Neighbourhoods

City & Hackney Living Better Together

Neighbourhoods Models Options appraisal: PHASE ONE Research into current approaches to Integrated Neighbourhood Teams

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Summary of the ask: please review the information in this paper for the basis of discussion on the different aspects of Neighbourhood teams development.

In particular, what are your reflections or questions on how the 4 aspects of Integrated Neighbourhood Teams (INT's) have developed in City and Hackney?

What are your early thoughts around aspirations for the future of INT's in C&H?

1.0 Introduction and overview

In March 2023 system leaders endorsed a proposal to review our approach to Neighbourhood working in City and Hackney (C&H). It felt necessary to reflect on the journey so far, consider where we are now and produce options for our vision of Integrated Neighbourhood Teams (INT's). This work is underpinned by the long history of place based working, collaborations/partnerships and aspirations for the future delivery of health, care and support in C&H. As such we are in a position to look outwards; to see what colleagues in other parts of the country have implemented or are starting to shape on a Neighbourhood footprint. The proposal included a fresh review of models across the country to make sure we are aware of the various ways in which Neighbourhood teams have been developed (Phase 1), a mapping of the current C&H Neighbourhoods working (Phase 2), an engagement process with an options paper that will outline a shared vision for Neighbourhoods. This all builds on what we have already achieved.

The scope of this work has been adult services. Although Children, Young People, Maternity and Families services (CYPMF) have been at the forefront of place based and integrated working in City

and Hackney the 8 Neighbourhood models around the Primary Care Networks (PCNs) have started with adults[1]. The CYPMF alignment and cross learning work continues with a dedicated Neighbourhood Programme Manager. Review of CYPMF place based working and Neighbourhoods working is beyond the scope of this research and we found the Neighbourhoods approach has primarily involved adult services. The 'Think family' approach to supporting residents is included in section 2.1.2.

This paper is Phase 1 and summarises our analysis of the key aspects of establishing INT's.

1.1 Approach to the research

A small working group was formed with representatives from adult social care, community health, voluntary and community sector (VCS), mental health and primary care. The group came together a number of times to talk through how to approach the research on INT's, as well as how we could map Neighbourhood teams and services, incubator projects and the infrastructure that supports them.

We conducted a review of desk based research to discover what INT's and Neighbourhood working processes have been developed in other parts of the country. Using documents, presentations and podcasts available in the public domain, as well as websites like the Kings Fund, the NHS Confederation, NHS providers, Think Local, Future NHS platform, Social Care Institute of Excellence, we amassed a large volume of relevant material. Colleagues were able to contribute things they had read in journals, news articles and other sources of information and insights.

A 'snowball' method was then used to engage with people from a number of different sectors, organisations and places to gather insights on INT's. Local networking with North East London (NEL) and greater London colleagues as well as opportunities to deep dive into integration work at national events (NHS Confederation conference, Innovation lab-York University) enhanced learning and proved invaluable. 26 discussions with people from 20 different areas (in the UK) were held over MS teams, accompanied by emails and the sharing of written information. This took a number of months and culminated in a site visit to Ipswich to learn more about how INT's

[1] Many Children, Young People, Maternity and Families services are already on a journey towards Neighbourhoods transformation and ways of working. Some key developments include:

- The Enhanced Health Visiting service has mobilised and been reconfigured to work according to Neighbourhoods since Sept 2023.
- The new School Nursing Service tender (currently live for applications) has Neighbourhoods working incorporated and will see school nurses as part of Neighbourhood teams.
- The Children and Family Hubs programme which proposes to broaden the role of some of the multi-agency children's centres in Hackney into four 'Children & Family Hubs' which will offer support for families with children and young people aged up to 19 years old (up to 25 with SEND) is being developed to be co-terminus with the Neighbourhoods geographies. This programme will see a departure from the previous hyper local working across children's services aligned to the children's centres clusters, towards a more Neighbourhoods model of place-based working. The four hubs will serve two Neighbourhoods each and staff across a range of different services will work closely together to deliver support for families, taking an integrated approach.

have been established across Suffolk. This research thus presents living developments of INT's and not a list of abstract models.

