

The Hidden Capacity Report

Barriers, enablers and policy
levers to expand day surgery

June 2026

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Foreword



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Healthcare systems across the world face a common and increasingly urgent challenge: how to deliver more care, to more patients, with finite resources, while maintaining the highest standards of quality, safety, and patient experience. Against a backdrop of growing elective waiting lists, workforce pressures, and constrained hospital capacity, the need for innovative and sustainable solutions has never been greater.

Day surgery represents one of the most important opportunities available to modern health systems. Over recent decades, advances in surgical techniques, anaesthesia, perioperative care, and recovery pathways have transformed what is possible. Procedures that once required prolonged inpatient stays can now be performed safely and effectively on a same-day basis, enabling patients to recover in the comfort of their own homes while reducing demands on hospital beds and resources.

Yet despite clear evidence of its benefits, the adoption of day surgery remains inconsistent. Significant variation persists between countries, healthcare organisations, specialties, and individual clinical teams. In many systems, day surgery has not yet reached its full potential, constrained by organisational, financial, operational, and cultural barriers that continue to favour traditional models of inpatient care.

This report provides a timely and important contribution to the ongoing debate about how health systems can address these challenges. Drawing upon international evidence, professional insights, expert interviews, and stakeholder perspectives, it offers a comprehensive examination of the barriers that hinder expansion, the factors that enable success, and the policy levers that can support meaningful and sustainable change.

What emerges is a compelling case for reimagining day surgery not as a marginal service improvement, but as a core strategic component of elective care delivery. The findings demonstrate that high-performing systems are characterised by deliberate pathway design, protected capacity, aligned incentives, workforce development, and a relentless focus on patient-centred care. Equally important, the report reminds us that expansion must be pursued thoughtfully, ensuring that safety, quality, equity, and patient choice remain paramount.

The recommendations presented here are pragmatic, evidence-based, and highly relevant to healthcare leaders, clinicians, policymakers, and service managers alike. They offer a clear roadmap for expanding day surgery safely and at scale, while recognising the realities of implementation within complex healthcare environments.

As healthcare systems continue to seek ways of improving productivity, enhancing patient outcomes, and building resilience for the future, the principles outlined in this report deserve careful consideration. The evidence is clear: where clinically appropriate, day surgery should increasingly become the default model of care. Achieving this transformation will require leadership, investment, and commitment, but the rewards for patients, healthcare professionals, and health systems alike, are substantial.

Executive summary

This report examines the barriers, enablers and policy levers associated with expanding day surgery safely and at scale. It argues that day surgery should become the default pathway for clinically appropriate procedures because it offers a practical route to increasing elective capacity, alleviating inpatient bed pressures, lowering costs, and improving patient experience.

Drawing on a rapid review of international literature, a survey of 256 healthcare professionals across ten countries, in-depth interviews, and advisory board input, the report finds that substantial untapped potential remains even in relatively mature systems where dedicated pathways, protected capacity, and reliable home recovery support are not yet fully established.

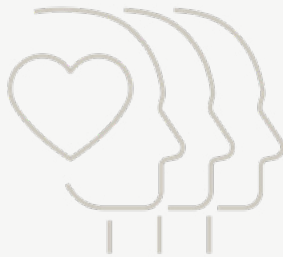
The report finds that day surgery rates increase when health systems deliberately redesign care around day surgery-specific pathways.

The barriers to scaling day surgery

The evidence points to a multifactorial set of barriers to scaling day surgery. These include competition with emergency and inpatient work for theatre space, beds, recovery capacity and staff; weak management focus; financial incentives that favour inpatient care in some systems; variation in clinical norms between teams; and patient-related barriers such as comorbidities, limited home support, travel distance, and low confidence in recovery at home. The report finds that day surgery rates increase when health systems deliberately redesign care around day surgery-specific pathways.

Features of high-performing systems

High-performing systems create dedicated ambulatory pathways, ringfence elective capacity, align incentives, standardise perioperative and discharge processes, invest in workforce capability, and treat day surgery as a system priority. The report emphasises that growth in day surgery must be grounded in patient safety and equity. Same-day surgery is at least as safe as inpatient care for many procedures when supported by careful patient selection, enhanced recovery protocols, functional discharge criteria, and clear routes for escalation after discharge.



Patient equity implications

Health inequalities persist across day surgery, affecting both access and outcomes. Expanding day surgery without attention to health literacy, transport, digital access, language needs, and the home recovery environment risks widening these inequalities. Communication with patients is an important consideration in the context of health inequalities.

Recommendations

The central policy implication is to build reliable, protected and patient-centred pathways, making day surgery the default where clinically appropriate:

- + **Make day surgery the default where clinically appropriate**, while maintaining patient safety and patient choice.
- + **Follow a three-step growth strategy**: prioritise high-volume low-complexity procedures, reduce unwarranted variation in established cases, and selectively expand to new frontier procedures and patient groups.
- + **Build reliable, distinct day surgery pathways** with standardised protocols for selection, perioperative care, discharge and post-discharge support.
- + **Protect elective capacity** by ringfencing day surgery resources and, where possible, creating dedicated facilities or pathways.
- + **Embed equity by design**, taking account of transport, health literacy, language, digital access, home support and wider social circumstances.
- + **Strengthen patient communication** and follow-up so patients understand home recovery, know when to seek help, and can access support after discharge.

Introduction

Across the world, health systems are struggling to deliver sufficient elective capacity to meet demand, resulting in long waiting lists and backlogs¹. Due to advances in minimally invasive techniques², standardised recovery and discharge pathways³, and increased policy attention^{4,5}, a growing range of procedures can now be performed as day surgery.

There is wide variation in the ability of health systems to shift surgery out of inpatient settings into outpatient settings.

Performing surgery as day cases means that operating teams can achieve higher throughput and productivity^{4,6,7}, reduce costs and resource utilisation⁸, and provide a better patient experience⁹. However, there is wide variation in the ability of health systems to shift surgery out of inpatient settings into outpatient settings, with substantial variation apparent between countries⁴, between hospitals and teams within countries¹⁰⁻¹², and across procedures and specialties^{2,13}.

This report combines multiple sources of evidence to examine the barriers, enablers and policy levers associated with safely expanding day surgery rates across health systems. It draws on a review of global literature covering international performance, payment models, pathway design, patient outcomes and emerging best practice, alongside interviews with clinical specialists and an expert panel of professionals with direct experience of delivering, managing and scaling day surgery services.



The expert panel consisted of:



Professor Jaideep Pandit

Chair and Professor of Anaesthesia,
University of Oxford, United Kingdom



Jaana Perttunen

President, European Operating Room
Nurses Association (EORNA), Finland



Laurens Van Houte

Manager of Surgical Department,
Medisch Spectrum Twente, Netherlands



Dr Shaan Chhabra

Transformation and Flow Improvement
Lead at Newham Hospital, Barts Health
NHS Trust, United Kingdom



Daniela Matos

Head Nurse Unidade Local de Saúde
de Santo António, Portugal



Dr Francesco Venneri

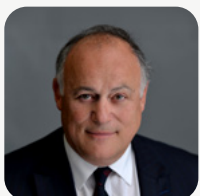
Director, Clinical Risk Management and
Patient Safety Center, Tuscany Region, Italy



Dr Jaroslaw J. Fedorowski

President, Polish Hospital Federation
(PFSz), Poland

Interviews were held with:



Professor Tim Briggs CBE

GIRFT programme lead and NHS England
National Director for Clinical Improvement,
Elective Recovery and UEC, United Kingdom



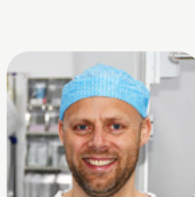
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Professor Karine Nouette-Gaulain

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Mr Bjarne Skjødt Hjaltalin

Chief Physician at the Day Surgery
Department, Amager and Hvidovre Hospital,
Denmark



This report contends that there is significant headroom for further growing day case rates

The research was designed to test where stakeholders believe untapped day surgery potential remains, what barriers most commonly prevent suitable cases from proceeding as same-day care, and which practical interventions would most accelerate progress. These findings provide a real-world complement to the published literature and help identify where policy ambition and operational reality still diverge.

This report contends that there is significant headroom for further growing day case rates, including in countries that have more mature day surgery systems. This headroom is best realised by making day surgery the default for appropriate procedures and developing distinct day surgery pathways with protected capacity and resources.

Methods

This report is based on a rapid assessment of the available literature on day surgery barriers and facilitators. An AI tool, Undermind.ai, was used to collect relevant English language sources from around the world that were published in the last five years.

Undermind is an AI tool developed to carry out academic literature reviews, and it queries the Semantic Scholar database of over 200 million articles (which contains PubMed and other life sciences collections). A reviewer assessed the abstracts of the collected articles to ensure relevance. 64 papers were included in the initial review. Themes relating to barriers and facilitators to expanding day surgery were extracted from the collected articles, and further targeted searches of grey literature and older academic literature were carried out to provide additional detail where necessary.

To complement these findings, a survey was commissioned to capture frontline perspectives on the future of day surgery.

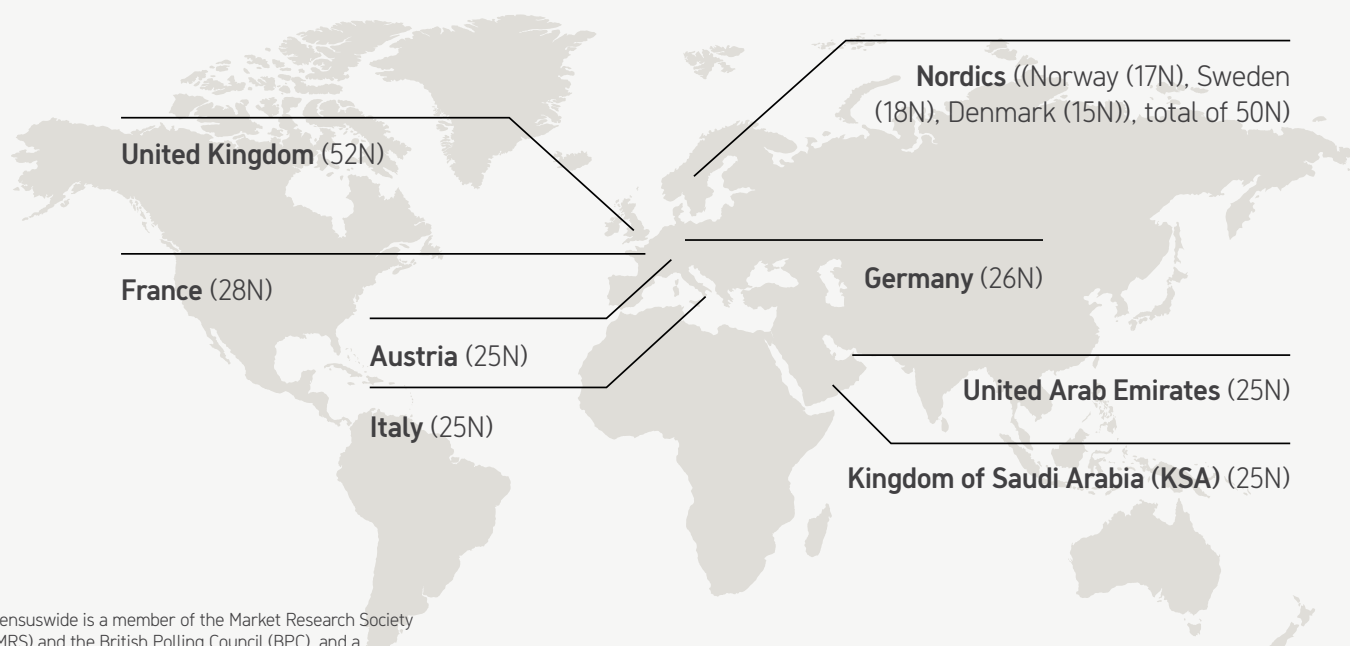
In addition, four semi-structured interviews were carried out with healthcare professionals involved in day surgery. All quotes and attributions in this report are included with the interviewees' permission.

A survey of

256

healthcare professionals across **10 countries** was conducted by Censuwide between 2 and 22 April 2026¹⁴.

The research targeted surgeons (63N), anaesthetists (25N), operating room nurses (60N), operating room managers (32N), procurement professionals (35N), hospital executive management (41N) who are involved in managing/procuring/conducting day surgery at least once per month.

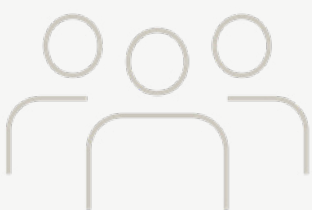


Censuwide is a member of the Market Research Society (MRS) and the British Polling Council (BPC), and a signatory of the Global Data Quality Pledge. It adheres to the MRS Code of Conduct and ESOMAR principles.



Finally, an advisory board of seven healthcare professionals from six different countries involved in day surgery were presented with a draft version of this report and a facilitated discussion was held to interrogate the report's findings and to develop recommendations¹⁵.

