Breast Surgery as Day Surgery
6th September 2016

Welcome
## Resources

1. Resource pack
2. 2 BADS booklets *per Trust* funded by RM Partners
3. Site visit support

<table>
<thead>
<tr>
<th>Resource Pack</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulatory Non-Reconstructive Breast Cancer Surgery</strong></td>
<td>A guide for breast units endeavouring to increase their day surgery rates for non-reconstructive breast cancer surgery</td>
</tr>
<tr>
<td><strong>The pathway to success-management of the day surgical patient</strong></td>
<td>The ideal pathway for day surgery patients including selection criteria, what happens on the day of surgery and patient discharge and support</td>
</tr>
<tr>
<td><strong>Ten dilemmas in the day surgery pathway</strong></td>
<td>This includes perceived rate limiting steps one stop services, value for money in pre-operative assessment, consent and judging capacity, achieving a prompt start to lists, managing complications, carer support</td>
</tr>
<tr>
<td><strong>Ten More Dilemmas in Day Surgery</strong></td>
<td>Topics include theatre procedure myths, preoperative fasting, communication issues, wound care, surgical site infection, alcohol abuse, The Mental Capacity Act, travel after day surgery, using local anaesthesia.</td>
</tr>
<tr>
<td><strong>Patient Safety in the Ambulatory Pathway</strong></td>
<td>This handbook highlights safety issues within the patient pathway for day and short stay surgery</td>
</tr>
<tr>
<td><strong>Team working and staffing in day surgery</strong></td>
<td>The roles and responsibilities of the day surgery team, operational Issues, skill-mixing, day surgery as a learning environment, developing day surgery practitioners, competency and skills assessment</td>
</tr>
<tr>
<td><strong>Organisational issues in pre-operative assessment for day surgery</strong></td>
<td>Managing demand, capacity, process and investigations in pre-operative assessment, training for nurse-led pre-operative assessment and auditing outcomes.</td>
</tr>
<tr>
<td><strong>Ten dilemmas in pre-operative assessment for day surgery</strong></td>
<td>Management of common comorbidities (hypertension, sleep apnoea, diabetes, heart valve disease, anti-platelet drugs, anticoagulants, haematological / neuromuscular disorders and respiratory tract infections</td>
</tr>
<tr>
<td><strong>Managing diabetes in patients having day and short-stay surgery (4th Edition)</strong></td>
<td>A booklet describing how to safely manage diabetic patients for day and short stay surgery</td>
</tr>
<tr>
<td><strong>Sedation in Day Surgery</strong></td>
<td>How sedation can be effectively and safely delivered in the day surgery environment</td>
</tr>
<tr>
<td><strong>Nurse Led Discharge</strong></td>
<td>A guide to implementing or updating the nurse led discharge process for day and short stay surgical patients</td>
</tr>
<tr>
<td><strong>Quality in Day Surgery</strong></td>
<td>How a quality service can be provided and evaluated in Day Surgery</td>
</tr>
</tbody>
</table>
23 hour discharge model
Summary of audit findings
May 2015

Falgungi Raja, Senior Project Manager
Breast Colorectal, Lung Pathway
Method

- Questionnaire sent to all LCA trusts except LNWL and Kings in May 2016

- Responses received from 7 trusts
23 hour discharge model audit May 2016 of 8 sites (7 Trusts)

- 100% of sites use 23 hour discharge model for all non-reconstructive breast surgery.
- 25% of theatre lists are suitable for the 23 hour discharge model.
- 88% of patients are booked for pre-assessment 1-2 weeks prior to surgery.
- 88% of patients' social needs are addressed prior to surgery.
- 88% of consultant and nurse lead discharge.
- 38% of sites have CNS follow up 24/48 hours post surgery.
- 50% of sites have documented 23 hour discharge pathway.
- 13% of sites are compliant against the proposed 23 hour discharge pathway.
- 100% of sites have 23 hour lead.
<table>
<thead>
<tr>
<th>Reported challenges, issues and obstacles for 23 hour discharge model compliance</th>
<th>Support requested</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operational</strong></td>
<td></td>
</tr>
<tr>
<td>• significant numbers of patients being operated on Friday lists, no breast team present on Saturday or on call</td>
<td>• Clear definition of how LOS data should be collected and measured</td>
</tr>
<tr>
<td>• Insufficient consenting time, lack of OPD space</td>
<td>• Commissioning of Physiotherapy services for breast patients</td>
</tr>
<tr>
<td><strong>Service support</strong></td>
<td></td>
</tr>
<tr>
<td>• Physiotherapy assessments at pre-admission</td>
<td>• Share other units pathways &amp; practices</td>
</tr>
<tr>
<td><strong>Data collection</strong></td>
<td></td>
</tr>
<tr>
<td>• Clear definition of how LOS data should be collected and measured</td>
<td>• Provide good quality data to support &quot;drain free&quot; breast surgery</td>
</tr>
<tr>
<td><strong>Patient focussed</strong></td>
<td></td>
</tr>
<tr>
<td>• Family support</td>
<td>• Better education of BCNs</td>
</tr>
<tr>
<td>• Patient expectation</td>
<td>• Improving resourcing for day case surgery</td>
</tr>
<tr>
<td><strong>Staff focussed</strong></td>
<td></td>
</tr>
<tr>
<td>• Medical staffs attitude to 23 hours</td>
<td></td>
</tr>
<tr>
<td>• Elderly Patients</td>
<td></td>
</tr>
<tr>
<td>• CNS enthusiasm</td>
<td></td>
</tr>
<tr>
<td>• Some consultants using drains routinely</td>
<td></td>
</tr>
</tbody>
</table>
The patient pathway for day surgery

Dr Anna Lipp
Past-President British Association Day Surgery
Overview of the day case pathway

- GP referral for procedure
- Surgical OPA
- Pre op assessment
- Admission
- Surgery
- Discharge
- Recovery at home
Overview

- Pathway from primary care referral to discharge home
- Fitness for referral
- Pre op assessment
- On the day
- Discharge
- Measuring success
- Process
- Patient outcomes
- Day surgery rates
Primary care referral

- Is this procedure suitable for Day surgery management?
- Is this patient potentially suitable to be a day case?
- Is this patient fit to refer for surgery now?
Fitness for referral

- Successful day surgery depends on careful patient preparation starting in primary care
- Many patients have elective procedures delayed due to pre-existing medical problems \(^1\)
  - BP uncontrolled
  - AF uncontrolled
  - Diabetes poorly controlled
  - Anaemia
- Primary Care referrer should check and optimise patients condition at time of initial referral
  - 1. NHS Midlands and East Report- Improving the pathway for planned care
     Feb 2013
"Primary care should provide blood pressure readings and document any appropriate action in non-urgent surgical referrals."

BP >180/110 refer back to GP for assessment of their blood pressures and if necessary control of their blood pressure to less than 160/100.

