# Day Case First: National Day Surgery Delivery Pack

September 2024, Version 2.0


GIRFT is part of an aligned set of programmes within NHS England

# Foreword

Expanding day surgery safely is key to elective recovery and has clear benefits for patients, staff and services. This document sets out why, what, who and how this can be delivered. Increasing day surgery can be highly efficient and cost-effective because it reduces the burden of staffing highly skilled out-of-hours rotas. More patients having surgery as day cases would not only help reduce long waits for patients having planned surgical care but would also reduce the demand for beds for patients waiting for emergency surgery.

While significant progress has been made in terms of expanding day surgery since this guide was originally published there remains further opportunity to increase and broaden day case surgery across England. Therefore, the Getting It Right First Time (GIRFT) programme has worked in collaboration with the British Association of Day Surgery (BADS) and the Centre for Perioperative Care (CPOC) to update this guidance to support trusts and systems to maximise use of day case surgery.

The pack highlights the importance of considering the day surgery pathway from the point of referral for surgery, and that the involvement of a multidisciplinary team, including managers, focussed on day case principles is vital to ensure successful delivery of day surgery. Embedding the actions and principles described in the pack will enable healthcare professionals to deliver best practice in day surgery and efficient use of resources, which will help to ensure good outcomes and a positive experience for patients.

We urge clinical, administrative and managerial colleagues to adopt this guidance which will be invaluable in supporting effective, safe and high-quality day case surgery.

Now is the time to consider day surgery as the default option.

***Professor Tim Briggs CBE***
GIRFT Programme Chair
NHS England National Director for Clinical Improvement and Elective Recovery

***Mr David Bunting***
President, British Association of Day Surgery

***Dr David Selwyn***
Director, Centre for Perioperative Care

# Contents

# Executive Summary

Developed by Getting It Right First Time (GIRFT), with input from the Centre for Perioperative Care (CPOC) and the British Association of Day Surgery (BADS), this guide is designed to enable NHS trusts to expand and increase day case surgery, for both elective and non-elective care, for the benefit of patients and the wider healthcare system.

CPOC is a cross-specialty collaboration dedicated to the promotion, advancement and development of perioperative care for the benefit of patients at all stages of their surgical journey. It is a partnership between eleven professional organisations and royal colleges.

BADS is a multidisciplinary professional organisation promoting excellence in and maximising the delivery of day surgery in the UK, including the setting of national benchmarks.

We recognise that not all principles are immediately realisable, and while serious consideration should be given to reconfiguration of hospital services to facilitate this, it is beyond the scope of this guide to address this issue and the associated funding required. Information within this guide should be used to optimise the delivery of day surgery services within existing environments to give all patients the opportunities and clinical outcomes which high-quality day surgery pathways provide.

This is the practical reference guide to help healthcare staff develop and deliver effective day surgery pathways aimed at improving patients' healthcare experience and health-related outcomes. Pathways from primary care attendance through to postoperative follow up should encompass health education, pre-optimisation, evidence-based clinical care, recording of outcome data, audit and service improvement.

Day surgery should be accepted as the major contributor to the future of surgical services but there is still wide variation in day surgery rates throughout England. Data from March - May 2024 shows that 83.9% of surgical procedures in the BADS Directory of Procedures within England are being undertaken as day cases or outpatient procedures (Model Health System), just shy of the 85%[1] expectation, with large variation between providers. It should be noted that the 85% day case rate target includes procedures undertaken in theatres as well as those performed in an appropriate outpatient setting.

[1] NHS England Priorities and operational planning guidance 2024/25.

Day surgery should be the default setting for all procedures identified by BADS. The list of procedures included in the BADS Directory of Procedures is continually growing and so there may be more procedures suitable to be considered as default to day case.

Furthermore, services should optimise the use of resources by moving some local anaesthetic procedures that can be safely and effectively delivered outside a theatre environment into an alternative setting such as an outpatient room, enhanced procedure room or community setting by following the principles of the Right Procedure, Right Place Programme. Taking this approach will help improve patient care and satisfaction, ensure best use of resources, improve efficiency, improve staff retention and morale and reduce the demand for inpatient beds. This expansion can only be achieved safely by following clear guidelines and creating good pathways aimed at improving quality.

## What is the guide's aim?

The guide provides practical advice to enable frontline staff, supported by administrative staff, clinical leaders, managers, and trusts to 'think day case first' to maximise day surgery in the most efficient way possible while ensuring high-quality day surgery and a good patient experience is delivered. It includes three main sections:

**Section 1: General principles for high-quality day case surgery in the UK** - addressing common misconceptions and making the case for expanding and increasing day case surgery, identifying variation in day case rates and addressing the areas of greatest opportunity identified by GIRFT and BADS.

**Section 2: The generic day case pathway** – the key components that can be applied to existing inpatient activity to convert to a day case approach, including essential information about the best practice management required for the delivery of a high-quality day surgery service and action checklists for each stage of the pathway.

**Section 3: Procedure specific best practice pathways** – examples of day case surgery procedures utilising 'default' day surgery pathways together with links to pathways and resources. In addition, links to resources contained in the Right Procedure, Right Place forum are provided to support moving procedures out of a theatre setting.

A separate appendix to the guide contains resources including protocols and templates.

## Key Actions

Throughout this pack best practice and actions to support an increase and improvement in day surgery are identified. The following actions are key to delivering change.

1. **Healthcare teams should develop day surgery pathways and ensure a 'default to day surgery' approach for all appropriate procedures (these can be found in The BADS Directory of Procedures).**
2. **Ensure all potential day surgery patients are listed and coded with a day surgery management intent and appropriately code procedures to capture accurate activity in benchmarking data (i.e. Model Health System (MHS) and The BADS Directory of Procedures and National Dataset).**
3. **Ensure preoperative assessment protocols for patient selection are inclusive rather than exclusive of day surgery.**
4. **Ensure all patients are given relevant advice on optimisation (exercise, nutrition, smoking cessation, alcohol reduction, psychological and practical preparation) – to improve their health and reduce their risk of complications.**
5. **Progress towards the development of dedicated day surgery units and teams, and establish a multidisciplinary day surgery management team.**
6. **Admit all day surgery patients to a dedicated admissions area.**
7. **Use day case operating trolleys rather than hospital beds.**
8. **Equip day surgery facilities with high-quality equipment.**
9. **Establish standardised protocols for anaesthesia, surgical techniques, perioperative analgesia and take-home medication.**
10. **Ensure that day surgery is a consultant or experienced Specialty and Associate Specialist delivered service, with clear training pathways for the future workforce.**
11. **Discharge day surgery patients through a dedicated day surgery ward staffed by nurses who are competent in day surgery discharge.**
12. **Ensure the day surgery unit has no capacity to accept inpatient activity and support this with a commitment from managerial teams to protect this policy even at times of escalation.**
13. **Have a process in place to support patients following discharge and to collect data on patient outcomes. This may include a telephone call the day after surgery.**
14. **Record and audit clinical and patient-reported outcomes in day surgery patients. Benchmark performance against the metrics produced by MHS which are based on The BADS Directory of Procedures and National Dataset.**

# General principles for High-Quality Day Surgery

## 1.1 Background to day case surgery in the UK

Over the past 20 years, numerous national initiatives have tried to improve day surgery performance in the UK and several organisations have emphasised the importance of day surgery being considered the default option for elective surgery. In 2019, the Academy of Medical Royal Colleges also strongly recommended that patients be given the option of day surgery wherever possible[2]. Shared decision making principles should underpin this approach to ensure that healthcare professionals and patients work together to reach a decision about surgery.

Day surgery brings benefits for patients and system-wide efficiencies relating to patient quality of care and experience, reduced waiting times, release of bed capacity and significant financial savings. Day surgery also supports the Greener NHS Programme, as one area of focus for carbon savings is reduced bed days.

While pockets of excellence exist across the UK, there remains significant variation in day surgery performance. Given the increasing demand versus capacity mismatch for surgical procedures, there is now further incentive to maximise the movement of procedures down the "intensity gradient" i.e., move all appropriate work away from inpatient pathways to a day surgery or outpatient/procedure room pathway.

### 1.1.1 Defining Day Surgery

**The patient is admitted and discharged on the same day, with day surgery as the intended management.[3]**

**Elective Procedures**: It is essential that the patient has intended management of day surgery when entered onto the hospital waiting list. Day surgery which occurs without being scheduled will not be counted in the trust's day case statistics. It is also likely to use hospital staff time and resources (i.e. beds), as the patient will often have an inpatient bed used or at least reserved for

[2] Choosing Wisely (2019) http://www.choosingwisely.co.uk/i-am-a-clinician/recommendations/
[3] Bailey, C.R., Bartholomew, S., Bew, L. et al (2019) Guidelines for day-case surgery 2019 Anaesthesia, Volume 74, Issue 6 https://doi.org/10.1111/anae.14639.

recovery. Best outcomes are achieved when the patient is prepared and expecting day surgery, when they and all the staff involved in their care are aware that the intended plan is for day surgery, and they follow a clear day case pathway.

**Emergency Surgery**: Many acute surgical conditions such as acute cholecystitis, appendicitis, ectopic pregnancy, and closed fractures can be treated as day cases if good pathways exist[4] [5]. For example, surgical assessment units or fracture clinics for shared decision making with consent and rapid nurse-led preoperative assessment (POA). Having access to 'hot clinics' or 'rapid access clinics' with a senior decision maker can reduce unwarranted admissions and allow for urgent day case surgery in some emergency presentations. For emergency ambulatory pathways, it is important to have clear coding which ensures that these procedures are correctly measured as day cases if undertaken on an ambulatory basis.

**Length of Stay**: In America the term "23-hour stay" is included within the day surgery remit. This is not the case in the UK and units which try to combine 23 hour stay wards with day surgery tend to have poorer day surgery processes. Reducing inpatient length of stay from two or three nights to one night is commendable, and often a useful progression towards day surgery management, but the process should be separated from day surgery activity. Combined units often send mixed messages to both patients and nursing staff regarding discharge criteria. Nursing staff may regard admission into an available overnight bed as an easier option rather than aiming for same day discharge.

### 1.1.2 Defining outpatient procedure activity

Outpatient activity is identified where activity is reported in the outpatient dataset, with a procedure that matches the BADS definitions in the Directory of Procedures.

### 1.1.3 Resources to Assist Choice of Surgical Procedure and Benchmark Data

The BADS Directory of Procedures and National Dataset currently lists 300 procedures suitable for day surgery. For each procedure a benchmark is set with a realistic day case rate. The rates quoted are arrived at by a combination of reported practice from leaders in their field, actual rates from Hospital Episode Statistics figures and expert opinion. This publication also contains

---

[4] Wei, N,. Baldock, T.E., Elamin-Ahmed, H. et al (2023) ORthopaedic trauma hospital outcomes - Patient operative delays (ORTHOPOD) Study: The management of day-case orthopaedic trauma in the United Kingdom. Injury Jun;54(6):1588-1594. DOI: 10.1016/j.injury.2023.03.032.

