

National day surgery rates are continuing to improve and that is a credit to the NHS.

There is still scope for many trusts to do more day surgery.

If the poor performers could reach the standards of the best, about 120,000 patients currently treated as in-patients could be treated as day cases.

# day surgery

Many trusts have spare capacity in their day surgery units to accommodate these extra cases.

Day surgery units should concentrate more on patients that really need the use of a bed and an operating theatre.

Most units meet the standard of having a consultant clinician in overall charge and a senior nurse or manager responsible for day-to-day running.

Only half of 14 good operational practices for day surgery recorded in the survey are routinely carried out by 50 per cent or more of day surgery units.

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# Introduction and background

## The benefits of day surgery

1. Day surgery is the admission of carefully selected patients to hospital for a planned surgical procedure, returning home on the same day.
2. Patients having day surgery rather than inpatient surgery:
  - often have shorter waiting times because more patients can be treated and they are not subject to last-minute cancellations by the hospital (as long as day surgery facilities are separate from those for emergency patients);
  - spend less time in hospital; and
  - receive care that is better suited to their needs.

At the same time hospital costs are lower because day surgery is more efficient than inpatient care and there is little or no additional community support required. Moreover, outcomes are at least as good as those for inpatient surgery. The evidence for this was reviewed in the Commission's first report on day surgery and since then it has become stronger.<sup>I</sup> The need for more day surgery is therefore widely recognised by patients, clinicians, NHS managers and the government. The Royal College of Surgeons has said that: *'Day surgery is now considered the best option for 50 per cent of patients undergoing elective procedures though the proportion will vary between specialties'*.<sup>III</sup>

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I Audit Commission (1990), *A Short Cut to Better Services, Day Surgery in England and Wales*.

II Rosalind Plowman et al. (1999), *Socio-economic Impact of Day Surgery*, London School of Hygiene and Tropical Medicine.

III Royal College of Surgeons of England (1992), *Guidelines for Day-Case Surgery*.

*The average proportion carried out as day surgery by 1996/97 exceeded the value for best performers in 1990*

### The Audit Commission's work on day surgery

3. The Audit Commission's work on day surgery began 11 years ago in 1990. It was the first value-for-money study on health issues when the Commission took on the external audit of the NHS. The work examined the extent and efficiency of day surgery activity and measured patient satisfaction using a questionnaire that was subsequently made available to NHS trusts all over the country.<sup>I</sup> The Commission reported wide variation in day surgery activity, a lack of proper facilities and poor utilisation of some of the facilities that existed at the time.<sup>II</sup> In response, the Department of Health set up a Day Surgery Task Force and provided £15m capital funds to expand the provision of dedicated day surgery units.<sup>III</sup> Almost all trusts now have at least one unit.

4. The Commission re-examined day surgery in 1998 as part of its follow-up programme and found that there had been considerable growth in the use of day surgery.<sup>IV</sup> For almost all 20 surgical procedures selected [BOX A], the average proportion carried out as day surgery by 1996/97 exceeded the value for best performers in 1990. However:

- there were still wide variations in performance between trusts and between procedures within a single trust;
- the performance of some trusts had slipped back for some procedures compared to 1990; and,
- the total volume of elective surgery and day surgery performance of the best trusts have increased, creating even greater potential to do more day surgery.

These findings underline the continued need to monitor progress.

5. This review reports the results of a national survey of day surgery carried out recently by the Audit Commission as part of its Acute Hospital Portfolio (see back cover). All NHS trusts in England and Wales that provide day surgery services were involved in the data collection that took place in mid-2000. Over 300 individual day surgery units (DSUs) within these trusts were surveyed. The comparative data obtained forms the basis for this review. The Commission's auditors, who produce tailored performance assessments for each NHS trust, take up the detailed issues underlying the results. This review sets out the:

- current day surgery performance of NHS trusts based on a new set of 25 procedures (Basket 2000) [BOX A];

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I Audit Commission (1991), *Measuring Quality: The Patient's View of Day Surgery*.

II (i) See footnote I, page 1.

(ii) Audit Commission (1992), *All in a Day's Work, An Audit of Day Surgery in England and Wales*.

III NHS Management Executive (1993), Report of the Day Surgery Task Force.

IV Audit Commission (1998), *Day Surgery Follow up: Progress Against Indicators from a Short Cut to Better Services*.

**BOX A****Measuring day surgery performance**

Day surgery performance can be measured as the number of day-case patients treated expressed as a percentage of the number of elective inpatients and day cases combined. This figure is often expressed in aggregate for a whole specialty like General Surgery or for a trust as a whole. Neither is adequate for assessing performance, as they take no account of the differences in the nature and complexity of cases treated. The Audit Commission therefore developed its basket of 20 surgical procedures to provide a more consistent measure of performance. The procedures included:

- are commonly performed, so account for a large volume of surgery;
- are suitable for treatment as day cases; and
- would not generally be performed for an outpatient, thus focusing attention on the potential to treat more inpatients as day cases.

If one of these procedures is commonly performed with another procedure that would render the operation as a whole unsuitable for day surgery, the operation is excluded.

The basket was developed over ten years ago so has recently been reviewed to bring it up to date. Many of the procedures originally included remain relevant because there is still scope to carry out more of them as day cases. All have been reviewed in consultation with the British Association of Day Surgery to ensure that they meet the criteria for inclusion and some procedures have been amended or excluded. On the other hand, technological developments have meant that more procedures can now be carried out as day surgery and some of these new procedures have been included where they also meet the criteria set out above. The new basket (Basket 2000) contains 25 procedures (Appendix 1).

