The ROYAL COLLEGE of OPHTHALMOLOGISTS

Ophthalmic Services Guidance

Higher Flow Any Complexity Cataract Surgery (HFAC)

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Version 3

The Royal College of Ophthalmologists 18 Stephenson Way, London, NW1 2HD

In partnership with

GIRFT
GETTING IT RIGHT FIRST TIME

Contents

1. High Flow Cataract Surgery Principles Apply to All

In March 2021, the RCOphth and GIRFT released joint guidance on cataract hubs. This new guidance builds on learning and expands the principles and recommendations to cover mixed lists (both routine and complex cases) and complex-only lists.

When implementing this guidance, note that surgical time and case volume per list will vary depending on patient complexity. The level and nature of complexity need to be identified in advance to ensure the appropriate resources (e.g. staffing numbers, surgeon experience and patient support) are.

It is both the College's and GIRFT's view that:

- high flow cataract surgery principles are applicable to all but the most highly complex cases
- high flow approaches should be used in all cataract surgery settings
- most case complexity is deliverable in stand-alone local anaesthetic day case units

High flow cataract surgery depends on a skilled, consistent multidisciplinary team across theatre, day case, and outpatient settings. These teams work together regularly, gaining shared experience that drives continuous improvement and better patient outcomes. This model also supports professional development for all MDT members through programmes such as the Ophthalmic Practitioner Training (OPT) Cataract Curriculum and provides valuable surgical training opportunities for ophthalmologists.

Cataract surgery has distinct specific requirements, which can be different from the general processes in hospitals for other surgeries, and should not be required to rigidly follow the same process as for every other operation, if this is not optimal for efficiency and patient safety.

It also has had one of the highest incidences of never events (wrong implants) and processes may need to be bespoke to ensure appropriate detailed safety checks can be undertaken without compromising high flow.

High flow on the day processes can only develop within a whole pathway approach – this needs to be prioritised by the clinical, operational and facilities management teams and strong commitment from provider and commissioner senior leaders with direct input from frontline clinical teams.

The key components underpinning high flow operating, in complex or lower complexity cases and in hospitals or standalone units, are described in this updated guidance. There should be as much consistency as possible between all surgical providers across a system or region, which allows greater flexibility for mutual aid for addressing surgical backlogs and supports more consistency in engaging with primary care optometrist referrers.

The delivery of high flow cataract lists of any complexity requires input from all stakeholders, including trust operational managers and executives, theatre teams, and commissioners, and national colleagues. Without the appropriate senior commitment, provision of resources and prioritisation for improvement support, high flow cataract lists will not be achieved.

2. Pathway requirements and recommendations

2.1 Pre-hospital: Referral and initial patient engagement

Stage	Recommendation
Referral	1. Standardised direct referrals from primary care optometry to regional single point of access to promote objective patient choice. There should be a minimum cataract data set for all new referrals. 2. Primary care optometry should be engaged early in developing the pathway. * 3. Processes should be in place to provide regular feedback to referrers** 4. Optometrists should use agreed shared decision-making resources to ensure only patents wanting and needing surgery are referred.
Standardised patient information	1. patient information and consent materials should be provided before the pre-op assessment: these can be given by the primary care optometrist or posted by the provider upon receipt of the referral. The RCOphth and GIRFT have designed a comprehensive standardised cataract consent form.
Keep waiting lists lean	1. initiate processes to identify and remove long waiters who no longer wish to have surgery, for example with phone calls prior to their pre-op appointments, whilst also identifying patients who are having increasing difficulties with independent living due to reduced sight whose surgery needs expediting.
Telephone/AI pre-operative assessment or optometry referral refinement	1. will make the in-person pre-operative assessment more efficient. Some units achieve a near 100% conversion rate from taking this approach. It is therefore strongly recommended that either of these approaches is used to maximise use of resources and to avoid wasting valuable hospital appointments.
Assessment process starts at the pre-1-stop clinic telephone call	1. Ascertain if the patient is visually symptomatic with their cataract 2. risks of surgery should be discussed, including those of immediate sequential bilateral cataract surgery. 3. If the patient is happy to proceed to surgery, book into a 1-stop cataract assessment clinic. 4. Most of the general health and social assessment can be performed during this call, including whether the patient would need a general anaesthetic. This allows a more streamlined flow on the day of assessment and ECGs/blood tests can be planned if the patient does require a general anaesthetic.

