Notice of Health and Wellbeing Board

Date: Monday, 29 June 2026 at 2.00 pm

Venue: HMS Phoebe, BCP Civic Centre, Bournemouth BH2 6DY

Membership:

Chairman:	To be elected
Vice-Chairman:	To be elected

Laura Ambler	Corporate Director for Wellbeing
Aidan Dunn	Chief Executive
Rob Carroll	Director of Public Health
Mark Harris	NHS Dorset
Glynn Barton	Chief Operations Officer
Cllr D Brown	Portfolio Holder for Health and Wellbeing
Cllr R Burton	Portfolio Holder for Children and Young People
Cllr K Wilson	Portfolio Holder for Housing and Regulatory Services
Cathi Hadley	Corporate Director for Children's Services, BCP Council
Matthew Bryant	Dorset HealthCare University NHS Foundation Trust
Dawn Dawson	Dorset Healthcare Foundation Trust
Louise Bate	Healthwatch
Karen Loftus	Community Action Network Bournemouth, Christchurch and Poole
Becky Whale	NHS Dorset
Siobhan Harrington	University Hospitals Dorset NHS Foundation Trust
Cllr S Moore	Portfolio Holder for Communities and Partnerships
Mark Callaghan	Dorset Police
Marc House	Dorset & Wiltshire Fire and Rescue Service

All Members of the Health and Wellbeing Board are summoned to attend this meeting to consider the items of business set out on the agenda below.

The press and public are welcome to view the live stream of this meeting at the following link: https://democracy.bcpcouncil.gov.uk/ieListDocuments.aspx?MId=6550

If you would like any further information on the items to be considered at the meeting please contact: Louise Smith, louise.smith@bcpcouncil.gov.uk or
email democratic.services@bcpcouncil.gov.uk
Press enquiries should be directed to the Press Office: Tel: 01202 454668 or
email press.office@bcpcouncil.gov.uk

This notice and all the papers mentioned within it are available at democracy.bcpcouncil.gov.uk

AIDAN DUNN
CHIEF EXECUTIVE

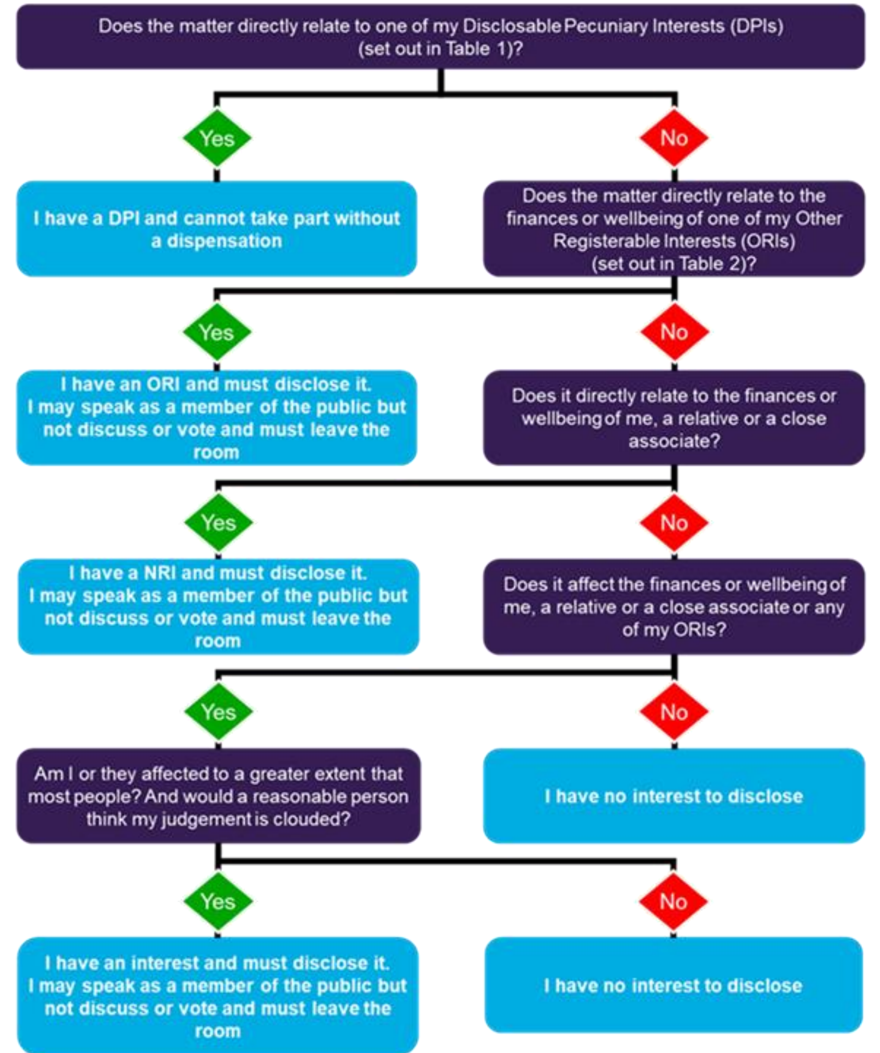
19 June 2026

Maintaining and promoting high standards of conduct

Declaring interests at meetings

Familiarise yourself with the Councillor Code of Conduct which can be found in Part 6 of the Council's Constitution.

Before the meeting, read the agenda and reports to see if the matters to be discussed at the meeting concern your interests



What are the principles of bias and pre-determination and how do they affect my participation in the meeting?

Bias and predetermination are common law concepts. If they affect you, your participation in the meeting may call into question the decision arrived at on the item.

Bias Test	Predetermination Test
In all the circumstances, would it lead a fair minded and informed observer to conclude that there was a real possibility or a real danger that the decision maker was biased?	At the time of making the decision, did the decision maker have a closed mind?

If a councillor appears to be biased or to have predetermined their decision, they must NOT participate in the meeting.

For more information or advice please contact the Monitoring Officer

Selflessness

Councillors should act solely in terms of the public interest

Integrity

Councillors must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships

Objectivity

Councillors must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias

Accountability

Councillors are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this

Openness

Councillors should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing

Honesty & Integrity

Councillors should act with honesty and integrity and should not place themselves in situations where their honesty and integrity may be questioned

Leadership

Councillors should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs

AGENDA

Items to be considered while the meeting is open to the public

1. Apologies

To receive any apologies for absence from Councillors.

2. Substitute Members

To receive information on any changes in the membership of the Committee.

Note – When a member of a Committee is unable to attend a meeting of a Committee or Sub-Committee, the relevant Political Group Leader (or their nominated representative) may, by notice to the Monitoring Officer (or their nominated representative) prior to the meeting, appoint a substitute member from within the same Political Group. The contact details on the front of this agenda should be used for notifications.

3. Election of Chair

To elect a Chair for the Health and Wellbeing Board for the 2026/2027 Municipal Year.

4. Election of Vice Chair

To elect the Vice Chair of the Health and Wellbeing Board for the 2026/2027 Municipal Year.

5. Confirmation of Minutes 7 - 14

To confirm and sign as a correct record the minutes of the Meeting held on 9 March 2026

6. Declarations of Interests

Councillors are requested to declare any interests on items included in this agenda. Please refer to the workflow on the preceding page for guidance.

Declarations received will be reported at the meeting.

7. Public Issues

To receive any public questions, statements or petitions submitted in accordance with the Constitution. Further information on the requirements for submitting these is available to view at the following link:-

https://democracy.bcpcouncil.gov.uk/documents/s2305/Public%20Items%20-%20Meeting%20Procedure%20Rules.pdf

The deadline for the submission of public questions is 12.00 noon on Tuesday 23 June 2026

The deadline for the submission of a statement is 12.00 noon on Friday 26 June 2026

The deadline for the submission of a petition is 12.00 noon on Friday 12

June 2026.

ITEMS OF BUSINESS

8. Health and Wellbeing Board Terms of Reference 15 - 18

To agree the refreshed Health and Wellbeing Board's Terms of Reference.

9. Neighbourhood Health 19 - 114

The Department of Health & Social Care published a Neighbourhood Health Framework on 17th March 2026 - [Neighbourhood health framework - GOV.UK](). The Framework sets out the key requirements associated with delivering on the governments ambition to embed neighbourhood health at the heart of bringing care into local communities; convening professionals into person-centred teams; and ending fragmentation. It also provides the platform for transforming access to general practice and preventing unnecessary hospital admissions whilst simultaneously supporting reintegration of healthcare into the social fabric of places.

Under the guidance of the Health & Wellbeing Board, system partners are expected to work together to develop a locally owned neighbourhood health plan ready for implementation from 2027/2028. The document describes the expected core elements of neighbourhood health plans.

10. BCP Council Suicide Prevention Action Plan 115 - 128

This document presents the 2026 BCP Suicide Prevention Action Plan for Bournemouth, Christchurch and Poole Council. The plan is informed by an evidence-based framework and outlines actions for council colleagues, alongside shared priorities to be delivered through pan-Dorset partnership working.

The draft plan has been considered by the Health and Adult Social Care Overview and Scrutiny Committee on 19th May 2026, and the resulting feedback has been taken on board in its development.

11. Better Care Fund 2026-27 Planning Documents/Better Care Fund 2025-26 End of Year Report 129 - 134

This report provides an overview of the planning document of the Better Care Fund (BCF) for 2026-27, as well as the 2025-26 End of Year Report.

The BCF is a key delivery vehicle in providing person centred integrated care with health, social care, housing, and other public services, which is fundamental to having a strong and sustainable health and care system.

The documents are part of the requirements set by Better Care England and the Department of Health & Social Care. These documents need to be jointly agreed and signed off by the Health and Wellbeing Board as per the planning requirements.

12. Health & Wellbeing Strategy 135 - 198

This report and associated documents provides;

- An update on the development of a new Joint Health and Wellbeing Strategy

for the Bournemouth, Christchurch and Poole

- An updated draft of the BCP Joint Health and Wellbeing Strategy (version 3) for approval following public consultaion and feedback from the Health and Social Care Overview & Scrutiny Committee

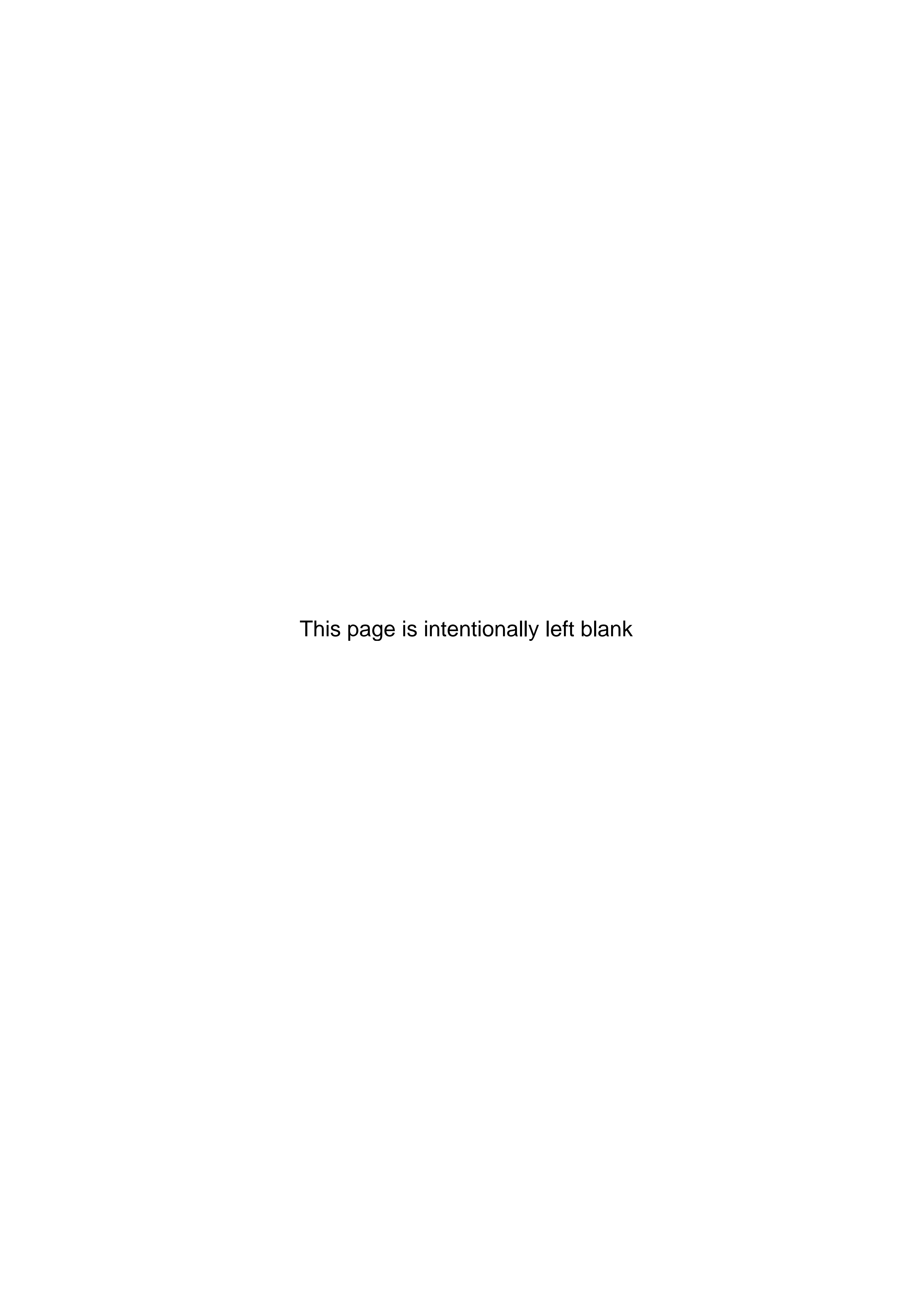
13. CQC Assurance Visit Outcome

To receive a verbal update on the outcome of the CQC Assurance visit.

14. Work Plan 199 - 202

To consider the Board's Work Plan.

No other items of business can be considered unless the Chairman decides the matter is urgent for reasons that must be specified and recorded in the Minutes.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BOURNEMOUTH, CHRISTCHURCH AND POOLE COUNCIL

HEALTH AND WELLBEING BOARD

Minutes of the Meeting held on 09 March 2026 at 2.00 pm

Present:-

Cllr D Brown – Chair

Mark Harris – Vice-Chair

Present: Cllr R Burton, Cllr K Wilson, Cllr S Moore, Laura Ambler, Rob Carroll, Cathi Hadley, Siobhan Harrington and Marc House

Also in attendance: Louise Bate joined the Board meeting virtually

39. Apologies

Apologies for absence were received from Matthew Byrant, Peter Browning, Betty Butlin, Aidan Dunn, Karen Loftus and Dawn Dawson.

40. Substitute Members

Ellie Lindop substituted for Dawn Dawson and Kate Parker substituted Karen Loftus on this occasion.

41. Confirmation of Minutes

The Minutes of the Board held on 12 January 2026 were confirmed as an accurate record and signed by the Chair.

42. Declarations of Interests

There were no declarations of interest on this occasion.

43. Public Issues

There were no public issues on this occasion.

44. NHS Dorset ICB 5 Year Commissioning Plan

The Deputy Director of Performance and Planning, NHS Dorset, presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'A' to these Minutes in the Minute Book.

NHS England’s new planning framework published on 24 October 2025, marked a shift from short-term operational cycles to a longer-term, locally led approach to improvement, aligned to the ambitions of the 10-Year Health Plan. It introduced a multi-year funding settlement, a revised operating model, and a focus on local innovation, prevention, digital transformation, and quality of care.

Integrated Care Boards were required to develop a Five-Year Commissioning plan setting out how local services would be transformed through strategic priorities, improving population health, reducing inequalities, and ensuring long-term financial sustainability. NHS Dorset ICB 5-year plan was submitted to NHS England on 12 February 2026 as per national requirements.

An initial high level overview of Dorset Integrated Care Boards (ICB) Five Year Commissioning Plan was presented to Health and Wellbeing Board members on 12 January 2026.

Feedback received from members was incorporated within the submitted plan. The commissioning plan remains iterative in nature and would evolve to incorporate more specific place-based priorities aligned to the local neighbourhood health plans once they were developed.

The Board discussed the report, including:

- A Board Member thanked colleagues from the ICB for taking comments on board and welcome an evidence based approach.
- Neighbourhood health was highlighted as a really positive step to shift from hospital to community and prevention from disease.
- Members welcomed the updated strategic commissioning intentions and noted that earlier feedback had been incorporated.
- It was emphasised that the work would be iterative, with ongoing alignment across commissioning activities and health partners, particularly in relation to neighbourhood plans.
- A Board Member praised the achievement of developing a coherent strategy despite wider system pressures.
- Enthusiasm was expressed for progressing neighbourhood health across Dorset and the BCP area, supporting a shift from hospital-based care toward prevention and community-focused models.
- The plan's clear focus on prevention, reducing inequalities, wider determinants of health, and co-designing services with people and communities was noted.
- The Board was advised of positive cross-organisational discussions in recent weeks regarding governance and future ICB cluster arrangements.
- It was acknowledged that there would be challenges during ICB cluster changes but constructive engagement to maintain delivery focus was welcomed.

RESOLVED that the Health and Wellbeing Board:

- **Note the final ICB Five Year Commissioning Plan; and**
- **Endorse the ICB Five Year Commissioning Plan.**

Voting: Nem. Con.

The Chair, with consensus, moved Agenda Item 8 - Developing a Place Based Partnership for BCP to be the next item considered by the Board.

45. Developing a Place Based Partnership for BCP

The Corporate Director for Wellbeing presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'C' to these Minutes in the Minute Book.

The report set out the background, rationale, purpose, and scope for developing a Place-Based Partnership (PBP) in Bournemouth, Christchurch & Poole (BCP), drawing on local and national context.

Ultimately the paper aimed to support the BCP Health & Wellbeing Board (HWBB) in considering the establishment and operation of a BCP Placed Based Partnership, clarifying its distinct role, governance, and relationship to existing structures.

In summary:

- Consensus to date had been that the PBP should act as a non-statutory strategic delivery group for the Health & Wellbeing Board which was a statutory and formal committee
- This would allow for greater agility and flexibility to determine local form and function and respond to local priorities and needs
- The HWBB would continue as a statutory committee and would formally provide strategic direction and oversight to the PBP. Strategic oversight could also be provided by the ICB Cluster Board as necessary to ensure join up and direction of NHS resources at place
- The PBP would act as an officer-led executive delivery group (similar to the previous ICS System Executive Group) for both the HWBB and the ICB Cluster Board, providing a collaborative space for senior executives to meet to plan, arrange and co-ordinate the delivery of key strategies and programmes that seek to transform and integrate services to improve the health & wellbeing of BCP residents.
- The partnership was where the work would be done to join together programmes and have honest and challenging conversations in a safe and respectful space.
- Initial programmes in scope include:
- BCP Health & Wellbeing Strategy
- BCP Neighbourhood Health Plan & Neighbourhood Health Programme and prevention
- Future Care Programme
- Better Care Fund and joint commissioning as appropriate
- Strategic commissioning intentions

- Place based engagement
- Focus on facts & data, insights (linked to BCP Continuous improvement programme)
- Building local knowledge
- Opportunities around asset review to deliver shared aims of partnership at place and neighbourhoods.
- The programmes in scope could be evolved and expanded over time to include other place-based programmes.
- The partnership could share and redistribute financial resources, on approval of the HWBB and the ICB Cluster Board, and act as forum for joint commissioning
- It was hoped that existing commissioning responsibilities could be delegated by the ICB to the PBP over time.

The Board discussed the report, including:

- Members discussed the place-based partnership plans and noted that previous challenges and opportunities had been outlined.
- The opportunity created by ICB clustering and wider partnership working across health, social care, and the voluntary sector was highlighted.
- It was stressed that neighbourhood health should not be interpreted as narrowly as traditional health services, but as a partnership vehicle to drive local plans.
- The Board was advised of increased clarity around system governance, with the partnership reporting to both the Health and Wellbeing Board and the ICB cluster board.
- The need to avoid duplicating governance structures and ensure alignment with national policy and local priorities was raised.
- The Board discussed gaps in representation on the Health and Wellbeing Board, particularly employer, skills, and education voices formerly present in integrated care partnership meetings.
- The importance of reassurance for residents that local needs would drive service design despite ICB clustering at a broader geography was highlighted.
- A Board Member queried how the partnership's work and purpose would be communicated publicly and recognised the importance of co-production and lived experience.
- There was a discussion regarding the relationship with the Health and Adult Social Care Overview and Scrutiny Committee, including its role in examining delivery, public participation, and effectiveness of commissioned services.

RESOLVED that the Health and Wellbeing Board:

- **That HWB discuss the proposals and give their views.**
- **Subject to views of HWBB that the Wellbeing Directorate progresses in briefings with relevant members, and wider stakeholders and setting up the place based partnership.**
- **That a workshop session on Place Based Partnership working and neighbourhood plans is scheduled for DSG/CMB/Cabinet and the HWBB.**

Voting: Nem. Con.

46. BCP Community Safety Partnership Annual Report

The Head of Communities, Safety and Partnerships presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'B' to these Minutes in the Minute Book.

The purpose of the Report was to note the BCP Community Safety Annual Report which was presented to Overview and Scrutiny Board on 23 February 2026.

The paper set out elements of development and delivery by ‘Safer BCP’, the BCP Community Safety Partnership (CSP), and its constituent agencies. It provided Members with an update since the last report to Overview and Scrutiny Board in January 2025.

The Local Government Act 2000 included crime and disorder scrutiny as one of the functions the council must ensure its scrutiny arrangements cover. Sections 19 and 20 of the Crime and Disorder Act 1998 and related regulations required the Council to have a committee with the functions of reviewing and scrutinising decisions and actions in respect of the discharge of crime and disorder functions by “responsible authorities”.