BP >140/90 < 180/110 inform GP but no reason to postpone surgery.
AAGBI Guidelines management peri-operative diabetes 2015

- "Glycaemic control should be checked at the time of referral for surgery"
- HbA1c should be < 69 mmol.mol\(^{-1}\) in the previous three months.
- If HbA1c ≥ 69 mmol.mol\(^{-1}\), elective surgery should be delayed while control is improved
Management of anaemia in pre op patients

- Ensure Hb checked at time of elective surgery referral
- If Hb < 12/13, GP responsible for investigating cause and starting treatment
- If Hb not improved with oral iron, intravenous iron to be available for pre op patients
- For non iron deficient anaemias EPO should be available
Surgical OPA

- Surgeon confirms day case management intention
  - Default suitable procedures to day case intention
    - Date for surgery ideal
- Triage
  - Fitness to proceed confirmed
    - BP
    - HbA1C
  - One stop assessment if suitable
  - Type and timing of further assessment planned
Pre operative assessment

- Plan appointment at time and place convenient and appropriate for the patient
  - Telephone
  - Face to face with nurse
  - Nurse plus anaesthetist plus other specialist
  - Discuss arrangements from admission to discharge home
  - Identify potential problems and address early
    - OT involvement
    - Medication
    - Analgesia
Pre operative assessment

• Nurse led
  – Standard protocol for all
  – Centralised team
    Day case and in-patient specialists
• Protocols to standardise management common conditions eg diabetes, anticoagulation
• Guidelines to determine suitability
“Fitness for day surgery procedure should relate to the patient’s health as determined at pre-operative preparation and not be limited by arbitrary limits such as ASA status, age or BMI”

- Aldwinckle R, Montgomery J. Unplanned admission rates and post discharge complications in patients over the age of 70 following day case surgery. *Anaesthesia* 2004;59:57-9
Pre op Patient Advice Leaflet

Norfolk and Norwich University Hospital NHS Trust

Day Procedure Unit

Pain relief after a surgical procedure

We hope the advice in this leaflet will help you:

- Choose which pain killers to buy before you come into hospital for your operation.
- Know how to take your tablets most effectively.
- Know what side effects to look out for.

Most people will experience pain after an operation. This can usually be relieved by a combination of simple measures and pain relieving tablets. This leaflet will explain what measures you can take to help relieve pain after your operation.

- Relax. Pain is reduced when you are relaxed and distracted. Reading in a comfortable chair, watching TV, listening to music or reading is helpful.
- Take pain killers. Simple pain killers that can be bought from pharmacies or supermarkets are effective. They should be taken before pain becomes too severe and repeated regularly. If one type of pain killer does not work, e.g. paracetamol, a different type such as ibuprofen can be taken as well. This combination is more effective than either tablet alone.

Before you come to hospital please buy some pain relief

- Which tablets should you buy?

For minor operations paracetamol or ibuprofen will probably be adequate. For other operations, the anaesthetic and liaison nurse will provide stronger pain relief. These can be purchased from your pharmacy or supermarket. When you purchase your tablets remember to tell the pharmacist if you:

- Are already taking any pain relief medication.
- Have any allergies.
- Cannot take some types of pain relief medication.
- Are asthmatic.
- Have a history of bad indigestion or stomach ulcers.

When you come to hospital please bring your pain killers with you.

When you come for your operation please bring your tablets with you in the original packet including the information leaflet. We will provide a bag for you to put all your medication in.
Stock up before your op

Make sure you have a good supply of painkillers before you come into hospital for your operation. When you go home you will need to take these painkillers regularly until you are comfortable.

Painkillers such as paracetamol and ibuprofen can be bought from supermarkets and pharmacies. The hospital will not supply painkillers to use at home that are available without prescription.

Please read the leaflet “Pain relief after your operation” and follow the instructions carefully.
Patients providing own analgesia

Patients given leaflet in POA

Asked to buy paracetamol and ibuprofen if appropriate.

Bring unopened boxes

Bag provided to bring all medication
Admission

• Dedicated day surgery facility best quality environment
• Details of admission clarified at POA
  • Written details
  • Text reminder
• Limit fasting and waiting times
  – Stagger admission times
  – Single admission area close to theatre
• Enable walking to theatre where possible
Planning the list

- “Smart” list order
  - Consider recovery times / diabetics first/very young or old
- Walking to theatre
  - Patients and staff prefer it
  - Review need for pre-op interventions that prevent walking
Surgery and anaesthesia

- Appropriate surgical and anaesthetic technique for rapid recovery
- Plan for recovery management
- Discharge criteria specified
- Documentation completed in theatre
Recovery

• Protocols for pain and PONV with standard management
• Pre printed analgesia and anti emetic prescriptions
• Criteria led discharge to second stage
Pain Management Protocol

Start
Assess Pain score on movement

Pain score 0
No pain
Reassess with next observations

Pain score 1
Mild pain
Reassess with next observations

Pain score 2
Moderate pain
Give oral analgesia

Pain score 3
Severe Pain
Assess sedation score
Score <3 give fentanyl 25mcg +/- NSAID /antiemetic Go back to start
Score 3 Check resp rate <8 give o2 call for help
Reassess with next observations
Patient Discharge

• Plan from initial referral and at pre op assessment
• TTOs, patient supplied or pre-prepared
• Nurse led discharge
  – Appropriate for any length of stay
  – Specify criteria
Patient support after surgery

- Need for transport home and carer afterwards must be explained
- Not all patients will need carer for 24 hrs*
  - Depends on surgery and risk of complications
  - Patients circumstances
  - Availability of support if needed
- 24 hour access to skilled advice
  - * RCA GPAS Day Surgery Services 2014
Post discharge contacts

- Patients must be given contact number for 24 hour access skilled advice
  - Should be specialty specific
- A&E or primary care not usually appropriate
- Supported by written information
Day Procedure Unit

Discharge Advice after any Laparoscopic Procedure

You can expect some swelling or bruising at the wound site(s) this is not unusual and there will be some discomfort and tenderness where the incision(s) have been made.

If however you experience any of the following problems within the first week you should seek medical advice.

- Increased abdominal pain, redness, swelling or discharge of the wound(s).
- Persistent bleeding from the wound(s).
- Difficulty in passing urine.
- High temperature.
- Nausea or vomiting.

If any of these occur or you need advice please contact the Day Procedure Unit on **(01603) 286008** during daytime – Monday – Saturday until 8pm or the General Surgical On-call Registrar via the hospital switchboard on **(01603) 286286** after 8pm or on Sunday. If your operation was for a gynaecological reason please contact the Arthur South Day Procedure Unit on 01603 286 008 until 8pm Monday to Saturday or after hours Cley Ward on 01603 286 286 ext 3242. Alternatively you may be able to see your General Practitioner.

Issued Oct 2010
Reviewed A. Lipp, G.Raje, H. Ball, J. Forder, K. Betts January 2013
Review Date: January 2015
Measuring outcomes in the patient pathway

Quality vs quantity
## Process measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Booking:</td>
<td>DNAs, utilisation</td>
</tr>
<tr>
<td>POA:</td>
<td>CAA/DNAs</td>
</tr>
<tr>
<td>Admission:</td>
<td>start times</td>
</tr>
<tr>
<td>Anaesthesia:</td>
<td>admission rates/post-op symptoms</td>
</tr>
<tr>
<td>Surgery:</td>
<td>admission rates/post-op symptoms</td>
</tr>
<tr>
<td>Recovery:</td>
<td>discharge times/admission rates/post-op symptoms</td>
</tr>
<tr>
<td>Discharge:</td>
<td>unplanned contact</td>
</tr>
<tr>
<td>Follow-up:</td>
<td>unplanned contact</td>
</tr>
</tbody>
</table>
Patient Outcomes

Cancellations
- Target 5%?

Unplanned Admission
- Target 2%

Symptoms after discharge
- Target <5% severe pain

Patient satisfaction
- Target 85%
Are Day Surgery Rates as high as they could be?

Are you achieving the day case rates specified in the BADS Directory of Procedures?"

