Whole System Flow
2017/18
Learning Report

Scott Gregory
Whole System Flow Programme Facilitator

Wendy Lewis
Whole System Flow Lead

May 2018
The Advancing Quality Alliance (AQuA) was established in 2010 to improve health and care quality in North West England. Our aim is to be a trusted and respected source of quality improvement expertise for the NHS and social care system.

We work with around 70 member organisations on a long-term basis, to help build improvement capability at all levels of their workforce, develop and implement quality strategies and to address their quality priorities through our extensive range of membership offers.

These aim to address four main priorities:

1. Delivering High Quality Care
2. Supporting System Transformation
3. Delivering Person Centred Care
4. Building Capability for Improvement

Our work spans across a range people and settings, from individual staff, teams, patients and service users, to whole departments, services and systems; covering frontline clinicians and support staff, to senior leaders and Boards.

We also carry out Consultancy commissions with a range of organisations across the UK; working with them to adapt our existing offers, or to design and deliver a bespoke package of support to suit their individual needs.
Contents

1. Introduction 4

2. Programme Overview 5

2.1 Model Overview – ‘Double Diamond’ 5

2.2 Model Overview – ‘The Four Arrows’ 6

2.3 Redesign Structure 8

2.4 Programme Elements 9

3. Key Success Factors 10

4. What Next? 10

5. Case Study – Bolton Intermediate Tier Services 11

6. Case Study – Wigan Respiratory Pathway 14

7. Case Study – Liverpool Complex Needs Pathway 17

8. Conclusion 19
1. Introduction

Discussions with AQuA members identified poor flow across and within health and care systems as 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, AQuA’s flow team analysed and reviewed worldwide research, evidence and experience of trying to improve ‘Whole System Flow’. Findings from this work were published in a joint report with The Health Foundation, ‘The Challenge and Potential of Whole System Flow’.

The report identified a model and supporting frameworks that AQuA then committed to test within current health and care context. It was at this point that AQuA's 2017/18 ‘Flow – Improving System Pathways’ (FISP) discovery programme was developed; with three systems within AQuA membership successfully applying to become test systems.

The three systems selected were:

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

From July 2017 to January 2018, each of these systems participated in the diagnostic phase of AQuA’s FISP programme, and currently form strands of integrated system transformation work within each locality.

Across the three test systems, the five overarching aims during the diagnostic phase were to:

1. Make the system visible to itself
2. Create an environment for discussion and engagement that spanned traditional professional or organisational boundaries
3. Map the current state of the system
4. Understand queues and waits in service provision
5. Equally involve and capture the views of people with lived experience

In this report, we provide a summary of the model used for exploring flow between existing services, including acute, community and social care.

We also share our learning from our work with each of our three systems during the programme’s diagnostic phase, which we hope will provide the foundations for designing subsequent improvements in flow.

2. Programme Overview

AQuA’s approach to understanding flows across health and care systems is based on learning from literature, previous improvement work, and discussions with our members around their challenges with flow and understanding their system. 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 with The Health Foundation, in order to frame the intention of the work:

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

We have used the Design Council’s ‘Double Diamond’ and Kreindler’s ‘6 Ways Not To Improve Flow’ in order to develop a new model for testing within the diagnostic phase. This allowed us to maintain focus in understanding the right problem we were trying to fix, rather than jumping to solutions before we fully understand the problems faced by each system.

2.1 Model Overview – ‘Double Diamond’

The Design Council’s ‘Double Diamond’ tool (Figure 1) shows that equal time should be spent diagnosing the problem, as should be given to designing solutions, and was a major influence on our design for the 2017/18 FISP programme.

---

2https://www.designcouncil.org.uk/news-opinion/design-process-what-double-diamond
3http://qualitysafety.bmj.com/content/early/2016/07/27/bmjqs-2016-005438
2.2 Model Overview – ‘The Four Arrows’

Over the early part of the FISP programme, the team identified four key lines of enquiry when exploring whole system flow; reflecting our learning that not intentionally exploring and understanding each element within a care system would prevent the generation of a shared system view.

This was later developed into our ‘Four Arrows’ model (Figure 2), that provides a structure for exploring processes and system conditions with each of our FISP teams.

Understanding these four arrows and their interdependencies of risk, leadership and culture in detail, allows us to analyse the system comprehensively and develop a full picture before designing sustainable improvements.

