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Six Goals for Urgent and Emergency Care

Same Day Emergency Care (SDEC) Strategy:
"UNDIWRNOD"



A framework for the development and delivery of
Same Day Emergency Care (SDEC) in Wales.

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Executive Summary

The NHS Wales SDEC Strategy aims to enhance Urgent and Emergency Care by implementing Same Day Emergency Care (SDEC) services across Wales. The strategy, named "UNDIWRNOD," aligns with the NHS England SAMEDAY strategy and focuses on providing rapid assessment, diagnosis, and treatment to patients, allowing for same-day discharge where clinically appropriate.

The strategy emphasises reducing variation in care, ensuring consistency in direct referrals to specialist care, and improving patient flow. It highlights the importance of paramedics being able to directly refer patients to SDEC via a single point of access. SDEC services are considered essential for future acute care provision, especially in an ageing society with limited healthcare resources.

The document outlines nine service priorities for SDEC, aiming to provide the right care in the right place first time. It also focuses the need for a multi-professional workforce, appropriate staffing, and the importance of having a senior clinical decision-maker on duty during SDEC opening hours.

The strategy also addresses the issue of non-bedding of SDEC areas, emphasising that these areas should not be repurposed during periods of pressure to ensure patient flow and discharge on the same day.

The overall goal is to provide effective, high-quality, and sustainable healthcare as close to home as possible, improving service access and integration while tackling inequalities and prioritising models of care that offer the most value to people.

We are keen to continue to develop and improve this document so that system leaders, clinicians and operational staff can best meet the needs of patients and the public. If you have any feedback, require further information or support, please contact the Six Goals PMO: abb.sixgoalsuec@wales.nhs.uk

Background

The Six Goals for Urgent and Emergency Care was co-designed by clinical and professional leads and spans the Urgent and Emergency Care pathway which reflect the priorities in the [Programme for government 2021 to 2026: Well-being statement | GOV.WALES](#) to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration. It focuses on strengthening signposting, clinically safe alternatives to admission, rapid emergency care response, good discharge practice and preventing readmission. But through the six goals approach, the aim is to tackle inequalities and prioritise new or existing models of care that are proven to work for all populations, ensuring it offers the most value to people, based on what matters to them.



As stated in the [Six Goals for Urgent and Emergency Care: policy handbook for 2021 to 2026 | GOV.WALES](#) the ambition is to implement SDEC services so that they support 100% of type 1 Emergency Departments (ED), allowing for the rapid assessment, diagnosis, and treatment of people presenting with certain conditions, and discharge home same day where clinically appropriate, twelve hours a day and seven days a week.

NHS England's [NHS Long Term Plan](#) ambition was that all hospitals with a 24-hour ED (type 1) will: Provide SDEC services at least twelve hours a day, seven days a week. To support the ambition in February 2024, NHS England published their [SAMEDAY strategy](#), a framework for the development and delivery of same day emergency care (SDEC).

In Wales, we have adopted the principles of the NHS England SAMEDAY strategy and to align to Welsh delivery we have called it The SDEC strategy "UNDIWRNOD".

We need to reduce variation in care and ensure greater consistency in direct referrals to specialist care, such as older people living with frailty to better respond to the needs of vulnerable patients at increased risk of admission.

SDEC Strategy: Summary

The SDEC service approach should also make connections across UEC to improve patient flow. For example, paramedics should be able to directly refer patients to SDEC, where appropriate, ideally via a single point of access (SPOA) to provide a single, simple route for referral to hospital. SDEC services are considered essential to the future provision of acute care, in an ageing society with limited healthcare resources, and are endorsed by both the Royal College of Emergency Medicine, and the Society for Acute Medicine.

NHS Wales describes Same Day Emergency Care as the provision of same day acute care for patients who would otherwise be admitted to hospital.

Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated (in a designated area) without being admitted, and if clinically safe to do so, will go home the same day their care is provided.

Same Day Emergency Care is the provision of care to a patient by clinicians within an Urgent and Emergency Care Service. Same Day Emergency Care is provided within 24 hours of the Urgent and Emergency Care Initial Assessment Timestamp, following formal initial clinical assessment (either virtual or face to face) and referral taking place.

Same Day Emergency Care is intended to provide an alternative to an Admitted Care Episode.

The SDEC strategy “UNDIWRNOD” with the 9 service priorities aspires to support the delivery of SDEC across Wales. SDEC is one of the many ways the NHS is working to provide the right care, in the right place, at the first time for patients in a standardised and consistent way so that patients are not admitted when it is not clinically appropriate.

Some of the growth in admitted non-elective activity over the past decade has been for patients who spend 1 or 2 days

in hospital; many could be safely and effectively managed using a same day approach. This involves ensuring the working patterns of senior clinicians support early clinical review, decision-making, treatment, and rapid access to diagnostic services, including point of care testing. Clear processes from referral to arrival also support early decision-making and maximise the opportunity to complete patient care within the same day.

SDEC is not an outpatient service as new treatment strategies, technology and investigations enable SDEC to deliver the same benefits as inpatient care, while reducing the risk of nosocomial infection and deconditioning, reducing delays in the emergency patient pathway and pressure on the system as a whole. It also improves patient and staff satisfaction.

System leadership is crucial to the impact SDEC can have on reducing the number of beds occupied by unnecessary emergency admissions, to expedite the admission of patients who do need to stay in hospital. Joint planning of SDEC across healthcare settings will improve patient flow between secondary, community and primary care settings following the completion of agreed treatment plans and will mean patients can be discharged to their usual place of residence, community setting or virtual ward for ongoing care where clinically appropriate to get the care they need safely and conveniently without delay.

SDEC Strategy: Service priorities

The SDEC strategy “UNDIWRNOD” has 9 priorities:

- U**nderstanding workforce need, making it safe & sustainable
- N**on-bedding of SDEC
- D**irect access available system wide
- I**dentify, define and report (Monitor & Evaluate) patients suitable for Same Day Care
- W**elsh Emergency Care Data Set (WECDs) Implementation
- R**ight Estate Infrastructure
- N**urturing effective communication
- O**ptimise a culture of visible leadership
- D**iagnostic and Testing capacity to support rapid access to same day services

The aim of each priority is stated below, along with recommendations for how the improvement, transformation and integration of each aim will be achieved, and the commitment to providers is outlined alongside the recommendations for providers and healthcare systems.

