

Patient Flow Industry Leaders' Report

National Health Executive



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Patient Flow:

Where next?

Amanda Sullivan, Chief Executive, Nottingham and Nottinghamshire Integrated Care Board

Flow is a term that describes a steady, continuous stream which moves easily. Patient flow refers to the movement of patients through different care interactions, facilities and processes. However, patient flow is not a continuous stream that can move easily between different care points – it is often sporadic, with diversions, holdups and bottlenecks.

This has probably always been the case, but current urgent and emergency care demand volumes and the length of time that people remain in services have made bottlenecks swell beyond what has been experienced before. This has consequences for access to care at multiple points along the patient pathway, with knock-on impacts on patient experience, safety and outcomes. Patient flow is a very hot topic for systems and at the source of the most challenging winter that many say they have ever experienced. But for today, I want to take a step back from critical incident calls and sector-specific debates to think about why flow problems seem intractable and where we need to go next.

Traditionally, initiatives to tackle flow have focused on specific services and small fragments of the population. Additional capacity in parts of the pathway can create short-term relief, but this is temporary unless flow through and out of the additional capacity is sustained. If not, it will simply become another bottleneck with even more built-in delays.

Any delays, deviations or bottlenecks impact on other parts of the system. Smooth patient flow requires an equilibrium between demand, capacity, workforce and operational processes in all areas, as well as smooth interfaces between services. In a health and care system with many entry and exit points, separate services, thresholds, professional frameworks and organisations, equilibrium is difficult to achieve and is easily disrupted. This is one reason why patient flow must be tackled at team level, organisational level and at system level.

Improving flow is a technical and a relational task. In many ways, the technical elements are more straightforward (at least in theory) – model population need, match capacity with demand at each care point, implement new ways of working that adapt to population changes, optimise operational processes and interfaces, evaluate changes and adapt. We have made great strides in each of these areas in Nottingham and Nottinghamshire, but problems remain and we cannot say that we have sorted flow.

“Serving our population is a collective endeavour that requires collective action and effort. This can be emotionally and psychologically challenging”

Our population modelling and system demand and capacity planning has come on in leaps and bounds since becoming an ICS. We have one plan and version of the truth through our System Analytics and Intelligence Unit and we track demand, capacity and impacts of schemes to see the overall picture. The quality of our analysis gives us a sound basis for planning, although the timing of events like flu and COVID-19 peaks are difficult to predict. Other factors, such as workforce absence rates introduce another variable that has an impact on overall flow. Our System Control Centre also gives us real-time data to help manage our actions across the system.

We have dispersed demand to help ease bottlenecks in our Emergency Departments. We have more services that can divert or prevent admissions to hospital – our Urgent Community Response is growing in capacity, scope and impact with links to a broad range of services, including pulling from the ambulance call stack. We have more respiratory care in community and primary care. We have more same

day emergency care in hospitals, integrated discharge hubs, more interim care home, more discharge to assess capacity, additional roles in primary care to support people and considerable innovation and tactical process changes. All of these things have been a big help to our citizens and to our staff. Some areas are still work in progress and will have further impact. But we still have very significant bottlenecks and delays in parts of our system – lots of technical elements have been enacted with a high degree of talent and innovation, but steady continuous patient flow is still elusive. Our clinical and care profession teams remain under immense strain, particularly in urgent and emergency care services.

So where next? Relational elements are key. Our relationships and ways of working have progressed beyond all recognition since becoming an ICS and will continue to evolve. Patient flow is an obvious area where the whole is much greater than the sum of its parts, so integrated care and integrated working are at the heart of any

improvements. This means bringing our diverse skills and perspectives together, having an evidence-based and shared view of the issues and actions and adjusting to accommodate the needs of others.

Serving our population is a collective endeavour that requires collective action and effort. This can be emotionally and psychologically challenging when opinions and data suggest things that are counter-intuitive and not instinctively trusted. However, our collective role as system leaders is to come to this with genuine curiosity and with positive intent to act for best population gain – alongside a high degree of tenacity, determination and ambition.

If we all continue to develop and refine the technical elements of flow and wholeheartedly work as systems, steady and continuous flow is in our gift.

Data, capacity and collaboration:

The keys to patient flow

Richard Murray, Chief Executive, The King's Fund

No-one would claim that England's urgent and emergency care system is working well, with ambulance response times and waiting in A&E perhaps the most obvious signs of deep stress. Behind these very visible pinch points, lies the (apparently) simple fact that there are not enough hospital beds to admit all the patients who need them, thereby leaving people stranded in A&E (or queuing outside of it) waiting for a bed to come free.

