1000 Lives Plus and the NHS Agenda - Lessons from Systems Thinking

Based on a seminar given by Professor John Seddon, on 28 September 2010.

Lead author:
Dr Alan Willson, Director, 1000 Lives Plus

Co-authors:
Professor John Seddon, Managing Director, Vanguard Consulting Ltd.
Andy Brogan, Consultant, Vanguard Consulting Ltd.
Dr Chris Jones, Medical Director, NHS Wales,
Jan Davies, Director, 1000 Lives Plus
Jon Matthias, Writer

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1000 Lives Plus and the NHS Agenda - Lessons from Systems Thinking

Executive Summary

1000 Lives Plus seeks to improve healthcare within NHS Wales, continuing the work of the highly successful 1000 Lives Campaign. Although the aims of 1000 Lives Plus are aligned with the over-arching values and long-term aims of NHS Wales, there is a divergence in terms of method.

1000 Lives Plus states quite clearly that “Safety problems can’t be solved by using the same kind of thinking that created them in the first place” and that there is a need to recognise that “most harm is caused by bad systems and not bad people”\(^1\).

Many of the interventions introduced through 1000 Lives Plus have focussed on better systems, for example the implementation of ‘bundles’ of care to prevent infection and pressure ulcers, speed up rehabilitation after stroke and recovery after surgery, and reduce the likelihood of surgical complications.

Analysing and changing systems and procedures in NHS Wales further will considerably improve the patient experience of healthcare and offer significant financial savings. Individual interventions at specific points in the patient journey will not necessarily result in improvement in the overall process. There is a need for system-wide change, that places the patient ‘front and centre’ in all aspects of service delivery.

An essential element of systems thinking is that “the cost is in the flow”. Shortening the process through offering the right treatment earlier (at the optimal time), is better for patients and also reduces costs.

Key to this will be a change in culture, a willingness to replace measures that currently add to problems, with new concepts of ‘success’, that set frontline clinical staff free to pursue ‘better practice’.

Improved systems will lead to better patient outcomes and experience, and will also bring additional benefits in reduced waste, less variation in services, greater staff engagement, and long-term sustainability through introducing reliable processes. Movement towards ‘systems thinking’ will enable both 1000 Lives Plus and the wider NHS in Wales as a whole to meet the aims and objectives set before them.

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\(^1\) See ‘Making patient safety a priority’ in the 1000 Lives Plus Improvement Guides. http://tinyurl.com/improvguides
The origin of this discussion paper
This discussion paper was born out of an invitation-only workshop that gathered leaders from across NHS Wales to hear presentations on ‘systems thinking’ by Professor John Seddon and his associate, Andy Brogan. This was set in the context of the successful improvement work of 1000 Lives Plus, with a view to applying the systems approach that was a key factor in the improvement work more widely across NHS Wales.

Dr Alan Willson, co-director of 1000 Lives Plus, and Dr Chris Jones, Medical Director for Wales and co-Chair of 1000 Lives Plus opened the session. The attendees included the Chief Executive of NHS Wales and chief executives from NHS organisations, the Chief Medical Officer and other representatives from the Welsh Assembly Government, medical directors from NHS organisations, representatives from the Bevan Commission, the Faculty for Healthcare Improvement and the National Leadership and Innovation Agency for Healthcare (NLIAH), among others.

Professor Seddon has had a notable career pioneering the development of a systems approach to the design and management of service organisations, improving the end-user experience while also reducing operating costs, and improving employee capital through increasing expertise and transforming morale.

He has helped numerous commercial organisations improve their systems to enhance their profitability and ensure their long-term viability. At the workshop, he presented an example from local government to show how a systems approach improves achievement of purpose at the same time as realising significant efficiencies. Crucially, in his example, traditional targets had given false impressions of whether a system was working and caused staff to focus on meeting targets often at the expense of good service.

Professor Seddon cited the work of W. Edwards Deming to assert that “we invented management so we can change it” and to ask penetrating questions like: “As we design for perfect, how many conventional management assumptions do we challenge?”