Following the advisory board, further targeted literature searches were undertaken into patient safety and health inequalities in day surgery. The report was redrafted and the recommendations developed based on the discussions at this advisory board. These were circulated to the advisory board for further feedback.



Defining day surgery

Different countries around the world use different terms for “day surgery”, with differences in how the concept is operationalised in their setting. The different terminologies used often reflect how countries govern and pay for care, and how day surgery is positioned within accountability frameworks and delivery models.

While some countries define day surgery as a stay of less than 24 hours⁹, others use a stricter zero-day length of stay definition because it is easier to observe in routine data¹⁶.

Table 1

Term	Typical meaning	Example country context	Caveats
Day surgery/ day case surgery	Planned surgery with discharge on the same calendar day as the operation	England, Ireland, Nordic countries ^{4,10}	
Ambulatory surgery	Surgery without overnight admission, often linked to dedicated ambulatory units	North America and Spain ^{6,17,18}	Can refer to both a pathway and a provider setting
Outpatient surgery	Surgery delivered outside an inpatient stay	Germany, Switzerland, United States ^{6,17,18}	Sometimes broader than same day discharge, potentially including stays that are less than 24 or 23 hours
Outpatient surgery	A financing term for same day surgical care in Hungary	Hungary ¹⁹	

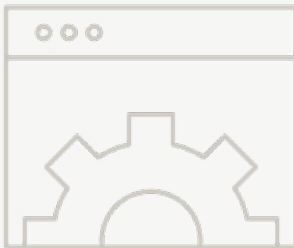
This report uses the International Association for Ambulatory Surgery (IAAS) definition: “An operation/procedure, excluding an office or outpatient operation/procedure, where the patient is discharged on the same working day”²⁰ and, like the IAAS, uses the terms “day surgery” and “ambulatory surgery” interchangeably.

What is ambulatory/day surgery?

Day surgery is an end-to-end pathway designed to deliver planned surgery without an overnight inpatient admission for appropriate patients and procedures²⁰.

In order to achieve earlier discharge, day surgery procedures involve a pathway made up of:^{3,9,21}

- + Patient selection
- + Anaesthetic and surgical techniques suited to early recovery
- + Standardised perioperative protocols
- + Clear discharge criteria based on patient function rather than time elapsed since the procedure
- + Post-discharge advice and support
- + Patient monitoring
- + Mechanisms for escalation if recovery at home does not go to plan



What is ambulatory/ day surgery?



Day surgery is a distinct alternative to inpatient stay. Our conversations with leading day surgery professionals suggest that health systems that are successful in pursuing growth in day surgery create day surgery-specific pathways, rather than trying to speed up existing pathways. Instead, they redesign the way that care is delivered for day cases. For the most successful systems, day surgery is the default option for appropriate procedures and patients.



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“It’s finding ways of making day surgery the new normal. And once you’ve crossed that bridge and it becomes the new normal, usually there’s enough momentum to sustain that because it is by its very nature much more sustainable than other types of surgery.”

At system level, sustained growth in day surgery can also enable a smaller elective bed base, or the potential to repurpose beds to other needs. This can reduce overall system costs and release constrained inpatient capacity for patients who would more benefit from an inpatient stay. For example, Ireland’s Elective Surgery Programme has estimated that **increasing day cases and reducing length-of-stay pathways across 14 surgical specialties could save approximately 41,500 bed days annually²³**, while wider evidence has shown that dedicated day surgery pathways can reduce costs and improve throughput, and can support shorter waiting times by increasing elective capacity^{3-5,19,24}.



Daniela Matos

Head Nurse, Unidade Local de Saúde de Santo António, Portugal¹⁵

“In my centre, we have 11 operating rooms and around 200 surgeries take place each day. In the main inpatient theatre, it takes a week to achieve the same, so our level of productivity is very high. Our turnover between patients in each room is about eight to nine minutes, thanks to our training. We have high satisfaction rates and low complication levels.”

What procedures and specialities are shifting to day surgery?



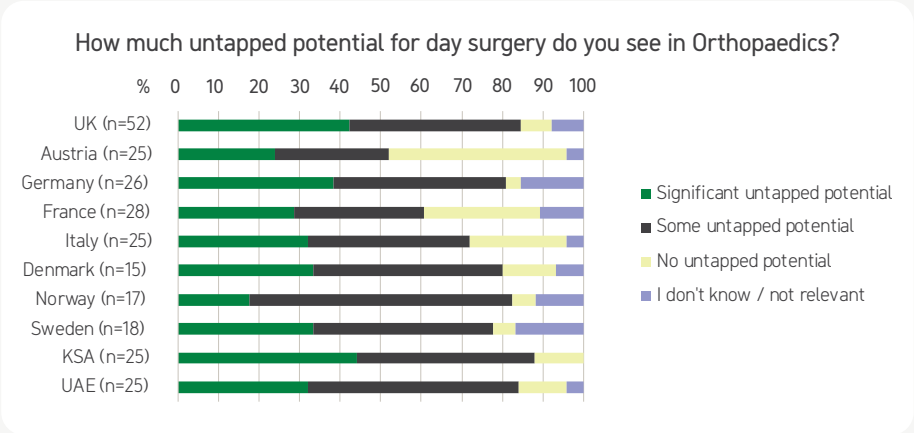
Jaana Perttunen
President, European Operating Room Nurses Association, Finland¹⁵

“ In Finland the percentage of day surgery is growing all the time, to 90% in some specialities. We use a lot of mobile apps for patients to allow them to communicate with the hospital. Almost all elective patients attend the morning of the operation, unless there is a long journey. Post-surgery patients can be discharged at a time that’s clinically safe and convenient for them. We are developing a number of apps to allow nurses to support patients across the surgical pathway. Patient education and nursing skills to support the patient are really important.”

Historically, day surgery has been most appropriate for minor, high volume, low complexity procedures^{4,12}. However, the scope of day surgery is continually evolving from minor procedures to some higher-complexity operations^{2,19,25-27}, due to advances in surgical techniques², procedures and recovery. This includes robotics²⁸, anaesthesia techniques, and enhanced recovery approaches and standardised perioperative protocols^{25,29}.

The shift to day case surgery is broadening across specialities, but at different rates globally^{2,4}. This trend was reinforced by the survey data¹⁴, where respondents identified untapped potential for day surgery across every specialty tested, which suggests many health systems believe the transition is still at a relatively early stage.

Figure 1a



What procedures and specialities are shifting to day surgery?

Figure 1b

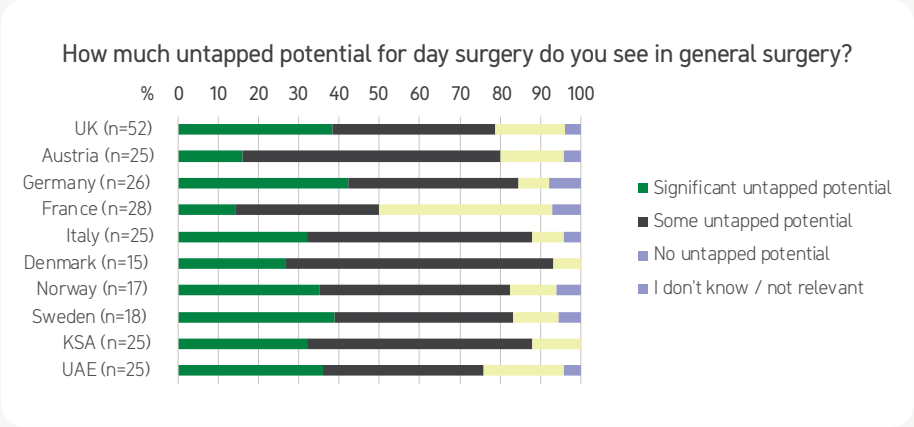
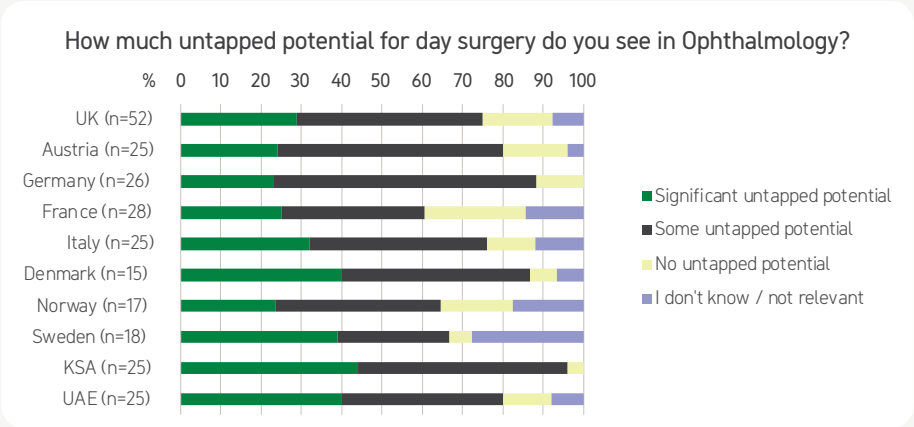


Figure 1c



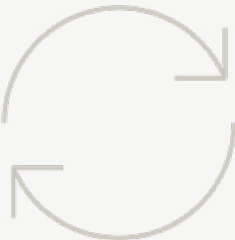
Source: Mölnlycke day surgery survey, Censuswide, 2–22 April 2026.
Base: all respondents (n=256).

Positive sentiment varied across countries. Respondents in the UK and Denmark were among the most optimistic about further expansion, with particularly strong confidence in orthopaedics, ophthalmology and general surgery. Germany also identified notable headroom in general surgery, while Saudi Arabian (KSA) respondents were notably positive about orthopaedics and ophthalmology. By contrast, respondents in France and Austria were comparatively more cautious in some established specialties, suggesting perceptions of remaining opportunity differ according to the maturity of local day surgery pathways and existing adoption levels.

High-volume surgery is still the most important for expanding day surgery rates. These procedures provide the most straightforward test case for health systems designing and building day surgery pathways and lend themselves most to being performed as day cases.

Several common elective procedures can be considered markers of system performance in adopting day surgery. These include:

- + Laparoscopic cholecystectomy²⁴
- + Inguinal hernia repair¹²
- + Ophthalmic surgery^{30,31}



What procedures and specialities are shifting to day surgery?

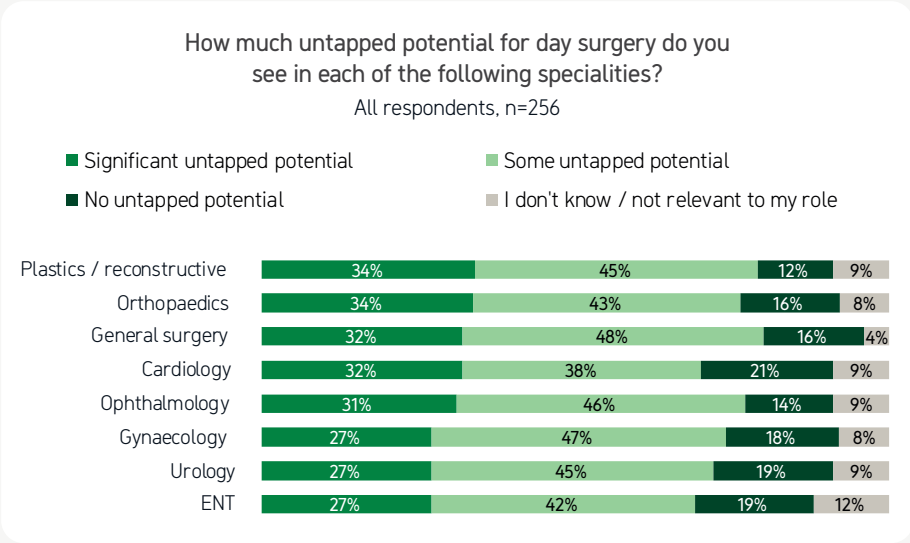
However, technical advances are reshaping what can feasibly be delivered as a day surgery, with several frontiers emerging. For example, in urology, minimally invasive surgical techniques involving lasers mean that surgery for benign prostatic obstruction can increasingly be delivered as day surgery².

Total joint arthroplasty is another frontier candidate for day surgery. In the UK, a meta-analysis of 17 studies demonstrated that day case total joint arthroplasty had a readmission rate of 1.9% versus 2.0% for inpatients, making the safety profile very similar between the two³². Performing these higher-complexity cases as day surgery can also have high patient acceptability too, with 80–96% stating they would choose outpatient arthroplasty again in one study³³.

This aligns with the survey findings¹⁴, where orthopaedics (77%) recorded one of the highest levels of perceived significant untapped potential, suggesting clinicians increasingly view major joint procedures as realistic same-day candidates when supported by the right pathways.

Figure 2

Up to
80%
see untapped potential in
day surgery pathways

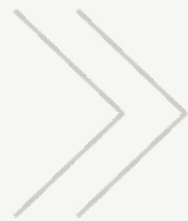


Source: Mölnlycke day surgery survey, Censuwide, 2–22 April 2026.
Base: all respondents. (n=256)

Importantly though, while technical advances have supported the expansion of day surgery rates across multiple specialties, **this must be delivered hand-in-hand with pathway redesign** to routinely convert potential day cases into procedures that are delivered as day surgery by default.

