



Quality, Experience and Safety Committee Unscheduled Emergency Care Update

8 April 2025

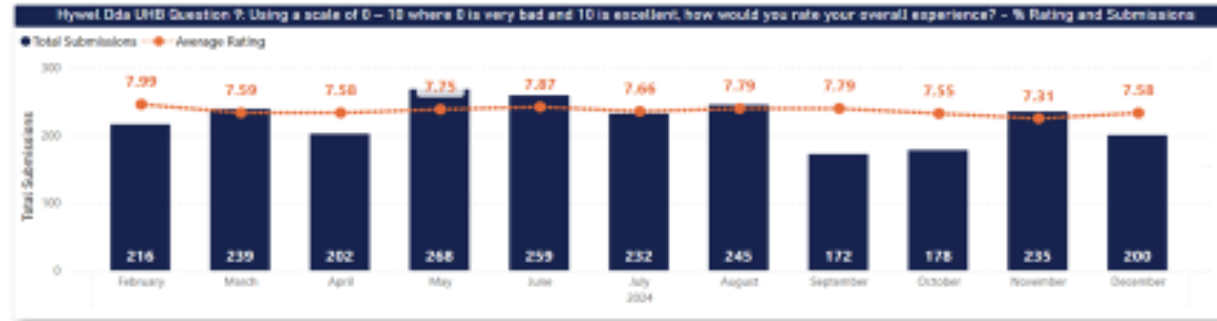
Senior Responsible Officer: Peter Skitt, Clinical Care Group Service Director - Community and Integrated Medicine
Executive Lead: Andrew Carruthers, Chief Operating Officer

Progress with the Six Goals Programme and National Initiatives:

- Patient Experience/Feedback in Emergency Departments (ED)
- Monitor the quality, performance and delivery of Out of Hours/Urgent Care Services
- Deliver the national ambulance patient handover guidance
- Realise more discharges earlier in the day, and increase discharges over the weekend
- Preparing for implementation of Welsh Emergency Care Data Set (WECDS) across local Emergency Departments, Minor Injury Units (MIU) and Same Day Emergency Care (SDEC)
- Urgent primary care capacity
- Implementation of community falls framework: Update on Stats overall position
- Pathways of care and impact of 50-day plan

Health Board Overview – Patient Experience in ED and National Experience Ratings

Health Board Overview – People’s Experience in the ED



Average experience rating (for completed surveys only) between Feb-24 to Jan-25 as of 31/01/2025

Organisation	Total Submissions (excluding Did not answer)	Average Rating (0-10)
CTMU UHB	11,360	7.71
HDU UHB	2,659	7.69
CVU UHB	5,759	7.44
BCU UHB	4,893	7.06
SBU UHB	1,115	6.34
ABU UHB	242	6.26
All Wales	26,028	7.45

Bronglais and Glangwili Patient Experience/Feedback in ED

Survey: NHS All Wales Questionnaire

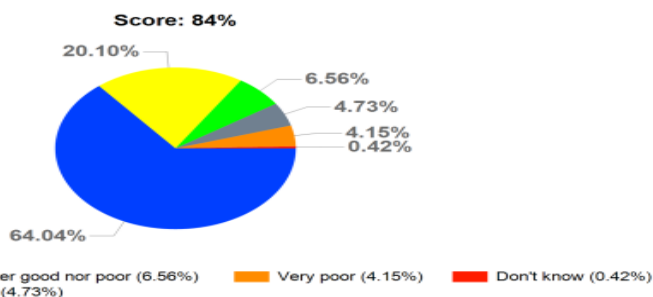
Start Date: 01/04/2024 12:00:00 AM End Date: 28/02/2025 12:00:00 AM

Results from: Bronglais General Hospital

Question 1: We would like you to think about your recent experience using our services. Overall, how was your experience of our service?

[Create new action](#)

Available Answers	Responses	Score (%)
Very good	771	64.04%
Good	242	20.10%
Neither good nor poor	79	6.56%
Poor	57	4.73%
Very poor	50	4.15%
Don't know	5	0.42%
Total	1204	100%



Survey: NHS All Wales Questionnaire

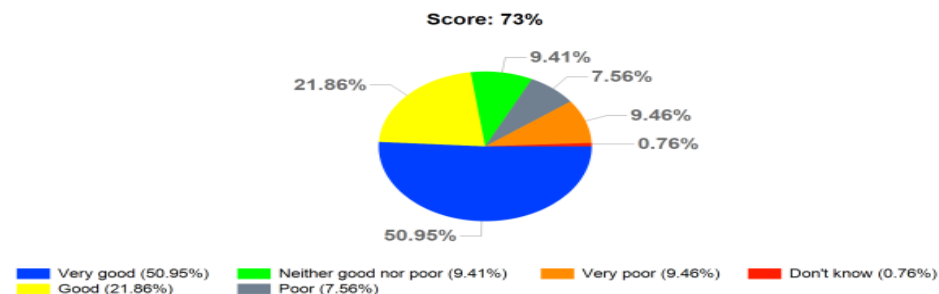
Start Date: 01/04/2024 12:00:00 AM End Date: 28/02/2025 12:00:00 AM

Results from: Glangwili General Hospital

Question 1: We would like you to think about your recent experience using our services. Overall, how was your experience of our service?

[Create new action](#)

Available Answers	Responses	Score (%)
Very good	937	50.95%
Good	402	21.86%
Neither good nor poor	173	9.41%
Poor	139	7.56%
Very poor	174	9.46%
Don't know	14	0.76%
Total	1839	100%



Prince Phillip and Withybush Hospitals Patient Experience/Feedback in ED

Survey: NHS All Wales Questionnaire

Start Date: 01/04/2024 12:00:00 AM End Date: 28/02/2025 12:00:00 AM

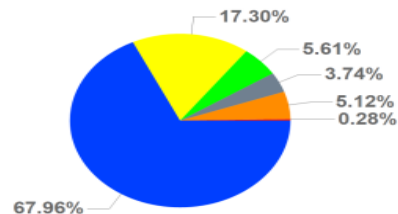
Results from: Prince Philip Hospital

Question 1: We would like you to think about your recent experience using our services. Overall, how was your experience of our service?

[Create new action](#)

Available Answers	Responses	Score (%)
Very good	982	67.96%
Good	250	17.30%
Neither good nor poor	81	5.61%
Poor	54	3.74%
Very poor	74	5.12%
Don't know	4	0.28%
Total	1445	100%

Score: 85%



■ Very good (67.96%)
 ■ Neither good nor poor (5.61%)
 ■ Very poor (5.12%)
 ■ Don't know (0.28%)
 ■ Good (17.30%)
 ■ Poor (3.74%)

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 1635

Survey: NHS All Wales Questionnaire

Start Date: 01/04/2024 12:00:00 AM End Date: 28/02/2025 12:00:00 AM

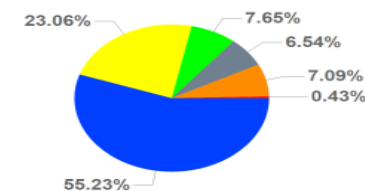
Results from: Withybush General Hospital

Question 1: We would like you to think about your recent experience using our services. Overall, how was your experience of our service?

[Create new action](#)

Available Answers	Responses	Score (%)
Very good	903	55.23%
Good	377	23.06%
Neither good nor poor	125	7.65%
Poor	107	6.54%
Very poor	116	7.09%
Don't know	7	0.43%
Total	1635	100%

Score: 78%



■ Very good (55.23%)
 ■ Neither good nor poor (7.65%)
 ■ Very poor (7.09%)
 ■ Don't know (0.43%)
 ■ Good (23.06%)
 ■ Poor (6.54%)

Monitor the quality, performance and delivery of Out of Hours/Urgent Care Services

Out of Hours Service

- Quality is measured through a 1% audit undertaken by Dr. Richard Archer (Clinical Lead) plus review of concerns and good news stories. These are discussed at monthly Journal Clubs. The Out of Hours move to Primary Care has seen a formal Quality, Safety and Experience group created which has so far met once but are bi-monthly.
- Performance is measured through Priority 1 calls answered timely and within an hour - the target is >90% and this is generally achieved monthly. We review performance through daily and monthly reports. These are being revamped as we have the ability to do more with reporting since our separation of the shared instance of Adastra with Swansea Bay University Health Board (SBUHB).
- Delivery is monitored and assured through a weekly clinical escalation tool which is RAG rated. Recently there has been a consistent level 1 (>90% shift fill). This is reported to Welsh Government and WAST and within the Health Board (HB) at least twice weekly.

(please refer to Clinical Streaming Hub updates further in the presentation for Urgent Care Service information, inclusive of the current evaluation of weekend working, Sam Day Urgent Care (SDUC), and the development of a dashboard for Clinical Streaming Hub activity in Hywel Dda).



Deliver the national ambulance patient handover guidance



(Please refer to the attached Ambulance Patient Handover Guidance papers)

- Hywel Dda University Health Board (HDdUHB) are handling the monitoring and delivery of this through the Emergency Department Quality Statement (EDQS) Action Group. The Welsh Government's Ambulance Handover guidance was recirculated to the EDQS Action Group members in February 2025.
- There is an NHS Executive (NHSE) audit due to be undertaken on the 19th of March at Glangwilli General Hospital (GGH).
- In the Six Goals 2025/2026 plan, one of the deliverables within the Safe Hospital Care Workstream is to review the handover process and develop an action plan following on from the recommendations of the NHSE handover audit
- The guidance will be going to the internal Improving Quality, Finance and Performance Delivery (IQFPD) group meeting on the 12th of March which links into the formal executive group as a refresh.

Realise more discharges earlier in the day, and increase discharges over the weekend

- The co-produced Discharge booklet is currently being piloted across hospital sites. Patient Advice and Liaison Service (PALS) have offered resource to support with the feedback from patients on the form and evaluation.
- The Discharge Toolkit (for health board staff) launched on 19 February 2025 with 350 views to date. The Toolkit has been developed to support with discharge management and houses resources, support and guidance relating to discharge planning in one place for ease of access. We have linked with social care to provide regional information
- Criteria Led Discharge (CLD) guidance has been developed and is being piloted in Bronglais General Hospital (BGH), Glangwilli General Hospital GGH, and Prince Phillip Hospital (PPH). There are challenges being addressed with the medical engagement in CLD and the workstream lead is currently planning with the Deputy Medical Director for a way to improve this position and put in place a medical CLD lead for the Health Board.

Preparing for the implementation of Welsh Emergency Care Data Sets (WECDS) across local EDs, Minor Injuries Unit (MIU) and Same Day Emergency Care (SDEC)

- Awaiting formal confirmation of the SRO for implementation of WECDS in Hywel Dda University Health Board (HDdUHB), this will likely be the ED Clinical lead for the HB.
- A high-level plan has been submitted to the WECDS Project Board, but is essentially wholly dependent on the Digital Health Care Wales (DHCW) plan and the provision of a suitable product.
- Concerns that the minimum viable product being communicated from DHCW will not be of a sufficient maturity to transform the way ED, MIU & SDEC units use a digital system to manage and care for their patients in one the most pressurised stages of our UEC pathway.
- The Health Board have not yet seen or been shown any output from DHCW around what the solution could look like.



Same Day Urgent Care (SDUC) Activity and Impact



Between 1st March 2024 and 28th February 2025, the number of patients counted as SDUC activity (which includes those attending the site and those served by the outreach service) totalled 6090.

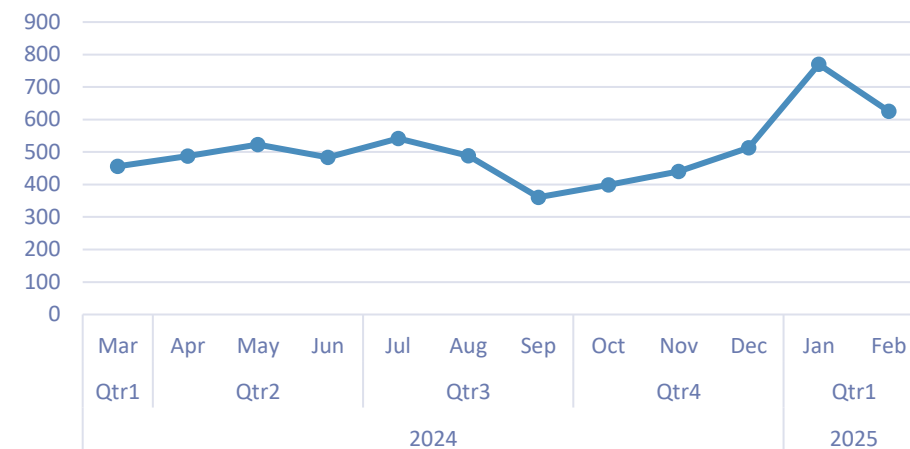
Patients are asked which service they would have used if they had not had access to SDUC: **3520 would have attended GGH A&E, 277 BGH A&E, 176 WGH A&E, 122 Welsh Ambulance Service Trust (WAST) and 1598 Primary Care.**

As a result of the SDUC opening in Cardigan Integrated Care Centre (CICC), there has been a significant increase in demand associated with the MIU service on site. The two services are codependent and rely on provision supported by the District Nursing, Specialist Palliative services and community wrap around services operating 7 days a week.

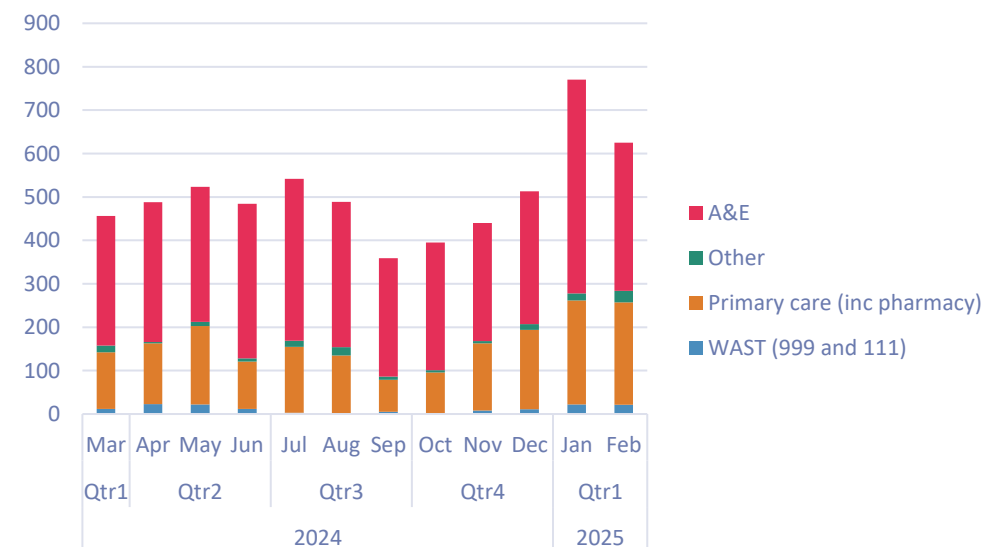
The Welsh Government Falls Response funding has enabled the Same Day Urgent Care and outreach service operating on Saturdays and Sundays since 11th January 2025. There is currently an Impact Assessment being undertaken to understand the value of operating the services across the weekends as the 7-day service is planned to cease on Sunday 30th March 2025. **Over the seven weekends when the service operated, 327 patients were seen, of those 209 would have attended GGH A&E, 13 BGH A&E, 6 WGH A&E, 19 WAST and 73 Primary Care (if available).**

A further impact of the SDUC and outreach operating 7 days a week with 50 day funding, has been the trial of a **Digital Ward model of care**, where over the two months, **63 patients have been ‘virtually admitted’** and cared for at home.