2.0 Analysis of approaches to INT's

At present there is no nationally agreed definition or formal specification for Integrated Neighbourhood Teams. Many areas are working on INT's based on what is already working for them, their available resources and importantly Neighbourhood need. The Fuller Stocktake report published last year placed INT's and Neighbourhood working in the spotlight with the quote below articulating what it is and why it is important. We note not all our key partners are included in the quote e.g. community and voluntary sector, community health and mental health teams which are central to our model in C&H.

> ***'…neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.'***
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> ***Fuller Stocktake report 2022, page 6.***

All of this means Neighbourhood working and INT's have different definitions and structures in various parts of the country. In some areas integration is represented by colleagues from different organisations coming together at regular intervals on a Neighbourhood footprint to talk about data, priorities and how to deliver on them. In more advanced areas, a small number are strategically and operationally integrated, colocated and led by specific INT managers. These are commonly referred to as 'teams of teams', with various services coming together under one name in the Neighbourhood. In some areas where health and care are integrated this doesn't automatically translate to VCS or wider public service involvement and vice versa. This highlights the point that at present there is no one way of delivering Neighbourhood working or INT's. This will be explored in more detail in the sections below.

Our analysis of the different forms of Neighbourhood teams involved defining key aspects and then categorising what form this took. These key aspects are: **scope or criteria** used by the INT to define their target group or way of working, **roles and sectors** included in the team, **location** of teams and **management or governance structures.** In reality expressions of these categories crossover and overlap. Above all we found that clear 'models' were not commonplace and this work is complex, messy and its nature (place based) not always easy to define or appropriate to replicate. The purpose of conducting this analysis is to frame phase 2 of this work that is in progress (mapping our Neighbourhood footprint) and offering us material for reflection on the appropriate ways forward for building on what we have achieved with our own teams and their scope or criteria, roles and sectors, location, and management/governance structures.

2.1 INT scope or criteria

We found 4 main types of scope or criteria to define a target cohort for Neighbourhood working, these are;

- ➔ Open criteria
- ➔ Think Family approach
- ➔ Defined criteria
- ➔ Preventative work and or strategic planning

2.1.1 Open criteria

In a small number of places (5) Neighbourhood or multi disciplinary teams (MDT) come together (either weekly, Blackpool, Wigan, West Essex & Herts), fortnightly (Liverpool), or monthly (Colchester), to discuss people they have concerns about, to find out and discuss other professionals or organisation's involvement and to make a plan together. There deliberately wasn't set strict criteria around who could be discussed. Many teams found this was an easy way to get dialogue started between professionals, people saw how many other teams were also involved or knew the resident or family. They found decisions could be made more quickly, with relevant information and a clear understanding around who was taking forward the plan or coordinating the care for the resident.

Those working in a weekly meeting felt they had built trust more quickly, and reduced duplication of involvement or interaction with residents. They also felt they knew more easily and clearly what the residents' wishes, goals and issues were. Several of the teams reported the meetings lead to the production of a joined up plan rather than several organisation specific plans. 3 out of 5 areas met in person in the Neighbourhood, with a flexible approach to the amount of time they were able to talk about individual residents. The other 2 meetings were held online.

In Colchester, the 'Live Well Neighbourhood Team' wanted to add more structure to their MDT team meeting. They introduced a brief referral form to guide discussions, they note they have needed to be mindful not to create barriers to case discussions. They have also produced a leaflet for the public, outlining what Neighbourhood working is. In Liverpool a referral comes into the whole team and then is allocated to a service or professional accordingly. Generally the people here are referred over 18 years of age, but the INT also supports with adolescents transitioning to adult services. The Liverpool Integrated Care Team (ICT) are clear their remit is not for those requiring urgent or emergency responses, those requiring specialist teams outside of the ICT such as diabetes, or for single services such as single referrals to adult social care. They have open criteria to access a range of roles and care coordination.

