



Advancing Quality Alliance



AQuA – Whole System Flow 17/18

Learning Report

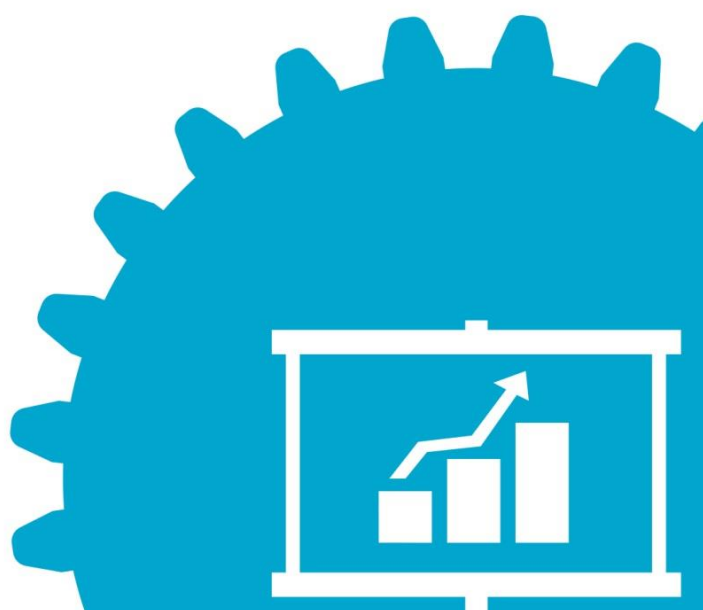
Scott Gregory

Whole System Flow Programme Facilitator

Wendy Lewis

Whole System Flow Lead

18th April 2018



Contents

1. Introduction.....	3
2. Programme Overview	3
2.1 Model Overview – “Double Diamond”	4
2.2 Model Overview - “The 4 Arrows”	5
2.3 Redesign Structure	6
2.4 Programme Elements	7
3. Key Success Factors	8
4. What Next?	9
5. Case Study – Bolton Intermediate Tier	10
6. Case Study – Wigan Respiratory Pathway	14
7. 18/19 Systems	20

1. Introduction

Discussions with our membership led to AQUA identifying that poor flow across and within care systems was a major concern. Consequently in 2016, AQUA began to explore how we could support organisations to understand flow in more detail and design an offer of support. Over 18 months the flow team at AQUA analysed and reviewed worldwide research, evidence and experience of trying to improve 'patient flow'. Our findings are summarised in "The Challenge and Potential of Whole System Flow"¹, a report that was co-authored with The Health Foundation.

The report identified a model and supporting frameworks that AQUA then committed to test within current NHS and Social Care context. It was at this point that AQUA's "Flow – Improving System Pathways" (FISP) programme was developed as a discovery programme and three member systems were successful in applying to be our test systems.

The three systems that were selected were:

- Bolton – Intermediate Tier Services
- Liverpool – Complex Needs Pathways
- Wigan – Respiratory Pathways

From July 2017 to January 2018 each of these sites participated in the Diagnostic Phase of AQUA's FISP programme, which included:

This report is a summary of model used for exploring the flows between existing services, including Acute, Community, and Social Care, as well as our key learning.

2. Programme Overview

AQUA's approach to understanding flows across care systems is based on the learning from research, previous improvement work and speaking with our members around the challenges of flow. When combined with Quality Improvement (QI) methodology this will enhance the likelihood of a successful shift to systems thinking. A definition of whole system flow was developed in order to frame the intention of the work:

"The coordination of all processes, systems and resources, across an entire local health and social care economy, to deliver effective, efficient, person-centred care in the right setting at the right time and by the right person".

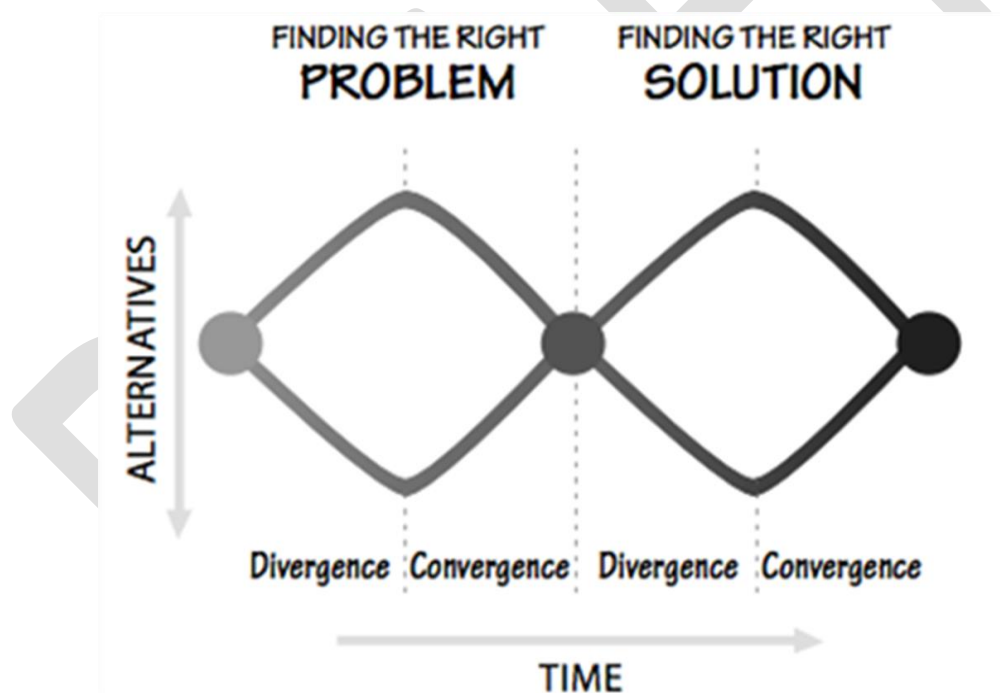
¹ <https://www.aquanw.nhs.uk/resources/whole-system-flow/Challenge-And-Potential-Of-Whole-System-Flow-Dec-2016.pdf>

