Prime Minister
BHP 2/11

(4)

PRIME MINISTER 29 October 1990

FIRST AUDIT COMMISSION REPORT ON THE NHS

The Audit Commission have produced their first report on the NHS (see summary at Annex A). It focuses on day surgery and finds:

- that if all District Health Authorities (DHAs) made maximum use of day surgery, up to 300,000 extra cases per year could be treated. This is equal to a third of the total waiting list for day and in-patient surgery.

The report helps to knock on the head the notion that long waiting times are mainly caused by lack of money. It is interesting that the "Today" programme's item on the Audit Commission report did not once mention "lack of resources".

Background

From a clinical point of view day surgery is now widely regarded as preferable to in-patient surgery for a range of procedures. It is firmly backed by the Royal College of Surgeons. Day surgery is widely used in the USA and Canada.

In the UK, the majority of DHAs have special day care units. But the Audit Commission found that the use which is being made of these units varies widely:

- two or three health authorities use day surgery for 5 per cent or less of their total operations;

- 55 DHAs use day surgery for between 15 and 20 per cent of total operations;

- four or five DHAs used day surgery for between 30 and 45 per cent of total operations.

These wide variations could not be explained away by differences in case mix.

Why isn't there more day surgery?

The Audit Commission found the following obstacles:

(i) Health Service managers have poor information about the use and cost of existing day care facilities;

(ii) a minority of DHAs do not have day care facilities. A dedicated ward is essential to realise savings from being able to close the ward down at night;

(iii) insufficient/inappropriate use of day care facilities (this links back to (i)). Day care facilities are sometimes used for outpatient procedures. This is unnecessary and extravagant;

(iv) poor management and organisation of day case units (again links back to (i));

(v) doctors' preferences for more traditional approaches. This is especially prevalent among older doctors who do not have the up-to-date skills necessary for day surgery;

(vi) disincentives for managers to bring about change under the present system lest treating more patients simply adds to their cash limited costs.

Can the problems be overcome? Will it cost money?

The Audit Commission think that the problems can be overcome:

- the Royal College of Surgeons could help change doctors' attitudes;

- from April 1991 the NHS reforms will change hospital managers incentives to increase the number of cases handled. Those who do more will get more money in future;

- the NHS reforms should lead to better financial and managerial information on which to plan optimum use of day care facilities.

Only one aspect requires more money. Day surgery is most effective where there is a separate theatre close to the day care ward. This would require capital expenditure in the minority of DHAs which do not have day care facilities. But:

- the Audit Commission say it is not essential to have a separate theatre. Simply dedicating an existing ward to day care would be a useful start;

- new incentives under the NHS reforms may well make capital investment in a theatre dedicated to day surgery look well worthwhile.

What happens next?

The Audit Commission believe in bringing about change at the coalface. They propose working through their local auditors in DHAs over the coming year:

- to estimate the potential for substituting day cases for in-patients in each DHA;

- to encourage managers and medical staff to plan on increasing the percentage of day cases in each DHA.

Conclusion

The report usefully highlights the many factors other than money which contribute to long waiting times. The follow-up work proposed by the Audit Commission will be another weapon with which to attack the problem of waiting times. These remain by far the major cause of public dissatisfaction with the NHS.

CAROLYN SINCLAIR

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A·U·D·I·T
COMMISSION

ANNEX A

The Audit Commission for Local Authorities and the National Health Service in England and Wales

REVIEW

October 1990

A SHORT CUT TO BETTER SERVICES
Day Surgery in England and Wales

The Audit Commission became responsible for auditing the National Health Service on 1st October 1990. This is a summary of the Commission's first report on the National Health Service. The full report is available from HMSO. (See page 4 for more details).

There are many non-emergency surgical procedures carried out in hospital which can be treated as either in-patients or day cases. For appropriate procedures and properly selected patients there is no difference in the outcomes of the two methods of treatment. As the Royal College of Surgeons says in its 1985 *Guidelines on Day Case Surgery*,

> '... it should be clear to all concerned, the surgeon, the nursing staff, and in particular the patient, that day-surgery is in no way inferior to conventional admission for those procedures for which it is appropriate, indeed it is better.'

