Recommendations

- Health and Wellbeing Board are asked to consider and support the following to progress with implementation of Oxfordshire's neighbourhood health and care approach for 26/27:

  I. National Context (to note)
  II. Objectives and guiding design principles
  III. Neighbourhood geographies (working drafts for 26/27)
  IV. Priorities
  V. Foundations
  VI. Population health management approach

- Primary and Community Care Board will then move to finalise the plan for 26/27

Oxfordshire Neighbourhood health and care plan 2026/27

Oxfordshire Place-based Partnership

Proposed Priorities: 12.03.26

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National Context

National Context

National NHS Neighbourhood guidance delayed – latest national update shared 23/2/26

Neighbourhood Health Next Steps

Next Step	Progress
National baseline of neighbourhoods	• The NNHIP programme has recently completed a baseline of the 43 pilot sites against the 7 steps that are likely to be outlined in the Model Neighbourhood Framework • A full baseline is being requested for March 2026, which is a self-assessment against a range of criteria, including a maturity matrix • For step 3 on interface this is likely to be around: • *How mature plans are to improve the interface management between primary and secondary care, mental health and community services' e.g using frameworks like the red tape challenge and bridging the gap?* • *Do these plans include actions to cover the following priority areas of focus as set out in 'Bridging the gap'?*
Neighbourhood Health Planning	• National guidance on the requirements for the Health and Wellbeing Boards on Neighbourhood Health is being awaited but it is expected that the Health and Wellbeing Boards will be required to complete a neighbourhood health strategy and delivery plan as some point during 26/27
Better Care Fund	• For 26/27 ICBs and Local Authorities have been asked to align their funding with neighbourhood health priorities, with a specific focus on priority cohorts e.g. frail elderly, LTCs. • ICBs and LA have also been tasked with identifying developments in intermediate care and how services can be better integrated to support step up and step down care. Specifically, to optimise home based intermediate care and review home-based versus bedded capacity to ensure the most optimal model for the population based on outcomes • From 27/28 there is likely to be greater integration between BCF and Neighbourhood plans, which will be consulted on in 26/27

National Context

National NHS Neighbourhood guidance delayed – latest national update shared 23/2/26

Oxfordshire Place-based NHS England South East

Model Neighbourhood Framework (Priority Steps)

We will be asking ICBs, working across NHS providers and in partnership with wider system partners, to take the following seven priority steps before throughout 2026/27. We recognise areas will be at different starting points and some may be in a position to go further and faster than the steps described.

Step 1	**Agree neighbourhood footprints around natural communities**	An agreed set of neighbourhoods for each HWB area that the public can recognise, and GPs, Trusts and LA partners can see their teams working together in.
Step 2	**Ensure good access to high quality general practice**	The population has good access to their practices and where not, there is an agreed plan between the ICB and the practice to better balance demand and capacity that will result in good access.
Step 3	**Continue to improve the interface between primary, secondary, community and mental health care**	Improved relationships, proven quantitative improvement in the areas listed in the interface document, and a clear plan to implement Red Tape Challenge recommendations.
Step 4	**Agree plans, with LA partners, to establish Integrated Neighbourhood Teams (INT) focused on people at higher risk of hospital admission**	INTs covering this cohort (frailty, care home residents, housebound and end of life) are accessible in every neighbourhood with clear leadership, focus and shared outcomes.
Step 5	**Agree an initial plan, developed with LA partners, to increase capacity for multi-neighbourhood urgent and acute care, rehabilitation and reablement.**	Better and more joined up management of urgent and acute care closer to home for the priority cohort above. Total non-elective bed days should be kept stable as the underlying growth in demand is met by the development of neighbourhood provision.
Step 6	**Agree how to use pooled funding under the Better Care Fund**	Ensure robust contractual arrangements in place to support the delivery of BCF priorities to deliver against the KPIs.
Step 7	**Improve access to specialist opinion and diagnostics across elective pathways, focusing on LTCs**	Patients receive more specialised support closer to home, whether that is from GPs, community or neighbourhood teams, digitally enabled where appropriate.