All 5 areas concur this level of collaboration did not happen overnight and often needed specific organisational development (OD) work to help cohesion and understanding. 2 out of 5 of the areas had dedicated administrative staff to support the delivery and outcomes of the meetings, which they felt they have benefited from. In Blackpool they were clear this had reduced the need for the number of 'referrals' between services. They felt the discussion and information shared was better than the often scant information relayed via the referral forms.

In Wigan, there is established place based working, evolving from the 'Wigan Deal' 2014. Wigan is part of the Greater Manchester (GM) combined authority who, in 2019, published a white paper 'The Manchester Model' describing work to unify public services. This outlined a vision for every Neighbourhood area to have an integrated place-based team of professionals (from all relevant public services), who are co-located and who work together.

The Wigan community hubs host weekly in person 'huddles', where a wide range of people working in the Neighbourhood can discuss challenges or specific residents they are working with. Initially, people were encouraged to come to the huddle and discuss what they felt they needed to. However, the teams across Wigan wanted to give this more structure to help the focus of discussions and so created a secure portal for sharing information through the council website. Relevant data sharing and IT agreements enable all members of the Neighbourhood team to access the portal. The huddles are supported by a Service Delivery Footprint (Neighbourhood) Manager who guides discussions, identifies professionals missing from the conversation, understands the community assets and strategically supports Neighbourhood development work.

2.1.2 Think family approach

The 'Think Family' approach wasn't always explicitly described in conversations or presentations involving INT's. However, in multi-disciplinary meetings (MDM's) in Liverpool, Colchester and Manchester both adults and children's services were represented. Roles such as the 'Early Years Lead' or representatives from the child and family wellbeing service, or the team around the family would attend Neighbourhood team meetings. People felt by linking up professionals working with both the parent(s), carers and children they were able to prevent some issues escalating. They believed sharing information and knowledge reduced repetition and enabled teams to utilise the best avenue or relationship for communication with residents. Where staff were co-located this made communication and relationship building easier.

In previous work carried out in one of the C&H Neighbourhoods, one of the Multi Agency Team (MAT) chairs from children's services attended the Neighbourhood MDM. The team were able to discuss insights for children and the adults involved and collaborate on supporting families. Case studies for this work can be found here. These examples demonstrate the benefits of bringing together people from adults and children's services and removing silos.

In November this year the new East Bury family Hub opened. Family hubs build on the traditional children's centre offer of support for 0-5 years and their parents, to offer all children and young people aged up to 19 (or 25 with special educational needs) with whole family access to activities, services and support when they need it. The team in Bury aim to implement 5 family hubs and

early help services in each of their 5 Neighbourhoods. By bringing more teams and services together (approx 25 different teams/organisations in the East Bury FH) the focus can move to proactive work with residents at risk of poor health and care outcomes. They are currently considering the role the teams and services play in the first 1000 days and considering what better integration with children's social services looks like. Next steps also include close collaboration between INT's and the family hubs to understand Neighbourhood profiles and cohorts at risk, undertake joint strategic needs assessments and produce shared priorities.

2.1.3 Defined criteria

A number of INT's and structures we reviewed had their criteria clearly articulated and defined. Two areas in particular were focused on supporting those who accessed health and care services frequently (Bury and Birmingham). This was done through a mixture of proactive identification through electronic information systems and referrals. Both these areas include people presenting a number of times to primary care, A&E, hospital, mental health or community and ambulance services. Through workshops and other development sessions in Birmingham colleagues agreed this was the cohort of people who could most benefit from an INT approach. Similarly in Hull population health data and local insights are used to identify and target 3 cohorts of people. These include those receiving homecare and are overdue an annual review, those demonstrating escalating need (unscheduled phone calls to social care or primary care) and people who are newly referred for homecare.

In Bury, teams are considering how they can work to 'improve adult lives' and are beginning to connect with services around the wider determinants of health e.g. housing benefits, benefits, the justice system (further discussion in roles section). By finding or uncovering unmet need this can be seen as creating more work and adding pressure to an already saturated health and care system.

In Frome, Somerset, a small team of professionals come together to support people living with frailty. They hold clinics in various Neighbourhood locations to run comprehensive geriatric assessment clinics, and meet local needs more effectively. In Somerset like many other areas they are considering how teams and services can work in a more Neighbourhood way.