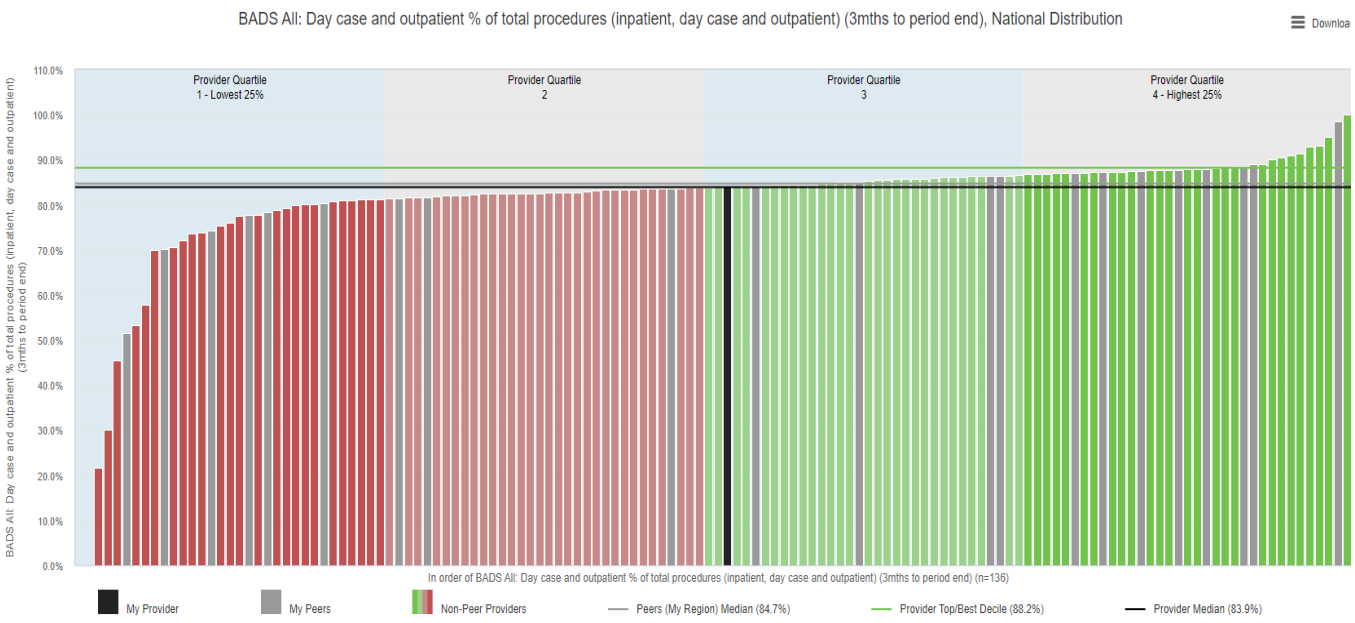
[5] BADS Surgical Same-Day Emergency Care 2nd Edition (2020).

data about the day surgery performance of the top achieving 5% and 50% of English hospitals for all the operations listed in the BADS Directory of Procedures and National Dataset[6], with the potential release of inpatient beds and cost savings achieved by maximising day case rates. The BADS dataset is produced in collaboration with Caspe Healthcare Knowledge Systems (CHKS) using their hospital benchmarking solution iCompare. The latter is a subscription-based benchmarking solution with metrics for the UK.

All NHS trusts should now be using Model Health System (MHS) which is a free data-driven improvement tool that enables NHS health systems and trusts in England to benchmark quality and productivity. The day cases and outpatient procedures compartment measures day case and outpatient procedure rates for all trusts in England for each procedure within the BADS Directory and ranks English trusts, and also provides specialty and organisational level totals. This enables identification of the top performing trusts and provides other trusts with opportunities to learn from best practice. A combination of national and local data should be used to support improvement of day surgery performance. There is still significant potential for expanding day case surgery. Figure 1 shows variation in combined day case and outpatient procedure rates across England (March - May 20244).

[6] NB: This dataset is produced in collaboration with Caspe Healthcare Knowledge Systems (CHKS) using their hospital benchmarking solution iCompare. The latter is a subscription-based benchmarking solution.

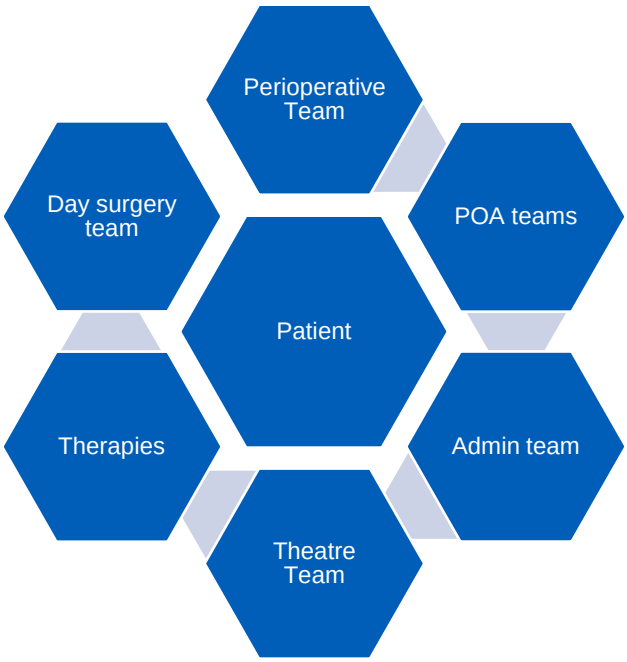
**Figure 1: BADS All: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period end), National Distribution (March - May 2024)**




A metric showing how many inpatient bed days could be released by increasing the rate of day cases and outpatient procedures is also available, along with a further metric that identifies potential opportunity to move activity to an outpatient setting. There are also metrics that highlight patients planned to be treated as a day case who subsequently required an overnight admission, and patients planned to stay overnight who went home on the same day. Both metrics can help identify opportunities to improve operational planning of day surgery.

## 1.2 Day Surgery Team

The contribution that the skills and competencies of the entire day surgery team, including the patient, make to the success of the day surgery pathway must not be underestimated.




Successful day surgery relies on patients being on a dedicated pathway throughout the whole surgical journey and being given a consistent day surgery message and setting patient expectations.

Day surgery patients cared for postoperatively alongside inpatients may receive mixed or even conflicting messages. Staff may be less confident discharging patients or be distracted from day surgery discharge by competing requirements to care for higher acuity patients. In this situation it is often (understandably) the day surgery patients whose needs are overlooked.

It is important to establish day surgery teams who are committed to driving service improvement. Training and support for the day surgery team and positive feedback and endorsement will ensure the day surgery service continues to develop.

### 1.2.1 Leadership

The day surgery team should be managed to enable collaborative and effective team working[7] as shown in figure 2.

**Figure 2**


The clinical lead should have a specific interest in day surgery and some managerial experience. They will be responsible for developing collaborative clinical guidelines and protocols for use within the day surgery pathways. For example:

- analgesia guideline
- anaesthetic guideline
- protocols for management of complex patients/procedures
- POA protocols.

They will also be responsible for working closely with the unit and operational managers to develop day surgery policies across the trust and working with surgical teams to implement new day case procedures.

[7] Academy of Medical Royal Colleges (2020) Developing professional identity in multi-professional teams

The management team should have overall responsibility for the entire day surgery process and pathways (even if it is not possible to deliver this through a dedicated unit) and be committed to the day surgery team. They will oversee staff in POA, admission, theatre, recovery and the day surgery ward/discharge team. They may also have responsibility for the administrative and clerical staff working as part of the day surgery team. Regular (weekly) meetings of the day surgery leadership team are essential for the smooth running of the unit and development of new initiatives.

### 1.2.2 Learning from Leading Units

There are a several infrastructure factors which result in successful day case surgery and are demonstrated within leading units in the UK:

- Strong consistent leadership with involvement of both the surgical and day surgery team.
- Dedicated facilities without inpatient beds, separated and protected from inpatient activity.
- Adoption of day surgery principles throughout the pathway.

Leading units have gained this position due to the competencies and experience developed within the day surgery unit teams over many years and willingness of surgical teams to embrace the potential for better outcomes that day surgery delivers.

It is important for the leaders to make time to talk with anaesthetists, surgeons, booking teams, POA teams and outpatient staff, in groups or individually. Many staff will feel peripheral to the day case surgery ethos, and some clinical staff may claim clinical autonomy that may detract from established procedures.

### 1.2.3 Day Case Surgery Facilities

Best practice for day surgery is, where possible, undertaking the entire day surgery process within a dedicated day case surgery unit.

Any future building developments should ensure that dedicated day surgery facilities are provided if possible. However, it is recognised that many trusts are limited by current estate configurations and in particular, location of operating theatres, meaning having an independent unit is not possible. In these cases, every attempt should be made to provide as much of the day surgery pathway through co-located dedicated day case facilities. Day surgery facilities should not contain any beds or facilities to enable overnight stay and should be located, where

possible, in an area geographically separate from inpatient wards. This not only encourages day surgery discharge but prevents medical overflow at times of escalation.

Dedicated day case surgery facilities have been recommended in the Anaesthesia and Perioperative Medicine GIRFT Programme National Specialty Report and by a variety of national organisations, for many years as shown below:

**Department of Health and Social Care**

*The ideal is a self-contained day surgery unit, with its own admission suite, wards, theatre and recovery area, together with administrative facilities. It is also the most cost-effective option.*

*Day surgery performed using inpatient wards and inpatient operating theatres is less successful and cannot be recommended*[8].

**Royal College of Anaesthetists**

*The ideal day surgery facility is a purpose built, self-contained, ring-fenced day surgery unit with its own preoperative, intraoperative and postoperative facilities. This unit may be contained within a main hospital or in its grounds to allow access to higher-level patient support services, if required, or it may be a freestanding unit remote from the main hospital site*[9].

**Association of Anaesthetists**

*Day surgery should take place within a dedicated unit or area within the main hospital site.*

*All members of the multidisciplinary team should be trained in day surgery practice.*

*Day case beds on wards do not provide the targeted service that is required to achieve good outcomes*[10].

