To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Monday, 8 September 2025 at 10.00 am
Room 2&3 - County Hall, New Road, Oxford OX1 1ND

If you wish to view proceedings online, please click on this Live Stream Link.

Martin Reeves
Chief Executive

August 2025

Contact Officer: ***Democratic Services***
Email: committees.democraticservices@oxfordshire.gov.uk

Membership

Chair – Cllr Liz Leffman (Leader, Oxfordshire County Council)
Vice Chair – Sir Jonathan Montgomery (Chair, Oxford University Hospitals NHS Foundation Trust)

Board Members:

Ansaf Azhar	Director of Public Health & Communities, Oxfordshire Co Co
Councillor Tim Bearder	Cabinet Member for Adults, Oxfordshire Co Co
Michelle Brennan	GP Representative
Stephen Chandler	Executive Director: People, Oxfordshire Co Co
Councillor Rachel Crouch	West Oxfordshire District Council
Councillor Rob Pattenden	Cherwell District Council
Councillor Georgina Heritage	South Oxfordshire District Council
Karen Fuller	Director of Adult Social Care, Oxfordshire Co Co
Councillor Sean Gaul	Cabinet Member for Children and Young People, Oxfordshire Co Co
Caroline Green	Chief Executive, Oxford City Council (District Representative)
Councillor Kate Gregory	Cabinet Member for Public Health and Inequalities, Oxfordshire Co Co
Lisa Lyons	Director of Children's Services, Oxfordshire Co Co
Grant MacDonald	Interim Chief Executive, Oxford Health NHS Foundation Trust
Don O'Neal	Chair, Healthwatch Oxfordshire

Councillor Helen Pighills	Vale of White Horse District Council
David Radbourne	Regional Director Strategy and Transformation, NHS England
Councillor Chewe Munkonge	Oxford City Council
Matthew Tait	Executive Sponsor, BOBICB

Notes:• Date of next meeting: 25 September 2025

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chair

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note below

4. Petitions and Public Address

Members of the public who wish to speak on an item on the agenda at this meeting, or present a petition, can attend the meeting in person or 'virtually' through an online connection.

Requests to present a petition must be submitted no later than 9am ten working days before the meeting.

Requests to speak must be submitted no later than 9am three working days before the meeting.

Requests should be submitted to committeesdemocraticservices@oxfordshire.gov.uk

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that if the technology fails, then your views can still be taken into account. A written copy of your statement can be provided no later than 9am on the day of the meeting. Written submissions should be no longer than 1 A4 sheet.

5. Development of Neighbourhood Health in Oxfordshire (Pages 1 - 34)

The Board is asked to note the early plans and timetable of delivery for Neighbourhood Health services in Oxfordshire.

In line with the government's 10 year health plan, which includes a priority for moving care from hospital to community, local areas are required to develop Neighbourhood Health services. The Health And Wellbeing Board will have leadership for local Neighbourhood Health plans jointly drawn up by local government, the NHS and its partners.

- Annex 1: 'Fit for the Future' – 10 Year Health Plan for England – Executive Summary
- Annex 2: NHS England – Neighbourhood Health Guidelines 2025/26.

Further information, including the full 10 Year Health Plan, can be found on the government website here: 10 Year Health Plan for England: fit for the future - GOV.UK

Councillors declaring interests

General duty

You must declare any disclosable pecuniary interests when the meeting reaches the item on the agenda headed 'Declarations of Interest' or as soon as it becomes apparent to you.

What is a disclosable pecuniary interest?

Disclosable pecuniary interests relate to your employment; sponsorship (i.e. payment for expenses incurred by you in carrying out your duties as a councillor or towards your election expenses); contracts; land in the Council's area; licenses for land in the Council's area; corporate tenancies; and securities. These declarations must be recorded in each councillor's Register of Interests which is publicly available on the Council's website.

Disclosable pecuniary interests that must be declared are not only those of the member her or himself but also those member's spouse, civil partner or person they are living with as husband or wife or as if they were civil partners.

Declaring an interest

Where any matter disclosed in your Register of Interests is being considered at a meeting, you must declare that you have an interest. You should also disclose the nature as well as the existence of the interest. If you have a disclosable pecuniary interest, after having declared it at the meeting you must not participate in discussion or voting on the item and must withdraw from the meeting whilst the matter is discussed.

Members' Code of Conduct and public perception

Even if you do not have a disclosable pecuniary interest in a matter, the Members' Code of Conduct says that a member 'must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself' and that 'you must not place yourself in situations where your honesty and integrity may be questioned'.

Members Code – Other registrable interests

Where a matter arises at a meeting which directly relates to the financial interest or wellbeing of one of your other registerable interests then you must declare an interest. You must not participate in discussion or voting on the item and you must withdraw from the meeting whilst the matter is discussed.

Wellbeing can be described as a condition of contentedness, healthiness and happiness; anything that could be said to affect a person's quality of life, either positively or negatively, is likely to affect their wellbeing.

Other registrable interests include:

a) Any unpaid directorships
b) Any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority.

c) Any body (i) exercising functions of a public nature (ii) directed to charitable purposes or (iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management.

Members Code – Non-registrable interests

Where a matter arises at a meeting which directly relates to your financial interest or wellbeing (and does not fall under disclosable pecuniary interests), or the financial interest or wellbeing of a relative or close associate, you must declare the interest.

Where a matter arises at a meeting which affects your own financial interest or wellbeing, a financial interest or wellbeing of a relative or close associate or a financial interest or wellbeing of a body included under other registrable interests, then you must declare the interest.

In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied:

Where a matter affects the financial interest or well-being:

a) to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
b) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest.

You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.

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UK Government

NHS

FIT FOR THE FUTURE

10 Year Health Plan for England

Executive Summary

July 2025

Executive Summary

The National Health Service (NHS) is at a historic crossroads. Lord Darzi's Investigation revealed the sheer extent of its current failings, concluding the NHS was in 'critical condition'. He set out in stark terms that this government's inheritance is an NHS where:

- many cannot get a GP or dental appointment
- waiting lists for hospital and community care[1] have ballooned
- staff are demoralised and demotivated[2]
- outcomes on major killers like cancer lag behind other countries[3].

That is why the NHS now stands at an existential brink. Demographic change and population ageing[4] are set to heap yet more demand on an already stretched health service. Without change, this will threaten yet worse access and outcomes - and even more will opt out to go private if they can afford to. People will increasingly wonder why they pay so much tax for a service they do not use, eroding the principle of solidarity that has sustained the NHS. We will be condemned to a poor service for poor people.

The choice for the NHS is stark: reform or die. We can continue down our current path, making tweaks to an increasingly unsustainable model, or we can take a new course and reimagine the NHS through transformational change that will guarantee its sustainability for generations to come. This Plan chooses the latter. It represents a break with the past.

That choice has been informed by the biggest conversation about the NHS in its history. Over the past 8 months, we have spoken to thousands of staff and members of the public and considered the 250,000 contributions to the Change.NHS website. The conclusion was clear: no one defends the status quo. Staff and patients are crying out for change.

This is a Plan to create a new model of care, fit for the future. It will be central to how we deliver on our health mission. We will take the NHS' founding principles - universal care, free at the point of delivery, based on need and funded through general taxation - and from those foundations, entirely reimagine how the NHS does care so patients have real choice and control over their health and care.

Science and technology will be key to that reinvention. Today the NHS is behind the technological curve. This Plan propels it to the front. The NHS of the future will be a service that offers instant access to help and appointments. One that predicts and prevents ill health rather than simply diagnosing and treating it. A patient-controlled system, in place of today's centralised state bureaucracy, and one where frontline staff are empowered to reshape services. A service with the core principles and values of the NHS but with the know-how of a wider network of technology, life sciences, local government, civil society and third sector organisations, working in partnership to improve the nation's health.