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Approach to Developing the 26/27 Plan

Our 26-27 plan is guided by

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i) Original 6 components NHS England » Neighbourhood health guidelines 2025/26

ii) NHS Medium Term Planning Guidance NHS MedimMedium term planning framework - delivering change together 2026/27 to 2028/29

i) Better Care Fund Better Care Fund framework 2026 to 2027 - GOV.UK

ii) National neighbourhood health and care framework and archetypes – delayed

iii) Oxfordshire's Health and Wellbeing Strategy Health and wellbeing strategy 2024-2030 | Let's Talk Oxfordshire

iv) Oxfordshire's Marmot principles The Marmot Place Programme | Oxfordshire County Council

v) Collaborative Oxfordshire Place wide initiatives including: Best start in life family hubs; special education needs and disabilities plan; health inequalities programme; Oxfordshire's programme for urgent and emergency care, community insight profiles, community capacity building approaches and partner and community engagement input

Objectives and Guiding Design Principles

Objectives

- Adapted from national policy objectives for Neighbourhood health and care:

1. Strengthening primary and community-based care to enable more people to be supported closer to home or work

2. Health and social care working together to prevent people spending unnecessary time in hospital or care homes

3. Connecting people accessing health and care to wider public services & their sector support including community assets, social care, public health, VCFSE services and support and government services

What difference will neighbourhood health and care make for people, families and our workforce?

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- More people and families supported to live independently in their homes and local communities.

- Narrowing health inequalities for our underserved communities and disadvantaged population groups.

- Strong alliances between the voluntary sector, community groups, local authorities and health and care services enabled through co-production between people, families and staff.

- Data alongside local insights and experiences from people, families, professionals and practitioners directly informs decision making

- Resources are aligned to achieve equity of outcomes for our neighbourhoods.

- Oxfordshire recognised as a model for how a rural-oriented with a historical City core delivers neighbourhood-based health and care guided by evidence, research, innovation and continuous improvement.

Guiding Design Principles - draft

- Principles have been developed following input from the Health and Wellbeing Board, stakeholder engagement across health and care partners, voluntary and community sector and patients, carers and families.
- The Health and Wellbeing strategy principles provide the direction
- Our Neighbourhood health and care principles are founded on **what needs to always be true** across our approaches to enable us to succeed

Oxfordshire's Neighbourhood health and care design principles

- Holistic, proactive and prevention focused
- Needs led built from evidence and good practice
- Collective responsibility for decisions, delivery and evaluation
- Sustainable through working together
- Equitable - challenges and redresses gaps

