South East London Integrated Care System

NHS South East London

Building a strong Neighbourhood Team

Our approach and principles to workforce governance and supporting neighbourhood teams in South East London

Developed in partnership with colleagues from our system partners, across our South East London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

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Introduction

Building and sustaining strong and effective Neighbourhood Teams requires a workforce that is supported, has clear structures and efficient processes. To enable development of teams, this document provides some core principles, key actions and links to resources.

The current landscape is complex, with different areas and organisations at varying stages of developing and rolling out neighbourhood care to best serve their priority population groups. Over time, the intention is that the pathways, services and teams involved in neighbourhood care will develop, evolve and grow.

Definitions

Neighbourhood working – this reflects a significant transformation of how our system will operate together. It brings Primary and Community Care closer together, and is a more place-based approach to how services are organised.

Integrated neighbourhood teams (INTs) - these are teams designed to meet the holistic needs of their local population, based in the neighbourhood and drawn from a range of partners across the community. It is to ensure people get the right care, at the right time, in the right place, from the right people, first time and to tackle health inequalities.

Integrators – this denotes the partnership arrangements at Place, which help to govern and drive neighbourhood working at a Borough level. Integrators are not replacements for place-based care partnerships but rather seek to provide the core infrastructure to support effective integrated neighbourhood team working as it develops, ensuring services are tailored to meet local community needs and operate smoothly across organisational boundaries. Each integrator will have a 'health host' which is the NHS provider.

How to use this document

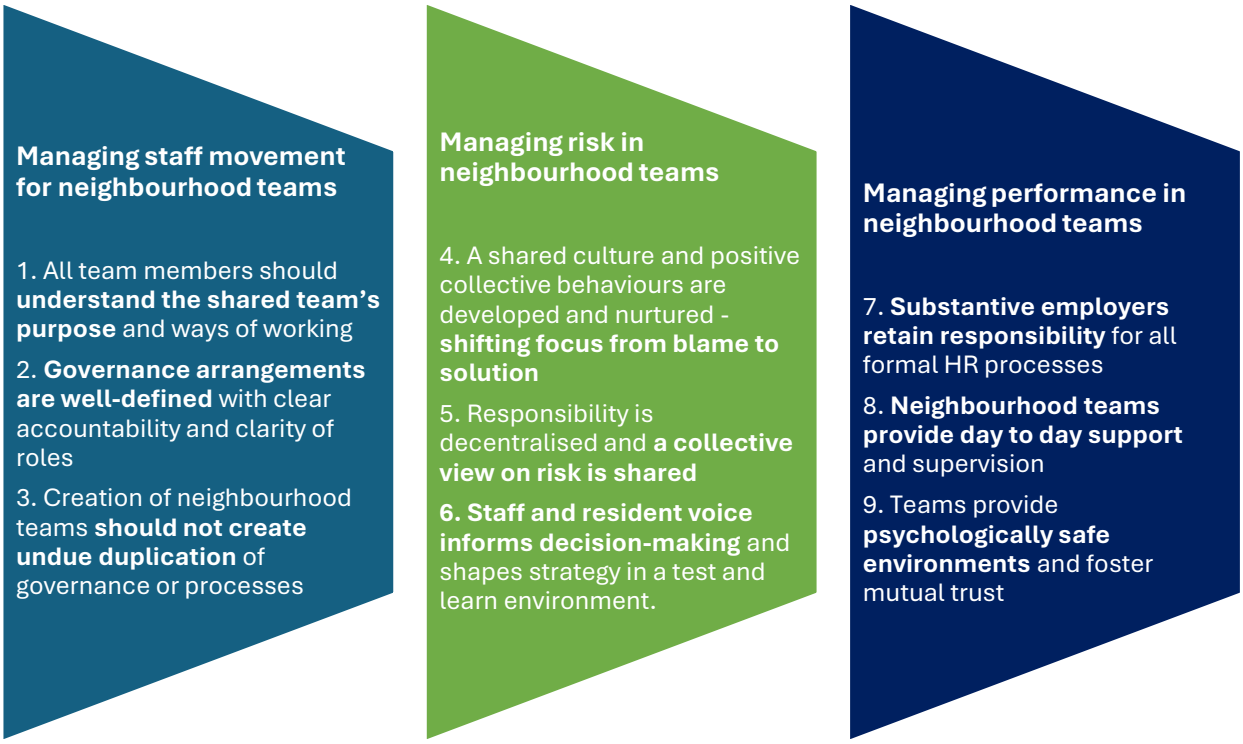
This document is designed for those leading, managing and working in neighbourhood teams. It is broken down the key areas into three sections

1. Managing **staff movement** for neighbourhood teams
2. Managing **risk** in neighbourhood teams and;
3. Managing **performance** in neighbourhood teams.

As neighbourhood teams are at varying stages of development, some sections may be more relevant than others. The intention is that the information supports local considerations and is used alongside national guidance and plans.