[8] Department of Health (2002), Day Surgery Operational Guide: Waiting, booking and choice. (Archived)
[9] Royal College of Anaesthetists (2024) Guidelines for the Provision of Anaesthesia Services for Day Surgery
[10] Association of Anaethetists (2019) Guidelines for day case surgery 2019

**Competency**

- **Patients are cared for by staff with expertise in day surgery pathways**
- **The entire team are committed to high-quality day surgery outcomes**

**Patient Experience**

- **Separation from inpatient activity and the idea of having a bed, nightwear and "the sick role" results in an increased likelihood of successful day case discharge. "Everyone else is going home so I will too" encourages a positive attitude to day surgery.**
- **Dedicated day case units increase resilience through ensuring activity continues even during maximum escalation resulting in fewer cancellations.**

### Hospital Flow and Escalation

Trusts should do everything possible to avoid using the day surgery unit either for inpatient theatre cases or as an overflow area for emergency medical admissions during times of high pressure. Senior management and ideally board level support is required to ensure that this policy is respected and adhered to.

At times of escalation (e.g. winter pressures, Covid-19 pandemic) the day surgery unit is essential to maintain surgical activity when many cases are cancelled due to infrastructural pressures that include lack of bed capacity and workforce pressures. Transferring inpatient theatre activity into a day surgery unit will adversely affect the pathway and the ability of the unit to function efficiently. For example, in a day surgery unit a patient may expect to remain in primary recovery for 5-10 minutes postoperatively, enabling flow from theatres to primary recovery to proceed efficiently. If a patient needs to return to a ward postoperatively, they will require a longer period of stability in primary recovery before being considered as safe for discharge. There will also frequently be delays before the ward bed is available to accept the patient. Transfer to the ward requires accompaniment by a suitably qualified healthcare professional who will have to leave the unit for up to 30 minutes to undertake the transfer. In addition, the delays in clearing primary recovery result in theatre lists being stopped due to no capacity being available to recover future patients.

Movement of emergency inpatient beds into a day surgery unit results in the inability to proceed with day surgery activity. Trusts which have allowed their day units to be used in such a way have great difficulties with day surgery performance, staff morale and retention, resulting in successful day surgery services becoming underperforming units.

## 1.3 Surgical Same Day Emergency Care (SDEC)

Following the success of day surgery pathways for elective procedures an increasing number of units have introduced pathways for the management of common surgical emergency procedures. A significant proportion of acute surgical patients occupy hospital beds while waiting for minor or intermediate emergency procedures. These procedures are often delayed by major operations taking priority. The result is increased bed occupancy, unnecessary prolonged fasting and poor patient experience. There is wide variation in day surgery trauma provision and planning across the UK meaning there is significant opportunity to increase day surgery rates for this group[11].

The SDEC model has several benefits for patients including avoiding unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and de-conditioning. NHS England guidance on SDEC states that under this model of care, patients presenting at hospital with relevant conditions can be assessed, diagnosed, treated and discharged home the same day if clinically safe to do so, rather than being admitted to hospital.

The BADS Surgical Same-Day Emergency Care handbook states:

'The priorities of SDEC are to provide the surgical patient with a rapid diagnosis and management plan, with immediate discharge where possible, thereby enabling the patient to avoid an overnight inpatient stay in a hospital bed. Treatment may be operative or non-operative depending on the condition. In each case, these underlying principles of care should be provided in a management plan by a surgically qualified senior decision-maker: usually a consultant or experienced middle grade surgeon.'

**Key Questions**

1. Are additional investigations required for diagnosis? Can admission be avoided prior to diagnostics?
2. Does the patient have a diagnosis which requires surgery?
3. Is it safe to discharge the patient with analgesia to wait for a theatre slot?
4. Is there an opportunity for surgery today and day case discharge postoperatively?

[11] Wei, N., Baldock, T.E., Elamin-Ahmed, H., et al (2023) ORthopaedic trauma hospital outcomes - Patient operative delays (ORTHOPOD) Study: The management of day-case orthopaedic trauma in the United Kingdom. Injury Journal, 54(6): p1588 – 1594. DOI: https://doi.org/10.1016/j.injury.2023.03.032

In March 2024 BADS updated the emergency surgery section of The BADS Directory of Procedures.

**Table 1: Types of urgent surgery suitable to be undertaken as day case procedures or in a procedure room**

| Specialty | Procedure |
|---|---|
| General Surgery | • Suture of skin wound.<br>• Incision and drainage of skin abscess.<br>• Incision and drainage of perianal abscess.<br>• Emergency laparoscopic appendicectomy.<br>• Emergency open appendicectomy.<br>• Emergency laparoscopic cholecystectomy. |
| Trauma and Orthopaedics | • Primary repair of tendon repair (wrist or hand).<br>• MUA fracture and application of plaster cast.<br>• Removal of foreign body from skin.<br>Primary reduction and open fixation of ankle.<br>• Primary reduction and open fixation of wrist. |
| Gynaecology | • Evacuation of retained products of conception.<br>• Removal of products of conception from fallopian tube (ectopic pregnancy), including laparoscopically. |
| Oral and Maxillofacial Surgery | • Reduction of fracture of zygomatic complex of bones.<br>• Reduction of fractured mandible. |

There are a variety of pathway options which can enable emergency patients to be managed on a day case basis:

- Assess, discharge and admit to future Trauma List (ideally 1st slot on the list) e.g. surgical management of abscess, MUA or ORIF of fracture.
- Assess, discharge and admit to elective day surgery list e.g. surgical management of miscarriage, knee arthroscopy, ACL reconstruction or tendon repair.

- Assess, discharge and admit to dedicated emergency day surgery list e.g. acute cholecystectomy, laser fragmentation of ureteric stones, day surgery trauma.
- Assess, operate on same day and discharge via day surgery pathway post-operatively e.g. management of ectopic pregnancy, testicular torsion, appendicitis.

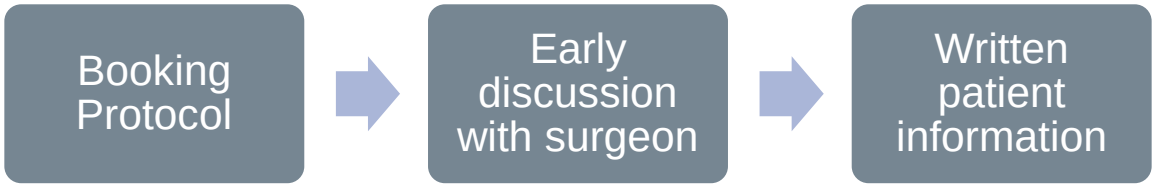
Different hospitals may choose to use a variety of these pathways for different surgical procedures.

### 1.3.1 Facilities and staffing

Surgical Assessment Units are pivotal to the coordination of emergency day surgery pathways. These can be single or multi-specialty units and may involve various surgical specific pathways, but one of the key factors for success is an ethos throughout the team of admission avoidance.

The surgical assessment team must develop processes which enable all patients to be tracked once discharged and re-admitted in a timely manner to an elective or semi-elective theatre list via a day surgery pathway. Many units are now using digital technology to enable more streamlined day case pathways. Patients need clear instructions regarding who to contact out of hours if there is any deterioration in their condition.

**Key factors to reduce patient stress and cancellations**




Daily ‘hot’ surgical clinics, which can often be delivered virtually, enable patients on an ambulatory emergency pathway to be reviewed by senior decision makers. Access to rapid diagnostics (in particular ultrasound) is essential to the smooth running of these pathways. Dedicated slots should be provided for this service, where a sonographer and scanner are available in the clinic or another specified location.

Dedicated regular day surgery emergency lists are required to deliver an efficient ambulatory emergency surgical service. Ideally a patient will be booked directly onto one of these lists whilst still in the surgical assessment unit and be given a specific time to return for surgery.

Fracture clinics work similarly to make decisions on urgent operating on an ambulatory basis, with many hospitals using a 'Trauma Coordinator' to maintain a list of patients and communicate between teams. Other specialties, such as urology, ENT and gynaecology, and paediatrics may benefit from 'hot clinics' to have assessment and shared decision making with patients who may potentially be day cases. While there may be potential to use day surgery facilities rather than a CEPOD list, discussion across the whole team, including the booking team and surgeons is needed. This includes formulating general processes and including specific details (such as standardising estimated length of common procedures and postoperative care).

### 1.3.2 Benchmark data for emergency activity

The MHS BADS Emergency Surgery Compartment contains metrics which reflect the emergency activity included in the BADS Directory of Procedures.

## 1.4 Using Information Technology to Support the Day Case Surgery Pathway

High-quality day surgery pathways are strongly supported by, and in many ways dependent on, good information technology. An electronic patient record (EPR) should be used to support the entire day surgery pathway and can be essential in driving day surgery success. The following sections outline the pathway/process, and a digital approach should be advocated where possible to facilitate more streamlined pathways.

**Components include:**

**Booking form**

Listing of patients electronically by the surgeon directly from their outpatient clinic ensures that the procedure is accurately recorded and transferred directly to the patient's record and subsequent theatre operating list. This avoids transcription errors resulting from matching a procedure description to the EPR codes or due to incorrect deciphering of handwriting. See the GIRFT Practical Guide: Theatres Booking Module for information on what should be included on the booking form. The listing information and equipment required should populate directly onto the theatre operating list to enable good communication in advance with the theatre staff and into the hospital booking system and POA record to avoid transcription errors.

**Preoperative assessment (POA)**

A major benefit of an electronic POA record is the ability for staff to review the record without recourse to a patient's notes. This enables teams to review their patients' records in advance of surgery and identify any concerns or outstanding issues.

This should include all the key aspects of the patient's medical history formulated as a series of drop-down menus with decision support guidance. Any investigations required will ideally be ordered directly from this system and results will populate automatically into the record.

**Record of the day of surgery**

This should include:

- Time stamps for admission, time to theatre, operation start and finish time, time into recovery and discharge time.
- Reasons for cancellation after arrival.
- Personnel involved in the patient's care.
- Record of the procedure undertaken, type of anaesthesia and the staff involved.
- Key outcome data from primary recovery such as pain and nausea scores.
- Documentation of discharge criteria being achieved with details of time and nurse undertaking the discharge.
- Information regarding whether a patient was admitted or discharged and reason for any unplanned admission.

**Operation notes**

This should include the following key information:

- date/time of procedure
- names of surgeon, assistant and anaesthetist
- type of anaesthetic
- incision
- findings
- procedure undertaken
- description of procedure
- description of prosthetic materials/drains used
- staff involved
- antibiotics
- VTE prophylaxis in theatre
- details of specimens sent
- postoperative instructions to include mobility allowed and diet
- follow-up plan (e.g. clinic appointment)
- specific information for primary care
- whether the surgeons wish to see the patient prior to nurse-led discharge.

See the Theatres Productivity Dataset: Updated collection for further information.

Follow-up information should be easily viewed electronically by all staff involved in the patient pathway. EPR systems should be built with engagement from clinical teams to ensure ease in useability and minimal administration burden. If a specimen is sent it should be possible to track and monitor this information electronically to ensure that all specimens are followed up and results checked.

