



University Hospitals  
of Leicester  
NHS Trust

# University Hospital of Leicester NHS Trust

## Adult day case surgery patient criteria

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## 1 Definitions and Abbreviations

AAA	Abdominal Aortic Aneurysm
AHI	Apnea-hypopnea index
ALT	Alanine Transaminase blood test
ASA	American Society of Anaesthesiologists
BADS	The British Association of Day Surgery
BMI	Body Mass index
BP	Blood Pressure
COPC	Centre for Perioperative Care
COPD	Chronic Obstructive Pulmonary Disease
COVID	Corona Virus Disease
CPAP	Continuous Positive Airway Pressure
CVA	Cerebral Vascular Accident
EMPCC	East Midlands Planned Care Centre
GA	General Anaesthetic
GIRFT	Getting It Right First Time
GGH	Glenfield Hospital
HB	Haemoglobin
HbA1c	The haemoglobin test to measure the amount of blood sugar (glucose) attached the haemoglobin
HRA	High Risk Anaesthetic
HVLC	High Volume Low complexity
IDDM	Insulin Dependent Diabetic
ITU	Intensive Care unit
LA	Local Anaesthetic
LD team	learning disabilities team
LGH	Leicester General Hospital
LOS	Length of Stay
LRI	Leicester Royal Infirmary
METs	Metabolic equivalents
MDT	Multi-disciplinary Team
MI	Myocardial Infarction
MS	Multiple Sclerosis
MDT	Multi-disciplinary Team
OPD	Outpatients Department
ORMIS	Operating Room Management System
OTDC	On the Day Cancellations
RCoA	Royal College of Anaesthetists
PCA	Patient Controlled Analgesia
POA	Pre-Operative Assessment

PONV	Post-Operative Nausea and Vomiting
SOP	Standard Operating Procedure
TIA	Transient Ischaemic Attack
UHL	University Hospital of Leicester
VTE	Venous Thromboembolism

## 2 Key Words

UHL criteria

Patient suitability

Day Case Criteria

### 3 Introduction

The basic criteria for selection of patients suitable for day surgery has been recommended in the jointly published Getting it right first time (GIRFT), British Association of Day Surgery (BADs) and Centre for Perioperative Care (COPC); National Day surgery Delivery Pack [2020]. It is recommended that majority of patients are in fact appropriate for day case management or can be enabled to be so with careful planning and pro-active management when scheduled for surgery.

#### Default to Day surgery

Advances in surgical and anaesthetic techniques, as well as published evidence of successful outcomes in patients with multiple comorbidities, have changed the emphasis on day surgery patient selection. It is now accepted that the majority of patients are appropriate for day surgery unless there is a valid reason why an overnight stay would be beneficial. If inpatient surgery is being considered it is important to question whether any strategies could be employed to enable the patient to be treated as a day case:

1. Is there any benefit to this patient of being in hospital overnight after surgery
2. Is there anything that needs to be done to enable the patient to be a day case

Effective preoperative assessment and patient preparation, performed as early as possible in the planned patient pathway, is essential to the safety and success of day surgery. Factors which determine whether a procedure or patient can be performed as day surgery fall into three main categories: social, medical and surgical.

## 4 Guideline Standards

### 4.1 Social Factors

	Suitable for Day Surgery	Not Suitable
<b><u>Home Support</u></b>	<p>The patient must understand the planned procedure and postoperative care and consent to day surgery</p> <p>Patient having a Local Anaesthetic (LA) living alone with easy access to a telephone</p> <p>A responsible adult should escort the patient home following sedation or General Anaesthesia (GA) and provide support within the same household for the first 24 hours, this could take form of a friend, relative or neighbour.</p> <p>Travelling time after surgery: Patients having a long journey time home need to be listed early in the day to allow an early discharge and have adequate analgesia for the journey home.</p>	<p>No responsible adult available to be with patient for first 24 hours after GA or sedation.</p> <p>Patient identified at OPP or POA requiring a package of care or community rehabilitation bed post-operative.</p>
<b><u>Age</u></b>	<p>Adults from their 18<sup>th</sup> Birthday</p> <p>From the 16<sup>th</sup> Birthday to 17 years that are deemed suitable for an adult pathway providing their weight is equivalent to a small adult.</p> <p>No upper age limit provided the patient is physiologically well and mobile.</p>	<p>From birth up to and including 15 years old.</p>
<b><u>Learning disabilities, dementia and autistic people</u></b>	<p>Many patients benefit from a shorter stay in hospital and rapid return to their normal environment.</p> <p>A familiar carer should be available if needed; this may include induction or primary and 2nd stage recovery from general anaesthesia.</p> <p>Reasonable adjustments can be made on a case by case basis; preferably it is best to let the relevant teams know before pre-assessment date to allow reasonable time at this appointment for specific adjustments discussion with the patient and main carer. Any advance plans to be discussed via email or through Teams meeting with the relevant people ahead</p>	<p>Where a person is deemed not to have capacity and no advance plans with the main carers, surgical and anaesthetic team have been made prior to admissions.</p> <p>Those who do not have capacity - may still be suitable for a day surgery. This will be based on the pro-activeness of clinicians involving the relevant team in advance.</p>