Which procedures meet these targets and which require improvements?“

How do you find out?
BADS Directory of Procedures

BADS DIRECTORY of PROCEDURES
Fifth Edition

BADS DIRECTORY of PROCEDURES
National Dataset Calendar Year 2015
# Specialty target rates in BADS Directory

## Breast Surgery

<table>
<thead>
<tr>
<th>Description</th>
<th>Procedure Room</th>
<th>Zero night stay</th>
<th>One night stay</th>
<th>Two night stay</th>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excision/biopsy of breast tissue including wire guided</td>
<td>95</td>
<td>5</td>
<td></td>
<td>B28.3</td>
<td>B28.7</td>
<td>B28.9</td>
</tr>
<tr>
<td>Wide local excision of breast (including Wire Guided)</td>
<td>95</td>
<td>5</td>
<td></td>
<td>B28.1</td>
<td>B28.2</td>
<td>B28.5</td>
</tr>
<tr>
<td>Excision of accessory breast tissue</td>
<td>99</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excision of breast with sentinel lymph node biopsy, axillary sample or axillary clearance</td>
<td>95</td>
<td>5</td>
<td></td>
<td>B28.1 + (T87.3, AND 014.2 OR T85.2)</td>
<td>B28.3 + (T87.3 AND 014.2 OR T85.2)</td>
<td>B28.4 + (T87.3 AND 014.2 OR T85.2)</td>
</tr>
<tr>
<td>Re excision of margins</td>
<td>99</td>
<td>1</td>
<td></td>
<td>B28.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple mastectomy (without axillary surgery)</td>
<td>50</td>
<td>50</td>
<td></td>
<td>B27.4</td>
<td>B27.5</td>
<td>B27.6</td>
</tr>
<tr>
<td>Simple mastectomy with axillary surgery</td>
<td>50</td>
<td>50</td>
<td></td>
<td>B27.4 + (T87.3, AND 014.2 OR T85.2)</td>
<td>B27.5 + (T87.3 AND 014.2 OR T85.2)</td>
<td>B27.6 + (T87.3 AND 014.2 OR T85.2)</td>
</tr>
<tr>
<td>Sentinel lymph node biopsy/ Axillary sample/Axillary clearance</td>
<td>95</td>
<td>5</td>
<td></td>
<td>T87.3 +014.2</td>
<td>T86.2</td>
<td>T85.2</td>
</tr>
<tr>
<td>Microdochotomy + other operations on duct of breast</td>
<td>99</td>
<td>1</td>
<td></td>
<td>B34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removal of breast prosthesis</td>
<td>99</td>
<td>1</td>
<td></td>
<td>B30.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operations on nipple</td>
<td>100</td>
<td></td>
<td></td>
<td>B35</td>
<td>B36.1</td>
<td>B36.4</td>
</tr>
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</table>
### Actual Day surgery rates by Procedure 2015 Dataset

#### BREAST SURGERY

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CURRENT NATIONAL PERFORMANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Top 5%</td>
</tr>
<tr>
<td>Excision/biopsy of breast tissue including wire guided</td>
<td>100%</td>
</tr>
<tr>
<td>Wide local excision of breast (including wire guided)</td>
<td>93%</td>
</tr>
<tr>
<td>Excision of accessory breast tissue</td>
<td>100%</td>
</tr>
<tr>
<td>Excision of breast with sentinel lymph node biopsy, axillary sample or axillary clearance</td>
<td>84%</td>
</tr>
<tr>
<td>Re-excision of margins</td>
<td>100%</td>
</tr>
<tr>
<td>Simple mastectomy (without axillary surgery)</td>
<td>44%</td>
</tr>
<tr>
<td>Simple mastectomy with axillary surgery</td>
<td>42%</td>
</tr>
<tr>
<td>Sentinel lymph node biopsy/axillary sample/axillary clearance</td>
<td>58%</td>
</tr>
<tr>
<td>Microdochotomy + other operations on duct of breast</td>
<td>100%</td>
</tr>
<tr>
<td>Removal of breast prosthesis</td>
<td>100%</td>
</tr>
<tr>
<td>Operations on nipple</td>
<td>100%</td>
</tr>
</tbody>
</table>
NHS Better Care, Better Value Indicators (incorporating Opportunity Locator)

Better Care Better Value indicators identify potential areas for improvement in efficiency which may include commissioners re-designing and shifting services away from the traditional setting of the hospital and out towards community based care.

The tool should prompt you to start thinking of "how" and "why" your organisation might differ from others and to support commissioning priorities for health communities. The opportunity is indicative only and local health communities should interpret it taking into account local knowledge.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest Value</th>
<th>Financial Opportunity</th>
<th>Volume Opportunity</th>
<th>Rank</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing First Follow Up</td>
<td>1.97</td>
<td>£272.8M</td>
<td>2,818M</td>
<td>1</td>
<td>Clinical</td>
</tr>
<tr>
<td>Reducing Length of Stay</td>
<td>13.91</td>
<td>£231.1M</td>
<td>1,145M</td>
<td>1</td>
<td>Clinical</td>
</tr>
<tr>
<td>Emergency Readmission (14 day)</td>
<td>5.40</td>
<td>£101.7M</td>
<td>95,390</td>
<td>1</td>
<td>Clinical</td>
</tr>
<tr>
<td>Outpatient Appointment DNA</td>
<td>8.64 (DNA %)</td>
<td>£89.7M</td>
<td>660,382</td>
<td>1</td>
<td>Clinical</td>
</tr>
<tr>
<td>Pre Procedure Non Elective Bed Days</td>
<td>1.80</td>
<td>£54.7M</td>
<td>268,266</td>
<td>1</td>
<td>Clinical</td>
</tr>
<tr>
<td>Increasing Day Surgery Rates</td>
<td>78.72 (Daycase Rate (%))</td>
<td>£14.3M</td>
<td>38,599</td>
<td>1</td>
<td>Clinical</td>
</tr>
</tbody>
</table>
NHS Better Care, Better Value Indicators (incorporating Opportunity Locator)

Select organisation: National

National

Dashboard > Increasing Day Surgery Rates

<table>
<thead>
<tr>
<th>Daycase Rate (%)</th>
<th>78.12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity</td>
<td>£15,468,277</td>
</tr>
<tr>
<td>Volume Opportunity</td>
<td>41,707</td>
</tr>
<tr>
<td>Rank</td>
<td>1</td>
</tr>
</tbody>
</table>

Download this list in CSV format
Norfolk and Norwich University Hospitals NHS Foundation Trust

Dashboard > Increasing Day Surgery Rates

<table>
<thead>
<tr>
<th>Daycase Rate (%)</th>
<th>77.77</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity</td>
<td>£137,411</td>
</tr>
<tr>
<td>Volume Opportunity</td>
<td>391</td>
</tr>
<tr>
<td>Rank</td>
<td>86</td>
</tr>
</tbody>
</table>

Peer Group Selection

Sign in to manage and select your own custom peer groups.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Price</th>
<th>Location</th>
<th>Qty</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>varicose veins (VNUS)</td>
<td>100.00</td>
<td></td>
<td>1</td>
<td>100.00</td>
</tr>
<tr>
<td>Removal of internal fixation</td>
<td>85.33</td>
<td></td>
<td>33</td>
<td>2815.49</td>
</tr>
<tr>
<td>from bone/joint, excluding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K-wires</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removal of ventilation device</td>
<td>100.00</td>
<td></td>
<td>1</td>
<td>100.00</td>
</tr>
<tr>
<td>Repair of recurrent inguinal hernia</td>
<td>90.00</td>
<td></td>
<td>14</td>
<td>1260.00</td>
</tr>
<tr>
<td>hernia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repair of umbilical hernia</td>
<td>85.11</td>
<td></td>
<td>38</td>
<td>3238.88</td>
</tr>
<tr>
<td>Resection of prostate by laser</td>
<td>67.86</td>
<td></td>
<td>3</td>
<td>203.58</td>
</tr>
<tr>
<td>Septorhinoplasty + graft implant</td>
<td>100.00</td>
<td></td>
<td>1</td>
<td>100.00</td>
</tr>
<tr>
<td>Simple mastectomy (with and without axillary surgery)</td>
<td>32.14</td>
<td></td>
<td>17</td>
<td>546.38</td>
</tr>
<tr>
<td>Submucous resection of nasal septum</td>
<td>100.00</td>
<td></td>
<td>1</td>
<td>100.00</td>
</tr>
</tbody>
</table>
Norfolk and Norwich University Hospitals NHS Foundation Trust