As less mature systems move towards increasing their day case rates, they should pursue a three-part strategy²². First, they should seek to build exemplar day surgery pathways in high volume, low complexity procedures that lend themselves to being performed as day cases. Second, they should reduce variation and achieve consistent uptake of procedures that already have a strong safety case as day cases but are not yet delivered that way by default across all providers.

What procedures and specialities are shifting to day surgery?



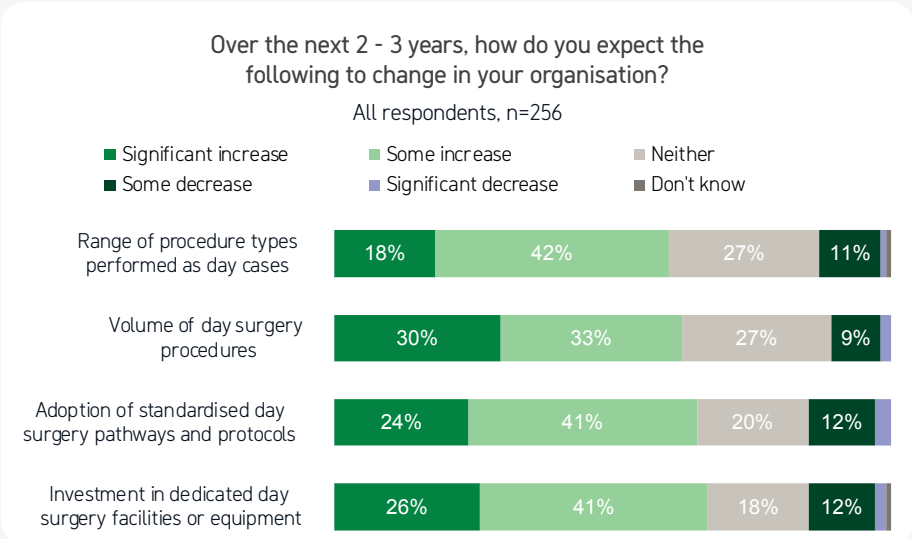
Finally, they should expand the frontier of possible day surgeries by identifying “new” procedures and patient groups that are now clinically suitable for same day surgery as techniques evolve.

In practice, this means²²:

- 1. Prioritising high-volume procedures to build mature same-day pathways and unlock fast capacity gains
- 2. Using pathway redesign, standard protocols and implementation support to convert potential day cases into actual day cases
- 3. Selectively building capability for frontier procedures, ensuring these are delivered as day cases when clinically appropriate

The opportunity for expanding day surgery is no longer limited to “minor” surgery, higher complexity cases and broader patient populations are increasingly in scope. The survey respondents identified substantial remaining opportunity (some or significant untapped potential and significant untapped potential) not only in traditional volume specialties, but also in Orthopaedics (77%, 34%), Cardiology (70%, 32%), Urology (72%, 27%) and Plastic and Reconstructive Surgery (79%, 34%)¹⁴, underlining how broad the next phase of day surgery expansion could be. This suggests that there is high headroom for achieving the hospital capacity gains promised by day surgery.

Figure 3



Source: Mölnlycke day surgery survey, Censuswide, 2-22 April 2026.
Base: all respondents. (n=256)

Quality, safety and equity considerations

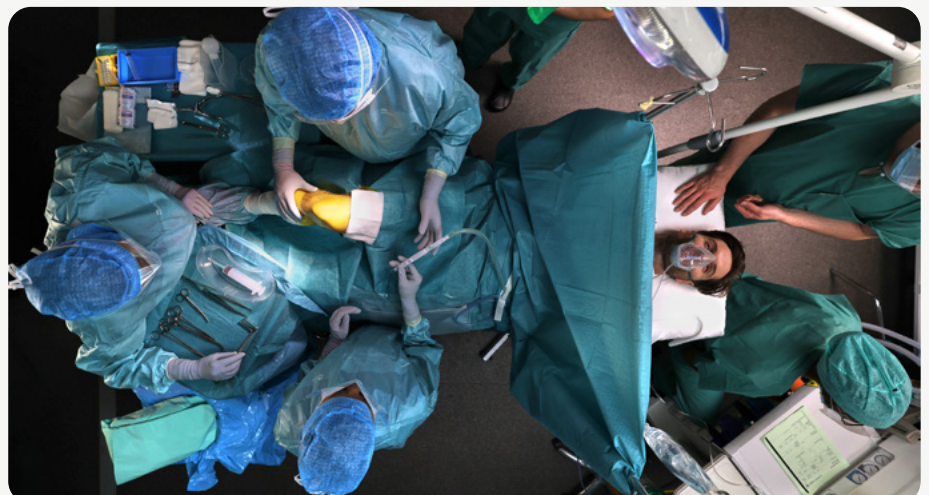
Safety

Patient safety should be central to any efforts to grow day case rates. In contrast to traditional inpatient surgery, day surgery sees a greater portion of patients' recovery taking place in their home environment, outside of the direct supervision of healthcare professionals^{9,34}. This means that there are important considerations about which procedures are appropriate for day surgery contexts, and also which patients are suitable for such an approach^{35,36}.

In current practice, day case surgery has consistently been demonstrated to be at least as safe as inpatient surgery^{16,32,37}. In benchmarking work carried out in the US, outpatient cases had lower complications and readmissions in 13 of the 14 procedures studied¹⁶. However, it is important to note that this safety profile has been achieved through appropriate patient selection, and a robust, intentional pathway that maximised the chances of a safe, complication-free procedure and recovery¹⁶.

There are interesting safety lessons from papers examining outcomes within procedure groups. In England, day case arthroplasty behaved differently across all joint replacements, with unicompartmental knee replacement appearing safe when performed as a day case. Total hip replacement was broadly safe, but required a learning curve, with a higher readmission risk in the first six day cases performed by each unit in the study. By contrast, total knee replacement demonstrated an increased risk of reoperation, especially for manipulation under anaesthesia to treat postoperative stiffness¹³.

This demonstrates the importance of not overgeneralising within surgical procedure categories and examining the patient safety profile of each procedure.



Whole pathway safety

Patient safety needs to be considered across the whole patient pathway, from selection and preassessment to discharge and home recovery.

Table 2

Pathway stage	Safety-promoting practices	Potential failure points
Selection and preassessment	Assessment of patient risk, procedure complexity, anaesthetic plan, facility capability, and home support ^{35,36,38,39}	Failed same day discharge, unplanned admissions ⁴⁰⁻⁴²
Perioperative care	Enhanced Recovery After Surgery (ERAS) protocols, fast-acting anaesthesia, opioid-sparing analgesia, effective Postoperative Nausea and Vomiting (PONV) prophylaxis, minimally invasive surgical technique, early mobilisation ^{34,43-45}	Pain, PONV, delayed mobilisation, longer recovery, overnight stay ^{29,41,46}
Discharge	Physiological (not time-based) discharge criteria: stable vitals alertness, ambulation, controlled pain and nausea, acceptable bleeding. Written instructions, escort, transport home, first night support ^{29,34,47,48}	Late discharge, unsafe discharge, preventable readmissions ^{40,49}
Home recovery	Clear route for escalation, proactive next-day follow up, remote monitoring, medication review, symptom tracking ^{34,50-52}	Missed deterioration of patient condition, unmanaged symptoms, medication errors, urgent care utilisation ^{40,51}
Governance	Routine measurement of unplanned admissions, hospital revisits, complications, discharge failure, patient reported recovery, and variation between practices ^{6,7,16,53}	Avoidable variation between practices and contexts, missed opportunities to improve ^{16,40}



Dr Francesco Venneri

Director, Clinical Risk Management and
Patient Safety Centre, Tuscany Region, Italy¹⁵

A meta-analysis of patients with obstructive sleep apnoea found that day surgery could be supported by active screening, adherence to algorithm-based perioperative management, and enhanced vigilance following the procedure⁴².

Selection and preoperative assessment

“ There could be a risk of underestimating the complexity of the patient. So, the patient could be considered suitable for an ambulatory setting, but in reality, they may have underlying risk factors that are not fully recognised.”

Patient safety for day surgery begins when assessing patients for suitability. In many health systems, practice has moved away from fixed patient selection categories towards a model that determines suitability dynamically, based on patient comorbidities, procedure invasiveness, anaesthetic technique, surgical setting, and social support/home environment³⁵. In deciding whether a patient is suitable for day surgery, patients should be assessed for both their physiological ability to tolerate the procedure and contextual factors – such as access to support in the community, living environment, distance from the hospital, their level of health literacy – that might affect their capacity to safely follow a recovery plan^{36,38}.

Across the literature, there are several physiological risk factors that are commonly associated with higher risk of inpatient admission or return to care following discharge. These include older age, obesity, respiratory disease, cardiac disease, diabetes, obstructive sleep apnoea, frailty, and a higher comorbidity burden^{37,40–42,54}. These risk factors do not necessarily exclude patients from day surgery^{37,55}, but they may require enhanced care and attention.

Outside of a patient's physical suitability, the literature highlights several areas of social readiness that determine whether a patient should be considered appropriate for day surgery. These include proximity to care, access to transport, availability of home support^{29,34,35,48}. The Getting It Right First Time programme in England, for example, recommends that patients should live one hour's drive from a hospital that would be able to provide care in the event of a complication, otherwise patients may need to be accommodated in a local hotel for the first night before travelling home⁵⁵. These are vital safeguards to patient safety, and should be given equal consideration alongside a patient's physical suitability.

Perioperative pathway design

Once patients have been selected appropriately, the next patient safety touchpoint is the perioperative pathway. Across the literature reviewed, Enhanced Recovery After Surgery (ERAS) protocols were frequently cited as a crucial safety-promoting strategy^{34,43,44}. The core elements of ERAS include preoperative patient education, optimising nutrition (including limited fasting) and hydration, fast-track anaesthetic technique, opioid sparing analgesia, PONV prophylaxis, fluid balance, minimally invasive technique where feasible, and early mobilisation^{34,43,44}. One study demonstrated that continuing staff education and feedback improved adherence to these protocols and consequently patient outcomes⁴⁵.

Discharge

The literature consistently recommends physiological, rather than time-based, discharge protocols^{34,47}. Instead of discharge taking place after a set period of time, patients should be assessed for a checklist that includes physiological items such as stable vital signs, wakefulness, and ambulation with pain and nausea under control³⁴, signalling that they are safe to continue their own care in their home environment. These functional discharge criteria can vary according to specialty^{29,48} to account for the features of different surgeries.

Recovery and home and post-discharge support



Bjarne Skjødt Hjaltalin

Chief Physician at the Day Surgery
Department, Amager and Hvidovre
Hospital, Denmark⁵⁶

“ We have to make sure that there’s kind of an escalation possibility for the patient afterwards.

If they feel safe and if they feel that they have a possibility to check in with someone after the operation... that’s the main thing that they’re asking for.”

A greater emphasis on home recovery is one of the defining characteristics of day surgery^{34,35}. This places much greater emphasis on the patient taking charge of their own recovery, shifting more responsibility onto patients and families to manage symptoms, self-care, and decisions about when to seek help^{9,57,58}. Many safety concerns can be avoided through careful patient selection^{36,38,59}, but day surgery pathway failures remain more common post-discharge than in the operating room⁴⁰. In one US study, ambulatory procedures carried a 4.8% readmission rate, with older age, comorbidity, and some procedure groups increasing risk⁴⁰.

One US study found that many outpatient procedures that were considered non-invasive were excluded from routine surgical site infection monitoring, but these procedures still carried a substantial infection burden⁶¹.

Postoperative pain and bleeding is one of the most common reasons for patients returning to care following day surgery⁴¹, demonstrating the importance of ensuring these symptoms are adequately controlled pre-discharge^{43,44}. Another important consideration is surgical site infections, which almost always require readmission: **93% of cases with surgical site infection require inpatient treatment⁶⁰.**

There is emerging evidence on electronic symptom reporting for patients recovering from surgery at home. In one study on ambulatory cancer surgery, electronic symptom reporting with nursing response reduced potentially avoidable urgent care visits⁵². Another study of virtual care with remote automated monitoring found improvements in medication error detection and in pain outcomes⁵¹.

Equity



Dr Shaan Chhabra

Transformation and Flow Improvement
Lead at Newham Hospital, Barts Health
NHS Trust, United Kingdom¹⁵

“Equity isn’t just about access, but also exclusion. Patients may be excluded for many reasons and circumstances. Some can’t navigate the healthcare system, have language barriers or no transport. Sometimes people aren’t able to cope with recovery at home, and we need to recognise that.”

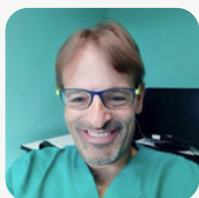
Health inequalities are endemic across all domains of healthcare, and the same is true of day case surgery. They especially apply in post-operative discharge, with lower health literacy, lack of access to transport options, and lower quality home environments all presenting potential barriers⁹.