*For example, Stoke Mandeville utilised existing educational channels to onboard their primary care optometrists such that, when high flow changes came into effect, patients could be told what to expect from the point of referral.

**for example, Heatherwood, Frimley utilised regular newsletters and meetings with their optometrists to support better referrals and shared understanding of the pathway.

2.1 Hospital – clinic: Assessment and list planning

Stage	Recommendation
One stop assessment	1. patients wishing to proceed with cataract surgery should not have to attend multiple pre-operative face to face assessments, particularly for those who do not require a GA. 2. face-to-face clinical assessment needs to include the eye examination, biometry & IOL selection, consent for one or both eyes, and any pre-op anaesthetic or medical health assessment that has not already been completed remotely e.g. blood pressure check. 3. Patients should be informed about the possibility that surgical training will take place. 4. Procedure specific consent forms and standardised pre- & post-operative information should be used and supplemented with details for the patient's specific situation particularly for those with higher complexity e.g. glaucoma, narrow angle, alpha-blocker drug (e.g. tamsulosin) use and pseudoexfoliation.
Drops and local anaesthetic	1. All non-medical health care professionals including technicians and health care assistants should be enabled to instil mydriatic and other drops such as local anaesthetic in the cataract one-stop clinic unless the patient or member of staff is allergic to the drug. See link: https://www.rcophth.ac.uk/resources-listing/eye-drops-instillation-by-unregistered-health-care-professionals-for-use-within-nhs-ophthalmic-services/
Pre-operative assessment	1. Rigorous preparation of the patient to avoid unexpected issues, and minimal repeat checks, on the day of surgery. 2. Most will undergo topical and intracameral anaesthetic, with sub-Tenon's anaesthetic used in specific cases. Pre-operative assessment of patients can be undertaken by a team of MDT clinician decision makers, including doctors, nurses, orthoptists and optometrists, supported by HCAs and technicians undertaking diagnostic tests, with oversight by the consultant or senior surgeon. 3. Lower risk patients may be assessed and consented in non-medically led clinics where skills and competency sign off for this have been completed. 4. Pre-operative assessment must clearly record the patient's medication, allergies, and underlying health conditions. The American Society of Anaesthesiologists (ASA) physical status classification system is widely used and stable ASA I, II, and III patients are suitable for high flow surgery: https://www.asahq.org/standards-and-practice-parameters/statement-on-asa-physical-status-classification-system. 5. For local anaesthetic patients, no medication needs to be altered or stopped - anticoagulants should not be stopped prior to surgery. In the case of warfarin, reasonable evidence from the patient's anti-coagulation record (yellow book) that the international normalised ratio (INR) is likely to be within its therapeutic range is sufficient and no extra measurement of INR is required.
Blood pressure	1. Should be checked at the assessment clinic. 2. If elevated but not above 180/110mmHg, patients should be advised to see their GP but listing for surgery should continue. 3. If the systolic or diastolic blood pressure is higher than this, patients should be referred rapidly to their GP or the acute medical team if indicated, and surgery delayed until this is managed. Such patients should not be discharged.