It will be a service equipped to narrow health inequalities. Evidence[5] shows that people in working class jobs, who are from ethnic minority backgrounds, who live in rural or coastal areas or deindustrialised inner cities, who have experienced domestic violence, or who are homeless, are more likely to experience worse NHS access, worse outcomes and to die younger. This is an intolerable injustice. Our reimagined NHS will be designed to tackle inequalities in both access and outcomes, as well as to give everyone, no matter who they are or where they come from, the means to engage with the NHS on their own terms.

Despite the scale of the challenge we face, there are more reasons for optimism than pessimism. The NHS is the best-placed system in the world to harness the advances we are seeing in artificial intelligence (AI) and genomic science. This Plan describes how we will use these advantages to propel the NHS into a position of global leadership. When coupled with our country's excellence in science, innovation and academia, the UK can lead the world in developing the treatments and technologies of the future[6].

This Plan will put the NHS at the front of the global genomics revolution and make the NHS the most artificial-intelligence -enabled care system in the world. We will get upstream of ill-health and make a reality of precision medicine. We will put the NHS on a sustainable footing by adopting a new value-based approach, that aligns resources to achieve better health outcomes. In turn, we will unlock broader economic benefits for the UK, helping to get people back into work and providing a bedrock for the industries of the future. This Plan will transform the NHS into an engine for economic growth rather than simply a beneficiary of it.

We will reinvent the NHS through 3 radical shifts - hospital to community, analogue to digital and sickness to prevention. These will be the core components of our new care model. To support the scale of change we need, we will ensure the whole NHS is ready to deliver these 3 shifts at pace: through a new operating model, by ushering in a new era of transparency; by creating a new workforce model with staff genuinely aligned with the future direction of reform, through a reshaped innovation strategy; by taking a different approach to NHS finances.

From hospital to community: the neighbourhood health service, designed around you

If the NHS does not feel like a single, coordinated, patient-orientated service, that is for a simple reason: it is not one. It is hospital-centric, detached from communities and organises its care into multiple, fragmented siloes. We need to shift to provide continuous, accessible and integrated care.

The neighbourhood health service is our alternative. It will bring care into local communities, convene professionals into patient-centred teams and end fragmentation. In doing so, it will revitalise access to general practice and enable hospitals to focus on providing world class specialist care to those who need it. Over time, it will combine with our new genomics population health service to provide predictive and preventative care that anticipates need, rather than just reacting to it.

At its core, the neighbourhood health service will embody our new preventative principle that care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary. To make this possible we will:

- shift the pattern of health spending. Over the course of this Plan, the share of expenditure on hospital care will fall, with proportionally greater investment in out-of-hospital care.
- This is not just a long-term ambition. We will also deliver this shift in investment over the next 3 to 4 years as local areas build and expand their neighbourhood health services

- end the 8am scramble by training thousands more GPs and building online advice into the NHS App. People who need one will be able to get a same-day GP appointment
- introduce 2 new contracts, with roll-out beginning next year, to encourage and allow GPs to work over larger geographies and lead new neighbourhood providers
- support people to be active participants in their own care by ensuring people with complex needs have an agreed care plan by 2027
- at least double the number of people offered a Personal Health Budget by 2028 to 2029, offer 1 million people a Personal Health Budget by 2030, and ensure it is a universal offer for all who would benefit by 2035
- through the NHS App, allow patients to book appointments, communicate with professionals, receive advice, draft or view their care plan, and self-refer to local tests and services
- establish a neighbourhood health centre in every community, beginning with places where healthy life expectancy is lowest - a 'one stop shop' for patient care and the place from which multidisciplinary teams operate
- neighbourhood health centres will be open at least 12 hours a day and 6 days a week
- increase the role of community pharmacy in the management of long-term conditions and link them to the single patient record
- improve access to NHS dentistry, improve children's oral health and increase the number of NHS dentists working in the system by making the dental contract more attractive, and introducing tie-ins for those trained in the NHS
- deliver more urgent care in the community, in people's homes or through neighbourhood health centres to end hospital outpatients as we know it by 2035
- end the disgraceful spectacle of corridor care and restore the NHS constitutional standard of 92% of patients beginning elective treatment within 18 weeks
- expand same day emergency care services and co-located urgent treatment centres. We will support patients to book into the most appropriate urgent care service for them, via 111 or the app, before attending, by 2028
- invest up to £120 million to develop more dedicated mental health emergency departments, to ensure patients get fast, same-day access to specialist support in an appropriate setting
- free up hospitals to prioritise safe deployment of AI and harness new technology to bring the very best of cutting-edge care to all patients. All hospitals will be fully AI-enabled within the lifetime of this Plan.

From analogue to digital: power in your hands

Modern technology has given us more power over our everyday lives. But that same scale of change has yet to come to the NHS. This Plan will take the NHS from the 20th century technological laggard it is today, to the 21st century leader it has the potential to be.

To do this, we will use the unique advantages of the NHS' healthcare model - world-leading data, its power in procurement and its means to deliver equal access - to create the most digitally accessible health system in the world. Patients will have a 'doctor in their pocket' in the form of the NHS App, while staff will be liberated from a burden of bureaucracy and administration.

By harnessing the digital revolution, we will be able to:

- ensure rapid access for those in generally good health

- free up physical access for those with the most complex needs
- help ensure the NHS' financial sustainability for future generations.

To make the move 'from bricks to clicks' we will:

- for the first time ever in the NHS, give patients real control over a single, secure and authoritative account of their data with a single patient record to enable more co-ordinated, personalised and predictive care
- transform the NHS App into a world leading tool for patient access, empowerment and care planning.

By 2028, the app will be a full front door to the entire NHS. Through the app, patients will be able to:

– get instant advice for non-urgent care and help finding the most appropriate service first time, through My NHS GP

– choose their preferred provider, whether it delivers the best outcomes, has the best feedback or is simply closer to home, through My Choices

– book directly into tests where clinically appropriate through My Specialist, and hold consultations through the app with My Consult

– manage their medicines through My Medicines and book vaccines through My Vaccines

– manage a long-term condition through My Care, access and upload health data through My Health or get extra care support through My Companion

- manage their children's healthcare through My Children, or co-ordinate the care of a loved one or relative through My Carer
- allow patients to leave feedback on the care they have received - compiled and communicated back to providers, clinical teams and professionals in easy-to-action formats
- use continuous monitoring to help make proactive management of patients the new normal, allowing clinicians to reach out at the first signs of deterioration to prevent an emergency admission to hospital
- build 'HealthStore' to enable patients to access approved digital tools to manage or treat their conditions, enabling innovative businesses to work more collaboratively with the NHS and regulators
- introduce single sign on for staff and scale the use of technology like AI scribes to liberate staff from their current burden of bureaucracy and administration – freeing up time to care and to focus on the patient.

From sickness to prevention: power to make the healthy choice

People are living too long in ill health, the gap in healthy life expectancy between rich and poor is growing[7] and nearly 1 in 5 children leave primary school with obesity[8]. Our overall goal is to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and to raise the healthiest generation of children ever. This will boost our health, but also ensure the future sustainability of the NHS and support economic growth.