The simple answer might appear to be to open more beds and indeed, England has historically been under-bedded when compared to other European countries. Opening more beds is part of the new Urgent and Emergency Care Strategy. Yet England has been under bedded for decades – and was so in 2019 before the pandemic – without such dire consequences so while part of the answer, it isn't the whole answer. Another piece of the puzzle may lie in greater levels of ill-health in the general population (a view supported by higher excess mortality) and, of course, an ongoing loss of capacity due to Covid-19, part of the problem

and the difference to 2019. Yet, in addition to these issues, one of the most significant contributing factors to this challenge is 'flow' – how patients move through the hospital from admission to discharge.

There is evidence that this 'flow' has slowed down. The number of patients staying in hospital beyond the point they were well enough to be discharged has increased, and with it, average length of stay. Many also think patients are, on average, more severely ill than they were pre-pandemic which may also have contributed to rising length of stay. A system generously provided with beds may be able to absorb higher demand and longer length of stay, but the NHS never had this luxury and certainly doesn't now. The damage is not limited to the urgent and emergency care pathway, as the need to free up beds means encroaching on elective capacity thereby hampering the drive to reduce waits for planned care too. It should be unsurprising then, that the Urgent and Emergency Care Strategy also looks to speed up discharge and patient flow.

In order to speed up discharge it is of course important to know the reasons for the slowdown. There may be many, some that lie within the hospital in terms of timely decision-making, but many lie outside of it of which the most obvious is the ability of services in the community to provide high quality, timely, support for the patient once discharged. Difficulties may be caused by a lack of social care support and it is true that the social care workforce has been shrinking. It may also be the ability of NHS community health services to provide support whether in people's own homes or residential care. The upshot, perhaps counterintuitively, is that one way to boost hospital capacity is to invest in services outside of hospitals, in the community.

However, a patient's journey often consists of much more than a handover from an ambulance to A&E followed, at some later point, by discharge back into the community. Patients move between primary care, the acute sector, social care in a residential facility and in their own homes, different

elements of community health services and, of course, mental health services both inpatient and community. Delays building up anywhere along these pathways will matter not only for the efficiency and effectiveness of that individual service itself, but for others along that chain. Building up this system wide view of patient (or user) flows can enable leaders to target the cause of delays, recognising the impacts of bottlenecks or shortages in one area may be most visible in the other services in the pathway. Ideally, thinking about flow shouldn't be limited to statutory services, given that the voluntary sector plays an important role in every community and supports many people alongside or instead of statutory services.

Improving flow at the system level can be a challenge: it will require data and understanding. The sometimes-strained relationships between the NHS and local government over discharge from hospital also underline the need for collaborative working. In institutional terms, new Integrated Care Boards would look well placed to oversee this system approach to flow and capacity, but others could also take this on – provider collaboratives or health and wellbeing boards, for example. The key point being that whoever does, it needs to be the whole system together.

But beyond these cultural and institutional issues, there remain workforce and capacity challenges in many sectors and whilst there has been some success in increasing workforce numbers in some areas (acute sector nurses, for example), others have proved much more difficult (general practice and social care, to name two). If better flow is going to be achieved it requires the right mix of better data, more capacity and stronger relationships across the whole urgent and emergency care system.





Improving patient flow:

The power of seamless communication

Dr Satya Raghuvanshi, Head of Clinical, Accurx

Everywhere, everyday, we hear about the challenges facing our health system. From blocked beds to delayed discharge, and long wait times for GP appointments, A&E and elective care, ultimately resulting in record low patient experience. It has been widely reported that the NHS is at breaking point.

At the centre of these system-wide issues is the daunting task to ensure a consistent patient flow through the NHS. Good patient flow demands easy collaboration and information sharing between multiple care settings - within and beyond the hospital - and to patients and their families. But when the system doesn't have the right tech in place to support this, it doesn't work like it should.

We work with 98% of GP practices and have users in 68% of trusts. We hear first-hand from our users that central to moving patients through the system is the ability for healthcare staff, teams and services to communicate easily

with each other and the patient. At each stage, the chance of delay increases as the wait time for responses or requests for information increases. Good communication, especially between care settings, can be the difference between fast and slow patient flow.

