



# High flow, all complexity, local anaesthetic cataract surgery implementation support guides:

Guide 1: How to deliver a high volume cataract theatre list:

Implementation of the GIRFT-RCOphth High-flow all-complexity cataract surgery pathway at East Lancashire Hospitals NHS Trust

October 2022

## Executive summary

Getting It Right First Time (GIRFT) is a key enabler for healthcare systems working on the [High Volume Low Complexity \(HVLC\) Programme](#) which is nationally rolled out, regionally led, and system delivered. HVLC focuses on driving improvement in high volume specialties such as Ophthalmology.

2022 GIRFT data shows the average number of cataract procedures completed in an average 4-hour theatre session is 6.3 nationally. **The HVLC standard is 10 cases on a high flow list and 8 cases on a standard/teaching list.** Therefore, there remains huge potential to improve access to timely cataract surgery. This delivery guide sets out the key elements that need to be in place to meet this standard using the GIRFT pathway.

## Who should read this guide?

This is the first in a series of four implementation guides intended to be of interest to organisations and systems aiming to improve efficiency and reduce waiting lists, enabling provision of cataract surgery in a timely manner through the implementation of a high-flow cataract surgery pathway.

## Purpose of this guide

This delivery guide provides insight on the successful implementation of the **GIRFT-RCOphth high-flow all-complexity cataract surgery pathway** at East Lancashire Hospitals NHS Trust (ELHT), which **increased potential throughput by 46% per week without additional resource.** It describes the implementation of an elective drive to enable the embedding of best practice resulting in optimised ways of delivering service, increased effectiveness, and productivity.

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# Overview

## 1. Case for change

- GIRFT worked in partnership with East Lancashire Hospitals NHS Trust (ELHT) to transform their cataract service by introducing the GIRFT-RCOphth high flow cataract pathway.

The aim was to implement widescale change including:

- Maximise ELHT's capacity to perform cataract surgery by increasing the number of cases performed per list (4/5) in line with high volume low complexity (HVLC) standards (8/10).
- Reduce the number of patients on the cataract surgery waiting list.
- Improve pre-operative assessment duration and process as patients were attending up to three pre-operative assessment appointments prior to the day of surgery

## 3. Elective drive

- This major transformation was achieved by delivering an elective drive which mirrored the GIRFT-RCOphth pathway.
- Completing a large number of cataract procedures using the new processes helped familiarise the whole department and embed the change.

## 5. Drive summary

- The drive utilised two theatres for 5 days.
- All focus and resources were directed towards cataract surgery for the week.
- A combination of high flow (10 pts), standard (8 pts) and general anaesthesia (GA) lists (6 pts) were performed based on patient need.
- Individual job roles and processes were meticulously planned to achieve optimal patient flow.

## 2. Baseline position

- A detailed review of the existing cataract pathway was performed from patient referral through to discharge.
- A gap analysis was undertaken between current practice and the GIRFT-RCOphth pathway to determine the changes required and to define the project scope.

## 4. Pre-operatively

- A new one-stop clinic was developed to pre-assess all patients prior to the elective drive. These were all additional sessions to minimise service disruption.
- Rigorous and standardised pre-operative assessment prior to the day of surgery was the most important factor for the success of high flow lists.

## 6. Results

- 121 cataract procedures completed without complication. Average of 9 per high flow list and 7 per standard list.
- COVID-19 predominant reason for late cancellation.
- Positive staff and patient feedback.
- All lists finished on time.
- Changes implemented are projected to increase number of cataract procedures by 46% per week without additional resources.

## Introduction

Following a GIRFT visit to ELHT in August 2021, the opportunity was identified to introduce high flow cataract surgery with the aim of increasing the average number of cataract procedures completed in a 4-hour theatre session from 4/5 to 8/10.

This delivery guide demonstrates how the implementation of the GIRFT-RCOphth high-flow all-complexity cataract surgery pathway increased weekly throughput by 46%. The pathway defines 'best practice', but the real challenge and crucial step is local implementation, to bring sight-changing surgery to patients as quickly and safely as possible. Associated [guidance](#) defines the optimal clinical and operational processes that should be adopted to improve quality of care, increase capacity, and ensure efficient use of resources.

