The Strategy Unit.

Neighbourhood Working

Network Event Summary

25 July 2018

NHS
Midlands and Lancashire
Commissioning Support Unit

Introduction

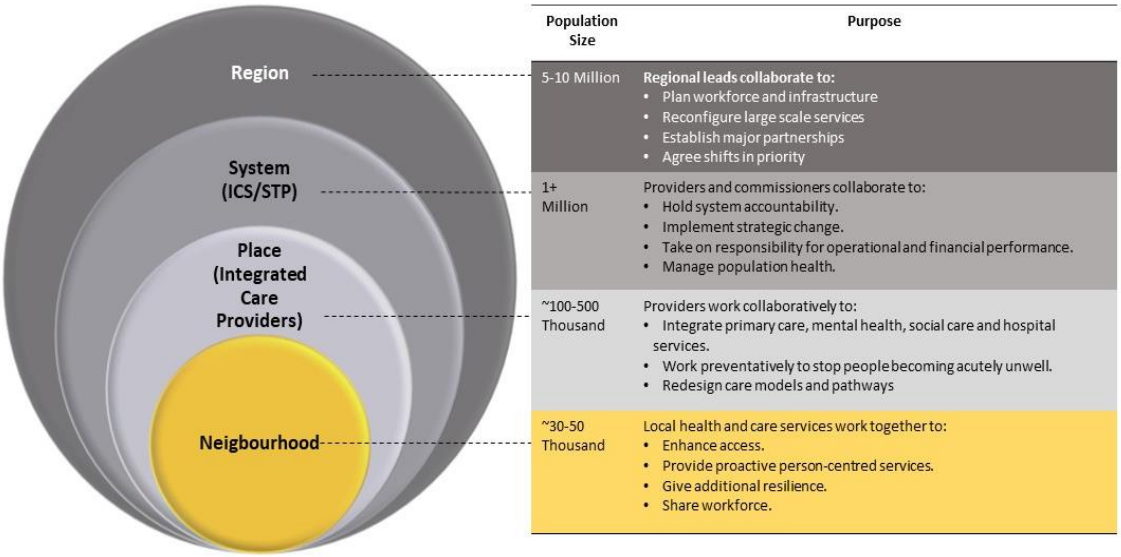
The Strategy Unit wants to support neighbourhood working. We want to help make a success of different services – health, social care, voluntary sector (etc) – coordinating their efforts to improve health outcomes for local populations. To do this, we have initiated a learning network. This network was launched at an event on 17th July 2018.

This summary document is aimed primarily at the network participants (and like-minded colleagues who were unable to attend). The objective of the document, like the network itself, is to stimulate thinking, learning and action. It provides both a record of the event and a brief summary of existing evidence related to neighbourhood working. Presentations from the event – referred to below - are also available via our website.

The disclaimer here is that the formal evidence-base is not well developed. It does however, provide useful pointers and tips; these are set out below, following a brief review of the policy and service context for neighbourhood working.

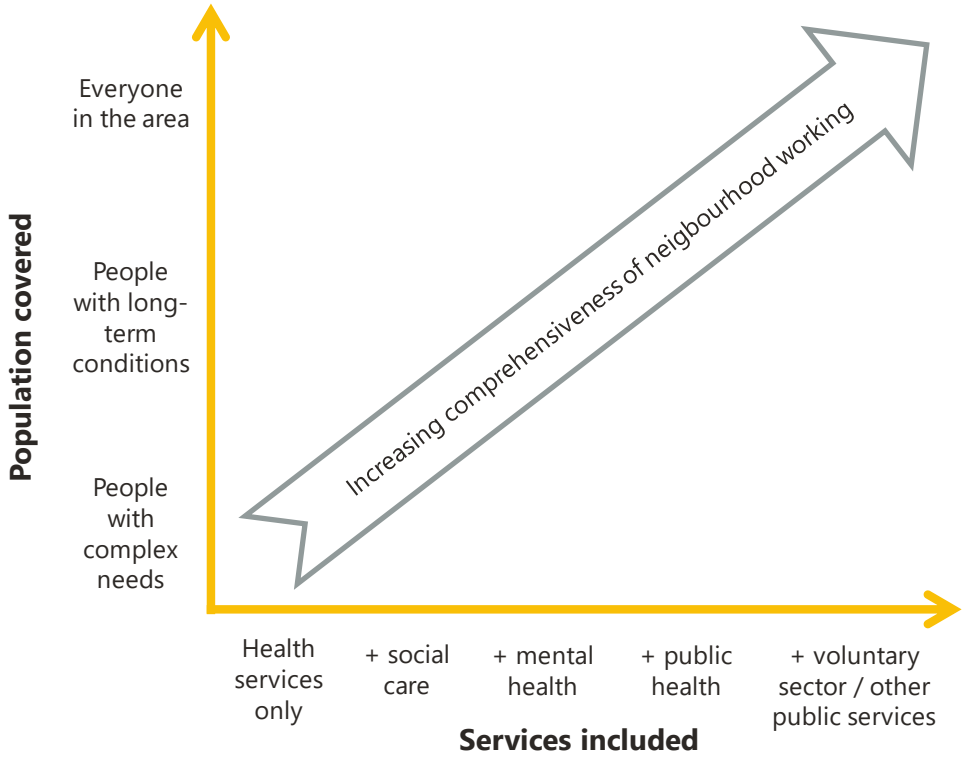
Neighbourhoods: policy, form and function