Three areas that have a number of services with defined criteria but come together under an INT umbrella can be found in Derby and Derbyshire, Suffolk and Sheffield. Throughout Derby and Derbyshire residents are supported by the 'Team Up' approach for urgent community care. Colleagues refer to this as 'teams of teams'. Teams such as the falls recovery service, rapid response nursing and therapies and ASC rapid response working at a bigger place scale supported by a Neighbourhood home visiting service from general practice. The Team Up steering group has been considering a vision of the future based on the integration of services rather than simple co-operation. They have found this helpful in implementing a 'no wrong door' approach. So if someone rings up for support a staff member centrally will aim to get them to the right team or service, rather asking them to ring around different services or teams.

Sheffield has implemented a Neighbourhood model called 'team around the person (TAP). Criteria for the service includes the need for two or more agencies involved with a person, concerns a person's needs may be escalating despite intervention, or uncertainty about a way forward. The individual professionals come together to share insights, decision-make and coordinate intervention and support. The team in Sheffield feel this is a flexible approach that works for them, the 'TAP' can include a range of different roles or services because it is based around the individual's needs.

INT's are well established in Suffolk. To learn more about the detail of their model, C&H representatives spent half a day with the Ipswich East INT. Similar to Derby a team of teams model is visible with community nursing team, community therapies team and adult social care service all being overseen by a single INT manager. The teams have their own referral criteria but work alongside each other in one open plan office. Clinical/Practitioner leads head up the 3 services and feed insights and issues to the INT manager. The teams feel they are reducing delays in care by alerting their colleagues to people's needs more quickly. Due to separate IT infrastructure they still need to formally 'make a referral' through separate call centres. This is something they are focusing on changing and improving through their clinical record system.

2.1.4 Targeting prevention and or strategic planning

Whilst some of the teams and models talk about trying to prevent hospital admission, this section explores the broader utilisation of preventative approaches by INT's. Other areas are developing preventative pathways which focus on specific cohorts, e.g. new Proactive Care and frailty pathways (as part of the ageing well programme). Colleagues are thinking about slowing the progression of frailty or supporting someone to move from moderate frailty to mild frailty. These services use data and local knowledge to identify need and use personalised care and strengths based conversations to improve outcomes for people. In many of the 20 places we spoke to, the proactive care pathway is still being established, as is the case in C&H. Some of these teams are working on a Neighbourhood footprint but not all.

In areas with very trusted relationships, joint governance and decision making there is flexibility around working to priorities that match Neighbourhood needs (see section five on management and governance structures). We found clear examples from Manchester, Leeds and Ipswich where INT's were embedded, enabling joint analysis and decision making around targeting health inequalities. In Manchester they are working to improve the uptake of bowel screening especially amongst some communities. In Ipswich there is a focus on increasing physical activity amongst families and mental health first aid training in barber shops to improve men's mental health. In these examples this work goes alongside day to day INT delivery and has needed additional funding and resources. This work highlights the strengths of the Neighbourhood model in knowing Neighbourhood needs and empowering teams to respond hyperlocally.

2.2 Roles in the INT

There are a variety of roles seen in mature or evolving INT's. The most commonly seen team compositions broadly fall into three categories, **core teams, core teams plus wider public services and teams with INT specific roles.**

2.2.1 Core roles in INT's

Core roles in INT's generally included the following - community nursing and therapies (commonly, Allied Health Professionals, AHP's), mental health practitioners, social care (social workers), primary care and VCS anchor organisation representation. In some areas they explained they had developed like this because they were often supporting the same residents. Whilst in other areas they were working on specific pathways together such as frailty and they wanted professionals to case manage residents, bringing in relevant expertise when needed. For example, in Herts & West Essex a specialist dementia and frailty service has been co-located with the Community Nursing Team, under a single manager to support the ageing population there. The majority of areas felt there was more work to do in getting the right balance of roles and continuously working on relationships within teams.

