

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

Guide 2: How to set-up a 'one stop' cataract pre-assessment clinic

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NECRTP



In collaboration with

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Introduction

Cataract surgery is the most performed operation in the NHS, accounting for 6% of all operations. Due to the pandemic, the elective surgery backlog has increased, and cataract operations make up a large proportion of that waiting list. Demand for cataract surgery is predicted to continue to increase over the next 10 years ([The Way Forward](#)), and delays to surgery result in prolonged visual impairment which contribute to mental health issues, worsening dementia, falls, loss of independence, the inability to work, and an overall poor quality of life.

Guidance on the development of cataract hubs and high flow cataract lists was produced jointly between Getting It Right First Time (GIRFT) and The Royal College of Ophthalmologists (RCOphth) in March 2021. Since the publication of these documents there has been significant transformation of hospital cataract services and further learning. The continued roll out of high flow cataract surgery is an essential step in tackling the elective backlog and providing patients with timely access to cataract surgery.

This is the second in a series of four implementation guides, produced in collaboration between GIRFT and the National Eye Care Recovery Transformation Programme (NECRTP) provide additional support and guidance for providers implementing the GIRFT-RCOphth [high flow all complexity cataract surgery pathway](#) and [guidance](#). The cataract pathway defines the high flow principles providers and commissioners should offer for cataract surgery.

'It is the view of the RCOphth and GIRFT that high flow cataract surgery principles are applicable to all but the most highly complex cases and high flow approaches should be used in all cataract surgery settings'

The content of these implementation support guides is based on current literature and existing national guidance, expert consensus (including anaesthetists, non-medical clinical and managerial colleagues in addition to ophthalmologists), learning from GIRFT and East Lancashire Hospital's NHS Trust (ELHT), supported by the NECRTP implementation of the high-flow all-complexity cataract surgery pathway. ELHT successfully ran a five-day elective cataract drive where 121 cataract procedures were completed and cemented changes so that the number of cataract procedures completed weekly is expected to increase by 46%, tackling the elective backlog to deliver sight changing surgery to patients more quickly.

The is the second in a series of [four guides](#) covering different aspects of high flow cataract 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.

Appendix 1 in the guide includes Frequently Asked Questions, and three related case studies are available on the [Eye Care Hub](#) from Guy's and St Thomas' NHS Foundation Trust, London North West University Healthcare NHS Trust, and Salisbury NHS Foundation Trust, all of whom have exemplar one-stop clinics in operation.

Why one-stop pre-operative assessments?

A crucial step in the high flow all complexity cataract surgery pathway is the one-stop pre-operative assessment clinic. Many NHS cataract providers do not have an operational one-stop clinic to review cataract patients prior to surgery and may undertake two or even three separate assessments to prepare a patient for one local anaesthetic cataract operation. The concept of a one stop clinic, where patients undergo all assessments and investigations necessary for surgery in one hospital visit, is simple, efficient, and far more patient-centred. However, operationally one-stop clinics can be challenging to set-up, and this guide is designed to support providers with implementation.

What are the benefits of introducing a one-stop pre-assessment clinic?

One-stop pre-operative assessment clinics provide substantial benefits for patients and providers. Reducing the number of hospital visits improves patient experience, avoids repeated healthcare site attendances during pandemic surges, and can reduce the Do Not Attend (DNA) rate in a cohort of patients who rely on assistance with transportation to hospital. There are over 400,000 NHS cataract operations done per year in England. This means avoiding multiple attendances per operation can free up large numbers of outpatient slots for higher risk patients such as those with glaucoma for whom delays can lead to loss of sight.

One-stop clinics encourage multidisciplinary team working, meaning problems or queries that arise during the patient assessment can usually be addressed on the day. Ophthalmologists are able to review all investigations during the one-stop clinic enabling an immediate decision regarding surgical requirements. Repeat or additional investigations can be performed on the day without delaying treatment.

The establishment of one-stop clinics requires re-organising and better co-ordination of existing 'pre-day of surgery' care for cataract patients and therefore should not increase costs. In fact, the increased efficiency, better utilisation of clinic time and reduced duplication of work, are likely to lead to reduced operating costs in the medium to long term.

One-stop clinics are also an essential component of low carbon models of care, helping to reduce the environmental burden of cataract surgery by reducing the number of hospital visits, duplication of work, and system inefficiencies.

Why is the one-stop pre-assessment clinic a particularly important component of the high flow cataract pathway now?

A rigorous and robust up to date patient pre-assessment is vital to the success of high flow cataract lists on the day of surgery.

