GIG CYMRU NHS WALES
Perfformiad a Gwella
Performance and Improvement

Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng

Six Goals for Urgent and Emergency Care

NHS Wales Winter Sprint
First System Reset Initiative
Dec 2025

Interim Report and Action Plan incorporating LHB feedback

Date of Report: Jan 2025

1. Executive Summary

The NHS Wales System Reset Initiative is a focused, two-week program (8–22 December 2025) designed to improve patient flow, discharge processes, and outcomes across all hospital sites in the lead-up to Christmas. Supported by the NHS Wales Performance and Improvement Team, the initiative aimed to embed seven-day working practices and deliver measurable improvements in urgent and emergency care over this period.

Updated metrics were included for the 11am National Conference Call and were specifically designed to include indicators which challenged the system to support timely patient flow and discharge over 7 days.

The Winter Sprint highlighted the impact of strong system leadership, integrated multi-agency working and digital innovation in improving urgent and emergency care flow. Focused action on PoCD delivered measurable gains in visibility, escalation, and joint decision-making, supporting wider objectives such as improved discharge rates, reduced emergency department congestion, and better ambulance handover performance.

2. Objectives

By 22nd December 2025, each hospital site was asked too:

- Increase daily discharges, ensuring at least 33% occur before midday.
- Boost weekend discharge rates by 30%.
- Embed Home First principles, starting discharge planning at admission.
- Strengthen front-door processes, including senior clinical decision-making in Emergency Departments, Same Day Emergency Care (SDEC), and Acute Frailty Services.
- Consider establishing dedicated in-hospital rehabilitation units to maintain patient mobility and independence.
- Enhance collaboration to optimise community capacity in domiciliary care, reablement, and step-down provision with the support from Local Authority partners.

3. Rationale

This initiative aimed to:

- Improve flow through Emergency Departments and acute units.
- Reduce deconditioning, especially in frail patients.
- Minimise delays in care pathways.
- Enhance ambulance handover times, focusing on reducing delays over 45

minutes.
- Improve patient outcomes and reduce harm related to delays.

Health Boards were required to submit requested data daily by 10:30 each morning to support the wider national call at 11am. Data submission was variable in the first few days however improved during the two-week period and we have continued to collect the data since this period.

WHAT WORKED WELL from an LHB perspective

- ✓ **Focused operational grip:** Time-limited sprint approach with daily huddles, clear priorities, and senior presence accelerated issue resolution. Improved visibility of risk, ownership, and escalation across pathways.
- ✓ **Early senior clinical decision-making:** Earlier consultant and senior decision-maker input improved discharge readiness and reduced unnecessary bed days. Strengthened challenge and effectiveness of board rounds.
- ✓ **Shared system data:** Use of the *Right Patient Right Place* dashboard created a single version of the truth. Improved trust-level and local authority alignment and strengthened delay coding accuracy.
- ✓ **Preparation and groundwork:** Early focus on complex discharges and long length of stay cases delivered benefits beyond the immediate sprint period.

A summary report from Local Health Boards detailing their specific feedback is included in **Appendix 1** and we have included direct commentary from organisations throughout this report.
A list of the daily measures introduced during the reset fortnight can be found within **Appendix 2** with the opportunity to further refine the measures going forward in Quarter 4.

Appendix 3 provides some indicative measures of improvement, noting that further analysis will be concluded in the coming weeks and will support Sprint 2 which will commence on the 21.1.26

4. High-Level All Wales Observations & Best Practices

4.1 System Flow, Discharge Planning & Weekend Resilience

Many sites were actively identifying opportunities and critical actions to improve flow and discharge planning. There was growing recognition of the value in embedding Optimal Hospital Flow Framework (OHFF), SAFER, Red to Green (R2G) and Discharge to Recovery and Assess (D2RA) principles from the point of admission, which is increasingly seen as a best practice.

For example, several Health Boards (HBs) have piloted extended pharmacy cover and the preparation of TTOs in advance, which has helped mitigate weekend discharge challenges. Some teams have also implemented Friday "weekend readiness" packs—ensuring transport is booked and equipment orders are verified ahead of time. These initiatives are supporting smoother patient journeys and more consistent weekend discharges.

All LHBs improved the reporting daily of discharge numbers by 12 noon and predicted numbers for the working day with a increased sophistication on the predicted number of discharges to reduce escalation status.

Areas for Improvement:

Flow remains fragile on some sites, with discharge planning often occurring late in the day and /or the overall patients clinical pathway. There remained an ongoing challenge in sharp drops in weekend discharges and obvious increased pressure on Mondays. Transport booking delays and pharmacy/TTO constraints continue to extend length of stay (LOS), indicating a need for further education and continued focus to improve these internal operational and clinical processes.

The use of the **Reluctant Discharge Policy** was not standardised across all organisations.

4.2 Leadership, Accountability & Communication

Local teams were calling for even greater visibility of leadership on wards and clearer governance frameworks, reflecting a strong desire for empowered ward managers and robust support structures. Where board rounds are structured and multidisciplinary teams in place, there are notable improvements in patient flow on a consistent basis. For instance, registrar-led board rounds with pre-checked results and strong multi-Disciplinary Teams (MDT) input have driven improved discharge rates, improved clarity on timely patient treatment /discharge. Additionally, some teams have adopted live Teams channels for action tracking, moving away from slower email-based communication and are piloting single sources of truth for action logging which was really encouraging to see and observe the benefits.

Areas of challenge:

There remained too many examples of risk-adverse cultures on wards and sometimes a disconnect between roles /functions /leaders. A reliance on a small number of "flow experts" or operational leaders on the ground creates vulnerability when those individuals are absent (or off-sick). Action logging and ownership remain inconsistent, with meetings generating "chase" actions that lack named owners or tracking. Digital documentation gaps and uncertain EDDs hinder timely discharge.

Delays are often operational, not clinical. Common causes included discharge medications prepared too late, transport and equipment booking delays, and unclear expectations for patients and families.

Many organisations also had executive director presence on site plus a number attended individual ward rounds to assess first hand both the internal and external bottlenecks. Many took direct actions to escalate directly to improve flow and was appreciated by staff.