We have used the Design Councils 'Double Diamond'² and Kreindler's "6 Ways Not To Improve Flow"³ in order to develop a new model for testing within the diagnostic phase. This allowed us to remain focussed to understand the right problem we were trying to fix and not jump to solutions before we fully understand the problems that are faced by the system.

2.1 Model Overview – “Double Diamond”

The double diamond is a tool that was produced by the Design Council. It shows that equal time should be spent diagnosing the problem as should be given to designing solutions. This has influenced the way that AQuA has designed the FISP programme.

The diagnostic phase of the programme is crucial to understanding the local context and root causes of issues each system. Only when this is fully understood can we design solutions. If done too soon, this process can result in solutions being designed for symptoms of a deeper problem.



The overarching aims for the diagnostic phase for all three test systems are listed below:

1. Make the system visible to itself

² <https://www.designcouncil.org.uk/news-opinion/design-process-what-double-diamond>

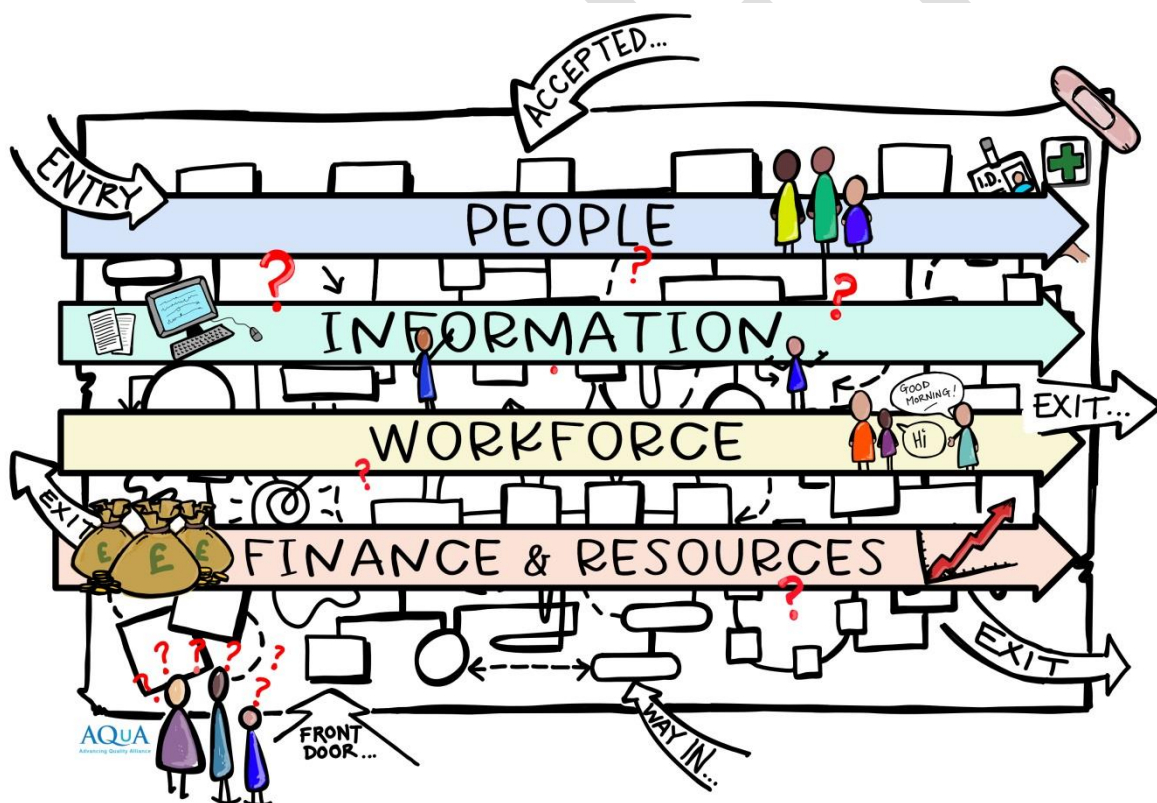
³ <http://qualitysafety.bmj.com/content/26/5/388>

2. Create an environment for discussion and engagement across traditional professional or organisational boundaries.
3. Map the current state
4. Understand Queues/Waits
5. Ensure the lived experience perspective is sought and involved equally

This report explores the different components of this phase in detail, sharing learning about each System that will provide the foundations for designing improvements.

2.2 Model Overview - “The 4 Arrows”

AQuA has developed a model that shows the 4 key lines of enquiry that we follow when exploring Whole System Flow. This evolved over the early part of the programme as we learnt that to not intentionally explore and understand each element within a care system would prevent the generation of a shared system view of the current state.



For the FISP programme, AQuA developed – “The 4 Arrows” – a model that provides a structure for exploring processes, systems and resources with each of our FISP systems. Spending time understanding these arrows will allow us to understand systems in the detail required and consequently design solutions that will deliver sustained improvement.