The specifics of the duty were set out in the Police and Justice Act 2006, which also allowed members to refer any “local crime and disorder matter” raised with them by anyone living or working in their area, to the Crime and Disorder Committee. The Board designated as the Crime and Disorder Scrutiny Committee must meet at least once every 12-month period to conduct the functions.

Guidance issued concerning how this role should be conducted include that:

• the role should be one of a critical friend, providing constructive challenge at a strategic level.
• the focus should be on the entire partnership and if issues arise that related specifically to a particular partner agency, it may be more appropriate to refer such issues to the governing bodies of that organisation.
• the scrutiny of partners should be “in so far as their activities relate to the partnership itself.”

In the BCP area, the Overview and Scrutiny Board undertake this function each year.

The Board discussed the report, including:

- The Chair thanked officers for the comprehensive update on the Community Safety Partnership.
- It was noted that the Community Safety Partnership team had received an award for its work.
- The Board recognised downward trends in antisocial behaviour but acknowledged challenges around reporting and public perception.
- The Board discussed cuckooing trends, noting unexpected age groups affected and wider safeguarding concerns.
- The Board was advised that domestic abuse funding remained at previous levels, amounting to a real-term reduction.
- It was noted that serious violence funding was being redirected nationally toward knife crime, which did not align with local priorities such as violence against women and girls.
- Raised concern that current funding streams did not support key local initiatives including night-time economy safety work and the 'Just Don't' campaign.
- A Board Member suggested including case studies in future reports to better demonstrate real-life impact.
- The Chair highlighted that fear of crime remained significantly higher than actual crime levels, impacting quality of life for some residents.
- The Board discussed the need for improved communications and a whole-system approach involving partners to promote positive safety messages.
- The Board discussed the need to explore opportunities to integrate community safety considerations into neighbourhood plans and the broader health and wellbeing work.
- The Board recognised the importance of national best practice examples, including the adoption of the 'Just Don't' campaign.
- Officers emphasised the role of multiple partners, including the voluntary sector, in delivering community safety outcomes.

RESOLVED that the Health and Wellbeing Board:

a. **note the progress of the Community Safety Partnership during 2025;**
b. **note the compliance of the BCP Community Safety Partnership as set out in the relevant legislation.**

Voting: Nem. Con.

47. Better Care Fund 2025-26 Quarter 3 Report

The Commissioning Manager and Senior Lead – Operations, NHS Dorset, presented a report, a copy of which had been circulated to each Member

and a copy of which appears as Appendix 'D' to these Minutes in the Minute Book.

The report provided an overview of the Quarter 3 Report of the Better Care Fund (BCF) for 2025-26.

The BCF was a key delivery vehicle in providing person-centred integrated care with health, social care, housing, and other public services, which was fundamental to maintaining a strong and sustainable health and care system.

The report was a part of the requirements set by the Better Care Fund 2025-26 Policy Framework. The report must be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements.

The Board discussed the report, including:

- Concerns were raised that, despite metrics showing activity 'on track', system pressures remained high, particularly around non-criteria-to-reside and people being in the wrong place in the system.
- A reset conversation was suggested to increase impact and ensure people were placed appropriately within the system.
- Discharge delays were acknowledged as not on track; enhanced caseload management, escalation pathways, and commissioning actions were highlighted as mitigation.
- Questions were raised regarding future local authority funding, including the freeze to the local authority element and possible absorption into the Revenue Support Grant.
- Concerns were raised about potential pressure on the Better Care Grant element if funding were absorbed into a broader formula and it was noted that the Council was waiting for clarification from government on future funding arrangements.

RESOLVED that the Health and Wellbeing Board retrospectively approve the Better Care Fund 2025-2026 Quarter 3 Report

Voting: Nem. Con.

48. CQC Assurance Visit Outcome

The Corporate Director for Wellbeing advised that the Council had not yet heard from the Care Quality Commission with feed back from the assurance visit and therefore no update could be provided at this time.

49. Work Plan

The Chair highlighted the items due to come to the next meeting and it was noted to add the CQC Assurance outcome, Health and Wellbeing strategy and Neighbourhood Health plans to the Work Plan.

Access to food partnership report and support required moving forward was highlighted as a potential topic for inclusion.

The Board noted its Work Plan.

The meeting ended at 3.30 pm

CHAIR

BOURNEMOUTH, CHRISTCHURCH AND POOLE (BCP) HEALTH AND WELLBEING BOARD

TERMS OF REFERENCE

STATUS

The Health and Wellbeing Board (the Board) is a statutory committee of the Council established under the Health and Social Care Act 2012. It forms part of the Council's executive governance arrangements.

PURPOSE

The purpose of the Board is to provide strategic leadership to improve the health and wellbeing of the local population, reduce health inequalities, and promote integration across health, social care, and wider determinants services. The Board acts as the system convenor at place within the Integrated Care System.

CORE DUTIES

The Board will: develop and publish the Joint Strategic Needs Assessment (JSNA); develop, refresh and oversee delivery of the Joint Health and Wellbeing Strategy (JHWS) including Neighbourhood health plans; promote integrated commissioning and provision of services; and encourage partnership working across the system.

SYSTEM LEADERSHIP AND ICS ROLE

The Board will act as the primary place-based forum for system leadership. It will influence the Integrated Care Partnership strategy, align with the Integrated Care Board and place-based partnerships, and ensure strategic coherence while avoiding duplication with operational delivery structures.

FOCUS ON INEQUALITIES AND POPULATION OUTCOMES

The Board will prioritise reducing inequalities and improving outcomes for the most vulnerable communities. It will recognise the impact of wider determinants including housing, environment, and socio-economic factors.

MEMBERSHIP

The membership of the Board will be reviewed and confirmed each year.
The Board may invite/co-opt other representatives to attend meetings for specific issues as appropriate. The quorum of the Board shall be one-third of the core voting membership, including at least one elected member and at least one NHS representative.

Core Voting Members:

BCP Portfolio Holder for Housing and Regulatory Services
BCP Portfolio Holder for Health and Wellbeing

BCP Portfolio Holder for Children, Young People, Education and Skills
BCP Portfolio Holder for Communities and Partnerships
Chief Executive BCP Council
Director of Adult Social Services
Corporate Director for Children's Services
Corporate Director for Wellbeing
Director of Public Health
BCP Place Director, NHS Dorset
Chief Executive, University Hospitals Dorset NHS Foundation Trust
Chief Executive, Dorset Healthcare Foundation Trust
Primary Care representative nominated by the ICB/place partnership
One Healthwatch representative
One Representative of the Bournemouth, Christchurch & Poole Community Action Network

Non-voting Advisory Members (advisory members are able attend as required depending on the agenda):

One Representative from Dorset Police Force
One Representative from Dorset and Wiltshire Fire and Rescue Service

Note Substitutes are permitted for the above representatives.

ELECTION OF CHAIR AND VICE CHAIR

The Chair and Vice Chair of the Board will be elected annually at the first meeting of the Board following the Annual meeting of the Council.

MEETINGS AND DEVELOPMENT SESSIONS

The following arrangements are proposed in respect of these matters:

- Meetings of the Board will be held on a minimum of 4 occasions each year. The meetings will be held in public. Special meetings of the Board can be arranged if required in consultation with the Chair and Vice-Chair.
- Development sessions will be arranged, when required and agreed with the members of the Board.

DISCLOSURE OF INTERESTS

In accordance with the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, Members and named substitute Members of the Board will be required to declare any disclosable pecuniary interests in matters before meetings of the Board. All Members and named substitute Members will have received and completed the necessary form giving details of their disclosable pecuniary interests.

PUBLIC ISSUES

The Board will conduct its business under the Procedure Rules contained in the Council's Constitution. The Procedure Rules will allow members of the public, subject to certain conditions being met, to appear before the Board to:

- Ask a question
- Present a statement
- Present a petition

In the event of any requests being received from the public to ask a question or to present a statement or petition, the Board will be advised of the relevant procedures at the meeting.

FUNCTIONS

The Board will set strategic priorities, monitor delivery of the JHWS, receive assurance on outcomes and inequalities, influence commissioning, and promote prevention and early intervention. The Board does not duplicate formal scrutiny functions.

REVIEW

These Terms of Reference will be reviewed annually to ensure they remain aligned with national policy, governance requirements, and local priorities.

Updated – June 2026

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Health & Wellbeing Board

Report subject	**Neighbourhood Health**
Meeting date	29th June 2026
Status	Public Report
Executive summary	The Department of Health & Social Care published a Neighbourhood Health Framework on 17th March 2026 - Neighbourhood health framework - GOV.UK. The Framework sets out the key requirements associated with delivering on the governments ambition to embed neighbourhood health at the heart of bringing care into local communities; convening professionals into person-centred teams; and ending fragmentation. It also provides the platform for transforming access to general practice and preventing unnecessary hospital admissions whilst simultaneously supporting reintegration of healthcare into the social fabric of places. Under the guidance of the Health & Wellbeing Board, system partners are expected to work together to develop a locally owned neighbourhood health plan ready for implementation from 2027/2028. The document describes the expected core elements of neighbourhood health plans. To support preparation for implementation, the guidance also sets out key actions to be completed during 2026/2027 as part of developing the local plan: • Agree the neighbourhood footprints around natural communities for the future development of INTs • agree plans to establish Integrated Neighbourhood Teams focused on high priority cohorts, including how devolving care budgets could work in their area Work has already commenced in relation to these two points with the Dorset Neighbourhood Health & Wellbeing Programme well established and dedicated workstreams in situ. High priority cohorts have been identified with pilot schemes developed. Neighbourhood geographies (footprints) are actively being considered with a proposed timetable for Health & Wellbeing Board agreement in October. Separate national guidance regarding enabling Neighbourhood Health Centres was also published late April with an NHS England requirement to complete an initial precis of a potential pipeline of schemes for consideration under a Public Private Partnership

	(PPP) arrangement. Specific eligibility criteria are set out including the need for an onsite GP surgery. Short turnaround times allied to the level of detail requested have restricted the initial pipeline of schemes included for BCP Place to known and existing unfunded opportunities: • Boscombe: Hawkwood Road / Kings Park Campus - Archetype 1: Hub-and-Spoke / Upgrade, Repurpose or Extend Existing NHS Estate • Poole Parkstone - Archetype 4: Purpose-Built Neighbourhood Health Centre • Poole Town Centre - Archetype 2: Repurposed Community or Civic Spaces Existing funded work includes the development Winton Neighbourhood Health Centre which is scheduled to be open during the summer of 2026. Beyond the initial three identified schemes, ongoing consideration as part of neighbourhood plans will be given to further NHC opportunities across Christchurch and other neighbourhoods across Bournemouth and Poole.
Recommendations	**The report recommends the Health & Wellbeing Board: It is** **1. Note the requirements set out within the national neighbourhood health framework and related guidance concerning neighbourhood health centres** **2. Endorse the proposed initial pipeline of local neighbourhood health centres schemes submitted for NHSE consideration** **3. Approve the proposed approach for developing and agreeing neighbourhood health geographies (footprints) in the BCP Place** **4. Approve the proposed approach for development of a Neighbourhood Health Plan for BCP**
Reason for recommendations	Adheres to requirements set out within the National Neighbourhood Health Framework Pipeline of initial schemes adopts a pragmatic approach utilising known schemes to support NSHE submission within the prescribed timeframe Pipeline represents an interim submission which will be reassessed in the future based on our neighbourhood health plan, together with a more detailed assessment of population need and estates mapping and modelling.

Portfolio Holder(s):	Cllr David Brown, Health & Wellbeing
Corporate Director	Laura Ambler, Corporate Director Wellbeing
Report Authors	Mark Harris, Dep Director of Place (BCP), NHS Dorset
Contributors	Laura Ambler, Corporate Director Wellbeing, BCP Local Authority Rob Carroll, Director of Public Health, BCP Local Authority Tim Branson, Interim Director of Adult Social Care, BCP Local Authority Becky Whale, BCP Place Director, NHS Dorset
Wards	All Wards
Classification	For Information & Decision

1. Background

1.1 The Department of Health & Social Care published a Neighbourhood Health Framework on 17th March 2026 - Neighbourhood health framework - GOV.UK. The framework is designed to support local system partners (NHS Integrated Care Boards, Local Authorities (including Health & Wellbeing Boards), health providers and local Voluntary & Community Sector organisations to deliver on the vision set out within the national 10 Year Health Plan - Fit for the Future Fit for the future: 10 Year Health Plan for England

1.2 **Neighbourhood health** puts the person at the centre of how we deliver their health and care, by organising services so they can work together to serve a defined local population. Neighbourhood health features a central core component of wider public sector reform to enable joined up services across the full spectrum that impact peoples' ability to live happy, healthy lives. As such it is a new operating model that includes a broad spectrum of service areas working across and within local communities such as:

- GP's and community services
- Urgent care, diagnostics, and outpatients
- Adult and Children's Social Care
- Public Health Services
- Housing, employment support and welfare

The framework sets out the ambition for Neighbourhood health services:

2. National Neighbourhood Health Framework: Key Requirements

2.1 At the heart of a successful neighbourhood health approach lies strong working arrangements across the NHS, local authorities and partners that enables development and agreement of a joint vision, and the re-design of commissioning and delivery of services at neighbourhood level, including through integrated neighbourhood teams (INTs).

The Neighbourhood Health Framework sets out a series of nationally determined goals and objectives:

- Goal 1: improve health outcomes
- Goal 2: improve access to general practice
- Goal 3: improve experience of planned care
- Goal 4: better urgent and emergency care performance
- Goal 5: improve patient and staff satisfaction

2.2 To achieve these, ICBs working with partners are asked to implement a series of minimum reform interventions in every community across two stages over the next 3 years:

Reform agenda 1- Improve routine healthcare, so neighbourhood health benefits everyone	Reform agenda 2- Improve proactive care for people	Reform agenda 3- Deliver alternatives to hospital care
• Better access to GP services • Empowering GPs to deliver better care • Quicker diagnosis and reduced delays • Cutting bureaucracy and improving system flow • Using technology to improve productivity • Strengthening out-of-hours and pharmacy service	• Develop integrated neighbourhood teams will coordinate care around people, not services to deliver better management of LTC, frailty, children and young people and cancer • Grow and strengthen community and neighbourhood care to reduce hospital demand • New model for planned care – shifting care closer to home through closer GP–specialist working • Joined-up data and pathways will enable proactive, personalised care	• Expand urgent community response • Increase capacity of virtual wards • Increase intermediate care capacity • Pilot 24/7 neighbourhood mental health centres

2.3 **Stage One (2026 – 2027)**

ICBs and HWBs to start developing and embedding new ways of working with local government and wider partners and to start jointly developing their approach to neighbourhood health and wellbeing services in their area. Specific considerations for the Health & Wellbeing Board include:

- agreeing neighbourhood footprints around natural communities for the future development of Integrated Neighbourhood Teams (INTs)
- agreeing plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area
- Work towards developing and agreeing a neighbourhood health plan for the local authority

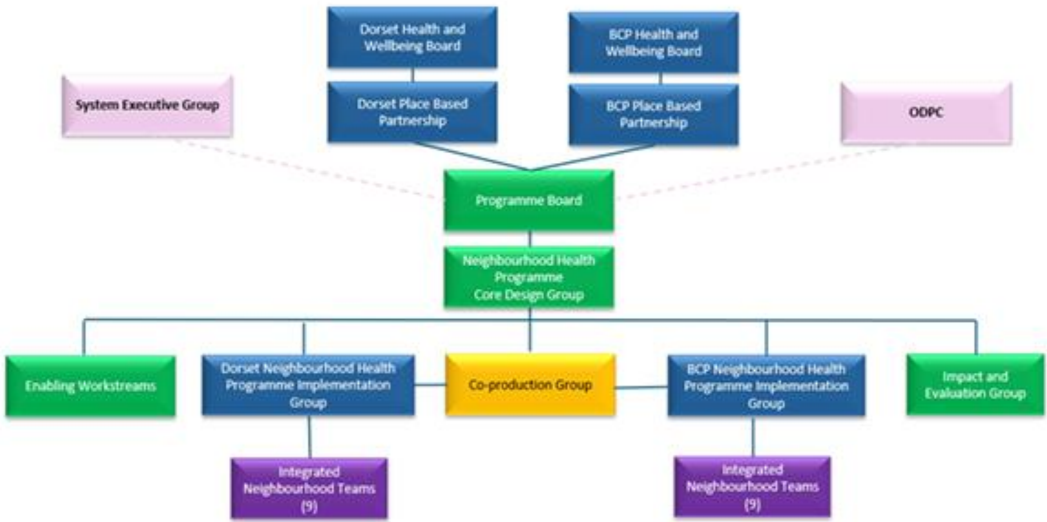
2.4 **Stage Two (2027 – 2029)**

For implementation from at least the 2027 to 2028 financial years, ICBs should work with HWBs and their partners to develop a locally owned neighbourhood health plan. Neighbourhood health Plans will need to:

- provide a broad overview of how the national NHS objectives will begin to be delivered through the 3 reform interventions outlined above
- set out how neighbourhood health will support wider local goals to improve health outcomes and reduce health inequalities, and deliver on any locally agreed wider public service reform agendas
- set out how local objectives are informed by the JSNA, and any other assessments by ICBs or local authorities
- confirm final neighbourhood geographies that partners will then work within
- confirm which organisations are responsible for different elements of delivery
- confirm the arrangements that will be in place to deliver this, including governance and operational partnership arrangements
- confirm how any other relevant initiatives align with the strategy (such as Best Start in Life Family Hubs, housing, mental health hubs, and employment support)

3. Dorset Neighbourhood Health & Wellbeing Programme

4.1 The Dorset Neighbourhood Health & Wellbeing Programme pre-dates the publication of the neighbourhood health framework and is a vehicle to support delivery of key elements of a neighbourhood health approach, notably improving proactive care for people via the development of Integrated Neighbourhood Teams. Although a Dorset wide programme, governance has been developed in a way that facilitates place-based delivery within each of the two places in Dorset – BCP Place and Dorset Place.



4.2 Work has commenced with particular efforts focused on addressing national NHSE requirements to target priority cohorts:

- People with frequent and highly intensive use of acute hospital services
- Frailty (High/Very High) & Falls (High / Very High Risk)
- Individuals identified as having a rising risk of hospital admission

4.3 Progress to date has been positive with development and activities completed under the broad headings of:

- Building the Team approach
    - Lunch and Learns – getting to know colleagues and services
    - Staff barriers and opportunities surveys
    - Neighbourhood Service Directories
    - Work shadowing, joint training and skill sharing
    - New insulin SOP being rolled out countywide
    - Continuing Health Checks – integrating ways of working to complete and support
    - Identifying co-Location opportunities
    - Integrated nursing team pilots

- Integrating care around Individuals:

    - Group clinics – leg clubs and now developing model in diabetes
    - Children and Young People Multi-disciplinary Teams (MDTs) development
    - Allied Health Professionals at the Social Care front door
    - Multi-disciplinary Falls Clinics
    - Scoping for an integrated community cancer service
    - Peri-Operative pathway development for complex patients
    - People with highly intensive use of services – Person centred MDTs commenced resulting in improved co-ordination and earlier identification of gaps that are informing targeted pathway and role development.

- o Developing and testing Carousel Clinic models across INTs, with different approaches emerging
- o Agreement to adopt a consistent Dorset Treatment Escalation Plan (TEP)

4.4 The focus for the programme over the next 12 months is:

Neighbourhood Team Delivery Framework	**Developing the operating model for optimal neighbourhood working** • Core Team and priority cohort INTs • Governance, workforce development and organisational barriers **Bringing acute specialists into Neighbourhoods** • Developing and testing models for specialists to support neighbourhoods
Cohort focused interventions and impact evaluation	**Supporting individuals at high and rising risk of frailty and falls** • TEPs, deprescribing and care co-ordination/ navigation **Local neighbourhood priority cohorts –** testing, learning and scaling **Expansion / extension of cohort**
Women's and Children's	**Co-produced women's health model pilots implementation and evaluation** **Children and Young People's MDT pilots – testing, learning and scaling**
Neighbourhood Estates	Developing a **neighbourhoods estates plan** across all sectors and integration with neighbourhood mental health hubs
Future Model Development	**Co-produced, holistic, care and support model for Adults with Multiple Long-Term Conditions**

4. Neighbourhood Geographies (Footprints)

4.1 The national framework outlines the need for Health and Wellbeing Board's to agree the neighbourhood geographies around which neighbourhood health services should be delivered. These geographies should enable people and communities to have input into the shift to neighbourhood health in their area. Key principles aimed at supporting this include:

- considering the footprint of INTs in terms of local authority boundaries
- choosing geographies that work best for the local place, taking into account a broad range of requirements such as:
  - o the local health economy
  - o access requirements
  - o local governance structures (for example, area committees, ward partnerships and town or parish councils or their equivalent)

4.2 This builds on existing principles previously set out by the national team as part of the National Neighbourhood Health Implementation Programme:

- Neighbourhoods that make up a place, are based, where possible, on 'natural' communities and boundaries recognisable to local people.
- Each neighbourhood has a range of services and statutory, non-statutory and community assets for people living in those communities.

- Neighbourhood health services form a component part of a wider support offer and work jointly with, local authority-commissioned services, including adult and children's social care and public health. Services should also be aligned to other services and community assets such as food banks, housing services, schools and faith groups.
- Neighbourhood footprints need to be balanced in terms of population size and level of need to ensure health inequalities are not concealed within larger geographical areas. Although original guidance suggested neighbourhood populations within the range of 30,000 – 50,000 people, this does not preclude local areas from defining larger or smaller footprints.