- progress that has been made since 1998;
- scope for further improvement in the use of day surgery and in the utilisation and management of day surgery units.

## Findings

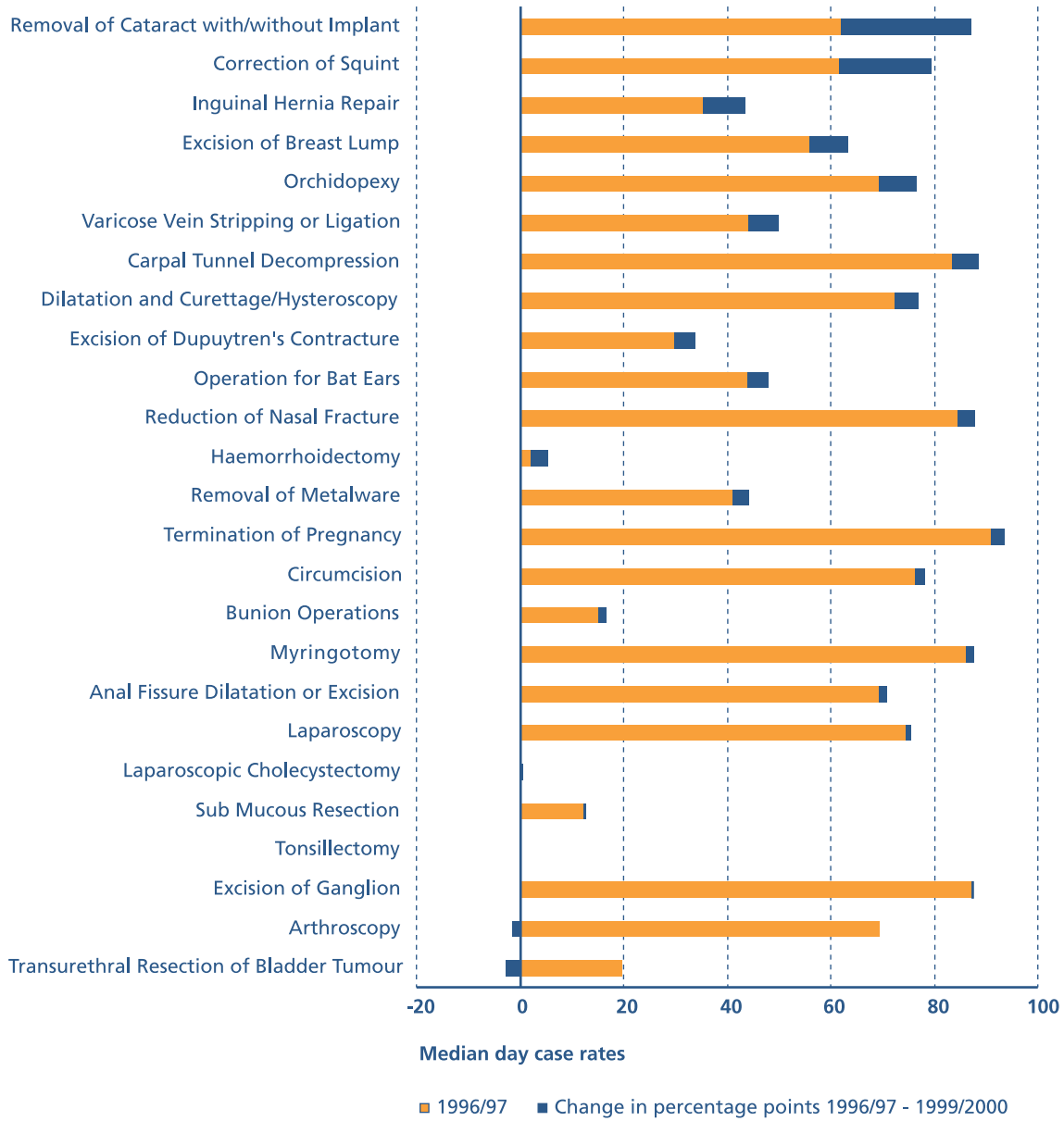
### Current day surgery performance

6. The latest data available for the Basket 2000 procedures (1999/2000) compared to data for 1996/97 – when day surgery was last reviewed by the Commission (see footnote IV, page 2) – show continuing growth in the use of day surgery for most of the procedures, notably in the case of extraction of cataracts and correction of squint [EXHIBIT 1, overleaf]. Not all patients having these procedures can be treated as day cases, but if all trusts could achieve the levels of the best performers (the upper quartile of the distribution of the percentage of day cases), 120,000 existing inpatients in England and Wales could be treated as day cases to the benefit of all concerned. The quartiles are given in Appendix 1.

EXHIBIT 1

**Progress in day surgery for procedures in the new Basket 2000 (England 1996/97 – 1999/2000)**

Progress has continued, notably in the case of cataracts and correction of squint.



Note: Procedures are in decreasing order of change. See Box A for explanation of the day-case rate and selection of procedures.