Naturally, discussion of a new approach raised several challenging questions and prompted some lively debate. This discussion paper includes several of the points made by Professor Seddon and Andy Brogan, and lays out some potential areas where new thinking could aid the change agenda within NHS Wales as the service moves towards its stated objective of becoming ‘world class’.

The NHS Wales situation
In his introduction to the workshop, Dr Chris Jones, Medical Director of NHS Wales and co-Chair of 1000 Lives Plus, likened the NHS in Wales to an oil tanker - a large vessel that takes a long time to turn around.

The use of Risk Adjusted Mortality Index (RAMI) and other outcome measures clearly underline there is room for improvement.

If “every system is perfectly designed to achieve the results it gets”, then the systems within NHS Wales need to change to improve patient outcomes. There are three essential elements within change for improvement - culture, structure and systems.
The reorganisation within Wales in autumn 2009 has created a new, robust structure, well suited to improvement. Positive changes can now be implemented across larger organisations, ensuring the benefits are felt by more people.

Cultural issues are being addressed through 1000 Lives Plus and other initiatives. A culture of openness, patient-centeredness and team-working is emerging, leading to changing the culture towards a goal of “a cohesive, motivated and professional workforce”.

The new NHS Wales culture should:
- See the patient as the most important player, not the professional;
- Hate waste;
- Focus on value as well as quality;
- Manage knowledge as carefully as it manages money;
- Give at least as much attention to systems as institutions.

The emphasis on systems is a key part of forming a new culture. It is acknowledged and understood that high-performing organisations display the following features:
- Team-based working;
- Autonomy and decentralised power;
- Fewer management levels and fewer, more focussed staff;
- Support systems that will support services - not demanding bureaucratic procedures;
- Networks, partnerships and alliances to achieve greater goals than could be achieved by individuals or organisations working alone;
- Intense customer focus;
- Unity of purpose through continuously propagated values.

In a healthcare setting, the ‘intense customer focus’ would mean putting the patient (and their family) first, ensuring that clinical staff understand what the patient wants, and then delivering what the patient wants, quickly, to meet their need.

If changing systems is going to have any real effect on the outcomes experienced by patients, then these characteristics need to be built into the system. In an era of tightened budgets where the need to prevent wastage is ever-more paramount, reducing bureaucracy, partnership working, and freeing up staff time, are all helpful.

Systemic change to shift the focus of management towards patient satisfaction, will carry with it benefits on a financial, motivational and cultural level.

How the lessons being learned through 1000 Lives Plus can inform systemic change
Dr Alan Willson addressed the question of how 1000 Lives Plus aligns with the NHS agenda, particularly in providing methods of improvement that can be applied to the multiplicity of systems operating in NHS Wales. He noted that the 1000 Lives Campaign placed an emphasis on ‘Will, Ideas, Execution’, and while there had been definite will to change and many good ideas, the execution element was not always as successful.

Key aspects of the 1000 Lives Plus programme align closely with the aims and values of NHS Wales, particularly attempts to reduce harm, waste and variation in services. The programme focuses on outcomes and people “in a way never seen before”, and seeks to engage clinicians to ensure positive change happens across the service.
However, although the aims of 1000 Lives Plus align and integrate well with the aims of NHS Wales, there is a divergence between the methodology of the improvement programme and the wider service. This is especially seen in the difference between the 1000 Lives Plus focus on improving systems, and the NHS culture of targets based on process and output measures.

Improvement requires changing the way our organisations work, rather than coming up with new ideas for organisations to implement. ‘Point interventions’ can change outcomes, but they will not necessarily change the system, even if multiple interventions are introduced.

The currencies that managers use to control the process that leads to outcomes need to change. It is important to know what the process entails to see what the ‘flow’ of the process is like. Often ‘static’ measures are used – e.g. ‘activity’ is viewed after the fact, rather than during the process. Length of stay is calculated at the end of stay, so there is no real way of knowing how long a given patient in the process has stayed already, and is likely to stay.

