

A photograph of a healthcare professional, likely a nurse or doctor, wearing a white lab coat and a ponytail, looking down at a patient. The patient is wearing a black and white checkered shirt and has their hair in a bun. They are in a clinical setting with a white table and a blurred background.

Chain Reaction

Managing patient flows across health
and care systems and services

June 2026



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1. Introduction

The health and care system in Wales faces unprecedented challenges which are complex and multifaceted. The system comprises a wide range of services and support delivered by people working for many different organisations in primary, community, social and acute care, each of which has its own governance, accountability structures and regulations. We need to remind ourselves that patients are at the centre of these systems, often being moved from pillar to post with little understanding of the ‘whole system’ and how and where they fit into it.

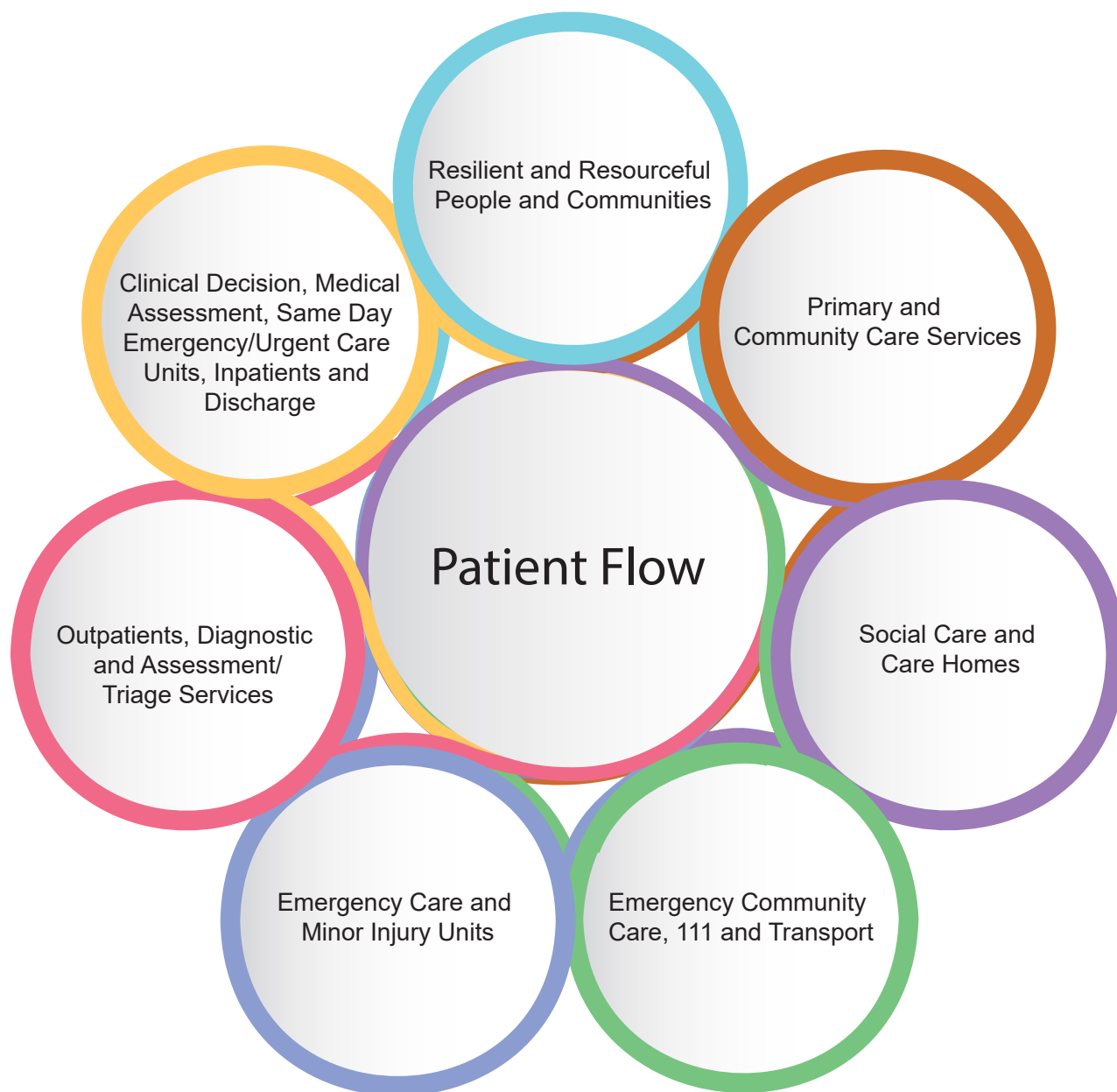
Keeping people healthy and preventing them from unnecessary admissions into hospital should be a key priority and the starting point for managing system flows. Preventing ill health and promoting healthy independent lives for an ageing population is critical using approaches and tools to predict risk and manage early interventions within the community. Prevention and community activities will reduce unnecessary and potentially inappropriate demand for both primary and secondary care services.

A coordinated “whole-system patient flow” is fundamental to enable care teams to deliver high quality, prudent services in a joined up and coordinated manner for patients. This will also help to avoid detrimental impacts upon different parts of the system as well as provide services which compress time, reduce waste and delays to improve patient care, productivity, effectiveness and efficiency.

Currently, health and care organisations are struggling to manage and balance priorities to promote and support health and wellbeing and manage demand. Identifying core building blocks to support patient flow across the whole system will help ensure improvements benefit every part of the system rather than creating pressure elsewhere.

This paper proposes a prudent approach to ensuring more effective flow across health and care services and systems, including measures to control, guide, and accelerate the flow as and when appropriate. It identifies seven key system components (Figure 2), highlighting their interdependencies and interconnectedness.

Figure 1 Seven key system components to deliver joined up care and the interconnectedness between them (Bevan Commission, 2026).



The paper provides details of evidence-based and evidence-informed causes, challenges and consequences of poor patient flow. It identifies approaches and innovative solutions to help optimise patient care, promoting prevention and early intervention, reducing inappropriate referrals and avoidable delays and waiting times.