1. Understanding Workforce

Staffing resources

There is currently ongoing work with the NHS Wales Executive and Health, Education and Improvement Wales (HEIW) to further develop a workforce framework aligned to the strategy.

Staff roles

A multiprofessional workforce is required to deliver SDEC and every SDEC service should determine its local requirements to meet patient demand.

Staff must be trained in and be competent to undertake the tasks needed to deliver SDEC and have the opportunity to gain further skills and competencies to expand their existing job roles, and to learn and develop.

To have an optimal and effective SDEC service there is a need to have readily available support from clinical and non-clinical staff and an in-reach capability from all specialties during SDEC opening hours.

SDEC is often best delivered by a multi-professional workforce that would include the following roles:

- Consultants, GPs with extended roles (GPwER), Specialist and Associate Specialist Doctors, and Doctors in training (emergency, general, acute and single organ specialists)
- Nurses (registered and unregistered), Allied Health Professionals (AHPs) (including consultants), Advanced Clinical Practitioners (ACPs) and Physician Associates (PAs)
- Pharmacists
- IT Business Analysts
- Administrative, Clerical, Portering and Housekeeping staff
- Service Managers and Operational staff

This list is not exhaustive and will be updated as the service continuously improves.

Access to other staff such as laboratory staff and radiographers will also be important, and links should be established with Social care staff to facilitate extra support for patients discharged home as required.

Senior clinical decision-maker

A key requirement is having an identified senior clinical decision-maker on duty in SDEC during opening hours. They should be available as early in the patient journey as possible to ensure that patients are directed to the right place at the right time.

Clinical leadership is more than providing a good standard of patient care. Clinical leaders identify where improvement is needed and enable change. The term is therefore relevant across all levels of the NHS in Wales. Taking responsibility for clinical leadership can improve patient outcomes, avoid wasteful use of resources and enhance the working environment

Senior clinical decision-makers can and should be from across the healthcare professional groups. They need:

- Excellent clinical assessment skills
- Rapid decision-making skills using limited clinical information
- Excellent interpersonal skills to challenge admission and referral decisions
- Detailed knowledge of SDEC service resources and capabilities
- Knowledge of the alternative pathways to admission and how to access them ideally supported by a single point of access/Directory of Services (DoS)
- Authority to request diagnostics
- Authority to act on their judgement
- Ability to independently manage the entire patient journey, including discharge

Staffing allocation

Appropriate staffing should be provided to operate SDEC services on a sustainable basis for a minimum of 12 hours a day, 5 days a week, and with Acute Frailty Services (AFS) operating for a minimum of 12 hours a day, 7 days a week. The aim is to cover 7 day working as a gold standard.

SDEC services should review activity levels during opening hours to quantify demand on the service, including the times when this is highest and lowest. This should be reviewed across 24 hours as opposed to the opening hours of the service to identify where peak demand times are. Staffing models should match these fluctuations, which may mean a move away from traditional shift patterns to meet 7-day service provision. Any changes to working patterns must consider work-life balance and

contractual agreements for staff.

Staff should be assigned to SDEC to ensure delivery of a consistent service offer and continuity of care. This is often easier to do for Nursing and AHP staff than medical staff who will often be part of an on-call rota. In-reach into SDEC by specialty doctors will be required, and Health Boards (HBs)/Trust should have robust inter-professional standards to support this. However, for specialties such as Acute Medicine and General Surgery, a designated workforce based in the SDEC unit service is beneficial to manage unplanned demand.

2. Non-bedding of SDEC

The bedding of SDEC areas continues to be an issue for many sites across Wales with capacity demands being seen across the whole Urgent and Emergency Care footprint. The challenge is how can this be stopped. This is reliant on local senior leadership buy-in and agreement that SDEC areas are not bedded. It is appreciated that the bedding of SDEC areas causes pressures across the hospital system but would ask that the impact of doing this is scoped out. Where SDEC areas are bedded and therefore unable to function in the expected way new patients who are accessing UEC services, are left without the ability to access SDEC.

SDEC services should not be bedded or repurposed during periods of pressure; these services are particularly critical to patient flow when inpatient beds are limited.

In periods of pressure, consider extending the opening hours of SDEC services to support the flow of patients and to discharge them on the same day.

What can support Non-bedding of SDEC?

- Having Executive and Senior Leadership buy in and agreement that the SDEC space is not bedded even when the HB/Trust is in escalation.
- The culture of the organisation to support the non-bedding of SDEC and buy-in to this approach, constantly championed and raised in flow/operational meetings
- The SDEC unit doesn't have the physical capability to have beds within its footprint.
- SDEC is not included in HB/Trust escalation plans, so cannot be escalated into in the day or overnight. This will need support from the revised National Escalation policy due to be launched in 2024.

- Having a focus on ensuring patients are seen in the right place, by the right team, at the right time, consistently so patients are cared for by the right specialty in the right place always. Bedding the SDEC removes this opportunity for patients.
- Staffing the SDEC for opening hours only, so no staff routinely available if bedded overnight.
- Set the challenge that the underlying principle of Red to Green (Goal 5) that everyone should have a value added 'Green day' and 'no patient attending acutely should spend an avoidable night in hospital'.

3. Direct access available system wide

Before April 2022 in Wales there were local variations of direct access to SDEC services. To standardise the approach nationally the Direct paramedic referral to same day emergency care All-Wales policy was published to support the Welsh Ambulance Services University NHS Trust (WAST) and Health Boards in implementing direct referrals into SDEC. [Direct paramedic referral to same day emergency care: All-Wales policy \[HTML\] | GOV.WALES](#). This was aligned to the NHS England publication from November 2021 [National guidance for ambulance clinician referral to SDEC \(NHSE\)](#).

The aim of the policy was not that more patients would go through SDEC units, but that patients would be managed in an SDEC unit from arrival at the hospital rather than go through an ED service only to be referred on later in their journey into SDEC.

As SDEC has become more established it was timely to review and update the current Direct Paramedic Referral policy and to review direct referral streams to ensure people receive the right skill, at the right time, in the right place, so that if someone requires SDEC, this is because it's the most appropriate care response for that individual's needs.

Workforce Engagement

Recognising the valuable contribution that clinical colleagues from across healthcare in Wales can make to informing a review, 3 workshops were arranged across Wales to bring together the SDEC clinical workforce, Paramedics, and related stakeholders/referring clinicians to highlight current challenges, agree an acceptance criterion and identify the Top 3 areas for change to enable seamless Direct referral pathways into SDEC services across Wales.

