

Day Surgery: Operational guide

Waiting, booking and choice

August 2002

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Foreword

The Day Surgery strategy was launched in January 2002 with the aim of driving forward day surgery in the NHS. There is a need to increase capacity within the NHS to meet current demands, and day surgery has an important role to play in achieving this. Expanding day surgery provides an exciting opportunity to improve patient care in modern clinical settings where staff too can enjoy a rewarding working environment. This guide aims to support clinicians and managers in their work. An increase in day surgery rates requires the input of many different groups and individuals, and this is reflected in a Reference Group which includes people with key experience in these areas. I would like to thank the members of this group for the extensive work that they have contributed to this guide.

The Reference Group members were:

Ms Bola Aworinde	NHS Modernisation Agency
Dr Jonathan Boyce	Audit Commission
Mr Joseph Cahill	British Association of Day Surgery
Mr Trevor Campbell-Davis	NHS Confederation
Dr Griselda Cooper	Royal College of Anaesthetists
Mr David Dandy	Royal College of Surgeons
Dr Valerie Day	NHS Modernisation Agency
Mr Alan Farthing	Royal College of Obstetricians and Gynaecologists
Mr Tony Snowdon	Royal College of Nursing
Ms Ann Stephenson	Department of Health
Mr Paul Woods	Department of Health
Miss Kate Bowe	Department of Health

Additionally, a Wider Network Consultation Group with representatives from many more organisations has commented on the guide. I would like to thank all those who helped in the drafting of this guidance for their comments and advice.

My particular thanks go to Joe Cahill, Paul Woods and Kate Bowe, who have all been major contributors to this project. They have never flinched at the workload or the deadlines, and their commitment has been key to the production of this guide.

Professor Ara Darzi

Advisor in Surgery to the Department of Health

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1. Introduction

- 1.1 The NHS Plan sets the patient firmly at the centre of a framework for modernising the NHS. Taking forward the agenda to reduce waiting times, implement booking systems and introduce choice requires fundamental changes in practice and for the NHS to “do things differently”. Day surgery will make a significant contribution to this agenda. Initiatives such as the Diagnostic and Treatment Centre programme will increase overall capacity, but there is still considerable scope to treat more patients within the current system by managing the overall surgical pathway and current facilities better. Day surgery provides a means of helping the NHS to achieve its targets, of treating more patients faster and is therefore a key strand of NHS modernisation.

Day Surgery Programme

- 1.2 This guide is an aide to managers and commissioners to improve efficiency in day surgery units. Taking it forward will also help them improve performance across a range of measures. It is part of an overall strategy, which includes:
- This operational guide, directed at those involved in planning and managing elective surgical services.
 - Clinical guidance currently being developed with the Royal College of Surgeons. This is looking at criteria for selecting patients for day surgery, training, day care resources and clinical governance, and will complement this operational guide.
 - Work by the NHS Modernisation Agency to help Trusts improve their performance by learning from and building on their own experiences. The Modernisation Agency has appointed a national programme lead to support day surgery expansion, including the development of learning sets. This programme will build on the lessons learned from other improvement programmes, and will work with Trusts to improve patients' experience.
 - A summit in September 2002 for Trusts with low levels of day surgery activity to look at methods of improving their rates, with support from Trusts achieving higher day surgery rates.
 - Appointment of clinical champions to assist Strategic Health Authorities develop day surgery locally.
 - A programme for clinical and managerial champions with an interest and proven track record in day surgery to visit Trusts with low levels of day surgery to offer support and advice.
 - Through the capacity planning exercise that is currently underway, Treasury Capital Modernisation Funding of £31 million in 2002/03 and £37 million in 2003/04 will be available. This funding will help tackle the blockages that cause delays and cancellations and to speed progress with day case booking. In particular, it will help to fund the purchase of medical equipment and small building work, particularly for those organisations which do not have a separate day case facility.

Programmes so far

- 1.3 During the early 1990s there was considerable growth in the use of day surgery, and provision of new facilities, but over recent years this has levelled off and in some cases declined. The 2001 Audit Commission Report on day surgery confirmed that day surgery units are not being used to their maximum capacity (1). The Audit Commission estimates that if all units operated to the standards of the best, there is the scope to carry out an extra 120,000 operations per annum. This is based on only the basket of 25 day surgery procedures that the Audit Commission has developed (Annex A), covering the most frequently performed procedures across all the major specialties. The British Association of Day Surgery's (BADS) wider list of procedures suitable for day surgery is derived from actual practice in day surgery units and indicates even greater scope (Annex B).
- 1.4 The NHS Plan predicts that 75% of all elective operations will be carried out as day cases, but benchmarking studies carried out by the British Association of Day Surgery and Newchurch Ltd (2) show that no Trust taking part in the exercises had reached this level. The Department of Health 2000/01 figure for the percentage of elective operations performed as day surgery was 68%, but this contains large numbers of procedures performed in day surgery units which do not need operating theatre facilities and that could be undertaken in other parts of the hospital or in primary care. The percentage of "true day surgery" is much less, and no hospital is performing at uniformly high levels across all specialties.

What is Day Surgery?

- 1.5 Day surgery is the admission of selected patients to hospital for a planned surgical procedure, returning home on the same day. "True day surgery" patients are day case patients who require full operating theatre facilities and/or a general anaesthetic, and any day cases not included as outpatient or endoscopy.
- 1.6 Day surgery provides benefits to all involved.
- Patients receive treatment that is suited to their needs and which allows them to recover in their own home. Cancellation of surgery due to emergency pressures in a dedicated day surgery unit is unlikely. The risk of hospital acquired infection is reduced.
 - Clinicians can provide high quality care for appropriate patients, and release inpatient beds for more major cases.
 - Trusts improve their throughput of patients, facilitate booking, and reduce waiting lists.
 - Primary Care Trusts (PCTs) can commission cost-effective healthcare.
- 1.7 The Audit Commission and British Association of Day Surgery/Newchurch reports identified a number of issues preventing some day surgery units from working to their optimum level. These include:
- Inappropriate and inefficient use of units, for example treating patients who could be cared for in a treatment room or outpatients.
 - Poor management and organisation, particularly in relation to the flow of patients.