Dashboard > Increasing Day Surgery Rates > Simple mastectomy (with and without axillary surgery)

Daycase Rate (%) 12.14

<table>
<thead>
<tr>
<th>Component</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity</td>
<td>6</td>
</tr>
<tr>
<td>Volume Opportunity</td>
<td>0</td>
</tr>
<tr>
<td>Rank</td>
<td>17</td>
</tr>
</tbody>
</table>

Increasing Day Surgery Rates - Simple mastectomy (with and without axillary surgery)

Peer Group Selection

**Sign In** to manage and select your own custom peer groups.
Summary

- Plan pathway at every stage to ensure intended day surgery management
- Evaluate process to ensure high quality
- Measure day case rates by procedure against national targets
- Monitor day case rates against peers
Questions
BREAST SURGERY AS DAY SURGERY: COMMON PITFALLS IN DEVELOPING AND SETTING UP SERVICE

ANY DATA OR CONTENTS FROM THIS PRESENTATION SHOULD BE USED WITH PERMISSION FROM JO MARSDEN
JO.MARSDEN@NHS.NET

Jo Marsden,
Consultant Breast Surgeon,
Kings College Hospital NHS Foundation Trust,
London
WHY IS THERE VARIATION IN SAME DAY SURGERY RATES NATIONALLY (including the LCA/ RM Partners)?

Health professional misperceptions
- It is unacceptable to patients, families and carers
- It fails to provide post-operative physical or psychological support
- It is unsafe to stop using wound drains
- There are too many organisational challenges

Reality
- Day surgery audit and patient feedback is favourable
- Wound drains can be avoided safely
- The process for change doesn’t have to be complex
- Unrecognised lack of confidence to make change
DEVELOPING A SAME DAY PATHWAY FOR NON-RECONSTRUCTIVE BREAST CANCER SURGERY

- Most breast units where the pathway has been implemented successfully have used the following methodology
  - Process Mapping (map the surgical pathway)
    - Cancer Services Collaborative Improvement Partnership (CSCIP)
  - Plan Do Study and Act (PDSA) cycles (NHS Modernisation Pathway)
MAPPING THE SURGICAL PATHWAY

- Identify of points in the in-patient surgical admission journey that can be adapted to design a same day / overnight stay pathway

[Diagram showing the surgical pathway with phases such as pre-assessment, pre-admission, and post-operative care, including points like diagnosis, nurse-led pre-assessment, ward admission, theatre, post-op in-patient stay, and doctor-led discharge after drain removal.]
PLAN DO STUDY AND ACT (PDSA) CYCLES

Once the pathway has been adapted don’t change service ‘overnight’

- Test service team involvement and collect data to assess its impact
- If benefit is shown you have evidence to support and implement further change

MODEL FOR IMPROVEMENT

What are we trying to accomplish?

How will we know if a change is an improvement?

What changes will result in improvement?

DO

Carry out the change. Collect data and begin analysis

STUDY

Compare data to predictions. What has been learned?

ACT

Plan the next cycle. Can the change be implemented?

PLAN

What are the outcomes and questions to be asked? Collect data
DEVELOPMENT OF THE SAME DAY PATHWAY AT KINGS

• Change was achieved without incurring financial cost
  – It’s not expensive

• Lead by breast unit surgeon and CNS
  – There needs to be ‘ownership’

• Service developed over time
  – Change doesn’t happen overnight
  – Successful implementation requires ongoing assessment and audit
<table>
<thead>
<tr>
<th>Change to service</th>
<th>Assessment of service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>March 2006</strong></td>
<td>6 month audit (PDSA)</td>
</tr>
<tr>
<td>Same day discharge introduced</td>
<td>• 44% patients had same day discharge</td>
</tr>
<tr>
<td>Initially one half day list on alternate weeks</td>
<td>• Reasons for not having day / overnight stay</td>
</tr>
<tr>
<td></td>
<td>− Lack of day surgery lists (26%)</td>
</tr>
<tr>
<td></td>
<td>− No overnight-stay facility (17%)</td>
</tr>
<tr>
<td></td>
<td>• No emergency re-admissions</td>
</tr>
<tr>
<td></td>
<td>• Patients deferred surgery until day list available</td>
</tr>
<tr>
<td><strong>Nov 2006 to March 2007</strong></td>
<td></td>
</tr>
<tr>
<td>Commenced weekly all day list in DSU</td>
<td></td>
</tr>
<tr>
<td>Overnight stay pathway started</td>
<td></td>
</tr>
<tr>
<td><strong>Jan 2007 to Jan 2008</strong></td>
<td><strong>Focus groups (with Breast Cancer Care) to assess patient and carer support and information needs</strong></td>
</tr>
<tr>
<td>Revision of patient information and support</td>
<td></td>
</tr>
<tr>
<td><strong>March 2006 to date</strong></td>
<td><strong>Patient feedback (CNS telephone follow-up, PREMs)</strong></td>
</tr>
<tr>
<td>Revision of patient information and service performance</td>
<td>5 and 10-year outcomes audit</td>
</tr>
</tbody>
</table>
KBC 10-YEAR NON-RECONSTRUCTIVE BREAST SURGERY AUDIT
(March 2006 to end February 2016; N=1586 patients for N=1892 admissions)

Same day discharge rates increased as clinical confidence grew
- It is unrealistic to expect high day surgery rates as soon as the pathway is changed
- Change will not happen overnight

Duration of stay by year of diagnosis
(as percentage of admissions)
UNPLANNED IN-PATIENT ADMISSION FROM DAY SURGERY

- There is no national standard for unplanned in-patient admission rates
- Unplanned in-patient admissions are a measure of:
  - Effectiveness of pre-assessment
  - Efficient planning of theatre lists

Annual unplanned admissions (as a percentage of annual procedures):
King’s Breast Care March 2006 to end Feb 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Unplanned</th>
<th>Undocumented</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2015</td>
<td>1.7</td>
<td>0</td>
</tr>
<tr>
<td>2014</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>2013</td>
<td>2.7</td>
<td>1.8</td>
</tr>
<tr>
<td>2012</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>2011</td>
<td>1.9</td>
<td>3.4</td>
</tr>
<tr>
<td>2010</td>
<td>1.2</td>
<td>1.8</td>
</tr>
<tr>
<td>2009</td>
<td>1.1</td>
<td>0.6</td>
</tr>
<tr>
<td>2008</td>
<td>0.8</td>
<td>1.5</td>
</tr>
<tr>
<td>2007</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2006</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Total unplanned N=25/1892 (1.3%)  Total undocumented N=22/1892 (1.2%)
COMMON MISPERCEPTIONS
RE-ADMISSION RATES FOR COMPLICATIONS ARE NOT HIGH

King’s Breast care (March 2006 to end Feb 2016)
• In-patient re-admission rate within 30 days 0.6% (N=10)
• Median length of stay 5 (range 2 to 11 days)
• Most complications are now managed safely without in-patient admission
  – Via day surgery or in the breast clinic

NHS Improvement audit (2012)
• Mean in-patient re-admission rate following same day or overnight stay of 2%

NHS Improvement Audit (2012): Percentage re-admission with complications

- Haematoma Mastectomy: 5.6%
- Haematoma Other: 1.6%
- Wound Dehiscence Mastectomy: 0.3%
- Wound Dehiscence Other: 0.6%
- Skin Necrosis Mastectomy: 0.3%
- Skin Necrosis Other: 0.1%
- Systemic Complications Mastectomy: 0.8%
- Systemic Complications Other: 0.4%
COMMON MISPERCEPTIONS
MORE COMPLEX SURGERY DOES NOT REQUIRE A LONGER LENGTH OF STAY

