As I write this letter we are in the last throes of an Indian summer which has temporarily lifted our spirits. This was certainly needed, because around the country people are unhappy and healthcare is no exception. In contrast to other public services, which have seen quite severe cuts, we constantly need to remind ourselves that the health budget was actually increased slightly. However, with a lower than inflation increase, and with medical inflation running at an even higher rate, it still feels like a fairly drastic cut. Many trusts are in severe financial difficulty; staff are being downgraded or made redundant, beds are closing and procedures are being rationed.

Against this background, the Royal College of Surgeons have raised concerns about the standards of care for patients having emergency surgery in England. Many of the issues they raise — insufficient consultant led care, delays in accessing imaging and theatres and shortages of critical care beds — will only be addressed by major investment or a significant shift in priorities. In contrast, there has been considerable investment in elective care in recent years, such that most patients are treated by consultant surgeons and anaesthetists, have a choice in when and where their procedure is performed, rarely have to wait too long for surgery and spend far less time away from home than used to be the case. If the aspirations of the Royal College of Surgeons are met, valid though they are, what will be the implications for elective care? Further investment seems unlikely at present and existing resources will only stretch so far; if emergency care is to be the priority, the elective side is likely to suffer and we risk slipping back to where we came from just a few years ago.

It is important to maintain the current elective standards, not least because of the potential impact on emergency services as gall bladder disease becomes pancreatitis, an untreated hernia leads to bowel obstruction and aneurysms expand and leak. To do this in the current climate will require even greater economies and efficiency savings. Although this has been the message for several years, it is amazing how much variation there still exists in so many aspects of how healthcare is provided. As the BADS Directory increasingly becomes the benchmarking tool of choice in day surgery, data become available for many more elective surgical procedures, almost all of which show enormous variations in day case rates throughout the country. One of the most surprising findings is that for a considerable number of procedures, some trusts are managing almost everyone as a day case, while others rarely perform that same operation on a day case basis. Even harder to explain is that a given trust may have one of the highest day case rates for some procedures, yet is achieving some of the lowest rates for others. Many of the commonly used justifications for a low day case rate, such as social deprivation, high rates of co-morbidities, unfavourable geography and inadequate facilities, cannot possibly apply under these circumstances and it is more likely that the explanation lies in ingrained customs and practices and in personal beliefs. Does this degree of variation really have a place in modern medicine?

Challenging variation in day surgery will be the theme of our 2012 annual meeting which is now at an advanced planning stage. We hope to illustrate best practice in a number of day case procedures and address ways of reducing variation in performance while still allowing freedom of clinical judgement and not stifling innovation. For this meeting we will be returning to the Riviera Centre in Torquay and the dates for your diary are 21–22 June 2012. There is still plenty of time to gather data and submit an abstract to showcase your own best practices, or just come along to network with your colleagues and see for yourself how their practice varies from your own.

Either way, I hope to see you there.

IAN SMITH