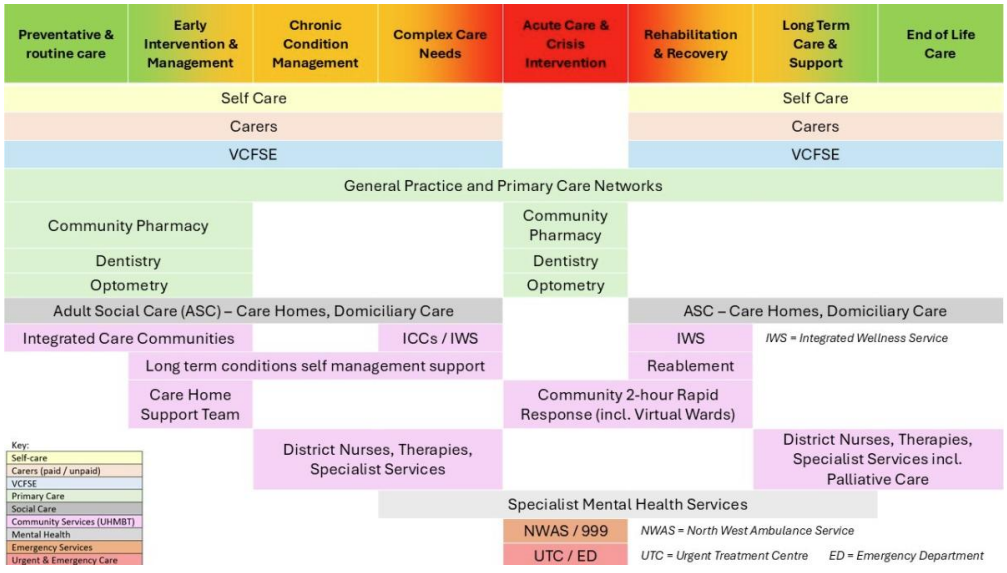
## What is a Neighbourhood from a Health & Care perspective?

## (or how do we organise it, who is in charge, who controls the money?)

For those of who have spent our professional lives working in the wider community this is a relatively easy question to respond to, although the answer is complex and multifaceted. It is both fascinating and noteworthy that several large-scale providers (in health) are asking the question, expressing confusion as to the definition and assuming thought leadership in working this through. We are also seeing this in national clinical & programme leadership, regional and ICB based management. The suspicion must be that organisational form, leadership and control of cash is driving the current debate, in part because we all only know what we know. Some of this is raw politics, but most stems from a lack of core knowledge. Command and control have become large provider centric, or decisions made at such a high level in the NHS that guarantees influence on those that have significant lobbying resource. It is therefore time that we articulate what a Neighbourhood is, in the terms of Heath & Care.

Neighbourhoods cannot be owned, they cannot be forced and they must make sense on the ground. They work well when a coalition of the willing agree to work around a defined population with a focus on cold and warm work (not hot). Hot work (when the citizen is in crisis and needs a significant escalation in care) is the purview of the Community 2 Hour Response (UCR), the Virtual Ward, local Ambulance Service (999) and Acute Health & Care Services (Physical, Mental Health & Crisis Care). Hot services need a certain population size to be safe & cost effective which will be larger than most Neighbourhood's (30-50 000 population) e.g. Northwest Ambulance Service working at a level of 7.5 million. Hot Providers must have effective working relationships with Neighbourhoods, and parts of their service offer may be visible (both as contributors and as deployable assets) but cannot be in charge. They exist to serve the Neighbourhood, not the Neighbourhood existing to serve the Hot Provider.

*Fig 1. Complexity of Care happening within a Morecambe Bay Neighbourhood from level of engagement, provider categorisation and location on the life and death continuum.*



Neighbourhoods start with a natural community collecting around shopping, transport, employment, educational and leisure services. They can and do cross local government boundaries, creating issues that in practice can be effectively controlled. They start at the level of the engaged and healthy community, taking an active interest in how they can live their best life (which includes a good death), supported by services as local to them as possible, who develop a longitudinal relationship. Effective Neighbourhoods may be digital and data driven/enabled, but they all have real humans at the heart of everything that they do. They are places of effective collaboration, of co-design with stakeholders and of a focus on trying to avoid illness or managing illness to the wishes of the citizen when it inevitably happens. They prize making social connections, of empowering the individual and hearing the lived experience. Of course, there has to be leadership, but it is very different in form, being based on soft vs hard power.

