



**Comptroller and Auditor General
Special Report**

Managing Elective Day Surgery

Contents

	Page
Summary	7
1 Introduction	15
2 Trends in rates of day surgery	17
3 Gaining improvements in day surgery rates	31
4 Views of the Secretary General of the Department of Health	45
 Appendix	
A 24 selected day surgery procedures	49

Report of the Comptroller and Auditor General

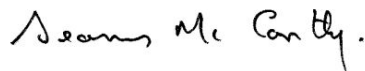
Health Service Executive

Managing elective day surgery

I have, in accordance with the provisions of Section 9 of the Comptroller and Auditor General (Amendment) Act, 1993, carried out a review of the management of elective procedures carried out on a day surgery basis.

This report was prepared on the basis of information, documentation and explanations obtained from the bodies and persons referred to in the report. The Health Service Executive and the Department of Health were asked to review and comment on the draft report. Where appropriate, the comments received were incorporated in the final version of the report.

I hereby submit my report for presentation to Dáil Éireann in accordance with Section 11 of the Act.



Seamus McCarthy
Comptroller and Auditor General

26 May 2014

Summary

Summary

Day surgery refers to treatment provided when a patient is admitted to hospital for a planned (or elective) surgical procedure and is expected to return home on the same day. Performing procedures on a day surgery basis, where clinically appropriate, has a number of potential advantages over inpatient treatment, where the patient stays in the hospital for one or more nights. It leads to reduced costs for hospitals, and waiting time should be reduced by improved throughput of cases. Benefits for patients include being able to recover in their own homes and reduced risk of hospital acquired infection.

The Health Service Executive (HSE) has stated that day surgery should be the default option for many elective surgical procedures unless there is a valid reason for an overnight hospital stay, such as an underlying medical condition.

This examination looks at trends in day surgery and considers key stages in the process to identify potential areas for improvement.

In 2012, around 247,000 surgical procedures were carried out in Irish hospitals. Elective surgery accounted for 198,000 of these, and 69% of elective surgery cases were treated on a day surgery basis.

In 2006, the HSE identified 24 surgical procedures, which cover the major specialties, for which hospitals were asked to submit details annually of the total number of elective cases and the proportion of these that were carried out as day cases.¹ From 2009 to 2012, the HSE set a 75% day surgery rate target for all acute hospitals for the set of 24 procedures. In its 2013 and 2014 National Service Plans, the HSE did not set any target day surgery rate.

Potential for improved day surgery rates

The overall day surgery performance rate for all hospitals, for the 24 target procedures, has increased from 57% in 2006 to 74% in 2012. There is significant variation in performance rates between individual hospitals. In 2012, the rates for individual hospitals ranged from 50% to 92%.²

The examination found that expressing performance in terms of an overall day surgery rate for all procedures in a hospital masks significant differences in performance of day surgery for individual procedures.

Separate targets should be set by the HSE for each surgical procedure. The standard targets should be based on the performance already achieved by the top-performing hospitals. Higher targets (where medically appropriate) could be set for those hospitals that are already among the top performers.

The HSE should monitor day surgery rates at both hospital and procedure level, and focus effort on improving performance in those hospitals and specialties where there is the greatest potential for gain.

¹ The procedures were based on a set of procedures monitored for day surgery rates in the UK.

² This range relates to hospitals that carry out more than 400 elective surgery interventions in 2012.

Procedures with low day surgery rates

Clinicians must determine whether inpatient or day surgery treatment is appropriate for an individual case. In the course of this examination, some clinicians expressed the view that a number of the 24 target procedures monitored by the HSE are not suitable for day surgery. This viewpoint may be reflected in very low day surgery rates for some high volume procedures. For example, some hospitals achieved significant increases between 2006 and 2012 for their day surgery rates for laparoscopic cholecystectomy, in contrast to others where the rates remained very low.

The HSE should seek to identify the factors associated with increased day surgery rates in some hospitals and whether there are good practices in the hospitals with the higher rates that are transferable.

Day surgery rates for tonsillectomy – also one of the target specialties – remain low in almost all hospitals and the day surgery rate is around a quarter of the rate in the UK. It may be appropriate for the HSE to consider whether this procedure should have a low day surgery rate target.

Potential savings

The HSE has estimated that day cases were on average almost 60% less costly to perform than inpatient cases.¹ The HSE and the Department of Health have pointed out that a high proportion of the costs are fixed and that, if the level of day surgery increases, the full potential savings will not accrue in the short term. Related cost reduction measures would also need to be put in place to achieve the full savings.

Trend in non-targeted procedures

The overall number of elective procedures recorded increased between 2006 and 2012. However, there was a marked difference in the increase in the number of target cases – up 3% over the six year period – and in non-target cases – up 39%. The increase in the proportion of target cases carried out on a day surgery basis was broadly offset by a corresponding drop in the number of cases treated on an inpatient basis.

For the non-target procedures, there was no drop in the number of cases admitted as inpatients, despite a very rapid increase in the number of admissions for day surgery. There is no demonstrable demographic factor that would explain this trend.

The HSE has concluded that an increasing number of minor surgical procedures are being carried out as day surgery cases, when it would be more economical to carry them out on an outpatient basis or in primary care settings. It estimates that as many as three in five of the non-target day surgery treatments could more appropriately be carried out in other settings at less cost.

The HSE's Accounting Officer pointed out that the current method of funding of hospitals does not provide an economic incentive to perform procedures in their most appropriate setting, because the payment rate for some procedures performed in a day surgery setting is higher than if the same procedure is performed in an outpatient setting. He noted that this situation will be addressed when outpatients are included in the new 'Money Follows the Patient' funding model, and mechanisms are put in place to pay the same price for a procedure regardless of the delivery setting.

¹ Calculated for 24 surgical procedures.

Bringing about improvements

This examination included a survey of hospitals and a number of site visits, using medical consultants, to examine the processes around management and delivery of day surgery. The results were measured against good practice at each of the key stages of the day surgery patient pathway, and recommendations are presented aimed at achieving improvements in the way day surgery is managed.

Treatment planning

Patient selection

It is good practice for hospitals to have in place written protocols that set out surgical factors, other medical criteria and social factors that should be considered by the clinician when assessing a patient's suitability for day surgery.

Where they have not already done so, hospitals should put in place documented, locally agreed protocols and checklists setting out clearly the criteria for use by clinicians when selecting patients suitable for day surgery. The HSE should oversee this process to ensure consistency in approach across hospitals.

Only one hospital in five reported that they monitor the rate of patients deemed to be unsuitable for day surgery. The absence in most hospitals of monitoring or review by senior management of the number of patients deemed unsuitable for day surgery makes it difficult for hospitals to identify and address where day surgery rates for individual clinicians or specialties are low and to investigate and address the causes of this.

Pre-operative assessment

Pre-operative assessments of patients selected for day surgery are not routinely performed in a significant proportion of hospitals despite the importance of the assessments in identifying medical risk factors that make day surgery inappropriate for individual patients and minimising the risk of cancellation for patients who are found unsuitable on the day of their planned surgery.

Hospitals should ensure that pre-operative assessment procedures that are appropriate to the planned procedure are put in place.

Patient information

Despite the importance of providing prospective day patients with essential information about their planned surgery, procedure-specific information is made available by hospitals only in around one third of cases. Absence of information and reassurance may partly explain why many patients do not attend, without prior notice, for planned day surgery.

Hospitals should ensure that appropriate information is made available to patients at pre-assessment, both verbally and in written form. Written information should be clear and complete.

Treatment delivery

Good practice models suggest that for optimum efficiency, day surgery should ideally be provided in a self contained unit with specially trained staff.

While 69% of procedures are carried out through day surgery, overall, hospitals reported that just 10% of operating theatres are dedicated to day surgery. They identified the provision of more dedicated theatres as a factor that would contribute to improved day surgery rates.

Around half of day surgery units are in use for less than the minimum 12 hour period that is recommended to ensure both optimal theatre usage and sufficient time for patients to recover from surgery. In order to optimise theatre utilisation rates, hospital management should monitor day surgery rates, identify the causes of sub-optimal utilisation and take appropriate steps to address these.

Post-operative care

The use of appropriately trained nurses in the discharge process may relieve some of the burden on clinicians, albeit that consultation with a clinician may be necessary or advisable for some procedures or patients. However, the examination found that nurses have responsibility for discharge in around 50% of cases only. Hospitals, in consultation with the HSE, should review the arrangements for discharging patients after day surgery and identify and address the causes of apparently low levels of nurse-led discharges.

The review also found that there is a poor level of written information given to day surgery patients at discharge with only half being given emergency contact details and a third provided with information regarding pain relief.

Performance management in hospitals

While 85% of hospitals surveyed reported that they have clear day surgery targets, no evidence of day surgery target setting was found during site visits to four hospitals.

In order to measure performance against targets and to identify areas where improvement is needed, hospitals should monitor and review information about key performance indicators across the full range of activities including day surgery. This information should be available to management and clinicians and should form part of the performance assessments of clinicians.

Report

1 Introduction

- 1.1 Around 247,000 surgical cases were carried out in publicly funded acute hospitals in 2012, of which
- 49,000 (20%) were emergency procedures that were carried out on urgent case or emergency admissions
 - 198,000 (80%) were elective procedures, carried out for patients who can have their surgery performed at a planned and predetermined time.
- 1.2 Elective procedures can be carried out as inpatient or day surgery cases. Performing procedures on a day surgery basis, where it is clinically appropriate, is beneficial for both patients and hospitals.
- Patients benefit from day surgery because they recover in their own homes. In addition, there is a reduced risk of hospital acquired infection, as less time is spent in hospital.
 - Benefits for hospitals include reduced costs as staff and facilities are not required overnight, release of inpatient beds for more complex cases and smaller waiting lists due to improved throughput of cases.
- 1.3 There is support for day surgery from the Health Service Executive (the HSE). In its Elective Surgery Programme, the HSE states that it is possible for 75% of all elective procedures to be carried out as day cases and that the historical test 'Is this patient suitable for day surgery?' should be replaced by 'Is there any justification for admitting this case as an inpatient?'¹
- 1.4 The HSE has set targets for acute hospitals for the proportion of certain elective surgery cases that should be carried out as day cases. Up to and including 2012, a target day case rate of 75% was set for 24 selected procedures. In its 2013 and 2014 National Service Plans, the HSE did not set a target day case rate.

What is Day Surgery?

Day surgery is defined as the admission of selected patients to hospital for a planned surgical procedure, returning home on the same day. The admission must be for a procedure that requires full operating theatre facilities and/or a general anaesthetic. It does not include minor surgical procedures performed under local anaesthetic, or endoscopies.¹

A day patient is defined as a planned case admitted and discharged as scheduled on the same day. The day surgery rate is measured as the number of day patients treated, expressed as a percentage of the total number of day patients and elective inpatients combined.²

1 *Elective Surgery Programme Implementation Support Guide*, published by Health Service Executive, Royal College of Surgeons in Ireland, College of Anaesthetists in Ireland, 2011.