As a result of the high flow all complexity cataract surgery pathway, the number of cataract procedures completed each week is increasing in comparison to traditional practice. Therefore, to prevent a bottleneck, the efficiency and capacity of pre-operative assessment clinics should be maximised.

When delivering high flow cataract surgery, it is crucial all patients have an up-to-date pre-operative assessment to ensure all preparation is done before admission so that no unexpected or unmanaged issues cause interruptions on the day of surgery. Units without efficient one-stop pre-assessments have reported that this is increasingly inhibiting their ability to provide an adequate supply of fully assessed and optimised patients who are ready to undergo surgery.

Key concepts for one-stop pre-operative clinic implementation

- The one-stop pre-operative assessment includes the following:
 - pre-operative assessment (medical health check)
 - biometry (+/-other investigations) and
 - ophthalmologist or ophthalmic surgical decision-maker review.

(The order can change to suit the local setup, but the ophthalmic decision maker assessment should always occur last so that they can make decisions with all relevant information available)
- The cataract pre-assessment clinic should be for ALL patients requiring cataract surgery. It is not just for low-risk patients.
- One-stop clinics require additional clinic room space and alignment of multiple job plans to work. These changes need to be addressed early in the implementation of one-stop clinics as they can take several months to complete.
- One-stop pre-operative assessment clinics should be senior independent surgeon-led to ensure any problems arising can be managed during the clinic. Patients need to be appropriately risk stratified and booked on to the correct type of operating list during the clinic. Some providers successfully use one consultant ophthalmologist to oversee a 'super clinic' where multiple non-consultant ophthalmologists and non-medical clinical decision makers (e.g., extended role optometrists) assess the patients, and a consultant ophthalmic cataract surgeon helps with decision making and queries as required.
- Following the one-stop clinic, patients are usually booked onto pooled lists to minimise waiting times, therefore the pre-assessment needs to be rigorously standardised, completed to a high standard and clearly documented for all patients.
- Following the pre-operative assessment clinic there are six possible outcomes:
 - Book on high flow list (10 patients)
 - Book on standard list (8 patients)
 - Book on named consultant list (for technically challenging cases or some "best interests" cases)
 - Book on list with anaesthetic cover (for patients requiring general anaesthesia (GA), sedation or medically very high risk)
 - Refer to GP for medical health optimisation
 - Discharge from service
- Where possible, a 'golden patient' should be identified who can be booked first on a list who is low risk, ideally lives close to the hospital and does not require hospital transport. Similar patients who would be happy to have their surgery brought forward in case of last-minute cancellation should also be identified.
- All non-medical health care professionals including technicians and healthcare assistants should be enabled to instil mydriatic drops, unless the patient or member of staff is allergic to the drug (see RCOphth guidance).
- All patients with a decision to proceed to cataract surgery following the one-stop clinic should be given an appointment for surgery before they leave hospital. The time between the one-stop clinic and appointment for surgery should be weeks and not months.

- All patients should be given a telephone number to contact the cataract team in case they need to change their surgery date or inform the team of a change in circumstances (e.g., out of range INR for patients on warfarin, change in medical health).

One-stop pre-assessment clinics

Before the clinic

1. Standardised referrals should be made directly from primary care optometry to the surgical provider including the use of a Shared Decision Making (SDM) tool to ensure only those patients wanting and needing surgery are referred. Written information including the risks and benefits of surgery should be provided to the patient at the outset. ([See NHSE shared decision-making tool](#)).
2. Surgical providers and primary care optometrists should meet regularly to develop and improve referral processes. Optometrists should be updated by surgical providers on what patients can expect following referral to ensure they are able to provide accurate information to patients.
3. A standardised referral should include a minimum data set for all new referrals. Surgical providers should work closely with primary care optometrists and commissioners to develop and commission pathways to refine the referral information. For example, identification of surgical risk factors or enhanced/dilated assessment.
4. All patients should be contacted by telephone a few days prior to the one-stop pre-assessment clinic to remind the patient about the appointment and ensure they still want to proceed with surgery. This telephone call can be performed by a trained member of the administrative team. The number of patients attending clinic who are successfully listed for surgery is termed the conversion rate and the GIRFT standard for this metric is 95%.
5. Some providers use the telephone call (step 4) to take a detailed history from the patient. This reduces the amount of time required for the one-stop clinic. The information gathered can be used to plan for the patients one-stop clinic appointment. Examples may include identifying patients:
 - who may require GA
 - who may require additional investigations e.g. A-Scan or B-Scan
 - who need to be seen by the ophthalmologist first e.g. when the patient is not sure they want to proceed with surgery and want to discuss with the surgeon before making a decision.
6. The appointment letter and reminder telephone call should emphasise this is a one-stop clinic involving multiple assessments and may take more than 60 minutes to complete.