To support an effective Neighbourhood, leadership *from a health perspective* needs to emerge, however it must have authenticity, lived experience and the ability to demonstrate balance, perspective and insight. It is likely that General Practice will provide this skill set, but it isn't an exclusive right. We cannot be in the business of allowing existing at scale NHS providers to continue their de-facto control of healthcare. They may well have executive capacity but assuming competency in financial management, governance and clinical expertise *(with respect to Neighbourhoods*) is open to challenge. In addition, their current accountabilities have a focus on the provision of secondary healthcare for which they are legally responsible and will likely dominate the internal conversation. Leadership here is less about the formal, and much more about strong relationships and maturity of the partnerships. That said, for Neighbourhoods to succeed they will require the wider landscape to be generally supportive with alignment of resource, consistency of priorities and coordination of behaviour across organisations.

Neighbourhoods, although local in delivery must have a standard structure, have a consistent medium and high-level function and deliver consistently on the five key areas, enabling *Empowerment*, being an *Integration Platform*, providing *Early Intervention* & *Case Management* via a *Holistic Care* lens. They need to be convened in an inclusive manner, where the direction of all partners is clear and the synergies and limitations are identified, leveraged or resolved. All have an equal seat around the table, as although all have a provider function, traditionally some are more visible and influential than others. The above diagram (in the vertical axis) identifies the full scope of partners, all of whom must be treated equally, as for example services provided on a voluntary basis can be professional in standard. Service competency, suitability and footprint matter more, along with a demonstrated willingness to collaborate (design, deploy, deliver), provide mutual respect and listen (and then adapt).

Within the Morecambe Bay Place we started on this journey in 2014 and have significant tactical, operational and strategic learning that we cannot afford to lose. It is not about protecting the status quo or existing power bases, but we have the foundations right, some of the key structures in place and can identify where the gaps are. Of course, mistakes were made but in these parts Neighbourhood working is now business as usual for many. Whilst the population characteristics change so much across our Place it is worth noting that all 9 Neighbourhoods have operational and strategic alignment with regards to partners, digital and relational integration, Proactive Care Plans (PCPs) and service organisation which will be expanded further.

Neighbourhood partners should include where possible/practicable: -

- The population e.g. via Parish Councils, local healthy living initiatives.
- Official & unofficial Carers.
- Voluntary, Community, Faith and Social Enterprise (VCSFE), either general or targeted, charitable or directly commissioned.
- General Practice and by extension Primary Care Networks (PCN's) & associated staff.
- Pharmacy, Dental & Optometry.
- Local Govt. Services-Fire, Police, Libraries, Health & Wellbeing.
- Local Govt. Social Care (Adult & Children).
- Local Govt. Public Health.
- Adult Physical Community Services including Integrated Care Communities.
- Children's Community Services/0-19 Service.
- Domiciliary, Residential & Nursing Home Services.
- Specialist Mental Healthcare Services.
- Statutory Ambulance Services.
- Acute (Hospital) care services.

Neighbourhood integration (relational) is achieved through at least 4 essential components: -

- Joint Public events e.g. Breathe Easy Groups, local Agricultural shows or Men's Club chats, where multiple agencies will collaborate around a given theme, advise as to the current service offer and listen to the lived community experience.
- Monthly Steering Group meetings, where all are welcome, have an equal voice, receive parish notices, local core team activity data, receive presentations and then round-robin their individual service offer/developments.
- Joint/collaborative triage function, where all parties working in a similar space combine in a single platform/discussion cases referred for case load distribution.
- Co-ordination around a single cohort of individuals, which in some cases could be via Multi-Disciplinary Team (MDT) working. Cohorts here include Adult Physical or Frailty, Children' s, Transition (0-25) or Mental Health. It is important to recognise that an MDT is a way of working, not the end point which is seamless integrated care. There are other models of co-ordination which will work better in certain Neighbourhoods e.g. more rural with less concentration of cases.

