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Meeting report

British Association of Day Surgery Clinical governance

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The management focus in the Health Service is continually shifting with day-surgery getting the greatest attention in the early 1990s. The Royal College of Surgeons made the case for day surgery, the Department of Health put up money for purpose-built units and appointed committees to write operational guidelines, and hospital managers would include the development of day surgery in their business plan and hope to boost their performance-related pay by doing so. The public watchdog, the Audit Commission, looked at what was done in *All in a day's work* and also surveyed patient experience. There was a lot to do; much was happening. So when the Audit Commission took stock again it was able to report earlier this year that the median level of activity now exceeds the upper quartile of what was achieved in 1991. What has not changed is the range of activity. Whether you look at hospitals, surgical specialties, surgeons or procedures the variation generally runs from 10 to 90% suggesting there is more still to be achieved.

But for most managers day surgery is yesterday's story. The colloquial description would be 'been there, done that and got the T-shirt'. So what the Association has to do is reinvent the day surgery theme in terms of New Labour's programme and priorities for a 'New NHS: modern and dependable'. This has come at the right time for the Association and is being tackled in a number of ways. It is timely because the Association was needing to change anyway. For a decade the Association has helped people to get started through advice, any number of educational events and publication of the journal *One Day Surgery*. There are now comparatively few departments starting up and though the established departments still have new recruits each year the 'How to do it' theme now seems rather played out. This was accentuated when those developing the new techniques in minimally invasive surgery decided to have their own association. So what will the new future be?

The starting point is the perennial problem we have with waiting lists. Perhaps the best remembered of all the Government's pledges at the last election was that they would reduce waiting lists by 100 000. This has proved more difficult to achieve than they had anticipated and whereas they may at one time have hoped that ridding the service of the Thatcherite marketplace and pulling together once again as a single team would achieve the necessary spurt in activity, they can now see this is not going to happen. With 2 years to go to the next election manipulation is rearing its ugly head. In future skin lumps and bumps will not be counted as surgical cases and cannot therefore be counted as on a surgical waiting list even if there is a delay of weeks or months before they are removed. Managers are worried if their waiting list numbers have risen so there is every reason to hide a few names in a locked drawer until the census date has past. But if you actually want the total number on the waiting list reduced, an increase in day surgery is likely to be the most efficient and cheapest way to achieve it.

Another boost to day surgery activity was produced by the winter pressures, the surge in medical emergency admissions which could only be coped with by requisitioning surgical inpatient beds. Surgeons could only find space for surgical emergencies and cancer patients, all their other elective work having to be postponed. For many the only elective activity that continued was in the day surgery unit. For some even this was stopped when day surgery trolleys were pressed into action for exacerbations of bronchitis and mild strokes. Not only

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was the trolley uncomfortable, the day surgery unit did not have the bathing and feeding facilities needed for inpatient care. For the first time advantages in free-standing day surgery units could be seen. With no physicians on site, medical patients cannot be looked after. Cover from a neighbouring hospital is not thought to be adequate and there are not enough physicians to form a new team posted to the day surgery unit. It is less convenient for surgical staff to travel there but at least they can keep working.

As well as these political and practical imperatives, the Government's programme also has new opportunities. Up till now the chief executive's pre-eminent responsibility has been to balance the books. Now similar attention is to be given to the quality of care in a process generically described as 'clinical governance'. In reporting on the care given in the hospital, the chief executive will be nervous of the comparisons that may be made with neighbouring hospitals or similar hospitals elsewhere in the country. Errant figures in the statistics will have to be defended and recourse will almost certainly be made to differences in the complexity and severity of the diseases and the risks inherent in curative rather than palliative care. For major illnesses and emergency care there is likely to be genuine uncertainty. Ignorance at a higher level is not however a vote winner so this could be an opportunity for day surgery. Almost by definition day surgery is focused on single, not complex conditions and care is taken to select out any patients whose recovery may not be straightforward. Apply clinical governance to this large volume of work going right first time and you could be on to a winner!

Everything will not of course be perfection but here is the second advantage. Many regular problems are likely to have a single cause more easily identified and rectified than difficulties in the main hospital. With any luck examples of successful action resulting from the Government's initiative should be available. Ministers would only be human if they warmed and responded to such success.

But the first thing of course is to achieve it. With this in mind the Association has launched two initiatives, one aimed at interpreting and taking action on the routinely available hospital statistical data; and secondly the development of a questionnaire giving, as the lawyers put it, fuller and better particulars of what is happening. The first scheme will at first be the more comprehensive covering over 120 units in the United Kingdom while the second questionnaire approach will concentrate on 50 day surgery units with dedicated wards and theatres in its first and pilot year.

Our fourth opportunity comes with the developments in primary care. The Government wants to see general practitioners and the clinicians who work with them forming first into groups and later into trusts to take financial responsibility for planning and provisioning healthcare. There are already a small number of general practitioners who have developed the facilities and received the training appropriate for a number of day surgery techniques. It is largely rhetoric at this stage but fired with an ambition which suggests that the interface between primary care, community hospitals and acute hospitals will be actively explored. Projects designed to examine these relationships with outcome, risk and patient preference to the fore should attract funding.

Our final major theme will take up issues regarding the ethics of day surgery. Pragmatism and expediency are sometimes the explanation given for actions which in principle are at least debatable. At our last Annual Scientific Meeting a room of 50 people were asked whether there was a surgeon in their unit to whom they would not send a relative for a day surgery operation. A third said yes, none had done anything about it — but then someone has to do the work!

The British Association of Day Surgery has a busy year ahead and hopefully in 2000 there will be achievements to report.