- Clinicians' preferences for inpatient surgery.
- Mixing of inpatients and day cases on the same list, leading to cancellations due to theatre overruns.
- Failure to recognise day surgery as a priority.

1.8 Some of these problems can be tackled through improving processes, but others are more difficult as they require a change in culture. Nevertheless, the need to improve patient services, to reduce access times and to improve convenience for patients and hospitals means that these difficulties must be addressed.

Operational Guide

- 1.9 This guide will assist Trusts in improving their performance in day surgery and to unlock the potential for further improvement. All acute Trusts received a tailored report on their performance from their auditors in 2001. Many have taken this further by commissioning in-depth audit work, or by using the data on procedures (from Hospital Episodes Statistics (HES)) and day surgery units provided to Trusts on CD-ROM by the Audit Commission. The procedures data are updated annually, so that Trusts will have 2001/02 data later this year (<http://www.audit-commission.gov.uk/itc/acuteportfolio.shtml>). In some cases the comparative analyses are provided to them by CHKS Ltd. The British Association of Day Surgery/Newchurch benchmarking exercise enables participating Trusts to examine factors underlying performance in considerable detail. A new accreditation system developed by the British Association of Day Surgery and HQS (Health Quality Service) will enable Trusts to examine the appropriateness of their day surgery facilities. See contact details at the end of the guide.
- 1.10 Many of the proposals in this report mirror those of the NHS Management Executive Report by the Day Surgery Task Force in September 1993 (3). Few have been implemented! This reaffirmation of the proposals needs to be followed by national and local action to encourage change.
- 1.11 A strategy of identifying constraints on activity, and then helping Trusts to deliver change through the Modernisation Agency will put in place a day surgery service that provides effective high quality care to a higher number of patients.

2. Patients

- 2.1 Patients want treatment that is safe, efficient and effective, and which provides the least possible disruption to their lives. Day surgery gives this patient-focused care. Repeated patient surveys have demonstrated that the great majority of patients prefer to recover in their own homes rather than staying overnight in hospital (4).

How does day surgery benefit patients?

- 2.2 Patients who need an operation and choose to have it as a day case want to know when it will take place to allow them to make arrangements for other aspects of their lives. The National Booking Programme is putting in place systems that allow patients to choose their admission date at a time that is convenient for them. In most Trusts the implementation of booking systems is well advanced. By March 2003 80% of day cases will be booked and by 2005 all day cases will be booked. Experience with booking in day surgery units is showing substantial decreases in cancellations and DNA (did not attend) rates with consequent increase in numbers of patients treated.

Which patients are suitable for day surgery?

- 2.3 Selecting patients for day surgery can be facilitated through use of protocols.
- 2.4 There are 4 main elements to day surgery:
- i. **Pre-operative assessment:** Selection criteria developed in the 1980s and 1990s (5,6) were devised to ensure safety as day surgery evolved in the UK. New guidelines being written to complement this document will suggest that patients undergoing most intermediate and some major operations should be considered for day surgery as the norm, and only excluded after a full pre-operative assessment shows a contraindication.

The pre-operative assessment protocol should include:

- Information on the day surgery experience to ensure that the patient understands the procedure to be undertaken and their likely post-operative course.
- Assessment of the patient's general medical status and fitness for anaesthesia.
- Assessment of the patient's home circumstances, and for certain types of surgery, access to the patient's home. Patients should be encouraged to arrange for a carer to stay with them or for them to stay with a carer, until they are able to be self-caring. Lack of social backup should seldom be a reason to exclude a patient from day surgery. A patient hotel may help a Trust to extend its day surgery activity.

Careful assessment is fundamental to the success of day surgery, and minimises cancellation of unsuitable patients on the day of surgery. It is important to ascertain that the patient

understands constraints on activities after general anaesthesia, and that this is made clear prior to the day of surgery.

- ii. **The operation:** This is covered in detail in section 3 below.
- iii. **Discharge:** The discharge protocol should:
 - Assess the patient's fitness for discharge.
 - Ensure that patients and their carers understand constraints on activity following an anaesthetic.
 - Include the provision of written information about potential side effects or complications, and of medication to be taken.
 - Include an adequate supply of post-operative analgesia with written information on how to take it.
 - Make arrangements for outpatient follow-up if appropriate.
 - Check that an emergency contact number has been given, and that the patient understands what to do should a problem arise.
 - Often be nurse-led using an agreed protocol.
- iv. **Post-operative support:** 24-hour support should be provided from the day surgery unit without planned reliance on primary care. This will often include issuing mobile telephones to nurses with an 'on call' commitment for out-of-hours care. Full details are provided in the clinical guidelines.

How do we approach the option of choosing day surgery with patients?

- 2.5 When it is decided that a patient requires a procedure that can be performed as a day case, it should be assumed that the procedure will take place as a day case unless this is not possible. The advantages of day surgery should be explained to the patient at an early stage and assessment undertaken to ascertain their suitability. Unless the patient specifically requests inpatient treatment, or is found not to be suitable, the operation should take place as a day case.
- 2.6 Patients should be reassured that in the unlikely event that they are not ready to go home on the day, they will be cared for overnight.

Are there different arrangements for children?

- 2.7 Day surgery is ideal for children, as overnight admission is often the most distressing part of visiting hospital for them. Children should be treated on dedicated lists, or at the very least, the first part of lists and separated from adults. They should be nursed in paediatric areas, with play facilities available. Operations should be performed by surgeons and anaesthetists with appropriate experience in the care of children. Registered children's nurses should be available to care for children in day surgery.

3. Day Surgery Activity

- 3.1 This section will help Trusts look at their day case activity and ensure that “true day surgery” procedures are carried out in day surgery units. By improving day case rates Trusts will also be making an important contribution to helping meet their other performance targets. Accurate information is essential, and the tools available to support its collection are described in the introduction (section 1.9).

What is the anticipated Day Surgery Rate?

- 3.2 The NHS Plan envisages that 75% of all elective surgery will be carried out as a day case in the near future. To reach this point every Trust should first aim to increase their day surgery activity to the 2001 upper quartile by 2005. Higher performers should seek to move 2 procedures from inpatient to day case treatment each year. Day case proposals should be detailed in the Trust’s annual business plan.