Current policy encourages neighbourhood working. At the event, both Fraser Battye and Professor Nick Harding described the need to be mindful of the policy context: to fit with it, be resilient from it, and to learn from previous failures. The current national plan to evolve Sustainability and Transformation Partnerships (STPs) into Integrated Care Systems (ICSs) encourages the 'improvement of health and care services centred around the population's needs' and 'integration between health and social care'.[1] The Figure below, adapted from an NHSE framework, shows the current system within which neighbourhoods operate.



Neighbourhood working is not new; joining up services at the very local level has long been a feature of many local authorities, for example. It has now caught hold in health and care policy as a means of coordinating health and care services within a local area – typically covering populations of around 30,000 to 50,000.

There is no blueprint. Based on the evidence, the examples that were presented at the network event (Telford and Wrekin, Wolverhampton and Worcestershire) and examples below it is fair to say there is no 'right' approach as to the design of neighbourhoods. Mapping examples onto the simple chart below shows the broad range of what might count as a 'neighbourhood' model:



Instead, form should follow function. One of the main messages from the event was the critical need to be clear as to the purpose of neighbourhood working. So, are they designed to reduce emergency admissions and/or improve care for people with long-term conditions and/or increase the resilience of primary care and/or link people into voluntary sector services (etc)? And – a level of detail down – people need to be clear on the theory underpinning neighbourhood working. Is it that staff will form strong working relationships and therefore better coordinate their efforts, for example? Or that very local knowledge can be used to tailor services provided? Or that neighbourhoods provide a useful level of performance management? (etc).

The answers to these questions are local. So, it is a relief that policymakers have – to date - heeded practice. Nick Harding's presentation at the event drew this out. We then take the following to be core features of neighbourhood working:

1. **Neighbourhoods are likely to be formed around natural communities – perhaps based on GP registered lists - often serving populations of around 30,000 to 50,000.**
   This neighbourhood size has been suggested for some time. This scale seems to be determined as much by the workforce as geography or any other factor. As Peter Spilsbury explained, human social networks are predicted to be most effective at a size of 150 - the 'Dunbar' number.[2] This number has been applied to healthcare team settings and it is believed (as yet, untested) that 100-150 member workforce can maximise the delivery of population health outcomes to a registered population size of 30,000-50,000.[3] This means that different models may support different population sizes.

2. **Neighbourhoods will be small enough to provide personal care, but large enough to provide a broad range of resilient services.**
   At the core of a neighbourhood is a community-centred, integrated team, working across healthcare, social care, public services, and voluntary agencies and the people it serves.[4] In essence these are multi-disciplinary front-line teams delivering integrated patient-centred pathways. It is intended that by working together, staff across different disciplines can communicate regularly, share knowledge and expertise and co-ordinate care planning and delivery.[5] Key to their effective working is the development of trust and collaboration within team members. It is this collaboration that will promote professional autonomy and empowerment which is critical for driving the cultural change required,[6] such as allowing members to spend their time where they add most value. As Matt Stringer from Worcestershire Integrated Partnership eloquently described it: "you can only move at the speed of trust."[7]

3. **The most effective neighbourhoods will create partnerships between services and citizens.**
   Neighbourhoods need to consider the factors that enhance both staff and service user engagement. For staff, the evidence suggests: aligning values and purpose; defining roles and responsibilities; providing time and space for learning with external facilitation or support; and funding for administrative or management resource.[8]Attention to such enablers at all levels (neighbourhood, place and system) can help to build connections between leaders and their organisations, recognise diverse skills and resources, and develop trust. As Paul Aldridge from Wolverhampton CCG described, individual organisational priorities can take away the focus from doing the right thing.[9]