4.3 Infection, Staffing & Capacity Pressures

Health Boards demonstrated increased resilience in the face of seasonal pressures, with ongoing efforts to strengthen infection prevention and control (IPC) resources and winter preparedness. Innovative use of bank and agency staff helped to address therapy capacity needs and there was a focus on optimising functional assessments to support timely discharges. For example, some sites prioritised OT/physio capacity and developed models for rapid functional assessment, while others have established pre-winter plans for surge staffing and cohorting capacity. As noted below, there was also clear demonstration of improved joint working with Local Authority partners and a focus on quicker turn-around of ED patients and those within assessment units *but note that further analysis is still required on some metrics*.

Areas of challenge:

IPC surges (flu/COVID, Norovirus) and cohorting obviously constraints flow by reducing bed flexibility and extended waits, especially in Emergency Departments. Staff sickness and therapy shortages, particularly in OT/physio, remained prominent bottlenecks during the reset fortnight with one organisation in particular having significant and ongoing challenges with HCPW shortfalls and in some instances ED consultant numbers.

Persistent outliers across specialist areas and high critical care occupancy complicate patient moves and flow prioritisation.

4.4 Community Interfaces & Local Authority Engagement

Across most organisations, there was a strong commitment to improving parallel processing of referrals and enhancing collaboration with Local Authorities (LAs). Some Regions have developing electronic dashboards (Betsi Cadwaladr) to improve day-to-day visibility and accountability and there was a growing emphasis on early patient choice conversations. For example, certain areas have built dashboards (such as WCCIS links) to track social work allocation and continuity, and some community hospitals have refined their pharmacy models to support quicker discharges by ensuring TTOs accompany transfers from acute care

Areas of Challenge:

Sequential referral processes and allocation delays, especially during annual leave, stall progress. CRT capacity and carer hours volatility create discharge delays and some patients refuse CRT once discharged, highlighting the importance of early patient choice conversations.

Community hospital pharmacy cadence can impede quick turn discharges unless TTOs are prepared in advance.

Capacity remains a critical constraint. Ongoing shortfalls in domiciliary care, reablement, residential/nursing placements, and specialist bed, combined with increased front-door demand, continue to restrict flow.

Granular understanding of delay reasons matters. Better analysis of time spent within each delay category is required to target interventions effectively and avoid misattributing root causes.

4.5 Clinical Pathways, Diagnostics & Escalation

Teams are identifying opportunities to optimise pathways for chest pain, DVT and ambulatory care, with a focus on increasing the use of SDEC /UPCC and direct referrals. For instance, some sites have created quick-reference criteria for chest pain and DVT, briefed ED and WAST teams, and measured diversion uptake with daily feedback loops. These actions are helping to ensure patients are routed efficiently and appropriately.

Areas of Challenge:

CT head access for elderly patients and radiology escalation routes remains a recurrent issue. Over-ordering of "urgent" tests that could be outpatient suggests an education need for appropriate criteria.

There were very few examples where WAST paramedics had the opportunity to directly refer into SDEC directly. Data collection was poor in this area however anecdotal evidence would suggest that this remains inconsistent and does not operate 7 days.

Weekend and end-of-life planning require strengthening. Earlier identification, better planning, and consistent criteria-led discharge are needed to reduce avoidable weekend delays.

Sprint intensity is effective but not sustainable. Improvements depend on embedding sprint behaviours into business-as-usual, rather than relying on prolonged senior escalation.

4.6 Data, Dashboard & Insights

The use of Estimated Date of Discharge EDD reports (or Criteria Led discharge) to target weekend discharges is beginning to show promising results in some areas, and efforts to close reporting lags are supporting more proactive planning. Several LHBs are developing dashboards that integrate with social care systems, providing a single source of truth and supporting more effective weekend action planning. For example, dashboards split by site/LHB and linked to social care systems are helping teams monitor and act on discharge priorities in real time (again, Betsi actively delivering in this area).

Areas of Challenge:

Reporting lags and fragmented ownership of POCD lists contribute to Monday firefighting, and the absence of weekend action on these lists remains a challenge in a number of areas.

Digital maturity is foundational. Reliance on paper-based board rounds, limited real-time access, and inconsistent data refresh rates constrained progress.

4.7 Wider Observed Good Practice (not covered by the above)

Structured, clinically led board rounds and the use of **transfer/assessment lounges** are driving early discharges earlier in the day and improved clarity for staff and patients. For example, registrar-led rounds with pre-checked results and strong MDT inputs have been particularly effective.

The targeted use of transfer/assessment lounges to decant patients from acute wards and step-down pathways is yielding early discharges but not yet in the volumes that this investment should be delivering. Preparing TTOs and Dr letters ahead of weekends and extending pharmacy hours are reducing delays, while early post-discharge follow-up calls to care homes are being positively received and may help prevent readmission.

Non-emergency patient transport (NEPTS) being booked earlier in the day really helped WAST smooth the bottleneck of requests that often comes through later in the day and the use of the daily tracker certainly helped during reset fortnight. Increased capacity and or extended hours also helped in the lead up to Christmas however the wider use of NEPTS and the critieria for booking patients into Outpatients is something that needs to be urgently considered (and how this capacity might be used to future).

Although the 33% of discharges by mid-day target was rarely hit, there was a step increase in confirmed and potential discharges across multiple sites during reset fortnight which impacted on Handover 45 improvements and better flow across a number of Emergency Department. Refer to **Appendix 3** for the step increase in discharge numbers and impact on Handover 45. We would however note that in some areas there was equally a step increase in patient care being provided in undesignated areas e.g. boarding and in corridors

Use of the daily metrics and consistency of reporting remains vital in supporting the above processes and with the introduction of an Microsoft Forms tool from the 19th January hopefully there will be a marked improvement in daily returns/ full completion of the dataset.

5. Opportunities & Next Steps

- **Make discharge planning "from admission" non-negotiable**. Embed OHFF principles ward to ward, with visible daily checks (EDD set and reviewed, R2G status, D2RA pathway assigned). Tie this to an action log with named owners and a live tracker visible to wards and LA partners.
- **Earlier review of patients**. Full review of a patient's requirements at day 7 with the aim of preventing patient experiencing a pathway of care delay.
- **Improve weekend flow /discharge** with standardised Friday "weekend readiness"

packs (draft TTOs, transport booked, equipment orders verified), confirm therapy cover / alternatives, and publish pharmacy & transport cut offs. Monitor weekend pre noon discharge rate as a Sprint KPI.

