UK OPHTHALMOLOGY ALLIANCE

UKOA Meeting
Emergency Eye Services

Tuesday 17th March 2026

12:30 – 14:30

Housekeeping Please

- Please stay on mute unless you are speaking
- We have a dedicated Q&A session at the end of each presentation so please raise your hand during this sessions if you have any questions – before your question please provide your name and your role
- We are monitoring the chat the function if you have any comments throughout the meeting
- The webinar is being recorded and this will be shared along with the slides on the UKOA website after the meeting – we will send all members a link

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Agenda

Introduction, Agenda and UKOA Update	12.30-12.35	Bushra Mushtaq, UKOA Chair
National Overview – Emergency Eyecare including Q&A	12.35-13.05	John Buchan Consultant Ophthalmologist, Leeds Teaching Hospitals NHS Trust RCOphth NOD, Cataract Clinical Lead Programme Director, MSc Public Health for Eye Care International Centre for Eye Health, LSHTM
Innovations in Emergency Eye Care at Moorfields ED including Q&A	13.05-13.35	Gordon Hay, Medical Director and Clinical Director of Emergency Services Moorfields NHSFT
Emergency Eye Care Birmingham including Q&A	13.35-14:05	Fizza Mushtaq Consultant Ophthalmologist Birmingham and Midlands Eye Centre
General Discussion	14:05-14:25	All
AOB/Close	14.25-14.30	Bushra Mushtaq, UKOA Chair

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Update on UKOA

- We have now arranged a schedule of meetings until **Sep 2026 -** a mixture of virtual and face to face meetings – on the next slide

- **Members Fees** – we have experienced significant issues in receiving member fees, please check that your organisation has paid its dues, we have industry sponsorships for which we are grateful but for long term sustainability requires members to pay their annual fees, which gives their whole organisation access to virtual and f2f meetings
- We have a **mailbox** to which members can write information requests, clinical and nonclinical service queries UKOA@rnib.org.uk
- **Our website** with all its resources, updates and an excellent opportunity for members to showcase their success stories, publicise events and local departmental changes etc.
- The **themes** of the next few meetings are based on those topics requested by members and/or considered a high priority with the changing NHS landscape and UKOA's mission to keep all the ophthalmology sector updated and engaged in NHS policies and strategies with a spirit of collaboration.

- We now please need your thoughts and ideas of the themes you would like us to cover in future meetings and/or if you have an area of work which will be of interest to members - **please can you put in the chat box or email the UKOA mailbox**

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UKOA Upcoming Events

Theme of Meeting	Meeting Chair	Date	Location
Ophthalmology Pharmacy, high-cost drugs, biosimilar , NHSE commissioning guidance and real-world experience of its implementation	Bushra Mushtaq	Tuesday 12th May 2026	Virtual
NHS England 10-year plan, Care close to home, Neighbourhood hubs? Workshops		Tuesday 14th July 2026	London
Ophthalmology training medical and AHP		Tuesday 22nd September 2026	Virtual

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UK Emergency Eye Care

Dr John Buchan

Programme Director - MSc Public Health for Eye Care

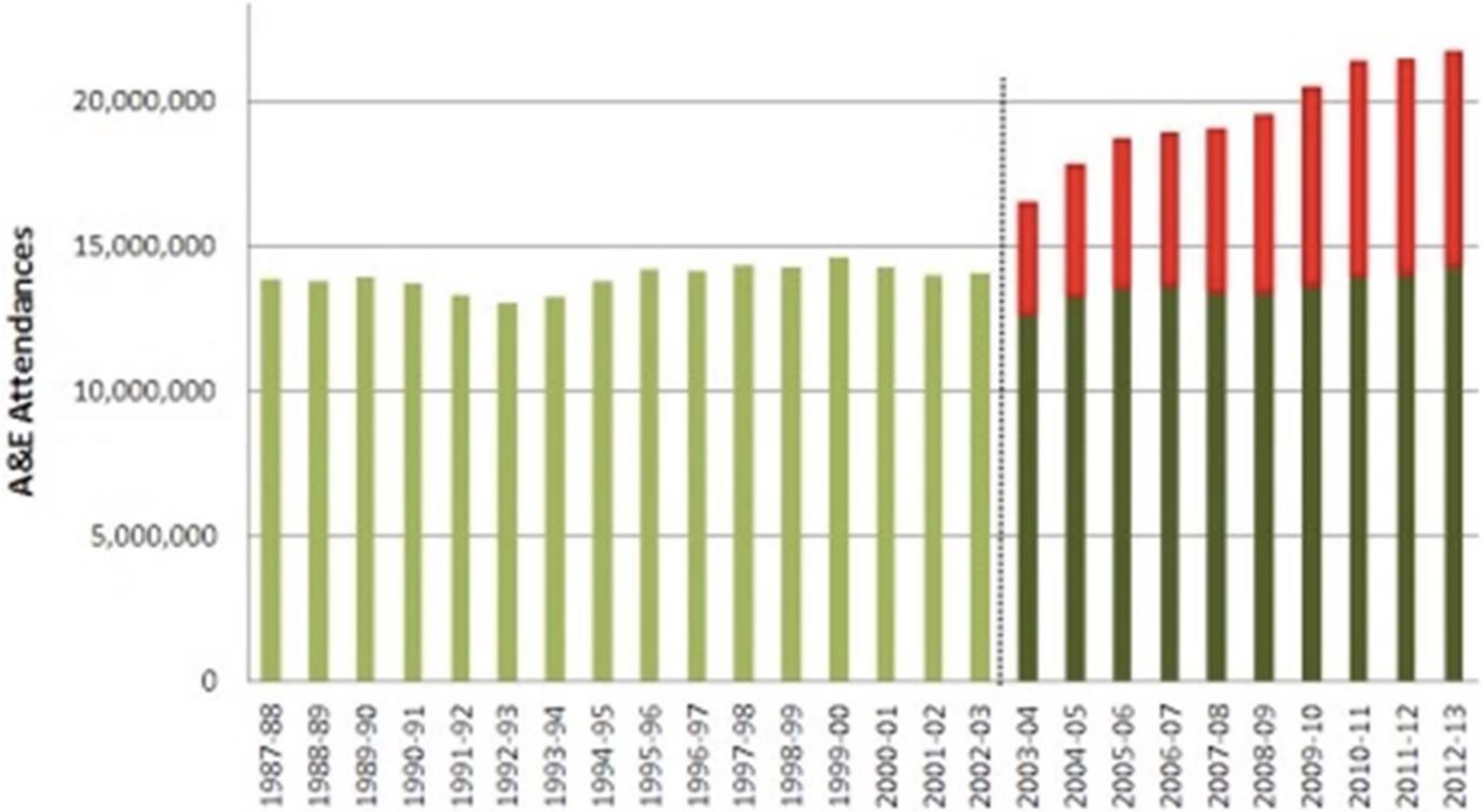
Consultant Ophthalmologist - Leeds Teaching Hospital NHS Trust

RCOphth NOD Cataract Audit - Clinical Lead

iceh.lshtm.ac.uk/

INTERNATIONAL CENTRE FOR EYE HEALTH

- The problem
- The solutions


A&E Attendances
20,000,000
15,000,000
10,000,000
5,000,000
0
1987-88
1988-89
1989-90
1990-91
1991-92
1992-93
1993-94
1994-95
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2002-03
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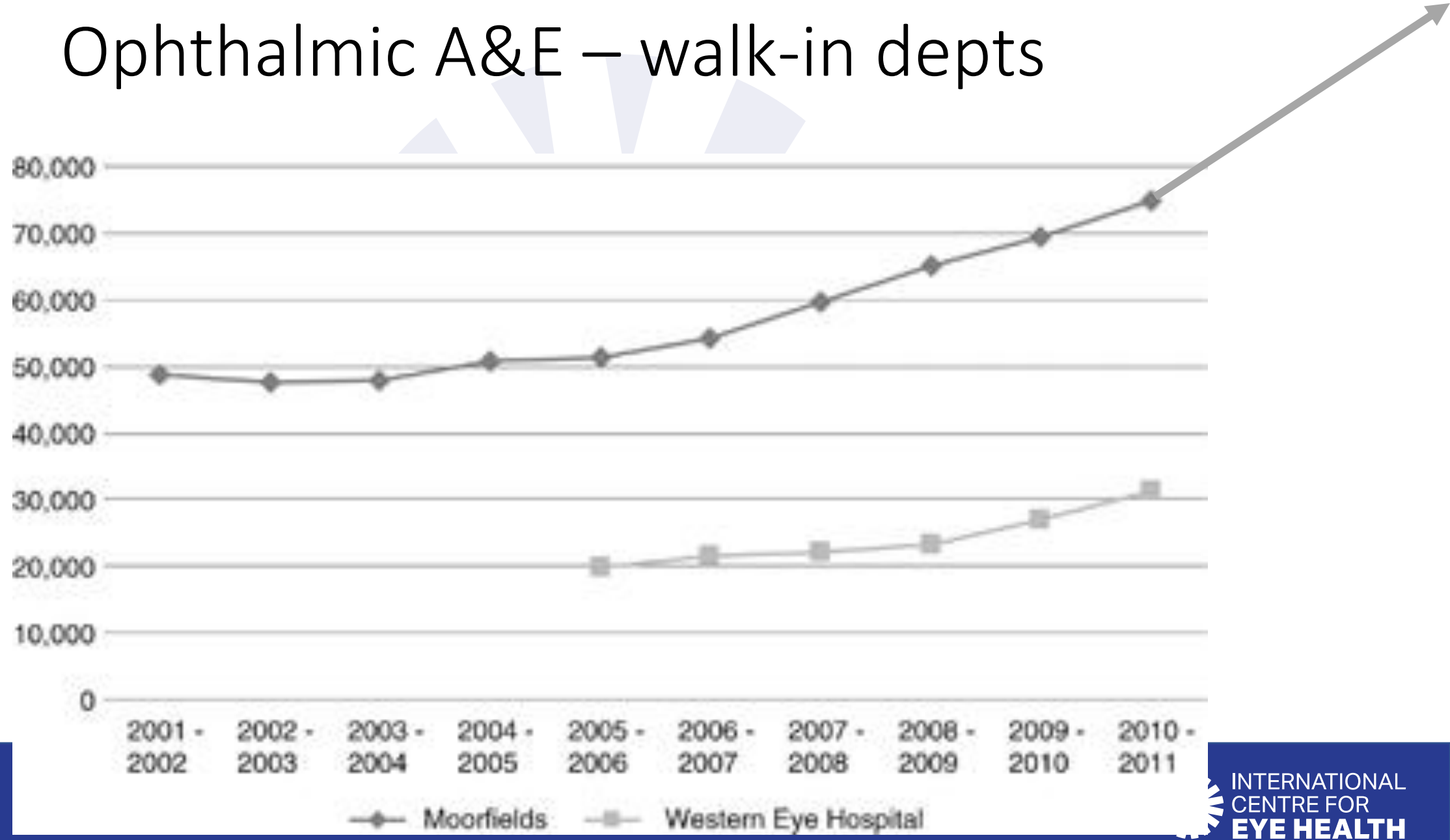
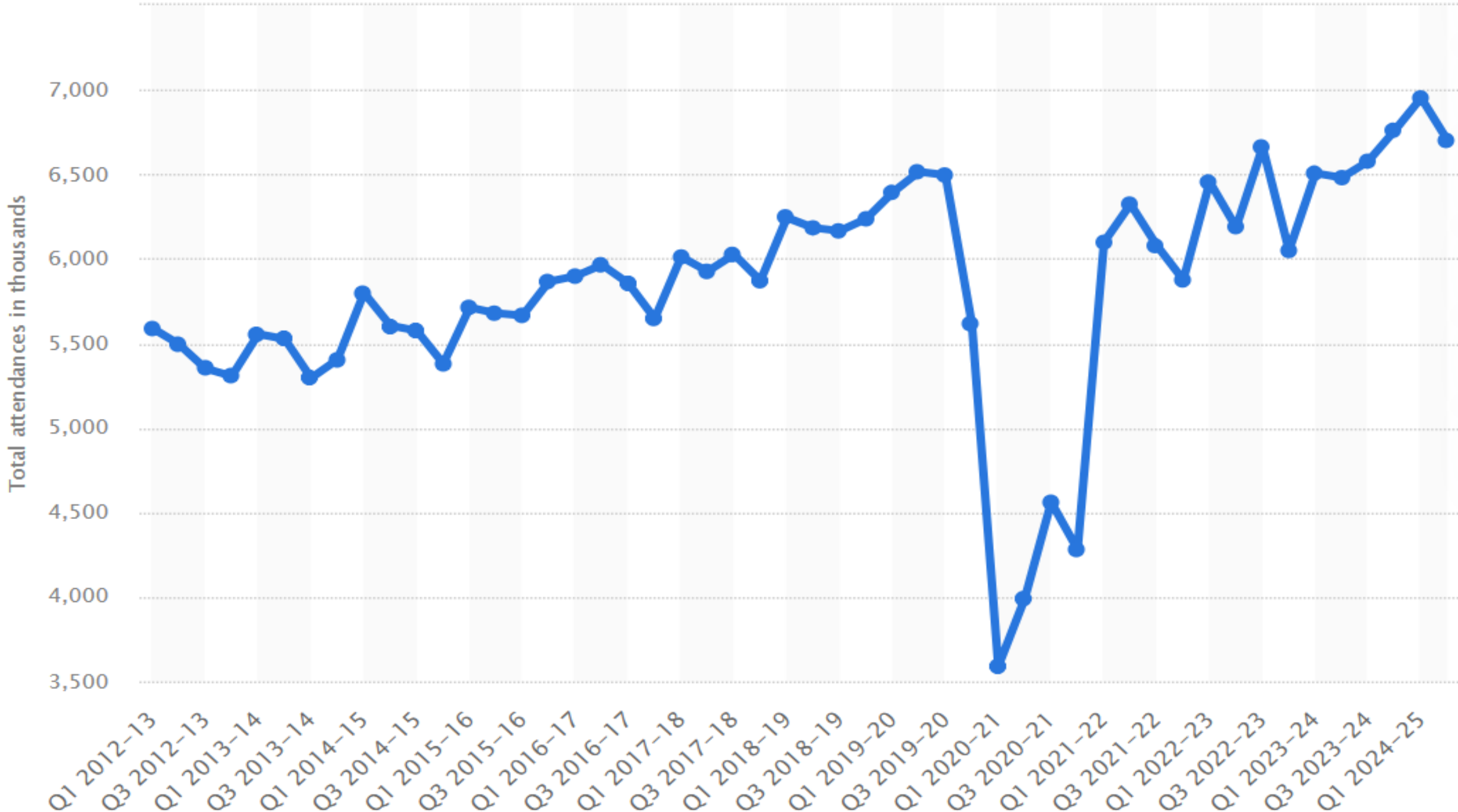
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13

