Workshop Write Up

28.11.18

Developing integrated neighbourhood networks in Southwark

Southwark
Local Care Network

Innovation Unit
New solutions
for thriving societies

Working together to improve health and wellbeing for the people of Southwark

What is neighbourhood working and why is it important?

We want Southwark to be an amazing place to be born, live a full, healthy life and spend one's final years.

- Neighbourhood networks are way of working better together around geographical populations of 30-50k
- Brings together health, care, and the voluntary and community sector to support peoples health, social and emotional needs
- It's about cross boundary connections, relationships and culture change to break down silos not 'hard inflexible boundaries'
- It's about making the right thing the easy thing to do for both staff and service users/patients
- We want people's experience of care to be more personalised and joined up with as much care and support is delivered as close to home as possible and people feeling more in control of their health and wellbeing (e.g. through self-management and social prescribing)

Recap on the aims by March 2018

When we kicked off the work we agreed that by March, success would be:

1. A clear description of a Neighbourhood and what it means in this context in terms of principle and practice
2. A clear roadmap for the next stage of the Neighbourhood model and its maturity to inform a next stage business case
3. Some examples of applying the Neighbourhood principles and practice
4. A clear description of what next in terms of
    a. Enablers
    b. Practice
    c. Ways of working
5. A set of hypotheses and questions we have tested with a set of further enquiry questions

Neighbourhood diagnostic: key findings

1. Respondents generally felt that the processes and infrastructure to support neighbourhood working was an area of weakness
2. There was a difference in confidence between managers and frontline staff, with managers on the whole, recording higher scores than frontline staff
3. Team working was highlighted as an area of weakness, particularly in terms of collaboration with VCS and communication between organisations
4. There was a strong level of support for neighbourhood working but less belief that it would happen in practice
5. Building skills that are wider than just health was an area for development

Neighbourhood diagnostic: key findings

> “ If you were offered support to improve any part of the model in your neighbourhood, which of the following would you like to focus on?

1. Improving relationships within the neighbourhood
2. Interface with mental health services
3. Improving communication within the neighbourhood
4. Key activities: supporting self care and social prescribing
5. Key activities: making the most of the Voluntary and Community Sector

Reflections from workshop

- There is a lot of energy and excitement about this work
- The scale of attendees made it hard to focus and we will need to work with a much smaller group in the Neighbourhoods
- There is a high level of uncertainty in this work and we will need to be able to hold this
- The Neighbourhoods are at different places and therefore need different types of support

Next steps

- Agree that the areas of focus are right for each neighbourhood
- Identify who needs to be part of the smaller group that we meet with in each Neighbourhood team
- Identify the natural opportunities to engage this group of people
- Agree what the profile of work will look like for January to March for each Neighbourhood and the timing for this
- Agree the resource above and beyond the IU team to support the work between December and March

Neighbourhood Priorities

Peckham

Areas of interest

Mental health-
Isolation and Loneliness-
Housing-
IT and information sharing-
Signposting hubs and social prescribing-
Self care and prevention-
Diabetes-

Agreed area of focus

Mental health, wellbeing and community support for individuals
Building on the linkage between mental and physical health especially with diabetes and breathlessness
Profile of priority groups:

- Diabetic/prediabetic
- Breathlessness
- Housing
- Loneliness
- Learning disabilities

Peckham

By the end of March, success will look like...

Foundation team working together and connected
Neighbourhood team know how to mage the priority group
Tested an MDT approach
Understanding of the learning in the North of Southwark
Understanding of the work of Time and Talents

In 3 years, success will look like...

Reduction in A&E attendances

Peckham

Early ideas for how we might get there

Engage with the Peckham Road wellbeing hub
Potentially explore coordinator roles
Refine the population group to make it smaller and more manageable
See how to make a small scale improvement
Connect any work into the VCS in the area
Consider North hub work on older people and disabilities

Peckham

The people we must involve

GPs
Southwark Diabetes UK
Walk away from diabetes
Specialist breathlessness nurse
Community diabetes nurses
Peckham social care hub
Time banking Southwark

Dulwich

Areas of interest

Data intelligence to focus QI
Improved engagement across practices and wider health and care
Social prescribing and VCS
Increasing patient voice
Estates and Dulwich Hospital
Improved Communication
Training and Education
Accessibility
Shifting commissioning approach

Agreed area of focus

Mental Health (adults)

Dulwich

By the end of March, success will look like...

Being able to translate the learning/change to other areas
We will have developed an approach and way of working to tackle some of our key local issues we've prioritsed

In 3 years, success will look like...

