Best practice day case hysterectomy delivery guide:

Learning from best practice exemplars in gynaecology services

September 2023

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

Executive summary

The GIRFT Maternity and Gynaecology National Report (2021) highlighted opportunities to reduce length of stay for women requiring hysterectomy through the use of minimally invasive laparoscopic and vaginal surgery which require less recovery time in hospital. Such techniques present an opportunity for trusts to further reduce length of stay by offering these as day case procedures.

There is wide variation in the availability of day case surgery for planned hysterectomy procedures which provides a clear opportunity to maximise resources and efficiency of services, whilst allowing women to recover from surgery in the comfort of their own home.

In 2022/23, 37% of hysterectomies (benign) were performed as open abdominal procedures. GIRFT recommends services move towards performing no more than 25% of all hysterectomies as open procedures, and therefore 75% of hysterectomy activity as minimal access (either vaginal or laparoscopic) to improve patient outcomes, bed day usage and support elective recovery in the wake of the pandemic. Of this 75%, services should aim for at least 50% of minimal access hysterectomies to be completed as a day case procedure.

Implementing these recommendations has the potential to unlock 22,698 bed days.

Who should read this guide?

This guide is aimed at providers delivering hysterectomy procedures, highlighting models for day case surgery. It is intended to be viewed alongside the appendices and resources found on the GIRFT FutureNHS Gynaecology Hysterectomy Hub.

Medical/surgical teams, nurses, allied health professionals, operational managers and commissioners will all find useful insights to consider the adoption of the described practices into their services.

What is the guide's aim?

This guide focusses on the opportunity for services to expand the use of laparoscopic and vaginal hysterectomy techniques, predominantly in the treatment of conditions such as *endometriosis, fibroids, heavy menstrual bleeding, and prolapse or in those not responding to more conservative measures*. It is intended to support and encourage:

- higher rates of activity using minimal access techniques for hysterectomy procedures;
- higher rates of day cases for minimal access hysterectomy procedures; and
- better experience for patients and staff.

Drawing on the learning of those who have successfully delivered the day case hysterectomy pathway, it aims to share the details for teams who wish start day case hysterectomies by outlining potential steps, guidance and practical advice.

Although the focus here is on treatment of conditions such as those noted above, the same principles can be applied to cancer treatment.

What the guide contains

1. Introduction

1.1 Hysterectomy surgery

There are different types of hysterectomy (Table 1) which can be performed a number of ways (Table 2). Typically this is determined by the disease/condition, training, experience and therefore confidence of the surgeon performing the operation.

Table 1 - Types of hysterectomy procedures

Procedure		
Total hysterectomy +/- bilateral salpingectomy/salpingo-oophorectomy	**Subtotal hysterectomy +/- bilateral salpingo-oophorectomy**	**Radical hysterectomy**
Uterus and cervix are removed. With/without removal of: • fallopian tubes • ovaries	Main body of the uterus is removed, leaving the cervix in place. With/without removal of: • fallopian tubes • ovaries	Uterus and cervix is removed, along with: • fallopian tubes; • part of vagina; • ovaries; • lymph glands; and • fatty tissue.

Table 2 - Surgical methods for hysterectomy procedures

Surgical method		
Open (abdominal) surgery	**Laparoscopic (minimal access)** • Lap total • Lap sub-total • Lap assisted + vaginal removal	**Vaginal**
Removal of uterus via incision of the abdomen	Use of laparoscope via small incisions in abdomen.	Removal of uterus via incision at the top of the vagina +/- vaginal/pelvic floor repair

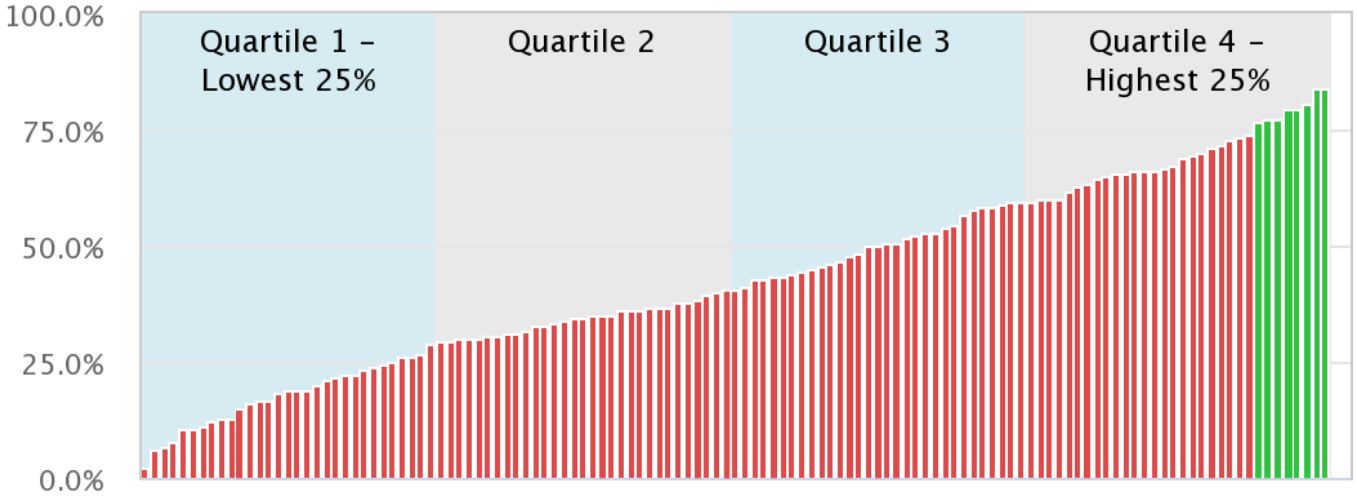
Hysterectomies have traditionally been performed as open procedures with average hospital stays of 3.97 days (HES, 2022-23). Advances in the assessment of patients, anaesthetic techniques, and adoption of minimal access approaches mean that more hysterectomies can be safely undertaken with lower lengths of stay or as a day case procedure, with appropriate pre-operative preparations and recovery processes in place. However, uptake in the NHS has been low. In 2022-23, 37% of hysterectomies were still performed as open procedures (Table 3), accounting for 44,696 bed days.

Table 3 - Hysterectomy activity in England 2022-23

2022/23	Total number of benign hysterectomies (England)	Percentage Total (33,098)		GIRFT procedure split recommendation
Open (Abdominal)	8,992	37%		Max 25%
Laparoscopic/ Minimal Access	8,645	36%	63%	Min 75%
Vaginal	6,630	27%		

GIRFT recommends services move towards greater minimal access rates, to at least 75% of total hysterectomy activity, with the remaining 25% as open procedures. Graph 1 demonstrates the opportunity to increase minimal access rates, with only eight providers meeting the 75% recommendation.

Minimal access rates for patients (<50 years) receiving hysterectomy for benign conditions, National Distribution, Q3 2022/23



Graph 1 - Minimal access rates for patients receiving hysterectomy

Although this guide does not cover surgical cancer treatment, the same day surgery principles apply.

1.2 Day case surgery

The definition of day surgery is that:

- the patient should be undergoing a planned procedure;
- the patient must have an intended management of day surgery;
- the patient must be admitted, operated upon and discharged on the same calendar day.