Guiding principles

Through our engagement, a set of principles have emerged as being key to building a strong neighbourhood team and supporting governance. This isn't an exhaustive list but is sharing a consensus opinion in the SEL system. It is not professional, legal or mandatory guidance. More detail and some resources relating to these principles is provided in each of the relevant sections.



1. Managing staff movement for neighbourhood teams

As neighbourhood teams are being set up, developing and expanding, it a likely there will be an increase in staff working across traditional organisational boundaries. To ensure this is done well, organisations contributing to INTs should ensure that mechanisms to manage governance and risk are appropriate. The principles below set out the key considerations when setting up a neighbourhood team.

The below assumes that the agreements and contracts relating to neighbourhood and integrated working are established and focuses specifically on workforce considerations including clinical governance and risk management, not commissioning decisions.

Core principles

Managing staff movement for neighbourhood teams

1. All team members should **understand the shared team's purpose** and ways of working
2. **Governance arrangements are well-defined** with clear accountability and clarity of roles
3. Creation of neighbourhood teams **should not create undue duplication** of governance or processes

Consider this

- ✓ Create and provide a neighbourhood-team-specific induction that complements each organisation's standard induction – including team purpose, governance, communication pathways and ways of working.
- ✓ Map governance responsibilities and confirm where liability sits.
- ✓ Identify how, where and when issues regarding staff movement and governance will be raised and discussed.
- ✓ Assess options to enable staff movement across organisations – selecting the appropriate mechanism for team members to use.
- ✓ Agree how expertise from across our organisations will be shared within the team and with residents.

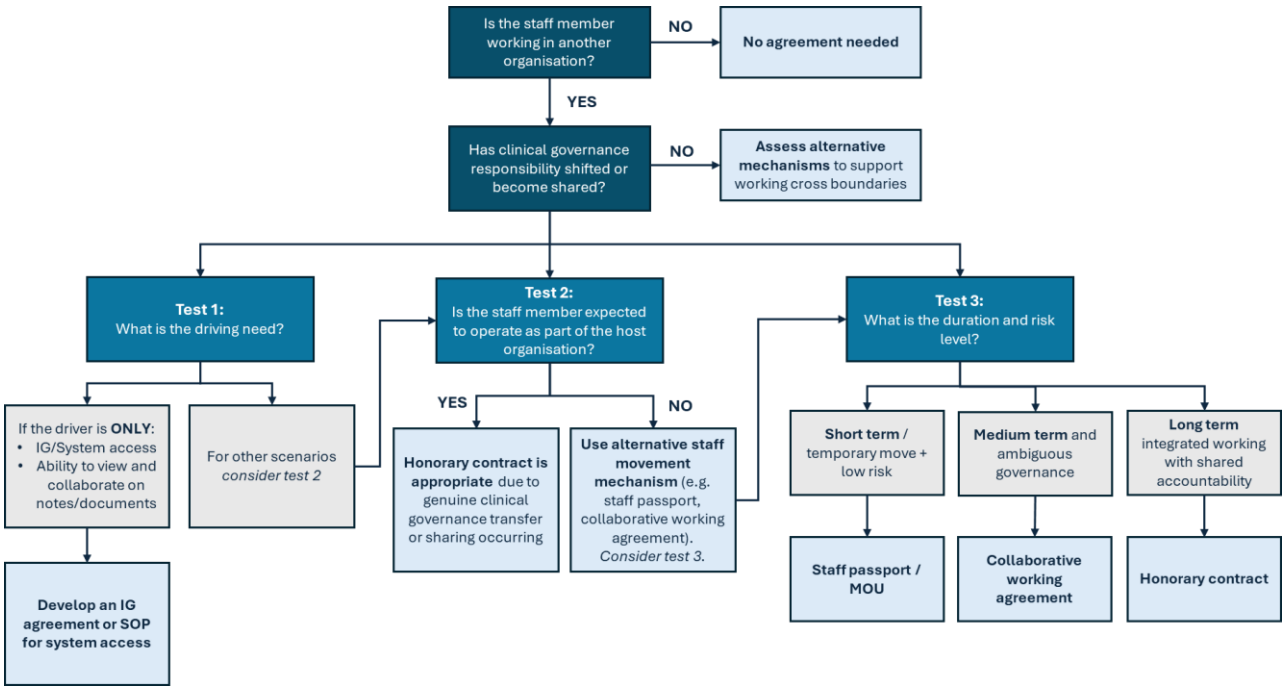
Working across organisational boundaries

To build successful INTs, staff may need to work in different organisations, settings and premises. Also staff may require access to a range of IT systems.

Across SEL, a range of mechanisms are currently used to support and enable staff to work across organisational boundaries. Examples of these are honorary contracts, secondment agreements, SLAs, dual employment, and local workarounds. There is often significant administrative burden associated with setting up these agreements.

