Workforce Voices

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GPs at the Deep End

Report 2: Workforce Voices Newcastle Learning Event. Neighbourhood Health and Workforce Development Session

Report on a learning event session on Neighbourhood Health, hosted by Workforce Voices held on Friday 27th February 2026 at the University of Newcastle

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Workforce Voices co-leads: Professor Gill Vance, Dr Bryan Burford, University of Newcastle
Workforce Voices partners: 30 plus attendees including representation from academics, healthcare professionals, ICB managers, patients, and public representatives ,local authorities, NHS colleagues, clinical and non-clinical, Local Maternity and Neonatal Services, GP Federations

Prepared on behalf of Workforce Voices and in collaboration with the London Deep End and Workforce Voices partners in Newcastle

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Executive Summary

Purpose

As part of an afternoon learning event hosted by *Workforce Voices* at the University of Newcastle, this session was opened by Dr Eleanor Hoverd, Research Fellow, welcoming the group and providing a brief overview of the realist review research led by Professor Sophie Park at the NDPCHS. This was followed by two activities exploring with WV partners what a "good" neighbourhood health workforce looks like and how systems can better support learning, boundary working, leadership, and protection for non-clinical staff. Professor Sophie Park facilitated group feedback, collated by Dr Eleanor Hoverd . Discussions are summarised below in relation to each activity, with key themes described.

Activity 1 (Lego activity): What does a "good" workforce look like in neighbourhood health to serve your local populations?

WV partners used Lego to model their vision of a "good" neighbourhood health workforce. The exercise generated rich metaphors and themes which are described below.

Key Themes – what "good" looks like

1. **Open, welcoming and accessible environments**

WV partners emphasised that neighbourhood health should be rooted in environments that feel open, safe and connected to the communities they

serve. Physical space was seen as influencing and contributing to trust, dignity and wellbeing for the workforce and the communities it serves. “Good” looks like:

Two-way doors and non-intimidating spaces that reduce barriers to access and create a sense of psychological as well as physical safety for patients and staff.

Flexible/mobile models embedded in communities (symbolised through creative metaphors during the Lego activity as boats and tractors) reflecting services that move towards communities rather than expecting communities to navigate complex systems.

Further described as needing multiple access points to services, ensuring people can enter and move through care without unnecessary complexity.

Sustainable, green, restorative work environments that support staff wellbeing and model long-term commitment to place.

Physical environments should actively support mental and physical wellbeing, recognising that space influences both workforce morale and patient experience.

Community pantries or shared food spaces as connectors would create informal, relational touchpoints can build trust and social cohesion.

2. Flattened hierarchies and shared leadership

WV partners consistently challenged traditional hierarchical models of healthcare delivery. Instead, they described neighbourhood health as requiring flatter structures, where leadership is transparent, shared and rooted in mutual respect. Hierarchy was not rejected entirely but

imagined with accountability and authority distributed in ways that protect dignity and enable collaboration. “Good” looks like:

Transparent leadership where decision-making processes are visible and leaders model openness, accountability and approachability.

Distributed decision-making enabling different roles both clinical and non-clinical to contribute meaningfully to service design and problem-solving.

Dignity for both staff and patients, ensuring that power dynamics do not undermine trust, wellbeing or equity of care.

Recognition of all roles, particularly non-clinical staff such as reception and administrative teams, whose relational and operational expertise is central to access and continuity.

“Ladder” metaphor was used to reflect a relational role for the workforce: supporting individuals and communities to navigate systems on their own terms, strengthening existing capacities, and addressing barriers that constrain opportunity.

3. Communication and collaboration

WV partners suggested that effective neighbourhood health depends on strong, intentional communication and genuine collaboration.
“Good” looks like:
Overcoming conflict across system divides particularly between primary and secondary care, statutory and voluntary sectors, and different professional groups. This requires open dialogue, shared problem-solving, and agreed mechanisms for resolving tension.

- **Two-way dialogue with communities** ensuring that neighbourhood health is shaped *with* communities *rather than delivered to them*. Listening was described as equally important as informing.