**Anaesthetic charts**

Electronic charts support accurate documentation of vital signs, physiological parameters, medications administered, and procedures undertaken using drop-down menus and an interface between the computer system and anaesthetic monitors to enable data transfer.

**Take-home analgesia**

Information about take-home analgesia should should populate directly into the GP discharge letter. See the GIRFT Practical Guide: Surgical Discharge Module for more information.

**Automatic generation of discharge letter**

Once a patient is discharged electronically from the system a standard discharge letter should be generated. EPR may be useful to prevent administrative burden for clinical staff and facilitate learning opportunities.

Copies of the discharge letter (paper or electronic) are required for patient notes, the GP and for the patient to take home. For information on what to include in the discharge letter see the GIRFT Practical Guide: Surgical Discharge Module.

**Audit Data**

All the information from the EPR should download into a central database which can be easily interrogated by clinicians and hospital informatics teams to support regular audit of activity and outcomes which will promote continuous quality improvement.

## 1.5 Using Audit and Quality Improvement Processes to Increase Day Surgery Rates

In addition to national audits, continuous audit of day surgery rates and patient outcomes is essential for service improvement. Comparison with national benchmarks and data from other trusts will drive this further. Data can be obtained from the MHS day surgery compartment, NCIP, hospital information departments and departmental data.

**Basic day surgery dataset requirements**

**For procedures in the BADS Directory of Procedures:**

- **overall unit day surgery rates**
- **specialty specific day surgery rates**
- **individual procedure day surgery rates**
- **unplanned admission rates**
- **missed opportunities.**

### 1.5.1 Unplanned Admission Rates

High unplanned admission rates can be a result of inefficiency at some point in the pathway and are a key measure of the quality of a day surgery pathway. They may happen because of:

- Inadequate patient preparation.
- Ineffective theatre scheduling.

- Inappropriate anaesthetic techniques.
- Lack of robust protocols for postoperative analgesia.
- Insufficient seniority of anaesthetic or surgical staff.
- Inexperience of day surgery ward staff to confidently achieve patient discharge.
- Poorly defined criteria to support day surgery and ward staff to achieve discharge.

While traditionally an overall target of <2% was recommended it is appreciated that units attempting more challenging procedures as day surgery (e.g. hysterectomies, major joint replacements and mastectomies) may have a higher unplanned admission rate than those whose case mix is more conservative (e.g. dental extractions and cataract surgery). This is reflected in MHS data, which enables trusts to benchmark their performance in terms of unplanned admissions by individual procedure, providing more information than an overall figure. Services should regularly review and analyse their conversion from day case to inpatient stay data and identify actions to support improvement.

### 1.5.2 Missed Opportunities (inpatients with length of stay = 0)

These are patients booked for inpatient admission who are discharged on the day of surgery. These are a missed opportunity as they will not count as day cases in hospital performance tables due to lack of day case management intent. They also often consume more resource in terms of ward beds and staffing than they would have if managed on a dedicated day surgery pathway. MHS contains metrics on conversion from planned inpatient stay to day case at organisation and specialty level. These metrics allow organisations to understand where surgery, intended as an overnight stay for one or more days, resulted in patients not staying overnight. Investigating whether there is a particular specialty that contributes disproportionally to missed opportunities can identify procedures where more confident booking of patients for day surgery management can create rewards with minimal changes to the clinical pathway.

### 1.5.3 Postoperative Symptoms

Evaluation of patient symptoms after discharge is an important measure of the quality of the service provided. Rates of postoperative pain, nausea and vomiting (PONV) and bleeding should be ascertained for all patients. Annual audits should be undertaken to determine any trends in postoperative symptoms associated with for example, medical personnel, specific procedures, and anaesthetic techniques.

### 1.5.4 Resources to Support Quality Improvement in Day Surgery

The Royal College of Anaesthetists (RCoA) have produced 9 Quality Improvement Programme recipes relating to day surgery as part of Raising the Standards: RCoA Quality Improvement Compendium:

- Optimising your day case rates.
- Day surgery cancellations/failure to attend.
- Day surgery within the main theatre setting.
- Performing Emergency Ambulatory Surgery.
- How effective is your day case spinal service?
- Pain relief after day surgery.
- The need for a carer at home after day surgery.
- Unplanned hospital admission after day surgery.
- Evaluating your day surgery pathway.

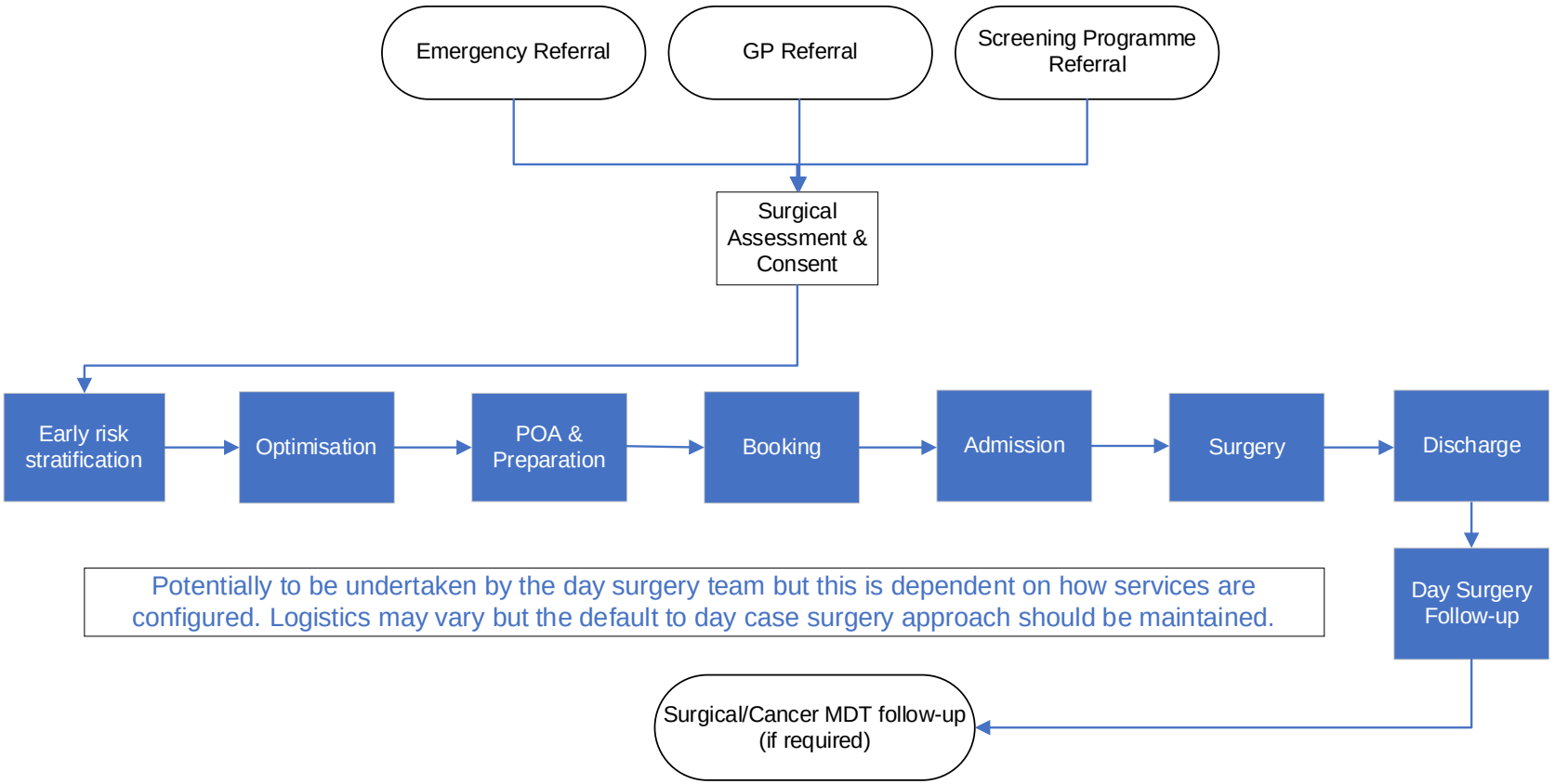
# 2. The Generic Day Case Pathway

Most surgery within specialties should be undertaken via a day case pathway with this being the standard pathway. A change in medical and nursing culture may be required to achieve this.

The day surgery pathway usually starts with GP or screening referral and ends after discharge home and active follow up. It is essential that there is consistent messaging from all healthcare professionals who interact with patients and that day surgery is reinforced at every stage of the pathway. Ensuring that where possible all aspects of the pathway are undertaken by the day surgery team will improve consistency of message and expertise.

It is essential to maintain close collaboration with all members of the surgical specialist multidisciplinary team as appropriate (e.g. breast-care nurses, orthopaedic physiotherapists) when developing and reviewing any day surgery pathways to ensure a positive patient experience. Their input both pre and postoperatively is vital to ensure efficient pathways.

## Generic Day Case Pathway



## 2.1 Referral

### Primary Care

GP's refer patients to secondary care for management of an obvious surgical diagnosis or for diagnosis and management of specific signs and symptoms, which may lead to surgery being recommended. They play an important role in starting the day surgery message and in ensuring that patients are "fit to refer" and fully optimised prior to a request for a surgical opinion. A pre-emptive review of chronic conditions such as hypertension, atrial fibrillation, diabetes and anaemia, in order to optimise a patient prior to referral is extremely valuable. GPs are likely to have knowledge of social factors and can provide advice about lifestyle choices that may impact on surgical outcomes including smoking, high body mass index (BMI), alcohol consumption and recreational drug use. Patients should be involved in decision-making, understanding the Benefits, risks, Alternatives and what if Nothing is done (BRAN), and discussion about how to improve their health. Patients should be made aware of literature to support fitness for surgery, such as the Royal College of Anaesthetists' Fitter Better Sooner Toolkit, and encouraged to use resources to prepare for surgery.

GPs should be kept up to date on the range of procedures which may be undertaken as day case surgery and the patient groups considered suitable. This information should be shared with GPs by their provider trusts.

### Screening Programmes

When patients are diagnosed via a national screening programme, GPs are not responsible for referral. However, they should inform the treating secondary or tertiary referral unit of underlying comorbidity and social and lifestyle issues, which may impact on outcomes, once they have been notified that surgery is recommended. The perioperative team should have communication channels in place to identify potential 'flags' about medical and social circumstances to enable safe pathway planning.

