NIHR | Applied Research Collaboration Greater Manchester

MANCHESTER 1824 The University of Manchester

Healthier Futures

Tackling inequalities to deliver fairer health

Integrated Neighbourhood Teams

What factors have shaped service integration and delivery by working across local health, care, and voluntary sector organisations?

Why does this matter?

In England, Integrated Neighbourhood Teams are set up to provide local, joined up, and personalised care to people. These teams include staff from health services, social care, and voluntary or community groups, working together to support local residents.

With changes to the health system expected in Autumn 2025, it's important to understand what helps these teams work well together, and what makes it harder. Trafford Council in Greater Manchester wanted to understand the research evidence on this to help plan better local services in their neighbourhoods.

What did we do?

We used rapid evidence synthesis methods to find research that answered this question: What 'factors' help or hinder integrated neighbourhood teams working together across health, care, and community organisations?

We looked for both primary research and evidence syntheses.

What did we find?

We found 26 relevant studies, including 9 primary studies based in the UK and 17 evidence syntheses.

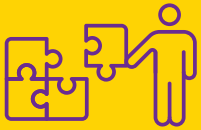
Key messages:

There was strong agreement in the research evidence about what helps teams work well and what can make things harder. The most important factors were:

Having a clear, shared vision and purpose

Strong leadership

Good working relationships based on trust and respect



Clear roles and responsibilities between professionals

Stable and ongoing funding and resources

Involving patients and the public in plans

Opportunities for staff to learn and develop

Teams being co-located together in the same place

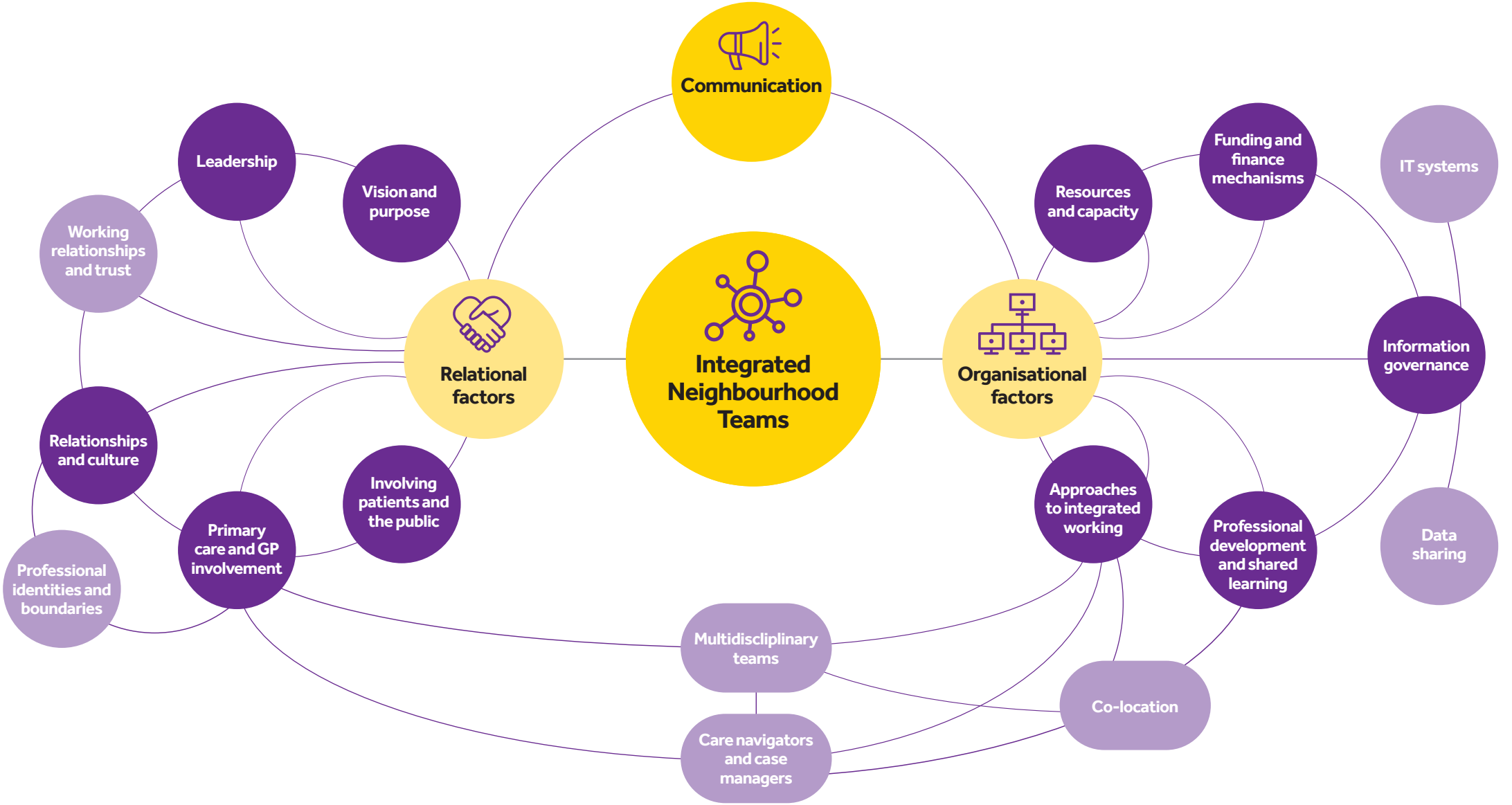
Regular time set aside for multidisciplinary team meetings