We will achieve our goals by harnessing a huge cross-societal energy on prevention. We will work with businesses, employers, investors, local authorities and mayors to create a healthier country together. Specifically, we will:

- deliver on our world-leading Tobacco and Vapes Bill, which will mean that children turning 16 this year (or younger) can never legally be sold tobacco. The number of 11 to 15 year olds who regularly vape has doubled[9] in the last 5 years, and to crack down on this unacceptable trend, we will also halt the advertising and sponsorship

of vapes and other nicotine products

- launch a moonshot to end the obesity epidemic. We will restrict junk food advertising targeted at children, ban the sale of high-caffeine energy drinks to under 16-year-olds, consider reforms to the soft drinks industry levy to drive reformulation; and - in a world first - introduce mandatory healthy food sales reporting for all large companies in the food sector. We will use that reporting to set new mandatory targets on the average healthiness of sales
- restore the value of Healthy Start from financial year 2026 to 2027, expand free school meals so that all children with a parent in receipt of Universal Credit are eligible, and update school food standards to ensure all schools provide healthy, nutritious food.
- harness recent breakthroughs in weight loss medication and expand access through the NHS. We will negotiate new partnerships with industry to provide access to new treatments on a 'pay for impact on health outcomes' basis
- encourage citizens to play their part, including through a new health reward scheme to incentivise healthier choices. We will also work with the Great Run Company to set up a campaign to motivate millions to move more on a regular basis
- tackle harmful alcohol consumption by introducing new standards for alcohol labelling. We will support further growth in the no- and low- alcohol market
- join up support from across work, health and skills systems to help people find and stay in work. We will work with all ICBs to establish Health and Growth Accelerators models
- expand mental health support teams in schools and colleges – and provide additional support for children and young people's mental health through Young Futures Hubs
- increase uptake of human papillomavirus (HPV) vaccinations among young people who have left school, to support our ultimate aim to eliminate cervical cancer by 2040. We will fully roll out lung cancer screening for those with a history of smoking
- create a new genomics population health service, accessible to all, by the end of the decade. We will implement universal newborn genomic testing and population-based polygenic risk scoring alongside other emerging diagnostic tools, enabling early identification and intervention for individuals at high risk of developing common diseases.

A devolved and diverse NHS: a new operating model

To realise the ambition of this Plan, we will create a new NHS operating model, to deliver a more diverse and devolved health service. Today, power is concentrated in Whitehall, rather than distributed among local providers, staff and citizens.

Our reforms will push power out to places, providers and patients - underpinned by an explicit goal to make the NHS the best possible partner and the world's most collaborative public healthcare provider. To achieve this, we will:

- combine the headquarters of the NHS and the Department of Health and Social Care, reducing central headcount by 50%
- make ICBs the strategic commissioners of local healthcare services. We will build ICB capability, and close commissioning support units
- introduce a system of earned autonomy and, where local services consistently underperform, step in with a new failure regime. Our priority will be to address underperformance in areas with the worst health outcomes. Our ambition over a 10-year period is for high autonomy to be the

norm across every part of the country

- reinvent the NHS foundation trust (FT) model for a modern age. By 2035, our ambition is that every NHS provider should be an FT with freedoms including the ability to retain surpluses and reinvest them, and borrowing for capital investment. FTs will use these freedoms and flexibilities to improve population health, not just increase activity
- create a new opportunity for the very best FTs to hold the whole health budget for a defined local population as an integrated health organisation (IHO). Our intention is to designate a small number of these IHOs in 2026, with a view to them becoming operational in 2027. Over time they will become the norm
- set higher standards for leaders, with pay tied to performance, and good work rewarded
- continue to make use of private sector capacity to treat NHS patients where it is available and we will enter discussions with private providers to expand NHS provision in the most disadvantaged areas
- work in closer partnership with local government and other local public services. We will streamline how local government and the NHS work together and make ICBs coterminous with strategic authorities by the end of the Plan wherever feasibly possible
- introduce a new patient choice charter, starting in the areas of highest health need. This will ensure the NHS is receptive and reactive to patient preference, voice and choice
- trial new 'patient power payments', which are an innovative new funding flow in which patients are contacted after care and given a say on whether the full payment for the costs of their care should be released to the provider.

A new transparency and quality of care

The NHS' history is blighted by examples of systematic and avoidable harm. The commonality in these tragedies has been a fundamental lack of transparency. We will make the NHS the most transparent healthcare system in the world.

From this foundation, we will reintroduce a new, rigorous focus on high-quality care for all. Specifically, we will:

- publish easy-to-understand league tables, starting this summer, that rank providers against key quality indicators
- allow patients to search and choose providers based on quality data on the NHS App, including length of wait, patient ratings and clinical outcomes. The App will also show data on clinical teams and clinicians
- use patient reported outcome measures and patient reported experience measures to help patients when choosing their provider on the NHS App
- set up a national independent investigation into maternity and neonatal services. We will also establish a national maternity and neonatal taskforce, chaired by the Secretary of State for Health and Social Care, to inform a new national maternity and neonatal action plan, co-produced with bereaved families
- reform the complaints process and improve response times to patient safety incidents and complaints
- change the time limit for the Care Quality Commission (CQC) to bring legal action against a provider and review how to improve patients' experience of clinical negligence claims
- reform the National Quality Board (NQB) with all other bodies, including Royal Colleges, feeding into it. We will task it with developing a new quality strategy as well as the development of modern

service frameworks. Early priorities will include cardiovascular disease, mental health, frailty and dementia.

- give all providers new flexibilities to make additional financial payments to clinical teams that have consistently high clinical outcomes and excellent patient feedback or are significantly improving care
- reform CQC towards a more data-led regulatory model. When concerns are identified, CQC will rapidly assemble inspection teams of highly qualified staff to assess service quality in greater detail
- make sure persistent poor-quality care results in the decommissioning or contract termination of services or providers, no matter the setting, no matter whether the provider is in the NHS or independent sector, and no matter whether they are a GP practice or an individual NHS trust.

An NHS workforce, fit for the future

It will be through the workforce that our 3 shifts are delivered. Because healthcare work will look very different in 10 years' time, we will need a very different kind of workforce strategy.

While, by 2035, there will be fewer staff than projected in the 2023 Long-Term Workforce Plan, those staff will be better treated, more motivated, have better training and more scope to develop their careers. The NHS will be not only the country's biggest employer but its best. To achieve this, we will:

- ensure every single member of NHS staff has their own personalised career coaching and development plan, to help them acquire new skills and practice at the top of their professional capability
- make AI every nurse's and doctor's trusted assistant - saving them time and supporting them in decision making. Over the next 3 years we will overhaul education and training curricula with the aim of future-proofing the NHS workforce
- work with the Social Partnership Forum to develop a new set of staff standards, which will outline minimum standards for modern employment. We will introduce these standards in April 2026 and publish data on them at the employer level every quarter
- continue to work with trade unions and employers to maintain, update and reform employment contracts and start a big conversation on significant contractual changes that provide modern incentives and rewards for high quality and productive care
- reduce the NHS' sickness rates from its current rate of 5.1%[10] - far higher than the average in the private sector[11] - to the lowest recorded level in the NHS
- give leaders and managers new freedoms, including the power to undertake meaningful performance appraisals, to reward high performing staff, and to act decisively where they identify underperformance
- develop advanced practice models for nurses and other professionals, and work across government to prioritise UK medical graduates for foundation and specialty training
- increase the number of nurse consultants, particularly in neighbourhood settings
- over the next 3 years, create 1,000 new specialty training posts with a focus on specialties where there is greatest need
- accelerate delivery of the recommendations in General Sir Gordon Messenger's review of health and care leadership[12] and establish a new College of Executive and Clinical Leadership to define and drive excellence
- introduce new arrangements for senior managers' pay to reward high performance and to withhold pay increases from executive leadership teams who do not meet public, taxpayer and

patient expectations on timeliness of care or effective financial management

- reorientate the focus of NHS recruitment away from its dependency on international recruitment, and towards its own communities - to ensure sustainability in an era of global healthcare workforce shortages. It is our ambition to reduce international recruitment to less than 10% by 2035
- create 2,000 more nursing apprenticeships over the next 3 years - prioritising areas with the greatest need. Expansion of medical school places will be focused on widening access to talented students from underprivileged backgrounds.

Powering transformation: innovation to drive healthcare reform

Our aim is to be in the driving seat of the biggest industrial revolution since the 19th century as we harness technology to create a new model of care in the NHS. We will use the UK's competitive edge - NHS data, life sciences prowess, world leading universities - to lead the world on the innovation that will most accelerate reform.