4.3 Prior to the Dorset Neighbourhood Health & Wellbeing Programme, GP practices and Primary Care Networks were used as the building blocks for integrated neighbourhood teams on the basis that:

- GP practices are intricately connected to their local communities, they are easily mapped to council wards and individuals tend to know which GP practice they are registered with
- GP Practices hold the most comprehensive health information set about the local population and by linking that to the data collected at ward level it enables a more complete understanding of local population needs.

4.4 In practice this has meant that Integrated Neighbourhood Teams have been developed in line with PCN footprints which are not aligned with local authority wards or natural communities. As such, currently a total of 9 INTs exist within the BCP place that are coterminous with existing PCN boundaries that in cases overlap and spread into neighbouring local authorities. Ongoing conversations with the BCP place as part of the neighbourhood health & wellbeing programme have highlighted a number of differing views on future neighbourhood health footprints. While the rationale to use GP practices as the building blocks for integration still makes sense, the recent national guidance puts into question the continued use of the PCN boundaries as the basis for developing neighbourhood health & wellbeing services. Thus, in accordance with national guidance requirements, work has commenced to develop an options appraisal and recommendation to be presented to the Health & Wellbeing Board for a decision.

4.5 The process and timelines for this are outlined below:

<u>April – May 2026</u>

1. Draft a set of principles, to be used to assess the footprint options.
2. Develop three options for consideration:
    - Existing PCN footprints
    - Ward based boundaries informed by the local authority, NHS Dorset and the GP Alliance
    - Further proposal based on BCP PCN collaboration discussions

<u>June – September 2026</u>

3. Engage key stakeholders in the review and refinement of the principles and invite other footprint options for consideration.

4. Complete options appraisal and develop recommendations.

October 2026

5. Recommendation to Health & Wellbeing Board for a decision

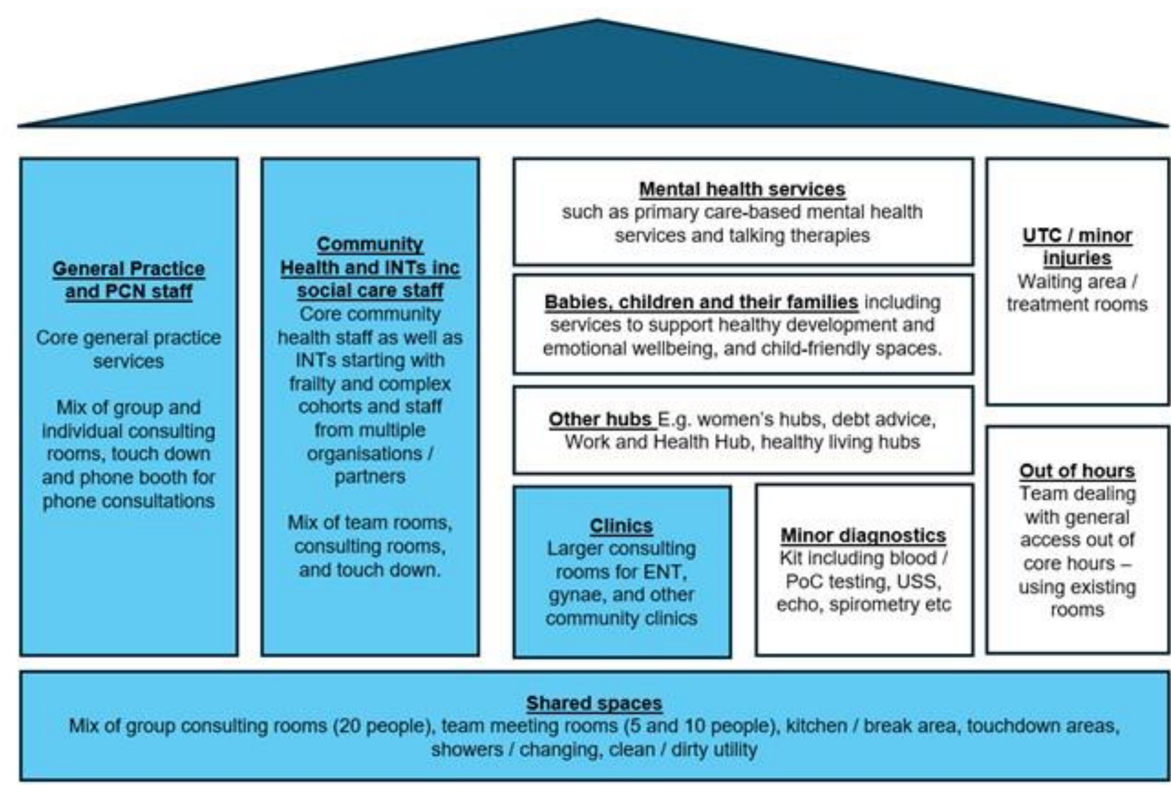
5. Neighbourhood Health Centres

5.1 The ambition within the 10-year Health plan for neighbourhood health centres (NHC) is that they may:

- be based in every community (defined as a population of around 50,000), focused on places where healthy life expectancy is lowest
- be a 'one stop shop' for patient care, and recognised as the place to go for the majority of health needs
- be based around general practices, co-locating community care and bringing traditionally hospital-based services such as diagnostics, post operative care and rehabilitation into the community
- be a place from which multidisciplinary teams operate
- ideally, co-locate a wider range of local government and voluntary sector services to help create an offer that meets population need holistically: for example, through offering services like welfare advice (covering issues such as debt and housing), employment support and smoking cessation or weight management services
- help ensure, through co-location, convenient access to services, particularly for those with complex needs, and support more integrated working by professionals
- shift outpatient care from hospitals into the community

5.2 Neighbourhood health centres are intended to form part of an asset-based neighbourhood approach, building on existing community strengths, services and infrastructure. They are designed to support prevention, integration and place-based working by connecting health services with wider networks of support, community activity and health promotion, rather than operating as standalone clinical facilities, contributing to a wider ecology of care that supports people throughout their lives.

5.3 The publication of NHS England » Neighbourhood health centre (April 2026) guidance defines the concept of a neighbourhood health centre and its core components in more detail.



5.4 The infographic shows the core components of a neighbourhood health centre, presented as a building layout. The layout is divided into coloured sections that represent different services delivered under one roof, supported by shared facilities. The shaded blue boxes identify the minimum requirements for designation as an NHC ie the core NHC model. Non-shaded areas represent additional elements that make up Core+ and Core++ NHCs.

5.5 The guidance positions NHCs as a core enabler of neighbourhood health delivery, supporting integrated, multidisciplinary models of care spanning:

- General practice;
- Community services;
- Mental health;
- Local authority services;
- Social care; and
- Community and voluntary sector.

5.6 It is expected that new NHCs will be open at least 12 hours a day, 6 days a week, providing access to co-ordinated services locally. On-site General practice is seen as a critical element of the model, not simply sessional input.

5.7 NHCs should also be viewed as anchor institutions: stable civic assets that contribute to wider social and economic development. By repurposing underused buildings and increasing local footfall, centres can support regeneration and strengthen community resilience, while addressing the wider determinants of health.

5.8 The NHS England Neighbourhood Health Centre guidance includes a requirement for ICBs to submit initial plans by the 28th May including:

- the latest thinking on how they will define neighbourhoods geographically in their area.
- a clear articulation of proposed neighbourhood health estate, listing existing facilities and the upgrade and new build schemes proposed.
- for upgrade and new build schemes, information about how these proposals align to the criteria against which schemes will be assessed.
- a list of disposals that will be enabled through investment and improved utilisation.

5.9 Schemes may continue to be refined or amended after submission as planning develops and further assurance is undertaken. It is not expected that all schemes will be fully worked up by the time of submission, but sufficient detail will be needed to enable regional and national review, challenge and prioritisation.

5.10 Given the tight timeframes for a return, it presents limited opportunities for widescale engagement. Thus, the approach adopted has been built upon existing strategic estates planning undertaken recently in support of NHS capital developments. Aligning existing work with the specific criteria set out above identified 3 initial BCP focused schemes that have been proposed for inclusion in the 28th May NHS England submission:

- Boscombe – Hawkwood Road & Kings Park (the latter as a neighbourhood mental health centre)
- Poole Parkstone
- Poole Town Centre

5.11 NHSE and Regions will assess submitted schemes against seven core criteria:

- Strategic alignment with neighbourhood health objectives;
- Coherence between service model, GP provision and physical estate;
- Intelligent strategic estates planning;
- Deliverability and pipeline readiness;
- Financial sustainability and revenue affordability;
- Governance, leadership and partnership maturity; and
- Local strategic alignment and regeneration impact.

5.12 A formal Neighbourhood Health Centre programme at ICB Cluster level is currently being proposed as a means of providing clear leadership, grip and assurance at scale alongside a pragmatic assurance view of the current pipeline, identification of key dependencies, affordability considerations and risks requiring management as schemes progress through governance and national assurance.

5.13 In tandem a proposal for a specific estates workstream is being considered within the aforementioned Dorset Neighbourhood Health & Wellbeing Programme with the aim of:

- Creating greater alignment across existing local estates conversations
- Ensuring local estates planning supports the neighbourhood model and service transformation ambitions (and vice versa)
- Identifying opportunities for shared use, co-location, and more integrated delivery models in each place
- Supporting more strategic, place-based decision making, rather than neighbourhood-by-neighbourhood or programme-specific approaches

It is envisaged the local workstream and programme will provide a local forum to foster greater connectivity, enable better use of existing assets and strategic estates planning that can be fed into the formal ICB cluster programme.

5.14 Within BCP Place, NHC developments are already taking shape via a separate scheme that pre-dates the publication of latest guidance. **Winton Neighbourhood Health Centre** is scheduled to open during the summer of 2026 following £1.2m NHS capital investment to create a modern, fit-for-purpose, facility that will host a GP practice and a range of community health services in accessible location with excellent public transport links.

6. Interdependent and Aligned Programmes

6.1 Best Start in Life – As part of Best Start in Life reform, local authorities have been asked to develop local plans to improve early child development and health outcomes by 2028 through integrated, locally tailored approaches, focused on prevention, that support the healthy development of all children. HWBs are encouraged to ensure alignment between neighbourhood health and Best Start local plans.

6.2 Best Start Family Hubs will provide health services, with a particular focus on 0 to 5 year olds, including Healthy Babies services. They improve child health and development outcomes by streamlining access to early, co-ordinated support and strengthening the integration of local services around families. As part of developing Neighbourhood Health Plans, HWB's are asked to consider how they will:

- use Best Start Family Hubs, as part of their neighbourhood health infrastructure, to provide health services in community settings
- ensure services are organised around the needs of babies, children and families to proactively identify risks and early signs of developmental delay and target early interventions
- make sure that existing plans for Best Family Hubs complement and do not duplicate any new Neighbourhood Health Centres and vice versa

6.3 Local SEND Reform Plans is designed to deliver high-quality support to children as soon as a need is identified. This includes development and implementation of an integrated local 'Experts at Hand' offer to provide early support to children with SEND.

6.4 Reform of children's social care and safeguarding will place more emphasis on earlier intervention and embedding support in communities for children and families, delivered through the Families First Partnership programme. Local authorities should consider, as part of planning with ICBs through HWBs, how the recruitment and deployment of

family help and multi-agency child protection teams will complement and work jointly with new INTs.

6.5 Three neighbourhoods in the BCP Place (West Howe, Boscombe West and Hamworthy West) have been selected for investment through the Government's Pride in Place programme, aimed at revitalising high streets, improving public spaces, and strengthening community pride. Pride in Place neighbourhood boards, made up of local people and led by an independent chair, will come together to come up with a plan for the future of their place (neighbourhood). Boards may choose to invest in interventions to improve health outcomes locally and will bring local residents together to shape and influence local health services and will need to be considered as part of developing aligned neighbourhood health plans.

6.6 Work to address wider determinants of health include Local Get Britain Working plans which set out a holistic approach to understanding and tackling challenges within local labour markets, including those related to health. The Get Dorset & BCP Working Plan brings together local organisations and services that support residents into work or training, while recognising that good health and wellbeing play a vital part in helping people start, stay, and succeed in employment.

6.7 The Pathways to Work Green Paper set out plans to offer personalised work, health and skills support for all disabled people and people with health conditions on out-of-work benefits. The goal is to combine new investment with existing capacity under the banner of 'Pathways to Work'; building upon and bringing together a range of existing support options tailored to individual needs from a diversity of providers, such as WorkWell, Dorset Work Matters (Individual Placement Support), and Connect to Work – Employment Support & Career Help in Dorset.

6.8 The government's national plan to end homelessness aims to end all forms of homelessness and improve local support for people with complex, co-occurring needs. BCP are updating the Homelessness and Rough Sleeping Strategy.

6.9 Housing policy reforms to improve housing in England, including the Decent Homes Standard, which will include new minimum energy efficiency standards. These will set a minimum standard for all rented homes to be safe, decent and warm. Awaab's Law also requires social landlords to investigate and remedy dangerous hazards within fixed timescales.

6.10 The Tackling Loneliness Hub is a government-funded platform for professionals across the country to share best practice and research with the aim of working together to tackle loneliness and build more social connections within our society.

6.11 Making more effective use of established networks and community resources, such as library services and sport facilities, is important. As established spaces in local communities that may already provide or host a range of important preventative work, there is scope to consider how such services can be used to contribute to neighbourhood health.

7. Neighbourhood Health Plan for BCP Place – Proposed Approach

7.1 As set out within the introduction, the national Neighbourhood Health Framework outlies a series of requirements health and wellbeing board partners need to consider as part of developing local neighbourhood health plans. The framework itself significantly strengthens the role of Health and Wellbeing Boards, positioning them as collective strategic leaders, convenors and stewards of neighbourhood health. Neighbourhood health plans also need to be embedded into the ICB 5-year strategic commissioning plan and relevant local authority strategies.

The HWB is expected to:

- Jointly develop the neighbourhood plans.
- Agree the neighbourhood footprints around which services will be delivered; ensuring they make sense for social care, housing, public health and VCSE.
- Set and agree local priorities, objectives and metrics (in addition to the national goals).
- Ensure alignment between local outcomes framework and adult and social care priorities.
- Hold the system to account for delivery and impact
- Anchor neighbourhood health in wider public service reform.

7.2 As a minimum, neighbourhood health plans need to:

- Set out how neighbourhood health will support wider local goals to improve health outcomes and reduce health inequalities, and deliver on any locally agreed wider public service reform agendas
- Provide a broad overview of how the national NHS objectives will begin to be delivered through the 3 reform agendas noted earlier:
  - Improve routine healthcare so neighbourhood health benefits everyone
  - Improve proactive care for people
  - Deliver alternatives to hospital care
- Set out how local objectives are informed by the JSNA, and any other assessments by ICBs or local authorities, as deemed necessary by them and the HWB
- Confirm final neighbourhood footprints that partners will then work with
- Confirm which organisations are responsible for different elements of deliver
- Confirm the arrangements that will be in place to deliver this, including governance and operational partnership arrangement
- Confirm how any other relevant initiatives align with the strategy (such as Best Start in Life Family Hubs, housing, mental health hubs, and employment support

7.3 Proposed approach to development of a neighbourhood health plan for BCP Place:

Action	Considerations	Timeframe
Convene a dedicated steering group to oversee plan development (health, local authority and voluntary sector)		May 2026
Develop a proposed joint vision		June 2026
Define local outcomes	informed by: • existing joint strategic needs assessments • community insights • health inequalities	June 2026
Map and understand existing work that aligns with delivery of the 3 reform agendas and defined local outcomes	• Neighbourhood Health & Wellbeing Programme • Planned Care Delivery Group • Urgent & Emergency Care Delivery Group • Primary Care Delivery Group • Mental Health, LD & Autism Delivery Group • Housing & Homelessness • Pride in Place • Pathways to Work • Children & Young Peoples Partnership	June – October 2026
Identify gaps in plan requirements, consider potential new initiatives and workstreams for inclusion	Consider alongside any proposed governance arrangements Understand impact on capacity	June – October 2026
Set out proposed governance and operational delivery arrangements for the neighbourhood health plan	Note governance arrangements for existing workstreams	October – November 2026
BCP Neighbourhood Health Plan approval by the Health & Wellbeing Board		January 2027

8. Summary & Recommendations

8.1 Health & Wellbeing Board members are requested to note the publication of the national neighbourhood health framework, the associated responsibilities for the Health & Wellbeing Board set out within this paper and the aligned workstreams.

8.2 The board is also requested to:

1. Endorse the proposed initial pipeline of local neighbourhood health centres schemes submitted for NHSE consideration

2. Approve the proposed approach for developing and agreeing neighbourhood health geographies (footprints) in the BCP Place

3. Approve the proposed approach for development of a Neighbourhood Health Plan for BCP

Appendices

1. Neighbourhood Health Framework, Department of Health & Social Care, 2026
2. Neighbourhood health centre guidance for regions and integrated care boards, NHS England 2026
3. Neighbourhood health centres: design and performance specification, NHS England, 2026

Department of Health & Social Care

NHS England

Policy paper

Neighbourhood health framework

Published 17 March 2026

Applies to England

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Ministerial foreword

Most people and communities want to access health and care as close to home as possible, in a way that is most convenient for them and that gives them what they need when they need it.

Similarly, our staff want to support patients and service users without being constrained by organisational boundaries, and often echo the frustrations voiced in their communities when the design and delivery of local services fall short of what the NHS could - and should - be delivering.

Despite these 2 things being persistently true, for too long the NHS and wider health and care system has struggled to create the environment in which local services can work together, be co-ordinated, funded and delivered in a consistent way that enables what is often described as the ‘left shift’ to happen in an industrialised way while still meeting local needs and circumstances.

This government and ministerial team are determined to change that.

In the 10 Year Health Plan for England (https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future), we promised to give power to people. If we are to do this, we need to end people being passed from pillar to post in a fragmented and, at times, chaotic system, and make local health services meaningfully accountable to local residents and service users.

We will address this by creating a neighbourhood health service - building on the plethora of inspiring pilot programmes that have tested this in different parts of the NHS, local government and wider health and care system over recent years.

Neighbourhood health will only work as a joint endeavour between the NHS and local authorities, alongside wider partners. We expect this to be a truly collaborative effort between all partners, combining the NHS’s responsibility for our health services with local authorities’ responsibility for adult and children’s social care services and public health. This will foster a true partnership for the benefit of all citizens to ensure we achieve the left shift from hospital to community, and sickness to prevention.

The Medium Term Planning Framework (https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/) commits to creating the conditions for making that vision a reality by enabling 4 crucial changes:

- creating the archetypes so local systems have the governance structures to help neighbourhood health succeed

- delivering guidance to create both a common description of neighbourhood health and a common set of outcomes and metrics to help define success
- developing early financial incentives to support local systems to accelerate change
- establishing a new approach to joint working across NHS and local government leaders, including more collaborative strategic commissioning that will help to hard-wire the establishment of neighbourhood health now and into the future

The first 3 changes are set out in this document and the NHS England guidance for population health delivery models (https://www.england.nhs.uk/publication/fit-for-the-future-towards-population-health-delivery-models/). These changes will be supported by the development of integrated care boards (ICBs) into strategic commissioners and this new collaborative way of working with local authorities.

All of this is designed to create the conditions through which local leaders can succeed in delivering their ambitions for neighbourhood health, and wherever possible, remains light touch and flexible.

The aim is to support greater consistency by building on existing best practice. At the same time, where neighbourhood health is scarce, the guidance is designed to support local leaders to accelerate the creation of provision.

This framework has been co-produced with leaders from primary care, mental health, community and acute providers and leaders in local government and ICBs. This framework won't just help to create the conditions to accelerate the delivery of neighbourhood health, it will be central to the continuing effort to regain public confidence in the NHS. This is something that can only happen when the public see and feel a difference when they use NHS services, and have better access and continuity of care when they need it, as well as reduced waiting times.

It's therefore essential that the reforms in this framework accelerate improvements in delivery in the short term while creating new, sustainable ways of working for the future. Early improvements in transforming outpatients and frailty, for example, can have an immediate impact on the way patients experience the services they use now and can help create the headspace for further reform and improvement.

In terms of improving the experience of people and communities, as a core part of the delivery of neighbourhood health, the government is investing in the future of the neighbourhood estate by building and upgrading 250 new neighbourhood health centres up and down the country.

Neighbourhood health centres (NHCs) will be seen as the place to go for most health needs in every community. They will:

- bring together GP services with a mix of community, local authority and civil society sector services
- allow staff to join up care, which is better for people and communities
- make care easier to access and easier to deliver, while also reducing pressure on other parts of the system

In line with NHS England's strategic commissioning framework (https://www.england.nhs.uk/publication/nhs-strategic-commissioning-framework/), ICBs are setting out their commissioning intentions over the next 5 years through 5-year strategic commissioning plans. As ICBs refresh these in the 2026 to 2027 financial year and beyond, this framework gives them the tools to properly reflect neighbourhood health in their commissioning approach. It's important to recognise this will be an incremental process - as local understanding develops and national reforms progress, plans for neighbourhood services will develop over time.

I am proud to be the Minister for Care and for neighbourhood health. I have seen that every day, across the sector, staff are working tirelessly to change the way the health and care system works to make it better for communities. However, I have also seen how frustrated they are at the rules, regulations and roadblocks put in their way. The government is fixing this, step by step.

This framework is designed to support ICBs and local authorities, including health and wellbeing boards (HWBs) and their local voluntary, community and social enterprise organisations (VCSEs) and wider system partners to deliver the vision that the 10 Year Health Plan offers, the truly modern service that people, communities and staff are crying out for.

As we work together to make neighbourhood health a reality across the country, we will regularly update this framework to reflect the learning from communities up and down the country.