People – This arrow represents all service users, carers, and families that are involved within the identified health and social care pathway. Their vital perspective should have equal weight to the other three arrows and requires detailed analysis to understand how people flow through the system and how this is experienced. Only by truly exploring this arrow can our programme be person centred. We are continually challenged to avoid the term patient flow and strongly advocate for viewing recipients and their supporters of health and care services as people.

Information – Exploring IM&T information flows between services in a system, but also exploring the flow of verbal and written information and the impacts on handovers between services. Information given to patients and carers throughout the journey should also be analysed to understand the impact this causes.

Total workforce – In the same way that service users and their families have a unique perspective on the system, so do the staff that work within it. Their views are often not heard; however, gathering views and engaging with decision makers at a range of different levels within the service is vital to understand the current state.

Finance and Resources – To influence systems, we have to understand the boundaries within which they operate and design improvements accordingly. This line of enquiry identifies contractual and performance influences and constraints within the system and highlights gaps in or duplication of resources

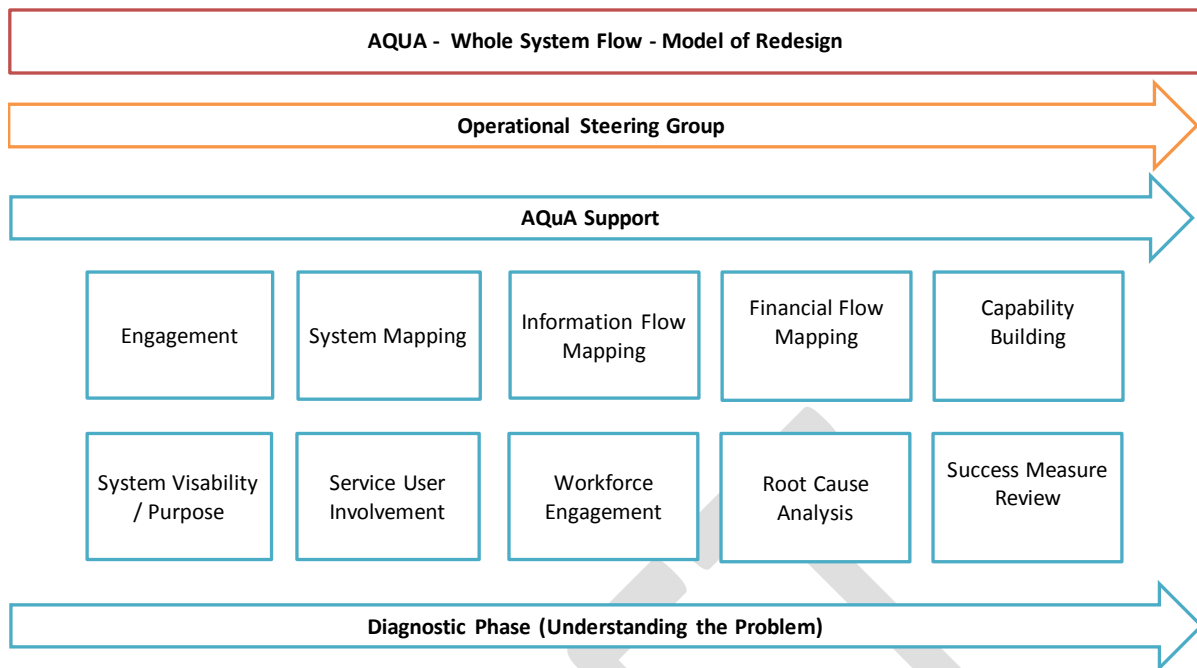
By understanding these 4 arrows and their interdependencies: Risk, Leadership and Culture - in detail we are able to analyse the system comprehensively allowing us to develop the full picture before designing improvements.

In our experience, if this model isn't followed with attention paid to all elements it results in a skewed view of the system and therefore leads to inappropriate or inadequate solutions to be drawn.

2.3 Redesign Structure

Often, service redesign is the product of selected leaders within a system that frequently don't have knowledge or experience of the inner workings of identified services and systems. AQuA's approach to redesign aims to exploit the expertise and experience of front line staff and service users, who have a truly unique perspective of the services we are trying to improve. Gathering their views on root causes allows us to understand the problems behind system issues rather simply resolving the symptoms of deeper lying issues, which ultimately results in unsustainable improvement and disengagement of frontline staff.

The structure of the AQuA's Diagnostic Phase can be found below:



AQuA Support - AQuA have supported meetings, provided leadership and been a critical friend, facilitated difficult conversations, and coached members of the team in order to make progress and instil local ownership of the project.

Operational Steering Group – To ensure that this programme moves at pace, a steering group that is representative of the system should be formed and meet regularly to review progress decide next steps.

Clinical Reference Group – For any clinical improvements, there must be clinical sign off, this group is only required to be formed in the “Design and Test” phase.

2.4 Programme Elements

Engagement - Must be at a range of staff levels, to ensure system wide buy in and understanding

System Visibility / Purpose - Must contain a mix of professions and skill mix from services across the system. Additionally, service users must be present to give opinions

System Mapping - To design sustainable solutions we must understand the “current system state”, AQuA and the local leadership teams spent time with colleagues mapping different services and understanding existing queues. This must take place within the individual services, with frontline staff, not managers.

Service User Involvement - A large part of our programme, AQuA's lived experience panel have conducted informal interviews with service users from across the tier. This provides real value and opinions have equal weighting throughout this process

Workforce Engagement – Engaging with the workforce within different services to understand their view of the system, taking their view of the current state and ideas for change into full consideration.