Connecting clinical leadership and managerial leadership is vital. This will help identify ways to reduce the process. For example, a lack of therapists to help stroke patients recover after experiencing a stroke, means that the length of stay for stroke patients in Welsh hospitals is longer than in hospitals in England. This issue cannot really be seen by viewing length of stay once the patient has been discharged – questions need to be asked in the process as to why patients are in hospital, and what can be done to speed up recovery and return to normal activity.

The theme of 1000 Lives Plus is simple, consistent, unifying, and positive. There is a need to emphasise method, and “not rely on magic”. The work also needs to take place on a large scale, which carries with it additional challenges. However, 1000 Lives Plus can help those who want to improve systems, and provide proven methodology for making positive changes happen and stick.

Change is inevitable and the challenge is to shape change rather than be shaped by it. The presentations by Dr Chris Jones and Dr Alan Willson both identified various aspects of NHS Wales where change was desirable and could be beneficial. Many of these areas were specifically addressed by Professor Seddon when he discussed systems thinking.

The 1000 Lives Campaign gained “formidable” political, clinical and managerial commitment. This was partly due to the honesty in the Campaign that admitted that there were and are problems in the system.

There have been dramatic changes and clinical improvements due to the 1000 Lives Campaign and its successor programme 1000 Lives Plus, but the achievements have been sporadic, not systematic. This variation in the level and take-up of improvement is a concern, and the problem is usually in the systems in different places rather than with clinical staff. Some scrutiny of existing systems is to be welcomed.
Would a systems approach lead to a step-change?
Three elements comprise change for improvement: culture, system and measures. It is axiomatic to a systems thinker that these three things should be understood together.

Professor Seddon chose an example of his approach that has some parallels with health. Portsmouth Council, with their private-sector partners, transformed their housing repair service. The new system:

- Allowed tenants to request a repair at a date and time of their choosing;
- Halved the average repair costs;
- Was instituted in just eight weeks.

The result is a truly customer-focused culture, created through a customer-focused system (organisation design), using measures that relate to the purpose. It represents an economic benchmark.

The transformation in Portsmouth began with managers and tradesmen from both parties (the council and supplier) studying their service as a system, following Seddon’s (Vanguard) Method. It revealed many counterintuitive truths.

One was that targets and their associated management information were completely misleading. While the service appeared to meet its targets, the true end-to-end time it took for a repair to be completed from the tenants' point of view was shockingly long.

Studying the system revealed how work orders were cancelled because otherwise targets would be missed. Targets invite people to be ingenious. Centrally-determined priorities - target times for different repairs - were not the tenants’ priorities.

Studying the front end (where tenants call in) revealed high levels of failure demand - demand caused by a failure to do something or do something right for the tenant. Failure demand accounted for 45% of the total demand, consuming enormous resource.

Spending time out with tradesmen revealed how frequently they were unable to complete a repair on first visit. In turn this meant tradesmen were wasting time every day returning for materials and completing forms to correct previous errors. At the heart of the problem was the ‘schedule of rates,’ a set of protocols for repairs with associated standard times and materials. The schedule of rates effectively prevented the service from absorbing variety; repairs were not ‘the same’. Paradoxically, managers believed the schedule of rates was controlling costs. Studying revealed how it drove costs up.

Studying also required a thorough knowledge of demand - this time ‘value demand’ - the repairs coming in from properties. Knowledge of demand became the cornerstone for redesigning the service; it was found to be largely predictable.

The new design made no attempt to diagnose the problem before the tradesmen attended. On arrival, accurate knowledge of what was required meant tradesmen were able to tell the centre when they would be finished and were carrying materials that would predictably be needed; this ensured that many repairs were completed immediately. In fact, the proportion of repairs completed on the first visit climbed to over 95%.
Costs were halved because management’s attention had moved from managing costs to managing value. By working on designing a service to serve the demand, costs were driven out of the system; another counterintuitive revelation.