In Leeds, as in C&H they work closely with third sector organisations to employ navigation roles. In 4 areas specific VCS colleagues were part of huddles or MDMs alongside statutory partners. Carers' charities were represented and in one area there was an anchor organisation; this was a social enterprise associated with the local football club. It was felt it was imperative to work in partnership with some VCS organisations to access groups within Neighbourhoods.

A small number of INT's talked about their focus on shared competencies for some clinical roles. This was seen with nursing or therapy assistants and was also being tested with registered nursing and therapy staff, e.g pressure area care. These frameworks were seen as working well once embedded, with staff feeling empowered to support residents within their own scope of practice. It was also felt in some areas this had reduced the need for multiple home visits to the same people.

Capacity to have each role represented in a core Neighbourhood team is a practical issue. In 2 areas (Blackpool and Manchester) they had needed to rethink how AHP staff from the community therapy staff worked as part of the INT. The small number of therapists working in a Neighbourhood caused issues when there was staff absence, leaving gaps in service delivery. In Manchester they had changed this so more therapists covered more Neighbourhoods to enable greater resilience.

2.2.2 A 'core team' with wider public services

In 4 out of 20 places (as well as a core team) they also have people from housing, benefits agencies, smaller VCS organisations, police officers, probation officers and specialist health or care services. Many of the areas considered their INT a 'teams of teams' with professionals working in the Neighbourhood identifying with their Neighbourhood team but also as part of a professional team with their peers. The wider public service roles tended to be the less 'core' in terms of attending official meetings or colocating. There were a few exceptions. For example, In

Manchester, wider public service roles are included in the 'team around the Neighbourhood (TAN)'. These roles include a council Neighbourhood manager, INT Lead, Neighbourhood Police Inspector, Registered Housing Provider Lead and Early Years Lead. The TAN's state '*we are one multi-agency team who unpick challenges together to improve outcomes for local people*'.

In Wigan, the weekly Neighbourhood huddles can include local police officers, safeguarding fire worker, housing officers and school representatives. They respond to local need and can look different week by week, colleagues in Wigan emphasised the ability to build trusted relationships over time through conversations and problem solving in the huddles. This led to better understanding between people about their role and how to contact them to enable joint working.

2.2.3 A 'core team' and INT specific roles

Almost half (9/20) of the areas we spoke with had INT specific roles in combination with the core team. These roles included INT manager or lead, INT coordinator and INT administrator.

From our discussions it was evident a number of areas had used the emergence of INT's to reconfigure some coordination, administration and management roles. In addition, some emerging teams had created specific roles to facilitate integration and ensure the smooth delivery of care through INT's. 5 areas also reported they had employed people in specific OD roles to enable Neighbourhood working. Some OD roles were matched with a Neighbourhood whilst others employed an OD role or transformation team across a bigger patch. The teams felt it had been essential to support and manage the change they were working through[2].

2.3 Location of INTs

The location of INT's ranges from the use of designated premises for permanent colocation of key workforce to virtual multidisciplinary meetings. In practice those in a physical space also make use of virtual meetings/digital technology and visa versa. We found that physical colocation plans were necessarily re-thought because of Covid and we know generally that Covid created working culture changes globally resulting in more blended virtual/face to face norms. Key to this is to understand what creates meaningful connection to Neighbourhood colleagues and residents. The majority (8) of the places where online only working was the norm were in earlier stages of establishing Neighbourhood processes.

2.3.1 Permanent physical space.

We found 7 clear examples of INT's being located in a permanent physical space. All of these INT's are quite well established as a core INT of health and care services and some with broader non health and care team members such as VCS services or housing colleagues. The physical space was not utilised fulltime and not all in each Neighbourhood (for example teams working on the footprint could be located together in one space, rather than in each Neighbourhood geography).

[2] In C&H we have a Neighbourhood Workforce and Partnership Project Manager leading an OD programme and have invested in 4 Neighbourhood Coordinators from April 2024.