Neighbourhood integration (digital) requires

- A single view of all relevant information within core systems (data not documents).
- Unified method to initiate referral/transition of care (Whole System Flow.)
    - Needs based, competency based & trusted assessment.
    - Providing read/write care planning and soft intelligence.
- Core clinical system standardisation/optimisation (including bolt-on).
- Single pathology/radiology ordering and results function.
- Single reporting function with a whole system view.

With a focus on healthcare services working within a defined Neighbourhood there appear to be 4 layers of organisation, that forms part of the wider onion. They need to be defined from the perspective of the Neighbourhood and can be statutory, private, voluntary or blended. Such services will deliver care within the Neighbourhood mainly as a core/structural function, but sometimes on an outreach basis. Scale of service operation has multiple factors but is often determined by minimal viability re cost and safety. Some services of a more specialist nature whilst delivering on the ground in a Neighbourhood, may have to operate at Place, Integrated Care System or even a regional scale. Once again being of a voluntary nature does not exclude a professional or fully accredited service that can take its place as an equal partner.

- **Neighbourhood based** Services that sit entirely within a Neighbourhood e.g. General Practice, Community Pharmacy, District Nursing, Integrated Care Communities and Primary Care Network (PCN) Additional Roles. *Strong relationships*
- **Partially based** Services that sit across several Neighbourhoods, deliver on the ground, and have seamless integration with fully based services e.g. core Physiotherapy, Rapid Response and Community Therapy. These services may well have a unified management & clinical structure across an entire Place but have several operational teams that cluster on top of Neighbourhoods. *Strong relationships*
- **Place based** Services that again can ONLY operate at the scale of a Place (300-500K population) e.g. Respiratory, Specialist Mental Health & Palliative Care. These teams are visible and present across the entire Place. *Weaker relationships*
- **External** Services provided on an ICS or regional footprint, even if delivering care on the ground, which requires digital vs relationship integration e.g. Statutory Ambulance, local Acute Care & Spinal Rehabilitation. *Weaker relationships*

The final aspect of standardised activity is the creation and maintaining of comprehensive co-produced multi-disciplinary PCP, about living and dying well. A PCP differs from a focussed Palliative Care/End of Life Care Plan and a more general Long Term Condition Care Plan. The PCP exists both as a physical entity to hold in the home (but outdated at point of creation) along with the data being held in clinical systems, being dynamically overwritten and therefore the latest iteration available through electronic record sharing. Arguably PCPs at scale to a target population are the most effective form of population health management tools that we have available. Whilst the individual structured conversation is happening between the health & care professional and the citizen there is an opportunity to empower individuals through articulation

and recording of their wishes, ask important questions that they may well not have considered and can offer insight into the relative benefits of existing options. Once complete PCP's have positively affected behaviours and decisions of relatives, of NWAS staff called in an unscheduled care episode, of Out of Hours Primary Care services, of Emergency Department and wider Hospital staff etc. Locally in Morecambe Bay we have a well-defined data set, a standard output document and the means of sharing the PCP electronically.

Call it a Holistic assessment, or a PCP, there is lived experience that transitioning a citizen through a well-designed PCP process in addition will seek to address many of the outstanding issues/loose ends of a far more practical nature e.g. loneliness, carer responsibilities or fire safety. Onward referrals/transitions into the wider Neighbourhood Health & care offer are a critical part of the PCP process. The individual can be seen in the round and adverse effects, from whatever source can be addressed. Hopefully at the end of the process the individual is empowered, optimised and connected. Of course, health can and will fail, but having done the essential groundwork, we can be far more discerning in who requests and/or requires additional care.