Diabetes management	1. Confirmation that diabetes management is stable and blood glucose is controlled should be done at the pre-assessment stage; either from a medical summary from the GP confirming blood glucose control or by doing finger-prick blood glucose testing in the assessment clinic.
List planning	1. Complete a cataract risk stratification tool (see example below) and related booking form consistently, to provide an objective way to define case mix. 2. Appropriate information needs to be recorded and shared pre-operatively to ensure staff booking lists and theatre staff can ensure more complex patients are directed to the right list, the right surgical time allocated and the right resources available on the day. 3. Providers must ensure adequate resources are in place to provide the operating lists below so that patients can be directed to the most appropriate theatre list for their needs: a. High flow list (HVLC) - 10 patients, lower surgical complexity, and no anaesthetist b. Higher flow any complexity (HVAC) - 8 patients, mixed surgical complexity, and no anaesthetist with or without a trainee c. Anaesthetist covered list (for example 4 GA cataracts and 2 LAs, mixed surgical complexity and anaesthetist present to provide GA / sedation or monitor the medically high-risk patient e.g. implantable defibrillator). 4. Identify a routine “golden patient” who can be expected with a high degree of confidence to arrive on time (i.e. not reliant on transport) and be straightforward to start a list to ensure the list starts on time. 5. Specific lists can be compiled from a pooled waiting list, if processes are consistently followed by all staff and information is recorded properly 6. Immediate sequential bilateral cataract surgery (ISBCS) should be considered where suitable, otherwise both eyes should be prepared at the first pre-operative visit, with listing of the second eye either by the surgical provider after the first eye is completed or after any post- operative assessment.

2.3 Risk Stratification Tool.[1]

Complexity Grading	Description/Risk Factors
1	Routine, no risk factors
2	2 risk factors: • Difficult access • Deep-set eye • Difficulty lying flat • Anxious / jumpy patient • Communication issues (language, deafness, dementia) • Multiple intravitreal injections • Poor pupil dilation (no hooks/ring required) • Tamsulosin (alpha blockers) • Dense, mature or brunescent cataract • Shallow anterior chamber • Vitrectomised eye • High myopia or high hypermetropia • >85yrs • Corneal guttata or early Fuchs • Previous complications with first eye cataract surgery
3	3 of the above, or any of: • Pseudoexfoliation • Small pupil (requires hooks / ring) • Very difficult access • Severe positional or mobility issues • Nystagmus • Corneal graft or previous trabeculectomy
4	• Phacodenesis 'Black cataract' • Nanophthalmia Posterior polar cataract • Previous significant trauma
Anaesthesia	• Topical Subtenons • Oral sedation (hospital with GA facility only) • IV Sedation • General Anaesthesia

[1] Extract from Guidance on the Resumption of Cataract Services during COVID, RCOphth, May 2020

2.4 Hospital – before the day of surgery

Stage	Recommendation
Reduce DNA rates and delays	Check in with the patient 5 days prior to their operation date: confirm attendance and transport. This helps to confirm that the patient will attend and is well prepared for the events of the day.
Intraocular lens implants confirmation	This should be undertaken at either: a. 1-stop assessment clinic and the list already planned, and lens implants confirmed **OR** b. If not attended 1-stop assessment clinic, surgical team and/or lead surgeon should review the list, list order, choice of intraocular lens implant and patient records, to ensure resolution of any issues before the day of surgery
pre-operative dilating drops	Self-application of pre-operative dilating drops is recommended for suitable patients, supported by relatives and carers as required; providers should use patient leaflets to facilitate this.

2.5 Hospital – theatre

Stage	Recommendation
On the day nursing assessment	1. Reassess the patient's health status, medications, and allergies to identify any changes since their pre-operative assessments to ensure the validity of the original pre-op review, which does not require a specific time cut-off if this step is completed. 2. The assessment should be conducted using a local anaesthetic cataract proforma—either paper or electronic—that is concise and tailored specifically for cataract procedures. This avoids the need for the broader set of checks typically required for general anaesthetic surgeries.
Unnecessary on-the-day measurements	1. These measurements can be omitted unless clinically indicated: • Blood Pressure readings taken on the day often reflect patient anxiety rather than true cardiovascular risk. If a safe blood pressure was recorded during pre-assessment or confirmed by the GP, it does not need to be repeated. • Blood Sugar (BM) levels should only be checked if the patient feels unwell. If BM is below 4 mmol/l, offer something sweet and proceed once levels normalize. High BM should not lead to cancellation unless there's concern for hyperosmolar hyperglycaemic state (typically >33 mmol/l) or ketoacidosis (BM >13.9 mmol/l with elevated ketones). • INR testing is not required on the day if there is evidence that the patient's anticoagulation is within the therapeutic range. • VTE checks are not indicated for local anaesthetic procedures lasting 30 minutes or less.
Timings and Theatre Efficiency	1. To streamline the surgical day, patient arrival times should be staggered. Most patients undergoing local anaesthetic procedures who can instil their own drops (or have a carer do so) should arrive 15–30 minutes before their procedure. For those requiring dilation in hospital, dilating pellets can be used to save nursing time, with arrival scheduled 45 minutes prior to surgery. 2. Theatre start times should be standardised and agreed upon by all team members to define what constitutes a late start. For example: 3. Morning list: Team Brief at 08:30, Knife to Skin (eye) by 08:45–09:00 4. Afternoon list: Brief at 13:30, Knife to Skin (eye) by 13:45–14:00 5. Regular audits of start and finish times should be conducted to identify and address delays. While patient arrivals are staggered, the Team Brief can still be held at the start of the list, as allergies and specific needs will have been identified during the 1-stop clinic or pre-op review. 6. There must be sufficient time allocated for the WHO Surgical Safety Checklist, including verification of biometry, intraocular lens choice, and implant availability. The checklist should be adapted specifically for cataract surgery to ensure efficiency and accuracy.