Information Flow Mapping – To build an understanding of how information systems integrate and whether this causes failure demand within the system

Financial Flow Mapping – Mapping financial flows is crucial to understanding the boundaries of the system and the availability and efficiency of resources.

Root Cause Analysis - Once we understand queues, we must understand the root causes of them to ensure we do not redesign pathways based on symptoms of underlying issues. This work focuses on areas highlighted within the earlier parts for the programme and through service user engagement to understand the key issues within the system to allow an improvement plan to be developed.

Capability Building – By helping to build capability amongst front line staff we enhance the delivery of improvements via PDSA cycles. It allows staff to champion improvements which aids sustainability.

Success Measures Review - Allows us to understand the current performance measures and whether they are providing the information required to measure system improvement.

3. Key Success Factors

Integrated System Leadership - For this programme to succeed, AQuA must work with an integrated leadership team, with representation from across the system to ensure this programme acts as the first step towards achieving integrated system behaviours.

Trust Culture – Taking risks and having permission to fail are key components of innovation. Ensuring that staff feel supported and trusted to try new things, fail, and still continue increased the speed of change.

Empowered Staff – To deliver sustained improvements, staff must be engaged. The best way to engage staff is to empower them. We have found though this programme that were staff at all levels have been fully involved and trusted to lead certain areas, the programme has flourished at a greater rate.

Communications – Improving flow across complex systems requires a detailed communications plan to ensure full system engagement. Staff at all levels must be informed of progress on a regular basis and have a means of sharing ideas and suggestions to maintain engagement.

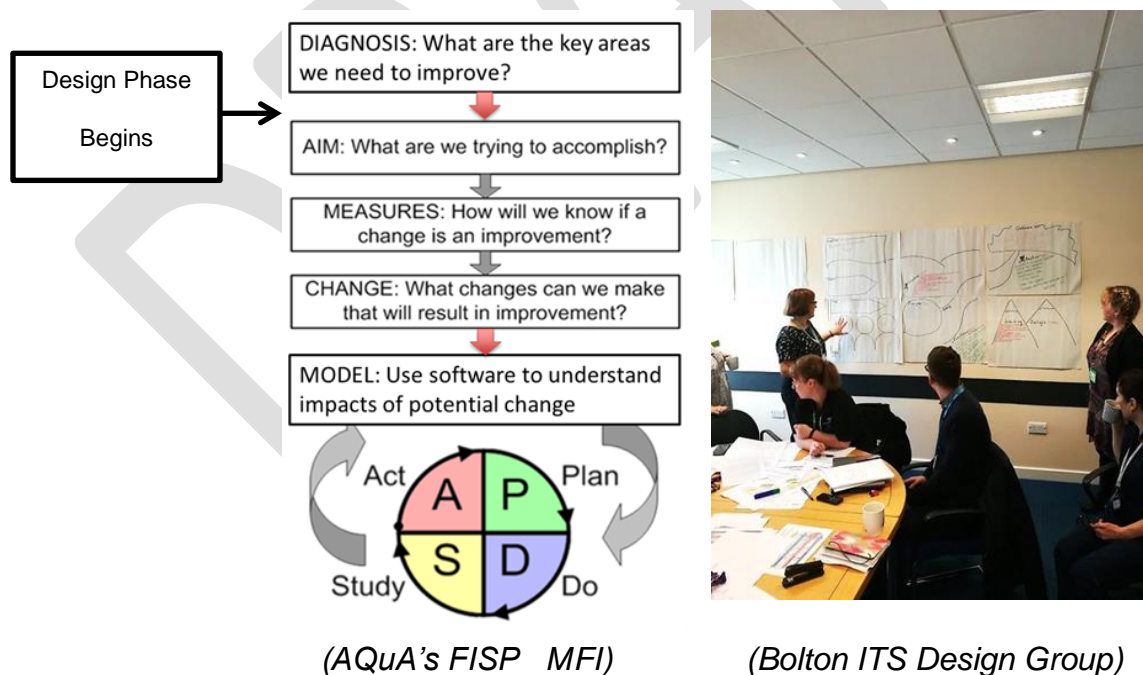
4. What Next?

A “design group” has been formed from a mixed range of staff volunteers from across each system, including a range of professional to ensure whole system buy in.

This group will be using all of the information and analysis developed during the diagnostic phase following the Model for Improvement to design PDSA cycles that would lead to system improvement.

These PDSA cycles will all have individual aims and a range of measures to ensure we can monitor improvement. Ideally we would like to nominate individuals to champion each PDSA cycle and utilise their skills developed within the Quality Improvement Training.

Simul8 will be used prior to PDSA testing to give a hypothesis for us to test and ensure we are testing changes that we are confident will bring about improvement.



Additionally, the tier will continue to engage with wider stakeholders, with events planned to communicate with Estates, IT, Governance, and third sector colleagues. This will ensure smooth implementation of new pathways and improvements.