Table 1 below details evidence of some of the main causes and consequences of poor patient flow into as well as within hospitals and the implications for people, patients and professionals across the whole system:

Table 1 Causes, challenges and consequences of poor patient flow

Causes or Challenges	Consequences
Underutilisation of supported self-care, self-management and health literacy resources and activation. ¹	<ul style="list-style-type: none"> • Increased cost for the health and care system. • Accelerated disease progression and complications. • Increased multi-morbidity and premature mortality.
Ageing population and increased demand in all care settings but particularly for emergency services ² , and in accessing GP services. ³	<ul style="list-style-type: none"> • Blocked ambulatory assessment/diagnostic units,⁴ resulting in longer waiting times for diagnostic test, investigations and elective surgeries. • Increase in number of Amber 1 999 calls (urgent but not immediately life-threatening), from elderly frail population.⁵ • Lower patient satisfaction. • Lack of care continuity.⁶
Lack of social care and residential care home capacity.	<ul style="list-style-type: none"> • High bed occupancy rates in hospitals e.g., 86.2% in 2025/26.¹⁰ • Pathways of Care Delays (PoCD) where the number of adults occupying an NHS hospital bed, who were 'clinically optimised' ready to return home or to the next stage of their care was 1,275 in April 2026. Prolonged hospital stays often lead to worse outcomes.¹¹

Health and care staffing shortages.	<ul style="list-style-type: none"> • Increased staff sickness and decreased efficiency.¹² • Staff burnout resulting in high staff turnover and early retirements.
Unnecessary or 'low-value' interventions or interventions taking place in the wrong place.	<ul style="list-style-type: none"> • Waste of resources. • Patient safety concerns.
Delays in ambulance transfers and ineffective use of other transport options.	<ul style="list-style-type: none"> • Overcrowded Emergency departments.⁸ • Slower ambulance call response times.⁹

The above challenges fall into three broad areas relating to: people's needs, demands, and the supply of services and support available. Although they are not new, they have been exacerbated by the COVID-19 pandemic and the cost-of-living crisis.

A comprehensive, integrated and system-wide approach is needed to address these challenges. This includes more flexible care pathways that allow patients and professionals to better manage their co-morbidities and the transition between different conditions, departments, organisations and practitioners, who should all be encouraged and supported to work together.

Initiatives which make the most effective use of all skills and resources, including the patient themselves, are crucial for improving patient flow and equity, as highlighted in the Welsh Parliament's Health and Social Care Committee in June 2022.¹³ A report published by Health Inspectorate Wales reviewed patient flow for stroke survivors¹⁴ and examined the entire acute stroke pathway to understand factors affecting timely care, maintain quality and safety, and identify good practices, with the goal of improving outcomes for patients. Key findings included challenges with resources, a shortage of suitable carehome beds for patients ready to be discharged, and system-level issues with cross-boundary packages of care. The report did not however, cover any pre-stroke health promotion and prevention, or the post-discharge recovery and rehabilitation phases.

2. What do we mean by patient flow?

Our current health and care system is made up of a number of disjointed, complex adaptive systems that span many sectors, professions and organisations, as well as the different needs of people.

Complex adaptive systems are those with many moving parts which often interact in unpredictable ways, producing patterns that emerge only at the level of the whole service.

'Flow' is a term that describes the *ongoing movement of people, products, equipment and information through a sequence of processes*^{15,16} i.e., between care team members, departments and organisations as part of care pathways. Poor or incomplete information can impede patient flow by triggering activities that create friction, such as redundant data, re-checking due to system inefficiencies or miscommunication. This dysfunction can manifest as delays in care, unnecessary resource use, and increased staff burden, highlighting a need for integrated and easily accessible information systems that streamline the patient journey and its activities and processes, rather than hinder.

Delivering service transformation requires both the flow of 'lean' processes and the holistic understanding of a 'systems thinking' perspective. For an effective deployment of a flow strategy, an "up-down-up" (people led-top down-people led) methodology is needed.¹⁷

The table below demonstrates how systems thinking complements the lean methodology of incremental improvement changes to deliver transformation:

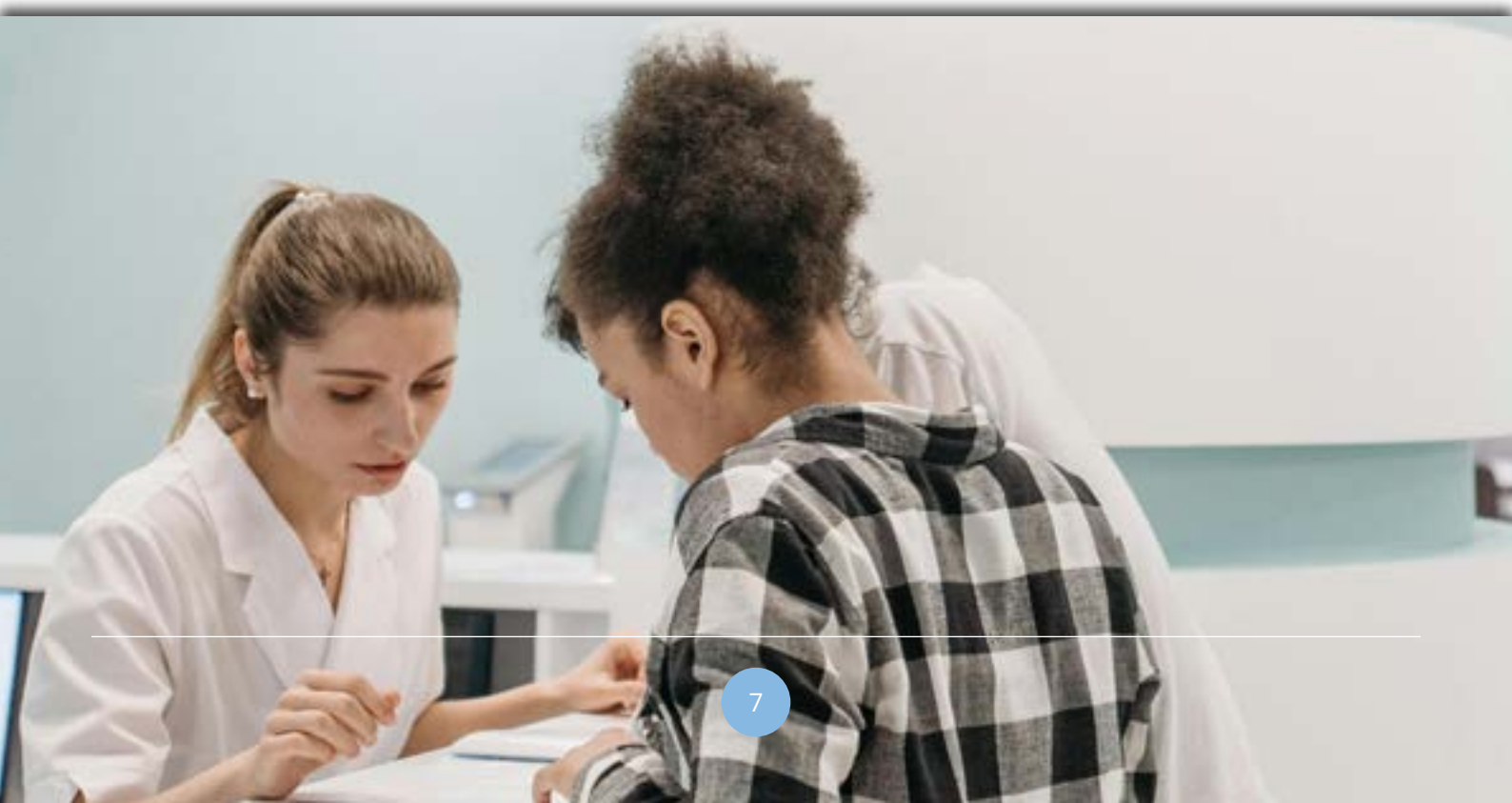


Table 2 Comparison of Lean and System Thinking approaches

Lean	Systems Thinking
Focuses on the internal and external handovers of care to enhance value.	Focuses on the wider impact of health services to enhance and create value for multiple stakeholders.
Does not often question the purpose of the service but focuses on its optimisation. Constrains an innovation by focusing on internal flows of direct services.	Expands an innovation project's scope to question the location, skills needed and appropriateness of a service. Includes radical and transformational changes.
Focuses on process and work allocation to smooth flow.	Focuses on purpose, identifying and utilising the biggest levers of organisations' operations to create ambitious innovations.
Focuses on reducing waste which cause uneven work patterns, safety issues, errors and delays.	Focuses on harnessing enterprise capacity and resources at other partners/ stakeholders in the solution provision.
Seeks to make incremental process improvements through continuous PDSA cycles.	Aims to transform ways of delivery through innovation and transformative re-design, rapid change, performance improvement across the system.

Current approaches to NHS health and care delivery often follow single condition-based pathways, resulting in fragmented patient experiences,¹⁸ duplicated interventions, excessive bureaucracy, unnecessary travel, increased workforce pressure, and issues with recruitment and retention, all contributing to heightened demand.¹⁹

Combining the tools from Lean (value stream maps, standardised working practices, rapid improvement cycles) with the Systems Thinking lens (seeing interdependencies, aligning incentives, balancing short-term solutions with long-term resilience) should enable system flow, reduce waiting times and blockages, improve patient safety, and facilitate resources being used where they add most value.

Some initiatives have focused on digital systems to manage physical patient flows, but Wright *et al.* argues that the optimal solution is a systems-based approach to service change. This should be underpinned by lean methodology, specifically through tracking the external 'value stream' - the full patient journey to improve both effectiveness and efficiency.²⁰

Historically, patient flow initiatives have focused on narrow, time-limited improvements at specific points in care pathways (e.g., Emergency Department (ED) discharge), often led by individual teams or services.²¹ While these efforts have achieved local gains, they lacked scale, were often siloed, and failed to produce sustainable, system-wide transformation due to limited cross-organisational collaboration.^{22,23}

To drive meaningful progress toward "joined up care," the UK Government's policy paper *Health and social care integration: joining up care for people, places and populations*²⁴ highlights the importance of integrated, forwardlooking strategies built on:

- Collaborative planning
- Transparent information sharing
- Coordinated service delivery

Breakdowns at any stage of the care pathway can create cascading delays, resulting in backlogs, wider system inefficiencies, and poorer patient outcomes. Addressing this requires a holistic, system-wide approach underpinned by realtime, high quality data analysis to anticipate and manage demand. Such an approach ensures care remains accessible, safe, and equitable without resorting to prioritising lower risk patients simply to preserve flow.