Honorary contracts shouldn't be assumed as the default. This is especially important for PCN/federation staffing models that already have clear accountability. They should only be used where governance responsibility is shared or transferred. There are numerous examples of staff working across organisations without the need for honorary contracts.

There are a host of arrangements and existing tools that can aid the movement between organisations. The decision tree below, helps you to work through what each of these are and when you may want to use them.



Explaining terms used:

- **Host organisation** – this denotes the organisation in which the employee is working within or providing services. This may differ from the **employing organisation** (that is the organisation in which the employee's contract of employment is held).
- **IG** – abbreviated term for information governance.
- **Staff passport/MOU** – this denotes the different agreements in place between organisations, which can help with staff working into different organisations, without need for a separate agreement. MOU is the abbreviation for memorandum of understanding.
- **Collaborative working agreement** – this denotes an agreement which is drawn up between involved organisations and parties, setting out expectations of each party for the duration of the working relationship.
- **Honorary contract** – this is a formal, unpaid agreement between an organisation and an individual, allowing them to work, research, or train without being directly employed by said organisation. It usually ensures legal liability coverage, defines responsibilities, and ensures compliance with policies.

Bringing this to life – example scenarios

Scenario 1 – Mariam's story: Integrated working within existing governance

Mariam, a PCN-employed First Contact Physio, works across three GP practices as part of the Integrated Neighbourhood Team. She runs MSK clinics, joins MDT discussions, and uses practice systems.

Although she moves between multiple organisations, her employment, supervision and clinical governance all sit with the PCN. The GP practices simply host her clinics and provide access to systems, via IG agreements and other existing processes.

A quick governance review confirmed that this arrangement is fully covered by the PCN DES, with no transfer of clinical accountability to the practices. Therefore, no honorary contract is required.

Clear communication and consistent induction across practices were put in place, enabling Mariam to work fluidly and safely without additional bureaucracy.

Scenario 2 – Sasha's story: Neighbourhood mobility with a collaborative working agreement

> *Sasha, a Mental Health Practitioner employed by the Mental Health Trust, and supporting several practices through ARRS funding. Initially, she worked entirely under trust governance.*
>
> *As the INT matured, Sasha was asked to deliver joint consultations, contribute to neighbourhood safety planning (e.g. risk mitigation for individual cases), and support neighbourhood-level audits. These activities meant she was increasingly acting within neighbourhood clinical workflows, not just alongside them.*
>
> *A governance review identified that while most of her work still belonged under the trust's governance, the new integrated activities involved shared decision-making and host-led processes.*
>
> *To reflect this, the neighbourhood introduced a collaborative working agreement, setting out clear expectations from all parties, covering the elements where Sasha operates under neighbourhood governance.*
>
> *This enabled greater integration and clarity while avoiding unnecessary or blanket contractual requirements.*

Further information and resources

The following pages provide selected information and resources to help with the suggested actions. A list of the information provided with links is below.

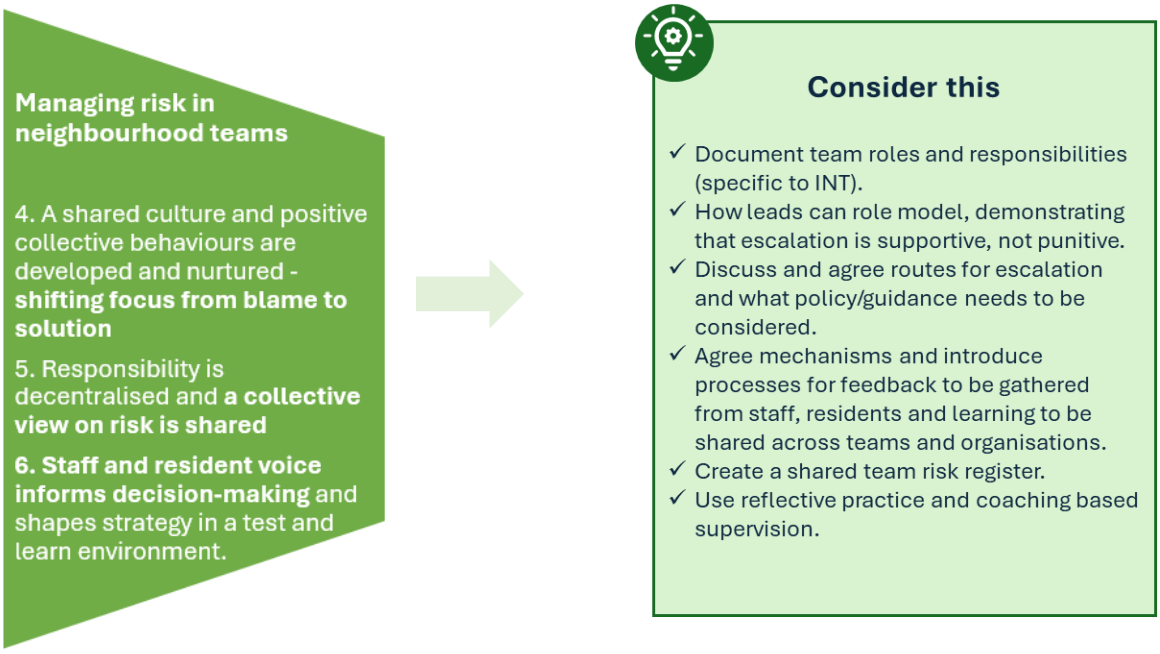
- Existing staff movement agreements - here
- National guidance on contractual mechanisms – here
- NHSE 'enabling staff movement' toolkit - here