5. Case Study – Bolton Intermediate Tier

<p>What is the system?</p>	<p>Bolton's Intermediate Tier is fully integrated with the Foundation Trust, but also has elements operated by Bolton Council. The Tier is comprised of the following:</p> <p>Darley Court – Bed Based Unit in the community for patients still requiring Nursing input but no longer require an Acute bed.</p> <p>Laburnum Lodge – Bed Based Unit in the community for patients with lower acuity requirements than Darley Court, yet still require rehabilitation before going home.</p> <p>4 Seasons - Bed Based Unit in the community for Discharge to Assess patients</p> <p>Wilfred Geere – Bed Based Unit in the community for patients with cognitive impairment.</p> <p>Intermediate Care at Home – A short-term programme of rehabilitation which is done in the patients home with the help of occupational therapists, physiotherapists and therapy instructors</p> <p>Re-Ablement – The focus is to provide intensive short term (max 6 weeks) support to people in their own home who have a physical or mental illness, injury or disability.</p> <p>Pharmacy – Provides medicines management support to patients in their own homes and across community bed base.</p> <p>IV Therapy –Provides a range of intravenous care treatments either in patients' own homes or at Brightmet Health Centre.</p> <p>The service is staffed by a range of different professions including Administrators, HCA's, Nurses, Occupational Therapist, Physiotherapist, Social Workers, Key Workers, and Pharmacists.</p>
<p>What were the reasons for the application?</p>	<p>Bolton Intermediate Tier submitted a joint application between the trust and the council as they recognised the flow between different services was poor and this was impacting services users.</p> <p>The challenges that providing a single system under both the FT and the Council required exploration and there was an agreement that services were operating in a fragmented way, despite a large proportion of them being co-located.</p> <p>The system wanted to understand the root causes of this poor flow and develop a new pathway as a system to ensure Whole System</p>

	buy in.
Key Programme Elements	<p>Root Cause Analysis – Using Quality Improvement methodology to understand the ‘true causes’ of visible issues within this system was really crucial to developing a complete view of the current state. This particular area was successful as we engaged with staff from a range of different parts of the system on a 1v1 level, ensuring that staff were able to speak freely knowing their views were confidential. This enabled us to understand that for example, that rather than just “referrals cause delays” that the referral form was too complex and poorly designed which led to staff filling it out poorly just to get it done quicker. This allows us to target a root cause of an issue that has large impact on a patient pathway.</p> <p>Staff Empowerment – Throughout this programme, leadership within Bolton’s ITS have devolved responsibility for this work to their operational staff. This has led to large ‘buy in’ across the system and a real desire to pull this improvement forward from the front, rather than implement ‘another change developed by managers’.</p> <p>Information Mapping – Given the number of different services within this system, understanding the how systems interact AND the knock on impact of this along a single patient journal was crucial. It shifted the mind-set of staff within the system of ‘we only do a couple of assessments’ to ‘this patient has already told their story 10 times before they’ve even reached us’. This was largely due to information being unavailable at different points in the system and identified a need to approach this differently.</p>
What did we find?	<p>Through the diagnostic phase we identified several areas that could be targeted for improvement on both a Macro and Micro level.</p> <p>It was clear that the existing pathways and referral criteria are not as efficient as they could be, and this is causing delays. Therefore, we are now reviewing a range of different options and utilising Simulation software to test various solutions and provide analytical structure to the redesign.</p> <p>For example, IMC@Home not accepting referrals at weekends is costing approximately 1680 Acute bed days per year.</p> <p>Using the “Trusted Assessment” so that referral to commencement of treatment is reduced to 24 hours of treatment is reduced to 24 hours reduces the overall length of stay in the system by > 3 days</p> <p>A brief overview of the different scenarios being tested and the expected outcomes can be found as Annex 1.</p> <p>Additionally, there were several areas that were identified as being parts of the exiting pathway that require improvement alongside the</p>

	<p>larger redesign, these are identified below:</p> <p>Inappropriate referrals – almost every service receives a high level of inappropriate referrals. This was the main area of communication that was mentioned. E.G.</p> <p><u>IMC@HOME</u> Between April 17 – Feb 18 IMC@Home had 2015 referrals, of which 81% were accepted. It takes approximately 30 minutes for a clinician to review and pass back an inappropriate referral resulting in approximately 191 clinical hours lost</p> <p><u>Darley Court</u> April 17 – Feb 18 – referrals 921– 46% accepted (this is increasing since implementation of trusted assessor late 2017) It takes 1 Hour to deal with an inappropriate referral, resulting in approximately 430 Clinical Hours lost.</p> <p>Additionally, audits have shown that 30% of all referrals from hospital to Darley Court could have gone home with a package of care.</p> <p><u>Laburnum Lodge</u> Audits have shown that approximately 50% of all referrals to Laburnum Lodge could have gone home with a package of care.</p> <p>Referral Criteria – Requires redesign / simplification and clear circulation amongst staff.</p> <p>Admin – lots of clinical time lost processing information and lots of Admin time spare.</p> <p>Under one roof doesn't equal integration – Despite being co-located, services are relying solely on verbal communication. This isn't robust and easily fails when there is illness / poor handovers.</p> <p>Joint MDT Audits – Teams don't appear to get together and discuss 'past' cases. This is one way of achieving continuous improvement.</p> <p>Duplication – There appears to be lots of duplication of skill sets within different teams, yet all services are not equipped to deal with sickness and annual leave. On one particular pathway through the system, a patient would have 17 different assessments.</p> <p>Yes Culture – Core functions of the services feel a lost.</p>
--	---

