The Principles of converting to ‘same day care’: Lessons learnt in Day Surgery?

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General & Breast Oncoplastic Surgeon
Milton Keynes University Hospital NHSFT
20th July 2016
Is day surgery better than in-patient surgery?

Not evidence based

but...

Day Surgery is a process not a procedure
Patients Like Day Surgery

• Quality Care
  – early recovery
  – minimal disruption
  – comfort of own home
• Patient-centred Pathway
• Better Care, Safer Care?
1. Timeline
2. Government Funding
3. Pathway Re-Design
4. Facilities
5. Benchmarking
6. Incentivisation
7. Sustainability
8. Emergency Day Surgery
Timeline
Father of Modern Day Surgery
- 1899-1908 reported on 8988 ops
- performed at the Sick Childrens’ Hospital & Dispensary, Glasgow

BMJ 2:753, 1909

James H. Nicoll
(1864–1921)
Ralph M. Waters (1883–1979)

1919:
The Down-Town Anesthesia Clinic, Sioux City, Woodbury & Plymouth Counties USA
Day Case Inguinal Hernia 1955

458 Consecutive Day Case Inguinal Hernia Repairs

Farquharson EL, Lancet 1955;ii:517-9
<table>
<thead>
<tr>
<th>Date</th>
<th>Key events</th>
</tr>
</thead>
<tbody>
<tr>
<td>1909</td>
<td>James Nicoll, a Glasgow surgeon, publishes ‘The surgery of infancy’ in the <em>British Medical Journal</em></td>
</tr>
<tr>
<td>1916</td>
<td>Ralph Waters opens his ‘downtown anaesthesia clinic’ in Sioux City, Iowa</td>
</tr>
<tr>
<td>1951</td>
<td>The first hospital-based day surgery unit is opened in Grand Rapids, Michigan</td>
</tr>
<tr>
<td>1955</td>
<td>Eric Farquharson, an Edinburgh surgeon, publishes a series of 458 consecutive day case inguinal hernia repairs in <em>The Lancet</em></td>
</tr>
<tr>
<td>1969</td>
<td>The first free-standing ambulatory surgical centre is opened in Phoenix, Arizona</td>
</tr>
<tr>
<td>1969</td>
<td>James Calnan opens the first day unit in the UK at the Hammersmith Hospital, London</td>
</tr>
<tr>
<td>1985</td>
<td>The Royal College of Surgeons of England suggest a 50% target for elective surgical procedures to be performed as day cases</td>
</tr>
<tr>
<td>1989</td>
<td>The British Association of Day Surgery (BADS) is formed</td>
</tr>
<tr>
<td>1991</td>
<td>Audit Commission <em>Basket of 20</em> published</td>
</tr>
<tr>
<td>1993</td>
<td>National Day Surgery Task Force suggests a 60% target for day surgery</td>
</tr>
<tr>
<td>1995</td>
<td>International Association of Ambulatory Surgery formed</td>
</tr>
<tr>
<td>2001</td>
<td>Audit Commission <em>Basket of 25</em> published</td>
</tr>
<tr>
<td>2006</td>
<td>Modernization Agency indicates a 75% target for day surgery</td>
</tr>
<tr>
<td></td>
<td>BADS <em>Directory of Procedures</em> published</td>
</tr>
</tbody>
</table>
Early UK Day Surgery

Late 1970s – early 1980s
- pioneering enthusiasts
- local developments
- medical & nursing establishment apathetic

Required a coordinated approach
- British Association of Day Surgery
- Formed 1989
Government Funding
75% Of Elective Surgery To Be Performed On A Day Case Basis

The NHS Plan
A plan for investment
A plan for reform

Alan Milburn 1999-2003

White Paper, 2000
Government Initiatives

NHS Modernisation Agency
- 2002–5
- Clinical Champions
- Lost momentum

Enhanced Recovery Prog
- time limited support
- losing momentum
“Day surgery is the admission of *selected* patients to hospital for a *planned* surgical procedure, returning home on the same day.