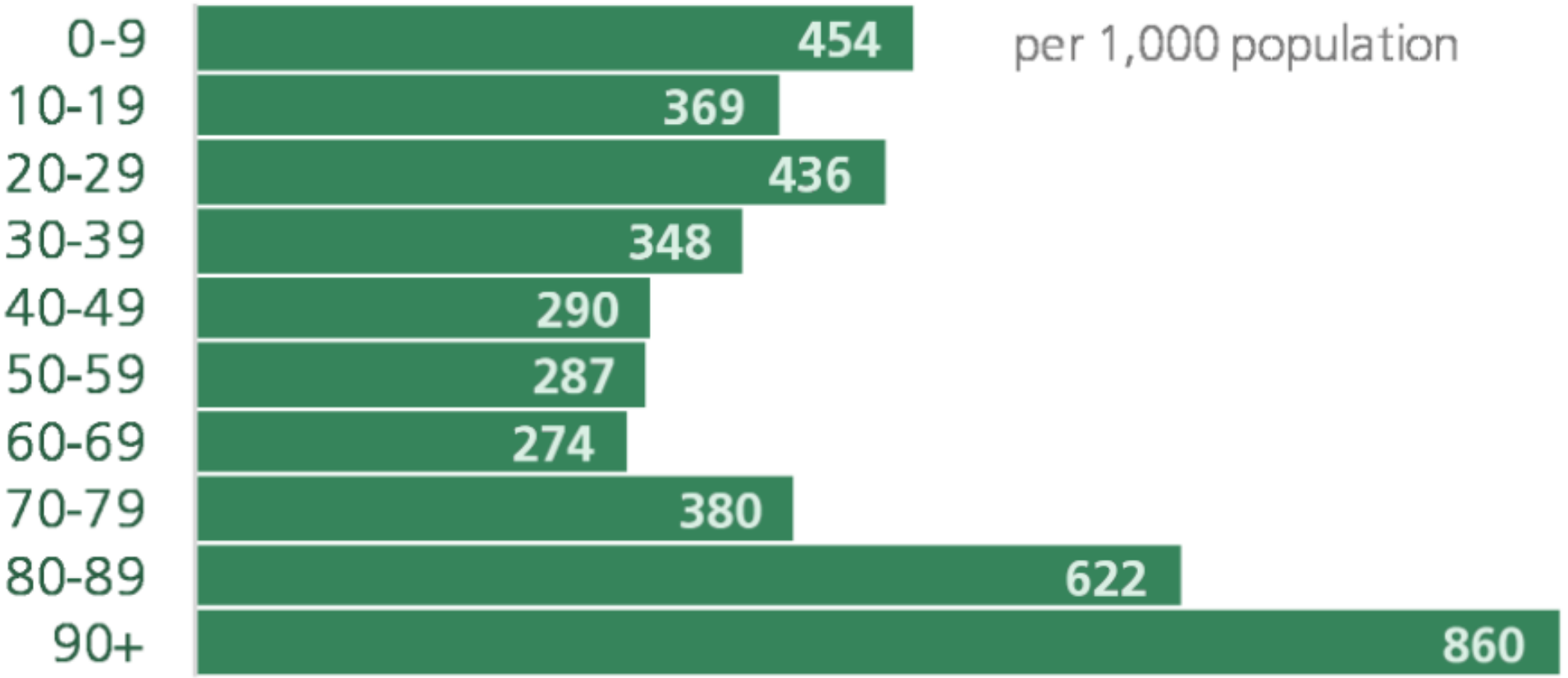
Ophthalmic A&E – walk-in depts



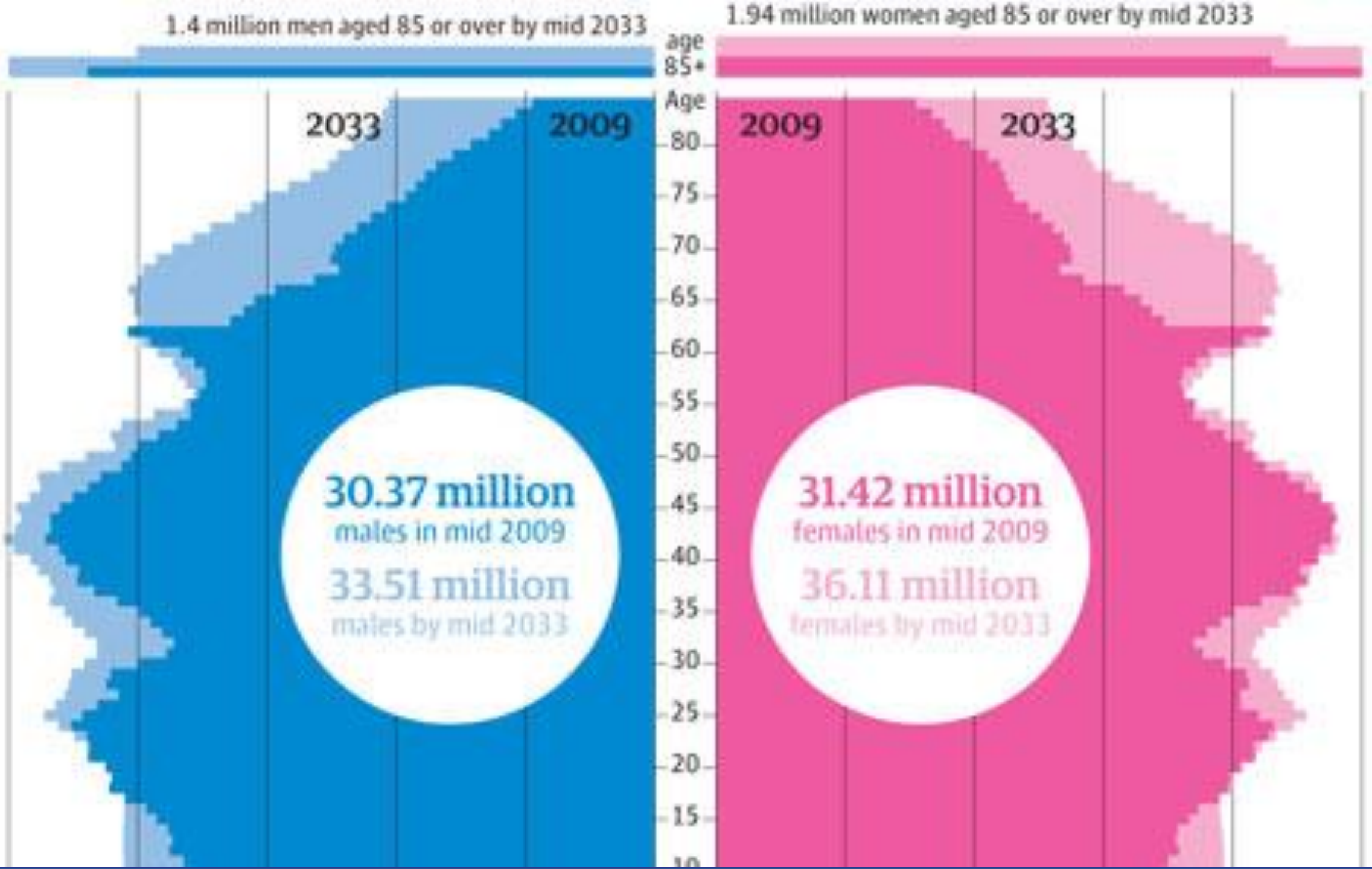
INTERNATIONAL CENTRE FOR EYE HEALTH

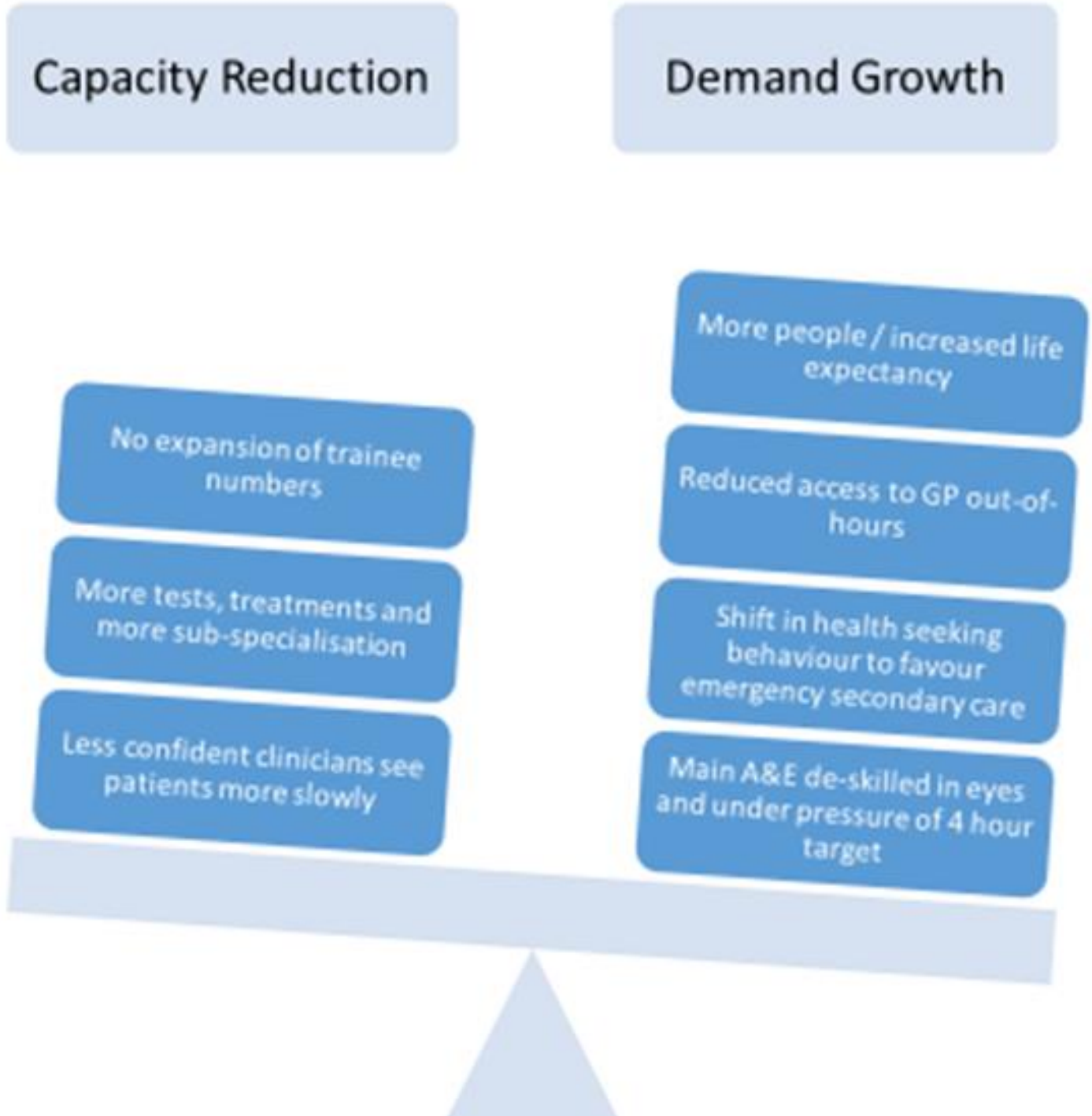

Total attendances in thousands
7,000
6,500
6,000
5,500
5,000
4,500
4,000
3,500
Q1 2012–13
Q3 2012–13
Q1 2013–14
Q3 2013–14
Q1 2014–15
Q3 2014–15
Q1 2015–16
Q3 2015–16
Q1 2016–17
Q3 2016–17
Q1 2017–18
Q3 2017–18
Q1 2018–19
Q3 2018–19
Q1 2019–20
Q3 2019–20
Q1 2020–21
Q3 2020–21
Q1 2021–22
Q3 2021–22
Q1 2022–23
Q3 2022–23
Q1 2023–24
Q3 2023–24
Q1 2024–25

People aged 80+ have the highest rates of A&E attendance. In terms of raw numbers, ages 20-24 are the most common adult attendees.