2.6 Discharge

Considerations	Recommendation
Efficiency savings	Remove steps without an evidence-based e.g. eye shields do not need to be used routinely for all lower risk patients.[1]
Nursing observations	Local anaesthetic patients do not need nursing observations (e.g. BP) prior to discharge unless their general clinical condition deteriorates. As on arrival, there should be a specific local anaesthetic cataract proforma (paper or electronic) for discharge which is brief and focused only on the required checks for these patients, not by the extensive set of "standard" discharge checks required by other operations or those done under GA.
Discharge pack	A locally agreed pack can be standardised with appropriate medications and a post-operative information leaflet/care plan provided at point of discharge (See Appendix 1) • based on case mix in advance for standard cases • increased or longer time for medication for those at higher risk of post- operative inflammation • additional medication to reduce the risk of an adverse event e.g. to prevent an IOP rise in glaucoma patients or cystoid macular oedema (CMO) in those at risk
Post-operative complications	There must be an agreed pathway for care and advice, so patients and their carers receive timely advice and treatment 24 hours a day, 7 days a week • include contact numbers that work • Staff taking calls must be trained to recognise key red flag symptoms, including those of endophthalmitis, and take appropriate action to ensure patients can receive emergency care through the agreed pathway.
Post-operative care routine/ uncomplicated cases	Patients should not be seen postoperatively in hospital. • Discharge to a sight test at their local optometrist at approximately 4 weeks with return of the post-operative outcome data to the surgical provider. • Some patients may need an early return to the hospital e.g. for an IOP check in some glaucoma patients. • If patients are discharged, it is important to ensure they have enough post-operative steroid drops to complete their full course without running out of drops. In some areas, optometrists already provide a commissioned enhanced post-operative assessment, and some post-operative care for more complex patients can be delivered in commissioned optometry services. For example, a patient who is over 85 years old with a history of multiple intravitreal injections and corneal guttate would be considered complex, however their post-op care following uneventful cataract surgery could still be handled by an appropriately trained primary care optometrist who may be able to list for the second eye. Some areas are successfully utilising AI platforms to contact the patient post-operatively with the ability to capture and report PROMS.
Post-operative care complex cases	Discharge to a primary care optometrist for enhanced assessment or sight test may not be appropriate. A plan must be in place to identify such cases in advance, made at the time of their one stop assessment visit
Post operative outcomes	For cases seen by an optometrist, whether in a commissioned enhanced post-operative assessment service or where the patient is discharged to a sight test, the key post-operative outcome data of best corrected visual acuity and refraction, should be returned (ideally electronically) to the provider to audit outcomes and return data to the National Ophthalmology Database (NOD).