We recently heard of the difficult story of a patient, Sama*, a 54-year-old woman and carer for her husband with a chronic health condition, which unfortunately epitomises the issues surrounding patient flow in the system right now.

Sama had experienced long-standing lower abdominal discomfort for some time. She became increasingly concerned when this intensified. She called her GP for an appointment, experiencing a long phone queue, and was told she had to wait four weeks to see someone face-to-face. When the appointment came around, her GP organised further tests before referring her to a hospital under a two-week cancer wait, due symptoms suggestive of ovarian cancer. However, due to a

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backlog, Sama received the referral letter weeks later, which gave her an appointment in just two days. She was unable to arrange a carer for her husband on such short notice and missed the appointment. Due to waiting list pressures, Sama was discharged after the first DNA. The hospital sent a letter to her GP, which was lost in the inbound post and never entered into her records. Six months later, Sama returned to her GP with worsened symptoms and the cancer two-week pathway was restarted. Unfortunately, at this point, Sama’s cancer had advanced with a poor prognosis.

This is the unfortunate and heart-breaking reality for millions of NHS patients right now. It’s a testament to the NHS that it can still operate and deliver patient care in these huge gaps. However, this isn’t the standard we want to maintain.

If we take a closer look at Sama’s story, we can see how the lack of tech to support staff with quick and easy communication stopped her from moving through the system like she should have.

In the moment that Sama decided to seek care from her GP, being able to complete an online triage form that would have identified warning signs and which her practice could easily view and decide the best course of action on would have saved her waiting in a long phone queue. Once the practice received the form and saw Sama’s concerns, they would have sent her a text message within hours containing a specific questionnaire that allowed them to obtain further information about her symptoms. The GP would have then noticed the red flag symptoms, organised investigations and subsequently referred Sama on a two-week cancer wait to secondary care.

Sama’s cancer service in the hospital she was referred to would have sent her a booking link via SMS for a face-to-face appointment, meaning Sama could have chosen a time and date that suited her caring responsibilities. A few days before her appointment, Sama would have been sent an SMS reminder, just in case she had forgotten.

Sama would have been commenced on an ovarian cancer pathway, possibly with a completely different prognosis. The consultant seeing Sama would have been able to see her history and record of communication, avoiding the need for Sama to repeat her story and be the arbiter of her own medical history.

Throughout the process, Sama’s GP, Oncology team, community nurses, and Sama herself, would have all had full visibility of all communication throughout the pathway, so she felt informed, secure and supported. This is of course a simplified journey, but it shouldn’t be unrealistic for what we can achieve

NHS staff are in need of tech that allows any healthcare professional to easily contact the right person in any organisation, or view necessary information about a patient, no matter where they are

registered. This would go miles in improving patient flow. In today’s world, this kind of tech shouldn’t be revolutionary, and its lack shouldn’t be one of the decisive factors in poor patient flow. Tech like this should be invisible - a daily touchpoint for healthcare staff that improves their working lives, just like how office workers use email, video conferencing and instant messaging without even thinking.

This kind of tech doesn’t need to stop at improving patient flow. It can also help with elective recovery by reducing unnecessary appointments, DNAs and managing waiting lists, so patients waiting can get the care they need. We are currently working with University Hospitals of Leicester (UHL) to do just this. So far, 140,000 patients have been messaged and 14,100 removed from their waiting list. This was done through simply SMS messaging patients on their waiting

list to ask if they still need their overdue appointment or not. For staff managing the waiting list at UHL, they now have a clear way to manage and understand the waiting list, and prioritise. It’s a game-changer (or so we’ve heard).

If patient outcomes are to be bettered, and the sustainability of the NHS protected, patient flow needs to be improved. In 2023, a lack of tech shouldn’t be the greatest need across the system to deliver efficient and safe patient care, and move patients through the system. New and existing tech, like Accurx’s, should be leveraged to improve and support the system to remove blockages for staff so they can do what they do best - care for patients.

*patient name and details have been changed to protect anonymity.





Our first lesson relates to the scale of intervention. A common problem with many previous flow improvement efforts is that they have been designed and delivered by one service in isolation, often without the explicit support of senior leaders, and only applied to a small segment of the care pathway or system. This means that their survival is often reliant on strategic and operational decisions taken elsewhere in the system, by leaders and managers who have little personal capital or resources invested in the intervention. Moreover, interventions that are led by a handful of enthusiasts become immediately vulnerable if one or more of those people moves on to a different role. What this shows is that scale of ambition matters. A system-wide challenge requires a system-wide response: one that has the support of all provider organisation leaders and benefits from the fact that it is an ICS-level strategic priority. This strategic alignment is vital to ensuring that managers at each tier of the participating provider organisations are committed to the intervention and are willing to allocate staff time and resources to it.