INTERNATIONAL CENTRE FOR EYE HEALTH


1.4 million men aged 85 or over by mid 2033
1.94 million women aged 85 or over by mid 2033
age 85+
Age
2033
2009
2009
2033
80
75
70
65
60
55
50
45
40
35
30
25
20
15
30.37 million
males in mid 2009
33.51 million
males by mid 2033
31.42 million
females in mid 2009
36.11 million
females by mid 2033

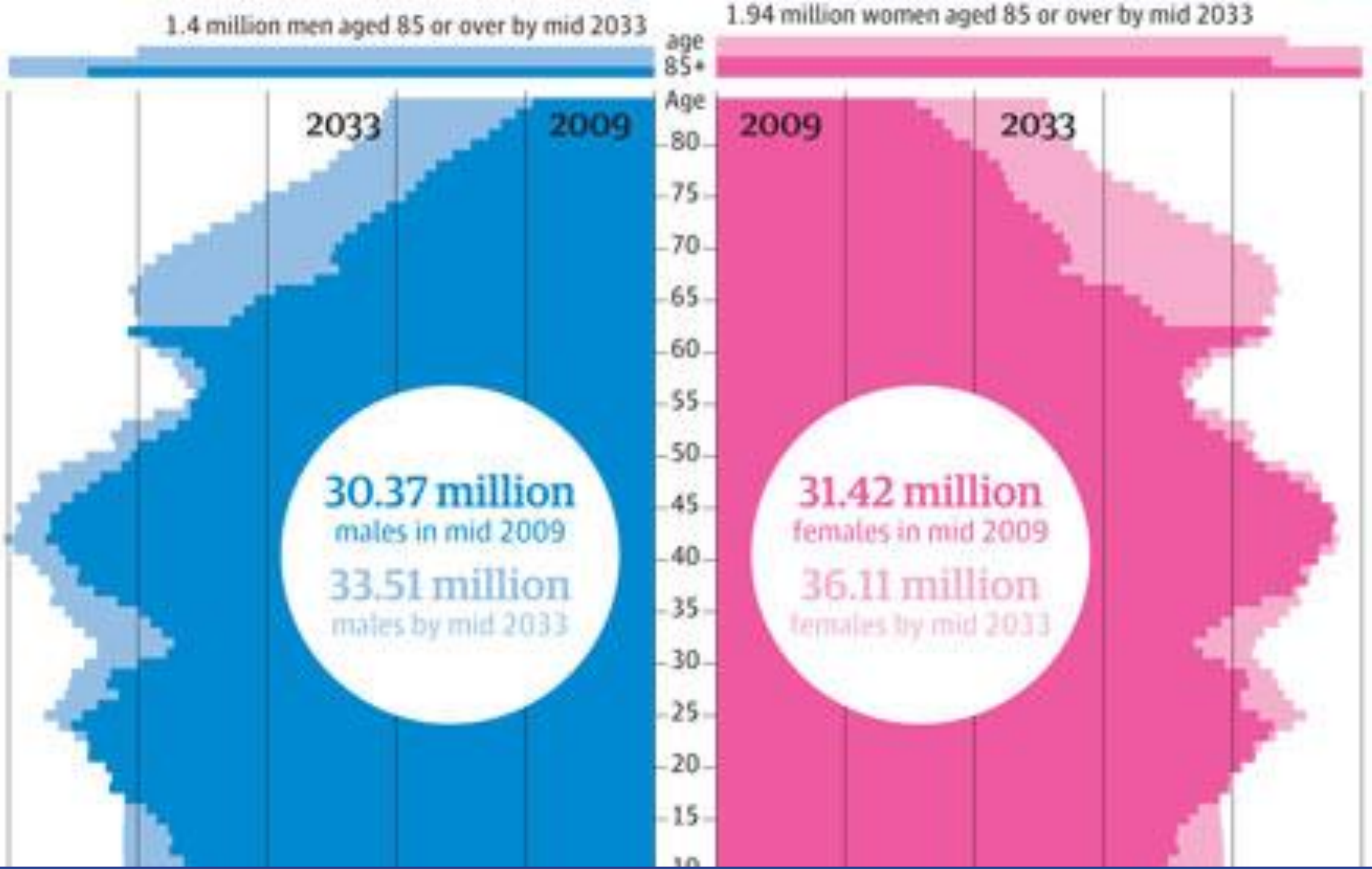

Capacity Reduction
Demand Growth
No expansion of trainee numbers
More tests, treatments and more sub-specialisation
Less confident clinicians see patients more slowly
More people / increased life expectancy
Reduced access to GP out-of-hours
Shift in health seeking behaviour to favour emergency secondary care
Main A&E de-skilled in eyes and under pressure of 4 hour target

Emergency eye care in hospital eye units and secondary care

15 MAY 2024 RCOPHTH

For more than a decade there has been increasing demand for all urgent and emergency care in the UK, including ophthalmic care, due to a combination of changes in demographics/disease prevalence and in the way patients choose to access care. It is difficult to know the national caseload but the incidence of new eye casualty attendances has been estimated at 20-30 per 1000 population per year and eye emergencies are thought to make up 1.46-6% of accident and emergency (A&E) attendances.

DOWNLOAD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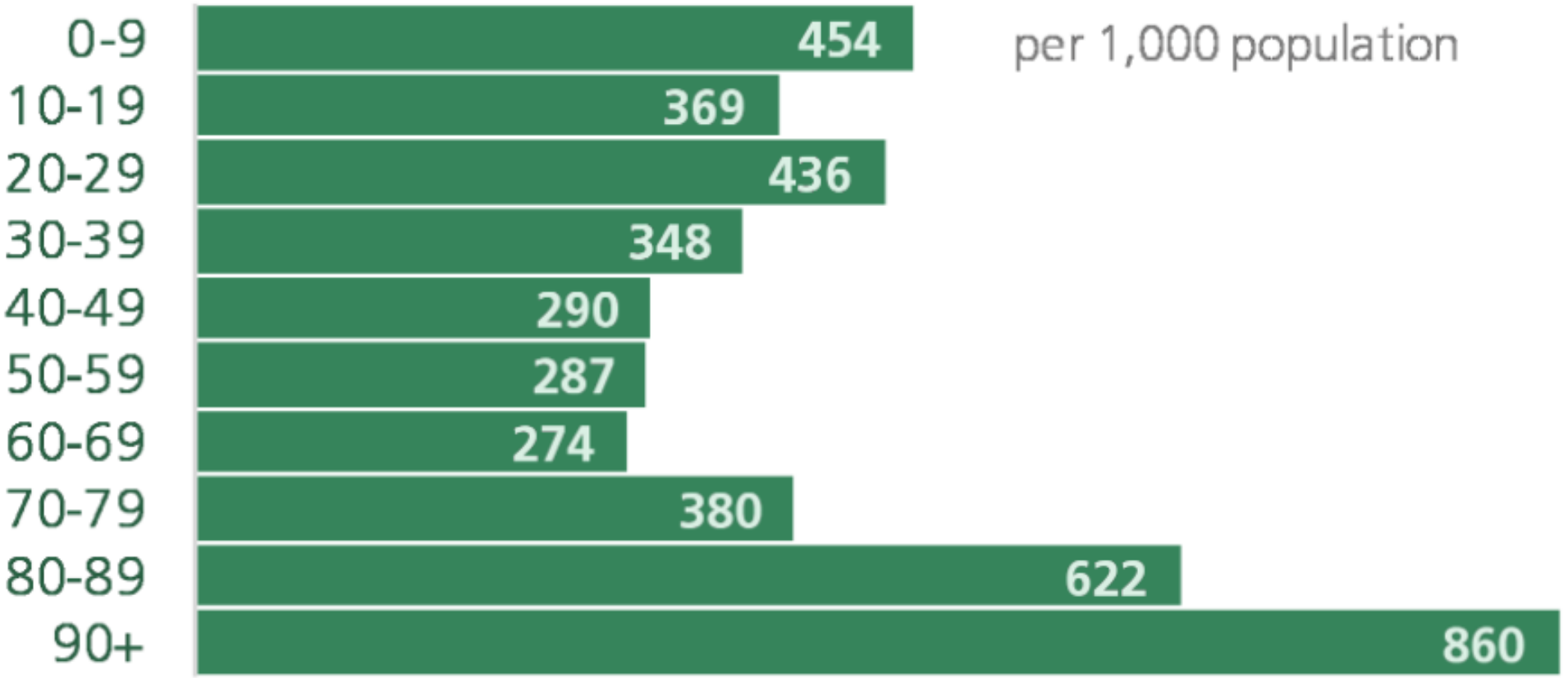
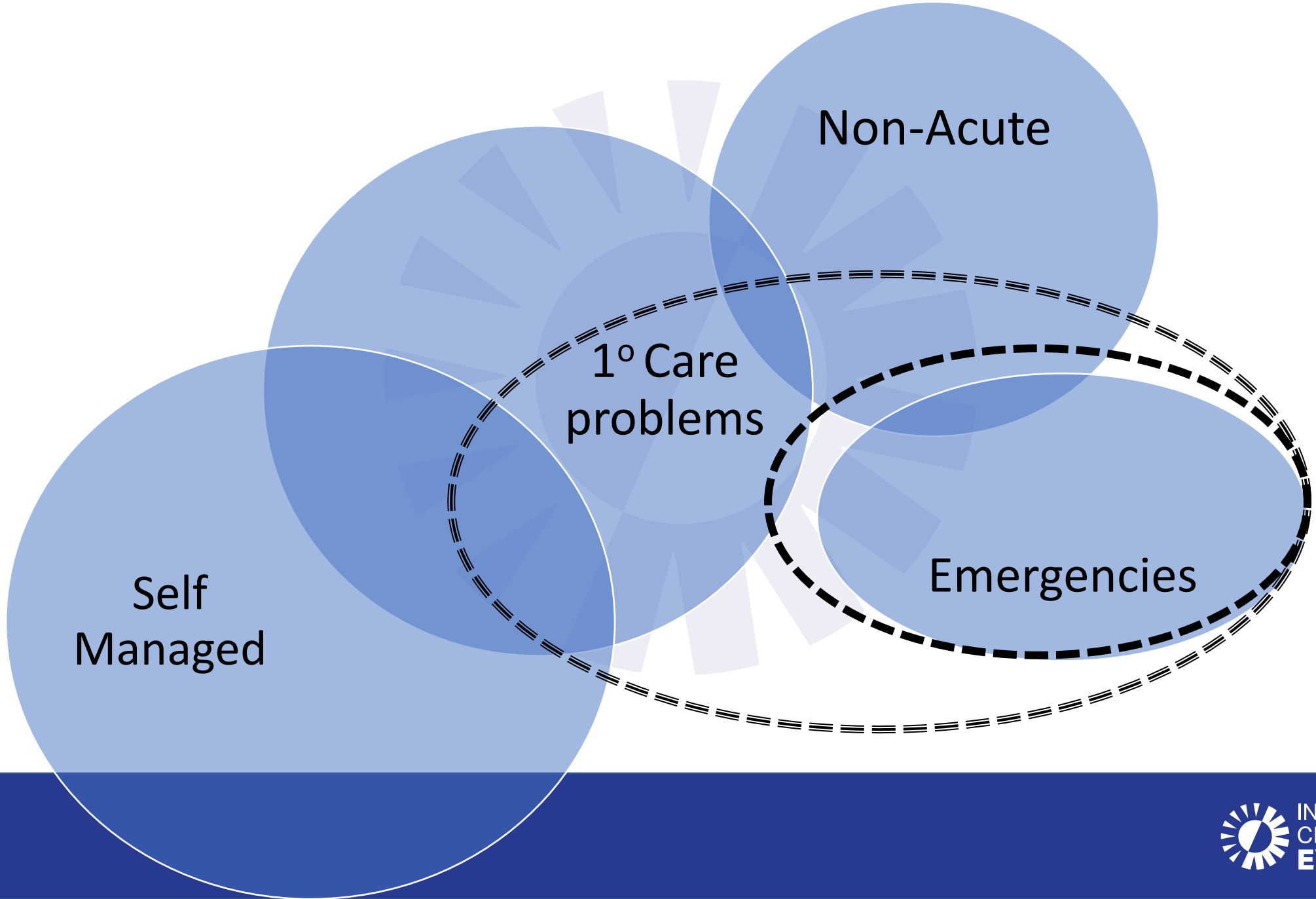
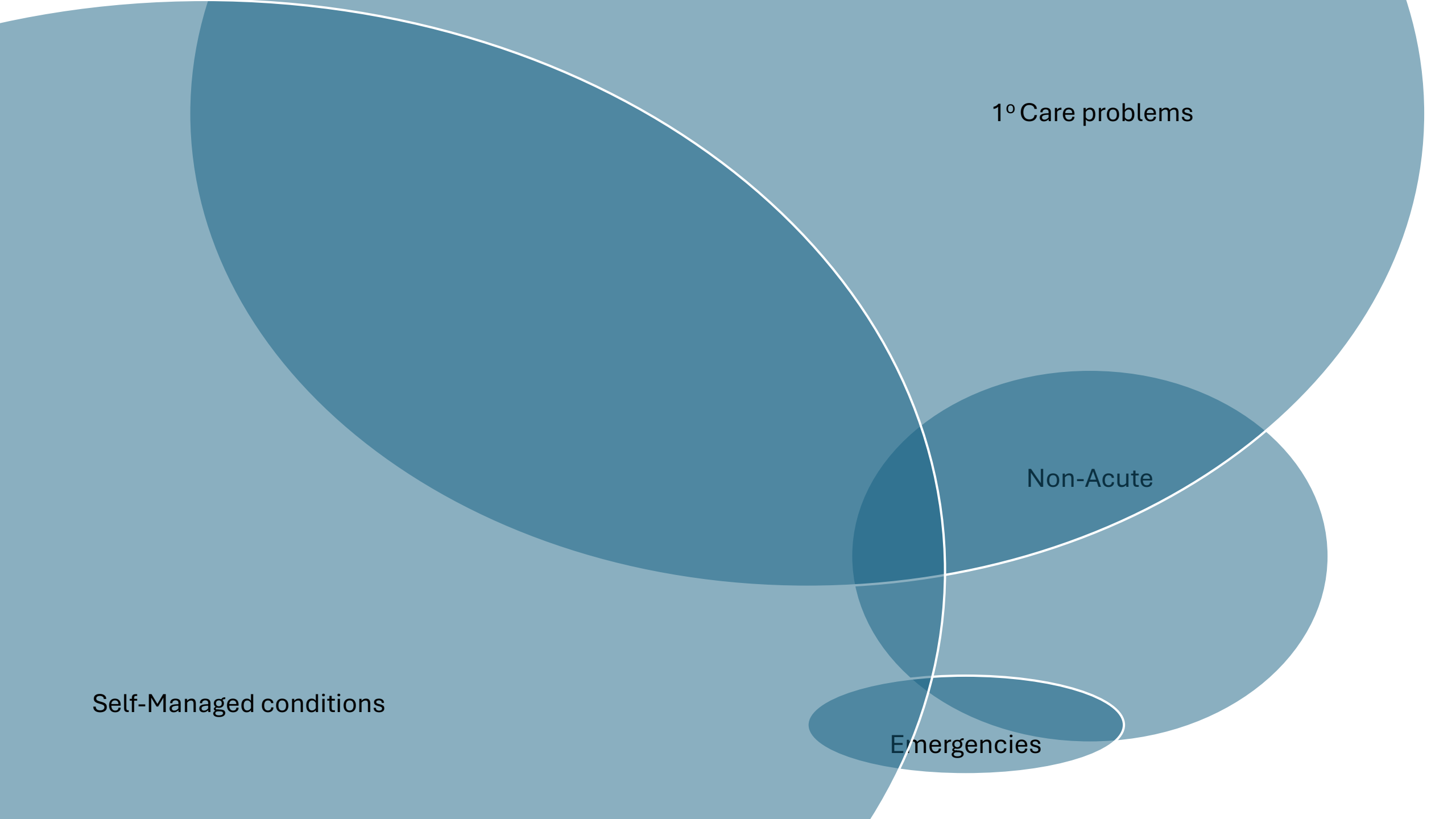