As part of the collaborative review, 3 keys questions were considered by all in attendance:

1. Why is the current pathway not working?
2. How do we ensure SDEC doesn't become a second Emergency Department?
3. What are the 'Top 3' areas requiring change to improve direct patient pathways into SDEC?

The 'Top 3 Priority' areas identified and to action were:

Priority	Required Action
1	<p>Creation of a single point of access. Leading to a final clinical conversation and clinical expert navigation to the appropriate service:</p> <ul style="list-style-type: none"> • Emergency Department • SDEC (<12hrs, inclusive of Frailty) • Acute Clinical Unit (<72hrs) • Specialty Ward <p style="text-align: center;">RIGHT PATIENT, RIGHT PLACE, FIRST TIME</p>
2	Stop bedding in SDEC. Utilise the optimal hospital flow framework to support inpatient flow
3	<p>Digital improvements and integration to enable the full tracking of a patient journey</p> <p>Full phased Implementation of Welsh Emergency Care Data Set (WECDS) as soon as it is available.</p>

As part of the National Six Goals for Urgent and Emergency Care 2021-2026, the Cabinet Secretary for Health and Social Care priorities noted the Implementation of SDEC services across all Hospitals in Wales, with the aim of providing clinically safe alternatives to admission to hospital as summarised below:

All providers across the healthcare system including NHS 111, 999, primary care, community care and mental health services, should have access to same day services.

Patients suitable for an SDEC model of care should be identified by asking:

- Is there an alternative non-admitted pathway that could more appropriately manage the patient?
- Would this patient otherwise be admitted to a hospital bed?
- Is the patient sufficiently clinically stable to be managed in SDEC?

Direct referral

Direct referral to SDEC should be available system wide and across a range of healthcare professionals to allow early identification of appropriate patients and help reduce clinical touchpoints, unnecessary triage, multiple handovers of care and history giving, ED crowding and avoidable ambulance conveyances.

Developing direct access pathways will standardise high-volume pathways to reduce variability and support patient access to SDEC/AFS.

The ambulance service where appropriate should be able to convey patients directly to SDEC services, reducing handover times and helping to protect resource for those patients with life-limiting or life-threatening illness or injury.

Directory of Services (DoS)

A National review of the Directory of Services was undertaken with the outcome recommending a national DoS for Wales. The Six Goals Programme is working with Health, Social Care and the 3rd sector to assess the opportunity of establishing a national integrated DoS, incorporating all partner services. A national DoS mandate has been sought via Welsh Government and this will direct the joint approach toward achieving this ambition.

SDEC services should be profiled in the DoS. NHS 111 and 999 services as well as primary and community care clinicians would have use of this directory as well as their internal Service Finder.

While some providers will use other tools to profile their services, the approach to profiling SDEC services should be standardised across each Health Board/Trust's regional footprint, including opening times (when referrals are accepted), referral pathways, and direct dial contact numbers. Referral information should also include appropriate cut-off referral times to avoid referring a patient after service closure.

4. Identify Define & Report (Monitoring and evaluation)

Alternatives to admission

Paramount in deciding a patient's suitability for SDEC is their safety: is an admission to hospital or treatment in a same day environment safest for them? Part of ensuring patient safety is challenging the assumption that admitted care is the most appropriate environment for the patient. If a patient does not need 'in hospital' care, the senior decision-maker should consider an alternative clinical setting.

Patients with complex social and/or functional needs, including mental health, dementia and end of life patients must not to be excluded from SDEC as they are potentially very well served by a same day environment that avoids lengthy admissions and deconditioning, as well as disruption to any community-based care packages. Using SDEC rather than admission allows community-based care to continue without interruption when the patient needs a period of emergency assessment and intervention in secondary care. There are opportunities to use the flexibility of SDEC to manage older people living with frailty in a way that is planned, personal and less distressing for the patient.

Patient selection

Patient selection for SDEC works best when senior clinicians and the referring clinician discuss the patient's clinical presentation, supported by NEWS2 and clinical history. For older patients living with frailty, a triple assessment approach of Clinical Frailty Score (CFS) for 65+ years, 4AT- Delirium scoring tool and NEWS2 should be used (that is based on the clinical guidance from both the [NHS England guidance for emergency department initial assessment](#) and [British Geriatric Society \(Silver Book\)](#)). SDEC services are one part of the UEC system, and it is important that patients access the most appropriate service for their needs.

Patient selection for SDEC should be based on:

- SDEC being the best place to meet the patient's clinical needs.
- SDEC staffing and facilities being appropriate to meet the patient's functional needs and maintain their privacy and dignity; including patients with frailty or mobility impairment.
- SDEC being able to treat, manage and discharge the patient to their usual place of residence on the same day.
- Patient's needs cannot be met by primary or community health services.

Patients who should not be managed in an SDEC service are:

- Outpatients.
- Inpatients.
- Patients needing the facilities of a discharge lounge.
- Patients waiting to be admitted to a hospital bed.
- Clinically unstable patients.
- Patients overflowing from another service which does not have the capacity to manage its own care.

Some patients initially identified as suitable for SDEC may require admission following investigation and review by the SDEC team. This should not be seen as a failure but the right course of action for the patient following review. The overall conversion rate of SDEC patients to admitted patients should be monitored and reviewed; currently NHS England has a suggested rate of 20–30%. This will be under review as Health Boards implement the WECDS dataset.

HBs/Trust should also monitor and review the number of patients who attend ED or an Acute Clinical Unit and then have a 1 or 2-day Length of Stay (LoS), to identify opportunities missed for referral to the SDEC service.

Effective patient streaming

Appropriate and direct referrals to SDEC will support the avoidance of multiple and duplicated assessments before the patient presents at SDEC. Patients should be identified as suitable for streaming to SDEC as early in their journey as possible.

Measurement resource

NHS England developed the following measurement resource with the Society for Acute Medicine (SAM), Royal College of Physicians (RCP) and NHS England's Getting it Right First Time (GIRFT) Programme. The following are linked to NHS Wales SDEC Data Standards and can also be implemented across Wales:

- The time spent in the ED or Urgent Care Centers (UCC) prior to transfer to an SDEC facility should be kept to a minimum. The patient should be transferred within 60 minutes of the patient arriving in ED or UCC.
- No patient should stay in the SDEC service longer than 12 hours. Patients who require admission must be transferred out of SDEC on the same day

they arrived.