10 High Impact Changes

NHS Modernisation Agency, 2004

John Reid 2003-5
Service Improvement and Delivery

**Top High Impact factor:**

Treat day surgery (rather than in-patient surgery) as the norm for elective surgery.

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**Table 1: 10 High Impact Changes for service improvement and delivery**

1. **Change No1:** Treat day surgery (rather than inpatient surgery) as the norm for elective surgery.

2. **Change No2:** Improve patient flow across the whole NHS system by improving access to key diagnostic tests.

3. **Change No3:** Manage variation in patient discharge, thereby reducing length of stay.

4. **Change No4:** Manage variation in the patient admission process.

5. **Change No5:** Avoid unnecessary follow-ups for patients and provide necessary follow-ups in the right care setting.

6. **Change No6:** Increase the reliability of performing therapeutic interventions through a Care Bundle approach.

7. **Change No7:** Apply a systematic approach to care for people with long-term conditions.

8. **Change No8:** Improve patient access by reducing the number of queues.

9. **Change No9:** Optimise patient flow through service bottlenecks using process templates.

10. **Change No10:** Redesign and extend roles in line with efficient patient pathways to attract and retain an effective workforce.
### WELSH HEALTH CIRCULAR

**Title:** 18WEEKS ACCESS PROJECT

**Issue Date:** 22 December 2005

**Status:** Active

**Funding Agency:** NHS Trusts/Governmental

**Lead Chief Executive:** [Name]

**Lead Information:** [Name]

**Sponsor:** [Name]

**Doe de unde:** [Name]

**National Assembly for Wales:** [Name]

**Department of Health:** [Name]

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**Content:**

- Better use of NHS capacity to deliver a better deal for patients

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**Website:** www.bads.co.uk
2009 DoH Enhanced Recovery Programme

Pre Operative
- Optimise health
- Preassessment
- Patient information
- Patient expectation
- Discharge Planning

Intra Operative
- Minimally invasive
- Regional anaesthesia
- Goal directed fluid therapy

Post Operative
- Planned mobilisation
- Regular analgesia
- Avoid opiates
- Minimal drains

Discharge
- Planned
- Patient Information
- Follow up if required

Andy Burnham 2009-10
Pathway Re-Design

THE PATHWAY TO SUCCESS - Management of the Day Surgical Patient
NATIONAL CLINICAL SPREAD NETWORKS
BREAST CANCER SURGERY DAY CASE / 23 HOUR STAY

Initial workshop August 2010, London
- Agreement about:
  - Implementation
  - The pace of change
  - Identify drivers for change / influence current clinical practice
  - Disseminate and expand clinical evidence
  - Reach a consensus on the 23 Hour Pathway
  - Agree outcome measures to assess impact
Keep improvement simple

Figure 5: A consistent systematic approach was applied to capture the impact and learning

Analysis
Baseline from different perspectives

Identify the real root of the problem

Visioning
What are you trying to achieve?

Testing Cycles
Test out the ideas/innovations
Test confidence and competence

Is it the right solution to address the real problem?

NO

Evaluate and check sustainability

Implementation
Implement the idea

Case for change
Plan the implementation of the test idea
Build the case for change

Agree the redesign and implementation of the improvements

Evaluation
Evaluate the benefits
What is the difference?

Clinical Spread Networks

Spread/Adoption Strategy

Winning Principles
Capture the impact and learning
2. Learning and unlearning

It is a MDT approach

- ‘Systemic approach’
- ‘Collate evidence’
- ‘Patient Experience’
- ‘Engagement’
- ‘Create a common purpose’
- ‘Give right messages’

Many lessons have been learned over the four years. Some of the learning was new, repetitive and challenging.

Supporting spread: Key learning from the clinical spread networks:
The knowledge of 13

Take a systematic approach to service improvement. This takes time but builds up a good evidence base and gets to the real root of the problem.