Wigan has 7 Neighbourhoods with a community hub where some key VCS organisations and services are based, offering support for residents and where Neighbourhoods staff can base themselves/work from. The team explained about the impact the pandemic had had on in person working. They are currently working to consider how to reconnect in some Neighbourhoods and challenge working from home where it is felt to be affecting relationships. The team acknowledges the hubs that have enabled the best integration and collaboration are those with open plan offices.

Similarly, Blackpool is a large and broadly defined INT. One of the teams we spoke to had permanent shared office and patient space in a building where 2 GP practices are housed. 'Team up' in Derbyshire are not fully on a Neighbourhood footprint but work across 'place', focussing on health and care integration for the housebound residents. They are co-located with community health and local authority staff. Feedback from Manchester emphasised the importance of good accessible wifi for shared locations, when working on different sites. Suffolk has also co-located and what has been most valuable is shared open office space with hot desk spaces.

Leeds all have a permanent physical space available and have made some roads into location in community settings. The main location of the INT's is mostly in NHS buildings with some use of council estate. The Additional Roles Reimbursement Scheme (ARRS) roles are now starting to utilise rooms or spaces with third sector organisations, where they might be speaking with residents. The third sector organisations are working to accommodate them e.g. we can find space for you if you need to stay a bit longer and make some calls or do a 1:1 with staff. This flexible approach is helping staff use the spaces, it's also helping them find out about their local areas, getting to know more about services and build relationships. Colocation, targeted outreach and collaboration with the voluntary sector has helped teams develop a culture of integrated working beyond the monthly MDM. The spaces are not necessarily used 7 days a week by teams and there is some variation in usage amongst different Neighbourhoods. Open plan spaces have worked best.

Initially Sheffield did co locate their 'team around the person' as a pilot, with people coming together in the family centres. A range of different services/roles were invited to co-locate: housing, community support workers, community nurses, family hub managers and the police. As people began to share the space they were able to make local plans. However, with Covid, people moved online and the TAP coordinator role started to evolve and became pivotal in pulling together the right people and information for relevant meetings. It is currently felt that staying online makes sense for time management for some of the team roles. The TAP coordinators work in a hybrid way. There were two other areas that started the colocation journey but due to the pandemic they are focusing on improving connection again in their INT. This demonstrates the iterative nature of change and the way finances, environmental conditions, relationships between different partner organisations and other unpredictable local conditions can affect change.

2.3.2 Blended in person and online

Blended approaches to working together across organisations have evolved iteratively in response to opportunities of available estates, culture and expectations resulting from the Covid working from home necessity, and the range of different reasons for being in the same room (team culture, seeing residents, 10 minute huddles). These responses often came from different Neighbourhoods rather than a planned strategic policy across the place.

Birmingham's INT's include a broad range of roles wider than health and care, using a mixture of online and face to face work. There is in person colocation for 2 days a week, and people can come in and out through the day as needed. They also ensure some protected 'together time' to help foster a cohesive team culture. The space utilised is currently in GP surgeries.

In Bury they make use of a variety of colocation opportunities. Some work in buildings slightly out of the Neighbourhood sometimes shared with other teams due to availability. The new family hub centres offer opportunities for face to face working in partnership with third sector colleagues. Similarly Frome combine virtual MDM with practical colocation opportunities in the Neighbourhood e.g. community hall, GP practice community hospital for pathway specific work.

Both of C&H's integrated teams, Neighbourhood Community Mental Health Team and the C&H Integrated Learning Disability Team work (not Neighbourhood structured) work colocating from a range of health and local authority locations and virtually often working from home.

Generally there was a move to trialling and protecting colocation in physical locations to improve integration and hyperlocal connection. For example post Covid Liverpool are now working to reinstate face to face meetings to about 50%. Sometimes that is not practical, for example with their 'Complex Lives' meetings there are a wide range of agencies (up to 25) and they may only come for one specific case that may only last 10 mins. In North East Essex, there are 90 minute face to face meetings once a month, which are reported as working well. Hot desking space has been offered to create a culture of seeing the Neighbourhood way of working as beyond the MDM. Other virtual space used are MS teams chat and WhatsApp.