Dulwich as a flagship of integration
Reduced inequalities for people with mental health
Service user empowerment/activation

Dulwich

Early ideas for how we might get there

Social prescribing
Knowing who's in our Neighbourhood, what's available and where the gaps are
Looking at the data
Think about the link worker/care coordinator
Think about Dulwich> input into the plans and how service integrate

Dulwich

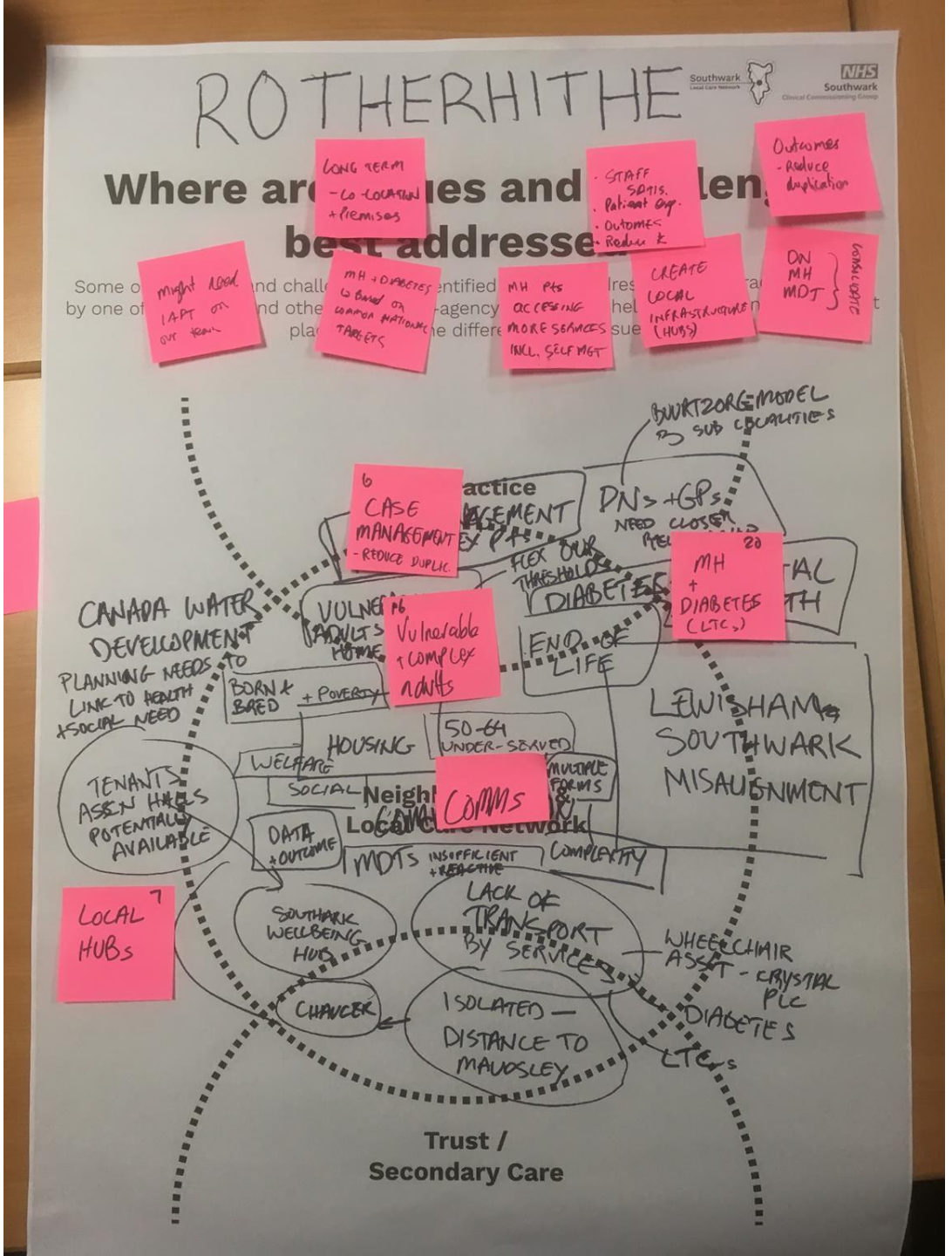
The people we must involve

We will have Neighbourhood forum to agree a core team
The people of Dulwich

Rotherhithe

Agreed area of focus

Adults with mental health + diabetes



Rotherhithe

Areas of interest

- Improve communications between professionals; this includes better MDTs that connect the right professionals around the right patient / residents; simplification of referrals, forms and IT systems
- Supporting vulnerable, disadvantaged and complex adults (18+; not just elderly)
- Accessibility: growing opportunities for delivery of secondary / specialist support in the local area, e.g. through use of community spaces, tenants association halls and co-location
- case management and coordination of complex patients to reduce duplication and improve consistency and continuity of care through
- Focus on patients with a comorbidity of mental health issue (enduring or low-level) and diabetes (or other long-term condition)