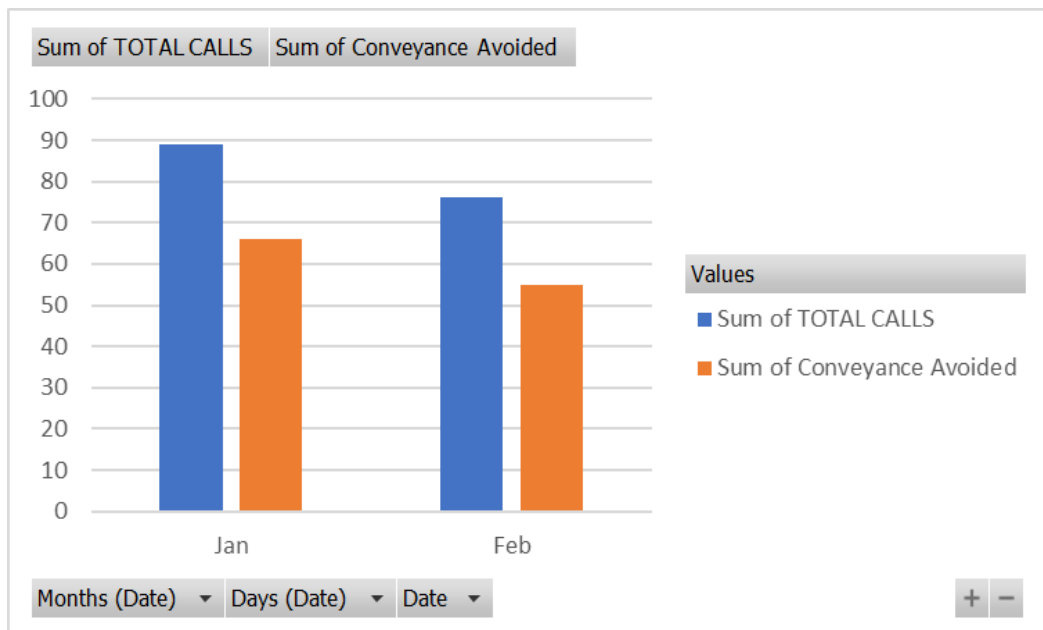
Number of people using the SDUC service



What service would they have used if not SDUC?



Integration of seven-day Clinical Streaming and community falls framework



The Health Board have integrated the extended community falls provision to seven days through integrating with the piloting of seven-day Clinical Streaming. This has enabled an enhanced level one and level two falls response to be available in Hywel Dda at weekends. The pilot is due to end in March and a comprehensive evaluation will be completed to inform effective future funding models going forward. Initial data is presented below:

- The Clinical Streaming hubs (CSH) have been piloting weekend working since 18th January 2025 but operating with limited clinical Multi-Disciplinary Team (MDT) resources. Effective clinical streaming requires multidisciplinary triage to be able to meet the need of the person, be this Clinical, functional, social or mental. Often patients with complex needs require input from more than one professional simultaneously. The MDT should have the correct skill mix to be able to problem solve effectively and address the person's urgent need in an appropriate time frame, and to 'get it right first time'.
- Between 18th January and 23rd February 2025, 165 calls were responded to through the Regional Clinical Streaming Hub and Locality Hubs resulting in avoidance of 121 patient conveyances and potential admissions (Please see adjacent graph, in addition please note that of a total of 121, 7 are assumed over the piloted period due to missing data input).
- The presenting complaint for 36 of these calls were due to falls, 11 of which were dealt with by falls response. There were 10 resulting patient conveyances/admissions and 26 avoided conveyances/admission.
- This data demonstrates that despite operating with limited part-time multidisciplinary clinical resource, there is a significant number of responses including advice and treatment and resulting admission/conveyance avoidance.
- Additionally, SDUC was available in Ceredigion with a total of 452 patient contacts during this period.



Pathways of Care Delays (POCD) and impact of 50-day plan



A POCD lead has been identified for the Health Board

The Q4 POCD Action Plan has been developed and submitted to National

There is a regional integrated monthly validation meeting in place

There has been a continuous improvement of Discharge to Recovery and Assessment (D2RA) pathway allocation since the Programme Workstream launched

A Hywel Dda Trusted Assessor Steering group has been established in order to provide a forum to share learning, monitor Trusted Assessor reports submitted to the POCD group and regularly review and evaluate the Trusted Assessor models in action across Hywel Dda

All DPOC data is pulled from the data system Frontier and validated as a region instead of each county

The Red2Green dashboard is now live which identifies pre clinically / clinically optimised constraints which will feed into site improvement plans

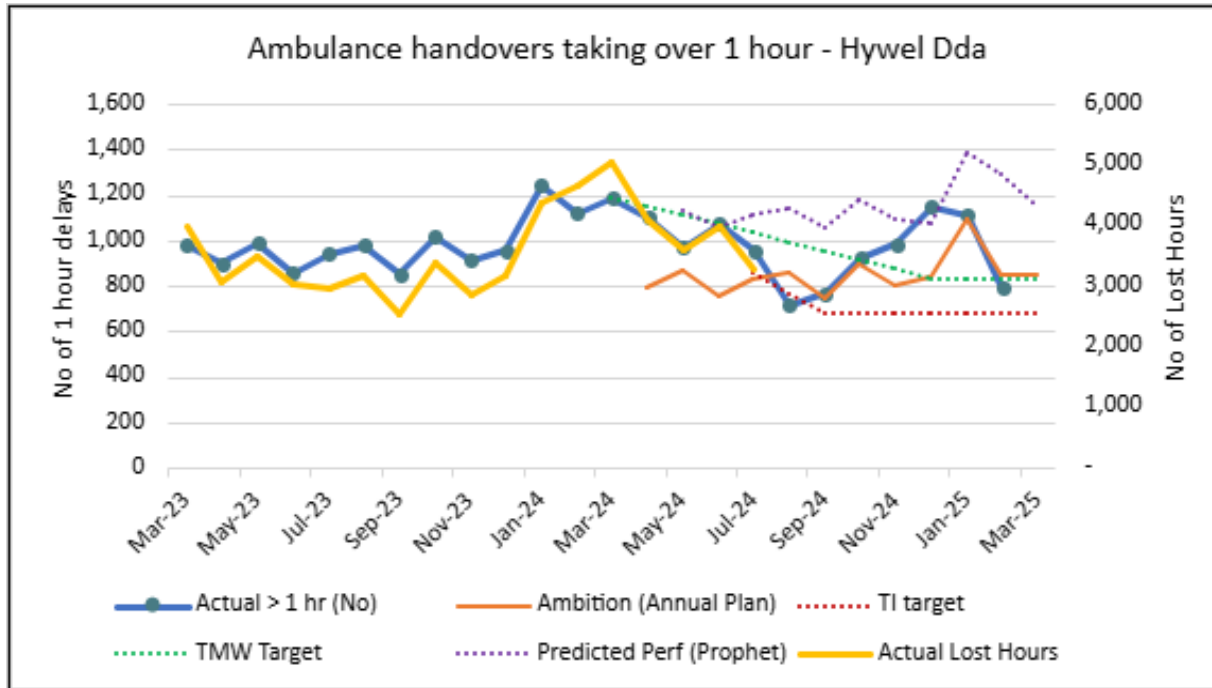
County wide escalation plans to review long length of stays (integrated with local authority). Scheme 5, regional meeting to discuss 21-18 days and the 20 longest Length of Stay (LoS) patients across region (weekly)

	Top 25% longest delays on 11 th November	Discharged by Dec 31st	Discharged by 24 th Jan	Remain delayed at 24 th Jan	Discharged by 4 th March	Remain delayed on 4 th March	Of those who remain delayed - No/% with discharge plan
West Wales	50	30 (60%)	8	12	8	4	None with a confirmed discharge date, 3 court of protection cases

Performance

- Ambulance patient handover performance
- Time to assessment
- Waits in ED
- Safety and oversight of the waiting room
- SDEC activity and impact

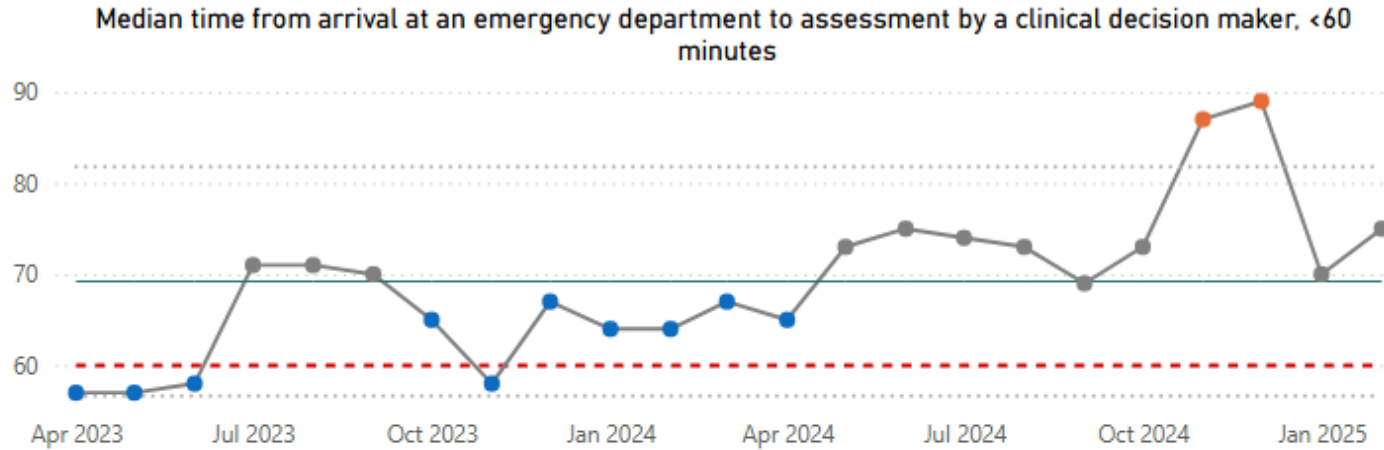
Ambulance patient handover performance



Health Board, 1 Hour Ambulance Handover

- Actual number of handover delays for February 2025 was 795
- HDdUHB are below annual plan target of 846 by 51, but above Targeted Intervention (TI) target of 680
- An improving position since December 24
- In year trend shows improvement, January 2024 had the highest reported Ambulance Handover >1hr number at 1245. February 2024 actual was 1124.

Time to assessment



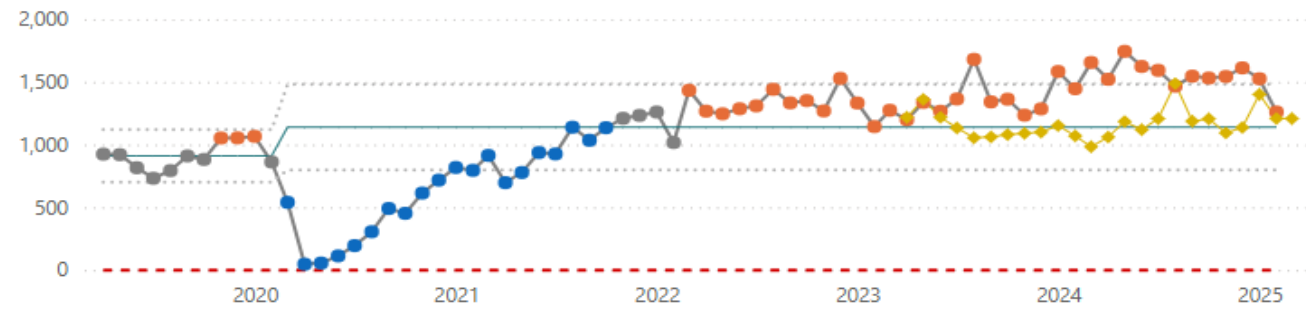
Health Board Median Time to Assessment by a Clinical Decision Maker

- Actual median time to assessment for Feb 2025 is 75 minutes.
- This is above the TI target of 60 mins and an increase of 5 minutes from the previous month
- Increasing trend evident for the year.
- The Health Board are ringfencing triage and treatment rooms in EDs to ensure improvement in this area.

Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Feb 2025	60	Lower	75.0	●	■	

>12 Hour Waits in ED

Number of patients who spend 12 hours or more in A&E / MIU



Health Board 12-Hour Emergency Department Breaches

- Actual number of patients waiting >12 hours in ED for February 2025 was 1260
- HDdUHB are just above annual plan target of 1208
- Improving position since December 2024
- In year trend shows an improvement, February 2024 actual number of patients waiting >12 hours in ED was 1446

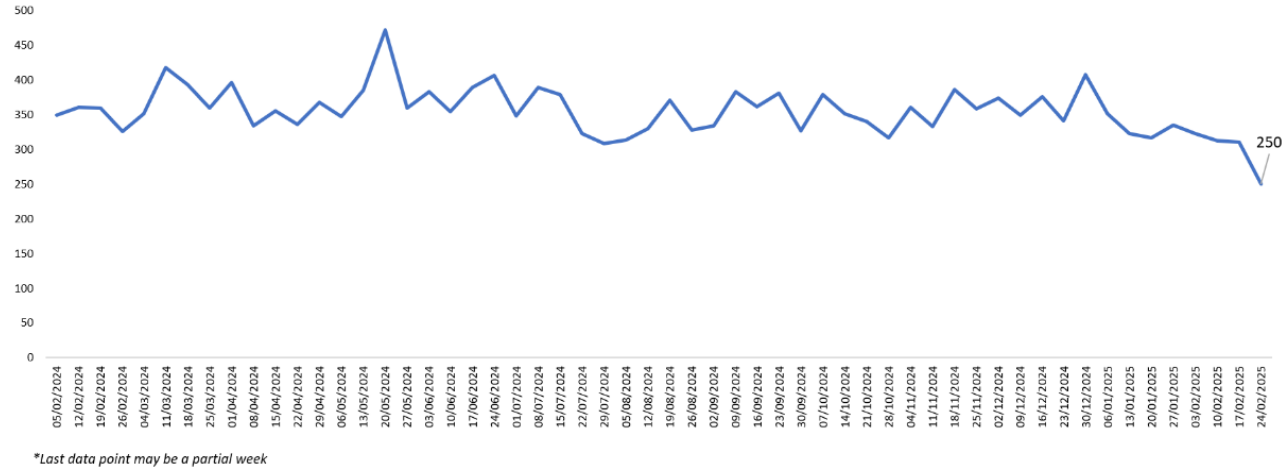
Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Feb 2025	0	Lower	1260.0	●	◻	◆