Understand the national and local context and coherence with local values and priorities. This should not be underestimated and is needed to gain commitment to deliver in challenging times.

Give the right messages in the right language to the different audiences and to spread the knowledge for persuasion and decisions.

Clinicians don’t like targets, managers do, and patients are more concerned with getting better.

Patient experience and feedback is a key factor in accelerating the pace of spread.

Engagement with key people leading change is not enough, support them to manage, organise and mobilise the change.

Build relationships across professions and organisational boundaries.

There is a need to create the common purpose.
From testing to spread... the approach

Throughout the service improvement phases (Figure 4) NHS Improvement shared the learning across the NHS to encourage local spread, adoption and adoption.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Year</th>
<th>Service Improvement stages</th>
<th>NHS coverage</th>
<th>Spreading the learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2007</td>
<td>• Baseline the current situation</td>
<td></td>
<td>The Winning Principles: Transforming Inpatient Care (July 2008)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review clinical procedures</td>
<td></td>
<td>Meeting the Challenge Together (October 2008)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Listen to all views and perspectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Understand the culture, context and content of Trusts, clinical teams and pathways</td>
<td>7 NHS hospital sites</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify best practice and challenges</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Consolidation Report (2009) From Testing to Spread</td>
</tr>
<tr>
<td>3</td>
<td>2009</td>
<td>• Prototype testing the transferability, confidence and competence of the improvement</td>
<td>13 clinical spread networks (72 hospital sites) 41% coverage across England</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2010-11</td>
<td>Spread, adoption and adoption</td>
<td></td>
<td>Spreading the Winning Principles case studies (July 2010)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Breast day case/one night stay case studies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><a href="http://www.improvement.nhs.uk">www.improvement.nhs.uk</a></td>
</tr>
</tbody>
</table>
Figure 7: The seven influential components

- Spread Making the Connections
- A Vision for Quality Improvement
- Systematic Improvement Approach
- Organisational Culture and Fit
- Linked Strategic and Operational Change
- Continuous Monitoring Progress and Impact
- Collaboration Partnerships and Team Working
- Learning & Unlearning
- Patient Centred
- Alignment with Opportunities and Levers
- Leadership Engagement Accountability
- Spread Simple Principles and Messages

- Monitoring
- Collaboration
- Learning & Unlearning
- Patient centred
- Leadership Engagement Accountability
- Alignment with opportunities
- Spread simple messages
Key Areas on the Patient Administrative Pathway

Rate limiting steps
1. Admission Criteria
2. Default Position
3. Operational Guide
4. Discharge Process

Domains
1. Quality
2. Cost
3. Safety
Preoperative assessment

Default to Day Surgery

• Can this patient be a day case?

• Is there any reason this patient cannot be a day case?
Nurse-Led Discharge protocol

Discharge Criteria:

- Vital signs stable
- Orientation
- Pain controlled
- Oral analgesics supplied
- Understands medication
- Ability to dress and walk
- Minimal nausea & vomiting
- Minimal wound bleeding
- Responsible adult to take them home
- Carer at home for next 24 hrs
- Driving after surgery
- Passing urine before discharge
Nurse-Led Discharge protocol

Discharge Criteria:

- Vital signs stable
- Orientation
- **Pain controlled**
- Oral analgesics supplied
- **Understands medication**
- Ability to dress and walk
- Minimal nausea & vomiting
- Minimal wound bleeding
- Responsible adult to take them home
- **Carer at home for next 24 hrs**
- Driving after surgery
- **Passing urine before discharge**
Some clinical practice were just clinical myths!!

“One must learn by doing the thing, for though you think you know it, you have no certainty until you try.”