2 *Projecting the impact of demographic change on demand for and delivery of health care in Ireland*, Economic and Social Research Institute, October 2009.

Scope of the examination

- 1.5** The aim of the examination was to review
- trends in the rate of day surgery in Ireland and identify where there is scope for further improvements and savings
 - current practices in hospitals in respect of day surgery in order to identify opportunities for improvement, to establish the current level of performance monitoring and to identify the barriers to increasing day surgery rates.
- 1.6** The focus of the examination is on the potential to reduce inpatient cases by ensuring that, where medically appropriate, such cases are treated as day cases.

Methodology

- 1.7** The examination was carried out by staff of the Office of the Comptroller and Auditor General with clinical expertise provided by two external consultants (an anaesthetist and a neurological surgeon) working in the United Kingdom.¹
- 1.8** Information on consultants' inpatient and day case activity levels is generated from the Hospital In-Patient Enquiry (HIPE) scheme in acute hospitals. The information is collated and validated by the Health Research and Information Division in the Economic Social Research Institute (ESRI) which forwards the information to the HSE National Casemix Unit, on a monthly basis.²
- 1.9** The National Casemix Unit provides monthly reports to the HSE's CompStat, which holds a databank of performance information on Irish public health services.³ Day surgery data used in this report was obtained from the National Casemix Unit.⁴
- 1.10** The external consultants provided expertise for the drafting and reviewing of a survey questionnaire which was issued to all acute public hospitals in the HSE. The survey was based on good practice, as identified by the external consultants and the Royal College of Surgeons in Ireland, in the areas of patient selection, pre-operative assessment, staffing resources, day of surgery, post-operative support and performance measurement.
- 1.11** The external consultants and staff of the Office visited one hospital in each HSE region, in the course of which interviews were conducted with key personnel including consultants (surgeons and anaesthetists), nurses and management. These visits provided more in-depth knowledge of the current processes in place, the barriers to increasing day surgery rates and the instances of good practice in place in hospitals.

¹ Dr Ronan Dardis MB
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FRCS FRCSI (NeuroSurg)
and Dr Carl Hillerman MB
FRCA

² From January 2014 the
information is collated and
validated by the HSE's
Healthcare Pricing Office.

³ CompStat replaced
HealthStat as the HSE's
performance management
system in January 2013.

⁴ Casemix provides a
means for standardising
data collected on activity
and costs within acute
hospitals so that
comparisons can be made
between different areas of
activity and different
hospitals.

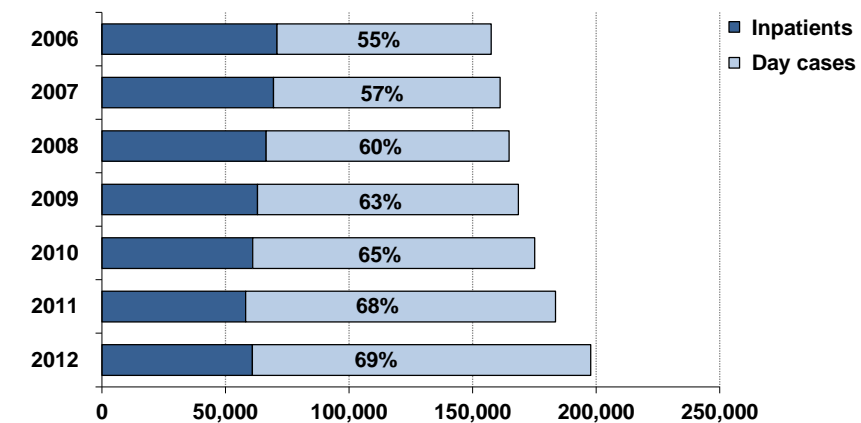
Structure of the report

- 1.12** Chapter 2 examines day surgery rates, in the context of the targets set by the HSE and the trends in day surgery activity since 2006. Chapter 3 examines the key stages in the day surgery process by reference to good practice, with the aim of identifying potential areas for improvement. Chapter 4 sets out the views of the Secretary General of the Department of Health.

2 Trends in Rates of Day Surgery

- 2.1** In 2006, around 157,000 elective surgical procedures were carried out in acute public hospitals. By 2012, this had increased to 198,000 elective procedures (an increase of 26%). The proportion of cases carried out by day surgery also increased in the same period, as illustrated in Figure 2.1.

Figure 2.1 Elective inpatient and elective day surgery volumes, 2006 to 2012



Source: Health Service Executive

Monitoring day surgery rates

- 2.2** From 2006, the HSE required hospitals to provide details of day surgery rates for a selected set of 24 procedures. These are listed in Appendix A.
- 2.3** From 2006 to 2008, the data reported by the hospitals was recorded by the HSE but targets for day surgery rates were not set. From 2009 to 2012, the data provided by hospitals was used to measure performance against an overall target day surgery rate of 75% for the 24 monitored procedures.
- 2.4** The HSE did not set a target day surgery rate in its 2013 and 2014 National Service Plans. This report reviews the performance by hospitals in 2012 against the target for the 24 procedures.

Day surgery rates achieved in 2012

- 2.5** The 24 target day surgery procedures accounted for around 62,000 elective procedures in 2012, representing 31% of all elective surgical procedures carried out. The data show that there was considerable variation both in the overall rate achieved by individual hospitals and in the rates for each procedure in different hospitals. The overall day surgery rate for these procedures in 2012 was 74%.

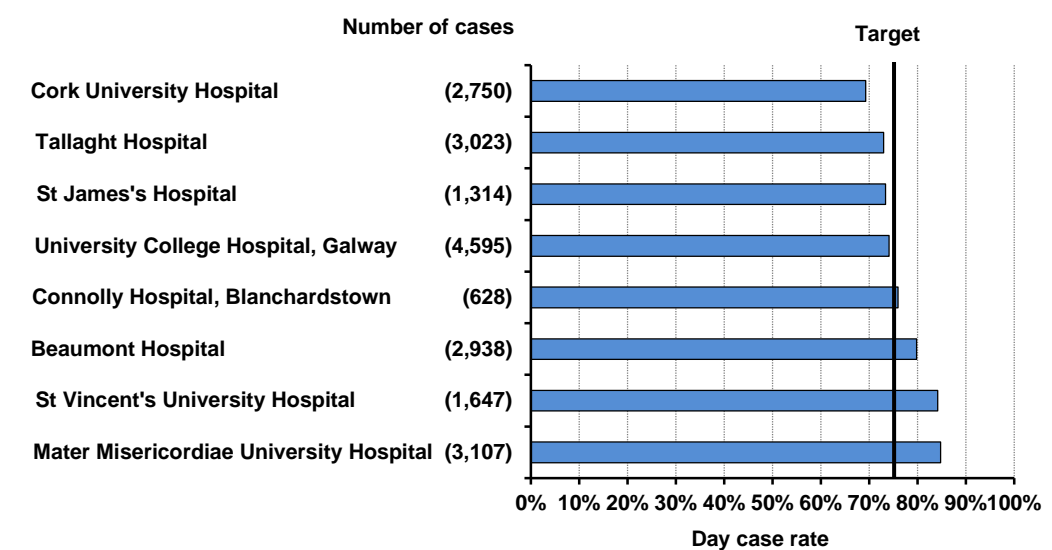
Analysis of rates by hospital

- 2.6** The range of procedures carried out in hospitals varies. Larger and regional hospitals usually carry out a significant number of the 24 target procedures while hospitals with specific areas of expertise typically perform high volumes of a small number of those procedures. For the purposes of comparing performance across hospitals, the hospitals have been grouped as
- major teaching hospitals
 - general and regional hospitals
 - specialist hospitals.

Teaching hospitals

- 2.7** There are eight major teaching hospitals which together account for 34% of elective cases for the target procedures. One hospital performed all 24 target procedures during 2012, and all teaching hospitals performed at least 18 of the target procedures.
- 2.8** There was a significant difference in the overall day surgery rates achieved by the major hospitals, which ranged from 69% to 85%, with a weighted average rate of 77%. The total number of target procedures cases carried out and the day surgery rates achieved in each hospital are set out in Figure 2.2.

Figure 2.2 Number of elective cases and day surgery rates (for 24 selected procedures), major teaching hospitals, 2012



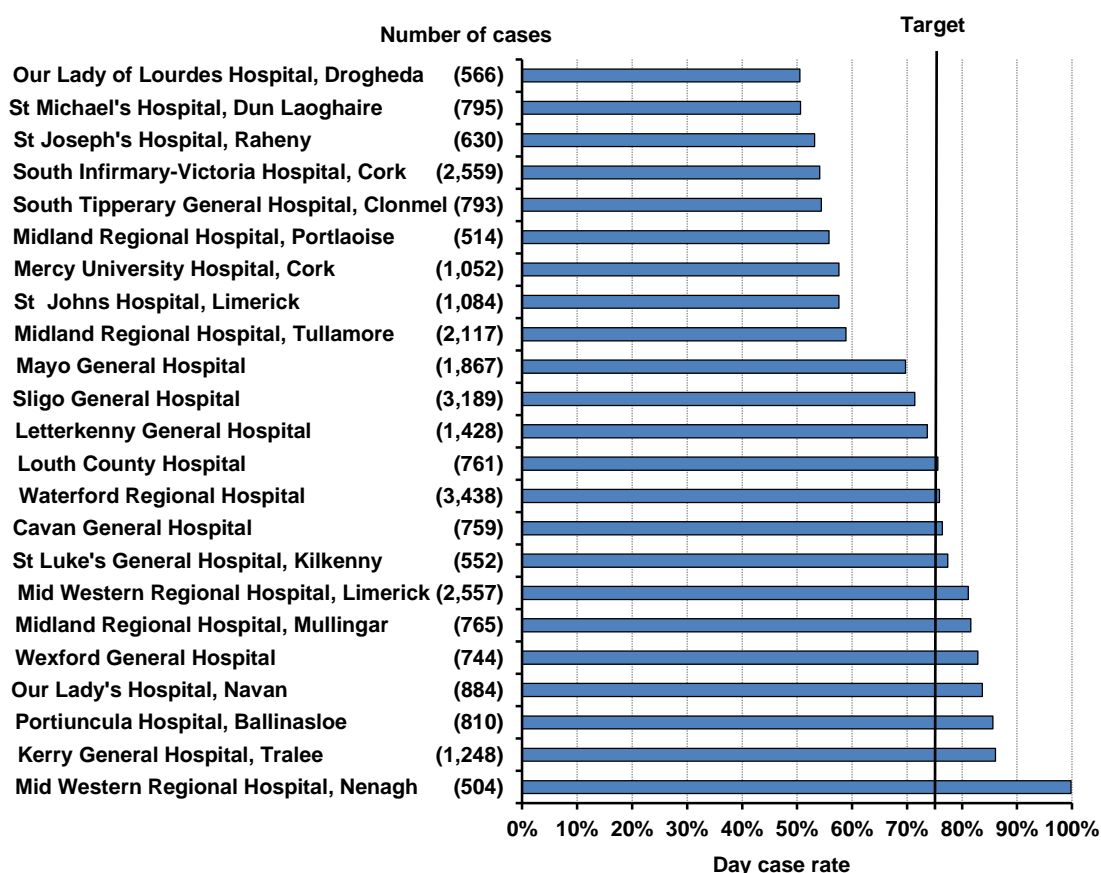
Source: Health Service Executive

- 2.9** While the teaching hospitals carry out broadly the same set of procedures, poor performance for one or more procedures can have a significant impact on a hospital's overall day surgery rate, especially if these are high volume procedures. For example, the procedure 'extraction of cataract' is carried out in five teaching hospitals. The average day surgery rate for four of the hospitals was 97% in 2012. The fifth hospital, Cork University Hospital, had a rate of 67% for this procedure. This hospital also had the lowest overall day surgery rate of the teaching hospitals at 69%. If Cork University Hospital were to increase its rate for 'extraction of cataract' to the average level of the other four hospitals, its overall average day case rate would increase to 79%.