### Emergency Departments

Patients with acute conditions, which require urgent surgery can be managed as a day case in a semi-elective pathway and may present via the emergency department or surgical take. Further details about this pathway have been covered in section 1.3 on Surgical Same Day Emergency Care.

| Action Checklist - Referral | |
|---|---|
| ☑ | Trust day case procedure lists are shared with GPs and regularly updated. |
| ☑ | GPs, when referring patients for contemplation of a surgical procedure, ensure that patients do not require any lifestyle optimisation that may preclude them from being listed. |
| ☑ | GPs share patient education leaflets e.g. Fitter Better Sooner Toolkit. |
| ☑ | GPs encourage patients to use available resources to prepare for surgery. |

## 2.2 Outpatient Team

Perioperative care is the whole journey from the moment surgery is contemplated. The whole team needs to be involved. The initial message delivered at the outpatient clinic, which is run by a multidisciplinary team of healthcare professionals, is pivotal in setting patients' expectations. Outpatient teams need to be aware of which procedures are appropriate for day surgery and default these procedures to day case intention. They also need to be informed that it is unusual for a specific patient to be unsuitable for day surgery (see section on patient selection below). If a patient is unfit for day surgery, they may be unsuitable for elective surgery and should not simply be switched to an inpatient pathway. Instead, if time allows, they should be optimised and then re-listed as a day case once fit.

Outpatient teams should be educated on the principles of day surgery management and informed about which patients can and should be listed for day surgery. They should understand shared decision making and agree expectations with the patient. Consent is an iterative process and should not be left until the day of surgery.

| Action Checklist – Outpatient Team | |
|---|---|
| ☑ | Default procedures appropriate for day surgery to day case intention. |
| ☑ | If not fit for day surgery, consider optimising the patient and re-listing as a day case once fit. |
| ☑ | Ensure patients receive information about day surgery. |

| | |
|---|---|
| ☑ | Build education of principles of day surgery management into induction for all staff, including doctors on rotation and new consultant induction. |

## 2.3 Surgical Criteria for Day Surgery

Developments in surgical and anaesthetic techniques mean that most surgery is now appropriate to be undertaken on a day case basis. Major procedures previously not considered appropriate are now routinely undertaken as day cases in some centres including:

- robotic/laparoscopic/vaginal hysterectomy
- robotic/laparoscopic nephrectomy
- robotic/laparoscopic prostatectomy
- mastectomy
- vaginal prolapse surgery
- lumbar discectomy
- total hip and knee replacements
- some craniotomies
- urgent laparoscopic cholecystectomy
- appendicectomy

**Key questions for determining if a procedure is appropriate for day surgery**

1. Can the patient be reasonably expected to manage oral nutrition postoperatively?
2. Can the pain of the procedure be managed by simple oral analgesia supplemented by regional anaesthetic techniques?
3. Is there a low risk of significant immediate postoperative complications?
4. Is the patient expected to mobilise with aid postoperatively, and if so, can this be taught in advance?

The next step is to evaluate existing inpatient procedures and determine if any aspects of the pathway need modifying to enable the procedure to be undertaken as a day case.

Surgical duration is no longer considered a limitation for day surgery and procedures lasting three or four hours are now routinely undertaken on a day case basis.

| Action Checklist – Surgical Criteria for Day Surgery | |
|---|---|
| ☑ | Surgical duration alone is not used to exclude a patient from having a day surgery pathway. |
| ☑ | Review existing default inpatient procedures and identify if criteria questions (1-4 above) are met. |
| ☑ | Evaluate inpatient procedures and determine what (if any) aspects of the pathway require modification to enable them to be undertaken as day cases. |

## 2.4 Patient Selection

Patients may be considered unsuitable for day surgery for a variety of reasons. However, many patients are appropriate for day case management or can be enabled to be with careful optimisation, organisation and proactive management. Taking a proactive approach is important to ensure that inequalities are reduced and not exacerbated.

### 2.4.1 Social Factors

**Distance from hospital -** Patients should live within approximately one hour's drive of a hospital that would be able to provide care resulting from a complication of the surgery. It is important to note that this **may not** be the hospital in which the surgery was undertaken. In some remote communities, it may be necessary for patients to be accommodated in a local hotel on the first postoperative night before travelling home the next day. This is still better and more cost effective than keeping the patient in a hospital bed unnecessarily.

**Availability of someone to care for the patient overnight -** Standard guidance is that patients should be escorted home by a responsible adult who should remain in their home for 24 hours after surgery. However, an increasing number of patients live alone, and a small number have difficulty finding anyone to provide this care. See the GIRFT Practical Guide: Surgical Discharge Module for information on patients having surgery with No-One at Home (NOAH).

| Action Checklist – Patient Selection | |
|---|---|
| ☑ | Social factors are rarely reasons to exclude a patient from day surgery. When identified, ensure they are discussed and a joint plan to address them is agreed by the POA team in partnership with the patient and recorded in the patient notes. |
| ☑ | If the patient is unable to provide their own carer, then consider alternative options using the NOAH flow pathway. |

### 2.4.2 Medical Factors

Factors such as age, BMI and American Society of Anesthesiologists (ASA) physical health classification are no longer considered a limitation for day surgery as it is recognised that these are arbitrary limits that do not relate to patient outcomes.

Medical exclusions to day surgery:

- Any poorly controlled comorbidity.
- Neonates.
- Ex-premature infants < 60 weeks post conceptual age (some units may lower the age depending on skill mix and experience as per local policy).
- Young sibling of a sudden infant death syndrome (SIDS) child.

ASA

- Most *stable* medical conditions can be managed as a day case.
- Most patients with *unstable* medical conditions should not be undergoing elective surgery. Urgent or emergency surgery in these patients may require an inpatient stay.

If a patient is not suitable for day surgery, in most cases they should not have elective surgery at all until their medical condition has been optimised. Cancer/urgent patients should be considered for surgery on an individualised basis using shared decision making principles.

The Royal College of Anaesthetists Guidelines for the Provision of Anaesthesia Services for Day Surgery includes a section on areas of special requirement which covers children, frail and older patients, and morbidly obese patients.

**1) Diabetes**

The value of day surgery for patients with diabetes has been recognised within several national guidelines (see resources on the next page). Patients with diabetes are more likely to maintain good diabetic control if they are in their usual environment with their normal diet and medication. Bringing them into hospital as an inpatient often results in poorer control as routines are disrupted. Diabetic patients are often better at managing their own diabetes than healthcare professionals.

**Important points to note:**

- Glycaemic control should be checked at the time of referral for surgery.
- HbA1c should be < 69 mmol.mol $^{-1}$ within the last 3 months.

- If HbA1c ≥ 69 mmol.mol $^{-1}$, consider postponing elective surgery while control is improved before proceeding with day surgery. There may be a minority of patients where the benefits of surgery outweigh the risk of suboptimal HbA1c levels, so it is appropriate to proceed with surgery for these. Where appropriate patients should be offered a referral for intervention and optimisation. Shared decision making should occur at each step of the patient pathway.
- At preoperative assessment (POA) patients' diabetes medications/insulin doses should be documented and patients should be provided with information about any changes that they need to make with regards to their diabetes medications or insulin for the day of surgery.
- Capillary blood glucose (CBG) should be recorded on admission for day case surgery, pre-surgery, in recovery and before the patient is discharged.
- Clear guidelines should be in place and easily accessible for the management of hypo and hyperglycaemia.

**Resources**

- **CPOC/AoMRC Guideline for Perioperative Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery**
- **GIRFT Diabetes National Report**
- **Association of Anaesthetists Peri-operative management of the surgical patient with diabetes**

**2) Older Patients**

There are no upper age limits for day surgery. Older people in particular benefit from day surgery as there is minimal disruption to their daily routine and a return to their usual environment as soon as possible. In 2016 the National Audit Office (NAO) report Discharging older patients from hospital found that older people who are admitted to hospital can lose 5% of their muscle function per day.

**3) Children**

Most paediatric surgery should be undertaken as day surgery. The main exclusions are:

- Neonates.
- Ex-premature infants (<60 weeks post gestational age). Some units may lower the age depending on skill mix and experience as per local policy.
- Young sibling (< 2 years) of SIDS child.
- Child with severe sleep apnoea undergoing tonsillectomy.

Postoperative respiratory observations are required in these children due to the higher risk of postoperative apnoea.

Services should have dedicated paediatric day surgery lists and where possible employ a play therapist to support good patient experience and patient flow.

**4) Obesity**

There are no upper limits for BMI for day surgery. Patients with a high BMI, including morbidly obese patients, can be safely managed through a day surgery pathway if appropriate staff and equipment (e.g. long instruments, appropriate operating table, difficult airway equipment) are available. Day surgery is advantageous for obese patients as they benefit from short duration anaesthetic techniques and early mobilisation associated with day surgery, and the potentially reduced risks of venous thromboembolism (VTE) and hospital acquired infection. Most potential complications of obesity are limited to the intra-operative and immediate postoperative environment. Once the patient has left primary recovery they are at no increased risk of complications as a day case compared with an overnight stay. Morbidly obese patients may not be appropriate to manage on an isolated site. However, they should still be managed through a day surgery pathway in the main hospital environment[12].

Whilst obesity is not a contraindication, theatre personnel should be aware of upper weight limits for trolleys in use. These should be suitable to manage patients across a wide weight range. If operating tables are moved between theatres for this purpose, trolleys are preferable to reduce manual handling risks for staff.

It is important to capture data on obesity but it is often poorly recorded in clinical records. All Trusts should implement a local clinical coding policy that instructs the Clinical Coding team to translate a Body Mass Index (BMI) score into an ICD-10 obesity code.

[12] The Association of Anaesthetists of Great Britain & Ireland and The Society for Obesity and Bariatric Anaesthesia Peri-operative management of the obese surgical patient (anaesthetists.org)

| Action Checklist – Medical Factors | |
|---|---|
| ☑ | Ensure existing medical criteria for day surgery are reviewed, updated and in line with national guidance. |
| ☑ | Ensure diabetic patients have their disease well controlled and therefore are not unnecessarily excluded from day surgery. |
| ☑ | Ensure elderly patients are not unnecessarily excluded from day surgery. |
| ☑ | Ensure paediatric exclusions to day surgery are limited to neonates, ex-premature infants < 60 weeks post gestational age (some units may lower the age depending on skill mix and experience as per local policy), young sibling (< 2 years) of SIDS child, child with severe sleep apnoea undergoing tonsillectomy. |

## 2.5 Patient Booking

Booking teams should work closely with day surgery units. This gives the following advantages:

- Interaction with theatre teams resulting in improved teamwork and list scheduling.
- Interaction with the surgical team ensures appropriate list case mix.
- Booking team can attend theatre debrief and learn ways of improving future list scheduling.
- Attendance at debrief gives an opportunity for positive feedback and learning opportunities.
- Lists to be planned in a smart order considering recovery times for different procedures or types of patients.