This is the beginning of an exciting new chapter in how we build an NHS, and wider health and care system, fit for the future.

Stephen Kinnock MP, Minister of State for Care

Introduction to neighbourhood health

Neighbourhood health puts the person at the centre of how we deliver their health and care by organising services so they can work together to serve a defined population. This includes the services that people rely on close to

home and on the high street, such as GPs and community services and, where appropriate, urgent care, diagnostics and outpatients. This also includes local authority-commissioned services, such as adult and children's social care and public health services.

The aims of this approach are set out below.

Improve people's health and care outcomes, reduce health inequalities and help them stay well at home

We aim to do this by:

- focusing on prevention and proactive care management, including using data to effectively manage risk and prevent escalation
- strengthening primary and community services
- working better with specialists traditionally based in hospitals, public health, adult and children's social care, VCSEs and other partners

Organise services around the person with more convenient, personalised and joined-up care

We aim to orientate services around a person's needs, rather than organisational convenience. A strong digital approach will be critical to this. This includes:

- improving access to care (by phone, online or in person)
- moving more outpatient care from hospitals into neighbourhoods
- improving continuity of care for those with longer-term needs
- more effectively co-ordinating services for those with the most complex needs, for example, those at end of life

Reduce pressure on more acute services - including hospitals and care homes

We aim to do this by:

- using effective neighbourhood working to decrease avoidable hospital admissions or attendances and facilitate timely discharge
- reducing the de-conditioning that happens to many people when they spend time in hospital
- reducing avoidable care home admissions
- ensuring acute services are focused on those who need them most

Cut waste and duplication

We aim to do this by:

- integrating services across health, local government and wider partners
- making full use of digital opportunities
- ensuring the NHS is more sustainable

Help the NHS deliver against core targets

This will ensure that patients get a better service overall and their rights under the NHS Constitution for England (https://www.gov.uk/government/publications/the-nhs-constitution-for-england) are honoured.

Conclusion

Similar proposals have been set out over the last 15 years and many other countries have moved to a similar way of working. Yet, over the last 10 years, the system has orientated more to hospitals, with significantly greater spend and investment in hospitals rather than in primary and community care. The challenge is the ability of the system to make the change.

Although the setup of neighbourhood health will be different for each community, the success of neighbourhood health hinges on the NHS, local authorities and partners transforming how they work together. They need to work collaboratively to agree a joint vision and re-design commissioning and delivery of services at neighbourhood level, including through integrated neighbourhood teams (INTs).

Local leaders should consider how they can plan neighbourhood health services. Services should complement and build upon local plans to transform the wider scope of public services, and support investment in local places and community regeneration. Health is an important contributor to that agenda, and our approach reflects the 3 principles that guide the government's approach to public sector reform. These principles are to:

- integrate services so that they are organised around people's lives
- improve long-term outcomes for people through a focus on prevention, relying less on expensive crisis management
- devolve power to local areas, which understand the needs of their communities best, with services that are designed with and for people, in partnership with civil society and the impact economy

Measuring the overall success of neighbourhood health

Neighbourhood health and care services will deliver clear benefits. Neighbourhood health will have clear national minimum goals and objectives, which will be complemented by locally developed aims and outcomes, specific to communities. These will be defined locally through the neighbourhood health plan, designed under the collective leadership of the HWB.

During the 2026 to 2027 financial year, as part of developing neighbourhood health plans for the 2027 to 2028 financial year, HWB members will need to work with communities, health and care organisations and wider partners on how to establish outcome measures that cover the whole life course of the individual and reflect both health and social care needs.

National NHS goals, objectives and metrics

For the NHS, there are minimum national goals, objectives and metrics - outlined below. These should be achieved over the course of the 10 Year Health Plan period, with initial progress expected over the Medium Term Planning Framework period of April 2026 to March 2029.

The national goals are based on the Medium Term Planning Framework. They are not the ceiling of what neighbourhood health can or should achieve. Where systems can set out credible and radical proposals to go

further, they should do so, and we will keep these metrics under review as system plans become clearer.

We recognise some of these metrics are still being developed and, as we confirm details, we will communicate them to the system as part of the usual planning round. This will include any changes that will take place as a consequence of the current development of modern service frameworks (covering cardiovascular disease (CVD), sepsis, frailty and dementia, severe mental illness, children and young people, and palliative and end of life care).

Goal 1: improve health outcomes
We aim to improve health outcomes with specific focus on high-priority cohorts:

- people with frailty
- care home residents
- housebound patients
- those receiving end of life care
- those with:
  - CVD
  - diabetes
  - chronic obstructive pulmonary disease (COPD)
  - dementia
  - mental health conditions
- children and young people
- any other cohort identified by local areas

Goal 1 objectives and metrics (compared with 2025 to 2026 baseline)
We have 4 core objectives and corresponding metrics for this goal. We will:

- help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer. We aim to reduce non-elective admissions and bed days of one day or over by 10% for this cohort by March 2029
- better identify people coming to the end of life and improve access to services so people can die in a place of their choosing. By March 2029, we aim to:
  - increase the number of people identified as approaching end of life by 10%
  - reduce non-elective admissions and bed days of one day or over for people in the end of life cohort by 10%

- have better diagnosis and treatment for people with long-term conditions, particularly people with CVD, diabetes, COPD, mental health conditions and dementia. ICBs should agree targets to reduce variation in access to elective care for each of these areas, in line with goal 3 below. Modern service frameworks will specify further metrics for CVD and mental health in due course. By March 2029, we aim to:
  - see an improvement of at least 10% in evidence-based clinical outcomes, measured through quality and outcomes framework standards for CVD, diabetes, COPD, mental health conditions and dementia, where warranted
  - increase the percentage of patients with diabetes who receive all 8 elements of the diabetes care process bundle in the preceding 12 months by 10%
- improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care. By March 2029, we aim to:
  - reduce acute outpatient appointments for children under the age of 16 by 10%
  - make substantial progress towards reduction of community waits for children, as part of delivering Medium Term Planning Framework success measures

Goal 2: improve access to general practice
We aim to improve access to general practice so people can see their GP in a timely, high-quality way.

Goal 2 objectives and metrics (compared with 2025 to 2026 baseline)
We have 3 core objectives and corresponding metrics for this goal. We will:

- ensure that clinically urgent patients are seen on the same day by their GP practice team. We aim to see 90% of clinically urgent patients on the same day by March 2027
- make sure there is faster access for routine GP care. During the 2026 to 2027 financial year, we will collect data to baseline and set future trajectories. In the interim, ICBs may set local goals in agreement with contractors
- improve patient satisfaction with GP access. During the 2026 to 2027 financial year, we will collect data to baseline and set future trajectories. In the interim, ICBs may set local goals in agreement with contractors

Goal 3: improve experience of planned care
We will improve experiences of planned care and cancer care, and support delivery of the referral to treatment (RTT) standard.

Goal 3 objectives and metrics (compared with 2025 to 2026 baseline)
We have 2 core objectives and corresponding metrics for this goal. We will:

- reduce variation in referrals to outpatient services across the system through a single point of access (SpoA) and multidisciplinary team model. We aim to contribute to a diversion rate of at least 25% by March 2027 for at least 10 high volume specialties, supporting overall RTT trajectories of 70% by March 2027 and 92% by March 2029
- make sure there is better co-ordination of outpatient activity across multiple specialties for patients in high-priority cohorts. We aim to deliver more follow-up outpatient care in neighbourhoods, and contribute to an overall reduction in secondary care follow-up appointments by at least 10% by March 2027. For cancer, these should be delivered in line with the metrics in the National Cancer Plan for England (https://www.gov.uk/government/publications/national-cancer-plan-for-england)

Goal 4: better urgent and emergency care performance
We aim to improve urgent and emergency care (UEC) performance in line with agreed standards, including improving ambulance response times.

Goal 4 objectives and metrics (compared with 2025 to 2026 baseline)
We have 3 core objectives and corresponding metrics for this goal. We will:

- make sure there is better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making use of a single point of access, urgent community response, hospital at home, and virtual wards. By March 2029, we aim to:
  - keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts
  - contribute to an increase in type 1 emergency department (ED or A&E) admitted and non-admitted performance, supporting overall 4-hour trajectories of 85%. We aim for an interim trajectory of 82% by March 2027
  - contribute to an overall reduction in type 1 ED attendances for high priority cohorts
- have fewer ambulance call-outs for the least urgent cases, with appropriate diversion to relevant urgent care provision in the community. We aim to reduce category 3 and 4 ambulance conveyances in high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life) by March 2029
- ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. We aim to contribute to an improvement in the average length of discharge delay for all acute adult patients, derived from:
  - the proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)

- for those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge

Goal 5: improve patient and staff satisfaction
We want to improve patient and staff satisfaction with NHS services.

Goal 5 objectives and metrics (compared with 2025 to 2026 baseline)
We have 2 core objectives and corresponding metrics for this goal. We will:

- take a proactive approach, where the patient feels in control of their care. We will introduce a reformed set of patient-reported experience measures and patient-reported outcome measures in the 2026 to 2027 financial year, with trajectories for improvement each year. These will be collected consistently across places and details will be confirmed in due course. In the interim, ICBs may set local goals. In addition, by 2027, 95% of people with complex needs will have an agreed care plan
- ensure that teams working within neighbourhoods feel more motivated in their work. We will introduce a set of neighbourhood staff experience measures in the 2026 to 2027 financial year, with trajectories for improvement each year. These will be collected consistently across places and details will be confirmed in due course. In the interim, ICBs may set local goals

Local goals, objectives and metrics

Through HWBs, ICBs and local authorities will:

- agree how neighbourhood health can deliver further measurable benefits and how these will develop over time
- address local priorities and health inequalities set out in the local joint strategic needs assessment (JSNA)

Firstly, the government recommends that HWBs consider the Local Outcomes Framework (https://www.gov.uk/government/publications/local-outcomes-framework/) metrics and outcomes across health and wellbeing, adult social care, Best Start in Life and neighbourhood health and integration.

Secondly, as part of this process, alongside their shared focus on improving local health outcomes, we recommend that ICBs and local authorities work with other HWB partners to identify how neighbourhood health can help improve relevant outcomes for adult social care (as set out in Adult social care priorities for local authorities: 2026 to 2027 (https://www.gov.uk/government/publications/adult-social-care-priorities-for-local-authorities) and detailed below):

- the proportion of people who receive long-term support who are enabled to live in their home or with family
- the number of adults whose long-term support needs are met by admission to residential and nursing care homes, split by age (18 to 64, 65 and over) per 100,000 population
- overall satisfaction of people who use services with their care and support
- overall satisfaction of carers with social services (for them and the person they care for)

Thirdly, neighbourhood health is part of the government's wider agenda of local public service reform. HWBs and their partners should build strong links between neighbourhood health and these wider reforms where possible. The government encourages HWBs, as part of setting their neighbourhood health plans, to consider how neighbourhood health plans can complement and build upon plans for opportunities for wider public service reform and further integration of services, refocusing services towards prevention and early intervention. Local authority leaders will play a critical part here in terms of ensuring that plans for wider public services integration are complementary and best serve the needs of their population.

As such, there are several other local initiatives and reform programmes that HWBs will wish to consider as part of the neighbourhood health strategy, where relevant, such as existing community initiatives and governance structures in place (for example, area committees, ward partnerships, parish councils or their equivalent and Pride in Place neighbourhood boards) and how they can constructively work with neighbourhood health services.

Examples of local initiatives and reform programmes
The Test, Learn and Grow programme (https://www.gov.uk/government/news/communities-across-the-country-to-benefit-from-innovation-squads-to-re-build-public-services) supports initiatives that start small to test reforms and innovations, iterating and growing what works. There are currently 2 such accelerator sites on neighbourhood health. Test, Learn and Grow can act as a channel for sharing lessons and evidence about iterative, patient-centred approaches in a neighbourhood health context. This evidence should be used when developing further plans for neighbourhood health.

As part of Best Start in Life reform, local authorities have been asked to develop local plans to improve early child development and health outcomes by 2028. Together, Best Start in Life (https://beststartinlife.gov.uk/) and neighbourhood health are a whole-government commitment to integrated, locally tailored approaches, focused on prevention, that support the healthy development of all

children. HWBs are therefore encouraged to ensure alignment between neighbourhood health and Best Start local plans.

Best Start Family Hubs (https://www.gov.uk/government/publications/best-start-family-hubs-and-healthy-babies-guidance-for-local-authorities) will provide health services, with a particular focus on 0 to 5 year olds, including Healthy Babies services. They improve child health and development outcomes by streamlining access to early, co-ordinated support and strengthening the integration of local services around families. Local authorities, ICBs and other health and wellbeing partners should consider, in their neighbourhood health plans, how they will:

- use Best Start Family Hubs, as part of their neighbourhood health infrastructure, to provide health services in community settings
- ensure services are organised around the needs of babies, children and families to proactively identify risks and early signs of developmental delay and target early interventions
- make sure that existing plans for Best Family Hubs complement and do not duplicate any new NHCs

Reform to the system of support for children with special educational needs and disabilities (https://www.gov.uk/government/consultations/send-reform-putting-children-and-young-people-first) (SEND) is designed to deliver high-quality support to children as soon as a need is identified. ICBs are already working with local authorities as they set out plans for delivery of SEND reforms in their areas and will be required to jointly establish an integrated local 'Experts at Hand' offer to provide early support to children with SEND.

Young Futures Hubs (http://www.gov.uk/guidance/young-futures-hubs) will offer open access provision and targeted, evidence-based support for young people who need additional help with early mental health advice, prevention from involvement in crime, and access to opportunities.

Reform of children's social care and safeguarding will place more emphasis on earlier intervention and embedding support in communities for children and families, delivered through the Families First Partnership programme (https://www.gov.uk/government/publications/families-first-partnership-programme). Local authorities should consider, as part of planning with ICBs through HWBs, how the recruitment and deployment of family help and multi-agency child protection teams will complement and work jointly with new INTs.

The Pride in Place programme (https://www.gov.uk/government/publications/pride-in-place-programme-prospectus) will deliver £5.8 billion of funding over the next decade to 284 communities that have been overlooked and left behind. Pride in

Place neighbourhood boards, made up of local people and led by an independent chair, will come together to come up with a plan for the future of their place. Boards may choose to invest in interventions to improve health outcomes locally and will bring local residents together to shape and influence local health services. Where relevant, ICBs and local authorities should consider the priorities of Pride in Place neighbourhood boards to ensure that health services meet the needs of communities.

Local Get Britain Working plans (https://www.gov.uk/government/publications/guidance-for-developing-local-get-britain-working-plans-england) set out a holistic approach to understanding and tackling challenges within local labour markets, including those related to health. Plans have been developed by local government in collaboration with ICBs, Jobcentre Plus and wider partners.

The Pathways to Work Green Paper (https://www.gov.uk/government/consultations/pathways-to-work-reforming-benefits-and-support-to-get-britain-working-green-paper) set out plans to offer personalised work, health and skills support for all disabled people and people with health conditions on out-of-work benefits. The goal is to combine new investment with existing capacity under the banner of 'Pathways to Work'. This will bring together and build on existing support to offer a range of different options tailored to individual needs from a diversity of providers, such as:

- WorkWell, which is an early intervention health and employment support service to help people with health conditions stay in or return to work that will be rolled out across all of England, backed by up to £259 million investment over the next 3 years
- Individual Placement and Support (IPS) for those with severe mental illness or substance dependency
- Connect to Work
- the new Get Britain Working trailblazers and the new national jobs and careers service

The government's national plan to end homelessness (https://www.gov.uk/government/publications/a-national-plan-to-end-homelessness) aims to end all forms of homelessness and improve local support for people with complex, co-occurring needs.

Housing policy reforms to improve housing in England, including the Decent Homes Standard (https://www.gov.uk/government/consultations/consultation-on-a-reformed-decent-homes-standard-for-social-and-privately-rented-homes), which will include new minimum energy efficiency standards. These will set a minimum standard for all rented homes to be safe, decent and warm.

Awaab's Law (https://www.gov.uk/government/publications/awaabs-law-guidance-for-social-landlords) also requires social landlords to investigate and remedy dangerous hazards within fixed timescales.

The Changing Futures programme (https://www.gov.uk/government/collections/changing-futures) improves outcomes for people experiencing multiple disadvantage (combinations of homelessness and rough sleeping, poor mental health, substance use, domestic abuse and contact with the criminal justice system) by transforming the way local public service systems respond to deliver holistic, tailored support that meets their full range of needs.

The Tackling Loneliness Hub (https://tacklinglonelinesshub.org/) is a government-funded platform for professionals across the country to share best practice and research with the aim of working together to tackle loneliness and build more social connections within our society.

Making more effective use of established networks and community resources, such as library services and sport facilities, is important. As established spaces in local communities that may already provide or host a range of important preventative work, there is scope to consider how such services can be used to contribute to neighbourhood health.

The government's cross-sector and place-based approach to increasing physical activity levels will be set out in the forthcoming national plan for physical activity.

The place-based budget pilots in 5 mayoral strategic authority areas were outlined in the 2025 Budget (https://www.gov.uk/government/publications/budget-2025-document). These pilots will explore how public services can refocus onto prevention and early intervention through pooled budgets, building on the legacy of Total Place.

The new Office for the Impact Economy (https://www.gov.uk/government/news/local-communities-set-to-benefit-as-new-office-for-the-impact-economy-to-partner-with-philanthropists-social-investors-and-businesses) (OfIE) was launched by the Prime Minister to:

- facilitate government partnerships with investors, philanthropists and businesses
- unlock impact capital
- make public funding work harder
- drive national renewal

Support for neighbourhood health (co-designed with the Department of Health and Social Care (DHSC) and NHS England) is likely to include:

- developing the capacity and capability of National Neighbourhood Health Implementation Programme places towards 'investment readiness' - see more on this programme in the 'Delivering neighbourhood health' section
- developing communities of practice to showcase impact partnerships across neighbourhood health
- facilitating or convening activity to support investment pipelines

Delivering neighbourhood health

To deliver the aims of neighbourhood health, the NHS and local authorities must transform how they work together - and with wider partners, including civil society (such as the VCSE sector) - to improve planning and, in turn, health and care outcomes. This will need to include increasing alignment across multiple services, contracts and pathways at a neighbourhood level, through to increasing alignment between ICBs and local authorities, and mayoral strategic authorities where relevant. This joint planning and working should build upon existing best practice.

ICBs and local authorities, working with other local partners, will make the changes to services to:

- improve services for people who need routine healthcare, so neighbourhood health benefits everyone
- improve proactive care for people with complex needs
- deliver better alternatives to hospital care

Many of the best ideas will come from people in our communities. These reforms will need to be led locally. ICBs need to reform services based on what's right for their local population, and what the frontline tells them needs to change.

Importantly, in line with the strategic commissioning framework, as part of developing the neighbourhood health plan, listening to and working with patients, people and communities will be central to delivery.

However, from listening to health and care partners, we have learned that there are many common-sense actions that work well everywhere. These are the building blocks of neighbourhood health that need to be in place in every community. Without them, it's difficult to make the changes we need.

That’s why we are asking ICBs to implement a series of minimum interventions in every community over the next 3 years.

These are not the ceiling of neighbourhood health, but the foundation upon which local priorities will be built.

Reform agenda 1: improve services for people who need routine healthcare, so neighbourhood health benefits everyone

General practice is the bedrock of neighbourhood health. Without good access to GPs and their teams, we cannot shift the dial on outcomes, patient experience or sustainability.

As part of building a neighbourhood health service, the NHS will support GP access recovery.

The NHS will deliver better GP access, with increased digital tools
We will improve access, as measured by new GP access targets. We will continue to tackle the outliers, ensuring all practices are open during core hours (all modes), improve the online experience, and ensure faster, more organised access.

The NHS will empower GPs to deliver better care
GPs will be empowered to better manage the health of their population by incentivising proactive population health management. This will take place through risk stratification, long-term condition management, secondary prevention and better continuity of care, backed up by improved access to specialist opinion. This will specifically benefit patients with frailty, in line with the Medium Term Planning Framework.

The NHS will improve GP access to diagnostics
The NHS will review direct access to diagnostics by GPs, aiming to make it easier for patients to receive a diagnosis and understand the need for secondary care intervention much more quickly. NHS England will begin by undertaking a review of diagnostic services, so we can map out existing community diagnostic centres (CDC) capacity and planned increases over the next 3 years.

The NHS will reduce bureaucracy so GPs can focus on delivering better care
ICBs will implement a ‘red tape challenge’, improving the connection between primary and secondary care through a range of common-sense interventions, including:

- full national implementation of the Getting It Right First Time (GIRFT) programme's bridging the interface (or gap) checklist
- new electronic patient records (EPRs), increasing access to shared care records
- direct prescribing to community pharmacies
- structured medication information
- prescriptions issued for 28 days in outpatients unless clinically inappropriate

NHS trusts will play a full role in maximising the interface for the benefit of patients and staff alike.

The NHS will improve the productivity of GP practices by increasing the use of technology to free up clinical time and assist flow
We will roll out artificial intelligence (AI) and ambient voice technology, expand AI-assisted triage pilots, embed access to online consultation tools through the NHS App and make the NHS App the default for messaging and push notifications from practices.

NHS England will work with ICBs to reform out-of-hours services, so the public can better access care when GP practices are closed
We will begin reforming out-of-hours services, which are currently fragmented and inefficient, setting a common minimum expectation across all systems, including the relationship to NHS 111. This will be addressed in the upcoming urgent and emergency care strategy.