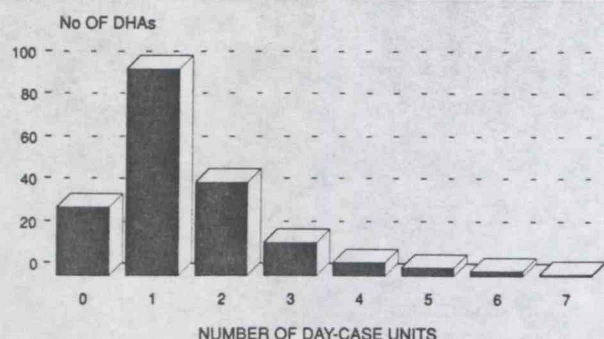
However, other differences make day surgery advantageous:

- patients are often treated sooner because more surgery can be done for the same money and waiting lists are shorter;
- many people prefer to spend less time away from home. This is especially important for children for whom hospitalisation should be avoided wherever possible;
- day surgery can be provided in a self-contained ward or unit which closes down at night. Because only a limited number of planned procedures are carried out, a routine can be developed which matches the needs of patients closely. Separation from the main hospital may be better for patients psychologically. They are also less likely to suffer sudden cancellation of their treatment by the hospital, as often happens to in-patients when their beds are needed for emergencies. Most District Health Authorities (DHAs) already have these units (Exhibit 1);
- the costs to the hospital are, on average, about 30% less than the equivalent in-patient surgery and there is no evidence of an increased need for community support. The extra costs incurred by patients and their families providing care at home are likely to be offset by the considerable benefits they receive.

Exhibit 1

DAY-CASE UNITS IN DHAs IN ENGLAND AND WALES

Most DHAs have at least 1 day-case unit.



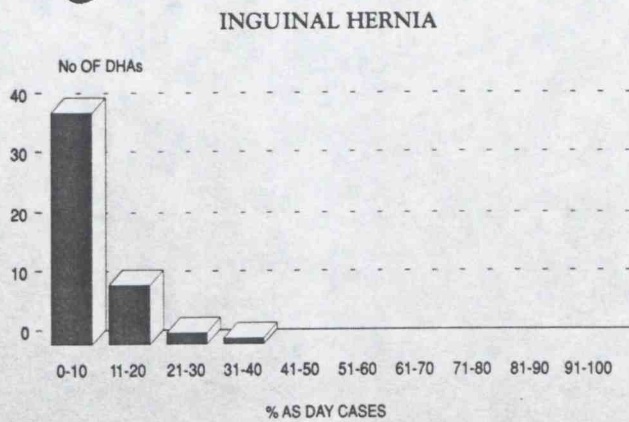
Source: Audit Commission survey (October 1989)

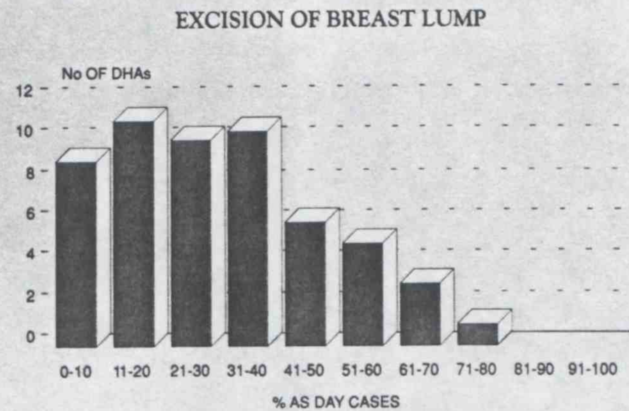
GROUNDS FOR CONCERN

In view of all these advantages and the extensive investment by DHAs in day-case units, it is surprising to find that the percentages of patients treated as day cases in England and Wales are still well below the levels achieved in some other countries. Moreover, for some operations, day-case percentages vary from 0% to 100% between DHAs (Exhibit 2).

The Audit Commission's study has focused on a "basket" of 20 common operations (Exhibit 3) which account for about 30% of all surgery. If all DHAs used day-case treatment to the same extent as the 25% that use it most, an additional 186,000 patients could be treated in England and Wales every year at no extra cost. Many other operations are also suitable, offering potential for an estimated 300,000 additional cases per year. Such an increase in activity would have a significant impact on waiting times for all types of surgery.

Exhibit 2
VARIATIONS IN THE % OF OPERATIONS DONE AS DAY CASES BY DHA (1988/89)
There is great variation in the percentage of cases treated as day cases.