- **Route optimisation to SDEC /Urgent Primary Care**. Create quick reference criteria for chest pain/DVT/ambulatory care, brief ED/WAST, and measure diversion uptake with daily feedback loops and re-assess direct admit pathways into SDECs.
- **Parallelise referrals with clear triggers**. Introduce a "no regrets" escalation for CRT/Home First equipment/housing when criteria are predictably met, rather than waiting sequentially. Build a common referral crib sheet and escalation framework with LA sign off.
- **External communication**. Clear and consistent national communication for purpose of acute hospitals to provide care when this is needed and for discharge home or to other appropriate services as soon as possible. The risks of harm and to safety through deconditioning are poorly communicated and there is a lack of awareness in the general public of these risks and personal responsibility to mitigate.
- **Strengthen IPC & staffing resilience**. Prewinter plans for IPC surge staffing (to include estates staff), cohorting capacity, and therapy resilience (e.g., bank/agency pools, OT functional assessment prioritisation model).
- **Tighten diagnostics governance**. Define which tests are truly "discharge dependent," set outpatient alternatives, and communicate radiology escalation contacts, surface delays in a daily diagnostics dashboard.
- **Leadership presence and rapid comms**. Ongoing support to daily /weekly executive walk rounds (linked to on-call arrangements) with a standard observation template; move actioning from email to live Teams channels with named task owners and due times.
- **Consistent and timely use of daily information** to improve discharge (mid-day) and overall step improvement in discharges in line with what was achieved during the reset fortnight.
- **Continued focus on Clinically Optimised Patients** and joint working with Local Authority partners to address bottlenecks in the system to improve flow.
- **Trusted Assessor** model remains a challenge to deliver in many organisations but is one that has been demonstrated to have significant impact /improved outcomes

SUMMARY

The Sprint demonstrated that targeted system leadership can strengthen collaboration and resilience, but also exposed limitations caused by short planning timescales, data availability, and partial alignment with existing regional improvement programmes. While Local Authority engagement was positive, further clarity is needed on system-wide actions, use of submitted data and feedback mechanisms for future sprints.

Sprint intensity is effective but not sustainable. Improvements depend on embedding sprint behaviours into business-as-usual, rather than relying on prolonged escalation.

Every inpatient day should add value, initiate discharge planning early and escalate barriers quickly!

6. Appendix

Appendix 1: Collective Key Learning and Recommendations (LHB)

Sprint Overview.docx

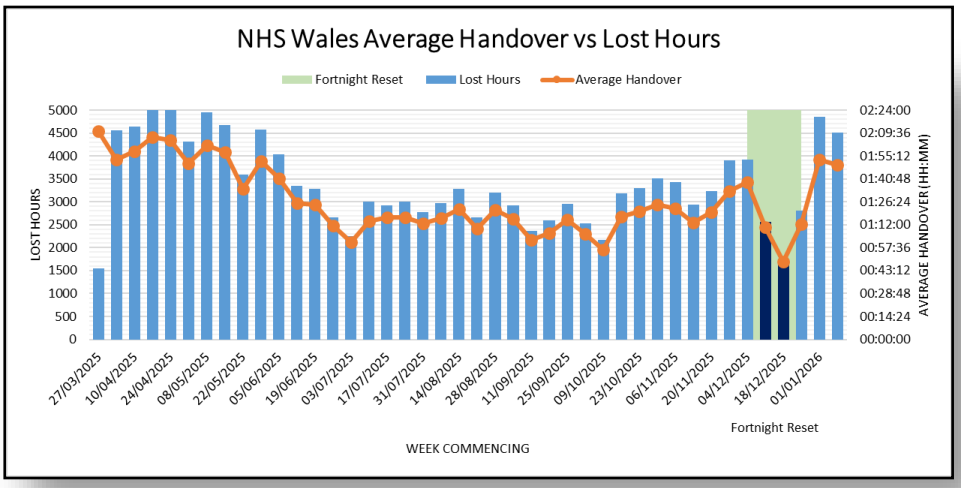
Appendix 2: Daily Measures used during Sprint Fortnight

- Revised Measures for daily submission
- Total number of patients who spent >12 hours in ED on previous day
- Total number of patients who spent >24 hours in ED on previous day
- Number of ED ambulance arrivals with ambulance patient handover completed >45 mins on previous day
- Total number of discharges from Acute Site inpatient ward on previous day (adult only, excluding internal transfers)
- Number of discharges above completed before 12:00 on previous day (includes discharge lounge transfers before 12:00)
- Total SDEC attendances on previous day
- Total number of patients clinically optimised for discharge but awaiting onward care on previous day
- LHB escalation area as per UEC System Escalation Framework (Levels 1-5)
- Composite score of operational risk factors (Risk 0-25)
- Total number of patients in ED non-designated clinical areas (corridors, waiting rooms)
- Patients in ED and acute units clinically ready for inpatient admission but awaiting bed (adult only)
- Current longest wait in ED awaiting inpatient admission(hrs)
- Current longest time a patient in ED is waiting for first clinical assessment (including rapid assessment (hrs)
- Number of ambulances currently waiting outside ED for handover
- Current longest wait for ambulance handover (mins)
- Total number of surge beds open
- Total number of patients in non-designated clinical areas in inpatient areas (all boarded patients)
- Patients with confirmed discharge plans for the day
- Patients potentially being discharged today but not confirmed

- Number of critical care beds available
- Predicted bed position at midnight
- Beds unavailable and empty (lost to the system) due to infection control measures
- Beds with confirmed COVID-19 or influenza patients
- Beds with confirmed norovirus or similar infections

Appendix 3: Measures taken from daily submissions during sprint fortnight and beyond