Key elements that contributed to successful implementation in this case:

- GIRFT worked in partnership with East Lancashire Hospitals NHS Trust (ELHT) to successfully implement high flow cataract surgery at pace
- An elective cataract drive was used as the catalyst to deliver widespread transformation of ELHT's existing cataract service to bring it in line with the GIRFT-RCOphth high flow cataract surgery pathway
- ELHT's five-day elective cataract drive held in 2022 saw the high flow cataract pathway used to deliver 121 cataract procedures without complication. The elective drive was a unique opportunity for ELHT's surgical division to pool knowledge and resource to implement a new way of working
- Following the elective cataract drive the pathway has been fully embedded into routine practice.

By continuing to deliver the cataract service as per the high flow cataract pathway, ELHT projects it will be able to do an additional 1,152 cataract procedures per annum without additional resources.

**This is the first of a series of [four guides](#) covering different aspects of high flow cataracts pathway implementation:**

- **Guide 1:** How to deliver a high volume cataract theatre list
- **Guide 2:** How to setup a 'one-stop' cataract pre-assessment clinic
- **Guide 3:** Designing effective perioperative data collection tools to support high flow cataract surgery, (includes example proforma for local adaptation)
- **Guide 4:** Perioperative management of patients with medical comorbidities and additional needs.

Other documents to read include:

- [GIRFT-RCOphth High Flow All Complexity Cataract Surgery Pathway](#)
- [RCOphth High Flow Cataract Surgery Service Document](#)

These documents are on the Getting It Right First Time (GIRFT) Academy [Best Practice Library](#) alongside other useful documents for ophthalmology.

## The East Lancashire Hospitals NHS Trust case study

GIRFT offered support and formed a partnership with ELHT to facilitate the implementation of the GIRFT-RCOphth high flow all complexity cataract surgery pathway. From the outset, a decision was made to use an elective drive to help deliver this widespread service transformation.

The sequence of activities leading to the delivery of the elective cataract drive are described in the sections below.

### Elective drives (or high-volume drives/super weeks)

Elective drives are an opportunity to focus the resources and energy of a clinical department towards completing a high volume of a specific procedure in a pre-determined time frame. They are an opportunity for teams to work together towards implementing long lasting changes for the benefit of the service and patients. The excitement and exposure which can surround these projects helps attract additional resource to support delivery and can be useful to engage colleagues in the change process. Completing a large number of cases over a short period of time during the elective drive helps to rapidly familiarise a large number of people with the new way of working.

Prior to an elective drive, the whole patient pathway must be closely reviewed and where necessary, transformed to maximise efficiency. GIRFT has set out a number of best practice pathways, including the high-flow all-complexity cataract surgery pathway, which can be found [here](#).

Following the event, an in-depth evaluation is necessary to determine if further adaptations to the processes introduced are required prior to the changes being embedded into long term practice.

The objectives of an elective cataract drive are:

- Perform **high-volume, high-quality** cataract surgery with a **low complication rate**
- **Inspire the current team** in a demonstration of what is possible
- **Modify current operational practices** and create a legacy for **more efficient working** in the future by implementing high flow cataract surgery
- **Tackle the elective backlog**
- Provide staff with an opportunity to **see the proposed practice changes in action** and involve them in **developing the future of the service**.

The challenges of an elective cataract drive include:

- Focusing on cataract surgery for the duration of the elective drive **can disrupt** the provision of other services
- Completing a large number of cataract procedures in a short period of time **requires pre-operatively assessing and reviewing a large number of patients**.

