The National Patient Flow Programme

MODULE ONE - Getting Started
Introduction: Patient Flow in Wales

On the 26 February 2013 teams from every NHS Wales health board and The Welsh Ambulance Services NHS Trust (WAST) attended a workshop at the SWALEC Stadium, Cardiff, to design a change strategy to support health boards and trusts deliver more effective and reliable unscheduled care.

The resulting plan was for a two year National Patient Flow Programme supported by 1000 Lives Improvement. The Programme’s goal was to ensure better flow through the health and social care system in NHS Wales for urgent and emergency care patients and to build organisational capability. It would build on Improving Quality Together, the national quality improvement learning programme for all staff and contractors in NHS Wales. It would also blur the divides between quality, safety, delivery and reliability.

In October 2013 the programme adopted a ‘Breakthrough Collaborative’ approach, modelled on the successful work of the Institute for Healthcare Improvement and used frequently in Wales in the 1000 Lives Campaign and 1000 Lives Plus. This Guide will help you navigate your way through this structured approach to improvement.
What’s different about this Guide

Those who have participated in previous Breakthrough Collaboratives in Wales will know that the accompanying guides follow a specific format. They always set out a common aim with accompanying measures and a wealth of literature specifying the exact interventions that need to be introduced. This Guide is different.

Firstly, the overall aim of the programme as set out above is quite general. This is deliberate because each hospital economy will have slightly different problems and therefore the aim of each will be subtly different. NHS Wales health boards and WAST are being encouraged to define their own specific aims although we anticipate that these will group around some common themes.

Secondly, health boards and WAST will adopt different interventions to tackle these individual problems and these have not been defined yet. Therefore, they cannot be included in this Guide. The types of interventions that have worked elsewhere are known, and these are accessible in the references provided as well, as in the online training course.

The Collaborative methodology usually begins with a driver diagram that links the chosen interventions to the overall aim. As the chosen interventions have not been defined, it is not possible to produce a driver diagram at this stage. Teams will create their own driver diagrams in Module Two.

Because of the two points outlined above, this Guide will be published in four modules. These are:

- Module One: Getting Started
- Module Two: Diagnosing your problems and their causes
- Module Three: Designing and implementing the new system
- Module Four: Maintaining the new system

We are publishing Module One to accompany the launch of the Collaborative and the others will be released at the relevant points during the Collaborative process.
The National Patient Flow Programme: Module 1

Why Flow Matters

The Health Foundation describe the term ‘flow’ as the progressive movement of people, equipment and information through a sequence of processes. In healthcare, the term generally denotes the flow of patients between staff, departments and organisations along a pathway of care (Health Foundation, 2013).

Flow is therefore not about the ‘what’ of clinical care decisions, but about the ‘how’, ‘where’, ‘when’ and ‘who’ of care provision. How services are accessed, when and where assessment and treatment is available, and who it is provided by, can have as significant an impact on the quality of care as the actual clinical care received.

The concept of using flow to improve care has received increasing traction within healthcare, especially in relation to reductions in patient waiting times for emergency and elective care. Awareness has been growing of the ideas, first tested in other industries, and results that organisations have generated by applying flow thinking to their organisations.

As the national policy agenda focuses more strongly on integration between primary care, acute services and social care, the need to understand and improve how patients flow through systems is more important than ever. High profile cases of failures in the timeliness and quality of care serve as warnings as to the painful consequences of poor quality systems and processes.

In a pressurised financial environment, faced with ever greater challenges to meeting quality objectives, there is understandably an appetite for approaches that have been shown simultaneously to improve quality and reduce cost.

There has already been considerable success in tackling issues of flow in NHS organisations in England. The Patient Flow Programme in Wales is seeking to expand on this and understand what is possible when flow concepts are applied systematically across whole organisations and populations.

As well as suggesting specific process changes that will have an impact on overall organisation performance measures, examining Flow raises questions about the way in which we structure leadership and delivery of services.

While improving quality, increasing efficiency and flow - and reducing costs - have traditionally been the responsibility of different functions (and executives) within healthcare organisations, it is increasingly understood that they are inextricably linked (MacArthur et al, 2012). Improving systems of care is a shared agenda - the full benefit is only realised if an end-to-end patient pathway approach is taken across all departments (Health Foundation, 2013).
The relationship between flow, quality and cost

Quality problems are often treated as if they are one-off events, rather than the inevitable consequence of random combinations of constantly occurring errors and delays in multi-task processes. A typical response therefore is to add more ‘checking’ tasks to spot and correct errors. However, as illustrated in Box 1, adding tasks or steps to the existing patient journey can actually make the inherent quality of the process worse - increasing the total number of tasks, each of which has the potential for errors - and can waste precious time and resource.