Which procedures can be included as day surgery?

- 3.3 Many elective operations are suitable for day surgery, and lists are likely to be proscriptive. The historical standard:

“Is this patient suitable for day surgery?”

should be replaced by:

“Is there any justification for admitting this case as an inpatient?”

- 3.4 The Audit Commission ‘basket’ of procedures [1990] (4) lists 20 procedures that can usually be performed as day cases. The updated basket [2001] (1) includes 25 operations that can frequently be performed as day cases. Some Trusts send all patients having these operations for day surgery pre-operative assessment to exclude only those shown to be unsuitable, and certainly most patients having these operations should at least be considered for day surgery.
- 3.5 The British Association of Day Surgery have proposed a list of more major procedures that can also be performed as day cases in perhaps 50% of cases (7). This list is shown at Annex B.
- 3.6 The Audit Commission report also highlighted that in some cases day surgery units are being used for procedures that could be carried out in primary care facilities or outpatient departments. These squeeze out “true day surgery” patients and reduce the capacity of the unit. Some of these procedures are listed in Annex C.

3.7 Trusts should therefore separate out different procedures to ensure that patients are treated in the most appropriate settings. Unless there are other clinical or social reasons, Trusts should plan their services as follows:

- Procedures such as those at Annex C are carried out in Primary Care Trusts, treatment rooms, endoscopy units or outpatient departments.
- Most elective operations should be considered for day surgery.
- Procedures unsuitable for day surgery should be carried out as inpatients.

3.8 Advances in medical technologies are likely to mean that over time many more procedures will move from inpatient to day case or day case to outpatients.

4. Accommodation for Day Surgery

- 4.1 Appropriate accommodation and facilities should be made available for day surgery. Day surgery units may all be designed slightly differently but there will be a number of elements common to all.

What accommodation is required to undertake day surgery?

- 4.2 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 (8).
- 4.3 Another possibility is a day case ward with patients going to the main operating theatre where lists may be made up entirely of day cases. This is a less satisfactory arrangement. Mixed lists of day cases and inpatients are even less successful, but if contemplated, the day cases should be performed first to ensure that they go home on the day. While surgeons may have found benefits in the past in performing major cases first, this runs the risk of a day case patient becoming an unplanned overnight admission.
- 4.4 Day surgery performed using inpatient wards and inpatient operating theatres is less successful and cannot be recommended. The stay-in rate (unsuccessful discharge of patients home on the day of surgery) rises from 2.4% in a free standing unit to 14% in an inpatient ward (9).
- 4.5 In smaller centres there may be some advantages to housing day surgery and endoscopy in adjacent areas and sharing some facilities, such as recovery. For larger units separate premises for endoscopy are desirable.

What facilities are necessary for day surgery?

- 4.6 Facilities will vary according to the needs of different hospitals. Health Planning Note 52 addresses these needs in detail, and Scottish Health Planning Note 52, which was updated in 2001, is particularly useful (10).
- i. **Car parking:** Day surgery patients need access to car parking, and at least a short-stay drop off and pick up point immediately adjacent to the unit or ward.
 - ii. **Reception:** Patients and relatives need adequate sitting accommodation while waiting for admission and discharge. Receptionists need facilities to admit and discharge patients.
 - iii. **Pre-operative assessment:** As long as all the required processes are undertaken it does not matter where pre-operative assessment takes place. It can take place in primary or secondary care. An area in the day surgery unit is ideal, as it enables the patient to visit the unit before the day of operation. Adequate consultation rooms are required for all patients to be assessed in privacy. Senior nursing staff would be ideal to carry out pre-operative assessment.

- iv. **Administration Office:** Day surgery administration is most efficient when carried out in the day surgery unit rather than a central admissions unit. Administration by individual consultants' secretaries is least effective as it reduces the opportunity to ensure that all operating lists are fully utilised. Dedicated administrative staff help to maximise access, booking and choice for patients.
- v. **Pre and post-operative ward areas:** Day surgery patients are best managed using operating trolleys designed for day surgery. These are increasingly sophisticated, combining operating theatre table fittings with a multi-purpose trolley. Transfer of unconscious patients is avoided, and patients remain on one trolley throughout their stay. Some units prefer to separate pre-operative and post-operative patients, and ward accommodation is designed accordingly. Staffing levels are inevitably higher, and other units return patients to the same ward area post-operatively.
- vi. **Operating theatres and recovery:** Operating theatres are required to be of the same specification as inpatient theatres – 40 sq metres with clean and dirty utilities, full lighting, X-ray, piped gases and scavenging etc. First stage recovery adjacent to the theatres needs at least one bay per theatre, and one-to-one staffing.
- vii. **Equipment:** Theatre equipment should always be equivalent to inpatient theatres so that the full range of appropriate surgery can be performed as a day case. This includes the provision of resuscitation and defibrillation equipment. Some duplication of equipment will be inevitable in day surgery and inpatient theatres; this is necessary to provide quality patient focussed care.
- viii. **Sitting accommodation:** Reclining chairs provide sitting accommodation for patients who do not need trolleys e.g. cataract patients. They also provide step-down facilities for other patients prior to discharge. Use of reclining chairs for later stages of recovery can help to increase turnaround of trolleys and may be more comfortable for patients requiring longer recovery periods.

Extended day surgery facilities

- 4.7 Some trusts have developed 23-hour stay facilities to support more major procedures. These may assist the transfer of operations from inpatient to day care, and extend the use of day surgery operating theatres beyond recovery times into the early evening. They can also reduce “true day surgery” activity if used badly – clinicians and patients may elect for an overnight stay just because the option is available. This can be prevented by separating day and 23-hour beds, and identifying the patients care path clearly at pre-operative assessment. Other Trusts have developed hospital hotels to support patients with social rather than medical needs for a longer stay, or negotiate twilight and night sitting arrangements through relatives, social care or voluntary organisations.

Is there any support available to help develop day surgery facilities?

- 4.8 Through the capacity planning exercise, Treasury Capital Modernisation Funding of £31 million is available for 2002/03 and £37 million for 2003/04. This funding will help tackle the blockages that cause delays and cancellations and to speed progress with day case booking. In particular, it will help fund the purchase of medical equipment and small building work, particularly for those organisations which do not have a separate day case facility. Trusts and Primary Care Trusts can access the Treasury Capital Modernisation Funding through the capacity plans being developed for each Strategic Health Authority by 31 October 2002.