- Waiting times for patients in SDEC should be minimized:
 - Observations must be obtained within 15 minutes of a patient's arrival.
 - Patients must be seen by a clinician who has the capabilities to assess and investigate the patients' symptoms within 60 minutes of arrival.
- A same day discharge summary for a single episode of care should be created at the end of the SDEC episode:
 - a. Sent to the GP
 - b. Given to the Patient

This should include details of investigations undertaken, any new therapies instigated and the follow up plan required and arranged. If there is more than one attendance, then the primary care team should receive regular communication, with the mechanism and content defined locally.

- For all attendances, completion of the SDEC episode should be clearly communicated and management transferred back to the care team in the community.
- Activity in SDEC must be protected, including during periods of escalation when the hospital is under pressure. Loss of this activity will likely increase pressure.

SDEC Measures

In NHS England, the Emergency Care Data Set (ECDS) provides Urgent and Emergency Care data at a patient level. The data collection for SDEC activity in NHS Wales was aggregated until the WECDS had been mandated and implemented for data collection across Wales. The ability to compare data on a national level will be restricted until the implementation of WECDS, which will be fully rolled out across Wales by the end of March 2026. As SDEC services mature the measures and recommendations will be reviewed and updated as evidence base grows and is refined.

Following HB/Trust consensus within Impact Assessment exercises and engagement with Clinical, Operational, and Digital leads, the 6 Goals Programme Board agreed and supported the SDEC definition, interim standards, and measures that could be reported on until the implementation of the WECDS across Wales. **[Appendix 1]**

Experience of care

It is important to collect accurate and timely data to evaluate patient experience of SDEC. We will be working with the Welsh Value in Health Centre to deliver PROMS/PREMS in relation to SDEC services across Wales. These help SDEC services reflect on the care they deliver from the patient's perspective and identify how they can continually improve.

NHS England developed 10 Quality Indicators for their SDEC services that are identified below and could be adopted across Wales. People referred to SDEC:

1. Will know what to expect from SDEC before they arrive (for example, clear directions, car parking and general facilities, eating and drinking, what the service provides and why they have been referred to it).
2. Are greeted when they arrive to make sure they know what is happening and understand what SDEC is.
3. Feel cared for, and we ask what matters most to them – making this a priority in their care.
4. Are given the opportunity to ask any questions they have and are provided with regular updates.
5. Will know the name and role of the person providing support and are assured they are being seen by the right person, at the right time.
6. Will have staff that are supported to offer the best care they can. We ask our staff what matters most to them – and directly involve them in service design and delivery.
7. Will know what to do when they leave the service and who to contact if they have any questions or concerns.
8. Are seen in the right place by the right person. SDEC teams connect with and inform other local services and referral routes to support appropriate referrals to SDEC.
9. Will have feedback from staff and people using SDEC which is welcomed, encouraged, valued and collected.
10. Will have feedback and ideas from staff and people who use SDEC which is used to co-produce service and quality improvements.

5. Welsh Emergency Care Data Set (WECDS)

What is WECDS?

The Welsh Emergency Care Data Set (WECDS) is a new data set to be used across Wales for capturing data relating to Urgent and Emergency Care. WECDS is adapted from version 4 of the Emergency Care Data Set (ECDS) which was first implemented across Trusts in England in 2017. WECDS is a key enabler for delivering the Six Goals for Urgent & Emergency Care strategy and is supported by the Welsh Government and other professional bodies such as the Royal College of Emergency Medicine (RCEM). WECDS was mandated via a DSCN in May 2024, and is set to replace the current Emergency Department Data Set (EDDS). The first phase of WECDS implementation will focus on Emergency Departments, Minor Injury Units and Same Day Emergency Care in line with Goal 4 of the 6 Goals for Urgent and Emergency Care policy. Further phases are planned to develop and implement WECDS further to capture data from NHS 111 Wales, the Ambulance Service, Urgent Care (UC).

What will WECDS do?

WECDS will facilitate the collection of more detailed and accurate Urgent and Emergency Care Data and will enhance our understanding of the complexity associated with delivering UEC services and help us better understand the patients journey through UEC services. The data that it will provide will help to demonstrate patient flow and exit blocks and underpin operational initiatives to improve UEC and other services. It will help to highlight the possible causes of rising demand, support injury, assault and public health surveillance, which will in turn lead to targeted service interventions potentially helping to reduce emergency care attendances and improve patient outcomes. WECDS is key in enabling the linkage of data across healthcare and social care services resulting in a clearer view of how patients access UEC services, what happens to them when they access these services and their onward journey.

WECDS will also provide an opportunity to compare UEC data across borders with the rest of the UK, promoting greater consistency in reporting across regions.

WECDS Delivery Dates:

WECDS Implementation Plan is scheduled as follows:

- **1st April 2025** – Vanguard Sites - Emergency Departments, Minor Injury Units and Same Day Emergency Care.
- **1st April 2026** – All remaining Health Boards - Emergency Departments, Minor Injury Units and Same Day Emergency Care.

The Data Standard will be reviewed following these dates to ensure that the Standard is fit for purpose and the data is being captured and collected appropriately and upholds its relevance and effectiveness.

WECDS is not a static data set and should continue to evolve. The DSCN will therefore need to undergo regular reviews and updates to ensure its alignment with the expanding scope evolution of Urgent and Emergency Care service delivery across Wales.

WECDS & SDEC strategy “UNDIWRNOD”

WECDS plays a crucial role in supporting the SDEC strategy “UNDIWRNOD” by enabling standardised data collection, improving patient management through data collection, and enhancing operational efficiency across emergency care settings in Wales.

6. Right Estates Infrastructure

The SDEC estate, facilities and equipment that should be available to deliver SDEC services vary across all healthcare settings in Wales.

Ideally SDEC services should be located close to ED or Acute Clinical Unit (ACU) to allow the quick transfer of suitable patients from these services to SDEC, but with its own external entrance for direct referral. SDEC having an external entrance reduces the footfall through ED and makes it easier for patients to leave the hospital when they are discharged.

Welsh Health Building Note (HBN) 15-02 (2021) gives guidance on the planning and design of an SDEC department.