	<p>Patient Choice - If patients have capacity, they seem to be able to demand to stay in a unit and block flow. Staff are unclear on this process.</p>
What Next?	<p>Locality events are being held that are involving support functions within the improvement work and making plans for system implementation. These include workforce, estate and IT solutions.</p> <p>The Programme Group continues to drive the work and reports to locality and organisational boards monthly.</p> <p>Bolton's ITS design group meet every two weeks. This group began by exploring the diagnostic findings and then developing a range of improvements as an integrated team that will result in system benefits.</p> <p>This team has developed a high level pathway that is exploring options for redesign as highlighted above, with Simul8 software testing the most effective system solution.</p> <p>Additionally, the team are currently testing a range of micro scale improvements. Each test of change that is currently being tested has a staff champion and they are responsible for the implementation and measurement of the improvement as well as updating the design group on progress. An overview of the improvements currently being tested can be found below:</p> <p>Micro Level Tests (In Progress)</p> <p>Direct Referrals - From Therapists based in the bedded unit into Re-Ablement this negates the need for social work assessment, a barrier identified during the diagnostic, whilst also reducing and supporting the implementation of trusted assessment GM standards.</p> <p>IMC @ home discharge dates -. The team leaders have reviewed the baseline data for discharge date setting by the team and have promoted the need improve the number of set discharges The setting of discharge dates will create visibility of progress/length of stay. They have seen an initial increase in patients with set discharge date from 39% - 64%. This has resulted in an initial improvement in the caseload; however, it is too early to report conclusive findings.</p> <p>Therapy Instructors - Now meet with the patient within 24hours at point of discharge from bedded unit. This should reduce duplicate assessments and reduce length of stay.</p> <p>Frailty Identification – Services are now using the Rockwood frailty Screen at point of assessment and discharge as a way of measuring progress and identifying the most suitable level of care for each patient. This should ensure that patient's goals are met</p>

	<p>sooner.</p> <p>A combination of these improvements alongside Trusted assessment role out and Red to Green implementation has resulted in a reduction in length of stay at Darley Court by 6.2 days. (32 -> 26)</p>
What do our members think?	<p>Lindsey Darley, Divisional Director of Operations – Integrated and Community Services, Bolton NHS FT</p> <p>“Participating in the FISP programme has enabled us to gain a view of our services not only as a system but as a single and complete version of the truth. We have seen benefits in understanding the flow of the entire pathway at team, service and system level, enabling us to understand the interactions between each, getting to the root causes which were not initially obvious, or evidenced”</p>

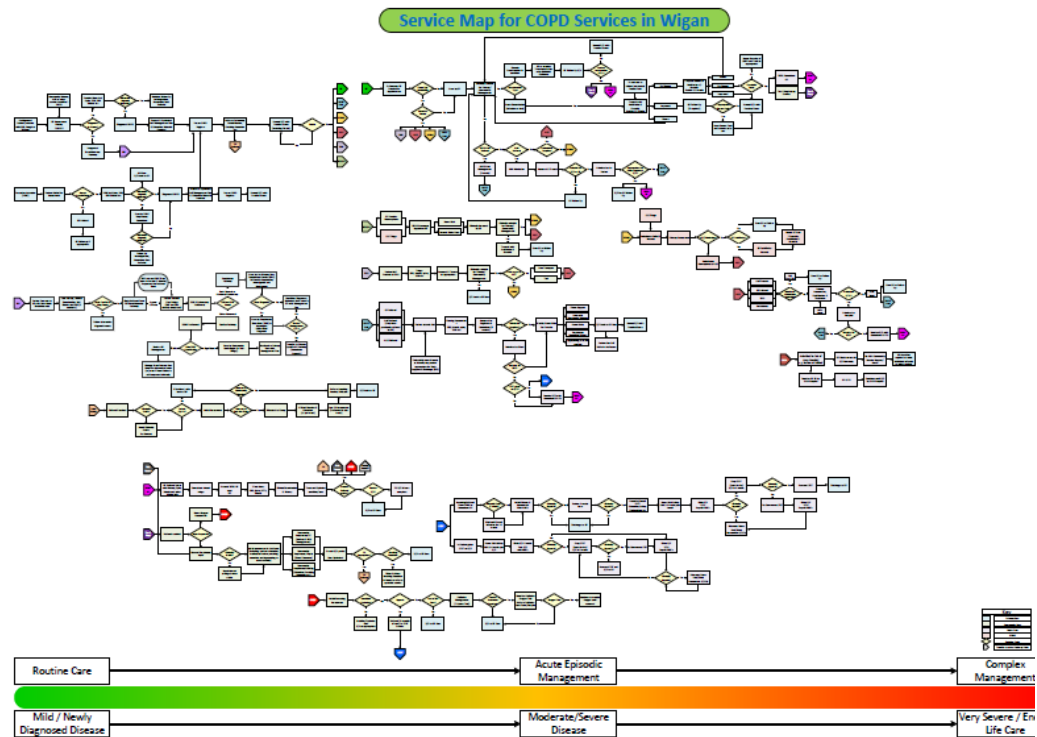
6. Case Study – Wigan Respiratory Pathway

What is the system?	<p>The Healthier Wigan Partnership is a partnership comprised of Wigan Council, Wigan CCG, Primary Care Clusters, Bridgewater Community Trust, North West Boroughs Trust, and Wroughtington, Wigan and Leigh FT.</p> <p>Their application was submitted on behalf of the partnership with Respiratory conditions, predominantly COPD, being the focus. This piece of work has covered all aspects of care including detection, self-care, community support, public health, support groups and the acute response to exacerbations/deterioration.</p>
What were the reasons for application ?	<p>Wigan’s respiratory system had already recently benefitted from a Respiratory redesign programme; however, this work had been put to one side due to pressures on the system. Leaders in Wigan recognised the need for a structured programme that all stakeholders could sign up to and use as a framework for exploring problems in more detail before implementing any solutions.</p> <p>Wigan submitted a range of Clinical and System outcomes that they wished to achieve as a result of this programme, with most of them focussed around improving patient education and self-care, improving community care and ensuring this was linked into the locality plan, improved levels of prevalence for COPD and reduced admissions as a result of the above.</p>