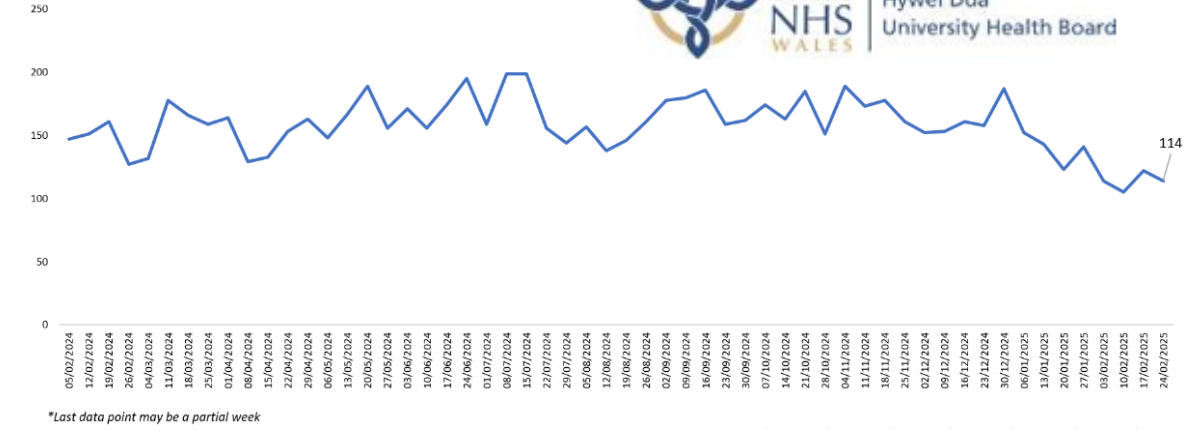
>12 Hour Waits in ED – By Site - TUEC



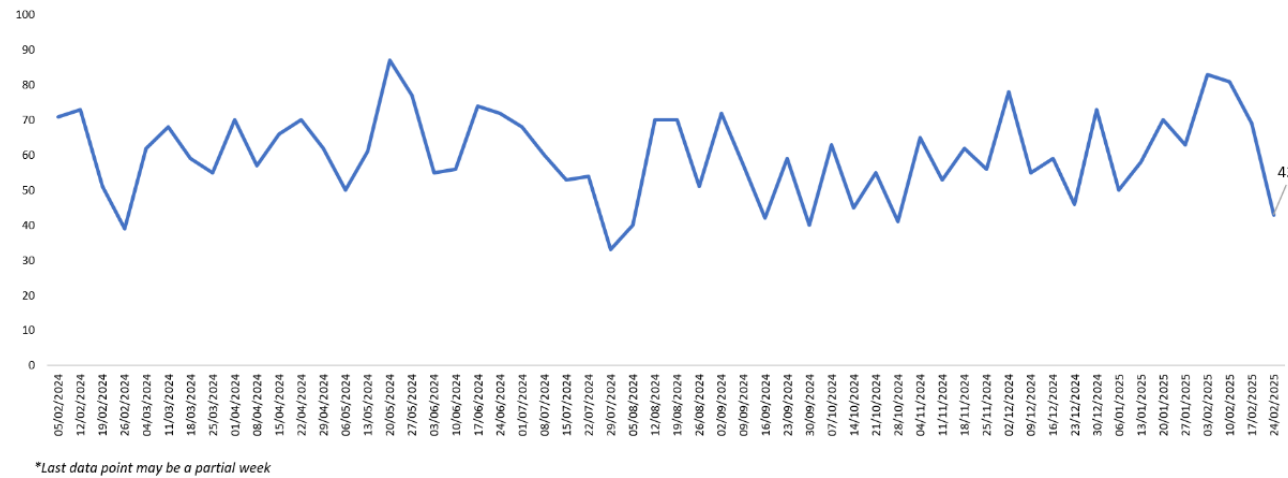
HDUHB



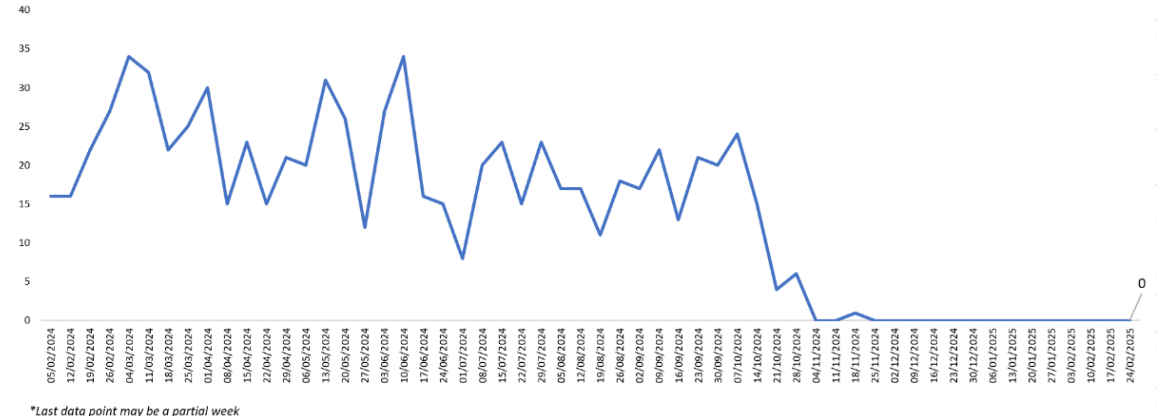
GGH



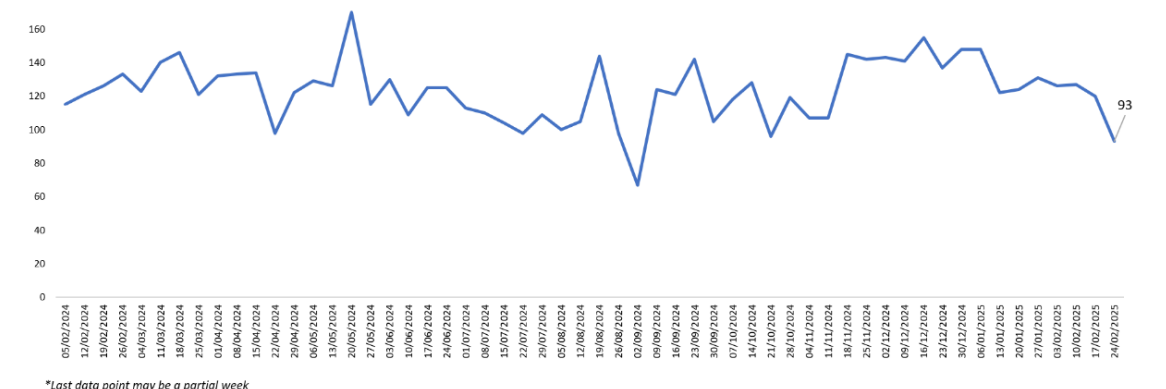
BGH



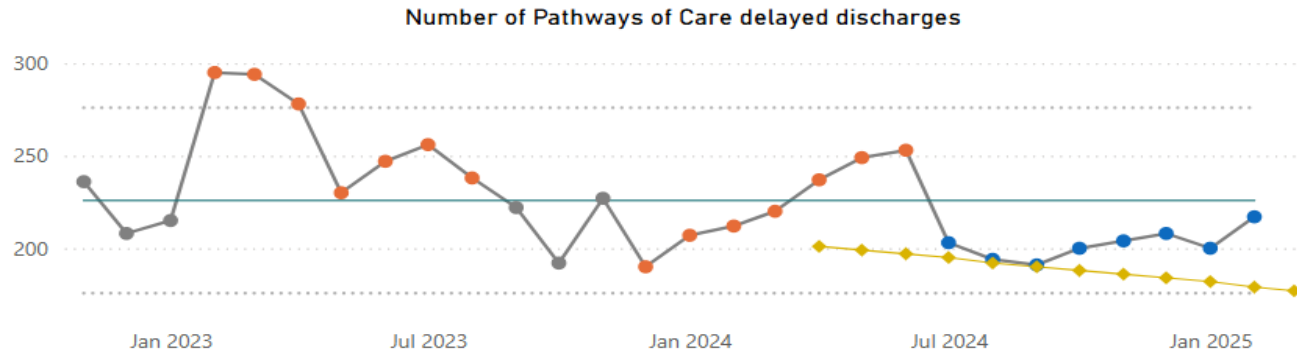
PPH



WGH



Pathway of Care Delays



- The Health Board continue to work on position with the support of the National Team
- There remains a number of Court of Protection Cases within the numbers which are challenging given court timetables

Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Feb 2025		Lower	217.0	●		◆

	Top 25% longest delays on 11 th November	Discharged by Dec 31st	Discharged by 24 th Jan	Remain delayed at 24 th Jan	Discharged by 4 th March	Remain delayed on 4 th March	Of those who remain delayed - No/% with discharge plan
West Wales	50	30 (60%)	8	12	8	4	None with a confirmed discharge date, 3 court of protection cases

Safety and oversight of the waiting room

Glangwilli Hospital (GGH)

- ED Safety Huddles, capturing all waiting room patients
- Patient flow huddles throughout 24-hour period, discussing demand v capacity for all patients awaiting admission
- Patient flow meetings highlight any patients of concern in the ED waiting room
- N&H stickers for patients offered food and drink in waiting room
- Generic handover form between each shift covering all waiting room patients
- Red cross monitor and assist with waiting room patients, offering food and drink.
- Allocated front of house team for all waiting admission/triage (4RN + 2HCSW, split between triage, PIT stop and zone C waiting room)
- Triage and Initial Assessment SOP in place
- Chest pain flow chart in place
- - Rather than GP expected medical referrals coming through to ED (in hours) and then spend long periods within ED – they are now streamed all through medical SDEC to support timely assessment, investigation, and management relieving some pressure within waiting room. We have the data to demonstrate this impact and relief on ED.
- - Streaming all other speciality patients also away from ED and the waiting room to the clinical areas.
- - Implementation of the weekly ED Big Room incorporating new ideas, managing risk and patient safety concerns.

Bronglais General Hospital (BGH)

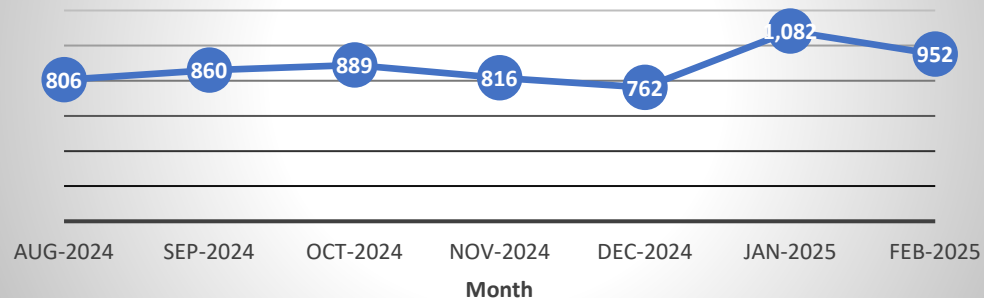
- Triage in place
- Short stay assessment being trialled
- Allocation of a staff member to the waiting room if possible
- Patient information in relation to waiting times and access to food and drink
- Daily 12:30 MDT board round
- All areas risk assessed

Withybush Hospital (WGH)

- Triage escalation process to ensure the triage wait time remains around 15 mins
- Triage and doctor wait times escalated on the site safety meetings to review if additional support required.
- Identification in triage of patients suitable for streaming to SDEC, SAU
- Nursing allocation to waiting area: Registered Nurse allocated with HCSW support to oversee waiting area.
- Regular observations undertaken as per individual need in waiting area.
- Staff aware to escalate any patients of concern to Nurse in charge who will then need to be brought into the main unit.
- Senior sister on all shifts 24/7 for senior oversight and support.
- Poster in waiting room to advise relatives/ patients to alert reception if any concerns who will contact nursing staff.
- Diet and fluids and support with fundamental care as required by HCSW. Area will be used within unit that patients can be taken to away from the waiting room for privacy.
- Monday- Friday in reach into ED by medical consultants/ specialities to review all patients awaiting their service and formulate treatment plans
- Pathways to FAU, SDEC and SAU promoted when able to reduce waits in waiting room.
- Consultant connect/ Porth Preseli/ intermediate care teams supporting hospital avoidance and/or planned attendance to alternative routes such as SDEC, Hot clinic
- Utilisation of boarding as per protocol
- Utilisation of surge across the acute site
- Huddles within ED to raise awareness of case-mix of patients

SDEC activity and impact

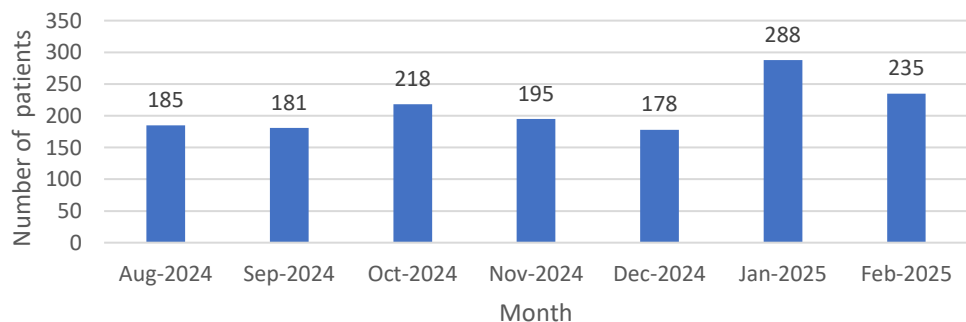
Number of patients counted as SDEC Activity at GGH, PPH and WGH by month from 1st August 2024 to 1st March 2025



SDEC Activity:

- Between 1st August 2024 and 1st March 2025, the number of patients counted as SDEC activity by month across GGH, PPH and WGH has remained relatively static, however there is a noticeable peak at 1,082 patients in January 2025. Please see adjacent graph.
- Within this period, the mean number patients counted as SDEC activity by month across GGH, PPH and WGH has been 881.
- Between 1st August 2024 and 1st March 2025, December 2024 had the lowest number of patients (762) counted as SDEC activity across GGH, PPH and WGH and January 2025 had the highest number of patients (1082) counted as SDEC activity.

Total number of patients leaving same day from SDEC (who were referred from ED/MIU) at GGH, PPH and WGH by month from 1st August 2024 to 1st March 2025



Same day discharge:

- Between 1st August 2024 and 1st March 2025, there has been fluctuation in the total number of patients leaving the same day from SDEC (who were referred from ED/ MIU) across GGH, PPH and WGH. Please see adjacent graph.
- Within this period, the mean number of patients by month leaving the same day from SDEC (who were referred from ED / MIU) across GGH, PPH and WGH has been 211.
- Between 1st August 2024 and 1st March 2025, Dec 2024 had the lowest number of patients (178) leaving the same day from SDEC (who were referred from ED / MIU) across GGH, PPH and WGH and January 2025 had the highest number of patients (288).

An increasing trend in both graphs is evident, indicating that over the last 6 months increasing numbers of people are utilising SDEC Services and an increase in numbers being discharged the same day.

Actions Taken

- Progress on reducing the length of stay at Withybush hospital
- Delivery of the optimal hospital flow framework
- Get it Right First Time (GIRFT) reports
- Ministerial Advisory Group actions

Progress on reducing the length of stay at Withybush hospital

Occupied bed days for patients aged 18+ with a LOS over 21 days



Emergency admissions with a LOS > 21 days, patients aged 18+



The above graph indicates an improving position since January 2025 for WGH Length of Stay (LOS) Measures. The actions currently being undertaken at WGH to maintain and improve this position further are as follows:

- Weekly system escalation meetings in place to consider any pathway delays across acute and community to troubleshoot
- Weekly review of people with a LOS of over 21, 50 and 100 days. This inpatient cohort is reported to Execs on a weekly basis.
- Deep dive fishbowl process on 100-day LOS across site to identify themes of delay, action learning focus further escalation as required.
- Strengthening our integrated working between enhanced community services and acute sector to facilitate earlier, safe, supported discharge through our clinical streaming hub mechanisms.
- A Discharge Toolkit and checklist are in use at WGH to support staff involved in discharge planning
- A Discharge Booklet has been developed and is being piloted at WGH
- Scrutiny panels in place in Local Authorities, right sizing of packages, signposting, third sector support established to minimise delays and support assessment processes.
- Areas of Alternative capacity under review to reduce delays in those awaiting Community Care



Delivery of the optimal hospital flow framework



- A quality impact assessment and Equality Impact Assessment (EqIA) has been produced for the ED MIU Redirection Policy which is due to be tabled at Quality Impact Assessment (QIA) panel on the 24th of March
- Each site has an Optimal Hospital Flow Framework implementation plan with delivery supported by the Quality Improvement Support Team (QIST) Team. A lead for the optimal hospital flow framework has been identified on each site to support engagement and implementation.
- There has been a refocus on the Hospital site meetings to provide structure and monitor data.
- The Red2 Green Dashboard is live which identifies pre clinically / clinically optimised constraints and is being used to drive improvement work across sites.
- Criteria Led Discharge (CLD) guidance is being piloted in a phased approach across the Health Board
- There has been a continuous improvement of D2RA measures since the Programme Workstream launched
- The co-produced Discharge booklet was taken to the Health Board Talking Health Group for feedback and is currently being piloted across hospital sites. PALS have offered resource to support with the feedback collation.
- The Discharge Toolkit (for health board staff) was launched on 19 February 2025 with 350 views to date. The Toolkit has been developed to support with discharge management and houses resources, support and guidance relating to discharge planning in one place for ease of access. We have linked with social care to provide regional information.
- A SharePoint page is established to house access to the optimal hospital flow framework, which to date has 1000+ views
- Hywel Dda representatives attend the National Policy Goal meeting to share learning with other Health Board's
- Deconditioning materials i.e. posters, leaflets have been developed and taken to the Talking Health Group for feedback. These are currently being disseminated across wards in the Health Board.
- The current escalation sit rep meetings are being reviewed to support actions to drive effective optimal flow
- Boarding Protocol updated and ratified