2. Managing risk in neighbourhood teams

As neighbourhood teams develop, effective people management becomes central to building the culture, relationships and shared ways of working that enable teams to function well and for individuals to flourish. However, managing risk in this environment can become increasingly complex.

The following principles outline the core principles for managing risk whilst working in INTs and points to consider.

Core principles



Developing team culture and shared sense of purpose

Developing a collaborative culture and a shared sense of purpose for your team is a crucial step in helping to minimise potential risk. It ensures team members are clear on the expectations on them. When doing this, it's important to think about:

Incorporating Culture & Purpose into Job Descriptions (JDs)	• Explicitly reference values and ways of working (e.g., collaboration, person-centered care, population health focus, neighbourhood problem-solving) • Include shared responsibilities across professions such as multidisciplinary decision-making, information sharing, and joint accountability for outcomes • Describe expected behaviours (not just tasks) such as proactive communication, mutual respect,

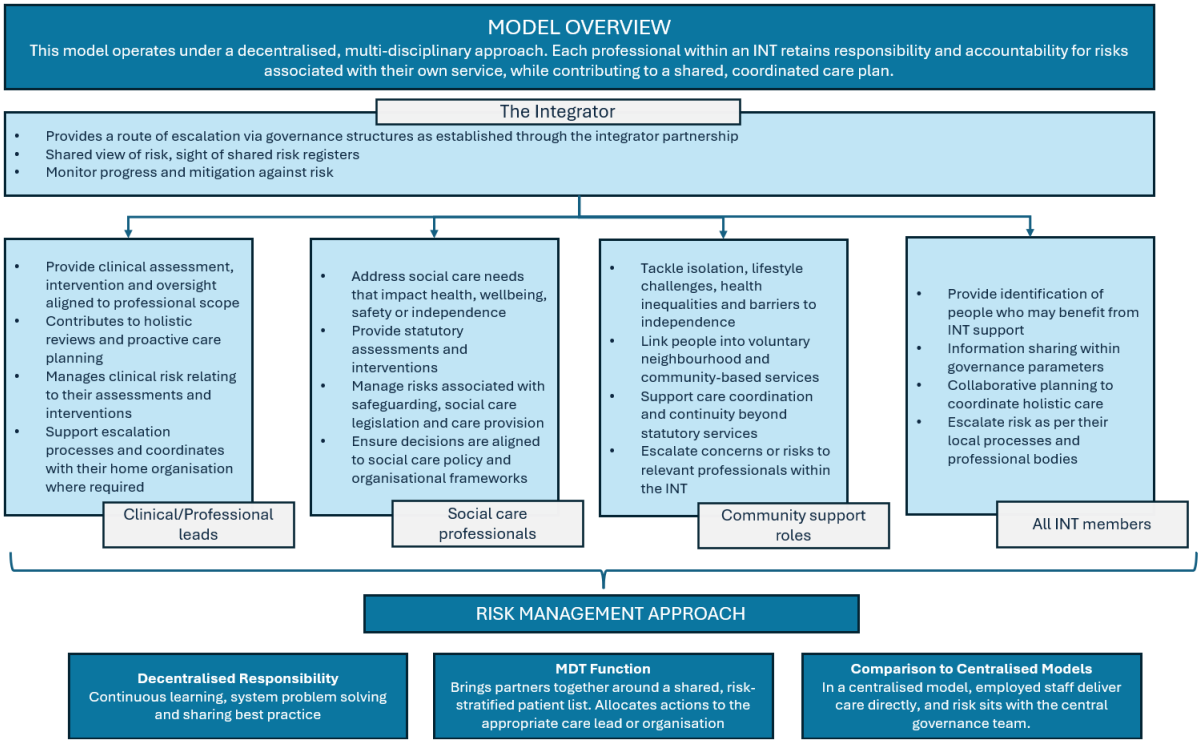
		learning mindset, and commitment to integrated working.
Delivering a Good Induction		• Provide a clear narrative of the INT's purpose and model, including local priorities, partner organisations, and how each role contributes. • Introduce team culture intentionally, e.g. shared norms, communication expectations, meeting structure, how decisions are made, and escalation routes. • Offer early relationship-building via shadowing, cross-professional introductions, buddy systems, and time with key operational leads.
Running Effective Team Meetings		• Use a consistent structure (purpose-led agenda, rota of leads, shared actions log) to reinforce culture and predictability. • Balance operational updates with reflective practice, case discussions, and space for learning or raising system issues. • Celebrate successes and shared wins to strengthen identity, motivation, and collective ownership of outcomes.