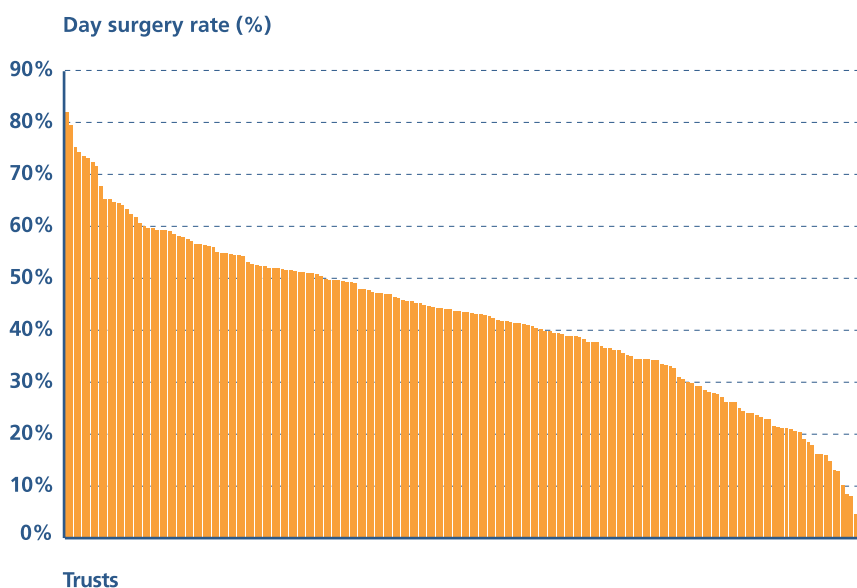
Source: Audit Commission. Data from the Department of Health

7. Although day surgery rates have improved overall, some trusts still have very low rates. The range of rates across trusts is large, especially for some procedures. Inguinal hernia repair is a typical example where the range is from zero to about 80 per cent [EXHIBIT 2]. The median percentages done as day cases for some of the new procedures added to the basket are very low (for example, laparoscopic cholecystectomy and tonsillectomy – Exhibit 1). This is because these procedures are not currently widely accepted as suitable for day surgery, even though they are considered to be suitable by leading clinicians in the field and there are some trusts doing many of these as day cases [EXHIBIT 3, overleaf].

EXHIBIT 2

**Variation in day surgery rates for inguinal hernia repair (England 1999/2000)**

There is still wide variation between trusts.

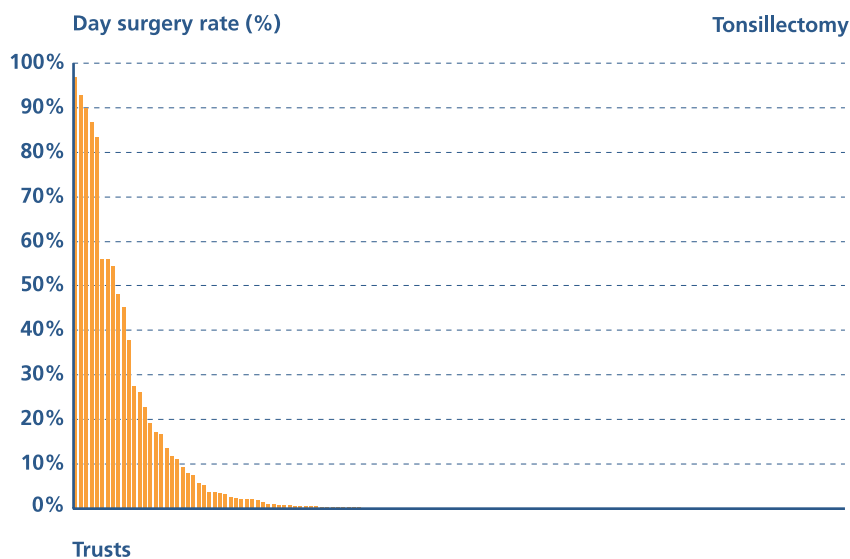
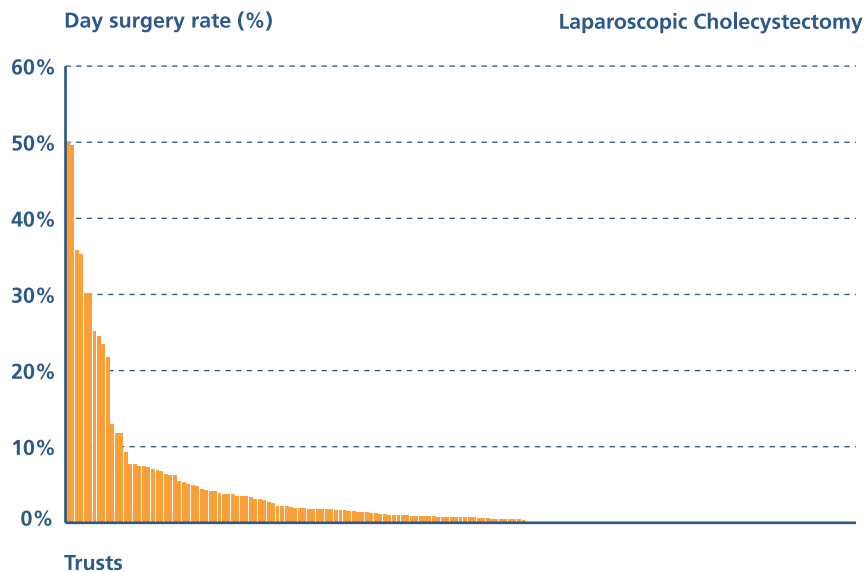


Source: Audit Commission. Data from the Department of Health

EXHIBIT 3

**Day surgery rates for Laparoscopic Cholecystectomy and Tonsillectomy (England 1999/2000)**

Day surgery rates are currently very low for these procedures in most trusts, but some trusts are achieving very high rates.



