Leading research to shape a stronger, fairer future with our health and care staff

What does a "good" workforce look like in neighbourhood health?

Learning from two workshops with the London Deep End group and Workforce Voices partnership in Newcastle

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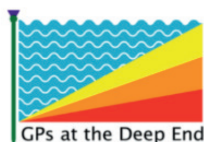
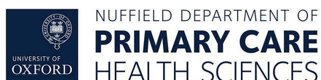




Introduction

What is the Workforce Voices Research Partnership?

Workforce Voices is a National Institute for Health and Care Research (NIHR) Health Services and Delivery Research (HSDR) workforce research partnership. The partnership works between universities and healthcare organisations to find ways to improve the working experience of different groups in the NHS. This includes the general practice setting, as well as the primary-secondary care interface and maternity services.

Workforce Voices aim to listen to and learn from the workforce experiences, building ways to improve working lives, careers and health and care services. We do this based on principles of collaboration to identify and develop improvements together.

In February 2026, Workforce Voices convened two complementary learning events focused on neighbourhood health and workforce sustainability in under-served areas: one with the London Deep End[1] group [1,2] and one in Newcastle with regional partners [3]. Both events explored how neighbourhood working can better support the NHS workforce serving communities experiencing longstanding inequity and deprivation. A diverse group of individuals attended the event to generate practice ideas and shared learning. These included representatives from: academia, primary care, Integrated Care Boards (ICB), local authorities and patient and public communities. Attendees reported feeling "connected" and valued sharing diversity of thought amongst a range of colleagues.

[1] 'Deep End' groups bring together primary care professionals working in areas of socioeconomic deprivation to share learning and advocate for health equity.

What We Did

The two events were held in different settings and shaped by distinct local contexts. However, we explored what this meant for the groups:

Each event generated rich discussion through creative exercises, facilitating dialogues between clinicians, non-clinical staff, managers, academics, and community representatives. Despite differences in geography and emphasis, the themes that emerged were complementary.

This report synthesises the learning from both events. It identifies shared principles, cross-cutting themes and practical policy implications. These have broad relevance for system leaders, commissioners, researchers, and Deep End colleagues working to strengthen neighbourhood health in under-served communities.

Together, these events made clear that neighbourhood health will only succeed if relationships, learning, and workforce sustainability are treated as core infrastructure, not optional extras [4].

In the spirit of reciprocity, this report is intended to feed-forward a summary of the discussions, to support and inform future work, conversations and learning across and beyond these groups. This document provides a summary of the learning and notable differences between the London Deep End and Newcastle events.

Opposite: Thought cloud reflecting some of the discussions during the workshops

Wondering

collaborative

empowered

inspiring

curious

Connected

interested

invigorated

connecting

thoughtful

fun

interesting

energising

inspired

enlightened

hope

enthusiastic

insightful

enjoyable

energised

solidarity

collective

Summary of Learning

The events identified a number of shared themes:

1. **Neighbourhoods are relational spaces**
   "Neighbourhood" is experienced as conversational, negotiated and locally-defined rather than a fixed organisational unit. Community ownership and locally defined priorities were preferred over top-down configurations. Neighbourhoods should build on and strengthen existing relational expertise within general practice and collaborating organisations.

2. **Open, welcoming, community-embedded workforce**
   Teams should be physically and psychologically accessible, acting as outward-facing "beacons" within their communities. This includes flexible or mobile models, restorative environments (for the workforce and its local populations), and simple points of contact that reduce barriers and accommodate diverse local needs.

3. **Flattened hierarchies and distributed leadership**
   Transparent leadership and shared decision-making were seen as essential. Recognising frontline leadership including reception and administrative staff, third sector organisations and community groups can strengthen responsiveness and may reduce moral injury.

4. **Learning everywhere, for everyone: practical, interprofessional and bi-directional**
   Learning was understood as embedded within everyday practice rather than confined to formal education settings (e.g. classrooms). Learning can occur within consultations, community settings, protected workplace reflection time, and service-learning models embracing reflexive conversations.

   Communities are seen as active partners in neighbourhood health. Professionals should learn through funded, protected time, from community knowledge and lived experience just as communities benefit from professional expertise. ***Learning, therefore, is reciprocal and relational.***

5. **Boundary work needs formal recognition and system supports**
   Boundary-spanning activity including cross-organisational coordination, interface management, and collaborative problem-solving was recognised as essential to neighbourhood health but frequently invisible and under-resourced.

   Discussions identified the need for structural enablers such as shared or pooled budgets, interoperable records, agreed escalation protocols, formal collaboration agreements, protected time to connect across the interface and job descriptions that explicitly include spaces for dynamic evolution of boundary work.

6. **Trust and psychological safety are core infrastructure**

   Relational continuity, local knowledge, and protected space for reflection were repeatedly described as foundational infrastructure – as critical as physical buildings or funding streams.