Instead of adding ‘assurance’ checks, the most reliable and sustainable way to improve both quality and cost is to systematically redesign processes of care. The basis for process improvement involves:

- Improving the quality (value) of each task or step.
- Removing any unnecessary tasks (waste) from the process.

Improving the quality of a system also reduces costs. If quality is improved by removing wasteful tasks from a process, the cost of staff time performing the tasks and caring for patients while they wait for them to be performed is reduced.

As well as the human costs involved for patients, family and staff, errors and patient harm have a financial impact (through, for example, increased length of stay, re-admissions, additional investigations and procedures). If the error rate and harm within a care system can be reduced, the costs can too.

While there is a logical productivity case for improving quality, the relationship between quality and cost is not linear, often making it difficult to see or realise the full potential contribution of these approaches to overall financial objectives.

‘Wasted’ or non-value adding staff time that is removed from a process can only be released incrementally (usually in Whole Time Equivalents). Similarly, capital costs, such as beds, can often only be released as ‘units’, such as whole wards.

Organisations therefore tend to find that financial benefits lag behind the implementation of quality improvement work and are sometimes not realised, as the additional step of taking out capacity is often itself far from straightforward (Health Foundation 2013).
Module One: Getting started

Introduction
In the first module we will look at the current problem that we have and describe the new approach we are taking in Wales to address this. Traditionally we have concentrated on Accident and Emergency (A&E) performance to tackle unscheduled care, but more recent evidence from the work carried out by Dr Kate Silvester and the Health Foundation (2013) have evidenced the need to concentrate our efforts on understanding patient flow through our health care system.

We will therefore look at the longer term solutions to unscheduled care problems and outline the resources that health boards will require to support this work. The first module will cover the ‘getting started phase’ and will include the first learning event and the guidance included as part of the event.

What’s the problem?
The unscheduled care system has been experiencing pressures for some time and these have become exacerbated in recent times. A recent report from Public Health Wales (2013) into the causes of this increased demand highlighted the following:-

- A long-term trend of a gradual annual increase in overall major A&E attendances.
- An ageing society has an increasing proportion of frail elderly. As the relationship between age and frailty is non-linear, a small increase in the elderly in a population will generate a disproportionate demand on acute care services and we are seeing evidence of this.
- Waiting time performance breaches in major A&Es are longstanding across Wales.

However it is not enough to understand these, action is needed to address the symptoms and underlying causes.

For this reason the Minister for Health and Social Services has identified unscheduled care and the development of a new Emergency Response Service (incorporating implementation of the McClelland Review, 2013), as first-order priorities for the Wales NHS. Key deliverables include:

- Accelerated development of improved systems of unscheduled care.
- Development of new measures across the full span of unscheduled care covering timeliness, safety and patient experience.
- Implementation of the McClelland review (2013).
- Delivery of the 111 service and improvement to GP services in hours and out of hours.
The Unscheduled Care Improvement Programme (2013) will co-ordinate a set of aligned initiatives to accelerate improvement across the whole pathway of emergency and urgent care. Problems with unscheduled care frequently manifest as emergency department overcrowding, particularly in winter, however the root cause may lie elsewhere. The programme will encompass the following strands of care, and in particular the interfaces between them.

It is anticipated that the programme will run for 18 to 24 months, with three broad key objectives:

Short-term measures directed at keeping emergency departments safe in the winter of 2013-14. The program will support the existing Welsh Government processes for scrutinising and monitoring organisational winter plans.

The development of an enhanced suite of unscheduled care metrics. The programme will support development of an enhanced suite of unscheduled care metrics by April 2014; initially providing near real-time measures of timeliness across the whole span of unscheduled care, with subsequent development to encompass other quality domains, for example, patient experience and patient safety.

Sustainable transformation across pathways of unscheduled care should be in place by the winter of 2014-15.

What is the Breakthrough Collaborative process?

