GIRFT
GETTING IT RIGHT FIRST TIME

ENTUK

BRITISH ASSOCIATION OF DAY SURGERY

NHS IMPACT
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Expanding Day Case Surgery in Ear Nose and Throat Services

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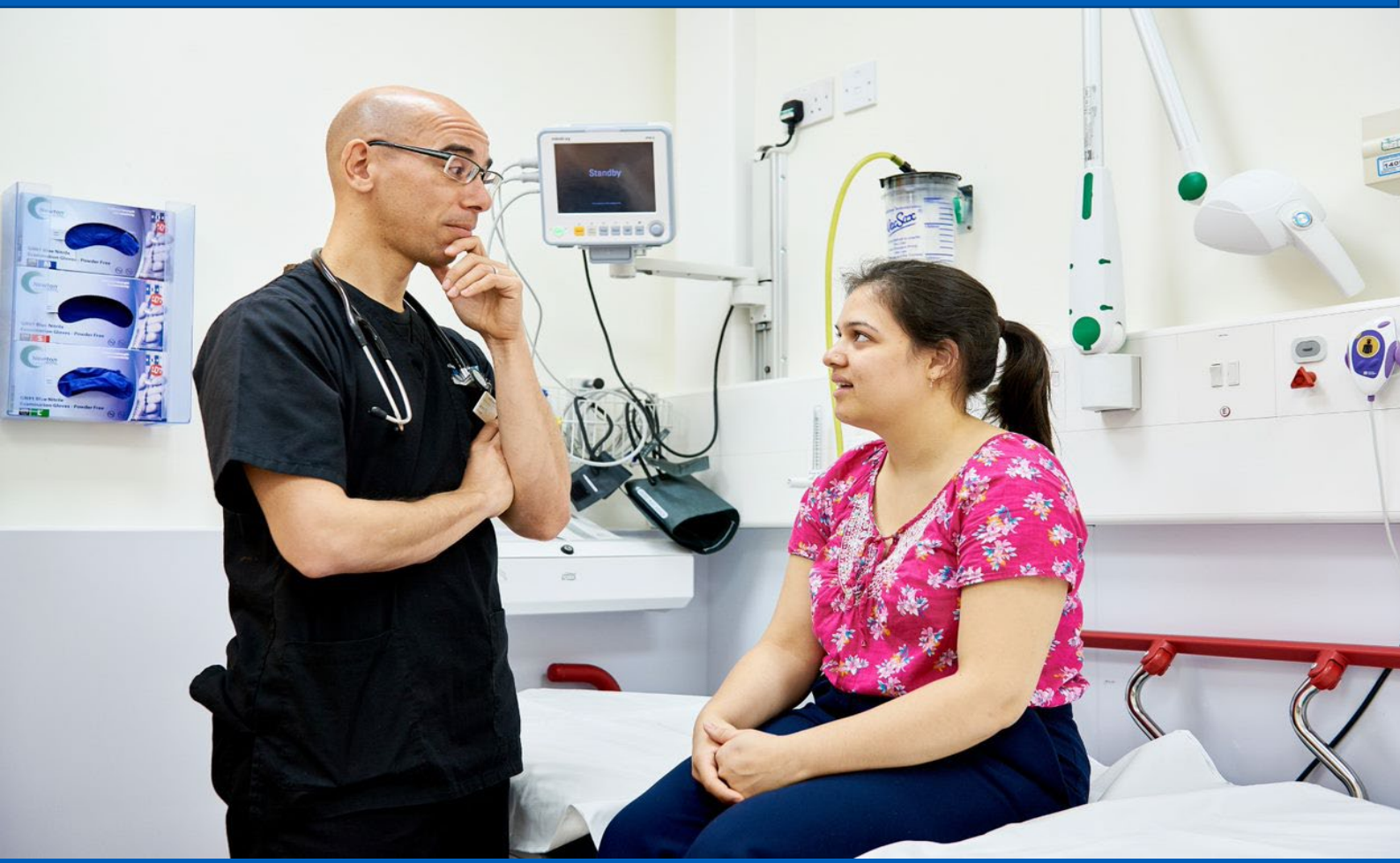

GIRFT is part of an aligned set of programmes within NHS England

Executive summary

Ear Nose and Throat (ENT) surgery is characterized by a wide range of treatments and surgical procedures with a significant proportion of outpatient activity. Surgery ranges from extensive head and neck cancer resection and reconstruction, through to low complexity procedures such as tonsillectomy.

