Llywodraeth Cymru
Welsh Government

Emergency and Acute Care Wales

Community by Design. Emergency to Recovery when needed. Only the clinically necessary time away from home.



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Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

Part 1: Ministerial summary

When you or someone who matters to you needs *emergency or acute care*[1] , you should be able to expect the right care, in the right place, at the right time.

You should be confident that if you become seriously ill or injured, help will arrive quickly, you will be assessed promptly, and you will receive the treatment and specialist care you need without unnecessary delay. You should also expect to spend only as much time in hospital as is clinically necessary, returning home as soon as it is safe and appropriate to do so.

Today, too many people are not experiencing this consistently. For some people, particularly older people and those living with frailty, unnecessary time in hospital can itself cause harm, including deconditioning, loss of function and reduced independence.

Long waits for ambulances, delays in emergency departments, difficulty accessing timely treatment, and extended stays in hospital can cause anxiety and uncertainty for patients and their families. They can also lead to poorer outcomes and place significant pressure on our dedicated health and care workforce.

We must change this.

You have told us what matters most

People in Wales consistently tell us they want easier access to healthcare close to home when appropriate. When emergencies do occur, people want ambulances to arrive quickly and they want shorter waits in emergency departments[2].

Health Foundation and Ipsos survey, the breakdown for the top priorities chosen by respondents in Wales

- 35% **prioritised** improving ambulance response times (making it the single highest priority in Wales).
- 33% **prioritised** improving waiting times for A&E.
- 29% **prioritised** making it easier to get appointments at GP practices.

This framework responds directly to those priorities. Every improvement set out in *Emergency and Acute Care Wales* is intended to make care more responsive, reduce unnecessary waits and ensure that, when you need emergency or acute care, the system works for you, your family, and your friends.

The challenge[3] before us is not whether change is needed, but whether we are prepared to make the changes necessary to ensure that high-quality emergency and acute care remain available, equitable and sustainable for future generations[4].

1 ***Emergency and acute care*** covers the services that respond when people experience serious illness, injury, deterioration or a health crisis requiring rapid assessment, treatment or specialist care. This includes emergency ambulance response, hospital assessment and treatment, critical care where needed, and the support people receive to recover safely and return home. The full definitions are set out within this Framework.

2 Public perceptions of health and social care polling - February 2025

3 Science Evidence Advice (SEA): NHS in 10+ years

4 NHS Wales decarbonisation strategic delivery plan 2025 to 2030

A whole-system approach to better health and care

We know that emergency ambulance services and hospitals alone cannot deliver the improvements in health and wellbeing that Wales seeks.

Good health starts long before someone needs emergency care5. It is shaped by the homes we live in, the communities around us, the opportunities available to us, and the support we receive throughout our lives.

We also know that the best-performing health systems do not choose between prevention, community services and hospital care[6]. They strengthen all three. They help people stay well for longer, provide more support closer to home, and ensure that when hospital care is needed it is timely, effective and of the highest quality[7].

That is why our Programme for Government[8] is:

- Investing in a cross-government approach to prevention.
- Providing a national whole health and care system framework for delivery of joined up health, social care, third sector and housing support closer to your home through an Integrated *Community Care System* for Wales; and
- Increasing GP capacity and strengthening social care as we move towards a National Care Service.

We will also deliver a fundamental shift towards prevention, early intervention and coordinated community-based care through our ambitious Community by Design programme, supporting you to live well, remain independent and to access urgent care on the same day in your local community.

Emergency and Acute Care Wales is the emergency and acute care contribution to the wider vision of *Community by Design*. The Framework sets out what you should be able to expect when your needs can no longer be met in our communities, and how health and care services will work together to deliver it.

Our ambition is simple: by 2034 we want you to stay well, live independently and access coordinated support closer to home, with hospital care focused on those who need specialist assessment, treatment and intervention.

But we recognise that when you, your family or friends need emergency or acute care, you deserve equally well-designed, coordinated and effective pathways that provide rapid assessment, diagnosis and treatment while limiting time away from home to what is clinically necessary.

By doing so, we can improve your outcomes, reduce inequalities, deliver better experiences for you, your friends, your families, and your community and ensure our emergency and acute care services remain sustainable and resilient for the future – and are there when you need it most.

5 A framework for NHS action on social determinants of health | The Health Foundation
6 NHS urgent and emergency care – a system under constant pressure | Audit Wales
7 NHS A&E performance improvements are smaller and slower than hoped for, watchdog finds - NAO press release
8 Programme for government 2026 to 2030 | GOV.WALES

What you should expect when you need emergency care

When an emergency happens, you should be able to trust that the right help will be available at the right time, whether that means an immediate response or transport to the right setting within a matter of minutes or hours.

Whether you experience a serious injury, develop symptoms of a life-threatening condition, or face an unexpected health crisis, you should be able to expect a rapid response, expert assessment and timely treatment.

You should not have to navigate a complex system or worry about where to turn. Care should be coordinated around your needs, delivered by the right professionals, and designed to get you the right treatment as quickly as possible.

1. If you need emergency help, you will receive the fastest response appropriate to your need.
2. If you experience an out-of-hospital cardiac arrest, you will have the best possible chance of survival and recovery.
3. You will be able to access timely emergency care in your community, wherever you live in Wales.
4. If you have a life-threatening or time-critical condition, you will receive rapid access to the expert assessment, treatment and care you need.
5. You will be directed to the right service first time, reducing unnecessary referrals, admissions and transfers.
6. You will experience coordinated care across emergency, acute and critical care services.
7. If your condition can be managed through same day emergency care, you will be assessed, treated and supported to return home on the same day wherever possible.
8. If you are living with frailty, complex needs or approaching the end of life, you will receive coordinated care that supports your independence, wellbeing and recovery wherever possible.
9. You will be listened to, involved in decisions about your care, and treated as a partner in planning your treatment and support.
10. If you need additional support or specialist expertise, you will be able to access it in a timely way regardless of where you live or your circumstances.

Delivering the change you should expect to see

This Framework sets out how emergency and acute care services across Wales will work together to deliver the improvements that matter most to you and your family.

It describes a single, connected pathway of care.

From the moment you recognise that you, your relative, friend or even a passerby need emergency help, through assessment, treatment and specialist care, to recovery and support at home, services should work together to provide a seamless experience centred around your needs.

To make this happen, health boards, NHS trusts, local authorities and partner organisations across Wales will be expected to work together, plan together and improve services together, focusing on the outcomes and expectations set out in this Framework.

You deserve to know when things will improve

People have told us that they want to know not only what we plan to do, but when they can expect to see improvements and how progress will be measured.

That is why this Framework includes a series of annual milestones running up to 2030. These milestones set out the progressive improvements we expect to see each year, beginning in 2027, and provide the basis against which delivery and progress will be measured across emergency response, access to care, hospital flow, recovery and timely return home.

They are intended to provide a clear roadmap for change and a transparent way for the public to judge whether progress is being made. Time does not stand still and in 2030, we will review delivery against the Framework's milestones and outcomes, taking stock of progress and identifying any further actions needed to achieve our 2034 ambition.

Supporting local services to deliver

We recognise that delivering these improvements will require support as well as accountability.

National NHS improvement teams will work alongside health boards, NHS trusts and partners to help spread effective practice, support service improvement, strengthen leadership and share learning across Wales.