The literature presented several domains of health inequality impact:

Table 3

Inequality issue	Evidence from the literature	Analysis of implications
Geography and deprivation	New ambulatory surgery centres in the US were more likely to open in better resourced and less deprived counties ¹⁸ .	Without intervention, capacity can expand where returns are strongest rather than where unmet need is greatest.
Race and ethnicity	Growth in outpatient hip replacement after removal from the Medicare inpatient only list was concentrated among white patients ⁶² .	Growth of day surgery can widen inequalities in uptake if access barriers are not addressed.
Income	Lower income areas had weaker procedure volume recovery in a US post-pandemic outpatient shift study ⁶³ .	Benefits from day surgery expansion and system recovery can be uneven.
Insurance and sector	Publicly insured patients in Spain were much more likely to receive outpatient hernia repair than privately insured or self-pay patients ¹² .	Provider incentives and business models affect access to same day pathways.
Family and home support	Patients with weak home support may struggle more after day surgery ⁹ .	Social factors are important - clinical eligibility is not enough without an adequate home recovery environment.
Digital access	Uptake of digital solutions is socially patterned and can entrench inequalities if it is the default route to support ⁶⁴ .	High quality, non-digital pathways should persist alongside digital innovation.



Dr Francesco Venneri

Director, Clinical Risk Management and Patient Safety Centre, Tuscany Region, Italy¹⁵

“

Home recovery

Who will take in charge the patient after dismissal, especially patients that don't have a family, or live in nursing homes, or live in social communities. These are all aspects that we have to take into account, because the context in which the patient goes back after surgery can strongly influence their outcomes.”

Health inequalities affect both access to care and outcomes following surgery^{62,65}, with recovery at home being a major driver of inequalities in an ambulatory surgery context^{9,57,58}.

Since outpatient surgery moves a significant share of post-operative care into patient homes^{9,57}, patients need to take on tasks such as monitoring symptoms, manage pain and mobility, and determine when the right time is to seek help. Patients without strong supportive networks, a challenge that cuts across a range of demographics, face the greatest difficulty in meeting these demands⁹. There is a risk that patient perceptions of day surgery, and the way it is presented by clinicians, can exacerbate this problem: patients often enter day surgery expecting a minor recovery process and are instead confronted with a recovery process that is more painful and frightening than expected⁵⁷.

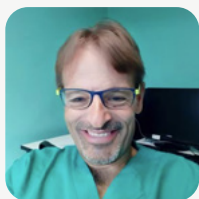
One orthopaedic interview study described a range of negative emotions that patients could feel after surgery. Patients described feeling lonely, unsure of whether their recovery was on track, and dependent on relatives for hygiene and other daily activities⁵⁸. Many patients wanted reassurance from nurses, but were hesitant to contact their clinic for fear of being a nuisance⁵⁸. This makes routine telephone follow up an important way of providing a low-threshold opportunity to ask questions that vulnerable patients may have otherwise kept to themselves⁶⁶.

In this context, patients who live alone and without dependable family support are the most vulnerable to struggling in the post-operative period^{9,57}.





Healthcare communication and health inequalities



Dr Francesco Venneri

Director, Clinical Risk Management and Patient Safety Centre, Tuscany Region, Italy¹⁵

“There are linguistic barriers, not only foreign languages but also dialects and differences in educational level. A patient may not fully understand the technical language that we use, and this can affect their ability to follow instructions or engage with their care. Trying to transfer information in a simple way, without too many technical terms, is therefore essential.”

Ability to understand and parse healthcare communication is also an important health inequality dimension in a day case surgery context. Day surgery can regularly feature compressed communication, delivered under tight time pressure before or after surgery when patients are rushed, anxious, or dealing with the effects of sedation^{9,67,68}.

In the English language literature, limited English proficiency is frequently associated with poorer care outcomes, especially as they relate to the process of care such as^{67,69} understanding of consent and discharge instructions⁶⁸. This can have real consequences, with patients with limited English proficiency experiencing worse pain control when an interpreter is not present for discharge⁶⁸.

If communication is poor, patients may appear clinically stable at discharge, but have a weaker understanding of how to recover safely at home⁶⁹.

Health literacy is another area where inequalities can manifest. Strong health literacy is a significant predictor of recovery quality in outpatient surgery⁷⁰, but surgical health literacy interventions are uncommon, heterogeneous, and poorly measured in the literature⁷¹, demonstrating a mismatch between patient need and existing practice.

Nurses have a vital role to play in communicating with patients in the operative and post-operative settings; their patient-facing role makes them a crucial source of support and guidance for patients.

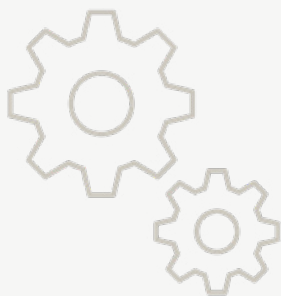
**Daniela Matos**

Head Nurse, Unidade Local de
Saúde de Santo António, Portugal¹⁵

“ In Portugal, same day surgery [has grown significantly] since it was introduced in 2008. We have a very meticulous pre-assessment either via the phone or increasingly digitally. Patient interaction takes place at every intersection, where they either give or receive information.

Following pre-assessment, the surgeon will decide with the patient surgery is suitable, they will then visit the anaesthetist and the nurse before deciding on the day for surgery. By the time the patient leaves the day consultation they already have a date for surgery. Afterwards the patient will be called with further online consultations with the nursing team to pre-assess if everything is OK.

By the time you reach the ambulatory surgery centre you go straight to the pre-operative bed or chair. We ensure criteria are strictly accomplished, with mandatory questions about health literacy and a responsible companion. A phone number and app are always available, to ensure patients are able to interact and engage throughout the process.”

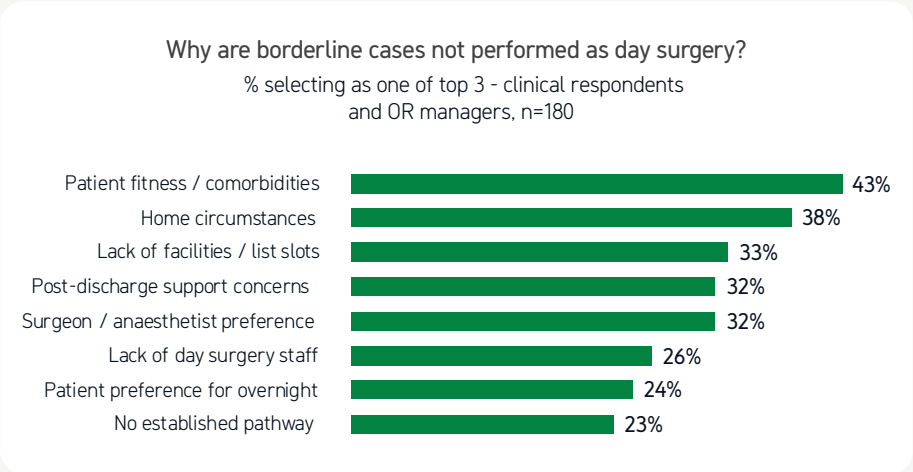


Barriers to scaling

Barriers to countries adopting day surgery as standard are multifactorial, and may differ between countries and specialties, and across pathways.

The survey findings strongly reinforce this, with respondents citing a mix of clinical, operational, workforce and patient-related reasons why borderline or suitable cases do not proceed as day surgery¹⁴. No single barrier dominated, suggesting that scaling day surgery requires system-wide solutions rather than isolated interventions¹⁴.

Figure 4



Source: Mölnlycke day surgery survey, Censuwide, 2–22 April 2026.
Base: Clinical respondents and OR managers, n=180

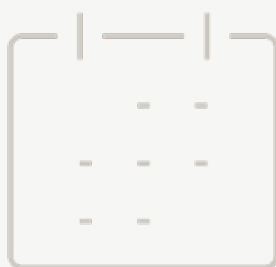




Operational and organisational barriers

Dedicated infrastructure and protected elective capacity

Evidence and stakeholder experience collected through our interviews consistently highlight the “contest” between planned elective and day surgery and emergency work for theatre time, beds, recovery space and staff attention. In the survey, 28% said that “procedures that could safely be performed as day cases are instead carried out as inpatient surgery” often or always¹⁴. This is a major practical barrier, especially for units operating at very high theatre utilisation. Where day cases share the same physical space, staff pools, and escalation routes as inpatient and emergency pathways, elective day surgery can be displaced, cancelled, or converted to overnight stays^{3,29}. This undermines reliability of the pathway and clinician confidence in day surgery.



High-performing systems therefore protect day surgery capacity through dedicated ambulatory/day surgery hubs where feasible, or through “virtual separation”, such as ring-fenced lists, dedicated recovery and discharge capacity, and clear escalation pathways where full separation is not possible. This was reflected in the survey, where 33% of respondents said borderline cases are not performed as day surgery because of lack of a suitable day surgery facility or list availability. This was even higher in the Nordics (42%), indicating that even relatively mature systems can face practical capacity constraints¹⁴.

In the UK, creating wherever possible dedicated high volume low complexity elective surgery hubs and separate “hot” and “cold” surgical sites⁷², have been key to achieving some of the highest global rates of day surgery. The USA⁷³ and Canada⁷⁴ also have dedicated “ambulatory surgery centres” to provide an exclusive space for ambulatory procedures. UK respondents were also especially likely to cite post-discharge support concerns as a reason cases are not converted to day surgery (49% vs 32% overall), suggesting that infrastructure alone is insufficient without equally robust recovery pathways beyond the hospital.



This review found that service mix, procedure volume, and infrastructure all contributed to the differences between outpatient surgery rates, implying that hospital organisation is a crucial driver of outpatient surgery rates¹¹.

Management prioritisation and change capacity

One of the most important barriers to growing day surgery rates raised in the interviews is the lack of organisational policy focus and not having standardised pathways designed to deliver day surgery.

Our interviews suggest that providers who systematically maximise day surgery typically treat it as a management priority. This means that there is clear ownership, delivery milestones, and coordination across scheduling, pre-assessment, theatres, wards and recovery, discharge processes, procurement, and data teams. Under operational pressure, elective day surgery extension can stall if management attention and resources are focused elsewhere, or because leaders are cautious about being perceived as intervening in 'clinical territory'.

In our advisory board, we heard that successful programmes address this by establishing joint clinical/operational governance, with explicit decision rights, and strong project/change management capability with routine measurement, feedback loops, and troubleshooting at both list and pathway level. The survey highlighted the concern that operational discipline remains inconsistent. Respondents frequently pointed to avoidable process barriers such as clinician preference, list access and concerns around escalation pathways in addition to infrastructure gaps¹⁴.

In Europe, Germany has been a comparatively slow adopter of day surgery (though recent reforms have seen Germany growing day surgery rates), especially when compared with similarly high performing health systems. In the literature, the historically lower day case rates have been associated with Germany's financial incentives that have instead rewarded inpatient stays⁴. However, one mixed-methods evidence review found that there was significant variation between outpatient surgery provision even between hospitals operating under the same financial framework¹¹.

One particular challenge emerges when day cases are collocated with inpatient procedures. When these two pathways compete for the same staff, space, and resources, hospitals struggle to maintain day surgery as the default option³. Several high performing nations, including the USA, make use of ambulatory surgery hubs which cater solely for ambulatory procedures, avoiding these issues.

Fundamentally, if theatre flow, patient protocols, transport, and working culture are all built around an inpatient model, day surgery rates will not flourish.