Rotherhithe

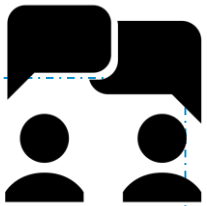
By the end of March, success will look like...

- *Successfully run joint MDTs across community nursing, mental health and primary care teams*
- *Patients are accessing more services and are better able to take control or and manage their own health*
- *Improvement of patient outcomes and experience, based on common, national targets for mental health and diabetes*
- *Identified opportunities and started working with under-utilised local premises*

In 3 years, success will look like...

- *Co-location of teams that support complex patients*
- *Neighbourhood-based case management and coordination reduces duplication of case management and admin, and improves quality of integrated local data analytics*
- *More premises available locally, increasing access to local residents*
- *Measurable improvements in patient experience and outcomes, staff satisfaction and system efficiencies*

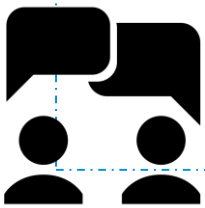
Rotherhithe



The people we must involve

Community nursing
IAPT
CMHT
GPs

TBC...



Walworth Triangle

Areas of interest

Population groups:

- People with mental health needs that fall between IAPT and secondary care service criteria and therefore have unmet needs
- People with mental and physical health needs e.g. diabetes (particularly thinking about reducing deterioration from one to other/ developing multiple complex needs)

Focus areas/ WoW:

- Improved awareness of resources available in neighbourhood and named contacts to get in touch with, in order to facilitate better communication
- A 'front door' to support for service users that is not need specific (both physical and digital)
- Greater collaboration and reduced competition between services with similar offerings, in order to enable greater investment in quality
- Using physical spaces to better support individuals, both in statutory services (e.g. co-locating MH services in GP practices) and in our communities (e.g. how can estates be used differently to support the neighbourhood)
- Managing consistency for service users better, particularly in light of staff turnover
- Connecting various navigator services in neighbourhood

Walworth Triangle

Agreed area of focus

Better knowing the service users in our neighbourhood to ensure better support, enabled by better communication and connection between all the service providers around that individual (or potential service providers)...

...with an initial focus on people with both physical and mental health needs, to prevent deterioration/ escalation

Walworth Triangle

By the end of March, success will look like...

- Using community spaces to house variety of service providers to test out possibilities
- Having drop in resources
- Testing out what a longer term community health hub would look like
- Trusting relationships with regular communication
- Getting people together to meet and share information - having good conversations in order to free up time
- Understanding roles/ objectives, and having a common goal
- ‘Network facilitator’
- Knowing who is who and who does what
- Central place to access records

In 3 years, success will look like...

- Making progressive successful partnership working a reality
- Closing the gaps and catching those who historically have fallen through gaps
- A cohesive holistic community space - Walworth Living Room
- Managing/ preventing anxiety and depression prior to escalation
- Services ‘under the same roof’
- Different services operating from GP services
- Informal/ comfortable spaces
- Education of parents around issues of mental health and breaking down stigma
- Involvement of faith groups
- Reduction in rates of anxiety and depression
- Reduction in A&E admissions
- Residents in Southwark know where to go

Walworth Triangle

The people we must involve

Social services
Commissioners
Welfare benefits
Housing
Befriending
Peer mentoring
Health and Wellbeing Hub
GPs and community services
Mental health/ clinical leads
Occupational therapists
Community centres
Schools
Faith groups
Physiotherapists
The Listening Place
Southwark Wellbeing

Have we moved on?