	of admission. This may include: LD team, waiting list team, admission & postoperative area, operating surgeon, anaesthetist and theatre team.	
<b><u>Recreational Drug Use</u></b>	<p>Particular caution should be taken with patients using ecstasy or cocaine.</p> <p>The risk of using recreational drugs within 24 hours of general anaesthesia should be discussed with the patient and the outcome of the discussion recorded at POA. Should the patient be unwilling or unable to comply with local policy, advice should be sought from the Consultant anaesthetist.</p> <p>Having minor/intermediate surgery with zero IV morphine intra and postoperative.</p>	<p>Patients using narcotics i.e. heroin may experience difficulties with pain control post-operatively. It may be necessary to admit these patients in the main buildings for pain management under the guidance of a pain team.</p>
<b><u>Alcohol intake</u></b>		<p>Any patient with cirrhosis</p> <p>Any patient drinking more than 70 units or alcohol dependent with deranged ALT/clotting</p> <p>Any patient who cannot stop drinking without anxiety</p> <p>Any patient who has a history of alcoholic related seizures and is currently drinking.</p>

## 4.2 Surgical Factors

	<b>Suitable for day surgery</b>	<b>Not Suitable</b>
	<p>The procedure should not carry a significant risk of serious postoperative complications requiring immediate medical attention, for example Haemorrhage or airway challenges</p> <p>The procedure must not prohibit the patient from resuming oral intake within a few hours of the end of surgery.</p> <p>Post-operative symptoms (Pain, Nausea and Vomiting) must be managed with the use of a combination of oral medication and Regional / local anaesthetic techniques.</p> <p>Patients should be able to mobilise before</p>	<p>Patients requiring Patient Controlled Analgesia (PCA) or Epidural post-operative.</p> <p>Procedures prohibiting the patient from resuming oral/nutrition intake post-operative and requiring artificial nutrition.</p> <p>Specialist postoperative care or continuing observation necessary.</p>

	<p>discharge as per pre-operative if mobilisation is not fully possible (or always essential), prophylaxis thrombosis medication should be consider and maintained.</p> <p>Surgical duration is no longer considered a limitation for day surgery, procedures lasting longer than 2 hours are now routinely undertaken on a day case basis.</p>	
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### 4.3 Medical Factors

<p><b><u>The WHO performance status classification categorises patients as:</u></b></p> <p>0: able to carry out all normal activity without restriction</p> <p>1: restricted in strenuous activity but ambulatory and able to carry out light work</p> <p>2: ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours</p> <p>3: symptomatic and in a chair or in bed for greater than 50% of the day but not bedridden</p> <p>4: completely disabled; cannot carry out any self-care; totally confined to bed or chair.</p>	<p><b><u>Estimated metabolic equivalents (METs) from activities of daily living (examples)</u></b></p> <p>1MET = Eating, getting dressed, working at a desk, walking on a flat surface for one or two blocks</p> <p>4METs = light/moderate house work, climbing a flight of stairs or walking up a hill, walking 6.4 km h<sup>-1</sup>, social dancing, washing a car and pushing a power mower</p> <p>10METs = moderate recreational activity such as brisk swimming, bicycling uphill, walking briskly, football and full-court basketball</p>	
	<b><u>Suitable for Day Surgery</u></b>	<b><u>Contraindications</u></b>
<b><u>BMI</u></b>	<p>There are not upper limits for BMI for day surgery, patients who are morbidly obese can be suitable for day surgery with <b>appropriate planning prior to admission</b> (HRA clinic, anaesthetic review, airway assessment and/or optimisation)</p> <p>Consultant anaesthetist and surgeon should be present when the BMI is over &gt;40.</p> <p>Particular focus and planning should be made in advance to any additional staffing and equipment requirements</p> <p>Considerations to be given for the upper</p>	<p><b>BMI &gt;40 with significant co-morbidities</b> (i.e. diabetic/ angina/ COPD) with poor performance status (&lt;4 METs) : lack of ability to perform activities such as self-care and confined to bed/chair more than 50% of waking hours <b>without appropriate planning and discussion with the patients surgical and anaesthetic team prior to admission.</b> May need to be seen in HRA by a Consultant Anaesthetist.</p> <p><b>All BMI &gt;45 for sedation or GA with or without significant co-morbidities without appropriate</b></p>