INTERNATIONAL CENTRE FOR EYE HEALTH


Non-Acute
1º Care problems
Emergencies
Self Managed


1º Care problems
Non-Acute
Emergencies
Self-Managed conditions

	Population served	Attendances per annum	Attendances / 1,000 pop. / ye
Slotting patients into clinics (n=3)	350,000	3,000	9
Acute Referral Clinics (n=33)	500,000	7,000	14
Daytime Walk-in Service (n=9)	760,000	15,000	20
24-hour Walk-in Service (n=2)	880,000	40,000	45

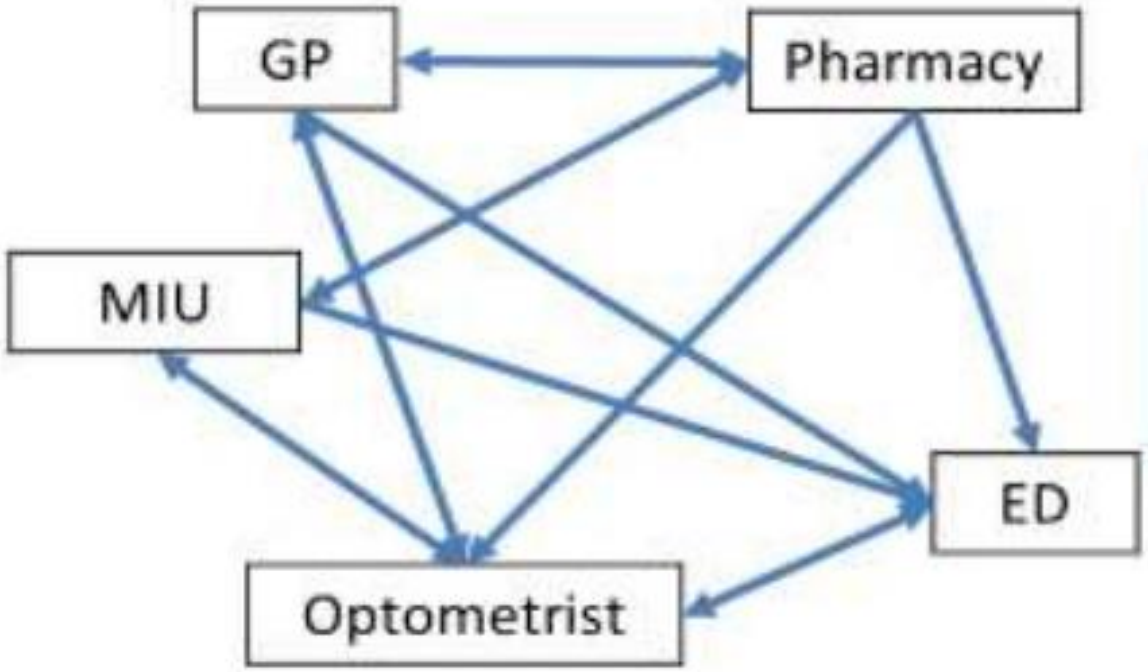
The ROYAL COLLEGE of OPHTHALMOLOGISTS

Commissioning Guidance

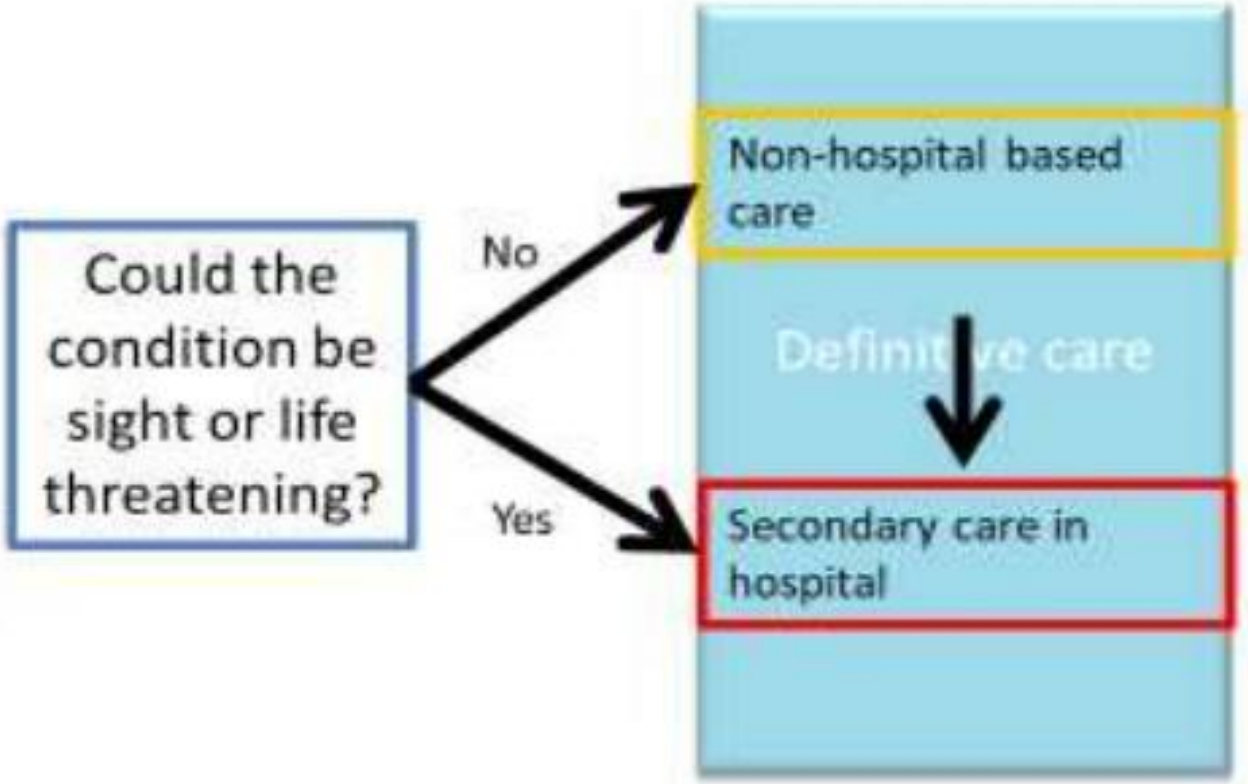
Emergency Eye Care

February 2020

Current

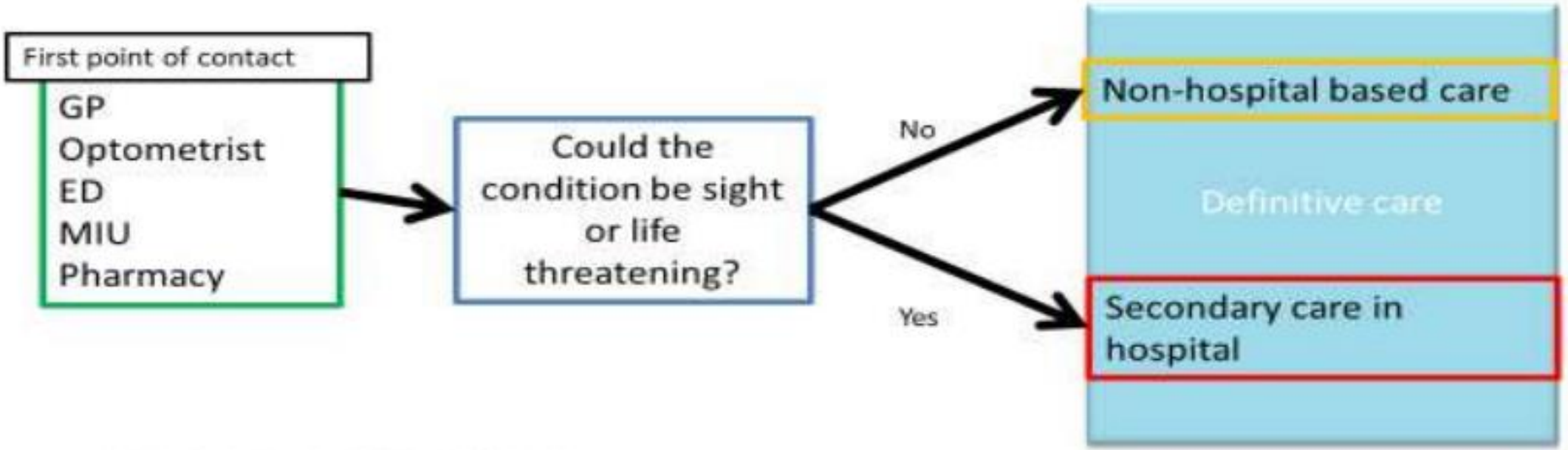


Patients may access multiple points of primary care, lengthening the time to definitive care