- Overall the trend is for a similar duration of stay (i.e. same day discharge) irrespective of non-reconstructive surgical procedure
- Rates of same day discharge increase for all procedures over time as clinical confidence grows

Non-reconstructive surgery procedure and same day discharge rates (%)
Kings Breast Care

- Sentinel Lymph Node Biopsy
- Axillary Clearance
- Breast conserving surgery + any axillary surgery
- Mastectomy + any axillary surgery
COMMON MISPERCEPTIONS
BILATERAL PROCEDURES ARE SAFE FOR SAME DAY DISCHARGE

- Patient selection for same day discharge should be based on medical and social criteria and *not* surgical procedure
- 83% (25/30) of bilateral surgeries went home on the same day (median age 60 years)

<table>
<thead>
<tr>
<th>All Bilateral Procedures: March 2006 to end Feb 2016 (N=30)</th>
<th>N</th>
<th>Age or median age (range)</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLNB + SLNB</td>
<td>5</td>
<td>49 (39-70)</td>
<td>0,0,0,0,0</td>
</tr>
<tr>
<td>Mastectomy + Wide excision / re-excision</td>
<td>3</td>
<td>77 (79-83)</td>
<td>0,0,1</td>
</tr>
<tr>
<td>Mastectomy + Mastectomy and ANC</td>
<td>7</td>
<td>51 (40-71)</td>
<td>0,0,0,0,0,0,1</td>
</tr>
<tr>
<td>Mastectomy + Mastectomy</td>
<td>4</td>
<td>56 (46-80)</td>
<td>0,0,0,1</td>
</tr>
<tr>
<td>Mastectomy + SLNB + Mastectomy + SLNB</td>
<td>1</td>
<td>78</td>
<td>0</td>
</tr>
<tr>
<td>Mastectomy + Removal of implant</td>
<td>1</td>
<td>67</td>
<td>0</td>
</tr>
<tr>
<td>Mastectomy + Localised wide excision</td>
<td>1</td>
<td>53</td>
<td>0</td>
</tr>
<tr>
<td>Mastectomy + Axillary dissection</td>
<td>1</td>
<td>85</td>
<td>0</td>
</tr>
<tr>
<td>Mastectomy + Mastectomy + SLNB</td>
<td>1</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>Wide local excision + Localised wide excision</td>
<td>1</td>
<td>74</td>
<td>0</td>
</tr>
<tr>
<td>Axillary dissection + Re-excision of WLE</td>
<td>1</td>
<td>74</td>
<td>0</td>
</tr>
<tr>
<td>Diagnostic localised excision + Sentinel node biopsy</td>
<td>1</td>
<td>54</td>
<td>0</td>
</tr>
<tr>
<td>Wide excision + ANC + Localised excision + ANC</td>
<td>1</td>
<td>42</td>
<td>3</td>
</tr>
<tr>
<td>Localised excision + SLNB + Local excision</td>
<td>2</td>
<td>51, 60</td>
<td>0,2</td>
</tr>
</tbody>
</table>
COMMON MISPERCEPTIONS
OLDER PATIENTS CAN BE DISCHARGED ON THE DAY OF SURGERY

- Patient selection for same day discharge should be based on medical and social criteria and *not* chronological age
COMMON MISPERCEPTIONS
POOR PROGNOSIS DISEASE DOES NOT REQUIRE LONGER ADMISSION

- Patient selection for same day discharge should be based on medical and social criteria and **not** breast cancer prognosis.

NPI and duration of stay at King’s Breast Care as a percentage of all admissions:

<table>
<thead>
<tr>
<th>Prognostic Group</th>
<th>Same day</th>
<th>Overnight</th>
<th>&gt; Overnight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>89%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Good</td>
<td>94%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Moderate Group 1</td>
<td>87%</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>Moderate Group 2</td>
<td>88%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Poor</td>
<td>84%</td>
<td>7%</td>
<td>9%</td>
</tr>
</tbody>
</table>
PATIENT EXPERIENCE
KING’S BREAST CARE

King’s Breast Care initiatives to assess quality of care and patient experience

- **Patient focus groups** (conducted by Breast Cancer Care, 2008)

- **Breast CNS post-operative telephone follow-up** (2006 to date)
  - Undertaken the day following discharge (present data 74% [1176/1592] women)
    - Questions about general well-being
    - Questions to identify potential early complications of surgery
    - It is also a care-plan

- **Pre and post-operative PREMs** (June 2012 to date)
  - Pre-admission clinic the day before surgery
  - Results clinic one week after discharge
### PATIENT EXPERIENCE

**KING’S FOCUS GROUP FINDINGS**

**Key issues identified for successful service planning and implementation**

- The importance of clarity of information for patients and carers about knowing what to expect in the first few days after discharge (aligning expectations)
- Patients don’t like having wound drains

**Patient support for day surgery was unanimous**

- All patients said they would have it again and it provided an early psychological boost
- Continuity of day surgery staff valued highly
- Important for carers to be at home on the day of discharge and for a few days after
- Knowing what to expect after discharge reduced patient and carer anxiety

**In-patient care was not deemed to be superior**

- Dissatisfaction with hospital environment
- Lack of continuity of nursing staff and specialist nursing care

**Wound management**

- Relief at not having a drain or seroma aspiration after drain removal
- Patients with drains found them inconvenient and uncomfortable – they didn’t like having wound drains
BREAST CNS POST-DISCHARGE TELEPHONE FOLLOW-UP
GENERAL WELL-BEING AFTER DISCHARGE

- Well-being does not appear to be affected by increasing complexity of surgery
- The main reasons for not going out were no need to, bad weather or felt too tired
BREAST CNS POST-DISCHARGE TELEPHONE FOLLOW-UP
WOUND MANAGEMENT

• 94% of patients had checked their wounds since discharge
  – The remainder had asked family or carers to check for them
• All were able to describe symptoms as informed pre-operatively what to look for and telephone questionnaire prompts response

Question: Have you noticed any of following changes with your wound(s)?
CNS POST-OPERATIVE TELEPHONE FOLLOW-UP
POST-OPERATIVE PAIN

- Median pain score 3 (range 0-10)
- 18% experienced pain, the rest (82%) described aching
- 22% of patients did not require *any* post operative analgesia following discharge
- 91% improved with use of simple analgesia prescribed from DSU prior to discharge

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Median pain score (range)</th>
<th>Proportion who had taken analgesia since discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentinel node biopsy</td>
<td>2 (0-6)</td>
<td>68%</td>
</tr>
<tr>
<td>Any breast conserving surgery</td>
<td>3 (0-10)</td>
<td>75%</td>
</tr>
<tr>
<td>Simple mastectomy</td>
<td>4 (1-6)</td>
<td>80%</td>
</tr>
<tr>
<td>Any breast conserving surgery and sentinel node biopsy</td>
<td>2 (0-10)</td>
<td>80%</td>
</tr>
<tr>
<td>Mastectomy and sentinel lymph node biopsy</td>
<td>2 (0-9)</td>
<td>90%</td>
</tr>
<tr>
<td>Axillary clearance</td>
<td>4 (0-9)</td>
<td>84%</td>
</tr>
<tr>
<td>An breast conserving surgery and axillary clearance</td>
<td>3 (0-8)</td>
<td>79%</td>
</tr>
<tr>
<td>Mastectomy and axillary clearance</td>
<td>2 (0-7)</td>
<td>83%</td>
</tr>
<tr>
<td>Any bilateral surgery</td>
<td>3 (0-5)</td>
<td>45%</td>
</tr>
</tbody>
</table>
BREAST CNS POST-DISCHARGE TELEPHONE FOLLOW-UP POST-OPERATIVE EXERCISES

• Most patients (80%) had commenced their exercises the day after discharge

• Commonest reasons for not doing
  – Not had time
  – Didn’t think they were necessary

• Women who did not receive post-operative telephone call reported more difficulty performing their post-operative arm exercises
  – More likely to report pain as a reason for not doing so
  – More likely not to have taken any analgesia post-operatively

• CNS call acts as a prompt to commence exercises and take analgesia
Early discharge does not substantially increase post-operative surgical or nursing workload.