A discussion ensued of connections between the housing repairs case and health.

In Portsmouth, staff had control of the work. Does this mean managers should take “a leap of faith”, “place trust in people” and “let go”? Seddon said while it might look like that, it is no leap of faith because the new design is based on knowledge. It also makes everyone more visible and, in any event, studying revealed how conventional ‘controls’ were not effecting control, but the reverse.

Putting workers in control of the work, using real rather than arbitrary measures, achieves greater control and managers, operating in new roles, become closer to the work. But at first it feels very odd for managers who are used to spending their time in different ways.

There is a need to free up staff from bureaucracy and unnecessary work. A figure of 760 measures for cancer services in NHS Wales was mentioned during the meeting, many of which are deemed to have little impact on improving services or clinical practice.

“Targets create de facto, unintended purposes and constraints, for example scheduling operations in known holiday periods so the patient has to reschedule and render the operation not liable to an 18 week attainment target.”

“Measures can make organisations worse. People often think targets will make the performance better but they are quite likely to have the opposite effect. Metrics drive the wrong behaviour. The need to reduce length of stay can lead to a ‘get them out’ attitude not ‘get them better’.”

Seddon: “Management’s conventional measures in Portsmouth wouldn’t have helped them halve the costs. One measure was tradesmen activity, the conventional idea is that management must ‘sweat the workforce’, get them to work faster, increase their utilisation, but, in fact, that will not help.

Consider, for example, how world class manufacturers focus on machines being ready when the part comes along. Idle is okay. In factory settings keeping the machines running just creates inventory, which actually increases cost because you’ve used materials, you need to store it, and so on. Cost is in the flow, not in activity. And so it is for tradesmen; Portsmouth designed a system where the tradesmen would be ready as the work arrives.”

“In hospitals a number of procedures are scheduled on wards at exactly the same time. This leads to delays and waste as patients cannot get to theatre on time. Pretty soon, firefighting is the norm.”

“Access strategies do not sort the problem out because people equate ‘getting in’ with ‘getting help’.”

Access strategies assume all demand is equal. A&E experience a predictable volume of patients with suspected heart attacks. But diagnosis generally takes between 6-12 hours. However the target says that patients must be either admitted or discharged by four hours. This places staff in a dilemma - they can “discharge and hope the patient will be okay” or admit the patient and handover mid-diagnosis to other staff.
Ideally patients should be kept in A&E until diagnosis is clear. However the pressure to meet the targets and yet not admit unnecessarily can lead to ‘ingenious’ solutions, for example to ‘partially admit’ into a room in A&E which means the four hour target is met but the patient can still be released once diagnosis is complete.

“Similarly, the target is whether the ambulances arrive in a certain time, not whether they save lives.”

Comparing Portsmouth and healthcare, the situation is often reversed, with citizens making frequent visits to the ‘home’ of healthcare providers (the surgery or hospital), but often frustrated in their attempt to gain treatment or progress along the treatment pathway.

An example would be if a citizen is sent for the ‘wrong’ type of scan. The likely response would be to send the end user away and schedule them an appointment for the ‘right’ kind of scan. It would be unusual, yet more helpful, for the attitude to be ‘you came here for a scan and we’re going to get you scanned’. This would cut out delays during which time the condition being scanned for may worsen past an optimal point of treatment.

One measure that was central to Portsmouth’s success was demand: knowing the predictability of repairs. What do we know about the predictability of demand in health care? To date there is only one study of demand into healthcare, in an English Trust. Interestingly, demand was found to be stable and predictable. If this is generally true, it suggests there is tremendous scope for improving the design of health care services. However, the greater priority would be to understand demand in primary care.

A blank sheet of paper
A phrase that came up in the example from Portsmouth was to redesign processes on a “blank sheet of paper.”

