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Ambulatory Surgery in France:Making it Happen

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Developing ambulatory surgery is a strategic option for hospitals that requires entrepreneurial skills, such as understanding the environment, setting priorities and the ability to take risks. The pressure to reform which French hospitals are currently under offers little incentive to develop such skills in regard to ambulatory surgery.

A new way of financing through DRGs, new clinical governance and new internal organisations are all being implemented simultaneously. The impact of these reforms on the development of ambulatory surgery is important and sometimes contradictory, but little effort is made to promote coherence between them.

This results in a complex environment that is not favourable to change. In addition, the messages that the officials and some professionals deliver on ambulatory surgery are often blurred and contradictory and do not contribute to making the issue clearer for frontline professionals.

This situation tends to deter managers and healthcare professionals from ambulatory surgery. Another consequence is that people are often diverted from the real issues and focus on peripheral ones. For example, many surgeons involved in the campaign paid closer attention to the incentives provided by the payment method than to the arrival time of their patients, or the security of the discharge!

Making it Happen: A Small Venture Focused on the Day-to-Day Job

Developing ambulatory surgery is an operational issue as much as a strategic one. Yet in France, no institution or professional society is conveying such a message or providing support for frontline professionals. The opportunity of a neglected operational field was seized and the campaign was designed around a very simple vision: it is up to the health professionals, hospital by hospital, surgeon by surgeon, act by act, to make ambulatory surgery happen.

If one was to find the ideal metaphor to describe an ambulatory surgery unit (ASU), one would consider that of a small venture. We identified that successfully developed ASUs relied on two indispensable actors: the medical manager; and the unit head nurse. The medical manager is the real entrepreneur, it is up to him to recruit new cases and convince his fellow doctors to work with the ASU. The head nurse can be seen as a production manager who is responsible for the quality of care and service offered to the clients of the ASU. Surprisingly, it appeared that the real client of the ASU was not the patient, but rather his surgeon. The final decision between ambulatory and conventional care is made by the latter and he must be the object of the ASU management duo's efforts.

Two Axes of Intervention: Developing the Activity and Controlling the Processes

Managing an ASU requires concentration on two axes: developing the activity and controlling the process of production. It is the responsibility of the medical manager of the ASU to increase activity. In order to do that, he must be able to identify and mobilise growth potential.

The first step, the identification of growth potential, relies on a effective information system. We identified two types of growth potentials: (1) substitution potential, i.e. conventional stays that could have been substituted by ambulatory stays, and (2) grouping potential, i.e. ambulatory stays that took place in a unit other than the ASU.

The second step is to mobilise these potentials and that is when the medical manager must display marketing skills. The medical manager must concentrate on those surgeons who possess the most important development potentials, try to convince them of the relevance of ambulatory surgery and negotiate with them on the number of operations that they are willing to make in the ASU.

It is important that the medical manager maintains a close working relationship, including follow-up, with these surgeons in order to strengthen this partnership.

The second axis of development of the ASU is the control of the production process. This depends mostly on the head nurse's organisational skills. Bearing in mind that surgeons are the main clients of the ASU, the head nurse must ensure that the service provided to them is optimal. In this respect, the arrival and discharge of the patients are crucial issues. So is the programming of the operating theatre. It is a complex issue to decide when ambulatory must be programmed vis à vis other types of surgery.

We observed various types of organisation regarding this issue: some surgeons began their morning programme with ambulatory cases, whereas some alternated ambulatory and "conventional" patients in their schedule. Another type of organisation is to dedicate time slots to ambulatory cases, the ultimate evolution being to dedicate operating theatres. None of these organisations emerged as the best, each one being fit to a certain level of activity, and having its own drawbacks. However, some simple rules could prove useful when a manager is faced with the choice of the most relevant organisation:

• do not add complexity to the planning of medical work time;

• do not create new constraints for surgeons;

• do not create bottlenecks in the recovery room; and

• do set priorities in operation planning: general before local, or loco-regional anaesthesias; lower limb before upper limb; clean procedures before contaminated procedure; etc.

The management of patient turnover may well prove to be a challenging organisational issue (programming arrivals, making better use of boxes, waiting rooms and discharge lounge, etc.). Finally, the head nurse is responsible for the satisfaction of the patients. The use of a relevant and adapted dashboard is often a valued tool for head nurses, as well as a basis for the reflections and the decisions of the management duo. The recommended indicators are well known: daily activity (week mean, min and max); contribution of each medical specialty regarding their potential; cancellations (and causes); in-bed unplanned admissions (and causes); patients' satisfaction; D+1 complications, etc.

Results

First, the intervention carried out by the MeaH (Mission d'Expertise d'Audit Hospitaliers) campaign, performed from 2005 to 2007 in 8 hospitals, led to significant improvements in most of the 6 hospitals that had an ASU:

• cancellation rates decreased significantly in 5 hospitals (still rising to 10% in one of them, but inferior to 2% for 2);

• unplanned in-bed admission fell in 4 hospitals (inferior to 1% for three);

• 4 out of 6 hospitals developed their ambulatory activity by increasing the rate of ambulatory surgery and decreasing the "out of ASU" ambulatory surgery.

Second, all the ASU management duos adopted a new vision of their daily work, their position within the hospital and the service they provide to other health professionals. This new vision relied on new tools (dashboards, etc.), new messages to be communicated and a controlled production process that made a daily turnover possible.

Finally, we also built a method, a portfolio of tools and improvement actions, and a clear message to convey.

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