Misaligned financial incentives

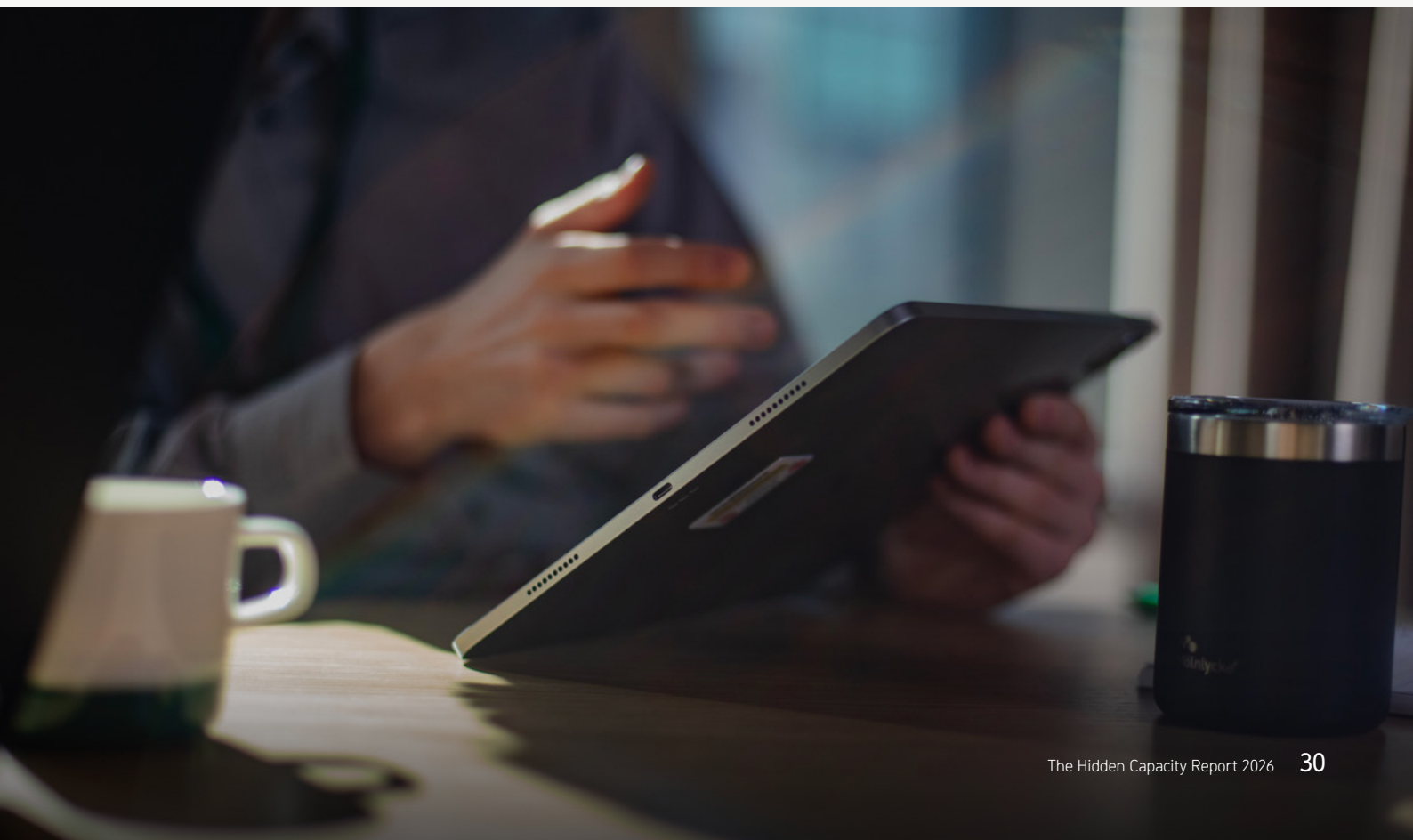
Misaligned financial incentives can present an intractable barrier to growing day surgery rates in countries where they are present⁴.

A comparison of 13 OECD countries' day surgery rates found that all three low-performing countries at the time of review (Austria, Germany, Switzerland) had misaligned financial incentives⁴. In Austria, both the payment systems and payers for outpatient surgery versus inpatient surgery were different, presenting a significant barrier to shifting activity into outpatient settings⁴.

In Germany, entrenched institutional separation between office-based ambulatory care and hospital-based inpatient care meant that those hospitals performing day surgery received reimbursement designed for private practices, failing to cover their higher fixed costs. In Switzerland, day admission surgery under Diagnosis Related Group (DRG)-based payments could reduce hospital reimbursement, rather than save money, creating a perverse financial disincentive to day surgery⁴.

In addition to operational set-up and infrastructure for day surgery, misaligned financial incentives can present a significant structural barrier to moving care out of inpatient settings, perversely rewarding a less efficient mode of surgery⁴.

Even in countries where financial incentives are aligned, the lack of ringfenced funding and capacity for day surgery can mean that resources flow towards inpatient surgery as the more established model of care¹¹.



Clinical and culture variation between teams



Professor Jaideep Pandit

Chair and Professor of Anaesthesia,
University of Oxford, United Kingdom¹⁵

“Intrinsic surgical training can be a barrier. Surgeons are often taught to regard certain operations as inpatient, for good and less good reasons. They may be reluctant to switch from inpatient to day surgery - call it psychological, habit, inertia or a bad experience.”

Several studies show that local practice variation can be challenging within systems. For example, in Ireland in 2019, day case rates for laparoscopic cholecystectomy ranged from 0% to over 90% across hospitals, with differences between surgical teams driving a large portion of this variation¹⁰. Similarly, in the USA, unexplained variation persists across institutions even after accounting for patient factors. This was especially prevalent in breast, endocrine, and hernia operations¹⁶.

Additionally, while our survey found that 44% see day surgery as a “rewarding, high-quality” area to work in, 31% still see day surgery as “lower status” than inpatient work¹⁴.

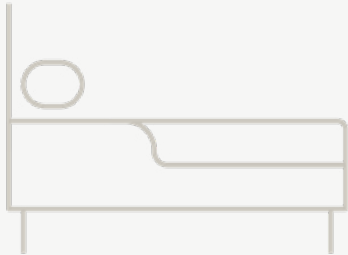
Overall, this report contends that there is an important tension between top-down policy and bottom-up consultant driven culture that needs to be resolved to maximally take advantage of the benefits of day surgery. Shared clinical norms need to be developed alongside policy efforts to expand day surgery. It is also important to seek out and scale examples of clinical best practice within systems, as early innovation is commonly led by individual clinicians and surgical teams.



Professor Tim Briggs CBE

GIRFT Programme Lead and NHS England
National Director for Clinical Improvement,
Elective Recovery and UEC, United Kingdom⁷⁵

“If we are going to solve the problem, it has got to be clinically led by respected clinicians with data to drive the change and then operationally enabled, not the other way around.”



Patient barriers

While in many countries patient acceptability of day surgery is high, with recovery at home prioritised over inpatient hospital stays, it is important to continue focusing on patient experience, especially as day surgery shifts recovery work from hospital to home⁹. Even minor surgery can mean pain, nausea, and fatigue, and health systems need robust mechanisms to set patient expectations, implement enhanced recovery protocols and at home monitoring. As the scope for day surgery broadens, it is vital to maintain patient experience as a priority.

This was one of the clearest messages in the survey. Patient fitness, comorbidities or procedure complexity was the most selected reason cases are not performed as day surgery (43%), followed by patient home circumstances such as living alone, travel distance or lack of carer support (38%). Concerns about post-discharge support or escalation if complications arise were selected by 32%¹⁴.

Additionally, patient acceptability of day surgery does vary between countries. There are some countries like Japan where longer hospital stays are a cultural expectation⁷⁶, potentially meaning that day surgery is anathema to patient expectations in these countries.

The survey also suggests cultural and pathway maturity differences across health systems. UK respondents were especially focused on safe discharge and home recovery support, while Nordic respondents more often cited list and facility constraints, indicating that barriers evolve as systems mature. Less mature systems may first need to build capacity, whereas more advanced systems may increasingly focus on patient confidence, discharge quality, and pathway reliability¹⁴.



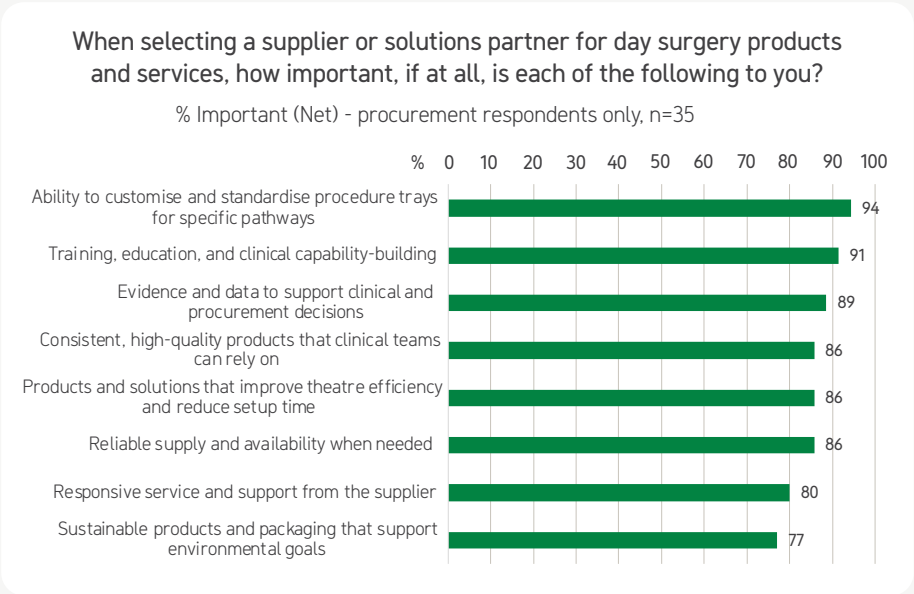
Facilitators to expanding day surgery

For high-performing countries, high day surgery rates are the result of a clear policy focus on growing day case rates, aligned financial incentives, and a responsiveness to on the ground clinical best practice.

This flows through to highly standardised pathways, protected capacity, and an expectation that appropriate procedures should be carried out as day cases by default. Commonly, these countries set ambitious targets for day case rates and look to continually expand the range of procedures and patient populations covered by day surgery.

The survey findings strongly support this interpretation. Respondents identified a combination of pathway, infrastructure, technology and patient-engagement interventions as the most effective ways to accelerate day surgery growth, reinforcing that no single lever is sufficient on its own. Overall, reliability and standardisation are key¹⁴.

Figure 5



Source: Mölnlycke day surgery survey, Censuswide, 2-22 April 2026.
Base: procurement respondents, n=35.



Pathway design

In moving towards day surgery, systems are moving from bed-based, hospital centric surgery with a minority of cases being done as day cases, to pathway driven surgical systems where the work done pre-surgery (risk assessment, digital triage) and post-surgery (early mobilisation and remote follow up) is vital to making these systems work¹⁵. Our advisory board panellists told us that effective whole pathway management needs to sit alongside surgeons determining which new procedures can be done as day surgery¹⁵.

Clear pathway design explicitly targeted towards achieving same day discharge is a prerequisite for successfully growing day surgery rates. Survey respondents shed further light on this: 27% selected more standardised clinical pathways and discharge protocols as one of the biggest practical differences to expanding day surgery rates, while a further 26% selected specific staff training programmes¹⁴.

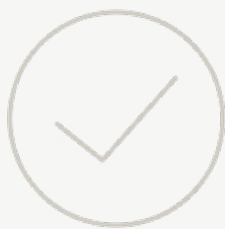
It is important that day surgery pathways are a distinct patient flow, separate from inpatient processes³ (and ideally from inpatient settings). Protected ambulatory capacity is potentially the strongest institutional signal to make day cases default within the setting. In contexts where a separate ambulatory surgery building or facility is not possible, protected day surgery capacity could include ring-fenced theatre time, protected recovery space, dedicated preassessment and discharge capacity, and separation from emergency settings^{3,24}. This was one of the most strongly supported actions in our survey, with 32% of respondents selecting purpose-built day surgery facilities or surgical hubs as a key enabler of further expansion. Central Europe was especially supportive of this approach (42%), suggesting infrastructure remains a particularly important constraint in some countries¹⁴.



In the survey,

94%

of procurement respondents said the ability to customise and standardise procedure trays for specific pathways was important when considering a supplier or solutions partner¹⁴.



Customisation of equipment and consumables also appears important to scaling day surgery efficiently. This was the highest-ranked option in that subgroup, suggesting respondents see customisable trays for day surgery procedures as a pathway tool that can improve theatre flow, reduce delays and help higher-throughput day surgery lists run more reliably.

Day surgery also tends to require a higher degree of standardisation and protocolisation than inpatient pathways, because there is less slack in the system for escalation and fewer opportunities to recover delays later in the day. For this reason, expanding day surgery needs to be a hospital management priority. Once there are established protocols, hospital leaders should also focus on adherence, for example through training, checklists, audits, feedback collection, and rapid issue resolution. This helps to ensure the pathway is consistent across teams.

Day surgery pathways should demonstrate: ^{3,9,11,20,29,55}

- + Standardised, prearranged protocols
- + A defined list of suitable procedures
- + Explicit inclusion and exclusion criteria for patients
- + Staggered “just in time” admissions
- + Patient preparation and comprehensive pre-assessment
- + Early mobilisation and functional discharge criteria (rather than time-based discharge criteria)
- + Nurse-led discharge
- + Scheduling eligible patients early in the day
- + Post-discharge support
- + Patient monitoring and escalation criteria, including a reliable route to post-discharge support
- + Continuing staff education and implementation support

Home recovery

What happens in the hospital – efficient pre-assessment, surgery, and discharge – is a vital part of successful day surgery, but so too is supporting successful home recovery²⁰.

Home recovery following day surgery shifts the responsibility of care from the hospital clinical team to the patient or carer, requiring a clear handover. Recovery must begin before the patient leaves the hospital, with comprehensive patient education. Patients should have access to both written and verbal instructions, with studies suggesting that patients can forget up to 80% of what they are told verbally⁷⁴. This was the single most selected practical intervention in the survey, with 34% choosing patient education to alter expectations around day surgery and recovery at home⁷⁴, highlighting the importance of patient confidence and preparedness as of similar importance to in-hospital efficiency.

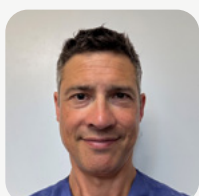


Professor Karine Nouette-Gaulain

Head of Department, Anaesthesia, Critical Care and Perioperative Medicine, Children's Hospital & Aliénor d'Aquitaine Maternity Unit, Bordeaux University Hospital, France⁷⁸

“The problem with ambulatory care is that patients are afraid to go home. Patients are afraid, and often we have to reassure them: if it does not go well, you will stay overnight. Once the procedure is done, they are ready to go home.”