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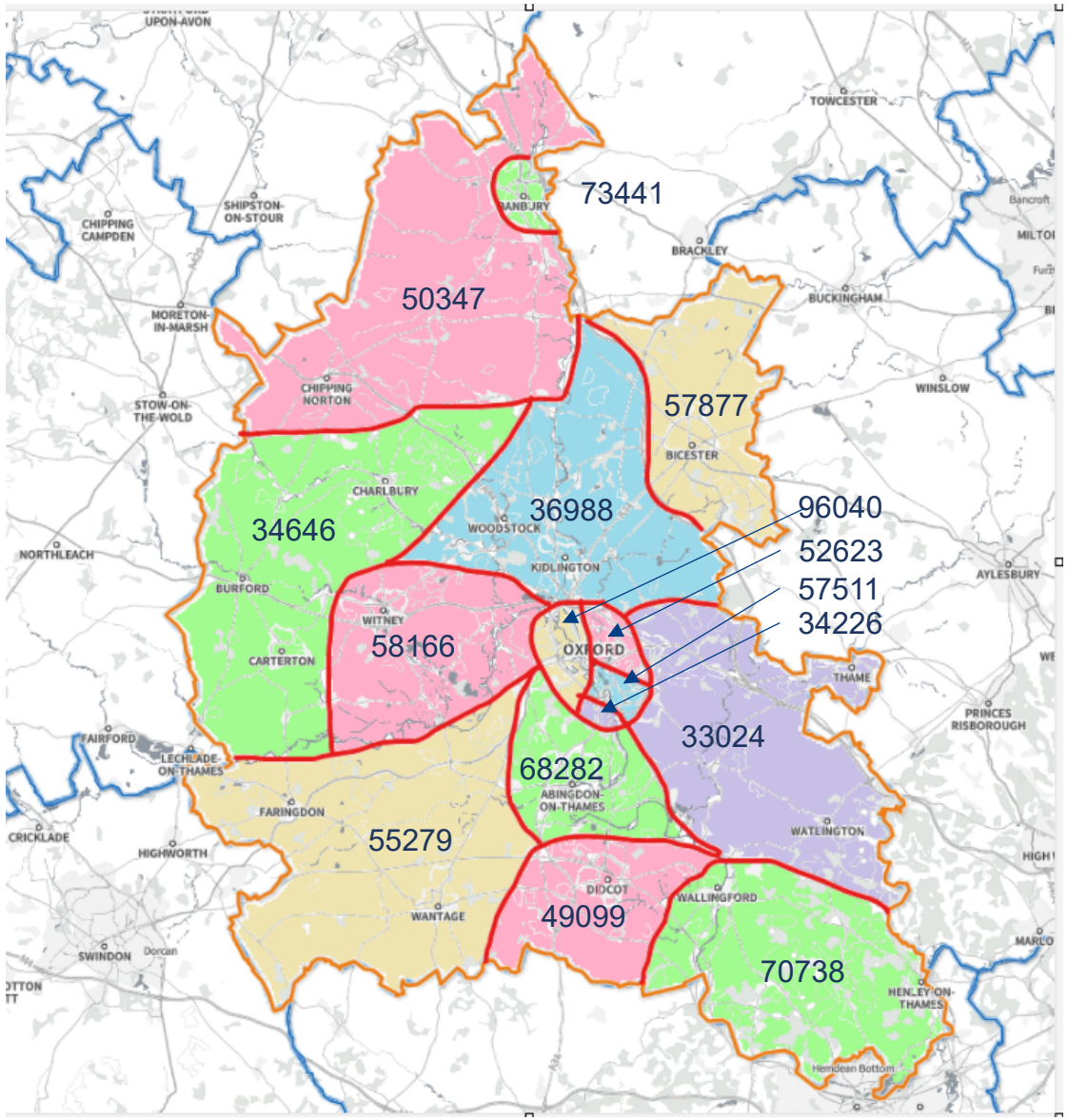
Neighbourhoods Structure

Working draft of Oxfordshire Neighbourhoods



- For visualisation only
- 15 Neighbourhoods
- Boundaries may not be accurate and are shown for illustrative purposes only

Note: The proposed geography has no implication on individual GP practices continuing to deliver Primary Medical Services to their local population

Neighbourhood functions

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System Partnership

Oxfordshire

Multi-Neighbourhoods

Neighbourhood

Where I Live

People & Families

My health and wellbeing (making healthy choices, having a sustainable environment and supportive social connections)

Self-care (where possible) with education

Easy digital or alternative supported access to all health and care and local community (community hall or virtual networks) particularly at times of need

GP Surgery, Pharmacy, Community hall, early years settings, schools (maybe co-located in Neighbourhood centre)

~5 – 30K population

Familiar, trusted, reliable, simple to access for all

Local community & voluntary groups supporting communities

Model of care targeted for those experiencing greatest inequalities

Neighbourhood Health and Care & Integrated Neighbourhood Teams

~50K Population

Cross border pathway interfaces (e.g. Berks)

Neighbourhood Centres (or as outreach "pop ups" located in a setting in where I live) Primary, community, mental health, social care and local authority services, secondary care, voluntary & community e.g. citizens advice. Non-urgent diagnostics to support timely assessment and ongoing management of health and care needs.

Maybe co-located with Family Hubs or mental health hubs or local GP surgery

Integrated Neighbourhood Teams (co-location/ virtual) of primary, community, mental health, social care and voluntary and community sector - co-ordinated care guided by population health management data and local insights and engagement with the community

Multi-Neighbourhoods

~250K Population

Intermediate care (step up and step down) and reablement.

Sub-acute care.

Community-based urgent care with access to more specialist diagnostics alongside secondary care

Acts as an anchor for Neighbourhood Health and Care Centres to support more community-based care

Place

~825K population

Infrastructure support, co-ordination and integration.