- **Bridging into and out of services through simple contact points** reducing fragmentation and ensuring patients experience a coherent journey rather than disconnected episodes of care.

Multidisciplinary working where different skills and perspectives are integrated.

- **Respect for diverse professional and community needs** acknowledging that different roles, organisations, and neighbourhoods face distinct pressures and priorities.

Understanding each other's roles and pressures creating empathy across teams and reducing misplaced expectations or blame.

4. Community-centred approach

WV partners emphasised that neighbourhood health must be rooted in the specific communities it serves. Rather than applying uniform models, services should respond to local context, history, strengths, and need. A community-centred approach was seen as essential to reducing inequity and building long-term trust.

"Good" looks like:

- **Local priorities, assets, and challenges shaping service design and delivery.** Each neighbourhood is different requiring flexibility rather than standardised solutions.

- **Patient-centred but community-connected** recognising that individual care is inseparable from wider social context, family networks, housing, employment, and community resources.
- **A "beacon" approach with the workforce** acting as a visible and trusted anchor within the neighbourhood particularly in underserved or Deep End communities working alongside residents to address structural disadvantage.
- **Social assets embedded into care** including community organisations, peer networks, and informal support systems, integrated alongside clinical services rather than treated as peripheral.
- **Outward-facing teams rather than closed systems** proactively engaging with communities, partners, and local services rather than waiting for demand to present at the practice door.

Activity 2: Group Discussions "In neighbourhood health…"

Building upon the creative work in Activity 1. small group discussions with WV partners were guided by four questions: where learning should happen in neighbourhood health, how boundary work can be recognised and supported, what sustains teams under pressure and how non-clinical staff can be protected from risk and blame. Insights have been synthesised to inform our next steps.

Q1. Where should learning happen?

WV partners emphasised that learning in neighbourhood health should be embedded in everyday practice rather than confined to formal classroom settings. A core message was that "**Learning should happen everywhere, for everyone"**. Learning was described as continuous,

practical, and relational occurring wherever care and collaboration take place as follows:

In the workplace, through the development of a learning culture that supports reflection, peer discussion, and shared problem-solving within teams.

In the community, including community centres, wellbeing hubs, and schools, enabling mutual learning between professionals and the populations they serve.

During consultations, recognising that complex patient interactions offer real-time opportunities for reflective and interprofessional learning.

Through service-learning models, where students and trainees learn by participating in community-based work rather than solely through classroom-based, or formal education and training.

Across organisations through shared training, promoting interprofessional understanding, reducing siloed working, and strengthening collaboration across neighbourhood systems.

Who Should Be Trained?

Undergraduates and healthcare professionals undertaking Continuing Professional Development (CPD), ensuring early exposure to neighbourhood working and ongoing skill development in community-centred, interprofessional practice.

Community pharmacy teams, recognising their critical role in access, continuity, and population health within neighbourhood settings**.**

Interprofessional teams, to build mutual understanding of roles, reduce siloed working, and strengthen collaboration across organisational boundaries.

Patients and communities themselves, supporting health literacy, shared decision-making, and community leadership in shaping services.

Q2. How should boundary work be recognised and supported?

WV partners explored the complexity of working across professional and organisational boundaries.

What is boundary work?

WV partners explored the complexity of working across professional, organisational, and sectoral boundaries, describing “boundary work” as a core but often an under-recognised component of neighbourhood health. Effective neighbourhood systems depend not only on individual roles, but on how those roles interact, overlap, and negotiate shared responsibility.

Although WV partners questioned what “boundary work” formally encompasses, it was broadly understood to include:

Working across roles, organisations, and sectors, particularly between primary and secondary care, statutory and voluntary services, and health and social care partners.

Challenging constructively and appropriately, creating space to question decisions, raise concerns, and address tensions without escalating conflict or blame.

Navigating accountability and shared responsibility, clarifying who is responsible for what, while recognising that complex patient needs often require collective ownership rather than siloed accountability.