5. Management of the Day Surgery Unit

5.1 Day Surgery needs a rigorous management structure, including a lead clinician, a day surgery manager/senior nurse and an operational group.

Who should manage the day surgery unit?

5.2 Strong management of day surgery is vital at both the clinical and managerial levels:

- Every Trust should appoint a dedicated clinical director of Day Surgery. The Audit Commission found that clinical directors had been appointed in only two-thirds of units. The clinical director should have paid sessional time to provide clinical leadership for the development of day surgery services, ensuring that consistent policies and guidelines are adopted across all surgical specialties. The clinical director will lead on innovations and development in day surgery practice, and clinical governance with particular emphasis on clinical risk management and clinical audit.
- Every Trust should appoint a day surgical manager/senior nurse. Where the manager is not a nurse then the Trust should appoint a senior nurse to support the clinical director in developing clinical protocols/guidelines, leading nursing practice, and practice development. The day surgical manager/senior nurse will be responsible for the day to day management of the unit and will contribute to the strategic development of services. The manager/senior nurse should have considerable experience in managing services; day surgery should account for 75% of a Trust's elective surgery.
- An experienced administrator will be required to support the clinical director, manager/senior nurse and will be responsible for efficient management of admissions and waiting lists.
- An operational group should oversee the organisation of the unit. This might be made up of representatives from anaesthesia, surgery, nursing, community services, GPs, hospital management, finance, audit, ancillary care, and other parties that are involved in patient care either prior to, during, or after time spent on the day surgery unit.
- Day surgery must be represented at Trust board level.

What policies & protocols are important to allow efficiency?

5.3 There should be clear policies and protocols in place to help ensure the smooth running of the unit. These should include policies to ensure:

- Selection of patients is optimal.
- The 'did not attend' (DNA) rate is monitored, and kept as low as possible. Low DNA rates are more likely when patients are given a choice of dates to fit in with their particular circumstances (booking), they are pre-assessed before the agreed date, and they are contacted a day or two before they are due to attend to confirm that they will attend.

- Trusts should put in place procedures to identify patients who would wish to be offered appointments on lists at short notice, in the event of last minute cancellations.
 - Cancellations on the day should be monitored and kept as low as possible by instituting robust clinical assessment protocols which identify avoidable causes of cancellation.
 - The operating theatre and wards are used to the best effect.
 - Clarity of expected start and finish times for staff.
 - Clarity of arrangements for leave of absence and the reallocation of lists.
- 5.4 Lessons can be learned from the Modernisation Agency's Theatre Programme especially around reducing cancellations and improving theatre performance (www.modernnhs.uk/theatreprogramme) (11,12).
- 5.5 The Royal College of Anaesthetists has produced a series of audits relevant to day case management and practice. These could be used by Trusts to analyse the quality of their services and to benchmark against other Trusts (13).
- 5.6 The monitoring of day surgery performance should be agreed and carried out through the day surgery/theatre management information system.

How should unplanned inpatient transfers be managed?

- 5.7 When complications do occur, procedures need to be in place to deal with unplanned admission of day case patients. Unplanned admissions must be recorded and audited. Diagnostic and Treatment Centres and other day surgery units that may not be on an acute hospital site must have agreed arrangements to transfer unplanned stay-in patients to inpatient care. Day surgery units should not be expected to support any inpatient care.

How should emergency admissions be handled?

- 5.8 Unplanned admission of emergencies to a day surgery unit represents failure of a Trust's capacity planning, and should only occur under exceptional circumstances – for example a major incident.
- 5.9 Few true emergencies are suitable for day surgery, as time constraints impair pre-operative assessment, adequate provision of information and the organisation of backup at home post-operatively. However, many urgent operations that can be arranged within 12-24 hours may well be suitable for day surgery. Evacuation of retained products of conception (ERCP), hand injuries and the management of some fractures fast-tracked from A&E are examples.

6. Staff

- 6.1 A wide range of staff are involved in day surgery and it is recognised that they may need to be supported in changing some of their working practices to allow day surgery rates to increase.

Which staff would be needed for day surgery units?

- 6.2 Teams usually include:

- Consultant surgeons.
- Consultant anaesthetists.
- Nursing staff for assessment, pre, peri and post-operative care, and discharge home.
- Theatre and recovery staff.
- Operating Department Practitioners (ODPs), Operating Department Assistants (ODAs), health care assistants and other technical staff.
- Administrative, housekeeping and other members of the team.

The clinical team should be developed to provide a multi-skilled workforce who can rotate within the areas of day surgery. This provides a well trained, flexible, highly efficient and effective workforce. The benefits of multi-skilling are:

- Staff appreciate and understand each other's role and responsibilities, which leads to a more cohesive and motivated team.
- Investment in training and development enables staff to develop their competencies and make a fuller contribution to the service. This leads to better job satisfaction and retention. Staff will stay longer in post if the job is interesting and variable, and offers opportunities for role expansion.
- Staff are better able to inform and educate patients and carers if they are familiar with the entire patient experience.
- Flexibility of the workforce to cover sickness and absence.
- Bank and agency usage can be kept to a minimum to help control staffing costs.

What is the impact on clinicians?

- 6.3 Surgical routine has often been based around individual surgeons' and anaesthetists' preferences and past experience. Trusts should encourage consultants to adopt a modern approach while remaining within the boundaries of optimal patient care. The practice of mixing inpatients and day cases on the same list should be discouraged as it can lead to cancellations of day cases when time runs out. It also encourages the practice of delegating minor cases inappropriately to junior staff.

How can these changes in working practices be facilitated?