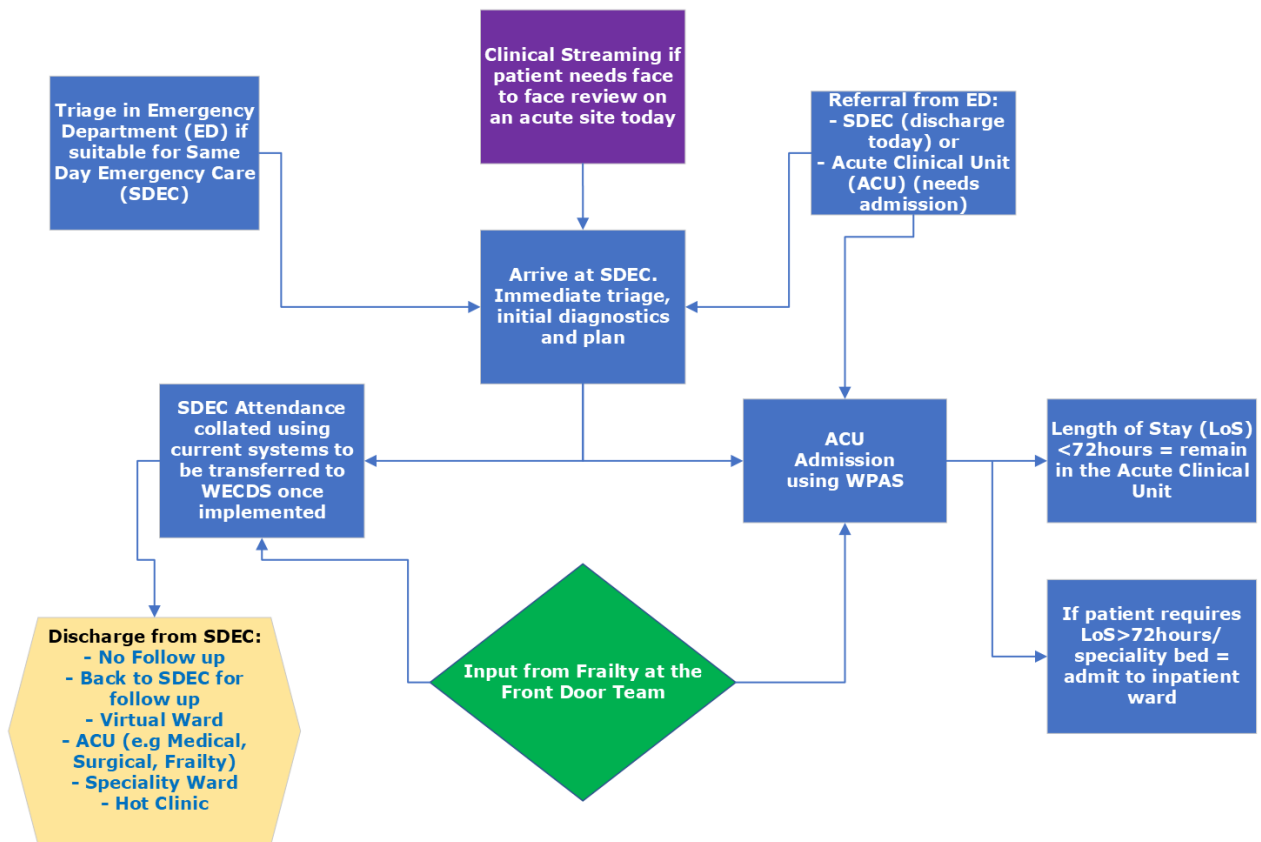


The core recommendations are:

- Where possible, the SDEC facility should be close to a type 1 Emergency Department.
- Patients should have access to diagnostics within the same time frame as other emergency patients as acuity and availability allows.
- The SDEC facility should have a combination of consulting rooms, patient trolleys and chairs for patient assessment and treatment.
- Beds should not be provided in an SDEC unit as it may have a negative impact on patient flow.

A well-designed SDEC unit will minimise patient delays as they move through stages of care. Good patient flow through SDEC is central to patient experience, clinical safety and reducing pressure on staff and the system.

An example of an SDEC Patient Flow Model



7. Nurturing effective communication

Effective communications and engagement are central to the delivery of any activity, ensuring that responsible stakeholders are aware of the issue, the environment that they are in, their responsibility as part of the delivery chain and the tools and support that are available to assist them.

Ensuring the reach and impact of any communications, and developing structures and approaches to support this, will therefore improve the implementation of core aims and activity.

Why effective communication is important in the workplace?

Communication is a vital skill in any field, but especially in the ones that involve interacting with diverse audiences, creating and delivering messages, and collaborating with others. To build connections with professionals in the field of communication, you need to be proactive, strategic and genuine.

Improving communication means being proactive. This involves regularly updating patients and the community about service changes, availability, and guidelines. Simple steps like clear signage, informative websites, and regular social media updates can bridge significant gaps.

Training in communication skills should be integral to all healthcare professionals' development. Empathy, active listening and clear language can transform a clinical interaction into a therapeutic one. In high-pressure scenarios, these skills are even more critical. They not only improve patient experience but also enhance the quality of care.

Proper communication can benefit HBs/Trusts in many ways. Namely, effective team communication positively affects employees in terms of:



8. Optimise a culture of visible leadership

SDEC should be promoted through strong clinical and executive leadership at Organisational level to give all teams new perspectives on courageous leadership that will shape behaviours and improve the quality and experience of care for patients. Clinicians, operational managers and system leaders need to understand the benefits SDEC brings for hospital capacity and flow, patients and their carers.

A successful SDEC model requires good relationships between all specialties including emergency medicine as well as primary care, community care and ambulance providers, diagnostics, and specialist service teams.

Appropriate patient selection and access to a multidisciplinary team (MDT) of clinicians and diagnostics are key.

Having an executive and a non-executive director sponsor and clinical lead for the SDEC service would champion the service's development, ensuring that this model is part of core service delivery. The clinical lead should have dedicated time for the ongoing development of the SDEC service, working with operational colleagues.

HEIW is the national leadership body for NHS Wales. They are responsible for setting the direction of leadership across all levels and managing succession planning for the most senior leadership roles in NHS Wales.

Compassionate Leadership

What is compassionate leadership?