Where progress is slower than expected, additional support will be provided to help local organisations understand the challenges they face and accelerate improvement. This support will never replace local responsibility for delivery, but it will help ensure that successful approaches are identified and adopted more consistently across Wales.

We will publish progress openly

You should be able to see whether services are improving.

We will therefore monitor progress against the outcomes and milestones set out in this Framework and publish regular information showing how emergency and acute care services are performing.

Over time, this will provide a clearer and more transparent picture of the care people experience across Wales, including information on experience, patient flow, delays, recovery and discharge from hospital.

Importantly, we will also strengthen our understanding of issues that matter to patients and families, including experiences of corridor care, avoidable delays and difficulties leaving hospital when clinically ready.

What you should expect if you need acute hospital care

We know that most people want to spend as much time as possible in their own home, surrounded by the people and things that matter to them. Hospital care plays a vital role when specialist assessment, treatment and support are needed, but no one should spend longer in hospital than is clinically necessary.

Evidence shows that prolonged hospital stays can affect yours and your relatives' mobility, independence and wellbeing, particularly for older people. That is why we want every day anyone spends in hospital to be purposeful, focused on recovery and helping people return home as soon as it is safe to do so.

This Framework sets out a different approach.

Rather than measuring success by how we manage your hospital stay, we will focus on rapid assessment, timely diagnosis, effective treatment and early recovery. Hospitals will continue to provide access to specialist expertise and advanced care when it is needed, but we want your recovery at home to become the norm wherever it is safe and appropriate.

Our ambition is clear: you should spend only the clinically necessary time away from home. In most cases, and wherever it is safe to do so, we expect you to receive the assessment, treatment and support you, your family or friends need and return home within 72 hours. Time spent at home helps you maintain independence, mobility and wellbeing, while ensuring hospital care remains focused on providing the specialist assessment and treatment that can only be delivered there.

Sometimes admission to hospital is required. When this is necessary you should also expect care that is coordinated, efficient and focused on helping you recover, regain independence and return home as soon as it is safe, with the right support in place.

1

You will benefit from coordinated care that helps you recover quickly and avoid unnecessary time in hospital.

2

You, your family and carers will be listened to and involved in decisions about your care and recovery.

3

You will spend only the clinically necessary time in hospital and be supported to continue your recovery at home when it is safe and appropriate.

4

You will receive care in the right place, in environments that protect your privacy, dignity and safety.

5

You will be supported to maintain your strength, mobility and independence throughout your hospital stay.

6

You will receive timely tests, specialist advice and treatment, enabling you to return home as soon as clinically appropriate.

7

You will be able to return home as soon as you are ready, seven days a week, with the medicines, equipment and support you need to recover safely.

8

You will experience coordinated recovery and rehabilitation that supports your independence, wellbeing and quality of life.

9

You will not experience unnecessary waits on the day you are discharged from hospital.

10

You will not remain in hospital solely because arrangements have not been put in place to support your return home.

This information will not be used simply to measure performance. It will be used to identify where improvements are needed, share learning between organisations and ensure action is taken quickly when people are not receiving the standard of care they should expect.

Each year we will report publicly on what has improved, where further action is needed, and whether we are on track to deliver our ambitions for 2034.

A commitment to people in Wales

At its heart, this Framework is a commitment to you.

It is a commitment that when you need emergency or acute care, you should receive the right care, in the right place, at the right time.

You should be listened to, treated with dignity and compassion, involved in decisions about your care, and supported to achieve the best possible outcome. You should spend only the clinically necessary time in hospital and be helped to return home as soon as it is safe to do so.

By working as one health and care system, focusing relentlessly on what matters to people, and being transparent about our progress, we can build emergency and acute care services that are faster, safer, more coordinated and more sustainable for future generations.

Most importantly, we can give the people of Wales what they should expect from a modern health and care system: timely access to expert care when it is needed, support to recover their independence, and more time living well at home.

Mabon ap Gwynfor AS/MS
Cabinet Minister for Health and Care



Figure 1. Emergency and Acute Care Wales: our shared aim and how we will deliver it by 2034

Community by Design. Emergency to recovery when needed. Only the clinically necessary time away from home.

One shared aim for 2034

Most people will have their needs met at home or closer to home.

Where a person's clinical need cannot be met in the community, and emergency, acute or critical care is required, they achieve the best possible:

- ✓ Experience
- ✓ Outcome; and, where possible
- ✓ Recovery

A connected pathway from rapid response to safe recovery at home

Guiding Principles (Primary Drivers)

1. Rapid access to emergency and time-critical care

When community-based care is not enough

- Fewer premature deaths and less avoidable ill health
- More life spent in good health – outcome bundle 1

2. Safe transition from hospital to home

Only the clinically necessary time away from home

- Fewer premature deaths and less avoidable ill health
- More life spent in good health – outcome bundle 2

Six Building Blocks (Secondary Drivers)

1. Rapid identification, prioritisation, response and transport to the right care
2. Timely access to definitive emergency and acute care pathways
3. Equitable and coordinated hospital care for people living with frailty, vulnerability, and at end of life
4. Effective early acute care and recovery in the first 72 hours
5. Safe, value-adding ward-based care, without avoidable delay
6. Integrated and safe seven-day transition home and continued recovery

Milestones to 2030

Measured through process and outcome measures

System Enablers

- **Equitable acute and emergency care** – Equity by design
- **Technology-enabled care** – Care beyond buildings
- **Digital and data** – One view of flow
- **Sustainable workforce** – Wellbeing and education
- **Accountability** – Clear ownership
- **Estates and infrastructure** – Environment that supports flow

Part 2: Why do we need to change?

What we mean by emergency and acute care

Emergency and acute care encompasses the services that respond when children, young people and adults experience illness, injury, deterioration or a health crisis requiring rapid assessment, diagnosis, treatment, monitoring or recovery support.

This includes emergency ambulance services, emergency medical retrieval and transfer services, emergency departments, same day emergency care, acute medicine, specialist acute and critical care services, mental health crisis services, inpatient hospital care, and the arrangements that support safe discharge, rehabilitation and transition home.

Emergency and acute care is not defined by buildings or organisational boundaries alone.

It is a connected pathway that spans community services, hospitals and recovery support, with success depending on effective collaboration across the whole health and care system.

Whilst many people can be supported at home or closer to home, hospitals remain a fundamental part of that pathway, providing specialist assessment, treatment and monitoring for people whose needs cannot be met safely elsewhere.



***Emergency care** is the response to immediate or time-critical risk. It is provided to people whose physical or mental health condition requires rapid assessment, stabilisation or treatment to prevent death, serious harm or permanent disability.*

It includes the identification, prioritisation, assessment and treatment of people with serious illness, injury or deterioration, ensuring access to the right care, in the right place, at the right time, including specialist emergency, acute, critical care services where required.

***Acute care** is the specialist assessment, diagnosis, treatment, monitoring and recovery support provided to people whose physical or mental illness, injury or deterioration cannot be managed safely through routine community-based services alone.*

Acute care is typically short-term and focused on active treatment in hospital, restoring health and function, supporting recovery, and enabling people to return safely home as soon as clinically appropriate.

Scope

This framework covers the emergency and acute care pathway from the point at which a person's needs can no longer be safely met within routine community services, through emergency response, in-hospital assessment, diagnosis, treatment and, where necessary, admission, to safe transition home.