On arrival to hospital

1. On arrival patients should receive an information leaflet providing information on cataract surgery including the risks and benefits of the procedure.
2. There needs to be an experienced member of staff coordinating the flow of patients on the day. Departments with an agile and adaptive system (rather than rigid) tend to work better. For example, if a bottle neck develops then patients can be re-directed to a stage of the process that is free. Flexibility throughout the process is essential.

Nurse-led pre-operative (healthcare) assessment

1. This should be completed by a pre-operative assessment nurse who regularly assesses patients for cataract surgery or, in some units, a trained and experienced technician or HCA is used, supported by a nurse for any specific aspects requiring nursing skills. Ideally, this team should be part of the ophthalmology department rather than a central service. The pre-operative assessment should have access to a consultant anaesthetist experienced in high flow cataract surgery to ask questions when they arise.
2. The assessment should include careful documentation of the patient's medication, allergies, and underlying health conditions.
3. Baseline investigations: blood pressure, heart rate, pulse-oximetry, height, and weight.
4. The assessment should rapidly identify patients who have unstable or unmanaged underlying health conditions or are American Society of Anaesthesiologists (ASA) physical status class IV. These patients often require further optimisation prior to surgery and information set out in '[Guide 4: Perioperative management of patients with medical comorbidities and additional needs](#)' should be used to guide this process. If further optimisation is not possible, additional safeguards may be required at the discretion of the ophthalmologist and consultant anaesthetist. These may include the location where surgery is performed, the detail of the pre-operative medical assessment and the presence of an anaesthetist on the day of surgery.
5. The pre-operative assessment should be documented on a bespoke electronic or paper proforma or data collection tool for LA cataract surgery. The aim should be to target the collection of a relevant lean dataset and to minimise the collection of unnecessary or irrelevant information. Exemplar lean proformas for this purpose are provided in [Guide 3: Designing effective perioperative data collection tools to support high flow cataract surgery](#).
6. Factors which may affect the type of list the patient is booked on, for example mobility issues, should be highlighted as part of the assessment to assist surgeons with correctly listing patients.
7. The medical assessment should take approximately 15 minutes to complete.
8. Each provider should have robust guidance on the perioperative management of common comorbidities (as outlined in '[Guide 4](#)' noted above). As most patients will be booked onto pooled lists, the pre-operative assessment should be standardised and easily reproduced without variability. Each department should have agreed universal parameters to avoid variation with regards to the pre-operative management of common conditions e.g., hypertension.
9. Patients requiring a general anaesthetic or sedation will need a more extensive pre-operative assessment. The options for the management of these patients when they attend the one-stop clinic include:
 - Complete the full GA assessment during the one-stop clinic
 - If time is limited, complete the face-to-face part of the assessment e.g., airway assessment during the clinic and complete the remainder of the assessment virtually at a later date.
 - In rare cases, the patient may need to return to complete the GA assessment. Wherever possible this should be avoided.
10. Patients requiring a GA who cannot undergo the more extensive pre-operative assessment during the one-stop clinic should complete all other components of the one-stop clinic as normal including ophthalmic investigations and assessment.

11. The availability of pre-assessment nurses can be a rate limiting step in the provision of one-stop clinics. Many surgical providers have trained ophthalmic technicians to perform components of the one-stop clinic including the medical assessment of straightforward patients. Only those patients who are medically complex or require a GA are seen by a pre-operative assessment nurse.
12. In addition to generic information about what to expect on the day of surgery, patients with specific comorbidities need to be issued with targeted advice. For example, insulin dependent diabetics need to be instructed to eat and drink as normal, take their insulin as normal and measure their blood glucose as normal on the day of surgery. The recommended advice is included in '[Guide 4](#)'.

Biometry and other investigations

- Providers should have a standard list of investigations required for each patient. For example, all patients with diabetes should routinely undergo the agreed local investigations before seeing the ophthalmologist/surgical decision maker. This reduces the risk of patients requiring additional investigations following review by the ophthalmologist.