Managing risk

A key challenge for any INT is managing risk. By bringing together professionals from across health, social care, and the voluntary and community sector, the model below enables shared understanding, early identification of concerns, and timely joint interventions.

A core aim of this model is to support consistent and transparent governance and risk management at INT level. It clarifies how risks are identified, discussed, and escalated within the team, while ensuring that each professional retains responsibility and accountability in line with their organisational frameworks.

This model has been adapted from the Bexley Ageing Well / Frailty Model.



Supporting individual risk management in neighbourhood working

In neighbourhood models of care, where responsibilities are shared across organisational boundaries, there is an increasing need for individual practitioners to actively manage risk within their own scope of practice, rather than relying solely on organisational systems. One practical approach is for prescribers and clinicians to maintain a personal or team-based risk register linked to their clinical activity. This is not intended to replace organisational governance processes, but to complement them by ensuring risks are identified and acted on in real time.

This may include:

- Identifying key hazards within scope of practice (e.g. high-risk medicines, monitoring requirements, transfer of care points)
- Considering likelihood and consequence to prioritise risks
- Recording current mitigations (e.g. shared records, MDT oversight)
- Defining achievable additional actions to reduce risk
- Reviewing and updating their own risks as care pathways evolve

Embedding this approach supports a shift towards proactive, practitioner-led risk management, enabling individuals to recognise and mitigate risks early, particularly in complex, multi-professional environments.

Establishing roles and responsibilities

In any complex working structure, it is important to be clear on roles and responsibilities for different tasks. **The RACI model** is a straightforward tool used for identifying roles and responsibilities and the time taken to undertake each activity.

Responsible	Accountable
The person who does the work to achieve the task. They have responsibility for getting the work done or decision made. As a rule this is one person.	The person who is accountable for the completion of the task. This must be one person and is often the project executive or project sponsor.
Consulted	**Informed**
The people who provide information for the project and with whom there is two way communication. This is usually several people.	The people kept informed of progress and with whom there is one way communication. These are people that are affected by the outcome of the tasks, so need to be kept up-to-date.

This can support the day to day running of your INT in the following:

- Clarifying roles across multi-agency partners, ensuring everyone knows who is responsible, accountable, consulted and informed on a decision
- Improve team coordination – for example, outlining who is responsible for case identification, MDT preparation, chairing, recording actions and following up
- Support planning, reducing duplication and delays when working across organisational boundaries
- Enhance communication, provides shared language and consistency regarding processes

'Nothing about you, without you' – involving residents in decision making

The 'Nothing about you, without you' approach means that data sharing is de-risked by ensuring residents are directly involved in every conversation about them. Coordinators would seek explicit permission before sharing information with any additional partners who may support the resident (such as a health visitors, social workers, clinicians, or any other relevant community asset). In order to work, it's important that:

- Frontline staff have access to timely support, such as the ability to contact a duty doctor or a named on-call contact
- Flexible systems and a culture of trust that enable staff to escalate concerns appropriately.
- Consistent, open, and reliable communication channels to ensure information flows effectively and support is readily available.

Bringing this to life – example scenarios

Scenario 3 – Mrs Patel's story: managing risk in ageing well

Mrs Patel, an 82-year-old living alone, is identified through the Ageing Well / Frailty Hub process as someone showing signs of increasing frailty. Recent missed appointments, a minor fall, and concerns from neighbours trigger a proactive review by the Integrated Neighbourhood Team (INT).

Primary Care notes medication non-adherence and a potential deterioration in cognition. Community Nursing highlights a slow-healing wound and reduced mobility. Social Care identifies possible self-neglect and a need to review care support. Ageing Well / Community Support notices that Mrs Patel has withdrawn from social groups, raising wellbeing concerns.

At the weekly team meeting, the team shares information and builds a shared understanding of Mrs Patel's risks while each professional maintains accountability within their own governance framework. They agree a coordinated plan:

- *GP home medication review and simplified regimen*
- *Community nurse wound care and falls assessment*
- *Social care reassessment to reinstate daily support*
- *Ageing Well Navigator reconnecting Mrs Patel with community activities and befriending services*

Within weeks, Mrs Patel's wounds heal, her mobility stabilises, and she reconnects socially. Risks reduce significantly, and she remains on the INT's proactive list for ongoing monitoring.

Scenario 4 – Mr Thompson's story: resident led risk management

Mr Thompson, a 76-year-old resident with three long-term conditions contacts his Care Coordinator early one morning. He is highly distressed, and reports that he has not taken his medications for two days due to feeling overwhelmed and confused by his regimen. He also mentions new swelling in his legs and that he has barely eaten. Recognising the urgency, the Care Coordinator reassures Mr Thompson that they can reach him within 20 minutes. They then phoned the duty GP and their line manager and informing them that they was going to see the resident.