Booking staff should be made aware of the day case process to ensure they are able to answer patient queries at the time of booking. They should also establish relationships and communicate effectively with clinical staff in the day surgery team.

## 2.6 Early Risk assessment and Screening

In 2023, NHSE and GIRFT published guidance[13] [14] regarding early screening and risk assessment for all intended inpatient pathways and identified that this guidance would also benefit day case pathways.

Main objectives:

- To identify patients who require no optimisation ("green"). These patients would be suitable to be added to a waiting list 'pool' so they can come for full POA (where necessary). These patients should be offered universal optimisation advice. This would include referral to smoking cessation or alcohol management services (where required) and signposting to the "My health and wellbeing" pages on www.myplannedcare.nhs.uk and any similar trust resources.
- Identify patients who have a long-term condition and/or other health challenges which requires pathway-guided optimisation ("amber"). All trusts should have pathways for key long-term conditions which can be implemented unsupervised by perioperative care coordinators with support from registered healthcare professionals. These pathways should specify the timing of POA prior to a date for surgery. These patients should also be offered universal optimisation advice in addition to long-term condition pathway specific support.
- Identify patients who have a significant long-term condition or multiple long-term conditions which require review by a senior decision-maker ("red"). These patients may be able to attend for day case surgery if they have the necessary interventions where appropriate.

## 2.7 Preoperative Assessment (POA) and Preparation

This provides the opportunity to:

- Prepare the patient for their day surgery and reinforce day surgery pathway messages.
- Identify medical concerns, which haven't been picked up through early screening and risk assessment, with the opportunity for intervention.

[13] NHS England Earlier screening, risk assessment and health optimisation in perioperative pathways: guide for providers and integrated care boards (2023)
[14] GIRFT Operational Implementation and Support Guide for Early Screening, Risk Assessment and Optimisation for Adult Patients (2023)

POA and preparation should be at a time and place convenient and appropriate for the patient. There should be an opportunity for early risk assessment via a questionnaire/digital process. Where possible, in particular for patients who require multidisciplinary preoperative input (e.g. with physiotherapy or a clinical nurse specialist), services should facilitate having all appointments in one day.

This provides the following benefits:

- Reduced number of hospital appointments for the patient.
- Early assessment leaving the maximum time for any optimisation required.
- Established pool of patients who have undergone POA and are fit for surgery maximising the likelihood of being able to fill surgery slots that open when unavoidable cancellations occur.

Some patients require a face to face assessment with a registered healthcare professional. However, practice changed because of the COVID-19 pandemic and the use of phone consultations for POA has increased. This is beneficial for patients as it reduces the number of attendances at hospital, but it is important to ensure this method of assessment doesn't increase on the day cancellations. See the Preoperative assessment services guidance for advice on which patients should be seen face to face and which can be assessed remotely. The assessment should be undertaken either by registered healthcare professionals who are part of the day surgery team, or by a centralised POA team that has clear pathways and messaging, to ensure that patients are appropriately prepared for day surgery.

Preoperative investigations should be done in line with current NICE Guidance. As we facilitate more major surgery through day case pathways, considerations for day case surgery and subsequent treatment pathways should include:

- Haemoglobin in patients undergoing major surgery (e.g. arthroplasty) who may benefit from preoperative oral or intravenous iron if anaemia is detected.
- Group and Save for procedures where major haemorrhage could occur such as nephrectomies, endovascular aneurysm repairs and where rhesus status is required e.g. evacuation of retained products of conception or termination of pregnancy.

Standard protocols should be provided for management of patients with:

- newly detected or poorly controlled hypertension
- newly detected atrial fibrillation
- new abnormalities in blood results
- poorly controlled diabetes.

Normally a standard letter can be sent to the GP highlighting the abnormality detected. In most cases (except for poorly controlled diabetes) it will not preclude surgery from progressing. Examples of standard letters are included in the appendix.

Anaesthetic support must be provided for review of notes or patients as appropriate. This should be provided by anaesthetists with expertise in day surgery pathways and familiarity with the unit protocols. Dedicated time must be allocated in job plans for this. Most referrals from the nursing team can be managed by a review of patients notes, supplemented by a phone call if required. The purpose of the review is to find out whether any further optimisation is needed to enable surgery to proceed or whether any specific additional equipment, specialised staff or change in process might be needed to safely care for a particular patient. For patients with significant comorbidities or unstable disease, there may be a need to coordinate a discussion between the day surgery team, surgeon and patient as to whether surgery is in the patient's best interests at this time as part of a shared decision making process.

| Action Checklist – POA and Preparation | |
|---|---|
| ☑ | The day surgery team includes dedicated booking staff where possible. |
| ☑ | Provide early screening and risk assessment in line with referral to treatment (RTT). |
| ☑ | POA is led by a day surgery team registered health professional and undertaken face to face with telephone or video consultations used as appropriate. |
| ☑ | Standard protocols are provided for the management of patients with newly detected or poorly controlled hypertension; newly detected atrial fibrillation; new abnormalities in blood results; and poorly controlled diabetes. |
| ☑ | A process is in place for identifying and contacting patients who are fit for surgery and have flexibility to attend at short notice, in line with trust screening protocols. |

| | |
|---|---|
| ☑ | Plan lists in a ‘smart order’ considering recovery times. |
| ☑ | Anaesthetic support must be provided for review of notes or patients as appropriate throughout the POA process. |

## 2.8 Admission

Admission to a dedicated day surgery area that is part of a day surgery unit (see facilities section) provides the best environment. However, an admissions area adjacent to the day surgery postoperative ward is the best alternative if a separate day surgery unit is not an option. The admissions area should be close to the operating theatre to avoid delays, aid communication between theatre and admission teams, and enable patients to walk to theatre. Any preoperative interventions which prevent walking should be reviewed. Where possible, admission times should be staggered and fasting times minimised.

Patients should remain in a waiting area with comfortable seating available, until they need to change for theatre. Consultation rooms should be available for preoperative review by the surgical and anaesthetic team. Admitting preoperative patients to their postoperative “trolley” space may limit the use of this space by preceding patients, resulting in reduced efficiency and the requirements for more trolley space. However, if separate consultation rooms are not available and use of the postoperative area for preoperative admission is necessary, patients should return to a waiting area once reviewed to enable separation of pre and postoperative processes.

Patients should be changed for theatre at an appropriate time to avoid delays but minimise the time waiting in a theatre gown to reduce hypothermia and maintain dignity.

## 2.9 Preoperative Fasting

Excessive preoperative fasting results in feelings of thirst, discomfort and a significant increase in postoperative nausea and vomiting. Stipulating two hours fasting from clear fluids preoperatively inevitably results in excessive fasting times as it is difficult for staff to judge when that two hour period begins. There is some evidence to show that allowing patients free access to water and encouraging drinking is associated with no increase in adverse events and a

significant reduction in postoperative nausea and vomiting[15] [16]. The unit should have a clear policy on fluids e.g. Sip Til Send and patients should be encouraged to stay hydrated. Consideration should be given to placing patients with diabetes on the first third of the operating list where possible to minimise the fasting period.

| Action Checklist - Preoperative Fasting | |
|---|---|
| ☑ | A dedicated day surgery area is used whenever possible. |
| ☑ | Patients should **not** be admitted to a bed or trolley area but remain in the waiting area until they need to change for theatre. |
| ☑ | Consultation rooms are available for pre-operative review by the surgical and anaesthetic team. |
| ☑ | Tea and coffee may be consumed up to two hours preoperatively. |
| ☑ | Consider Sip Til Send until the time of surgery. |

## 2.10 Surgery and Anaesthesia

**Staffing:** Day surgery should be a consultant or experienced Specialty and Associate Specialist (SAS) delivered service for both surgery and anaesthesia. There are opportunities for teaching and learning in the day surgery environment and staff in training should be supervised to ensure high-quality day surgery outcomes.

**Equipment:** Day surgery facilities should be equipped to the same standard as inpatient operating theatres. This will enable undertaking complex surgery to a high enough standard to enable same day discharge.

**Operating Trolleys:** Most procedures should be undertaken on operating trolleys. Patients should get onto the trolley in the anaesthetic room and remain on it until ready for mobilisation prior to discharge.

---

[15] McCracken, GC., Montgomery, J. (2018) Postoperative nausea and vomiting after unrestricted clear fluids before day surgery. European Journal of Anaesthesiology, 35(5):337-342. https://pubmed.ncbi.nlm.nih.gov/29232253/

[16] Sands, R., Wiltshire, R. and Isherwood, P. (2022) Preoperative fasting guidelines in National Health Service England Trusts: a thirst for progress. British Journal of Anaesthesia, 129(4): E100-E102. DOI: https://doi.org/10.1016/j.bja.2022.07.004.

Advantages:

- ✓ Reduced time delays transferring patients from trolley to operating tables.
- ✓ Reduced postoperative nausea and vomiting associated with rolling and transfer.
- ✓ Reduced manual handling risks for staff.

**Anaesthesia:** Guidelines should be established for the provision of short acting anaesthesia and multimodal analgesia. The principles of anaesthesia for day case surgery are as follows:

- Premedication with oral analgesia.
- Short acting anaesthetic agents.
- Avoidance of emetogenic medication.
- Effective use of local anaesthetic and regional anaesthesia.
- Multimodal analgesia.
- Short acting opioids for rescue analgesia if required[17].
- Good postoperative analgesia.

### 1) Premedication

Patients should be premedicated with oral paracetamol and if appropriate a non-steroidal anti-inflammatory drug (NSAID). If NSAIDs are used, then long acting preparations such as Ibuprofen slow release 1600mg have been found to be efficacious in a number of leading day surgery centres and avoid the risk of missed doses later in the day.

### 2) Intraoperative Anaesthesia

Short acting anaesthetic agents should be used. Total intravenous anaesthesia (TIVA) is suited to day surgery anaesthesia, but units have also had success using the short acting volatile anaesthetic agents. Avoidance of agents likely to contribute to PONV such as nitrous oxide or long-acting opioids (morphine) is important. Patients should be warmed and appropriately hydrated.

With these techniques routine use of antiemetic medication is often not required. However, for

[17] Srivastava, D., Hill, S., Carty, S. et al. (2021) British Journal of Anaesthesia. Surgery and opioids: evidence-based expert consensus guidelines on the perioperative use of opioids in the United Kingdom. DOI: https://doi.org/10.1016/j.bja.2021.02.030

patients with a significant history of PONV or having particularly emetogenic procedures such as tubal or ovarian, testicular, laparoscopic, squint or middle ear surgery, prophylactic antiemetic use should be considered.

**3) Postoperative medication** (see example perioperative prescription chart in the appendix):

a. Simple analgesia is often sufficient (regular paracetamol and ibuprofen).
b. There should be agents available for rapid analgesic rescue if required. Standard prescriptions of intravenous fentanyl (6 x doses of 25 mcg) and oral morphine sulphate are effective.
c. Rescue antiemetic medication should be available.