   Similarly, greater service user / patient involvement in their own care to improve outcomes requires them to be equipped with certain knowledge and skills. These include health literacy – a greater understanding of the health and care context generally and their own conditions specifically – and the tools and confidence to manage their own care.[10] The evidence shows that facilitated support rather than simply signposting is more effective in

assisting people with wider social needs and maintaining follow-up, it also builds greater levels of confidence and autonomy in service users.[11]

4. **Neighbourhoods provide a basis for the sharing of very localised information – and using this to learn and improve**.
   To make neighbourhoods sustainable means that they will need to respond to the many different interests of the providers and needs of the communities, with a variety of approaches and skills. As communities are not static, they require continued engagement, facilitated through support networks and joint working arrangements including the involvement of voluntary and community agencies.[12] Anna Hammond and Louise Mills from Telford and Wrekin described their co-operative approach and shared narrative across all community stakeholders.[13]

   Sustainability is also dependent on iterative learning and for that to be viable, information sharing between organisations is a prerequisite. ICS learning and improvement can be accomplished through training and feedback loops, built into audit and formative evaluation[14] and these are reported to be characteristic of organisations seeking to achieve transformational change.[15]

An initial set of design principles

The above shows that designing and delivering neighbourhoods is a complex task. In the table below, we provide a set of evidence and experience-derived principles, their underpinning rationale and some national examples. These provide an initial framework for thinking about the design of neighbourhood working.

Principle	Rationale	Example
Establish a clear ***vision and rationale for change***	A shared vision and agreed objectives are required to create a shared identity.[16] This has to be predicated on a clear rationale for change[17] and there needs to be organisational and leadership support for new ways of working; for instance, for shared decision making or developing a culture of quality improvement.[18]	**Sheffield Neighbourhoods:** Coordinated health and social care delivered through an integrated workforce. Increased personalisation of care and population health outcomes by aligning clinical and financial drivers through a unified capitated budget, risk/rewards share and provision of care to a defined registered population (30-50,000).
Maintain continuity of ***relationships and leadership***	Emerging and experiential evidence suggests that where historical relationships of collaboration and partnership working exist, progress is made more quickly in forming a neighbourhood way of working. Local leaders and champions can help drive forward change.[19] Flux in this leadership is likely to create uncertainty for staff and they may revert to organisational, rather than neighbourhood, ways of working.	**Torbay Integrated Health and Social Care:** Five 'zones' serving c. 50,000 populations with multidisciplinary teams working with primary care and specialist services. Each zone has a manager who reports to the Chief Operating Officer and there are also professional leads spanning the zones such as the Head of Social Care, Head of OT, Head of Physiotherapy, Head of Nursing. There is a strong emphasis on multi-disciplinary leadership within the teams.
Consider ***Co-locating*** *teams where appropriate*	The physical co-location of staff within an MDT has been found to support care integration efforts and improves the relationships between staff based on a mutual understanding[20] and is associated with improved outcomes for patients.[21]	**Encompass MCP:** Established five Community Hub Operating Centres (CHOCs) that each tailor their services to their local population's needs. Each CHOC houses a group of professionals representing GPs, Geriatricians, social care, community nursing, mental health and social prescribing, with others included as appropriate.
Co-produce *neighbourhood*	Good relationships between healthcare professionals and service users facilitate shared decision making.[22] However, patients may need training, coaching, facilitation and tools to support shared decision making.[23]	**Bromley by Bow:** A patient-centred approach that supports people to improve their health and wellbeing, learn new skills, find employment and develop confidence to achieve their goals. At the heart of the neighbourhood is the Bromley by Bow Centre that