Source: Audit Commission. Data from the Department of Health

8. The barriers to high rates of day surgery, found by the Audit Commission in its original report on day surgery,<sup>1</sup> still apply:

- inappropriate and insufficient use of day surgery units;
- poor management and organisation of day surgery units;
- clinicians’ preferences for inpatient surgery.

In some trusts that are already achieving high rates of day surgery, these are issues of concern in their own right because the trust may have too much day surgery capacity or simply not be running it well.

<sup>1</sup> Audit Commission (1990), *A Short Cut to Better Services, Day Surgery in England and Wales*.

*There is a tenfold variation in weighted throughput per patient per bed...*

## Day surgery units

### The volume of patients treated

9. Day surgery units are an expensive resource, particularly if they have dedicated operating theatres, so must be well used. This means ensuring sufficient numbers of the right patients are treated. Patients treated in day surgery units can be divided into four main categories:

- **‘True’ day surgery patients** – day-case patients who require full operating theatre facilities and/or a general anaesthetic and any day-case patients not included in the category ‘minor day cases’.
- **Minor day cases** – day-case patients who generally do not require full operating theatre facilities or general anaesthetic for example, patients having endoscopies or colposcopies and many, but not all, pain relief procedures and minor surgery.
- **Inpatients** – although inpatients should not be mixed with day cases because their needs are very different, some day surgery units do end up treating inpatients, so they need to be included in any assessment of activity. Inpatients are treated in day surgery units for two main reasons:
  - a) A patient admitted as an emergency needs a bed but no beds are available elsewhere in the hospital.
  - b) Sometimes operations on inpatients (elective or emergency) are carried out in the day unit operating theatre.
- **Patients having pre-operative assessments.** It is important to ensure that only appropriate patients are offered day surgery. Patients with complex medical conditions may not be suitable and those living alone or with elderly spouses may be better treated as inpatients. Pre-operative assessments are carried out to ensure that only suitable patients are offered treatment. They should be done some time before the operation is due, so that someone else can be offered treatment if the patient being assessed is found to be unsuitable. Although each individual assessment is a relatively small amount of work, many units carry out large numbers of them, so they need to be counted.

10. The different categories of patients impose different workloads on day surgery units so in order to arrive at a measure of workload for a unit as a whole, the categories have been given weights. The weights attached (derived from consultation with a number of units) are:

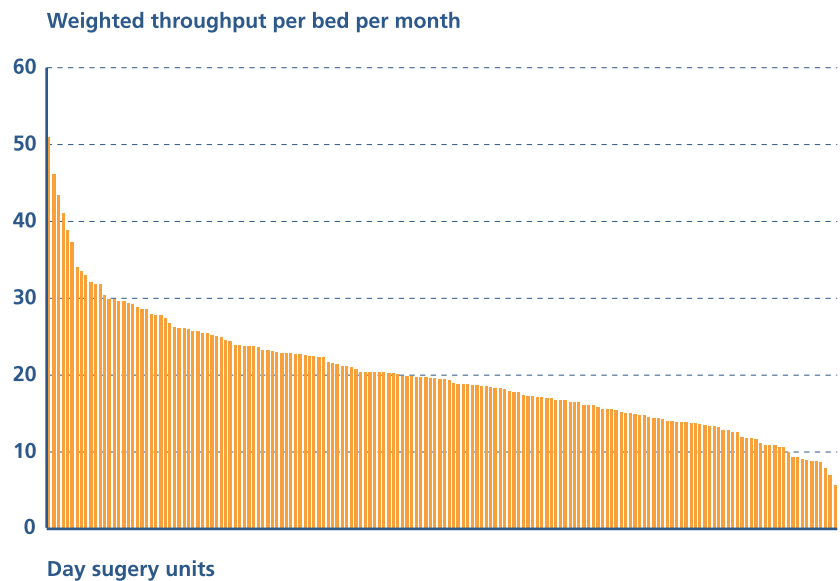
- True day surgery and inpatients: 1.0
- Minor day cases: 0.5
- Pre-operative assessments: 0.1

Weighted throughput per bed per month (that is, the sum of the monthly numbers of each category times its weight divided by the number of beds in the unit) is a measure of the efficiency with which a unit is utilising its capacity. There is a tenfold variation in this measure (for similar units all with theatres) suggesting considerable scope for some of the units with lower throughput per bed to treat more patients [EXHIBIT 4]. If all day surgery units were performing at the level of the best trusts (upper quartile of the distribution of weighted throughput per bed) most trusts should be able to accommodate their share of the additional 120,000 Basket 2000 day cases mentioned earlier, within existing capacity and still have spare capacity for other day-case patients [EXHIBIT 5].

EXHIBIT 4

**Weighted throughput per bed per month in day surgery units (England and Wales 2000)**

The range is wide, suggesting scope for improvement.