# Launching the project and convening a senior oversight group

## The steps taken:

1. GIRFT met with the Medical Director of **Moorfields Eye Hospital** to capture learning about their 2021 elective cataract drive which saw 713 cataract procedures (across 8 theatres) successfully completed in 6 days. **Details of the Moorfields project can be found [here](#).**
2. A preliminary meeting was held with key stakeholders from GIRFT and ELHT which included medical, nursing, and operational board level executives in addition to the National Director for Clinical Improvement. This group became the senior oversight group which covered:
  - a. An overview of high flow cataract surgery and the GIRFT-RCOphth pathway
  - b. Why the transformation was needed and the intended benefits for patients, staff, and the organisation.
  - c. How an elective drive would support the transformation and examples from successful elective drives in other trusts
  - d. An outline of how the transformation would be delivered, including timescales and potential delivery challenges.
3. There was unanimous support for the project from ELHT clinicians and executives.
4. A project delivery team was identified which included the Matron for Ophthalmology, Directorate Manager for Ophthalmology, Clinical Director for Ophthalmology, Service Improvement Manger, GIRFT Clinical Fellow and GIRFT Senior National Implementation Manager.
5. The senior oversight group met every two months to review progress and resolve any challenges encountered.

## Key learning:

- Learning from providers who have implemented the HVLC pathway
- Executive clinical, nursing, and operational involvement from the outset with regular meetings to monitor progress and overcome challenges
- The transformation requires a close working relationship between medical, nursing, and operational leads
- Project scope should be agreed to set expectations. Important factors to consider include:
  - For the medical and nursing leads: introduction of pooled lists, standardising clinical processes, introducing new ways of working, engaging staff, and ensuring clinical governance processes maintain quality and safety
  - For the operational leads: date and duration of elective drive, number of operating theatres, projected number of additional cataract procedures, additional staffing requirements, funding requirements, potential impact to other services, managing increased patient flow, ensuring adequate supply of consumables and involvement of key services (e.g., sterile services and pharmacy).

# Establishing a baseline position and performing a gap analysis




- **Baseline:** the provider’s existing cataract surgery pathway prior to the intervention
- **Gap analysis:** identifying the differences between the baseline and GIRFT-RCOphth high flow all complexity cataract pathway

**The steps taken:**

1. **Identified the baseline** by meeting with the key staff members to define existing processes in addition to exploring the issues effecting the service. ELHT’s existing cataract service was reviewed in its entirety from patient referral to discharge. This included reviewing all documentation, proformas, patient letter templates, leaflets, guidelines/SOPs, and operational processes. There was focus on what components of the existing cataract service worked well and areas which needed to be altered.
2. **A gap analysis was performed** to identify differences between the baseline practice and the GIRFT-RCOphth high flow all complexity cataract pathway. Below is a sample from the exercise:










GIRFT-RCOphth high flow all complexity cataract pathway requirement	Gap analysis results
A one-stop pre-operative assessment clinic incorporating pre-operative assessment (POA), biometry and clinical review.	Currently patients have at least two out-patient appointments prior to surgery. Sometimes three visits are required due to the availability of biometry.
Offer Immediate Sequential Bilateral Cataract Surgery (ISBCS) to all patients when clinically appropriate.	ISBCS not routinely performed.
Criteria-led discharge with pre-prepared discharge medication and advice pack.	Nurse led discharge performed and post-operative drops available on day of surgery ward.

3. **The project implementation team reviewed the results of the gap analysis** and attributed one of three actions below:

	This requirement for high flow cataract surgery is not performed as part of the existing cataract surgery pathway. It will not be implemented for the elective cataract drive. This requirement will be addressed once high flow cataract surgery has been successfully implemented to further refine the process and improve the service. It is not an immediate change that is fundamental for the implementation of high flow cataract surgery.
	This is an essential requirement of high flow cataract surgery and is not performed as part of the existing cataract surgery pathway. This needs to be implemented for the elective cataract drive.
	This is an essential requirement for high flow cataract surgery and is already done as part of the existing cataract surgery pathway.



4. **Following the baseline review in step 1, the project implementation team uncovered some local issues** which were not covered by the GIRFT-RCOphth pathway and would have impacted the successful implementation of high flow cataract surgery. A table of requirements and the associated action was created to address each issue. The table below provides an example:

Issue identified	Additional requirement	Action
A generic day case surgery proforma not specific for high flow cataract surgery is used. It is time consuming to complete and multiple additional documents are required which can get lost. Information is hard to find causing frustration and delays.	Streamlined patient documentation to support the entire episode of care and high flow cataract surgery.	
Lengthy medical pre-assessment for a one-stop clinic. The assessment needs to be appropriately tailored for assessing patients undergoing high flow cataract surgery under LA.	To reduce the nurse led pre-operative assessment from 40 mins to 10-15 mins.	
Clinics are run by junior and non-surgical staff leading to variation in the quality of the pre-surgical assessment. Consultant presence in pre-operative clinics supports junior team members rigorously prepare patients for surgery and reduce the number of on the day cancellations.	Surgeon (consultant and senior clinical fellows) led one-stop clinic	
There is widespread variation in the management of diabetes, hypertension, and anticoagulation perioperatively. This often leads to a high number of on the day cancellations.	Standardised management of common patient co-morbidities	
Currently biometry is the rate limiting step for increasing pre-operative assessment capacity. The trained biometry workforce needs expanding, and biometry machines need updating.	Increase capacity for biometry	
Currently patient information letters are informing patients to be nil by mouth (NBM) for LA cataract surgery. This is not necessary and could lead to issues if patients are diabetic.	Patients do not need to be nil by mouth prior to local anaesthesia (LA) cataract surgery	
The clinical director for ophthalmology determined local changes to equipment would support patient throughput on the day of surgery.	Additional surgical instruments and consumables required	
The need for repeat clinical reviews and investigations on the day of surgery needs to be reduced.	Minimising the time between pre-assessment and surgery, consultant led pre-assessment and surgery, Surgeon-led pre-assessment and standardised management of co-morbidities	
The on the day of surgery patient pathway needs to be streamlined to prevent delays between patients which can contribute to on the day cancellations.	A push (rather than pull) system on the day of surgery	



### Key learning:

- Involve staff at all levels when establishing the baseline position. This valuable step should not be rushed.
- Encourage staff to share ideas about how the service could be improved. Engaging the team will help drive motivation for the upcoming change process.
- Identifying and fixing local issues which may impact the ability to deliver high flow cataract surgery early in the process is essential.
- Highlighting areas of good practice in the existing cataract pathway is important.
- Use actions defined in step 3 to differentiate pathway changes which are essential for the implementation of high flow surgery and those which are important but can be done later to minimise the change process becoming overwhelming. Our philosophy was to ask: *'is this change essential to run high flow lists during the elective drive?'*
- The tables created in steps 2 and 4 (above) identify the scale of the required change and form the action plan and progress tracker for the transformation.
- Practice within an Integrated Care System or region should be standardised. For example, using the same parameters to risk stratify patients makes it easier to facilitate mutual aid between providers.

## Engagement and training

### What was done:

1. Seek peer support from providers with established high flow cataract surgery lists. The project team learnt about the cataract service at Moorfields Eye Hospital NHS Foundation Trust and Frimley Health NHS Foundation Trust.
2. The GIRFT team delivered an educational session as part of a departmental audit afternoon. National leads joined this event to convey the importance of high flow surgery and alleviate any staff concerns.
3. All staff were encouraged to get involved and help with the transformation process.
4. The project delivery team were responsible for ensuring their teams were kept updated on all changes introduced for the elective drive, in addition to providing specific training for new roles. For example, the Ophthalmology Matron ensured all ODCU staff were appropriately trained to check consent and mark the patient's eye prior to the elective drive.
5. The project delivery team worked in partnership with the senior oversight group to ensure the necessary SOPs were in place for the elective drive. For example, the amended policy on COVID-19 testing which was specifically updated to include the use of lateral flow testing for the elective drive.
6. A pilot one-stop pre-assessment clinic and two pilot high flow cataract lists were undertaken prior to the elective drive to test the changes introduced and develop the necessary processes in anticipation of the elective drive.

### Key learning:

- Peer support was useful to demonstrate how other providers were delivering effective high flow cataract surgery. The sessions provided opportunities to visualise the reality of the changes being made and were a huge boost to all involved. It was particularly valuable discussing how certain aspects of the GIRFT-RCOphth high flow pathway could be delivered, for example, how it is possible to turn over a theatre ready for the next patient in 5 minutes.
- Staff support and engagement was critical to the success of the project, especially when relying on staff to change well established practices. For example, the pre-operative assessment nursing team were heavily involved in the redesign of patient proforma which they would subsequently use.
- If staff feel involved in the change process, they are more likely to engage with and support the anchoring of change in the long term following the elective drive.
- Pilot projects helped build confidence amongst staff and were a fundamental part of staff training. The feedback received from the pilots helped make improvements and shaped the overall project to ensure success.