6.4 Trusts should assist surgeons with the move to day surgery. They should provide where required:

- Specific training for the surgeon and anaesthetist in day surgery techniques and the advantages to the patients.
- Opportunities to see and experience day surgery on a first hand basis.
- Changing operating list timing and scheduling to promote day surgery - for example performing day cases first rather than the traditional tendency to perform major cases first on a list.
- Providing day surgery lists to replace inpatient lists.
- Local incentives, such as the availability of enhanced resources to those who make good use of day surgery facilities, to encourage clinicians to work in day surgery units.
- Sessional allocation for expected day case surgery. Surgeons who will not carry out day surgery will be required to transfer their patient referrals to those who do. Pooled day surgery lists keep waiting times shorter and allow surgeons to perform inpatient-only operating lists or both inpatient and day surgery lists. This should be addressed through the Trust's clinical governance framework and Trusts will need to have a local policy for such cases. Lead clinicians and Medical Directors will need to influence change.

What incentives exist to facilitate changes in working practices?

6.5 It is important to stress the benefits of carrying out a procedure as a day case.

- Day surgery units operate regular hours, and clinicians will know what hours they work, to allow them to meet their family commitments and plan their lives.
- Day surgery patients are rarely cancelled at the last minute.
- Professional satisfaction as more patients are being treated to the best quality of care in a certain time period.
- Patients receive the treatment and care that fits in with their lives and are less likely to be cancelled.
- Day surgery can free up resources for additional inpatient operations or emergency care;
- Lists are more likely to be fully utilised.
- Trusts should develop protocols that would allow local managers to offer local incentives to the clinical staff.

What changes will there be for anaesthetists?

6.6 High quality anaesthesia is pivotal to successful day surgery. Poorly controlled pain and nausea are common reasons for unplanned admission after day surgery. Anaesthetists should develop protocols for suitable peri and post-operative analgesia, and should audit their effectiveness.

- 6.7 Day surgery incorporates an important role for anaesthesia, and it has been the recent improvements in anaesthetic drugs and procedures that have allowed more operations to be completed as day surgery cases.
- 6.8 Careful selection of patients appropriate for day surgery is vital. The general anaesthetic criteria for day surgery will be developed and agreed by anaesthetists. Nursing staff carrying out pre-operative assessment will use the protocol and agreed criteria to assess the suitability of patients for a general anaesthetic. If the patient does not meet the criteria, then a nurse will refer them to the consultant anaesthetist who will make the final decision. It is therefore essential that the anaesthetist has received appropriate training in day care, and follows the Royal College of Anaesthetists' *Guidance on Day Case Anaesthesia*.

What impact will there be on nursing staff/ODPs and Allied Health Professionals?

- 6.9 The nursing staff and ODPs play an essential role in the day surgery unit. Staff should receive appropriate induction on appointment to the day surgery unit and continuing professional development through competency-based education and training. The competencies will need to enable staff to gain generic competencies in all areas of day surgery, as well as core specialist competencies. This will provide a multi-skilled, flexible workforce to support the day surgical teams. The British Association of Day Surgery have developed generic competencies for day surgery (www.bads.co.uk).
- 6.10 Day surgery attracts and retains highly motivated nursing staff and ODPs. The role is complex and demands the use of a potentially wider variety of skills than are required in other surgical nursing specialties. The importance and use of clinical skill mix promotes efficiency within the unit and provides staff with significant variety within their role. The British Association of Day Surgery is about to publish a guide to skill mix in day surgery and this will be available on their website in August 2002. Hours are predictable and support family friendly policies, with emergency cases being very rare. Day surgery can also be attractive to those returning to nursing. Specific post registration/graduation courses are highly developed and exist locally and nationally to support personal development. Both the Royal College of Nursing and the British Association of Day Surgery actively encourage and promote the enhancement of nursing within this field.
- 6.11 The day surgery environment is also an opportunity to explore options for workforce redesign and role expansion and extension for nurses and ODPs. The role of First Assistant has been developed within many surgical teams, and opportunities for designing non-medical roles as assistants in surgical practice have been taken forward in a number of Trusts to support the clinical team. The National Association of Theatre Nurses published a guide on *Future Ways of Working - Unleashing the Potential of Perioperative Practice*. This gives practitioners and managers guidance on the development of expanded roles including strategic planning, risk assessment, and implementation (www.natn.org.uk). The National Association of Assistants in Surgical Practice is working with the Royal College of Surgeons to develop core and specialist competencies and a professional accreditation framework to support expanded roles and new ways of working (www.naasp.org.uk).
- 6.12 Clinical Nurse Specialists often follow the patient through day surgery or will visit patients whilst in day surgery. Specialist nurses are an experienced and knowledgeable resource and should share their clinical knowledge and expertise with the wider clinical team.

- 6.13 Pharmacists play an important role in day surgery units as pharmacy advisor and educator for patients and staff. Their expertise should be sought regarding the development of protocols for discharge medication and pain relieving regimes to ensure that patients are discharged with effective and adequate medication supplies.
- 6.14 Physiotherapists may come to see patients in the day surgery unit. They should advise day unit staff, patients and their carers about mobilisation techniques e.g. stairs practice, use of crutches. Their input is required when producing written information sheets for patients and carers, and exercise regimes for patients e.g. post arthroscopy procedures.
- 6.15 Healthcare assistants or support workers are essential members of the team and investment in their development will result in a well supported clinical team and better experiences for patients. Support workers will include health care assistants, housekeepers, porters, and administrative and clerical staff.

What impact will there be on primary and social care?

- 6.16 Generally good quality day surgery, performed well, will have no significant impact on primary or social care (14,15). Trusts in areas with limited social backup for patients should consider the hospital hotel concept. However, as the case-mix for day surgery changes to include more complex procedures then Trusts are encouraged to plan the care pathway for patients in partnership with primary and secondary care. The future models of Diagnostic and Treatment Centres may see a component of the service being led by primary care.
- 6.17 Generally post-operative support and follow-up of patients occurs by telephone and is provided by day surgery nurses. Patients are given emergency contact numbers for expert nursing advice on discharge from the day surgery unit.

How can training aid the move to day surgery?

- 6.18 A drive to increase day surgery will have a significant impact on staff. Staff need to feel confident in their abilities to carry out such surgery, and this should be facilitated with the use of appropriate and timely training. Due to the practical nature of day surgery, beneficial training might consist of secondment of doctors and nurses to existing day surgery units performing high levels of day surgery procedures. Day surgery staff may also need to rotate to main theatre units to increase/update their skills.
- 6.19 Consultant attachment should be to clinicians with experience and expertise, and attract continuing professional development (CPD) accreditation.
- 6.20 Day surgery leads should be encouraged to participate in learning sets to facilitate spread of knowledge and optimal standards in day surgery.