For elective procedures it is essential that the patient has intended management of day surgery when entered onto the waiting list. Patients who happen to be discharged on the same day as surgery "by chance" i.e. without being scheduled as a day case, do not count in the provider's data.

The best outcomes are achieved when the patient is adequately prepared for day surgery, with all of the staff involved in their care aware and supportive of the intended plan for day surgery, and they follow a clear day case pathway.

Whilst many trusts will have a Day Surgery Unit (DSU), and a respective Day Surgery team in place, it is recognised that not all services will be able to access these immediately due to staffing and capacity, therefore piloting the pathway may need to take place within the service. In the absence of a dedicated DSU, the pathway requires specific attention to ensure day surgery management will not be impeded.

1.3 Day case hysterectomy surgery

The advantages of a day case pathway include:

1. improved quality and consistency of care – standardised pathway ensures everyone is clear on process and role;

2. improved patient and staff experience – patients able to recover in the comfort of their own home;
3. reduced on the day cancellations – surgery less likely to be disrupted by emergencies;
4. better use of resources and opportunity for intra-specialty mutual aid – allows appropriate allocation of resources i.e. theatres and staffing, where traditionally used for inpatients;
5. reduction in Hospital Acquired Infections (HAIs) and Venous Thromboembolism (VTE);
6. release of inpatient bed and theatre capacity for more complex cases; and
7. increased capacity to treat patients on the waiting list quicker – not needing to rely on limited inpatient bed capacity.

Concerns raised about day case pathways include:

- unplanned admissions: processes should be in place to enable this, but this should not preclude even complex patients being offered day surgery; and
- perceived risk of increased readmission rate within 30 days: same day surgery has been shown to have lower readmission and complication rate when audited, and the GIRFT Maternity and Gynaecology National Report (2021) found no strong correlation between shorter lengths of stay and rates of readmission.

Laparoscopic total / subtotal hysterectomy day case rate, National Distribution, January 2023

Graph 2 - day case rates for laparoscopic hysterectomies

The British Association of Day Surgery (BADS) recommends 60% of vaginal hysterectomy (including laparoscopic assisted), and 50% of laparoscopic hysterectomies (total/subtotal) to be done as day case procedures (BADS Directory of Procedures, 6th ed.), however as of January 2023, only 24 trusts in England – out of 122 trusts – recorded a day case laparoscopic hysterectomy. Of the 24, day case rates vary from 2.2% to 80%, with only three trusts meeting the 50% BADS benchmark (see Graph 2).

Therefore the objectives of this guide are to support services to:

- ☑ **Increase minimal access provision to at least 75% of all hysterectomy activity**
- ☑ **Deliver at least 50% of minimal access procedures as day cases**

There is a huge opportunity to reduce inpatient bed days and improve productivity, whilst maintaining or improving clinical quality and patient experience for women[1]. If all trusts performing hysterectomies met the GIRFT aspiration to increase minimal access, and day case rate, there is an opportunity to save almost **23,000 beds days** across the NHS. Maximising day case hysterectomy rates as recommended by BADS would release an annual sum of just under £5,000,000 (BADS Directory of Procedures, 6th ed.).

A project checklist is provided alongside this document to support teams through the process.

[1] It is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecology services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

2. Day case hysterectomy pathway

2.1 Designing a local day case pathway

Teams starting a day case service, should start by developing a clinical pathway (template given in Figure 1), which outlines key steps along the patient pathway. An example of this is the "Same-day discharge benign Laparoscopic Hysterectomy pathway" developed by the London Regional Elective Recovery team (Figure 1).

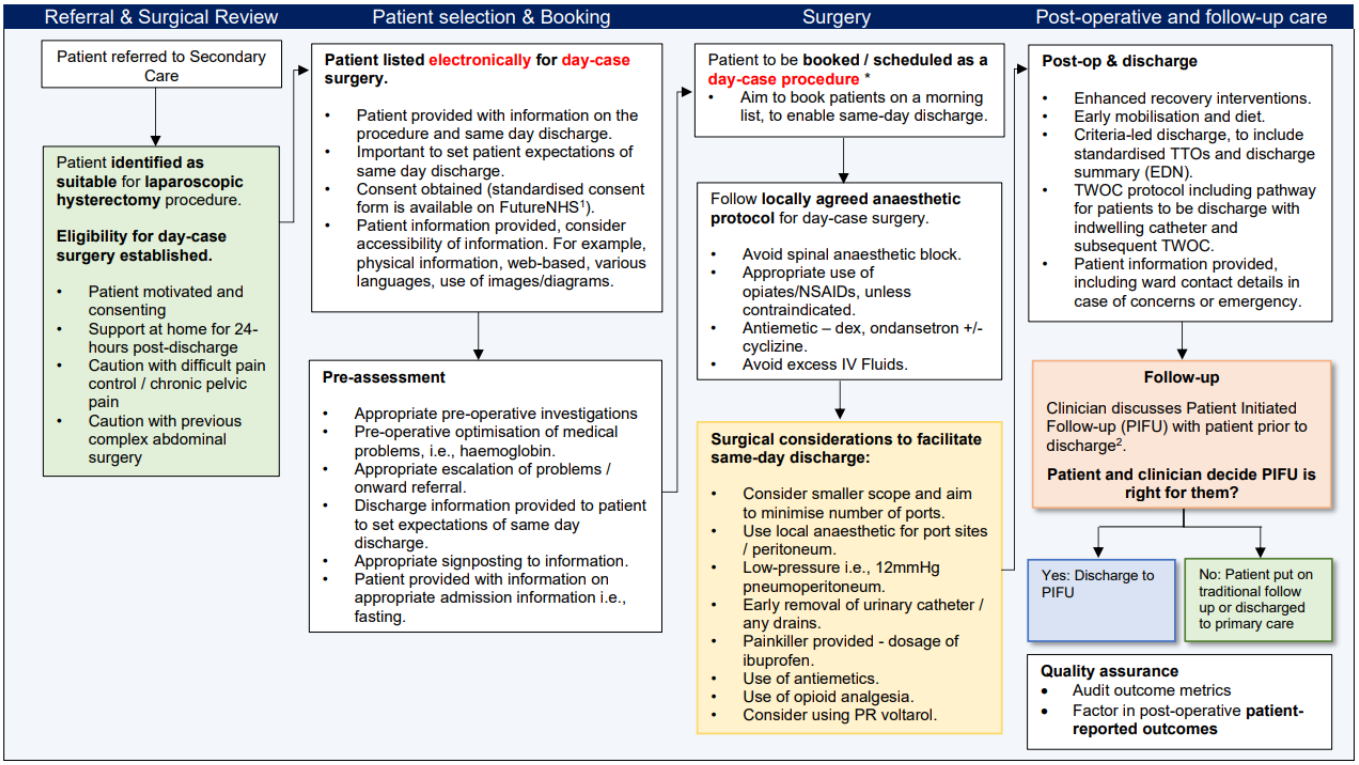


Figure 1 - NHS England – Same-day discharge benign laparoscopic hysterectomy pathway – London region

Development of the pathway should include the day surgery team and gynaecology team including pre-operative assessment, surgical, anaesthetic, admissions and discharge teams with involvement from primary care and any other relavent stakeholders including patient represenation.