Ambulance Handover



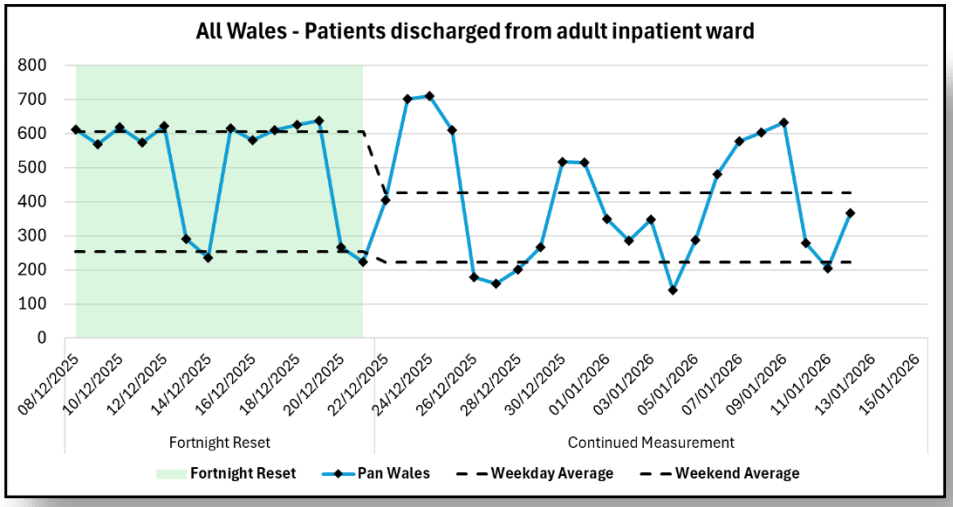
Noting the above run chart for the last 12 months there would appear to be a significant step change /improvement in Handover 45 and ambulance lost hours during the reset fortnight.

Particular praise should be given to Betsi Cadwaladr who performance across all three sites during the reset period was significant and they routinely were reporting Level 2 escalation status throughout the period.

Further analysis is required on overall activity during this period however over the last 5+ years we have not have a sustained period of delivery in the early part of

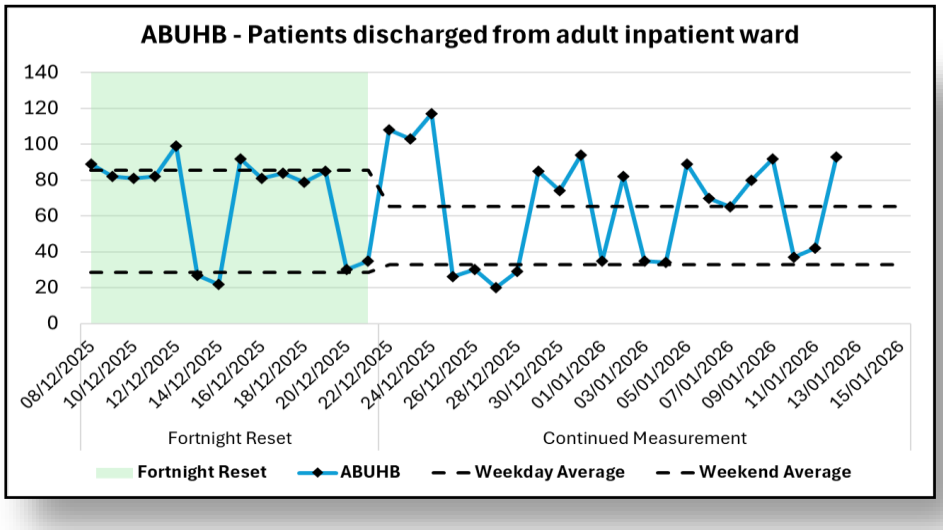
December which was then sustained into Christmas week and in the days leading up to NYE.

Inpatient ward discharges – All Wales and Health Board level

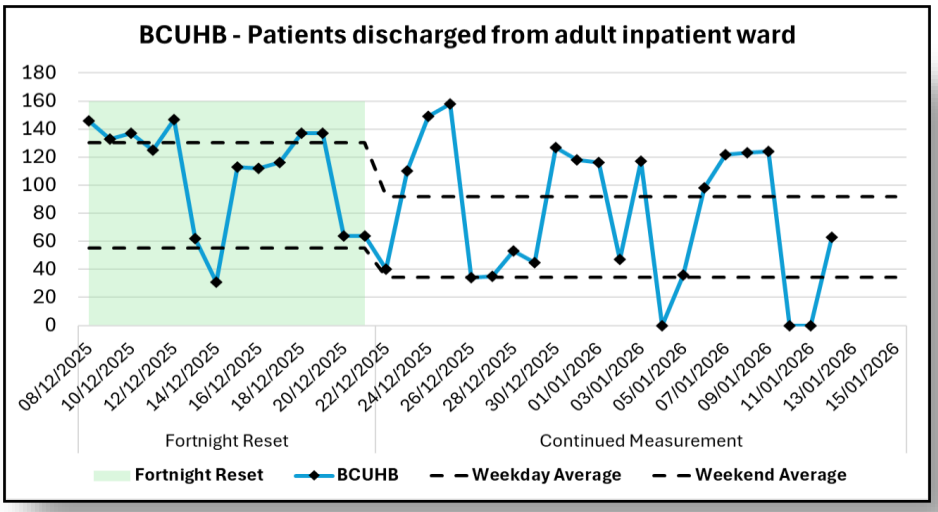


There was a change in recording during reset fortnight so that we excluded activity from day-surgery, maternity etc.

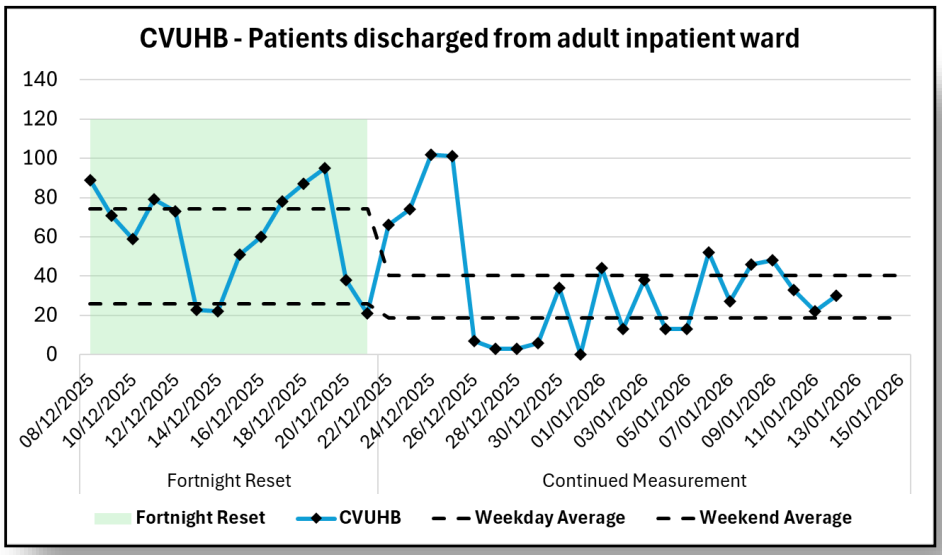
We can therefore only illustrate the step reduction post reset fortnight both at an All Wales and LHB level.