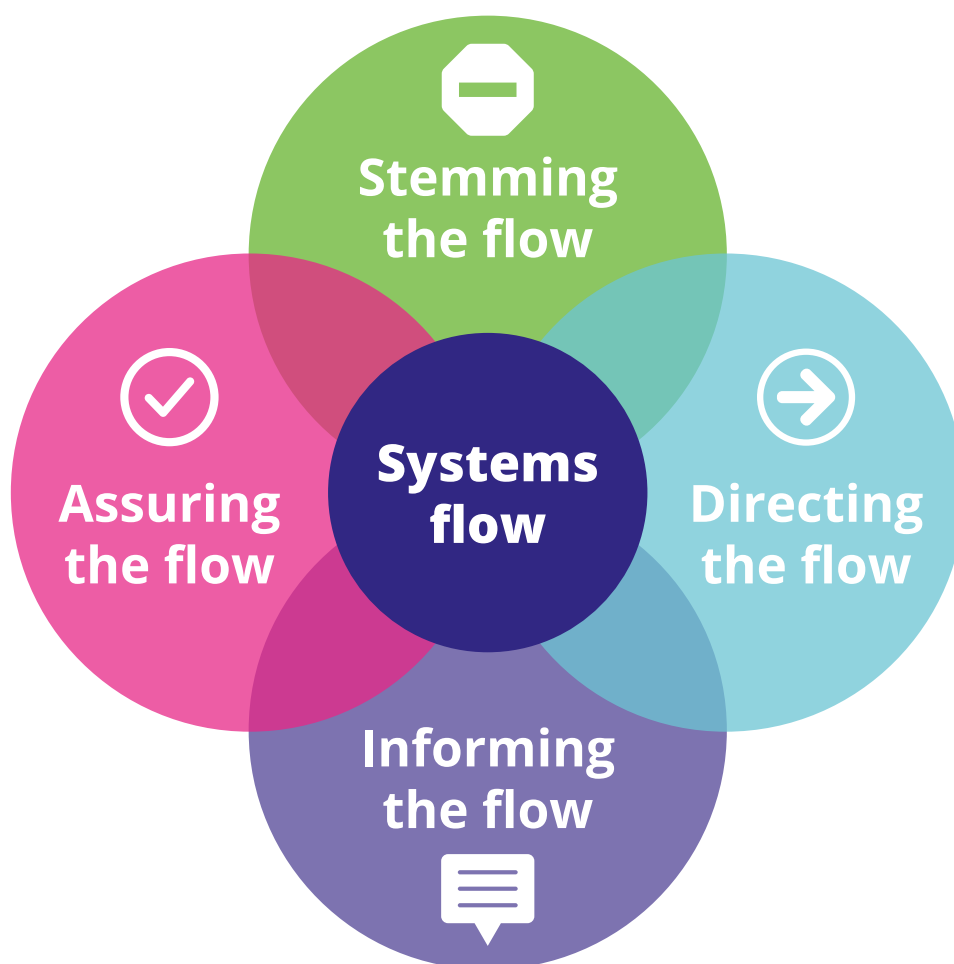
Effective patient flow depends on recognising and addressing the interconnectedness and interdependencies among all key system components (Figure 1). It should also be noted that while social determinants of health are acknowledged as influential, they are beyond the scope of this paper.

3. Patient flows to better care

The health and care system can become more efficient, equitable, and responsive by improving how it manages diverse patient needs and referral processes. Many cases involve multiple touchpoints or don't require clinical intervention at all, highlighting the need for better coordination, communication and use of wider community resources.

The following section explores different aspects of flow, and the key issues involved at each stage.

Figure 2 Main aspects of flow



3.1 Stemming the flow

Health outcomes are influenced far more by socio-economic factors than healthcare access, which only accounts for around 10% - 20 % of a population's health.²⁵ Promoting well-being and preventive health at a community level will be essential to stemming the flow into the healthcare system. Education and health literacy, digital tools such as predictive risk and support programmes like EPP and telemonitoring can reduce unnecessary demand on health services, in line with Welsh Government policy ([A Healthier Wales](#)).²⁶ Emphasis is placed on early intervention and leveraging both formal and informal community networks to support healthier lifestyles where people live, work and play ([People, Place, Health](#)) and reduce unnecessary clinical dependence.

3.2 Directing the flow

Fully understanding and modelling service demand is key to managing and directing patient flow effectively. Data will be critical to this, alongside effective communication and service coordination to enable appropriate care delivery. Approaches and care pathways that focus on 'one stop shops' and 'single points of contact' help direct patients efficiently, improving access and reducing hospitalisations. Importantly, services should align with individual needs rather than broad demographics, as mismatches in service design and patient needs can lead to poor outcomes despite adequate capacity (see [Getting it Right First Time \(GIRFT\)](#)).²⁷

3.3 Informing the flow

Real-time data and interoperable IT systems support integrated care, informed decision-making, and efficient patient pathways. Dashboards and digital tools facilitate coordination across care settings and are being introduced to support patient flow in hospitals. In Wales, population health needs assessment and chronic conditions management have long been important aspects of government policy and practice. Local Authorities and Health Boards, working through Regional Partnership Boards, are responsible for assessing population health and wellbeing needs using data and evidence to inform services. Targeted, data-driven approaches such as risk stratification can enhance targeting care to those individuals who are most likely to benefit and help reduce variation.

3.4 Assuring the flow

Real-time monitoring and evaluation of patient flow is vital to ensure responsive and effective care delivery. However, an excessive focus on measurable targets such as emergency care can inadvertently sideline other crucial priorities such as prevention and early intervention. To counter this, the adoption of integrated objectives and cross-sector collaboration, steered by Regional Partnership Boards, is strongly advised.

Promising initiatives like GIRFT and the [Bevan Exemplars](#) programme highlight the potential for improved outcomes. For these efforts to succeed, strategies must be tailored to local contexts through co-production with stakeholders, fostering genuine engagement and ownership of change. These approaches demand committed leadership and active support from senior teams across all involved organisations.

Addressing funding inequalities, particularly within social care, is essential to prevent system blockages, such as delays in hospital discharge. To encourage smoother service flow, stronger integration, and collaborative practice, innovative contracting approaches (e.g., capitation and alliance models) alongside financial reforms are recommended

4. From whole-system pathway theory to prudent practice - making it happen

Recent research and evidence from a range of sources reveals a significant number of successful innovative practices and multi- and trans-disciplinary 'team' thinking, guidance and case studies. Many of these are of Welsh origin, including Bevan Exemplar projects, and reveal useful and proven new methods for health and care system clinicians and managers.

However, many of these approaches, along with valuable evidence from NICE guidelines, Health Technology Assessment and Value-based Health and Care models, have not been consistently implemented. The Bevan Commission's [Adopt, Spread and Embed](#) programme sets out a systematic and evidence-informed approach to support the adoption and adaptation of these projects enabling their benefits - individually and collectively - to be realised across the whole system in Wales.