	<p>weight limits of hospital equipment.</p> <p>Having minor/intermediate surgery with minimal or zero IV morphine postoperative.</p> <p>Good functional status (i.e. can achieve 4 METS or above</p>	<p><b>planning and discussion with the patients surgical and anaesthetic team prior to admission.</b></p> <p>Having major operation with likely need for IV morphine intra-op.</p> <p>Have a STOP BANG 5 or above</p> <p>Having sedation or GA with SpO2 on air consistently 93% or below.</p>
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**BMI rational**

There is no upper limit for BMI for day surgery

Therefore if a patient is otherwise fit and well, they are suitable for day case surgery as long as appropriate staff and equipment (long instruments, appropriate operating table, bariatric equipment and difficult airway equipment) are available and have been arranged prior to admission.

All BMI's over 40 must be highlighted on ORMIS during scheduling (at least 2 weeks ahead of surgery) with appropriate staffing requirements and any additional equipment needs to maintain safe care.

It may be inappropriate to operate patients who are living with obesity (>40) on an isolated site (UHL community sites). In this case, their surgery could be undertaken through a day surgery pathway using the main UHL hospital operating theatres with access to the specialist equipment required for obese patients. The patient should, where possible, be transferred to the day surgery unit for subsequent secondary recovery and discharge.

For any speciality where patients could be done under a Regional Block either central neuraxial blockade or a peripheral nerve block, it could be agreed with the Anaesthetic and Surgical Consultant to proceed with a Higher BMI where risk of haemorrhage is minimum or the risk could be minimised by the use of medicines e.g. tranexamic acid or tourniquets i.e Ambulatory Trauma..

**American Society of Anesthesiologists (ASA) physical status grade**

<https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system>

- 1 Healthy patient. Localised surgical pathology with no systemic disturbance.**
- 2 Mild/moderate systemic disturbance (the surgical pathology or other disease process). No activity limitation.**
- 3 Severe systemic disturbance from any cause. Some activity limitation.**
- 4 Life-threatening systemic disorder. Severe activity limitation.**
- 5 Moribund patient with little chance of survival.**
- 6 A declared brain-dead patient whose organs are being removed for donor purposes**

	<b><u>Suitable for Day surgery</u></b>	<b><u>Contraindications</u></b>
<b><u>ASA grade</u></b>	<p>Patients who are assessed as American Society of Anaesthesiologists (ASA) grade 1-3 are generally acceptable unless other contraindications are present</p> <p>Some ASA 4 patients (for example under local anaesthetic) may be acceptable. Please ensure early discussion of such patients with the surgeon responsible.</p>	<p>ASA 3 patients with significant functional limitations and unstable/poorly controlled co-morbidities. Most patients with unstable medical conditions should not be undergoing elective surgery.</p> <p>ASA 4</p>
<p>Recommendations are that if a patient is not suitable for day surgery, in the majority of cases they probably should not be undergoing elective surgery at all until their medical condition has been optimised. Once this has occurred, they can proceed on a day case basis <sup>(2)</sup>.</p>		