We have identified 5 transformative technologies - data, AI, genomics, wearables and robotics - that will personalise care, improve outcomes, increase productivity and boost economic growth. We will:

- create a new Health Data Research Service in partnership with the Wellcome Trust and backed by up to £600 million of joint investment
- make the NHS the most AI-enabled health system in the world with AI seamlessly integrated into clinical pathways
- support the Generation Study as it sequences the genomes of 100,000 newborn babies. This study will inform our longer-term ambition to make genomic sequencing at birth universal
- launch a new large-scale study to sequence the genomes of 150,000 adults this year - and assess how genomics can be used in routine preventive care. A new globally unique set of studies will explore personalised prevention of obesity, applying genomic and other insights to identify people who are at the highest risk of developing obesity
- make wearables standard in preventative, chronic and post-acute NHS treatment by 2035. All NHS patients will have access to these technologies, which will be part of routine care. We will provide devices for free in areas where health need and deprivation are highest
- beginning next year, expand surgical robot adoption in line with National Institute for Health and Care Excellence (NICE) guidelines
- establish new global institutes with the ambition to help the UK lead the world on science and innovation
- speed up clinical trial recruitment. By March 2026, clinical trials setup time will fall to 150 days
- expand NICE's technology appraisal process to cover devices, diagnostics and digital products. NICE will also be given a new role to identify which outdated technologies and therapies can be removed from the NHS to free up resources for investment in more effective ones
- introduce multi-year budgets and require NHS organisations to reserve at least 3% of annual spend for one-time investments in service transformation, to help translate innovations into practice more rapidly
- expand the role life sciences and technology companies can play in service delivery. We will streamline procurement of technology, and we will move to a single national formulary for medicines within the next 2 years.

Productivity and a new financial foundation

Today the NHS accounts for 38% of day-to-day government spending - a figure projected to rise to nearly 40% by the end of the Parliament[13]. While the NHS will need investment in the future, it is now self-evident that more money alone has not always led to better care.

The era of the NHS' answer always being 'more money, never reform' is over. It will be replaced with a new value-based approach focused on getting better outcomes for the money we spend. Our new financial flows will incentivise innovation to support the flow of money from hospital into community and reward best practice across the NHS.

Our three shifts each help secure financial sustainability. More care in the community is cheaper and more effective than care in hospitals. Digitalisation, as in other industries, will deliver far more productively for far lower cost. Prevention bends the demand curve. We will:

- urgently resolve the NHS' productivity crisis. For the next 3 years we have set the NHS a target to deliver a 2% year on year productivity gain
- restore financial discipline by ending the practice of providing additional funding to cover deficits. Over time, our aim is for the NHS to move into surplus, with the majority of providers achieving that by 2030
- break the old, short-term cycle of financial planning, by asking all organisations to prepare robust and realistic five-year plans, demonstrating how financial sustainability will be secured over the medium term
- deconstruct block contracts - paid irrespective of how many patients are seen or how good care is - with the intention of realigning the activity delivered and funding being provided by an ICB. Payment for poor-quality care will be withheld and high-quality care will attract a bonus. In addition, we will introduce new incentives for the best NHS leaders, clinicians and teams
- move from national tariffs based on average costs to tariffs based on best clinical practice that maximises productivity and outcomes. We will also test the development of 'year of care' payments starting in financial year 2026 to 2027. This will drive the shift of activity and resource from hospital to community
- distribute NHS funding more equally locally, so it is better aligned with health need. In the meantime, we will target extra funding to areas with disproportionate economic and health challenges.
- ensure all trusts have the authority to retain 100% of receipts from the disposal of land assets they own, and are able to use the proceeds from disposals across multiple financial years
- develop a business case for the use of Public Private Partnership (PPP) for Neighbourhood Health Centres, ahead of a final decision at the autumn budget
- explore a new mechanism for the NHS to access low risk pension capital
- in the longer-term, move to a new NHS financial model, where money will increasingly follow patients through their lifetime. Providers will be rewarded based on how well they improve outcomes for each individual, as well as how well they involve people in the design of their care, not solely on whether they provide episodic instances of care on demand.

Endnotes

1 Darzi A. 'Independent investigation of the NHS in England' 2024. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england (viewed on 18 June 2025)

2 NHS Staff Survey. 'National Results' 2025. https://www.nhsstaffsurveys.com/results/national-results/ (viewed on 25 June 2025)

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Neighbourhood health guidelines 2025/26

Publication (/publication)

Content

Why a new approach is needed

1. There is an urgent need to transform the health and care system. We need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. More people are living with multiple and more complex problems, and as highlighted by Lord Darzi (https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england), the absolute and relative proportion of our lives spent in ill-health has increased.

2. Addressing these issues requires an integrated response from all parts of the health and care system. Currently, too many people experience fragmentation, poor communication and siloed working, resulting in delays, duplication, waste and suboptimal care. It is also frustrating for people working in health and social care.

3. Neighbourhood health reinforces a new way of working for the NHS, local government, social care and their partners, where integrated working is the norm and not the exception. Some places have already made progress in developing an integrated local approach to NHS and social care delivery. The full vision for the health system will be set out in the 10 Year Health Plan (https://www.gov.uk/government/publications/change-nhs-help-build-a-health-service-fit-for-the-future), including proposals to help make this emerging vision for neighbourhood health a reality, informed by existing work and public, staff and stakeholder engagement.

4. This document sets out guidelines to help integrated care boards (ICBs), local authorities and health and care providers continue to progress neighbourhood health in 2025/26 in advance of the publication of the 10 Year Health Plan. The appendix provides more specificity around the initial 6 components of neighbourhood health to create a common understanding of what lies at its core, but the guidelines are deliberately short and permissive about how neighbourhood health should be implemented, setting out a framework for action that can be tailored to local needs.

5. Neighbourhood health aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care. This will be achieved by better connecting and optimising health and care resource through 3 key shifts at the core of the government's health mission:

- **from hospital to community** – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
- **from treatment to prevention** – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
- **from analogue to digital** – greater use of digital infrastructure and solutions to improve care