Are there any other methods of training?

- 6.21 All junior surgeons and anaesthetists should have experience of day surgery during their training.
- 6.22 As a supplement to secondments working with existing day surgery experts, video conferencing and satellite transmission of day surgical procedures in theatre could be used. These provide an additional distance learning tool for staff on day surgery units without requiring them to leave their base.

Who will be available to promote day surgery?

- 6.23 It is important that there are champions for day surgery in each Trust, and they should be nominated from within the day surgery unit. Trusts should have both managerial and clinical champions for day surgery, who will also act as links with external organisations, especially those in primary and social care. These champions can help to drive forward the day surgery agenda within the Trust and to communicate with other Trusts in relation to how the unit might be run more efficiently.
- 6.24 The British Association of Day Surgery is developing a network of “linkpersons” in every Trust to promote communication. These need not be British Association of Day Surgery members, and Trusts without a linkperson should consider joining this scheme. Patient Advice and Liaison Services (PALS) and patient representatives on day surgery unit operational groups will promote patients’ views.
- 6.25 The NHS Modernisation Agency is putting in place a network of clinical champions, one for each Strategic Health Authority area, who will be trained in the tools and techniques which will support improvement in the organisation and delivery of day surgery. They will link with local champions and support their work.

7. Primary Care Trusts

7.1 Primary Care Trusts (PCTs) have an important role to play in increasing the level of day surgery. The increase in day surgery will aid the achievement of key targets for access, booking and choice. Primary Care Trusts can influence the use of day surgery by three methods:

- Care protocols with Trusts.
- Commissioning services.
- Carrying out minor procedures.

How will care protocols be affected?

7.2 Primary Care Trusts working with GPs and Trusts should seek to adopt protocols for different types of treatment, so that patients are directed to the most efficient and appropriate setting for their care. When a patient is identified as requiring a certain type of procedure, there should be a recognised protocol that is followed by the healthcare professional diagnosing their condition. This should automatically indicate the expected pathway to treatment, be it in a primary care setting, outpatient facility, day surgery centre or inpatient care. The care protocols for the procedures that can be performed in day surgery units (such as those in Annex A) should indicate that they are normally undertaken as a day case, unless there are strong clinical or social reasons for not doing so.

How will commissioning be affected?

7.3 Primary Care Trusts, as commissioners, should look at ways of encouraging the increased use of day surgery. Whilst the costs of day surgery are lower than those of inpatient care, it has been reported that the outcomes are at least as good (Audit Commission 2001), therefore day surgery should be the rational choice as far as commissioners are concerned. Day surgery offers a cost-effective option, without compromising patient care.

7.4 Primary Care Trusts should provide incentives to Trusts to undertake day surgery in preference to inpatient care where appropriate for patients. Additionally, there may be mechanisms to encourage day surgery within the new hospital payment incentive structure. For instance, new tariffs could be used to penalise excessive inpatient admissions and reward increased day case surgery.

7.5 Under the financial flows reforms announced in *Delivering the NHS Plan*, we will progressively pay for as much hospital and specialist activity as possible based on a standard price tariff for Health Resource Groups (HRGs). HRGs are a tool for classifying hospital activity on the basis of the patient's diagnosis, and other variables which determine the level of resources generally required to treat people with that diagnosis. These reforms will create stronger rewards for providers to increase the share of surgery carried out as day cases. From 2003/04, standard HRG tariffs will apply to commissioning of additional elective activity over baseline. There will be

consideration of how to incorporate into the scheme additional incentives to promote higher day surgery rates for those procedures which should generally be performed as day cases. There will be an information and consultation document about the new financial flows scheme in September 2002.

What will be the impact on GPs and PCTs?

- 7.6 GPs should refer patients directly for day surgery improving access for patients to treatment.
- 7.7 Staff in Primary Care Trusts are beginning to carry out minor procedures that would previously have been carried out on an outpatient or day case basis in a Trust. These include procedures such as those listed in Annex C. Carrying out these procedures at primary care level should mean that patients are treated more quickly and that patients with more appropriate conditions can be treated in the day surgery unit. It is important to ensure that where minor procedures are carried out in PCTs, they are subject to the same rigorous audit applied to hospital-based day surgery.
- 7.8 Experience has shown that day surgery does not significantly increase the workload of the GP. Patients may return to see their GP in the same way as inpatients would to ensure that the treatment is progressing as planned, and the Trust should have policies in place to support the patient following discharge (14-16).

8. Conclusion

- 8.1 Day surgery is particularly suited to providing patient-centred treatment as it is safe, efficient and effective, and provides the least possible disruption to their lives. If day surgery units are managed efficiently, they can increase capacity and help to meet waiting time targets.
- 8.2 Huge variations in day surgery exist between Trusts for no explicable reason. New facilities, particularly the Diagnostic and Treatment Centres will enhance capacity, but changing practice within existing day surgery units is needed immediately.
- 8.3 This guide will be used by clinicians, managers and commissioners to help them look at their day surgery rates and ways they can be improved. The main messages are:
- i. Day surgery provides patient-centred care.
 - ii. It is an integral part of the agenda to reduce waiting times, implement booking systems and introduce choice.
 - iii. Clinicians, managers and commissioners should be actively looking to increase day surgery rates.
 - iv. Clinicians should receive training in day surgical procedures.
 - v. Appropriate facilities and equipment must be provided, and units should consider using the Treasury Capital Modernisation Funding available through the capacity planning exercise.
 - vi. Surgical procedures should be carried out in appropriate settings:
 - Procedures such as those at Annex C should be carried out in Primary Care Trusts, treatment rooms, endoscopy units or outpatient departments.
 - Most elective operations should be considered for day surgery.
 - Procedures unsuitable for day surgery should be carried out as inpatients.
 - vii. Primary Care Trusts, through care protocols, commissioning and carrying out minor procedures can improve day surgery rates.
- 8.4 This guide is part of an overall strategy for day surgery and should be circulated widely within Trusts and Primary Care Trusts. The next stage of the strategy is implementation. This will be led by the NHS Modernisation Agency which will work with Trusts to improve local processes.

