caesarean Section
- Joint Replacements
- Carotid Endarterectomy
- Endovascular Aneurysm Repairs
- Emergency Procedures

She pointed out that day surgery has come a long way since the early 90s – within gynaecology, day case units have moved from performing hysteroscopies to undertaking hysterectomies; within orthopaedics, they have moved from arthroscopy to uni-chondylar knee replacements/total hip replacements; and, in head and neck surgery, they have moved from tonsillectomy to thyroidectomy.

When deciding which patients are eligible, surgical teams need to consider: are the patient's risks increased in any way by treatment on a day stay basis and would management be different if he/she were admitted as an inpatient? If the answer is 'no', the patient is probably suitable for day surgery.

Other considerations include social factors. What about patients who live alone? Are all procedures equal and does everyone require a carer? In the past, patients who lived alone had to be treated as inpatients, but this is now changing.

The Torbay Model provides carers into patients' homes if they live alone, while the Norwich Model allows some patients home without carers after certain procedures, but they must have someone to safely escort them home. Both pathways have now been in place for a number of years, have resulted in excellent patient satisfaction and no adverse outcomes, and



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are endorsed by BADS and the Royal College of Anaesthetists.[5]

Dr. Stocker pointed out that distance from hospital is rarely a problem even in rural areas. It is important to remember that the patient only needs to be one hour from a hospital that can treat the condition, not necessarily the operating hospital. She added that the vast majority of patients are socially appropriate for day surgery or can be enabled to be so with proactive management. She went on to discuss the medical factors that require consideration. However, in the 1980s and early 1990s, the Royal College of Surgeons of England's selection criteria included an age limit of 65-70 years, ASA I & II, BMI<30 and stipulated that the maximum operating time should be 60 minutes. In 2002, the Department of Health announced that "patients should only be excluded from day surgery if a full pre-operative assessment shows a contraindication."

"Our population is getting larger and older, so we have to think differently, and we do," commented Dr. Stocker. "There is now no limit for ASA for day surgery. The elderly are actively encouraged to be day cases and are much better managed through the day surgery pathway, as are patients with morbid obesity and specific conditions – such as sleep apnoea and insulin dependent diabetes – as we find they come to less harm," she continued. In terms of ASA, most stable medical conditions can reasonably be managed as a day case; most patients with unstable medical conditions should not be undergoing elective surgery – they need to be optimised and brought back onto the day case pathway.

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Dr. Stocker went on to discuss patients with diabetes. The *AAGBI Guidelines for management of peri-operative diabetes* (2015)[6] stated that "Glycaemic control should be checked at the time of referral for surgery".

Patients must have their diabetes stabilised; HbA1c should be < 69 mmol. mol 1 in the previous three months. If HbA1c is ≥ 69 mmol.mol 1, elective surgery should be delayed while control is improved, then the patient can proceed ▶

with day surgery. Dr. Stocker pointed out that surgery on patients with HbA1c of ≥ 69 mmol.mol 1 is associated with a significant increase in perioperative complications, so optimisation is really important. However, she added that "by managing diabetic patients in hospital, we often do them a disservice. Diabetic patients are usually better at managing their own diabetes than we are."

Elderly patients are also often better managed in their own environment. According to a report from the National Audit Office (2019), the average 67-year-old admitted to hospital loses 5% loss of muscle strength per day. Ten days in hospital reduces lung capacity by 12%, hip and knee muscle strength by 14% and life expectancy by 10 years.

Dr. Stocker said that there is particular hesitation around treating obese patients as day cases, but most potential complications of obesity are limited to the intra- and immediate post-operative environment, so these patients can still be managed as a day case.[7]

Even morbidly obese patients can be safely managed in expert hands, with appropriate resources. These patients benefit from the short duration anaesthetic techniques and early mobilisation associated with day surgery. In addition, day surgery arguably reduces risk of DVT and infection.[8]

However, she acknowledged that: "everything is more difficult and takes longer" when managing obese patients, so it may not be appropriate for surgery to take place at an isolated site. Senior staff will be required, along with additional kit (including for the airway, long instruments and a special table etc.)

In summary, Dr. Stocker called for hospitals to adopt an inclusion rather than an exclusion philosophy. Surgical teams should apply limitations to the procedure rather than the patient. Day surgery should take place in dedicated facilities, for the entire pathway if possible. The unit should be protected at all costs from "inpatient sabotage" and staffed by nurses with day surgery expertise.

"Some of the best day surgery units across the country have been brought to their knees, where medical patients have been accepted into beds on the unit – some patients may be there for ten months of the year, which stops day surgery from continuing.

"The solution is trolleys. The day surgery unit should have no beds, no showers and only simple catering facilities. There should be no capacity to accept an inpatient," commented Dr. Stocker.

She added that day surgery performed using inpatient wards and inpatient operating theatres is less successful and is not recommended, therefore – the rate for unsuccessful discharge of patients home, on the day of surgery, rises from 2.4% in a free standing unit to 14% in an inpatient ward.

Concluding, Dr. Stocker urged delegates to plan the pathway at every stage to ensure intended day surgery management and emphasised that all appropriate patients should be managed as day cases.

She called on surgical teams to "embrace the BADS directory" – social care and medical conditions are rarely an issue. All hospitals should measure their day case rates by procedure against national targets and monitor this against their peers. CSJ

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The British Association of Day Surgery

The British Association of Day Surgery (BADS) is a multidisciplinary organisation, promoting excellence and enhancing education in the delivery of day surgery. To support the delivery of day surgery, BADS has published a '*National Day Surgery Delivery Pack*', developed in collaboration with GIRFT and The Centre for Perioperative Care, Royal College of Anaesthetists, which outlines best practice. To access this, visit: www.gettingitrightfirsttime.co.uk/wp-content/uploads/2020/10/National-Day-Surgery-Delivery-Pack_Sept2020_final.pdf To access the BADS Directory of Procedures 6th Edition, visit: https://publications.bads.co.uk/bads-directory-of-procedures-6th-edition-1-p.asp

Dr. Mary Stocker

Mary read chemistry at Oxford University, including research into novel approaches towards drug design; subsequently she worked as a research chemist in the pharmaceutical industry. In 1990, she turned her hand to medicine, qualifying from Bristol University. Her anaesthetic training was undertaken in the South West with a year at the University of Virginia, US. She now works in Torbay as a consultant anaesthetist.

Since 2004, she has been director of day surgery for South Devon Healthcare Trust, one of the national leading Trusts for day surgery in terms of innovation, day case rates and the quality of patient outcomes. She has developed training modules in day surgery for medical students and anaesthetic trainees and a training course for nurses undertaking day surgery preoperative assessment. She worked with the Royal College of Anaesthetists to produce an e-learning package in pharmacology. She has published widely in the day surgery literature and authored a number of book chapters on the subject. Mary has been a member of the council of the British Association of Day Surgery for 10 years, their conference secretary for three years and president from 2016-2019.