

Neighbourhood Health Services

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Neighbourhood Health Guidelines

- At its heart, the neighbourhood health model is intended to join up services in the community in a more effective way, particularly for people with more complex health and care needs, helping children thrive and supporting adults to stay independent for longer, improve health and wellbeing, and reduce avoidable pressures on health, social care and other public services. This clearly requires close partnership between the NHS, local government, social care providers, the voluntary sector and other community partners, working closely with people who draw on care and families and unpaid carers.
- There are many good examples of local integration and collaboration, which provide the foundations of neighbourhood health. In 2025-26, we are asking local systems to focus on supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations, developing and bringing together into an integrated service offer six core components of a neighbourhood health model:
 - a) Population health management
 - b) Modern general practice
 - c) Standardising community health services
 - d) Neighbourhood multi-disciplinary teams
 - e) Integrated intermediate care with a 'Home First' approach
 - f) Urgent neighbourhood services







NHS England Neighbourhood Health Guidelines for 2025/26

- The Neighbourhood Health Guidelines set a framework for how systems can move towards a community-centric model of healthcare delivery, working towards achieving the three strategic shifts set by the government for the NHS in 2024. In keeping with other recent NHSE publications, these guidelines are deliberately short and permissive, enabling systems to build services tailored to local needs, existing infrastructure and relationships.
- Systems will be supported by NHSE regional teams to set specific goals for the upcoming financial year, with the overall focus being to set the foundation for the neighbourhood model which can be scaled in the future. A national implementation programme will support one exemplar place in each ICB to develop its model building on existing work and best practice, plus a small number of learning and evidence sites that will test implementation at scale.
- Integrated care boards and local authorities are asked to jointly plan a neighbourhood health model for their local populations that consistently delivers and connects these core components, focusing initially on people with the most complex health and care needs. We will provide further details of a national implementation support programme over the coming months

The 5–10-year vision

1. NHS and social care working together to prevent unnecessary time in hospitals or care homes (focus for 2025/26 is on this step)
2. Strengthening primary and community-based care to enable support closer to home or work
3. Connecting people to wider public services and third-sector support

6 core components of an effective neighbourhood service

	Population health management <ul style="list-style-type: none">• A person-level, longitudinal, linked dataset of all health and social care data, underpinned by appropriate data sharing and processing agreements, expanding to wider public services over time• A single system-wide PHM segmentation and risk stratification method, e.g. via Federated Data Platform
	Modern general practice <ul style="list-style-type: none">• ICBs should continue to support general practice with the delivery of the modern general practice model• This model should streamline care, improve access and continuity, and provision of more proactive care
	Standardising community health services <ul style="list-style-type: none">• Utilisation of the Standardising community health services publication to maximise use of funding for local needs and priorities, including commissioning of community health services• Connect mental and physical health services to ensure complete provision, and link with the VCFSE sector
	Neighbourhood multidisciplinary teams (MDTs) <ul style="list-style-type: none">• Multidisciplinary coordination of care for population cohorts with complex health and care or social needs who require support from multiple services and organisations• A core team assigned for complex case management, with links to an extended specialist team• A care coordinator assigned to every person or their carer in the cohort as a clear point of contact
	Integrated intermediate care <ul style="list-style-type: none">• Short-term rehab, reablement and recovery services delivered under a therapy-led approach• Home First approach to delivery of assessment and interventions, underpinned by step-up referrals and step-down planning directly between community and acute services
	Urgent neighbourhood services <ul style="list-style-type: none">• Standardise and scale services such as urgent community response and hospital at home, ensuring alignment with local demand, and with front-door acute services such as Urgent Treatment Centres• Involve senior clinical decision makers as part of a “call before convey” approach in ambulance services, and enable healthcare staff and care home workers to access clinical advice without needing to call 999

Enabling delivery in 2025/26

Complex health and social care needs

- Individuals with complex health and social care needs comprise ~7% of the population and are associated with ~46% of hospital costs
- 2025/26 should focus on sub-cohorts of this population where there is greatest potential to improve independence, outcomes and free up resources to focus on prevention

Evolution of the model

- ICSs should consider how to evaluate impact of changes
- Embrace the Test and Learn approach to enable continuous improvement, building on good practice
- A formal evaluation framework will be developed

Best practice

- Systems should support personalisation and continuity of care, including improving self-agency
- Supported by a Single Electronic Health and Care Record used in real-time by health and social care staff
- Apply learnings from existing and emerging models of successful neighbourhood collaboration e.g. women's health hubs and 24/7 mental health centres

Healthcare inequalities

- Apply PHM methods to design and deliver tailored care models for each population cohort
- Tackle health inequalities, building on the foundations outlined in the Fuller Stocktake

Critical elements for effective implementation

- Mechanism for joint senior leadership in each place to drive integrated working
- Collaborative high-support, high-challenge culture, supported by shared values, objectives, organisational structure and lines of accountability
- Visible clinical and professional leadership and management at all levels, to co-develop the model
- Effective processes to enable collaboration
- Maximise funding arrangements, including pooled funding, to facilitate partnership working

The Devon Road Map

The Health & Wellbeing Board, Plymouth Local Care Partnership and Plymouth City Council play an essential role in developing these services at a neighbourhood level, building on the community resources already in place. The ICB is keen to work collaboratively with partners in taking this forwards.

The ICB is coordinating a system **Steering Group** to work collaboratively to develop a roadmap for the development and delivery of Neighbourhood Health Services.

Locality teams are also beginning to **map what we already have across Devon**. This will be a **Local Care Partnership (LCP)-level self-assessment** against the framework to get a position on the strengths and assets we already have in each LCP which we will review as a Steering Group.