In our experience, if enough attention is not given to all elements of this model, this may give a skewed view of the system, and lead to the design of inappropriate or inadequate solutions.
This arrow represents all service users, carers, and families that are involved within the identified health and care system.

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 could our programme be person centred.

During our work, we continually challenged against the term ‘patient flow’, and strongly advocate for viewing recipients and their families and support as people.

This line of enquiry involves exploring Information and Technology (IM&T) flows, alongside those of verbal and written information between services in a system, 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.

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 understanding the current state.

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.
2.3 Redesign Structure

Service redesign can often be the product of leaders lacking detailed knowledge and experience of the inner workings of their particular system.

AQuA’s approach to redesign aims to utilise the expertise and experience of frontline staff and service users; as each have a truly unique perspective of the services we are trying to improve.

Gathering their views on system conditions allows us to understand the problems behind issues, rather than simply resolving the symptoms of deeper lying causes; which ultimately results in unsustainable improvement and disengagement of frontline staff.

The structure of the AQuA’s diagnostic phase can be found in Figure 3.

**Figure 3**
AQuA Diagnostic Phase

**Flow Improving System Pathways (FISP) Model of Redesign**

**AQuA Support**
Within each system team, we provided a range of support to help facilitate their progress and instil local ownership of the project. This included supporting team meetings, providing leadership advice and acting as a critical friend, facilitating difficult conversations, and individual coaching.

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

**Clinical Reference Group**
There must be clinical sign off for any clinical improvements. This group is only required to be formed in the ‘Design and Test’ phase.

**1. Engagement Meetings**
**2. Diagnostic Day**
**3. System Mapping**
**4. Service User Involvement**
**5. Systems Conditions Analysis**
**6. Data Analysis & Simul8**
**7. Financial Flow Mapping**
**8. Information Flow Mapping**
**9. QI Training**
**10. Success Measure Review**
2.4 Programme Elements

Throughout the diagnostic phase of the programme, we found the following key elements for consideration:

**Engagement**
This must be across a range of staff levels, in order to ensure system wide buy-in and understanding

**System Visibility / Purpose**
Ensuring a mix of professions and skills from services within the system is vital. Additionally, service users must be present to give opinions.

**System Mapping**
To design sustainable solutions, we must understand the ‘current state’ of the system. AQuA spent time with local leadership teams and their colleagues to map the different services and understand existing queues. This must take place within the individual services, and with frontline staff, managers, and service users, to ensure all perspectives of the system are captured.

**Service User Involvement**
AQuA’s Lived Experience Panel (LEP) formed a large part of this programme, by conducting informal interviews with service users from across each of the systems. This activity provides valuable insight, and ensures the views of service users have equal weighting throughout this process.

**Workforce Engagement**
Engaging staff working within different services ensures you understand and consider wider views of the system, and its current state, as well as their ideas for change.

**Information Flow Mapping**
This helps 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, as well as the availability and efficiency of resources.

**System Conditions Analysis**
Once we understand queues, we must understand the root causes of them; to ensure we do not redesign systems based on symptoms of underlying issues.

**Capability Building**
By helping to build capability amongst frontline staff, we enhance the delivery of improvements via PDSA cycles. This allows staff to champion improvements, which aids sustainability.

**Success Measures Review**
Establishing measures allows us to understand the current performance of the system, and provide the necessary information to inform improvements.
3. Key Success Factors

Several factors key to the programme’s success included:

**Integrated System Leadership**
Working with integrated leadership teams ensured representation from across the system. This also allowed the systems to take their first steps 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. Throughout the FISP programme, staff at all levels have been fully involved and trusted to lead improvements.

**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?

‘Design groups’ comprising of staff from across different areas of each system have been formed to ensure whole system engagement and leadership.

These groups utilise all of the information and analysis developed during the diagnostic phase, and follow the Model for Improvement to design PDSA cycles that would lead to system improvement.

These PDSA cycles have individual aims, as well as a range of measures to ensure we can capture learning and monitor improvement.

Simul8, our simulation and modelling software, will be used prior to PDSA testing. This software uses historic data to help test our assumptions and predict outcomes; ensuring that we are confident that any changes implemented will bring about improvements.