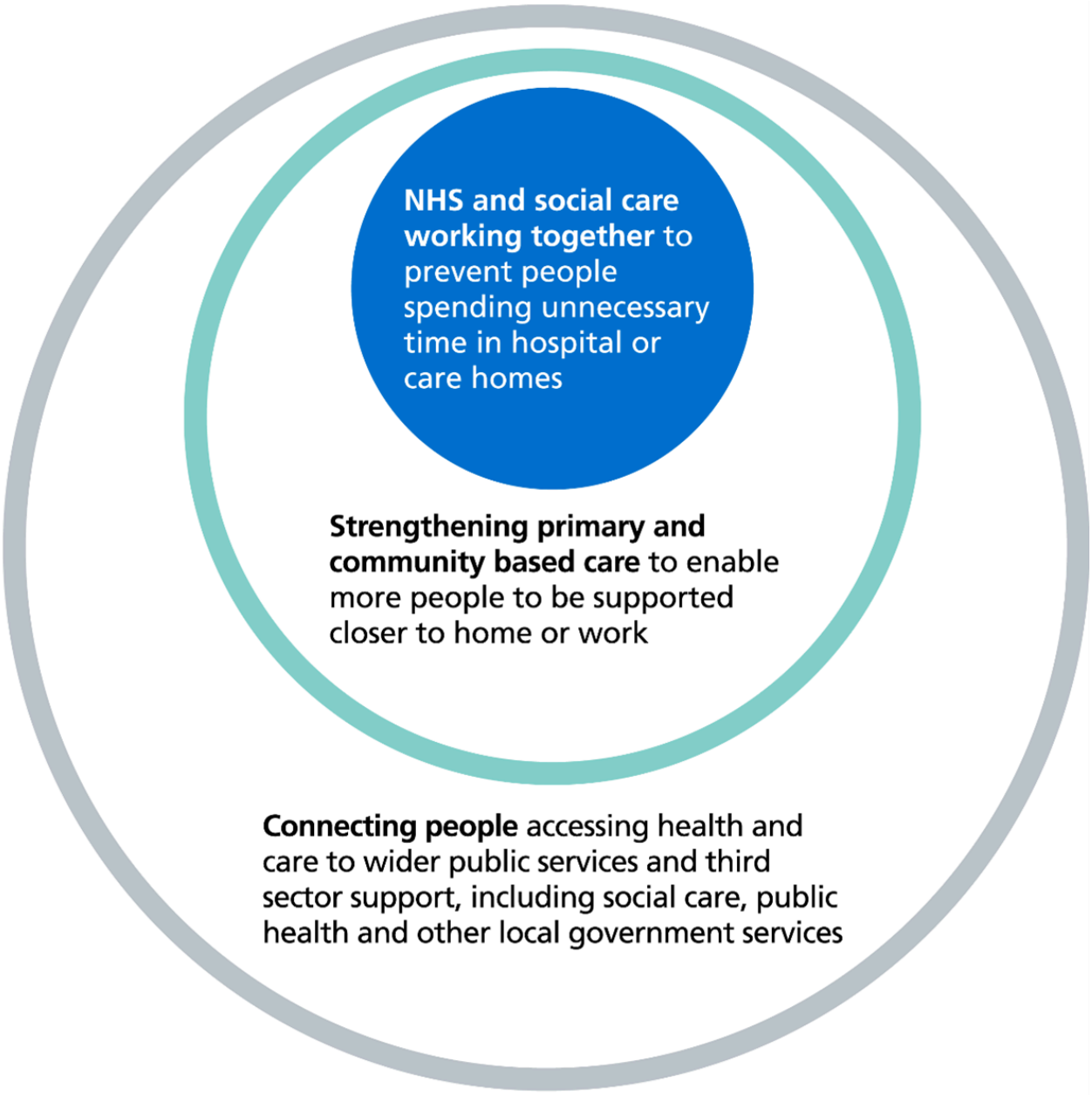
The plan to reform elective care (https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/) is an example of this commitment in action, improving experience and convenience by providing more direct access to tests, scans and surgery in dedicated local centres and empowering people with more choice over when and where they will be treated, including through the NHS app.

6. All parts of the health and care system – primary care, social care, community health, mental health, acute, and wider system partners – will need to work closely together to support people's needs more systematically, building on existing cross-team working, such as primary care networks, provider collaboratives and collaboration with the voluntary, community, faith and social enterprise (VCFSE) sector. In some parts of the country this is already happening, and much can be learned from these experiences. System* leaders will need to work with partners across local communities, together creating a collaborative high-support, high-challenge culture, to develop a shared vision and outcomes, define population boundaries for neighbourhood health and introduce joint accountability arrangements.

* Use of the term "system" in this publication refers to integrated care system.

7. In the coming months, drawing on learnings from existing work, the focus will be on creating the national and local conditions for different ways of working. The diagram below shows the aims for all neighbourhoods over the next 5 to 10 years. For 2025/26, through the standardisation and scaling of the initial 6 components, we are asking systems to focus on the innermost circle to prevent people spending unnecessary time in hospital and care homes. As core relationships between the local partners grow stronger, we expect systems to focus increasingly on the outer circles. This will involve exploring their own ways of building or reinforcing links with wider public services, the third sector and local communities to fully transform the delivery of health and social care according to local needs:

Diagram showing the aims for all neighbourhoods over the next 5 to 10 years



(https://www.england.nhs.uk/wp-content/uploads/2025/01/Diagram-showing-the-aims-for-all-neighbourhoods-over-the-next-5-to-10-years.png)

Image text:

- NHS and social care working together to prevent people spending unnecessary time in hospital or care homes.
- Strengthening primary and community based care to enable more people to be supported closer to home or work.
- Connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services.

Neighbourhood health is an important part of wider public sector reform. Previous estimates suggest around 1 in 5 GP appointments are taken up for non-medical reasons, such as loneliness or to seek advice on housing or debts. A less complex and simpler connection between health and wider local public services, as depicted in the outer circle of the diagram, has the potential to improve outcomes for people and wider public sector productivity, and to reduce pressure on GP surgeries, emergency departments, acute hospital services and providers of long-term social care. It is an opportunity to enhance the partnership between councils, local public agencies like job centres, the third sector and NHS partners, and to design much clearer pathways for non-medical support from the local public and third sectors.

8. NHS England regional teams, working with local government partners and informed by the evidence generated from existing work in systems, should work with systems to agree locally what specific impacts they will seek to achieve during 2025/26. We expect these to include, as a minimum, **improving timely access** to general practice and urgent and emergency care, **preventing long and costly admissions** to hospital and **preventing avoidable long-term admissions** to residential or nursing care homes.

9. This document provides further guidelines on neighbourhood health. These draw together key points from earlier guidance and build on existing local best practice. It should be read alongside the 2025/26 NHS operational planning guidance (https://www.england.nhs.uk/publication/2025-26-priorities-and-operational-planning-guidance/) and 2025 to 2026 Better Care Fund policy framework (https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026), so systems can make progress against the above aims in advance of the publication of the 10 Year Health Plan.

Making a start on delivery

10. Many local organisations across England have collaborated over the past few years to develop great examples of one or more of the individual components that make up an effective neighbourhood health service. Many of these best practice examples have informed the development of national policy or guidance, including the Fuller Stocktake (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/) and Intermediate care framework (https://www.england.nhs.uk/publication/intermediate-care-framework-

for-rehabilitation-reablement-and-recovery-following-hospital-discharge/). The priority now is to connect those components and implement them system-wide, starting with frontline services for people with the most complex health and care needs.

11. While 2025/26 will be a challenging financial year for the NHS, local government and social care, the coming months offer a significant opportunity to build on current momentum for a neighbourhood health approach in order to ensure the ongoing sustainability of health and social care delivery. Systems are asked to do this by:

- **standardising 6 core components of existing practice** to achieve greater consistency of approach
- **bringing together the different components into an integrated service offer** to improve coordination and quality of care, with a focus on people with the most complex needs
- **scaling up** to enable more widespread adoption
- **rigorously evaluating** the impact of these actions, ways of working and enablers both in terms of outcomes for local people and effective use of public money

This will set the foundations for scaling and expanding the neighbourhood approach over the coming years.

12. The focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. This cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs, according to NHS England analysis from adapted Bridges to Health data. It is likely that systems will initially prioritise specific groups within this cohort where there is the greatest potential to improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care, both improving outcomes and freeing up resources so systems can go further on prevention and early intervention. This approach is likely to focus on around 2% to 4% of the population. Examples of population cohorts with complex needs include:

- adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia)
- people of all ages with palliative care or end of life care needs
- adults with complex physical disabilities or multiple long-term health conditions
- children and young people who need wider input, including specialist paediatric expertise into their physical and mental health and wellbeing
- people of all ages with high intensity use of emergency departments

13. Increasing coordination, consistency and scale in delivering health and social care to specific sub-cohorts should result in the following benefits over time:

- avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life
- streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up
- maximising the use of community services so that better care is provided close to or in people's own homes
- reducing emergency department attendances and hospital admissions, and where a hospital stay is needed, reducing the amount of time spent away from home and the likelihood of being readmitted to hospital
- reducing avoidable long-term admissions to residential or nursing care homes
- reducing health inequalities, supporting equity of access and consistency of service provision
- improving people's experience of care, including through increased agency to manage and improve their own health and wellbeing
- improving staff experience
- connecting communities and making optimal use of wider public services, including those provided by the VCFSE sector

14. Evidence from services and research (https://www.prucomm.ac.uk/assets/uploads/files/commissioning-for-integrated-service-delivery-at-place-initial-report-final-2.pdf) has identified elements of partnership working that are critical for effective implementation of neighbourhood health:

- **a mechanism for joint senior leadership**, such as a joint neighbourhood health taskforce, **in each place** to drive integrated working, comprising senior leaders from the constituent organisations across health and care, including the acute hospital
- **a collaborative high-support, high-challenge culture,** which fosters strong relationships between all system partners, including the NHS, local government, social care providers and the VCFSE sector. This culture is supported by **shared values, outcomes, clear lines of accountability and definitions** for how services are organised at place and neighbourhood level (https://www.england.nhs.uk/publication/designing-integrated-care-systems-icss-in-england/) (aligning service delivery across organisations to agreed populations at these levels)

- **visible clinical and professional leadership and management**, at both system and place level, supported through the effective clinical and care professional leadership framework (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/#heading-13). This includes **working in partnership with communities** (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/#heading-12) (including people and carers* with lived experience and local third sector organisations) to co-develop neighbourhood health locally, and to mobilise change
- **effective processes** (including communication channels, IT systems and information governance processes) and **training and workforce development** to enable collaborative working
- **making best use of all funding arrangements**, including those that are formally pooled, to facilitate partnership working

* Wherever “carer” is used in this publication, it refers to both paid and unpaid carers, however there are key differences between the two. Unlike paid carers (professionals either employed by the individual receiving care, or via NHS or local authority funding or services), unpaid carers can be anyone – including children – who look after a family member, partner or friend who cannot cope without their support. The Care Act 2014 requires local authorities to assess, provide support and promote the wellbeing of unpaid carers.

15. Learning from work in 2025/26, alongside emerging research and innovation, will inform the future development of the neighbourhood health and care model as it extends to other population cohorts. This learning will also shape support offers to systems, and a more formal evaluation framework for the future delivery of neighbourhood health systems will be developed. We now ask systems to:

- consider how they will evaluate the impact of the changes they make in a systematic, consistent and scalable way to build the case for future expansion and link to the triple aim of improving population health outcomes, people’s experience of health and care services and value for money
- embrace the government’s “test and learn” approach (https://www.gov.uk/government/speeches/reform-of-the-state-has-to-deliver-for-the-people) to enable continuous improvement in real-time and build on existing good practice such as the NHS IMPACT Improving Patient Care Together framework (https://www.england.nhs.uk/nhsimpact/)

Summary of requirements for 2025/26

16. Building on the foundations laid by the Fuller Stocktake (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/), approaches to tackle health inequalities, such as Core20PLUS5 (https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/) and Core20PLUS5 for children and young people (https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/), outreach work and using data and local insights, systems should work with partner organisations to:

- **apply a consistent, system-wide population health management approach** which draws on quantitative data and qualitative insights to understand needs and risks for different population cohorts
- **use this information to design and deliver the most appropriate care for each population cohort** and to inform best-value commissioning decisions that empower frontline staff to provide more person-centred care, enabling people to live independently for longer
- **continue to embed, standardise and scale the 6 initial core components of a neighbourhood health service** (detailed in appendix 1) and ensure capacity and structures across providers are aligned to best meet demand

17. Best practice also suggests systems should consider:

- improving coordination, personalisation and continuity of care for people with complex needs, including increased agency in managing their own care, supported by:
    - a single electronic health and care record that is actively used in real-time by frontline health and social care staff
    - a care coordination function between the person or their carer and the wider multi-professional team supporting them if needed, working across organisational boundaries
- applying learnings from existing or emerging neighbourhood health models, such as enhanced health in care homes (https://www.england.nhs.uk/community-health-services/ehch/), the 24/7 neighbourhood mental health centres (https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/localising-and-realigning-inpatient-services/), women's health hubs (https://www.england.nhs.uk/publication/womens-health-hubs/), family hubs (https://www.gov.uk/government/collections/family-hubs-and-start-for-life-

programme) and the Health and Growth Accelerators (https://www.england.nhs.uk/2024/12/world-leading-nhs-trial-to-boost-health-and-support-people-in-work/), ensuring that services are delivered at an efficient and effective scale

18. Systems should also tackle health inequalities (https://www.england.nhs.uk/long-read/publication-of-nhs-englands-statement-on-information-on-health-inequalities/) when developing their neighbourhood health service. This will include:

- getting the basics right (such as ensuring services are accessible to people with disabilities and implementing reasonable adjustments as needed)
- engaging with local communities and working with them as equals to design and deliver services, working particularly closely with specific communities that have been historically underserved
- analysing outcomes by population demographics, deprivation, age, ethnicity, disability (supported by the reasonable adjustment digital flag (https://digital.nhs.uk/services/reasonable-adjustment-flag)) and inclusion health groups (https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)

Next steps

19. ICBs and local authorities are asked to jointly plan a neighbourhood health and care model for their local populations that consistently delivers and connects the initial core components at scale, with an initial focus on people with the most complex health and care needs. More mature systems will be working to develop an integrated neighbourhood delivery plan across the 6 initial core components, published as part of Joint Forward Plans and informed by engagement with local communities, that includes:

- improving collaboration and enabling effective ways of working
- agreeing commissioning models, new funding flows and contractual mechanisms between the NHS and local authorities
- workforce planning and development
- evaluation
- exploring the use of neighbourhood buildings across all partners, including local government, following on from recent ICB-led estates strategy work

20. We will provide further details of a national implementation programme over the coming months, designed for all parts of the health and social care system involved in delivering neighbourhood health. The initial phase of this programme will aim to work with at least one place in every system. These places will already be demonstrating a more developed approach to delivery at local level, with clear

leadership across the ICB, local NHS and local authority. System partners in these places will be provided with facilitation support, as well as support to ensure robust evaluation and monitoring of progress. This test and learn approach will help to identify what is working most effectively and the conditions that are required to deliver a set of target outcomes. The national implementation programme will sit alongside a very small number of learning and evidence sites, which will test the model at scale, including its impact on flows in and out of an acute hospital.

21. We have shared case studies of existing good practice (https://www.england.nhs.uk/publication/neighbourhood-health-case-studies-of-good-practice/). NHS England regional teams, working with local government partners, will continue to have a key role in sharing and spreading emerging best practice and learning with systems.

22. We will continue to work with systems to co-develop the vision for neighbourhood health, focusing on removing barriers and creating the conditions for success. These guidelines will be kept under review as further learning emerges.

Appendix 1

The foundations of a neighbourhood health service are already in place in many areas across the country. This appendix describes 6 core components (A to F) associated with an effective neighbourhood service, as identified from the current evidence.

Initial 6 core components

Local systems will need to consider each component within the context of the needs of their local population and the current configuration of services. They will also need to evaluate how effectively individual interventions link together to improve the way services are delivered for their local population and the outcomes people achieve.

Given local projections of future need and demand, systems will want to consider how to have the greatest impact on health and wellbeing outcomes for the local population as well as benefits for the system when prioritising resource allocation, strategic leadership and quality improvement efforts.

A. Population health management

- Ensure there is a person-level, longitudinal, linked dataset encompassing:

    - general practice and wider primary care
    - community health services
    - mental health
    - acute care
    - social care
    - public health

Over time, this dataset should be broadened to include other data held by local or central government, including employment, education, safeguarding and housing status. It should be supported by appropriate data sharing and processing agreements. This should enable analysis of population health outcomes, biopsychosocial risk drivers and health and care system resource use. NHS England will continue to work with the National Data Guardian to support integrated care boards (ICBs) to navigate the necessary information governance requirements, but partners should already share existing data wherever possible.

- Apply a single, consistent system-wide population health management method to ICB analytics platforms to segment and risk stratify populations, based on complexity and forecasted resource use. Where systems do not already have an existing tool, they must work with the NHS Federated Data Platform team to select one which is compatible. In 2025/26, NHS England will work with ICBs to review the impact and evidence behind effective risk stratification to enable further signposting to validated tools.
- A population health management approach should be supported by a system-wide intelligence function (https://www.england.nhs.uk/long-read/building-an-ics-intelligence-function/) used to:
    - inform strategic commissioning and resource allocation
    - enable providers to work together to best organise their workforce to deliver health and care

Systems should ensure they complement these analytical approaches with wider quantitative and qualitative insight into groups that might be under-represented in NHS datasets, for example, people with severe mental illness or learning disability or autistic people. Implementation of the Reasonable Adjustment digital flag information standard (https://www.england.nhs.uk/long-read/the-reasonable-adjustment-digital-flag-action-checklist-what-you-need-to-do-to-achieve-compliance/) will also help analyse data for some of these population groups.