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8th October 2026

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| Appendix 1 | What is an Integrated Care Community? | (Emma Paul) |
| Appendix 2 | What is a Primary Care Network? | (Abi Staveley) |

**Appendix 1**

**What is an Integrated Care Community (ICC)?**

Integrated Care Communities (ICCs) are integrated neighbourhood-based teams comprising health and care professionals, social care, voluntary sector partners and wider community assets working together around a defined population. Established in Morecambe Bay in 2014, there are 9 ICCs across the UHMBT footprint. ICCs are the delivery vehicle for population health management, Proactive care coordination and neighbourhood working and they have two distinct but interconnected components:

1. Clinical Case Management function

The ICC Case Management Team provides a Proactive clinical service for people at risk of deterioration, admission or increasing complexity. Teams are led by a GP / Clinical ICC Lead and a Clinical Team Leader and typically include Case Managers, Care Coordinators and Care Navigators who:

- Undertake Proactive case finding and risk stratification.
- Develop and complete personalised Proactive Care Plans (PCPs).
- Coordinate support with agencies across the health, social care and VCSFE system.
- Facilitate MDT discussions and reviews.
- Support individuals with complex or rising risk needs.
- Intervene early to prevent deterioration, crisis presentations and avoidable hospital admissions.

The clinical element of the ICC provides direct support to individuals and families and works in conjunction with Primary Care and the wider Neighbourhood network.

2. Neighbourhood Development Function

ICC Development Leads work with communities and partners to:

- Analyse population health intelligence and local neighbourhood data
- Identify inequalities and unmet need.
- Map local assets and community resources.
- Convene partners.
- Design and deliver engagement and prevention initiatives.
- Support collaborative working across organisations.
- Develop community-led solutions to local priorities.

These clinical and development functions enable ICCs to improve outcomes for individuals while simultaneously strengthening the wider health and wellbeing of the neighbourhood population.

**From an ICC to a fully established Neighbourhood**

Rather than replacing ICCs, a mature Neighbourhood builds upon the foundations already created by ICCs. To become a fully established Neighbourhood, an ICC would need:

1. Broader community ownership - Stronger participation from citizens, carers, community groups, parish councils and local leaders in shaping neighbourhood priorities and decision-making.
2. Full system representation - Consistent engagement from all neighbourhood partners including social care, health, education, housing, emergency services, VCSFE organisations, community services, mental health providers and acute providers.
3. Mature governance and leadership - A shared neighbourhood leadership model where organisations work collectively around population outcomes rather than individual organisational objectives.
4. Stronger digital integration - Shared care records, interoperable systems, read/write care planning and seamless referral pathways across all partners.
5. Expanded neighbourhood infrastructure - Regular neighbourhood forums, community events, collaborative triage arrangements and neighbourhood-level planning mechanisms involving all stakeholders.
6. Scaled personalised care planning - The systematic use of co-produced Proactive Care Plans as a shared tool for coordinating support around individuals and families.

Integrated Care Communities should be viewed as the operational and clinical foundation of neighbourhood working within Morecambe Bay. Through their combination of Proactive clinical case management, population health management and neighbourhood development, ICCs already deliver many of the capabilities expected of a mature neighbourhood. The journey to full neighbourhood maturity is therefore largely one of broadening awareness of ICCs, strengthening neighbourhood participation and embedding whole-system integration around a defined population, rather than creating an entirely new model.

**Appendix B**

**What is a Primary Care Network (PCN)?**

A Primary Care Network (PCN) is a formal collaboration of local GP practices serving a defined population. Through the Network Contract Directed Enhanced Service, member practices work together to provide services that would be difficult to deliver consistently through individual practices alone. PCNs are usually led by a Clinical Director and PCN Manager and operate through an agreed governance structure between their member practices.

PCNs also employ or commission an extended multidisciplinary workforce through arrangements such as the Additional Roles Reimbursement Scheme. Depending on local need, this can include pharmacists, social prescribing link workers, care coordinators, health and wellbeing coaches, first-contact physiotherapists, paramedics, mental health practitioners and other clinical and non-clinical roles.

A PCN is therefore more than a grouping of practices, but it is not a complete Neighbourhood and should not be regarded as the organisation that owns or controls it.

**How does a PCN fit within a Neighbourhood?**

The PCN provides the organised general practice contribution to the wider Neighbourhood. It brings together the registered populations, clinical knowledge, workforce, relationships and delivery capacity of its member practices. This gives the PCN a detailed understanding of local health needs and an established connection with people throughout their lives.