General and regional hospitals

- 2.10** There are 30 general and regional hospitals which together account for 48% of the elective cases for the target procedures. Of these, seven carried out less than 400 of the target procedures each and therefore are excluded from the following analysis.
- 2.11** One hospital (Nenagh General Hospital) carries out only day surgery. Average day surgery rates for the remaining 22 hospitals were just under 70% with the rates ranging from 51% to 86%. Figure 2.3 sets out the total number of target procedure cases and the average day surgery rates for each of the hospitals for 2012.

Figure 2.3 Number of elective cases and day surgery case rates (for 24 selected procedures), regional and general hospitals, 2012



Source: Health Service Executive

Note: The hospitals in this group each carried out an average of 17 procedures from the selected 24 in 2012. For some procedures, volumes were very low.

Specialist hospitals

- 2.12** Hospitals with specific areas of expertise typically perform high volumes of a smaller number of specialty related procedures. In 2012, these hospitals performed 18% of elective cases for the target procedures. The number of cases and the day surgery rates, for the 24 target procedures, for four hospital types are set out in Figure 2.4.

Figure 2.4 Elective surgery rates for target procedures in specialist hospitals, 2012

Hospital type	Number of cases	Day case rates
Maternity	2,201	86%
Orthopaedic	1,729	78%
Ophthalmic	3,121	82%
Paediatric	3,486	75%

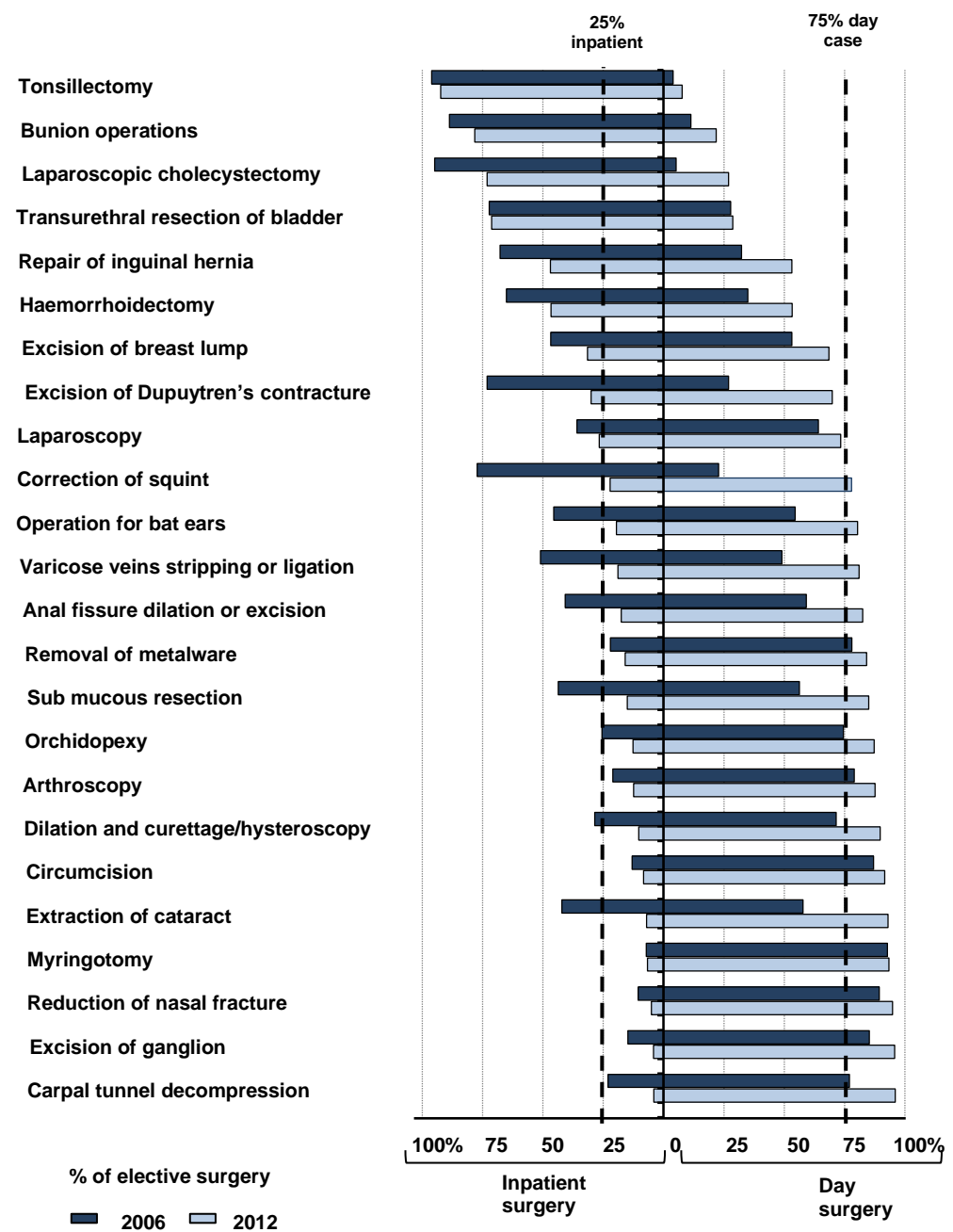
Source: Health Service Executive

- 2.13** In 2012, three maternity hospitals dealt with just over 2,200 cases in respect of two of the target procedures from the selected 24.¹ The rate for one hospital, at 71%, was well below the other two which achieved day case rates of over 90%.

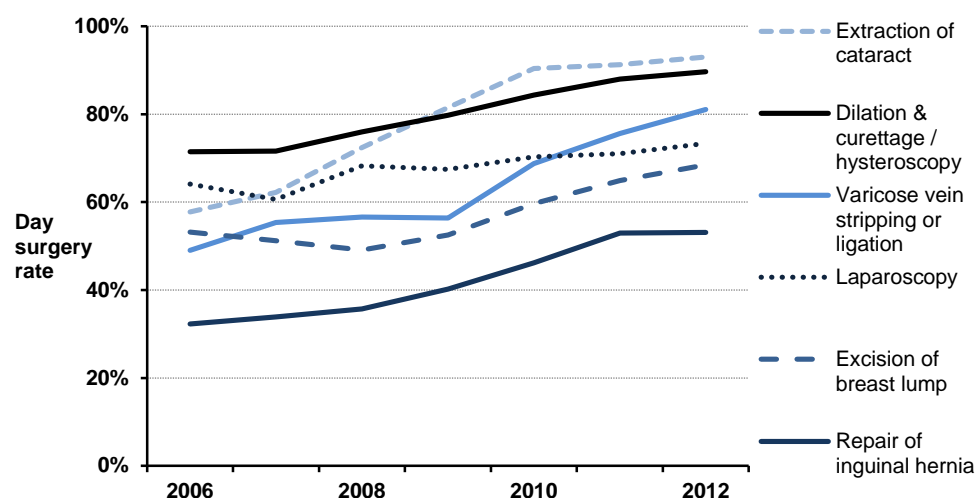
Analysis of rates by procedure

- 2.14** Because the average day case rate for individual procedures may vary, the mix of procedures undertaken by a hospital has a significant impact on its overall day surgery rate.
- 2.15** There was an improvement in day surgery rates for all the selected 24 procedures between 2006 and 2012 (see Figure 2.5). Overall, the average day surgery rate across all the target procedures increased from 57% in 2006 to 74% in 2012.

¹ The two procedures are dilation and curettage/hysteroscopy (almost 1,800 cases) and laparoscopy (just over 400 cases).

Figure 2.5 Day case rate performance for 24 selected procedures, 2006 and 2012

Source: Health Service Executive

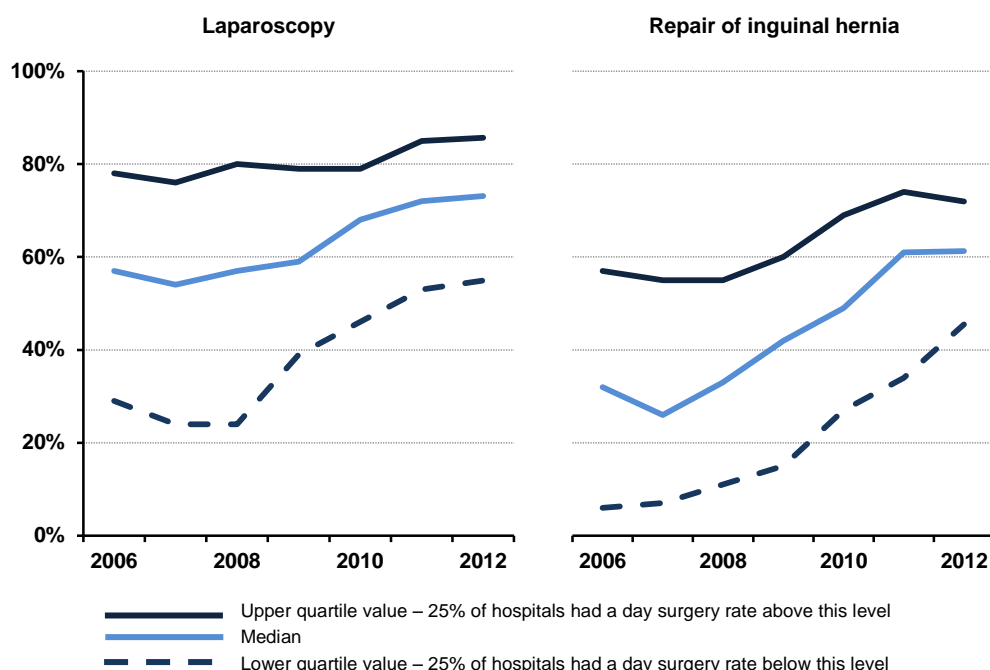
Figure 2.6 Trends for six selected procedures, 2006 to 2012

Source: Health Service Executive
 Analysis by the Office of the Comptroller and Auditor General

- 2.16** The trends for six high-volume procedures are set out in Figure 2.6. The average day case rate for these six procedures rose from 58% in 2006 to 83% in 2012.
- 2.17** Two procedures accounted for almost a third of all of the target procedure cases carried out in 2012, and were the main drivers of the increase in the overall rate.
- For extraction of cataract, where the total number of elective procedures rose from 9,500 in 2006 to 10,600 in 2012, the day case rate increased from 58% to 93%.
 - For dilation and curettage/hysteroscopy, the total number of procedures rose from 9,300 in 2006 to 9,900 in 2012 and the day case rate rose from 72% to 90%.