	<b><u>Suitable for Day Surgery</u></b>	<b><u>Contraindications</u></b>
<b><u>Hypertension</u></b>	BP well controlled in community (i.e. below 160/100 on GP or home reading within 12 months)	<p>BP over 160/100 in community with evidence of end organ damage (i.e. renal impairment)</p> <p>BP over 180/110 in POA clinic</p>
<b><u>Valvular disease</u></b>	<p>Good LV function associated with</p> <p>Mild Aortic Stenosis Asymptomatic</p> <p>Mild Mitral Stenosis Asymptomatic</p> <p>Asymptomatic or Mild mitral regurgitation</p> <p>Asymptomatic</p>	<p>Moderate to severe aortic stenosis (i.e. valve area below 1.2cm<sup>2</sup> or mean gradient above 25mmHg)</p> <p>Moderate to severe mitral stenosis (i.e. valve area below 1.5cm<sup>2</sup>)</p> <p>Severe mitral regurgitation (i.e. associated with heart failure symptoms, fast AF or pulmonary hypertension)</p>
<b><u>Pacemaker / ICD</u></b>	<p>Cardiac rhythm monitors</p> <p>Pacemakers suitable provided: Device details are known, functioning normal also has been checked within the last 12 months and patient's symptoms well controlled</p>	<p>Symptoms of pacemaker malfunction; eg: Syncopal attacks</p> <p>ICD devices: Relative contraindication- needs discussion with cardiac physiologist in each case to reprogram the device and discussion with surgical/anaesthetic team before posting.</p>
<b><u>MI</u></b>	>12 months and minimal angina with good functional status (i.e. CCS 1 or 2)	<p>MI within 6 months</p> <p>On-going restrictive angina since MI (CCS 3-4)</p> <p>MI with occluded vessel being</p>

		medically managed
<b><u>Angina</u></b>	Angina only during strenuous prolonged activity, such as digging the garden discuss with Consultant Anaesthetist.	Any other Angina (CCS 3-4*) Achieve less than <4 METs Angina at rest Angina associated with poor functional status
<b><u>Classification of angina</u></b>		
<p><b>0 No angina.</b></p> <p><b>1 No limitation of ordinary physical activity. Angina caused by strenuous or rapid, prolonged exertion.</b></p> <p><b>2 Slight limitation of normal activity, eg angina with rapid walking, climbing stairs, emotional stress.</b></p> <p><b>3 Marked limitation of normal activity, i.e. angina on one flight of stairs. Comfortable at rest.</b></p> <p><b>4 Incapacitation. Angina at rest.</b></p>		
	<b><u>Suitable for day surgery</u></b>	<b><u>Contraindications</u></b>
<b><u>Coronary angioplasty / stenting / CABG</u></b>	No symptoms of angina (i.e. CCS 1-2) since procedure and good exercise tolerance >4 mets	On-going limiting angina (i.e. CCS 3-4)
<b><u>Dysrhythmia</u></b>	Ventricular bigeminy/trigeminy 1st degree heart block asymptomatic atrial fibrillation Asymptomatic bradycardia . Physiological Bradycardia	Atrial Fibrillation or flutter with a rate >100bpm on no rate control.  In certain cases (i.e. urgent, minor surgery) it will be suitable to proceed providing the patients is reviewed by their GP beforehand and appropriate rate control titrated to effect.  - 2nd or 3rd degree heart block . Will need a cardiology input before can be scheduled for surgery as may need a pacemaker
<b><u>Peripheral vascular disease</u></b>		Poor exercise tolerance and restricted functional ability
<b><u>Aortic Aneurysm</u></b>	Surveillance only Having superficial LA surgery while awaiting AAA repair	Having sedation or GA while waiting for AAA repair  Intra-abdominal surgery with AAA or thoracic Aneurysm of over