3. Multidisciplinary Team Requirements for High-Flow Ophthalmic Theatre

Considerations	Recommendations
Staffing Essentials	1. Consistent, ring-fenced staffing with enhanced competencies is the most critical factor for effective theatre flow. 2. Teams should regularly perform high-flow lists to maintain efficiency.
Theatre Team Composition	1. Dedicated ophthalmic and anaesthetic teams (where needed) are essential for rapid surgery and turnaround. 2. Local Anaesthetic (LA) lists do not require a dedicated anaesthetist. 3. General Anaesthetic (GA) lists benefit from consistent collaboration between ophthalmic and anaesthetic teams.
Day Case Area Staffing	1. Requires ring-fenced perioperative staff with experience in patient preparation and escorting. 2. Minimum staffing per high-volume theatre: a. 2 staff nurses b. If using healthcare assistants (HCAs) instead of porters: 2 HCAs (1 for escorting and monitoring, 1 as runner)
Admission Team (Per List)	1. Minimum: a. 1 nurse & 1 HCA, or b. 2 nurses
Operating Team (Per List)	1. Minimum: a. 2 scrub nurses b. 2 HCAs & 1 Operating Department Practitioner (ODP)
Alternative Staffing Models	1. Stoke Mandeville Model: a. 1 receptionist, 2 HCAs, no nurses b. Floating trained ODP between theatre and day case area 2. Primary Nurse Model: a. One nurse/HCA accompanies patient throughout the pathway to reduce handovers
Theatre Staffing Examples	1. Minimum per list: 2 scrub practitioners + 1 runner (all trained) 2. Enhanced models: a. Moorfields: 3 scrub nurses b. Sunderland: 2 scrub + 1 runner + 4–5 primary nurses (high volume) or 3 (training lists) c. Fife & Stoke Mandeville: Minimum 3 staff; Stoke Mandeville uses floating ODP 3. Some units are exploring dedicated cataract scrub technicians
Key Roles and Responsibilities	1. Consent & Eye Marking: Done by a trained healthcare professional (usually a nurse) 2. WHO Checklist & Anaesthetic Drops: Performed by ODP or trained HCA 3. Surgeon Confirmation: Side of surgery and biometry checked before theatre entry 4. Scrub Duties: Skin prep, draping, speculum insertion 5. Sub-Tenon's Blocks: Can be administered by trained MDT members (e.g., ODPs) 6. Operation Notes: Drafted by theatre/nursing staff for surgeon approval

	7. Pre-List Review: Surgeons or trained team members must review list and documentation in advance
Flexible Staffing	1. Some units rotate staff across ward, theatre, and outpatient settings to improve understanding of the full pathway and enhance safety and productivity.
Surgeon Welfare	1. High-flow operating can lead to fatigue. 2. Stoke Mandeville limits surgeons to half-day sessions for sustainability.
Anaesthetist Requirements	1. Not required for low-risk patients. 2. Monitoring must be done by a designated theatre team member. 3. Recording of monitoring is only needed if clinical changes occur.
Emergency Preparedness	1. Staff Training: • ILS if anaesthetic support is nearby • ALS if operating remotely 2. Emergency SOP: • Must exist for transferring unwell patients to A&E via 999 • SOP must be agreed with receiving hospital and reviewed regularly
Systemic Complexity	1. Anaesthetist required for patients with systemic complexity, guided by ASA grading.

4. Facilities and patient flow

Considerations	Recommendations
Waiting area	Provide an adequate waiting area, even with staggered arrival times, to accommodate patients waiting whilst respecting distancing and IPC requirements, to ensure no delays in taking the next patient to theatre
Theatre lay out	• an adjacent anaesthetic room or area for the administration of sub-Tenon's blocks and allowing patients to get onto the operating trolley or couch outside of the theatre room • a clean preparation room with enough space to lay up more than one trolley in advance and a waiting area / day case area very close to the anaesthetic room and theatre. • Lack of bespoke cataract theatre layout should not prevent a high flow approach being developed. 1. Consider a standard operating procedure for 'double scrubbing' in theatre agreed with local infection control policy enabling the second scrub nurse to prepare the second cataract trolley for patient two in theatre whilst the first scrub nurse is assisting the surgeon with patient one. 2. Other options include focussed laminar airflow machines situated in anaesthetic rooms for second cataract set preparation. See link: https://future.nhs.uk/GIRFTNational/view?objectID=157698533
Patient flow	• Patients should be on the trolley/surgical couch and comfortable prior to entering the operating room where possible and not climbing on and off the trolley in theatre. 1.
Sterilisation turnaround times and stock levels	• Ensure sufficient instrument sets and consumables are available to support high flow lists to ensure lists are not delayed due to instrument sterilisation turnaround times or lack of consumables. • Standardise the surgical instrument and pack sets. Consider using a streamlined set suitable for straightforward surgery (with more instruments available if required single packed). • There may be a role for disposable sets, but cost and environmental impact need to be considered.
Intraoperative complications	• Ensure there is a clear understanding of how to manage the flow of the list in the event of a complication or delay: a written process should be in place detailing a locally agreed protocol for example use of second theatre, limitations on how much vitrectomy is done, and when and how to cancel other patients. • Providers must have internal vitreoretinal surgeons available or a formal agreement and excellent communication channels with nearby vitreoretinal providers to ensure that complications requiring VR surgery are assessed within 24 hours.