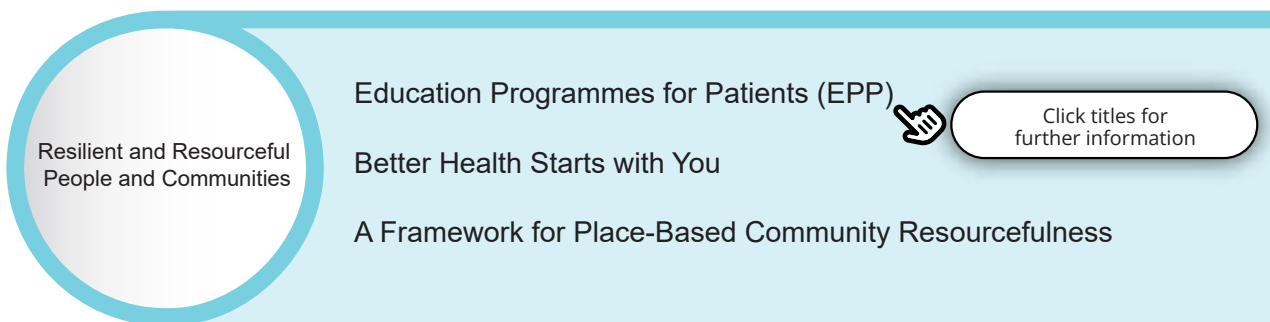
The following section explores each component of a modern 'high flow' health and care system, providing details of evidence-based, innovative good practices and Bevan Exemplar projects that have demonstrated impact and have the potential to be adopted across Wales.



5. Understanding the seven key system components

This section examines each of the system components and highlights three prominent, evidence-based examples of good practice and guidance that should be deployed to provide the building blocks for further innovation and transformation.

5.1 Resilient and resourceful people and communities



Resilient and Resourceful People and Communities

Education Programmes for Patients (EPP)

Better Health Starts with You

A Framework for Place-Based Community Resourcefulness

Click titles for further information

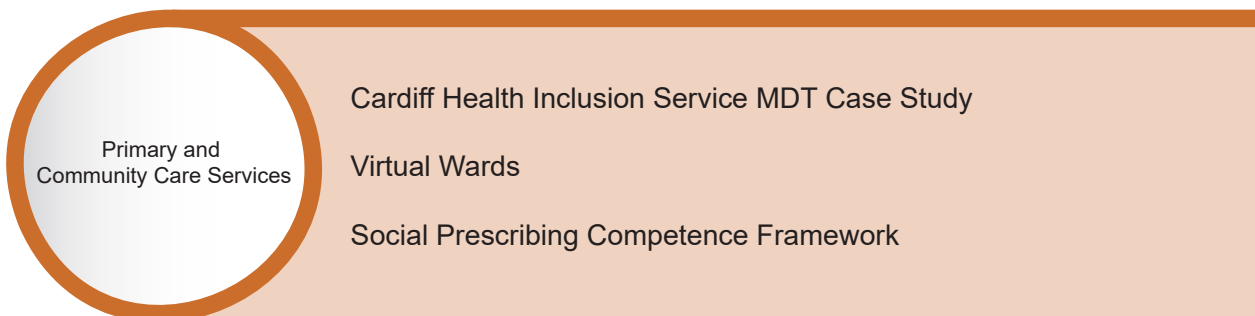
Building community resilience in Wales aims to empower individuals and communities to take greater control of their health and well-being, involving collaboration with third sector organisations, social care professionals, and the broader community. Key strategies include anticipatory care planning, promoting healthy lifestyles, and reintegrating people into their community post-discharge. The Bevan Commission's Foundations for the [Future Model for Health and Care in Wales](#) and its joint paper with ARUP, [People, Place, Health](#), advocate for a collaborative, whole-society approach that integrates public health and community support.

Programmes like Education Programmes for Patients (EPP), remote monitoring, and enhanced digital resources are helping to build resilience in a more digitally capable post-Covid Wales.²⁸ The Welsh Government's [Help Us Help You](#) campaign supports this by directing people to the right care, at the right time.

While the Wales Audit Office's [Together We Can](#)²⁹ report outlines objectives for building community resilience, a comprehensive, coordinated strategy involving the third sector remains lacking. This gap affects patients' dignity and experiences, including end-of-life care at home. Social Care Wales also calls for more initiatives that enhance community resourcefulness to support resilience.³⁰

Volunteering, rooted in Welsh cultural values, is a vital part of this ecosystem. The third sector in Wales comprises over 41,000 organisations, with increased participation noted post-pandemic. The Bevan Commission and the Wales Council for Voluntary Action have acknowledged this through frameworks and resources like the [Framework for Volunteering in Health and Social Care](#) and the Bevan Commission's [Values and Value of Volunteering](#).

5.2 Primary and Community Care Services



Primary and
Community Care Services

Cardiff Health Inclusion Service MDT Case Study

Virtual Wards

Social Prescribing Competence Framework

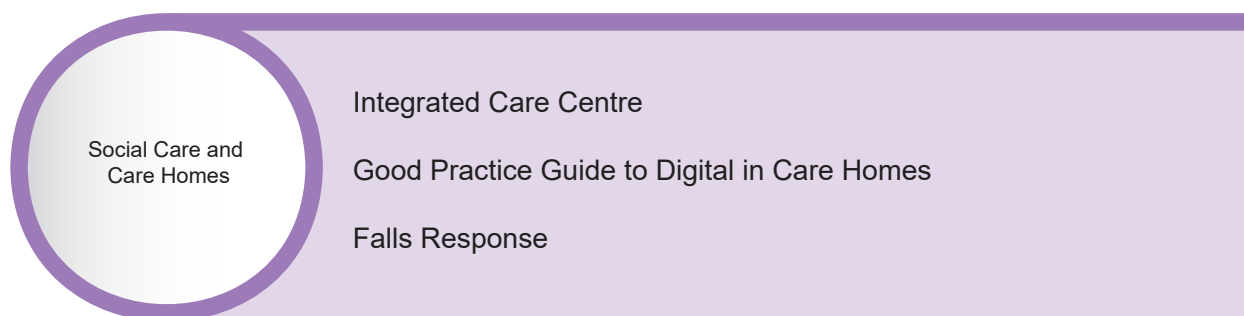
Primary and community care typically serve as the first point of contact within the healthcare system. They encompass a wide range of services including general practice, community pharmacy, dentistry, optometry as well as community nursing and other community-based services and support. Resilient people and communities often engage in proactive health behaviours, supported by trusted primary and community care teams as recognised by the Welsh Government's Primary Care One [Community by Design](#) approach. These services are delivered across various settings, such as homes, clinics, community centres, schools, and leisure facilities, ensuring care is accessible and embedded within local communities and is an integral part of Wales' [Integrated Community Care System](#) (ICCS).