Additionally, systems will continue to engage with wider stakeholders, to ensure the smooth introduction and implementation of new pathways.

---

**AQuA’s FISP Model For Improvement**

**DIAGNOSIS**: What are the key areas we need to improve?

**AIM**: What are we trying to accomplish?

**MEASURES**: How will we know if a change is an improvement?

**CHANGE**: What changes can we make that will result in improvement?

**MODEL**: Use software to understand impacts of potential change

---

*Lindsey Darley, Bolton NHS Foundation Trust, presenting to staff*
5. Case Study – Bolton Intermediate Tier Service

What is the system?

Bolton’s Intermediate Tier Service (ITS) is fully integrated within Bolton NHS Foundation Trust, but also has elements operated by Bolton Council. The Tier is comprised of the following:

Community Bed-Based Units

- **Darley Court** - For patients no longer requiring an acute bed, but still requiring nurse input
- **Laburnum Lodge** - For patients with lower acuity requirements than Darley Court, yet still require rehabilitation before going home
- **Four Seasons** - For Discharge to Assess patients
- **Wilfred Geere** - For patients with cognitive impairment.

Short Term Support Services

- **Intermediate Care at Home (IMC@Home)** - A programme of rehabilitation which is done in the patient’s home, with the help of occupational therapists, physiotherapists and therapy instructors
- **Re-Ablement Service** - Intensive home support (max 6 weeks), for people with a physical or mental illness, injury or disability.

Pharmacy

Provides medicines management support to patients in their own homes, and across the community bed base.

IV Therapy

Provides a range of intravenous care treatments, either in patients’ own homes, or at Breightmet Health Centre.

The service is staffed by a range of different professions, including: Administrators, Healthcare Assistants, Nurses, Occupational Therapists, Physiotherapists, Social Workers, Key Workers, and Pharmacists.

What did they want to achieve from the FISP programme?

Bolton Intermediate Tier submitted a joint application between the Trust and the Council, as they recognised that flow between different services was poor and was impacting service users.

The challenges of providing a single system under both organisations required exploration, and there was an agreement that services were operating in a fragmented way, despite a large proportion of them being co-located.

The system wanted to understand the causes of this poor flow, and develop a new pathway to ensure whole system buy-in.

Key programme elements:

System Conditions Analysis

Using Quality Improvement methodology to understand the ‘true conditions’ of visible issues within this system, was really crucial to developing a complete view of the current state.

One-to-one engagement with staff across different parts of the system was really successful, and ensured that staff were able to speak freely knowing their views were confidential.

This enabled us to understand beliefs such as ‘referrals cause delays’, to find that the referral form was too complex, poorly designed, and led to staff filling it out poorly just to get it done quicker. This allowed us to target a specific issue that had a large impact on service users.

Staff Empowerment

Throughout this programme, leadership within Bolton’s ITS devolved responsibility for this work to their operational staff. This 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’.

**Information Mapping**

Given the number of different services within this system, understanding how systems interact along a single patient journey, and the knock-on impact of this, was crucial.

This helped to shift the mind-set of staff from ‘we only do a couple of assessments’, caused by information being unavailable at different points in the system, to ‘this patient has already told their story 10 times before they’ve even reached us’.

**What did we find?**

Through the diagnostic phase, we identified several areas that could be targeted for improvement on both a macro and micro level.

It was clear that the existing pathways and referral criteria were not as efficient as they could be, and were causing delays. Therefore, we are now reviewing a range of different options and utilising simulation and modelling software, to test various solutions and provide analytical structure to the redesign.

**For example...**

**IMC@Home**

IMC@Home not accepting referrals at weekends is costing approximately 1680 acute bed days per year.

Using the ‘Trusted Assessment’, so that referral to commencement of treatment is reduced to 24 hours, reduces the overall length of stay in the system by > 3 days.

A brief overview of the different scenarios being tested and the expected outcomes are detailed below.

Additionally, several areas within the existing pathway also required improvement, alongside the larger redesign:

**Inappropriate Referrals**

Almost every service received a high level of inappropriate referrals. This was the main area of communication that was mentioned:

- **IMC@HOME** - Between April 2017 – February 2018, 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.