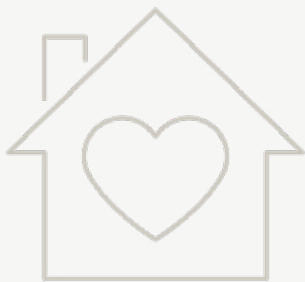
As day surgery shifts recovery into the home, infection prevention and wound care become even more important. Post-operative infections can be harder to detect early in community settings and may present after the patient has left direct supervision of the surgical team⁷⁹. Pathways should therefore specify clear wound-care instructions, building the patients' understanding of expected symptoms compared to complications and encourage consistent use of appropriate dressings and infection control practices^{79,80}. This should be accompanied by routes to seeking clinical advice. This is particularly relevant when scaling same day surgery to higher-complexity procedures or higher-risk patient groups. There are also opportunities to advise patients on optimal pre-operative preparation to lessen the chance of infection, for example through pre-operative bathing⁸¹.



David Bunting

Consultant in Upper Gastrointestinal and Abdominal Wall Reconstruction Surgery, North Devon District Hospital
Management Body Officer, International Association of Ambulatory Surgery
Past President, British Association of Day Surgery, United Kingdom

“Any time we've conducted patient reported outcomes, we've found that in general, probably over 95% of the time, our patients prefer day surgery. They generally prefer to recover in the comfort of their own home.”



Patients must also understand the difference between normal post-operative discomfort and serious complications⁷⁹. They should have a robust way of reaching out for further support should serious complications arise. There should be a proactive, rather than reactive, strategy in place to manage pain-related symptoms. Post-operative nausea and vomiting (PONV) is a leading cause of unplanned hospital readmission⁸². Effective pathways should include 'rescue' anti-emetics for use at home⁸³.

Patients should also understand realistic timelines for recovery, including when they can perform routine activities such as driving, return to physical activity, and work to avoid jeopardising the recovery process⁸⁴.

Continuing monitoring and communication with the patient in their home setting is vital⁹. The Centre for Perioperative Care recommends a 24-hour follow up call from a nurse to identify minor issues before they escalate⁸⁵. Follow up calls are also associated with improved patient satisfaction and confidence⁶⁶.



Workforce

Day surgery works best when there is a dedicated workforce for day cases. Achieving the high-throughput possible with day surgery requires hospital staff to have clear roles within the day surgery pathway, and an expertise in delivering day surgery cases^{9,29}.

A strong day surgery pathway should break each case into distinct episodes, with staff having clear ownership of different functions^{3,9,28}.

Table 4

Function in the pathway	What the role needs to do	Why it matters
Preassessment and selection	Check clinical suitability, social support, and whether recovery at home is feasible	Prevents failed same day discharge and unsafe selection ^{9,29}
List coordination	Place suitable patients early enough on the operating list	Preserves time for patient mobilisation, symptom control, and discharge ²⁹
Recovery and discharge	Apply functional discharge criteria for pain, nausea, mobility, and bleeding	Makes discharge decisions more consistent and less dependent on judgment or time-based criteria ²⁹
Patient education	Explain what recovery at home will actually involve and when to seek help	Manages expectations for postoperative experience ⁹
Post-discharge support	Provide phone contact, proactive follow up, or community support where needed	Reassures patients and catches issues early ⁹
Data and coordination support	Track patient flow, outcomes, and complications across sites/units	Supports standardisation and continuous improvement ^{3,29}

These functions do not align perfectly with existing inpatient models, so they need to be developed in a bespoke way for outpatient surgery, with appropriate training and development for staff moving to day surgery. This aligns directly with the survey, where 26% selected specific training programmes for theatre, ward and recovery staff as a priority intervention, while in a separate question 88% rated training, education and clinical capability-building as important from suppliers and partners¹⁴.

Nurses should be given particular consideration as part of the day surgery workforce – they are the healthcare professionals who spend the most time with patients, and they have a vital role in safely guiding patients through the process of day surgery¹⁵. Surgery is an extremely vulnerable time for patients, and nurses can provide both practical and emotional support to patients during this period, ensuring their needs are heard and responded to¹⁵.



Jaana Perttunen

President, European Operating Room Nurses Association, Finland¹⁵



Guiding patients through the entire day surgery process is an extremely important job for nurses.”



Technology

With appropriate pathways and incentives in place, technology is a vital enabler of growing the frontiers of day case surgery.

Robotic surgery, for example, is increasingly compatible with ambulatory surgery as it facilitates minimally invasive surgery, with less required recovery time²⁸. Over 50% of robotic-assisted radical prostatectomies in the United States are now performed as same-day discharge, resulting in 20% less expenditure compared to inpatient admission⁸⁶.



David Bunting

Consultant in Upper Gastrointestinal and Abdominal Wall Reconstruction Surgery, North Devon District Hospital
Management Body Officer, International Association of Ambulatory Surgery
Past President, British Association of Day Surgery, United Kingdom

“The robotic platforms are enabling us to do a lot of ventral hernia work which would have previously required several nights’ stay, perhaps four to five nights with drains, converting that into a day case without the use of drains.”

On the home recovery side, digital health and remote monitoring tools help to achieve earlier and safer discharge. Telemedicine follow-up in surgical patients achieves satisfaction ratings of “very good” from 80.6% of patients, with demonstrated cost savings of over \$1 million across five-year periods. In Australia, an acute day-surgery cholecystectomy model with remote monitoring saved 1.7 days per patient and AU\$1,416 per case compared to conventional inpatient care⁸⁷.

“We’re seeing remote monitoring being used at home. So virtual ward platforms, started off being used in same day emergency care in the medical arena. We’re seeing that used in the post-operative environment now, so patients who go home with remote monitoring provides quite a lot of reassurance for clinicians and for patients for certain procedures.”

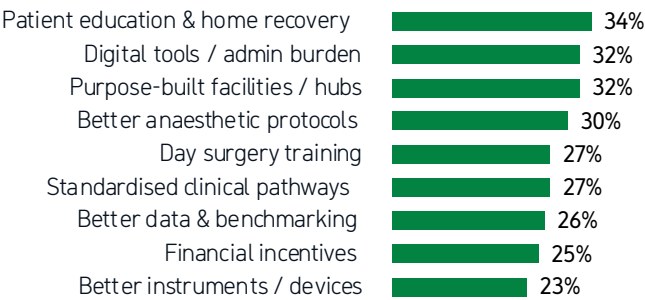
Policy and financial levers

Figure 6

32%

said digital tools / admin burden would help make the biggest difference in expanding day surgery

What would make the biggest difference in expanding day surgery in your organisation? (Select up to 3)
% selecting as one of top 3 - all respondents, n=256



Source: Mölnlycke day surgery survey, Censuswide, 2-22 April 2026.
Base: all respondents.

Given the clear benefits of day surgery in terms of cost saving,⁴ capacity sparing^{19,23}, efficiency⁴, and patient satisfaction⁹, there is a strong incentive to prioritise day surgery as default. The barriers and facilitators for increasing day surgery are multifactorial, so policy needs to be carefully designed and take into account potential health inequalities and safety considerations.

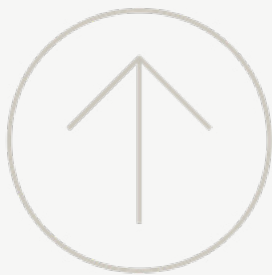


Professor Tim Briggs CBE

GIRFT Programme Lead and NHS England National Director for Clinical Improvement, Elective Recovery and UEC, United Kingdom⁷⁵

“ We have proven with the British Association of Day Surgery group that by increasing day case rates, readmission rates and complications are no higher. But patients’ satisfaction really is important - they are pleased to be getting their surgery.”

The survey findings strongly reinforce this case for prioritisation¹⁴. Respondents identified a blend of clinical innovation, patient demand, efficiency pressure, safety considerations and explicit policy targets as the main drivers of the shift towards day surgery, suggesting momentum is being created by several forces at once rather than one single policy lever¹⁴.



One strong system incentive is using cross-country comparison and benchmarking to drive uptake. The review of 13 OECD countries⁴ demonstrated that all countries identified transitioning to day surgery as a strategic priority, but they differed in how strongly they backed that priority with regulation, payment reform, and accountability. Comparative reporting has the potential to demonstrate that low day case rates are not an inevitability, and that progress is possible. It also helps to justify the use of other policy mechanisms by highlighting comparative underperformance. Using benchmarking also helps by making day surgery a measurable performance issue, incentivising local systems to meet targets and demonstrate compliance.

Financial incentives can provide signals to the system where investment and priority should be taking place. A good example of this is in Hungary, where policymakers first redeployed unused inpatient capacity towards day surgery (“one day surgery” in Hungary’s system). Initially, Hungary had one day volume caps, which it removed in 2015. To further boost day surgery uptake, in 2017 Hungary added a 10% payment uplift for these procedures, better aligning its financial incentives to the outcomes it wanted to see¹⁹. Between 2010 and 2019, Hungary saw day case rates for in scope procedures rose from 42% to 80%, with inpatient hospital days falling by 17% over the same period. In general, health systems should at minimum ensure that there are no financial disincentives to day surgery⁴.

27% of respondents cited cost or budget pressure as a key driver of day surgery expansion¹⁴.



Regulation and policy can also succeed in the absence of financial levers. Switzerland has successfully used mandatory substitution rules to shift selected procedures into outpatient care, even after removing enhanced reimbursement in 2017⁵. This has made day surgery more affordable for Switzerland’s health system, increasing its desirability to national budget holders, while safeguarding the progress made towards day surgery that had been achieved using financial signals. The survey indicates that policy can be effective when combined with clinical feasibility¹⁴. Overall, the most selected driver of day surgery growth was improvements in surgical techniques and recovery protocols (36%), ahead of purely financial or regulatory pressures. This suggests mandates are most credible when supported by practical clinical capability¹⁴.

It is also important to be careful with financial incentives as they can be blunt instruments. England’s experience with the English Best Practice Tariff did see positive spillover in terms of selected procedures being targeted and growing. However, the gains weakened over time and the tariff incentives also saw diversion of resources and investment away from non-targeted procedures in the elective portfolio, meaning that some gains were coming at the expense of other areas⁸⁸. The survey findings support this caution. Respondents did not view financial pressure alone as sufficient, instead ranking patient education, purpose-built facilities, digital tools and pathway redesign among the most practical interventions for further growth¹⁴.

Irish evidence too demonstrates why financial incentives must be delivered hand-in-hand with operational changes, redesigned care, protected capacity. In Ireland's case, neither activity based funding nor a targeted price incentive for day case laparoscopic cholecystectomy produced a measurable change in day case rates or average length of stay⁸⁹. The Irish example demonstrates that financial reform can fail when it is too weak in relation to the operational effort required to access it; hospitals may simply absorb the signal without redesigning care. Policy signals only work when they incentivise making day surgery a management priority.

Another strong option for policy is a concerted effort to create dedicated, protected, or ringfenced capacity for day surgery. The evidence reviewed repeatedly demonstrated that co-located services blur the lines between inpatient and outpatient care, creating a risk that surgical procedures would default to inpatient settings. The gold-standard of protecting day surgery care is dedicated facilities for this purpose, but policy makers and hospital leaders can consider other ways to protect day surgery capacity and resource.



David Bunting

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Management Body Officer, International Association of Ambulatory Surgery
Past President, British Association of Day Surgery, United Kingdom

“ One of the most important things is ring-fenced day surgery beds that are protected from unplanned medical and surgical admissions.”

Then policy efforts to improve day case rates must take a holistic view of the problem, identifying the contextual barriers and facilitators in the system, and seek to create a distinct and standardised pathway for day surgery. There are a variety of methods to get there, from regulation, to financial signalling, to accountability measures, but all should be assessed to guard against perverse incentives and unintended distortions. The survey supports this balanced conclusion. Respondents described the shift towards day surgery as being driven simultaneously by innovation, patient expectations, budgetary realities, waiting list pressures and explicit targets¹⁴. The most successful policy models are therefore likely to be those that align these drivers rather than relying on any one intervention in isolation.

It is vital also to give due consideration to clinical best practice by identifying individual innovators and scaling and learning from their work. Moving towards increased day case rates is both policy-driven and culture-driven – both must be considered.



Professor Tim Briggs CBE

GIRFT Programme Lead and NHS England
National Director for Clinical Improvement,
Elective Recovery and UEC, United Kingdom⁷⁵

“ The more we can separate elective from urgent and emergency care, the better.”



Dr Shaan Chhabra

Transformation and Flow Improvement
Lead at Newham Hospital, Barts Health
NHS Trust, United Kingdom¹⁵

These recommendations were discussed and refined at the outpatient surgery advisory board¹⁵ and were subject to an additional round of review afterwards.



Policy recommendations

“ There are two major issues associated with the rise of day surgery in the UK: variation and planning. For some surgery types, ICBs achieve up to 95% of procedures as day surgery, while others, sometimes within the same region, achieve only 60%. Around 20% of day surgery cases in the NHS are cancelled either at pre-op or within 24 hours of the operation, making it difficult to plan and operate efficiently.