ED Getting it Right First Time (GIRFT) reports



The Health Board are uploading all ED GIRFT reports to the Audit Management and Tracking system (AMaT). Going forward GIRFT reports will be regularly submitted to the Integrated Quality, Financial Performance Delivery Group (IQFPD) and managed through the Safe Hospital Care Workstream. Please refer to the attached plans and following summary reports against progress for each site



Progress against the recommendations following the GIRFT reports – Bronglais Hospital



Recommendation	Completed Action
<p>We recommend that the site introduces a manager of the day that is supporting patient flow for the site is visible throughout the day and can support the patient flow team and add value by taking additional decisions and actions that will support the site to de-escalate into a safer position.</p>	<p>A new job description has been prepared and is currently subject to job evaluation within the HB. This role encompasses the MOD responsibilities and will provide additional ‘supernumerary’ support and oversight to the clinical practising team and act as a conduit between triumvirate leads and silver command structures.</p>
<p>The hospital would benefit greatly from an SDEC Unit to assess and turnaround patients the same day. Review Demand & Capacity of medical and surgical patients being streamed through Bronglais. Current MIU footprint would be ideal to establish SDEC which only had 1 patient in when we visited.</p>	<p>The BGH site is significantly constrained in terms of available capacity to support a dedicated SDEC function. However, 2 bays within ED have been repurposed to provide medical assessment functionality for EAU presentations at present, in the region of 30 patients per day are being seen. MIU does not hold sufficient capacity and routinely supports surge pressures within the unit when the hospital is functioning at high levels of escalation</p>
<p>We recommend an immediate review of the Nurse in Charge (NIC) role, as the current demands are unsustainable and pose significant human factor risks to those in the position. The NIC cannot effectively oversee two departments, provide direct patient care and be responsible for taking primary care referrals</p>	<p>A nursing workforce plan has been developed in support of improved staffing levels within the ED to include supernumerary roles. The NIC role is being assessed as part of a revised incremental approach to improving nurse staffing- balanced against the ongoing vacancy already registered within the Dept.</p>
<p>We recommend that with immediate effect, safety huddles are routine practice throughout the day within the emergency department.</p>	<p>Board rounds (safety huddle) now operational within the ED, supported by the site manager team- plans confirmed and issues raised in relation to flow/ constraints within the dept.</p>
<p>Hospital workforce: Review of footprint, workforce, and service provision. Ensure succession planning in place to support staff retiring. Review workforce to include Acute Physicians, Frailty Specialists, Advanced Nurse Practitioners, Physician Associates, ED Clinicians, Pharmacists, and Therapists. Review HCSW bank/agency support as a first line. Review student placements – is it safe? Review incentives to attract future employees to the area. Financial review of agency/locum spend aligned to providing incentives for permanent staff recruitment.</p>	<p>2 cohorts of Internationally Educated Nurses (IEN) have now commenced across the site and are subject to obtaining their OSCE and NMC registration.</p> <p>Emergency Nurse Practitioner (ENP) and Advanced Nurse Practitioner (ANP) framework in place. Intention of Minors injuries Unit becoming nurse led. 2 Clinical Nurse Practitioner (CNP) completing ANP and one Clinical Nurse Specialist (CNS) now completed ANP. 1 CNS undertaking thorough annex 21.</p> <p>Medical workforce stabilisation programme has commenced (led by Deputy Director of Workforce) in order to improve workforce intelligence and to identify gaps in resources. Medical Stabilisation will support with improving workforce intelligence in relation to succession planning</p> <p>Workforce plan in development which addresses issues of recruitment and retention</p>
<p>Strong leadership with a triumvirate of Clinical, Operational and Informatics is required to improve the flow in the system. Improve the communication across all levels in the organisation. Review leadership principles in the organisation to ensure staff are motivated and empowered to deliver the UHBs values and strategy. Ensure that leadership vacancies are made attractive and are filled asap.</p>	<p>Acting General Manager in place since October 24, supporting wider Triumvirate team in these actions. Wider Operational Directorate organisational restructure is continuing with appointments into vacant positions anticipated by Q1 24/25</p> <p>In collaboration with relationship managers, improvements are being made in terms of communication where possible. Teams channels and email circulation adds to the enhanced communication along with various meetings such as Consultants, Heads of Service and partnership forums etc.</p>



Progress against the recommendations following the GIRFT reports - Bronglais Hospital



Recommendation	Completed Action
<p>We recommend that the HB considers including the risk and pressures within the ED department and the WAST position, community risk and pressures in their sitrep document. This will enable this position to be communicated widely in one document to relevant individuals across the organisation and produce a whole system view of the site.</p>	<p>HB Sitrep document details hospital escalation levels as well as specific departmental breakdown (demand, unallocated and unplaced patients, performance metrics etc). This is reviewed in a HB wide meeting held as a minimum of twice per day. The BGH sitrep meetings (x3 per day) feed the documentation and the HB sitreps also provide opportunity for verbal narrative etc.</p>
<p>We recommend that the site considers reviewing the site escalation process to include boarding against query discharges after boarding against confirmed discharge had taken place in times of high escalation.</p>	<p>The site has (in December 2024) identified 10 areas where Boarding can be supported across the site, in line with the boarding policy. It should be noted that the BGH estate does not lend itself well to this, and some areas (such as toilet areas) have had to be converted to support. IP&C constraints also impact the availability of space as does the wider hospital discharge position, lack of discharge lounge and other factors such as staff absence. However, this increase, led by the Head of Nursing, marks a significant improvement in the boarding capacity.</p>
<p>The Health Board could look at the utilisation and occupancy of discharge lounge on a daily basis as a performance Key Performance Indicators (KPI) to embed the early and proactive use of the facility as much as possible.</p>	<p>Th Triumvirate team is about to (Jan 2025) embark on a review of the pathways at the Hafan Y Wain facility, offsite from BGH. The purpose of the review is to improve flow, and to improve on-site capacity within BGH. The re-development of the Y Banwy ward foot print may lend itself to the development of a small discharge lounge. The triumvirate team acknowledge the importance of this facility and will work to establish as soon as possible.</p>



Progress against the recommendations following GIRFT reports, Glangwili Hospital



Recommendation	Completed Action
Options are explored in terms of the location of the ED huddle whilst acknowledging the challenges the teams are facing with capacity within the department	Huddle has been moved to Glass office within Emergency Department
When discussing patients, initials or bay/trolley numbers are only used to identify the patients rather than full names	Trolleys are now numbered and initialised with any risks identified.
The IDT are present at the morning patient flow meeting with the view that suitable patients can be identified and a prompt decision can be made to 'pull' them out into the community setting	Review of attendance to Patient Flow meetings to maximise community 'pull' complete - IC MDT engagement/Virtual Ward are now included
Greater senior nursing input and oversight on the wards supporting and challenging ward activity The Manager of the Day that is supporting patient flow for the site is visible throughout the day and can support the patient flow team and add value by taking additional decisions and actions that will support the site to de-escalate into a safer position	Full compliance with PG5 Principles - Red & Green, Board rounds, Frontier - D2RA. Peer review and monitoring by SNM Team. TUEC Assurance meeting now set up monthly to monitor progress. Full QI support.
The Manager of the Day (MOD) that is supporting patient flow for the site is visible throughout the day and can support the patient flow team and add value by taking additional decisions and actions that will support the site to de-escalate into a safer position	<p>Reviewed MOD Role and responsibility as well as that of SNM and Clinical Site Manager - with key focus on Optimal Flow. Reviewed OOH support and cover.</p> <p>Omitted duplication with SNM and MOD role. Chain of escalation for patient flow concerns to Clinical Site Manager initially. Escalated to MOD if no resolution.</p> <p>MOD will be visible as part of patient flow hub.</p>
The HB escalation process and action cards are explicitly clear to all relevant personnel within the hospital to ensure that there is a consistent and clear approach adopted throughout the hospital	<p>Emergency Pressures and Escalation Policy readily available.</p> <p>Additional focus work on Major Incident action cards specific to role and responsibilities.</p>
Review the site escalation process to include boarding against query discharges after boarding against confirmed discharge had taken place in times of high escalation	Patient Boarding Protocol in place and being utilised. Monitored Daily. Review of effectiveness of this to be undertaken. Boarding protocols in place and board at extreme risk currently.
The IDT and staff from Discharge Lounge attend this meeting to identify patients who may require the input of these teams early, with the aim to arrange an early review from the IDT and/ or a review from the discharge lounge team to review their suitability of a patient to move to the lounge when it opens the following day	Review of attendance at Patient Flow Meeting. IC MDT/Discharge Liaison Team and Discharge Lounge all attend



Progress against the recommendations following GIRFT reports, Glangwilli Hospital



Recommendation	Completed Action
<p>An intelligent suite of measures are captured and regularly scrutinised by clinical, managerial and executive teams to assess outcomes, experiences and value in emergency departments, with appropriate escalation and actions taken aligned to local and national improvement planning.</p>	<p>Linked to GGH 12 Week Plan Data Capture and Review</p>
<p>In most of the EDs of Wales, large numbers of ED nurses are engaged for long periods in caring for patients who are waiting for an inpatient bed. (This effectively reduces the number of nursing staff that are available for core emergency work.) There should be a formalisation of these arrangements, with a senior nurse responsible for the care of specialty patients. (This, of course, is a temporising measure for reasons of patient safety, until the problems of delays for inpatient admission can be resolved.)</p>	<p>Additional support at night due to surge within ED – medical agency nursing (not ED rates). Currently fully established RN.</p>
<p>Many EDs are dependent on locum doctors, especially for their middle grade rotas, and also bank nurses. Conditions of service should be offered that tempt these staff to accept longer-term contracts, wherever possible, whilst remaining cognisant of local financial pressures. Senior and junior rotas for both medical and nursing staff should be reviewed to ensure adequate out-of-hours cover for EDs at all times.</p>	<p>Only one Locum Consultant in post (currently acting Clinical Lead for unit). Efforts always in place to offer contracts. Completed</p>
<p>A column is added to the sitrep report to input confirmed discharges for the following day, so those identified patients can be 'pulled' to discharge lounge as soon as it opens, releasing early capacity that can be utilised</p>	<p>Column available on Sitrep to capture next day discharges. 20th December met with NHS Exec to go through plan Overarching 12 –week plan</p>

Recommendation	Completed Action
<p>Clinical and patient safety risk- There were SDEC patients paper notes in a locked filing cabinet that had been there for three months and were waiting to be added to the patient’s medical records. Advised that there was no administrative support.</p>	<p>Meeting undertaken with Medical Secretary Coordinator on 30th Sept to review options for admin support for SDEC department - 8 hours now allocated per week. Will re-review scope of admin support from MIU once overnight closure is actioned to.</p>
<p>Clinical and patient safety risk- Medical Register receives calls to accept referrals over the phone, these are not documented anywhere</p>	<p>Call logging sheet introduced to record information given by referring medic. Documents stored for a month's period in the SDEC department. Documents include time and date of call patient symptoms and reason for referral to SDEC service and the discussion notes in relation to suitability and criteria.</p>
<p>A variety of different clinics using the space in SDEC therefore difficult to plan daily activity. Workforce sessional support sporadic- some days are consultant lead some days are GP lead. Locum use to cover sickness and leave</p>	<p>Review of frequency/purpose of clinics identifying impact on SDEC capacity e.g. virtual clinics. Scope alternative areas to support clinics to maximise SDEC activity.</p>
<p>SDEC waiting room not visible to clinicians or staff members. A mixture of SDEC, MIU and outpatients sit in the same waiting room. At 6pm the OH GP patients that include children also use that waiting area.</p>	<p>Front of House Task & Finish Group in place to progress and explore all options.</p>
<p>SDEC opening times 10am – 8pm Staff coming in early as patients are being directed to SDEC from 8:30 and there is cross cover with GP OHS and MIU</p>	<p>Review of opening hours is being undertaken as part of the MIU overnight closure. GP OOH also being relocated as part of the MIU closure. Full review to follow. Combined review function of SDEC at PPH & GGH.</p>
<p>High number of MDU activity currently being seen in SDEC. A service need but not SDEC activity.</p>	<p>Review of Geri Day activity to scope ability to remodel as a Medical Day Unit to support activity - scoping via Front of House T&FG.</p>
<p>Staff not aware of how to follow up activity that is captured on the system. There is currently an internal methodology used by some staff but not all</p>	<p>Review of data capture and performance to determine next steps of SDEC & MDU activity split.</p>



Progress against the recommendations following the GIRFT reports – Prince Phillip Hospital



Recommendation	Completed Action
Frailty Support given by TOCALs team but they cover the whole Hospital and require direct referral	Discussed within Front of House T&FG. Frailty ANP on-boarding - awaiting start date. Frailty team pathway started. ANP recruited and recruitment of Physio and OT underway with in-reach into AMAU front door. SOPs agreed. Plans for dedicated FAU on ward 3 underway.
AMAU advised that the unit is unique and not seen as one similar across the UK	Acute Medical admission criteria for AMAU has been shared with WAST. AMAU SOP completed and in place. Fully functional Resus unit within AMAU with support from Acute Medical Physicians.
AMAU - all areas are being used for surge capacity and the corridor	Review of AMAU Side Room to support IP&C risk - captured within twice daily patient flow meeting/ AMAU patient safety huddles. Boarding against definite discharges to reduce surge within AMAU. Review of patient flow - through daily board rounds, PG5 principles, Red & Green, D2RA, Criteria Led Discharge. Escalation review of Clinically Optimised patients twice weekly. Close collaboration with IC MDT and Virtual Ward usage.
Minor injury unit (not visited) But advised that it was open 24 hours a day and staffed by GP's and lead clinicians	MIU temp Overnight Closure 1st November 2024 – open 8:00am to 8:00pm with staff finishing at 10:00pm. Steering group in place to look at future service model.

Progress against the recommendations following the GIRFT reports – Withybush Hospital (WGH)

Recommendation	WGH Action Updates
There was clear evidence to suggest that discharge activity occurred later in the day at WGH. We recommend that the Health Board explore this in more detail to be able to clearly understand the root cause of this and be able to put measures in place to, where possible ensure that discharge activity occurs earlier in the day.	As part of the 6 Goals Programme, Safe Hospital Care Workstream. The Optimal Hospital & Patient Flow framework plan for WGH is to review and optimise the use of the discharge lounge and review discharge data.
We recommended that Porth Preseli is expanded to a 7 day service as a priority, recognising that workforce constraints will be a challenge.	This is being reviewed as part of the WGH Winter Plan/Annual Plan and the 50-day Cycle. However, expanding to 7-day service would require funding.
We recommend the Health Board considers changing the approach it adopts to patient flow. We recommend a model where the patient flow team act as a central hub and the role of information gathering and responding to actions to create capacity is the responsibility of a designated lead for each service group.	As part of the 6 Goals Programme, Safe Hospital Care Workstream. There is a plan in place and being implemented for the Optimal Hospital & Patient Flow framework plan for WGH. Ringfencing a resuscitation room, ringfencing RATS room, a Triage room and second Triaged which can then be utilised for ED flow
We recommend that the Health Board reviews the workforce model within the patient flow team. Suggestions in report (point 17)	We will continue with the current model due to demand and footprint of WGH
We recommend that the Health Board revisit the Optimal Flow roll out plan and, supported by the QIST Practitioners, ensure a consistent application of the Optimal Flow Framework across all wards at WBH within clear and achievable time scales	As part of the 6 Goals Programme, Safe Hospital Care Workstream. There is a plan in place and being implemented for the Optimal Hospital & Patient Flow framework plan for WGH. This is being supported by the QIST Team and Senior Nurse Management Team. Fortnightly meetings are held with the site to monitor progress and identify areas of support from the 6 Goals Programme.
We recommend that there is greater senior nursing leadership presence in all areas until complete assurance regarding the implementation of the optimal flow framework is embedded.	A Senior Nurse Manager has been identified as Lead for the Safe Hospital Care: Optimal Hospital & Patient Flow framework for WGH supported by the Hospital Service Manager and QIST.
We recommend that the senior leaders within the organisation endorse the implementation of the framework and promote a culture shift within the hospital that sees some current practices and ways of working challenged (this one is a Six Goals Team to do).	There has been significant improvements in D2RA data.
We also strongly recommend that as a priority the TUEC group delivery group meetings are reinstated. (this one is a Six Goals Team to do)	This is an action for the 6 Goals Programme.
Re LOS meetings in WWG we recommend that the health board continue to communicate and provide assurance through robust action plans into the goal 6 programme structure. Re LOS meetings in WGH we recommend that the HB review the structure of this meeting and its chair. We also recommend that the content of the meeting is reviewed to ensure that it is action focussed, and processes are put in place to ensure actions are followed up and completed	This has been actioned. The Length of Stay meeting structure has been reviewed and is co-chaired by acute and community SNM.