Sophocles, 400BC

Four specific aspects were commonly highlighted:

1. Changing clinical practice relating to the use of wound drains, drainage of seromas and pain control.

2. Assumptions that patients would not want to go home earlier.

3. Perceptions that the redesign was a cost cutting exercise.

4. Preconceptions “We do this anyway” and “this will increase re-admissions.”
Passing Urine

“Passing urine for patients at low risk of post-operative urinary retention is not essential before going home.”

Jackson I, McWhinnie D, Skues M
The pathway to success.
BADS London 2012
“Passing urine for patients at low risk of post-operative urinary retention is not essential before going home.”

Jackson I, McWhinnie D, Skues M
The pathway to success.
BADS London 2012
Facilities
Facilities: What’s Special?
Patient Admission
Dedicated Facilities for day surgery

Unplanned admissions

Dedicated day unit - 1.0 %
In-patient ward - 17.0 %
Satellite day unit - 2.7 %

Day Surgery in Different Guises
Fehrmann K, Matthews CM, Stocker ME
J One-Day Surgery 2011; 19;39-47
Day Surgery vs Inpatient Nursing

- Higher turnover
- Lower dependency
  - time for individual needs
  - different priorities
- Wider ranging
  - sub-specialty skills
  - value of protocols
Medical Staffing

The high standards required demand that
- operator & anaesthetist must be experienced
- trainees should be personally supervised
- requires higher consultant ratio
## Choice of Anaesthetist

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of cases</th>
<th>Unplanned admission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>36,719</td>
<td>2.3%</td>
</tr>
<tr>
<td>Career Grade</td>
<td>11,657</td>
<td>3.1%</td>
</tr>
<tr>
<td>Trainee</td>
<td>9,908</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

*Hanousek, et al. — Anaesthesia 64:152, 2009*
Benchmarking
“The NHS Plan envisages that 75% of all Elective Surgery will be carried out as a day case in the near future”
But....

This data includes “diagnostics” and non surgical interventions...

• Radiology
• Endoscopy
• Transfusion
“The NHS Plan envisages that 75% of all Elective Surgery will be carried out as a day case in the near future”

Definition: “near future” = 2032
Audit Commission’s Basket of 25 Procedures 2001

<table>
<thead>
<tr>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract Extraction</td>
</tr>
<tr>
<td>Excision Breast Lump</td>
</tr>
<tr>
<td>Carpal Tunnel Decompression</td>
</tr>
<tr>
<td>Bat Ears</td>
</tr>
<tr>
<td>R/O Metalwork</td>
</tr>
<tr>
<td>Bunion Operations</td>
</tr>
<tr>
<td>Laparoscopy</td>
</tr>
<tr>
<td>Tonsillectomy</td>
</tr>
<tr>
<td>TURBT</td>
</tr>
<tr>
<td>Squint Correction</td>
</tr>
<tr>
<td>Orchidopexy</td>
</tr>
<tr>
<td>Anal Fissure</td>
</tr>
<tr>
<td>D&amp;C / Hysteroscopy</td>
</tr>
<tr>
<td>Nasal Fractures</td>
</tr>
<tr>
<td>Myringotomy</td>
</tr>
<tr>
<td>Laparoscopic Cholecystectomy</td>
</tr>
<tr>
<td>Excision of Ganglion</td>
</tr>
<tr>
<td>Hernia Repair</td>
</tr>
<tr>
<td>Varicose Veins</td>
</tr>
<tr>
<td>Dupuytren’s Contracture</td>
</tr>
<tr>
<td>Haemorrhoidectomy</td>
</tr>
<tr>
<td>Circumcision</td>
</tr>
<tr>
<td>Arthroscopy</td>
</tr>
<tr>
<td>Arthroscopy</td>
</tr>
<tr>
<td>SMR</td>
</tr>
<tr>
<td>Termination of pregnancy</td>
</tr>
</tbody>
</table>
Problems with index procedures: “Basket Problems”