On arrival, the Care Coordinator assesses the situation, noticing a cluttered environment, and signs that Mr Thompson is struggling to manage his self-care. Together they have a conversation and come up with a plan. With Mr Thompson's consent, the Care Coordinator calls the relevant members of the INT team.

As a result, the district nurse (whom Mr Thompson knows well) manages to conduct a same-day home visit and checks Mr Thompson's observations. The duty GP follows up that afternoon with a full clinical review, adjusts his medications, and arranges urgent blood tests. Given concerns about declining functional ability, the social care practitioner also agrees to carry out a home visit the next morning to explore support needs.

The Care Coordinator debriefed with their line manager the same day and calls Mr Thompson the next morning to ensure he was okay and understood the plan.

This scenario reflects the importance of high-trust and highly supportive environments. Strong relationships and communications between INT members enable co-ordinated intervention and ensures the Care Coordinator can remain safe and confident in managing risk within their role.

Scenario 5 – Alex's story: developing a risk-based approach to prescribing

Alex, a clinical pharmacist working within the Integrated Neighbourhood Team (INT), reflects on several recent cases where responsibility for aspects of care had been unclear. These included missed blood monitoring for high-risk medicines, duplication of medication reviews, and uncertainty during transfer of care following hospital discharge.

Although no harm had occurred, Alex recognises a pattern of risk linked to working across organisational boundaries. As part of their reflective practice, they decide to take a more structured approach to identifying and managing these risks within their prescribing role.

Alex develops a simple risk matrix, outlining common hazards within their scope of practice, including high-risk medicines, monitoring requirements, and transfer of care points. For each, they consider likelihood and consequence, identify existing mitigations (such as shared records and MDT discussions), and define additional actions to reduce risk.

This leads to practical changes in their day-to-day practice. For example, Alex routinely confirms and documents responsibility for monitoring when initiating or reviewing high-risk medicines, and proactively raises potential gaps during MDT discussions. They also begin sharing their approach with colleagues, encouraging a more consistent way of thinking about risk across the team.

Further information and resources

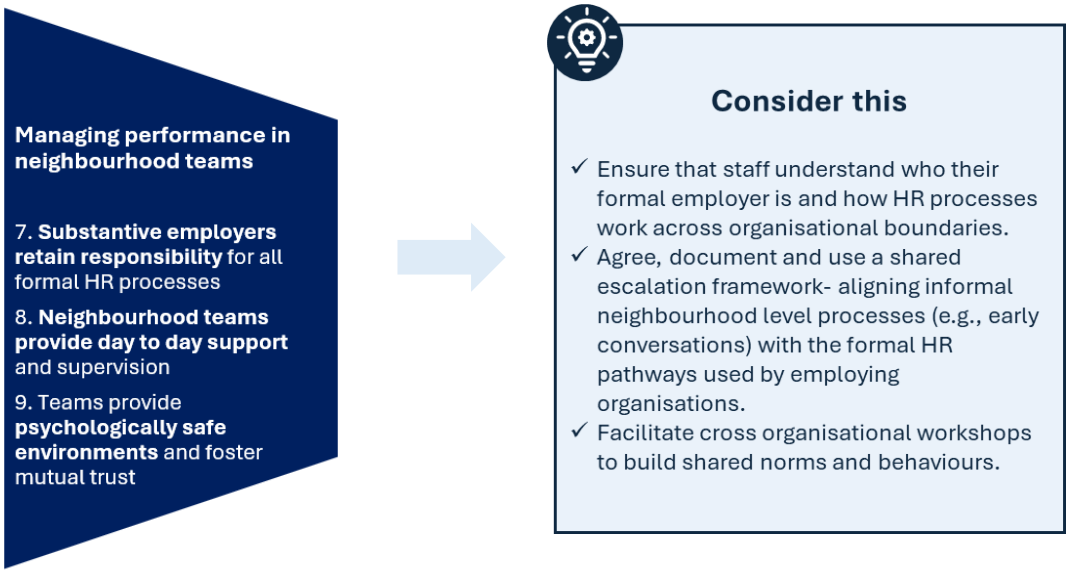
- NHSE assessing and managing risks across ICS - here
- NHSE RACI model template - here
- NHSE introduction to system workforce planning – here

3. Managing performance in neighbourhood teams

Managing performance of individuals working in neighbourhood teams requires a clear and coordinated approach between substantive employers and the members of the INT providing day-to-day supervision, support and oversight. High performing teams lead to overall better outcomes for staff and residents.