Overall 4.8% of patients required appointments in addition to their planned care:
- CNS initiated 36%, patient initiated 13%, not classified 51%
DAY SURGERY PREM
(Results from October 2012 to end October 2014)

- High perception of quality of information provided by KBC clinical staff (consultants and CNS)
- Reflects the importance of continuity of information from a small number of permanent staff familiar with breast cancer and management pathways

Q: Did you receive clear and helpful information about....
DAY SURGERY PREM
(Results from October 2012 to end October 2014)

- Variation in the perception of the quality of information provided via pre-assessment clinics
- Likely reflects high turnover of clinic staff with variable experience

Q: Did you receive clear and helpful information about....

- Anaesthetic?
- Wound care?
- Pain killers?
- What to tell others about your operation?
- Post-operative exercises?
- Who to contact if post-operative concerns?
Information provided pre-operatively met needs of patients and their family and carers post-operatively but this could be improved.
THE NHS IMPROVEMENT TRANSFORMING INPATIENT CARE PROGRAMME

The NHS Improvement Transforming Inpatient Care Programme (2011-2012)

- Supported Trusts in 13 cancer networks to implement same day / overnight stay
- Audited practice over 6 months of initiating this pathway
  - Data submitted on 2,087 patients (mastectomy N=666, other N=1421)

Key findings

- Use of wound drains
  - There was a move away from their routine use
- Pain control
  - For most patients, paracetamol alone was sufficient
- Arm and shoulder exercises
  - There was a move to patient education pre-operatively rather than after surgery
- Delays in discharge
  - Were usually due to a failure to follow the agreed surgical pathway
WOUND DRAINS AND OUT-PATIENT SEROMA ASPIRATION

• Omitting drains
  – Simplifies management without impacting adversely on recovery
  – Enables same day discharge
  – Promotes increased activity and early mobility
  – Makes it easier to wear a bra post-operatively

• Using drains (early removal or discharge with drain in situ)
  – Increased risk of post-operative pain and infection
  – Timing of removal has no effect on time to seroma resolution
  – Patient concern about drain management at home
  – Median duration of in-patient admission 4 (range 3 – 8) days
OUT-PATIENT SEROMA ASPIRATION

- NHS Improvement audit showed a higher incidence of seroma aspiration if wound drains were used

- Seroma aspiration can be avoided
  - Consider this a side effect and not a complication of surgery
  - Counsel patients swelling is common, the volume varies and it resolves with time
  - It is very unusual for a seroma to be painful
THE NHS IMPROVEMENT TRANSFORMING INPATIENT CARE PROGRAMME
PATIENT EXPERIENCE

1. Conducted an audit using selected questions from the NCPES
   - Responses from over 2,000 patients showed more than 90%:
     • felt involved in decisions about their care and adequately informed about their breast cancer and treatment
     • knew who to contact following discharge if they had any concerns

2. Focus group feedback (Health Experiences Research Group, University of Oxford)
   - Demonstrated positive feedback once patients, family and carers understood this was driven by improving service and not cost-cutting
   - Experience was undermined if hospital staff seemed critical of short stay

3. Captured patient experience on video
ADOPTING A DAY SURGERY APPROACH WILL IMPROVE PATIENT EXPERIENCE

In-patient Admission

- Need to confirm bed on day of admission
- Discharge planning starts when admitted
- Support during admission is ad hoc
- Ward changes during admission
- Lack of continuity of nursing staff and doctors
- Hospital is not restful or private
- Discharge uncertainty (ward rounds, TTOs)
- Drains – timing of removal
- Increased analgesia use (adoption of sick role)

Same Day Discharge

- No need to confirm bed
- Discharge planning starts at pre-assessment
- ‘Protected’ time pre and post op to see CNS
- On the same ward pre and post op
- Continuity of nursing staff and doctors
- Patient has control of their environment
- Controlled discharge, pre-prescribed TTOs
- Discharge can be breast CNS led
- At home routine is maintained – less analgesia
QUALITY OF CARE: PATIENT EXPERIENCE
“HOME BY HALF-PAST THREE”
### Breast Cancer Day Surgery - Post-op Telephone Questionnaire

**Name:**
**Hospital Number:**
**Date of surgery:**
**Date contacted:**
**Age:**
**Operation:**

#### Since your discharge home

1. **Have you had someone with you?**
   - Yes □ No □

2. **If you have had someone at home, have they had worries about helping you?**
   - Yes □ No □
   **If YES: what have they been worried about?**

3. **Have you been out of the house?**
   - Yes □ No □
   **If NO: what has stopped you?**

4. **Have you been able to eat and drink?**
   - Yes □ No □
   **If NO: what has stopped you?**

5. **Have you been sleeping well?**
   - Yes □ No □
   **If NO: why was it difficult to sleep?**

#### Your operation site

1. **Have you had pain?**
   - Yes □ No □

2. **Have you had aching?**
   - Yes □ No □

3. **How would you describe this on a scale of 1-10?**

4. **Have you taken pain relief today?**
   - Yes □ No □
   **If YES: has this helped?**

5. **Have you looked at your wounds today?**
   - Yes □ No □
   **Have you noticed any of the following?**
   - Bruising □
   - Redness □
   - Swelling □
   - If you have swelling is this painful? □
   - Discharge □
   - Altered sensation in the arm / breast? □

6. **Have you started your shoulder and arm exercises?**
   - Yes □ No □
   **If NO: what has made it difficult for you?**

#### Follow-up

7. **Would you like your breast care nurse:**
   - To call you later in the week? □
   - To arrange a clinic appointment for you? □

8. **For the CNS only, does this patient:**
   - Need a further telephone check? □
   - Need to be reviewed in clinic? □

9. **Do you or the patient have any comments?**
   .................................................................
   .................................................................

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Revised Aug 2015
Questions
"Physiotherapy management of the Breast Cancer patient - from Pre-habilitation through to Survivorship"

Kat Tunnicliffe
Senior Physiotherapist
King’s College Hospital Breast Care Unit
Aims

- Physical side effects of treatment for Breast Cancer (BC)

- King’s Breast Physiotherapy Service & it’s support of the Breast MDT throughout Rx pathway

- Impact of NHS Improvement Transforming Inpatient Care (2011)

- Key management guidelines in absence of a specialist Breast Physiotherapy Service
Background

- Numerous studies have reported both short and long term reduction in quality of life both during and following Rx for BC
- 10-60% of women report some upper limb morbidity in 6 months - 5 years after breast cancer surgery
- The needs of BC patients vary significantly at different points of the Rx pathway
- 57% of cancer survivors reduce hours of work after diagnosis by >4hrs/week
- Physiotherapy exercise is significant in managing longer term side effects, helping people return to work, reducing recurrence following remission and increasing survival and quality of life

Hayes et al, (2012), *Cancer*, 118 (8)
Chopra & Kamal, (2012), *Health and Quality of Life Outcomes*, 10 (14)
Steiner et al (2008), *Psycho-Oncology*, 17(2)
Physiotherapy Management of BC

- Managing physical health expectations
- Manual therapy
- Muscle energy techniques
- Education
- Strengthening techniques
- Stretching techniques
- Improving diaphragmatic control to facilitate lymphatic flow & drainage
- Postural correction
- Acupuncture
- Taping
- Balance / Proprioception
- Exercise / Physical Activity prescription

