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Conference report

Report from The British Association of Day Surgery 2000; benchmarking day surgery

We recently held our Annual Scientific Meeting in Cardiff, which attracted a wide range of papers and posters from our members, news of further advances in nursing practice and developments in day surgery in primary care. The main focus was on performance in day surgery where our membership confirmed their support for three avenues of work that we think are distinctive and complimentary. There have been major developments in all three, which are outlined in the following paragraphs.

Firstly the Chief Executive of a hospital trust now has responsibility for Clinical Governance in which an overview is required of the clinical work of all the departments. This is based mainly on national statistics, and we have worked with CHKS in developing a reporting sheet of activity that makes comparison between trusts for individual surgical procedures with the surgeons identified by a code number. The sheet also includes the percentile ranges and waiting times for treatment, and includes the reported numbers of complications, adverse reactions and misadventures though this data is very variable. We have paid particular attention to the selection of the procedures with our secretary Joe Cahill expanding the original basket of 20 procedures chosen by the Audit Commission into a trolley of nearer 40. This expansion means you can not only follow the bulk of the work but also look at the growing edge such as laparoscopic operations. There are also areas in which day surgery is reducing with for instance the transfer of cystoscopy to outpatients and in the year ahead a reduction in the number of 8 s extracted following the guidance from the National Institute for Clinical Excellence.

We see the Chief Executives responsibility to be the determination of the overall pattern of the clinical programme so that the policy of the trust, investment in facilities, funding of devices equipment and drugs, budget for staff employment, education and training, and priorities in the research programme move hand in hand.

To go back in time to Rudyard Kipling's 'serving men' this covers largely the What question, with comparison in terms of Where for inpatients and day cases, When in terms of waiting times and a little about the Who in terms of the surgeon concerned.

The feeling of unity that the title day surgery implies has been dispelled in our work with Roger Dyson and the Clinical Benchmarking Company. Members of Council formed an Expert Panel for the development of a questionnaire covering the activity, the facilities, the staff, the expenditure, the equipment and the management arrangements of day surgery units, which were either self contained or had their own dedicated wards or theatres. The word unity has to be replaced by the word diversity to describe our findings from the 37 hospitals that have taken part.

Day surgery may be performed in several sites in the hospital and in collaboration with units in other hospitals. Procedures are performed not only in the theatres but also in converted anaesthetic rooms. endoscopy and laser treatment rooms. The sessional count is therefore different between hospitals with similar space The combination of surgery and medicine, pain relief, radiology and other practices varies greatly placing different requirements on the nurses and operating department practitioners in terms of numbers needed for a session and their training. This does not come out in a simple procedural count and vitiates the calculation of staff productivity ratios. Preoperative assessment by nurses is widespread and there is the beginnings of nursing surgery for the excision of skin lesions and some eyelid surgery. Who does the majority of the surgery varies with some staff grade surgeons seeing their own patients and others drawing patients for surgery from consultant lists by local negotiation. Both the work of the staff grade surgeons and the nurses affects the apparent productivity of the surgeons, while the activity of the anaesthetists is confounded by the increasing number of sessions performed under local anaesthetic. In the staffing returns we found managers and nurse specialists left out of the count and such variation in the arrangements for ancillary help that it could not be summarised.

Only the self-contained day surgery units that had their own cost centre and computerised management system knew what the practice was costing. Others might not know the cost of drugs, maintenance, equip-

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ment or devices, would not have discussed overhead charges and would not be able to proportion the cost of shared staff. Day surgery directors with no responsibility for a budget were unlikely to have authority over the use made of particular sessions or to have the staff from the various professions reporting to them. Surgeons, anaesthetists and other clinicians may not attend audit and management meetings on day surgery. Rather cruelly some would say that in many hospitals day surgery is more like a happening rather than a planned event which affects the nature, methods and rates at which practice can be modified.

The questionnaire has given us full and better particulars as the lawyers would say. To return to Rudyard Kipling this has given insight into the How, added the other staff to the consultants in the Who, and the non-surgical work to the what. The ideas about Where have also expanded and it has highlighted the need to ask again and again 'why not' in response to the evidence of slow uptake.

Based on his experience with the pathologists and radiologists, Roger Dyson tells us it will take at least two more annual cycles of modified questionnaires and improved analyses to derive a minimum data set in which the participating hospitals have confidence as a basis for comparisons to be made. This work is primarily of interest to the Directors of Day Surgery and the Directors of the Clinical Divisions using day surgery facilities.

The third strand in our work involves tying day surgery into more managerial developments in the hospital, and here we have begun work with Peter Griffiths and the Health Quality Service. We are thinking of the programmes in risk management, the handling of complaints, focusing on patent satisfaction and revalidation of clinical competence. We are also concerned that the number of reviews of clinical practice are proliferating with Deans and Royal Colleges as active as the Commission on Health Improvement intends to be. This raises the question whether there is a basic accreditation day surgery units could achieve that would obviate the necessity for starting at square one on every occasion. This will lead us into site visitation where we shall learn much from the experience of HQS over the last ten years-and they will for the first time become involved in the assessment of clinical practice.

What all three programmes have in common is that the hospital is the paymaster and therefore can expect CHKS, CBC and HQS to work in their interest and the interest of their patents. The cost of taking part is reasonable in terms of the turnover and from what we already know considerable progress could be made. As the director of one of the largest and best of the day surgery units said, the questionnaire had surprised him by the number of improvements it has shown to be possible in his own unit.

This is of course a major change in perspective for the Association. We recognised the need for change in our Council and are glad that John Shaw has joined us with his experience in the Department of Health and latterly the Patient Association. We anticipate that David Wood the Chief Executive in Aintree will be elected to Council this year-Aintree has a large virtually free standing day surgery unit on the old Walton Hospital site in Liverpool. And the programme at our ASM has changed to include speakers such as Ian Carruthers on the new NHS, David Bowden on risk management David Colin-Thome on primary care and Chris Ward on surgical ethics. Last week in Kdiff the Association Lecture was given at John Shaw's suggestion by Nancy Kline on the importance of listening and the Keynote Address by Graham Whitehead of British Telecom on the Electronic Revolution. Carrying our membership with us in this evolution is of course essential and we have therefore been pleased to see the number grow by a hundred to 750 in the last year with 325 coming to the ASM.

When I say that these are interesting times, the Chinese would think we are cursed, but we are more optimistic and expect that our taking control of our affairs will be to the good of our patients and make for more fulfilling careers.

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