Source: Audit Commission analysis of data from W Midlands Mersey, S Western & NW Thames Regional Health Authorities (54 DHAs)

Exhibit 3
THE AUDIT COMMISSION'S "BASKET" OF PROCEDURES

1. Inguinal hernia repair	11. Orchidopexy
2. Excision of breast lump	12. Cataract extraction, with or without implant
3. Anal fissure excision	13. Correction of squint
4. Varicose veins stripping or ligation	14. Myringotomy, with or without insertion of grommets
5. Cystoscopy, diagnostic and operative	15. Sub mucous resection
6. Circumcision	16. Reduction of nasal fracture
7. Excision of Dupuytren's contracture	17. Operation for bat ears
8. Carpal tunnel decompression	18. Dilatation and curettage
9. Arthroscopy, diagnostic and operative	19. Laparoscopy, with or without sterilization
10. Excision of ganglion	20. Termination of pregnancy

THE UNDERLYING PROBLEMS

It is surprising that day surgery has not developed to a greater extent. But the cultural change and associated management effort required are substantial. Six main barriers have been identified by the study:-

(i) **Lack of information to assess current performance, estimate the potential and monitor change.** Many managers rely on the Health Service Indicators produced by the Department of Health, which are insensitive to procedures are examined, the data may still be inconsistent, incomplete or inaccurate. This is due in particular to confusion about whether some patients should be classified as day cases or out-patients and the lack of attention given to computer coding of operations and procedures.

(ii) **Lack of appropriate facilities.** Not all DHAs have day-case units (Exhibit 1). The ones that do not have them never treat a high percentage of patients as day cases. But a large number of DHAs with units still do not achieve very high percentages (Exhibit 4). In other words, day-case units are necessary but not sufficient for achieving high proportions of day cases.

(iii) **Poor use of existing day-case units.** The study found generally low levels of throughput (cases treated per bed per year) and wide variation from one DHA to another. Only one exceeded the Commission's good practice indicator of 346 cases per bed per year; most managed between 200 and 250. But the problem is not just one of simple under usage. There are hundreds of different procedures carried out in day-case units. Some are entirely appropriate to that setting, for example the 20 operations in the Commission's "basket". There are other procedures, such as colposcopy, which generally do not require the operating theatre facilities nor level of nursing cover found in most day-case units. These can be carried out in an out-patient department. Day-case units vary considerably in the types of procedures carried out and some may be using their facilities inappropriately (Exhibit 5).

(iv) **Poor management and organisation of day-case units**. Units often lack clear objectives, leadership and good management information.

(v) **Clinicians' preferences for more traditional approaches.** Some surgeons and anaesthetists never carry out day surgery because they see no advantage in it and have not been confronted with the need to change. Of the majority who do consider it as a possibility, the main problems they raise are:

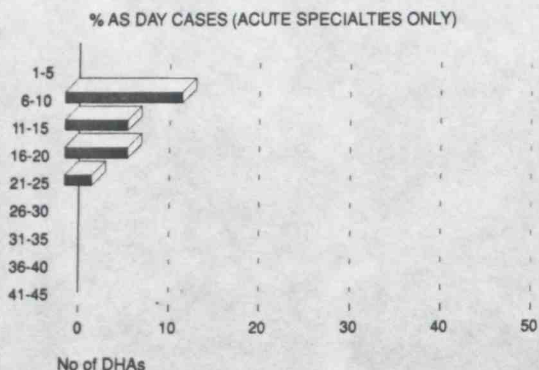
- lack of appropriate facilities;
- poor organisation and management of day-case units;
- fear that the quality of service offered to patients will not be as good as that for in-patients;

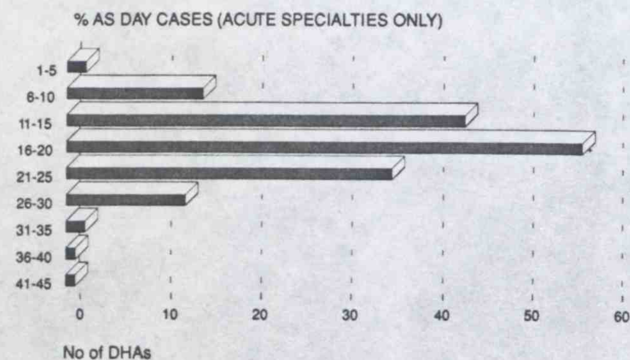
Exhibit 7
DISTRIBUTION OF THE % OF PATIENTS TREATED AS DAY CASES IN DHAs WITH AND WITHOUT DEDICATED DAY-CASE UNITS