	<p>To do this there was a recognition within the application that they would have to operate as a system for patients to see improvements to their overall levels of care, and that patient involvement throughout this programme was key to this success.</p>
<p>Key Programme Elements</p>	<p>Process Mapping – This exercise, completed at the Whole System Diagnostic day, highlighted the sheer size and complexity of this system. Upon seeing the full model, most staff so far are in agreement that simplification is required of the system, as well as easy access to service criteria to ensure patients end up in the right place.</p> <p>Lived Experience – Patients with Respiratory Conditions in Wigan have a vast network of support groups provided in the community. This was an area that AQuA's Lived Experience affiliates wanted to ensure was fully involved in the process. Our affiliates visited the majority of groups and held conversations about respiratory care provided across the locality. The findings have reaffirmed our knowledge in some areas but also changed the thinking of local leaders in others. A full Lived Experience report was produced and the findings are treated with equal weighting to the root cause analysis findings.</p> <p>Programme Structure – Wigan have adopted an integrated leadership structure that forms a regular operational group. This group, with representation from all Healthier Wigan partnership providers, has been a platform for regular updates and decision making that has allowed the programme to meet expectations regarding timescales.</p>
<p>What did we find?</p>	<p>Throughout the root cause analysis work that was carried out, there were several key themes that emerged, with the underlying causes being identified and forming the basis of the design phase.</p> <p>Handovers – Handovers within the system caused large amounts of failure demand, with root causes ranging from too many similar referral roots to patient medication not being documented properly.</p> <p>Duplication – Multiple aspects of the current system were leading to duplication of staff time which has a knock on effect to patients. This is being caused by lack of system integration, unknown spirometry processes and too many referral roots. Staff mentioned how commissioning and measurement structures contribute to duplication.</p> <p>Reactive vs Proactive – Staff highlighted that services are still responding to patient deterioration rather than proactively putting measures in place to help manage this in the right place for the patient. Lack of patient education and community service resource is resulting in larger than expected admissions. Through an audit it was found that 57% of the audited COPD cohort has attended A&E 2 or more times in the year. A third of these patients had not had an annual review and almost half have anxiety and/or depression. By identifying these patients earlier, measures can be put in place to</p>

ensure they do not reach crisis point.

System Visibility – The complexity of the system highlighted within the process mapping identified that staff aren't fully aware of complementary services. Communication is therefore a key cause of duplication and this will be targeted in the design phase. However, we must also tackle the root cause, which is too many referral routes for staff to be expected to know in depth, as shown below:



What Next?

When considering the service user and clinician feedback together, alongside the discussion with wider stakeholders, 4 key themes emerged to focus on in the design phase:

Theme 1: Education & Communication - development of education programmes that are focussed on empowering both staff and patients. This will enhance staff knowledge of the system and help patients to manage their condition specifically within the Wigan context.

A communication plan requires development and internal ownership to ensure that momentum is maintained.

Theme 2: Activity and Exercise – development of an approach to improving levels of activity and exercise across the disease spectrum. This should include prescribed exercise (i.e. pulmonary rehabilitation) in the routine, acute and longer term maintenance clinical settings and consider numerous methods of engagement (group, one to one, digital and self-directed).

Theme 3: a Pro-active & Co-ordinated Intervention – By utilising

	<p>the systems and information collected in a more cohesive way, we will be able to recognise patterns of activity that indicates a patient at risk of acute deterioration, allowing a highly co-ordinated and integrated system response. This enhanced provision of care should be a holistic, place & asset based response and moves away from reactionary care to preventative intervention</p> <p>Theme 3b: System Response – to operate as a true ‘system’ and provide co-ordinated response to detection and deterioration that supports the Locality Plan in reducing the demand on the acute and urgent care services wherever possible. This must be response must innovative, ensuring a more simplified approach, whilst ensuring rapid access and follow up care.</p> <p>There should be a clear focus on integrating information systems here. Can shared records be explored or permissions extended?</p>
What do our members think?	<p>Jay Mangan, Strategic Lead Business & Strategy, Healthier Wigan Partnership</p> <p>“We’ve learned an amazing amount, we’ve got a really good model going forward, we’ve engaged our service users and patients, and we’ll be taking those service users with us to design a much better system for everyone.”</p>

7. Case Study – Liverpool Complex Needs

What is the system?	<p>Liverpool’s application was submitted by the CCG and the City Council with a focus on the pathways and services available to support individuals with Complex Needs across the city, and how they interact as a system.</p> <p>This includes Primary, Secondary and Community services commissioned by the CCG, as well a range of services provided by Liverpool’s Charity and Voluntary services (LCVS).</p> <p>Whilst the application identified all individuals with complex needs as the focus for this programme, the scope was initially thought to be too large to see demonstrable impact, and thus the pathway was narrowed somewhat to focus largely on the homeless community and the systematic support available to them.</p>
What were the reasons for application?	<p>Liverpool’s application identified that there is no ‘current pathway’ for these complex individuals and this can at times result in a ‘postcode lottery’.</p> <p>There is an array of different services provided across the city that individually deliver great services, however, the integration and information sharing across these organisations is either poor or non-existent. This results in particularly poor ‘flow’ via their acute</p>