This question is often never answered, leading to further delays

Desired

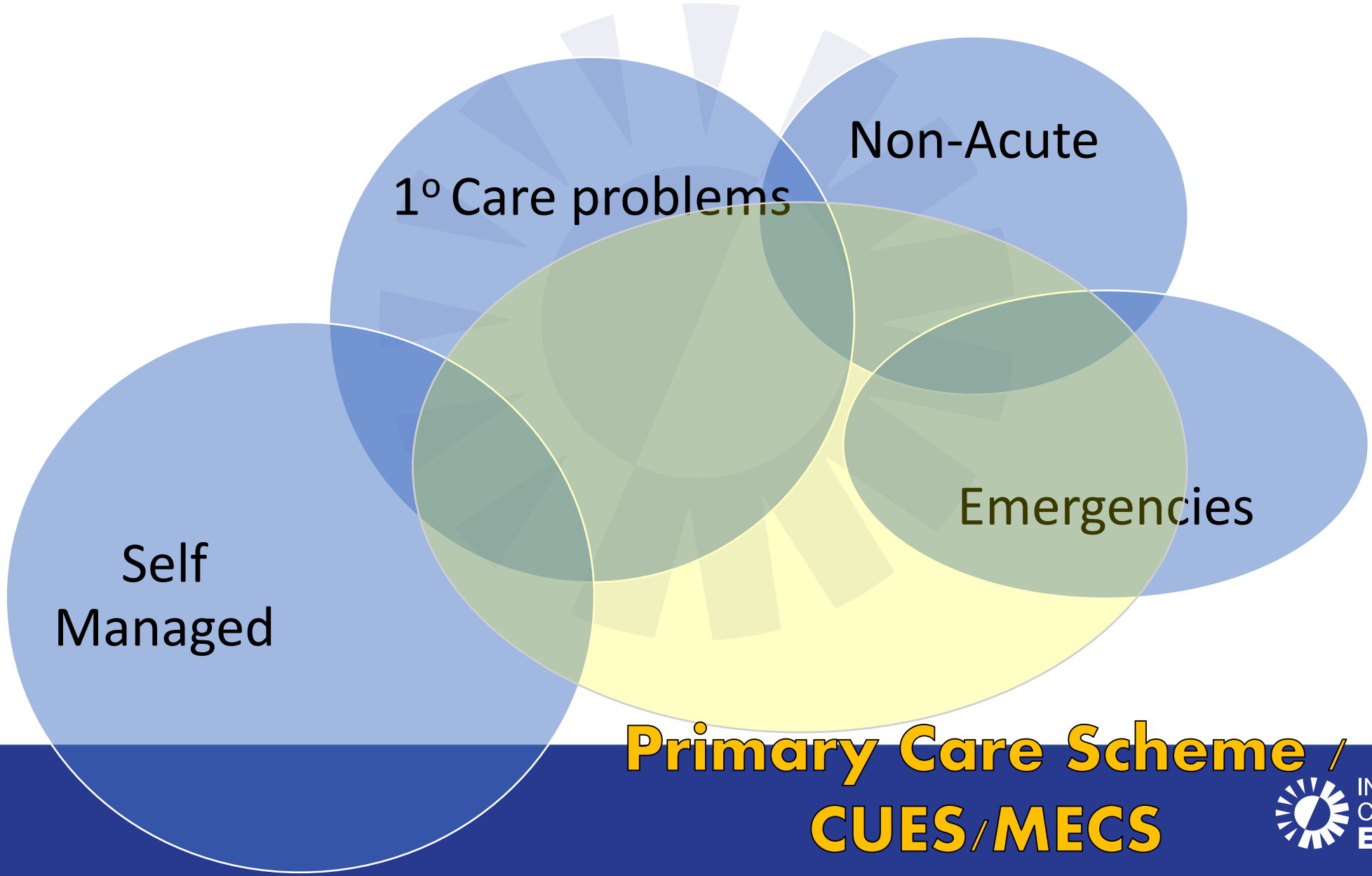


Patients who are suspected of having a sight or life threatening condition are able to rapidly access the correct practitioner using the same locally agreed triage tool.

GP – General practitioner, ED – Emergency department, MIU – Minor Injuries unit

A well-designed service should include:

✓	An understanding of the local population eye health needs and current service provision
✓	Whole pathway assessments – audit, cost effectiveness, governance This should be integral to new service design and occur before, during and after any changes are introduced
✓	New pathways and services should be designed by all stakeholders. This should include patients, ophthalmologists, optometrists and commissioners
✓	Ensure the patient is seen at the right place, right time by the right professional. Minimising unnecessary patient visits, creating seamless pathways, working across boundaries, saving costs and enhancing efficiency – improving outcomes and patient experience.


1º Care problems
Non-Acute
Self Managed
Emergencies

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Ophthalmic Service Guidance

Emergency eye care in hospital eye units and secondary care

May 2024

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Studies showing effect early senior opinion

Cooper et al (2009) *Caring to the end? A review of the care of patients who died in hospital within 4 days of admission*, NCEPOD

Martin et al (2007) *Emergency Admissions: A journey in the right direction?*, NCEPOD

Christmas et al (2013) *The impact of 24 h consultant shop floor presence on emergency department performance: a natural experiment*

Geelhoed et al (2008) *Positive impact of increased number of emergency consultants.*

Sen et al (2012) *The impact of consultant delivered service in emergency medicine: the Wrexham Model*

White et al (2010) *Impact of senior clinical review on patient disposition from the emergency department*

Shetty et al (2012) *Senior Streaming Assessment Further Evaluation after Triage zone*

Terris et al (2004) *Making an IMPACT on emergency department flow: improving patient processing assisted by consultant at triage*

McNeill et al (2009) *What is the effect of a consultant presence in an acute medical unit?*

Bell et al (2013) *Consultant Input in Acute Medical Admissions and Patient Outcomes in Hospitals in England: A Multivariate Analysis*

Mullen et al (2009) *Timing of first review of new ICU admissions by consultant intensivists in a UK district general hospital*

1998

INTERNATIONAL CENTRE FOR EYE HEALTH

2000

INTERNATIONAL CENTRE FOR EYE HEALTH

2002

INTERNATIONAL CENTRE FOR EYE HEALTH

2004

INTERNATIONAL CENTRE FOR EYE HEALTH

2006

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2008

INTERNATIONAL CENTRE FOR EYE HEALTH

2010

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2012

INTERNATIONAL CENTRE FOR EYE HEALTH

2014

INTERNATIONAL CENTRE FOR EYE HEALTH

2016

INTERNATIONAL CENTRE FOR EYE HEALTH

2018

INTERNATIONAL CENTRE FOR EYE HEALTH

2020

INTERNATIONAL CENTRE FOR EYE HEALTH

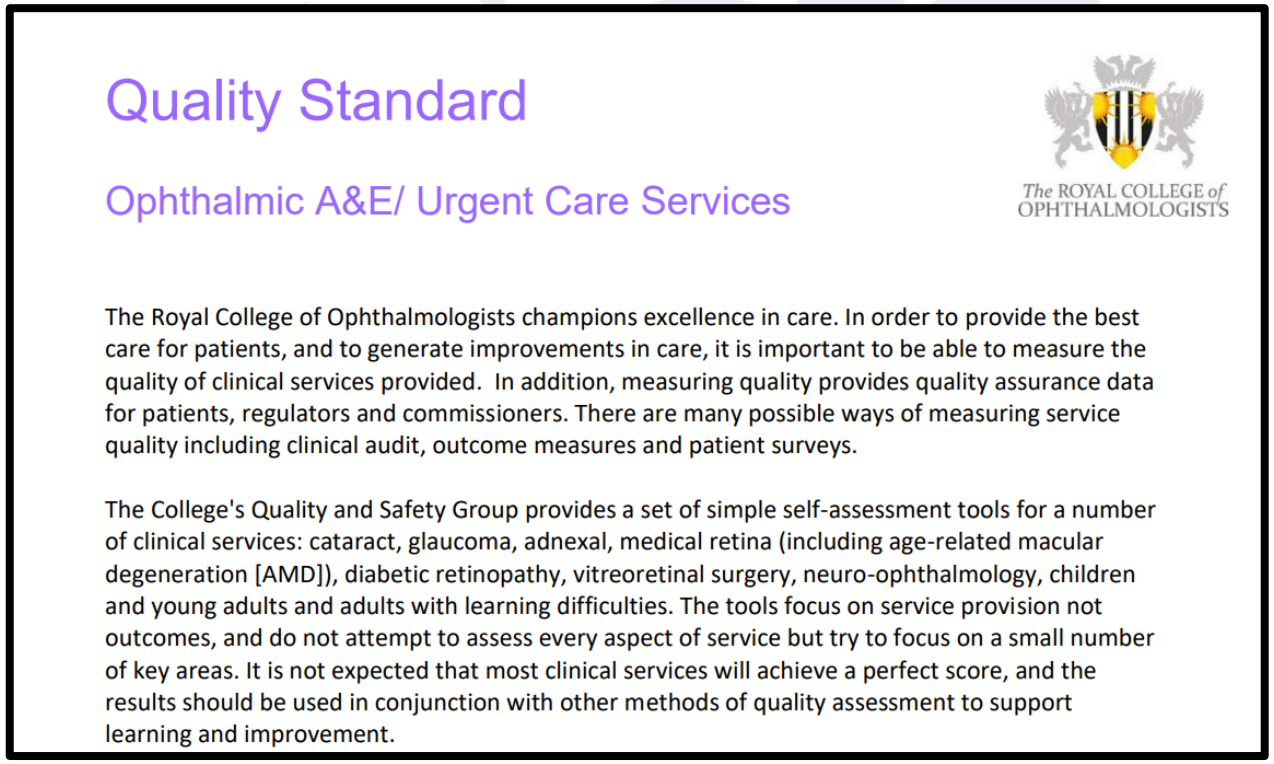
2022

INTERNATIONAL CENTRE FOR EYE HEALTH

2025

INTERNATIONAL CENTRE FOR EYE HEALTH

https://www.rcophth.ac.uk/wp-content/uploads/2021/12/Quality-Standard-for-AE-Urgent-Care-Services.pdf



Quality Standard

Ophthalmic A&E/ Urgent Care Services

The ROYAL COLLEGE of OPHTHALMOLOGISTS

The Royal College of Ophthalmologists champions excellence in care. In order to provide the best care for patients, and to generate improvements in care, it is important to be able to measure the quality of clinical services provided. In addition, measuring quality provides quality assurance data for patients, regulators and commissioners. There are many possible ways of measuring service quality including clinical audit, outcome measures and patient surveys.

The College's Quality and Safety Group provides a set of simple self-assessment tools for a number of clinical services: cataract, glaucoma, adnexal, medical retina (including age-related macular degeneration [AMD]), diabetic retinopathy, vitreoretinal surgery, neuro-ophthalmology, children and young adults and adults with learning difficulties. The tools focus on service provision not outcomes, and do not attempt to assess every aspect of service but try to focus on a small number of key areas. It is not expected that most clinical services will achieve a perfect score, and the results should be used in conjunction with other methods of quality assessment to support learning and improvement.

Quality Standard

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1. Leadership

There is a nominated eye unit clinical lead for the urgent service with the role defined in their job plan. The job description includes liaison with non-ophthalmic A&E staff and community / primary care colleagues.

YES ☐ NO ☐

The eye unit provides training and support to the trust's non-ophthalmic A&E doctors, nurses and AHP staff who may be required to deal with ophthalmic conditions.

YES ☐ NO ☐

Comments/reasons for non adherence:

Quality Standard

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6. Protocols, guidelines and staffing

There are departmental protocols / guidelines for the management of common emergencies such as acute glaucoma and endophthalmitis based on College, NICE or other recognised national guidance.

YES ☐ NO ☐

There are triage guidelines for staff taking calls or providing initial assessment.

YES ☐ NO ☐

For nursing and AHP staff delivering extended role A&E care there are:

Training and sign off against the College common competency framework	YES ☐	NO ☐
Guidelines / protocols including for ophthalmologist involvement	YES ☐	NO ☐
Supervision of practice by an ophthalmologist	YES ☐	NO ☐
Audit and appraisal of performance	YES ☐	NO ☐

5. Equipment and facilities

There is a dedicated ophthalmic A&E room equipped with the essential equipment: standard visual acuity testing chart; near vision and colour vision testing equipment; slit lamp with tonometer; gonioscope lens; indirect ophthalmoscope; 20 dioptre and 90 dioptre lenses; exophthalmometer; ideally also trial frames and a trial lens set.

YES ☐ NO ☐

There is access to the other equipment and investigations outlined in the College A&E service guidance? **

YES ☐ NO ☐

There is an adequate stock of medications which may be required to treat emergency conditions where there is no pharmacy service immediately available**

BEECS

British Emergency Eye Care Society

Gordon Hay

Medical Director and Clinical Director of Emergency Services Moorfields NHSFT

UKOA
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MIDLAND METROPOLITAN UNIVERSITY HOSPITAL

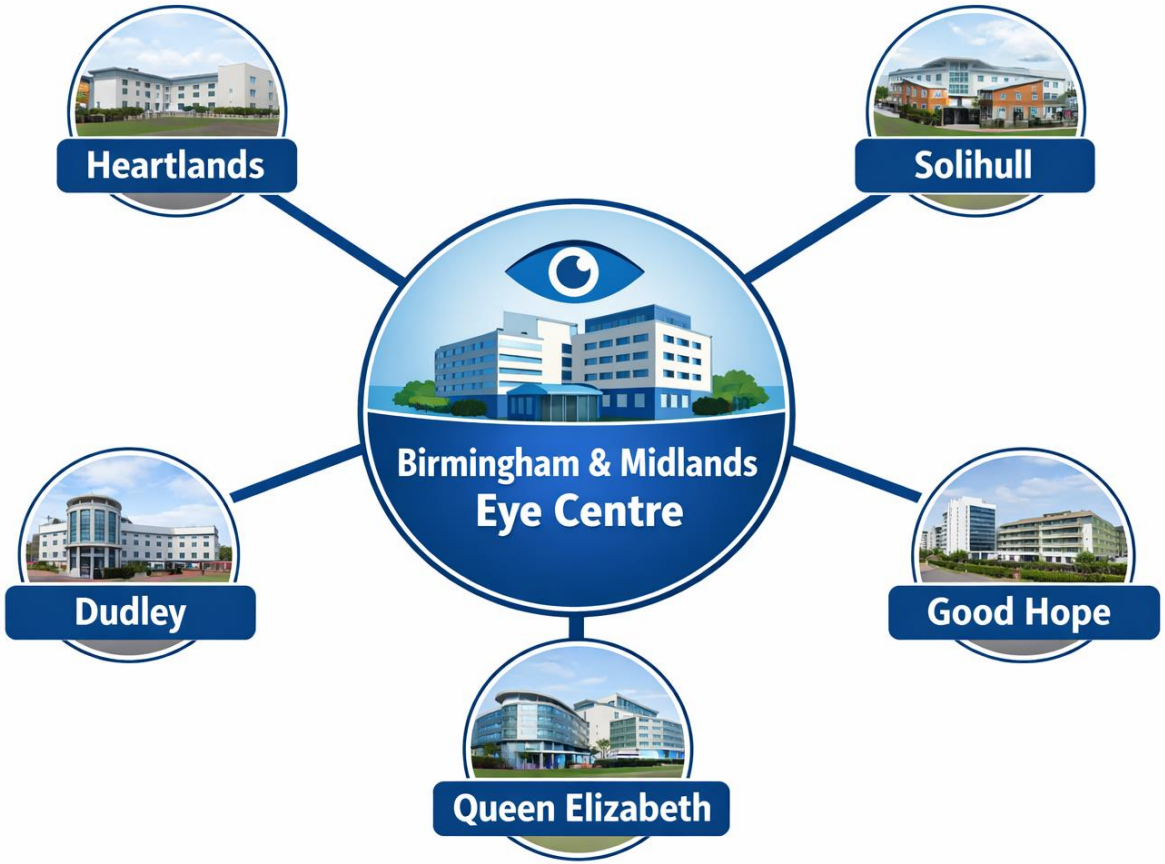
BMEH 200 years Established 1823

Emergency Eye Services

Birmingham and Midlands Eye Centre
Fizza Mushtaq
Consultant Ophthalmologist
BMEC Emergency Eye Service Lead