WITHOUT UNIT
DISTRICTS WITHOUT A UNIT NEVER ACHIEVE A HIGH PERCENTAGE AS DAY CASES

but

WITH UNIT
HAVING A UNIT IS NOT SUFFICIENT, AS MANY OF THESE DHAs STILL HAVE LOW PERCENTAGES





Source: Audit Commission survey of health authorities in England and Wales 1988/89

- a belief that patients prefer to be treated as in-patients;
- their own lack of training in day surgery techniques.

(vi) **Disincentives faced by managers.** Poor financial and activity information make it difficult for managers to assess and monitor the benefits and costs. They also often feel that they lack control over clinicians' practices and that moves towards day surgery will always result in additional patients being treated, with little or no substitution of day cases for in-patients, thereby posing a threat to their cash limited budgets.

WHAT NEEDS TO BE DONE

The Audit Commission has made recommendations which are aimed at overcoming these barriers:-

(i) Performance comparisons should be based on a consistent set of operations, such as the "basket" of 20 used in the study. In the longer term, there is a need to collect comprehensive data on all procedures, whether out-patient or day case, and for DHAs to pay more attention to computer coding of procedures.

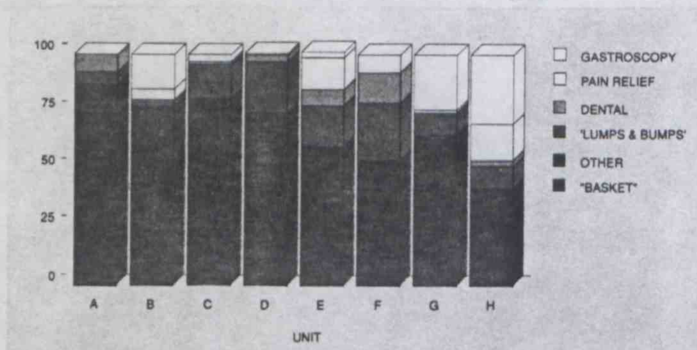
(ii) Specialist day-case units should be provided in all DHAs. This does not require extensive capital expenditure if based on existing wards. There are considerable benefits attached to having a dedicated operating theatre, but this can be added at a later stage as part of a phased programme of capital development.

(iii) Local managers and clinicians should assess and monitor carefully the use being made of existing day-case units, particularly the appropriateness of the cases being treated for the level of facilities available.

(iv) Management and organisation of day case units can be improved with:

- a written operational policy (Exhibit 6) covering patient selection, information given to patients and monitoring of their satisfaction with the service; as well as systems for booking, admission and discharge of patients;
- proper managerial control, including the appointment of a clinical director from amongst the consultant staff who should take a leading role in the policy and management of the unit;
- better management information, including much more on the quality of service received by patients. The Commission is developing a patient satisfaction questionnaire which can contribute towards this. It will be circulated to all health authorities in due course.