This programme adopts a national breakthrough collaborative format. It offers the opportunity to accelerate change, coincide with the timing requirements of the National programme and to capitalise on peer group learning. It will preserve the original intention to encourage local solutions to be developed for local needs.

The Breakthrough Collaborative

A breakthrough collaborative approach emphasises mutual learning rather than teaching (IHI, 2003). The approach taken is to:

Pay attention to motivating and empowering teams
Ensure teams have measurable and achievable targets
Equip and support teams to deal with data and change challenges

Members of the Collaborative will be at different stages of understanding and so will learn from each other. This is one of the principles of the Collaborative approach that “all teach, all learn”.
The following work programme and timetable apply this evidence based approach. It is represented diagrammatically as follows:

**IHI Breakthrough Series**
**(6 to 18 Months Time Frame)**

The classic Collaborative structure envisages a period of preparation centrally where the evidence for the proposed interventions are weighed and sifted. The Patient Flow Programme Collaborative will instead build directly on the experiences of the Health Foundation work (2013) and use the principles that were used successfully by NHS teams in Sheffield and Warwick.

The remainder of the framework holds as in the diagram with Learning Events in December 2013, March and June 2014. The action periods will be supported by 1000 Lives Improvement staff and an external expert facilitator.
The timetable for the Collaborative is given in the table below:

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning Session 1</strong></td>
<td>16 December 2013 - this is a national learning event</td>
<td>Health Boards are expected to come to the event with high level data (such as Warwick charts that demonstrate flow issues) that has been analysed, the executive to present the flow issues that the organisation has and their learning so far.</td>
</tr>
</tbody>
</table>
| **Action Period 1**          | Dec 2013 - March 2014 | Opportunity to start the work in each health board with Dr Kate Silvester.  
Data analyst to collect and submit the flow data to Dr Kate Silvester.  
Dr Kate Silvester to analyse the data and train the data analyst to produce the high level measures for improvement.  
One day Executive Board development workshop with Dr Kate Silvester to understand their data and emergency patient flow in the health board.  
All the above members in each health board are identified and have completed online Foundations in Improvement Science for Healthcare (FISH) programme.  
First 2-day workshop with the health board team above to learn more advanced flow thinking and to start creating value steam map with the data of their emergency flow supported by online coaching via 1 x week WebEx with Kate Silvester  
Online coaching with Simon Dodds for the 2-3 of the health board team above who sign up for the Improvement Science Practitioner Course. |
| **Learning Session 2**       | March 2014            | Feedback from the actions and learning following the 2-day workshop with Dr Kate Silvester in each health board.                                |
| **Action Period 2**          | March - June 2014     | Complete the second 2-day workshop with Dr Kate Silvester to review and plan:  
The order of implementation of changes at each of the constraints to patient safety |
and flow programme plan. 
Measures for monitoring improvement. 
Strategy and plans to maintain improved performance.

| Learning Session 3 | June 2014 | Present results so far |

**The First Learning Event**

Prior to each collaborative learning session it is expected that there will be some pre-work to complete. For the First learning session, health boards will have been expected to:

Recruit their Collaborative Team - see the ‘What’s the team we need’ section below;

Register 6 Executives and the Collaborative Team for Foundations in Improvement Science for Healthcare (FISH) and begin online modules. Participants will be expected to have completed at least the first module. This will take around 45 minutes.

Complete ‘Warwick Charts’ & begin populating hospital flow tool - see the ‘How are we doing’ section for more details. Health boards are expected to come to the event prepared to share what flow data they have created and what it is telling them.

Think about which patient flow they would like to work on and why.

Identify dates to book Kate Silvester for the Executive session and the first 2-day workshop.
The FISH online training course

The online training, the Foundations of Improvement Science in Healthcare (FISH), has been designed and produced by Mr Simon Dodds MA FRCS. 1000 Lives Improvement is using this to train health board team members in the principles of diagnosing flow problems and testing solutions. The way staff access this is described below and comes in two parts.

❖ Part One

You register and complete Module 1 of the FISH course. This is completely free and you don’t need to let us know in advance.

To do this, follow these steps:

Go to [http://www.Saasoft.com](http://www.Saasoft.com);
Click on FISH in the bar at the top of the page. This takes you to the FISH page;
Click on *FISH on line* in the Individual FISH courses section;
Register and then login to complete the module.