5. Training

Training During High-Flow Lists

Providers should enable surgical training to be undertaken during high flow lists. This is necessary from the perspective of attaining surgical skills and for surgeons to develop the ability to independently run high flow lists. See the College guidance on training in high flow lists for more details: https://www.rcophth.ac.uk/wp-content/uploads/2021/12/Cataract-Training-Report-1.pdf

The cataract complexity system below provides a generic approach to complexity scoring and consideration could be given to a more granular system to better assist with case selection for trainees or to direct to specific list types.

8 cases per list provides time for a trainee who is not yet able to complete a cataract operation within 20 minutes to undertake supervised training.

Lists with 10 cases are suitable both for more experienced trainees who can consistently complete a cataract operation within 20 minutes and for less experienced trainees using modular training to focus on specific skills.

Training Requirements for Providers

All providers of NHS commissioned cataract surgery should have the requirement to train incorporated into the contract. There needs to be a local strategy to ensure that resident and SAS doctors receive adequate training.

6. Supporting high flow surgery outside the cycle of care

Considerations	Recommendation
Scoping exercise	providers and commissioners should assess their cataract referral demand and current and future population need, before looking at their theatre activity. When assessing efficiency, it may be beneficial to go to a more granular level. Consider using RCOphth Cataract Services Workforce Guidance March-2021 and cataract workforce calculator tool to support workforce planning to meet demand. https://www.rcophth.ac.uk/news-views/new-cataract-services-workforce-guidance/
Leadership & teamwork	appointment a cataract clinical lead tasked with providing an overview and coherent vision of the solution. This gives consistency throughout the change process. Consider appointing two co-leads, the benefits can be to provide some flexibility to attend meetings, etc. in case of leave or sickness.
Consider the wider trust	early engagement of the entire trust is crucial in planning for elective activity expansion
Consider a pilot	a pilot high flow initiative can be used as a tool to test proposals ahead of a department-wide implementation of radical changes.

7. Clinical governance and quality

Formal clinical governance arrangements involving all members of the pathway MDT and should ensure the pathway is fully understood by all.

Considerations	Recommendation
Standardised processes	1. are adhered to across the whole pathway. This is particularly important where pathways involve multiple surgical providers on different sites and large numbers of optometric practices. 2. The pathway is fully supported by SOPs or memoranda of understanding between organisations.
Training	1. All ophthalmologists and ophthalmic health care professionals should have appropriate training for their role according to recognised standards (e.g. for ophthalmologists through Ophthalmology Specialist Training (OST) or Ophthalmology Local Training (OLT), and for practitioners through Ophthalmic Practitioner Training or equivalent).
Culture, learning, improvement and safety	1. Constant and consistent emphasis on improvement and learning from best practice including a regular audit cycle 2. Regions should ensure that systems are in place to centrally record and investigate incidents and complications, to ensure that lessons are learned and disseminated to the whole multidisciplinary team across organisations, with shared learning between hubs. 3. All complications and adverse events, if presenting elsewhere, must be reported back to the surgical provider promptly. 4. All providers must be fully compliant with, and submit data annually to, the NOD audit 5. The provider must regularly monitor the efficiency of its theatre lists, and patient arrival to discharge (journey) times, which should be within 1 hour for routine cases and for non-routine, the increased duration should be proportionate to the degree of complexity. This can be performed with the trust's own software or using applications such as the eye efficiency app eyefficiency.org or the cataract-hub.com resource.