Clinical pathways should be written up into Standard Operating Procedures (SOPs) and communicated to all members of the team so everyone is clear of their role and responsibilities. Examples of clinical protocols and SOPs can be found in Appendix 1 and on the GIRFT FutureNHS Gynaecology Hysterectomy Hub.

3. Delivering the day case pathway

This section explores the different elements of a day case hysterectomy service, drawing on the experience of the trusts who currently deliver above average day case rates, and highlighting how this has been achieved.

3.1 Understanding the data

3.1.1 Day case metrics

To classify as a day case in the UK, planned procedures must fulfil two criteria:

1. have a management intent of day surgery: essential to the day case pathway is ensuring the patient is prepared for day surgery and all members of the team clearly understand the intended management;
2. patients must be admitted, operated upon and discharged on the same calendar day.

23-hour stays are not included within the day surgery remit in the UK (as they are in the USA). Units which try to combine 23-hour stay wards with day surgery tend to have poorer day surgery rates (GIRFT, 2020).

Patients planned as inpatients are much less likely to achieve successful day case discharge and may even be cancelled in times of high bed pressures because of teams anticipating the need for a bed post-operatively. if a patient is planned as an inpatient but discharged on the day of surgery they will not appear on hospital data as a day case, instead they will be recorded as an inpatient with a zero length of stay.

To drive this, many trusts have implemented a **day case as default policy**. Any patient listed for a surgical procedure that is deemed appropriate for day surgery should be booked as a day case, and only switched to an inpatient pathway in exceptional circumstances.

When first starting same day discharges, teams may benefit from agreeing a **clear inclusion criteria for day surgery** and expanding this out as confidence builds – well-established day case services (see Appendix 1) now use very broad criteria with no limit to ASA (American Society of Anaesthesiologists Physical Status Classification System), BMI or age, and evidence (see Further reading section) suggests many patients with complex medical conditions can be safely manged via day case pathways.

Pre-operative assessment should have these clear criteria for day surgery with involvement of an experienced day surgery pre-op anaesthetist to review the more complex patients.

View day case metrics on Model Health System

3.1.2 Outcome measures

Trusts embarking on change should take the time to understand the data before making any changes to services to truly evaluate any impact. Doing this before any change, allows the identification and correction of any errors in data, as well as understanding the processes in which the data is generated to ensure correct input going forward.

As part of local governance arrangements, services should, at a minimum, regularly review the following key metrics:

- ✓ Time to discharge;
- ✓ Length of stay;
- ✓ Rates of unplanned admissions (and cause);
- ✓ Missed opportunities (inpatients with zero length of stay);
- ✓ Day 1 symptoms (pain, nausea, satisfaction);
- ✓ Readmissions within 30 days;
- ✓ Patient reported outcome measures (PROMS).

An Audit template is available on the GIRFT FutureNHS Gynaecology Hysterectomy Hub

3.1.3 Quality Assurance

The British Society for Gynaecological Endoscopy Surgical Information Collection System (BSGESICS) audit tool allows electronic data capture at both individual and comparative level. This data can be used in appraisal and service evaluation.

3.1.4 Patient feedback

Patient involvement and experience should factor into pathway design from an early stage, and is to be supported and encouraged. Involving patients in the design of the pathway allows for the patient perspective to be taken into account, and to make suggestions which are likely to be more acceptable to patients.

A Patient Experience team or similar (if available), is a valuable resource to have and should be involved in the change to collect, analyse and summarise patient feedback back to the team, to release staff from collecting and amalgamating/data analysis, to focus on learning, delivering the change and acting on feedback.

Patient feedback is key when delivering service changes to build confidence within the team and identify areas for improvement. Patient feedback should be reviewed and shared regularly with all members of the team (clinical and non-clinical) involved in the pathway, to celebrate successes and highlight what can be done better.

Actions from patient feedback should be added to an action log, allocated to a person who is responsible for ensuring feedback is acted upon, and regularly reviewed by the project and relevant team to ensure progress is being made.

3.2 Day case facilities

BADS recommends the use of dedicated facilities to deliver the day case pathway, ideally for the entire pathway (from admission to discharge), protected from inpatient pressures. This way, the day surgery team are able to focus on same day post-operative recovery and discharge rather than being distracted by emergencies and higher acuity patients.

Having a dedicated unit for day surgery with a dedicated day surgery team increases the chances of same day discharge and reduces on the day cancellations due to hospital pressures.

Day surgery wards should use trolleys rather than beds and should only have simple catering facilities and no showers and therefore not be used for inpatients.

At St Richard's Hospital (University of Sussex), day case patients are admitted to the treatment centre which houses the admission area, theatre suite, recovery area and discharge lounge. The discharge medications are pre-packed and provided with supporting information to include contact numbers, recovery advice, physiotherapy tips and troubleshooting for common problems.

Services that do not have a separate day case unit or lack the space to create one, should look to have a clear separation of day case care from inpatient care within ward areas, including a secondary recovery area with only trolleys, set aside for patients returning from theatre until discharge.

3.2.1 Theatre facilities and equipment

A ring-fenced or elective theatre is preferable for day case surgery to minimise disruption from emergency cases. Where there are no ring-fenced facilities, complex day case procedures should be undertaken as early on the list as possible to enable maximum post-operative recovery time prior to discharge and hence maximise the possibility of same-day discharge.

3.3 Workforce training and engagement

Critical to delivering the day case pathway is having a dedicated day surgery team comprised of experienced and trained staff across all professional groups who are supportive of the day case pathway. Standards for training day surgery staff are available in a series of guidelines produced by BADS and CPOC and outlined in the GIRFT BADS CPOC National Day surgery delivery pack. Lack of confidence is cited by many as a major contributor to delays in adopting day case pathways, and for some staff this may be more difficult due to lack of experience and training. Supporting teams with regular education, audit and patient feedback builds confidence within the team.

Birmingham Women's and Children's Hospital have employed a dedicated Advanced Nurse Practitioner whose role includes leading the review and revision of the day case pathway. Much of their time is spent talking to the different teams to understand the barriers and concerns. From this, they have developed and delivered workshops and presentations to the teams to address the issues as well as creating resources to support staff.

3.3.1 Surgical teams

The surgical team makes up a part of the day surgery workforce and plays a vital role in supporting and delivering the day surgery pathway. Educational and governance processes should be in place to ensure all members of the surgical team understand the overall process and their individual roles, to share day surgery unit performance outcomes (using audit data) and to build an environment of continuous learning.

Clinicians should be discussing the potential for day case surgery with the patient from the moment surgery is being considered, which should be supported with relevant patient information (see supporting resources) to allow patients the maximise time to consider and ask questions ahead of surgery.

3.3.2 Nursing pre-op, theatre, recovery and discharge teams

Dedicated time should be taken to support and train all nursing teams involved in delivering the day case pathway – including preparing for surgery, managing pain and post-operative nausea and vomiting, and nurse-led discharge. Consistency in care delivers optimal outcomes.