❖ Part Two

To access the remaining 3 modules of the on-line programme will cost £200 + VAT per team member. The 1000 Lives Improvement Service will pay for up to 12 team members, if health boards want more staff to access the material they will have to fund this.

Instructions:

Give 1000 Lives Improvement the email addresses of those registered and the project you will be using learning from the FISH course on.
1000 Lives Improvement will submit these to SAASoft and pay the course fees.
Once members have been authorised, they will be informed and they are then free to complete the 3 outstanding modules.
Who should be on the team?

Every NHS Wales organisation involved in the Patient Flow Programme is advised to appoint a core team to be involved in the Patient Flow Collaborative. Organisations can decide how many staff are added to the core team.

The organisation needs to empower the core team to make changes and decisions based on the learning from the collaborative. Ideally, the core team would comprise of one representative from each of the below categories:

1. Executive Lead
2. GP
3. Hospital consultant
4. Senior Nurse
5. Data Analyst
6. Service Manager
7. Diagnostics service manager
8. Service Improvement representative
9. Intermediate care manager
10. Adult Social Care manager

To successfully address the delays associated with unscheduled care across the organisation, you will need to cover each hospital that admits emergency patients. Because each is likely to have different issues, you will need a team for each. You cannot assume that one solution will work for all. The core team members listed will work on the delays for one hospital. If there are two hospitals then you will need two teams. It may be that some individuals are common to both teams.
The Model for Improvement

Successful improvement initiatives don’t just happen - they need careful planning and execution. There are many things to consider and techniques to employ. You need to generate the **Will** to pursue the changes, despite difficulties and competing demands on time and resources. You need the good **Ideas** that will transform your service. Finally you need to **Execute** those ideas effectively to get the change required.

**Will**

The interventions you need to build Will are explained in the ‘Leading the Way to Safety and Quality Improvement’ and ‘How to Improve’ guides available from 1000 Lives Improvement. They concentrate on raising the commitment levels for change and then providing the project structure to underpin improvement approaches.

Spreading changes to achieve transformative change across the whole health system requires strong leadership. We need to create an environment where there is an unstoppable will for improvement and a commitment to challenge and support teams to remove any obstacles to progress.

**Ideas**

The learning sessions will produce ideas for achieving changes that result in improvements. Methods and techniques for generating new ideas or innovative ways to implement the evidence can be found in the ‘How to Improve’ guide and other improvement literature.

**Execution**

However, to bring these ideas into routine practice in your organisation, it is essential that you test the interventions and ensure that you have achieved a reliable change in your processes before attempting to spread the change more widely.
1000 Lives Improvement uses the Model for Improvement, which is a proven methodology for effective change, as the basis for all its work.

It requires you to address three key questions and then use Plan-Do-Study-Act (PDSA) cycles to test a change idea.

The three key questions are:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in improvement?

After answering these questions, you need to start a PDSA cycle. You need to Plan your change, Do the change, Study the change, and then Act - either adapt the change or try it on a larger scale.

By doing repeated small-scale tests through a PDSA cycle, you will be able to adapt change ideas until they result in the reliable process improvement you require. Only then are you ready to implement and spread the change more widely.

When testing and implementing the changes you identify you will be using the Model for Improvement. It is a fundamental building block for change and you need to understand how to use it. A full explanation is found in the Improving Quality Together (IQT) bronze level module, and it is recommended all staff involved in the Collaborative team also do IQT bronze to ground them in the methodology.

IQT bronze can be accessed at [www.IQT.wales.nhs.uk](http://www.IQT.wales.nhs.uk)
Support for the collaborative

It may be that once your team has completed the course, they feel confident enough to tackle their chosen project on their own. However, there is more support available.

Each NHS Wales organisation involved has a designated 1000 Lives Improvement link person who will be available to support the Collaborative Team as they plan, do and study their improvements.