Cannock
STAFFORDSHIRE
Lichfield
Ibstock
LEICS
Tamworth
Wolverhampton
Walsall
Sutton
Coldfield
West Bromwich
Dudley
WEST MIDLANDS
Nuneaton
Oldbury
Birmingham
WARWICKSHIRE
Stourbridge
Halesowen
Birmingham
Airport (BHX)
Solihull
Coventry
Kidderminster
HEREFORD & WORCESTER
©World Guides
Redditch
Leamington
Spa

Hub and Spoke



Population

- Over 500,000 local residents for SWBH
- 2.5- 3 million surrounding population
- MMUH /Dudley
- Solihull
- Heartlands
- Good Hope
- Queen Elizabeth

Where did it start

- Old hospital moved to new site in 1996
- Hub and Spoke Model
- Joint appointments for Consultants in Birmingham
- **Lead employer was SWBH**
- General On Call for Birmingham from BMEC
- **All Consultants** provide emergency cover including paediatric ophthalmologists
- All regional trainees work in BMEC

2006-2008

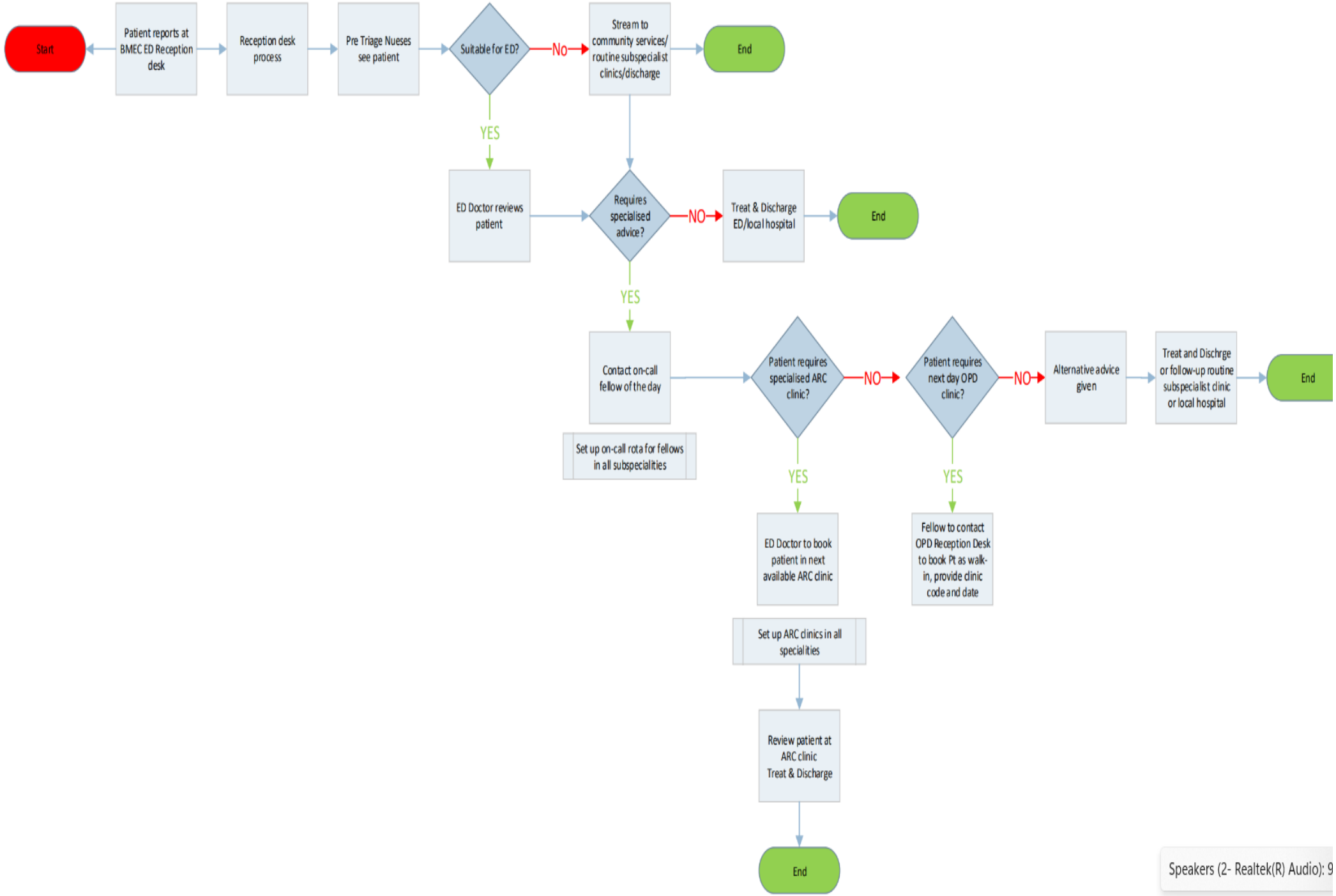
- Neighbouring trusts start to appoint their own consultants
- No clinical sessions at BMEC
- Neighbouring trusts withdrew their consultants SLAs from BMEC
- Regional general on call in **2011 was 1:32**

Current Status

- Number of BMEC consultants 21 FTE
- Number of regional ophthalmology consultants exceeds 50 (UHB, RHH and BCH)
- 1:14 regional general ophthalmology on call (BMEC only consultants)
- 1:7 Regional VR on call (5 BMEC colleagues)
- Emergency eye care 24 hour
- Inpatient eye care
- Offering primary to tertiary referral activities for Pan Birmingham, Black country and other counties

Level of Care

- Level 2 care
- 4 streams
  - Advice Guidance and Discharge
  - Advice and Guidance- streamed to CUEs
  - Booked into a scheduled appointment (UCC)
  - Continue on the acute stream- ED



Speakers (2- Realtek(R) Audio): 9

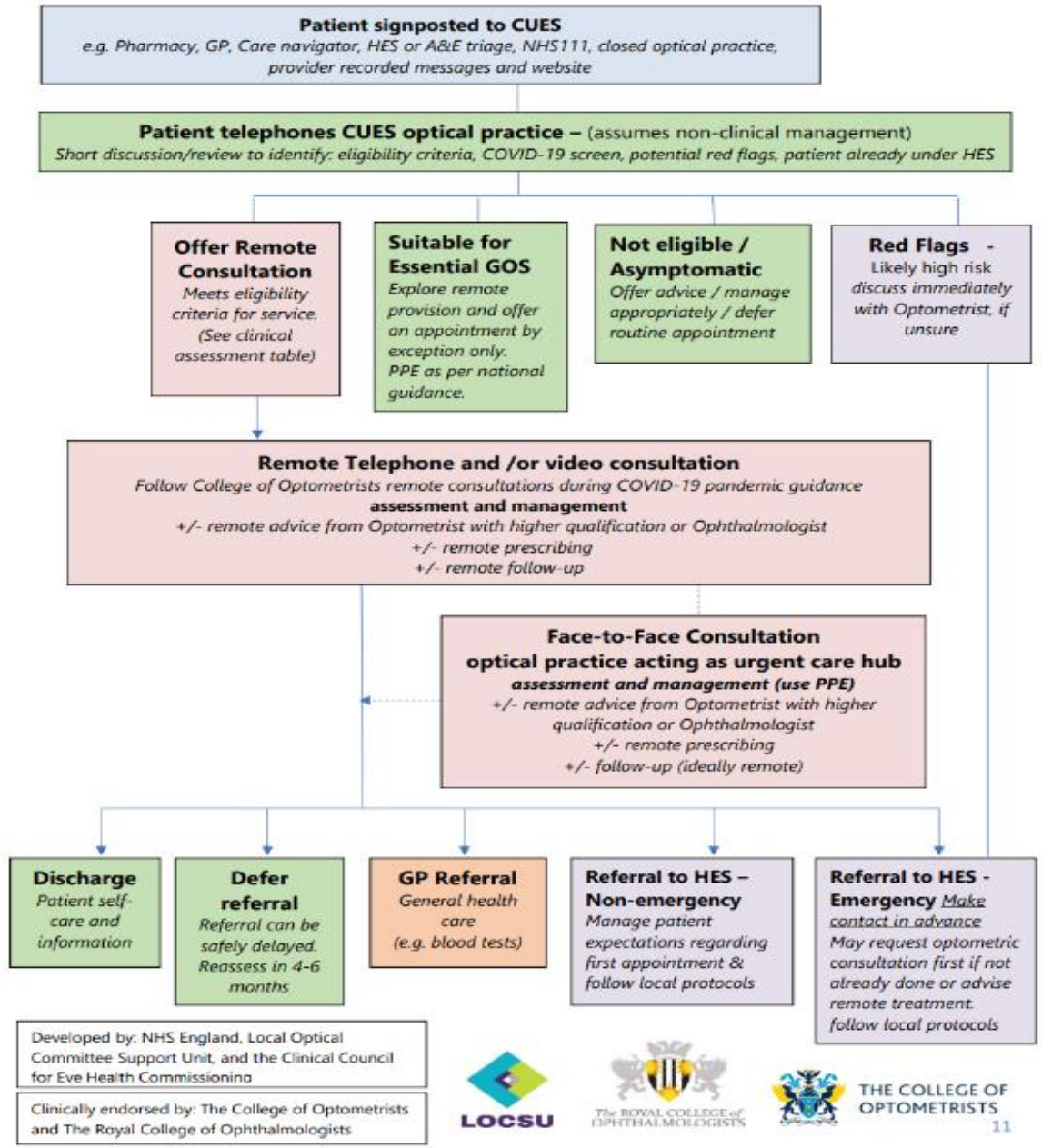
CUEs

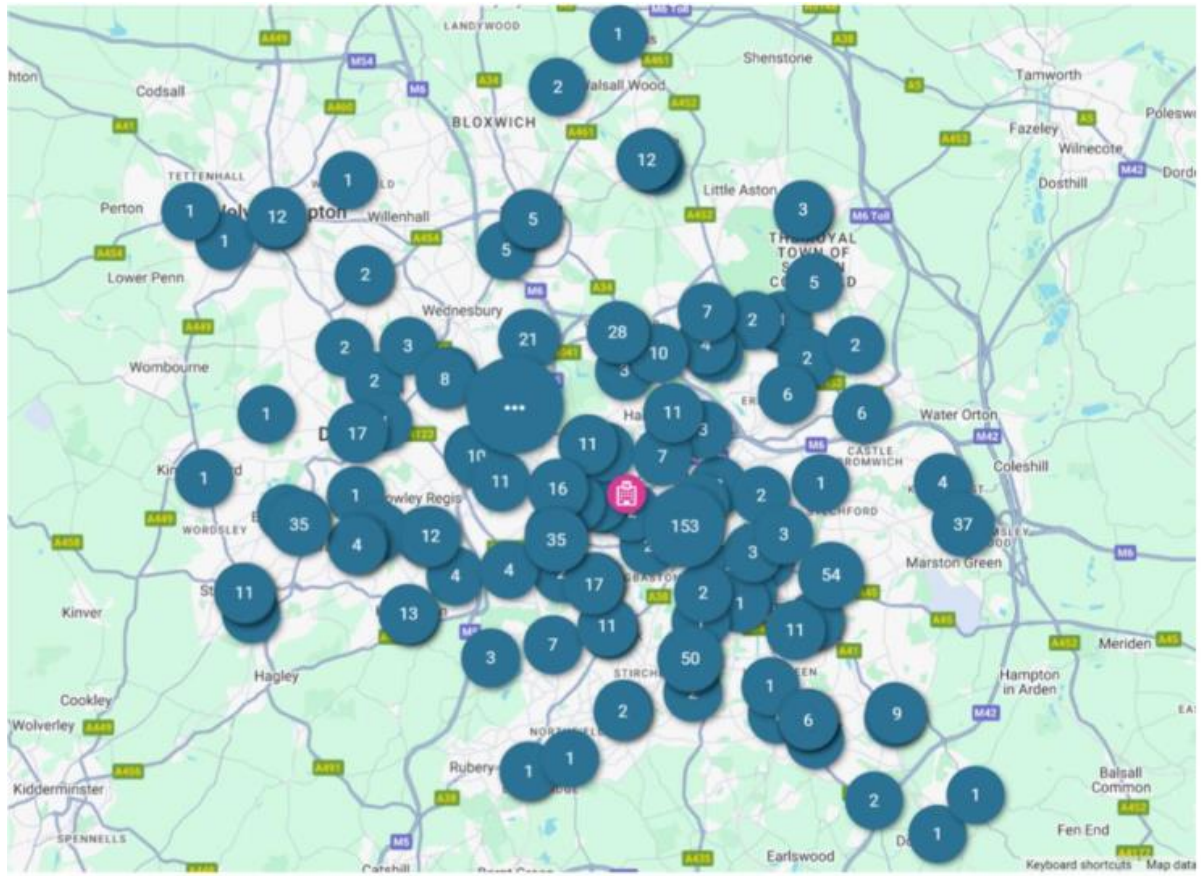
- Community Urgent Care Eye Services

What Symptoms Can Be Treated by the Community Urgent Eyecare Service?