- **Darley Court** - Between April 2017 – February 2018 there were 921 referrals, with only 46% of these accepted (this is increasing since implementation of Trusted Assessment in late 2017). It takes one hour to deal with an inappropriate referral; resulting in approximately 430 clinical hours lost. Additionally, audits showed that 30% of all patients referred from hospital to Darley Court could have gone home with a package of care.

- **Laburnum Lodge** - Audits showed that approximately 50% of patient referrals to Laburnum Lodge could have gone home with a package of care.

**Referral Criteria**

This required simplification and clear circulation amongst staff.

**Admin**

Lots of clinical time was being lost processing information, with a significant amount of spare admin time.

**Being Located Under One Roof Doesn't Equal Integration**

Despite being co-located, services were relying solely on verbal communication. This was not robust and easily failed during illness / poor handovers.

**Joint Multidisciplinary Team Audits**

Teams didn’t appear to get together and discuss ‘past’ cases, which would have promoted learning and aided continuous improvement.

**Duplication**

There was a lot of duplication within different teams. For example, on one particular pathway, a patient would have 17 different assessments. Additionally,
skill sets were duplicated in different teams, yet each service struggles to cover sickness and annual leave.

**Yes Culture**
Core functions of the services felt lost.

**Patient Choice**
Patients with capacity could often demand to stay in a unit and block flow, with staff unclear on this process.

**What next?**

Local engagement events are being held to involve key stakeholders, including workforce, estates and IT solutions.

The Programme Group continues to drive the work and reports to locality and organisational boards on a monthly basis.

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.

This team has developed a high level pathway that is exploring options for redesign as highlighted above; with simulation software testing the most effective system solution.

Additionally, the team are currently testing a range of micro scale improvements. Each test of change has a staff champion, who is 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 to the right.

**Micro Level Tests (In Progress)**

**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.

**IMC@Home Discharge Dates**
Having reviewed baseline data on discharge date-setting by teams, team leaders are now promoting the need to 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 a set discharge date from 39% to 64%. This has resulted in an initial improvement in the caseload; however, it is too early to report conclusive findings.

**Therapy Instructors**
Now meet with the patient within 24 hours of being discharged from the bedded unit. This should reduce duplicate assessments and reduce length of stay.

**Frailty Identification**
Services are now using the Rockwood frailty screen at point of assessment and discharge; this is a way of measuring progress and identifying the most suitable level of care for each patient. This should ensure that a patient’s goals are met sooner.

A combination of these improvements, alongside Trusted Assessment rollout and Red to Green implementation, has resulted in a reduction in length of stay at Darley Court by 6.2 days (32 to 26).

**What our members say…**

“Participating in the flow 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, and get to the root causes which were not initially obvious, or evidenced.”

**Lindsey Darley**
Divisional Director of Operations, Integrated and Community Services, Bolton NHS Foundation Trust
6. Case Study – Wigan Respiratory Pathway

What is the system?

The Healthier Wigan partnership is made up of Wigan Council, NHS Wigan Clinical Commissioning Group, Primary Care Clusters, Bridgewater Community NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, and Wrightington, Wigan and Leigh NHS Foundation Trust.

The partnership wanted to explore flow across their respiratory conditions pathway, predominantly around Chronic Obstructive Pulmonary Disease (COPD). This covered all aspects of care, including detection, self-care, community support, public health, support groups and the acute response to exacerbations.

What did they want to achieve from the FISP programme?

Wigan’s respiratory system had already recently benefited from a redesign programme; however, this work had merged into other existing redesign programmes and ultimately lost its original pace and specific clinical focus.

As part of the emerging Local Care Organisation (Healthier Wigan Partnership), 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.

Wigan submitted a range of clinical and system outcomes that they wanted to achieve through the programme. Most were focussed around improving patient education, self-care, community care and ensuring this was linked into the locality plan, improving levels of prevalence for COPD and reducing admissions.

The partnership recognised the need to operate as a system, if patients were to see improvements to their overall levels of care, and that patient involvement throughout this programme was key to this success.

Key programme elements:

Process Mapping
This exercise, completed at the whole system diagnostic day, highlighted the sheer size and complexity of this system.

Lived Experience
Patients with respiratory conditions in Wigan have a vast network of support groups available in the community, and this was an area that AQuA’s Lived Experience Panel wanted to ensure was fully involved in the process.