Ministerial Advisory Group actions (GGH)

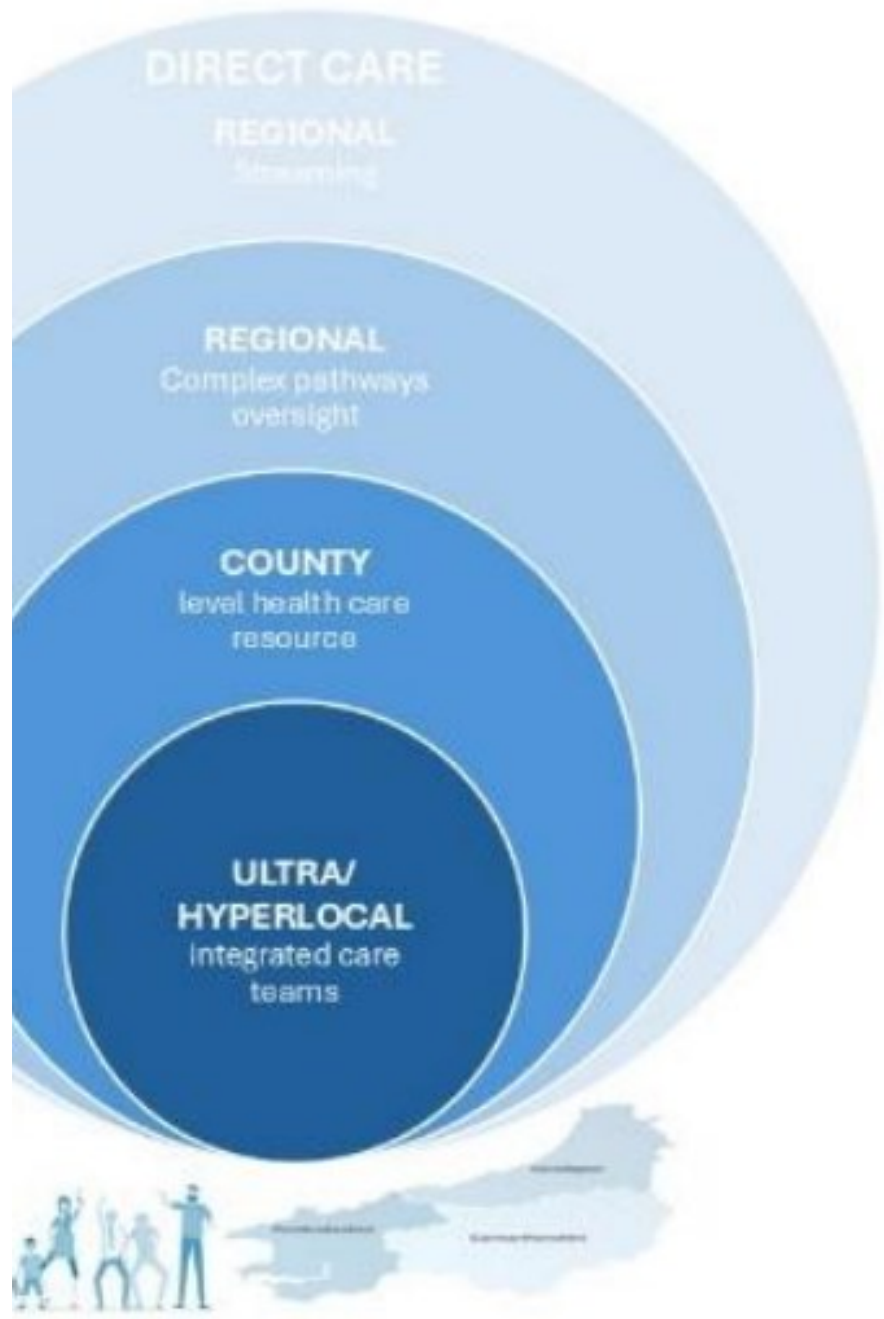
Hospital Area	MAG Comment	Action(s)
ED	Seriously crowded and was told that a doctor (who had only been there for 18 months) had not seen a patient in a cubicle during that period.	Improvement plans in place to address this key area. Medical take is now via SDEC and not ED Jan 25. Surgical SDEC taking all surgical referrals. Task and Finish group in place to expand medical SDEC to deliver a plan by Q3 WG monies available for capital enablement works Good working relationships seen but flow was an issue – this was more of an Acute Medical and Surgical Unit and not an ED.
ED	New UEC model: the HB is brave and solution focused by driving the innovative model that is a fantastic model the HB needs to get right	Significant focus on streaming hubs avoiding ED moving to a 7-day model HB wide. Expansion of SDEC to enable speciality takes to be seen and treated outside of ED
ED	Support: Encourage teams to work between organisations to remove barriers	Closer working across primary, acute and secondary care. Implementing pathways to avoid ED. Focus on frailty models and admission avoidance scoping resource across the system to have unified pathways.
ED	Organisational Development cultural issues – suggest junior doctors have training in difficult conversations	Deputy hospital director chairs meetings with junior doctors with a focus on key topics and communication and complaints review
SDEC	Good model for the future but also need to support patients in the here and now	Increased patients seen in SDEC and model to support those needing admission. Reviewing options for an acute frailty unit expansion also to incorporate pre and post op surgical/orthopaedic patients
SDEC	Positive and weaknesses that it is not co-located with ED	Plans to expand SDEC but no option (geographically) to co-locate with ED
SDEC	Barriers: lack of 7-day a week working and diagnostic delays.	Tried to recruit 6th consultant for acute medicine which was not successfully so currently unable to expand to a 7-day model. Diagnostic activity extremely high in GGH Task and Finish group in place with radiology to review options for timelier access to diagnostics.
SDEC	Review acute flow and elective workload	12-week decompression programme has taken place with key actions to improve flow. Weekly big room and separate for ED for wider MDT to review current position, actions and plans for improvement. Elective lists jointly discussed with Unscheduled Care and increased medical outliers into surgery to maintain acute flow

Ministerial Advisory Group actions

Hospital Area	MAG Comment	Action(s)
ED	Brilliant and committed staff but the HB is relying on their resilience	As a HB recognised the pressures ED face and in GGH a weekly ED big room is place to progress key actions to support ED. ED consultant posts advertised with 4 shortlisted interviews mid-April.
ED	High level of frailty and was told that the Frailty Pathway was better in WGH.	More Care of the Elderly physicians at WGH, GGH consultants are being job planned and then a review in April 25 for revised frailty model
ED	Lack of Executive visibility	Planned exec and board walkarounds in place to review all clinical services in GGH and across the HB
ED	Pathology: talked about an issue with the tube between ED and Pathology that requires an upgrade. The impact is a delay in in bloods being sent between departments resulting in an hour delay for partners to collect. This also impacts on the Labs with a lack of continuous flow. An inefficiency that needs to be addressed	This has been addressed and shortly after the visit the tube system back in operation
SDEC	Capacity: only six out of the ten chairs were in use and told that GP referrals presented later in the day.	Now the medical take is going via SDEC the unit has higher occupancy at the start of the day. Medical day unit co-located and a demand and capacity review in place to look at alternative pathways to increased SDEC footprint
FAU	Juxtaposition of perfection in ED – needs to be investigated	Improved communication between ED and Frailty Assessment Unit (FAU) with patients identified early in the pathway for the FAU. FAU surges to take additional patients at high escalation to support ED and system flow

Whole-System Transformation

- **Regional Transformation:** 24/7 Technology-enabled, Clinically-led streaming and scheduling. 'Phone-First' and App-based access.
- **Locality Transformation:** Hospital@Home, Urgent Community Care Centres, 'Straight to Speciality' pathways, Step-Up Integrated Beds.
- **Hyper-local, Pro-Active Transformation:** Place-based care, integrated through-age community networks. Multi-Agency teams co-located and embedded within communities. Risk- stratification and pro-active anticipatory care planning



Direct Care: Whole System Scheduling
 TEC logistics
 24/7 Intelligent solutions – integrated eHR
 Digital inclusion



Clinical Streaming Hub
 Clinical Governance
 Professional contact centre

- SRO Expertise/ on-call
- Front-end flow (referrals)

 WAST logistics
 Tertiary care interface (patient contact centre)



Hospital (Short stay specialist support and management)



Integrated Care Centres
 Urgent Care Centres
 Emergency & Community Diagnostic Centres



Cluster/ Community Connector
 Multi Agency Teams – 3rd Sector
 Primary Care/ Community Care



Integrated Urgent Care

46% of patients attending ED could be better supported elsewhere: 56% of these were directed to an ED by a professional

1. Co-ordination planning and support for populations at greater risk of needing urgent or emergency care

ACCESS TO URGENT PRIMARY/ EMERGENCY CARE



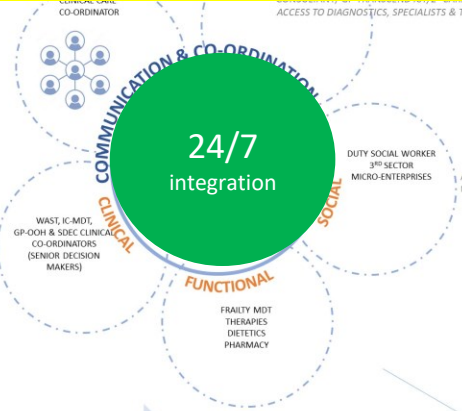
All accounts for 38% of monthly acute medical activity (2200 admitted to acute sites)

28%

35% medical intake is via SDEC (releasing ED capacity) 850 attendances per month 91% discharged same day

Admission Prevention Activity = 500 per month (36% are advice only) in hours

24/7 integration



ACCESS TO ELECTRONIC 360° PATIENT CARE RECORD

VERBAL RESPONSE (ADVICE) CONSULT & CLOSE

VIRTUAL RESPONSE ACTION/ PATHWAY & CLOSE INC 3RD SECTOR REFERRAL

ELECTRONIC SCHEDULING PRIMARY CARE ACCESS

36% SCHEDULED RESPONSE (HOT CLINIC/ SDEC/ ED) ACCESS TO SPECIALISTS

22%

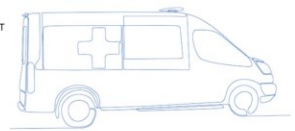
MULTI-AGENCY RESPONSE CRISIS RESPONSE CATCH TEAM

NURSING/ CARE HOME RESIDENTS (HISTORIC CONVEYANCE)

4. Rapid response in a physical or mental health crisis



APPROPRIATE RESPONSE



PORTABLE DIAGNOSTICS



CARE HOME ACCESS DIRECT DIAL INTERFACE SINGLE POINT OF CONTACT



3. Clinically safe alternatives to admission to

ALTERNATIVE BEDDED FACILITY BED BASED

DIRECT ACCESS TO WAST FOR H@H THAT DETERIORATE



6. Home first approach and reduce the risk of readmission

TECHNOLOGY ENABLED CARE

HOSPITAL @HOME ENHANCED COMMUNITY CARE

ACCESS TO ELECTRONIC 360° PATIENT CARE RECORD EPMA VIRTUAL WARD/ MDT

REMOTE MONITORING SELF-REPORTED OUTCOMES WITH COMPLETE DIGITAL SOLUTION



WINTER ED BUSIEST DAY 2023 REDIRECTABLE REVIEW FINDINGS REPORT

ED GLANGWILI GENERAL HOSPITAL ED WITHYBUSH GENERAL HOSPITAL Produced: April 2024 Version:0.08

Author Ellen Lewis, Interim Project Manager Dr Karen Brown, Clinical Lead for Acute Medicine Dr Siobed Richards, Clinical Lead for GP Intermediate Care



UEC Redesign

A Strategic Solution

- **Strategic Intent:** To truly address the safety concerns in the Emergency Department requires broader and deeper transformation. We aim to pull together the learning from across many non-recurrent funding streams that are currently piloting innovative ways of working and to work with strategic partners to deliver an Integrated Community Care System to eradicate failure demand in secondary care. .
- **Current UEC Reality:** Overcrowded Emergency Departments (ED), compromised quality & safety. Only 20-30% of demand is appropriate for ED, as an organisation we are therefore exploring more upstream ways to address the issues that are currently manifesting in the emergency arm of the service.
- **Challenges:** Ineffective solutions, unsustainable expenditure in secondary care, and traditional silos. Workforce challenges that can only be overcome by integrating across professional and organisational boundaries.



“A Good Life, Well Lived”

Whole System Transformation



There is ample evidence that the strategic intent exists to deliver a whole system of care - what is required now is the passion, belief, culture and drive among leaders and staff across all services and at all levels to commit to its delivery. It is what our population deserves.

Recommendation

The Committee is asked to:

- Take assurance from the Progress with the Six Goals Programme for UEC
- Note the challenges with sustainable Service delivery in the present System and the requirement to develop a revised approach as we move forward.

Grŵp Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Gweithrediadau, GIG Cymru

Health and Social Services Group
Director of Operations, NHS Wales



Llywodraeth Cymru
Welsh Government

Chief Executives

Chief Operating Officers

Medical Directors

Executive Directors of Nursing

Local health boards

Welsh Ambulance Services University NHS Trust

29 October 2024

Dear colleagues,

WHC/2024/041: Ambulance Patient Handover Guidance

I am writing to draw your attention to a newly published Welsh Health Circular relating to Ambulance Patient Handover Guidance.

This guidance is intended to set a statement of intent for health boards to deliver when managing the ambulance patient handover process, and to set out key actions for consistent delivery to support optimal outcomes and experience. It has been developed with clinical and operational input and should be read as a second iteration of the [original document](#) released in May 2016.

This guidance is intended for executive level staff of health boards, the NHS Wales Joint Commissioning Committee and the Welsh Ambulance Services University NHS Trust. It may also be useful to emergency department and ambulance service clinical and managerial teams when designing local protocols.

As you will be aware, ambulance patient handovers continue to represent a significant challenge to patient experience and outcomes and the ambulance service's ability to respond quickly to people in the community. You will also be aware this is an issue requiring system wide solutions, both in the community and in supporting timely patient flow through emergency departments, the hospital system and back out into the community.

All members of the health board executive team have a responsibility for timely and safe ambulance patient handover, and the communication of this guidance and its content throughout their organisation. This may sometimes include an acceptance of sharing risk across the system, in line with local and national escalation frameworks.

We will continue to monitor progress against ambulance patient handover trajectories over the coming weeks in conjunction with the NHS Executive which will undertake audits of organisations' compliance with the guidance over the remainder of 2024/2025.

Thank you for your assistance.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'J Griffith', is positioned below the text 'Yours sincerely,'.