PCN boundaries and natural communities will not always align perfectly. In some areas, a PCN may closely reflect a recognisable Neighbourhood. Elsewhere, a Neighbourhood may contain more than one PCN, or a PCN may work across communities with different identities, service patterns and needs. Geography, rurality, travel routes, access to services and existing relationships are therefore as important as population size when determining how the arrangement should work locally.

The PCN should consequently be understood as an important building block within the Neighbourhood rather than as a replacement for it.

**The contribution of PCNs**

The PCN is well placed to provide continuity between individual care and wider population-level planning. General practice holds long-term relationships with individuals and families, often from birth through to the end of life. It can therefore identify patterns of need that may not be visible to services that become involved only during a specific episode of illness or crisis.

Through its member practices and wider workforce, a PCN can:

- Identify people and communities who may benefit from earlier support.
- Coordinate proactive and personalised care.
- Support continuity for people with complex or multiple needs.
- Contribute clinical insight to Neighbourhood planning.
- Connect people with community, voluntary and preventative services.
- Use population data to identify variation, inequality and unmet need.
- Provide a practical route through which jointly agreed Neighbourhood priorities can be delivered.

The PCN also acts as an interface between individual General Practice and services working at a larger scale. It can translate Place, system and provider-led programmes into approaches that make sense locally, while ensuring that the experience and needs of the Neighbourhood are represented in wider planning.

**Leadership and accountability**

A PCN has identifiable leadership through its Clinical Director, PCN Manager, member practices and Network Agreement. This provides accountability for PCN services, staff and resources. It does not, however, give the PCN or its Clinical Director authority over all Neighbourhood partners.

Neighbourhood leadership should remain collaborative and relational. Depending on the issue, leadership may come from general practice, local government, community services, social care, the voluntary sector or local residents themselves. The role of the PCN is to participate fully in this shared leadership and to ensure that primary care is embedded within decision-making rather than being consulted only after priorities have been determined.

The Clinical Director/PCN Manager may be well placed to convene or support the Neighbourhood partnership, particularly where the PCN has established local relationships and population knowledge. However, this should be based on trust, capability and local agreement rather than an assumption that contractual responsibility for PCN services creates ownership of the wider Neighbourhood.

**Funding and resources**

PCNs receive specific NHS funding to deliver nationally and locally agreed primary care functions. This includes funding attached to the Network Contract and the employment or deployment of additional workforce roles. These resources can make an important contribution to Neighbourhood priorities, but they remain subject to their contractual requirements and cannot be treated as a general Neighbourhood budget.

Similarly, a PCN does not control resources held by community providers, local authorities, mental health services, acute trusts or voluntary organisations. Effective Neighbourhood

working therefore requires partners to align their existing resources around shared outcomes rather than concentrating all funding within one organisation.

Over time, commissioners may choose to delegate or pool additional resources at Neighbourhood level. Where this happens, governance should protect the equal contribution of partners, provide transparency about how decisions are made and avoid allowing the organisation holding the contract or funding to dominate the partnership.

**PCNs as a platform for delivery**

Within the model described in this paper, the PCN can provide an important delivery platform for Neighbourhood working. It offers an existing population footprint, clinical infrastructure, workforce and connection with almost every household through registered general practice.

Its greatest value is not in becoming another large-scale provider or managerial tier. Its value lies in combining the continuity and local knowledge of individual practices with the capacity to work collectively across a wider population.

The PCN should therefore:

- Retain and strengthen the identity and relationships of its member practices.
- Support shared working where this adds value.
- Connect primary care with the full range of Neighbourhood partners.
- Contribute workforce, data and clinical expertise.
- Help turn jointly agreed priorities into practical local delivery.
- Represent the needs of its population in Place and system-level discussions.

The PCN is neither the whole Neighbourhood nor simply another provider operating within it. It is the organised primary care component of the Neighbourhood: rooted in local communities, connected to individual citizens and capable of helping partners move from discussion and coordination towards sustained delivery.