3.3.3 Anaesthetist teams

Anaesthetists need to follow agreed anaesthetic guidelines and protocols (see Appendix 1 for examples from trusts). It is important that these cases are anaesthetised by experienced anaesthetists with confidence in day surgery anaesthetic techniques and appropriate analgesic protocols. These procedures can be valuable as training cases but should only be undertaken as solo lists by senior trainees who have developed appropriate expertise in the day case pathways involved.

Guidance can be found from the Royal College of Anaesthetists - Guidelines for the Provision of Anaesthesia Services for Day Surgery (2021).

3.3.4 Administration teams

Booking and scheduling teams should be made aware of day case procedures as these may require less time in theatre, as well as plans for same day discharge so that patients are scheduled early in the theatre list to allow sufficient recovery time for the patient, as well as to provide the correct information to patients. Booking rules should be agreed with the team and regularly reviewed alongside audit data to ensure theatre time is being utilised appropriately.

Patients on this pathway typically need a minimum 4 hours in hospital post-procedure prior to discharge and this should be accounted for when planning an operating list, bearing in mind the recovery area and discharge lounge opening times. This is to ensure the patient meets all discharge criteria and is fit to go home.

3.3.5 Physiotherapy teams

Physiotherapy teams should be involved in the development of the pathway early on, to allow time to ensure patient resources reflect the changes in the pathway and can be linked to the patient information for the procedure.

3.4 Patient information

Key to the success of day case pathways is setting patient expectations and consistent messaging.

Patient expectation and information is one of the biggest factors towards the success of the pathway, which is why consistent messaging from Decision to Treat (DTT) to the day of the procedure is so important.

Trusts should work with communications departments to ensure printed and online patient information is in line with the expected pathway including patient education tools, Q&As, tips for recovery and how to contact the department in an emergency or discuss concerns.

Alongside this document is a range of educational resources on the GIRFT FutureNHS Gynaecology Hysterectomy Hub, which can be replicated.

3.5 Pre-operative assessment

Pre-op assessment (POA) is a vital part of the day case pathway and all staff should have specific day surgery training and have availability of an experienced anaesthetist with a day surgery interest for advice and review of more complex patients.

Birmingham Women's and Children's Hospital complete pre-op over the phone, patients are asked to come into hospital only if tests and/or clinician review is needed.

Surgeons should have explained the procedure to the patient once decision for surgery is made and should have outlined the expected post-operative course. POA nurses should be aware of the likely surgical and anaesthetic course to discuss with patients whilst emphasising the day surgery intent and ensuring the patient has appropriate care at home for 24 hours.

Appendix 1 shows a summary of what is covered at pre-op assessment at various centres.

See GIRFT's Pre-operative assessment services guidance for further recommendations

3.6 Clinical protocols

Planning the development of a day case service should include the entire team so that clear processes and procedures are in place and agreed, within local governance structures so that monitoring and auditing of outcome measures can take place to enable learning.

Services that have introduced the day case pathway have adopted individual protocols to support delivery suitable for their service.

Appendix 1 is a summary of clinical protocols at featured trusts who deliver day case laparoscopic hysterectomy.

Surgical and aesthetic tips for laparoscopic procedures can be found in Appendix 5.

3.7 Post-operative care

3.7.1 Post-operative ward care

Enhanced recovery interventions support same day discharge which include:

- ✓ Pain relief;
- ✓ Early mobilisation;
- ✓ Management of nausea and vomiting;

- ✓ Introduction of diet and fluids;
- ✓ Removal of catheters and packs (if used).

Any packs or catheters inserted during surgery should be removed whilst the patient remains in hospital. Patients should be encouraged to pass urine once they are awake however, a pathway should be developed with the Trail With Out Catheter(TWOC)/urology team for the care of patients who are unable to pass urine prior to discharge, which involves discharge with a catheter in-situ. Such patients can often be given self-removal instruction for the next day to increase day surgery rates and reduce the need for further healthcare intervention.

3.7.2 Patient discharge

Nurse-led discharge is key to the day case pathway to minimise delays – services should develop a clear protocol for discharge which is outlined in nursing proformas/documentation. As a minimum, this should include:

- ✓ Pain controlled with oral analgesia;
- ✓ Nausea and vomiting controlled (or acceptable for transfer home);
- ✓ Patient tolerates oral fluids;
- ✓ Patient can mobilise safely;
- ✓ Patient has stable observations.

Discharge information for patients should include:

- ✓ Copy of discharge letter detailing procedure they had undertaken and any follow up arrangements;
- ✓ Five days supply of post-operative medication;
- ✓ Instructions as to when medication is next due;
- ✓ Details of who to contact if they have any concerns (see section 3.8.3) – patients should not be directed to GP out of hours services, the emergency department or 111.

3.7.3 Post-operative care post-discharge

Table 7 gives the varying levels of post-operative care that can be offered following a day case procedure, as well as suggested staffing.

As per GIRFT BADS CPOC best practice day surgery recommendation, all patients should receive a **Day 1 post-op telephone call** by the day surgery unit team or gynaecology Advanced Nurse Practitioner (ANP) (see Birmingham Women's and Children's interview schedule as an example). Questions should, as a minimum, cover:

- ➢ pain;
- ➢ nausea/vomiting;
- ➢ fever;
- ➢ any other symptoms;
- ➢ patient concerns and questions.

As confidence in the pathway is built, services may choose to no longer do day 1 post-op calls – as Northumbria Healthcare NHS Foundation Trust has done – but ensuring patients have a means to contact the team with any concerns or emergencies.

Patients should be able to contact the day surgery team through a dedicated **patient advice line** or telephone number to the day surgery unit or gynaecology ward. Staffed by a dedicated nurse/team in hours, or ward staff out of hours, patients can call if they have any concerns and to arrange Hospital **Outpatient Treatment (HOT) clinic appointments** where required. There is unlikely to be a large number of patients needing physical review so it is suggested to use protected appointments within an existing clinic rather than setting up a new clinic.

For patients who need to be seen immediately, some services allow patients to **reattend on the ward or gynaecology assessment unit** for up to 6 weeks post-surgery without needing to attend the Emergency Department or GP.

Table 4 - levels of post-op care

Post-op care	Patient condition	Staffing & resources required
Day 1 post-op telephone call	All patients	Gynaecology ANP or day surgery team
Patient advice telephone line (clinical)	Available for all patients to address any concerns over the phone	Gynaecology ANP or day surgery team
Outpatient Treatment (HOT) clinic appointment	Clinically well but require physical review	Consultant/experienced doctor or nurse Combined with outpatient clinics or ward attends
Ward/gynaecology assessment unit (if available)	Require urgent review	ANP/consultant/experienced doctor/nursing team
Emergency Department	Acutely unwell	Gynaecology on-call

Follow up post-surgery

Following successful, uncomplicated surgery, patients can be moved straight to a Patient Initiated Follow-up (PIFU) (see GIRFT OPRT Gynaecology Outpatient Guide) pathway for up to 6 months provided there are no concerns, however this may also be a gradual process, moving from follow-up appointments, to straight to PIFU.