Jeremy Griffith

Director of Operations

NHS Wales / Health and Social Services Group, Welsh Government

Cc: **Judith Paget**, Director General Health and Social Services / NHS Chief Executive
Nick Wood, Deputy Chief Executive, NHS Wales
Sue Tranka, Chief Nursing Officer, Welsh Government
Richard Bowen, National Director for the Six Goals for Urgent and Emergency Care Programme



Llywodraeth Cymru
Welsh Government



Ambulance Patient Handover Guidance

Purpose

This NHS Wales guidance is intended to set a statement of intent for health boards to consider when developing plans to improve ambulance patient handover, and to set out key actions for consistent delivery to support optimal outcomes and experience. This guidance should be read as a second iteration of the [original document](#) released in 2016.

Audience

This guidance is intended for executive level staff of health boards, the NHS Wales Joint Commissioning Committee and the Welsh Ambulance Services University NHS Trust. It may also be useful to emergency department and ambulance service clinical and managerial teams when designing local protocols.

Strategic context

This guidance further reaffirms our shared commitment to reduce ambulance patient handover delays and should be read in conjunction with the [Six Goals for Urgent and Emergency Care policy handbook](#) and the [Quality Statement for Care in an Emergency department](#). It should also be considered in the context of the [Health and Care Quality Standards](#) and statutory duties within the [Duty of Quality](#).

Statement of intent

All members of the health board executive team have a responsibility for timely and safe ambulance patient handover, and the communication of this throughout their organisation. This may sometimes include an acceptance of sharing risk across the system, in line with local and national escalation frameworks.

Ambulance clinicians are trained for life-saving interventions and not to meet ongoing care needs. When a patient is conveyed to a hospital by ambulance, care must be handed over to the receiving hospital team as soon as possible, in order of clinical priority and within 15 minutes. Health boards are responsible for ensuring this happens reliably and that there is sufficient available capacity throughout the receiving hospital.

Key actions to support ambulance patient handover have been highlighted and summarised in this document. They are intended for implementation by health boards, the NHS Wales Joint Commissioning Committee and the Welsh Ambulance Services University NHS Trust and should be incorporated into local escalation plans.

Delivery of these actions will be routinely audited and reviewed by the NHS Wales Executive to ensure organisations are compliant, and to enable support to be provided where necessary.

Key actions for health boards, NHS Wales Joint Commissioning Committee ('the committee') and the Welsh Ambulance Services University NHS Trust (WAST)

1. The organisational leadership and culture of care in a health board is of the utmost importance in ensuring that prompt ambulance patient handover becomes business as usual. Health board executives should work with local clinical leaders to communicate the importance of timely ambulance patient handover. Health board executives should model this visibly and repeatedly to all staff.
2. Health boards should use the GIRFT 'SEDIT tool' and baseline data to support capacity planning across the hospital footprint, ensuring 24/7 access to safe care and treatment of patients arriving by emergency ambulance.
3. The committee and sufficiently senior nominated health board and WAST leads should regularly come together to review ambulance patient pathway data to identify opportunities to better manage patients in the community where safe to do so. This should include an assessment of 'hear and treat' and 'see and treat' performance to enable a collective understanding of patient activity.
4. The committee, WAST and health boards should regularly review and benchmark service provision matched to ambulance case mix and pattern of daily demand by local and regional area. Data should inform the delivery of robust community and alternative pathways by health boards which are clearly communicated to ambulance clinicians. This should include direct access pathways to enable patients to bypass the emergency department when safe and appropriate to do so.
5. Communication before the patient arrives:
 - Health boards should ensure ambulance clinicians have access to a care co-ordination service (i.e. navigation or flow hubs) that can accept or transfer care of suitable patients and support the flow into their services.

Patients requiring immediate resuscitation

- Where a patient requires immediate life-saving treatment on arrival at hospital the ambulance crew must provide a pre-alert to the hospital. WAST and health boards should have agreed processes in place based on national guidance for identifying, communicating and managing pre-alert cases.

- When an ambulance arrives at hospital with a patient who requires immediate life-saving treatment, the patient must be taken immediately to the resuscitation area. Effective hospital escalation should be in place to enable this seamlessly.

Patients requiring specialist emergency treatment

- Patients requiring treatment for conditions such as STEMI, vascular, burns, stroke or obstetric conditions should be taken directly to receiving units other than the hospital emergency department in line with the agreed local or regional pathway.
- Additional pathways must be agreed between WAST and health boards who have a responsibility for clearly communicating their expectations to the Trust. WAST has a responsibility to ensure ambulance clinicians are informed of health board expectations and maintain a regularly updated directory of services.
- Health boards should incorporate regular audits of compliance with these pathways as part of annual clinical audit forward planning activity. The NHS Executive will also periodically audit compliance.

6. Ambulance patient handover on arrival:

Booking in

- Booking in of patients must take place immediately on arrival at the emergency department or other admitting areas. WAST staff will complete an electronic Patient Clinical Record (ePCR) for all patients.
- The ePCR will be processed by the receiving hospital for all patients conveyed by WAST depending on local protocols. This should be matched to the patient and uploaded to Welsh Clinical Portal when the care episode is complete.

Triage / signposting

- Patients should be assessed on arrival at the hospital receiving area and treated for the acute condition they have presented with; remembering frailty can co-exist with the presenting acute complaint.
- Guidelines should be in place for safe and effective triage and streaming of patients to the correct area (e.g. majors, minors, same day emergency

care, acute frailty teams etc), and to identify patients who are 'fit to sit' in the waiting area. These processes should be standardised between health boards and WAST.

- On arrival a detailed summary must be given by WAST to support triage / initial assessment by health board clinicians. This will include clinical information and also considerations of other personal and social information where relevant. Processes should be implemented by health boards regarding the grade / training / level of experience required for this task.
 - Senior clinical decision makers should consistently be present at the hospital front door and their presence supported and strengthened as part of local escalation plans when pressures build in the system.
 - Patients are to be handed over at a definitive destination of care, with both ambulance and hospital staff complying with the dual pin process, inputting individual staff ID pins into the HAS screen. For those areas where HAS screens are not available, health boards and WAST should ensure that equally robust arrangements are in place to ensure rapid handover, within 15 minutes of arrival.
- 7.** Health boards should deliver safe, sustainable, staffing levels for emergency departments and acute receiving areas, able to flex to meet demand, with appropriate levels of seniority available for timely assessment and supervision, in line with expectations set within the Quality Statement for Care in an Emergency Department. Staff of all grades should have clear lines of responsibility and accountability and an appropriate level of supervision, (e.g. resident doctors, health care assistants and clinical practitioners).
- 8.** Management of handover delays:
- Patients and their carers should be kept fully informed of the reason for any delay and the progress in resolving it.
 - WAST crews should not routinely be responsible for monitoring patients over prolonged periods outside emergency departments or other admitting areas, and hospital clinicians should be responsible for overseeing the assessment of patients.
 - If delays occur immediate action must be taken by the health board to resolve them. Where ambulances are delayed beyond 30 minutes the actions must include:

- The WAST Operational Delivery Unit (ODU) and the hospital operational team must be notified immediately.
 - Health boards should have in place appropriate procedures and identified individuals for the management, flow and co-ordination of patients arriving by ambulance.
 - Hospital staff must ensure that the patient has been assessed and moved immediately into an appropriate clinical space if there is a risk to patient safety.
- Delays of over 60 minutes are unacceptable, and should be exceptional. They must be clearly visible to the health board executive teams and monitored through quality and safety management systems. After 60 minutes of delay the following actions must take place if they have not already:
 - The WAST ODU should be informed for escalation to the national system leads and must be notified immediately where there is a risk a patient will wait in excess of four hours.
 - Hospital wards must increase their ability to pull patients safely from the acute areas at times of peak demand. This should be risk managed to ensure that patients are treated in a suitable clinically supervised area with appropriately qualified staff. A patient's safety is the utmost priority and any infection control, or any other risk including deconditioning, should be managed proactively.
 - Formal ambulance diverts should be put in place in line with local and national escalation processes agreed between the health board and WAST.

GETTING IT RIGHT FIRST TIME for Emergency Medicine The Emergency Departments of Wales

Supplementary report following Hywel Dda visits in January 2025



This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to enable a rapid improvement in the delivery of urgent and emergency care and the adoption of the GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

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1. Introduction

Ten of the 12 major ED in Wales were visited by the RNOH/GIRFT UEC Team in June 2024 and a report was subsequently written. For logistical reasons, the EDs of Withybush and Bronglais in West Wales could not accommodate the GIRFT visitors at that time and so these two departments were visited at the end of January 2025. The following supplement to the main report relates to these two EDs.

2. The major ED sites in Wales

The most recently available maps of the ED sites and emergency helicopter bases in Wales are shown below:



Two of the three hospitals in Hywel Dda UHB were visited in January 2025. They are highlighted in red in this table:

Hospital	Health Board	Locality
Wrexham Maelor Hospital	Betsi Cadwaladr UHB	Wrexham
Ysbyty Glan Clwyd	Betsi Cadwaladr UHB	Bodelwyddan
Ysbyty Gwynedd	Betsi Cadwaladr UHB	Bangor
Bronglais Hospital	Hywel Dda UHB	Aberystwyth
Withybush Hospital	Hywel Dda UHB	Haverfordwest
Glangwili Hospital	Hywel Dda UHB	Carmarthen
Morrison Hospital	Swansea Bay UHB	Swansea
Princess of Wales Hospital	Cwm Taf Morgannwg UHB	Bridgend
Royal Glamorgan Hospital	Cwm Taf Morgannwg UHB	Llantrisant
Prince Charles Hospital	Cwm Taf Morgannwg UHB	Merthyr Tydfil
University Hospital of Wales	Cardiff & Vale UHB	Cardiff
Grange University Hospital	Aneurin Bevan UHB	Cwmbran

3. Bronglais Hospital: Hywel Dda UHB (Aberystwyth)

Bronglais Hospital: OVERVIEW

The ED at Bronglais Hospital is a very nice, compact and efficient unit. Everything required is present and has been carefully planned and designed by the dedicated and skilled team of professionals in the ED. The vital position of Bronglais Hospital in mid-west Wales makes closure impossible and therefore its maintenance and successful development is the correct and only sensible option.

The SEDIT for Wales (SEIT-W) shows the Demand, Capacity, Flow and Patient Outcomes in detail. The main issues from this data are shown below. Many of the flow and outcome metrics have improved over the last few months.

Bronglais Hospital: DATA QUALITY

Quartile	Data quality
	Completeness and validity of emergency care data = 46.4%
	Accuracy of discharge coding = 98.5%

Bronglais Hospital: DEMAND

Quartile	Demand metric
	More than 37% of the hospital's catchment population attend the ED each year.
	Around 36% of all patients admitted from the ED are over 75 years of age. But the overall catchment population is young, due to attendances by students.

	Almost 85% of all emergency admissions occur via the ED.
	The ED is not designated as a Trauma Unit, despite its geographical situation.

Bronglais Hospital: CAPACITY

Quartile	Capacity metric
	The ED is very short of senior medical staff. There is only one ED consultant at the present time and this doctor is a locum.
	The ED is relatively short of registered nurses. (The departmental nursing staff are shared with the acute ward, with only a proportion allocated to the ED.)
	The annual number of admissions per whole time equivalent (WTE) Hywel Dda UHB consultant is more than 383. (This is all hospital consultants of all specialties in the UHB.) The mean figure on the SEDIT is 262.

Bronglais Hospital: FLOW

Quartile	Flow metric
	GEMI ranking = 137 out of 191 sites across England, Wales and Northern Ireland (using unvalidated metrics from all Welsh EDs)
	Over 73% of ambulance handovers to the ED staff take more than 30 minutes.
	Validated four-hour performance is just over 65%.
	Unvalidated four-hour performance is just over 65%. (Validation gap = <1%)
	The mean time in ED for non-admitted patients is around 4.3 hours from time of arrival.
	The mean time in ED for admitted patients is over 12.6 hours from time of arrival.
	Around 54% of admitted patients are still in the ED more than six hours after time of arrival.
	These patients then spend a further 15 hours in the ED on average before admission.

Only around 27% of emergency patients have a zero-day length of stay.

Bronglais Hospital: OUTCOMES

Quartile	Outcome metric
	Over 9% of all ED patients spend more than 12 hours in the ED from time of arrival.
	More than 32% of admitted patients are still in the ED after 12 hours from time of arrival.
	These patients then spend a further 17.5 hours in the ED on average before admission.
	ED litigation costs are high.

Bronglais Hospital: ADDITIONAL INFORMATION

There are both decontamination and isolation facilities in the ED; there is also a mental health room. The ED has a weighbridge and an Omnicell machine for ambulance crews to use. A GP is located in the outpatient department. The IT system is Welsh PAS. The two dedicated staff toilets are accompanied by a washroom and kitchenette.

Bronglais Hospital: FINDINGS AND RECOMMENDATIONS

[See also Section \[4\] of the main GIRFT-EM report: Overall recommendations for emergency care in Wales.](#)

- The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.
- The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances (especially in rural areas) and thus also cause harm to patients.
- The lack of ED senior medical staff must be addressed. There is only one ED consultant at the present time and this doctor is a locum; there are no substantive consultants in emergency medicine. However, the future viability of the department may require a different model of care, at least in the short- to medium-term. Possibilities include: a senior nurse clinical director (rather than a doctor), more ANPs, increased links with the local university and school of nursing, a professor of emergency nursing and an ED nurse consultant. Better links with other units may also help. More newly qualified consultants in EM are having to look for jobs outside the big cities, as the available city jobs are getting gradually filled. Sometimes, advertising for a group of four or five consultants, each with a specialised role (e.g. teaching, children’s care, pre-hospital care) yields better results than single adverts.
- There are no housekeepers, dedicated porters or several other non-clinical roles in the ED. With a relative shortage of nursing and other clinical staff, it makes no sense not to have a wide range of supporting non-clinical staff.
- The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to “power” the hospital beds in a timely and efficient way that ensures good patient flow.

- The high catchment attendance level suggests that there are poor alternatives to ED attendance in the local area, probably including primary care, and this deficit is almost certainly worse out-of-hours. Student populations are known to attend EDs in large numbers, often in unsocial hours.
- There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope, specialties and hours of availability. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED (currently high at ~85%).
- Patients with strokes get a very timely and efficient service at Bronglais Hospital. It seems a great shame that plans are now in place to move these patients south to Withybush Hospital for their rehabilitation. This will undoubtedly cause inconvenience to many elderly relatives.
- The causes of the high cost of ED litigation should be examined.
- Emergency care data quality must be improved.

4. Withybush Hospital: Hywel Dda UHB (Haverfordwest)

Withybush Hospital: OVERVIEW

The ED at Withybush Hospital would be a very nice and adequately sized one, good for both patients and staff, if it was allowed to function as such. Unfortunately, it is completely full, including a considerable number of overflow spaces, with mostly medical patients who are waiting many hours for hospital admission. The ED has put into place many mitigating factors, in particular relocating the functioning part of the ED to another specially converted area, but this too has become overwhelmed by patients awaiting an inpatient bed. Almost all the ED rooms have two patients in them, a clear infection, patient care and fire risk, with a complete lack of privacy and dignity for those patients. Two extra rooms have been converted from storerooms, to treat ambulatory patients; they also now accommodate patients in chairs awaiting inpatient beds. The ED majors area has become an admission cohort ward, with medicine rounds, regular meals and ward-level care. Specialist physicians work constantly in the area, but it is staffed by ED nurses. The overall experience for patients is very poor; staff are also affected in a very negative way and suffer from so-called “moral injury”.

Consequently, we are putting a GIRFT UEC red warning in place for Withybush Hospital, which has been agreed with senior members of the Six Goals for Urgent and Emergency Care Team:

The ED at Withybush Hospital is grossly over-crowded and is not providing a safe environment for patients. It is also unsuitable as a place to work for both ED staff and visiting specialists. It is currently functioning as an admission cohort ward. An urgent solution must be found to care safely for patients awaiting a hospital bed and to allow a proper environment for ED work. It is accepted that this solution will be a “patch” and not a long-term answer to the problem.