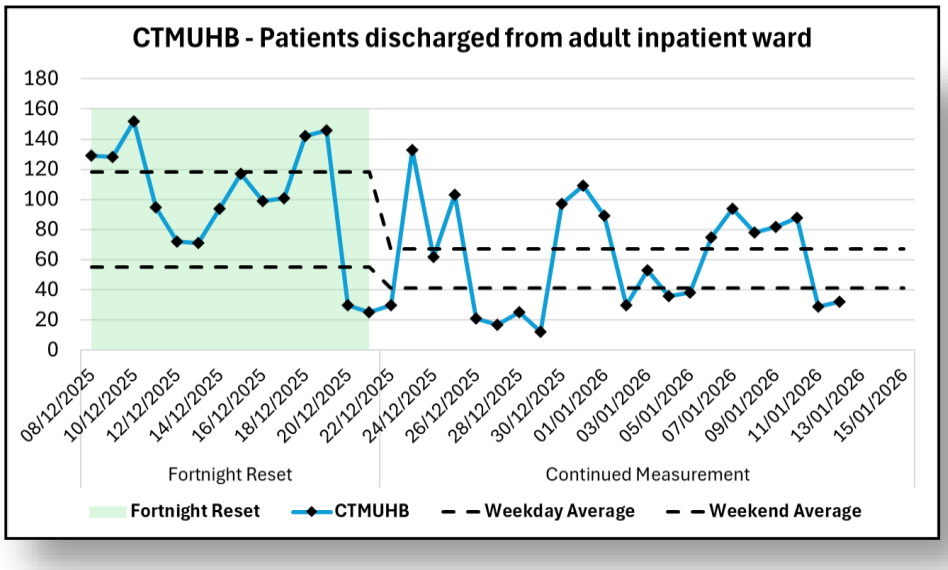
Step reduction in weekday discharges however since the initial fortnight, there would appear to be a marginal improvement in w/e discharges but this needs to be assessed over a longer timescale.



Despite this profile, Betsi made the biggest improvement overall in discharge volumes during reset fortnight so if this can be replicated consistency then this would have significant impact on several metrics and patient care. Note some days there would appear to be nil return so this needs to be

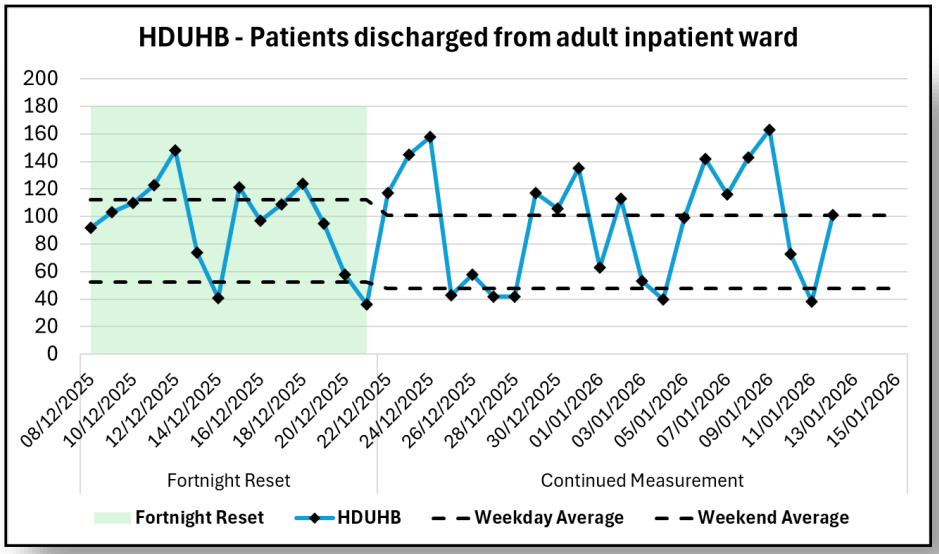


Step reduction on overall discharges however data validation required as C&V consistently delivers against H45 and overall, smaller range between weekday and weekend discharge volumes (if correct).

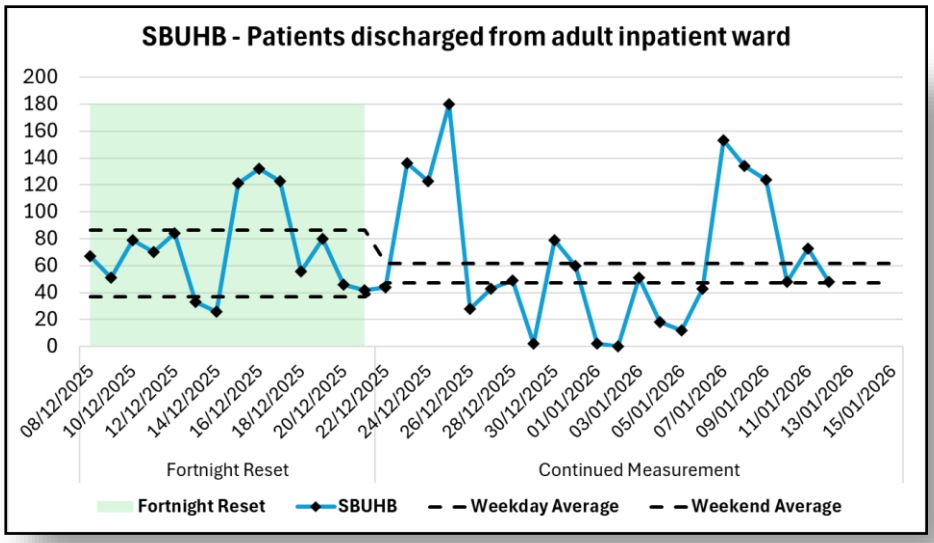


Step reduction in weekday discharges however CTM continues to consistently deliver against H45.

Organisation plans on 50,50,40 discharges per day for PCH, RGH and POW respectively



Similar to CTM, Hywel Dda have prescribed daily discharge volumes for each site and there has only been a slight reduction in discharges post reset fortnight (despite IPC and staff sickness issues).