It includes emergency, acute, frailty and end-of-life pathways, together with the transitions required to ensure people spend only the clinically necessary time away from home. It does not seek to replace wider prevention, primary care, community care, mental health, elective care or social care strategies, but aligns with them where they support emergency and acute care outcomes.

Why change is needed

The dedication and professionalism of NHS Wales staff continue to provide high-quality care in exceptionally challenging circumstances. However, too many people still experience long waits for assessment, treatment, transfer or discharge, with consequences for their outcomes, experience, dignity and safety.

People may wait longer than is clinically appropriate in emergency departments, undergo avoidable transfers within hospital, remain in hospital after they are ready to leave, or receive care in environments that do not meet the standards patients and staff rightly expect. Rising demand, an ageing population, increasing complexity of need and workforce pressures mean that maintaining the status quo is not an option.

What the evidence suggests

Evidence gathered through stakeholder engagement and literature review highlighted that many of the challenges facing emergency and acute care are not isolated to individual services.

The NHS in 10+ years review[9] identifies increasing demand, an ageing population, higher levels of frailty and multiple long-term conditions, workforce pressures and delayed transitions of care as major pressures on health and care systems. Critically, it also highlights the need for services to become more integrated, preventative and person-centred in response to these challenges. This reinforces the need to view emergency and acute care as a connected pathway rather than a series of separate services.

9 Science Evidence Advice (SEA): NHS in 10+ years

In Wales, NHS urgent and emergency care – a system under constant pressure, published by Audit Wales[10], concludes that pressures across ambulance services, emergency departments, hospital care and discharge pathways are closely interconnected. The report highlights how delays and constraints in one part of the system can create consequences throughout the wider urgent and emergency care pathway, reinforcing the need for a whole-system approach to planning, delivery and improvement.

These pressures also affect the wellbeing and safety of the workforce. The Royal College of Emergency Medicine[11] has highlighted overcrowding and increased workloads as contributors to burnout among emergency department staff. The Royal College of Nursing[12] has also linked long waits in emergency departments and corridor care with an increased risk of violence and aggression towards staff.

Evidence from across the UK and internationally increasingly shows that emergency department performance and the experience of care delivered across the hospital 'front doors' are shaped by patient flow across the wider acute hospital and community care system. Delays in assessment, admission, transfer, treatment, discharge or recovery restrict timely access to care, intensify pressure on emergency departments and can adversely affect patient outcomes. High-quality emergency and acute care saves lives, restores health, preserves independence and provides access to specialist assessment and treatment.

This position is further supported by recent National Audit Office analysis[13], which concluded that sustainable improvement requires whole-system management of patient flow, strong operational leadership, better use of data and more effective support for people leaving hospital.

Improving emergency and acute care therefore requires a focus not only on access, but on enabling people to move safely and efficiently through every stage of their journey, from first contact and emergency response, through specialist assessment and treatment, to recovery and return home.

10 NHS urgent and emergency care – a system under constant pressure | Audit Wales

11 RCEM Acute Insight Series: Crowding and its Consequences

12 Corridor care: unsafe, undignified, unacceptable | Royal College of Nursing

13 Managing the flow of patients through hospital from A&E - NAO report

Key facts

2 hours, 24 minutes
two-year average stroke 'call to door' performance in Wales.
(Source: WAST)



184,850
ambulance hours lost reported in 2025/2026.
(Source: WAST/NHS Wales JCC)

7 hours, 13 minutes
on average spent in an emergency department before admission or discharge by people aged over 85 (March 2026).

Every hour of avoidable delay in emergency care increases the risk of harm and worsens outcomes for patients.
(Source: WG KAS)



15%
of patients who spent 12 hours or more in an emergency department from their arrival to discharge, admission or transfer in 2025/2026.
(Source: WG KAS)



33%
aim for realisation of discharges by midday.



18%
performance in Wales in March 2026.



(Source: NHS Wales Performance and Improvement)



62,346
people reported as admitted as an emergency who remained in an acute or community hospital over 21 days after admission 2025/2026.
(Source: DHCW)



In March 2026
1,400
people waited more than 48 hours to leave hospital despite being clinically ready for discharge.
(2025/2026: Audit Wales)

In 2025/2026, delays beyond 48 hours for transition home led to
345,000 lost bed days in Wales.
(Source: Audit Wales)



This cost around
£172m
a reduction of
15%
could release
£26m
of resources.





£500-£600
per day estimated daily cost of every hospital bed occupied by someone who is clinically ready to leave and is unavailable to another patient needing emergency or planned care.

The most expensive hospital bed is one occupied when a patient no longer needs hospital care. Reducing avoidable bed days improves patient outcomes, releases capacity, and makes better use of public resources.
(*Source: King's Fund*)

What matters to patients

People have told us they want emergency and acute care to be there when they need it, with shorter waits and timely access to the right care, in the right place.

They want services to work together around them, particularly when their needs are complex, and to be involved in decisions about their care, with clear information about what is happening and what comes next.

People also want to spend only as long in hospital as necessary, with the right support to recover safely at home, and fair access to high-quality care regardless of who they are or where they live.

Just as importantly, people want timely advice, primary and community care and support to manage their health so that, wherever possible, they can remain healthy and independent and avoid needing emergency or hospital care[14].

In its national review of emergency care experiences[15], which heard directly from more than 700 people across Wales, Llais identified concerns relating to long ambulance waits, extended stays in emergency departments, communication, comfort, dignity, coordination of care and discharge arrangements.

Llais reported that people want emergency and acute care to feel safe, calm, dignified and coordinated, with care tailored to individual needs and regular communication throughout their journey.

People further emphasised the importance of joined-up services, better transitions between organisations, improved discharge arrangements and reducing the need to repeatedly provide the same information.

A poll conducted for the Health Foundation[16] on perceptions of health and social care further supports our focus on emergency and acute care. It found that Wales was the only nation in the UK survey where ambulance response times was considered the top overall priority.

However, despite these challenges, people consistently expressed appreciation for the dedication, professionalism and compassion shown by NHS staff working in difficult circumstances.

What frontline staff have told us

Feedback from frontline staff reinforces that many of the pressures experienced in emergency departments, ambulance services and acute hospitals are symptoms of wider system pressures. Delays in assessment, treatment, transfer and discharge restrict patient flow, contribute to overcrowding and corridor care, and adversely affect the experiences and outcomes of patients and staff.

Staff consistently identified five priorities for improvement:

- better flow through hospitals, supported by earlier discharge and recovery planning;
- greater access to care closer to home and support for recovery in the community;
- a sustainable and supported workforce able to deliver safe care;
- more integrated services, pathways and information sharing; and
- improved safety, dignity and personalised care, particularly for people with frailty, dementia, mental health needs and other vulnerabilities.

These priorities have directly informed the outcomes, building blocks and delivery enablers set out in this Framework.

14 Welsh Government Beaufort Wales Omnibus Emergency and Acute Care Survey 2026

15 Llais - Getting Urgent and Emergency Healthcare Welsh Hospitals

16 Public perceptions of health and social care polling - February 2025

What other stakeholders have told us

Feedback from local health boards, NHS trusts, professional bodies, third-sector partners and national improvement bodies highlighted a strong consensus that emergency and acute care should be understood as a single pathway rather than a collection of separate services.

Stakeholders consistently described delays, overcrowding and corridor care as visible symptoms of wider pressures affecting prevention, hospital flow, discharge, recovery and community support.

Stakeholders also emphasised the importance of improving communication, coordination and information sharing across organisational boundaries.