		5.5cm
<b>Dyspnoea grading</b>  <b>0 No dyspnoea whilst walking on level at normal pace</b> <b>1 Mild, non-specific (speed not distance) restriction. "Walk as far as I like provided I take my time."</b> <b>2 Moderate, specific, outdoor limitation. "Stop for a while after (a recognizable distance limitation)"</b> <b>3 Marked dyspnoea on mild, indoor exertion. "Stop for a while between kitchen and bathroom."</b> <b>4 Incapacitation. Dyspnoea at rest.</b>		
	<b>Suitable for day surgery</b>	<b><u>Contraindications</u></b>
<b><u>Asthma</u></b>	Stable well controlled asthma Good functional ability	Chest infection within 6 weeks (i.e. from date of antibiotic course completion) should be discussed with preoperative anaesthetist.  If there is a history of brittle asthma with exacerbations from anaesthesia these patients may benefit from a night of postoperative observation.  Having sedation or GA with an ITU admission due to asthma attack within last 12months  Oral steroid course completed for asthma within 6 weeks  Normal activities extremely limited by asthma
<b><u>COPD</u></b>	Stable well controlled COPD Good functional status  Superficial LA cases for patients with severe COPD patient on home oxygen where the procedure does not require the patient to lie flat.	SOB rest or on minimal exertion  Oxygen therapy at home  Cor pulmonale  Oral steroids within 6 weeks
<b><u>Obstructive sleep apnoea</u></b>	Procedure under Local or regional Anaesthetic  Minor / moderate procedure on patient established on CPAP for longer than 6 weeks and full compliance.  Procedure should be on morning or early	Procedure is moderate/major with need for significant IV morphine or postoperative opioids  Poor compliance with CPAP (AHI over 30 at latest review)  Resting SpO2 on air are under 93%

	afternoon list	Presence of non-optimised comorbidities (i.e. hypertension, arrhythmias, heart failure)  Operation which might prevent the use of CPAP mask post op e.g. nasal septoplasty, necessitates overnight stay
<b><u>Chronic Respiratory Conditions</u></b>	Well controlled, stable Cystic Fibrosis  Pulmonary fibrosis with stable symptoms and reasonable functional ability	Cystic Fibrosis with moderate/severe disease or multisystem involvement.  Symptomatic bronchiectasis with chest infection within 6 weeks of surgery  Pulmonary fibrosis causing extreme limitation of everyday activities
<b><u>Airway (Mallampati pharyngeal) assessment</u></b>		
The patient must fully extend the tongue during maximal mouth opening. The view is classed as:		
<b>Class 1</b> Pharyngeal pillars, soft palate and uvula visible.		
<b>Class 2</b> Soft palate and uvula only visible.		
<b>Class 3</b> Soft palate only visible.		
<b>Class 4</b> Soft palate not visible.		
<b><u>Contraindication</u></b>		
Patients who are unable to open their mouths, or who have very limited mouth opening, class 3 and 4 Mallampati view, known difficult intubations requiring fiberoptic laryngoscopy or other complex techniques should be referred to anaesthetist as early as possible so that appropriate planning, staffing and specialist equipment are put in place.		
	<b><u>Suitable for day surgery</u></b>	<b><u>Contraindications</u></b>
<b><u>Epilepsy</u></b>	Grand Mal Seizure more than 6 weeks before planned surgery and been optimised and seen by the neurologist.	Grand mal Seizure within 6 weeks of planned surgery
<b><u>TIA/CVA</u></b>	More than 6 months ago and plan put in place by Neurologist regarding stopping their medications in the peri operative period.	TIA /CVA within the last 6/12
<b><u>Parkinson's Disease</u></b>	Good functional status  <u>Time critical Medication</u> – ensure patient brings ALL medication into hospital and	Poor functional status  Requires significant assistance with all activities of daily living

	receives this on time.	Impaired swallow Severe cognitive impairment or previous post-operative delirium
<b><u>Multiple Sclerosis</u></b>	Good functional status Minimal weakness	Patients with severe restrictions due to MS - Patients with MS who have weakness may have an unpredictable response to Neuromuscular blocking agents.
<b><u>Diabetes</u></b>	HbA1c under 69 mmol/mmol in three months before surgery or as per Trust guidelines IDDM minor or intermediate procedure only Only likely to miss one meal and can resume normal diet and medication post-operative	Likely to miss more than one meal and procedures prohibiting the patient from resuming oral/nutrition intake post-operative. HbA1c >70 Demonstrably poor blood sugar control and requiring diabetic review
<b><u>Liver disease</u></b>		Abnormal coagulation Abnormal LFTs secondary to liver failure Known liver cirrhosis Patient with advanced liver disease are unsuitable for day surgery
<b><u>Renal disease</u></b>	Simple ambulatory procedures can be undertaken under LA i.e. fistula formation. Good functional status (i.e. can achieve 4 METS or above)	Day surgery is generally not suitable for patients undergoing haemodialysis or chronic ambulatory peritoneal dialysis (CAPD) due to practical difficulties and to co-morbidity.
<b><u>Myopathies/dystrophies.</u></b>		History of malignant hyperpyrexia is a contraindication
<b><u>Anaesthetic history contraindication</u></b>		
<p>Personal history of anaesthetic problems – need to obtain medical notes or details and then refer to the anaesthetist i.e. Suxamethonium apnoea, malignant hyperpyrexia, and significant morbidity during or after anaesthesia.</p> <p>Previous airway difficulties - previous failed or needing FOI (Fiberoptic intubation) should be excluded on the EMPCC site.</p> <p>Details of any unexplained, significant morbidity in a relative during or after anaesthesia should also be noted and discussed with the anaesthetist.</p>		
	<b><u>Suitable for day surgery</u></b>	<b><u>Contraindications</u></b>