Compassionate leadership requires people to listen, understand, empathise and support others. This enables everyone to feel valued, included and encouraged, so they can reach their full potential and do their best at work. In health and care settings, this can result in:

- an inclusive and positive working environment and culture
- engaged and motivated teams
- improved staff wellbeing
- high-quality care and outcomes for patients

Gwella (translation: to improve, get better) is the Leadership Portal

managed by the HEIW Leadership and Succession team with the goal of providing users with an accessible, intuitive system that allows them to access a range of compassionate leadership resources with ease. This platform is accessible to everyone within health and social care in Wales regardless of their position or qualification - [Gwella HEIW Leadership Portal for Wales](#).

9. Diagnostics and testing

Patients should have direct and rapid access to diagnostics and investigation as standard over 7 days to support swift assessment and treatment, facilitating discharge on the same day. For this to happen diagnostics and testing capacity should support early review by senior decision-makers, rapid assessment and treatment facilitating discharge on the same day. Therefore, patients attending SDEC should have access to diagnostics within a similar timeframe as Type 1 ED patients as standard.

SDEC providers should also review innovative technologies to support rapid diagnosis or monitoring of conditions that can present acutely. Consideration should be given to the development of point of care testing (POCT) to support rapid decision-making and management of patients.

Next Steps – Acute Frailty Service (AFS)

People living with frailty have reduced resilience to illness and are at increased risk of adverse health outcomes. SDEC services incorporating AFS can often manage older people living with frailty in a way that is planned, personal and much less distressing for the person concerned.

It is important to recognise that many patients will need both community and hospital care. An outcome of COVID-19 has accelerated the urgency for local services to work towards developing patient pathways to facilitate direct access for GPs, paramedic to hospital-based teams including SDEC, and AFSs.

In many areas of the country a large proportion of people attending ED are over 65 years of age and have higher likelihood of presenting with frailty; this requires early recognition and the patient to be directed to the right place for treatment, in the right time. Poor or late recognition of frailty or its associated syndromes increases the likelihood the patient will be admitted to hospital, have a longer length of stay (LoS) in hospital and generally experience poor long-term health outcomes.

What is an Acute Frailty Service?

The definition is:

“An acute frailty service routinely and systematically identifies and grades frailty in people who present acutely to community or hospital based Urgent and Emergency Care services. These services then consider the personalised needs of individuals living with frailty, considering their grade of frailty and degree of illness, supported by clear reliable pathways into and out of hospitals aligned to the grade of frailty identified.”

What is a hospital Acute Frailty Service?

Principle

“An acute frailty service is an integrated approach involving most staff working in an ED, SDEC and urgent care services. It is not simply a unit, and it is not just a team. Depending on the local context and resource, how the AFS is run will vary but its essential purpose and principles are constant.”

Staffing allocation for Acute Frailty Services

Appropriate staffing should be provided to operate an Acute Frailty Service on a sustainable basis for a minimum of 12 hours a day, 7 days a week.

We acknowledge the multiple pressures on a finite workforce, including from the introduction of new services such as virtual ward, hospital at home and urgent community response. However, providers must look at working across boundaries to increase their workforce to meet current and future demand.

Suggested roles needed to deliver an efficient Frailty at the front door model

- Consultant with Frailty Expertise/Consultant Geriatrician
- Nurse/ AHP consultants
- Advanced Clinical Practitioners with Frailty Expertise
- Medical staff (which can include GPs with Extended roles (GPwER) and Physician Associates)
- Nursing staff (both registered and unregistered) to assess, deliver direct care, provide treatment and discharge patients
- AHPs, e.g. (but not limited to) physiotherapists, occupational therapists, dieticians,
- Pharmacists and pharmacy technicians
- Administrative and Clerical staff
- IT Business analyst
- Service managers and Operational staff.

Access to other staff such as porters and radiographers will also be important, and links should be established with social care staff to facilitate extra support for patients discharged home as required.

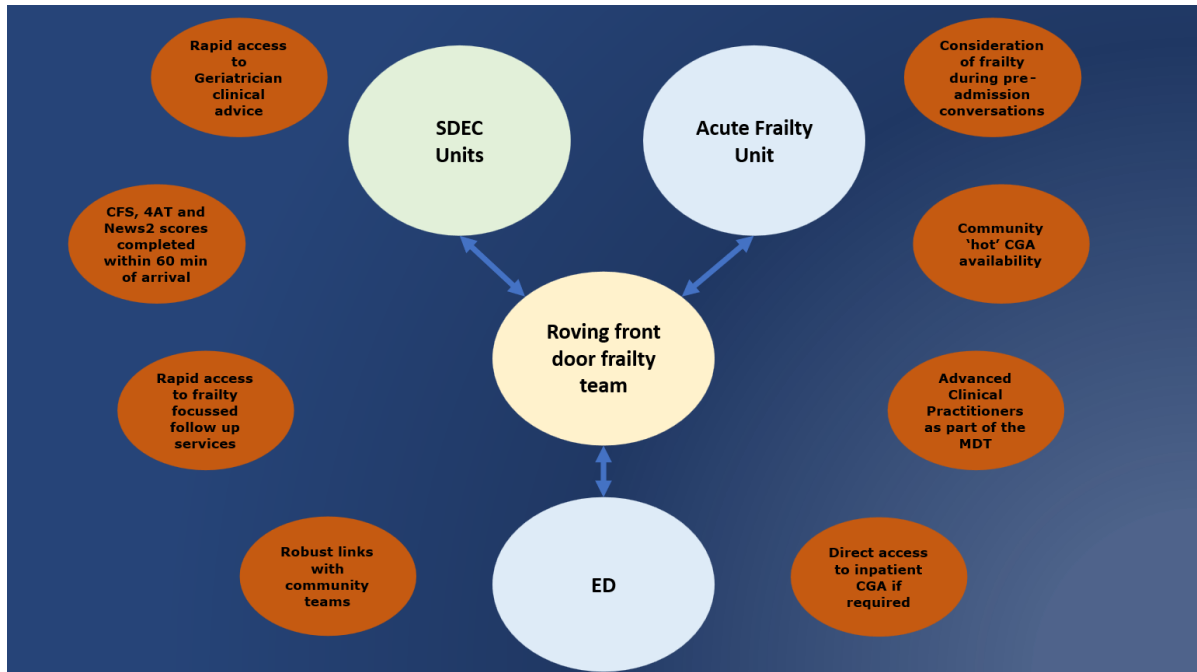
Acute Frailty Service Provision

SDEC services incorporating AFS can manage frail older people in a way that is planned, personal and much less distressing for the person concerned.