Variation between hospitals at procedures level

- 2.18** Figure 2.7 indicates how the distribution of day surgery rates between hospitals changed between 2006 and 2012 for two of the target procedures – laparoscopy and repair of inguinal hernia. In both cases, there was a narrowing of the spread in rates between hospitals.
- 2.19** Notwithstanding the significant increase in the day case rate for each of these procedures, there are significant differences in the rates achieved for the same procedure in different hospitals. The wide range of day case rates for these and other procedures indicates that considerable scope remains for achieving higher overall rates.

Figure 2.7 Spread of day surgery rates, 2006 to 2012

Source: Health Service Executive
 Analysis by the Office of the Comptroller and Auditor General

- 2.20** If all hospitals were to achieve the 2012 upper quartile level for laparoscopy, the average day case rate for the procedure would improve from the current 73% to around 88%. Similarly, if all hospitals were to achieve the 2012 upper quartile level for repair of inguinal hernia, the average day case rate for the procedure would improve from the current 53% to around 73%.

Procedures with low day case rates

- 2.21** Two procedures have a high volume of cases but have low day case rates
- laparoscopic cholecystectomy, where 3,700 cases were carried out with a day case rate of 27% in 2012 and
 - tonsillectomy which had a day case rate of 8% for just over 5,200 cases.
- 2.22** The consultants noted a view among some clinicians that these two procedures may not be suitable for day surgery due to their complexity and, for example, the risk of post operative bleeding and pain in tonsillectomy surgery. Notwithstanding these views, there is considerable variation in the day case rates in hospitals in Ireland for these two procedures.
- 2.23** In the UK, 43% of laparoscopic cholecystectomies and 40% of tonsillectomies are carried out on a day surgery basis.¹

¹ National Health Service, *Better Care, Better Value Indicators 2012*.

Laparoscopic cholecystectomy

- 2.24** There are significant differences in the rates achieved for laparoscopic cholecystectomy across the 35 hospitals where this procedure was carried out in 2012.¹ The day surgery rates ranged from zero in five hospitals to 70% in the hospital with the highest day surgery rate.
- 2.25** The examination compared the average day case rates in 2006 with the rates achieved in 2012, grouping the hospitals by their 2012 performance. Details are shown in Figure 2.8.

Figure 2.8 Laparoscopic cholecystectomy – day case rates, 2006 and 2012

Hospital bands (% of 2012 cases)	Average day case rate	
	2006 ^a	2012
	%	%
Top 9 hospitals (31% of cases)	16	61
Hospitals 10 to 18 (19%)	3	31
Hospitals 19 to 26 (23%)	0.3	9
Lowest 9 hospitals (27%)	–	1
Overall	6%	27%

Source: Health Service Executive; analysis by the Office of the Comptroller and Auditor General

Note: a A number of hospitals that carried out the procedure in 2006 but did not do so in 2012, or had ten or less procedures in 2012, have not been included. The overall day case rate in 2006, including these hospitals, was 5.2%.

- 2.26** The nine hospitals with the highest day case rates in 2012 had improved their average rate more than threefold over the period. Of these, three that each carried out just one day case out of a total of 369 cases in 2006 achieved day case rates of between 56% and 70% out of a total of 441 cases in 2012.
- 2.27** The significant increase in day case rates by the 18 top performing hospitals contrasts with the continuing low levels of day cases in the remaining hospitals. These hospitals had an average rate of 5%. Ten hospitals carried out between zero and three procedures on a day surgery basis in 2012.
- 2.28** The wide range of day case rates and the rate of improvement achieved by some hospitals indicates that there is considerable scope for achieving a higher overall rate for this procedure. In 2012, the top nine hospitals all achieved a day surgery rate of at least 44%. If all other hospitals were to improve their performance just to this level, then over 830 additional cases would be carried out on a day surgery basis.

¹ One hospital that carried out fewer than ten procedures was excluded from this analysis.

Tonsillectomy

- 2.29** 5,200 tonsillectomy procedures were performed in 20 Irish hospitals during 2012. As Figure 2.9 illustrates, the two national children's hospitals carried out just under 13% of the procedures with an average day case rate of 20%. The sixteen remaining hospitals had an average day case rate of 6%. Of these
- The top four performing hospitals carried out 10% of cases with an average day case rate of almost 27%. The rates ranged from 10% to 46%.
 - The eight poorest performing hospitals carried out 51% of the cases at an average day case rate of 1.5%.

Figure 2.9 Tonsillectomy - day case rates, 2006 and 2012

Hospital bands (% of 2012 cases)	Average day case rate	
	2006 ^a	2012
	%	%
Two national children's hospitals (13% of cases)	14	20
Top 4 hospitals (10%)	4	27
Hospitals 5-8 (26%)	1.1	7
Lowest 8 hospitals (51%)	0.6	1.5
Overall	4%	8%

Source: Health Service Executive; analysis by the Office of the Comptroller and Auditor General

Note: a Two hospitals where ten or less procedures were performed in 2012, have not been included. One hospital that carried out the procedure in 2006 did not do so in 2012. The overall day case rate in 2006, including this hospital, was 3.9%.

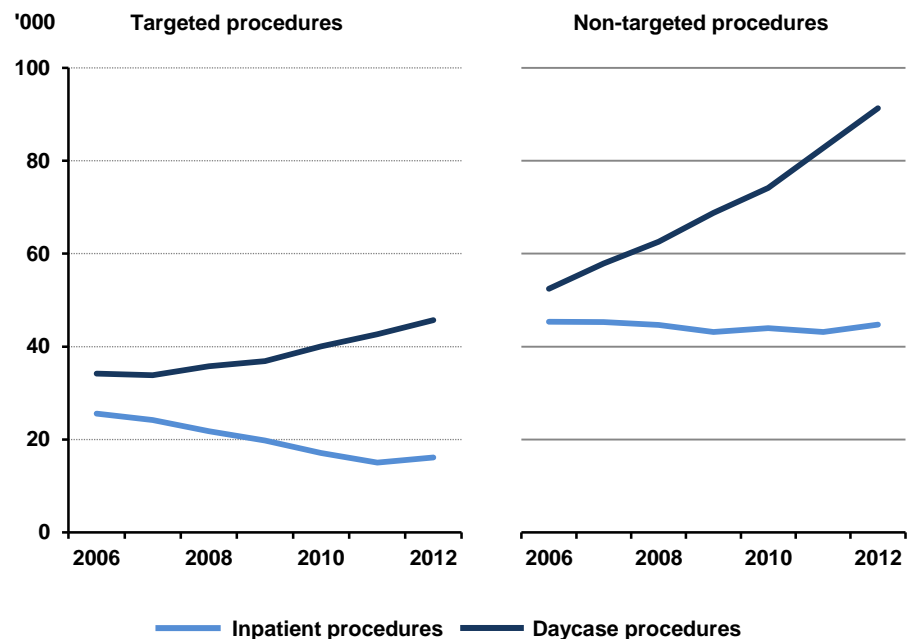
Potential impact of increases in day surgery

- 2.30** In order to provide an indication of the potential impact from achieving higher day surgery rates, the examination reviewed how day case rates would change if all hospitals were to improve their performance to levels achieved in the better performers.
- 2.31** If all hospitals were to achieve the upper quartile level and the hospitals at or above that level were to maintain their 2012 day case rates, the overall day case rate for the 24 procedures would increase from 74% to 85%, with conversion of approximately 7,000 cases from inpatient to day surgery.
- 2.32** The targeted procedures represented just under a third of all elective activity in 2012. Consequentially, there may be potential for further savings from the remaining two-thirds of elective procedure cases if their day case rates can be improved.
- 2.33** The HSE sets out the average cost for inpatient and day cases for the hospitals that participate in the National Casemix Unit. For the target procedures, the HSE estimates that day cases are, on average, almost 60% less costly than inpatient cases.
- 2.34** The HSE pointed out that if cases switch from being inpatient to day cases, the difference in costs would not automatically translate into cash savings due to the fixed nature of a high proportion of the costs. The fixed cost proportion is typically 65% to 70%. Full savings could be realised on this type of change in activity only if certain other measures are put in place such as ward closures or elimination of agency staff.

Trend in non-targeted procedures

- 2.35** The 24 categories of procedures previously targeted by the HSE for increased day surgery rates accounted for around 31% of all elective surgery carried out in 2012. Figure 2.10 indicates that the number of day surgery cases in that category increased from around 34,200 in 2006 to around 45,700 in 2012 – a cumulative increase of one-third. Over the same period, there was a broadly corresponding drop in the number of target procedures carried out on an inpatient basis, which fell from 25,500 in 2006 to 16,100 in 2012. There was a net increase of just over 3% in the total number of procedures in those categories in that seven year period.
- 2.36** In contrast, there was a very rapid increase in the number of other, ‘non-target’ elective procedures. All of that increase was due to additional day surgery cases, which increased by a total of 74%. There was only negligible change in the number of those non-target procedures carried out on an inpatient basis. This suggests that the growth in day surgery cases for these procedures was not related to substitution for inpatient cases, and so would not have yielded any savings.
- 2.37** It is unlikely that the rapid increase in non-target day surgery is due to general demographic factors, which should affect most categories of procedures in roughly similar ways. Other explanatory factors could be more hospital resources being allocated to non-target treatments, or minor treatments being misclassified as elective surgery.

Figure 2.10 Elective surgery for targeted and non-targeted procedures, 2006 to 2012



Source: Health Service Executive
Analysis by the Office of the Comptroller and Auditor General

- 2.38** The HSE's Accounting Officer stated that the increase in day surgery activity is due, in part, to an increasing number of relatively minor cases that do not need to be carried out in a day surgery setting. He pointed out that some procedures currently carried out as day cases could be carried out in a general practitioner's surgery, a hospital outpatient department or in an outpatient minor operations theatre. Based on a review of day cases admitted under surgeons in 2011, he estimated that just two out of five of the cases examined were 'true' surgical day cases.
- 2.39** He noted that currently there is no economic incentive to perform procedures in their most appropriate setting within the system. He stated that, at present, the payment rate for some procedures performed in a day case setting is higher than if the same procedure is performed in an outpatient setting (an example is removal of a skin cyst under local anaesthetic). He noted that this situation will be addressed when outpatients are included in the Money Follows the Patient process and a mechanism is put in place to pay the same price for a procedure, regardless of the setting.
- 2.40** He stated that, at present, outpatient procedures are not coded in the Hospital In-Patient Enquiry (HIPE) scheme. He also noted that there is inconsistent coding of minor procedures within hospitals as there is no separate code for those procedures and day case procedures in HIPE.
- 2.41** He stated that there has been some initial engagement between the National Clinical Programme for Surgery and the HSE's Healthcare Pricing Office on a reclassification of procedure coding from inpatient to day case and from day case to minor or outpatient procedures, in the context of Money Follows the Patient.¹ He also stated that this approach will be further developed in the future, with a view to constructively reworking remuneration and allocated volumes for individual hospitals in respect of procedures.
- 2.42** The Secretary General of the Department of Health also noted that the National Clinical Programme for Surgery has identified that a significant proportion of all recorded day case procedures nationally are in fact minor operations that do not require hospital admission. This raises issues in relation to the correct clinical pathway and the most effective utilisation of resources. Ideally, these patients would be seen and treated in primary care. If no service exists in primary care, then the patients need to be streamed into a separate unit away from day surgery where the procedure is undertaken in a 'clean room'. This may require infrastructural investment which may not be easily achieved within current resources.
- 2.43** He stated that it is important that the clinical pathway for patients is very clear and is supported by evidence-based referral criteria allocated to the correct pathway in terms of effective utilisation of a resource. He also stated that the HSE should review cases currently classified as day surgery cases with a view to re-categorising some in 'minor operations'. He pointed out that the clinical programmes can assist in implementing protocols to change practice in relation to these procedures and information can then be collected to manage that implementation and test the results into the future.