The Getting It Right First Time (GIRFT) 2019 National ENT Report recommends expanding day case surgery to improve care for ENT patients and provide benefits to hospital trusts. Increasing day case rates will:

- Ensure more patients are treated without the inconvenience of an inpatient stay in hospital;
- Make ENT departments more resilient to pressures on inpatient beds;
- Allow trusts to free up capacity for other patients, both surgical and non-surgical;
- Result in cost efficiencies for hospital trusts.

Across ENT departments, there is wide variation in day case surgery provision and productivity, with pockets of excellence where day case surgery has been expanded displaying evidence of good patient outcomes.

Model Health System using data extracted from HES shows that the provider median for the proportion of all admissions that were day cases for the group of procedures in the ENT section, is 88.4% as of February 2023 (three month rolling metric). Case studies which highlight how some trusts have optimised their day case rates are documented in the Further resources section.

Who should read this guide?

This guide is intended to be of interests to clinicians, organisations and systems aiming to expand their day case surgery rates to ensure efficiency.

Purpose of this guide

This guide presents examples of how ENT departments can transform their services to provide more day case surgery. This includes guidance on patient eligibility and safety; the challenges faced, and examples of ENT procedures carried out as day case.

Contents

Introduction

Over the years there has been a revolution in surgical techniques, advances in anaesthesia, clinical research, development of facilities and changes in hospital policies to support the move to day case surgery. Many ENT operations and procedures are well suited for day surgery because of short operating times, low complication rates, and minimal post-operative morbidity.

Day case surgery is recognised to have advantages over inpatient surgery:

- Patients prefer to recover at home.
- Reduced risk of infection.
- Lower costs, greater efficiency.
- Avoid cancellations due to bed pressure.
- Improving productivity to drive down waiting lists.

This can be achieved without compromising patient experience of care and in many cases enhances it.

The GIRFT deep dive visits found no significant correlation between day case rates and readmission rates despite some units with relatively low day case rates expressing concerns on the possible detrimental patient outcome and/or increased readmission rates. Analysis reveals that even if the NHS continues to reduce the length of time people spend in hospital there will be 20-35% extra beds required in 2030-31 to maintain pre-pandemic standards of care[1].

The cause of variation in day case rates can be summarised into the following themes:

- Historical clinical practice and protocols
- Resistance to change among senior clinicians, surgeons, anaesthetists and nursing staff.
- Lack of dedicated day case facility.
- Lack of established up to date guidance and protocols.
- Widespread geographical catchment
- Day case targets not set by trust.
- Erroneous belief that patient population is different, for example older, more complex or unable to manage early discharge.
- Transfer of more complex patients, particularly paediatric, not suitable for day case care to tertiary level unit due to high-risk co-morbidity reducing their day case percentages.
- Administrative processes and structures that do not promote day case admission and may default to inpatient listing unless day case specifically ordered.
- Lack of morning lists
- Early closure of day case recovery unit.

[1] New analysis reveals future NHS beds shortage (health.org.uk)

Apart from major head and neck, and skull base surgery, few ENT procedures routinely require inpatient admission. Day case should be the default listing option unless specific instruction is given. Guidance of appropriate procedures is available in the British Association of Day Surgery (BADS) Directory of Procedures.

Waiting list managers should be given clear guidance on the more common operative procedures that should be listed as day case:

- Septoplasty
- Septorhinoplasty
- Tonsillectomy adult and children
- Adenoidectomy
- Grommets
- Endoscopic sinus surgery/nasal polypectomy
- Myringoplasty/tympanoplasty
- Pinnaplasty
- Endoscopic examination of pharynx, larynx, oesophagus
- Endoscopic laser procedures on larynx

They should confirm the surgeon's intentions on less frequent or ambiguous listings.