Participants felt they had made progress in understanding the neighbourhoods and making network connections

Prioritisation made less progress overall but moved significantly from the starting point

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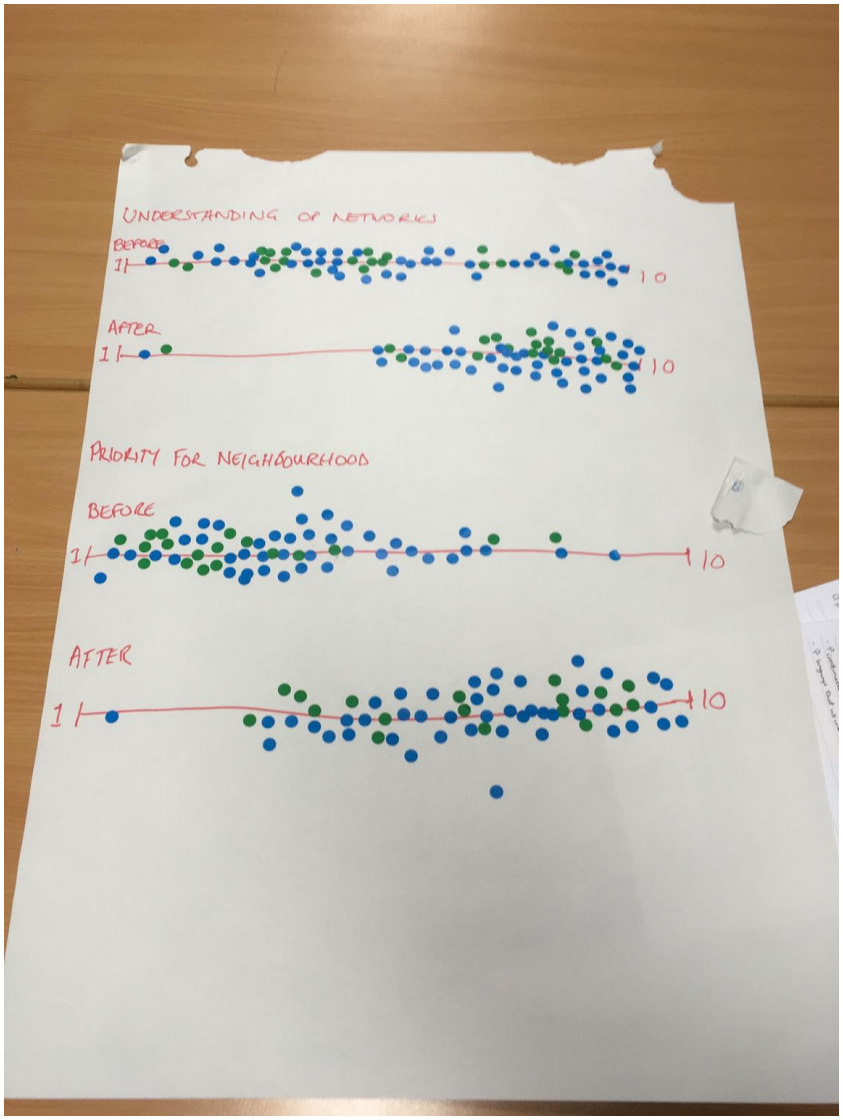

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What next…

FORMING

In the neighbourhoods

Socialise, refine and generate enthusiasm about the area of focus in each neighbourhood

+

Mine existing data, great ideas from elsewhere and best practice to inform area of focus and target outcomes

Agree tests to run in each neighbourhood to make progress towards agreed outcomes

Run iterative tests, with regular learning, reflection and refinement

Neighbourhood leadership team

Take learning from neighbourhood tests to create enabling conditions and draft shared principles and ways of working for neighbourhood working in Southwark

Cross neighbourhood learning event

In practice this will look like...

- Supporting neighbourhood teams to “prototype” neighbourhood working by creating a neighbourhood team to organise care for a discreet cohort of residents with multiple long term conditions *(see subsequent slides for examples)*
- Developing ways of working that improve communication and information sharing within the neighbourhood team, and the neighbourhood more widely
- Identifying practical barriers to neighbourhood working within each neighbourhood, and finding borough wide solutions to these barriers
- Connecting VCS and self care into neighbourhood working
- Creating time and space for the teams involved to reflect and learn from their experience in order to inform next steps

Progress and next steps

December

- Neighbourhood working groups established: still some gaps in membership which need to be addressed
- Initial review of workshop outputs and refining areas of focus using data and local intelligence
- Further engagement and identification of information required to support this work

January

- Neighbourhood working groups finalise areas of focus and develop ideas/hypothesis to test (e.g. through process mapping)
- Planning test arrangements
- Development of outcome measures and evaluation metrics via logic model
- Ongoing engagement with staff within organisations
- Engaging with local staff initially through Locality Patient Participation Groups

February

- Initiate testing
- Neighbourhood forum to enable better links between health, care and VCS, and to update staff on progress and inform next steps

March

- Refine testing based on learning
- Joint neighbourhood learning event to inform next phase developments