¹ The National Clinical Programmes are a strategic initiative between the Health Service Executive's Quality and Clinical Care Directorate and the various post-graduate training bodies.

Conclusions

Analysis of day surgery rates

- 2.44** There has been a steady increase in the proportion of reported elective surgery carried out as day cases between 2006 and 2012. The volume of elective surgical procedures carried out in acute public hospitals increased by 26% while the day case rate for those procedures increased from 55% to 69% over the same period.
- 2.45** The HSE has monitored the day surgery performance of hospitals by tracking the day case rates for 24 selected procedures which represent around a third of all elective surgery. The overall day case rates for each of these procedures increased between 2006 and 2012, with an overall day case rate of 74% being achieved in 2012. There is, however, significant variation in the performance by individual hospitals indicating that considerable scope remains for increasing the day case rate in some hospitals.
- 2.46** The examination found that if all hospitals achieved even the lowest rate of the 25% best performing hospitals in 2012 for each of the 24 procedures, around a further 11% of elective surgery could be carried out as day cases, thereby increasing the overall day case rate for these procedures from 74% to 85%.

Recommendation 2.1

In order to achieve the potential for higher rates of day surgery for elective procedures, separate appropriate targets should be set by the HSE for each surgical procedure. The overall day case targets set for each procedure should be based on the performance already achieved by the top-performing hospitals while more challenging targets could be set for those hospitals that are already among the top performers. The HSE should monitor the levels of day surgery by hospital, procedure and specialty to establish where the level of day cases is low for high volume procedures, and focus effort on improving performance in those instances where there is the greatest potential for gain.

Accounting Officer's response

Agreed. Day case rates are monitored by the National Clinical Programme for Surgery and each hospital is given its own data annually. A new tool will be launched in 2014 giving more current quarterly data.

Recommendation 2.2

In order to ensure that hospitals focus attention on increasing day surgery rates for all elective surgery, the HSE should increase the number of procedures for which it sets day case rate targets.

Accounting Officer's response

Agreed. The selection of 24 day case procedures has been dropped. A new monitoring tool (the National Quality Assurance Intelligence System) will look at all procedures performed nationally over 60 times per year. The system facilitates the monitoring of day case rates for 85 procedures against targets which were determined by best performers and/or international best practice. This tool is currently available via secure internet access to key personnel in all general regional hospitals in Ireland. The system is being further developed in conjunction with Health Intelligence Ireland to facilitate monitoring of day case rates for all (approximately 400) surgical procedures which are performed as day cases, amongst other features.

Low day case rates procedures

- 2.47** For some high-volume target procedures, there are low day case rates. Consultants engaged for this examination noted a view among some medical consultants that certain of the target procedures are not suitable for day surgery. Some hospitals have achieved significant increases in day case rates for laparoscopic cholecystectomy, but the national average in 2012 was only 27%. For tonsillectomy, there has been no significant increase in the overall day case rate between 2006 and 2012. The day case rate in Ireland for this procedure is just a quarter of that in the UK.

Recommendation 2.3

For those procedures where some hospitals have achieved significant improvements in day case rates but rates are low in others, the HSE should seek to identify the factors that contributed to the improvements and whether good practices in the hospitals with the higher rates are transferable.

Accounting Officer's response

Agreed. Shared learning is part of National Clinical Programme for Surgery hospital visits. A national conference on day surgery was held in the Royal College of Surgeons in Ireland in March 2013.

Recommendation 2.4

The HSE should investigate the reasons for the persistent low day case rate for tonsillectomy in order to ascertain whether it is appropriate to include tonsillectomy as a procedure for which a high day case target is set.

Accounting Officer's response

Agreed. The National Clinical Programme for Surgery has met and will continue to address this issue with Otolaryngology Head and Neck surgeons.

Trend in non-targeted procedures

- 2.48** The volume of 'non-target' elective day surgery cases carried out in acute hospitals increased by 74% between 2006 and 2012, without a corresponding change in the number of 'non-target' procedures performed on an inpatient basis. The likelihood is that increasing numbers of minor surgical procedures are being carried out on a hospital admissions basis, when it would be more economical to carry them out on an outpatient basis or in primary care settings.

Recommendation 2.5

The HSE should monitor cases currently classified as day surgery cases with a view to ensuring that all hospitals direct surgical cases to the most appropriate and economical delivery settings.

Accounting Officer's response

Agreed.

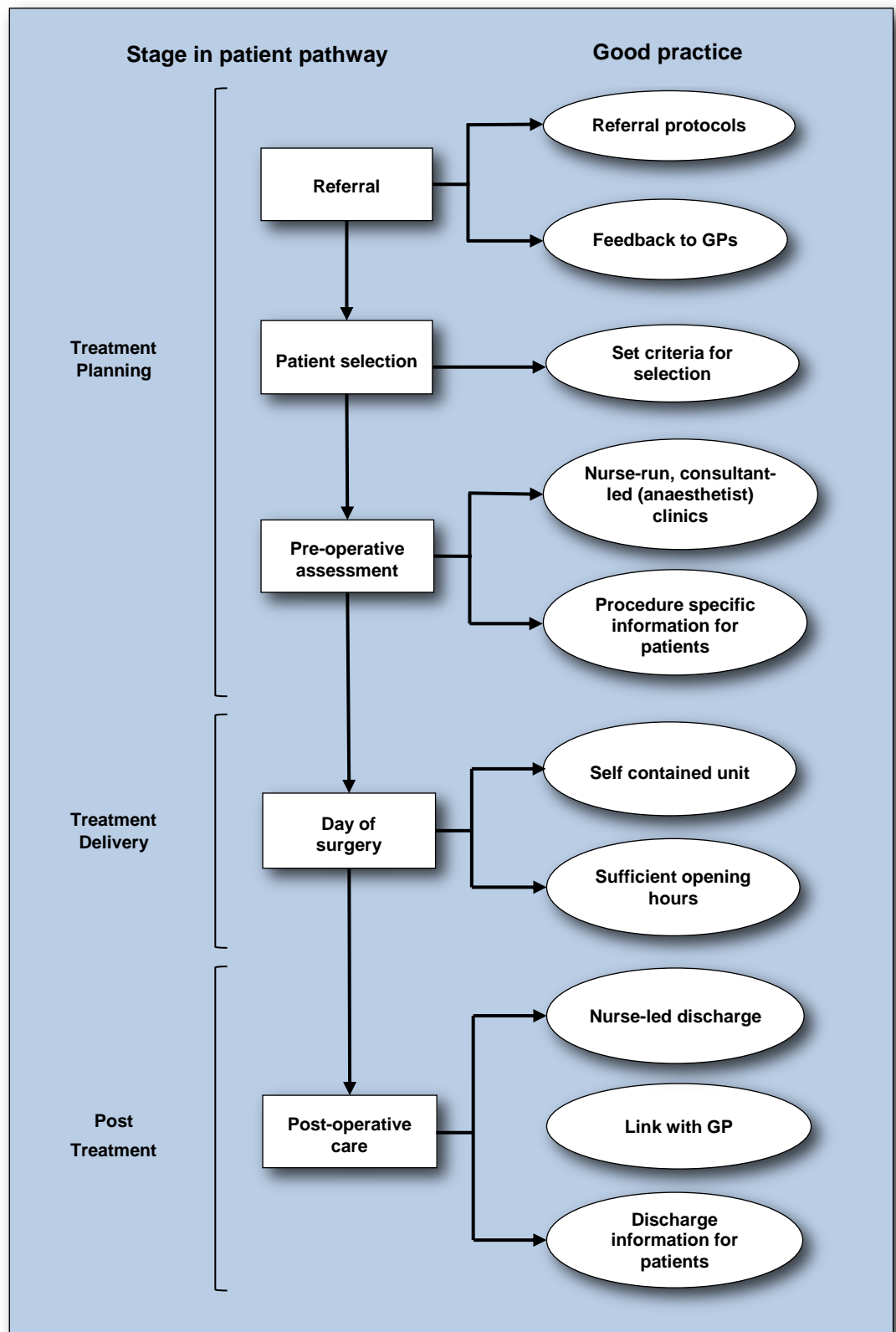
3 Gaining Improvements in Day Surgery Rates

- 3.1 In order to achieve the potential gains, the HSE and individual hospitals need to identify and address issues that may be keeping day surgery rates low.
- 3.2 The National Clinical Care Programme for Surgery is a strategic initiative between the HSE's Clinical Strategy and Programmes Division and the Royal College of Surgeons in Ireland and was established in line with a number of other national clinical programmes in medicine. The programmes are aimed at implementing change initiatives and standardising the quality of care and access for patients in a cost effective manner.
- 3.3 One of the initiatives, called the Elective Surgery Programme, aims to improve the patient journey along the elective surgical route through a set of reproducible processes.¹ It aims to increase day surgery rates through conversion of inpatient cases by standardising good practice across elective surgery through a series of guidelines and agreed protocols.
- 3.4 Based on the results of visits to four hospitals and the examination survey, this chapter reviews the extent to which good practice, as identified by the examination consultants and the British Association of Day Surgery, is carried out at each stage.² It also includes some recommendations for raising the rate of day surgery for elective procedures.
- 3.5 Figure 3.1 sets out the key stages in the day surgery patient pathway and outlines points of good practice for each stage.

1 Elective Surgery Programme Implementation Support Guide
- Health Service Executive, Royal College of Surgeons in Ireland, College of Anaesthetists of Ireland 2011.