The responses to this idea predicted challenges: “The idea of a blank sheet of paper is difficult - in the NHS there are many tweaks to the current system.” “A problem is the pseudo-religious attachment to process, transformation is great but it needs to be sold well.”

Professor Seddon suggested, “In big organisations you perhaps need to start in different places and create different designs. Then roll in the changes - get people in to the new way of working. People have to unlearn current ways of working and then learn the new way.” The use of the phrase ‘roll in’ instead of ‘roll out’ is deliberate, as it is more effective to help people understand the new philosophy, methods, roles and measures as they move to the new way of working, rather than impose it on people who are yet to be convinced about the efficacy of the change.

“Spreading method - how to base change in knowledge - and enabling people, is more useful than spreading ‘best practice’, which is an ambiguous term because it is essentially static copying. ‘Better practice’ is a more constructive lodestar.”

Triaging in primary care is often done by administrative staff and therefore medical staff are not always aware of the total demand for their services. Proper study of demand at GP level will help to design a better system for GP care. It could increase the services provided at that point of transaction.
“We need the opportunity to rethink the outcomes we want to deliver. The pressure to deliver targets means there is often no time to think it through. That pressure moves people towards command and control management.”

“We have the well paid-managers and clinicians at the back of the system, concentrating on delivering targets.”

Redesign needs to involve citizen patients and frontline clinical staff, in order to give citizens the care they need at the point they need it. The redesigned system will involve enabling clinicians to make the decisions and take the steps that are needed to deliver care.

It is important to design into the system ways of encouraging people to keep the work and not just refer it onwards. Resources and knowledge need to be pulled in to the front end to give patients the care they need at an earlier point. Managers would be responsible for ensuring demand is being met and whether the relevant expertise is being pulled in.

Some initial studies in health
Andy Brogan presented some of the findings from early studies of healthcare as a system. One was an example of a patient with a knee problem, tracking progress through the system from the GP to various specialists. Each person did their job well - “nothing abnormal” - but it took 18 weeks to sort it out (18 weeks is the limit).

A problem in the way the process was viewed stemmed from the staff involved regarding each point in the progression as a ‘transaction’. Clinicians do care whether their transactions go well, but don’t have an overall view of the process. The GP thought things were good as the patient received a specialist appointment after two weeks - but getting that appointment was not the solution to the problem, even if the GP thought ‘problem solved’.

Generally, staff are not shocked at the delay in patients getting treatment because they are so used to it. Andy succinctly summed this issue up as: “The process is ‘normal’ but even if it’s normal, it’s still rubbish.”

He presented a case study of a family carer for a dementia patient who needed some respite care. Their GP referred them to day care, which was inappropriate, social services became involved, and several abortive attempts were made to provide respite. After five months and seventy “touches” by fifteen staff the carer has still not had their original request – for a break - met. “There is confusion between ‘getting in’ and ‘getting the job done’.”

Andy had been approached to resolve problems in a primary care location; at a GP surgery. The issue was that patients could not get appointments with GPs when they wanted them.

The surgery had tried various strategies including ‘book on the day’, non-named doctors, and standard appointment times. None of these strategies had worked, and, in fact, the feeling was that the service offered was worse than ever.

Studying the system showed that 20% of appointments were due to failure demand, for example, aftercare for an operation where there had been insufficient or misunderstood post-operative instructions.
In addition, 10% of the practice population were responsible for 40% of the appointments. These were people whose illnesses or conditions were not being helped, or who were not being equipped to self-manage their conditions.

Andy and his team looked at 80 cases and saw that on average it took four appointments for patients to get their problem sorted. It could take up to 15 appointments to resolve a problem. When they started to drill down into why people had to repeatedly visit the surgery, it seemed many of the problems lay in the ‘access strategies’ adopted to improve the process.

For example, because booking could only be made on the day, people couldn’t get through as everyone was phoning at the same time. There was inconsistency because patients saw different doctors each time - and each time doctors needed to have the same conversation, and often did not know exactly what had been said or done by the previous doctor.