- Specialist post graduate training required for the management of Cording, Oedema/Lymphatic drainage
Benefits of Physical Activity

- Improves fatigue
- Improves Cardiovascular System
- Helps maintain Strength & Function
- Immune System restores faster (Hb & WBCC)
- Improves Mood (& possibly Memory)
- Improves Sleep
- Lymphoedema management
- Increases Exercise Tolerance
- Decreases Risk of Osteoporosis
- Reduces the risk of BC recurrence
- Improves Body Composition
- Improves Body Composition

Sources:
- Courneya et al 2007; Courneya et al 2009; Kashyap et al 2000; McNeely et al 2006; Cramp & Daniel 2008; Cancer Research UK 2010
KCH Breast Physiotherapy Pathway

MDT Meeting attendance/Liaison

Pre-operative

Throughout Active Treatment

Survivorship

Pre-Operative Ax
(1:1)
Within 1/52

Post Operative F/U
(Group)
Every 4/52

Outpatient Service
(1:1)
Drop-in/Ad hoc

End of Rx Health & Wellbeing
Event
(Group)
Every 3/12
KCH Breast Physiotherapy Pathway Outcome Measures

- **At diagnosis**
  
  *QuickDASH*

- **Post-Operative (Group):**
  
  *Client satisfaction survey & QuickDASH*

- **Outpatient Physiotherapy Service:**
  
  *QuickDASH*

- **End Of Active Treatment Health & Wellbeing Event (HWBE)**
  
  *VAS rating confidence levels to statements regarding living well beyond Cancer, Friends & Family survey.*
The QuickDASH Assessment Questionnaire
Pre-operative Assessment Clinic

- Pre-operative surgical education can have significant impact on long-term survivorship
- All Mastectomies & Axillary surgeries
- Ascertain any pre-morbid upper quadrant pain or dysfunctions/other MSK problems/Current fitness levels
- Ascertain PMH/SH which may impact on physical response to BC Rx/Healing
- Teach & practice post operative exercises (divided into 2 stages)
- Education
The NHS Improvement Transforming Inpatient Care Programme National Audit (2012)

A key finding across the 13 cancer network test sites was:

- A move to education about arm and shoulder exercises \textit{pre-operatively}
- Where pathways were re-designed with pre-operative exercise education
  - 30\% of patients reported they did not do them (but ? unnecessary e.g. WLE)
DAY SURGERY PREM: KEY FINDINGS  
(Results from October 2012 to end October 2014)

- Variation in perceived quality of pre-operative information about arm exercises reflects difficulty performing these post operatively

Q: Did you receive clear and helpful information about your post-operative exercises?

%  
0  
20  
40  
60  
80  
100  


Yes  Difficulty with exercises
# Benefits to Pre-operative Physiotherapy Review

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>MDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protected time slot with the patient</td>
<td>Informed on positioning of patients in theatres</td>
</tr>
<tr>
<td>Expectations, beliefs, goals identified and managed</td>
<td>Feeds well into CNS post operative call improving patient experience</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercises taught &amp; practiced before surgery with coherent patient or</td>
<td>Informed on other pre-emptive therapy needs</td>
</tr>
<tr>
<td>modified to suit patient’s individual needs</td>
<td>which may impact other treatments</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Best practice evidence supports early vs. delayed commencement of</td>
<td>Informed SH / Mobility / ADL issues manage pre-operatively /</td>
</tr>
<tr>
<td>exercises (and no drains to impact this)</td>
<td>coordinate post op inpatient stay</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Improves patient experience &amp; survivorship outcomes</td>
<td>Physio involved in Rx decision making</td>
</tr>
<tr>
<td></td>
<td>Continuity of care</td>
</tr>
</tbody>
</table>

Personal reflection

- Physiotherapy role has expanded as a result of experience
- More involvement with MDT and clinical decision making
- Much more seen as up-front is prevention and management of potential problems associated with non-surgical treatment
- Quick DASH assessments now also at diagnosis, end of active treatment and targeted follow-up appointments yielding more robust data on the benefits to early intervention
- Timely and appropriate referrals made into the service
In absence of a Specialist Breast Physiotherapy Service – **Minimum** requirement

- Six key points

  1) Provide post-operative exercises
  2) Provide information on reducing the risk of lymphoedema
  3) Education about the benefits of exercise and physical activity
  4) Manage pain appropriately
  5) Refer to MSK / occupational health physiotherapy
  6) Survivorship and health and well-being events

- Manage patient expectations early and prepare them for the lengthy recovery times
1) Provide Post-Operative Exercises (at pre-op)

- Exercise leaflet – Breast Cancer Care
- Recently been updated
- Available free of charge

- Reiterate to patients that even if they have full range, to resume their exs throughout Radiotherapy and at least 6/12 after
2) Provide Information on Reducing the Risk of Lymphoedema

- BCC leaflet
- Ensure patients know who to contact with concerns
- Educate regarding lymphoedema ‘myths’ with exercise/physical activity
- Timely referral to Lymphoedema services
3) Educate regarding the benefits of Exercise and Physical Activity

• Hospital Based Classes
• Exercise on Referral
• Activities in local community
4) Manage Pain Appropriately

- Ascertain whether a pain is nociceptive, neuropathic, central, biopsychosocial, visceral or a combination of all.
- Ascertain if it is physical, psychological or spiritual to aid in minimising ‘vicious cycles’ or behaviour

Rankin & Murtagh (2009) Rehabilitation in Cancer Care. Chichester: Wiley
Blackman
5) Refer to MSK / Occupational Health Physiotherapy as required

- Senior clinician
- Thorough Rx history and desired treatment goals eg Radiotherapy positioning
- Indicate any specific precautions or contraindications to Physiotherapy
6) Survivorship / Health & Wellbeing Events
(DOH, Macmillan Cancer Support and NHS Improvement 2013)

- Breast Ca Care – ‘Moving Forwards’
- Macmillan / The Haven
- Local groups
Key Summary Points

- Numerous physical side effects following Rx for BC which often last for several years

- BC patients’ needs vary at different stages along Rx pathway

- Physiotherapy pre-operative Ax instigated as a result of the same day surgical pathway has shown importance of early post diagnosis assessment and preparation

- Benefit to patient and MDT management

- 6 key management guidelines in absence of specialist Physiotherapy services
Questions
Break

Don’t forget!

1. To pick up your BADS booklets
2. Sign up for BADS site visit support
Day Case Breast Surgery
City Hospital Experience
2006 - 2016

Simerjit Rai - Surgical Care Practitioner
2006.....How we started

• NHS Improvement test site with Kings Hospital

• Inner city unit
  – 31% non white British ethnicity*
  – 23 % income deprivation*

• 250 new cancers/year
• 50% screen detected disease

• LOS 5.4 days – worse than average

* Data from 2011 Breast Cancer Service Profile
City Hospital Length of Stay
May 2005 - May 2006

Breast Cancers May 05 - May 06

Number of Cases vs Length of Stay

- 0 cases for 1 day
- 0 cases for 2 days
- 0 cases for 3 days
- 5 cases for 4 days
- 20 cases for 5 days
- 45 cases for 6 days
- 10 cases for 7 days
- 2 cases for 8 days
- 0 cases for 9 days
- 0 cases for 10 days

Sandwell and West Birmingham Hospitals
NHS Trust
2006 – Standard Practice

- Preadmission clinic by FY1
- Admit afternoon before surgery
- Drain & PCA
- Physiotherapy / Temporary prosthesis supply
- Home when drain < 50mL in 24 hrs /day 5
- Discharge planning during admission