Many described a need for care to feel more joined up, with fewer repetitive assessments, smoother transitions between services and better use of shared information to support decision-making and continuity of care.

There was broad support for a greater focus on outcomes, safety, dignity, independence and recovery, alongside timely access to care. Stakeholders consistently highlighted the importance of clear priorities, visible milestones, stronger accountability and the more consistent spread of proven practice across Wales.

These themes have directly informed the Framework's focus on whole-system flow, person-centred outcomes, integrated pathways and delivery through measurable milestones.



Part 3: What we expect of NHS Wales and partners

Shared aim for 2034

Our aim is that by 2034, most people will have their health and care needs met at home.

Where a person's clinical needs cannot be met in the community, and emergency acute or critical care is required, our aim is that they achieve the best possible experience, outcome, and where possible, recovery.

What this means for service users

Our aim is best understood through the experiences of people who need different forms of emergency and acute care.

The following three illustrative journeys show what people should be able to expect by 2034 – from their first contact with services, through assessment and treatment, to recovery and ongoing support at or closer to home.

Each journey demonstrates how services should work together around the person to provide the right response at the right time, avoid unnecessary delay and support the best possible recovery.

From vision to delivery

The three journeys overleaf illustrate the experience we want people to have by 2034. Delivering this consistently across Wales will require coordinated improvement across the whole emergency and acute care pathway.

The framework therefore moves from the experience of the person to a clear delivery architecture:

- Primary drivers – our guiding principles – describe the fundamental changes the health and care system must achieve.
- Outcomes define the improvements people should experience as a result.
- Building blocks – the secondary drivers – set out the standards, capabilities and ways of working needed to deliver those outcomes.
- Delivery milestones establish the progressive steps and measurable improvements expected each year between now and 2034, providing a basis for implementation, measurement and accountability.
- Inbuilt review period in 2030 to reset and re-establish milestones up until 2034 to ensure agile delivery route to outcomes.

Together, these elements connect the national vision to practical action – showing what needs to change, what good looks like, how it will be achieved and how progress will be demonstrated.

Journey 1
Imran, 49, experiencing a stroke

Background

Imran is 49 and lives in Swansea with his wife and two children.

He works as an electrical engineer and is generally fit and active, but his treated high blood pressure has not always been monitored closely.

What happens today

One night, Imran wakes with weakness in his right arm but assumes he has slept awkwardly. The weakness remains the next morning and the right side of his face feels unusual. Imran and his wife are concerned but do not recognise the signs of stroke. After being advised that an ambulance may take several hours, his wife drives him to the emergency department.

While Imran waits, his face begins to droop and he struggles to speak and move one side of his body. Following several assessments, brain imaging confirms a stroke and treatment begins, but valuable time has been lost.

Imran spends more than three weeks in hospital. Rehabilitation begins during his admission, but communication and planning are fragmented and his family remain uncertain about his recovery and the support available after discharge.

Twelve months later, Imran has not returned to work and the family are struggling with the financial, caring and emotional effects of his stroke. They feel unsupported and unsure where to turn for help.

What matters to him

- Returning home to his family.
- Regaining his independence and returning to work.
- Confidence that serious illness will be recognised and treated quickly.

Current challenges

- Opportunities to identify and manage Imran's stroke risk were missed.
- Stroke symptoms were not recognised quickly and self-conveyance delayed pre-hospital assessment.
- Repeated assessments and handovers delayed specialist treatment.
- Rehabilitation, family support and longer-term recovery were not well coordinated.

What Imran should expect by 2034

- Imran and his wife immediately recognise the symptoms of stroke and calls 999. The emergency call is supported by specialists who are trained to recognise stroke. The stroke emergency process has started before the ambulance even arrives.
- Using video calling, paramedics connect directly with stroke specialists to do an assessment. The hospital stroke unit is alerted that Imran is on his way.
- When arriving at hospital, Imran is taken directly to the stroke unit. Emergency scans and other reviews take place immediately. Treatment begins without unnecessary delay and staff begin to make plans for Imran's recovery.
- Imran and his family are given lots of information to help them understand what is happening, what treatment is being provided and what recovery is likely to involve. Imran is supported by health and care teams, charities, community groups and peer support and he feels supported and surrounded by the help he might need throughout his recovery.
- Imran's wife and wider family are given separate advice and support to understand their new roles caring for someone recovering from stroke.
- Following a short inpatient stay, Imran's rehabilitation and follow-up are coordinated through community services and digital support, after six months, Imran returns to work on reduced hours initially and he and his family feel hopeful for the future.

What success looks like

- Better prevention and management of stroke risk.
- Faster recognition, specialist assessment and treatment.
- Better survival and recovery, with less avoidable disability.
- Coordinated rehabilitation and family support, enabling more people to recover at home and return to work.

Journey 2
Mair, 84, living with frailty and multiple long-term conditions

Background

Mair lives alone in rural Gwynedd and Welsh is her first language. She lives with frailty, COPD, heart failure, osteoarthritis and mild cognitive impairment.
Her daughter lives nearby and helps with shopping, medicines and appointments.

What happens today

After several days of increasing breathlessness, cough and confusion, Mair becomes acutely unwell. Her daughter calls 999.

Because demand is high, she waits several hours for an ambulance response. On arrival at hospital, ambulance crews experience handover delays and Mair waits further before reaching an appropriate clinical area. She is eventually diagnosed with sepsis secondary to pneumonia.

Over the first few days she moves between multiple care environments. Assessment of her mobility, cognition, social circumstances and discharge needs happens at different times and by different teams.

Although the infection improves, the hospital stay affects her mobility and confidence. Discharge planning starts late and delays occur while support arrangements are coordinated.

Mair leaves hospital clinically recovered from her infection but less independent than she was before admission.

What matters to her

- Remaining independent.
- Living safely in her own home.
- Communicating in Welsh when she is unwell.
- Avoiding unnecessary time in hospital.
- Staying connected to her daughter and local community.

Current challenges

- Delays before treatment begins.
- Fragmented assessment.
- Repeated handovers.
- Risk of deconditioning and delirium.
- Delayed discharge planning.
- Loss of independence.

What Mair should expect by 2034

- Mair's daughter seeks help as soon as her condition deteriorates. Clinicians can access Mair's shared record, including her frailty assessment, medicines, care preferences, language needs and previous admissions.
- Mair receives an urgent clinical assessment, including consideration of whether enhanced community care could safely meet her needs at home. She is showing signs of severe illness and requires emergency transfer for hospital assessment and treatment. The receiving acute and frailty teams are alerted before she arrives.
- Assessment considers Mair's suspected infection alongside her frailty, cognition, mobility, independence and support network. Diagnostics and treatment begin without unnecessary delay, supported by early Comprehensive Geriatric Assessment that follows her throughout the pathway.
- Staff know that Welsh is Mair's preferred language, enabling her and her daughter to understand the plan and participate in decisions. Her daughter is recognised as a partner in her care and recovery.
- Maintaining mobility, confidence and independence is treated as an essential part of her care, and planning for recovery and transition home begins on admission.
- Once acute hospital treatment is no longer required, Mair returns home with coordinated medicines, rehabilitation and community follow-up, with clear arrangements for further help if her condition deteriorates.

What success looks like

- Early recognition and treatment of suspected sepsis, with hospital admission only where clinically necessary.
- Early Comprehensive Geriatric Assessment and coordinated care throughout the pathway.
- Less delirium, deconditioning, avoidable movement and loss of independence.
- Earlier supported recovery at home, with care that reflects Mair's language, preferences and individual needs.