For many months, Swansea (Morriston) has routinely been delivery massive improvements in H45 and ED pressures however since the New Year, significant pressures are causing challenges to the discharge profile and wider COP volumes.

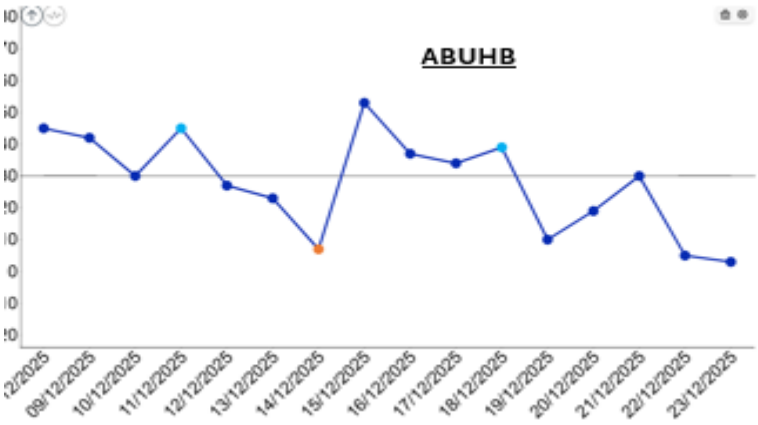
Again, we need to be careful with the interpretation of data as there were some days in late

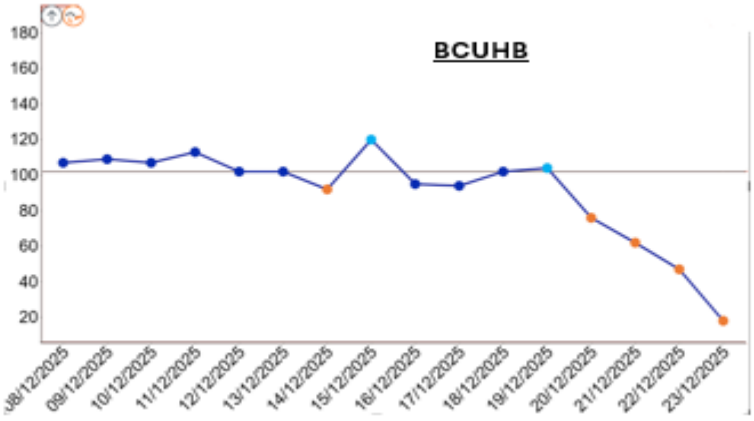
Appendix 3: Data from reset fortnight only (additional data will be available prior to the commencement of the next reset)

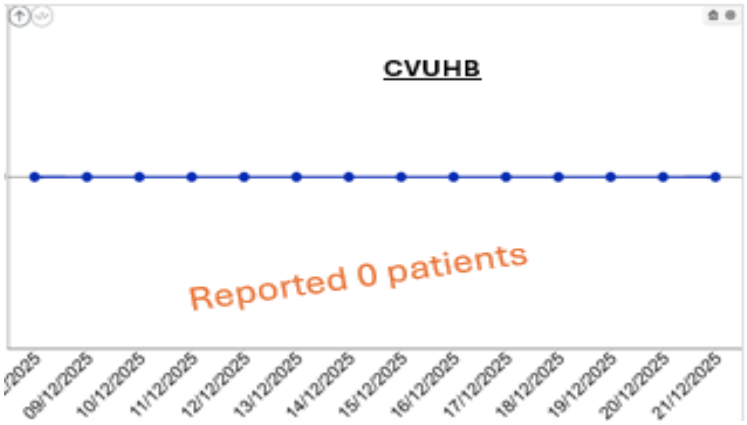
Patients in ED not in an allocated space

There are a significant number of patients being cared for in unallocated or non-configured clinical ED spaces. Which can impact both patient safety and the efficiency of care delivery.

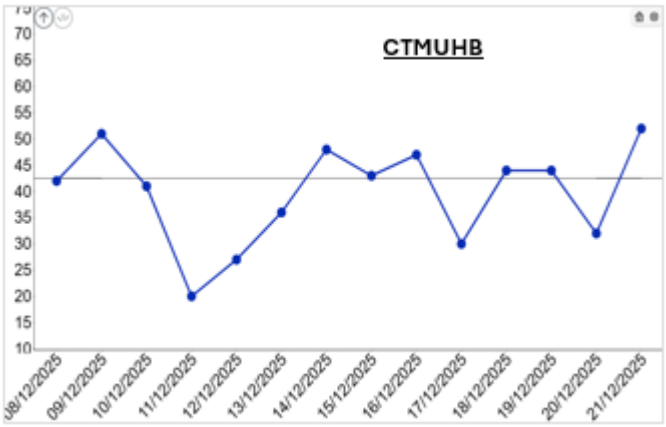
There was an improving picture during the 2-week reset



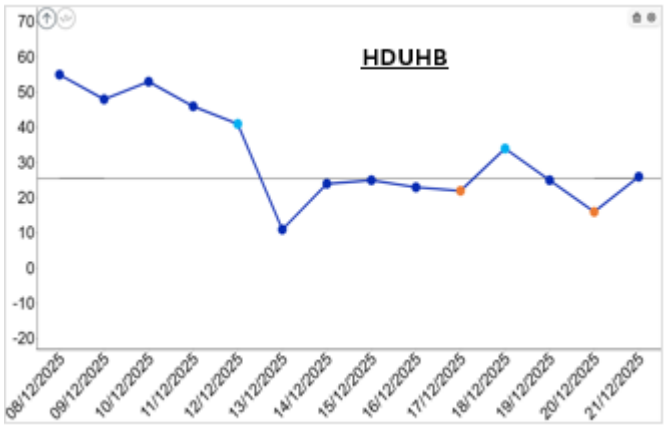




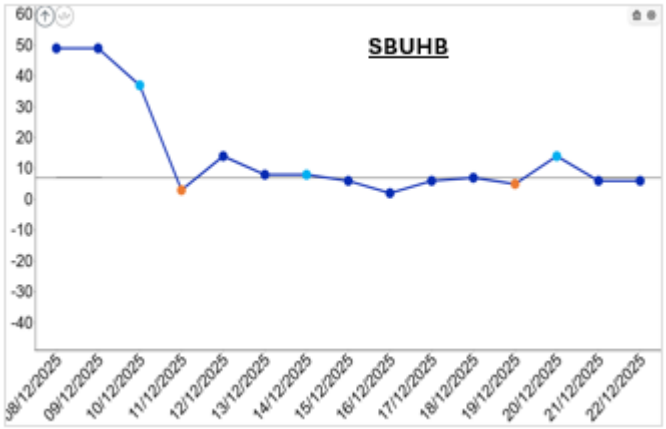
No data returns for this specific metric so further validation required