- Clinical data systems should have complementary functionality, including compatibility and integration between GP systems, digital social care records and other provider systems. This will support effective case finding, care navigation and risk-based prioritisation of proactive, planned, responsive and urgent care. This will also inform the design and work of neighbourhood multidisciplinary teams.

- Further guidance on using data to segment and risk stratify populations will follow in 2025, to complement existing resources (https://www.e-lfh.org.uk/programmes/population-health-management/) and the Population Health Academy (https://future.nhs.uk/connect.ti/populationhealth?sm_newemail=).
- Learn more in case study 1: Linking data and embedding a single system-wide population health management approach (https://www.england.nhs.uk/long-read/linking-data-and-embedding-a-single-system-wide-population-health-management-approach/).
- Read case study 4: Transforming care through modern general practice and population segmentation (https://www.england.nhs.uk/long-read/transforming-care-through-modern-general-practice-and-population-segmentation/) to learn more about how automated stratification is integral to Brookside Group Practice's approach.

B. Modern general practice

- ICBs are asked to continue to support general practices with the delivery of the modern general practice model (https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/), to deliver improvements in access, continuity and overall experience for people and their carers. This is a response to increasing demand and a foundational step to enable practices to move from a model of reactive to more proactive care.
- ICBs are expected to streamline the end-to-end access journey for people, carers and staff, making it quicker and easier to connect with the right healthcare professional, team or service, including community pharmacy, use of Pharmacy First (https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/pharmacy-first/) and digital self-service options such as repeat prescription ordering via the NHS app. This approach will accommodate the needs of different groups and patients and support continuity of care.
- People and their carers should have the ability to access services equitably (https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/) in different ways (online, telephone and in person) with highly usable and accessible online systems (the NHS app, practice websites, online consultation tools) and telephone systems. There should also be structured information gathering at the point of contact (regardless of contact channel) and clear navigation and triage based on risk and complexity of needs.
- Staff should have access to structured information about the complexity of the presenting complaint and need. This information should be organised

alongside population segmentation (including by age) and risk stratification information into a single workflow. This approach will support staff in efficiently navigating and triaging needs safely and fairly, including enabling risk-based prioritisation of continuity of care and optimising use of the general practice and wider multi-professional team.

- Read case study 3: Improving access and workforce wellbeing through a modern general practice model (https://www.england.nhs.uk/long-read/improving-access-and-workforce-wellbeing-through-a-modern-general-practice-model/) for more information about Lime Tree Surgery's approach, including using an online consultation platform and making use of Additional Roles Reimbursement Scheme (https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/) (ARRS) staff.
- Read case study 4: Transforming care through modern general practice and population segmentation (https://www.england.nhs.uk/long-read/transforming-care-through-modern-general-practice-and-population-segmentation/) to learn more about how Brookside Group Practice have used digital innovation to improve primary care and health outcomes.

C. Standardising community health services

- Many community health services will play a key role in delivering neighbourhood health and care, and many of these services should be commissioned as part of an integrated neighbourhood health offer.
- When designing, commissioning and delivering neighbourhood health, ICBs and providers should be using the Standardising community health services publication (https://www.england.nhs.uk/publication/standardising-community-health-services/) (covering NHS-funded specialist support for people with physical health needs and neurodevelopmental services for children and young people). This will ensure funding is used to best meet local needs and priorities.
- Some people will have both physical and mental health needs, or drug and alcohol dependency. It is essential that care is planned to meet all health and social care needs and that service boundaries do not prevent seamless, joined-up care. Systems should continue to make use of the mental health Additional Roles Reimbursement Scheme (https://www.england.nhs.uk/mental-health/working-in-mental-health/mental-health-practitioners/), which is jointly funded with primary care, to improve primary care mental health and access to community-based mental health services for people of all ages, as well as through services such as NHS Talking Therapies for anxiety and depression

(https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/). For children and young people, it's also critical to join up with mental health services (https://www.england.nhs.uk/mental-health/cyp/) and mental health support teams (https://www.england.nhs.uk/mental-health/cyp/trailblazers/#_Mental_Health_Support) in schools and further education. For people with co-occurring drug and alcohol dependency, services should engage with local authority commissioned substance misuse services. It will also be important to link in with VCFSE sector support for adults, children and young people around mental health, social isolation and substance misuse.

- Read more in case study 2: Addressing health inequalities faced by people with severe mental illness through mental health practitioners in primary care teams (https://www.england.nhs.uk/long-read/addressing-health-inequalities-faced-by-people-with-severe-mental-illness-through-mental-health-practitioners-in-primary-care-teams/).
- Read case study 5: Standardising community health services to address variation and improve outcomes (https://www.england.nhs.uk/long-read/standardising-community-health-services-to-address-variation-and-improve-outcomes/) to learn more about how North Central London ICS developed a core offer as part of a 5-year plan.

D. Neighbourhood multidisciplinary teams (MDTs)

- The approach to establishing integrated neighbourhood teams has been well defined in the Fuller Stocktake (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/). Such teams bring a wider range of expertise together, from across health, social care, VCFSE and wider partners to benefit a shared population. As part of this approach, there will need to be multidisciplinary coordination of care for population cohorts with complex health and care or social needs who require support from multiple services and organisations. They are expected to deliver proactive (https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty/), planned and responsive care, and prioritise care based on individual people's needs and the opportunity for greatest impact. Footprints should be designed to optimise neighbourhood working and partnership with local authorities. Detailed guidance on neighbourhood MDTs for children and young people (https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/) has been published.
- Functions include overseeing or delivering holistic joint assessments, case reviews and deployment of coordinated provision, medication reviews, care

planning for long-term conditions and personalised care and support planning (https://www.england.nhs.uk/personalisedcare/pcsp/), including social prescribing (https://www.england.nhs.uk/personalisedcare/social-prescribing/), comprehensive geriatric assessments and advanced care plans. For people with co-occurring severe mental illness, we would expect these functions to remain within core community mental health services. However, we would expect a joined-up approach to planning care for people with significant mental and physical health needs across teams.

- In best practice models, a core team is assigned for complex case management, with links to an extended team that enables access to additional specialist resource as needed. The composition of teams may vary depending on the population being served by the MDT and local prioritisation of clinical need. Teams could include GPs, specialist nurses or consultants (such as, specialist dementia nurses and secondary care clinicians, including paediatricians and geriatricians), district nurses, GP nurses, acute hospital consultants, allied health professionals, health visitors, mental health professionals, social prescribing link workers and social workers, home care staff, residential care home and nursing home staff, as well as wider system and community partners (such as from public health and the VCFSE sector).
- It is best practice to assign a care coordinator to every person or their carer in the population cohort as a clear point of contact to improve both their experience and continuity of care. The role could be undertaken by any member of the core team and will link into clinical triage and onward referrals as required. It will also set expectations with the person or their carer as part of the care plan process, so that all parties understand their part in improving outcomes.
- Case study 6: Strong working relationships as the bedrock of neighbourhood multidisciplinary teams (children and young people focused) (https://www.england.nhs.uk/long-read/strong-working-relationships-as-the-bedrock-of-neighbourhood-multidisciplinary-teams-children-and-young-people-focused/) highlights relevant learning from Connecting Care for Children.
- Learn more about Northamptonshire's co-produced model of care in case study 7: Working with communities to mobilise change through neighbourhood multidisciplinary teams (frailty focused) (https://www.england.nhs.uk/long-read/working-with-communities-to-mobilise-change-through-neighbourhood-multidisciplinary-teams-frailty-focused/).
- Read more in case study 8: Provision of person-centred holistic care delivered by neighbourhood multidisciplinary teams (high intensity use focused) (https://www.england.nhs.uk/long-read/provision-of-person-

centred-holistic-care-delivered-by-neighbourhood-multidisciplinary-teams-high-intensity-use-focused/).