Shapes health and wellbeing strategy including reducing inequalities

Ensures consistency of core offer

Specialist services and their input into Neighbourhoods

Acute hospital care

Cross border pathway's strategy management

Primary Care Networks

Core service offer to all

Our Priorities

Our Framework for Neighbourhood Health and Care

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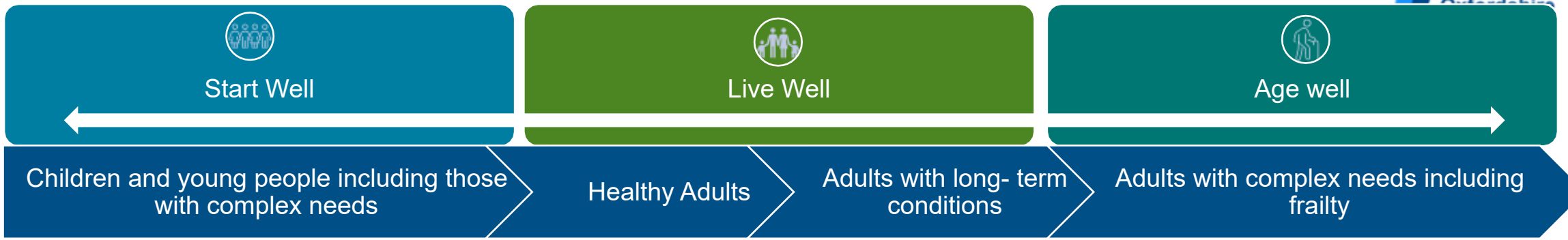
Four phases over the next five years underpinned by population health management and guiding design principles:

- Phase 1: Establishing the **foundations** (Sept 25 - April 26)
- Phase 2: **Developing** our Neighbourhoods (April 2026-28)
- Phase 3: **Maturing** our Neighbourhoods approach (2028-30)
- Phase 4: **Embedding** (2031-onwards)

Oxfordshire Neighbourhoods Health and Care Plan 26/27 - Summary



Priority Cohorts

Keeping well/ Staying Well

People and families take more control of own health and wellbeing with targeted support to reduce inequalities

Children and Young People's Multi Disciplinary Teams (MDTs) to consider

Management of multiple long term conditions (MLTCs) in working age adults (>2 or 1 + health inequality)

Proactive and integrated care for people living with frailty

Place

Focusing on the foundations

Population Health Management
Segmentation and risk stratification analytics to inform population cohorts of focus

Improving Primary Care interface with
Secondary care, Community, Mental health, ICB

Partnerships
Governance to enable effective neighbourhood working

Elective Care
Increasing Information, advice and guidance (IAG) and patient initiated follow ups (PIFUs)
Scoping future community-based model

Intermediate urgent care
Maximising home-based intermediate care capacity (step up and step down)

Digital

Workforce

Estates

15* Neighbourhoods
Links up and down through Place focusing on priority cohorts and local priorities

Engagement and co-production

- With targeted cohorts of the population and individuals with lived experience
- With voluntary, faith and community groups
- With professionals and practitioners

* Working drafts for 26/27

Population Health Management Approach

Population health management approach for 26/27

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- Health Evaluation and Population Health Management Steering Grp in March to consider role and function and terms of reference from April 26 to co-ordinate population health data and insights work to support neighbourhood plan implementation and monitoring of impact:

1. Baseline metrics aligned to priorities
2. Data insight packs for each Neighbourhood
3. Risk stratification and segmentation approach for priority population cohorts to enable and support case finding
4. Utilisation of shared care records
5. Triangulation of activity, outcomes and impact metrics with resources deployed

Our Approach

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- The **Health and Well-being Strategy** signed up by all partners on the Health and Well-being Board recognises that not only do we need interventions at the life course approach, so at the start of life during your working life and then as you age but also key principles including **tackling health inequalities**. So for example, making sure there isn't a gap between the outcomes in a more deprived area than in a less deprived area and having really close **collaboration between our professional partners and with the community** when developing services and care pathways.