Annex A

The Audit Commission “Basket of 25”

1. **Orchidopexy** – correction of undescended testes
2. **Circumcision** – removal of foreskin
3. **Inguinal Hernia Repair** – repair of outpouching of the abdominal sack of the groin
4. **Excision of Breast Lump** – removal of a lump in the breast
5. **Anal Fissure Dilatation or Excision** – treatment for a tear of the skin at the anal region
6. **Haemorrhoidectomy** – removal of haemorrhoids from within the anal canal
7. **Laparoscopic Cholecystectomy** – removal of the gallbladder by means of an instrument introduced through a small hole in the stomach wall
8. **Varicose Vein Stripping or Ligation** – removal of tortuous and incompetent veins in the leg
9. **Transurethral Resection of Bladder Tumour** – removal of a tumour by an instrument inserted into the bladder
10. **Excision of Dupuytren’s Contracture** – removal of fibrous tissue under the skin of the palm that causes the fingers to become bent
11. **Carpal Tunnel Decompression** – incision in the wrist to relieve the pressure on the median nerve as it passes into the hand
12. **Excision of Ganglion** – removal of a lump usually around the wrist, hand or foot
13. **Arthroscopy** – the use of an instrument to look inside a joint for diagnosis and/or treatment
14. **Bunion Operations** – straightening of the big toe and removal of bony overgrowth causing it to bend
15. **Removal of Metalware** – removal of pins or plates used to stabilise a fracture
16. **Extraction of Cataract with/without Implant** – removal of a cloudy eye lens and, if appropriate, replacement with a synthetic one
17. **Correction of Squint** – repositioning of the muscles of the eyeball
18. **Myringotomy** – relief of glue ear by making a small hole in the ear drum to release pressure and inserting a tube to avoid recurrence
19. **Tonsillectomy** – removal of the tonsils
20. **Sub Mucous Resection** – relief of nasal blockage caused by bent cartilage in the middle of the nose
21. **Reduction of Nasal Fracture** – repositioning of the bone in the nose
22. **Operation for Bat Ears** – removal of skin and cartilage at the back of the ears
23. **Dilatation and Curettage/Hysteroscopy** – examination of the inside of the uterus and removal of tissue if necessary
24. **Laparoscopy** – use of an instrument introduced through the abdomen for diagnosis and treatment of internal organs often by gynaecologists
25. **Termination of Pregnancy** – evacuation of the contents of the pregnant womb

Audit Commission 25 basket procedures coding

Methodology for classifying day surgery procedures using OPCS 4 codes

The Trust level day surgery performance data used for the Acute Hospital Portfolio audit were derived from Hospital Episode Statistics (HES) using OPCS 4 codes to select the appropriate procedures. It has been found by examining empirical data, that the procedures are not always coded in a straightforward manner and so a methodology has been devised to overcome this as explained below.

Any coded hospital episode can have up to four procedure codes. The most important is the first, or primary code, and the subsequent or secondary codes should be of diminishing importance or seriousness. Therefore, for example, if a woman comes into hospital for a laparoscopy, but as a result of the findings she proceeds to have a hysterectomy, the hysterectomy should be the primary procedure and the laparoscopy the secondary even though the two procedures took place in the opposite order.

The descriptions of operations used in the audit have been translated, using expert advice from clinicians and the National Centre for Codes and Classification, into the appropriate OPCS 4 codes for each procedure. This has led to three categories of code as set out in the attached table:

- Definition codes i.e. those which refer to the procedure itself.
- Acceptable combination codes; for procedures which do not preclude day surgery.
- Exclusion codes for procedures which are judged to require an overnight stay and therefore cannot be classified as potential day surgery.

The simplest method of identifying the basket operations would be to count those where the definition codes appear as primary procedures. While this method will give quite a good indication of the numbers, it will:

- Miss some episodes where the definition code is in the second, or subsequent position.
- Include some episodes inadvertently which also have exclusion codes.

Our estimate from examining empirical data is that, for some procedures such as cystoscopy or laparoscopy, the errors in the numbers of procedures identified might be as high as 10%.

The Audit Commission has therefore adopted the approach described below, which overcomes these objections but errs on the side of leaving out procedures if the codes are not known, as in the original audit.

An episode is identified as a particular basket procedure if:

- Its primary code is one of the definition codes, or
- Its second code is one of the definition codes and its primary code is one of the acceptable combination codes.

Both of the above conditions are subject to there being no exclusion codes present in any position.

Therefore, for example, an episode would be counted as a 'myringotomy' if the primary code was D151 (insertion of ventilation tube) and it would also be counted if the primary code was D072 (removal of wax – which is an acceptable combination) and the second code was D151.

This method achieves a closer approximation than just relying on primary codes and at the same time, avoids the risk of double counting. In the example, if the primary code had been E036 and the second code still D151, it would not have been included as a myringotomy because E036 is not an acceptable combination code. It is in fact one of the definition codes for a sub mucous resection and would therefore have been included under that heading.

This type of coding example, where an episode is coded to more than one basket procedure, is very common in urology and gynaecology, less so in ENT and orthopaedics and virtually non-existent for some other procedures, such as excision of breast lump or cataract removal.

The table attached, shows the actual codes used for each procedure under the three categories defined above. In some cases diagnosis codes are also used, for example, the diagnosis codes for cataract procedures ensures that the lens removal and replacement is always because the patient had a cataract.