s with communities		supports families, young people and adults to learn new skills, improve their health and wellbeing, find employment and develop the confidence to achieve their goals. A GP Partnership has developed a healthy living centre model which operates from the centre and focuses on the widest possible network of support and intervention for patients.[24]
*Establish **shared records** within the neighbourhood*	Electronic health records enable the management and co-ordination of patient care in integrated care delivery.[25] Patient-centred digital technologies are expected to enhance health and wellbeing, particularly those that promote physical activity or those that enhance mental health and wellbeing.[26]	**Erewash MCP:** Two primary care hubs which offer an on the day service for patients who need to see a GP or advanced nurse practitioner, and a Community GP has been appointed to provide medical support to care homes, the acute home visiting service and community matron service. A TPP[27] hub has been commissioned to allow a full integrated record between the primary care hubs, home visitors and GPs. Information governance agreements have also been put in place between all partner organisations to facilitate this.
*Dedicate resource to **long-term** planning*	Transparency and understanding regarding the assets available to the neighbourhood aid in the development of a sustainable model.[28] Commit to a programme of organisational development to align values and activate collaborative and system-wide ways of working including consideration of pooling resources in the long-term.	**Beacon Medical Group:** Key feature has been the creation of two health and community hubs providing space for MDTs and community use. The model is GP led, and the team has worked closely with staff, patients and partners to develop their model through co-design. Their approach to integration started small and organically with organisational development and a shared vision being key elements.
*Implement **continuous** review*	Develop a single set of measures to understand progress and use for improvement.[29]	**Healthier Wigan Partnerships:** The partners have agreed performance metrics and outcomes to be measured across the whole system. There is an IT strategy group who have developed the 'Share to Care' programme which is working to ensure that the right information is available at the right time to support patient care.

Next steps for the network

It's early days for the network. We've gathered the views of participants at the event and reflected on the themes that emerged. Our initial thinking on core themes – and what the network might do to address them – is set out below:

Clarity of purpose. There are many good potential reasons for neighbourhood working: more integrated services for people; primary care resilience; efficient use of resources; opportunity to link with community assets and the voluntary sector; tailor services using very local knowledge; target the most vulnerable to reduce emergency admissions, reduce variation (etc). Each is legitimate and many are complementary. But having a clear – and shared – purpose is essential. It defines development support, measurement, innovation, team culture, amongst other things. The network could help areas and services gain this clarity and provide advice as to how to 'sell' it.

Clarity of 'type'. There are many different types of neighbourhood working. Some focus on specific population groups, others take a whole population approach. Some focus largely on primary care; others include social care; others the voluntary sector and others the wider public sector. No single model is best – but some models are more appropriate than others, depending on what the purpose is. The network could help here by describing different types of neighbourhood working and how they might achieve different aims. This could be supplemented by detailed case study examples. It could also examine workforce implications: for each type of neighbourhood, what competencies would be required and how would this translate into staffing?

Leadership and culture. Neighbourhood working is multi-disciplinary working. To work effectively therefore, neighbourhood teams have to work across organisations, across services, across systems and across cultures. This presents significant challenges: not least within an NHS built on a 'command and control' model. How to lead across teams when formal powers are lacking? How to influence others? How to create win-win arrangements? How to build distinctive and healthy neighbourhood team cultures? Indeed, as was asked at the event, "who is in charge of the neighbourhood?". Participants were also concerned with how to create the capacity for transformation and describing the realities of what is desirable and what is possible. The network could help bring tools, techniques and lived experience to address these questions.

Data, tools and innovation. There are so many measures in the system that it's hard to know where to focus and what to think. What should neighbourhood teams prioritise and measure? How should they access this information? What actions should they take using the results? How can they stay informed about shifting needs in their local area? And what are the expectations on teams in terms of service innovation: are they expected to identify their own problems, devise their own solutions and evaluate the results? Again, the network can provide specific support on this topic – and enable the sharing of specific products and outputs. The network also expressed a desire to be

one voice in describing effective means of collecting and using information, creating metrics that are useful and meaningful to the system. There is more confidence that this voice will be heard by policy makers.

Links with the voluntary sector and wider public services.

No-one disputes wider involvement and everyone starts with this as a key intention in their neighbourhood programmes. However, doing it properly is challenging. Most find that the first stage is in identifying 'community assets' and harnessing them for involvement, but what if neighbourhoods find assets aren't available sufficiently to support the need? What if historical relationships preclude assets from confidently delivering, even when identified? Do neighbourhoods need to lead to a certain level of maturity before all those involved can confidently work together and deliver? Some of this knowledge will be locally understood but the network can help to describe how these partnership links might be made and maintained, identify the tasks and responsibilities of the different individuals and sectors and learn from the lessons of others.

This initial set of themes will be refined through further engagement and set out into a work programme. We will also consider how to put this into practice, but this might include a microsite, events, conference calls and webinars, study tours and good practice case studies.

Most immediately, the date of the next event is **October 11 2018**. Further details and invites will be sent nearer the time!

References

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