2 British Association of Day Surgery, The Pathway to Success - Management of the Day Surgical Patient, April 2012.

Figure 3.1 Day surgery patient pathway



Referral process

- 3.6 The day surgery process starts when a patient is referred to a clinician, usually by a general practitioner, for assessment for possible elective surgery.
- 3.7 In October 2012, the HSE requested that the Health Information and Quality Authority (HIQA) undertake a series of health technology assessments of high volume elective procedures to examine and advise on clinical referral and treatment thresholds based on the available evidence of clinical effectiveness, cost-effectiveness and best practice.¹
- 3.8 The first series of health technology assessments were carried out on four procedures – tonsillectomy, adenoidectomy and grommet insertion, cataract surgery and varicose vein surgery. Each of these procedures is included in the 24 targeted procedures monitored by the HSE for day surgery rates. The results and recommendations of one of the assessments, tonsillectomy, are set out in Figure 3.2.
- 3.9 The HIQA report noted that the effectiveness of some procedures may be limited in some cases and that, by restricting these procedures for patients who may derive limited benefit, there may be potential to free capacity for treatments of higher clinical value thus maximising population health gain for the finite resources available.
- 3.10 Potential benefits arising from the introduction of clinical referral thresholds identified by HIQA include appropriate management of patients, reduced inappropriate referral to surgical outpatients, shortening the patients' elective journey and standardisation to best practice.

Figure 3.2 Tonsillectomy health technology assessment

The tonsillectomy health technology assessment found that it was unclear what thresholds general practitioners and surgeons were using to select patients for referral, or if the thresholds were being applied consistently. Assessment findings suggest that general practitioners are referring patients earlier than necessary, due to long waiting lists for outpatient appointments and surgery, in anticipation that the patient will continue to experience episodes of tonsillitis and so warrant surgery by the time they are reviewed in the outpatients department.

HIQA noted that, by referring patients early, general practitioners are possibly making hospital outpatient waiting lists less efficient, as the patient may not be suitable for surgery at the time of their appointment, or may not attend because their condition has improved. As hospitals generally do not monitor general practitioner referrals or provide feedback, there is no incentive for general practitioners to delay referrals until such time as a patient is in need of surgery.

The health technology assessment recommended that patients should only be referred for day surgery if they experience seven or more sore throat episodes in a year or five or more episodes in each of the preceding two years or three episodes in each of the preceding three years. Other thresholds have also been recommended.

¹ A health technology assessment is a HIQA evaluation of the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

Conclusion

- 3.11** In April 2013, HIQA published the results of four assessments of high volume elective procedures with recommended clinical referral criteria. It is too early to say what effect the application of the criteria will have on surgery rates for these procedures.

Recommendation 3.1

The HSE (and hospital managements) should put a process in place to ensure that general practitioners are made aware of the appropriate clinical referral thresholds for elective surgical procedures. Systems should also be put in place to monitor referrals by general practitioners and to provide feedback to general practitioners on whether patients attend scheduled appointments and of the outcome of those appointments.

Accounting Officer's response

Agreed. Greater engagement with primary care is important and is encouraged by the National Clinical Programme for Surgery.

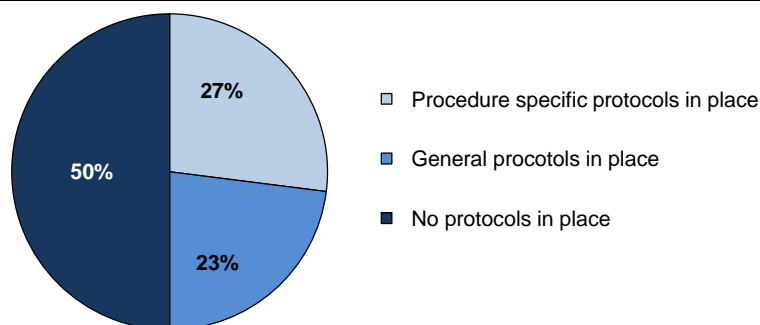
Patient selection

- 3.12** The identification of patients for whom day surgery is appropriate is critical in order to optimise the use of available resources. Clinicians need to consider
- surgical factors – for example, the procedure should not have a significant risk of serious complications
 - other medical criteria – for example, suitability for day surgery should be related to a patient's health assessed at pre-operative assessment and not by arbitrary limits such as age or body mass index, and
 - social considerations - for example, appropriate arrangements for post-operative care.

Protocols and checklists that are agreed with a hospital's anaesthetic department, setting out criteria for consideration by clinicians when assessing patients' suitability for day surgery should be in place.

Findings

- 3.13** Figure 3.3 shows the results of the survey of acute public hospitals as to whether protocols or selection criteria are in place, for the selected 24 procedures.

Figure 3.3 Selection criteria in place for 24 procedures

Source: Survey of hospitals by the Office of the Comptroller and Auditor General

- 3.14** Survey responses regarding the use of formal patient selection protocols were compared with the consultants' findings from the four hospital site visits. In the survey, two hospitals stated they did not have protocols in place. The other two hospitals had asserted that they had protocols in place for 15 and 23 of the selected 24 procedures, respectively.
- 3.15** Notwithstanding the survey responses, the consultants reported that they did not find evidence of any formal protocols or selection criteria for selecting suitable day surgery patients during any of the four hospital site visits. In one hospital, the consultants noted that the decision to list a patient for day surgery appeared to come down to the overall 'gut feeling' of the clinician in the outpatients department and there was no evidence that different consultants were using the same criteria.
- 3.16** The attitude of individual clinicians to day surgery and an absence of leadership in developing day surgery were identified by some hospitals as significant barriers to improving day case rates.
- 3.17** In response to survey questions about monitoring the rate of patients deemed unsuitable for day surgery, just 21% of hospitals reported that the rate is monitored. Of these, two-thirds said they reported the results to the Clinical Director or other senior management for further investigation.

Conclusion

- 3.18** The absence of written protocols and checklists regarding the selection of patients for day surgery means that the criteria applied when clinicians decide whether to list a patient for day surgery or inpatient treatment may not be clear or consistent and it may not be possible for management to assess the extent to which good practice has been followed or why patients have been deemed unsuitable for day surgery.
- 3.19** The absence in almost 80% of hospitals of monitoring or review by senior management of the number of patients deemed unsuitable for day surgery makes it difficult for hospitals to identify where day surgery rates for individual clinicians or specialties are low and to investigate the causes of this.

Recommendation 3.2

While a decision about the appropriateness of day surgery or inpatient treatment for individuals is ultimately a matter for the relevant clinician, all hospitals should put in place documented locally agreed protocols and checklists setting out clearly the criteria for use by clinicians when selecting patients suitable for day surgery. The HSE should oversee this process to ensure consistency in approach across hospitals.

Accounting Officer's response

Agreed. Guiding criteria are an integral part of the Elective Model of Care. The development of local integrated care pathways are supported by the National Clinical Programme for Surgery. Setting up of appropriate governance structures for clinical and managerial leadership in hospitals is very important and is monitored by the National Clinical Programme for Surgery at hospital visits.

Recommendation 3.3

In order to identify areas where day surgery rates are low, hospital management should monitor day surgery rates for individual clinicians and for each speciality. Where a procedure is generally considered appropriate for day surgery but is to be carried out on an inpatient basis, clinicians should be required to state why day surgery was not considered appropriate. This would assist hospital management in investigating the reasons for low day case rates and in identifying actions that might need to be taken to improve them. The HSE should seek confirmation from hospitals that low day surgery rates are routinely discussed with the relevant clinical teams.

Accounting Officer's response

Agreed. Day case rates are monitored by the National Clinical Programme for Surgery and each hospital is given its own data annually.

Pre-operative assessment

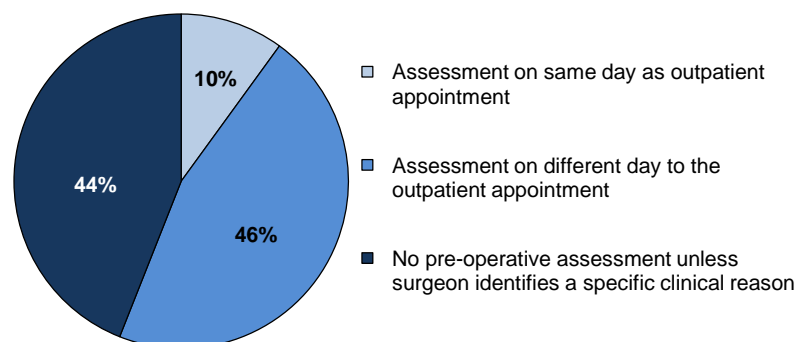
- 3.20** Pre-operative assessment of patients' suitability for day surgery is an important step in the day surgery process, especially when the patient is expected to receive a general anaesthetic.
- 3.21** Good practice assessments should be carried out by a person trained in pre-operative assessment for day surgery with the aim of identifying medical risk factors that make day surgery inappropriate and minimising the risk of cancellation of day surgery for patients who are found unsuitable on the day of their planned surgery. Pre-operative assessment clinics should be directed by a consultant anaesthetist and led by a suitably qualified nurse and should ideally take place on the day of a patient's outpatient department appointment. There should be protocols in place to ensure that nurses carrying out the assessments have access to consultant anaesthetists or consultants from another speciality where this is required.

- 3.22** An important part of the preparation for day surgery is to inform patients and carers about planned procedures and post-operative care requirements in order to assist them in making decisions and to reassure them about the process. The issues relating to day surgery can be discussed at outpatient appointments or at pre-operative assessments. In addition, information leaflets should be available for each day surgery procedure carried out by a hospital. Essential information should be provided, including specific information about the planned procedure, arrangements for the day of the surgery and post-operative recovery. Where possible, information leaflets should be available in the first language of the patient.
- 3.23** Hospitals should monitor the rate of cancellations of planned day surgery and the reasons for the cancellations. Where a high rate of cancellations is due to patients' unsuitability for day surgery, this might indicate poor pre-operative assessment procedures. Cancellation by patients might indicate that their anxieties about the planned procedure have not been adequately addressed.

Findings

- 3.24** In regard to the carrying out of pre-operative assessments, just over half of the hospitals surveyed reported that these are carried out routinely. Survey results are set out in Figure 3.4.

Figure 3.4 Pre-operative assessments in hospitals



Source: Survey of hospitals by the Office of the Comptroller and Auditor General

- 3.25** 85% of hospitals reported they have protocols in place for identifying patients who need to be reviewed by an anaesthetic consultant, while 64% have protocols in place to identify patients in need of review by a consultant of another specialty.
- 3.26** There may be a link between the quality of the pre-operative assessment process and the cancellation rate of day surgery. One hospital visited by the consultants focused its pre-operative assessment process on those undergoing more serious operations. This hospital carries out the assessments by telephone around four to five days in advance of the planned surgery and this is regarded by the hospital as key to minimising the rate of patients who do not attend on the day of surgery.
- 3.27** The consultants noted that in one of the hospitals visited, the hospital had recently audited the cancellation rate and found that 10% of cases had been cancelled on the day of the planned surgery because the patient was found not to be a suitable candidate. The consultants noted that such cancellations could have been identified with formal pre-operative assessments, which are not carried out for all specialities in the hospital.