In the UK, effective primary and community care services are defined by their local accessibility, person-centred approach and comprehensive service delivery providing continuity of care and care coordination including access to multidisciplinary teams (MDTs). This model of strong community ties and trust in local care providers facilitates timely access to appropriate care and helps reduce avoidable visits to emergency departments. They can also help improve uptake of services like screening, vaccination and chronic conditions management. In Wales, the MDT approach is further strengthened through Primary Care Clusters and social prescribing, which addresses non-clinical factors that influence health and wellbeing.

To reduce preventable hospital admissions and support early discharge, Wales has introduced several community-based initiatives. These include “Hospital at Home” services, where care is extended into the community by trained staff, and “Virtual Wards,” which utilise MDTs, sometimes involving secondary care clinicians, for clinical oversight and ongoing patient monitoring. These models often incorporate telemonitoring technologies and require workforce strategies tailored to match patient needs with the right expertise.

Guidance from organisations such as the Institute of Healthcare Management and the British Geriatrics Society offers valuable recommendations for enhancing virtual wards, hospital-at-home services, and telemonitoring, particularly in the care of older adults.

5.3 Social Care and Care Homes



In Wales, the interconnection between social care, care homes, and the NHS is explicitly recognised in national policy frameworks such as the *Social Services and Well-being (Wales) Act 2014*, the *Well-being of Future Generations Act 2015*, and the Welsh Government’s Six Goals for Urgent and Emergency Care. These policies emphasise that patient flow, resilience, and community-based care are inseparable from the sustainability of the health and care system.

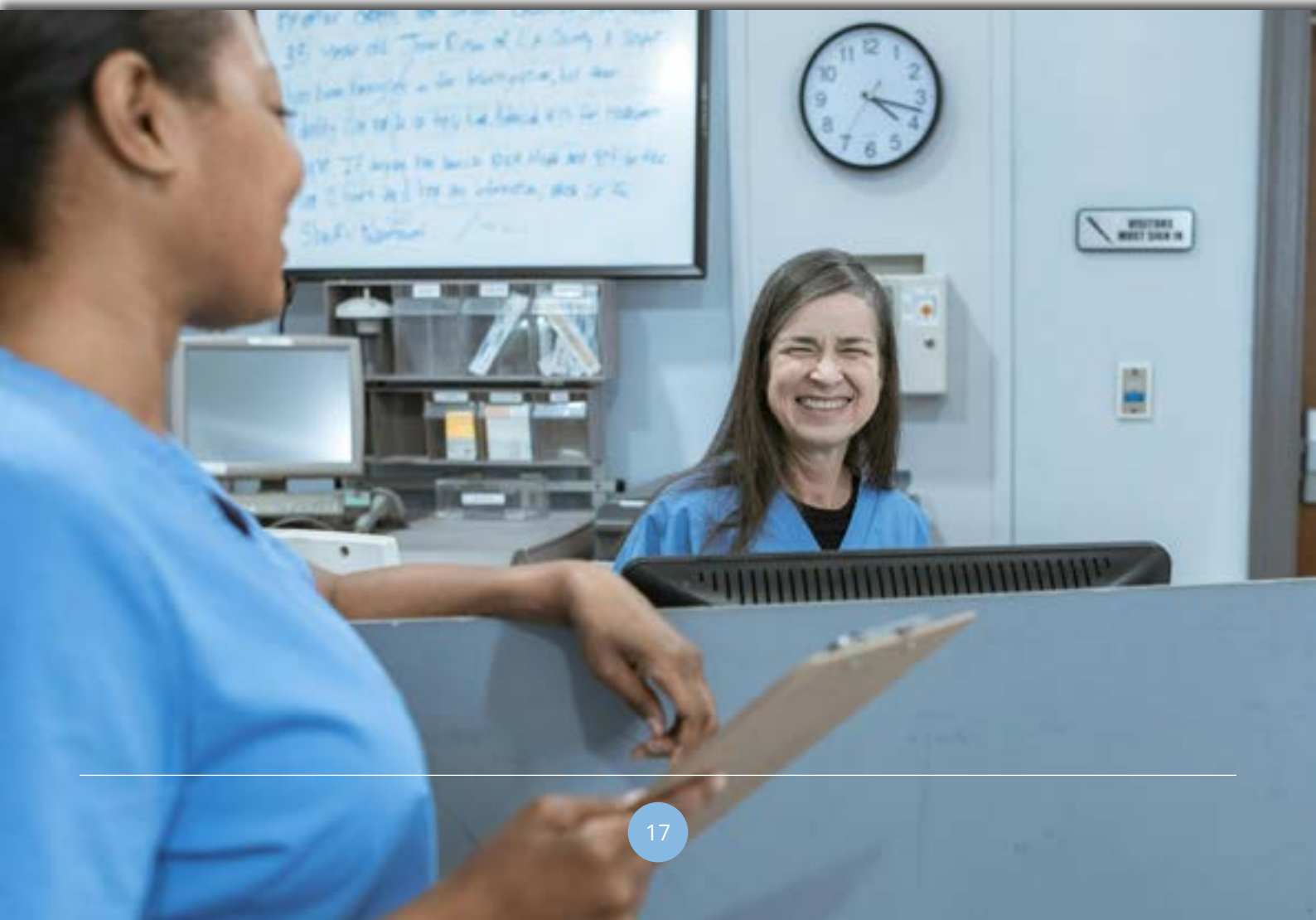
Social care is provided by local authorities, private providers, and the third sector for adults and children. Whilst service and workforce pressures often cause delays in assessments and services, increasing patient vulnerability and reliance on healthcare and family carers, Social Care Wales’ [Ymlaen the Research Innovation and Improvement Strategy for the Social Care Sector 2024 - 2029](#) aims to develop and test new ways of doing things, making services more person-centred, and understanding what works and why.