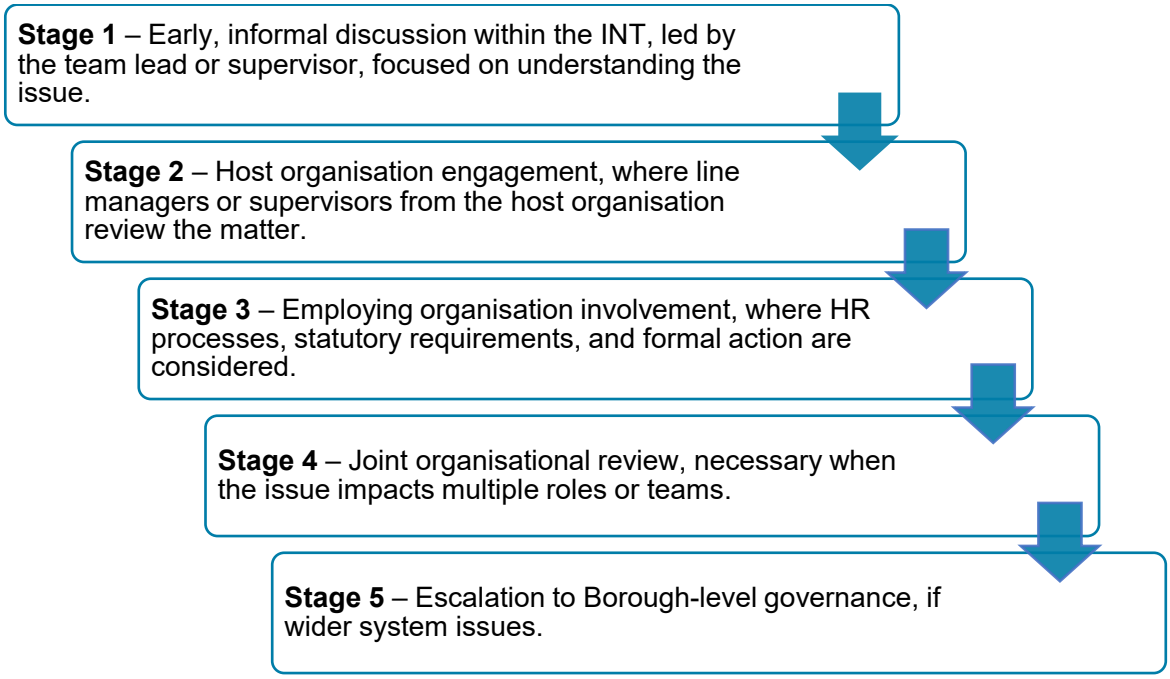
The below sets out the principles and actions that support early, constructive conversations; maintain organisational responsibilities; and enable safe, confident escalation where needed.

Core principles



Escalation pathway

Whilst neighbourhood working provides an opportunity for us to optimise our collective strengths, in situations where performance challenges emerge, it's important to ensure that this is caught and communicated early, and a supportive conversation takes place to resolve. However in the case this should be escalated, we recommend the following staged process:



Supporting and developing staff through supervision

- The **INT team lead** should manage day-to-day supervision, early performance conversations, and support for improvement.
- The **employing organisation** retains responsibility for formal HR actions, legal processes, capability procedures, and documentation.
- **Host organisation** where necessary should share timely info, to ensure informed decisions are made.
- **Joint meetings** between the organisations contributing staff to the INT should occur for any issue that may progress beyond informal management.

Bringing this to life – example scenarios

Scenario 6 – Sam's story: Managing performance

Sam is an INT Team Lead begins to notice concerns about one of their team members who works day-to-day within the INT but is employed by a partner organisation. Over several weeks, the Sam has observed a pattern of missed follow-ups, inconsistent documentation, and an overall reduction in output from this team member. Although this team member is not employed by Sam's organisation, these issues are affecting the quality of service delivery for the INT.

Sam arranges an early and supportive conversation with the team member, exploring workload, expectations, and any barriers. The discussion is documented, and with the team member's knowledge and agreement, Sam contacts the line manager in the employing organisation to share discussion outputs transparently.

A joint meeting is arranged between all parties and together, they agree a shared improvement plan: clearer expectations, protected time for documentation, buddying with an experienced colleague, and regular check-ins led by Sam but monitored jointly

by both organisations. This allows the Sam to oversee day-to-day improvement while the employing organisation retains ownership of any formal processes.

With structured support and clarity on expectations, Sam makes the required improvements and returns to full performance. A final joint review closes the process, confirming ongoing supervision arrangements and a shared understanding of escalation routes.

Through transparency and clear roles and responsibilities from Sam (operational oversight) and the employing organisation (HR and contractual processes), all are able to support individual and team performance in an effective way.

Further information and resources

- NHS Employers toolkit for people performance management (co-developed by NHS Employers and Skills for Care) - here

4. Further resources

Existing staff movement agreements

Below provides an overview of existing cross-Borough staff movement agreements and mechanisms.