- Not representative
- The Basket represents only 30% of all Day Surgery activity
- No recognition of the Short Stay Pathway
- No recognition for innovation
<table>
<thead>
<tr>
<th>Table 1 Definition of lengths of stay in Directory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Room: An operation that can be performed in a suitably clean area outside an operating theatre. The varying complexity of such procedures may require the commissioning of a specific environment and equipment beyond the expectation of a standard outpatient room (e.g., endoscopy or outpatient hysterectomy suites).</td>
</tr>
<tr>
<td>Zero night stay: Patient admission, treatment and discharge occurring on the same calendar day. National definitions of Day Surgery also include the mandate that such care should be intentionally pre-planned.</td>
</tr>
<tr>
<td>One night stay: Patient admission, treatment and discharge occurring over two consecutive days.</td>
</tr>
<tr>
<td>Two night stay: Patient admission, treatment and discharge occurring over three consecutive days.</td>
</tr>
</tbody>
</table>
Short Stay Equation

Scenario I

– 100 Laparoscopic Cholecystectomies
  • 50 Day Cases
  • 30 Overnight Admission
  • 20 Two Night Admission

Total 70 Inpatient Bed Days

Scenario II

– 100 Laparoscopic Cholecystectomies
  • 40 Day Cases
  • 50 Overnight Admission
  • 10 Two Night Admission

Total 60 Inpatient Bed Days
Surgical Sub-specialties

Breast Surgery
ENT
General Surgery
Gynaecology
Head and Neck Surgery
Ophthalmology
Orthopaedics
Paediatric Surgery
Urology
Vascular
Emergency Surgery
Medical Procedures

12 sub-specialties
> 180 procedures
Day Case Surgery is World First

Without realising it until after the event, one of our surgeons recently performed the world’s first laparoscopic nephrectomy (the removal of a kidney by keyhole surgery) as a day case operation.

The keyhole operation was first performed in 1991 and has since become common practice, but has normally involved a two or three day stay in hospital. On this occasion, however, the operation went very well as normal, but the patient recovered so quickly and was so keen to go home the same day that the surgeon, Anurag Golash, agreed.
Introduction

Awake craniotomy is becoming more popular for supratentorial tumour resection. Cortical mapping allows "disconnection" of eloquent brain (i.e., functional brain such as motor cortex, sensory cortex or speech areas) to be identified and preserved, facilitating maximal tumour resection while minimizing the risk of permanent deficit. Day case awake craniotomies have been undertaken for a number of years in other international centres and the concept of awake craniotomies being performed on a day case basis in the United Kingdom has been suggested previously. However, we believe this is the first such case report performed for tumour resection.

Case Report

In December 2006, a 47-year-old right-handed female presented with a history of right temporal localising symptoms including speech and visual disturbance. She had a past history of breast cancer. Radiological investigations revealed a 1.5 x 2.0 cm subcortical lesion in the left parietal region close to the surface. The mass was uniformly enhancing with surrounding oedema and lay anatomically in, or close to, Wernicke's area.

Following a multidisciplinary meeting and discussion with the patient, neurosurgical resection was advised. Prior to further anaesthesia, TCI perfusion monitoring was performed with the patient awake using a cortical mapping and identification of speech and sensory cortex in order to minimize the risk of permanent deficit and allow maximal tumour resection. Preparation for surgery began in the neurosurgical outpatient clinic. On the day of surgery, the patient was given oral and written information about the procedure. This was followed by a preoperative anaesthetic assessment on the day of admission. Following consent, performance of an endocrine, 135 mg of midazolam, 10 mg of atropine, were given prior to surgery, potentially minimising the risk of gastric aspiration.