Appendix 1 High Flow Checklist

Leadership, culture and pathways	**Yes**	**No**
All stakeholders (trusts/surgical providers, commissioners, regional teams, primary care optometrists, etc) desire to work together to operate high flow lists		
Trust appointed clinical lead(s) for cataract, ops managers, nursing, and ophthalmology commitment for trust to operate high flow working as part of whole pathway		
Trust / surgical provider commitment to training future surgeons on high flow lists		
Commitment to offer immediate and delayed sequential bilateral cataract surgery		
Clear pathway for the management of the acutely unwell patient		
Process in place to manage flow of list in event of delay / complication		
Process in place for vitreoretinal review within 24 hours if required		
Process in place for discharge to sight test for routine patients with return of outcome data by optometrist		
Commissioned optometrist post-operative pathway for suitable patients who cannot be discharged to sight test		
Resources	**Yes**	**No**
Electronic patient records (EPR) suitable for ophthalmology available in trust		
Electronic patient records (EPR) or connectivity with optometrists available for entire pathway (electronic referral, post-op data returns)		
Ophthalmic operating suite available, allowing patients a short walk to theatres, theatre adjacent wait area or room for anaesthesia and to be positioned on trolley / couch, and discharge within acceptable time of arrival		
Single member of staff to admit and follow patient through pathway		
Nurses trained and routinely available to confirm consent & mark eye(s) to be operated		
Scrub professionals trained, routinely available and able to clean (prep), drape, and insert speculum		
Consistent, trained ophthalmic cataract theatre and day case team routinely available		
Consistent ophthalmic anaesthetic team for sedation or GA lists routinely available		
Theatre / nursing professional trained and able to complete 1st draft of operation note routinely available		
Member of theatre team with primary responsibility to monitor patient trained and routinely available		
Minimum of 2 scrub nurses and 1 runner in theatre, plus good availability of staff to move / accompany patients to and from theatres		
Agreed post-op drop regimens for standard and complex / specific scenarios (eg to prevent post-operative IOP spike) and associated patient leaflet with local post-op urgent contact details and discharge to optometrist explained		
Agreed pre-op drop self-instillation process with supporting leaflet		
Agreed risk rating for cataract surgery and booking proforma used to inform list numbers to suit level of trainee experience and type list/numbers on list.		

Appendix 2 Example standardised discharge drop regimens

Standardised regimen		
Drug	**Frequency**	**Weeks**
g. Chloramphenicol (*without preservative if definite preservative allergy)	qds	Weeks 1 & 2
g. Dexamethasone 0.1% (*without preservative if definite preservative allergy)	qds 2/52 bd 2/52	Weeks 1 – 4
For Diabetic Cataracts or those at High Risk of CMO Only g. Ketorolac (Acular) 0.5%	tds	Weeks 1 – 4
For those at High Risk of IOP Spike Only g. Iopoidine (Apraclonidine)1%	tds	Days 1 – 3
High risk regimen		
Drug	**Frequency**	**Weeks**
g. Chloramphenicol (*without preservative if definite preservative allergy)	qds	Weeks 1 & 2
g. Dexamethasone 0.1% (*without preservative if definite preservative allergy)	2 hourly 2/52 qds 2/52 tds 1/52 bd 1/52 od 1/52	Weeks 1 – 7
For Diabetic Cataracts or those at High Risk of CMO Only g. Ketorolac (Acular) 0.5%	tds	Weeks 1 – 4

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1. Shield or not to shield? Postoperative protection after modern cataract surgery, Lindfield D, Pasu S, Ursell P. Eye (Lond). 2011 Dec; 25(12): 1659-1660.
2. Sustainable Cataract Surgery, RCOphth, September 2025 https://www.rcophth.ac.uk/resources-listing/sustainable-cataract-surgery/

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