- Red or painful eye or eyelids
- Recently occurring flashes and floaters
- Recent and sudden loss of vision
- Foreign body in the eye

CUES: COVID -19 Urgent Eye Care Service: Patient Pathway




Codsall
BLOXWICH
Shenstone
Tamworth
Fazeley
Wilnecote
Dosthill
Little Aston
Perton
Willenhall
TETTENHALL
Lower Penn
Wednesbury
Wombourne
Water Orton
Coleshill
CASTLE BROMWICH
Marston Green
WORDSLEY
Kinver
Hagley
Cookley
Wolverley
Kidderminster
Rubery
Hampton in Arden
Meriden
Balsall Common
Fen End
Earlswood
SPENNELLS
Keyboard shortcuts
Map data

Streamed to Eye ED

- Urgent and emergency eye problems
- Works to a 4 hour wait
- Active tracking of cases
- Breaches validated- to allow service improvement

A&E Attendance

- Historical estimates from colleagues audits

A&E walk in	2006/2007	2007/2008	2009/2010	2016/2017
Total	15000	22000	32500	38200

- Latest data

A&E walk in	2018	2019	2020	2021	2022	2023
Total	48100	51090	41677	43760	45525	48178

- Reduced numbers during COVID 2020-2022

A&E Attendance

- Daily Attendances

	2018	2019	2020	2021	2022	2023
Average	132	140	114	120	125	132

	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Average	136	139	140	139	150	131	88

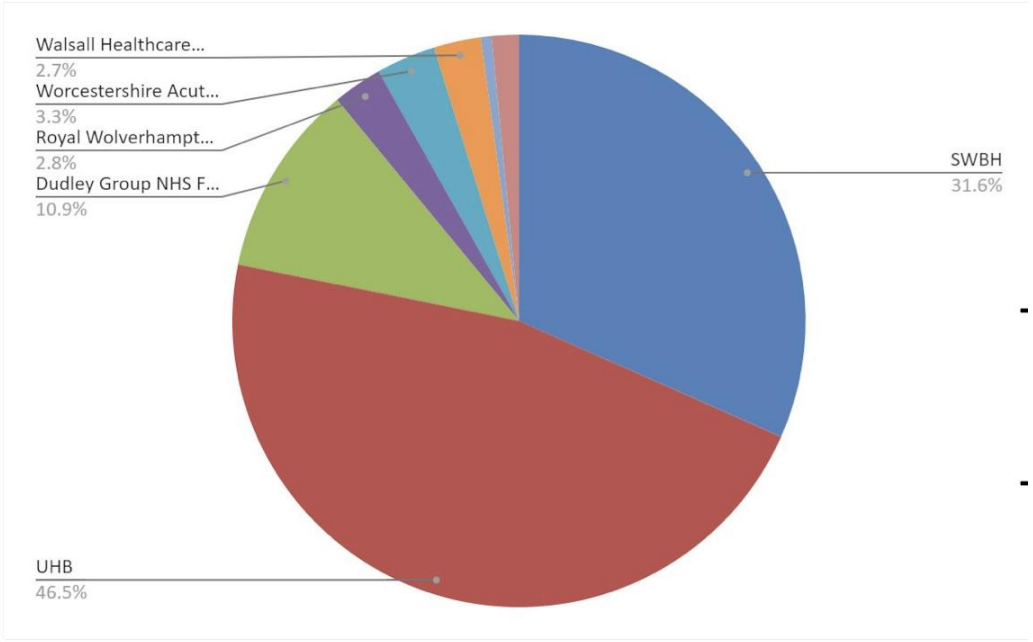
ED Activity By Year and Catchment (as a % of Total for the Year)

Note : B17 assigned to City

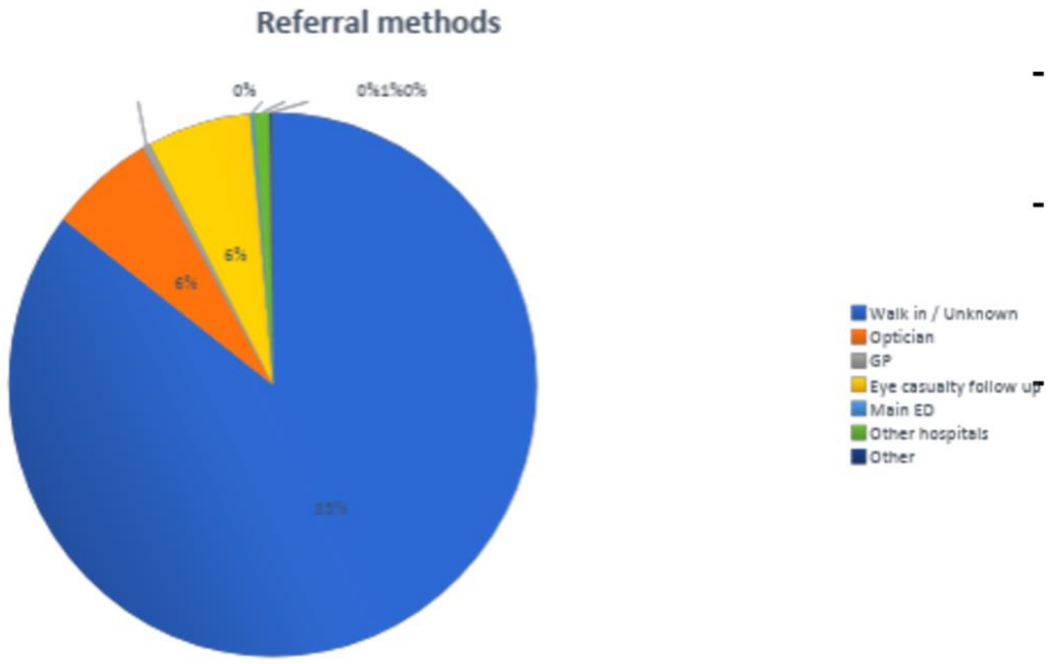
Catchment Si / Year	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Grand Total
City	24.95%	25.20%	24.36%	24.14%	23.00%	21.74%	22.46%	21.60%	21.76%	22.14%	22.59%	22.92%	20.67%	22.23%	22.34%	22.78%	22.76%
Sandwell	4.86%	5.50%	5.67%	5.97%	6.15%	6.36%	6.59%	7.20%	6.68%	6.46%	7.13%	7.08%	7.11%	7.04%	7.10%	7.28%	6.58%
Rowley	0.64%	0.76%	0.74%	0.90%	1.02%	0.92%	1.02%	0.97%	1.09%	0.91%	1.07%	0.94%	1.04%	1.12%	0.94%	0.92%	0.95%
QEH	19.44%	19.02%	18.95%	19.13%	18.83%	18.45%	17.86%	17.27%	18.49%	18.12%	17.36%	17.21%	17.28%	16.96%	17.10%	17.30%	17.96%
Heartlands	16.01%	15.98%	15.83%	15.51%	15.05%	15.24%	15.68%	15.25%	15.40%	15.11%	14.33%	14.59%	14.85%	15.10%	15.10%	14.64%	15.17%
Good Hope	13.34%	12.15%	12.51%	11.58%	12.32%	12.18%	12.41%	12.02%	11.38%	11.00%	11.07%	10.95%	11.41%	10.75%	10.95%	11.13%	11.58%
Alex (Redditch)	1.94%	1.92%	1.92%	2.41%	2.60%	2.49%	2.44%	2.41%	2.45%	2.57%	2.28%	2.30%	2.36%	2.48%	2.35%	2.40%	2.34%
Kidderminster	0.55%	0.60%	0.55%	0.74%	0.60%	0.75%	0.66%	0.59%	0.63%	0.59%	0.73%	0.76%	0.87%	0.89%	0.94%	0.71%	0.71%
New Cross (Wolv)	0.38%	0.46%	0.50%	0.47%	0.45%	0.57%	0.50%	0.50%	0.55%	0.69%	0.63%	0.68%	0.64%	0.67%	0.67%	0.57%	0.57%
Russells Hall	3.44%	4.50%	4.89%	5.18%	5.55%	6.14%	5.59%	6.43%	6.79%	7.58%	8.13%	7.81%	8.61%	8.35%	7.79%	7.42%	6.71%
Russells Hall+New Cross	0.61%	0.88%	1.01%	1.21%	1.24%	1.38%	1.26%	1.56%	1.48%	1.41%	1.49%	1.62%	1.64%	1.72%	1.52%	1.60%	1.38%
Solihull	6.16%	6.59%	6.80%	6.33%	6.46%	6.45%	6.75%	7.01%	6.62%	6.30%	5.94%	5.92%	5.93%	5.54%	5.50%	5.09%	6.15%
Solihull+Redditch	0.24%	0.22%	0.21%	0.22%	0.32%	0.27%	0.26%	0.33%	0.26%	0.27%	0.23%	0.22%	0.28%	0.23%	0.21%	0.20%	0.24%
Walsall Manor	1.30%	1.29%	1.42%	1.44%	1.40%	1.33%	1.48%	1.47%	1.44%	1.45%	1.39%	1.56%	1.51%	1.60%	1.71%	1.67%	1.48%
Walsall Manor - Ref to SWBH	0.80%	1.04%	1.20%	1.28%	1.33%	1.47%	1.37%	1.53%	1.43%	1.48%	1.68%	1.48%	1.71%	1.44%	1.50%	1.43%	1.40%
Other	5.37%	3.90%	3.47%	3.48%	3.70%	4.26%	3.69%	3.88%	3.55%	3.93%	3.93%	3.96%	4.10%	3.88%	4.28%	4.86%	4.01%
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

- SWB catchment area patients represent less than 1/3 of ED attendance over decade
- Patients from UHB catchment area account for more than half of BMEC A&E attendances 51.1%

Results- Local Eye Trust



Results- Referral Methods



A&E

- Increased number of patients attendance
- Reduced supporting staffing levels
  - Reduced number of trainees 9-5 (other trusts pulled their trainees during the day)
  - Skill mix of trainees
- Limited number of consultants to support in A&E due to specialised work at BMEC

A&E

- Increased number of patients daily breaches
- Patients' safety
- Staff wellbeing
- Increase sickness rate among trainees
- Many Exceptional reports/ unsatisfactory GMC survey
- Poor Recruitment & Retention
  - Newly appointed consultants leaving after 3-4 years
  - Inability to recruit to most posts
  - Neighbouring trusts have been able to appoint 8-10 consultants during same period

Patients Experience

- Long waiting times
- Lack of repatriation to neighbouring trusts in timely manner
- Patients treated far from their locality
- Increased pressures on elective care plans at BMEC and its patients from SWB catchment area
- Inability to meet targets at SWB due to increase demands
- Increase of 300% of A&E attendances in 15 years

Staff Experience

- Increased pressure on current workforce
- Wellbeing
- Increased sickness rates/locums and impact on services quality/finances
- Lack of enough workforce (senior & junior) between 9-5