ENT best practice pathways are available on the GIRFT academy website

Changing clinical culture to embrace day case surgery is important to progress this needed change.

This guide explains steps taken by trusts to achieve this culture change to deliver improved day case rates. Case studies from these trusts can be found here.

Approach to change

ENT departments choosing to increase or develop day case surgery should take a patient pathway, and collaborative multidisciplinary approach to ensure a safe transition. A strong project management approach is required for this change process. The sequence of activities required for successful implementation are described below.

Using data to promote change

Departments could start by reviewing day case rate performance against the BADS day surgery metrics using Model Health System. The review should include the evaluation of performance in comparison with other organisations within your system and nationally to identify organisations from which learning can be shared.

Stakeholder engagement

Medical, administrative and theatre staff – A structured and documented consultation process is essential to achieve a quick and effective development of a new day case structure, especially if a new facility is being developed. It is much easier to introduce new additions to the list of day case procedures once the basic principles have been agreed and the admission and discharge process are established.

In many ENT units' day case is already the norm or at least often applied to common procedures and most surgeons and anaesthetists will have had some experience, so will not find a structured increase in numbers too concerning. Units performing below GIRFT targets often have simply not introduced a culture of day case as the default position and prior to Covid had not felt the effort to change was imperative.

Surgeons and anaesthetists should meet collectively to develop written guidance and pathways and agree on the procedures that should always be day case unless exclusion criteria apply. An implementation team consisting of surgeons, anaesthetists, senior ward nurses, operating room nurses, recovery nurses and administration staff should be established to formulate and agree detailed operating policies to be agreed and signed off by the whole clinical team.

Detailed advice on surgical technique, anaesthetic technique, recovery and discharge criteria are outside the scope of this document, clinicians will always want and have clinical discretion but consistent application of proven methods will deliver consistently successful same day discharge.

Medical secretaries, booking clerks and admission staff should all be made aware of the changes, if any, and the clear message that day case is the default position for the HVLC procedures listed.

Primary care referrals – Local services should be made aware of changes in routine admission practice. Primary care practitioners should be given clear guidelines and information, also provided to patients, on how and where to access emergency support or intervention if required.

Patient engagement and understanding – Clear written and verbal guidance must be provided detailing pre- and post-operative advice pertinent to the operation, likely time of discharge, suitable travel and support requirements, information on potential complications and what to do and where to go if they occur. Confirmation and consent for day surgery should be taken when surgery is recommended in outpatients. This information should be reinforced at pre assessment especially for long waiting times.

Units with over 52 week waiting time should have a validation process in place to ensure individual patients still require surgery and no other medical issues have developed.

Inter-discipline engagement – Involvement of other specialties should be anticipated for patients with more complex medical history, most commonly endocrinology and haematology. Systems for preoperative assessment and notification of admission should be agreed and if necessary, protocols

developed to ensure timely discharge. For example, prebooking post-operative blood tests or radiology or arranging medical assessment and follow up before discharge.

Recognising and managing resistance – Resistance to change (e.g., disengagement) can be on an individual or organisational level, change managers need to be able to recognise this and take actions to support key stakeholders in engaging in change. Methods to manage resistance include education and communication, involvement, facilitation, and negotiation.

Governance

Development and implementation of day case surgery will require approval through trust governance structures. Trusts should recognise the importance of expansion of day case in post-COVID recovery and future service provision, and give appropriate priority to provide adequate facilities, staff, and equipment. Current clinical governance structures and audit of newly adopted protocols should ensure safe practice.

Clinical pathway and protocol

Pre-operatively, surgeons and anaesthetists should meet collectively to develop written guidance and pathways and agree on the procedures that should always be day case unless exclusion criteria apply. An implementation team consisting of surgeons, anaesthetists, senior ward nurses, operating room nurses, recovery nurses and administration staff should be established to formulate and agree detailed operating policies to be agreed and signed off by the whole clinical team.

The implementation of day case pathways for procedures established as suitable for most patients should be planned and delivered by a multidisciplinary team utilising aids provided by GIRFT and BADS. The GIRFT ENT best practice pathways can be found here. The GIRFT, Centre for Peri-operative Care (CPOC), and BADS National Day Surgery Delivery Pack can be found here.