1000 Lives Improvement link persons

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Link Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abertawe Bro Morgannwg</td>
<td>Claire Lloyd</td>
</tr>
<tr>
<td>Aneurin Bevan</td>
<td>Carys Jones</td>
</tr>
<tr>
<td>Betsi Cadwaladr</td>
<td>Claire Lloyd</td>
</tr>
<tr>
<td>Cardiff &amp; Vale</td>
<td>Carys Jones &amp; Iain Roberts</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>Claire Lloyd &amp; Mike Davidge</td>
</tr>
<tr>
<td>Hywel Dda</td>
<td>Carys Jones</td>
</tr>
<tr>
<td>Powys</td>
<td>Claire Lloyd</td>
</tr>
<tr>
<td>WAST</td>
<td>Carys Jones</td>
</tr>
</tbody>
</table>

Contact details for link persons

<table>
<thead>
<tr>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claire Lloyd</td>
<td><a href="mailto:Claire.Lloyd@wales.nhs.uk">Claire.Lloyd@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Carys Jones</td>
<td><a href="mailto:Carys.Jones4@wales.nhs.uk">Carys.Jones4@wales.nhs.uk</a></td>
</tr>
<tr>
<td>Iain Roberts</td>
<td><a href="mailto:Iain.roberts@wales.nhs.uk">Iain.roberts@wales.nhs.uk</a></td>
</tr>
</tbody>
</table>

Kate Silvester is available to present to your senior management team. You might want to consider this as a way of engaging this important group.

There is also a face-to-face version of FISH lasting four days in two two-day blocks. This will be facilitated by Kate Silvester in conjunction with 1000 Lives Improvement staff.

Visit the Flow programme website at [www.1000livesplus.wales.nhs.uk/flow](http://www.1000livesplus.wales.nhs.uk/flow)
Understanding your flow problem

You cannot tackle generic problems; you need to know what your specific issues are. To help you there is a Flow analysis tool available to download from the Flow programme website. It is an Excel file containing the descriptions of the relevant hospital level data you will need to obtain. It also contains examples of the types of charts that will be useful to you in understand the pattern and volume of different types of activity as well as the time spent in secondary care.

It is not a requirement of the programme that you submit a completed tool to the 1000 Lives Improvement team. It is to guide you into understanding the variation in your unscheduled care system. If you have other ways or systems that can produce and display the appropriate data, you can use these.

As you move through the first action period, you will become more certain what the specific issues are that you need to tackle in each hospital economy. Using the data tool is one of the methods of arriving at that certainty.

Measuring how you are doing

Success in this programme will come at different levels and so you will need to have a measurement strategy that mirrors these. There are four levels of measurement:

Level 1: The high level (Board) measures
Level 2: Flow level measures
Level 3: Organisation and department level measures
Level 4: The support level services measures

Level 1: The high level (Board) measures

At present three common measures are suggested, which can be augmented by specific measures once Collaborative teams have identified their aims and objectives.

The 3 common measures are:

1. The ‘Warwick’ chart: A&E breaches and in-hospital emergency mortality by date of admission
2. Whole Time Equivalent (WTE) staff and cost of those staff including locums, agency and bank staff
3. Risk-Adjusted Mortality Index scores (RAMI)

The measures can be presented as weekly or monthly time series charts (run charts).
Level 2: Flow level measures:
These will be developed during the first action period as teams get to grips with the patient flow they have selected and work their way through the FISH online training. The types of measure that will be included comprise: demand, Work In Progress (patients in the system), lead time (time is the system) and activity.

Level 3: Organisation and Department level measures.
Once the flow team have completed both FISH and the first two-day workshop, they will be in a position to develop the right measures at departmental level. Notice that this is a different order to the one you are used to. Typically, healthcare organisations have moved from the high level metrics into departmental ones. The Flow level is quite new.

With flow constraints identified, departments will set their own aims in relation to the overall flow goals, and from these derive the appropriate measures.

Note that departmental measures are subservient to the overall flow measures. It is the overall flow that drives performance, not maximising the efficiency of individual departments.

Level 4: The support level services measures
The support services (HR, finance, IT, information, estates and supplies) are there to support the operational departments. So, if there are policy constraints that impact on Flow, these will need to be addressed. This is not something that departments can do and often requires Executive intervention.