	<p>services and they often have difficulty with discharge. Due to the lack of a single dedicated 'pathway' Liverpool see high rates of admissions and re admissions for this cohort.</p> <p>Through the flow programme, Liverpool highlighted a range of targets they would like to accomplish, with some shown below.</p> <ul style="list-style-type: none"> • Work to support the development of a new pathway to be developed in the next 12 months • Mapping the current complex journey of patients across the health, housing and care pathways to identify gaps and areas for improvement • Inform future commissioning decision making.
Key Programme Elements	<p>Lived Experience - AQuA's lived experience affiliates, Carl O'Loughlin and Wendy Bell, spent time speaking in depth to service users and carers that navigated the health and social care system with Complex Needs within Liverpool.</p> <p>They held informal conversations with 17 service users and staff from a range of organisations as follows:</p> <ul style="list-style-type: none"> • Waves of Hope service user hub • The Basement drop in • YMCA • Riverside Refuge • Regular meetings at the LCVS: <p>The themes that this work identified have formed the backbone of our diagnostic phase and have provided a real case for change and integration.</p> <p>Diagnostic Day - AQuA held a diagnostic day at The Adelphi Hotel on November 30th. There were approximately 80 people from across the system in attendance making up a mix of staff from more than 16 different services, as well as service users and carers.</p> <p>The aims for the day were:</p> <ol style="list-style-type: none"> 1. Allow the system to network and make new connections 2. Define a purpose for the system 3. Map the current state of all services within the system 4. 4N's exercise – (No-No's, Niggles, Nuggets, Nice Ifs) 5. Understand queues in the system <p>This day was really well received across the city and was the first time that many people working in the same sector had shared a</p>

	<p>room. The conversations and collaboration that occurred as a result exceeded expectations, with staff collectively identifying blockages in the system.</p>
<p>What did we find?</p>	<p>Existing System - Service users and front-line workers frequently told us that the system too complicated. With provision being very reactive and only provided when people reached 'crisis point'.</p> <p>Training - Services do not have enough training to support homeless people with complex needs and do not understand the system well enough to navigate.</p> <p>Collaboration - Service users told us that they don't feel the services work together to provide them with the support they feel they need to give them the best chance of positive outcomes</p> <p>Culture - Service users consistently told us that they felt they were treated as 'second class' citizens by statutory services</p> <p>Mental Health Services - Every service user we met suffered with mental health problems. A consistent theme from service users and front-line workers was that it was extremely difficult to get a referral to mental health services until service users were clean and their alcohol and drug issues had been resolved. There is an obvious gap in provision here that requires addressing.</p> <p>Housing - It was reported to us that there is an extremely limited amount of suitable housing across Liverpool for people with complex needs</p> <p>Commissioning Structure - The ethos in this area is all about short term financial gains / targets, and long term interventions do not deliver this.</p> <p>Co-Production - A regular theme amongst front line staff and service users is that co-production has been really poor.</p> <p>Engagement - There has been little engagement in the past with service users and they do not feel heard.</p> <p>Royal Liverpool Hospital - Most service users that we engaged with had a poor experience within RLH.</p>
<p>What Next?</p>	<p>The programme within Liverpool is currently paused due to several internal factors relating to leadership and political challenges across the city system. To best position the diagnostic work for successful completion we presented and handed over the findings to the Complex Needs Board (Members representing Royal Liverpool & Aintree hospitals, Mersey Care, Liverpool Community, CCG,</p>

	<p>NWAS, City council, community groups and Public Health)</p> <p>The diagnostic work carried out by our Lived Experience Affiliates has been handed over to the City Council and voluntary sector engagement leads and is being utilised.</p> <p>Additionally we have also recommended that the CCG and the Council explore NHS England's HIU programme as part of their commissioning intentions. This programme sees dedicated employees build personal relationships with service users in the city and help them access the most appropriate services for their needs. However, due to the structural complexities within the organisations involved within Liverpool, this is currently on hold whilst re-organisation occurs.</p>
What do our members think?	<p>Alison Brook, Complex Needs Lead, Liverpool CCG</p> <p>"I've had a really great experience of working with AQuA on the FISP programme of work. This came at a time when the Complex Need Programme had initial data analysis and some understanding of the complexity of services involved however, the FISP programme has helped give traction, direction and progression to the programme working within timelines using good practice and shared learning in Systems Flow and Improvement."</p>

8. 18/19 Systems

Having spent 8 months working alongside our 3 test systems, we are now confident that we have a robust diagnostic model that enables tailored design solutions to improve flows. Therefore, for 18/19, with additional internal resources and more streamlined programme delivery, we intend to complete the support of design and implementation phase with our 3 discovery systems and will recruit additional systems for 18/19.

The Diagnostic phase for 18/19 systems will take 4 months to complete. With the completion of the design and implementation phases for discovery systems we will identify the AQuA model for this component of the programme and ensure development into future programme work.

Each new system will be different and therefore our programme elements will be tailored to each. Additionally, for 18/19 we are hoping to explore alternative delivery methods that will allow us to extend our offer to wider membership; this may include coaching a system through the programme, rather than AQuA delivery on site. This will be explored if a suitable system applies to the programme.

We will be more intentional with future sites to quantify failure demand and manage expectations around programme engagement and identification of outcomes.

Produced by

Advancing Quality Alliance (AQuA)

3rd Floor,
Crossgate House,
Cross Street,
Sale
M33 7FT

www.AQuAnw.nhs.uk

@AQuA_NHS

© AQuA 2018

All information contained in this document is, as far as we are aware, correct at time of going to press.

No part of this document report may be reproduced in whole or in part without written permission of AQuA.

DRAFT