Patient inclusion and exclusion

The High Volume Low Complexity and other procedures referred to previously should be day case for the majority of patients and therefore all patients are initially included. Some patients are not suitable for same day discharge because of pre-existing medical conditions and comorbidities, social circumstances, or anticipated increased risk of complications due to anatomical or physiological abnormalities.

The National Day Surgery Delivery Pack provides a comprehensive overview of medical and social exclusion criteria for day surgery. The risk versus the benefit must be adequately evaluated on an individual basis.

Patient selection is key for success and can enable avoidance of on the day cancellations, post-operative complications, and delays. Patient suitability for day case surgery is determined on a case-by-case basis. Eligibility criteria should be set out within a protocol to enable staff familiarisation. The risk/benefit ratio for a patient is based on a combination of medical, surgical, psychosocial, and

environmental criteria. Once a certain procedure is deemed as default to day surgery it should be the pre-operative assessment team (nurses supported by anaesthetist review) that determine a patient is unsuitable. Otherwise, you increase the potential for inpatient listing for the wrong reasons. Therefore, exercising clinical judgement when selecting patients is imperative to the safe implementation of all day case procedures.

Developing the clinical pathway for more complex surgery

Protocols and evidence have prompted same day discharge for more complex procedures in ENT, particularly mastoidectomy, hemithyroidectomy and targeted parathyroidectomy.

For some procedures inclusion criteria are required to enable the identification of low risk patients for example, the British Association of Endocrine and Thyroid Surgeons (BAETS) defines low risk hemithyroidectomy as the absence of factors that might increase the risk of haemorrhage including retrosternal goitre, peri-operative antiplatelet or anticoagulant therapy and re-operative surgery.

Considerations include:

1. Outcome of pre-operative assessment.
2. Patient gives informed consent for day surgery. This should be obtained using the shared decision-making principles.
3. Time of day and length of operation – long operations may not be suitable for day case surgery, although day surgery for mastoidectomy taking three or four hours is often undertaken on a day case basis but a late finish may not allow adequate recovery time.
4. Development of guidelines to manage post-operative haemorrhage pathways to support the management of patient-specific risk of post-operative haemorrhage.
5. Post-operative monitoring period. For most day surgery there should be no defined recovery time but for some higher risk procedures there are, for example, BAETS suggests six hours post-operative stay for hemi-thyroidectomy.
6. Availability of responsible adult to accompany patient home and stay overnight.
7. Distance between post-operative residence and the hospital.
8. Access to a telephone and transport in the event of an emergency.

Pre-operative assessment

Pre-operative assessment is the norm in current safe surgical practice and fundamental to achieving successful day surgery admission, reduction of late cancellation, enhanced recovery and avoid unexpected complications due to undiagnosed co-morbidities. Most trusts have pre-assessment units staffed by trained nurses working with the support of dedicated day surgery anaesthetists and guided by local and/or national protocols. The timing of assessment should ensure sufficient leeway to deal with problems or allow list re-organisation. The pathways in the GIRFT Academy Resources shows how pre-operative assessment fits into an ideal surgery pathway.

Anaesthesia and Surgery protocol

Most ENT procedures are suitable for a nurse led discharge. Some ENT surgeons and anaesthetists have been reluctant to adopt day case discharge for certain procedures because of the risk of life-threatening primary haemorrhage, particularly in children following adenotonsillectomy and adults after thyroidectomy. Concerns about recovery from general anaesthetic in adults and children with sleep apnoea, obesity and chronic airway conditions have also held back introduction. The development of surgical and anaesthetic techniques that reduce the likelihood of bleeding and allow quick recovery of consciousness have made day case discharge safe and desirable.