   Psychological safety and trust were seen not as optional cultural features, but as prerequisites for sustainable collaboration and a thriving workforce.

7. **Protect non-clinical staff from risk, blame and overload**

   Reception and administrative staff were identified as central to access, continuity, and patient experience, yet frequently exposed to disproportionate risk without corresponding authority or recognition. This imbalance if unsupported, can contribute to moral injury and high turnover.

   Some individuals called for explicit protections, including clear governance frameworks, defined escalation pathways, embedded training and debriefing, and equitable resourcing across neighbourhoods.

8. **Small experiments, "trojan mouse" approaches and learning together**

   There was a clear preference for iterative, locally driven innovation rather than single, large-scale system solutions.

   Mechanisms such as story capture, shared repositories of learning, and inter-practice exchange were seen as important for spreading innovation without imposing uniformity.

9. **Metrics need to capture relational value and speak funders' language**

   Attendees expressed frustration with reductive performance metrics which often alienate the workforce by valuing bureaucratic data entry over meaningful patient care. There was also recognition that funding decisions rely on measurable outcomes. The challenge is to ensure that selected metrics are relevant and purposeful in supporting groups to make a difference: to making them locally generated and aligned with relational and community-centred practice.

   This includes translating lived experience stories, moral moments, and relational impact into evidence frameworks that retain meaning while supporting meaningful system accountability requirements.

Notable differences between events

While the two events were closely aligned in their core messages, each brought distinct emphasis shaped by context and format.

The Newcastle Workforce Voices event, foregrounded physical and environmental metaphors to describe neighbourhood health. Workforce Voices partners used Lego to represent open doors, ladders, gardens, and restorative spaces to articulate accessibility, uplift, and sustainability. The discussion also generated explicit support including clear governance structures and the formal recognition of boundary work.

In contrast, the London Deep End event placed stronger emphasis on workforce moral injury, solidarity, and the lived experience of working in contexts of deprivation. Discussions highlighted the emotional and ethical pressures faced by staff and gave prominence to concrete, small-scale "trojan mouse" initiatives [5], including examples from practice such as proactive COPD winter care reviews, smear outreach projects, greener practice initiatives, and receptionist retention interventions. The Deep End conversation articulated a clear, detailed set of next steps, including six priority actions for workforce sustainability.

Taken together, the two events are complementary. Together, they propose the rationale and practical foundations needed for a "good" workforce and for implementing relational neighbourhood health in under-served areas.

The synthesis above highlights the shared themes that emerged across the events. Individual reports that capture the nuance and diversity of perspectives from each gathering can be found here :

'Report 1 Connecting, sharing and celebrating: a landmark celebration of the London Deep End community coming together in-person, for the first time, in partnership with Workforce Voices'

DOI https://dx.doi.org/10.5287/ora-vgxemoyy9

'Report 2: Workforce Voices Newcastle learning event. Neighbourhood Health and Workforce Development session' to the Oxford University Research Archive (ORA).

DOI https://dx.doi.org/10.5287/ora-mvmpdvjvd

Above: Attendees at the Deep End London event

Opposite: Lego activity at the Newcastle learning event

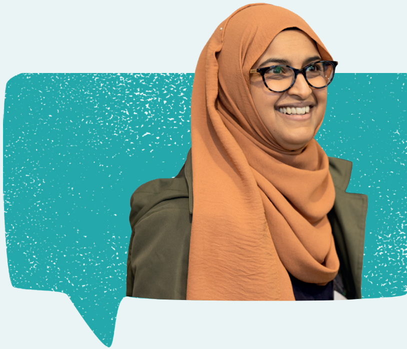
Key Recommendations: What does 'good' look like?

What we heard in our learning events really brought to life that neighbourhood health is a lived experience and may change from one person to the next, making it difficult to define. However, together we explored what this could look like, posing the question 'what does a "good" workforce look like in neighbourhood health to service its local populations?. The groups distilled several clear recommendations for neighbourhood health, that are shaped by the unique challenges of the NHS workforce serving our most deprived communities. These are outlined below in Table 1.

Table 1. Key recommendations for neighbourhood health from the front line

Neighbourhoods as relational, not just structural	NHS and local authority partners should co-create neighbourhood definitions with frontline staff and residents, recognising existing strengths, informal labour and relational work that are sustaining care but are invisible to funding and metrics.
Move away from seeking single, system-wide solutions	Reject the pursuit of a singular, "one-size-fits-all" solution for neighbourhood health. Instead, the system should fund and encourage "Trojan Mouse" approaches e.g. small, low-risk, creative interventions that allow practices to learn iteratively. Encourage incremental change and rapid learning. Focusing on marginal gains (e.g., local housing drop-ins, providing access to crisis funds) empowers patients through cumulative change while easing the daily operational strain on staff by reducing acute crises and administrative bottlenecks.
Co-design meaningful metrics for highly complex care	Move away from standardised metrics that generate "failure demand" and inappropriate interventions. Funders and frontline teams should co-produce a new valuation framework that translates stories, relational work and moral moments into recognised evidence. This will ensure that the essential labour of Deep End practice is captured in the system's language without stripping it of its clinical and social meaning. These provided ways of improving and sustaining practice.