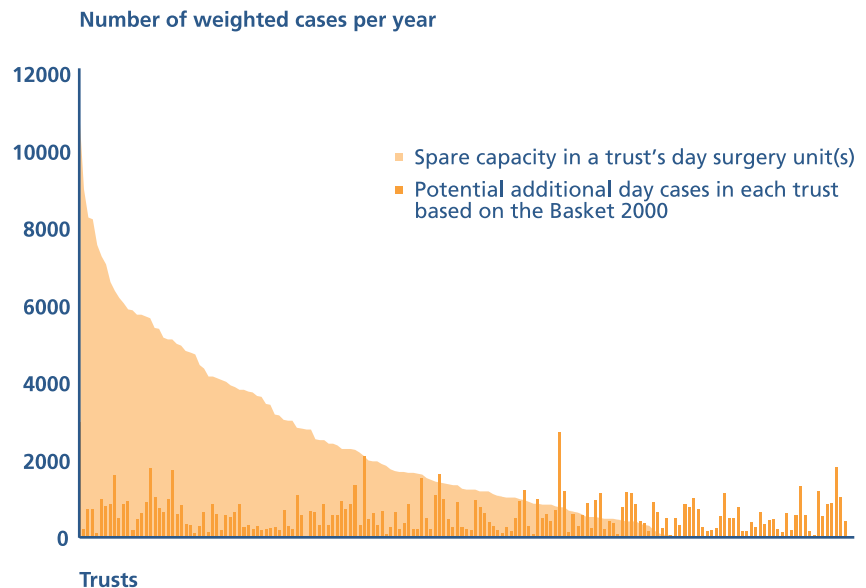
Note: "Bed" means patient recovery space and includes trolley or reclining chair.

Source: Audit Commission

EXHIBIT 5

**Spare capacity in day surgery units (England 2000)**

Most trusts could accommodate additional Basket 2000 day cases and still have some spare capacity.



Note: For explanations of the calculation of spare capacity see paragraph 10, and for the potential additional Basket 2000 cases see paragraph 6.

Source: Audit Commission

11. Low throughput of patients may be due to many factors, for example:
- poor utilisation of the unit's operating theatres;
  - inappropriate facilities in the unit, thus discouraging its use by clinicians;
  - an imbalance between theatres and beds, causing a bottleneck;
  - insufficient cases being treated for the current capacity;
  - poor staff productivity, or inadequate or inappropriate staffing.

The Commission's auditors are investigating these problems at individual trusts. Where appropriate, action plans for change are agreed and progress will be reviewed within the next three years.

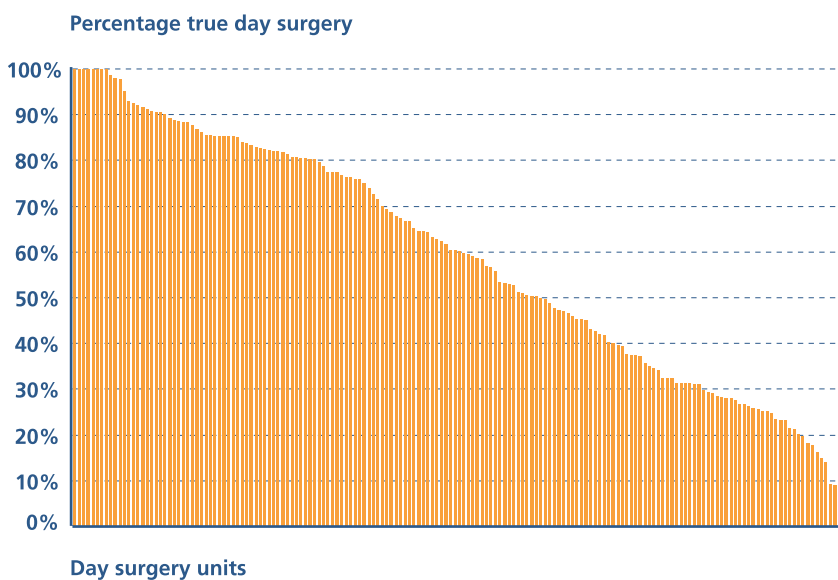
### The complexity of patients treated

12. The category 'true day surgery' includes procedures in the Basket 2000 and a range of other appropriate surgical interventions. Ideally, day surgery units with operating theatres should be concentrating on these procedures – those that really need these facilities and the accompanying intensity of staffing – leaving other minor procedures to be carried out in treatment rooms or outpatient departments. However, in practice, some units will be carrying out mainly minor procedures. The percentage of 'true day surgery' patients treated in day surgery units varies from 0 to 100, suggesting considerable scope for improvement [EXHIBIT 6].

#### EXHIBIT 6

##### True day surgery patients treated as a percentage of all day-case patients (England and Wales 2000)

The range is from 0 to 100, suggesting considerable scope for improvement.



Source: Audit Commission

13. The need and scope for individual units to maximise the treatment of patients appropriate to their facilities by substituting true day surgery patients for minor day cases depends on the answers to two main questions:

- **Are minor day cases squeezing out true day surgery patients?** Many day surgery units have treatment rooms where minor day cases are treated and some units operate as joint day surgery/endoscopy units. These arrangements may be efficient good practice for the trusts concerned, provided that minor day cases are not depriving true day surgery patients of operating theatres, beds or trolleys.
- **If minor day-case patients are squeezing out true day surgery patients, can the minor day cases be moved elsewhere?** This depends on the availability of spare capacity elsewhere in the trust and may require investment if additional capacity is needed.