Acute frailty teams will provide same day emergency care for people presenting in ED as an alternative to hospital admission. This includes clinical frailty assessment and rapid access to a Comprehensive Geriatric Assessment (CGA) (if required), linked to treatment and reablement services.

It is recommended that:

- An AFS is set up at the front door in all UHBs to support ED, SDEC and acute units, with an attached Acute Frailty Unit providing up to 72hrs LOS for patients requiring more than same day care.
- All AFS need access to a community infrastructure that enables a transfer of care back to the patients' home ensuring a whole system response.



- An AFS will provide 7 day a week, 12 hours a day (84hrs a week) cover at the 'front door'
- All Health Boards 'front door' staff are trained on how to use the Clinical Frailty Score (CFS) for 65+ years, 4AT- Delirium scoring tool and NEWS2 with scores completed in all patients 65+ years within 60 minutes of arrival to the unit.
- Patients with moderate to severe frailty who are felt to need a >72hr inpatient stay should be rapidly streamed to either an acute older persons' inpatient ward for ongoing medical intervention alongside comprehensive geriatric assessment, or have access to specialist frailty teams that can deliver CGA in other acute ward settings (such as surgical liaison services)
- All acute areas (ED, SDEC and Acute Clinical Units) that receive frail older patients should ensure staff are proactive in avoiding deconditioning, with particular focus on maintaining continence and supporting patients to maintain their independence during their stay

- All HBs to provide local training to staff on accessing clinical and social pathways in hospital and community settings. This will allow the streamlining of patients to the right place first time.

Specialty SDEC

While the requirements to deliver SDEC will be similar across most medical and surgical SDEC services, some specialty-specific elements will need to be considered.

APPENDIX 1

1. Interim SDEC Standards

Area	Definition
Standard 2	Patients who require admission must be transferred out of SDEC on the same day they arrived.
Standard 4a	A same day discharge summary for a single episode of care should be created at the end of the SDEC episode and: a) Sent to the GP

2. Interim SDEC Aggregate Measures

Measure ID	Measure Description	Measure to Record
1	Activity and performance within the SDEC unit:	1 a. The number of patient attendances counted as SDEC activity
2	Activity prior to presenting at SDEC Unit:	2 a. Total number of SDEC patients who presented within the Urgent and Emergency Care system (ED or MIU) prior to arrival at SDEC. 2 b. Median length of stay (hours and minutes) for patients who presented within the Urgent and Emergency Care system (ED or MIU) prior to arrival at SDEC.
3	SDEC attendances who were discharged/leaving hospital the same day:	3 a1. Total number of patients leaving same day from SDEC (who were referred from ED/MIU) 3 a2. Total number of patients leaving same day from SDEC (who were referred direct to SDEC unit) 3 b1. Median time from arrival at hospital ED, MIU to the time they are discharged from hospital (hours and minutes e.g. 05:00 (5 Hours)) . 3 b2. Median time from arrival at SDEC unit to the time they are discharged from hospital (hours and minutes e.g. 05:00 (5 Hours)) .
4	SDEC attendances who were admitted to hospital:	4 a1. Total number of SDEC patients who were admitted to hospital from SDEC (who were initially referred from ED/MIU) 4 a2. Total number of SDEC patients who were admitted to hospital from SDEC (who were referred direct to SDEC unit) 4 b1. Median time from arrival at hospital ED, MIU (referred to SDEC) unit to the time they are admitted (hours and minutes e.g. 05:00 (5 Hours)) inpatient 4 b2. Median time from arrival at SDEC unit (referred direct to SDEC) to the time they are admitted (hours and minutes e.g. 05:00 (5 Hours)) inpatient

3. Proposed SDEC Standards

Area	Definition
Standard 1	The time spent in the Emergency Department (ED) prior to transfer to an SDEC facility should be kept to a minimum. The patient should be transferred within 60 minutes of the patient arriving at the ED.
Standard 2	Patients who require admission must be transferred out of SDEC on the same day they arrived.
Standard 3a	Waiting time in SDEC should be minimised: a. Observations must be obtained within 15 minutes of arrival.
Standard 3b	Waiting time in SDEC should be minimised: b. Patients must be seen by a clinician who has the capabilities to assess and investigate the patients' symptoms within 60 minutes of arrival.
Standard 4a	A same day discharge summary for a single episode of care should be created at the end of the SDEC episode and: a) Sent to the GP
Standard 4b	A same day discharge summary for a single episode of care should be created at the end of the SDEC episode: b. Given to the Patient

4. SDEC recommended metrics after WECDS Implementation

a) Currently available

Measure ID	Metric	Available
1.	Review of activity and performance within the SDEC: a. The number of patients counted as SDEC activity	
2.	Review of activity prior to presenting at SDEC: a. Total number of SDEC patients who presented within the Urgent and Emergency Care system (ED or MIU) prior to arrival at SDEC.	
	b. Median length of stay (hours and minutes) for patients who presented within the Urgent and Emergency Care system (ED or MIU) prior to arrival at SDEC.	
3.	SDEC attendances who were discharged/leaving hospital the same day: a. Total number of patients leaving same day from SDEC (who were referred from ED/MIU)	
	b. Total number of patients leaving same day from SDEC (who were referred direct to SDEC unit)	
	b1. Median time from arrival at hospital ED, MIU to the time they are discharged from hospital (hours and minutes e.g. 05:00 (5 Hours)).	
	b2. Median time from arrival at SDEC unit to the time they are discharged from hospital (hours and minutes e.g. 05:00 (5 Hours)).	
4.	SDEC attendances who were admitted to hospital: a1. Total number of SDEC patients who were admitted to hospital from SDEC (who were initially referred from ED/MIU)	
	a2. Total number of SDEC patients who were admitted to hospital from SDEC (who were referred direct to SDEC unit)	
	b1. Median time from arrival at hospital ED, MIU (referred to SDEC) unit to the time they are admitted (hours and minutes e.g. 05:00 (5 Hours)) inpatient	
	b2. Median time from arrival at SDEC unit (referred direct to SDEC) to the time they are admitted (hours and minutes e.g. 05:00 (5 Hours)) inpatient	