- 3.28** The HSE stated that many of the cancellations that currently occur are due to the occupation of day beds as a result of the overflow from emergency departments. However, the HSE has not quantified the proportion of cancellations that occur for this reason and stated that the data is not well recorded.
- 3.29** In response to the survey, almost one third reported they provide procedure specific leaflets. 62% of hospitals reported that they provide patients with general information leaflets. Only 6% reported that they did not provide any patient information literature.

Conclusion

- 3.30** Pre-operative assessments are not routinely performed in a significant proportion of hospitals despite the importance of the assessments in identifying factors that make day surgery inappropriate for individual patients. Less than half the hospitals surveyed monitor the cancellation rate of scheduled day surgery. This mitigates against management being able to identify the causes of cancellation, including instances where appropriate pre-operative assessment might have identified the issue that subsequently caused cancellation, and take appropriate action to address these.

Recommendation 3.4

Patients who are unsuitable for day surgery due to medical reasons should be identified in advance of their planned surgery. In order to achieve this, hospitals should ensure that pre-operative assessment procedures that are appropriate to the planned procedure are put in place.

Accounting Officer's response

Agreed. Pre-operative assessment is an important part of the Elective Model of Care and is re-enforced by the National Clinical Programme for Anaesthesia. While there has been significant expansion in pre-assessment clinics in the last 18 months, there is still a long way to go.

Recommendation 3.5

In order to assist management in addressing the reasons for cancellation of planned day surgery, the rate of cancellations and the reasons for these should be recorded and monitored at hospital level and appropriate follow-up action taken.

Accounting Officer's response

Agreed. This is an essential part of good governance which is stressed in and monitored by the National Clinical Programme for Surgery and the Elective Model of Care.

- 3.31** Despite the importance of providing prospective day patients with essential information about their planned surgery, procedure specific information is made available by hospitals in just 32% of cases. Absence of information and reassurance for patients may be a factor in non-attendance, without prior notice, for day surgery.

Recommendation 3.6

In order to ensure that prospective day patients are made aware of the issues regarding a planned surgical procedure, hospitals should ensure that appropriate information is made available to patients at pre-assessment, both verbally and in written form. Written information should be clear and complete. Where there are significant linguistic sub groups in the patient population, information should be provided in relevant languages. Given the range of procedures and languages, the HSE could play a central role in assisting hospitals in providing this information.

Accounting Officer's response

Agreed. This is emphasised in the Elective Model of Care as part of locally developed integrated care pathways.

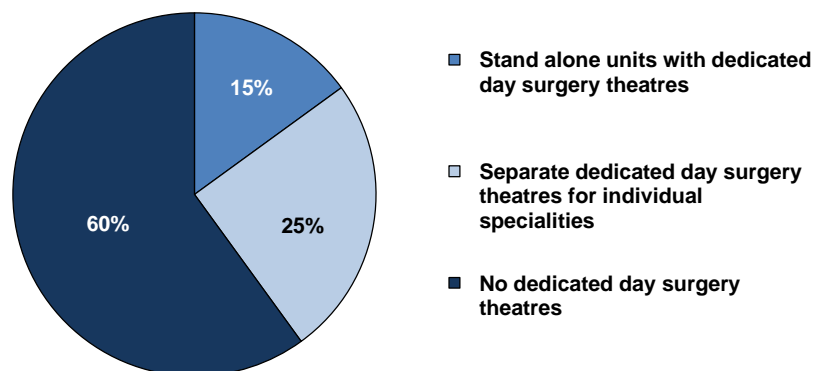
Day of surgery

- 3.32** For optimum efficiency, day surgery should ideally be provided in a self contained unit with specially trained staff and day surgery units that remain open for at least 12 hours a day, in order to optimise theatre usage and provide adequate time for patients to recover from surgery. 44% of hospitals surveyed identified the provision of stand alone dedicated day surgery theatres as a key factor that could assist in improving rates of day surgery.
- 3.33** In the absence of a dedicated day surgery unit, allocated day case beds should be dedicated to day surgery in order to minimise cancellations of elective day surgery cases due to the overflow from emergency departments.

Findings

- 3.34** In response to the examination survey, 48 hospitals reported that they have around 250 operating theatres available of which around 85% were in use in March 2012. 10% of the available theatres are dedicated to day surgery. 60% of hospitals do not dedicate theatres to day surgery. Figure 3.5 shows the availability of dedicated day surgery theatres in hospitals, based on survey responses.

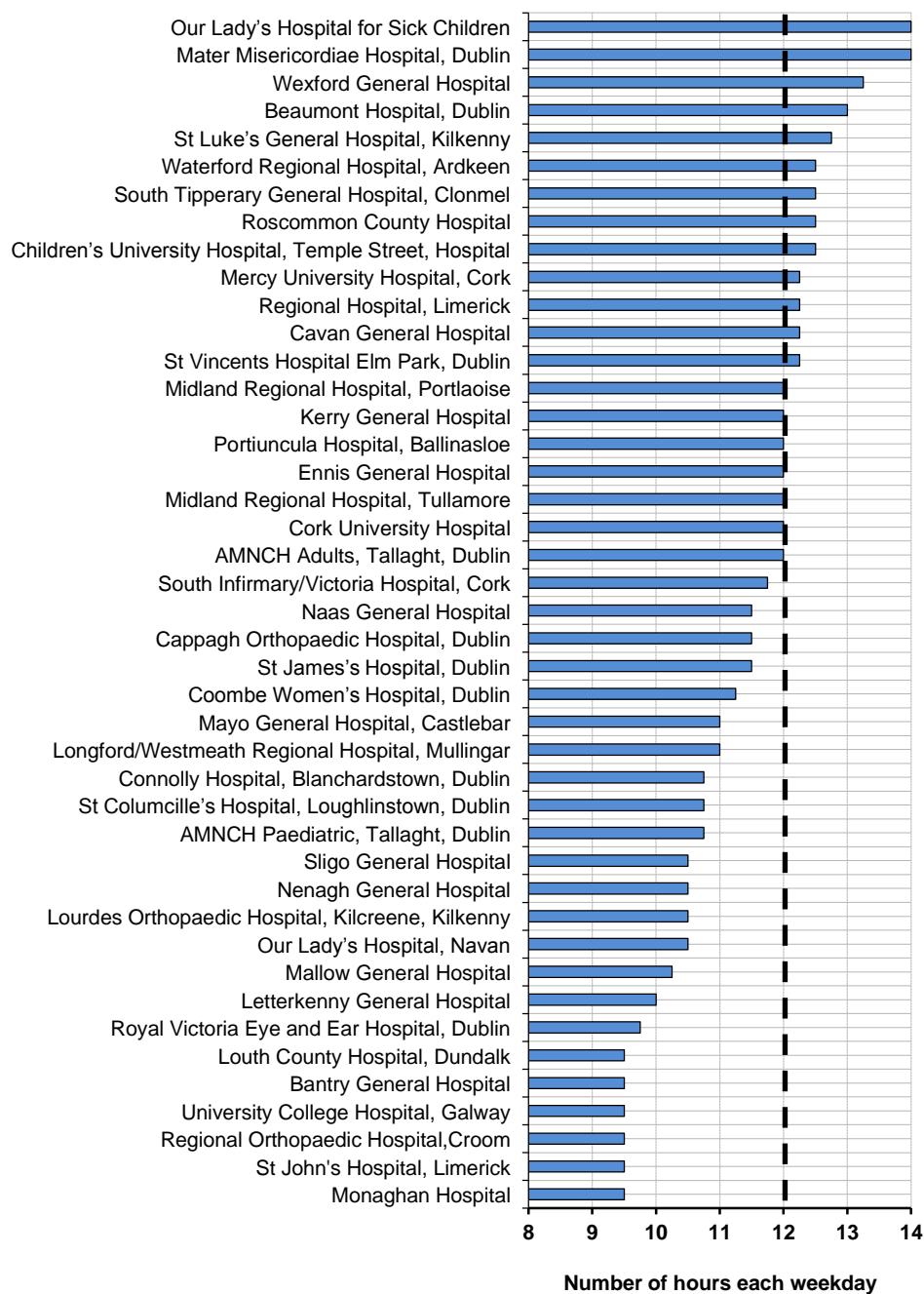
Figure 3.5 Day surgery theatre arrangements in hospitals



Source: Survey of hospitals by the Office of the Comptroller and Auditor General

- 3.35** Planned versus actual theatre usage and throughput by clinicians is monitored by the clinical director or other senior management in around half of hospitals.
- 3.36** The opening hours of day surgery units reported by hospitals varied as set out in Figure 3.6. Almost half of day surgery units are open for 12 hours or more. These accounted for 53% of day surgery in 2012.

Figure 3.6 Day surgery unit opening periods



Source: Survey of hospitals by the Office of the Comptroller and Auditor General

Note: Five hospitals did not provide details of day surgery closing times and are not included in the above chart.

Conclusion

- 3.37** While day surgery is best delivered in dedicated day surgery theatres and the provision of more of these has been identified by hospitals as a factor that would contribute to improved day surgery rates, just 10% of operating theatres nationally are dedicated to day surgery. This is in contrast to 69% of reported elective procedures carried out through day surgery.
- 3.38** Planned versus actual theatre usage and throughput by clinicians is monitored by the clinical director or other senior management in less than half of the hospitals surveyed.
- 3.39** Around half of day surgery units are open for less than the minimum 12 hour period that is recommended to ensure optimal theatre usage and that sufficient time is provided for patients to recover from surgery.

Recommendation 3.7

In order to take steps to maximise theatre utilisation rates, hospital management should monitor day surgery rates, identify the causes of sub-optimal utilisation and take appropriate steps to address these.

Accounting Officer's response

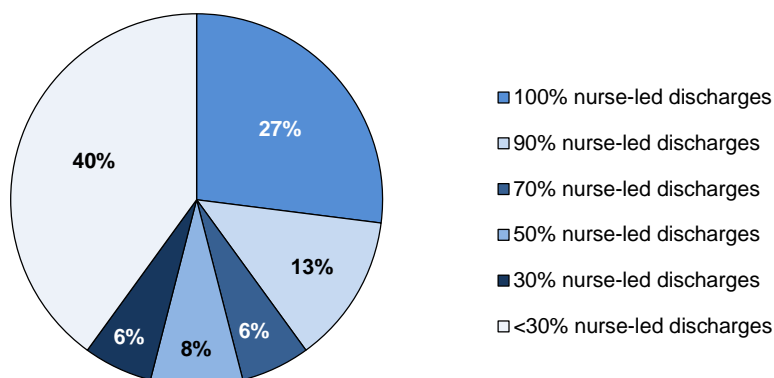
Agreed. Theatre usage is starting to be monitored using a new information technology tool developed by the National Clinical Programme for Surgery.

Patient discharge

- 3.40** For efficiency, discharge home from hospital following day surgery should be nurse-led using clear criteria for assessing the patient's suitability for discharge. The protocols should address areas such as pain relief, readiness for discharge, patient information, primary care and the management of unplanned inpatient admissions. Arrangements should be in place to facilitate same-day discharge in circumstances where a patient has not recovered sufficiently to be discharged at the time a day surgery unit is scheduled to close but is likely to meet discharge criteria within a few hours. Hospitals should monitor unexpected post-operative overnight stay rates and their causes.
- 3.41** Patients should be provided with procedure-specific discharge information, including contact details in case of an emergency and pain relief guidance.