All services providing day case hysterectomy should, as a minimum:

- ☑ **Provide all patients with a Day 1 post-op telephone call**
- ☑ **Have a hotline/telephone number for patients to seek advice**
- ☑ **Build in capacity for patients who need to be seen immediately either though HOT clinics or appointments on the ward**

3.8 Communicating service changes

Any change to service should be notified to the wider gynaecology service, Trust teams, and health community. Table 5 outlines key stakeholders that may need to informed depending on the trust set up and requirements.

Stakeholder	Reason
Primary care	GPs to communicate with patients the possibility of day surgery at point of referral and share experience with service
Inter-dependent specialties e.g. sterile services, diagnostics, pharmacy, physiotherapy, Continence nursing (urology)	Ensure pharmacy are aware pre-prepared take home medications (TTOs) are required on the day of surgery. Sterile services to be aware of potential increased use of service. Pathology to be aware of need for quick turnaround to enable discharge (if needed). Physiotherapy changes to service may require changes to rotas/service provision. Continence nurses/urology team may be needed for patients failing to pass urine and trial without catheter.
Hospital site teams	Changes of bed base
Procurement	The delivery of the day case pathway is likely to increase overall activity and therefore procurement should be informed to ensure there are sufficient supplies and consumables
Finance	Differences in tariff between day case and admitted procedures and increased consumable spend is likely to change month-end budgets and forecasting. To inform business planning, budget setting and commissioning rounds
Coding & contracting teams	To ensure procedures are being coded and remunerated appropriately
Communications team	To update patient information and website information
Patient experience team	To collect and audit outcomes of the change process
Human Resources (HR)	To support any staff who may be impacted by changes
Information Technology (IT)	Uploading of new proformas, changes to electronic patient record (EPR)/ patient administration systems (PAS)
Quality improvement/ transformation team	To provide PMO/project support

Table 4 - Stakeholder list

3.9 Monitoring the change

Change can be daunting however working as a team and learning from others can drive change and create improvements. Using the data explained in section 3.1, regular audit provides opportunity for the team to learn and improve the pathway. Many trusts have an informatics or clinical audit team who can help with collating and reviewing audit data.

Audits should include:

- Unplanned admission rates
- Readmissions
- Patients not recruited to pathway
- Patient satisfaction

- GP satisfaction and concerns

An Audit template is available on the GIRFT FutureNHS Gynaecology Hysterectomy Hub

GPs are a key source of information and feedback so thought should be given on how best to collect this information e.g. by setting up a dedicated email.

4. Trust experiences

This section explores the experiences of trusts who have implemented same day discharge for hysterectomies.

4.1 University of Sussex NHS Foundation Trust – St Richard's Hospital Cancer Unit

Prior to implementation of the day case pathway, audits showed that patients – regardless of ASA – were being discharged within 23 hours which was then used as the driver towards day case procedures.

The gynaecology oncology team at St Richard's Hospital, driven by a motivated consultant, started day case procedures using a small pilot to prove the concept. The pilot started in November 2021 using agreed clinical criteria for patient eligibility, which identified 41 patients suitable for the day case pathway. Of these, 11 were diagnosed with a malignancy and planned for day case surgery.

Nine of the 11 planned patients were successfully discharged as day cases (the remaining two stayed in hospital overnight and were discharged on day one), with zero readmissions within 28 days post-surgery demonstrating the day case pathway could be delivered safely.

The team took a gradual approach to implementing the pathway, making small changes along the way to build experience and confidence in the pathway, as well as focusing on supporting patients and staff with education and communication. Involving members from across the Multi-Disciplinary Team (MDT) was crucial to the successful implementation of the day case pathway which is now the default surgery option, delivering 25.4% of procedures as day case.

A year since implementing the pathway, the service has undertaken 91 day case hysterectomies, with 90% of patients either agreeing or strongly agreeing to recommending a day case hysterectomy to friends or family. Direct feedback highlighted patient's preference to recovering in their own bed and ease of being able to contact the service once at home.

See GIRFT case study here: Introduction of day case hysterectomy at University of Sussex NHSFT.

4.2 Newcastle Upon Tyne Hospitals NHS Foundation Trust

In 2021, using Model Health System metrics, the trust identified a missed opportunity for developing an enhanced recovery programme to focus on day case laparoscopic hysterectomy.

To implement the day case pathway, the team focused on coaching staff and highlighting the trust's performance in comparison to other trusts nationally. The coaching approach motivated and engaged

the staff to want to improve the pathway, optimising discharge and as a result reducing bed days and HCAI.

In addition to this, the team modified patient information in the outpatient and pre-assessment settings to ensure patients were being given a consistent message about day case surgery, as well as remodelling of the data capture to ensure procedures were being recorded properly.

The team found a key driver for the improvement was understanding how data is captured and flows to Model Hospital System, where the team could see an improvement in performance over time.

In the first 12 months of introducing the pathway, the team were able improve their day case rates by more than 20% with consistent, sustained performance.

See GIRFT case study here: Newcastle Hospitals NHSFT improving day case rates TLH.

4.3 Torbay and South Devon NHS Foundation Trust

Since 2014, Torbay and South Devon NHS Foundation Trust has offered hysterectomies as day surgery. It has developed a robust standard operating procedure, beginning with patient preparation and extending through post-operative care. The option is discussed from an early stage, so women are fully aware of the intent and what the procedure will entail. Women are admitted on the day, surgery is conducted laparoscopically or vaginally according to surgical indication and there are clear instructions on discharge. The day after surgery, nurses call each patient to check on their wellbeing.

The hospital has also introduced a network of approved volunteers to provide overnight care for any woman who lives alone, hence enabling them to benefit from the day case pathway, with patient feedback from the approach being excellent.

There have been very low rates of post-operative pain, or nausea and vomiting the day after surgery, and unplanned admission rates of 7%. Now, around 85% of the trust's hysterectomies are conducted as day cases.

4.4 Northumbria Healthcare NHS Foundation Trust

Northumbria successfully increased planned day case surgeries through introducing an enhanced recovery pathway, by streamlining the patient journey from referral to surgery with the aim of enabling rapid recovery, shorter lengths of stay, as well as reduced unplanned admissions and improved patient experience.

Using a clear criteria for patient selection, counselling and consenting, optimisation and pre-assessment protocols, the service have standardised the pathway for all day case patients with standard proformas (see GIRFT FutureNHS Hysterectomy Hub for resources) and patient questionnaires.

Attributed to the success was the implementation of the Royal College of Obstetrician's and Gynaecologist's Enhanced Recovery guidance, using PROMS, and the role of the nurses in achieving day surgery and discharge.

As of February 2023, the service delivered 100% of laparoscopic total/subtotal hysterectomies, and 73.5% of vaginal hysterectomies as day cases, with respective conversion from day case to inpatient stay at 0 and 17%.

4.5 Worcestershire Acute Hospitals NHS Trust / West Midlands Quality Improvement Initiative

A quality improvement programme to increase day case procedures across eight trusts in the West Midlands was initiated as a result of observations of variation in day case rate and LOS on Model Health System. The trusts included all had the capability of performing laparoscopic hysterectomy, and a desire to facilitate same day discharge but no prior experience of achieving same day discharge for TLH. The aim was to improve quality and consistency of the procedures, with improved patient experience whilst increasing the chance of surgery proceeding and better utilising resources.