Our Panel visited the majority of groups, and held conversations about respiratory care provided across the locality. The findings reaffirmed our knowledge in some areas, but also changed the thinking of local leaders in others. A full Lived Experience report was produced; with findings given equal weighting to those of the system conditions analysis activity.
Lived Experience

Patients with respiratory conditions in Wigan have a vast network of support groups available in the community, and this was an area that AQuA’s Lived Experience Panel wanted to ensure was fully involved in the process.

Our Panel visited the majority of groups, and held conversations about respiratory care provided across the locality. The findings reaffirmed our knowledge in some areas, but also changed the thinking of local leaders in others. A full Lived Experience report was produced; with findings given equal weighting to those of the system conditions analysis activity.

Programme Structure

Wigan have adopted an integrated leadership structure that forms a regular operational group. This group, with representation from all Healthier Wigan partners, acted as a platform for regular updates and decision making, that allowed the programme to meet expectations regarding timescales.

What did we find?

Throughout the system conditions analysis activity, underlying causes for poor flow were identified, with a number of themes emerging during the programme’s design phase:

Handovers

Handovers within the system caused large amounts of failure demand; with root causes ranging from too many similar referral routes, to patient medication not being documented properly.

Duplication

Duplication within the current system, including through lack of integration, unknown spirometry processes and too many referral routes, were having a knock-on effect on patients. Staff mentioned how commissioning and measurement structures contribute to duplication.

Reactive vs Proactive

Staff highlighted that services were still responding to patient deterioration, rather than proactively putting measures in place to help manage this in the right place for each patient. A lack of patient education and community service resource, was resulting in larger than expected admissions.

An audit found that 57% of audited patients had attended A&E two or more times in the year. A third of these had not had an annual review and almost half had anxiety and/or depression. By identifying these patients earlier, measures could be put in place to ensure they do not reach crisis point.

System Visibility

The process mapping identified that staff were not fully aware of all of the services within the system.

Poor communication was a key cause of duplication, and formed a key improvement for the design phase. However, they also had to tackle the root cause of there being too many referral routes for staff to know these in depth.

This is shown in the system mapping diagram below:
What Next?

Four key themes emerged from discussions with clinicians, service users and wider stakeholders, that formed the programme’s design phase:

**Education and Communication**

The development of education programmes focussed on empowering both staff and patients. This would enhance staff knowledge of the system, and help patients to manage their condition specifically within the Wigan context.

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

**Activity and Exercise**

An approach was needed to improve levels of activity and exercise across the disease spectrum. This needed to include prescribed exercise (i.e. pulmonary rehabilitation) in the routine, acute and longer term maintenance in clinical settings, and consider numerous methods of engagement (group, one to one, digital and self-directed).

**A Proactive and Coordinated Intervention**

Through a more cohesive use of systems and information collected, we would be able to recognise activity patterns that may indicate a patient at risk of acute deterioration.

This would allow a more coordinated and integrated response from the system, as well as enhance provision of care to a more holistic, place and asset-based response, instead of reactionary care to a preventative intervention.

**Acute Response**

When an acute crisis occurs, the patient is already informed on immediate steps through self management. However, an intelligent and innovative acute response will bring the right clinicians to the patient at the right time. This enhanced service offering will react quickly to manage the patient in the most appropriate setting; adopting a home-first approach where possible.

This would also support Wigan’s Locality Plan by reducing demand on acute and urgent care services wherever possible.

There should also be a clear focus on integrating information systems.

What our members say…

“We’ve learned an amazing amount, got a really good model going forward, and engaged our service users and patients. We’ll be taking those service users with us to design a much better system for everyone.”

Jay Mangan
Strategic Lead Business & Strategy, Healthier Wigan Partnership
7. Case Study – Liverpool Complex Needs

What is the system?

Liverpool’s system is a partnership between NHS Liverpool Clinical Commissioning Group and Liverpool City Council, and focussed on pathways and services available to individuals with complex needs across the city, and how they interact as a system.

This included Primary, Secondary and Community services commissioned by the CCG, as well a range of services provided by Liverpool’s Charity and Voluntary Services (LCVS).

Whilst initially they wanted to look at all individuals with complex needs, this was thought to be too large in scope to see a demonstrable impact. Therefore, this was later narrowed to largely explore the city’s homeless community and the systematic support available to them.