## The elective drive – planning

### The steps taken:

1. A five-day elective drive was planned (Monday to Friday) using two designated ophthalmic theatres.
2. There were two theatre sessions already scheduled for pre-planned corneal grafts during the elective drive week which were not disrupted. All other elective surgical lists in the two theatres during the elective drive were cancelled. In total 17 theatre lists for cataract surgery were organised during the five-day elective drive.
3. Four list categories were developed:
  - a. High flow (10 patients)
  - b. Standard (8 patients)
  - c. General anaesthesia (GA) (or anaesthetist presence required)
  - d. Named consultant (for extremely complex cases)
4. The number of each type of list during the elective drive was determined following the risk stratification of patients performed pre-operatively.
5. A theatre timetable was constructed outlining the staffing for each theatre throughout the elective drive and was distributed to staff in a timely manner to help individuals prepare.
6. Theatres were staffed with two ophthalmologists comprising one consultant and one experienced registrar/fellow (who took the operations in turn). There were also two anaesthetic practitioners, two scrub nurses and one health care assistant allocated per theatre. A contingency plan was produced for any short notice staff absence.
7. A plan was put in place to deal with any ophthalmic surgical emergencies arising during the elective drive which involved the consultant on-call managing any emergency cases and only disrupting the elective drive if clinically necessary.

### Key learning:

- Limiting the elective drive to a normal working week (Monday to Friday) eliminated the need to use bank staff, therefore eliminating any additional staffing costs for ELHT.
- Finalising the elective drive outline, including the date and proposed number of theatre sessions is a crucial step, and provides an important goal for everyone to work towards.

## The elective drive – pre-operative processes

### The steps taken:

The longest waiting patients were invited to a newly created one-stop clinic for assessment prior to listing for cataract surgery.

1. Many of these patients had already been pre-operatively assessed. However, the decision was made to reassess this group of patients for the following reasons:
  - a. The assessment had been done many months previously, and for some, was out of date and leading to delays and cancellations on the day of surgery.
  - b. Patients had not been risk stratified as per the RCOphth scoring system. Therefore, it was not possible to determine the most appropriate list for them.
  - c. Patients had not been issued with dilating eye drops to use prior to arriving at hospital on the day of surgery.
  - d. Patients were previously assessed using the old-style paperwork which had subsequently been updated to facilitate the high flow cataract surgery.
  - e. Not all patients had been consented for surgery.
  - f. The lens selection process had not occurred.
  - g. Prescriptions for the day of surgery including discharge medications had not been signed.
  
2. The one-stop clinic model was used to review patients prior to surgery in one hospital visit. All patients were seen by a pre-operative assessment nurse and a consultant ophthalmologist or senior fellow. Biometry was only repeated if necessary. 18 one-stop clinics were performed as additional clinics to avoid negatively impacting normal departmental activity. 261 patients were invited for assessment. From the patients assessed:
  - a. 58% booked onto high flow list
  - b. 27% booked onto standard (8 patient list)
  - c. 13% booked onto named consultant list
  - d. 3% booked onto the GA list
  - e. 8% discharged from service or referred to GP for optimisation.
  
3. A new proforma was introduced to replace a generic local anaesthesia (LA) day case proforma. This was designed to collect the minimum necessary data set for each patient and guide staff through each step of the GIRFT-RCOphth pathway as well as streamlining multiple forms into one. The proforma was started for each patient at the one-stop clinic and then completed on the day of surgery until discharge.
  - a. The new proforma contained a redesigned section for the pre-assessment nurses to record relevant medical history and highlight any red flags which may require

additional considerations. This intervention immediately reduced the pre-assessment stage by 25 minutes. Further information and the exemplar proforma developed can be found here in [Guide 3 Designing effective perioperative data collection tools to support high flow cataract surgery](#).