The project started with a preliminary meeting of gynaecologists and anaesthetists from each of the eight trusts to agree a basic protocol, which was then launched in September 2021 with a face to face meeting of all staff groups (gynaecologists, anaesthetists, nurses from all areas of the service and operational leads and system leads including GPs) to review the entire patient pathway.

Here the teams agreed on eligibility criteria, surgical and anaesthetic protocols (focusing on enhanced recovery), in particular:

- Patient eligibility criteria was kept very loose to maximise the numbers of suitable patients for the pathway;
- Surgical procedures to be done as early in the day as possible so patients could be discharged before the unit closed at 7pm and therefore avoid an overnight stay;
- Use of the smallest ports and lowest pneumoperitoneum pressure as possible; and
- catheters to be removed at the end of procedure.

Messaging to patients needed to be consistent throughout the pathway so the teams developed a template patient information leaflet (see GIRFT FutureNHS Gynaecology Hysterectomy Hub for resources) for use across all hospitals, which could be adapted with site-specific information – e.g. contact numbers.

The rates of Same Day Discharge TLH in Worcestershire started at 0% in January 2021, increasing to 17.5% (15/86) by January 2022, and further increased to 35% by January 2023. Over this period there were no significant increase in post-op complications requiring re-admission. Challenges were found in ensuring patients received their day 1 and day 3 post-op telephone calls – however no patients came to harm as a result. Worcester is now aiming for 50% day case rate.

Of the patients who underwent day case surgery:

- average age was 43 years (30-52 years)
- 20% were ASA I and 80% ASA II (ASA III was not excluded)
- Included a range of BMIs.

The plan now is to scale the principles of day case procedures to other procedures including adnexal surgery, endometriosis, repairs, vaginal hysterectomy, and continence procedures across hospitals in the West Midlands.

5. Further information

The GIRFT FutureNHS Gynaecology Hysterectomy Hub has been set up to support services wishing to introduce day case hysterectomy procedures with a range of useful resources for trusts to use. See Appendix 3 (Day case hysterectomy resources) for full list of hysterectomy resources.

5.1 Further reading

British Association Of Day Surgery (bads.co.uk)

BADS: Day Case Gynaecology Surgery guide (2020)

Fergusson, A, Weir, A., Mankiewitz, R., Narayanan, S., Hindley, J., Rayner, E., Stocker, M. (2020) *Is it time to default hysterectomies to day surgery? A review of outcomes in a district general hospital day surgery unit.* Journal of One-Day Surgery https://appconnect.daysurgeryuk.net/media/43854/304-fergusson.pdf

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6. Appendices

Appendix 1 – Summary of Trust clinical protocols for day case laparoscopic hysterectomy

Access Appendix 1 on the GIRFT FutureNHS Hysterectomy Hub, here.

Appendix 2 – Day Case Hysterectomy Frequently Asked Questions

Here are a series of frequently asked questions relating to day case hysterectomy. If you have a question that isn't answered here, please add these to the GIRFT FutureNHS Gynaecology Forum.

1. What are the difficulties of running a day case pathway in an inpatient ward area?

Having day case patients on the inpatient ward can create more work for nurses on the ward who find it more difficult to maintain the same day discharge. Maintaining a separation of day case and admitted patients is best practice, allows the ward staff to focus on the pathway and processes needed, without being distracted by admissions or emergencies.

Planned day case pathway patients who are sent to an inpatient area for discharge have a higher discharge failure rate. This is felt to be because there are many conflicts to ensuring the discharge happens. Inpatient wards do not have the appropriate discharge medications packs with a member of staff who is dedicated to cover all the pertinent information around how to manage symptoms, what to do in you have concerns and how to access physiotherapy. Those patients who are planned to stay in hospital are normally reviewed each morning and those planned for home have discharge medications and plans put in place. Following this, the ward based team may not be available to review and discharge a patient and the nursing staff are not familiar with the pathway. Once the patient arrives on the ward it's straightforward to settle them in to a bed and then allow the morning team to make the discharge plan. Some patients require an inpatient stay and these can undermine the confidence of those who can go home and lead them to believe they would benefit from a night in hospital.

2. What is the impact on GP contacts following a day case procedure?

It's not been established what the impact on GPs is however, trusts have implemented a dedicated post-op hotline for patients to call with any concerns rather than contacting the GP which would avoid additional workload on GPs.

It's likely that day case hysterectomy does not impact GP services vs those patients who stay overnight where there are clear protocols in place for patients to contact secondary care in the first 24 hours if any concerns.

From St Richard's, University Hospitals Sussex: General Practitioners should not notice a significant impact by this pathway as the patients are provided with all relevant information and medication. Where they require additional review within first 7 days they can access this through the helpline. It is important that if there is a problem this is picked up through audit and the issues reviewed and a plan put in place for future cases. The data and pathway have been presented to Primary health care providers locally and they are supportive of the pathway. There has also been agreement to support disposal of LMWH syringes and arrange hormone replacement therapy prescriptions as needed. To date, no negative feedback has been received.

3. Where can patients be directed overnight in the event of post-op complications?

Trusts have shared out of hours telephone numbers with patients to contact in the event of post-op complications where day staff are no longer around. These are staffed by the ward team or senior surgical bleep holder who can advise the patient whether they need to come in or arrange a review for the following day, avoiding the need for the patient to need to attend the Emergency Department.

Other trusts have a gynae emergency unit that patients can call/attend rather than the Emergency Department.

If attendance to A&E is required overnight, an agreement should be in place between gynaecology and the Emergency Department on how best to manage these patients. At St Richard's, the patient will be seen directly by the gynaecology team and referred at triage (by-passing A&E medics).

4. Can day case hysterectomies be performed in an off-site day case unit?

Yes – as long as the facility is set up to manage the procedure away from the main unit and all relevant equipment and skilled workforce are available. Some day case units have overnight facilities in case a patient requires it, or the patient is transferred to an inpatient facility.

5. What criteria do you use to assess a patient for a day case procedure?

Teams should agree a criteria they are comfortable with to start with and gradually expand this as confidence builds.

6. Do patients need to be sent home with anti-emetics?

Patients do not generally need to be given anti-emetics to take home. If patient has history of severe Post-Operative Nausea and Vomiting (PONV) or there are issues in recovery / post-op ward anti-emetic TTO could be considered.

7. Is oral morphine given to patients?

This would only be needed in recovery, not always for the patient to take home. Some units give oramorph/liquid morphine for patients to take home on an "as needed" basis – finding it gives the patient confidence knowing they have a back up if required. Patients are advised to use with caution and only when simple analgesia has been exhausted. Usage is can then be discussed on the post-op telephone call.

8. How long do patients need to stay post-op?

Generally, patients need to stay 4-6 hours post-op, so day case patients should be listed first or second on the operating list to maximise time available for this the chance of going home on the same day. The patient should be comfortable, alert and able to pass urine and tolerate fluids and light diet before discharge home.

9. What happens if the patient can't pass urine?

Where they cannot pass urine and are happy for discharge using a catheter then this can be arranged with a plan to remove the catheter at an interval. Patient is sent home with catheter in-situ and booked for TWOC 7-10 days later in Gynae clinic or other local community service.