In addition, the work of the Regional Partnership Boards to develop and test six new models of care, together with creating 50 integrated care hubs/centres across Wales is ongoing and


forms part of the new Integrated Community Care System (ICCS) approach. This is bringing together the primary and community, urgent and emergency care strategic programmes and should help facilitate and streamline performance, governance and accountability across the health and care system, as can be seen in the case study for the Integrated Care Centre in the north of England.

Expanding social care capacity and adopting innovative models are vital to improving patient flow. Integrated Care Centres help avoid admissions and ED visits, address discharge delays and deconditioning by offering multidisciplinary assessments and care planning. This enables patients to return home safely and the model has potential to be included in the newly established integrated care hubs in Wales.

Residential and supported living settings are key parts of the care infrastructure. The pandemic accelerated digital health adoption, like video consultations and telemonitoring, with support from TEC Cymru and Digital Communities Wales. Falls prevention has also advanced through a Welsh Ambulance Service model that avoids unnecessary hospitalisation and is now part of the [Six Goals for Urgent and Emergency Care](#).



5.4 Emergency Community Care, 111 and transport



Emergency Community
Care, 111 and Transport

Advanced Paramedic Practitioners Evidence Appraisal and Guidance

Age-friendly Communities Handbook: Community Transport
Case Study

GoodSAM and CWRs

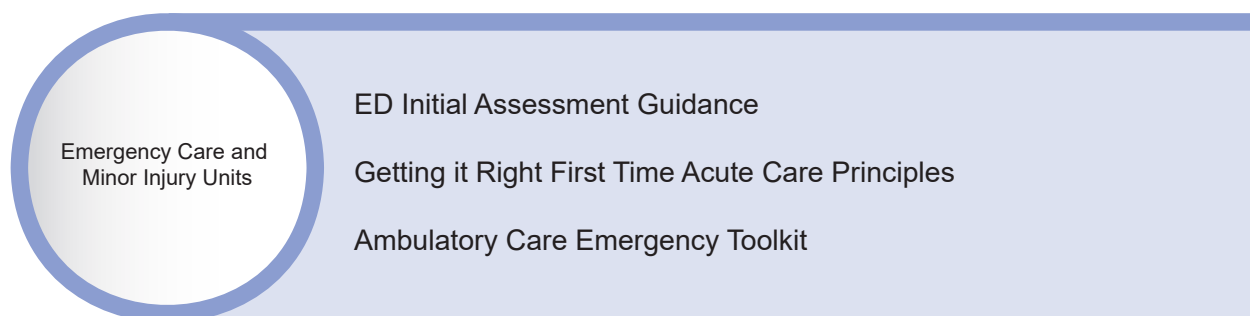
Efficient patient flow in health and care systems is essential for ensuring patients receive timely and appropriate care, particularly in emergency and unplanned situations. Reducing unnecessary conveyance to ED is critical. Ensuring only those 999 callers whose needs cannot be addressed otherwise are transported will help prevent overcrowding, reduce harm, and improve outcomes.

The Welsh Ambulance Service NHS Trust (WAST) has introduced several innovations to support urgent care in the community, including Advanced Paramedic Practice (APP), remote clinical assessments, and point-of-care testing. These approaches help avoid unnecessary hospital transfers as demonstrated by Health Technology Wales' evaluation of the pilot service. Continued investment in such models, along with expanded paramedic roles, aligns with the *Six Goals for Urgent and Emergency Care* programme and aims to further reduce hospital conveyance rates.³¹

WAST also provides non-emergency transport for eligible patients, supported by a broader community transport network that enhances access to healthcare and supports independent living. Community transport schemes can play an important role in reducing barriers to accessing health and wellbeing services, particularly for older people, people living in rural communities, and those at risk of social isolation, as highlighted in the Age-friendly Communities Handbook community transport case study.

Community engagement is further bolstered by volunteer first responders using the GoodSAM app, which alerts trained individuals, including NHS, police, and fire personnel, to nearby cardiac arrests. Thousands of responders in Wales, including 800 WAST staff and volunteers, are part of this life-saving initiative. In addition, the Community Welfare Responders (CWR) scheme was launched by WAST in 2024. CWRs are trained volunteers who attend less life-threatening 999 calls in their local communities to provide initial welfare checks and clinical observations, which helps remote clinicians determine the most appropriate care pathway for the patient.

5.5 Emergency Care and Minor Injury Units




The Welsh Government's Six Goals for Urgent and Emergency Care strategy, published in May 2022,³² aims to address the complex challenges facing the urgent and emergency care system by enhancing patient flow into, within, and out of care settings. While many effective ED flow improvement practices exist, their implementation often depends on adequate capacity in linked services, especially social care and enablement.

NHS data reveals that 44% of ED attendees are assessed, treated and discharged with no further follow-up, and 16% are referred to other providers such as GPs, indicating that a significant number of visits may be unnecessary. Contributing factors include limited GP appointment availability, personal preference, perceived need, and lack of awareness about alternative care options.

Timely treatment in ED is essential, as delays are linked to worse outcomes, including higher mortality and complications.³³ This has led to greater emphasis on effective triage and rapid assessment following the ED *Initial Assessment Guidance* produced by NHS England. To help reduce delays and avoid unnecessary admissions, the *Same Day Emergency Care (SDEC)/ Ambulatory Emergency Care (AEC)* model based on the *GIRFT Acute Care Principles*, supported by the ambulatory care toolkit from the Royal College of Emergency Medicine, has been introduced in parts of the UK, including Wales. This model delivers urgent treatment on the same day, avoiding overnight hospital stays.³⁴

To further support this approach, the Welsh Government published the [Direct paramedic referral to same day emergency care: All-Wales policy](#) in April 2022, enabling the Welsh Ambulance Service and health boards to refer appropriate patients directly to SDEC services. Some health boards have already adopted this policy, helping to streamline emergency care and improve system efficiency.