The support departments will also have flow issues of their own, for example the lead time to recruit staff. These will be need to be tackled in order to improve the overall situation and will be addressed when the staff in these departments have completed the FISH online training for themselves.
Progress Reporting

1000 Lives Improvement is required to report progress of health boards and trusts to its key stakeholders, Team Wales. Reporting needs to relate to where health boards and trusts are on their journey.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Item</th>
<th>Task</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Getting ready</td>
<td>0.1</td>
<td>Team identified.</td>
<td>To free up nominated individuals and ensure resources are in place.</td>
</tr>
<tr>
<td></td>
<td>0.2</td>
<td>Programme governance agreed.</td>
<td>To ensure that the internal programme is run correctly.</td>
</tr>
<tr>
<td></td>
<td>0.3</td>
<td>Warwick charts created.</td>
<td>To show that analytical capacity is present in the health board.</td>
</tr>
<tr>
<td></td>
<td>0.4</td>
<td>Topic/pathway selected.</td>
<td>To provide the purpose for the internal programme.</td>
</tr>
<tr>
<td></td>
<td>0.5</td>
<td>Six Executives and Health Board team completed online FISH.</td>
<td>So all relevant individuals understand the principles underlying good flow.</td>
</tr>
<tr>
<td>1 - Getting started</td>
<td>1.0</td>
<td>Attended Learning Session 1.</td>
<td>To demonstrate commitment to learning &amp; sharing.</td>
</tr>
<tr>
<td></td>
<td>1.1</td>
<td>Flow data submitted to Dr Kate Silvester.</td>
<td>To prove that the HB can produce the right data.</td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>Data analyst trained to produce the high level measures for improvement.</td>
<td>So these measures are routinely available to senior decision makers.</td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>One day Executive Board development workshop run with Dr Kate Silvester.</td>
<td>To understand their data and emergency patient flow in the health board.</td>
</tr>
<tr>
<td></td>
<td>1.4</td>
<td>First 2 day workshop held with the health board team.</td>
<td>To learn more advanced flow thinking and to start creating value stream map with the data of their emergency flow.</td>
</tr>
<tr>
<td></td>
<td>1.5</td>
<td>Problems identified.</td>
<td>To show that enough diagnostic work has been done to identify the right problems to work on.</td>
</tr>
<tr>
<td>2 - Making changes</td>
<td>2.0</td>
<td>Attended Learning Session 2.</td>
<td>To share the lessons learnt especially what the particular problems are in the health economy.</td>
</tr>
<tr>
<td></td>
<td>2.1</td>
<td>Second 2 day workshop with Dr Kate Silvester completed.</td>
<td>To review potential solutions and plan their implementation.</td>
</tr>
<tr>
<td>3 - Sustaining changes</td>
<td>3.0</td>
<td>Attended Learning Session 3.</td>
<td>To share progress made so far.</td>
</tr>
<tr>
<td></td>
<td>3.1</td>
<td>Further actions?</td>
<td></td>
</tr>
</tbody>
</table>

The actions identified are arranged in a logical order, with certain checkpoints or milestones populating a reporting framework. The following table below defines what these are, with five status levels to describe where health boards are at any given time, in addition this will allow 1000 Lives Improvement to report which of the specific steps or tasks have been completed.
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<table>
<thead>
<tr>
<th>Level</th>
<th>Status</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Engaged</td>
<td>Health board has agreed to participate in the Collaborative Flow programme</td>
</tr>
<tr>
<td>2</td>
<td>Preparing</td>
<td>Health board has completed at least one of the Stage 0 actions</td>
</tr>
<tr>
<td>3</td>
<td>Problem solving</td>
<td>Health board has completed the Stage 0 actions and attended Learning Session 1</td>
</tr>
<tr>
<td>4</td>
<td>Testing &amp; implementing</td>
<td>Health board has completed the Stage 1 actions and attended Learning Session 2</td>
</tr>
<tr>
<td>5</td>
<td>Sustaining</td>
<td>Health board has completed the Stage 2 actions and attended Learning Session 3</td>
</tr>
</tbody>
</table>

References


Public Health Wales (2013) *External Factors (Drivers) Affecting Long-Term Trends and Recent ‘Pressures’ on Unscheduled Care Use and Performance in Wales*. Available at [www.2nphs.wales.nhs.uk](http://www.2nphs.wales.nhs.uk)


Resources

1000 Lives Improvement web-page: [www.1000livesplus.wales.nhs.uk/flow](http://www.1000livesplus.wales.nhs.uk/flow) This includes links to key resources, including a video interview with Mike Davidge offering a quick introduction to Flow.


The National Patient Flow Programme: Module 1


About 1000 Lives improvement

1000 Lives Improvement is part of Public Health Wales, supporting organisations and individuals to deliver improved health, healthcare outcomes and user experience in NHS Wales. www.1000livesi.wales.nhs.uk

The National Patient Flow Programme MODULE ONE - Getting Started

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