Ophthalmologist review and surgical decision

1. The history and examination should be recorded on a standardised proforma (electronic or written – see 'Guide 3' for example) to ensure consistency in assessment and presentation of the information, and aiding rapidity in reviewing the information on the day of surgery by the surgical team.
2. The medical pre-operative assessment should be reviewed by the clinician to help identify any contraindications to surgery or additional steps which may be required e.g., additional time.
3. All patients should be risk stratified using the national RCOphth tool (see the FAQ section below). This is a critical step to ensure patients are booked onto the correct type of list.
4. A shared decision-making process should be performed as per NICE guidance. Patients proceeding with surgery need to have written consent completed during the one-stop clinic. Cataract specific consent forms for cataract surgery are provided by the RCOphth/UKOA with room for additional patient specific content.
5. The biometry should be reviewed, and an appropriate lens selected. This should be carefully documented and signed.
6. Where appropriate, patients proceeding with surgery should be issued with dilating eye drops (and receive appropriate instruction) for use on the day of surgery.
7. Immediate sequential bilateral cataract surgery (ISBCS) should be offered where suitable. If delayed sequential bilateral cataract surgery is more appropriate, both eyes should be assessed and prepared during the one-stop clinic appointment.
8. Where possible, any prescriptions required for the day of surgery including TTO's should be completed during the one-stop clinic.

Appendix 1 - Frequently asked questions

What are the risk criteria for high flow and standard/non-high flow lists?

A cataract surgery risk stratification tool should be used to help identify key risks and complexities which are associated with the need for more resource (staff, equipment), time or a higher risk of intraoperative complication. Widespread adoption of a risk stratification tool is imperative to ensure all patients are correctly listed. We recommend use of The Royal College of Ophthalmologists risk grading system (see below).

Documenting a risk score for each patient pre-operatively helps to understand the type of patients presenting for surgery and allows planning for service requirements (e.g., number of each type of list required). Furthermore, accurate risk stratification using a nationally recognised tool makes subsequent mutual aid between providers much easier. Systems should be using the same risk stratification grading tool and score nomenclature for this purpose.

The table below provides a summary of the criteria for different types of lists as per the RCOphth risk stratification tool. A full copy of the tool is available in the [RCOphth high flow guidance](#) document.

Grade	Description	Surgeon Roles	List Type
1: Routine 0 risk factors	Straight forward case which should cause no difficulties ISBCS – needs consultant present	Registrar, Junior Fellow	High flow list
2: Low complexity 1-2 risk factors	Straight forward case which should cause an experienced surgeon no difficulties, no special patient needs ISBCS – needs consultant present	Registrar, Junior Fellow	High flow list
3: High complexity 3 risk factors or pseudoexfoliation, iris hooks, graft/trabeculectomy, very difficult access or positioning, very high refractive errors/small or large globe	More challenging case for an experienced surgeon, likely to take longer and carrying a high risk of complication OR ISBCS OR higher patient needs e.g., severe dementia, best interests, hoist, significant positioning difficulties ISBCS – needs consultant present	Consultant, Senior Fellow	Standard (non-high flow) list
4: Very high complexity phacodonesis, black cataract, nanophthalmia, posterior polar cataract, previous significant trauma	A very challenging case with a very high risk of major complication	Consultant with Specialist interest	Named consultant list
Needs GA or sedation OR patient ASA 4 or medically unstable			Anaesthetist list

Is immediate sequential bilateral cataract surgery recommended? Is it appropriate for high flow cataract lists?

Immediate sequential bilateral cataract surgery (ISBCS) is recommended to be offered to suitable patients by The Royal College of Ophthalmologists, NICE and GIRFT. When offered to the correct cohort of patients, it has the potential to provide immediate visual improvement for both eyes. Furthermore, treating both cataracts at the same time prevents multiple hospital visits, avoids potential delays to treatment and is more efficient. The Royal College of Ophthalmologists has produced an [advice document](#) to support trusts starting a ISBCS service. There is a national ISBCS tariff in development at 185% of a unilateral cataract tariff.

Patients with bilateral cataracts should undergo preparation for surgery for both eyes pre-operatively and, where appropriate, be offered ISBCS or automatically receive a date for second eye surgery following satisfactory outcome following the first eye postoperative review. ISBCS can be scheduled on high flow lists when the risk stratification criteria for high flow surgery are met.

Which type of list is appropriate for patients requiring an interpreter?

Requiring an interpreter is not a contraindication to high flow cataract surgery. Providers should ensure they have interpreters reliably available for the day of surgery whether that be in person, virtual or over the telephone. We recommend patients requiring interpreters are booked early on the list (not first) and at the same time as a patient not requiring translation services to minimise the knock-on effect of any delays.

Which type of list is appropriate for patients requiring hospital transport?

Patients who require hospital transport should not be excluded from high flow lists based purely on this factor. We recommend patients arriving on hospital transport are booked early on the list (not first) and at the same time as a patient arriving independently to minimise the knock-on effect of a late arrival.

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Contact girft.academy@nhs.net if you have feedback or questions.