2.4 Management or governance structures

Unsurprisingly the areas that had been working on integration within Neighbourghoods longer reported having more established governance in place. Governance in Neighbourhood teams focuses on operational management (safe effective working practices, relevant policies), staff management (line management and appraisal) and strategic management and decision making. Many areas also use data and population health management to support devolved responsibility and prioritisation across Neighbourhoods.

2.4.1 Own organisational specific governance

Four areas with INT's or teams configured from joining a number of individuals with different roles and from separate organisations, asked staff to use their own organisational policies to guide their work. They were operationally managed and appraised by their own organisation. For example in Birmingham and Blackpool, staff were using policies such as the lone worker policy from their own

organisation, and were not operationally managed by anyone in the INT. Frome and Hull did not have separate governance either.

2.4.2 Own organisational specific governance with agreed Neighbourhood principles

Six places were using organisational specific governance alongside co produced principles for Neighbourhood working. Herts & West Essex told us each service contributing to the INT had a service specification but this had evolved over time to reflect their role and input in Neighbourhood working. Others such as Bury and Liverpool had gone further with operational management originating from the INT, but not line management. In North East Essex and Wigan specialist OD support was employed to think about agreeing shared values and behaviours to underpin Neighbourhood working. These are regularly reviewed and amended to reflect changes in dynamics and culture. In North East Essex they used operational working groups to bring service leads together to determine staffing structures. However there was no additional funding or resource for this.

2.4.3 INT governance is evolving

In Manchester and Leeds there are formal integrated governance arrangements in place that bring services together to work on agreed priorities with clear leadership structures. In Manchester system partners have formed a 'Local Care Organisation' (LCO). The LCO leads the provision and some commissioning of health, care and wellbeing services in each Neighbourhood through INTs, ensuring the delivery of agreed outcomes and priorities, aligned funding and shared decision making. The LCO is therefore a lead service provider in Manchester. Collectively the INT Leadership Team is responsible for all the services that MLCO deliver at Neighbourhood level, ensuring the delivery of equitable, accessible, and sustainable community health, care and wellbeing services for children and adults. The LCO has its own management structure but uses some functions from Manchester Foundation NHS Trust e.g payroll. To help with scale and alignment Manchester has 13 Neighbourhoods (32 wards), 12 Integrated Neighbourhood Teams (health, social care and wellbeing) and 14 PCN's (all practices). Some staff (e.g. social workers) will be operationally managed by an INT lead but maintain professional supervision outside of the INT. They have developed a 'bringing services together' framework to focus on governance, footprints, plans, workforce, place based working and enhancing knowledge around people and the places they live in. The plan is to clarify the different service offers available and align different budgets at Neighbourhood level. Future INT development work builds on their existing model, outlining how INT's and their responsibilities for Neighbourhood health, care and wellbeing will be further integrated and aligned to commission and provide services to maximise delivery and avoid duplication and less effective approaches.

Local Care Partnerships (LCP's) build on Leeds City Council's strong history of NHS and third sector (community organisations) staff working together. There are 19 LCP's covering all of Leeds and 19 INT's. Some meet together due to historical ways of working in that geography. Recognising the city's diversity, they are tailored to local need and the features of that particular community. All LCP's have a range of people working together, regardless of the employing organisation, to

deliver joined-up collaborative care that meets the identified population's needs. Colleagues in Leeds talk about having 'flexibility within a framework' in relation to Neighbourhood working, not all 19 INT's look or operate in the same way but do have many shared principles. The team in Leeds have produced their own podcast on partnership working at place, this includes many tangible examples and interviews with both staff and residents.

In 2 different areas (Suffolk and West Essex) we also found examples of 'single points of access' or 'care coordination centres' in particular across a range of rapid response, intermediate care, specialist care and complex care management. The teams in these areas felt the single referral or entry points helped to reduce duplication and reduced the number of 'inappropriate' referrals to different services.