Name	Description	Organisations covered	Further information
London Staff Movement Agreement	The London Staff Movement Agreement (LSMA) was devised to allow NHS staff to work at different hospitals across the region.	It is intended for any NHS organisation based in any London borough, any ICS and other participating bodies involved in the provision of healthcare services.	This agreement is annex D - www.england.nhs.uk/wp-content/uploads/2019/08/PRN01565v-annex-d-london-staff-movement-agreement.docx.
Kings Health Partners – honorary passport	Enables all current members of staff to work at another King's Health Partners Founder organisation without having to go through pre-employment checks with the host employer, provided the duties being performed are similar. It is an honorary arrangement between the staff member's primary employer and the host organisation.	- King's College London - Guy's and St Thomas' NHS Foundation Trust - King's College Hospital NHS Foundation Trust - South London and the Maudsley NHS Foundation Trust May apply to clinical and non-clinical duties, including staff who provide care to patients or services to departments.	www.kingshealthpartners.org/get-involved/staff-and-student-benefits/khp-honorary-passport
Honorary contracts	Honorary contracts are used to enable staff movement across organisations.	An honorary contract can be used for individuals coming for a period of work, research or training at an organisation, but will be paid directly by another organisation.	www.nhsemployers.org/articles/honorary-contract-template#:~:text=An%20honorary%20contract%20can%20be,paid%20directly%20by%20the%20organisation.

Guidance, reports and links

The table below provides a range of links to relevant guidance for those involved in setting up and managing neighbourhood teams have found beneficial.

Type	Description	Link
Guidance		
NHSE London workforce guidance – May 2025	Guidance on developing neighbourhood teams.	www.england.nhs.uk/london/our-work/a-neighbourhood-health-service-for-london/a-neighbourhood-health-service-for-london/the-structure-of-the-operating-model/workforce-developing-our-teams/
DHSC Neighbourhood health framework	Policy Paper setting out details relating to neighbourhood health.	Neighbourhood health framework - GOV.UK
NHSE - Fit for the future: towards population health delivery models	Sets out new population health delivery models to facilitate this change, supporting ICBs to commission providers around the needs of defined populations.	NHS England » Fit for the future: towards population health delivery models
SEL ICS guidance on primary/ secondary care interface	Guidance on improving the primary/ secondary care interface. Includes a variety of links e.g. to a SEL ICB consensus document.	www.selondonics.org/icb/healthcare-professionals/connected-primary-secondary-care-interface/
NHSE - Principles for assessing and managing risks across integrated care systems	Sets out key principles to use when assessing risks in environments or scenarios that are rapidly changing or based on multiple factors (e.g. multiple services/organisations involved).	www.england.nhs.uk/long-read/principles-for-assessing-and-managing-risks-across-integrated-care-systems/
NHSE WTE Workforce planning guidance	The three-phase methodology is a practical application of the approach to system workforce planning.	System workforce planning guidance NHSE WTE Workforce planning guidance
Reports		
London Neighbourhood Health simulation report	Report summarising the approach, experience, insights and recommendations for Implementing neighbourhood health across London and the rest of England.	The-London-Neighbourhood-Health-simulation-learning-report.pdf
Community of practice		
Neighbourhood health network – Community of Practice	Part of the National Neighbourhood Health Implementation Programme (NNHIP). This Community of Practice will be central to accelerating the spread and scale of neighbourhood health.	Join the Neighbourhood Health Network Community of Practice – Fill in form Neighbourhood Health - Home

Glossary of terms

Term	Definition
ARRS Roles	Additional Roles Reimbursement Scheme posts funded to expand multidisciplinary teams in primary care.
BCF – Better Care Fund	A pooled NHS/local-authority funding mechanism for integrated community-based services.
Clinical Governance	The framework ensuring quality, safety and standards in clinical practice.
Escalation Pathway	A structured process for raising and managing performance or safety concerns across organisations.
Federation	A provider organisation that may employ staff on behalf of multiple PCNs and deploy them across practices.
Governance	Structures, processes and responsibilities that ensure safe, effective and accountable decision-making.
Honorary Contract	An agreement allowing staff to work in another organisation without transferring employment.
HWB – Health and Wellbeing Board	A statutory local partnership responsible for joint health and care planning, including developing Neighbourhood Health Plans. [
IHO – Integrated Health Organisation	A provider holding a population-level budget to plan and deliver integrated care across a wider geography.
INT (Integrated Neighbourhood Team)	A team model bringing together health, care and community partners to coordinate support around neighbourhood populations.
MNP – Multi-Neighbourhood Provider	A provider coordinating consistent delivery of neighbourhood services across multiple neighbourhoods.
Neighbourhood Health Centre (NHC)	A local hub bringing together GP, community, local authority and VCSE services to provide joined-up neighbourhood care.
Neighbourhood Team	A multi-disciplinary group working across organisational boundaries to deliver integrated care within a defined local area.
NP – Single Neighbourhood Provider	A provider commissioned to deliver neighbourhood-level services for a defined population, working through integrated neighbourhood teams.
PCN (Primary Care Network)	A group of general practices working together with partners to deliver primary care services at neighbourhood scale.
Staff Movement Agreements	Mechanisms enabling staff to work across multiple organisations, such as honorary contracts or secondments.