- It is well recognised that there are **building blocks of health and care** and our local Health and Well-being strategy is addressing these wider determinants of health. So if, for example, somebody is experiencing difficulty with having secure housing or they don't have financial stability or haven't had good access to education that has a long-term impact on the outcomes for their life course and the outcomes for their health and care needs.

- **For Neighbourhood health and care**, we'll be taking a population health management approach and what this means is having a look at the needs of the population and segmenting those populations by a particular need and then looking at the risks that are presented and looking at all the things that you could do to help with that health risk – so what is going to have the greatest impact is called population health management. It is very much a data driven approach and really helps us understand both the high risk needs of our population, but also where can we make the biggest difference and where we can achieve the best value with our resources.

What determines our health and care needs?

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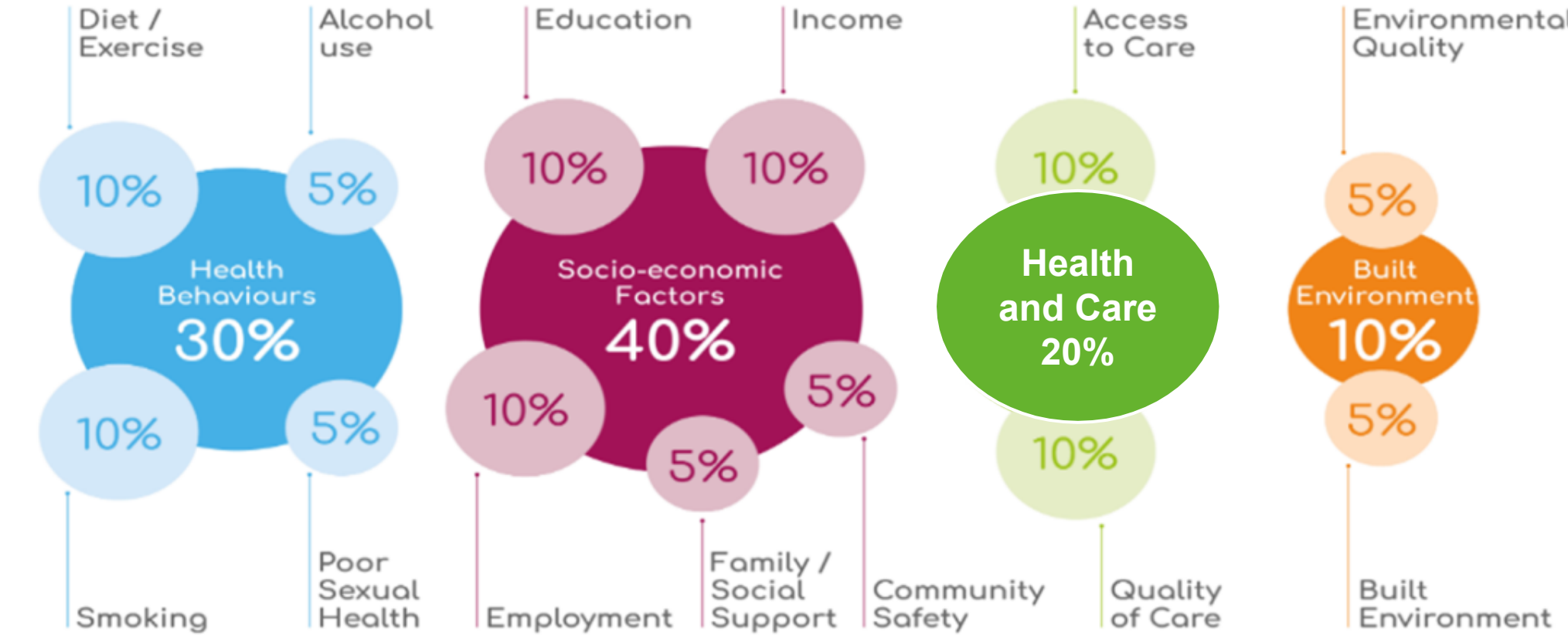
Our neighbourhood health and care plan is designed and delivered across all of the interdependencies that shape our health and wellbeing and not in isolation of these factors



SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

Risk stratification and segmentation approach

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