Variable capacity option across site but these would be additional chair waits /capacity within ED as limited 'corridor' capacity



Step improvement over the two-week period with less patients in trolleys around EU workstation and /or in other undesignated capacity

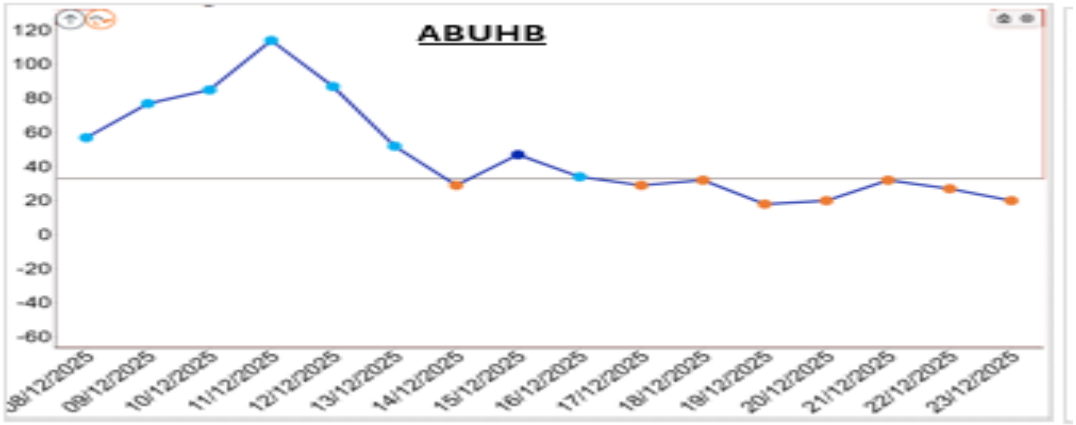


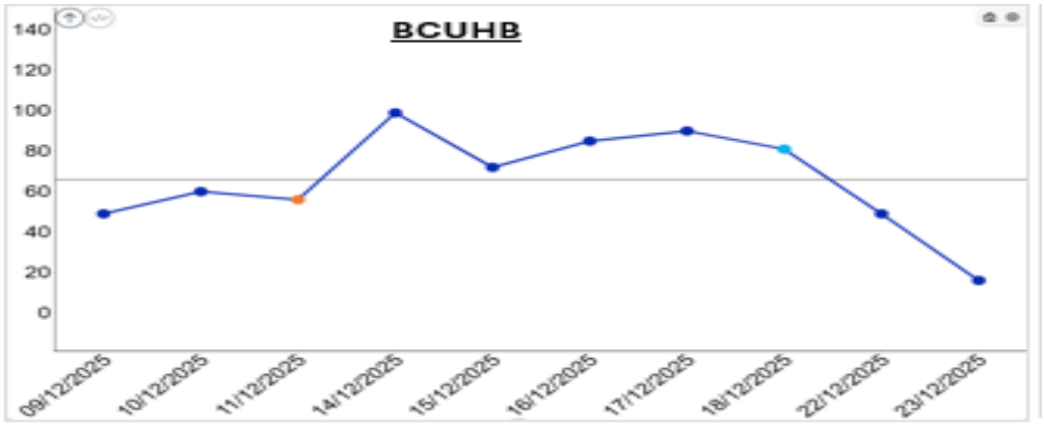
Step improvement over the 2 week period.

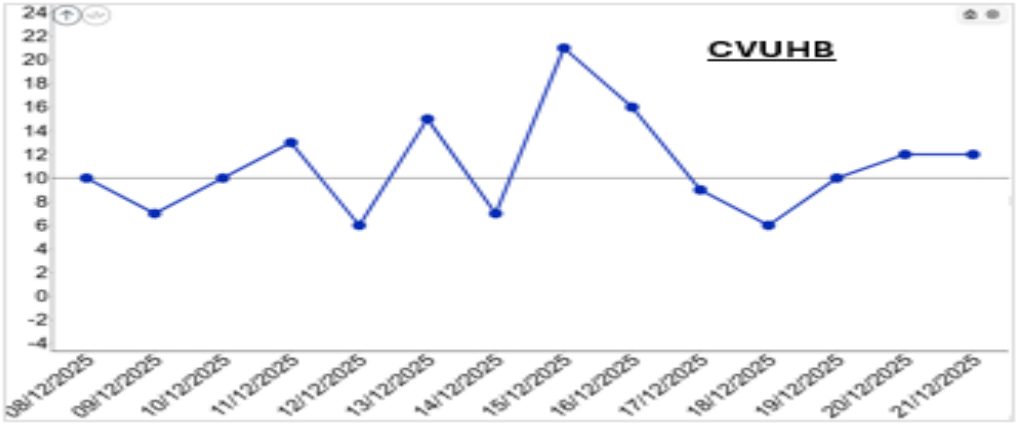
Patients at the front door waiting for an inpatient bed

This highlights the number of patients every morning at 10am across Wales who have had a decision to admit and are waiting for an inpatient bed.