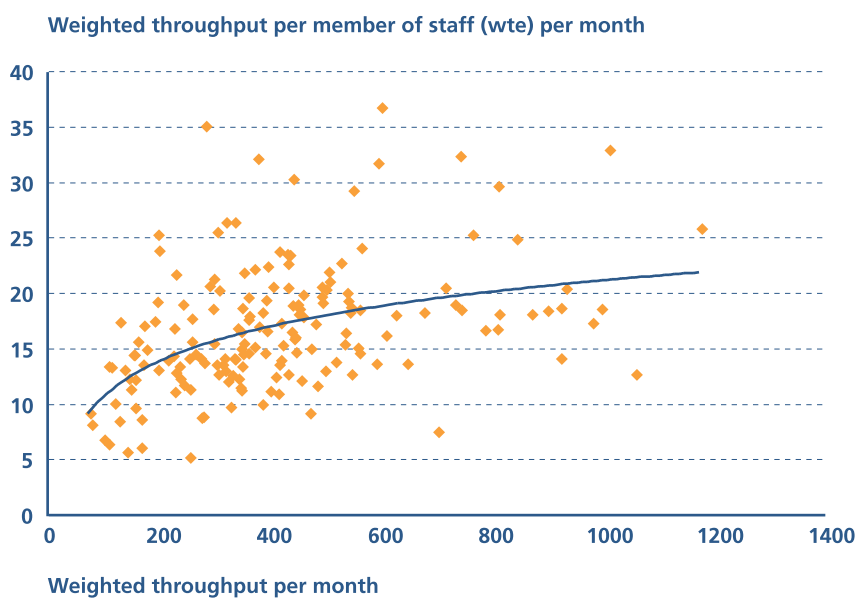
### Staffing

14. Inappropriate staffing may be a contributory factor in poor utilisation of a unit. There is wide variation in staff productivity between units and productivity increases with the size of unit [EXHIBIT 7]. Many factors can affect productivity, for example, grade mix of staff and the degree of clerical support, but there is no evidence of a relationship in the data between productivity and these factors. Differences in the operation and management of units may also explain differences in productivity and efficiency.

EXHIBIT 7

**Staff productivity in day surgery units.**

Staff productivity increases with the size of unit.



Source: Audit Commission

*All units should monitor  
DNA and 'stay-in' rates*

### Management

15. A senior consultant (usually a surgeon or an anaesthetist) should be in overall charge of day surgery in a trust to ensure that consistent policies are adopted in its various specialties and day surgery units. He or she should also be in charge of the individual day surgery units or have delegated this role to another consultant for each unit. Senior consultants who carry weight and authority with their colleagues are needed. This is because so many of the issues involved with managing day surgery touch on clinical practices and need to be agreed with all the professional staff involved, but particularly the medical staff who are in overall charge. A senior nurse or manager should also be responsible for the running of each day surgery unit. Most units (65 per cent) meet these requirements. But although clear responsibilities are necessary, they are not in themselves sufficient to ensure that policies are in place and acted upon.

16. Two important indicators of good management are:

- **The DNA rate** (patients who did not attend (DNA) without giving notice expressed as a percentage of all day-case patients). A high percentage of DNAs is wasteful of resources because it will be too late to offer the operating theatre slot to another patient. The same applies to patients who give notice on the day of their procedure. Currently a quarter of units have DNA rates above 5 per cent.
- **The Stay-in rate** (day-case patients that have to be transferred to inpatient facilities rather than go home, expressed as a percentage of all day-case patients). A high stay-in rate will have important resource implications for a trust in that the patient has to be transferred to an inpatient bed. There are also disadvantages to the patient because they are not able to return home as planned. A small percentage of unplanned stay-ins is inevitable because DSUs cannot foresee all eventualities, but they should be kept to the minimum. Currently a quarter of units have stay-in rates above 3 per cent.

Although most units do not apparently have problems, it is important that these indicators are regularly monitored. A sudden change could indicate a problem with the working of a unit that may not otherwise come to light.

### Patient care

17. Many factors need to be in place if day surgery units are to provide high quality patient care. Fourteen key operational practices were covered in the survey. Only half of these are routinely carried out by 50 per cent or more of day surgery units [EXHIBIT 8]. The most notable areas for improvement are:

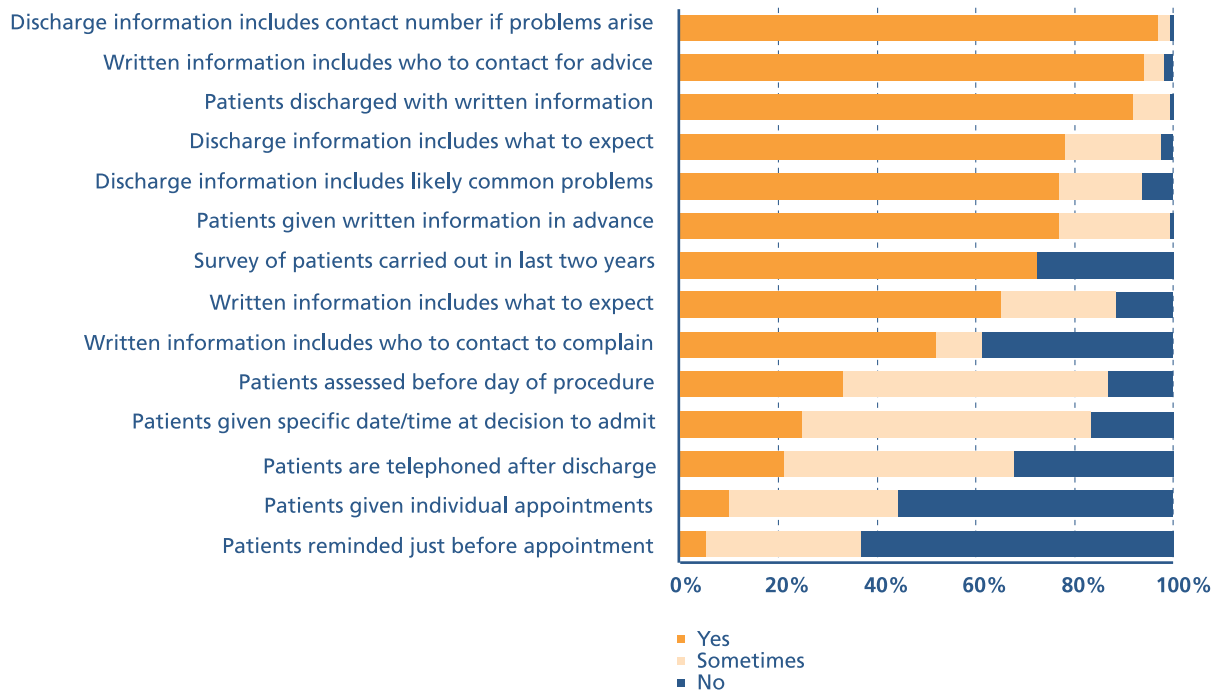
- reminding patients of their appointments just before their operations to minimise the likelihood of a patient forgetting to attend and wasting a theatre slot;
- giving patients individual appointment times close to the time of their procedures rather than expecting them all to arrive at the same time;
- telephoning discharged patients at home to check that everything is progressing well; and
- giving patients specific appointment times in advance at the time of the decision to admit.

The rationale for good practice underlying these statements is in Appendix 2.

#### EXHIBIT 8

#### Implementation of good practice guidelines

Only half of the 14 practices are routinely carried out by 50 per cent or more of trusts.



Source: Audit Commission

## Clinicians' practices

18. If poor day surgery rates in a trust cannot be explained by insufficient day surgery capacity or poor use or management of its day surgery units, the reason is likely to be related to consultants' practices. Consultants still largely determine their own practices, but they must take account of what is regarded as good practice in their particular specialty and of the policies put in place by the trust. A consultant may have legitimate concerns about the way day surgery is functioning in the trust, or the problem may be his or her preference for inpatient work or inertia or resistance to change. Auditors are investigating these issues at those trusts where the diagnostic indicators used in the Acute Hospital Portfolio suggest there might be a problem.

## Conclusions

19. Whilst day surgery performance nationally continues to improve, the range of performance between NHS trusts remains wide, leaving considerable scope for the poorer performers to improve. About 120,000 patients currently treated as inpatients could be treated as day cases, based on the 25 Basket 2000 procedures alone. This could help to reduce long waiting times for many of these procedures. There is also scope to improve the utilisation of day surgery units. Calculations by the Audit Commission show that if all day surgery units operated at the rates of throughput achieved by the best, most of them could accommodate the extra 120,000 patients identified and still have spare capacity to treat other day-case patients.

20. The impetus for more and better day surgery has diminished in the light of the very positive improvements that have been made in recent years, but this review shows there is still some way to go for many trusts. For other trusts the priority now is to ensure that their achievements are maintained. One major threat is the increasing use of day surgery units for inpatient work. This contravenes the key principle of separation of day surgery and inpatient surgery, on which good and efficient day surgery depends. More attention should also be given to the scope to adopt more surgical procedures as suitable for day surgery as improvements in technology allow.

*Although day surgery rates have greatly improved there is still considerable scope to do more.*

## Appendix 1

### Basket 2000 procedures and benchmarks

PROCEDURE	DESCRIPTION	DAY CASES AS A PERCENTAGE OF INPATIENTS AND DAY CASES COMBINED (ENGLAND 1999/2000)			
		Lower quartile	Median	Upper quartile	95th percentile
1 Orchidopexy	Correction of undescended testes	66	77	85	93
2 Circumcision	Removal of foreskin	68	78	84	93
3 Inguinal hernia repair	Repair of an outpouching of the abdominal sack of the groin	33	43	52	65
4 Excision of breast lump	Removal of a lump in the breast	47	63	73	86
5 Anal fissure dilatation or excision	Treatment for a tear of the skin at the anal region	57	71	81	92
6 Haemorrhoidectomy	Removal of haemorrhoids from within the anal canal	2	5	13	38
7 Laparoscopic cholecystectomy	Removal of the gallbladder by means of an instrument introduced through a small hole in the stomach wall	0	1	3	22
8 Varicose vein stripping or ligation	Removal of tortuous and incompetent veins in the leg	37	50	62	78
9 Transurethral resection of bladder tumour	Removal of a tumour by an instrument inserted into the bladder	8	17	31	49
10 Excision of Dupuytren's Contracture	Removal of fibrous tissue under the skin of the palm that causes the fingers to become bent	13	34	54	74
11 Carpal tunnel decompression	Incision in the wrist to relieve pressure on the median nerve as it passes into the hand	81	89	93	98
12 Excision of ganglion	Removal of a lump usually around the wrist, hand or foot	82	88	91	97