ICBs will build on the progress we have made to strengthen pharmacists' role in delivering care, recognising that pharmacies are one of the most accessible parts of primary care
Pharmacies' convenience for patients means they are optimally placed to offer services such as contraception, blood pressure checking and support on smoking cessation, as well as the Pharmacy First service. As pharmacies become increasingly established in supporting prevention and treating minor illness our ambition is for pharmacies to become a first point of contact for more patients to support demand on general practice. In September 2026, all newly qualified pharmacists will for the first time be qualified to independently prescribe. This provides an enormous opportunity for the NHS and over time, as the number of prescribing-trained pharmacists grows, the ability to manage demand in primary care will rely on pharmacy teams including prescribers managing a greater volume of patient need.

The Medium Term Planning Framework asked ICBs to start to roll out local prescribing-based services and we will support this through national digital infrastructure. Not only will these developments support a greater range of patients within existing currently patient group direction (PGD) led services, but they will unlock opportunities to improve management of everyday

prescriptions, support medicines value and overprescribing opportunities and reduce pressure on general practice. Our ambition is for pharmacies to be a first port of call.

Reform agenda 2: improve proactive care for people

We will redesign services to prevent deterioration, avoid unnecessary hospital use and provide seamless care across settings.

Integrated neighbourhood teams (INTs) will help people stay healthier, for longer

INTs will bring together different professions and partners to work side by side to support people. These teams know their neighbourhoods inside out and can tailor care to what matters most for local people. In line with the 10 Year Health Plan's commitment to support people to be active participants in their own care by ensuring 95% of people with complex needs will have an agreed care plan by 2027, these teams will deliver assessment, care planning, co-ordination and follow-on support.

The NHS will not define nationally what should constitute an INT. This will vary based on different conditions and populations and will be decided locally. The NHS will amend national contracts and funding flows so ICBs can ensure the provision of INTs is commissioned effectively at an appropriate scale to serve patient cohorts. ICBs will work closely with local authorities and partners on how these can be set up, considering the interdependencies with adult and children's social care and VCSE services. For example, some INTs may benefit from the inclusion of care workers.

When ICBs, or partners, are setting up INTs, they need to ensure effective follow-on provision of care and treatment of people with mental illnesses, taking advantage of the opportunity to align the delivery of physical and mental healthcare, as most treatment for such patients happens in primary care settings.

Nationally, NHS England will ask ICBs to ensure INTs are set up with an initial focus on:

- people with frailty, and those who need end of life care: this cohort is the priority because those over 75 living with frailty, those at end of life and care home residents account for 3 to 5% of the population yet represent over 25% of non-elective admissions and 50% of bed days
- multiple long-term conditions: better management of multiple long-term conditions can result in slow onset of frailty and reduced incidences of acute presentation. INT development should focus on the conditions that have the highest impact (CVD, diabetes, COPD, dementia). In some

medical disciplines, such as diabetes, these will align with outpatient reform, and ICBs should consider how these areas will align

- children and young people (CYP): GPs will use children and young people INTs to provide timely access to paediatric expertise in the community, alongside wider health and care professionals, including mental health and community services. INTs will also help families to manage some conditions at home if clinically appropriate. The evidence base shows that many ED attendances and outpatient appointments are a result of children receiving care in the wrong place. The NHS will address this through the INTs, and we will build this service over time, with every child who needs one having access to an INT by the 2028 to 2029 financial year. In practice, we expect systems will see a shift in outcomes through the reduction of outpatient appointments, with wider benefits including a reduction in ED attendances and hospital appointments. As part of setting up INTs, ICBs and local authorities should work together to consider how these services join up with other children's services - for example, safeguarding, family help and multi-agency child protection teams, Best Start Family hubs, and the 'Experts at Hand' service for children with SEND
- cancer: in line with the National Cancer Plan, over the course of the next 3 years, INTs will be set up to improve the quality of life for those living with cancer

Where ICBs can go further and faster, they will do so, setting up INTs for other conditions, population groups and communities as they and their partners see fit, based on the priorities identified by HWBs.

NHS England will produce a best practice guide for NHS frailty pathways
This will set out essential actions for ICBs and providers to improve the entire frailty provision, from identification and assessment to proactive and urgent care. This will be based on what systems have told us works across the health and care service, and ICBs will be able to use this as a baseline on which to improve pathways in line with the upcoming modern service frameworks.

ICBs will maintain and develop access to women's health services as part of neighbourhood care, and women's health hubs will be aligned to new neighbourhood health pathways and structures
Women face disproportionate challenges in access and quality of healthcare over the course of their lives. Women's health hubs are designed to improve care for women, including avoiding them having to have multiple appointments in different settings. ICBs will ensure that any changes to wider neighbourhood provision are aligned with women's health hubs.

ICBs will grow core community services and work with providers to reduce waiting times

We recognise that community waits are having an impact on many high-priority population groups - those with frailty, those needing palliative and end of life care, children and young people, and those with multiple long-term conditions. We'll deliver better access to core community services by increasing capacity to meet demand growth (around 3% per year nationally), and actively managing long waits for community health services, with at least 78% of community health service activity occurring within 18 weeks by the 2026 to 2027 financial year and at least 80% by the 2028 to 2029 financial year, and backed up by new ICB plans to eliminate all 52-week waits.

The NHS will introduce a new model for planned care that meets the 10 Year Health Plan commitment of "ending outpatient care as we know it", starting with closer working between GPs and specialists

The NHS will put GPs in control when it's unclear whether a patient needs specialist care, so people do not make unnecessary trips to hospital and instead focus on providing care closer to home. GPs and secondary care consultants will work closer together, first by expanding advice through single points of access (starting with at least 10 specialties in all providers in the 2026 to 2027 financial year).

We will move more follow ups, for those who need specialist input, into neighbourhood settings, delivered by professionals in the community, starting with conditions such as diabetes, all backed up by new digital pathways and single points of access. In line with the Medium Term Planning Framework, systems should start planning for the introduction of a radical new neighbourhood approach to elective pathways, establishing a single point of access with better access to specialist opinion and diagnostics.

This should focus on the core specialties identified in the elective reform plan (https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/): gastroenterology, ENT, cardiology, respiratory, diabetes, gynaecology and urology. We will work closely with GPs to ensure these arrangements work effectively within their competency and that they are supported. Where systems are ready to go further and faster, devolution of budgets and reforms to funding flows will be available in exchange for credible plans.

The NHS will standardise the expectations of data sharing between neighbourhood health services and hospitals

Systems will make the NHS work around the needs of the individual, not the other way round, by improving data sharing between hospitals and neighbourhood health services, including social care. This will mean neighbourhoods can put in place more effective proactive care for those who might otherwise default to secondary care, rather than leaving patients to co-ordinate their own care.

Reform agenda 3: deliver better alternatives to hospital care

Patients are going to hospital as the default too often and are stuck in ward beds when they should be cared for safely in the community. This is bad both for those who don't need to be there and for those who need specialist hospital care. Working closely with our partners, including social care, the NHS will take the following actions.

Expand urgent community response services, so the NHS is there for people when they need it most
We will prevent avoidable attendances, particularly for frailty and falls, by expanding urgent community response capacity, delivered through the new community INTs.

The NHS will increase the capacity of virtual wards, so people don't have to attend hospital unnecessarily
Rather than make patients come to hospital, the NHS will come to them by radically increasing the capacity and efficiency of virtual wards.

The NHS will work with local authorities and other partners to increase intermediate care capacity
Increasing and optimising the capacity of step-up and step-down intermediate care will help avoid admissions and attendances, improve discharge and support better recovery. This includes making best use of community beds and expanding home-based care. We will reduce the length of stay in NHS-commissioned community beds, maintain that improvement and build intermediate care capacity (step-up and step-down).

We will explore better alternatives to mental health hospitals
Some local areas have been piloting a neighbourhood approach for mental health through 24/7 neighbourhood mental health centres. These centres for people with severe mental illnesses are intended to improve care continuity, reduce crisis and provide an alternative to hospital for people experiencing a mental health crisis, and are distinct from INTs.

Rather than having care passed to a separate team, pilots are testing having patients being supported by the same team, whether they need planned care, crisis care or an overnight stay in an alternative to hospital. The aim is to reduce how often people reach the point of needing hospital care and make it easier for those who do to access hospital care quickly and close to home. Pilots are also aiming to reduce the number of people who end up presenting to A&E in a mental health crisis. For systems that wish to use this approach, further guidance on the model will be made

available in autumn 2026, following the results of an independent evaluation.

National Neighbourhood Health Implementation Programme

Local systems will be supported by the National Neighbourhood Health Implementation Programme (https://neighbourhood-health.co.uk/), which will build capability, develop infrastructure and identify success criteria for the scaling of these new models. The programme will mobilise change and build relationships to transform care delivery for the priority national cohorts, as well as supporting the development of local partnership working across health, social care and other relevant agencies. It will help local systems generate the necessary changes in culture and integrated working across neighbourhoods, and we will share learning with the wider NHS, local government, social care, public health and VCSE communities as part of that ongoing work.

Going further in other services

We know there are areas where we need to go further. This framework describes the minimum expectation. Neighbourhood health will be built over time.

Over the next few years, we will look at how we can support other important services to effectively contribute to neighbourhoods, such as community pharmacy, dental services, optometry, learning disabilities and neurodiversity services and others. In the meantime, important reform agendas will continue to improve services in these areas.

If they choose to, ICBs can - and will - go further and earlier in such services as part of their neighbourhood plans.

Importantly, ICBs will work with local authorities to agree how to design and deliver those aspects of neighbourhood health that require joint working across the NHS, social care and other local services. They will also agree, through HWBs, how neighbourhood health will support wider local priorities for improving overall health outcomes and reducing health inequalities, having due regard to both local JSNAs and the Local Outcomes Framework published by the Ministry of Housing, Communities and Local Government (MHCLG) and the Civil Society Covenant

(https://www.gov.uk/government/publications/civil-society-covenant) principles of partnership working.

Representatives of mayoral strategic authorities sitting on ICB boards can support ongoing work to integrate and co-ordinate neighbourhood health at the sub-regional level, including with skills provision and spatial planning, providing further democratic accountability and strategic alignment.

Providers of neighbourhood health

Care will continue to be delivered by those who know their communities best, such as, among others:

- GPs
- nurses
- therapists
- pharmacists
- community health service providers
- hospitals
- social care providers
- public health services

What will change is how services are commissioned and contracted, removing barriers that prevent the integration the NHS and councils have long known is needed and enabling improvements in the core services themselves.

The focus will be on outcomes, not organisational form. ICBs will be responsible for ensuring neighbourhood health is the default for NHS care provision in their population.

ICBs will work closely with both local authorities as commissioners of social care and public health services, and the providers of those services across civil society and the public, private and VCSE sectors.

Neighbourhoods are not currently single organisations. In many cases, they won’t need to be. It may make sense in some areas for a single organisation to begin delivering the different parts of neighbourhood health. It is for local providers, ICBs and local authorities to work through what is right for them and their communities.

Neighbourhoods need to be organised around populations, with the ability to develop management models that can join up resources and form partnerships that enable them to hold contracts. As part of developing the neighbourhood health plan, HWBs will need to set the geography ('a neighbourhood') around which services should be delivered. Many of these already exist and are working well.

DHSC and NHS England will take an enabling, non-prescriptive approach, allowing local systems to determine optimum models. Over time, we will assess whether these can or should be standardised, depending on what we learn from local systems.

Local areas will want to consider the footprint of INTs in terms of local authority boundaries - including new local government boundaries through the Local Government Reorganisation programme (https://www.gov.uk/government/collections/local-government-reorganisation-policy-and-programme-updates) where possible. Local areas should choose geographies that work best for them, taking into account a broad range of requirements such as:

- the local health economy
- access requirements
- local governance structures (for example, area committees, ward partnerships and parish councils or their equivalent)
- Pride in Place neighbourhood boards

This will help enable people and communities to have input into the shift to neighbourhood health in their area. Over time, we will assess whether these can or should be standardised, depending on what we learn from local systems.

For the NHS, ICBs will set clear expectations and contract accordingly - DHSC and NHS England are not going to dictate how all of this should be delivered and by whom. We do have some red lines - hospital standard contracts and general medical service contracts will remain the primary vehicles of delivery for the 2 biggest groups of NHS providers.

Therefore, at least in the initial stages, neighbourhood health will be delivered through commissioning reform. In its simplest form, this means changes to existing ways of working and contracts.

In some areas of the country, parts of neighbourhood health are being run effectively, and we don't want to disrupt good work.

In addition, we will develop options for population health contracting if systems believe better outcomes can be achieved through different provider models. Single neighbourhood provider contracts and multi-neighbourhood

provider contracts aim to strengthen the infrastructure and capability to design and deliver integrated services within and across neighbourhoods, with the potential for more incentive and outcomes-based contracts at greater scale.

Single neighbourhood providers

Single neighbourhood providers (SNPs) will deliver new services through INTs within a defined single neighbourhood.

SNPs enable primary care to take on new neighbourhood services that are not contracted for through today's general practice contracts (General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS), which will continue to be determined nationally and commissioned locally).

The SNP contract holder will need to work closely with practices that cover the neighbourhood population to ensure they can deliver care to the registered patient lists of the neighbourhood population. NHS England will consult on how this collaboration might work in the coming months.

Multi-neighbourhood providers

Multi-neighbourhood providers (MNPs) will co-ordinate the consistent delivery of services across multiple neighbourhoods.

MNPs will have a clear relationship with SNPs and practices, so they too can deliver care to the registered population list across the neighbourhoods they serve. This will allow commissioners to set consistent outcomes for aligned populations. As with SNPs, NHS England will consult on how this collaboration might work in the coming months.

MNPs will use their scale to design and co-ordinate the neighbourhood health services in their footprint, which may include delivering services directly at a larger scale than a neighbourhood, or 'filling in' services where it is locally agreed to be more appropriate for an MNP to deliver.

New risk-sharing approaches will incentivise neighbourhood providers to deliver effective preventative care that reduces avoidable non-elective admissions, focusing on high-priority cohorts.

It is our working assumption that an MNP contract would work well for a population of around 250,000 or more, and an SNP contract would work for

a population of around 50,000. However, we will not mandate nationally the size of neighbourhood health geographies under these arrangements. Contracts will be commissioned at the scales ICBs consider appropriate for their population. The size and shape of neighbourhoods will be agreed with local authorities and HWBs as part of the planning process, given the interdependence with public health and social care services.

Integrated health organisations

Integrated health organisation (IHO) contracts give providers a whole population health budget for a geographically defined population, underpinned by a contract.

IHO contract holders will take on responsibility for resource allocation and planning of services across the whole care pathway, holding responsibility for effectively meeting the needs of that population using available resources. Models where providers do not take on the whole population risk for a geography, for example, by taking on funding for a set of services, pathways or cohorts, are lead provider arrangements rather than an IHO.

The model will empower highly capable providers to lead change through their understanding of local population need, knowledge of activity and costs, and ability to engage frontline clinicians in service redesign. IHOs will undo needless NHS fragmentation and create incentives to invest in community-based preventative care.

IHO contract holders will allocate resources and design services to support implementation of new models of person-centred care - including the shift to neighbourhoods - that will improve health outcomes, patient and staff experience and efficacy of care. This will require the designated host provider to work with and contract other providers to deliver services, including multi-neighbourhood providers.

The IHO contract holder will develop decision-making infrastructure to shift the balance of care, and the balance of existing spend, out of the acute sector and into the community, demonstrating a strong understanding of cost effectiveness, healthcare value and the relationship between cost and outcomes.

The defined population covered by an IHO contract should share borders with one or more MNP footprints to create an aligned delivery chain for the local population and to enable commissioners to set consistent outcomes.

NHS trusts will be designated as eligible to hold IHO contracts by DHSC and NHS England. Designation will provide assurance that these trusts have the capability to work in partnership across systems and to manage

the additional risk and subcontracting requirements of holding an IHO contract. Initially, these will be high-performing and highly capable advanced foundation trusts. Designated trusts will be commissioned by ICBs using a newly developed IHO contract. We anticipate that community, mental health and acute trusts could all be eligible to be designated as IHO contract holders.

NHS England will work alongside the first wave of IHO contract holders to test the model and develop a pipeline for wider rollout, including to areas where there is compelling evidence that an IHO approach can solve entrenched problems in a health system.

We expect all IHO contract holders to think carefully about how they build and sustain mature partnerships with their local communities, including local authorities and third sector organisations, both as they develop their proposals and in their future governance. In particular, primary care clinical leadership in IHOs will bring local insight and patient-centred design right to the heart of decision-making. This will enable communities to design care that works for them, integrating primary, community and specialist services into one seamless system.

IHO contracts will only ever be held by NHS organisations. However, we will develop routes to enable mature neighbourhood providers to lead an IHO through forming, working within or developing alliances or joint ventures with statutory NHS organisations - blending the agility of general practice with the scale and accountability of the NHS.

In all primary care contract types, General Medical Services (or PMS or APMS), General Dental Services (or Personal Dental Services), community pharmaceutical services and General Ophthalmic Services contracts will continue to be commissioned in accordance with national contracts, with the ICB delegating commissioning responsibilities to the IHO, if an IHO is agreed and constituted.

We will consult on how MNPs, SNPs, GMS and the Primary Care Network Directed Enhanced Service (PCN DES) will work together, including how primary care networks might evolve into SNPs.

We will consult on how the 3 new contractual options will work. Between MNPs and SNPs, it will be up to ICBs to decide in their commissioning how to organise these arrangements based on what’s right for their local population, although we would expect an appropriate level of coterminous arrangement.

Figure 1 below demonstrates how these population-based contracts could fit together in a system where all 3 contractual mechanisms are in use - though many systems will have different arrangements where IHOs are not constituted.

The IHO, MNP and SNP (and GMS, PMS and APMS) are all population-based contracts. The populations should be nested where possible to ensure commissioners can set aligned outcome objectives.

The ICB contracts a single IHO for an area. The IHO then contracts a number of multi-neighbourhood providers. Each MNP works with multiple SNPs. Each SNP works with all local GP practices in the neighbourhood.

The dotted line shows how GP contracts will remain nationally determined.

Figure 1: population-based contract arrangements

ICB
Other commissioning
IHO
MNP
MNP
MNP
SNP
SNP
SNP
SNP
SNP
GP practice
GP practice
GP practice
GP practice
GP practice

NHS England will insist on strong clinical leadership, particularly from general practitioners. Any provider will need to provide clinical leadership, with accountability, professional oversight, and responsibility for the quality of care and evidence-based practice delivered locally. NHS England will also set clear expectations that providers must be data-led, with a strong analytical approach to informing proactive care management.

ICBs, local authorities and providers will need to transform how they work together, including through HWBs, to design and deliver a neighbourhood health service. Local communities need to work together to determine what

is right for them through strong partnership working - this will be a necessity. This is particularly important if ICBs and local authorities decide they wish to integrate aspects of local authority-commissioned services (for example, social care or sexual health services) into their neighbourhood health architecture. It is for local communities to decide how that is done.

See further details on these arrangements in the NHS England guidance for population health delivery models (https://www.england.nhs.uk/publication/fit-for-the-future-towards-population-health-delivery-models/). We will also set out the minimum requirements the NHS will expect of the governance, leadership and financial discipline of any provider.

Neighbourhood health estates and locations

In many cases, services will be delivered in the same locations as now. Some services may move online, or from a hospital to the GP practice, pharmacy or health centre.

The 10 Year Health Plan promised services would happen:

- as locally as it can
- digitally by default
- in a patient's home if possible
- in an NHC when needed
- in a hospital if necessary

NHCs are a crucial part of the neighbourhood health model, and work has been rapidly progressing to identify essential criteria of an NHC, develop guidance for systems and ensure we are able to deliver on our ambitious pipeline goals.

However, across the country, the quality of buildings in many GP practices is poor and not suitable for modern-day care. There is often a plethora of buildings used for different services - community care, mental healthcare, primary care, acute care and so on. This is confusing and inefficient, resulting in considerable amounts of money being spent on buildings rather than on care.

In addition, we have an opportunity to bring together healthcare and wider support for individuals, families and communities - for example, by co-locating healthcare services with Best Start Family Hubs, food banks, housing services and employment support.

NHCs will be seen as the place to go for most health and wider needs in every community. They will bring together GP services with a mix of community, local authority, civil society and VCSE sector services, allowing staff to join up care, which is better for patients.

Our pipeline is ambitious: we are aiming to deliver 250 NHCs by 2035, 120 of those by 2030. They will be a mixture of repurposed underused estate and new builds, with 20% of new builds funded from public capital and the rest through public-private partnerships. Our wave 1 pipeline for 2026 to 2027 will largely focus on repurposing existing NHS buildings - mostly NHS Property Services and LIFT (NHS Local Improvement Finance Trust) estates - in areas with the highest deprivation. Future waves are under development and will include further repurposed estate alongside new builds, funded through public capital and public-private partnerships.

We are developing guidance for systems to inform estates planning around neighbourhood health. Nationally, we are aligning this work with neighbourhood mental health centres and community diagnostic centres. ICBs and HWBs should consider if plans can complement and build upon existing programmes, including, for example, Best Start Family Hubs, or in community centres and spaces funded and developed as part of the Pride in Place programme. Locally, planning will need to be led by ICBs and undertaken alongside local partners to maximise opportunities from One Public Estate (https://www.local.gov.uk/our-support/one-public-estate) and from the broader growth and housing agendas and investments in local areas).

Beyond that, it is for ICBs, as the commissioners, and providers to work together to decide the best location.

The neighbourhood health workforce

In most cases, this is about existing staff working differently. For example, consultants in hospitals will work more closely with GPs and community health services, and GPs will work with INTs alongside district nurses and others.

In some cases, we will be setting up new services, and this will require new staff roles at local level.