In the anaesthetic room, standard monitoring was placed, including non-invasive blood pressure, ECG, and pulse oximetry. A single large bore intravenous cannula was inserted. No invasive monitoring was used and no urinary catheter was placed. 7% thiopentone anaesthesia, midazolam 2 mg, was given intravenously. Identification and marking of the optimal pin position on the patient's skull was followed by induction of an ultra-short general anaesthetic using a plasma see target controlled infusion (TCI) of propofol at 4 mg/min in combination with a remifentanil infusion (10 µg/min) running at 88 ml/h. During this short anaesthetic, bag and mask ventilation was provided via main airway exchange. As loss of eyelash reflex, 2 ml of 1% lidocaine was instilled into the scalp as each identifed pin was for the Marfield clamp. Once the clamp was in position, the TCI propofol was turned off and the patient allowed to awaken before being transferred to the operating theatre.

The patient was placed in the right lateral position and the Marfield clamp was secured to the operating table. Monitoring was reconnected and supplemental oxygen was given via a Hudson mask at 51/min. In addition, a gas sampling line was inserted to the side of the mask to give a guided the end-tidal partial pressure of carbon dioxide. With the patient neurologically stable, any pain or discomfort was measured. TCI propofol was recommenced with a plasma target of 9.7 µg/ml and the cranial incision was continued as 20
Day Case Thyroid Surgery: Patient’s are up for it – Are You?

Bettina Lieske, Glynis Howat, Matthew Sarnes & Andrew McLaren

Wycombe Hospital

Study design of a pilot randomised clinical trial comparing day surgery and inpatient surgery for breast cancer

S Marla, S Stallard

Victoria Infirmary

Glasgow

Laparoscopic Gastric Banding for Morbid Obesity in The Day Surgical Setting

MF Dunsire, AG Patel, N Awad, T Whitfield, G Allan, T Livingstone

King's College Hospital

NHS Foundation Trust

NHS Greater Glasgow

British Association of Day Surgery www.bads.co.uk
### Medical Approach:

<table>
<thead>
<tr>
<th>Condition/ Scenario</th>
<th>HRG Codes 11/12</th>
<th>HRG Codes 11/12 Detail</th>
<th>% Potential Ambulatory Care (Primary ICD-10 Coded Admissions)</th>
<th>Specific Safety Issues (Not Exhaustive)</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DZ16B</td>
<td>Pleural Effusion with CC</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>DZ15E</td>
<td>Asthma with CC without Intubation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10</td>
<td>J90X, C782, J111</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10</td>
<td>J450, J451, J458, J459</td>
<td></td>
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</tr>
</tbody>
</table>
2010-2011

- Same tariff for DC and IP
- Best Practice tariff for DC laparoscopic cholecystectomy
## The Development of ‘Best Practice’ Tariff

### Payment by Results Guidance for 2012-13

<table>
<thead>
<tr>
<th>BPT.</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Stroke</td>
<td>Introduced</td>
<td>Increased price differential</td>
<td>Further increase in price differential</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Introduced and maintained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fragility hip fracture</td>
<td>Introduced</td>
<td>Increased price differential</td>
<td>Further increase in price differential and expansion of best practice characteristics</td>
</tr>
<tr>
<td>Day case procedures</td>
<td>Gall bladder removal</td>
<td>12 further procedures added</td>
<td>2 further procedures added: breast surgery procedures amended and revision to some day case rates</td>
</tr>
<tr>
<td>Adult Renal Dialysis</td>
<td>Vascular access for haemodialysis</td>
<td>Home therapies incentivised</td>
<td></td>
</tr>
<tr>
<td>Paediatric Diabetes</td>
<td>Activity based structure (non-mandatory)</td>
<td>Year of outpatient care structure (mandatory)</td>
<td></td>
</tr>
<tr>
<td>Transient ischaemic attack</td>
<td>Introduced and maintained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary total hip and knee replacements</td>
<td>Introduced and maintained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventional radiology</td>
<td>2 procedures introduced</td>
<td>5 further procedures added</td>
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</tr>
<tr>
<td>Procedures in Outpatients</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Same day emergency care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Major trauma care</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
**Promoting Quality Day Care**