Ambulance flow into the ED at Withybush Hospital has been maintained recently by a skilful continuous flow model that the ED senior staff have implemented. In fact, experience has demonstrated that good ED performance is possible when patient outflow from the department is even minimally improved. Ambulance handover times of 100% within 15 minutes have been achieved for many consecutive days, despite all the odds against this occurring.

There is good medical in-reach into the ED with MDT support, but the numbers of staff involved are rather few.

Closure of Withybush Hospital is not a viable option. It occupies a vital position in an isolated but important holiday area. Moreover, there is no hospital that could currently absorb its workload; Glangwili Hospital also suffers from extreme over-crowding.

The SEDIT for Wales (SEdit-W) shows the Demand, Capacity, Flow and Patient Outcomes in detail. The main issues from the data are shown below.

Withybush Hospital: DATA QUALITY

Quartile	Data quality
	Completeness and validity of emergency care data = 57.0%
	Accuracy of discharge coding = 99.7%

Withybush Hospital: DEMAND

Quartile	Demand metric
	More than 39% of the hospital's catchment population attend the ED each year.
	Over 45% of patients admitted from the ED are over 75 years of age. The average age of patients admitted from the ED is 67.
	More than 30% of all ED patients come from areas in the highest quintile of deprivation.
	The ED is not designated as a Trauma Unit, despite its isolated situation.

Withybush Hospital: CAPACITY

Quartile	Capacity metric
	The ED is short of senior medical staff. There are not enough to create a viable rota.
	The ED is very short of registered nurses. Many of the nursing staff spend their time caring for a large cohort of patients who are awaiting hospital admission.

The annual number of admissions per whole time equivalent (WTE) Hywel Dda UHB consultant is more than 383. (This is all hospital consultants of all specialties in the UHB.) The average number on the SEDIT is 262.

Withybush Hospital: FLOW

Quartile	Flow metric
	GEMI ranking = 162 out of 191 sites across England, Wales and Northern Ireland (using unvalidated metrics from all Welsh EDs)
	Nearly 59% of ambulance handovers to the ED staff take more than 30 minutes.
	Validated four-hour performance is nearly 53%.
	Unvalidated four-hour performance is around 52%. (Validation gap = <1%)
	The mean time in ED for non-admitted patients is around 5.25 hours from time of arrival.
	The mean time in ED for admitted patients is over 22.6 hours from time of arrival.
	Over 71% of admitted patients are still in the ED more than six hours after time of arrival.
	These patients then spend almost a further 25 hours in the ED on average before admission.
	General and acute bed occupancy is nearly 97%.

Withybush Hospital: OUTCOMES

Quartile	Outcome metric
	Over 16% of all ED patients spend more than 12 hours in the ED from time of arrival.
	Almost 54% of admitted patients are still in the ED after 12 hours from time of arrival.
	These patients then spend nearly 26 hours more in the ED on average before admission.

ED litigation costs are high.

Withybush Hospital: ADDITIONAL INFORMATION

There are both decontamination and isolation facilities in the ED; there is also a mental health room. An out-of-hours GP is available for 40 hours a week. The IT system is Welsh PAS. There is a single dedicated staff toilet.

Withybush Hospital: FINDINGS AND RECOMMENDATIONS

[See also Section \[4\] of the main GIRFT-EM report:](#) Overall recommendations for emergency care in Wales.

- The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.
- The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients.
- There are long stays in the ED for all patients that should be reduced. Some patients are undoubtedly discharged from the ED with a finished episode of care, before there is time for them to be admitted.
- The lack of ED registered nurses must be addressed. This is made worse by the huge amount of ED nursing time that is spent caring for the large cohort of patients who are waiting for an inpatient bed.
- The lack of ED senior medical staff must be addressed. More newly qualified consultants in EM are having to look for jobs outside the big cities, as the city jobs are gradually getting filled. Sometimes, advertising for a group of four or five consultants, each with a specialised role (e.g. teaching, children's care, pre-hospital care) yields better results than single adverts.
- The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to "power" the hospital beds in a timely and efficient way that ensures good patient flow.
- The high catchment attendance level suggests that there are poor alternatives to ED attendance in the local area, probably including primary care. This is undoubtedly worse in out-of-hours periods and at holiday times.
- There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope and specialties involved. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED and the number of admissions.
- Transfer arrangements to other hospitals must also be improved. There is no onsite paediatrics, and we were told that visiting paediatricians, working in outpatient clinics, refuse to support the ED in emergency situations. Moreover, children who require transfer to paediatric inpatient units are not accompanied by an anaesthetist, unless an endotracheal tube is in-situ. This lack of support for the ED is unacceptable and does not reflect a positive view of the importance of safe patient care.
- The causes of the high cost of ED litigation should be examined.
- Data quality must be improved.

5. Supplementary note on SDECs

On Page 8, in Section 4.2, of the main GIRFT Emergency Medicine report for Wales, we wrote:

13. There should be a good range of Same Day Emergency Care (SDEC) and urgent clinic spaces, with a focus on admission avoidance and complex patients. This must include mental health services (e.g. mental health SDEC provision), which should target patients waiting for long periods in ED for either assessment or admission. The capacity of all specialty SDEC and urgent clinics must meet the local demand. Patients should be accepted directly from a wide range of referrers to all SDEC facilities, without the need for prior ED assessment or even to pass through the ED.

This recommendation is important because SDECs provide an alternative route into hospital care for emergency patients and a system of care that avoids traditional hospital admission. As such, SDEC has the potential to decompress the major EDs, to increase acute bed availability and thus to reduce the long waits for admission that blight all the major EDs of Wales.

6. Supplementary note on UTCs

On Page 43, in Section 7.1, of the main GIRFT Emergency Medicine report for Wales, we listed all the minor injury units (MIUs) of Wales and wrote:

- The MIUs of Wales provide an important and essential service to rural communities which lie at some distance from the major EDs.
- There are no urgent treatment centres (UTCs) commissioned in Wales at the present time, and this situation is unlikely to change in the near future. However, a review of urgent primary care services is underway (*Six Goals for Urgent & Emergency Care Programme, personal communication to GIRFT*).
- Further development of UTCs in Wales will be expensive and will also consume valuable UEC staff. Moreover, it is very unlikely to address the major admission flow problems that exist in all the EDs of Wales.
- Of the 10 Welsh EDs visited by the GIRFT UEC team, only Morriston Hospital in Swansea had general practitioners (GPs) working in the ED (in a hybrid role, from 8am until 8pm).
- MIU activity is not included in the SEDIT data (for any country).

The situation has now changed somewhat, with recent Welsh government plans to encourage co-located UTCs in each health board. However, our advice remains consistent:

- The many MIUs of Wales provide an important and essential service to rural communities which lie at some distance from the major EDs. If combined with a minor illness service, then the newly designated urgent care centres (UCCs), could increase their valuable offer to these communities.
- The efficacy of such a service depends on a good balance of staff i.e. GPs, nurse practitioners and perhaps physiotherapy practitioners and others.
- The availability of x-ray may be a limiting factor; around 50% of the minor injuries seen in a major ED require an x-ray.
- A standard offer for UCCs throughout Wales would be desirable, including facilities, opening hours and presenting conditions/age ranges that can be treated.
- Transfer arrangements should also be standardised, as should telemedicine links for x-ray and ECG interpretation etc.
- Development of collocated UTCs at all the major EDs in Wales will be expensive and will also consume valuable staff. Moreover, it is very unlikely to address the major admission flow problems that exist in all the EDs of Wales.

ACTION PLAN / DEVELOPMENT OF MANAGEMENT RESPONSES

Report: Getting it Right First Time for Emergency Medicine- Bronglais visit January 2025

Issued By:

Issued On:

Service Lead: BGH GM

Suggested Overseeing Committee:

Process

On receipt of report, please complete the table below to confirm:

- a) If the recommendation is accepted or not (and justification if not accepted to be noted);
- b) A management response to accepted recommendations detailing how it will be implemented, and who will own this recommendation;
- c) A realistic and achievable completion date; and
- d) What evidence will be uploaded to AMAT to demonstrate the full implementation of the recommendation;

Completed action plans should be reviewed and signed off by relevant Directorate Management Leads.

GIRFT reports

For GIRFT reports, the General Manager and Director of Secondary Care should review and approve, after which an SBAR to be submitted to Operational Planning Governance and Performance (OPGP) meeting for final approval by the Director of Operations.

On approval at OPGP, finalised action plan to be sent to the Head of Assurance and Risk for addition to AMAT, and who will forward to relevant Committee Services Officer for inclusion at the next relevant Committee Meeting.

Progress against recommendations should be directly updated on AMAT by relevant recommendation owners.

Progress made against recommendations raised are reported via the monthly internal escalation framework process.

Recommendation	Management Response	Recommendation Owner	Completion Date	Expected Evidence of Implementation
<p>The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.</p>	<p>Work to improve hospital flow (as also identified in NHS Exec and 6 goals actions) is underway and has been factored into performance trajectories currently awaiting Executive sign off.</p>	<p>Care Group GM</p>		<p>Annual plan and performance trajectories</p>
	<p>Dedicated NOF pathway QI project commenced march 25.</p>	<p>BGH HoN, QI team, Hospital Director</p>	<p>30th Sept 2025</p>	<p>EQUIP project outputs</p>
	<p>Rapid assessment area in place within ED since December 2024, supports circa 30 ambulatory patient attenders per day. Work is needed to evaluate this new model- with a view to introducing SDEC principles to enhance patient experience and performance.</p>	<p>BGH HoN, GM and SDM</p>	<p>31 May 2025</p>	<p>Report demonstrating benefit of trial and breakdown of patient groups and conditions – to be considered in line with SDEC principles</p>
	<p>Revision of nurse staffing position underway to support dedicated triage and ambulance bay nurses to enhance care offered at times of handover delay/ support handover into RATS area- paper for Exec Team currently being prepared (06/03/25)</p>	<p>BGH HoN</p>	<p>31 March 2025</p>	<p>Stable nurse staffing position Improved ambulance handover performance Reduced datix submissions/ improved quality and PROMS/PREMS</p>
<p>The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and</p>	<p>Immediate release requests are almost always supported especially for red release calls- and any non adherence is investigated and lessons learned are shared- clear communication with ODU in</p>	<p>Lead EUCC consultant SSr EUCC Clinical site managers</p>	<p>Complete</p>	<p>Annual plan and performance trajectories</p>

<p>thus also cause harm to patients</p>	<p>place to support decision making and assessment of pressures in area- with a view to minimising risk. Pre-alerts are also prioritised which in turn would release ambulance capacity- and corridor care (surge) is frequently utilised to support urgent ambulance calls.</p> <p>Work to introduce a discharge lounge has now been proposed for 2025/26 with a view to supporting up to 6 patients per day who currently would be delayed on wards – this will have a positive impact on flow.</p> <p>Boarding policy and capacity now in place- affected by surge pressures- offers up to 10 spaces to support boarding/ boarding at risk</p> <p>A review of hospital flow (to include re-allocation of ward spaces) is due in 2025/26 to minimise bed clocking within the trauma / surgical pathway beds- which will improve emergency pathway access.</p>	<p>BGH triumvirate</p> <p>BGH HoN</p> <p>BGH Triumvirate</p>	<p>Pending decision on YBwa</p> <p>Complete</p>	<p>Improvement in flow by up to 6 patients per day as a minimum</p> <p>Improved flow and ED performance</p>
<p>There are long stays in the ED for all patients that should be reduced.</p>	<p>Above workstreams will also positively impact this issue</p>	<p>BGH Triumvirate</p>	<p>30th July 2025</p>	<p>Annual plan and performance trajectories</p>
<p>The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a</p>	<p>Consultant lead currently employed on a locum basis (only 1 wte). This is currently subject to recruitment to substantiate the post.</p>	<p>BGH GM & SDM Consultant recruitment</p>		<p>Substantive Consultant appointment</p>

<p>different model in the long-term.</p>	<p>A medical staffing stabilisation programme has commenced at BGH with the support of the medical workforce team with a view to improving workforce intelligence- to include confirming total locum opportunities and any opportunities to substantiate positions.</p> <p>Interim County Director has instigated a review of ED staffing models in March 2025 with a view to generating a proposal to increase consultant cover.</p>	<p>Medical Workforce BGH Service Manager & SDM</p> <p>County Director/ Care Group GM</p>	<p>31 August 2025</p> <p>31 March 2025</p>	<p>Completed review with agreed staffing level identified and appointments made</p>
<p>The high catchment attendance level suggests that there are poor alternatives to ED attendance in the local area, probably including primary care, and this deficit is almost certainly worse out-of-hours. Student populations are known to attend EDs in large numbers, often in unsocial hours.</p>	<p>There is no significant local health provision with the exception of primary care services and the 111 system along with community nursing teams. In the south of the county, a Same Day Urgent Care (SDUC) facility has been introduced. The ambition is to launch a phased SDUC model from Aberaeron ICC- which will have a positive benefit/ reduction in ED attendances, and this has been considered in planning and trajectory assumptions for the 2025/6 financial year.</p> <p>Ceredigion is currently supported by a streaming hub- in line with the SDUC expansion, development of a HB wide streaming facility will improve patient flow by signposting to more appropriate</p>	<p>Care Group Leadership Team</p>	<p>Phase 1, weekend provision complete</p>	<p>Annual plan and performance trajectories</p>

	resources. Decision making on a HB basis will ensure consistency in approach to advice offered to patients following clinical assessment of need.			
The causes of the high cost of ED litigation should be examined.	All incidents and concerns occurring within the EUCC footprint are subject to robust and well established investigatory and review processes prior to being subject to a scrutiny panel. Datix, Duty of Candour and PTR (PALS) are all sources of information which allow themes and trends to be identified. Where identified, lessons are always shared with the teams and reflections encouraged. Any subsequent notifications (such as to Welsh Government) are also supported.	HoN and ED leads	Complete – already reviewed regularly	DITS escalation review outcomes BGH Quality assurance meetings
Emergency care data quality must be improved.	It has recently been identified that breach validation for ED performance had been suspended – the reasons for this are unclear. BGH triumvirate team are working to resolve this by reviewing current administrative capacity with the aim to reintroduce in Q1 2025, this work will include retrospective validation.	BGH Triumvirate	30 th April 2025	All A&E breaches to be validated within 3 days of attendance. Reduction in reported A&E breaches
There are no housekeepers, dedicated porters or several other non-clinical roles in the ED. With a relative shortage of nursing and other clinical staff, it makes no sense not to have a wide range of supporting non-clinical staff.	2 dedicated domestic assistants currently deployed within dept. Budgetary constraints prevent dedicated porter and housekeeper appointments. Review of nurse staffing position is a priority in terms of any financial considerations at this time	SSr, EUCC, BGH HoN	Within nursing model 31 March 2025	A reduction in infection control issues. Improved patient flow

<p>The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to “power” the hospital beds in a timely and efficient way that ensures good patient flow.</p>	<p>A medical staffing stabilisation programme has commenced at BGH with the support of the medical workforce team with a view to improving workforce intelligence- to include confirming total locum opportunities and any opportunities to substantiate positions.</p>	<p>Medical Workforce BGH Service Manager & SDM</p>	<p>31 August 2025</p>	<p>Improved patient flow Reduction in LoS and No. of patients admitted</p>
<p>There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope, specialties and hours of availability. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED (currently high at ~85%).</p>	<p>Space within the hospital footprint is significantly constrained. However, there is potential to introduce SDEC areas and principles into the following areas:</p> <ul style="list-style-type: none"> • ED Rapid assessment area • Medical Day Unit • Oncology triage and assessment in Meurig Ward (X2) when reopen. 	<p>6 Goals SDEC Lead BGH Triumvirate WAST Leads</p>	<p>31st July 2025</p>	<p>Reduction in A&E attendances Improved Patient Flow</p>
<p>Patients with strokes get a very timely and efficient service at Bronglais Hospital. It seems a great shame that plans are now in place to move these patients south to Withybush Hospital for their rehabilitation. This will undoubtedly cause inconvenience to many elderly relatives.</p>	<p>The clinical services plan for HDUHB stroke services is currently out to public consultation. While options are being finalised, and there are no currently preferred solutions</p>	<p>Clinical Services Plan</p>	<p>Dependent on CSP/Public consultation timelines</p>	<p>Patient safety and quality Patient and stakeholder feedback</p>