Audit Commission – Codes for 25 Basket procedures

		Definition Codes	Combination Codes	Exclusion Codes	ICD 10
1	Orchidopexy	N08,N09(xs 081+091)			
2	Circumcision	N30.3,N30.4			
3	Inguinal Hernia	T19,T20,T211,T212, T213, T218,T219			
4	Excision of breast lump	B28.3			
5	Anal fissure dilation or excision	H50,H54,H56.2,H56.4	H25,H28,H412, H443, H444,H48,H52		K60
6	Haemorrhoidectomy	H511			
7	Lap cholecystectomy	J183 with approach code Y508(access minimal)			
8	Varicose vein stripping or ligation	L85,L87			
9	Transurethral resection of bladder tumour	M42		M65	
10	Excision of Dupuytren's contracture	T52.1,T52.2,T54.1			
11	Carpal tunnel decompression	A65.1			
12	Excision of ganglion	T59,T60			
13	Arthroscopy	W82,W83,W84,W85, W86, W87, W88		W74,W70, W283,W783, W69, W085	
14	Bunion operations	W79,W59,W151, W152,W153			
15	Removal of metalware	W283			
16	Extraction of cataract with/without implant	C71,C72,C73,C74, C75,C77	C601		H25,H26, H28, Q120
17	Correction of squint	C31,C32,C33,C34,C35			
18	Myringotomy with/without grommets	D15		E08.1,E20.1, F291,F34, D191	
19	Tonsillectomy	F341-F344			
20	Sub mucous resection	E03.1,E03.6,E04.1,E04.6		E081,E201,F34, F291,E02,E142, F328	
21	Reduction of nasal fracture	V09.1,V09.2			
22	Operation for bat ears	D03.3			Q17.5
23	Dilation and curettage/hysteroscopy	Q10.3,Q18	P313,Q013,Q02,Q03, Q413		Not O04
24	Laparoscopy	Q17,Q35,Q36,Q38, Q39,Q50, T43,T42,Q49	P313,Q013,Q02,Q03, Q413		
25	Termination of pregnancy	Q10.1,Q10.2,Q11.1, Q11.2, Q11.3	Q14		O049

ANNEX B

Maintaining the supermarket analogy, the British Association of Day Surgery proposed a “trolley” of procedures which are suitable for day surgery in some cases.

Some have been adopted by the Audit Commission into their revised basket (2001). The others are:

1. **Laparoscopic hernia repair**
Repair of abdominal hernias using minimally invasive keyhole technology
2. **Thoracoscopic sympathectomy**
Keyhole chest surgery to reduce excess sweating of the hands
3. **Submandibular gland excision**
Removal of the salivary gland under the jaw when affected by stones or inflammation
4. **Partial thyroidectomy**
Removal of diseased thyroid gland in the front of the neck
5. **Superficial parotidectomy**
Removal of the salivary gland in the cheek – usually for non-cancerous tumours
6. **Wide excision of breast lump with axillary clearance**
Breast cancer operation removing up to ¼ of the breast, and the glands in the armpit
7. **Urethrotomy**
Division of narrowing/stricture in the outflow from the bladder, often through a telescope
8. **Bladder neck incision**
Division of the muscle in the bladder neck to relieve some cases of enlargement of the prostate gland
9. **Laser prostatectomy**
Shrinkage of some cases of prostate enlargement using laser
10. **Trans cervical resection of endometrium (TCRE)**
Removal of the lining of the womb through a telescope; to avoid hysterectomy in some cases of heavy periods
11. **Eyelid surgery**
Correction of drooping or deformed eyelids
12. **Arthroscopic meniscectomy**
Removal of damaged knee cartilage using keyhole technology

- 13. Arthroscopic shoulder decompression**
Use of keyhole surgery to correct abnormalities limiting movement at the shoulder joint.
- 14. Subcutaneous mastectomy**
Removal of swollen breast tissue in men, or some cases of very early cancerous changes in women.
- 15. Rhinoplasty**
Plastic reconstruction of deformity of the nose
- 16. Dentoalveolar surgery**
Removal of impacted or complex wisdom teeth
- 17. Tympanoplasty**
Repair of perforated ear drum

Other proposals to change the basket were not accepted; details can be found in “Basket cases and trolleys” – day surgery proposals for the millennium (7)

Annex C

Procedures being performed in day surgery facilities that can usually be performed in endoscopy, outpatients or primary care

Endoscopy

Bronchoscopy

Colonoscopy

Cystoscopy

Oesophagogastroduodenoscopy

Sigmoidoscopy

Outpatients

Blood transfusion

Chemotherapy

Colposcopy

Hysteroscopy

Local anaesthetic minor operations

Sigmoidoscopy

Pain management procedures and nerve blocks

Urodynamic tests

General Practice

Local anaesthetic minor operations

Most of the procedures on the above two lists with appropriate facilities and support

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Contact Details

British Association of Day Surgery (BADs)

35-43 Lincoln's Inn Fields
London WC2A 3PN
Tel: 0207 973 0308
Fax: 0207 973 0314
E-mail: bads@bads.co.uk
www.bads.co.uk

Royal College of Surgeons

35-43 Lincoln's Inn Fields
London WC2A 3PN
Tel: 0207 405 3474
www.rcseng.ac.uk

Royal College of Anaesthetists

48-49 Russell Square
London WC1B 4JY
Tel: 0207 908 7300
E-mail: info@rcoa.ac.uk
www.rcoa.ac.uk

NHS Modernisation Agency

4th Floor
St John's House
30 East Street
Leicester LE1 6NB
Tel: 0116 2225109
www.modernnhs.uk

Audit Commission

1 Vincent Square
London SW1P 2PN
Tel: 0207 828 1212
Fax: 0207 976 6187
E-mail: enquiries@audit-commission.gov.uk
www.audit-commission.gov.uk

Association of Anaesthetists of Great Britain and Ireland

21 Portland Place
London W1B 1PY
Tel: 0207 631 1650
Fax: 0207 631 4352
www.aagbi.org

National Association of Assistants in Surgical Practice

NAASP Headquarters
Drumcross Hall
Bathgate EH48 4JT
Tel: 01506 811077
Fax: 01506 811477
www.naasp.org.uk

National Association of Theatre Nurses

Daisy Ayris House
6 Grove Park Court
Harrogate
North Yorkshire
HG1 4DP
Tel: 01423 508079
Fax: 01423 531613
Email: hg@natn.org.uk
www.natn.org.uk

Newchurch Ltd

Causeway House
The Causeway
Teddington
Middlesex TW11 0JR
Tel: 0208 783 3300
Fax: 0208 783 8198
www.newchurch.co.uk

The Health Quality Service

15 Whitehall
London SW1A 2DD
Tel: 0207 389 1000
Fax: 0207 389 1001
www.hqs.org.uk

CHKS Ltd

1 Arden Court
Arden Road
Alcester
Warwickshire B49 6HN
Tel: 01789 761606
Fax: 01789 764608
www.chks.co.uk



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