- b. The proforma was placed on the local risk register as an interim measure pending official review, and finalisation of the document after the elective drive.
4. Patients proceeding with surgery were risk stratified and consented, a lens was selected, and they were given dilating eye drops to use on the day of surgery. [Further guidance](#) has since been published on developing a one-stop clinic.
5. The agreed standardised parameters for the management of medical co-morbidities were used. [See Guide 4 Perioperative management of patients with medical comorbidities and additional needs](#), for more information.
6. Patients who were deemed fit for surgery following the one-stop assessment clinic were scheduled for surgery during the elective drive.
7. A group of reserve patients were identified who were happy to be contacted at short notice in case of a last-minute cancellation (e.g., due to a positive COVID-19 result).

### Key learning:

- The GIRFT-RCOphth high-flow all-complexity cataract pathway should be the default pathway. Significant variations to the GIRFT-RCOphth pathway are only required for patients requiring a GA or for highly complex surgery under a named surgeon.
- The elective drive is open to all patients on the waiting list for cataract surgery and should not focus only on less complex or straightforward cases as this would lead to inequity of access. The purpose of one-stop pre-operative clinics is to fully assess and prepare **all** patients for surgery.
- It was a difficult decision to reassess patients for surgery, but it was felt the overall benefit and reduction in risks for patients meant it was the best option.
- Running the additional one-stop clinics as extra sessions was an additional expense but was better than repurposing existing clinicians.
- Wherever possible there was continuity in staffing between the one-stop clinics to enable the learning and setup from previous clinics to be quickly replicated to reduce variation.
- Clinics should be organised with sufficient notice to patients to minimise DNAs.
- Pre-operatively assess more patients than required for the elective drive. Firstly, this provides a group of reserve patients in case of last minute patient cancellations. Secondly, it creates a pool of patients ready to be booked on high flow lists immediately after the elective drive. This keeps the momentum of the project going.
- A high-quality standardised pre-assessment for all patients prior to cataract surgery ensures there are no outstanding issues likely to cause an issue on the day of surgery.
- Changes to all aspects of the pathway are equally important. The pre-operative processes were the most challenging. Do not underestimate the importance of this part of the transformation.

## The elective drive – the day of surgery

### The steps taken:

1. Patients arrived in stages to prevent overcrowding of the department.
2. The Ophthalmology Day Case Unit (ODCU) ward staff checked patients in, confirmed the medical pre-operative assessment was up to date, checked pupils were adequately dilated, marked the eye, and checked consent.
3. No routine observations were taken for any patients during their admission.
4. While the first patient was admitted by the ODCU ward staff, the theatre team conducted a team brief.
5. Once patients were ready for theatre the newly designed theatre checklist (part of the new proforma in [Guide 3](#)) was completed by the anaesthetic practitioner and ODCU nurse.
6. Patients were taken to the anaesthetic room and positioned on a surgical trolley. This is a critical component of a 'push system' which forgoes the traditional practice of sending for a patient which tends to cause delay.
7. While the patient was waiting outside the theatre, the surgeon not operating (see [The elective drive – a brief overview point 6](#)) would meet the patient and answer any questions. The sign-in section of the WHO checklist was completed, and the lens selection was checked by the surgeon using the patient's biometry.
8. Once the lens had been verified, a health care assistant retrieved the correct lens prior to theatre.
9. The anaesthetic practitioner then administered the local anaesthetic and iodine eye drops.
10. As soon as the theatre team were ready, the next patient was transferred into theatre.
11. The surgeon who checked the lens then proceeded with the procedure as normal.
12. Immediately after the procedure, the patient was transferred from the trolley to a wheelchair in theatre recovery. The theatre team informed ODCU of any exceptions to standard treatment and the patient was escorted back to ODCU by the anaesthetic practitioner.
13. Theatre teams were able to prepare the theatre for the next patient in 5 minutes or less. Multiple equipment trollies were not prepared in advance due to IPC concerns therefore the set-up of each equipment trolley was within the 5-minute turnaround time. However, normal national practice is to prepare multiple equipment trollies in advance, thus facilitating an optimised turnaround time.
14. The above steps were repeated until the list was completed.
15. Active list management was utilised to redistribute patients between the two theatres if any delays or issues occurred.
16. Once patients arrived back to the ODCU following their procedure, staff prepared the appropriate take home eye drops as per the operation record. The eye drops were pre-prescribed available to be dispensed immediately from ward stock.