Journey 3
Ffion, 16, experiencing diabetic ketoacidosis

Background

Ffion is 16 and has type 1 diabetes. She is moving from paediatric to adult diabetes services and is becoming more independent in managing her condition, with support from her parents.

Following a viral illness, Ffion develops increasing thirst, vomiting and fatigue. Overnight, she becomes confused and difficult to wake.

What happens today

Ffion's parents recognise that she is seriously unwell and call 999. In the emergency department, she is diagnosed with profound diabetic ketoacidosis affecting her level of consciousness. Emergency treatment and resuscitation begin, and adult critical care support is requested.

Emergency, general medicine, diabetes and critical care teams review Ffion at different times. Delays and multiple handovers mean that she waits longer in the emergency department before transfer to critical care.

As Ffion improves, transfer to a medical ward is also delayed. Rehabilitation, diabetes education and discharge planning begin later than they should, prolonging her critical care and hospital stay.

Information from Ffion's paediatric diabetes care and transition plan is not readily available to every team. Ffion and her parents repeatedly explain her history and remain uncertain about who is coordinating her care and what will happen next.

What matters to her

- Feeling safe and understanding what is happening.
- Being involved in decisions about her care.
- Returning to education, friends and normal life.
- Receiving support that recognises her growing independence without excluding her family.

Current challenges

- Delayed and poorly coordinated input from adult diabetes, medical and critical care teams.
- Multiple handovers and delays between emergency, critical care and ward settings.
- Recovery, education and discharge planning starting too late.
- Poor continuity of information during transition from paediatric to adult diabetes care.
- Uncertainty for Ffion and her family about responsibility and next steps.

What Ffion should expect by 2034

The severity of Ffion's illness is recognised immediately. Emergency treatment begins without delay and the adult diabetes, medical and critical care teams work to one agreed plan. She is transferred promptly to critical care for the monitoring and treatment required because of her reduced consciousness and severe illness.

Her shared clinical record includes relevant information from paediatric diabetes services and her transition plan. Adult teams can see her usual diabetes management, previous care and agreed support needs without asking Ffion or her family to repeat the same information.

Ffion is treated as a young person entering adult care. She is involved in decisions as soon as she is able to participate, while her parents remain informed and involved in accordance with her wishes. Her physical condition, emotional wellbeing, education and family circumstances are considered together.

Diabetes specialist nurses, dietetics and other relevant professionals contribute early. Recovery, education and discharge planning begin from admission rather than after critical care treatment is complete.

As Ffion improves, responsibility transfers seamlessly from critical care to specialist ward care and then to community follow-up. Before discharge, Ffion and her parents understand what contributed to the DKA, how to recognise deterioration, how to manage illness safely and where to seek urgent help. Ongoing care is coordinated through adult diabetes services, with continued transition support from paediatric services where needed.

What success looks like

- Immediate recognition and evidence-based treatment.
- Coordinated emergency, critical care, medical and specialist diabetes care.
- Clinical information and care plans transferring seamlessly from paediatric to adult services.
- Timely transfer to and from adult critical care, without avoidable delay.
- Recovery, education and discharge planning starting from admission.
- Safe recovery, a shorter hospital stay and return to education and normal life.

Guiding principle 1: People should receive rapid access to emergency and time-critical care

Our first priority is to ensure that people with serious or life-threatening needs are identified quickly and receive the right response without avoidable delay.

Rapid access to emergency and time-critical care saves lives, improves outcomes and reduces avoidable harm.

When people experience serious illness, injury or deterioration, delays in assessment, diagnosis and treatment can have significant consequences. The health and care system must therefore be organised to identify need quickly, prioritise effectively and ensure people receive the right care, in the right place, at the right time.

Ensuring rapid identification depends on timely access to the diagnostics needed to confirm or exclude serious conditions and guide definitive treatment. Diagnostic pathways should be organised around clinical need, with results interpreted and acted upon without avoidable delay.

This requires the whole system – from first contact and clinical triage to ambulance response, transfer and specialist treatment – to work as one coordinated pathway.

This section sets out:

- the building blocks needed to deliver our policy priority consistently across Wales
- the milestones that will demonstrate progress towards 2030; and
- the outcomes we want to achieve by 2034.

Building blocks for delivery by NHS Wales and partners

The building blocks are used to describe one connected pathway.

They begin with recognising emergency need and getting the person to the right response, then cover access to definitive care and tailored support for mental health, frailty and vulnerability.

For our first guiding principle there are three key building blocks:

1. **Rapid identification, prioritisation, response and transport to the right care.**
2. **Timely access to definitive emergency and acute care pathways.**
3. **Equitable and coordinated care for people living with frailty, vulnerability, and at end of life.**

» Building block 1: Rapid identification, prioritisation, response and transport to the right care

The outcomes we want to achieve by 2034:

- The people who need emergency help most receive the fastest response suitable for their need.
- Every person who experiences an out-of-hospital cardiac arrest has the best possible chance of survival and recovery.
- People can expect timely community emergency care wherever they live in Wales.

Building block 1 is about the first critical minutes and hours. It ensures that the people with the greatest clinical need receive the fastest appropriate response and are taken directly to the service best able to treat them. It also recognises the part the public can play in improving survival, particularly through early CPR and defibrillation.

The milestones we expect the NHS and partners to deliver over the next 3 years:

2027: Reset

- National standards are established – informed by the independent evaluation of the Welsh Ambulance Services University NHS Trust's Clinical Response Model – to ensure faster recognition and response to time-critical conditions, narrowing inequalities in access and outcomes, while innovation such as drone-delivered defibrillators is explored to save more lives.
- Rapid ambulance patient hospital handovers keep emergency ambulance response capacity available for those who need it most.
- More people are supported to recognise the signs of time-critical conditions and know when and how to act, enabled by a coordinated cross-Government approach.

2028: Consolidate

- More people with time-critical conditions receive the right response and are taken directly to the right service, reducing delays and bypass emergency departments where it is the right thing for their clinical need.
- Ambulance and community clinicians can rapidly access specialist in-hospital advice and pathways, enabling people to get the right care sooner.

2029: Demonstrate improvement

- Variation in emergency care access, response and outcomes is demonstrably reduced, improving equity across Wales.
- Wales becomes a nation of lifesavers, and far more people survive out-of-hospital cardiac arrest because life-saving intervention starts sooner and reaches more people.

» Building block 2: Timely access to definitive emergency and acute care pathways

The outcomes we want to achieve by 2034:

- People with life-threatening or time-critical conditions receive rapid access to the expert assessment, treatment and care they need.
- People are directed to the right service first time, with fewer unnecessary referrals, admissions and transfers.
- People experience coordinated care across emergency, acute and critical care services.
- People suitable for same day emergency care are assessed, treated and supported to return home on the same day wherever possible.

Building block 2 is about moving rapidly from initial response to definitive care. It should not matter where the person enters the system.

Priority pathways should provide direct access to the specialist assessment, diagnostics and treatment needed to reach a definitive clinical decision without avoidable handovers, repeated assessments, transfers or default attendance at an emergency department.

The milestones we expect the NHS and partners to deliver over the next 3 years:

2027: Reset

- A consistent national approach is defined and implemented for the delivery of faster assessment, diagnosis and definitive treatment, with parity between physical and mental health needs.
- Access pathways for time-sensitive complaints and specialist clinical conditions, are reviewed to help people reach the right specialist care faster, with fewer delays, handovers and repeat assessments.