**4) Spinal and Regional Anaesthesia**

It is important to provide alternatives to general anaesthesia (GA) or sedation, either due to patient choice or medical conditions where GA should be avoided. Use of regional anaesthetic techniques and awake surgery enables the patient to be transferred from the operating theatre as soon as the surgical procedure is finished, resulting in reductions in theatre turnaround time.

- Spinal anaesthesia is appropriate for day surgery using short acting agents with appropriate dosing regimens (see protocol).
- Regional anaesthesia may be very useful. A number of centres have developed 'awake surgery' pathways which have been demonstrated to significantly increase efficiency in terms of list turnover, and to reduce resources and staffing required (for example, no primary recovery unit or staff are needed as the patient can progress directly from the operating theatre to the secondary recovery ward prior to discharge).
- Patients should be advised to take oral analgesia available at home for when the block reduces.
- Take home medication: protocols should exist to ensure that the correct analgesia regimes are prescribed and dispensed according to procedure severity. Prescribing according to evidence-based guidelines rather than individual clinicians' preference results in improved analgesia after discharge.

| Action Checklist – Surgery and Anaesthesia | |
|---|---|
| ☑ | Day surgery is a consultant or experienced SAS delivered service for both surgeons and anaesthetists. |
| ☑ | Day surgery facilities are equipped to the same standard as inpatient operating theatres to expand the range of procedures that can be undertaken and ensure the best equipment is available. |
| ☑ | Most procedures are undertaken on operating trolleys to minimise transfer delays and manual handling risks. |
| ☑ | Guidelines are established for the provision of short acting anaesthesia. |
| ☑ | Regional anaesthetic techniques are employed to support day surgery. |
| ☑ | Protocols exist for take home medication including evidence-based prescribing rather than clinician preference. |

## 2.11 Primary Recovery

This is the first stage of recovery after surgery, in which patients spend from as little as ten minutes to an hour after leaving the operating theatre. One to one care is provided until a patient is fully awake, with any airway adjunct removed, and any immediate postoperative symptoms of pain or nausea under control. Standard perioperative prescription charts should be available in primary recovery to ensure immediate availability of analgesic and antiemetic medication (see example in the appendix). Patients should remain in primary recovery only until they are awake, pain is under control and they fulfil local discharge criteria to secondary recovery. There should be no minimum duration for primary recovery, enabling patients to transfer to the secondary recovery ward within a few minutes of regaining consciousness.

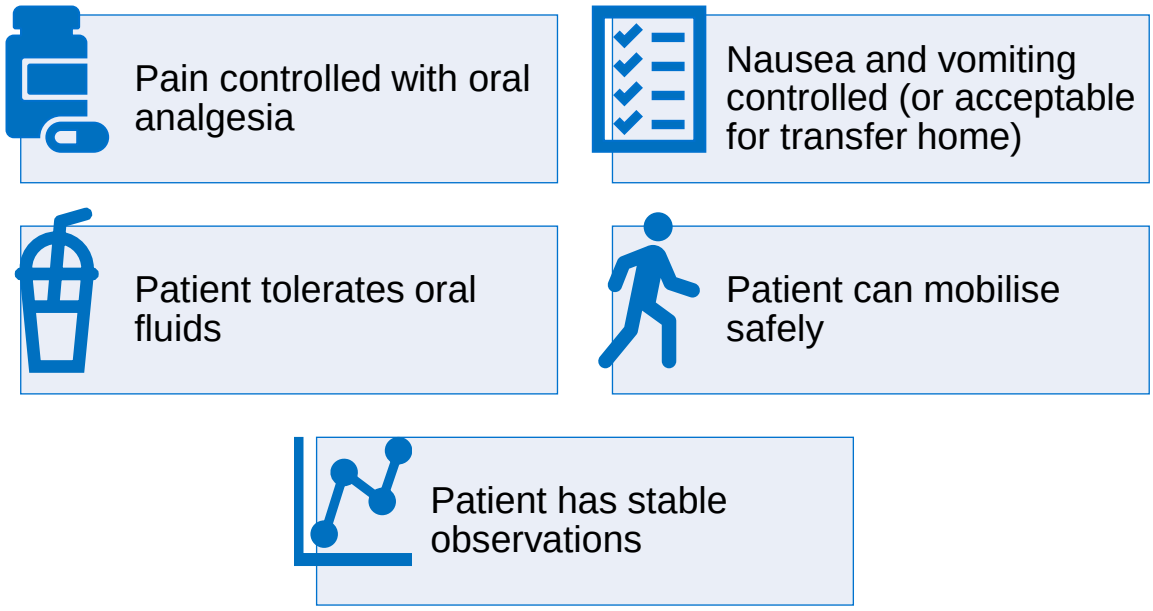
Patients undergoing procedures under spinal, regional or local anaesthesia may bypass primary recovery and go directly to the secondary recovery area enabling more efficient use of space and faster progression through the day surgery pathway.

## 2.12 Secondary Recovery and Discharge

The secondary recovery unit or ward is the area where patients spend most of their postoperative recovery prior to being ready for discharge. It should be staffed by nurses who are trained and competent in nurse-led discharge for day surgery (see the BADS Handbook on

Nurse Led Discharge) and ideally be trolley or chair-based care with no bed stock. Patients should be encouraged to drink, eat, mobilise, dress and be discharged in a timely manner. Nurses with expertise in day surgery are essential to ensure that the focus on progression through the secondary recovery process occurs without delay. Support from clinical nurse specialists and other members of the MDT may also be useful following specialist surgery.

**Key Discharge Criteria**




For most patients there is no specified time before which they can be discharged. There are exceptions including patients who might be at risk of significant hemorrhage. Most patients do not need to pass urine prior to discharge, the exceptions to this are some patients who have had spinal anaesthesia and those who have undergone urological surgery or gynaecology incontinence surgery[18]. Patients who have not passed urine following high risk surgery should have a bladder scan to determine whether they are in retention. In which case they can be discharged home with a catheter in situ and either return to the day unit for a trial without catheter or have this undertaken in the community. Failure to pass urine should not necessitate hospital admission.

[18] British Association of Day Surgery Spinal Anaesthesia for Day Surgery Patients A Practical Guide 4th Edition (2019).

For information on discharge see section 1 of the appendix.

Patients must have the following information prior to discharge:

- A copy of their discharge letter detailing the procedure they have had and any follow-up arrangements.
- Five-day supply of postoperative medication (see example protocols).
- Instructions for when the medication is next due (see example chart).
- Details of who to contact if they have any concerns. This should be a dedicated phone line to the day surgery unit within working hours and a senior surgical nurse out of hours. It is not appropriate for them to be directed to GP out of hours services, the emergency department or 111.

This should be explained to them and their carer and provided in writing.

**Resources**

- **BADS Handbook on Nurse Led Discharge 2nd Edition**
- **BADS Spinal Anaesthesia for Day Surgery Patients A Practical Guide 4th Edition**

## 2.13 Unplanned Admission after Surgery

Implementation of best practice guidance with respect to facilities, staffing and protocols will ensure that rates of unplanned hospital admission are kept to a minimum. It is important that there is a process in place for admitting patients who are not considered safe for discharge. However, easy access to hospital beds, such as in 23-hour stay units, can adversely affect outcomes and significantly increase unplanned admission rates. Patients are often admitted overnight and receive no additional medication, observations or management compared to what they would have had available at home. **A key question for the day surgery team and the patient if hospital admission is being considered is, "What care will be provided overnight in hospital that would not be available at home?"** Follow-up of any patient admitted the previous day by a nurse from the day surgery team can result in increased understanding of this and often give the nursing team confidence to support patients in returning home after surgery, even where their postoperative symptoms are not fully controlled.

## 2.14 Follow-up and Audit

Follow-up and audit are essential components of the day surgery pathway. It ensures delivery of a high-quality patient-centred service and drives quality improvement. Data capture from all day surgery patients is more effective than retrospective audit. One way of approaching this is to have a phone call with patients the day after surgery. Data obtained should be directly entered into a dedicated database preferably at the time of the call to avoid duplication of effort and transcription errors or omissions. Dissemination and discussion of this data with the perioperative team is important to ensure improvements to the service can be made.

Data collection may include:

- Pain scores.
- Nausea and vomiting score.
- Satisfaction.
- General well-being “how do you feel?”
- Whether the patient liked being a day case.
- Whether the patient liked the unit they were treated in.
- Whether they have needed to seek additional medical help/advice since discharge.
- Any other specific comments/concerns.

| Action Checklist – Follow up and Audit | |
|---|---|
| ☑ | One to one nursing care is provided for the primary recovery phase until the patient has met primary recovery criteria – there should be no minimum time duration. |
| ☑ | Standard perioperative prescription charts are available. |
| ☑ | Pathways exist to enable patients who have undergone regional or spinal anaesthesia to bypass primary recovery. |
| ☑ | The secondary recovery area is staffed by nurses trained and competent in nurse-led discharge for day surgery. |
| ☑ | There is a dedicated phone line to the day surgery unit within working hours and a senior surgical nurse out of hours. |
| ☑ | Support from a clinical nurse specialist and other MDT members is available following specialist surgery. |

| | |
|---|---|
| ☑ | There is an agreed process for admission to a hospital bed for patients deemed unsafe to discharge. |
| ☑ | A process is in place to support patients following discharge and to collect data on patient outcomes. This may include a telephone call the day after surgery. |
| ☑ | A nurse from the day surgery team undertakes a next day follow up visit to any patient admitted to review the benefit of that overnight stay. |

# 3. Procedure Specific Best Practice Pathways

The following elective and emergency procedures should serve as a focus for development of day surgery pathways across a range of surgical specialties. Many of these have been identified by GIRFT due to wide variation in day case rates across the country. Development of robust day surgery pathways for these procedures should then result in other surgical activity within the same specialty being encouraged into the day surgery arena. The resources section in table 2 includes links to specialty specific metrics, case studies which highlight how some trusts have optimised their day case rates, and other useful resources.