- Case study 9: Women's health hubs providing integrated care at neighbourhood level (https://www.england.nhs.uk/long-read/womens-health-hubs-providing-integrated-care-at-neighbourhood-level/) highlights learning about harnessing the skills of multidisciplinary teams.
- Case study 10: Strong relationships between system partners and multi-professional teams (palliative care and end-of-life care focused) (https://www.england.nhs.uk/long-read/strong-relationships-between-system-partners-and-multi-professional-teams-palliative-care-and-end-of-life-care-focused/) looks at an example of collaboration across primary care, community care and the voluntary sector.

E. Integrated intermediate care with a 'Home First' approach

- Systems are asked to deliver short-term rehabilitation, reablement and recovery services (integrated intermediate care) taking a therapy-led approach (rehab or reablement care overseen by a registered therapist) working in integrated ways across health and social care and other sectors.
- Ensure referrals can be made directly from the community (step-up) or as part of hospital discharge planning (step-down (https://www.england.nhs.uk/publication/intermediate-care-framework-for-rehabilitation-reablement-and-recovery-following-hospital-discharge/)), applying a 'Home First' approach (https://www.england.nhs.uk/publication/a-community-rehabilitation-and-reablement-model/), with assessments and interventions delivered at home where possible and working closely with urgent neighbourhood services.
- Implement good operational case management systems and measure outcomes (with reference to the objectives and metrics set out in the Better Care Fund policy framework for 2025 to 2026 (https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026)) to ensure best use of resources.
- Read more about how this can work in practice in case study 11: Supporting effective collaboration for 'Home First' rehabilitation, reablement and recovery services through a system-wide reporting suite and common analytics dashboard (https://www.england.nhs.uk/long-read/supporting-effective-collaboration-for-home-first-rehabilitation-reablement-and-recovery-services-through-a-system-wide-reporting-suite-and-common-analytics-dashboard/).

F. Urgent neighbourhood services

- Standardise and scale urgent neighbourhood services for people with an escalating or acute health need. This means ensuring urgent community response (https://www.england.nhs.uk/community-health-services/urgent-community-response-services/) and hospital at home (virtual ward) (https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/) services are aligned to local demand and work together (with access increasingly through a single point of access (https://www.england.nhs.uk/long-read/single-point-of-access-spoa/)) to deliver a co-ordinated service. These urgent neighbourhood services should align with services at the front door of the hospital, such as urgent treatment centres (https://www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards/) and same day emergency care (https://www.england.nhs.uk/urgent-emergency-care/same-day-emergency-care/), which are also increasingly accessed through a single point of access.
- As part of ambulance service improvement of See and Treat and Hear and Treat pathways, senior clinical decision makers in a single point of access should provide advice and referral to appropriate services either before ambulance dispatch or as part of a “call before convey” approach. Single points of access should also provide clinical advice to other healthcare professionals and care home workers, so staff avoid calling 999.
- As outlined in the integrated intermediate care section above, ensure step-up pathways (to prevent avoidable admissions) and step-down pathways (to support timely and effective discharge) use resources efficiently and effectively. Service footprints should be determined locally, balancing scale of delivery with building on local relationships to ensure smooth referral pathways into urgent and planned care services. Where footprints span multiple neighbourhoods, services should still operate in a way that feels like a seamless service for people and carers.
- Read more in case study 12: Clear lines of accountability and clinical governance structures to deliver effective urgent neighbourhood services (https://www.england.nhs.uk/long-read/clear-lines-of-accountability-and-clinical-governance-structures-to-deliver-effective-urgent-neighbourhood-services/).

Secondary care contribution to neighbourhood health

Local acute services can provide significant contribution to the development of a neighbourhood health service. Home First and person-centred approaches need to be embedded throughout the health and care system so that appropriate risk-based decisions are always made, and hospital care only used when clinically

necessary. In this way, every part of the system works collaboratively to reduce the risks associated with a hospital admission and a lengthy hospital stay if admission is unavoidable.

Clinicians in hospitals can continue to work collaboratively with community-based teams to ensure that their patients benefit from a neighbourhood health service by:

- supporting continuity of care in the community for people under the care of a specialist hospital team such as respiratory, diabetes, stroke or cardiology. This might include providing specialist input to neighbourhood MDTs such as through clinics delivered jointly in primary or community settings, using digital technology and infrastructure, or by establishing pathways into the hospital which avoid the emergency department, for example, by using urgent treatment centres, same day emergency care pathways or outpatient clinics.
- supporting the development of hospital at home (virtual ward) (https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/), single point of access (https://www.england.nhs.uk/long-read/single-point-of-access-spoa/) and community diagnostic centres (https://www.england.nhs.uk/long-read/community-diagnostic-centres/)*, including providing clinical advice and oversight as required.
- ensuring that frailty services are joined up in all settings, whilst maximising the delivery of these services within community settings. This will include the development of frailty-attuned hospital services (https://www.england.nhs.uk/urgent-emergency-care/same-day-emergency-care/acute-frailty/), ensuring they connect with community frailty provision to support integrated end-to-end frailty pathways, and support for care transfer hubs (https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance), which arrange support services to assist discharge from hospital for those with the most complex needs.

By delivering proactive, planned, responsive and urgent care close to or in people's own homes, effective local neighbourhood services will relieve pressure on acute services.

* Community diagnostic centres are likely to be considered anchor sites between primary, community and secondary care, enabling direct referral for diagnostic tests from a range of providers and optimising onward referrals to a range of health care settings for adults and children. 170 community diagnostic centres will be open by March 2025, with more than one in each ICB. The development of neighbourhood health services should include close working with associated community diagnostics centres to ensure that pathways are streamlined.

Planning for a flexible workforce

A flexible workforce working within and for local communities will be crucial for delivering neighbourhood health services.

To prepare for the move towards neighbourhood health, ICBs and local authorities are encouraged to connect as broadly as possible across their local communities to agree how best to use their collective local resources.

- Building on partnerships developed through the Better Care Fund, continue to develop **joint demand and capacity assessment, modelling and planning across health and social care.** This will provide a clear understanding of the capacity available to serve the local population across all providers and commissioners. This should include joint bottom-up mapping of existing workforce capacity, skills and capabilities across all partners and providers (including hospitals and mental health services) to optimise staff deployed across pathways, irrespective of organisational boundaries. This co-ordinated approach will help staff be deployed more flexibly where needed most, enable continuity of care, and create opportunities for streamlined joint recruitment, training and staff rotation across services.
- Take a user-centred approach to the design of teams, including job planning across different settings. This may include upskilling teams within the MDTs to **cover multiple functions that traditionally may have been delivered separately** so they are safely able to work in a more agile way and increase continuity for people and carers.
- **Ensure staff are aware of, and are involved in building, the local neighbourhood service model** to optimise the use of all services, including wider primary care, general practice, mental health, community health services, neighbourhood MDTs, social care services and “self-access” options where appropriate, supported by shared digital tools.
- Identify barriers and opportunities to **better enable productive integrated working** so that staff have the skills and tools to safely work across organisational boundaries and serve their local populations, ensuring best use of funding to meet local need, and improving workforce interactions and experience. This should include ensuring care workers can deliver delegated healthcare activities such as blood pressure checks and other healthcare interventions. The government has recently published new guidance on safe delegation to care staff (https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Managing-a-service/Delegated-healthcare-activities/Delegated-healthcare-activities.aspx).

Case studies

These case studies (https://www.england.nhs.uk/publication/neighbourhood-health-case-studies-of-good-practice/) provide examples of existing good practice that forms the foundations of neighbourhood health.

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