Standard appointment times were also problematic. “Patients need to be listened to but also to listen and understand what the doctors are telling them - they need to listen to us as we try and help them.”

Andy paraphrased John Locke’s maxim that ‘Madness is sound reasoning from flawed assumptions’, and suggested reviewing the healthcare system, looking at treatment or care from the patient’s point of view. This will help to build a more efficient system that delivers a better user experience.

The patient’s point of view is always going to be ‘Give me the help I need’. Patients and their families and friends are not concerned about configuration or criteria.

‘Give me the help, or the care, I need’ could be a motto or guiding principle for the NHS as it seeks to serve patients. Being patient-focused in this way would mean focussing on:

- Timeliness - in terms of diagnosis and seeing the clinicians who can treat;
- Evidence-based ‘better practice’;
- Good explanations and communications with patients;
- Compassion and dignity as hallmarks of care.

Further discussion

“The process is important. Too much management is static. There is a need to look at flow. For example, money spent on stroke patients could be reduced if the average length of stay in hospital was reduced to the English average. But we hear examples of where there is a freeze on hiring therapists, which means stroke patients will inevitably stay in hospital for longer periods of time.”

“The experience of working in healthcare is like a ‘bar magnet’. Those in the ‘North’ of the organisation focus ‘North’, while those facing ‘South’ have a different focus and are talking a different language. It is felt that work happens in spite of the management team, not because of it.”

The central thrust of systems thinking is that NHS Wales could improve the patient experience and make significant cost savings by shortening the flow and putting expertise at the beginning of the system. This would give patients faster, more effective, treatment that minimises the number of ‘touches’ in the system before the patient gets the treatment they want.
Demand can be anticipated through taking a time historic view and working out how many patients have presented with a certain condition in a given locality. “Economy is flow and flow is local.” Demand will vary geographically, so locality leaders need to be equipped to identify and meet local demand. In terms of scale, individual teams need to reflect on purpose and design for that.

“No one [in the NHS] seems to know the predictability of demand at the front end, but that is the place with the most leverage.”

“We need to measure achievement of purpose from the customer’s point of view - the length of time it takes from beginning to end. We don’t usually have the data, but we can go backwards through the system and work out how long it has taken to give patients the care they need.”

Service is not the same as access. One of the issues with NHS Direct is that it frequently passes people to other places. If cost is in the flow, then NHS Direct needs to solve the problem over the phone, otherwise it is just an extra step in the patient pathway and ramps up the cost of treatment by adding another stage to it.

“The right structure comes after system redesign - design the end-to-end core processes then fix the support mechanisms including roles for managers. Managers then identify things that interfere with core processes and eliminate them. This will create greater cooperation from staff.”

“You need to find causes of variation [e.g. in treatment times] and design them out. Meet demand in the front end of the system and the cost of meeting demand will fall.”

Problems occur when care is seen as transactions by clinicians who only care about whether their part in the process has gone right. “The problem will be ‘beyond our sight’ because the whole process has not been looked at.”

“Why can’t patients go through the process and out the other end? Blockages in the pipe are based on how we focus and think.”

Measures have to be appropriate to the patient viewpoint. A challenge is that current patient groups have become institutionalised and hold people to account for command and control style measures that are unhelpful.

“Care must be understood from one end to the other. Optimising the parts does not optimise the whole. The focus has to be on purpose and value creation, with measures derived from purpose.”

Clinical staff still compartmentalise services, with a ‘we’ve done our bit okay, therefore everything is fine’ mentality. However, the system view is much broader. Ultimately frontline clinical staff would need to aggressively pursue a solution to the patient’s problem, and not just be satisfied that they have carried out their small part in the chain correctly. It is ‘better practice’ to ensure the patient gets the help they need, even if that means going beyond the job description.
Measures
There are unintended consequences to current measures. “The harder we push the system, the more we get what we don’t want.”