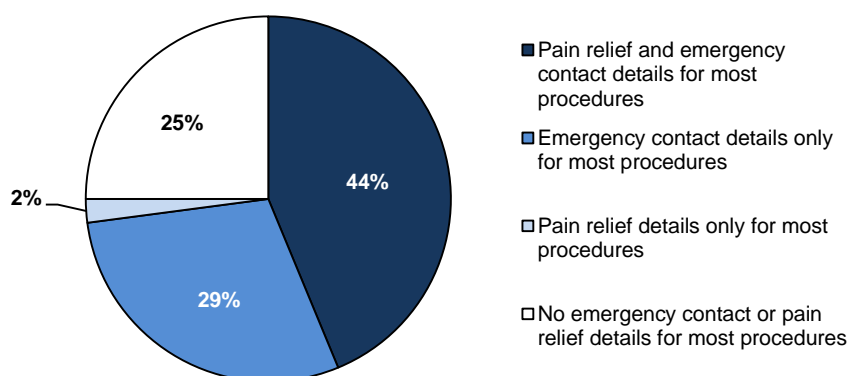
Findings

- 3.42** Around half of hospitals reported in the survey that they have nurse-led discharge for most procedures. The majority of hospitals have stated post-operative discharge criteria in place. However, in the visits to hospitals for this examination, the consultants found that just one of the four hospitals had a well developed nurse-led discharge process in place. The consultants noted that the nurses in that hospital had been trained in a competency programme and that the surgeons had confidence in the decision-making of nursing staff. Survey results are set out in Figure 3.7.

Figure 3.7 Post-operative discharge practice in 48 acute hospitals

Source: Survey of hospitals by the Office of the Comptroller and Auditor General

- 3.43** Only 18 of the 48 hospitals that responded to the survey monitor overnight stays rates following day surgery.
- 3.44** All but one hospital reported that details of the procedure and post-operative issues are discussed with patients prior to discharge. However, the provision of written information is poor – just over half the hospitals provide leaflets with emergency contact details while only a third provide written information about pain relief (see Figure 3.8.).

Figure 3.8 Provision of discharge information leaflets following targeted day surgery procedures

Source: Survey of hospitals by the Office of the Comptroller and Auditor General

Conclusion

- 3.45** Assessing patients' suitability for discharge should ideally be carried out by nurses using set criteria. While consultation with a clinician or other doctor may be necessary or advisable for some procedures or patients, the use of appropriately trained nurses in the discharge process may relieve some of the burden on doctors. However, nurses have the responsibility for discharges in around 50% of cases only.

Recommendation 3.8

Hospitals, in consultation with the HSE, should review the arrangements for discharging patients after day surgery and identify and address the causes of apparently low levels of nurse-led discharges.

Accounting Officer's response

Agreed. Proper discharge planning is stressed by the national clinical programme for surgery and is specifically addressed in the Elective Model of Care.

- 3.46** There is a poor level of written information given to day surgery patients at discharge with only half being given emergency contact details and a third provided with information regarding pain relief.

Recommendation 3.9

In order to ensure that discharged day patients have appropriate information about essential post-discharge issues, including emergency contact details and pain relief guidance, hospitals should ensure that appropriate written information is made available. Written information should be clear and complete. It should be available in relevant languages so as to assist patient groups who do not have Irish or English as their first language. The HSE should assist hospitals in providing this information. There should also be continuing audit and comment on the quality and clinical evidence base of the information provided in the leaflets.

Accounting Officer's response

Agreed. Proper discharge planning is stressed by the National Clinical Programme for Surgery and is specifically addressed in the Elective Model of Care.

Performance management

- 3.47** In order to measure performance against targets and to identify areas where improvement is needed, hospitals should monitor and review information about key performance indicators across the full range of activities including day surgery. This information should be available to management and clinicians and should form part of the performance assessments of clinicians.
- 3.48** The survey set out a number of barriers to day surgery that had been identified in an earlier survey by the Irish Journal of Medical Science in 2010 and asked hospitals to identify the most significant of these for their hospital.¹ One of the most significant barriers identified was the custom, practice and culture in a hospital or specialty including a lack of clinical governance and clinical leadership. The consultants engaged for this examination noted a culture to increase the number and percentage of day surgery procedures in one hospital. However, in another, a clinician stated that he would not consider undertaking a laparoscopic cholecystectomy as a day case. The day case rate for the procedure in that hospital was nil.

¹ *National Survey of the provision of day surgery across public and private hospitals in Ireland* – Irish Journal of Medical Science, August 2010.

- 3.49** As part of the National Clinical Programme for Surgery, the HSE has undertaken to fund ring-fenced day surgery beds if hospitals agree to deliver on targets which have been developed for procedures in each surgical specialty. 85% of hospitals reported that they set clear day surgery targets and have developed strategies to improve day surgery rates while half of the hospitals reported that feedback information is provided to clinicians. The consultants reported that during their site visits they found no evidence that targets for day surgery rates are set (or, if set, they do not appear to be monitored), or that day surgery rates of individual medical consultants were monitored.

Recommendation 3.10

Hospitals should set specific targets for day surgery rates for each clinician and review of clinicians' surgical performance assessments should include consideration of day surgery performance rates.

Accounting Officer's response

Agreed. Hospitals, specialties and individuals are performance monitored for individual procedures and are compared on a 'best in class' principle.

4 Views of the Secretary General of the Department of Health

Policy and operational initiatives

- 4.1 The Secretary General stated that there are three key policy and operational initiatives, which are guided by the Government's Future Health policy document, which will have a growing impact in the area of day surgery. These are
- hospital groups
 - 'money follows the patient' and
 - national clinical programmes.
- 4.2 The Secretary General stated that the implementation of these policies together promises to provide a very good basis to address this report's recommendations. He stated that he is determined that the policies will be implemented with maximum synergy to maximise the efficiencies and effectiveness gains both in relation to day surgery and across the entire hospital system in Ireland.

Hospital groups

- 4.3 A key Government policy for hospital services is the formation of hospital groups which include small, medium and larger hospitals in each group working as a single cohesive entity under a group management team which will include clinicians all linked with a key academic partner. As the individual hospitals move into groups and changes are implemented in their workload, and in the specialties and procedures offered, some larger hospitals will take on the more complicated surgery, while smaller hospitals will take on less complex procedures.

Money Follows the Patient

- 4.4 Encouraging hospitals to use the resources at their disposal more efficiently and increasing transparency in the provision of hospital services are two of the central objectives of the new Money Follows the Patient funding system. This system is being introduced on a phased basis from January 2014. The new funding system will involve moving away from inefficient block grant budgets to a new system where hospitals are paid for the actual level of activity undertaken. This will have the effect of ensuring that hospitals will be funded based on the quantity and quality of the services they deliver to patients.
- 4.5 The new system will be a case-based funding model using Diagnosis Related Groups (DRGs). The approach taken will enable a transparent comparison of hospital costs, quality and efficiency.
- 4.6 The types of efficiencies which will be incentivised under the new system include reducing lengths of stay, increasing day of surgery admissions and encouraging the delivery of care in the most appropriate setting and at the lowest level of complexity that is safe, timely and efficient. This would include shifting work from an inpatient to day case basis.

- 4.7** When Money Follows the Patient is fully implemented, the payment system will encourage a move from inpatient to day activity because services will be defined and priced by reference to complexity adjusted episodes of care and not by reference to setting. This will be an important driver of change in the model of care delivery and means that, to the greatest extent possible, the same service will attract the same price regardless of where it is provided. This will ensure that hospitals will have a financial incentive to carry out procedures on a day case rather than an inpatient basis.
- 4.8** It is also intended that, in time, the Money Follows the Patient model will include a system whereby prices for particular activity will be based on best practice pathways. This is a fair, efficient and transparent approach to setting prices that will be based on pre-agreed, published guidelines with hospitals then appropriately reimbursed for providing services to that standard. As such, the approach is consistent with the principle of developing prices which support the provision of care in the most appropriate setting. An additional benefit of best practice pricing is that it is a powerful tool for driving optimal quality of care, thereby improving effectiveness.
- 4.9** The absence of clear day case target setting is noted. The introduction of Money Follows the Patient will require the establishment of transparent activity targets for all participating hospitals. Activity targets will initially be set for all inpatient and day case activity within the hospitals with payments to those hospitals being explicitly linked to the achievement of the targets. This approach will ensure that activity will be closely monitored at the hospital level and centrally in the HSE.
- 4.10** Money Follows the Patient will also help to improve transparency by driving and encouraging significant improvements in the quality and timeliness of the coding of hospital activity. These improvements will be incentivised because all payments under the system will be based on the submission of coded activity. The expected improvements in coding will deliver improved and more timely performance information. This transparency will also facilitate the analysis of activity that will give greater visibility to variations in the performance of different hospitals, specialties and consultants in terms of achievement of day case ratios.

National clinical programmes

- 4.11** The HSE's National Clinical Programmes provide a national, strategic and co-ordinated approach to a wide range of clinical services. Currently there are 33 clinical programmes in different stages of development or implementation.
- 4.12** The primary role of the programmes is the provision of clinical leadership and advice through development models of care, guidelines and clinical pathways. In addition, areas for process improvement are identified and direction provided to achieve these improvements. Many of the programmes have produced models of care and guidelines which have been jointly agreed and endorsed for implementation with/by the Royal College of Surgeons in Ireland and the College of Anaesthetists in Ireland. This is being done through standardising access to and delivery of high quality, safe and efficient hospital services, and also maximising linkages to primary care and other community services.

Collation and analysis of day surgery rates

- 4.13** The Secretary General stated that better collation of day surgery rates is clearly important. The information collected as a result must be analysed and presented in a way to help manage the implementation of the recommendations of this report from a national perspective and in hospitals. He noted that additional information and communication technological infrastructure and investment need to be targeted on these objectives.
- 4.14** He also noted that setting overall day case rates for each procedure, based on the performance of the top-performing hospitals, may show where there are issues with patients not being treated as a day case.
- 4.15** Increasing the numbers of procedures monitored may increase the use of day cases, generate cost savings and deliver faster treatment for patients. Models of this approach are available – for example the National Health Service in the UK. However, this needs to be done carefully so as not to produce an undue bias towards performing the targeted day case procedures as opposed to other day case procedures which may be equally important but less amenable to clear target setting.

Patient selection

- 4.16** If patients are planned to be admitted as inpatients at considerable extra cost to the hospital, a clear reason should be provided for this. This will be especially important in the implementation of Money Follows the Patient.

Appendix

Appendix A

The 24 selected day surgery procedures, where referred to, are as set out below.

1	Orchidopexy	correction of undescended testes
2	Circumcision	removal of foreskin
3	Inguinal hernia repair	repair of outpouching of the abdominal sac 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

Source: The Audit Commission Day Surgery Operational Guide, UK Department of Health, August 2002