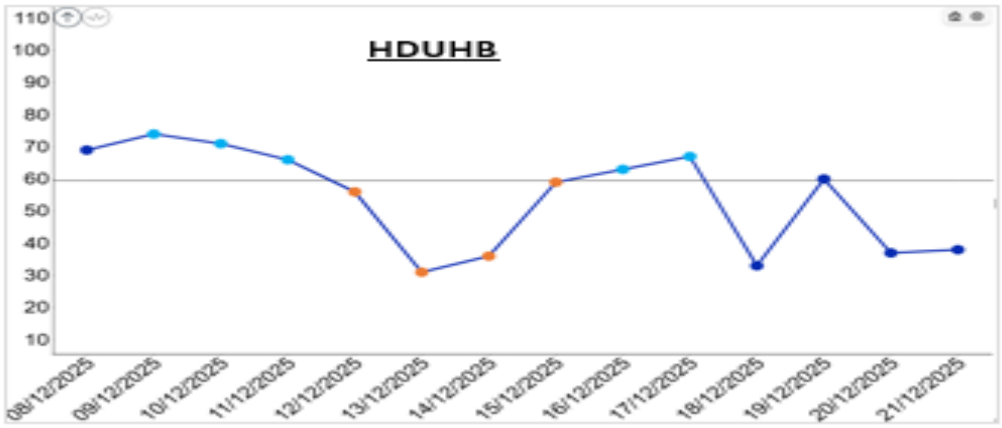
There was a mixed picture across Wales with 4 HBs showing a decrease in numbers with 2 HBs static

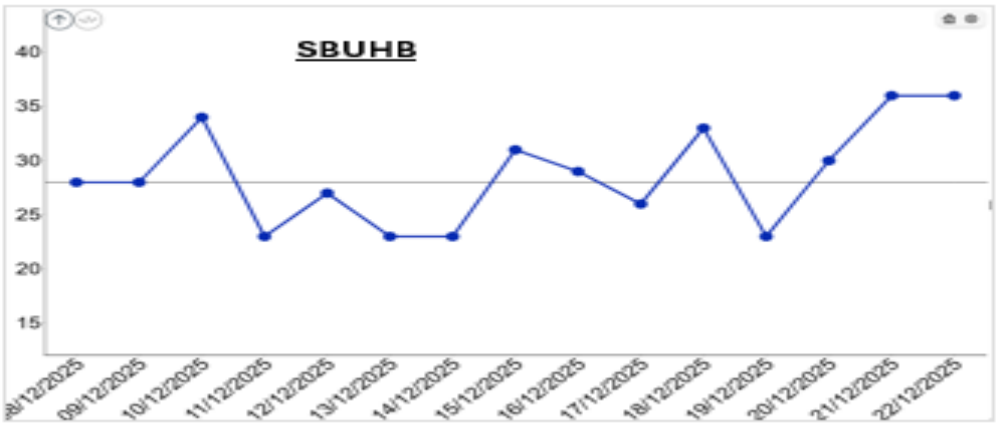







CTMUHB
180
170
160
150
140
130
120
110
100
08/12/2025
09/12/2025
10/12/2025
11/12/2025
12/12/2025
13/12/2025
14/12/2025
15/12/2025
16/12/2025
17/12/2025
18/12/2025
19/12/2025
20/12/2025
21/12/2025

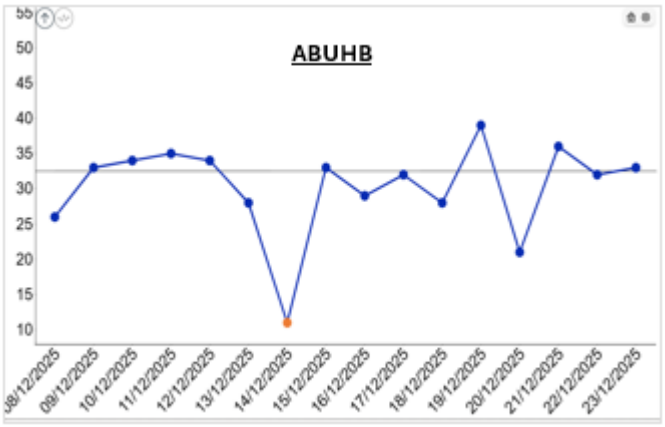

HDUHB
110
100
90
80
70
60
50
40
30
20
10
08/12/2025
09/12/2025
10/12/2025
11/12/2025
12/12/2025
13/12/2025
14/12/2025
15/12/2025
16/12/2025
17/12/2025
18/12/2025
19/12/2025
20/12/2025
21/12/2025


SBUHB
40
35
30
25
20
15
09/12/2025
10/12/2025
11/12/2025
12/12/2025
13/12/2025
14/12/2025
15/12/2025
16/12/2025
17/12/2025
18/12/2025
19/12/2025
20/12/2025
21/12/2025
22/12/2025

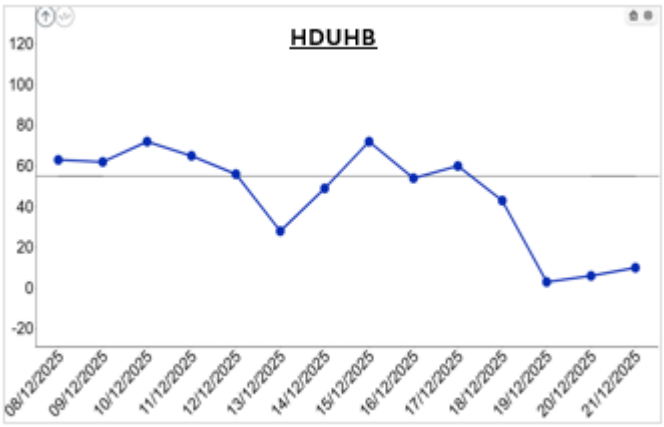
Ward Boarded Patients

Between 100 – 140 patients across 3 Health Boards were on inpatient wards, but not in an allocated bed space (boarded). **The data quality was poor for the other 3 HBs so have not been included in this initial data set. We need to be very cautious about any interpretation of this information at this time.**

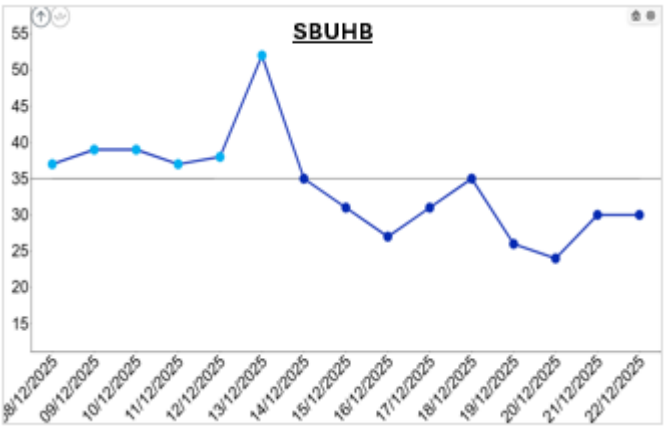
2 HBs showed an improved position with one static:



AB relatively static over the two week period with one /two exceptions (but was this quality of data return?)



Step improvement over the two week period which continued into Xmas /NY period.



Improving trend over the two week period.