The big lever for change is designing for customer demand - once this is measured, work can be planned more accurately, variation can be accounted for, and staff can be equipped to treat patients with the care that they need. Designing to serve demand well will drive failure demand out and release capacity.

Achievement of purpose
“Measures should be derived from purpose.” (John Seddon)
- or, put another way -
“Purpose leads to measures leads to method.” (Andy Brogan)

John Seddon proposed a statement of purpose: In NHS Wales, all demand will be met with fast and accurate diagnosis; all treatment will be delivered on time as required.

It follows that these two foci should dominate management’s attention. Measures of demand and capability (to diagnose and treat) will be central to managing and improving the flow of work, driving costs out as service improves.

The first example of Seddon’s method applied to health was presented at Vanguard’s Leaders Summit (25 November, 2010). Stroke care services were improved and the costs of the service halved [see bibliography].

Potential barriers to Change

Clinical procedure
Clinicians are used to complex systems, in terms of the human body, so a complex system in itself is ‘normal’ for clinicians. Resistance to change can be because people simply do not see the need for change. Conventional management would look to see refinements in the system or the introduction of new targets to stimulate change. Studying the ‘what and why’ of performance as a system builds collective knowledge, reducing resistance and the new design is built locally, not imposed.

Regulatory bodies
The first phase of systems change is a study phase. The regulators need to be included so that they realise if regulations are adding to current problems. The experience of John and his team is that regulators are supportive of change when the proposals are based in sound evidence.

Political considerations
“Politicians don’t want to be held responsible for worse, slower, less safe, more costly healthcare.” Selling system change may be difficult politically, so there is a need for dialogue. Politicians need to be made aware of what is learned in the study phase and the results being achieved in redesigns, so that they are better equipped to make informed decisions and answer questions.
Making a start
This change starts with studying. Perhaps the priority is to study demand in order to understand the priorities for studying flow (provision).

Studying demand - both value and failure - needs to be done at the local level.

All predictable failure demand is preventable; it is due to service design.

Predictable value demand facilitates the design of more efficient services.

Studying the ‘what and why’ of performance against demand - the flow, its capability, the extent and causes of sub-optimisation - reveals the scope and means for improvement.

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About 1000 Lives Plus

1000 Lives Plus aims to improve outcomes and drive quality improvement in Wales through reducing harm, waste and variation in the system and improving the overall experience of care.

It was launched in May 2010 and is one of several national programmes which form a five year strategic framework for NHS Wales.

As a national programme, it is committed to enabling rapid acceleration in the scale and pace of sustainable improvements to give every person in Wales reliable, high-quality care every time.

Meeting this challenge is central to improving services and cultural transformation in Wales. It requires exceptional leadership and commitment to ensure continuous improvement is integrated into everyday working.

Through a series of work streams 1000 Lives Plus takes forward the standardised improvement methodology, use of evidence-based interventions and measurement for improvement introduced by the 1000 Lives Campaign and Intelligent Targets work.

It supports all health boards and trusts to set and achieve appropriate targets for the reduction of harm and hospital mortality through the reliable implementation and spread of evidence-based interventions and the tracking of outcomes.

1000 Lives Plus currently delivers several evidence-based areas of work to ensure better health outcomes, a better experience of care and better use of resources. New areas driven by population-need will continue to be introduced to enable innovations and local developments, whilst also embedding improvements across Wales.
About the author

Dr Alan Willson is joint director of the 1000 Lives Plus national programme, a director of the National Leadership and Innovation Agency for Healthcare (NLIAH) in Wales, Honorary Senior Lecturer in Swansea University and Visiting Professor at the School of Pharmacy in London.

He has directed several national collaboratives including critical care, medicines, mental health services and most recently in stroke services. His research interests are medicines management and the spread of improvement. He has recently published on the evidence base for improving effectiveness of medicines in primary care.

Alan qualified as a pharmacist working in senior pharmacy and then general management in London before coming to Wales. He completed a PhD looking at causes of the high rates of Welsh prescribing.