10. What follow-up do patient's receive?

This depends on the day surgery experience and level of confidence within the service:

- to begin, all patients receive a day 1 call to review symptoms which can be stopped once confidence is built;
- some centres will have a nurse/consultant clinical follow-up and others will move directly to PIFU for uncomplicated surgery;
- confirmed cancer cases would depend on MDT outcome.

Services starting out a day case service, should review their current follow up provision, and using data, resources and guidance available, work towards standardising follow up care.

Routine follow up for all patients is not required. When results of any tests performed are available they should receive a letter advising them of these and this letter should include if they are due to have further follow up. The patient should also be advised regarding hormone replacement therapy and whether they can commence this and examples of suitable regimes. Patients should be asked to provide feedback on their care.

11. Why does our data not reflect the number of day cases we actually do?

It's important that where a day case hysterectomy is planned it is booked as such, and that the coding team record the data to reflect this. If a case is not booked as a day case but goes home on the same day it will not be captured in the data and will appear as a 0 day inpatient stay.

12. How do we evidence our pathway is safe?

All surgeons should use the NCIP portal to review their own data. Within any unit there should be a Gynaecology risk management process and a trigger list for all adverse outcomes used. This trigger list should capture readmissions and return to theatres as well as complications after surgery. The risk team should report on trends and areas of concerns. The data should be compared to the previous data relating to inpatient stay after hysterectomy.

13. How do we show that this is a positive change for our unit?

You should be able to evidence less cancellations of cases as surgery is independent of bed status as well as patient satisfaction and evidence that there has not been an increase in complications.

14. What audits should be run?

1) Failed planned discharges

2) Readmissions

3) Return to theatres

4) Complications relating to surgery

An audit template can be found here to get you started.

Appendix 3 - Day case hysterectomy resources

Resource	Resource
Templates for trusts	Standardised consent forms: Total Laparoscopic Hysterectomy Standardised consent forms: vaginal hysterectomy & repair Day case Hysterectomy Audit template
Project documents	One page guide – Implementing Day Case Hysterectomy Pathway Key Points Day case hysterectomy Project checklist
Case studies (GIRFT)	Newcastle Hospitals NHSFT improving day case rates TLH Introduction of day case hysterectomy at University of Sussex NHSFT
Case studies (non-GIRFT)	Northumbria day case poster presentation University of Sussex BMJ presentation article University of Sussex poster – introduction of the day case hysterectomy in a cancer unit
Example Pathways (trust and system level)	London-wide SSD laparoscopic hysterectomy pathway (Aug 23) Sheffield pathway for Abnormal Uterine Bleeding NHS South London Menopause and HRT pathway (Oct 22)
Webinars	London Workshop: Same Day Discharge - lap hysterectomy (26th April 2023) South West England Gynaecology Day Case Symposium (14th December 2022) London Elective Transformation and Recovery Programme Day case Laparoscopic Hysterectomy webinar (16th December 2022)
Presentations	University of Sussex - "Total Laparoscopic Hysterectomy and Recovery: Time to discharge during the Covid-19 pandemic" poster University of Sussex "presentation and waiting times in ACA (Ambulatory Care Assessment) on the Emergency floor" poster Northumbria Healthcare NHSFT “Gynaecology Day Case Surgery Pathway in Northumbria”
Patient information	Worcestershire Acute Hospitals NHST lap hysterectomy patient information Worcestershire Acute hospitals NHST patient information discharge advice following surgery University Hospitals Sussex NHSFT patient information RCOG - Laparoscopic hysterectomy – recovering well patient information leaflet British pain society - managing pain after your surgery Birmingham Women’s and Children’s NHSFT patient education slides Birmingham short stay laparoscopic "key hole" hysterectomy" leaflet Choosing Wisely patient decision making aid British Pain Society - Managing pain after surgery
Clinical protocols / SOPs	University Hospitals Sussex NHSFT day case TLH clinical protocol Torbay and South Devon NHSFT day case laparoscopic hysterectomy clinical protocol Torbay and South Devon NHSFT day case vaginal hysterectomy and vaginal repair surgery clinical protocol Birmingham Women’s and Children’s NHSFT same day discharge SOP Birmingham Women’s and Children’s NHSFT Nurse interview day 1 Birmingham Women’s and Children’s NHSFT pre-op checklist for same day discharge Royal Hallamshire Hospital online referral form for abnormal uterine bleeding Sheffield Teaching Hospitals PIFU clinical protocol conservative management of pelvic floor conditions United Lincolnshire Hospitals PIFU protocol for gynae
Documentation	Northumbria Healthcare NHS Foundation Trust day case surgery pathway proforma
Patient experience	Birmingham patient experience week 6 survey
Guidance	GIRFT BADS CPOC National Day surgery delivery pack GIRFT OPRT Clinically-led Gynaecology Outpatient guide GIRFT Preoperative assessment services guide Royal College of Anaesthetists - Guidelines for the Provision of Anaesthesia Services for Day Surgery (2021)

Resources by pathway stage

Referral and outpatient resources	Abnormal uterine bleeding	Royal Hallamshire Hospital online referral form for abnormal uterine bleeding
	Patient information	Choosing Wisely patient decision making aid
	PIFU	Sheffield Teaching Hospitals PIFU clinical protocol conservative management of pelvic floor conditions
	Guidance	GIRFT OPRT Clinically-led Gynaecology Outpatient guide
Day case resources	Guidance	GIRFT National Day surgery delivery pack Royal College of Anaesthetists - Guidelines for the Provision of Anaesthesia Services for Day Surgery (2021)
	Pre-assessment	Standardised consent forms: Total Laparoscopic Hysterectomy Standardised consent forms: vaginal hysterectomy & repair GIRFT Preoperative assessment services guide Birmingham Women's and Children's NHSFT pre-op checklist for same day discharge
	Patient information	Birmingham Women's and Children's NHS Foundation trust patient education slides Birmingham short stay laparoscopic "key hole" hysterectomy" leaflet Worcestershire Acute Hospitals NHS Trust lap hyst patient information University Hospitals Sussex NHSFT patient information
	Clinical protocols/SOP	Northumbria Healthcare NHS Foundation Trust day case surgery pathway documentation University Hospitals Sussex NHS Foundation Trust day case TLH clinical protocol Torbay and South Devon NHS Foundation Trust day case laparoscopic hysterectomy clinical protocol Torbay and South Devon NHS Foundation Trust day case vaginal hysterectomy and vaginal repair surgery clinical protocol Birmingham Women's and Children's NHSFT same day discharge SOP
	Example Pathways	London-wide SSD laparoscopic hysterectomy pathway (Aug 23) Sheffield pathway for Abnormal Uterine Bleeding NHS South London Menopause and HRT pathway (Oct 22)
Recovery and Discharge	Patient information	Worcestershire Acute hospitals NHS Trust patient information discharge advice following surgery Laparoscopic hysterectomy – recovering well patient information leaflet | RCOG British pain society - managing pain after your surgery British Pain Society - Managing pain after surgery
	Clinical protocols/SOP	Birmingham Women's and Children's NHSFT Nurse interview day 1
	PIFU	United Lincolnshire Hospitals PIFU protocol for gynae
	Audit data collection	Day case Hysterectomy Audit template
	Patient experience	Birmingham patient experience week 6 survey

GIRFT is grateful to the teams who have generously shared their work for the benefit of others. GIRFT encourages teams to review the resources to avoid "reinventing the wheel" with due care and attention to local needs. Resources are for sharing of information only and have not been reviewed or ratified by GIRFT.