5.6 Outpatients, Diagnostic and Assessment/Triage Services



Outpatients, Diagnostic
and Assessment/
Triage Services

Improving Planned Care for the Frail

Health Pathways Programme

Outpatient Transformation: See on Symptoms (SOS) and Patient Initiated Follow-Up (PIFU) guidance

A common feature of many good practices relating to improving patient flow within and out of hospitals is effective and timely communication between the acute, primary and community health and social care team members, across clinical specialties, patients and their families. In addition, availability of and timely reporting on diagnostic tests and investigations facilitates appropriate treatment and care service delivery outside the hospital environment.

There have been a number of innovative approaches to help inform planned elective inpatient care generally and especially for people living with frailty who often experience longer lengths of stay and worse outcomes postoperatively. Two Bevan Exemplar projects^{35,36}, as part of the Planned Care Innovation Programme, developed and tested approaches to screening, assessing and triaging older people living with frailty who were awaiting elective surgical procedure. Both projects demonstrated positive outcomes for patients and staff as well as benefits for the health and care system, including significant numbers of older people who decided that surgery was not the most appropriate way of managing their symptoms. The projects are now being adapted and adopted across health and care delivery settings in Wales.

In April 2025, the [NHS Wales Performance and Productivity Independent Review](#) stated very clearly that the model for outpatients needed further transformation building on the work of the Health Pathways Programme.

The transformative approaches to follow-up appointments for outpatients, for example Patient Initiated Follow-Up (PIFU) and See on Symptoms (SoS), also play a key role in helping to free up both space and time. These are also dependent on reliable information and communication. The aim of these approaches is to give patients and their carers the flexibility to arrange their follow-up appointments (from surgical and medical admissions as well as outpatient consultations), as and when they need them.

5.7 Clinical Decision, Medical Assessment, Same Day Emergency/ Urgent Care Units, Inpatients and Discharge

Clinical Decision, Medical Assessment, Same Day Emergency/Urgent Care Units, Inpatients and Discharge

Six Goals for Urgent and Emergency Care Policy Handbook

Delivering Optimal Outcomes and Experience for People in Hospital

Hospital at Home and Virtual Wards: What works?

Wales' *Six Goals for Urgent and Emergency Care* programme focuses on whole-system urgent and emergency reform. Its scope includes the implementation of Same Day Emergency Care integrated with NHS 111, urgent primary care, ambulance handover and discharge pathways. Together, these enable better signposting, provide safe alternatives to admission, speed up emergency response and help prevent unnecessary admissions and readmissions.

For inpatient admissions, a number of initiatives have been implemented in hospitals across Wales. *The Delivering Optimal Outcomes and Experience for People in Hospital* guidance was published in 2024 to bring together these key approaches to embed hospital flow best practice, risk assessment, reduce variation, and support continuous improvement.

To support patients who are medically fit but face hospital discharge delays or reducing unnecessary emergency admissions, initiatives such as 'Ready to Go/Ready for Home' wards or units and 'Virtual Wards' have been implemented in some hospitals and health boards in Wales. However, there is a lack of model consistency which makes it difficult to measure impact, strengths, weaknesses and improvement opportunities.³⁷

5. Conclusions

Flow should reflect seamless, high-quality care shaped by patient and citizen needs, grounded in systems thinking rather than driven by siloed operational targets. Delays at any point in a person's care create cascading impacts across the wider system, generating backlogs, worsening outcomes, and embedding inefficiencies as the norm.

As set out in this paper, the causes of poor flow are well understood. They arise from fragmented planning and delivery, underutilisation of prevention and self-management, growing demand and demographic pressures, workforce and capacity constraints, and misalignment between services and people's needs. Left unaddressed, these challenges will continue to drive inefficiency, inequity and poorer outcomes for patients, staff and the wider system.

Improving flow is therefore not a single intervention, but a whole-system transformation priority requiring coordinated action across all seven components of the health and care system. It demands a shift from reactive, service-led models to proactive, integrated and person-centred approaches.

Action is now required in four key areas:

1. **Stemming the flow through prevention and community capacity.**

Rebalance the system towards early intervention, health literacy, self-management and community-based support to reduce avoidable demand and support people to remain well and independent.

2. **Directing the flow through better coordination and pathway design.**

Align services to patient need through integrated pathways, improved communication, and models such as single points of access, step-up and step-down care, and rehabilitation.

3. **Informing the flow through data, digital and patient insight.**

Enable real-time, system-wide visibility of demand and capacity, supported by interoperable digital infrastructure and co-production with patients to improve decision-making and reduce variation.

4. **Assuring the flow through aligned accountability and system leadership.**

Strengthen cross-sector collaboration, including through Regional Partnership Boards, supported by shared objectives, integrated performance frameworks, and innovative financial and contracting models that incentivise collective responsibility.

Delivering these priorities will require strong, visible leadership at all levels, alongside a culture that empowers staff to use data, innovate and drive continuous improvement. It will also require alignment of planning, resources and accountability across organisations, moving beyond organisational boundaries to focus on whole-system outcomes.

The evidence is clear: improving flow improves outcomes and reduces waste across the system, reinforcing the principles set out in the Bevan Commission's *Let's Not Waste* report. By reducing unnecessary demand, minimising delays, and ensuring care is delivered in the right place at the right time, the system can achieve shorter waiting times, improved safety, better patient and staff experience, and more sustainable use of resources.

Wales has the policy foundations, innovation, and system architecture to lead this transformation. The priority now is to move from insight to implementation at pace and at scale, embedding proven approaches across the whole system to deliver lasting impact for people and communities.

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Comisiwn Bevan Commission

School of Management,
Swansea University Bay Campus,
Fabian Way, Swansea SA1 8EN

www.bevancommission.org
bevan-commission@swansea.ac.uk
+44 (0)1792 604 630