The shift to neighbourhood health will entail a fundamental reimagining of the roles, skills and ways of working across health and social care over the next decade. We are developing proposals for the 10 Year Workforce Plan that will deliver our aim to make neighbourhoods great places to work, with strong leaders and teams skilled at delivering proactive, preventative and personalised care that improves health outcomes and stops need

escalating. Staff will work together seamlessly across boundaries as part of multidisciplinary integrated teams, and their careers will develop fluidly through different parts of the system. People will experience better care that is easier for staff to deliver.

The shift to neighbourhood health should be felt by staff working in all parts of the health and care system, not just those based in community settings. Systems will need to ensure they have shared planning assumptions about the scale of the shift from and to different places and professions, to ensure patients feel the benefit. These will necessarily vary depending on the configuration of local services, and the 10 Year Workforce Plan will set out some aggregate assumptions and scenarios to help inform local plans. We will need to ensure we have the right modelling assumptions about the scale of the shift across all parts of the workforce, and this is currently being tested.

System leaders will need to focus on collaboration across boundaries, innovation and transformation, with the 10 Year Health Plan setting out more detail on this.

Neighbourhood health finances

As strategic commissioners, ICBs will identify funding for NHS-delivered neighbourhood health through active prioritisation. This must be led locally as one size does not fit all - it will be up to ICBs to decide the optimal way to configure local services to meet population needs.

Where HWBs agree any changes to public health, adult and children’s social care or other local government services to reflect agreed local priorities for neighbourhood health, this does not alter the accountability or funding responsibilities of local authorities.

Nationally, the NHS will support this by:

- progressing vital interventions described here by constructing allocations and expectations in the Medium Term Planning Framework on the basis that, over the Spending Review period, ICBs will move funding from the acute sector into neighbourhood services
- amending the financial framework from the 2026 to 2027 financial year, including changes to block contracts and payment flows, to help systems invest in the left shift and deliver better outcomes within constrained financial resources
- supporting neighbourhoods with credible and agreed plans to reduce UEC attendances and non-elective admissions by testing payment approaches that incentivise prevention and community-based care

In parallel, we will develop financial mechanisms that support the establishment and scaling of neighbourhood health. Over the coming months, we will work with finance, commissioning and operational colleagues to shape these mechanisms so they are simple, flexible and support service redesign. We will take a permissive approach when neighbourhoods propose changes to money flows, new payment mechanisms or alternative contractual approaches, provided these are backed by credible plans and deliver improved outcomes and value for money.

This may include proposals to test more population, risk or outcome-based contracting approaches, as signalled in the 10 Year Health Plan, where systems believe these models could strengthen incentives for prevention, improve value for money, and support the shift towards neighbourhood-based care. These plans should, however, demonstrate that neighbourhood health will be funded by rebalancing existing resources rather than relying on new funding, while recognising that the scale and pace of the shift will be determined locally.

This permissive approach sits alongside existing arrangements such as outpatient and frailty budget devolution and other potential left-shift funding reforms.

Next steps

DHSC and NHS England will set the baselines ICBs need to proceed with new arrangements. Over the coming months, we will:

- publish the model NHCs definition, which will describe different archetypes of provision of neighbourhood health services that can be used to inform the better use and enhancement of existing estates, together with new-build solutions, where appropriate
- support the goals of neighbourhood health in national reform agendas, including introducing new GP access targets, developing new payment approaches that support the left shift and the development of neighbourhood health, and publishing a series of modern service frameworks on core conditions to give ICBs the baseline they need to inform future commissioning

Our plans will be delivered in 2 stages, which can run in parallel.

Stage 1: immediate changes in the 2026 to 2027 financial year

The Medium Term Planning Framework asks ICBs to prioritise the fundamentals at pace and to work with their local partners to make the changes required to deliver neighbourhood health.

ICBs will need to ensure the NHS delivers the minimum basic requirements in 2026 to 2027, as well as laying the groundwork for more fundamental reform. As part of this, ICBs and HWBs should start developing and embedding new ways of working with local government and wider partners in 2026 to 2027 to start jointly developing their approach to neighbourhood services in their area. These minimum basic requirements are:

- agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis
- agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements
- agree neighbourhood footprints around natural communities for the future development of INTs
- agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area
- start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population
- confirm plans to meet 18-week community waits and eliminate 52-week waits.
- confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund (BCF) in line with BCF guidance (https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027) (noting that any funding decisions must also be consistent with the national conditions for the fund, including the required increases in ICBs' minimum contributions to adult social care over the next 3 years)
- continue to improve the primary and secondary care interface in line with the red tape challenge
- confirm organisational ownership of planned deliverables

- confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation

Regional teams will work with ICBs on progress against the essential actions. ICBs are requested to ensure these are completed as soon as possible.

Stage 2: longer-term reform (April 2027 to March 2029)

In parallel to stage 1 and over the longer term, the NHS and local authorities must work together with partners to deliver the fundamental changes we want to see. For implementation from at least the 2027 to 2028 financial years, ICBs should work with HWBs and their partners to develop a locally owned neighbourhood health plan.

Once agreed with HWB partners, the plan will need to:

- provide a broad overview of how the national NHS objectives will begin to be delivered through the 3 reform agendas outlined above
- set out how neighbourhood health will support wider local goals to improve health outcomes and reduce health inequalities, and deliver on any locally agreed wider public service reform agendas
- set out how local objectives are informed by the JSNA, and any other assessments by ICBs or local authorities, as deemed necessary by them and the HWB
- confirm final geographies that partners will then work within
- confirm which organisations are responsible for different elements of delivery
- confirm the arrangements that will be in place to deliver this, including governance and operational partnership arrangements
- confirm how any other relevant initiatives align with the strategy (such as Best Start Family Hubs, housing, mental health hubs, Pride in Place and employment support)

Once this is agreed, the ICB will incorporate this locally owned plan into their refreshed 5-year strategic commissioning plan, in line with the strategic commissioning framework, which will be the formal NHS commissioning strategy for neighbourhood health. Systems are expected to go beyond the measures outlined in this framework (for example to develop the role of neighbourhood health in prevention) if they choose to do so.

The success of neighbourhood health hinges on the NHS, local authorities and partners transforming how they work together by working

collaboratively to agree a joint vision, and redesign commissioning and delivery of services at the neighbourhood level. We expect ICBs and local authorities to work constructively together during this process, with local authorities involved in the strategic development of the approach for all reform agendas outlined above (and particularly 2 and 3), which critically rely on common approaches to cohorts such as people with frailty and people nearing end of life.

Conclusion

Creating the conditions for neighbourhood health to be universally established - and to flourish in the future - is central to the leadership challenge the NHS and local communities face over the next period.

A thriving health service in every community has always been in reach, but the conditions needed to make this a truly universal offer haven't aligned until now.

Those conditions now exist. We have the very real opportunity to make the kind of change that will impact communities today and long into the future. But success depends on local leaders working together beyond the boundaries of their own organisations.

The motivation is simple: creating accessible services as close to home as possible will be pivotal to regaining the confidence of our local communities and our staff across the NHS and care services.

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Neighbourhood health centre guidance for regions and integrated care boards

Publication (/publication)

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Introduction

This guidance is both a statement of policy intent and a practical planning instruction for neighbourhood health centre (NHC) development in the current planning period. It:

- sets out the strategic framework for how ICBs and NHS England regions, working with providers, should identify and develop NHC schemes to support neighbourhood health: the archetypes to consider, estate planning, pipeline development and funding routes
- instructs ICBs and NHS England regions on the planning work now required to develop a coherent pipeline of NHC schemes

In doing so, it mirrors the principles of the broader capital framework of long-term planning certainty, transparent rules-based approaches, local leadership and a commitment to maximise the value of existing NHS and public estate.

Neighbourhood health is a central pillar of the government's 10 Year Health Plan and represents one of the most significant shifts in the organisation of health and care services since the creation of integrated care systems. Its purpose is to improve access to general practice, bring care closer to home, reduce unnecessary reliance on hospitals, and support a fundamental shift from reactive treatment to prevention, proactive care and integrated multi-disciplinary working. NHCs are a key physical and operational tool to support the neighbourhood health model, alongside care delivered in people's homes, digitally and in general practice, pharmacies and other community settings. They will be the place to go for most health needs in every community. This approach also reflects the government's wider public service reform principles: shifting from reactive services to prevention, integrating services around people's lives, and devolving power to local areas in partnership with communities and civil society.

This guidance should be read alongside the neighbourhood health framework (https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework), which sets out the wider delivery expectations for 2026/27 and beyond.

Spending Review 2025 and subsequent announcements

The 10 Year Health Plan sets a long-term ambition for NHCs to become the place to go for most health needs in every community.

As part of the Autumn Budget (https://www.gov.uk/government/news/chancellor-to-double-down-on-drive-to-cut-nhs-waiting-times-and-rollout-of-new-neighbourhood-health-centres), the Government set out its plans in more detail – which confirmed it would deliver 250 NHCs by 2035, with 120 of those by 2030. These will comprise a mixture of upgrades to existing buildings and new build centres, with the balance between the two to be informed over time by local need, value for money and deliverability. New build schemes are expected to be funded through a combination of public capital and public private partnerships (PPPs), with around 20% funded through public capital and the remainder through PPP routes. A first wave of upgrade schemes for delivery in 2026/27 has already been identified and announced.

This investment in NHCs will support improved access to general practice, service transformation and a more strategic reshaping of the community and primary care estate and put us well on the way to our longer-term goal of a centre in every community supported by a combination of new capital investment, disposals and repurposed estate.

Neighbourhood health centre estate proposals

Planning for NHCs must align with the NHS Medium Term Planning Framework and emerging neighbourhood health implementation plans.

NHC estate proposals for upgrading, repurposing or building new centres should build on and be informed by the service changes ICBs are committing to deliver over 2026/27 and beyond in their planning submissions, including improved access to general practice, enhanced support for people with complex needs and the shift of appropriate activity out of acute settings. There should be a clear line of sight between neighbourhood health ambitions, clinical strategies, service redesign plans and the estate solutions proposed to enable them.

The NHC design specification published separately provides detailed guidance on the design, spatial requirements and operational layout of NHCs. It is intended to support greater consistency and efficiency in core components such as digital infrastructure, functional requirements and key design principles, while allowing local flexibility in service mix, use of space and partnership arrangements to reflect population need and local context. While primarily intended for new build centres, the specification should be considered when developing upgrade schemes.

The 10 Year Health Plan establishes a commitment to create a modern neighbourhood health service built around multidisciplinary working and seamless collaboration, including across general practice, community services, social care, mental health, diagnostics, wide LA and public services, and civil society. This model is designed to improve people's access to services, reduce fragmentation and provide a single coherent offer at neighbourhood level, with professionals organised around population needs rather than organisational or contractual boundaries. This should include where appropriate stronger integration with adult social care and other local authority services as part of the wider neighbourhood health model.

NHCs should be planned as part of an asset-based neighbourhood model, connected to wider networks of support, health promotion and community activity, rather than as stand-alone clinical facilities. ICBs should engage with the community, as well as health and wellbeing boards, local authorities, civil society and other partners, to ensure that these spaces meet the needs of local people. This might mean working with the community to design multi-use spaces that work for them or consulting local people on decisions about the location of a new health centre. Where a neighbourhood has received Pride in Place Programme funding, this might mean involving the neighbourhood board in the design and use of public spaces in NHCs.

Neighbourhood health is not limited to a building; it is an operating model. However, without suitable estate many areas will be unable to deliver the integrated teams, the convenient access to co-located services, the urgent neighbourhood services, and the ‘home first’ rehabilitation models envisaged by the 10 Year Health Plan and national neighbourhood guidelines. Estates planning is therefore both a prerequisite and an accelerant for neighbourhood transformation.

What is a neighbourhood health centre?

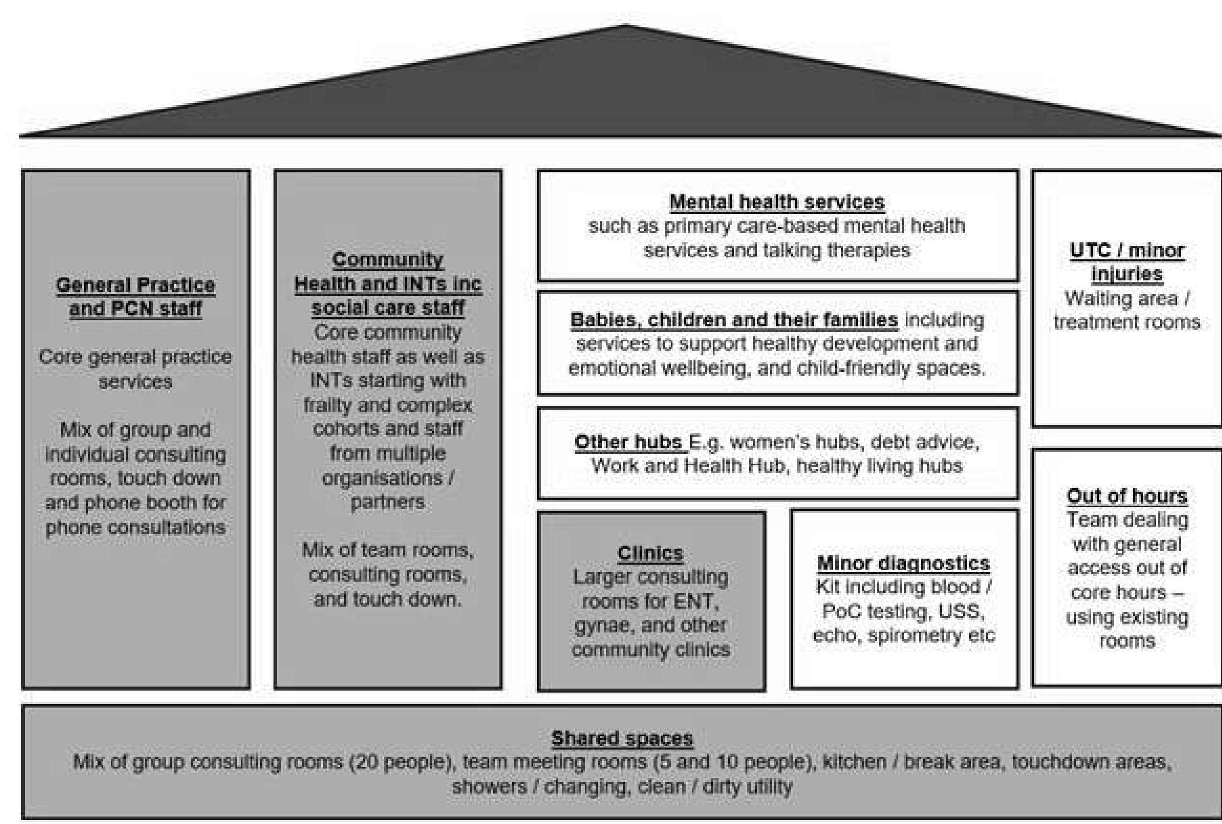
NHCs bring together GP practices and a mix of community, local authority, adult social care and civil society services, allowing staff to deliver more co-ordinated and effective care for better patient outcomes and experiences.

Centres will be expected to:

- meet the expectation set out in the 10 Year Health Plan to be open at least 12 hours a day and 6 days a week providing access to coordinated services locally
- include on-site general practice as a core element of the model, not solely GP staff or sessional input

As part of developing the neighbourhood health plan, health and wellbeing boards will be agreeing the geography (‘a neighbourhood’) around which services should be delivered. ICBs and regions should align their proposals with this work, and plan for NHCs to serve a population footprint at a scale in line with the Neighbourhood Health Framework (around 50,000, recognising the need for local flexibility), with General Practice at the core. We would generally expect GP services within an NHC to be operating at the scale of a PCN. We recognise of course that other types of services will operate best on different footprints. For example, Minor Diagnostics and UTCs are likely to operate better on a larger footprint, whilst Integrated Neighbourhood Teams, e.g. for frailty, will need to be operating at a neighbourhood level in most places. Proposals should show how the Centre improves integration, access and the range of neighbourhood services available locally, and should improve reasonable patient access to core services.

The infographic below outlines the core components expected in an NHC, with the shaded boxes identifying the minimum requirements for designation as an NHC. The specification explains and describes these more fully.



(https://www.england.nhs.uk/wp-content/uploads/2026/04/core-components-expected-in-an-nhc.jpg)

The image is a diagram showing the core components of a neighbourhood health centre, presented as a building layout. The layout is divided into coloured sections that represent different services delivered under one roof, supported by shared facilities.

On the left, a large light-blue section represents General Practice and Primary Care Network staff, providing core general practice services. This area includes a mix of group and individual consulting rooms, touchdown spaces, and phone booths for telephone consultations.

Next to this is another large light-blue section for Community Health and Intermediate Care Teams, supporting social care staff, NHS staff, voluntary sector organisations, and partners. This space is designed for staff working with frailty and complex cohorts and includes team rooms, consulting rooms, and touchdown areas.

The central white section highlights a range of clinical and support services, including:

- mental health services, such as primary care-based support and talking therapies
- services for babies, children and families, including support for healthy development and emotional wellbeing in child-friendly spaces
- other hubs, for example NHS debt advice, Work and Health Hubs, and healthy living hubs

To the right are additional clinical services, including:

- urgent Treatment Centre (UTC) or minor injuries, with waiting areas and treatment rooms
- out-of-hours services dealing with general access outside core hours using existing rooms

Below the central block are two clinical areas:

- clinics, providing larger consulting rooms for ENT, gynaecology, and other community clinics
- minor diagnostics, offering blood point-of-care testing, ultrasound scanning, echocardiography, and spirometry

At the bottom of the diagram, a long shared blue bar represents Shared Spaces, including group consulting rooms for up to 20 people, meeting rooms for 5–10 people, kitchen and break areas, touchdown workspaces, showers and changing facilities, and clean and dirty utility rooms.

Blue boxes represent the minimum requirements for designation as an NHC. As a minimum, this includes an on-site GP practice and a model capable of operating at scale over time.

These minimum requirements are intended to establish a consistent national threshold for designation, while the precise mix of complementary services, including diagnostics and other hospital-to-community functions, will vary by place according to local need and the wider service model.

Mental health provision within NHCs focuses on primary care-led and early intervention support, closely integrated with GP services. This is distinct from secondary care mental health services (including community mental health centres where they exist). Community-based mental health centres complement, rather than replace, NHCs and the person’s named GP, ensuring continuity of care and coordinated support across neighbourhood teams.

Neighbourhood health estate archetypes

The optimal approach to delivering the right estate to support neighbourhood health in a local area will depend on the needs of the local population, existing service configuration and how that configuration needs to change, as well as the estate currently available. In many areas, it will not be necessary nor represent good value to create wholly new centres. To illustrate the range of approaches NHS organisations can consider, NHS England has identified 4 archetypes for the neighbourhood health estate.

Archetype 1: Hub-and-spoke and upgrading, repurposing or extending existing NHS estate

Upgrading or reconfiguring existing GP, community or other NHS buildings, often complemented by ‘spokes’ such as mobile units or small satellite sites. This is typically the quickest and most affordable route to creating an NHC and is appropriate where there is high-quality existing estate that can be extended to provide the right neighbourhood health service offer.

Archetype 2: Repurposing community or civic spaces

Across the NHS, local government, the wider public sector and civil society, there is already substantial estate that can be used to host neighbourhood health services. Some high street premises, libraries, leisure centres or other civic assets may be suitable for adaptation to host neighbourhood health services. This brings care closer to people’s homes and can be delivered at pace and comparatively low cost. These facilities often will not be able to provide the full range of services expected from a NHC, but they can form a valuable part of the local offer.

Archetype 3: Cohort-specific hubs

Existing hubs that provide health or care services in the local community for particular groups, such as women’s health hubs, Best Start Family Hubs for children and young people, community based mental health centres or respiratory hubs can be integrated into the wider neighbourhood health offer. These hubs will not always be physically located within an NHC, but should complement, align with and, where it makes sense locally, be co-located or consolidated with NHCs.

Archetype 4: Purpose-built neighbourhood health centres

New-build centres designed specifically for co-located services and multidisciplinary teams (see the NHC design specification for the detail). These will be delivered through a mix of public capital and a new PPP model in areas where current estate cannot readily be repurposed to deliver convenient access for patients to the full range of neighbourhood health services.

These archetypes are not prescribed templates. However, ICBs and regions should consider them in a pragmatic but ambitious way when developing their pipeline of neighbourhood health schemes. They should identify the model or combination of models best suited to each neighbourhood, based on population health needs, existing assets and local service configuration. In doing so, they should seek to develop an estate that supports the full vision for neighbourhood health, maximising opportunities to improve utilisation, exit substandard or no longer fit-for-purpose buildings, and create higher quality facilities in the right locations. We expect ICBs to be able to draw heavily on their existing estates strategies, as well as the work done since last summer in preparation for and as part of medium-term planning.

Digital integration and infrastructure

Digital capability is fundamental to the functioning of neighbourhood health services. NHCs must therefore be planned as digitally enabled facilities, in line with the approach set out in the NHC design specification. Costings for proposed schemes should reflect this.

As part of their planning, ICBs and regions should consider the interaction between physical estate and digital transformation, including the potential to reduce space requirements through modern general practice models, and the need for all clinical and administrative staff working in neighbourhood models to access shared digital systems across organisational boundaries whilst maintaining digital and physical security.

Existing estate, partnerships and other considerations

Existing estate and scale of opportunity

Across the NHS, local government, wider public sector and civil society, there is already substantial estate that can support the development of NHCs. Work with Community Health Partnerships (CHP) and NHS Property Services (NHSPS) suggests that many buildings could already function as NHCs or could do so with modest investment. Community hospitals, local authority facilities, One Public Estate sites and primary care buildings all offer opportunities to bring services

together and create a more joined-up local offer. Furthermore, other initiatives such as local Get Britain Working plans and associated partnerships can support agreements around shared estates.