Appendix 4 - Day Case Hysterectomy pathway - project checklist

Stage 1: Assemble Project Team					
Surgeon	✓	Pharmacy		Ward/discharge nurse	
Anaesthetist		Physiotherapist		Booking and Scheduling Rep	
Day surgery team		Service/ Operational Manager		Service User/Carer	
Pre-op Rep		Nurse (gynae service)		Executive Sponsor	
Analyst		Coding Lead		*Other*	
Improvement Lead		GPSI			

Stage 2: Design a Pathway to Pilot		
Action	**Responsible (*suggested*)**	✓
Review daycase hysterectomy guide and resources on the Hysterectomy Hub	All	
Collect and analyse relevant data (section 3.1 in guide) using the audit template	Analyst	
Agree inclusion and exclusion criteria	Surgeon/Anaesthetist /Nurse	
Agree location/facilities for day case service	Clinical and operational	
Agree anaesthetic approach	Anaesthetist	
Agree surgical approach	Surgeon	
Consider information from GIRFT, NICE, BADS, CPOC, RCOA, RCOG and RCN	All	
Include enhanced recovery principles	Surgeon/Anaesthetist /Nurse/Physio	
Build in PREMS & PROMs to understand patient and carer experience of the pathway.	All	
Survey staff to understand experience of the new pathway	All	
Agree items for and process of prescription and timely provision of TTOs	Surgeon/Anaesthetist /Nurse/Pharmacy	
Agree nurse-led discharge criteria	Nurse/Surgeon	
Agree mechanism of follow up: call at 24 hrs, call at 6 weeks, open access, PIFU, discharge.	Surgeon/Nurse	
Have 24 hour patient advice line in place	Nurse	
Update patient information (pre-op, discharge)	Operational/Nurse/Surgeon /Physio	
Inform relevant stakeholders (see section 3.8 in guide)	Operational	
Collect audit data (see audit template) and regularly review	Surgeon/Nurse	
Stage 3: Action Focussed Governance		
Set up diary invites for a weekly meeting	Operational	✓
Agree light touch governance to appropriate group or committee to share progress.	All	
Develop action log and take action point and decision minutes	Improvement/Operational	
Agree clear objectives and get executive sponsorship to enable all of those involved in project to make changes.	All	

Agree key process metrics to monitor any changes to outcomes i.e. number of patients booked as day case by default.	Improvement	
Agree outcome metrics to understand progress towards goal. i.e. number of women who successfully have day case TLH, number of and reason for re-admissions	Improvement	
Be asset based – learn from what is working well internally already perhaps in other divisions or specialities.	Improvement	
Communicate widely using project team links to ensure everyone is aware of the change and understands their specific role in it.	Improvement/Operational	
Use model health system data to help to find a other trusts you can learn from/with.	Analyst	
Explore potential unintended consequences and put plans in place to mitigate them.	All	
Anticipate potential resistance and blockers and put a plan in place and seek support to manage that.	All	
Consider how principles of behaviour change can help you. EAST COM-B / SCARF® Model	All	
Use external contacts (including GIRFT) to help build a vision and community of practice either through 121 support or existing webinars.	All	
When pathway is successfully embedded, celebrate and share your success.	All	

Appendix 5 – Surgical & anaesthetic tips for hysterectomy procedures

Laparoscopic hysterectomy – Surgical tips
Avoid vaginal packing
Catheters inserted at start of procedure and removed before leaving theatre
Aim for 10mmHg or less operating pressure with deep neuromuscular blockade and insufflator settings: ○ Shoulder supports to prevent patient movement in Lithotomy Position ○ Exaggerated Lithotomy Position
Maintaining intra-abdominal pressure: ○ Smoke extractor ○ AirSeal ○ Start colpotomy from back to front
Suction-irrigation: ○ Set up at the start ○ Avoid extensive suction irrigation through the procedure as this can lead to oedeamatous tissue planes and difficult dissection associated with increased pain. ○ At the end of the procedure, wash out the peritoneal cavity for haemostasis and remove any blood that has collected. This will reduce adhesions and reduce pain in recovery.
Haemostasis: ○ Drain should not be routinely used ○ If used, do not leave drain in – not recommended for routine use in Enhanced Recovery After Surgery (ERAS) patients and associated with delayed discharge and surgical site infections ○ Consider using a haemostatic agent, e.g. Arista or Veriset, on the vault of the vagina if there is an ooze. Routine use is not recommended as there is concern this may be associated with increased risk of infection at the vault. Consider 1g intravenous tranexamic acid at start of procedure to reduce intraoperative blood loss and risk of vault haematoma
End of procedure: ○ View out ports ○ Remove as much CO_2 as possible ○ Long-acting local anaesthetic up to the maximum dose should be used to anesthetise all port-sites down to the level of the abdominal wall muscles +/- peritoneal cavity local anaesthetic instillation according to local protocol. ○ Consider glove change after specimen extraction to reduce SSI risk ○ Remove catheter before patient woken up
Vaginal hysterectomy – Surgical tips
Technique: ○ Open the rectouterine (Pouch of Douglas) at the same time as opening the posterior vaginal wall ○ Use Littlewoods forceps to hold the posterior vaginal wall between the insertions of the uterosacral ligaments. Push the vaginal wall against the back of the uterus, so that you also include the peritoneum in this ○ Palpate to ensure that you haven't got any bowel in your grasp and then make a bold cut using either Curved Mayo or Ferguson's scissors ○ This is to reduce bleeding from the space between the peritoneum and the vaginal wall ○ Do not dissect the vagina too laterally from the Cardinal Ligaments, to reduce the risk of rupturing arterioles and also reduce the risk of vault prolapse

Haemostasis:

- Use finger switch diathermy for the rest of the incision.
- Diathermy as you go along:
  - Reduces bleeding from vaginal edges
  - Helps haemostasis
  - Reduces risk of haematoma, infection and pain

End of Procedure:

- No pack or catheter – use if difficult to achieve haemostasis and aim to remove within 2 hours
- Don't empty the bladder – allow patient to void on their own when fully awake - decreases risk of bladder complications

Day case hysterectomy – Anaesthetic tips

- Minimise pre-operative starvation times
- Allow patients to drink water until required in theatre
- Give all patients pre-operative oral analgesia e.g. paracetamol 1g and ibuprofen modified release 1600mg if they can tolerate NSAIDs safely
- Day case anaesthetic techniques – recommend total intravenous anaesthesia
- Consider prilocaine spinal for vaginal surgery if patient preference or significant co-morbidities
- Routine antiemetic prophylaxis (consider ondansetron and dexamethasone).
- Large bolus of fentanyl at end of procedure (laparoscopic surgery) – see Appendix 1 for doses
- Standardised rescue analgesia (fentanyl – avoid morphine) and antiemetics in primary recovery

7. Authors and Contributors

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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 which are available via FutureNHS. These are available at: Getting It Right First Time - FutureNHS Collaboration Platform

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