Best Practice Tariff – Laparoscopic Cholecystectomy

**2012/13**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Daycase tariff (£)</th>
<th>Elective spell tariff (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA10D</td>
<td>Laparoscopic Cholecystectomy with length of stay 1 day or more without CC</td>
<td>-</td>
<td>1,367</td>
</tr>
<tr>
<td>GA10E</td>
<td>Laparoscopic Cholecystectomy with length of stay 0 days without CC</td>
<td>1,662</td>
<td>1,367</td>
</tr>
</tbody>
</table>

Planned as day case
Discharged day of surgery
Tariff incentivisation for 2011-12
Enhanced reimbursement

- Breast Surgery
- Hernia Surgery
- Orthopaedic Forefoot Surgery

.........**IF** performed as Day Case!!
Impact of Best Practice Tariff

Day Case Laparoscopic Cholecystectomy
1999-2000
Over the last 10 years
Sustainability
NHS Institute for innovation and Improvement toolkit

Delivering Quality and Value
Focus on: Cholecystectomy

Our Elective Cholecystectomy Pathway

<table>
<thead>
<tr>
<th>Referral</th>
<th>Outpatients</th>
<th>Pre-assessment</th>
<th>Scheduling</th>
<th>Admission</th>
<th>Theatre</th>
<th>Post-operative Care</th>
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British Association of Day Surgery

www.bads.co.uk
Start of Programme

Day surgery rate (%)

Trusts

It Won’t Work Here...

- Rural population
- Urban population
- Teaching hospital
- DGH
- Local poverty
- Local co-morbidities
- DSU capacity
- Layout of wards/theatres
Applying Basic Principles

Day surgery rate (%)

- Start Oct 2008
- End Nov 2009

Trusts

Sustainable?

Day surgery rate (%)

- **Start Oct 2008**
- **End Nov 2009**
- **National Data, Mid 2012**

Data from: www.productivity.nhs.uk
### Sustainable?

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**Data from:**

[www.productivity.nhs.uk](http://www.productivity.nhs.uk)
Figure 1: Proportion of all patient activity during the year carried out as day cases: England, 1974-2013
Figure 2: Spending on elective inpatients and day case patients in England, 1998-2014: actual versus estimated amount if day case activity remained at 1998 levels

£2 billion - saving due to increase in day case surgery
Emergency Day Surgery
Emergency Surgery

- Unselected
- Unplanned
- Unscheduled
- Day or Night
Classification of Emergency Surgery

**Immediate** – Immediate life, limb or organ-saving intervention (within minutes)

**Urgent** – Intervention for acute onset or deterioration of potential life-threatening conditions (within hours)

**Expedited** – Patient requiring early treatment where the condition is not an immediate threat to life (within days)

**Elective** – Intervention planned or booked in advance of routine admission (planned)
Planned emergency surgery pathway

Minor emergency procedure required

Pre-operative assessment by surgical team

Home with fasting instructions

Next morning, coordinator assigns theatre slot

Patient advised time and place of admission

Emergency procedure performed as scheduled

Patient discharged on day of surgery
Procedures

Appendicectomy (laparoscopic)
Arthroscopy
Biopsy
  - lymph node
  - temporal artery
Evacuation retained products of conception
Incarcerated Hernia
  - inguinal
  - para-umbilical
  - femoral
Incision & Drainage of Abscess
  - axillary
  - groin
  - neck
  - perianal
  - pilonidal
K – wiring
  - finger or wrist
Laparoscopic ovarian cystectomy
Reduction and internal fixation
Tendon repair
Financial Considerations

- Cost savings

- Resources rather than cash savings due to:
  - Reduction of in-patient bed days
  - Utilisation of beds for other procedures
  - Improved operation room efficiency
1. Timeline
2. Government Funding
3. Benchmarking
4. Incentivisation
5. Sustainability
6. Facilities
7. Pathway Re-Design
8. Emergency Day Surgery
No place like home!