What did they want to achieve from the FiSP programme?

Liverpool’s application identified that there was no defined pathway for the city’s homeless community, and this can at times result in a ‘postcode lottery’.

There are array of different services provided across the city that individually deliver great services. However, the integration and information sharing across these organisations was either poor or non-existent. This was resulting in particularly poor flow via their acute services and they often had difficulty with discharge.

Due to the lack of a single dedicated pathway, Liverpool was seeing see high rates of admissions and re-admissions for this cohort.

Through the flow programme, Liverpool highlighted a range of targets they would like to accomplish, with some shown below:

• Support to begin to develop a new pathway over 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

• Use intelligence from the programme to inform future decision making in commissioning.

Key Programme Elements

Lived Experience

AQuA’s Lived Experience Panel spent significant time speaking to service users and carers with complex needs from across the City.

They held informal conversations with 17 service users and staff from a range of organisations including:

• Waves of Hope service user hub
• The Basement drop-in
• YMCA
• Riverside Refuge
• Regular meetings at the LCVS

The themes identified from this work formed the backbone of our diagnostic phase, and provided a real case for change and integration.

Voluntary and Housing Engagement event in Liverpool
Diagnostic Day
A diagnostic day event was held in November 2017 in Liverpool, welcoming around 80 people from across the system; including staff from more than 16 different services, as well as service users and carers.

The aims for the day were:

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

The day was really well received across the city and was the first time that many people working in the sector had shared a room. The conversations and collaboration that occurred as a result exceeded expectations, with staff collectively identifying blockages in the system.

What did we find?

Existing System
Service users and frontline workers frequently told us that the system was too complicated; with provision being very reactive and only provided when people reached ‘crisis point’.

Training
Services did not have enough training to support homeless people with complex needs, and did not understand the system well enough to navigate.

Collaboration
Service users felt that services did not work together, to give them the support they needed for the best chance of positive outcomes.

Culture
Service users consistently told us that they felt they were treated as ‘second class’ citizens by statutory services.

Mental Health Services
Every service user we met suffered with mental health problems. A consistent theme both from them and frontline workers, was that it was extremely difficult to get a referral to mental health services until their alcohol and drug issues had been resolved.

Housing
There was an extremely limited amount of suitable housing across Liverpool for people with complex needs.

Commissioning Structure
The existing ethos around commissioning was predominantly centred on short term financial gains/targets, and long term interventions do not deliver this.

Co-Production
A regular theme amongst frontline staff and service users is that co-production has been really poor.

Engagement
There has been little engagement in the past with service users and they do not feel heard.

Royal Liverpool Hospital
Most service users that we engaged with had a poor experience within RLH.

What Next?

The programme within Liverpool was paused following the diagnostic phase, whilst the CCG and Council handled a number of pressing organisational challenges.

However, findings from the phase were presented to the Complex Needs Board (members representing Royal Liverpool & Aintree hospitals, Mersey Care, Liverpool Community, the CCG, North West Ambulance Service, City council, community groups and Public Health).

The diagnostic work carried out by our Lived Experience Panel was handed over to the City Council and voluntary sector engagement leads, and is now being utilised elsewhere.
Additionally, we have also recommended that the CCG and Council explore NHS England’s High Intensity User (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 where they need them.

However, due to the leadership changes within the organisations involved, this phase of our work is currently on hold.

What our members say…

“I’ve had a really great experience of working with AQuA on the FISP programme. This came at a time when the Complex Needs Programme had initial data analysis and some understanding of the complexity of services involved.

“The FISP programme has helped give traction, direction and progression to the programme; working within timelines, using good practice and sharing learning in Systems Flow and Improvement.”

Alison Brook
Complex Needs Lead, NHS Liverpool Clinical Commissioning Group

Conclusion

We are confident that we have a robust diagnostic model that enables us to truly understand flows across health and care systems.

We are currently in the design phase with our test systems, using the diagnostic findings to help us design sustainable solutions and improve quality across the whole system.

We are always keen to hear examples of improved flows, so if you would like to get in touch please email.

Scott Gregory
Whole System Flow Programme Facilitator
scott.gregory@srft.nhs.uk

Wendy Lewis
Whole System Flow Lead
wendy.lewis@srft.nhs.uk

Whole System Flow event, Manchester