2028: Consolidate

- Emergency and crisis pathways provide timely assessment of both physical and mental health needs, in suitable environments and without one need delaying or becoming a barrier to the other.
- People with stroke, cancer and other specialist conditions are connected quickly to the expert teams and treatment they need, wherever they enter the health system.
- Emergency departments, same day emergency care, critical care and other ‘front door’ services become a clinically connected, digitally and AI-enabled system where expertise is available when needed, decisions are made faster and people receive the right care without delay.

2029: Demonstrate improvement

- Timely access to specialist assessment, diagnostics and treatment becomes the standard for people with emergency and acute conditions across Wales.
- Avoidable delays, transfers and repeat assessments are demonstrably reduced, enabling faster diagnosis, decision-making and treatment – including a demonstrable reduction in prolonged waits for mental health assessment in emergency departments.

» Building block 3: Equitable and coordinated care for people with frailty, vulnerability, and at end of life

The outcomes we want to achieve by 2034:

- People living with frailty, complex needs, and at end of life receive coordinated care that supports their independence, wellbeing and recovery where possible.
- People are listened to, involved in decisions about their care and treated as partners in planning their treatment and support; and
- People who need additional support or specialist expertise are able to access it in a timely way regardless of where they live or their circumstances.

Building block 3 recognises that clinical acuity is only part of the picture. People with frailty, vulnerability, complex needs and end of life may need earlier multidisciplinary input, adapted environments and different approaches to assessment and risk.

Equity means adjusting the pathway so that people have a fair opportunity to achieve the outcomes that matter to them, including choice and control over their care during the final days or weeks of life.

The milestones we expect the NHS and partners to deliver over the next 3 years:

2027: Reset

- National standards are established for the early identification of people with frailty, vulnerability, complex needs and at end of life, supporting equitable, personalised care and clear visibility of preferences that are respected and acted upon across the system.
- Unmet need and inequalities experienced by population groups at the 'front door' of hospitals are identified earlier and addressed systematically, improving experiences and outcomes, and reducing variation across Wales.

2028: Consolidate

- People living with frailty, vulnerability or approaching the end of life increasingly receive timely multidisciplinary assessment, coordinated decision-making and seamless care across services.
- Personalised planning, reasonable adjustments, accessible communication and appropriate specialist involvement are embedded across acute pathways.
- Access to acute oncology, palliative and end of life care is improving, particularly for under-served and disadvantaged populations.

2029: Demonstrate improvement

- Fewer people experience avoidable emergency admissions, transfers and hospital stays in the last year of life.
- Hospital-acquired harm, distress and loss of independence among people with frailty, vulnerability or at end of life are reduced.

Guiding principle 2: People should experience a safe transition from hospital to home

People should spend only the clinically necessary time away from home.

While hospital care is essential when specialist assessment and treatment are needed, prolonged stays can reduce independence, delay recovery and expose people to avoidable harms.

Safe and timely transition home is therefore a key outcome of high-quality acute care, ensuring people can continue their recovery in the most appropriate setting, supported by coordinated health, care and community services.

Achieving this requires rapid access to diagnostics, specialist interpretation and clinical decisions throughout the hospital journey. A faster test alone is not sufficient: results must inform treatment, recovery and transition planning without creating a further wait.

Building blocks for delivery by NHS Wales and partners

The final three building blocks focus on delivering effective treatment, recovery and transition home:

4. **Effective early acute care and recovery in the first 72 hours.**
5. **Safe, value-adding ward-based care, without avoidable delay.**
6. **Integrated and safe seven-day transition home and continued recovery.**

Together with the first three building blocks, they move the policy from rapid response, through definitive treatment and recovery, to only the clinically necessary time away from home.

» Building block 4: Effective early acute care and recovery in the first 72 hours

The outcomes we want to achieve by 2034:

- People benefit from coordinated care that helps them recover quickly and avoid unnecessary time in hospital.
- People, families and carers are listened to and involved in decisions about care and recovery.
- People spend only the clinically necessary time in hospital and are supported to continue their recovery at home when it is safe and appropriate.

Building block 4 underscores how acute hospitals should be designed around rapid assessment, diagnosis, treatment and recovery. A hospital stay should be as short as clinically necessary, with the majority of people able to have their needs identified, treated and safely discharged on the same day or within 72 hours of arrival, avoiding unnecessary admission and supporting recovery closer to home.

Early senior clinical decision-making, rapid access to diagnostics and timely interpretation of results, definitive treatment, multidisciplinary care and recovery planning should give people the best chance of a short, safe hospital stay. Care during the first 72 hours should be organised around maintaining function, preventing deterioration and enabling recovery, rather than simply observation.

Patients, carers and families should be active partners in care, understanding the plan, contributing to decisions about treatment and recovery, and helping to identify deterioration, barriers to recovery or concerns about discharge at any stage of the pathway.

The milestones we expect the NHS and partners to deliver over the next 3 years:

2027: Reset

- A national and clinically agreed model is established for the assessment, treatment and recovery support people need within the first 72 hours from arrival at hospital, enabling a safe return home sooner and making unnecessary hospital stays the exception rather than the norm.
- To support a 72-hour model, a nationally agreed approach is developed for rapid access to diagnostics to enable timely decisions, earlier treatment and more people to return home on the same day or within 72 hours where it is safe to do so.
- National guidance is in place and embedded so that deterioration is recognised earlier, and concerns raised by patients, carers, families or staff are acted on quickly and consistently.

2028: Consolidate

- More people receive rapid assessment, diagnosis and treatment through same-day emergency and acute care services, avoiding unnecessary hospital stays and helping them return home sooner and within 72 hours.
- Recovery begins on admission, with mobility, cognition, nutrition, rehabilitation and discharge planning considered as a standard alongside treatment.
- Patients, carers and families are consistently involved in decisions, understand the care plan and can raise concerns about deterioration.

2029: Demonstrate improvement

- Demonstrably more people complete their acute hospital episode within the first 72 hours, reducing avoidable ward transfers, prolonged stays, hospital-associated harm and loss of independence.
- Fewer people experience avoidable deterioration, delirium, deconditioning, loss of function or a prolonged stay during early acute care.
- Avoidable variation, transfers and delays in diagnosis, clinical decision-making and treatment are demonstrably reduced.

» Building block 5: Safe, value-adding ward-based care, without avoidable delay

The outcomes we want to achieve by 2034:

- People receive care in the right place, in environments that protect their privacy, dignity and safety.
- People are supported to maintain their strength, mobility and independence throughout their hospital stay.
- People will receive timely tests, specialist advice and treatment, enabling them to return home as soon as clinically appropriate.

Building block 5 is about safe progression through hospital. It means the right bed or care setting first time, clear clinical ownership and effective daily management of everything needed to move treatment and recovery forward. Better flow should eliminate avoidable delay and prevent care being delivered in corridors or other inappropriate environments.

Ward-based care should be organised around active daily progression, with treatment, diagnostics, specialist review, rehabilitation and discharge planning working together to support recovery and timely transition home.

Outstanding investigations and treatment decisions should be clearly identified, prioritised and reviewed through multidisciplinary decision-making. Diagnostic tests should only be requested where they will inform care, and delays in testing, reporting or acting on results should not unnecessarily prolong a person's hospital stay.