17. The ODCU staff finalised the discharge letter and followed any bespoke instructions as per the operation record.
18. Once the OCDU nurse confirmed discharge criteria were met the patient was discharged with post-operative instructions and medication.
19. Post-operative follow-up was conducted by community optometrist as part of a longstanding arrangement.
20. A standard operating procedure (SOP) was written in collaboration with the infection prevention control team to mitigate the risk of on the day cancellations due to pre-operative issues with COVID-19 testing.

#### Key learning:

- The redesigned clinical documentation ensured the appropriate steps of the high flow pathway were followed for each patient. Furthermore, the streamlined and focused nature of the new documentation created time for staff to take on additional patient focused roles e.g., marking the eye and confirming consent.
- Designing a 'push' rather than 'pull' system was fundamental to patient flow on the day of surgery. The ODCU team continued to prepare patients on arrival and send directly to the anaesthetic room as soon as it was available. Always having a patient fully prepared and waiting outside the theatre is key to maintaining the momentum of the list.
- Each list was staffed with two anaesthetic practitioners who worked as a relay team to ensure patients were where they needed to be.
- All team members were clear on what their roles were for each list. Completing 10 procedures in a 4-hour operating session requires a well-rehearsed and efficient on the day pathway to ensure patient flow.
- The clinical director for ophthalmology or designated deputy was on site to trouble shoot issues and maintain close communication between the theatres. For example, if a patient was waiting in the anaesthetic room for a prolonged period due to a delay with the previous patient they would be switched to the other theatre.

## Results

1. There were 121 successfully completed cataract procedures during the elective drive. There were no recorded complications, complaints or incidents that occurred during the elective drive.
2. An average of 9 cataract procedures were successfully completed on high flow lists and 7 on standard lists.
3. Feedback from staff and patients was overwhelmingly positive and supported long term adoption of high flow cataract surgery at ELHT.
4. The introduction of high flow cataract surgery following the elective drive is expected to increase the number of cataract procedures completed each week at ELHT by 46%. This will deliver 1,152 additional cataract procedures per annum without any additional resource or theatre sessions.

The table below provides a summary of operations before and during the elective drive:

	Before Elective Drive	During Elective Drive
Pre-operative assessment	Up to 3 pre-operative appointments	One-stop clinic
Nurse led LA pre-operative assessment duration	45 minutes	15-20 minutes
Average number of cases on a list	4/5	9 (on high flow lists)
Duration in day case unit	4 hours	2.5 hours
Standardised management of patient co-morbidities e.g., Hypertension	No	Yes
IOL chosen pre-operatively	No	Yes
Staggered patient arrival	No	Yes
Patients self-dilated	No	Yes
Routine on the day observation	Yes	No
Nurses checking consent and marking the eye	No	Yes
Turnaround time between patients	15 minutes	5 minutes

## Feedback

*“Selling “the dream” to our nursing colleagues was unexpectedly easy, the appetite to address the inefficiencies in the service, improve our patients experience and reduce the recurrent issues which hindered admissions and discharges was well received.*

*We knew what we needed to do, it just seemed such a huge endeavour to change practice, documentation, and processes all at the same time.*

*We have learnt that anything is possible with the right team approach, floor to board engagement and determination. **I am delighted with the success of the elective drive.**”*

### **Ophthalmology Matron**

*“I would like to thank and congratulate the whole team for making the elective drive a success. I was very apprehensive before the week started on various aspects - patients, pathways, surgeons, equipment, the need to work outside everyone's comfort zone, COVID, staff morale etc but the whole department proved me wrong.*

*Feedback from the whole team has been overwhelmingly positive and one common question posed to me is "why can't we do more high-volume lists!!". The elective cataract drive has proven we have the capacity to do a lot more. I am very excited about what the future holds.”*

### **Director of Ophthalmology**

## Key steps in the change process

### **Stakeholder management**

Key stakeholders in the project should be identified early in the change process.

Analysing stakeholders by understanding their role in the organisation, willingness to engage, influence they could have on the project what perspective they bring to the project

Mapping stakeholders by considering their level of influence and potential to impact on the project informs how stakeholders should be managed for the success of the project, for example the frequency of communication and how to manage expectations.