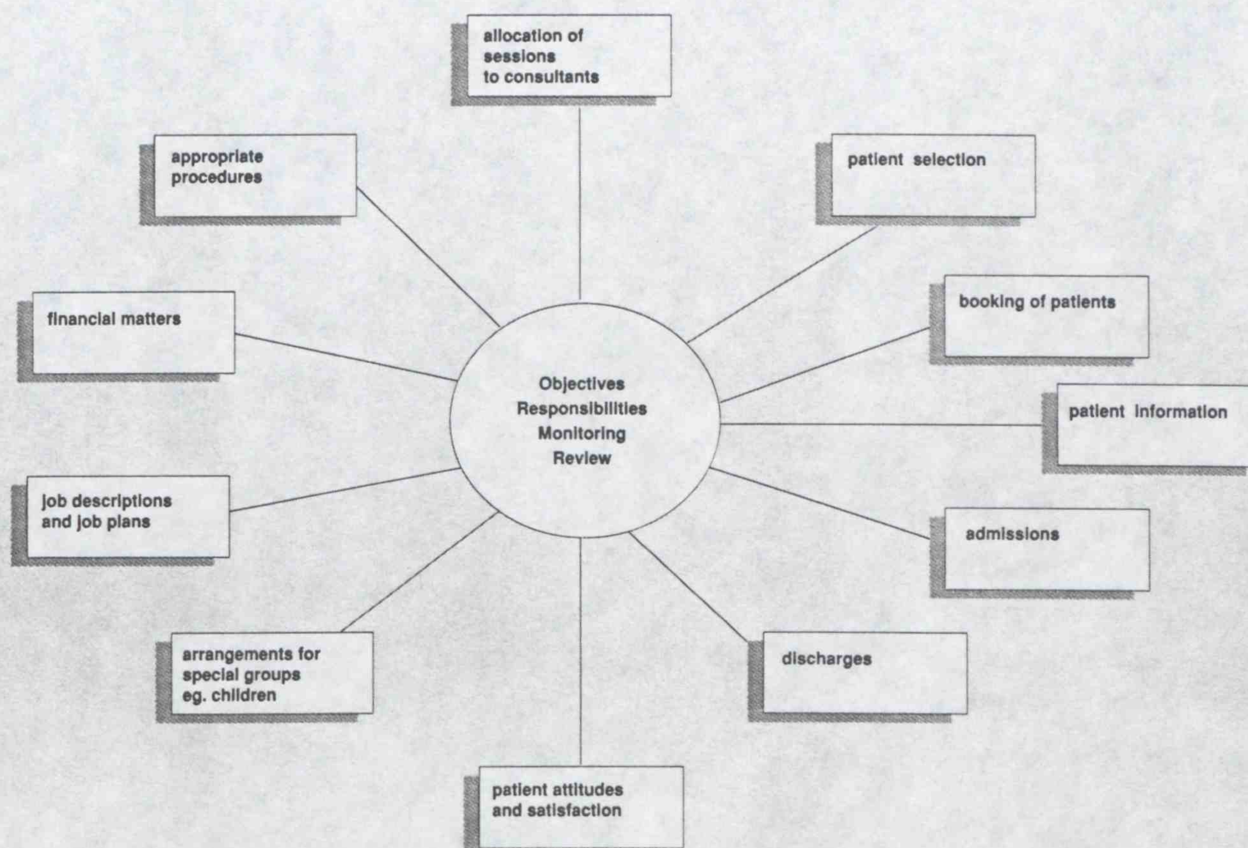
Exhibit 5
PROCEDURES CARRIED OUT IN 8 DAY-CASE UNITS
There is substantial variation in the mix of procedures carried out in day-case units.



Source : Audit Commission survey of day-case units

OPERATIONAL POLICY

Every day-case unit should have an operational policy covering:



(v) Many of the actions already discussed will go a long way towards reassuring clinicians that day surgery is a viable option. It is also important to ensure that training in day surgery techniques is available both for new doctors and existing surgeons and anaesthetists. The Royal Colleges could play a major role here, for example, by making day surgery experience a criterion for the accreditation of training posts.

Regular reports to clinicians on their own day-case activity in comparison with that of their colleagues may also help to encourage change.

(vi) The National Health Service and Community Care Act (1990) will remove many of the disincentives faced by managers. In particular, DHAs as purchasers of services from hospitals will be better placed to influence which non-emergency operations are carried out and in what setting: out-patient, day case or in-patient. The Act also helps the problem of reconciling extra activity with cash limits. In future extra activity will be part of a planned expansion, and matched by an increase in revenue. Hospitals with an efficient day surgery programme will be able to offer good quality surgery at less cost and attract funds for expanding in this way.

THE NEXT STEPS

Over the coming year, the Commission's auditors will be undertaking audits of day surgery in every DHA in England and Wales. They will be collecting new data to assess current performance on a consistent basis and estimate the potential for future growth. Detailed plans, with firm targets for achieving this potential, should then be agreed by the managers and clinicians involved.

The Commission also intends to produce a report on the results of the audits and to monitor progress in subsequent years.

IF YOU WANT TO KNOW MORE . . .

A fuller explanation of the Commission's approach is contained in *A Short Cut to Better Services: Day Surgery in England and Wales*, price £8.50. This and other Commission publications can be obtained from HMSO, PO Box 276, London SW8 5DT, Tel: 071-873 9090