IT systems that work together and allow safe data sharing

Most studies investigated local integrated care across different services and patient groups instead of integrated team functioning for specific services or groups. That said, there was some evidence that the above factors were consistent across integrated services for particular patient groups (e.g., many of the same factors were relevant for integrated team functioning in services for frail older patients as for services for patients with severe mental illness).

Most studies looked at local integrated care in general, rather than focusing on specific services or patient groups. However, there was some evidence that these same 'help' or 'hinder' factors applied across different types of care - for example, whether the team was supporting frail older people or people with severe mental illness.

There wasn't much evidence on the best size of these teams or how wide their reach should be (for example, how many organisations or areas they cover). More research is needed to understand the best size and structure for these teams.


Communication
Leadership
Vision and purpose
Working relationships and trust
Relational factors
Integrated Neighbourhood Teams
Organisational factors
Resources and capacity
Funding and finance mechanisms
IT systems
Information governance
Relationships and culture
Involving patients and the public
Primary care and GP involvement
Professional identities and boundaries
Approaches to integrated working
Professional development and shared learning
Data sharing
Multidiscliplinary teams
Co-location
Care navigators and case managers

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Optimising service integration and delivery in Integrated Neighbourhood Teams: Checklist

Clear vision and purpose of integration's goals
- ☐ Co-developed with partners
- ☐ Communicated across all partners
- ☐ Positive & solution focused

Strong leadership
- ☐ Flexible & responsive
- ☐ Innovative
- ☐ Enabling & supportive

Good working relationships
- ☐ Trusting
- ☐ Respectful
- ☐ Sustained

Clear professional identities and boundaries
- ☐ Clarity on roles & responsibilities between professionals
- ☐ Clarity on decision-making authority
- ☐ Clear frameworks for roles, communications, & data sharing

Involving service users, patients, and the public
- ☐ In the design of integrated services
- ☐ In the delivery of integrated services
- ☐ In decisions about patients' care

Involving Primary Care and General Practitioners
- ☐ GPs are present in MDT meetings
- ☐ GPs are well-informed about local available services
- ☐ Dedicated time & infrastructure to host MDTs in primary care

Adequate and sustained resources and capacity
- ☐ Staff capacity
- ☐ Staff capabilities
- ☐ Supporting staff retention

Sustained funding and suitable financial mechanisms
- ☐ Appropriate & sustained funding
- ☐ Suitable & equitable payment mechanisms
- ☐ Pooled budgets (where appropriate)

Opportunities for professional development and shared learning
- ☐ Joint staff training
- ☐ Dedicated time & organisational support
- ☐ Opportunities to share knowledge (e.g., cross-sector rotations, 'learning windows')

Multidisciplinary teams
- ☐ Protected time
- ☐ Consistent attendance from members
- ☐ Appropriate mix of professionals (to meet patients' needs)

Co-located teams
- ☐ Physical co-location (where possible)
- ☐ Plan for and provide sufficient space
- ☐ Actively identify & address barriers (e.g., professionals on the same floor but in different offices)

Appointed care navigators and case managers
- ☐ Present in MDT meetings
- ☐ Advocates for patients' needs & preferences
- ☐ Offers good communication, trusting relationship, & active listening to patients

Compatible IT systems and pathways for data sharing
- ☐ Interoperable platforms & software
- ☐ Actively identify & address barriers (e.g., data access during co-location)
- ☐ Trust-building between partners to support data sharing