### **Communication**

Ensure frequent communication at strategic, operational, and individual level. Communication covered the purpose of the elective drive, how it will run and staff involvement. Team meetings provided the opportunity for staff members to give their perspective, raise concerns and discuss suggestions.

### **Identify and empower champions**

Visible and engaged champions support a change process and should be identified at the outset.

Champions advocate for change and tackle any resistance.

Ensure champions are equipped for their role. Champions should understand the high flow cataract surgery pathway, be informed of what processes need to change, be able to support others throughout the project and articulate the vision clearly.

### **Identify drivers and barriers**

Identifying and assessing the drivers and barriers is an important step. Resistance to change can occur at varying levels and needs to be pre-empted where possible. The project team strengthened, built, and sustained the drivers for change wherever possible.

### **Provide feedback and positive reinforcement**

Recognising and celebrating milestone achievements and the success of teams and individuals involved helps the adoption of change and is essential.

Using data to provide credible feedback, document progress, and reinforce new behaviours helps to sustain change. At ELHT, data from the pre-operative assessment and high flow cataract list pilots were used to highlight successes as well as areas that required further work.

### **Anchoring change**

Identifying and fixing teething problems during and after the change process is important. Keep a log of issues and ensure change champions can coach people through difficulties to avoid people reverting to traditional methods. Share success/progress from the change at every opportunity to promote motivation.

## Supplementary reading

[GIRFT Ophthalmology National Report](#)

[GIRFT-RCOphth High Flow All Complexity Cataract Surgery Pathway](#)

[GIRFT-RCOphth High Flow Cataract Surgery Guidance](#)

Other **guides** in this series:

**Guide 2:** How to setup a 'one-stop' cataract pre-assessment clinic

**Guide 3:** Designing effective perioperative data collection tools to support high flow cataract surgery, (includes example proforma for local adaptation)

**Guide 4:** Perioperative management of patients with medical comorbidities and additional needs.

## Glossary

<b>Cataract Pathway</b>	GIRFT-RCOphth high flow all complexity cataract surgery pathway
<b>ELHT</b>	East Lancashire Hospitals NHS Trust
<b>GA</b>	General anaesthesia
<b>GIRFT</b>	Getting It Right First Time programme
<b>HVLC</b>	GIRFT High Volume Low Complexity programme
<b>IPC</b>	Infection Prevention Control
<b>ISBCS</b>	Immediate sequential bilateral cataract surgery
<b>MDT</b>	Multidisciplinary Team
<b>NBM</b>	Nil by mouth
<b>POA</b>	Pre-operative assessment

## **GIRFT High Volume Low Complexity Programme and elective recovery**

With demand for hospital treatment outstripping capacity prior to COVID-19, the demands of delivering care during a pandemic led to significant backlogs and longer waits for patients.

There is a significant need to improve the productivity and resilience of services, many of which are still disrupted by the consequences of the pandemic and impacted by ongoing operational pressures. Waiting times vary considerably across different parts of the country, but also between individual hospital trusts in the same system. In 2020, GIRFT established the High Volume Low Complexity ('HVLC') programme with the NHS London Region to address these challenges.

The HVLC programme promotes productivity through optimised delivery of services.

## **About GIRFT and the GIRFT Academy**

Getting It Right First Time ('GIRFT') is an NHS programme designed to improve the quality of care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The GIRFT Academy has been established to provide easily accessible materials to support best practice delivery across specialties and adoption of innovations in care.

Importantly, GIRFT Academy is led by frontline clinicians who are expert in the areas they are working on. This means advice is developed by teams with a deep understanding of their discipline.

**GIRFT Academy has also published other pathways and case studies on the best practice library. These are available at: [Best Practice Library – Ophthalmology](#)**

**GIRFT Academy contact: [girft.academy@nhs.net](mailto:girft.academy@nhs.net)**

**For more information on the GIRFT programme, visit our website at:**

**[www.gettingitrightfirsttime.co.uk](http://www.gettingitrightfirsttime.co.uk)**

## Acknowledgements

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