The availability, suitability and scale of existing estate varies significantly between ICBs and neighbourhoods. This variability is expected; NHCs are defined by their function in supporting integrated neighbourhood services, not by ownership of a specific NHS building. ICBs should therefore take a broad and pragmatic view of suitable estate, including all public, community and other civic assets, where these align better with neighbourhood geographies and service models.

Systems should take account of planned population and housing growth when developing NHC plans, so that future estate capacity keeps pace with changes in demand. ICBs and regions should work with local authorities to align neighbourhood health estate planning with local development plans and regeneration activity, for example as part of the Pride in Place Programme, including securing developer contributions such as Section 106, where appropriate, to support the delivery of neighbourhood health centre schemes.

Where new build centres are proposed, locations in or close to existing community focal points, including town and local centres and high streets, should normally be preferred where they support accessibility, integration and wider regeneration objectives. Locating a new neighbourhood health centre away from an existing community focal point should be undertaken with caution and will need to be justified clearly (for example, where there is a clear commitment from the local authority and housing developers to deliver significant future housing growth). Evidence from local authorities and STRATA (previously SHAPE) may be used to support this assessment.

The challenge is as much about consolidating and better using existing estate as extending or creating new facilities. Across the country, there are over three million square metres of primary care and community care estate. Some of it predates the founding of the NHS and is not best suited for providing modern patient care – and needs to be decommissioned and disposed of. However, some of it has the potential to provide the additional capacity needed for neighbourhood health services through improved utilisation (supported by digital pathways, redesigned workflows, reconfiguration and relocation of services, and extended opening).

Partnership, co-location and anchor institutions

Effective partnership working is fundamental to the NHC model. Providing a range of services in a single, trusted location improves access for residents and supports real-time collaboration between professionals. Proposals should

demonstrate how local partners, communities and relevant civil society organisations have informed the development of the scheme, particularly in relation to location and the wider service offer.

Centres should bring together NHS, local authority, and civil society services to provide a coordinated, population-focused offer. In doing so, due regard should be given to the Civil Society Covenant principles of partnership, working throughout the planning, decision-making and operational service delivery of NHCs. Clear partnership arrangements, including robust information governance and data-sharing agreements, are essential to enabling seamless multidisciplinary working.

Through their NHC proposals, ICBs should consider co-locating or aligning the following with NHS services, where this represents the best local solution:

- adult social care
- social welfare advice (for issues including housing, family breakdown, employment, welfare benefits, debt, domestic violence and immigration)
- mental health and substance misuse services
- carers' support
- integrated health and employment support services
- community-led activity
- services for babies, children and their families and other place-based services such as women's health hubs

Local partners should also consider broader opportunities for co-location that align with initiatives such as community sport, physical activity and leisure provision, which have significant potential to drive shared goals around health and wellbeing.

Areas should take a pragmatic approach to rationalising overlapping hubs and services where this would create a clearer and more joined-up local offer. The Best Start Family Hubs and Healthy Babies: guidance for local authorities (https://www.gov.uk/government/publications/best-start-family-hubs-and-healthy-babies-guidance-for-local-authorities) emphasises that local authorities should build a coherent network of Best Start Family Hubs and network sites and identifies NHCs as examples of potential network sites.

NHCs should also be viewed as anchor institutions: stable civic assets that contribute to wider social and economic development. By repurposing underused buildings and increasing local footfall, centres can support regeneration and strengthen community resilience, while addressing the wider determinants of health.

For these reasons, ICBs must work closely with a range of local partners in developing their neighbourhood health plans, including the estates elements. Partners may include, MPs, the local authority, mayors and strategic authorities, civil society, leisure providers, and the local Active Partnership.

Relationship with the new system architecture

NHCs will need to operate coherently within the wider neighbourhood health architecture set out in the 10 Year Health Plan and neighbourhood health framework, including the neighbourhood health plans developed by health and wellbeing boards. Over time, this may include alignment with emerging contractual and delivery models such as new single neighbourhood providers, multi-neighbourhood providers and, in some areas, integrated health organisations. These models remain subject to further national development and consultation, and this guidance should not be read as prescribing a single delivery form.

Estate should be capable of supporting population-based neighbourhood models, including multidisciplinary working, co-location, shared use of space and, where relevant, shared clinical, diagnostic or support infrastructure across neighbourhoods, whilst being able to preserve the data and physical security necessary to delivering clinical services.

The development of NHCs is not an end in itself. NHCs are one feature of the new model of care set out in the 10 Year Health plan, which is designed to deliver more proactive, preventative and personalised care for people through a left shift in activity and resources, improved access to General Practice, reduced pressure on hospitals, and enhanced digital and physical access to services locally. For each proposed NHC, the ICB will be expected to demonstrate how the chosen site fits within this and forms part of a coherent clinical strategy.

Programme pipeline and funding

This guidance is intended to support ICBs and regions to work in partnership to develop their full pipeline of schemes, covering both upgrades and new builds. While the national pipeline of schemes may be announced in waves, planning should consider the full future pipeline required across the footprint.

Regions will play a central role in shaping a coherent pipeline across their geographies, working with ICBs and providers to develop their overall estates strategy and individual schemes and ensuring that proposals (refurbishment or new build) are realistic, strategically aligned and deliverable within available funding envelopes.

Upgrades: refurbishment, repurposing and extension of existing estate

Evidence from national estates work indicates that a significant number of NHCs can be delivered through relatively modest investment in upgrading, refurbishment, repurposing, reconfiguration and extension of existing estate across the NHS and public sector: unlocking improved utilisation, co-location and service integration without the time, cost and risk associated with wholly new development.

ICBs and regions should therefore consider upgrades to existing estate where these can support the required neighbourhood service model. This includes upgrading primary care and community buildings, adapting civic or shared spaces, extending existing facilities where appropriate, and improving utilisation through extended hours, digital pathways and redesigned workflows. Where suitable estate exists, upgrading, repurposing or extending existing estate should generally be the preferred approach when it offers a better value for money solution than new build. Proposals should align with the overall criteria for funding NHC schemes set out later in this document, including the expectation that ICBs demonstrate intelligent use of existing estate before proposing new build solutions.

Where multiple small upgrades could be combined into a more strategic scheme (for example converting a community hospital into a major neighbourhood hub) regions should support ICBs to take that broader approach.

Refurbishment schemes will need to be funded through public capital routes – through existing regional capital allocations for constitutional standards and left shift and through additional funding being made available specifically for NHCs.

New builds

ICBs and regions may conclude that building a new centre is the most appropriate option – where there is no existing estate in the right location to serve the population of a NHC, where existing buildings are of low quality or poorly configured, or where the creation of a new centre would better enable the service reorganisation needed to deliver the vision. New build proposals should be brought forward where they represent the strongest overall case in terms of local need, service fit, affordability and value for money, rather than to meet a pre-determined delivery route.

We expect 80% of new builds to be delivered through PPP and 20% through public capital. Decisions on which delivery route will be used for which schemes will be taken centrally. ICBs should develop and propose robust schemes that are

suitable for either route.

ICBs need to consider long-term affordability and revenue implications when developing any new build proposals (including PPP). This includes consideration of unitary charges over the life of a scheme. In a PPP arrangement, the unitary charge is the payment made to the private partner and typically covers the capital cost of the facility, hard facilities management, lifecycle maintenance and associated funding costs. ICBs should also consider the treatment of soft facilities management costs, together with wider building and site management arrangements. All proposals will need to demonstrate a credible affordability position and value for money case.

Public private partnership model

The government has confirmed that a new publicly led public private partnership (PPP) model will form part of the delivery approach for some new build schemes, alongside schemes delivered through public capital. The purpose of this new PPP model is to support the timely delivery of high-quality, purpose-built NHC infrastructure by harnessing private sector capability to deliver schemes to time and to cost. In doing so, the model is intended to enable the NHS and its partners to focus on service transformation, integration and the delivery of improved outcomes for patients. The PPP model will be suitable only for new build schemes. The PPP model is not intended to displace stronger refurbishment or repurposing options where those better meet local need and offer better value for money. National decisions on scheme progression and delivery route will therefore need to balance local value for money, affordability and strategic fit with the need to maintain a credible and deliverable pipeline of PPP-suitable schemes.

The new PPP model is being developed by the National Infrastructure and Service Transformation Authority, supported by the Department of Health and Social Care (DHSC), and will build on lessons learnt from past and current models and harness private sector expertise to deliver the new NHCs. Areas of consideration include but are not limited to: changes to the payment mechanism, improvements to the variations protocol and enhanced monitoring provisions. To ensure the Neighbourhood Health Centre PPPs are managed transparently and are fiscally sustainable, these projects will be budgeted for as though they are on balance sheet. In addition, by delivering NHCs through a combination of private and public investment the government will be able to build further evidence and compare different models of delivery.

We expect PPP schemes to be procured in batches of 5 to 10 projects, rather than as individual schemes, which is one of the reasons we need a clear early understanding of the future pipeline of new build projects within an area over time. This means early pipeline development will need to identify not only individual suitable schemes, but also a coherent forward pipeline of proposals that could support batching where appropriate.

All new build proposals will need to demonstrate value for money, strategic fit, deliverability, affordability and maturity in order to progress. At this stage, a new build scheme's inclusion in the pipeline will not in itself imply a funding commitment, as that will be subject to business case approval.

Indicative capital planning approach for the pipeline

DHSC and NHS England will discuss with regions the indicative position re the level of funding available for upgrade schemes and the broad numbers of new builds we anticipate supporting. Regions will then work with ICBs to guide the number and scale proposals to be developed across their geography, informed by neighbourhood health planning and local estates strategies.

Planning requirements to 28 May 2026

Between now and 28 May, regions should complete their work with ICBs to develop a proposed strategic NHC pipeline for each ICB. This should set out the ICB's latest view of how neighbourhood health centres will be organised across its footprint to deliver effective clinical strategies, the places in which capital investment is likely to be prioritised, and the mix of upgrades and new builds it proposes to deliver over time.

Working with their ICBs, regions must develop early-stage, site-specific proposals that identify location, population served, service model, estate option (refurbishment, extension or new build), site constraints, planning considerations, digital requirements and indicative capital needs, and how local partners and communities have informed the proposal.

This planning exercise is intended to produce a clear, structured articulation of proposed schemes and to test these against the national criteria set out in this guidance. Schemes may continue to be refined or amended after submission as planning develops and further assurance is undertaken. It is not expected that all schemes will be fully worked up by the time of submission, but sufficient detail will be needed to enable regional and national review, challenge and prioritisation.

By 28 May 2026, regions working with ICBs should set out:

- the latest thinking on how they will define neighbourhoods geographically in their area.
- a clear articulation of proposed neighbourhood health estate, listing existing facilities and the upgrade and new build schemes proposed.
- for upgrade and new build schemes, information about how these proposals align to the criteria against which schemes will be assessed.
- a list of disposals that will be enabled through investment and improved utilisation.

This information should be provided in the single template that NHS England will provide and should build on existing ICS estates strategies and medium-term capital planning work.

Local Improvement Finance Trust estate considerations

Some ICBs will have Local Improvement Finance Trust (LIFT) buildings reaching contractual expiry over the coming years. In developing neighbourhood health plans and NHC proposals, ICBs should explicitly consider the status and future role of any LIFT estate within their area. This includes clearly setting out assumptions on whether existing LIFT facilities are expected to be retained, upgraded, repurposed, replaced, or exited, and how this informs the overall neighbourhood estate strategy.

Where LIFT buildings are expected to continue to play a role in neighbourhood health delivery, proposals should set out how they will be adapted to support neighbourhood models of care and represent value for money. Where LIFT buildings are not assumed to be retained, ICBs should reflect this in their assessment of future estate need and investment requirements.

Regional oversight and national support

Regions have a strengthened role in estates planning under the new operating model and they will lead the planning exercise with ICBs across their geographies.

Regions should ensure that each ICB develops a coherent strategic view of its neighbourhood estate model, aligned to a clear clinical strategy, the places where capital investment is likely to be prioritised to deliver the most value and the pipeline of schemes required to support delivery over time.

Regions should test the extent to which proposed schemes are aligned with the NHC definition and delivering the aims set out in the Neighbourhood Health Framework, (https://www.gov.uk/government/publications/neighbourhood-health-framework) the planning requirements in this guidance, and the criteria and

metrics against which proposals will be assessed. Regions should challenge areas where proposals are insufficiently developed, inconsistent with neighbourhood health objectives, or do not yet demonstrate a credible case for investment.

National teams will provide technical guidance and template materials to support planning, including a standard submission template. National oversight will support consistency, value for money and a credible national pipeline, while giving local areas flexibility to determine the service model and configuration best suited to their needs.

Scheme approval process

Criteria for funding NHC schemes

NHC scheme funding will prioritise proposals that best support the delivery of neighbourhood health at scale, demonstrate value for money, and can be delivered within the relevant planning and spending periods.

ICB funding prioritisation and national assurance will be guided by 7 criteria:

1. **Strategic alignment with neighbourhood health objectives** – For each proposed NHC, the ICB will be expected to demonstrate how the chosen site forms part of a coherent clinical strategy. Proposals should clearly support the shift toward a neighbourhood health service articulated in the Neighbourhood Health Framework, (https://www.gov.uk/government/publications/neighbourhood-health-framework) including prevention, proactive care and delivery closer to home. Schemes should demonstrate how the NHC scheme enables service integration, supports neighbourhood multidisciplinary teams, strengthens integration with relevant non-health services, and helps reduce pressure on acute services. Where possible, schemes should demonstrate alignment with relevant health and wellbeing boards' work to develop neighbourhood health plans. Proposals will need to demonstrate a link to population need, noting the 10 Year Health Plan commitment to "'begin establishing NHCs in the places where healthy life expectancy is lowest". The Wave 1 sites announced in March 2026 were prioritised according to deprivation (among other criteria) and this should continue to be taken into account in future waves.
2. **Coherence between neighbourhood service model, GP provision and physical estate** – The proposed estate solution must be driven by a neighbourhood service model that is anchored around general practice. Schemes should include, as a core component, general practice services

operating at scale (generally the scale of a PCN but with some scope for local flexibility where there is a strong rationale). They should enable joined-up delivery across primary care, community services, mental health, local authority and civil society where appropriate, and deliver the expected opening hours. Proposals will be viewed more favourably if they demonstrate coherent co-location with, or rationalisation of, other place-based services while improving the overall offer for local people.

3. **Intelligent strategic estates planning** – Opportunities to reuse, repurpose or upgrade existing estate should be fully explored before proposing new-build solutions. New-build schemes should be justified on the basis of estate quality, backlog maintenance, fitness for purpose, location and value for money. Investment in additional space, through upgrades, new builds and improved utilisation, should be leveraged to enable the disposal of estate that is in poor condition or no longer required.
4. **Deliverability and pipeline readiness** – Proposals should be deliverable within the timeframe proposed by the ICB. This includes clarity on site availability, planning position, stakeholder alignment, and a realistic delivery timetable.
5. **Financial sustainability and revenue affordability** – Proposals must demonstrate clear revenue (RDEL) affordability, including how running costs will be met within existing or agreed funding flows. This includes consideration of workforce, unitary charges, occupancy, utilisation, and the long-term financial implications of the estate solution.
6. **Governance, leadership and partnership maturity** – Governance arrangements should be clear and robust, with strong clinical and system leadership and effective partnership working across NHS, local authority and wider civil society partners. Proposals should demonstrate readiness to operate the NHC as a shared system asset rather than a single organisation facility but also set out clearly which organisation will be accountable for delivery of the scheme and full utilisation of the NHC.
7. **Local strategic alignment** – Proposals are expected to be locally generated, drawing on the expertise and insight of providers, general practice and other partners, including local authorities. Proposals should demonstrate early engagement with relevant stakeholders, such as local authorities, MPs, and civil society, and provide evidence that services, estates and local integration plans are aligned and take account of wider plans for local infrastructure investment as well as wider public estate development opportunities. Where relevant,ICBs should consider local regeneration plans and highlight how facilities will form anchor institutions in their communities. New build schemes should demonstrate that they are in locations accessible to residents and that attract footfall to high streets and town centres.

In assessing proposals against the criteria set out above, regions and national teams will use a common set of strategic and scheme-level metrics and tests. NHS England will use these to support a broadly consistent national approach to data collection, monitoring and impact assessment across the programme, while recognising that some additional local metrics may also be needed to reflect different service models and population needs.

ICB wide planning metrics include the:

- current utilisation of the community and primary care estate and how utilisation will improve through investment
- square metres used for neighbourhood health per the proposed population size
- number and size of disposals enabled through the proposed estate model
- number and size of poor-quality GP estate that could be exited over time through the proposed pipeline

Scheme-level metrics will include the:

- left-shift benefits enabled by the scheme
- proportion of relevant providers signed up to the proposed utilisation model
- scale of GP practice provision
- cost per square metre
- indicative RDEL affordability case, particularly for new build proposals

Planning and business case approvals

The approvals process for NHC schemes will mirror other national approaches (as detailed in the 2026/27 to 2029/30 capital guidance (https://www.england.nhs.uk/publication/capital-guidance/)), ensuring consistency, pace and value for money, while being as streamlined as possible. The process is designed to focus national assurance on strategic fit, affordability and deliverability.

The first stage will be consideration of ICBs' proposed schemes for outline approval based on the information provided in the planning templates being shared separately. We aim to hold approval panels from early June so that we have an agreed pipeline of schemes during summer 2026. ICBs and/or providers will then need to develop more detailed business cases in order to secure funding and/or inclusion in the PPP programme. Both stages of approval will be taken through the Neighbourhood Estates Investment Committee, a new, nationally convened panel that will provide assurance in line with HM Treasury Green Book principles. Where needed, support will be provided to help new-build schemes progress their business cases once they have received first stage approval.

Planning and submission

Planning for NHC provision should align with place-based planning arrangements, including health and wellbeing boards, where NHS, local authority and voluntary, community and social enterprise (VCSE) partners agree priorities for prevention, left shift and asset use. Local authorities should also be engaged early to ensure that public transport and, in particular, parking provision are considered up front as part of the planning of schemes.

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Neighbourhood health centres: design and performance specification

Publication (/publication)

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Context

This specification supports the planning and delivery of new-build neighbourhood health centres. It is not a detailed technical rulebook, but a tool for consistent planning and design by providing a common starting point for local systems to develop designs that reflect community needs while remaining aligned with national policy.

It sets out shared principles to guide design, rather than prescribing a single model. While developed for purpose-built facilities, the principles can also be applied, where appropriate, to refurbishments, extensions and repurposed buildings, including health-on-the-high street models.

While the aim of this specification is primarily to support new-build neighbourhood health centres, it is explicitly intended to enable and encourage refurbishment, repurposing and extension of existing estate as a primary route to delivery. In many locations, adapting existing buildings will offer the fastest, most affordable and most appropriate way to establish neighbourhood health centres, applying the same core principles proportionately.

Neighbourhood health centres should be co-designed with local communities, including people with lived experience and specific health needs such as a learning disability, to ensure services and spaces genuinely reflect local priorities and needs.

Status and intended use

The document is for integrated care boards (ICBs), local authorities, providers, design teams and delivery partners when developing proposals and briefs. It should be read alongside the accompanying neighbourhood health centre guidance for regions and integrated care boards (https://www.england.nhs.uk/publication/neighbourhood-health-centres/) and relevant NHS technical guidance; health building notes (HBNs) and health technical memoranda (/HTMs (https://www.england.nhs.uk/estates/)). It should also be read alongside relevant planning policy and guidance, including the National Planning Policy Framework (https://www.gov.uk/government/publications/national-planning-policy-framework--2).

How to interpret language

The specification does not introduce new burdens or compliance mechanisms. ‘Must’ is stipulated only where there is an existing legal or regulatory requirement. Beyond this, it sets common principles and aspirations that local systems should follow, adapting to local contexts as necessary.

These principles are intended to be applied proportionately and pragmatically, recognising that high-quality neighbourhood health centres can be delivered through refurbishment, repurposing or extension of existing estate, as well as through new-build schemes.

Definition and primary objective

> Neighbourhood health centres will be seen as the place to go for most health needs in every community. They will bring together general practice services and a mix of community, local authority and voluntary sector services, allowing staff to deliver more co-ordinated and effective care, leading to better patient outcomes and experience. They will be open at a minimum of 12 hours a day, 6 days a week.

Delivering on neighbourhood health, as set out as part of the broad transformative vision in the 10 year Health Plan, will involve bringing together a wide range of health and healthcare services. Where feasible, neighbourhoods will also align with a wider range of public services through proactive cross-government working and co-design, consistent with the government's place-based approach to public service reform.

The ambition within the 10 year Health plan for neighbourhood health centres is that they may:

- be based in every community (defined as a population of around 50,000), focused on places where healthy life expectancy is lowest
- be a 'one stop shop' for patient care, and recognised as the place to go for the majority of health needs
- be based around general practices, co-locating community care and bringing traditionally hospital-based services such as diagnostics, post operative care and rehabilitation into the community
- be a place from which multidisciplinary teams operate
- ideally, co-locate a wider range of local government and voluntary sector services to help create an offer that meets population need holistically: for example, through offering services like social welfare advice (covering issues such as debt and housing), employment support and smoking cessation or weight management services
- help ensure, through co-location, convenient access to services, particularly for those with complex needs, and support more integrated working by professionals
- shift outpatient care from hospitals into the community

Neighbourhood health centres are intended to form part of an asset-based neighbourhood approach, building on existing community strengths, services and infrastructure. They are designed to support prevention, integration and place-based working by connecting health services with wider networks of support, community activity and health promotion, rather than operating as standalone clinical facilities, contributing to a wider ecology of care that supports people throughout their lives.