A recent project I worked on to address complication rates showed some really interesting results. We learnt that issues around team identity and purpose, the late receiving of patients through non-streamlined processes, being too tied to the hospital leading to competition for beds, and limited sharing of data all contributed to a poorer understanding of how improvements could be made. For me, this demonstrated that if teams are allowed to purposefully set up for day surgery, we can drive success.”

Patient safety comes first

Day surgery is a vital tool in tackling elective waiting lists, improving hospital efficiency and throughput, and in protecting bed capacity. However, it is only appropriate where it is safe for patients. Any incentives that encourage growing day surgery rates should be reviewed for the potential for perverse outcomes that could diminish patient safety, and adjusted accordingly. Day surgery should always add value for patients.

Patient safety should be protected across the day surgery pathway, especially in selection and pre-operative planning and in consideration to recovery at home. Patients should have a named healthcare professional to contact in the event of post-operative complications, and should understand what constitutes normal recovery. There should be clear routes for escalation.

Healthcare professionals should prioritise the main drivers of readmissions, giving close attention to pain management, post-operative nausea and vomiting, and surgical site infection (including for minimally invasive procedures).



Bjarne Skjødt Hjaltalin

Chief Physician at the Day Surgery Department, Amager and Hvidovre Hospital, Denmark⁵⁶



Make day surgery the default where clinically appropriate

“Daytime surgery should be the main route, and physicians should argue if they want to do it differently.”

Health systems should strive to make day surgery pathways the default for procedures that have a strong safety case and are clinically appropriate, and for patients who are physically and socially capable of undergoing the procedure as a day-case. This can be achieved through a variety of means, including protected, ring-fenced capacity; dedicated facilities; operational expectations; accountability; and financial incentives. Patient choice should be maintained, and patient satisfaction/acceptability should be tracked as an important indicator of success.

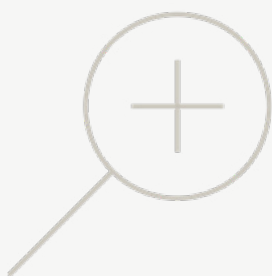
Follow a three step approach to grow day surgery

1. Deliver high volume low complexity cases as day surgery by default, where clinically appropriate for the patient
2. Reduce variation in procedures that have a good safety/feasibility profile but varied local implementation
3. Expand the frontiers of day surgery by identifying new possible procedures and populations

Focus policy attention on building reliable pathways

Day surgery should have distinct pathways to inpatient surgery and should be designed from the ground up with the unique features of day surgery in mind. From a patient safety perspective, strong consideration should be given to patient selection and pre-operative planning and communication. While standardisation is important, new frontiers for day surgery should develop their own pathways that account for their distinct features.

Health systems should also consider the interface between surgical centres and community services and social services, conceptualising the patient pathway for day surgery as one that extends beyond the hospital or clinic.



As the healthcare professional with the most face-to-face time with patients in the perioperative period, nurses should be empowered to have sufficient time available to dedicate to patient communication and interaction.

Standardise pathways while preserving flexibility

Embrace adaptable standardisation within pathways, ensuring that processes are standardised to promote clear lines of accountability, repeatable tasks, efficiency, and staff familiarity, while protecting the level of flexibility required to account for differences between procedures and contexts. Innovations like customised procedure trays can help to deliver this type of adaptable standardisation across different procedure types.

Protect elective capacity by ringfencing day surgery capacity/resourcing and building dedicated facilities

Avoid defaulting to inpatient stays by ringfencing or otherwise protecting day surgery capacity, while always ensuring that there is a route to enhanced care for patients that genuinely need it.

Embed equity by design

Health systems should strive to identify and monitor locally relevant health inequalities. Health inequalities should not exclude patients from receiving day surgery. Instead, health systems should seek to enact adjustments to protect safe access to day surgery for vulnerable patients. Close consideration should be given to patients' home recovery environment, and appropriate community services should be engaged to facilitate patients' recovery in the community where they do not have strong family support.

Patients should be seen in a holistic sense, with their social circumstances given equal weighting alongside clinical features.

Communicate with patients in a way that is simple to understand

Health systems should ensure that communication with patients is prioritised as part of pathway planning. Patients should receive information in the simplest possible terms, avoiding medical jargon and delivered through an interpreter when necessary. Patients should receive important information at a time when they are most likely to retain it and be given ample time to ask questions. Patients should receive all relevant information in writing, as well as verbally. Routine follow-ups should be conducted after surgery to give patients the opportunity to raise concerns.

Healthcare professionals should endeavour to give time to patients, and listen with an empathetic and attentive demeanour, recognising that surgery places patients in an extremely vulnerable position. Patients should have a clear understanding of what day surgery entails, the implications for home recovery, and have the opportunity to give informed consent.

Conclusion

Day surgery has considerable potential to improve patient experience within health systems, while cutting costs and recovering elective capacity for more inpatient cases that genuinely require overnight care. However, there remains significant variation in day case rates globally, with some examples of sluggish take-up even when day surgery is identified as a system priority. This report makes the case for a wide-ranging effort to grow day case rates, focusing first on high-volume, low-complexity cases, and expanding the frontier by establishing standard protocols and pathways, and utilising a variety of policy tools to incentivise the shift to day cases.

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Appendix

Survey questions

Q1

In your day-to-day work, how often, if at all, does each of the following occur?

	Always	Often	Sometimes	Occasionally	Never	I don't know / not applicable	Prefer not to say
Procedures that could safely be performed as day cases are instead carried out as inpatient surgery	7%	22%	30%	32%	8%	1%	1%
Pressure to increase day surgery volumes negatively influences patient selection decisions	7%	22%	30%	28%	12%	1%	0%
Patients are discharged from day surgery when I am not confident they are ready	9%	16%	24%	32%	18%	1%	0%
Patients are discharged from day surgery without adequate support for recovery at home	4%	19%	28%	27%	22%	0%	0%
Patients suitable for day surgery are delayed due to lack of theatre capacity	7%	25%	33%	24%	10%	1%	0%

N: Surgeons, Anaesthetists, OR Operating room nurses (148)

	Always	Often	Sometimes	Occasionally	Never	I don't know / not applicable	Prefer not to say
Planned expansion of day surgery is delayed by lack of facilities or investment	9%	19%	34%	26%	11%	0%	1%
Pressure from payers, regulators, or national targets to increase day surgery rates	9%	20%	34%	32%	3%	0%	1%

N: Operating room managers, Procurement OR Hospital executive management (108)

	Always	Often	Sometimes	Occasionally	Never	I don't know / not applicable	Prefer not to say
Difficulty recruiting or retaining staff for day surgery roles	10%	27%	33%	23%	5%	0%	1%

N: Operating room managers OR Hospital executive management (73)

	Always	Often	Sometimes	Occasionally	Never	I don't know / not applicable	Prefer not to say
Delays in sourcing or availability of equipment and consumables needed for day surgery	9%	14%	20%	43%	14%	0%	0%

N: Procurement (35)

	Always	Often	Sometimes	Occasionally	Never	I don't know / not applicable	Prefer not to say
Day surgery lists are cancelled or shortened due to operational constraints	8%	21%	39%	27%	5%	0%	0%

N: All (256)

Q2

How would you rate each of the following in your current setting?

	Very poor	Somewhat poor	Neither poor nor good	Somewhat good	Very good	I don't know / not applicable
Training and preparedness of staff for day surgery procedures	2%	12%	17%	36%	31%	1%
Standardisation of day surgery pathways and protocols	3%	9%	18%	44%	27%	0%
Pre-assessment and patient selection processes for day surgery	5%	11%	22%	36%	27%	0%
Physical facilities and equipment available for day surgery	2%	11%	17%	41%	29%	1%
Staff wellbeing and working conditions in day surgery compared to inpatient work	5%	8%	22%	38%	28%	0%
Availability of post-operative recovery and discharge capacity	4%	10%	24%	38%	24%	0%

N: All (256)

Q3

Thinking about suitable patients and procedures, based on your own experience or understanding, which setting, if any, do you think achieves better results on each of the following?

	Much better in day surgery	Somewhat better in day surgery	About the same	Somewhat better in inpatient surgery	Much better in inpatient surgery	I don't know
Surgical complication and post-operative infection rates	11%	30%	30%	19%	9%	1%
Unplanned readmission or return-to-hospital rates	11%	29%	30%	21%	7%	2%
Patient-reported pain and recovery experience	12%	26%	30%	20%	10%	1%
Lower overall healthcare costs for both hospitals and payers	22%	28%	24%	15%	9%	2%
Reduced anaesthesia-related side effects	11%	32%	29%	18%	9%	0%
Higher throughput and operational efficiency for surgical teams	11%	35%	25%	18%	10%	1%

N: All (256)

Q4

How much untapped potential for day surgery, if any, do you see in each of the following specialties – i.e. where more procedures could realistically be done as day cases but currently aren't?

Speciality	No untapped potential	Some untapped potential	Significant untapped potential	I don't know / not relevant to my role
Orthopaedics	16%	43%	34%	8%
General surgery	16%	48%	32%	4%
Ophthalmology	14%	46%	31%	9%
Gynaecology	18%	47%	27%	8%
Urology	19%	45%	27%	9%
ENT	19%	42%	27%	12%
Plastic / reconstructive surgery	12%	45%	34%	9%
Cardiology (e.g. catheter-based interventions)	21%	38%	32%	9%

N: All (256)

Q5

In your setting, which factors, if any, are most strongly driving the move toward day surgery? (Select up to 3)

	All
Improvements in surgical techniques and recovery protocols	36%
Patient preference for same-day discharge and home recovery	30%
Reduction of hospital-acquired infections risks and improve patient safety	27%
Cost or budget pressure	27%
National or regional health system targets for day surgery rates	26%
Capacity pressure driving throughput targets	25%
Reducing elective waiting lists or backlogs	25%
Development of dedicated day surgery centres or surgical hubs	24%
Pressure to improve operating theatre efficiency	22%
Policy, regulatory, or reimbursement changes	21%
I don't know	0%
Other, please specify	0%

N: All (256)

Q6

For each pair of statements below, where do you sit between the two statements?

Left-hand statement	Strongly agree with statement on the left	Somewhat agree with statement on the left	Neither / equal	Somewhat agree with statement on the right	Strongly agree with statement on the right	Right-hand statement
Day surgery is seen by professionals as a rewarding, high-quality area to work in	15%	29%	25%	22%	9%	Day surgery is seen by professionals as lower-status or less complex than inpatient work
Day surgery allows better teamwork and coordination across roles	13%	29%	23%	23%	11%	Day surgery makes effective teamwork harder
Clinical staff have meaningful input into how day surgery pathways are designed	14%	26%	23%	27%	10%	Day surgery pathways are largely designed without enough input from the staff who deliver them
Day surgery works best when it's delivered in a dedicated unit with its own team	16%	29%	21%	24%	10%	Day surgery works well within a general hospital theatre environment
Decisions about which cases are suitable for day surgery are made collaboratively across clinical and management teams	13%	25%	27%	24%	12%	Decisions about which cases are suitable for day surgery are driven by one group without enough input from others
The workload and pace in day surgery is manageable and sustainable	12%	24%	27%	25%	13%	The workload and pace in day surgery puts staff under excessive pressure

N: All (256)

Q7

What, if anything, would make the biggest practical difference to expanding day surgery in your setting?
(Select up to 3)

	All
Patient education to alter expectations around day surgery and recovery at home	34%
Purpose-built day surgery facilities or surgical hubs	32%
Digital tools that reduce administrative burden and give staff faster access to the information they need	32%
Better anaesthetic protocols for rapid recovery (e.g. regional anaesthesia, shorter-acting agents)	30%
Standardised clinical pathways and procedure-specific protocols	27%
Specific training programmes for day surgery teams	27%
Better data and benchmarking on day surgery outcomes	26%
Clearer financial incentives to treat patients as day cases	25%
Better-designed instruments and devices for day surgery procedures	23%
I don't know	1%
Other, please specify	0%

N: All (256)

Q8

In your experience, what, if any, are the main reasons a borderline case is not performed as a day surgery procedure?
(Select up to 3)

	All
Patient fitness, comorbidities, or complexity of the procedure	43%
Patient's home circumstances (lives alone, distance from hospital, carer availability)	38%
Lack of a suitable day surgery facility or list availability	33%
Concerns about post-discharge support or escalation if complications arise	32%
Surgeon or anaesthetist preference to keep the patient in	32%
Lack of availability of appropriate day surgery staff	26%
Patient preference for an overnight stay	24%
No established day surgery pathway for that procedure	23%
Other, please specify	0%
I don't know	0%

N: Surgeons, Anaesthetists, Operating room nurses OR Operating room managers (180)

Q8a

What, if anything, would most increase your confidence in expanding day surgery in your organisation?
(Select up to 3)

	All
Standardised procedure trays that reduce setup time and variability between cases	42%
Better post-operative wound care protocols for patients recovering at home	38%
Infection prevention solutions designed for high-throughput day surgery environments	36%
Training and education programmes to build day surgery capability across teams	36%
Evidence and benchmarking data on day surgery outcomes by procedure type	30%
Pathway redesign support to reduce non-value activity and improve theatre efficiency	30%
Digital tools that streamline material handling, surgery day workflows, and activity insights	21%
Sustainable solutions that reduce waste without compromising safety	21%
I don't know	1%
Other, please specify	0%

N: All (256)

Q9

When selecting a supplier or solutions partner for day surgery products and services, how important, if at all, is each of the following to you?