Enablers of effective boundary work

WV partners emphasised that boundary work does not happen automatically. It requires intentional structural and cultural support. Without clarity, resourcing, and formal recognition, boundary-spanning activity risks becoming informal, invisible labour that increases pressure rather than improving collaboration.

Key enablers identified included:

Clarity of roles and remits, ensuring that responsibilities are transparent and reducing duplication, confusion, or inappropriate escalation.

Shared or pooled budgets, enabling collaborative working across organisational boundaries rather than reinforcing siloed incentives.

Shared records and information systems, supporting continuity of care and reducing friction at service interfaces.

Agreed escalation protocols, clarifying how concerns or risks should be managed across teams and organisations.

Organisational recognition of collaboration (rather than competition), aligning incentives and performance measures to support collective rather than individual organisational success.

Formalising boundary work within job roles and expectations, so that cross-sector coordination is acknowledged, protected, and resourced rather than undertaken informally.

Cultural requirements

Alongside structural enablers, participants emphasised that effective boundary work depends on cultural conditions. Formal agreements and protocols alone are insufficient without trust, openness, and shared commitment. Collaboration across boundaries must be actively cultivated.

Key cultural requirements included:

Psychological safety, enabling individuals at all levels to raise concerns, question decisions, and admit uncertainty without fear of blame or reprisal. WV partners noted that fostering this kind of environment represents a cultural shift, as traditional NHS structures have not always consistently supported open challenge or shared vulnerability.
Safe spaces to speak up, particularly for those in roles with less structural power, ensuring that concerns are heard and acted upon constructively.

Transparency in communication and decision-making, reducing misunderstanding and fostering shared accountability.

Peer support and opportunities for reflection, allowing teams to process complex cases, moral dilemmas, and cross-organisational tensions.

Commitment and intentionality, recognising that collaborative working does not emerge organically but requires intentional and sustained leadership and investment.

System-level learning from mistakes, shifting from individual blame to collective reflection and adaptation, thereby reducing the repetition of avoidable failures.

Q3. What holds teams together under pressure?

Protective factors

When discussing what sustains neighbourhood teams under pressure, WV partners identified a set of relational and organisational factors that act as protective infrastructure. These were seen as essential to maintaining morale, preventing burnout, and enabling teams to respond flexibly to complex community needs.

Key protective factors included:

Trust and strong relationships, built over time between colleagues, services, and communities, forming the foundation for effective collaboration.

Shared purpose, providing a unifying sense of direction and reinforcing commitment to serving under-served populations.

Good communication, characterised by openness, clarity, and regular dialogue across roles and organisations.

Transparent leadership, modelling accountability and creating confidence in decision-making processes.

Investment in teams, including time, training, and emotional support, rather than assuming resilience will emerge without resource.

Flexibility and mutual respect, enabling individuals and teams to adapt to changing pressures while recognising and valuing different contributions.

Distributed leadership (including receptionists and administrative roles). WV partners highlighted the need to:

- Recognise longstanding, community knowledge
- Value relational work alongside performance metrics
- Support those with less structural power
- Shift traditional NHS leadership models toward neighbourhood-based leadership

One group proposed that the question "Who has got my back?", is fundamental to sustaining teams working under pressure. This may reflect the fundamental importance of trust and collective responsibility in high-pressure environments. When staff feel supported by both immediate colleagues and by operational leadership, they may be more likely to be able to manage risk, make complex decisions, potentially helping them to navigate challenging conditions which could have an impact on retention.

Q4. What protects non-clinical staff from risk, blame and overload?

Significant concern was raised that risk within neighbourhood systems can disproportionately fall on non-clinical staff, particularly reception and administrative teams. WV partners highlighted that these roles often act as the first point of contact for patients, manage complex access

decisions under pressure, and absorb frustration generated elsewhere in the system frequently without the authority or protection to do so.

Key issues identified

Blurred accountability, where it is unclear who holds responsibility for managing complex situations, leading to risk being informally shifted onto frontline staff.