- Anaesthesia for day surgery includes general and local anaesthesia. The type of anaesthetic chosen will be influenced by surgical requirements, patient-specific considerations, facilities, and expertise. However, the risks of surgery have been modified by the application of certain established techniques such as routine use of steroids and antiemetics, local anaesthetic infiltration to reduce opiate requirements. Anaesthetic techniques such as use of laryngeal mask with spontaneous breathing, deep extubation to minimise coughing and total intravenous anaesthesia can improve recovery time.
- Rigorous theatre list planning is required. Surgeons should check the list order well in advance to ensure patient's recovery time is appropriate for time of surgery, especially if staggered admission times are used. This may not always be obvious even to an experienced waiting list clerk/secretary. Surgeons should also be informed of late cancellations in case admission times need revision.
- The risk of post-operative bleeding should be minimised in all surgical procedures. Surgical technique, anaesthetic method and patient-specific factors have all been implicated in increasing the risk of post-operative haemorrhage. Meticulous intra-operative haemostasis is an important aspect of all safe surgery, surgical technique should not be altered specifically for day case or inpatient admission. Most head and neck surgeons now use a combination of bipolar and harmonic scalpel for sealing vessels, combined with traditional ties and monopolar cutting devices.
- Topical haemostatic agents have been proven to be an effective adjunct in reducing the incidence of haematoma and volume of drainage post-parotidectomy and may be useful in ambulatory thyroid surgery to reduce the requirement for post-operative drains.
- It is now widely accepted that intracapsular coblation tonsillectomy in children significantly reduces post-operative pain and re-admission rates resulting in safe day case tonsillectomy (see GIRFT best practice pathway).

Post-operative and Recovery

There are three stages of recovery from day surgery.

First stage

After general anaesthesia or deep sedation, the patient is transferred to a recovery area staffed by specialist nurses/ODP until patient awakes, protective reflexes have returned and pain is controlled.

Second stage

All patients will then return to the formal day surgery ward/ambulatory care facility where nurses trained in nurse-led discharge will complete the recovery process, provide appropriate post-operative information and analgesia.

Late stage

Follow up requirements vary from none required, PIFU, nurse-led telephone check or formal outpatient review by nurse or surgeon. Clear protocols are required to ensure patients are given correct follow up. It is vital that clear arrangements are in place to allow safe return if complications arise

Discharge

A decision on the timing and appropriateness of discharge should be through a nurse-led discharge system with medical support where appropriate, based on the BADS recommended criteria for day surgery and GIRFT, CPOC, and BADS national day surgery delivery pack.

Patients should be given verbal and clearly written surgery specific bespoke post-operative information on what to expect after surgery with a contact number for advice if concerned. This is particularly important post-tonsillectomy, the incidence of re-admission in adults has doubled in the past 15 years yet the return to theatre rate is unchanged. Most re-admissions relate to small bleeds, pain and post-operative infection which are avoidable if patients know what to expect and are given adequate analgesia and can access help at day 4 or 5 if recovery seems delayed.

Trusts operating a day case unit should ideally have a discharge drug cupboard with all routine TTO medications available. This is more efficient, will reduce delays on discharge and ensure patients, particularly children go home with a structured analgesic regime. Post-operative instructions should be reiterated at discharge.

A clearly defined emergency pathway should be agreed.

Where a trust operates only a day case unit, there should be clarity on where patients can access inpatient ENT services in case of an emergency.

Monitoring outcome measures

Model Health System and the National Consultant Information Programme (NCIP) provide key metrics to support the reduction of unwarranted variation and improve clinical quality.

Audit should be seen as an essential tool to assess, monitor and maintain efficiency and quality of patient care. Outcome measures should include cancellation on the date of admission, time to discharge, reasons for failed same day discharge, procedure specific complications, readmissions within 30 days of discharge and length of stay. Consultants can access their individual and unit surgical activity and outcome data via the NCIP system which provides local and national benchmarks against metrics. NCIP displays pseudonymised patient-level data to allow full interrogation consultant level outcome data.

Structured Patient Reported Outcome Measures (PROMS) should be carried out where available, for example pre- and post-operative NOSE questionnaire following septoplasty.

Significant development is required to provide validated standardised PROMS for general use to ensure that surgical interventions are effective and have clinical value.