	Not important at all	Not important	Somewhat important	Very important	I don't know / not relevant to my role
Consistent, high-quality products that clinical teams can rely on	4%	8%	36%	51%	2%
Reliable supply and availability when needed	3%	13%	34%	50%	1%
Responsive service and support from the supplier	2%	13%	44%	41%	0%
Products and solutions that improve theatre efficiency and reduce setup time	3%	10%	41%	45%	1%
Evidence and data to support clinical and procurement decisions	2%	11%	45%	41%	2%
Training, education, and clinical capability-building	3%	8%	30%	57%	2%
Sustainable products and packaging that support environmental goals	2%	14%	41%	41%	2%
Ability to customise and standardise procedure trays for specific pathways	2%	11%	43%	43%	1%

N: All (256)

Q10

Over the next 2–3 years, what change, if any, do you expect to see in your setting in each of the following areas?

	Significant decrease	Some decrease	Neither decrease nor increase	Some increase	Significant increase	I don't know
Volume of day surgery procedures	2%	9%	27%	33%	30%	0%
Range of procedure types performed as day cases	1%	11%	27%	42%	18%	1%
Investment in dedicated day surgery facilities or equipment	2%	12%	18%	41%	26%	1%
Adoption of standardised day surgery pathways and protocols	3%	12%	20%	41%	24%	0%
Reduced anaesthesia-related side effects	11%	32%	29%	18%	9%	0%
Higher throughput and operational efficiency for surgical teams	11%	35%	25%	18%	10%	1%

N: All (256)



David Bunting

Consultant in Upper Gastrointestinal and Abdominal Wall Reconstruction Surgery, North Devon District Hospital
Management Body Officer, International Association of Ambulatory Surgery
Past President, British Association of Day Surgery, United Kingdom

1 April 2026

Interviews

Questions:

- + From your perspective as both a practising surgeon and a national day surgery leader, what are the biggest reasons why some parts of the UK have been able to scale day surgery successfully, while others still lag behind?
- + In upper GI and abdominal wall surgery specifically, where do you see the greatest remaining opportunity to shift more care safely into ambulatory or day-case settings over the next few years?
- + What are the most important pathway or service design features that make day surgery work well in practice, particularly in an NHS setting under pressure?
- + As day surgery expands into more complex procedures and patient groups, how should providers think about patient selection without becoming too risk-averse?
- + How important are innovation and technology, such as minimally invasive techniques, robotic surgery, better analgesia, and digital follow-up, in enabling the next phase of ambulatory surgery in the UK?
- + For health systems outside the UK looking to expand ambulatory and day surgery, what do you think are the most transferable lessons from the UK experience, and what should not simply be copied without adaptation?



**Prof. Karine Nouette-Gaulain,
MD, PhD**

Head of Department, Anaesthesia, Critical
Care and Perioperative Medicine Children's
Hospital & Aliénor d'Aquitaine Maternity
Unit Bordeaux University Hospital (CHU
de Bordeaux)

10 April 2026

Questions:

- + Selon votre expérience, comment les modèles de chirurgie ambulatoire et de chirurgie de jour ont-ils évolué en France au cours des dernières années, et quels changements vous semblent les plus structurants aujourd'hui?
- + Dans le système de santé français, quels sont les principaux facteurs cliniques, organisationnels ou systémiques qui expliquent l'accélération de la transition vers des parcours de chirurgie avec sortie le jour même?
- + Dans quelle mesure le développement de la chirurgie ambulatoire nécessite-t-il, selon vous, une plus grande priorité accordée à des infrastructures et à des capacités dédiées d'éviter la concurrence permanente entre la chirurgie programmée et les activités d'urgence pour le temps opératoire et les ressources cliniques?
- + Du point de vue de l'anesthésie-réanimation, quels progrès ont été les plus déterminants pour rendre la sortie le jour même plus sûre et plus fiable pour un nombre croissant de patients et de procédures?



Prof Tim Briggs

GIRFT Programme Lead and National
Director for Clinical Improvement and
Elective Recovery, NHS England

23 April 2026

Questions:

- + From a national policy perspective, what do you see as the most effective levers for increasing day case surgery rates across the NHS, particularly in procedures where variation between trusts remains high?
- + Based on your experience with GIRFT, what are the main barriers that prevent trusts from moving more appropriate procedures into a day case setting, even where the clinical evidence supports this approach?
- + In your view, how much progress depends on clear national policy direction, and how much depends on leadership at trust or system level when it comes to reducing variation in day case surgery rates?
- + To what extent do current funding arrangements, incentives, and performance frameworks support trusts to prioritise day surgery and ambulatory care pathways as part of elective recovery?
- + As more care shifts into day case models, how should policy makers and clinical leaders think about recovery at home, and what needs to be in place to ensure patients are supported safely and consistently after discharge?
- + Looking ahead, what further policy changes or national priorities would have the greatest impact in making high quality day surgery and home recovery the norm across the NHS?
- + Given your experience in orthopaedics, where do you see the greatest opportunities to expand day case surgery, and what lessons could orthopaedics offer the wider system?



Bjarne Skjødt Hjaltalin MD, MPG

Chief Physician, Department of Day Surgery,
Amager and Hvidovre Hospitals

30 April 2026

Questions:

- + Drawing on your experience in anaesthesiology, intensive care and emergency care, what do you think are the most important clinical safeguards for expanding day surgery safely?
- + From your experience, what have been the biggest practical barriers to scaling day surgery in your hospital?
- + From your experience, what are the key enablers that have supported Denmark's progress in ambulatory and day surgery?
- + Looking specifically at Denmark, what trends do you expect to shape the future of day surgery over the next five to ten years?
- + Given your role in Nordic ambulatory surgery strategy, what lessons from Denmark's experience do you think are most relevant for other European health systems?

The Reimagining Day Surgery report was reviewed and discussed by a panel of clinical experts in a 120 minute advisory board. The panel convened via Microsoft Teams on Thursday 7th May between 17:00 - 19:00 BST.

Advisory board

Participants:



Chair: Mr Chris Hopson

Former Chief Strategy Officer of NHS England



Professor Jaideep Pandit

Chair and Professor of Anaesthesia, University of Oxford, United Kingdom



Laurens Van Houte

Manager of Surgical Department, Medisch Spectrum Twente, Netherlands



Daniela Matos

Head Nurse, Unidade Local de Saúde de Santo António, Portugal



Dr Jaroslaw J. Fedorowski

President, Polish Hospital Federation (PFSz), Poland



Jaana Perttunen

President, European Operating Room Nurses Association (EORNA), Finland



Dr Shaan Chhabra

Transformation and Flow Improvement Lead at Newham Hospital, Barts Health NHS Trust, United Kingdom



Dr Francesco Venneri

Director, Clinical Risk Management and Patient Safety Center, Tuscany Region, Italy

Discussion agenda

Agenda Item	Description
Welcome and introductions	Overview of meeting objectives and agenda; introductions of advisory board members.
Section One A: Outpatient day surgery in my health system	Attendees provide a three-minute overview of the current state of outpatient surgery in your country or health system. The aim is to provide a quick comparison of how outpatient surgery is currently defined, delivered and prioritised across different settings, and to identify the most important similarities and differences between systems.
Section One B: Reflections on presentations	Discuss the common themes, differences and implications for the report. The purpose of this session is to identify the most important patterns emerging across systems and determine which issues should be emphasised in the final report. Questions for discussion: 1. What were the most important similarities and differences between the health systems presented, and what do these tell us about the barriers and enablers of outpatient surgery? 2. Which themes, examples or lessons from the presentations should be reflected more strongly in the report?
Section Two: Reflections on the report	Group discussion to provide reflections on the draft report, whether it accurately frames the opportunity for outpatient surgery across different health systems. Questions for discussion: 1. Does the report clearly articulate the potential and importance of outpatient surgery? 2. Does the report strike the right balance between presenting outpatient surgery as an opportunity and recognising practical limitations? 3. Does the report accurately reflect the following challenges? Consider how this reflects on your own healthcare system if not specifically discussed in the report. + Bed pressures + Workforce shortages + Efficiency of OR processes + Elective backlogs + Financial constraints + Any you feel are missing
Section Three:	This session will examine whether the report focuses on the right procedures, specialties and opportunities for expanding outpatient/day surgery. Test whether the proposed prioritisation framework reflects real-world practice across different health systems and whether there are important specialties, procedures or emerging trends that are currently missing from the draft. The group should consider where the greatest opportunities for rapid capacity gains exist, where progress has been slower than expected and which areas are most likely to shape the future direction of outpatient/day surgery. Questions for discussion: 1. Does the proposed prioritisation approach make sense? + High-volume procedures with mature same-day pathways + Procedures with strong evidence but low adoption + Frontier procedures that may become feasible in future 2. Which specialties or procedures are most important to include for your system?

Agenda Item	Description
Section Four: Delivering Efficiencies in the Operating Theatre	This session will explore whether the draft report's recommendations are sufficiently practical, relevant and actionable across different health systems. The discussion will focus on whether the report identifies the right actions, priorities and levers to support wider adoption of outpatient/day surgery in different settings. Please consider how the report can best support clinicians, executive teams and policymakers. The session will also explore what additional guidance, examples or adaptations may be needed to ensure that the recommendations are compelling and usable in practice. Questions for discussion: 1. Do the draft recommendations reflect the most important actions needed to accelerate outpatient/day surgery? 2. Which recommendations are likely to be most achievable in your health system? 3. Which recommendations are likely to be most challenging or controversial? 3. Does the report provide enough guidance on: + Workforce redesign + Protected elective capacity + Financial incentives and reimbursement + Safety and equality considerations + Use of digital tools and remote follow-up
Next steps and follow up	Overview of next steps, timeline for report development and invitation for further feedback.

The Advisory Board meeting focused on validating the findings and recommendations within the draft report on outpatient/day surgery, while gathering international perspectives on the barriers, enablers and future opportunities for expanding same-day care.

Summary of topics discussed

1. Current State of Outpatient Surgery Across Health Systems

Board members shared perspectives on how outpatient surgery is currently defined, delivered and prioritised within their respective countries and health systems. Discussions explored variations in policy frameworks, levels of adoption, reimbursement models, infrastructure and clinical pathways.

Key areas of discussion included:

- + Differences in national definitions and measurement of outpatient/day surgery
- + The degree to which outpatient surgery is prioritised within healthcare policy and hospital strategies
- + Common barriers limiting expansion, including workforce constraints, infrastructure limitations and reimbursement challenges
- + Examples of successful approaches that have accelerated adoption

2. Common Themes and Cross-System Learning

Following the presentations, the group reflected on similarities and differences across health systems and considered the implications for the report.

Discussion focused on:

- + Shared challenges affecting outpatient surgery regardless of geography
- + System-level enablers associated with higher adoption rates
- + Lessons that could be transferred between health systems
- + Areas where the report should place greater emphasis based on recurring themes emerging from the presentations

3. Reflections on the Draft Report

The board reviewed whether the report accurately captures the opportunity presented by outpatient surgery and appropriately reflects the realities facing healthcare systems.

Key discussion points included:

- + Whether the report clearly articulates the strategic importance of outpatient surgery
- + The balance between highlighting opportunities and acknowledging practical implementation challenges
- + The extent to which the report reflects major pressures facing health systems, including:
 - Bed capacity constraints
 - Workforce shortages
 - Operating theatre efficiency
 - Elective care backlogs
 - Financial pressures
- + Identification of any additional challenges or contextual factors that should be incorporated

4. Prioritising Procedures and Future Opportunities

The discussion examined whether the report focuses on the right procedures, specialties and growth opportunities.

Topics included:

- + The suitability of the proposed prioritisation framework
- + Opportunities to expand established same-day pathways for high-volume procedures
- + Procedures with strong evidence supporting outpatient delivery but where adoption remains limited
- + Emerging and frontier procedures that may become suitable for outpatient settings in the future
- + Specialty-specific opportunities and variations across health systems
- + Areas where progress has been slower than anticipated and the reasons behind this

5. Delivering Operating Theatre and System Efficiencies

The board considered whether the report's recommendations are practical, actionable and relevant across different healthcare settings.

Discussion focused on:

- + The actions most likely to accelerate outpatient surgery adoption
- + Recommendations that are realistic and achievable within different health systems
- + Areas likely to face implementation challenges or stakeholder resistance
- + The role of:
 - Workforce redesign and skill mix changes
 - Protected elective capacity
 - Financial incentives and reimbursement mechanisms
 - Safety and equity considerations
 - Digital technologies and remote follow-up pathways