Whole System Flow

Bryan Jones, Senior Improvement Fellow, The Health Foundation
Penny Pereira, Q Initiative Managing Director, The Health Foundation

As hospitals, ambulance services and social care providers up and down the country grapple with a daunting range of capacity, demand and workforce challenges, it’s no surprise that improving patient flow has become a priority for national policymakers and local system leaders. The need to tackle the constraints leading to poor patient flow through hospitals, especially at their front and back doors, is strongly highlighted in NHSE’s urgent and emergency care recovery plan. Meanwhile,

many Integrated Care Systems (ICSs) have rightly identified patient flow as an issue that requires a concerted system-wide response. Yet this is not the first time that flow has been the focus of national and local leaders’ attention. Over the last decade there have been plenty of attempts to improve flow, particularly along urgent and emergency care pathways. Some efforts have delivered tangible and sustained improvements in process and patient outcomes: a notable

example is a multi-year programme led by Sheffield and South Warwickshire NHS Foundation Trusts that was supported by The Health Foundation. But others have made only a marginal impact, or led to promising interventions that failed to become embedded in the system. So what can we learn from these previous efforts, and what needs to happen to ensure that future interventions stand the best possible chance of achieving a sustained impact?



“Arguably, the health and care system in England is better placed now than it has ever been to drive forward integrated system-wide efforts to improve flow.”

Our second lesson is connected to the sheer complexity of delivering flow-related improvement. In many cases, the focus is squarely on patient flow, and how to optimise their progressive movement along a care pathway through a series of processes. Yet in order to improve patient flow, it is important to pay attention to the flow of management and patient information, equipment, staff and money – to name but a few things – along a pathway. There is also a welter of socio-environmental factors that impact on patients’ health and have a material impact on their journey through the health and care system that need to be considered. Even mapping these flows and understanding the issues that might be constraining them is challenging, let alone the task of tackling any bottlenecks or obstacles that are found. This is why an organising framework, one focused on ‘whole system flow’, rather than discrete flows of one kind or another through specific organisation or service, is a useful tool for local system leaders. The Health Foundation’s whole system flow framework, which describes eight domains – among them service design, governance, information and IT and culture – that system leaders should consider when devising an integrated operating model for flow, is just such a resource.

Our final lesson is to do with relationship building. The sustained impact of the previously mentioned flow work in Sheffield and South Warwickshire was due to a large extent to their success in bringing together the key stakeholders from across a pathway on a regular basis to work collectively to identify and solve problems. This approach, known as the ‘Big Room’, is designed to create an open, honest and collaborative atmosphere in which each individual, regardless of their position in the hierarchy, feels empowered to contribute on an equal footing. It now forms one of the cornerstones of the Flow Coaching Academy, which is supporting a network of people, organisations and systems across the UK to improve flow. Approaches like the Big Room, which are designed to create a working culture that is conducive to improvement, are of central importance to any flow related intervention. Without a focus on fostering the right collaborative behaviours and attitudes it is extremely hard for flow improvements to become embedded in a system.

Arguably, the health and care system in England is better placed now than it has ever been to drive forward integrated system-wide

efforts to improve flow. ICSs, now replete with their statutory powers and responsibilities, look well placed to lead, or at least co-ordinate and convene, such efforts. In doing so, they can draw on a wealth of skills and experience within their systems in redesigning pathways, eliminating waste from care processes and enabling effective collaboration on improvement. The question is whether ICSs, working in partnership with provider organisations and regional and national improvement bodies, are able to earmark sufficient time and resource to building the relationships and undertaking the planning necessary to secure meaningful flow improvements. There is a strong case for doing so. Improved flow at acute provider level has already delivered an impressive array of benefits – ranging from sustained reductions in emergency care length of stay, bed occupancy and readmissions through to striking improvements in patient safety and experience. Yet, the system-wide gains of improved whole system flow could be even more significant, not least in terms of improvements in staff experience due to large-scale reductions in waste, delay and duplication across the system. It is high time therefore that whole system flow is given the priority it deserves.



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