Key Learning and Factors for Success

Most trusts should be able to adopt day case pathways with minimal adjustments to their operational procedures and without the requirement for significant changes to infrastructure. Key learning from trusts that have provided supporting case studies for this guide are described below:

1. Standardised processes, pathways and documentation is essential.
2. Engagement of all members of the surgical team including surgeons, pharmacy, nursing, anaesthetists, theatre, recovery and administration.
3. Proactive pre-operative assessments to ensure patients are medically optimised for day case procedures that also takes into consideration co-morbidities and social situation.
4. Establish pathways within the trust to ensure timely investigations pre-, intra-, and post-operatively as required.

5. Theatre lists should be ordered appropriately, prioritising day case patients to allow time for adequate observations before discharge.
6. Anaesthetists should employ techniques that have been proven to be safe and effective for specific day case procedures.
7. Ensure day surgery staff are trained to identify and manage post-operative emergencies, supported by comprehensive standard operating procedures.
8. Ensure fail safe arrangements are in place to support a rapid pathway into acute care for re-admission and complication management.
9. Audits should be carried out to evaluate, monitor and maintain efficiency and quality of patient care. Complications, re-admissions, patient experience and reported outcomes should be recorded. This will help to highlight areas for improvement.

Summary of Good Practice Points from the Pathway Overview

Pathway Component	Key good practice points
Referral	• Primary care referrers informed of day case procedures
Pre-operative assessment & patient booking	• Shared decision-making principles to be applied in the consent process for day case surgery to enable patients to provide informed consent • Health screening and medical optimisation (where required) • Careful patient selection using pre-assessment clinics to ensure patient suitability for day case surgery
Day of surgery	• Time of patient on the operating list must allow sufficient time for recovery
Post-operative	• Procedure appropriate monitoring of vital signs in recovery
Discharge and follow-up	• Pain adequately controlled • TTO completed prior to discharge • Appropriately timed condition specific outpatient review

Further resources

Recommended document	Author	Overview
2019 GIRFT National ENT Report	Getting It Right First Time	The ENT report presents a detailed review of the ways in which services are delivered. It makes 23 recommendations aimed at closing gaps in service provision.
GIRFT Academy Resources	Getting It Right First Time	Best practice pathways and guides developed by GIRFT and endorsed by professional societies
Day case surgery - GIRFT	Getting It Right First Time, Centre for Perioperative Care & British Association of Day Surgery	National day surgery delivery pack
British Association of Day Surgery website	British Association of Day Surgery	A multidisciplinary organisation, promoting excellence and enhancing education in the delivery of day surgery
Case study	Yorkshire Auditory Implant Service	Cochlear implantation under local anaesthesia
Case study	Doncaster and Bassetlaw Teaching Hospitals NHS	Open-minimally invasive parathyroidectomy (O-MIP)
Case study	The James Cook University Hospital	Drainless day case superficial parotidectomy with ARTISS
Case study	London North West University Healthcare NHS Trust	Drainless day case hemithyroidectomy with ARTISS
Case Study	Royal Cornwall Hospitals NHS Trust	Day case superficial parotidectomy
Case study	Sheffield Children's NHS Foundation Trust	Sheffield Children's Hospital ENT Rapid lists

Acknowledgements

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GIRFT High Volume Low Complexity Programme and elective recovery

With demand for hospital treatment outstripping capacity prior to COVID-19, the demands of delivering care during a pandemic led to significant backlogs and longer waits for patients.

There is a significant need to improve the productivity and resilience of services, many of which are still disrupted by the consequences of the pandemic and impacted by ongoing operational pressures. Waiting times vary considerably across different parts of the country, but also between individual hospital trusts in the same system. In 2020, GIRFT established the High Volume Low Complexity ('**HVLC**') programme with the NHS London Region to address these challenges.

The HVLC programme promotes productivity through optimised delivery of services.

About GIRFT and the GIRFT Academy

Getting It Right First Time ('**GIRFT**') is an NHS programme designed to improve the quality of care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The GIRFT Academy has been established to provide easily accessible materials to support best practice delivery across specialties and adoption of innovations in care.

Importantly, GIRFT Academy is led by frontline clinicians who are expert in the areas they are working on. This means advice is developed by teams with a deep understanding of their discipline.

GIRFT Academy has also published other pathways and case studies on the best practice library. These are available at: Best Practice Library – ENT Workstream – GIRFT

GIRFT Academy contact: girft.academy@nhs.net