A Typical Day

Morning Huddle- 0800

Doors Open 0830

Reception start booking patients from 0835

Doctors and AHPs start clinics 0900

Typical UCC shift 9-12 or 130-430

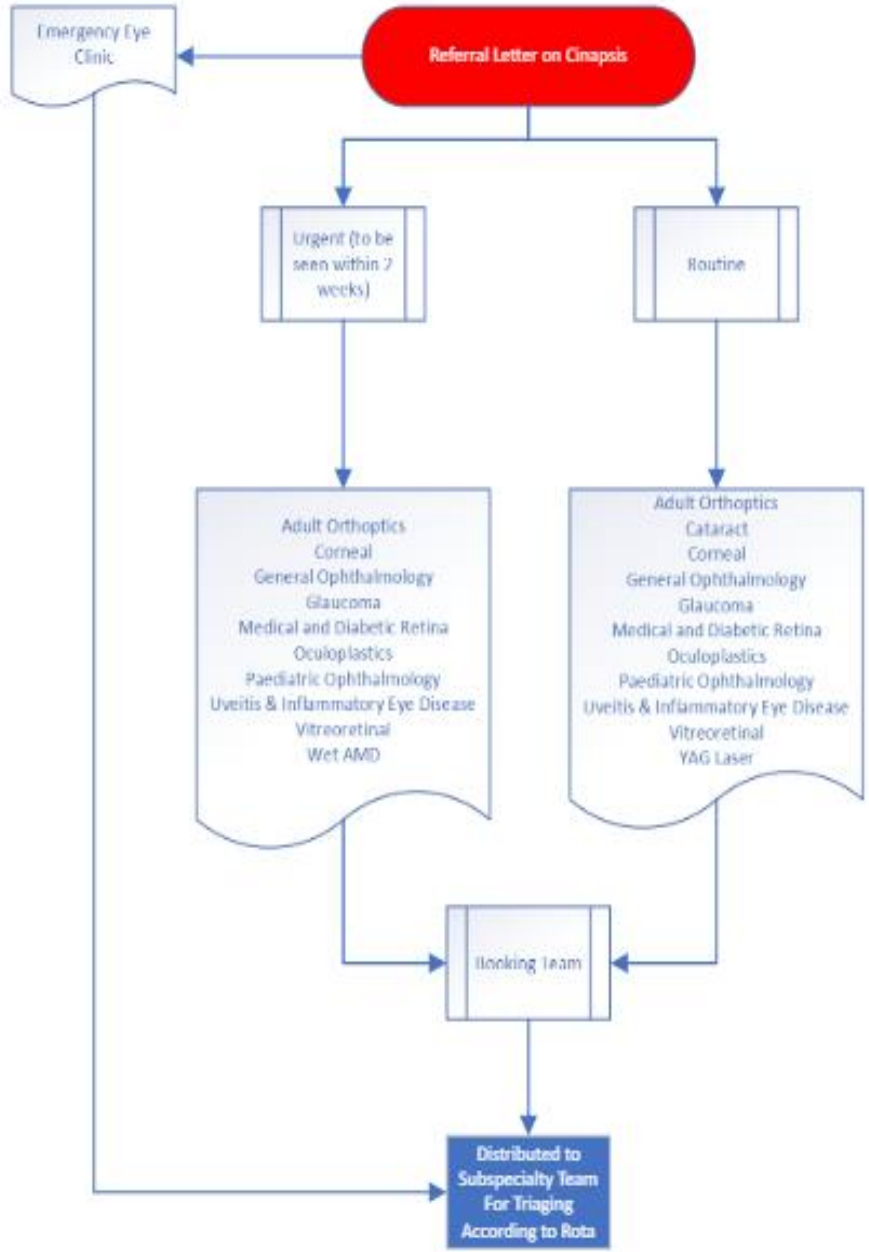
ED-0900-1900 Sunday it is 0900-1800
Overnight- oncall doctor can be contacted

Triaging- 2 triage nurses
ED cons on floor for support

2 doctors in ED
4 AHP clinics am and 4 pm

Service Improvements

- Cinapsis- etriage
- Telephone Triage-2 slots per clinic blocked for any phone consult that is converted to F2F
- Flow coordination- active breach management. Daily escalations at various time points
- PIFU- patient initiated follow up
- Repatriation


Emergency Eye Clinic
Referral Letter on Cinapsis
Urgent (to be seen within 2 weeks)
Routine
Adult Orthoptics
Corneal
General Ophthalmology
Glaucoma
Medical and Diabetic Retina
Oculoplastics
Paediatric Ophthalmology
Uveitis & Inflammatory Eye Disease
Vitreoretinal
Wet AMD
Adult Orthoptics
Cataract
Corneal
General Ophthalmology
Glaucoma
Medical and Diabetic Retina
Oculoplastics
Paediatric Ophthalmology
Uveitis & Inflammatory Eye Disease
Vitreoretinal
YAG Laser
Booking Team
Distributed to Subspecialty Team For Triaging According to Rota

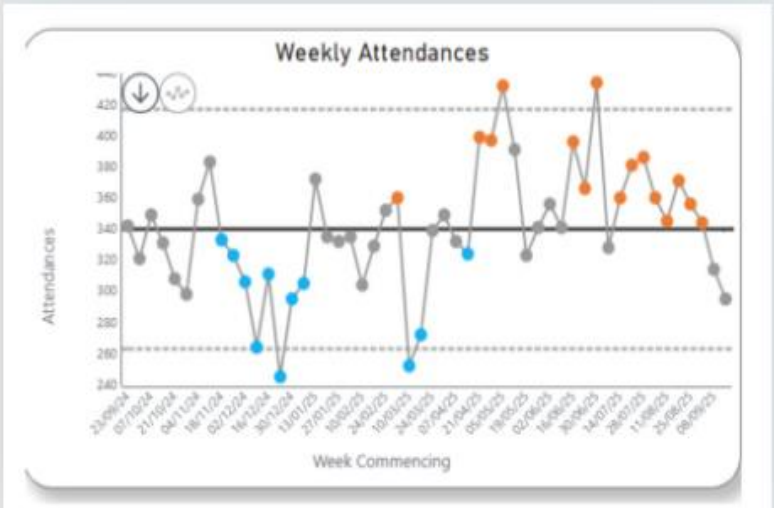
PIFU

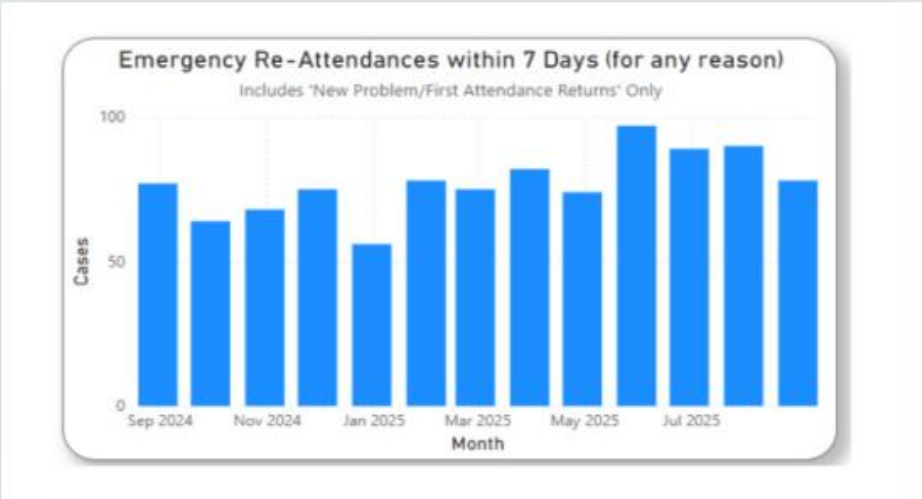
- From ED or UCC
- Patient Selection Criteria:
  - Non-granulomatous acute anterior uveitis and no vitreous/retina involvement
  - Corneal abrasion (large)
  - Corneal foreign body (after removal) – if required
  - Conjunctivitis
  - Preseptal cellulitis with unaffected vision
  - Episcleritis
  - Keratoconjunctivitis

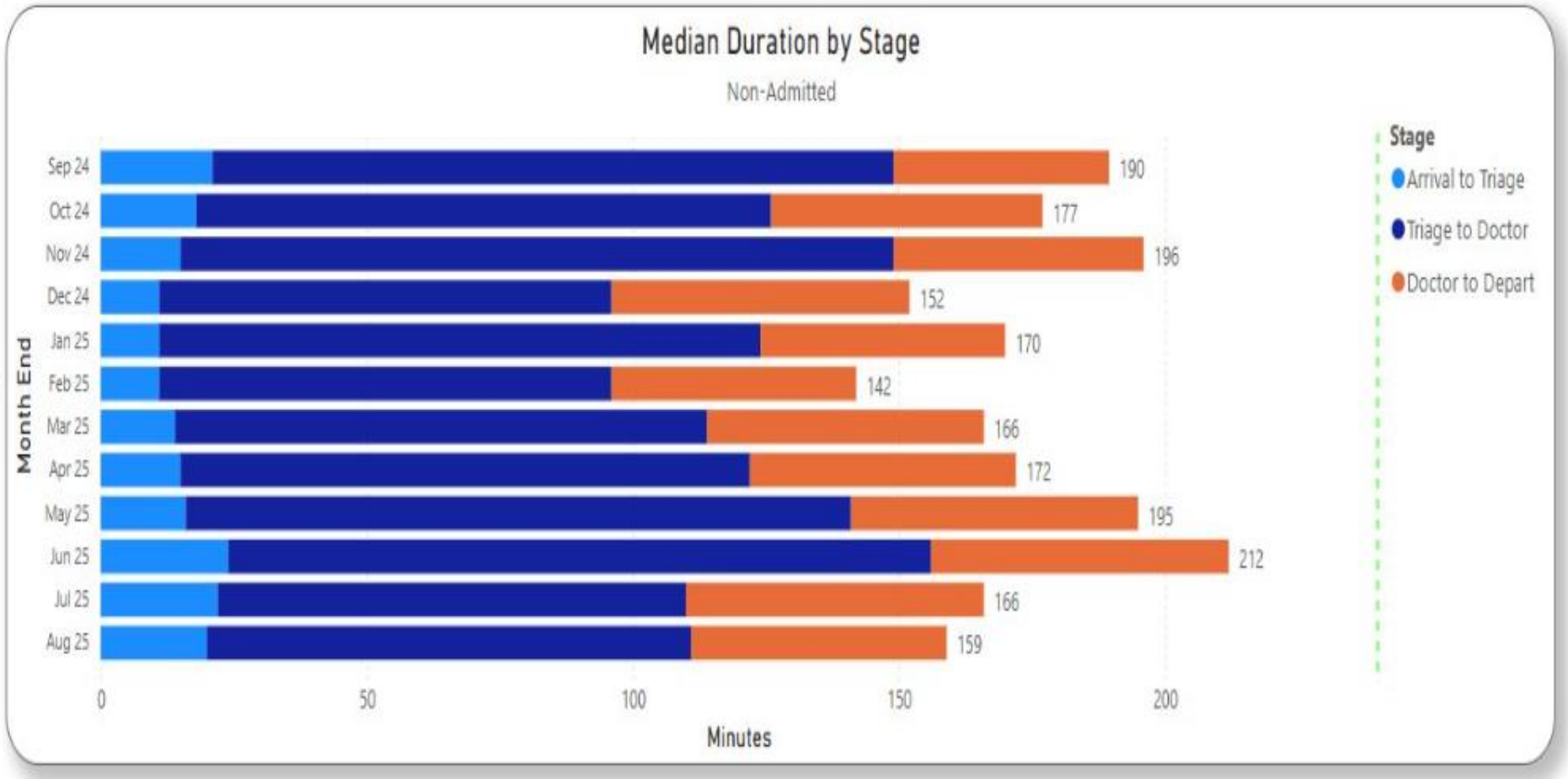
BMEC	HEARTLANDS	QEH	GOOD HOPE (SUTTON COLDFIELD)	SOLIHULL	SANDWELL	RUSSELLS HALL	ALEX (REDDITCH)	ROWLEY REGIS	Walsall Manor Hospital	KIDDERMINSTER	NEW CROSS (WOLVERHAMPTON)
B1	B7	B11	B23	B46	B68	B62	B45	B65	WS1	DY10	WV1
B2	B8	B12	B24	B90	B69	B63	B48		WS2	DY11	WV2
B3	B10	B13	B44	B91	B70	B64	B80		WS3	DY12	WV3
B4	B25	B14	B72	B92	B71	DY1	B95		WS4	DY13	WV4
B5	B26	B17	B73	B93		DY2	B96		WS5 and SWBH	DY14	WV5
B6	B27	B28	B74	B94 And Redditch		DY3	B97		WS6		WV6
B15	B33	B29	B75			DY4 and New Cross	B98		WS7		WV7
B16	B34	B31	B76			DY5			WS8		WV8
B17	B35	B32	B77			DY6			WS9		WV9
B18	B36	B38	B78			DY7			WS10 and SWBH		WV10
B19	B37	B49	B79			DY8			WS11		WV11
B20	B40	B50				DY9			WS12		WV12
B21	B47	B60							WS13		WV13
B66		B61							WS14		WV14
B67									WS15		WV15
B42											WV16
B43											
B99											

Sandwell and West Birmingham (SWBH) NHS Trust = BMEC, Sandwell, Rowley Regis
University Hospitals Birmingham (UHB) NHS Foundation Trust = Heartlands, QEH (QE Hospital), Good Hope, Solihull
Dudley Group NHS Foundation Trust = Russells Hall
Worcestershire Acute Hospitals NHS Trust = Alexandra Hospital (Redditch), Kidderminster
Walsall Healthcare NHS Trust = Wallsall Manor Hospital
The Royal Wolverhampton NHS Trust = Wolverhampton

Triaging Challenges






Median Duration by Stage
Non-Admitted
Month End
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
190
177
196
152
170
142
166
172
195
212
166
159
0
50
100
150
200
Minutes
Stage
Arrival to Triage
Triage to Doctor
Doctor to Depart

Next Steps

- Direct booking service for peripheral units for patients presenting 9-5
- Appointment of permanenet Nurse in Charge to coorindating flow and any potential breaches
- Audit of the repatriation
- Peripheral unit emergency eye cover

General Discussion

UKOA
UK OPHTHALMOLOGY ALLIANCE