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	Recommendation	Management Response	Recommendation Owner	Completion Date - Please enter a specific implementation date for your action. For recommendations that are reliant on factors external to the Health Board, please note as "External"	Expected Evidence of Implementation
Yellow	The ED is small and cramped and desperately needs more space, if it is to accommodate large numbers of patients waiting for a hospital bed. However, better patient outflow from the ED is obviously required. The current situation is clearly causing increased risk and harm to patients and is distressing for staff.	Review of ED space completed. Limited capacity. Exploring alternative space within Medical Day (Podiatry) to support increased medical take away from ED. T&F Group to be planned.	Iona Evans/Louisa Standeven/ Caryl Bowen/ Dr Ghosal	01/05/2025	Email trail
Yellow	<p>The ED is used by the hospital as a general waiting room for all specialties and input to the ED by inpatient specialists is poor.</p> <p>The implementation of Internal professional standards is urgently required.</p>	<p>Speciality Pathway Reviews underway. Surgical SDEC (Phase 1 Complete). Review of T&O, Urology, ENT & Gynea Pathways.</p> <p>Standards have been disseminated by Deputy Medical Director. Formal monitoring arrangements to be agreed.</p> <p>Deputy Medical Director currently aligning speciality specific pathways from ED in line with professional standards.</p>	<p>Iona Evans/ Louisa Standeven/ Paul Smith</p> <p>Eiry Edmunds/Mandy Davies</p>	01/05/2025	<p>SBAR T&F Minutes SOPs Surgical SDEC Data</p> <p>Email trail. Internal Professional Standards. Audit for implementation.</p>
Green	Children are seen in the main ED department with no separation	Complete – Fully functioning area (though refurbishment planned).	Iona Evans/Louisa Standeven	Complete	Photographic evidence

	<p>Ambulances wait outside the ED for long periods.</p>	<p>Boarding protocol implemented with patients boarded against predicted discharges.</p> <p>Safety Huddles, Patient Flow review.</p> <p>Emergency Pressures and Escalation Policy (489)</p> <p>Role of the Senior Nurse Manager, Clinical Site Manager and 'Manager of the Day' strengthened, supporting key escalation of actions, status and risk.</p> <p>Optimal Flow Framework implementation:</p> <ul style="list-style-type: none"> - LOS Reviews & Escalation process review - Board round monitoring & Frontier usage - Criteria Led Discharge - Repatriation Database - POCD monitoring <p>Initiatives to facilitate admission avoidance:</p> <ul style="list-style-type: none"> - Streaming Hub - Virtual Ward - Re-direction Policy (Draft) - Perfect week (Jan 25) completed with some initiatives adopted as business 	<p>Iona Evans/ Louisa Standeven</p>	<p>01/06/2025</p>	<p>Boarding protocol, Recorded on Siterep.</p> <p>Policy (as per Intranet)</p> <p>Action Cards</p> <p>Weekly LOS review data</p> <p>Frontier use weekly reports</p> <p>Weekly performance monitoring reports</p> <p>Perfect Week Evaluation SBAR</p>
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GGH GIRFT Update March 2025

	<p>as usual (GP medical take via SDEC).</p> <ul style="list-style-type: none"> - Optimised Weekend working Pilot planned (22/23 March). <p>Weekly Big Room</p> <p>Advertising for a 6th Acute Physician to enable SDEC, CDU and Medical Liaison in ED rotation to provide sufficient medical cover across the front door. Recruitment process instigated.</p>	<p>Mandy Davies/ Iona Evans/ Louisa Standeven/ Caryl Bowen</p> <p>Caryl Bowen</p>		<p>6 Goals Assurance Meeting minutes</p> <p>ED Big Room Actions</p> <p>Tracs</p> <p>Email Trail</p>
<p>The departmental configuration makes imaging difficult to access in a timely way. However, the suspected cauda equina syndrome (CES) pathway is good</p>	<p>Review completed and ED & SDEC radiology request prioritisation agreed – requires further measurement of data to determine impact.</p> <p>OOH Cauda Equina pathway review being undertaken.</p>	<p>Caryl Bowen</p>	<p>01/05/2025</p>	<p>Big Room actions.</p>
<p>Training opportunities are poor.</p>	<p>ED Big Room. Training Needs Analysis underway ED Practice Educator in place. Weekly Roster efficiency monitoring – monitoring of Study Leave compliance.</p>	<p>Iona Evans/Louisa Standeven</p>	<p>01/05/2025</p>	<p>ED Big Room actions. TNA/ Training Database.</p> <p>Competency plan</p>

GGH GIRFT Update March 2025

	Patients with a stroke requiring thrombectomy have to be transferred to Southmead Hospital in North Bristol, England	This is an agreed HB commissioned pathway with Bristol.	HB commissioned pathway	Complete	Thrombolysis Care Pathway
	SDEC will take GP referrals (and some ambulance referrals) directly but closes at 8pm and only accepts new patients up to 5pm. There is a poor flow of patients to SDEC from the ED.	Change in pathway for medical referrals from GP to GGH SDEC (embedded since perfect week). SOP being updated. Optimised Weekend working Pilot planned (22/23 March) will include SDEC	Iona Evans/Louisa Standeven/ Caryl Bowen/ Dr Ghosal	01/06/2025	SDEC Data SDEC SOP
	The co-located MIU is ENP-led, with patients streamed from the ED reception. The out-of-hours primary care centre will not accept patients from the ED	OOH's primary will accept patients as per re-direction policy – pending sign off.	David Richards/ Sarah Perry	May 2025	Re-direction Policy
	The shortage of senior medical staff and registered nurses must be addressed.	ED Consultant Recruitment – process underway. Safe Staffing Review (RN) has been progressed over last 18 months with key recruitment. Further reviews planned (B2/B3)	Caryl Bowen/ Dr Ghosal Iona Evans/Louisa Standeven/ Janice Cole Williams	Interviews/ Stakeholder Panel week commencing 7 th April 2025 June 2025	Tracs Email Trail Safe Staffing/ Recruitment Data
	Tertiary referral systems should be considered in detail.	Repat database rolled out and operational - Complete. Cardiology, Neuro & Renal pathway in place.	Caryl Bowen HB commissioned pathway. HB commissioned pathway.	Complete Complete Complete	Database Site-rep Performance data

		<p>Southwest Wales Vascular Network Repatriation Policy in place and disseminated.</p> <p>Review of performance metrics within repat database from time pathway end to transfer to referring hospital.</p>	Caryl Bowen/ Gareth Beynon/ Iona Evans/ Louisa Standeven	Monthly Review	
	Data quality must be improved.	<p>Informatics Training within ED staff.</p> <p>Internal Audit – management of bed capacity T&F.</p> <p>ED Breach Validation assurance in progress. Review data quality and validity.</p>	<p>Caryl Bowen/ Gareth Beynon/ Louisa Standeven</p> <p>Stuart Bancroft</p> <p>Caryl Bowen/ Louisa Standeven</p>	<p>May 25</p> <p>May 25</p> <p>May 25</p>	<p>Training data</p> <p>Email Trail T&F Minutes</p> <p>ED Breach SOP WPAS Breach Reason Guide</p>

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Recommendation	Management Response	Recommendation Owner	Completion Date - Please enter a specific implementation date for your action. For recommendations that are reliant on factors external to the Health Board, please note as "External"	Expected Evidence of Implementation
<p>The ED at Withybush Hospital is grossly over-crowded and is not providing a safe environment for patients. It is also unsuitable as a place to work for both ED staff and visiting specialists. It is currently functioning as an admission cohort ward. An urgent solution must be found to care safely for patients awaiting a hospital bed and to allow a proper environment for ED work. It is accepted that this solution will be a "patch" and not a long-term answer to the problem.</p>	<p>We have stopped doubling up in the 6 cubicles.</p> <p>1 resus, 2 triage/see and treat, Rapid assessment, mental health spaces are ringfenced.</p> <p>These steps are REDLINES, if the site/OOH managers believe they require to use any of the above space for patients requiring beds then a site/ED risk assessments is required.</p> <p>We still use around the nurse's station 6 patients at max, but now we do need to use the old paediatric rooms.</p> <p>Nurse allocated to the waiting room for clinical oversight</p>	<p>Hospital GM</p> <p>Completed</p>	<p>Click or tap to enter a date.</p>	<p>Annual plan trajectories: 1 hour baseline: 246 goal: 188 4 hour baseline: 31 – 123 Goal: 3.05 - 83.20</p> <p>SEDIT current performance: 49.8% Expected improvement: 58%</p>
<p>The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.</p>	<p>Need clear pathways for patients. FAU/SDEC/SAU/ASU/NOF pathways and functions need to be maintained. Need to de- surge key assessments areas to keep flow active. Pathways discussed during Site safety briefings with actions to support maintenance of accessibility to pathways.</p>	<p>Hospital GM</p> <p>Commencing April</p>	<p>31/10/2025</p>	<p>SEDIT current performance: 24.8 hours Expected improvement: Q1 +Q2 20% and Q3 + Q4 10% improvement</p>

	<p>Review needed of the NOF pathway and pathway for T&O patients to present as an alternative to ED.</p> <p>Speciality Medical teams in reach into ED to start treatment plans from admission. Need to reduce access points to in-patients wards to reduce competing priorities for inpatient beds. Boarding protocol in place. Need to consider continues flow.</p>			
<p>The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients.</p>	<p>Improving the flow out of ED will improve on ambulance handover delays.</p> <p>Further work required (in Annual plan) to determine the demand and capacity of ED. Working within the 6 Goals framework.</p> <p>WAST staff already attending 8:30 safety meeting.</p>	<p>Hospital GM</p> <p>Commencing April to November</p>	<p>31/10/2025</p>	<p>Annual plan trajectories: Ambulance Handovers taking over 1 hour Baseline: 246 Goal: 188 (38 to 69% improvement)</p>
<p>There are long stays in the ED for all patients that should be reduced. Some patients are undoubtedly discharged from the ED with a finished episode of care, before there is time for them to be admitted.</p>	<p>WGH do have clear pathways for patients. Medical teams in reach to start the treatment plan from admission.</p> <p>Need to reduce access points to in-patients wards. Need to de- surge assessments units to keep flow active.</p> <p>Boarding protocol in place.</p> <p>Need to consider continues flow.</p>	<p>Hospital GM</p> <p>Commencing April 2025</p>	<p>31/10/2025</p>	<p>SEDIT current performance: 24.8 hours Expected improvement: Q1 +Q2 20% and Q3 + Q4 10% improvement</p>
<p>The lack of ED registered nurses must be addressed. This is made worse by the huge amount of ED</p>	<p>The Registered Nurse allocation within the department has significantly increased over the previous 18 months with</p>	<p>Head of Nursing WGH</p>	<p>Click or tap to enter a date.</p>	<p>SEDIT Current: 26.0 (WTE)</p>

nursing time that is spent caring for the large cohort of patients who are waiting for an inpatient bed.	<p>additional uplift for additional senior nursing workforce the current workforce is:</p> <p>1 Managerial Band 7 (Supernumerary to roster).</p> <p>5.42 Band 7 Senior Sister</p> <p>5.5 Emergency Nurse Practitioners</p> <p>11.45 Band 6</p> <p>31.65 Band 5</p> <p>2 ACPs</p> <p>There are also 2 further Registered Nurse who will be on boarding as part of nurse recruitment later this year.</p> <p>Work ongoing to support enhancing skilled workforce</p>	Completed		Expected Improvement: 55.02 (WTE) excluding ACP
The lack of ED senior medical staff must be addressed	Review of medical workforce required Need Healthboard collaboration	Hospital GM and Clinical Director	Click or tap to enter a date. No date can be estimated as requires and reliant on wider Health Board workforce planning	SEDIT Current: 5.0 (WTE) Expected improvement: TBC
The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to “power” the hospital beds in a timely and efficient way that ensures good patient flow.	Review of medical workforce required Need Healthboard collaboration	Hospital GM and Clinical Director	Click or tap to enter a date. No date can be estimated as requires and reliant on wider Health Board workforce planning	
The high catchment attendance level suggests that there are poor	The Clinical Streaming Hub will incorporate both in hours and out of hours staff to	System GM	31/10/2025	Current number on H@H ward: 60

<p>alternatives to ED attendance in the local area, probably including primary care. This is undoubtedly worse in out-of-hours periods and at holiday times.</p>	<p>ensure that there is a consistent approach for patients and Health Care Professionals. It is acknowledged that a full 24/7 model may not be available across the Clinical, functional and social element of the model, but this is what is being aspired to be achieved in order to deliver a gold standard Clinical Streaming Hub.</p> <p>The aim of the CSH would be to facilitate the patient's journey to receive the right treatment first time, to give community professionals a single point of contact to aid with signposting, rather than to place barriers and make it more difficult to access urgent care.</p> <p>The Clinical Stream hub pathways current include advice, stream to SDEC, crisis response, Hospital at Home.</p> <p>In addition to in hours Primary Care provision, there are 29 Pharmacies across Pembrokeshire that offer the Common Ailments Service.</p> <p>NHS111Wales provide interactive site to enable public to access relevant service to their geographical location.</p> <p>Alternate services ie Same Day Emergency Care, Walk-in-Centre provision are advertised regularly on Hywel Dda</p>	<p>Commencing April 25</p>		<p>Expected Improvement: 79 (5 days) or 111 (7 days)</p>
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	<p>Facebook sites, providing detail of services provided, hours of service.</p> <p>Action – Review Communication Plan with HB team, monitor access numbers to FB site, NHS111Wales site access, Porth Preseli Clinical Streaming Hub, Out of Hours access.</p>			
<p>There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope and specialties involved. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED and the number of admissions.</p>	<p>SDEC is open form 8-8 Fully staffed Approx 60% of the medical take does attend SDEC. Planning for complex streaming at front door. Frailty SDEC – need to de surge unit. Unit to take direct from ED and will start to take referral direct form WAST, therefore, to avoid ED.</p> <p>HOT clinics in medical specialties already in place (manged by the medical Consultants)</p>	<p>Hospital GM</p> <p>Commencing April 2025 to October 2025</p>	<p>31/10/2025</p>	<p>Baseline: 60% medical take through SDEC Expected improvement: 100% medical take through complex front door streaming</p>
<p>Transfer arrangements to other hospitals must also be improved. There is no onsite paediatrics, and we were told that visiting paediatricians, working in outpatient clinics, refuse to support the ED in emergency situations. Moreover, children who require transfer to paediatric inpatient units are not accompanied by an anaesthetist, unless an</p>	<p>Clear pathway already in place for paediatrics.</p> <p>A designated ambulance is on standby outside ED for transfers.</p>	<p>System GM</p>	<p>31/10/2025</p>	<p>Expected improvement: No incident reported for delayed transfer for paed</p>

<p>endotracheal tube is in-situ. This lack of support for the ED is unacceptable and does not reflect a positive view of the importance of safe patient care.</p>				
<p>The causes of the high cost of ED litigation should be examined.</p>	<p>We undertake a full investigation on all incidences and concerns raised. Which could lead into litigation. The ED team have their own Governance meeting to discuss such matters and then they will feed up to the Hospital Governance group. WGH has also set up a mortality review group. ED will conclude any incident with a Learning from Events communication to the team.</p>	<p>System GM</p>	<p>31/10/2025</p>	<p>Further discussions required for redress for baseline</p>
<p>Data quality must be improved.</p>	<p>Regarding validation of breaches WGH does have admin staff working with the SNM to undertake this request. SNM to ensure clinical team engagement and discussion relating to thematic surrounding breaches and assurance of correct data validation.</p>	<p>Clinical Director Commencing April 2025</p>	<p>31/10/2025</p>	<p>Sedit Current: 56.9% Expected improvement: 20% improvement per Quarter</p>