<b><u>Anaemia</u></b>	<p>HB over 90 in cases with low risk of haemorrhage</p> <p>Completed treatments for anaemia before surgery/admission. This could include advice on changes in diet, oral treatments such as iron supplements and the use intravenous iron when necessary</p>	<p>If the patient is expected to lose 500mls or 10% blood volume</p> <p>If the patient needs monitoring and anaemia management postoperatively</p>
<b><u>Platelets</u></b>		<p>&lt;100x10<sup>9</sup>/L</p> <p>Patients requiring platelet infusion before surgery</p>
<b><u>Bleeding disorders</u></b>		<p>Known bleeding disorders i.e. hemophilia A (factor VIII deficiency), hemophilia B (factor IX deficiency) and von Willebrand disease</p>
<p><b><u>SARS- COVID-19</u></b></p> <p>For elective or planned surgery, a delay of seven weeks after infection is recommended.</p> <p>Timing of surgery following a COVID infection should involve shared decision-making between the patient and their healthcare team – this includes discussions about the risks and benefits of operating, alternatives to surgery, and doing nothing.</p>		

## 5 Training and Education

It is essential that training is provided in day-case Anaesthesia. The RCoA recommends that training in day surgery is delivered as part of core general duties and not only involves learning appropriate anaesthetic techniques, but encompasses the entire day surgery process. This should include: teaching on patient selection; effective analgesic regimens; PONV; requirements for safe discharge; and the management of patients following discharge. There should also be emphasis on educating trainees about the necessity for providing a multidisciplinary service for day-case surgery. For advanced training, the greatest benefit will be gained from developing the trainees’ management and leadership skills in relation to the organisation of a day surgery unit.

Preoperative assessment staff should be specifically trained in day surgery preoperative assessment, including optimisation and preparation for day surgery.

High-quality anaesthesia is pivotal to achieving successful outcomes following day surgery. The majority of anaesthesia for day surgery should be delivered by consultants or autonomously practising anaesthetists. Staff grade, associate specialist and specialty doctors and experienced trainee anaesthetists may also provide anaesthesia for day surgery. However, these doctors should be suitably experienced and skilled in techniques appropriate to the practice of day surgery and have undertaken appropriate training in the provision of anaesthesia for day surgery. Anaesthetists should have been trained in this field to the standards required by the Royal College of Anaesthetists.

## 6 Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
On the day cancellation for patient not suitable/unfit for day surgery.	ORMIS OTDC data	POA DC Matron Speciality GM	Monthly	Anaesthetic and Surgeon letter on nerve centre detailing the reasons for cancellation and corrective plan.  Matron for Day Surgery through Shared learning outcomes  Weekly Theatre productivity and Monthly TPAB
Conversation from Day case to inpatient stay	Model Hospital rates Local Performance - unplanned admission into inpatient wards	Matron/Ward sister Speciality GM	Monthly	Monthly TPAB
Discharge criteria process	24/48 hr Post-operative patient phone calls/text messages	DC unit	Monthly	Shared learning, review common themes

## 7 Supporting References

British Association of Day Surgery [BADs], Directory of Procedures and National Dataset – 7<sup>th</sup> Edition, 2021. <https://bads.co.uk/>

Getting It Right First Time [GIRFT]; National Day Surgery Delivery Pack, 2020. <http://www.gettingitrightfirsttime.co.uk>

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