- Pre SLN era
- No dedicated day case facilities
Key Changes – Preadmission 2006

- Standardised multidisciplinary pre-op assessment & discharge planning
  - SCP
  - FY1 – TTOs pre-ordered
  - Breast Care Nurse
    - Post-op exercises
    - Temporary prosthesis
    - Assess social circumstances

- Access to Consultant Surgeon
- Access to anaesthetic & cardiology opinions
- Reduced cancellations / postponements
Key Changes – Day of Surgery 2006

- Admit on day of surgery

- Discharge within 23 hours (+/- drain)
  - Nurse led discharge to protocol

- 24 hour contact number

- BCN wound check at 3 days +/- drain removal

- No additional primary care involvement
Pilot Study – 23 hour

- May – Sept 2006 - 60 patients
- Close prospective audit
- Patient satisfaction survey

- Identified problems
  - Pt lack confidence re drains
  - Friday operating lists
  - Nausea & vomiting
  - Bed availability & delays
Pilot Study – Delayed Discharge

Admin Error | PONV | Medical | Social | Drain
---|---|---|---|---
11 | 7 | 4 | 3 | 2
Pilot Study – Results & Outcomes

• LOS end of pilot – 2 days
• Minor complaints
• 28 day emergency readmission 1%

• Adoption of SLN post New Start training
• Review of drain use
Birmingham Treatment Centre

• Gradual migration of theatre lists from inpatient to BTC

• 2008-9 DAY CASE DEFAULT POSITION
Progressive Move to Day Case

### 2006-7
- %BTC: 10
- %DC: 20

### 2007-8
- %BTC: 20
- %DC: 30

### 2008-9
- %BTC: 80
- %DC: 70

Legend:
- %BTC
- %DC
Service Reconfiguration

• Previously 2 separate MDMs – City & Sandwell

• Reconfiguration of Breast Service

• Initial combined MDM

• 2011 – All breast services on City site
And in 2016....

• All breast lists are in BTC
• Inpatient list on ad hoc basis – co-morbidity

• No upper BMI or age limit
• Exclusions
  – IDDM if needs sliding scale / other transfusions
  – Mobility issues / need for hoist
Pre-admission Clinic

- Fitness for surgery
- Opportunity for further discussion about surgery
- Check list (starving instructions, meds, etc)
- Wound advice (out of hours)
- Psychological support
- Prosthesis fitting (Mastectomy)
- Consent
- Identify problems for delaying discharge
Theatre Scheduling

• Ensure patients starved for minimum period
  – Delection of AM & PM patients with some wiggle room

• Avoid larger cases in PM list eg mast & ANC especially on a Friday afternoon.

• Flexibility to book to colleagues lists

• BTC – previous 23 hour capability -
  • Now closes at 10pm

• Patients transferred to inpatient ward if needed e.g social circumstances, PONV
Day of Surgery

• BTC – ring-fenced beds - No medical outliers!

• Anaesthetic
  - Pre-op paracetamol
    – Remi(fentanyl)
    – i.v. ketoralac / diclofenac
  - Avoid morphine
  - No PCA
  - No clever LA blocks – only infiltration
Discharge

• Nurse led discharge - Protocol led

• Prepacked TTOs
  – Paracetamol / codeine / NSAIDs

• SAU at Sandwell Hospital out of hours
• BCN Mon-Frid

• Practice nurse wound check at 7-10 days
Drains

• Routine use of drains abandoned 2009

• Now selective use of drains mainly in mastectomy + ANC

• Drain removal in OPD by BCN

• Patient Education
Patient Views

• Most patients welcome being back home

• More comfortable / Better sleep

• Risk of hospital acquired infections

• Get back to normal faster

• .......A few feel discharged too soon

• Education / manage expectations – especially no need for additional support / special care at home
Acknowledgments

- Many thanks to all members of the Breast Team – past & present

- Acknowledge the work Hamish Brown & Luna Vishwanath
Croydon Experience: Developing Same Day Discharge for Breast Cancer

Mr Sanjay Joshi
Ms Caroline Pogson
Mr Wail AL-Sarakbi
Annual work load

• Annualy 4000-4500 New patients seen in OPD

• New Cancer diagnosis 200-250
Unit Policy –2016 onwards

Since January 2016 Unit has implemented policy for 23 hrs discharge pathway of all Cancer cases except

1) With Reconstruction
2) Other Co-morbid conditions
3) Social reasons
January 2016 onwards

- 101 New Cancer diagnosis Jan-July 2016
- All Breast conserving Sx with or without Axillary sx were discharged.
- Mastectomy with without Axillary sx

<table>
<thead>
<tr>
<th>Total Mastectomy</th>
<th>Same Day discharge</th>
<th>23 Hrs pathway</th>
<th>Over 23 Hrs pathway</th>
<th>Seroma</th>
<th>Haemato ma</th>
<th>Seroma Aspirated</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>2</td>
<td>19</td>
<td>5</td>
<td>22</td>
<td>2</td>
<td>13</td>
</tr>
</tbody>
</table>
Benefits and Further workload

• Less hospital stay
• Decrease chances of infection
• Careful selection of cases is necessary
• Work load on BCN – likely to increase.
• True incidence of seroma, haematoma will need audited
Questions
# Next Steps

1. Local pathway mapping and implementation
2. Resource pack
3. 2 BADS booklets per Trust funded by RM Partners
4. Site visit support

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Ambulatory Non-Reconstructive Breast Cancer Surgery</td>
<td>A guide for breast units endeavouring to increase their day surgery rates for non-reconstructive breast cancer surgery</td>
</tr>
<tr>
<td>The pathway to success-management of the day surgical patient</td>
<td>The ideal pathway for day surgery patients including selection criteria, what happens on the day of surgery and patient discharge and support</td>
</tr>
<tr>
<td>Ten dilemmas in the day surgery pathway</td>
<td>This includes perceived rate limiting steps one stop services, value for money in pre-operative assessment, consent and judging capacity, achieving a prompt start to lists, managing complications, carer support</td>
</tr>
<tr>
<td>Ten More Dilemmas in Day Surgery</td>
<td>Topics include theatre procedure myths, preoperative fasting, communication issues, wound care, surgical site infection, alcohol abuse, The Mental Capacity Act, travel after day surgery, using local anaesthesia.</td>
</tr>
<tr>
<td>Patient Safety in the Ambulatory Pathway</td>
<td>This handbook highlights safety issues within the patient pathway for day and short stay surgery</td>
</tr>
<tr>
<td>Team working and staffing in day surgery</td>
<td>The roles and responsibilities of the day surgery team, operational issues, skill-mixing, day surgery as a learning environment, developing day surgery practitioners, competency and skills assessment</td>
</tr>
<tr>
<td>Organisational issues in pre-operative assessment for day surgery</td>
<td>Managing demand, capacity, process and investigations in pre-operative assessment, training for nurse-led pre-operative assessment and auditing outcomes.</td>
</tr>
<tr>
<td>Ten dilemmas in pre-operative assessment for day surgery</td>
<td>Management of common comorbidities (hypertension, sleep apnoea, diabetes, heart valve disease, anti-platelet drugs, anticoagulants, haematological / neuromuscular disorders and respiratory tract infections</td>
</tr>
<tr>
<td>Managing diabetes in patients having day and short-stay surgery (4th Edition)</td>
<td>A booklet describing how to safely manage diabetic patients for day and short stay surgery</td>
</tr>
<tr>
<td>Sedation in Day Surgery</td>
<td>How sedation can be effectively and safely delivered in the day surgery environment</td>
</tr>
<tr>
<td>Nurse Led Discharge</td>
<td>A guide to implementing or updating the nurse led discharge process for day and short stay surgical patients</td>
</tr>
<tr>
<td>Quality in Day Surgery</td>
<td>How a quality service can be provided and evaluated in Day Surgery</td>
</tr>
</tbody>
</table>