The milestones we expect the NHS and partners to deliver over the next 3 years:

2027: Reset

- National standards and accountability are established for safe, effective and recovery-focused ward-based care.
- National work identifies where people experience discharge delays, avoidable harm or poor experiences in hospital, including a consistent approach to measuring and reporting corridor care and action to reduce its use and underlying causes.
- National work is delivered to aid a clearer identification of unnecessary waits for tests, results and treatment decisions to help more people receive timely care and return home sooner.

2028: Consolidate

- Ward-based care consistently provides clear clinical ownership, effective multidisciplinary decision-making, active daily progression of treatment and recovery, and discharge planning from the point of admission.
- Fewer people receiving care in corridors or other inappropriate environments with clinical, operational and patient information used to routinely identify and address avoidable delay, deterioration and hospital-associated harm.
- Daily multidisciplinary review identifies and resolves outstanding diagnostic, treatment, rehabilitation and discharge actions, with clear clinical ownership and escalation where delay is affecting treatment, recovery or transition home.

2029: Demonstrate improvement

- Avoidable delays in assessment, diagnostics, treatment, specialty input, transfer and progression through hospital are demonstrably reduced.
- More people receive care in the most appropriate setting first time, with fewer unnecessary ward moves, transfers and delays.
- Corridor care is eliminated as a routine response to operational pressure, with sustained reductions in hospital-acquired harm, functional decline and prolonged hospital stays associated with avoidable delay.

» Building block 6: Integrated and safe seven-day transition home and continued recovery

The outcomes we want to achieve by 2034:

- People are able to return home as soon as they are ready, seven days a week, with the medicines, equipment and support they need to recover safely.
- People experience coordinated recovery and rehabilitation that supports their independence, wellbeing and quality of life.
- People do not experience unnecessary waits on the day they are discharged from hospital.
- Nobody remains in hospital solely because arrangements have not been put in place to support their return home.

Building block 6 is about making the transition home part of the care pathway, rather than an administrative event at the end of admission.

Planning starts on day one, medicines and ongoing care needs are coordinated before the person leaves hospital, partners work together across seven days, and treatment and recovery continue at home.

Recovery should support people to regain confidence, function and independence, with health, social care and community services working together around the person rather than organisational boundaries.

The milestones we expect the NHS and partners to deliver over the next 3 years:

2027: Reset

- National standards are established for transition planning from admission through to continued recovery at home to include clear understanding of shared accountability.
- National work is delivered to aid a clearer understanding of delayed pathways of care, additional time in hospital, return to usual residence, readmission, independence following discharge and patient and carer experience.

2028: Consolidate

- Hospital, community, primary care, social care and other partners provide coordinated transition and recovery arrangements across seven days that support more people to regain independence.
- Medicines, care information, ongoing treatment, rehabilitation and recovery needs are coordinated across settings, with patients and carers understanding the plan, their role in recovery and who is responsible for ongoing support.

2029: Demonstrate improvement

- Demonstrably more people return to their usual place of residence without avoidable delay and receive coordinated support for continued treatment, rehabilitation, recovery and independence.
- Unnecessary additional days in hospital, variation in seven-day transition arrangements and avoidable readmissions related to poorly coordinated care are demonstrably reduced.

Part 4: Support, accountability, and assurance

Accountability and assurance

Improving emergency and acute care outcomes is a shared responsibility across the health and care system:

- Health boards and NHS trusts are accountable for planning, commissioning and delivering safe and effective services that meet the expectations set out in this Framework.
- Regional Partnership Boards play a critical role in strengthening integration between health, social care and community services, particularly in relation to prevention, recovery, rehabilitation and transitions of care.

The milestones set out in this Framework describe the changes we expect to achieve by 2030. NHS Wales Performance and Improvement, working with the NHS Wales Leadership Board and its supporting governance and delivery structures, will develop and oversee detailed implementation plans to support their delivery. These plans will bring together performance and improvement priorities, and set out actions, responsibilities, measures and reporting arrangements, aligned with existing NHS Wales planning, performance and accountability processes[17].

In addition to delivery milestones, progress will be monitored through a combination of outcome measures and process measures. By April 2027, Welsh Government and NHS Wales Performance and Improvement will agree, with clinical and professional leaders, a national set of outcome indicators, supporting process measures and, where appropriate, quantified improvement targets. These will establish baselines and trajectories for delivery against the Framework's milestones, including reducing corridor care, avoidable delays and unnecessary time in hospital.

The outcome indicators developed to support this Framework will align with the wider Health Outcomes for Wales approach, ensuring that improvement in emergency and acute care contributes to, and is assessed against, the health outcomes we seek for the population of Wales.

Welsh Government will maintain strategic oversight of delivery through existing planning, performance and accountability arrangements, while health boards, NHS trusts and partners will be expected to demonstrate continuous improvement, work collaboratively across organisational boundaries and use data transparently to understand variation and improve outcomes.

Delivery enablers

The ambitions set out in this Framework cannot be achieved through service redesign alone.

Delivering sustainable improvement in emergency and acute care requires a set of cross-cutting enablers that support every part of the pathway, from first contact through to recovery at home.

These enablers underpin all six building blocks and are essential to improving outcomes, reducing variation and ensuring services remain sustainable for future generations.

1. Equitable Emergency and Acute Care

People should receive high-quality emergency and acute care regardless of their age, disability, ethnicity, language, location, socioeconomic circumstances or individual needs.

Equity should not be measured solely through equal access to services, but through ensuring that people receive the support, adjustments and coordinated care required to achieve equitable outcomes regardless of their circumstances or background.

Equity must be designed into services from the outset, ensuring care is accessible, inclusive and responsive to the needs of diverse communities across Wales. Organisations should use data and engagement to identify inequalities in access, experience and outcomes and take action to address them.

Services should recognise and respond to the needs of people who experience disadvantage, exclusion or barriers to care, including those requiring reasonable adjustments, accessible communication, advocacy, carer support or additional assistance to achieve equitable outcomes.

To support delivery of these ambitions, the Welsh Government will work with partners to develop an Equity Action Plan for emergency and acute care. The Plan will set out the actions required nationally and locally to identify, reduce and ultimately eliminate avoidable inequalities in access, experience and outcomes for people using emergency and acute care services.

2. Technology-Enabled Care

Technology should support care beyond traditional organisational and physical boundaries. Digital consultations, remote monitoring, virtual services, telehealth and assistive technologies can help people receive timely assessment, treatment, recovery support and follow-up care closer to home.

Technology-enabled care (TEC) should be used to improve access, support clinical decision-making and reduce unnecessary admission at hospital where appropriate.

Point-of-care testing, remote specialist interpretation and digitally supported diagnostics should be considered where clinically appropriate to shorten the time to diagnosis, support care closer to home and reduce avoidable transfer or admission to hospital.

Delivery of this framework will align with and support the emerging NHS Wales TEC improvement programme, ensuring digital and technology-enabled solutions are developed and implemented as core enablers of person-centred, integrated care.

3. Digital and Data

This framework and the emerging Health, Care and Prevention Group *Digital Change and Data Strategy* share a common ambition to create a more connected, data-driven health and care system. Through improved interoperability, real-time operational intelligence and a stronger use of data to drive improvement, they will support a single view of patient flow and enable safer, timelier and more coordinated care from emergency response through to recovery at home.