Role ambiguity, particularly in relation to access, triage, and escalation processes, creating uncertainty about decision-making boundaries.

Hierarchical cultures, which may limit the ability of non-clinical staff to question decisions, seek support, or challenge inappropriate expectations.

Performance metrics prioritising numbers over relationships, undervaluing relational continuity, emotional labour, and the work required to navigate complexity.

Risk of blame culture, where systemic pressures are individualised, and staff may feel exposed when things go wrong.

Protective measures suggested

In response to these concerns, WV partners identified a range of structural and cultural protections necessary to safeguard non-clinical staff and strengthen neighbourhood teams more broadly:

Psychological safety, ensuring staff at all levels can raise concerns, seek advice, and admit uncertainty without fear of blame or reprisal.

Clear governance principles, outlining decision-making authority, accountability, and shared responsibility across teams and organisations.

Clarity of boundaries and accountability, reducing ambiguity around who is responsible for managing complex situations or escalating risk.

Agreed escalation pathways, providing formal mechanisms for support when frontline staff encounter situations beyond their remit.

Parity across neighbourhoods, so that staff in under-served areas are not exposed to disproportionate risk due to inconsistent resourcing or policy variation.

Recognition of professional contributions, particularly the relational and operational expertise of non-clinical roles.

Digital and technological support, improving information flow and reducing unnecessary friction at service interfaces.

Leaders setting the cultural tone, modelling openness, fairness, and collective responsibility.

System-level accountability rather than individual blame, embedding cultural approach that focuses on learning and improvement rather than fault-finding. Participants emphasised shifting from:

“Who is to blame?”
to
“Where did the system fail this individual?”

Conclusion

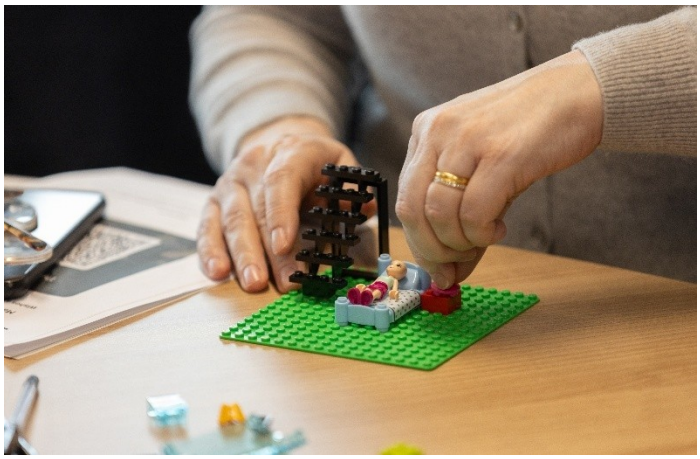
WV partners articulated a coherent and values-driven approach to neighbourhood health. This approach extends beyond structural integration and emphasises culture, relationships, and workforce sustainability as foundational to effective care in under-served areas.

A strong message emerged that culture, trust, and relational work are as important as structures and metrics. Sustainable neighbourhood health requires intentional investment in people, boundary work, and shared leadership.

Photographs (Photograph credit: Mark Slater Photography https://www.markslaterphotography.com/)

Alt text: A woman laughing candidly while sitting at a table during a workshop session.

Alt text: A workshop attendee focused on building a structure with colourful Lego bricks at their table.



Alt text: A close-up photo of a person's hands assembling colourful Lego bricks on a green baseplate.

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Alt text: Capturing the positive energy from our afternoon breakout session. A workshop attendee wearing a hijab and glasses, smiling during the event.

Alt text: A man in a yellow and blue plaid shirt engaging in conversation across a table at a busy event.

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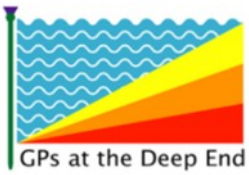

Acknowledgements

We would like to thank our WV partners for contributing so enthusiastically to this session.

Disclaimer

The views in this report from the group discussions were analysed and collated by the authors of this report, and do not necessarily reflect the views of all discussants.