Fund protected thinking space for social complexity	Formally ring-fence time within the GP contract or local network agreements specifically for community engagement and advocacy e.g. build relationships outside of clinical encounters, fostering mutual trust and shared understanding. This recognises that staff need permission and protected time to use their expertise to advocate, innovate and respond to social complexity. Protected time for all staff allows them to process "moral moments" and ethical dilemmas, utilising both formal sessions and informal story exchanges to make invisible work visible. Rewrite workforce roles (for both clinical and non-clinical staff) to explicitly include relational space and relational continuity as core duties. Rather than adding new roles, the focus should be on providing the existing workforce with the permission and time to "do relationships differently," with built-in reflection periods after any structural change.
Formalise communities of practice	Support regional Deep End networks as a core retention strategy. Shift the focus from professional isolation and blame toward collective meaning-making, where struggles are shared, acknowledged and supported, hope is balanced with realism, and ideas grow through shared stories rather than competition. Promote cross-regional collaboration. Invest in spaces where struggles can be acknowledged and supported without competition. This visibility reduces the burden of hidden trauma and fosters collective strategies for addressing social complexity.
Create open, welcoming and accessible environments	Environments should feel open, safe and connected to the communities they serve. Physical space should be non-intimidating reducing barriers to access and create a sense of psychological as well as physical safety for patients and staff. Services should balance provision where feasible to move towards communities with multiple access points. Staff need sustainable, green, restorative environments to support their well-being, influencing morale and patient experience. Create informal , relational touchpoints to build trust and social cohesion e.g. food spaces, or community pantries.



Neighbourhoods as relational, not just structural

Move away from seeking single, system–wide solutions

Co–design meaningful metrics for highly complex care

Fund protected thinking space for social complexity

Formalise communities of practice

Create open, welcoming and accessible environments

Conclusion

The combined learning from Newcastle and Deep End London events makes clear that neighbourhood health is fundamentally relational. Governance structures, funding models, and workforce policy must reflect this reality. Neighbourhood working can be strengthened by utilising and supporting existing general practice expertise and connections across the community, services (e.g. third sector, secondary) and the patients they serve.

Without investment in trust, protected time, boundary work, and non-clinical workforce protection, neighbourhood reform risks increasing strain rather than relieving it. With deliberate system support however, small, locally driven innovations ("trojan mouse" approaches) can scale into sustainable models of equitable care.

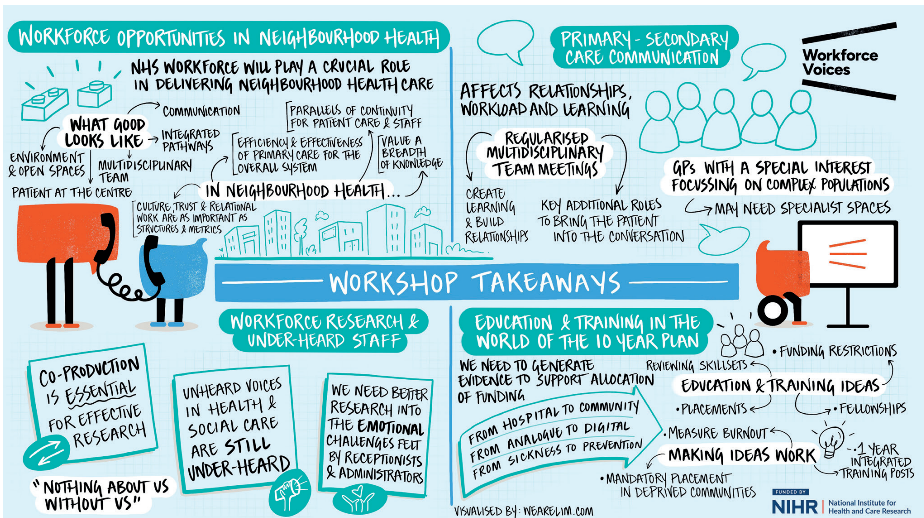
The opportunity now is to move from conversation to implementation. Workforce Voices and its partners are well positioned to translate this shared learning into targeted pilots, robust evidence generation, and meaningful policy influence ensuring that neighbourhood health reform is both relationally grounded and practically sustainable.

Opposite: Participants at one of the learning events

Below: Diagram visualising workforce opportunities in neighbourhood health

For further information about other events, please visit the Workforce Voices website:

www.workforcevoices.org



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