Information about a person's care, treatment and preferences should follow them seamlessly throughout their journey, reducing duplication, supporting clinical decision-making and helping people experience care as one coordinated pathway rather than a series of separate services.

Digital and data solutions should enable agreed models of care, support standardised pathways and provide the information needed to improve outcomes, experience and system performance.

Digital systems should support electronic requesting, real-time visibility of diagnostic status, timely reporting and reliable communication of results across care settings.

Data should measure the full pathway from diagnostic request to clinical action, enabling organisations to identify delay, variation and opportunities for improvement.

4. Sustainable Workforce

Delivery of this framework will depend on a skilled, supported and sustainable workforce. It aligns with the emerging *Long term NHS Wales Workforce Strategy* and its priorities of healthy and inclusive workplaces, sustainable services and effective use of resources; and skills and teams for the future.

The strategy will support services to plan and develop the workforce, skills, roles and multidisciplinary teams needed to respond to changing population needs and deliver safe, sustainable and person-centred care.

Workforce plans should include the clinical, scientific, technical and support capacity required to provide rapid diagnostics across seven days. This includes radiology, pathology, endoscopy, physiological science, point-of-care testing and the specialist workforce needed to interpret results and translate them into timely clinical decisions.

5. Accountability, support and assurance

Improving emergency and acute care outcomes is a shared responsibility across the health and care system.

Welsh Government, NHS Wales Performance and Improvement, health boards, NHS trusts, Regional Partnership Boards and partner organisations each have a distinct role in setting direction, delivering improvement, providing support and assuring progress.

Clear expectations, transparent reporting and effective governance arrangements are required to understand performance, identify variation, support improvement and ensure people receive safe, high-quality care regardless of where they live or access services.

Accountability will focus not only on organisational performance, but on the outcomes, experiences and improvements achieved for people using emergency and acute care services. It should be supported by openness, shared learning, evidence-based improvement and a collective commitment to reducing unwarranted variation across Wales.

6. Estates and Facilities

The framework aligns with the emerging Health, Care and Prevention Group *Estates and Facilities Strategy*, recognising that the environments in which care is delivered play a critical role in patient outcomes, experience, safety and flow. Both share a commitment to ensuring that health and care infrastructure is sustainable, fit for purpose and designed to support modern models of care.

Diagnostic capacity should be located and configured around modern emergency, acute, and same day care pathways. Estates planning should support rapid access to imaging, pathology, physiological testing and other priority diagnostics, while enabling appropriate diagnostics to be delivered in community settings where this is safe and effective.

Part 5: Glossary of terms

This glossary explains key terms used throughout the Framework.

Definitions are written for a general audience and reflect how the terms are used in the document.

Acute care

Specialist assessment, diagnosis, treatment, monitoring and recovery support provided when a person's illness, injury or deterioration cannot be managed safely through routine community-based services alone. Acute care is usually short-term and focused on restoring health and supporting recovery.

Ambulatory care

Assessment, diagnosis and treatment provided without the need for an overnight hospital stay.

Building blocks

The key standards, capabilities and ways of working required to deliver the framework's outcomes and ambitions.

Clinically ready for discharge

The point at which a person no longer requires acute hospital treatment and can safely continue their recovery elsewhere, subject to appropriate support arrangements.

Community by Design

The principle that health and care needs should be met at home or as close to home as possible, with hospital care used when specialist assessment or treatment is required.

Comprehensive Geriatric Assessment (CGA)

A multidisciplinary assessment process used to understand and address the medical, functional, psychological and social needs of older people living with frailty.

Corridor care

A frequently used term describing the provision of care in temporary or inappropriate environments, such as corridors, due to capacity pressures. This can compromise privacy, dignity, safety and patient experience.

Critical care

Specialist care for people with life-threatening illnesses or injuries who require intensive monitoring, treatment and support.

Definitive care

The specialist assessment, diagnosis and treatment required to reach a clear clinical decision and address the person's health needs.

Delayed transition of care

A delay that occurs when a person is clinically ready to leave hospital but cannot do so because the required arrangements, support or services are not yet in place.

Delivery milestones

The annual steps and expectations that organisations are expected to achieve between now and 2030 to demonstrate progress towards the framework's outcomes.

Diagnostics

Tests and investigations used to identify, rule out or monitor health conditions, including imaging, pathology, physiological measurements and laboratory testing.

Emergency care

The response to immediate or time-critical illness, injury or deterioration where rapid assessment and treatment are needed to prevent death, serious harm or permanent disability.

Emergency department (ED)

A specialist hospital department providing emergency assessment and treatment for people with urgent or life-threatening conditions.

Frailty

A state of increased vulnerability, usually associated with ageing, where a person is more likely to experience adverse outcomes following illness or injury.

Hospital flow

The movement of people through the healthcare system, from arrival and assessment through treatment, recovery and discharge, without unnecessary delay.

Integrated care

Care coordinated across organisations, professions and settings so that people experience seamless support throughout their health and care journey.

Integrated Community Care System (ICCS)

The Welsh Government approach to delivering coordinated care closer to home through partnership working across health, social care and community services.

Multidisciplinary team (MDT)

A group of professionals from different disciplines working together to plan and deliver coordinated care.

National Clinical Services Plan

A national plan for the development and delivery of clinical services across Wales, informed by population need and service sustainability.

NHS Wales Performance and Improvement (NHSWPI)

The national organisation providing improvement, benchmarking, delivery support and shared learning across NHS Wales.

Outcome measures

Indicators used to assess whether improvements have been achieved in areas such as patient outcomes, experience, safety and recovery.

Out-of-hospital cardiac arrest (OHCA)

A cardiac arrest that occurs outside a hospital setting, requiring an immediate emergency response and early resuscitation.

Pathway

The route a person takes through health and care services from first contact to treatment, recovery and ongoing support.

Person-centred care

An approach that places the individual, their preferences, values, needs and outcomes at the centre of decision-making.

Primary drivers

The guiding principles and major system-level outcome changes required to achieve the framework's shared aim and desired outcomes.

Rapid assessment

Prompt clinical evaluation to determine a person's condition, immediate needs and appropriate next steps in care.

Reasonable adjustments

Changes made to services, environments or communication methods to ensure equitable access and outcomes for people with additional needs.

Regional Partnership Board (RPB)

A statutory partnership bringing together health boards, local authorities and other organisations to improve integrated health and social care services.

Same day emergency care (SDEC)

Assessment, diagnosis and treatment for emergency patients who can safely return home on the same day without admission to a hospital bed.

Shared aim

The framework's overarching ambition: for most people to have their health and care needs met at home, and for those requiring emergency, acute or critical care to achieve the best possible experience, outcome and, where possible, recovery.

Technology-enabled care (TEC)

The use of digital and technological solutions, such as remote monitoring, virtual consultations and telehealth, to support care closer to home.

Time-critical care

Care for conditions where delays in assessment, diagnosis or treatment can significantly worsen outcomes, including stroke, sepsis, heart attack and major trauma.

Transition home

The coordinated process of supporting a person to leave hospital and continue their recovery safely at home or in a community setting.

Unwarranted variation

Differences in access, quality, experience or outcomes that cannot be explained by clinical need or patient choice.

Vulnerability

Circumstances or characteristics that may place someone at greater risk of poorer outcomes and require additional support, adjustments or specialist input.

Whole-system approach

An approach that considers how services, organisations and partners work together across the entire health and care pathway rather than focusing on individual parts in isolation.