2.4.4 INT specific governance

In Suffolk they have been focusing on INT development since 2015, as described earlier we visited Ipswich East INT recently. Whilst services such as community nursing, therapies and social care are well integrated, the team continue to work on partnerships with primary care, mental health and VCS organisations. They have found collaborating on INT priorities has helped move focus from organisations' agendas to the Neighbourhood priorities. The INT managers are responsible for day to day running and performance, have operational and strategic oversight and financial responsibility for the INT. Alongside other Neighbourhood leads they are aware of health and care budgets and have structures to line manage all INT staff. They produce a monthly highlight report documenting their Neighbourhoods priorities, outcomes, key activities completed in the previous month, key activities for completion next month, learning to share, requests for help or support and identifying issues and risks. The team produced a Neighbourhood delivery plan which is reviewed throughout the year.

They have coproduced a vision for their work as well as shared values;

- ➔ To be an integrated workforce.
- ➔ To have one agenda and open communication.
- ➔ To enable everyone to contribute to a clear outcome.
- ➔ To recruit together.
- ➔ To work flexibly and create new opportunities.
- ➔ To be innovative and adaptive.

All of the above is paired with a monthly review of population health management data obtained via primary care and other sources. Information is fed upwards through the relevant boards and place wide governance structures. The team in Ipswich talk about working together, having joint leadership and pooled resources as a system rather than as organisations.

2.4.5 Leadership groups

Many mature INT's have smaller, more strategic, decision making groups as part of their model (Neighbourhood leadership groups). These groups often include roles such as a lead GP, lead professionals from community health services, mental health, adult social care and children and

young people's services. Some leadership groups include wider public service roles such as those from the police or housing (Bury and Manchester). In Manchester as in Ipswich each INT has access to a 'sponsor'. These are senior roles within the health and care system who can help remove or work through barriers or unlock access to things. Both areas told us they had found the sponsor role essential to making progress on integration work.

Some groups will meet monthly to understand population health data, Neighbourhood intelligence, health inequalities, challenges like the cost of living crisis and how the Neighbourhood team can jointly respond to meeting people's needs or offer more coordinated proactive support. It was noted as the groups or boards had matured there had been a move away from clinical or pathway specific discussions, with more focus on root causes of deprivation and poor health and wellbeing (e.g. Leeds and North East Essex).

Where groups or partnerships boards have been established for some time, they have developed memorandums of understanding or terms of reference to describe how they work together and how decisions are made (Herts and West Essex). Here, the team told us they had funded some PCN Clinical Director time to ensure primary care were able to have protected time for this leadership role. People reflected this had helped to articulate the distinct difference between the role of the leadership team (strategy) and the Neighbourhood team (delivery). In a small number of places this has led to the pooling of budgets with shared decision making around service provision in the Neighbourhood.

3. Conclusion

The research revealed a range of stages of development of INT's that all had in common place-based evolution. The principles of Neighbourhoods working for health and care are simple and broadly accepted: working around smaller populations will enable a more targeted approach and create access to services closer to where people live, working on a smaller footprint will enable professionals from different sectors to communicate more effectively and respond to local need. Residents will be supported more holistically with their views and wishes at the centre of their care. Places had case studies of best practice and there was wide-spread agreement that staff preferred working in this way. To our knowledge there are no formal evaluations of Neighbourhoods approaches.

There were no 'off the shelf' models of INT's and there was no linear road map. The change processes often involve test and learn approaches with stopping and starting integration aspects like colocation. Where areas had more established INT's there was clear senior leadership for the direction of travel and to ensure resource unlocking of estates, budgets and time for innovation. Teams, once established were supported with OD, cross organisational learning opportunities and there was local Neighbourhood level decision making, governance and transparency.

This paper was created for reflection on an 'options appraisal' for the future of INT's in C&H. We can see many similarities in the 4 key aspects of Neighbourhood Teams. These key aspects are; **scope or criteria** used by the INT to define their target group or way of working, **roles and sectors** included in the team, **location** of teams and **management or governance structures.** In

phase 2 of this work we will bring our mapping of our current INT. We recommend then considering how we want each of these aspects to develop into a shared vision for Neighbourhoods working. A direction of travel can then be integrated into Phase 5 of the Neighbourhoods Programme 2024-2027 (of change): Deepening Integration and establishing impact.