b) Available following WECDS implementation

Measure ID	Metric	Available
5.	The number of SDEC attendances split by referral source and aligned to the data item Emergency Care Attendance Source within WECDS.	
6.	The number of discharge outcomes from SDEC as aligned to the data items within WECDS: <ul style="list-style-type: none"> •Discharge Status •Discharge Destination •Discharge Follow-up 	
7.	The number of unplanned re-presentations of patients into the Urgent and Emergency Care system who had been managed by an SDEC service within the previous seven days. Recorded as per Emergency Care Attendance Category in WECDS.	
8.	The number of hours a day the SDEC service is available. <i>Include a description if this deviates from business as usual</i>	
9.	The number of days a week the SDEC service is available. <i>Include a description if this deviates from business as usual</i>	
10.	Review of SDEC investigations: a. The number of initial investigations performed within the SDEC service broken down by: <i>Blood Tests, Plain Film, X-Rays, Ultrasound, CT Scan, MRI</i>	
	b. The average (mean and median) time from arrival at the SDEC service to the time the initial investigation was performed and recording of the investigation broken down by: <i>Blood Tests, Plain Film, X-Rays Ultrasound, CT Scan, MRI</i>	
11.	Review of SDEC diagnosis: a. Top ten diagnoses by SDEC specialty (Surgical, Medical, Frailty) for patients discharged from hospital.	
	b. Top ten diagnoses by SDEC specialty (Surgical, Medical, Frailty) for patients admitted to hospital."	

APPENDIX 2

1. Self-assessment tool: Current delivery

This tool helps you assess if your SDEC model meets the recommended minimum requirements.

Self-assessment tool: Current delivery		
SDEC SERVICE MINIMUM REQUIREMENT	ARE THEY MET? YES/NO	IF NO,SEE PRIORITY:
1. A named senior clinical decision maker is on duty and present in SDEC during peak demand hours of operation, with access to an appropriate consultant to support decision-making as required.		1
2. SDEC service has its own dedicated workforce when open.		
3. An agreed medical and nursing/AHP workforce template is used for SDEC service.		
4. Access to a pharmacy service for patient medication advice, dispensing, supply and counselling of medication on discharge.		
5. SDEC services must operate for a minimum of 12 hours a day, 5 days a week, with a plan for 7 days working.		
6. Acute frailty services must operate for a minimum of 84 hours a week and are available over 7 days.		
7. SDEC should not be bedded to ensure continuous service provision.		2
8. SDEC is not included in escalation plans.		
9. SDEC services are only staffed for the opening hours of the service.		
10. SDEC does not have the physical capability to have beds in its footprint		

11. Referrers are able to discuss referrals with an SDEC senior clinical decision maker to ensure they are appropriate for the service.		3
12. Primary care can refer patients directly to SDEC.		
13. Ambulance clinicians can refer patients directly to SDEC.		
14. Patients can be streamed direct from ED to SDEC.		
15. Standardised referral process are agreed and shared with healthcare partners.		
16. SDEC service is profiled in DoS/local intranet site with up-to-date opening times, referral process and contact details.		4
17. SDEC activity is captured as an attendance		
18. Staff use a triple assessment approach for older people living with frailty: Clinical Frailty Score (CFS) for 65+ years, 4AT- Delirium scoring tool and NEWS2		
19. SDEC service collects feedback from patients and identifies actions to improve patient experience.		5
20. Prepared for WECDS Implementation		
21. SDEC aligned to definition in DSCN		6
22. Adequate waiting and treatment room/chair capacity should be available to meet demand.		
23. SDEC unit has a combination of consulting rooms, trolleys and chairs for patient assessment and treatment.		
24. Signage to SDEC unit is clear and bilingual		7
25. Regular meetings with Clinical, Operational and Informatics leads in place.		
26. Each SDEC clinical lead has professional activity sessions in their job plan to support the development of the SDEC (for example, development of policies and guidance, review of clinical practice, audits).		8
27. Each SDEC service has a designated SDEC clinical lead who works in the service.		
28. An executive director and a non-executive director are identified as sponsors for SDEC services.		
29. SDEC services has the same access to diagnostics and reporting that ED has locally.		9

2. Self-assessment tool: Striving to achieve

The tool helps you assess the potential to transform further and identify what you should be striving to achieve to improve your SDEC service model.

Self-assessment tool: Striving to achieve		
SDEC SERVICE STRIVING TO ACHIEVE	ARE THEY MET? YES/NO	IF NO,SEE PRIORITY:
1. Workforce training and development plan is in place for all roles in SDEC.		1
2. Advanced level practice roles are embedded in the service model (for example, advanced clinical practitioners, nurse practitioners, clinical nurse specialists, clinical pharmacists).		
3. A full MDT presence is embedded in the SDEC workforce model.		
4. SDEC staffing model supports unplanned demand using 0 Length of Stay as a proxy measure for all patients.		2
5. SDEC service is supported by an updated National Escalation policy to not bed the Unit		
6. NHS 111 services can refer patients directly to SDEC		3
7. Community services (including Urgent Care Centres), virtual wards and Single Point of Access services can refer patients directly to SDEC.		
8. Referral criteria for SDEC are standardised across a HB/ trust footprint.		
9. Digital tools are considered as part of future planning to ensure ease of referral and sharing of patient information.		
10. Booking tools are considered as part of future planning to ensure ease of referral and sharing of patient information.		
11. Workforce boundaries are reduced by working across all areas of the HB/Trust, maximising the opportunity to work across primary, community, mental health and secondary care.		4
12. Plans are in place within each HB / trust to record all SDEC activity in WECDS as Type 5 activity when available.		
13. SDEC services have PROMS and PREMS in place to seek feedback from patients and from this identify any necessary changes to service provision.		

14. All SDEC activity is recorded via WECDS		5
15. Capital investment for SDEC estate is adequate to improve both physical and virtual capacity.		6
16. Demand and capacity modelling is undertaken to ensure that the SDEC footprint is fit for purpose.		
17. SDEC unit has its own external entrance to support direct admissions to SDEC		
18. Robust communication loops in place at all levels to ensure constant staff feedback to improve the service		7
19. Staff working in SDEC are involved in developing the service.		8
20. HB/Trust leadership supports the provision of SDEC across primary, community, mental health and secondary care boundaries.		
21. SDEC services has the same access to diagnostics and reporting that ED has locally.		9
22. SDEC services have access to Point of Care Testing (POCT) to facilitate prompt diagnosis and treatment of patients.		
23. SDEC services have access to community diagnostic centres to reduce pressure on acute diagnostic services.		
24. SDEC services work across the community to support delivery of hospital@home.		