**Table 2: Key procedures for improving day case rates**

| Specialty | Procedures (links to GIRFT Pathways included where available) | Resources |
|---|---|---|
| Breast Surgery | • Simple mastectomy with or without axillary clearance<br>• Wide local excision of breast (partial excision of breast) with or without axillary clearance<br>• Oncoplastic wide local excision<br><br>Note: the benchmark values for day case surgery for wide local excision and oncoplastic wide local excision are different. | MHS Breast Metrics |
| Emergency | • Laparoscopic cholecystectomy<br>• Laparoscopic appendicectomy<br>• Incision and drainage of abscess | MHS Emergency Metrics |

| | | |
|---|---|---|
| | • Removal of products of conception from fallopian tube (ectopic pregnancy)<br>• Evacuation of retained products of conception<br>• Bartholin's abscess<br>• Open reduction and internal fixation of mandible<br>• Fractures of the zygomatic complex<br>• Orbital fractures<br>• Open Reduction and Internal fixation of wrist or ankle<br>• Manipulation Under Anaesthetic (MUA)/K-wire fixation of the wrist<br>• Elbow fracture<br>• Management of ureteric stones (laser and stent) | |
| ENT | • Tonsillectomy<br>• Tympanoplasty<br>• Myringoplasty<br>• Septoplasty<br>• Mastoidectomy<br>• Stapedectomy<br>• Functional endoscopic sinus surgery (FESS) | **MHS ENT Metrics**<br>**Day Case Hysterectomy Delivery Guide**<br>**Case Study: South West – Tonsillectomy in Children** |

| | | |
|---|---|---|
| | • Hemithyroidectomy<br>• Parotidectomy<br>• Targeted parathyroidectomy | **Case Study: Cornwall – Parotidectomy**<br>**Case Study: London – Hemithyroidectomy**<br>**Case Study: South Tees – Parotidectomy** |
| General Surgery | • Hernia repair<br>• Laparoscopic cholecystectomy<br>• Haemorrhoids/anal fissure surgery<br>• Laparoscopic repair of hiatal hernia<br>• Anal fistula<br>• Pilonidal sinus surgery | **MHS General Surgery Metrics**<br>**Case Study: Croydon - Cholecystectomy**<br>**Case Study: Mid & South Essex - Cholecystectomy**<br>**Case Study: Shrewsbury & Telford - Inguinal Hernia** |
| Gynaecology | • Laparoscopic hysterectomy<br>• Vaginal hysterectomy<br>• Anterior or posterior vaginal repair | **MHS Gynaecology Metrics** |

| | | |
|---|---|---|
| | • Bartholin's abscess | **Case Study: Newcastle - Laparoscopic Hysterectomy**<br>**Case Study: Sussex - Laparoscopic Hysterectomy** |
| Ophthalmology | • Vitrectomy | **MHS Ophthalmology Metrics** |
| Orthopaedics | • Anterior cruciate ligament reconstruction<br>• Uni-compartment knee replacement<br>• Total hip replacement<br>• Total knee replacement<br>• Therapeutic shoulder arthroscopy (rotator cuff repairs, subacromial decompression)<br>• Bunion surgery | **MHS Orthopaedics Metrics**<br>**Case Study: Bury – Super Saturday Day Case Initiative**<br>**Case Study: Exeter Physio Approach - Arthroplasty** |
| Urology | • Transurethral resection of prostate (TURP)<br>• Transurethral resection of bladder (TURBT) | **MHS Urology Metrics** |

| | | |
|---|---|---|
| | • Laser destruction of prostate<br>• Ureteroscopic destruction of calculus in ureter<br>• Endoscopic insertion of prosthesis into ureter<br>• Urolift<br>• Rezum steam therapy<br>• Bladder neck incision<br>• Holmium laser enucleation of the prostate<br>• Greenlight laser vaporisation | **Case Study: Maidstone & Tunbridge Wells - TURBT**<br>**Coder Guidance: Male Bladder Outflow Obstruction**<br>**Urology Outpatient Procedure Codes** |
| Vascular | • Endoluminal operations on femoral or ileac arteries (angioplasty)<br>• Varicose vein surgery<br>• Carotid endarterectomy<br>• Endovascular aneurysm repair (EVAR) | **MHS Vascular Metrics** |

## Moving Procedures out of a day surgery theatre setting

The Right Procedure, Right Place programme of work aims to support moving appropriate elective procedures, performed under local anaesthetic, out of a theatre setting and into an alternative environment such as an outpatient setting, enhanced procedure room or community setting. It is important that appropriate facilities exist to enable the change in care setting. Procedures where the focus should be to develop an outpatient rather than day surgery pathway can be found in the RPRP Procedure List and the RPRP Practical Guide outlines the principles and processes of the programme and presents case studies.

# 4. Appendix

The following example protocols referenced in the document and other resources are contained in the appendices to this pack.

**Section 1**

- Example template letters from POA
- Patient postoperative self-medication chart
- Perioperative prescription chart
- Acute pain protocol for adult surgery
- Day surgery care planning summary letter
- Procedure targeted spinal anaesthesia
- Bladder management flowchart
- Vignette: Productivity and Patient Outcomes
- Postoperative phone call proforma

**Section 2**

- Day case hip/uni-knee replacement anaesthetic protocol
- Day care primary hip arthroplasty pathway
- “How I Do It” series of Articles (reproduced with permission from BADS)
    - Day Case Anterior Cruciate Ligament Reconstruction
    - Day Case Laparoscopic Cholecystectomy
    - Day Case Tonsillectomy
    - Day Case Total Hip Replacement
    - Day Case Trans-Urethral Resection of Prostate
    - Day Case Laparoscopic Hysterectomy
    - Day Case Vaginal Hysterectomy and Vaginal Repair Surgery
    - Day Case Laparoscopic Gastric Bypass
    - Day case Inguinal Hernia Repair
    - Day Case Umbilical/periumbilical hernia repair

# 5. Further information

**Benchmarking**

- British Association of Day Surgery (BADS) Directory of Procedures and National Dataset (2022)
- Model Health System (MHS) Day Case and outpatient procedures metrics
- National Consultant Information Programme (NCIP) Online Portal for Consultant Learning

**Generic Day Surgery Resources**

- GIRFT Operational Implementation and Support Guide for Early Screening, Risk Assessment and Optimisation for Adult Patients (2023)
- GIRFT and SWLEOC Elective Hub Toolkit (2023)
- BADS/The Association for Perioperative Practice (AfPP) Competencies for the Day Surgery Team (2024)
- GIRFT Preoperative assessment services guidance (2023)
- CPOC National Safety Standards for Invasive Procedures (NatSSIPs) (2023)
- CPOC Perioperative Care: The key to reducing waiting lists (2023)
- GIRFT Design and layout of elective surgical hubs guidance (2022)
- NICE Guideline Shared Decision Making (2021)
- CPOC Impact of perioperative care on healthcare resource use: rapid research review (2020)
- BADS Handbook on Nurse Led Discharge 2nd Edition (2016)
- GIRFT Theatre Productivity Series
- CPOC Shared Decision Making
- CPOC Patient Pages

**Pathway Specific Resources**

- British Association for Paediatric Otorhinolaryngology Day Case Paediatric Adenotonsillectomy Consensus Guideline (2024)
- GIRFT Best Practice day case hysterectomy delivery guide (2023)
- GIRFT FutureNHS Hysterectomy Hub
- GIRFT Expanding Day Case Surgery in Ear Nose and Throat Services (2023)
- GIRFT/BOA Orthopaedic Elective Surgery Guide to delivering perioperative ambulatory Care for patients with hip and knee pain requiring joint replacement surgery (2023)

- GIRFT Pathway for Paediatric Forearm Fracture Manipulation in the ED (2023)
- BADS Wide Awake Local Anaesthetic, No Tourniquet. Technique, Uses and Guidance (2023)
- CPOC/AoMRC Guideline for Perioperative Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery (2023)
- CPOC Guideline for the Management of Anaemia in the Perioperative Pathway (2022)
- GIRFT Spinal Surgery: Day Surgery Discectomy Pathway (2022)
- GIRFT Breast Surgery National Specialty Report (2021)
- CPOC/BGS Guideline for Perioperative Care for People Living with Frailty Undergoing Elective and Emergency Surgery (2021)
- BADS Day Case Breast Surgery 2nd Edition (2020)
- BADS Day Case Gynaecology Surgery (2020)
- BADS Day Case Hip and Knee Replacement 2nd Edition (2020)
- BADS Surgical Same-Day Emergency Care 2nd Edition (2020)
- BADS Day Case Laparoscopic Cholecystectomy 4th Edition (2024)
- BADS Paediatric Issues in Day Surgery 2nd Edition (2018)

**Day Case Anaesthesia**

- Royal College of Anaesthetists Guidelines for the Provision of Anaesthesia Services for Day Surgery (2024)
- GIRFT Anaesthesia and Perioperative Medicine National Specialty Report (2021)
- Royal College of Anaesthetists Raising the Standards: RCoA Quality Improvement Compendium 4th Edition (2020)
- Association of Anaesthetists Guidelines for day case surgery 2019 (2019)
- BADS Spinal Anaesthesia for Day Surgery Patients A Practical Guide 4th Edition (2019)

# 6. Contributors

| | |
|---|---|
| Dr Mary Stocker | Consultant Anaesthetist, Torbay and South Devon NHS Foundation Trust (Original Author) |
| Mr David Bunting | Consultant Upper GI Surgeon, Royal Devon University Healthcare NHS Foundation Trust, BADS President |
| Ms Nicky Dunning | Devon Clinical Commissioning Group* |
| Mrs Nicola Dalgleish | Devon Clinical Commissioning Group* |
| Mr Thomas Glover | South East Regional Manager, Getting It Right First Time Programme (GIRFT) (2021) |
| Mrs Julie Kennedy | Senior Content Development Manager, GIRFT Academy |
| Ms Jo Marsden | Retired Consultant Breast Surgeon, Kings College Hospital Foundation Trust, London, Immediate Past President BADS |
| Mrs Emma McCone | RGN, GIRFT National POA Advisor |
| Professor Scarlett McNally | Consultant Orthopaedic Surgeon, Deputy Director CPOC |
| Dr Kim Russon | Consultant Anaesthetist, Rotherham NHS Foundation Trust |
| Dr Chris Snowden | Consultant Anaesthetist, Newcastle Upon Tyne NHS Foundation Trust, GIRFT National Clinical Lead for perioperative medicine |
| Dr Mike Swart | Consultant Anaesthetist, Torbay and South Devon NHS Foundation Trust, GIRFT National Clinical Lead for perioperative medicine |
| Mrs Ruth Tyrell | National Delivery Director, GIRFT Programme |

*(Based on original document produced for Devon STP)

**About GIRFT and the GIRFT Academy**
Getting It Right First Time ('**GIRFT**') is an NHS programme designed to improve the quality of care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The GIRFT Academy has been established to provide easily accessible materials to support best practice delivery across specialties and adoption of innovations in care.

Importantly, GIRFT Academy is led by frontline clinicians who are expert in the areas they are working on. This means advice is developed by teams with a deep understanding of their discipline.

**GIRFT Academy has also published other pathways and case studies which are available via FutureNHS. These are available at:** Getting It Right First Time - FutureNHS Collaboration Platform

**GIRFT Academy contact: girft.academy@nhs.net**