PROCEDURE	DESCRIPTION	DAY CASES AS A PERCENTAGE OF INPATIENTS AND DAY CASES COMBINED (ENGLAND 1999/2000)			
		Lower quartile	Median	Upper quartile	95th percentile
<b>13</b> Arthroscopy	The use of an instrument to look inside a joint for diagnosis and/or treatment	59	68	77	86
<b>14</b> Bunion operations	Straightening of the big toe and removal of bony overgrowth causing it to bend	8	17	30	59
<b>15</b> Removal of metalware	Removal of pins or plates used to stabilise a fracture	35	44	57	67
<b>16</b> Extraction of cataract with/without implant	Removal of a cloudy eye lens and, if appropriate, replacement with a synthetic one	72	87	94	100
<b>17</b> Correction of squint	Repositioning of the muscles of the eyeball	59	79	91	98
<b>18</b> Myringotomy	Relief of glue ear by making a small hole in the ear drum to release pressure and inserting a tube to avoid recurrence	82	88	93	100
<b>19</b> Tonsillectomy	Removal of the tonsils	0	0	1	53
<b>20</b> Sub mucous resection	Relief of nasal blockage caused by a bent cartilage in the middle of the nose	7	13	31	87
<b>21</b> Reduction of nasal fracture	Repositioning of the bone in the nose	75	88	94	98
<b>22</b> Operation for bat ears	Removal of skin and cartilage at the back of the ears	29	48	81	93
<b>23</b> Dilatation and Curettage/Hysteroscopy	Examination of the inside of the uterus and removal of tissue if necessary	70	77	85	91
<b>24</b> Laparoscopy	Use of an instrument introduced through the abdomen for diagnosis and treatment of internal organs often by gynaecologists	67	76	81	87
<b>25</b> Termination of pregnancy	Evacuation of the contents of the pregnant womb	90	93	96	99

## Appendix 2

### Indicators of good practice patient care

INDICATOR USED IN THE SURVEY	GOOD PRACTICE IMPLICATION
<p><b>1</b> Are patients given a specific date and time for the procedure when the decision to go ahead with the procedure is taken?</p>	<p>Given the planned nature of day surgery, patients should be given definite times for their appointments in advance.</p>
<p><b>2</b> Are patients given individual appointment times or booked to arrive in blocks throughout the day?</p>	<p>Patients should be given individual appointment times as much as possible. This minimises their waiting time in hospital.</p>
<p><b>3</b> Are patients contacted in advance by telephone to remind them of their appointment?</p>	<p>Doing so may help to avoid wasted appointments.</p>
<p><b>4</b> Are patients seen and assessed for the procedure between the decision to admit and the day of the procedure?</p>	<p>Doing so may help to avoid cancellation by the hospital on the day and thus a wasted appointment.</p>
<p><b>5</b> Are patients given written information in advance, before the day of their procedure?</p>	<p>Essential to keep patients fully informed and to help ensure the day surgery process works well and efficiently for all concerned.</p>
<p><b>6</b> Does the written material include:</p> <p>a) What to expect when they arrive at the day surgery unit? This should include a description of the procedure and the sequence of events that will take place in the unit.</p> <p>b) Who to contact for further help and advice?</p> <p>c) Who to contact if they have a complaint?</p>	<p>It is important that patients are fully aware of what will happen in advance so that they are less anxious.</p> <p>Peace of mind for a patient should a problem arise.</p> <p>So that it can be dealt with and action taken to avert the problem in future.</p>
<p><b>7</b> Are patients given written information at discharge?</p>	<p>Essential to reduce patient anxiety and avoid unnecessary use of other health services.</p>
<p><b>8</b> Does the written material at discharge include:</p> <p>a) Advice on what to expect that specifically addresses the procedure they have had? This should include information on likely speed of recovery and common problems.</p> <p>b) Advice on how to deal with common postoperative problems such as control of pain, nausea and vomiting? It should include what to do themselves and when to seek further advice.</p> <p>c) A telephone number at the hospital for queries and emergencies.</p>	<p>It is important that patients know what to expect so that they are less anxious and can take appropriate action if routine or unexpected problems arise.</p> <p>So that patients can take action themselves to avoid contacting the hospital or GP unnecessarily.</p> <p>Peace of mind for a patient that they can contact an informed source should a problem arise.</p>
<p><b>9</b> On discharge are patients telephoned when they are at home to check progress?</p>	<p>Just to check that everything is going well and no further action is needed by the health care services.</p>
<p><b>10</b> Have you conducted a patient satisfaction survey in the last two years? This is defined as a questionnaire or interview given to a minimum of ten patients asking them about their experiences whilst in the care of your unit.</p>	<p>An essential part of a well-managed unit to ensure that services are properly reflecting the needs of patients.</p>

## acute hospital PORTFOLIO

The Acute Hospital Portfolio is a collection of audits that are available for auditors to undertake at acute trusts, according to local priorities. They focus on key service areas or resources within the trust that are of concern to trust managers and patients. Each year the Audit Commission selects up to four topics from the Portfolio to survey across all trusts. There are three main stages to the survey work carried out in sequence.



The data collection and diagnostic work are the core of the survey and each trust receives from its auditor a tailored assessment of its performance based on the data collected. In-depth audit work is then carried out at only a minority of trusts – those that demonstrably need it. The survey is repeated for each topic within four years so that progress can be monitored both at individual trusts and nationally. A maximum of 16 topics is currently envisaged to allow coverage of all the key issues and service areas.

This review reports the results from the survey of day surgery. This is one of the first four topics in the Portfolio. Similar reviews have already been produced for each of the other three topics this year: Accident and Emergency, Catering and Ward Staffing, and next year's topics are: Medicines Management, Medical Staffing, Radiology and Supplies and Procurement.

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