The neighbourhood health centre

Neighbourhood health centres are integrated primary and community care facilities, designed to support prevention and bring more care closer to home, reducing pressure on acute services.

A core neighbourhood health centre is typically built around co-located general practices and may bring together several practices serving the same locality. It provides space for primary care, community services and some secondary care clinics, supporting more joined-up working while remaining convenient and accessible for local people.

Core+ centres include additional space for services such as family support and healthy child development, primary care-led mental health provision and minor injuries or walk-in services. Core++ centres also include diagnostic space and 24-hour phlebotomy provision, supporting local need and, where appropriate, acute services. All models are designed to accommodate mobile diagnostic units.

Neighbourhood health centres are designed around adaptable, shared spaces rather than fixed, service-specific rooms. This allows a wide range of services, such as physiotherapy, occupational therapy, community nursing, diagnostics, social care and voluntary sector support, to operate from the building in response to local need. These services are delivered in standard consultation and treatment rooms, therapy and group spaces, team bases and flexible community rooms, enabling efficient use of space and supporting multidisciplinary working over time.

Mental health provision within neighbourhood health centres focuses on primary care-led and early intervention support, integrated with general practice services. This is distinct from community based mental health centres, which bring together community and crisis mental health teams with local authority and voluntary sector partners to support people with more complex or acute needs. Community based neighbourhood mental health centres complement, rather than replace, neighbourhood health centres and the person's named GP, ensure continuity of care and co-ordinated support across neighbourhood teams.

Where possible, neighbourhood health centres should be connected to existing community pharmacy provision, particularly in high street or town centre locations. Co-location with nearby pharmacies is preferred, supporting accessibility, local regeneration and efficient use of space. Fully embedded pharmacies are not expected as standard due to their space and operational requirements but may be considered where there is a clear local need and service rationale.

Best Start Family Hubs and Network Sites form part of the wider neighbourhood offer. Local authorities, ICBs and partners should ensure that they complement, rather than duplicate, neighbourhood health centres, while retaining their own identity and national branding. Neighbourhood Health Centres should work collaboratively with Best Start Family Hubs as part of a joint network so that families can easily find and navigate the help they need. Best Start Family Hubs and Healthy Babies Guidance for Local Authorities (https://www.gov.uk/government/publications/best-start-family-hubs-and-healthy-babies-guidance-for-local-authorities) emphasises the importance of Best Start Family Hubs delivering services through 'network sites' (other trusted community locations such as Neighbourhood Health Centres) wherever possible – to ensure services reach families where they are and deliver the greatest impact.

Neighbourhood health centres are designed to provide a physical setting and a digital hub for:

- integrating primary and community health and social care
- localising ambulatory and diagnostic services
- partnering with the third sector and local authority services where appropriate.

The centres will:

- embody the shift from reactive to proactive care, moving services, wherever appropriate, from settings in hospitals or isolated general practice premises to integrated local centres
- be simple, adaptable and non-specific 'long life, loose fit' buildings that can flex and change throughout their life
- meet the Net Zero Building Standard and provide exemplars for low carbon construction and operation, with an aspiration to achieve Passivhaus standards where appropriate
- be healthy buildings, providing well-tempered and well-designed environments with alignment to strategies such as BREEAM or the WELL Building standard, or similar
- contain standard rooms and standard systems of assembly
- be designed, manufactured and assembled in accordance with the principles of modern methods of construction (MMC)
- achieve improved rates of utilisation of space

Archetypes and space utilisation

Archetypes

Recognising that different geographies will be starting from different points, we have identified 4 potential archetypes (configurations) through which the neighbourhood health model can broadly be delivered:

- hub-and-spoke model
- repurposed community or civic spaces
- cohort-specific hubs
- purpose-built neighbourhood health centres

These archetypes are not intended to be restrictive. Local partners may develop variations or hybrid models where these meet service needs and align with the principles set out in this specification.

The archetypes described below relate to components of the wider neighbourhood health model and network within a place. Together, they create a flexible network that brings care closer to where people live while maintaining a coherent neighbourhood offer.

They distinguish between locations that function as neighbourhood health centres and other hubs or settings that support specific population groups as part of the wider neighbourhood health system. Not all the archetypes represent places that can be designated as neighbourhood health centres in their own right. 2 of the archetypes – the hub-and-spoke model and new neighbourhood health centres – function as the primary neighbourhood health centre setting, providing a central base for integrated care. The other 2 – repurposed community or civic spaces and cohort-specific hubs – operate as supporting neighbourhood health services, extending reach into high street, community and specialist settings.

Neighbourhood health centres operate as anchors within a wider neighbourhood health network, supported by digitally connected cohort-specific and community-based hubs. All archetypes are therefore expected to operate as digitally-enabled and connected components of a wider neighbourhood network, with digital infrastructure acting as a key enabler to integrate services, co-ordinate activity and connect centres across a place, in line with the digital requirements set out later in this specification.

This specification, including the supporting schedules of accommodation and layout plans (https://www.england.nhs.uk/publication/neighbourhood-health-centres/) , applies primarily to the new-build archetype. However, the underlying principles, including flexibility, high utilisation, inclusive design, net zero alignment and digital connectivity, should be applied, where feasible, to refurbishment, extension and repurposing schemes, as well as health-on-the-high street models.

Archetype 1: Hub-and-spoke/upgrade, repurpose or extend existing NHS estate

Upgrading or reconfiguring existing general practice, community or other NHS buildings is typically the quickest and most affordable way to establish a neighbourhood health centre. It is appropriate where existing high-quality estate can be extended or complemented by 'spokes' such as mobile or small satellite sites to provide the right neighbourhood health service offer.

Archetype 2: Repurposed community or civic spaces

Adapting high street premises, libraries, leisure centres or other civic assets to host neighbourhood health services brings care closer to where people live and can be delivered at pace and comparatively low cost. While these facilities will often not be able to provide the full range of services expected from a neighbourhood health centre, they can form a valuable part of the local offer.

Archetype 3: Cohort-specific hubs

Existing hubs that provide health or care services in the local community for particular groups, such as women's health hubs, Best Start Family Hubs, community based mental health centres or respiratory hubs, and can be integrated into the wider neighbourhood health offer. These hubs will not always be physically located within a neighbourhood health centre, but should complement, align with and, where it makes sense locally, be co-located or rationalised with neighbourhood health centres.

Archetype 4: Purpose-built neighbourhood health centres

New-build centres that are designed specifically for multidisciplinary teams, co-located services and strong digital integration. These will be delivered through a mix of public capital and a new public private partnership model in areas where current estate cannot readily be repurposed to deliver convenient access for patients to the full range of neighbourhood health services.

Utilisation of space

Key utilisation assumptions for neighbourhood health centres are:

- 30,000 general practice population (core)
- 50,000 community care population (core+)
- 100,000 'other' for example diagnostic (core++)
- rooms are shared between services on a timetabled basis delivering an integrated service model
- all services operating at 80% utilisation of spaces
- open 6 days a week.
- open 12 hours
- spaces out of hours available for community activities

These assumptions are intended to support flexibility and shared use of space. They should be applied alongside realistic modelling of workforce growth, service expansion and evolving primary care roles over time.

A high level of space utilisation is expected to be achieved primarily with longer operating hours, shared use of rooms across multiple services and improved co-ordination of activity across the day, rather than intensifying individual clinical sessions.

Neighbourhood health centres are designed to support extended opening hours and multiple, co-ordinated sessions within the same room across a broader range of providers. This represents a shift from traditional models where rooms are occupied for limited, fixed sessions within a longer opening day, towards a more flexible, system-wide approach to scheduling and use of space.

The activity modelling tool (https://www.england.nhs.uk/publication/neighbourhood-health-centres/) we used to derive the accompanying schedules of accommodation and layouts (https://www.england.nhs.uk/publication/neighbourhood-health-centres/) is provided alongside this specification for local providers to use.

In their operation neighbourhood health centres are expected to be highly flexible and adaptable facilities that can alter their space allocations to match changing provider demand, not ones that preserve exclusivity and 'ownership' of space over long periods of time. This ambition is supported by the proposed centre funding, ownership and occupation models.

Where spaces are made available outside core operating hours, this is expected to support targeted health, wellbeing and social prescribing activity that aligns with neighbourhood priorities, not general commercial hire, and will be subject to local operational, security and cost considerations.

Integrated and unintegrated operating models

In considering space utilisation, this specification distinguishes between unintegrated and integrated operating models, reflecting different approaches to the use and management of space.

In an **unintegrated model**, services typically operate independently, with rooms and spaces allocated to individual organisations, teams or clinicians. Space is sized and planned to meet the peak needs of each service, and rooms are often occupied for fixed sessions within a wider opening day. While this model provides a high degree of ownership and familiarity, it can result in lower overall utilisation and reduced flexibility as service needs change.

In an **integrated model**, space is shared across services and sized to support a broader range of activity over the course of the day. Rooms are booked and used flexibly by different providers and teams, supported by co-ordinated scheduling, extended operating hours and shared operating models. This approach enables higher levels of utilisation, reduces duplication of space and supports multidisciplinary working and more seamless care for patients.

Neighbourhood health centres are designed to support the integrated model, with adaptable rooms, shared booking systems and operational arrangements that allow space to respond dynamically to changing demand and service mix, rather than being tied to single users or fixed patterns of use.

Location

Neighbourhood health centres should be located at the heart of the communities they serve. Sites should be places people already visit regularly, with good public transport and local infrastructure, to avoid creating high-quality but under-used buildings.

When identifying sites, systems should consider location, accessibility, footfall, social value and regeneration together. Existing community focal points, such as high streets and town centres, are often well recognised, accessible and well served by amenities. While such locations may mean higher land or rental costs, their visibility and accessibility can improve use, support regeneration and deliver better long-term value.

Neighbourhood health centres should act as community anchors, supporting wider social value and the broader determinants of health. Sites should therefore be selected in collaboration with local authorities to align with local planning priorities, regeneration strategies and wider public service provision. With local input, each centre should reflect local need, identity and pride in place.

Locating a centre away from an established community focal point should be approached cautiously and only where there is clear evidence of future population growth, such as committed large-scale housing development. Information about such developments is available from local authorities and on the STRATA platform (previously branded SHAPE).

Site selection and design should align with NHS England's Building for health principles (https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/contacts-and-resources/building-for-health/), supporting accessibility, wellbeing and integration with the surrounding place.

Key principles for location are:

- social value
- regeneration
- accessibility
- footfall
- community

Inclusive by design

Neighbourhood health centres should function as accessible, practical community facilities, supporting access to services, advice and prevention activity.

The design approach should prioritise usability, dignity and safety, informed by established guidance rather than bespoke or experimental solutions, for people to use these centres with confidence.

The design should provide clear layouts, allow ease of movement and create environments that reduce confusion and unnecessary stress. Natural light and views to the outside should be maximised where possible. Waiting and shared areas should be calm, clearly organised and appropriately scaled.

Dementia-friendly design is a core requirement and should be embedded from the outset. This includes clear and intuitive wayfinding, consistent colour cues, simple circulation routes and the avoidance of glare, visual clutter and confusing patterns.

Designs should take account of a wide range of physical, sensory and cognitive needs. This includes step-free access, suitable seating, clear entrances and environments that support people with sensory sensitivity, including those living with dementia, autism, a learning disability or mental health condition. Public areas should feel familiar and non-institutional, supporting use by a wide range of people and services.

Design teams are encouraged to draw on emerging good practice, including the sensory-informed design principles set out in HBN 00-03: Clinical and clinical support spaces (https://www.england.nhs.uk/publication/designing-generic-clinical-and-clinical-support-spaces-hbn-00-03/) and relevant professional guidance on design development, such as the inclusive design overlay to the RIBA plan of work (https://www.riba.org/work/insights-and-resources/inclusive-design-overlay-to-riba-plan-of-work/), adapting these principles proportionately to local context and service need.

Where appropriate, provision may be made for quiet or multi-faith spaces. Engagement with local communities should inform design choices, proportionate to the scale and context of the scheme.

Key principles for inclusive design are:

- dementia-friendly design
- accessibility
- sensory comfort
- wayfinding
- natural light and biophilia
- community wellbeing

Brief

Defining service requirements

Neighbourhood health estate will enable long-term flexibility in clinical service delivery. Clinical briefing and patient flow improvements are key priorities for the NHS and should be embodied in the development of all schemes.

All systems considering a neighbourhood health centre will establish a clinical brief. This brief will:

- be based on the identified services that are present in a core neighbourhood health centre through to the larger core++ version
- appropriately define and model currently acknowledged population health needs and outcomes, and identify the preferred service mix to improve outcomes and reduce inequalities. From this process, space requirements and improved patient flow can be understood and developed
- clearly state expected benefits and key performance indicators for added value, including socio-economic, health outcomes and local regeneration

Rather than adopting traditional approaches to healthcare planning in primary care, neighbourhood health centres will be modelled on bookable rooms and flexible floor space to achieve occupancy rates of 80% during opening hours (at least 72 hours a week).

Integration of social care within neighbourhood health centres

Neighbourhood health centres are designed to enable the integration of social care services through flexible, shared and non-clinical spaces rather than fixed, single-purpose accommodation. Social care functions may be delivered through a combination of interview rooms, group rooms, shared workspaces and community support rooms, co-located alongside health and voluntary sector services.

This approach supports joint working, warm handovers and multidisciplinary collaboration, while allowing the scale and form of social care presence to respond to local commissioning arrangements, workforce models and population need. Social care integration is therefore enabled by adaptable space, shared operating models and digital connectivity, rather than by prescribing specific room types or layouts.

We have based the development of the activity modelling tool (https://www.england.nhs.uk/publication/neighbourhood-health-centres/) (in Excel), provided alongside this specification, on agreed population definitions and utilisation for healthcare only services at this stage. It can be adapted to input social care parameters at briefing stages to reflect local

requirements.

Training and education opportunities

System-owned and system-controlled assets provide opportunities to accommodate medical, nursing and other training programmes. These requirements should be considered when developing the clinical brief and schedule of accommodation. Neighbourhood health centres should support shared training environments for the wider neighbourhood workforce, enabling team-based learning across primary, community, mental health, social care and voluntary sector partners.

Local educational institutions, including deaneries, should be contacted to understand training needs, recognising that flexible occupation and standard room types can often be used for more than one function. In addition to providing training opportunities for NHS staff, neighbourhood health centres may also support the education needs of the local community. Training provision should recognise the growing scale and diversity of the primary and community care workforce and support multidisciplinary learning within neighbourhood teams.

Flexible spaces in neighbourhood health centres may provide:

- clinical training rooms
- educational debriefing rooms, which can be multipurpose with general meeting rooms
- neighbourhood work facilities with IT equipment to replace traditional 'staff library' facilities

Operational principles

It is important that all providers co-locating and integrating into a neighbourhood health centre building understand the fundamental change in approach away from traditional commercial models of estate ownership and occupancy.

This programme proposes an alternative way of occupying space to drive greater efficiency, promote system and partnership working and facilitate genuine integration between the NHS and other services. There are vital underlying principles for occupying and operating within a neighbourhood health centre to maximise opportunities to address the wider determinants of health and social care;

- co-location of multiple services within the same building to promote the health and wellbeing of local populations, grounded by general practice services as an 'anchor tenant'
- primary occupancy for all users is via bookable and shared space
- use of an effective electronic room booking system
- monitoring and measuring ongoing utilisation
- working together to use the space to its full capacity
- applying a greater level of flexibility and adaptability to meet the changing needs of service delivery and local population health
- strategic alignment with local authority regeneration and place-based plans, ensuring neighbourhood health centres support wider ambitions for town centre renewal, accessibility, social value and sustainable community development
- working in partnership with other health, care and community settings within the neighbourhood to ensure services are aligned, complementary and shaped around people's lives, rather than organisational boundaries, for example through effective collaboration between neighbourhood health centres and cohort-specific hubs such as Best Start family hubs – to support early identification, prevention and targeted early intervention. This could include co-location of services, or co-ordinated referral pathways for babies, children and their families.

Co-location is intended to support, but not substitute for, integrated working, which is enabled through shared operating models, digital connectivity and multidisciplinary team collaboration across physical and virtual settings.

Occupancy will be through the use of short to medium term flexible leases and licence agreements, allowing services to change and adapt over the life of the neighbourhood health centre to meet the strategic objectives and vision for place-based services responding to population health needs and social determinants of health.

This ethos behind the centres is more than a 'lift and shift' of activity. The facility will enable new ways of system working brining benefits for:

- managing the cost for services that improve local population health by ICBs or relevant boards of integrated health organisations
- removing personal liabilities and responsibilities associated with ownership and management of facilities by the integrated care system (ICS)
- removal of unnecessary commercial and administrative barriers that limit flexibility and integration
- creation of a more sustainable model of adaptability and flexibility (long life, loose fit)

These identified early benefits will free up providers from dealing with estates and facilities management issues, allowing them to better focus on delivering clinical services and promoting health and wellbeing.

The operational principles set out in this specification will be supported by clear, consistent frameworks for cost allocation, data reporting and performance management, to be applied across owners and occupiers and aligned with national guidance.

Managing utilisation and avoiding void space

Neighbourhood health centres are intended to operate as managed system assets, with a single, co-ordinated approach to room booking and space allocation. Responsibility for the day-to-day management of rooms, including booking, utilisation monitoring and reallocation of space, should sit with the organisation responsible for operating the building, supported by the centre manager the neighbourhood health centre employs to oversee the smooth and efficient operation of the building. The centre manager co-ordinates and chairs the building user group and is responsible for the measurement, reporting and delivery of the agreed benefits of neighbourhood health centres.

Smart building technology will monitor the utilisation and efficiency of the building and provide regular reports to the centre manager and building user group.

All bookable rooms are expected to be managed through a shared electronic booking system, providing visibility of availability across services and enabling space to be allocated dynamically in response to demand. Individual organisations or services will not have exclusive control over rooms unless this is explicitly agreed as part of the operating model.

All centre occupants will have access to the electronic booking system to book the space for the delivery of clinical, social care or other appropriate services as determined by the ICS and relevant stakeholder groups. They will co-operate with each other to develop and implement proposals to improve the utilisation of the building, which include:

- agreeing the principles of understanding and obligations for occupying and maximising space use
- surrendering excess space that is found not to have been used
- varying the rights and reservations of any occupancy agreement
- sharing occupation with others that provide health and care or complementary services
- carrying out utilisation studies or surveys to inform proposed use and room allocation

The centre manager, working with the building user group, is responsible for resolving booking conflicts, identifying under-utilised capacity, and enabling space to be reallocated or shared where appropriate. This ensures that rooms are used efficiently across the day and that the building can respond flexibly to changes in service delivery, workforce patterns and population need.

In multi-occupant neighbourhood health centres, active management of space is essential to avoid under-utilisation and void space, and to ensure the building operates effectively as a shared system asset.

Digital check-in and reception functions will be designed to streamline access and reduce waiting times. Each centre will provide self-service digital check-in points, integrated with the NHS App and shared care systems, enabling patients to register their arrival quickly and independently. A single, shared reception desk will support all services within the building, offering face-to-face assistance and safeguarding oversight and inclusive support for those who require or prefer personal interaction. This unified approach ensures a consistent welcome, improves operational efficiency and reinforces the neighbourhood health centres role as an integrated, co-ordinated point of access.

Local systems may adopt a range of commercial and funding mechanisms to incentivise efficient use of space, reflecting local ownership and contractual arrangements. The specification does not prescribe a single commercial model, but all models should align accountability for utilisation with responsibility for the cost and operation of the building.

Long-life, loose-fit: sizing a neighbourhood health centre

Healthcare planners are encouraged to support conversations that arrive at the new way of working for flexible space allocation, the effectiveness of which will depend on an effective room booking system and building monitoring system.

The activity modelling tool (https://www.england.nhs.uk/publication/neighbourhood-health-centres/) provides a structured basis for NHS service planning and should be complemented locally by qualitative and place-based approaches to sizing shared community, local authority and voluntary sector spaces.

From the start of proposal development, the activity modelling tool (https://www.england.nhs.uk/publication/neighbourhood-health-centres/) should be used to aid in determining the number of patient facing rooms required with the parameters set for opening hours and utilisation.

The calculator encourages users to think of rooms as flexible spaces that can be utilised by multiple different professionals and services throughout the day and over an extended period, not for a single purpose.

The supporting schedules of accommodation, which have been tested for better utilisation for core through to core++ centres, can be used as a basis to adjust the building size to suit the local need.

The sizing of shared community and non-clinical spaces will require locally informed judgement, co-design and iteration, recognising that demand may not be defined by activity data alone.

Sizing a neighbourhood health centre

Determining the size of a proposed neighbourhood health centre will require reference to the range and scope of services provided by the partners involved.

Demand and capacity modelling in healthcare planning seeks to process clinical activity data by applying a range of agreed growth and defined operational parameters for neighbourhood health centres. Sizing will be an iterative process, with early assumptions refined in the schedule as local needs, service models and pathways are confirmed.

The factors that need to be considered when estimating size are:

- population growth estimates
- access rates by age demographic
- adjusted access rate by ethnicity
- any proposed services relocating from hospital to community
- care pathways and model of care that support improving population health management priorities
- mode of appointment applicable to access rates and clinical model, such as proportion of home visits and face-to-face, telephone and video appointments
- appointment lengths for each mode of appointment
- setting needed for each mode of appointment
- open plan administration requirements alongside work spaces and remote working
- an increase in digital care models

Where proposals support the transfer of services from acute to community settings, systems should consider the full affordability and estate impact, including how income flows with activity and how any vacated estate is repurposed, reconfigured or released. This supports sustainable implementation and avoids creating unintended financial or operational pressures.

Neighbourhood health centres will achieve a target room occupancy rate of 80% during operational hours.

The activity modelling tool consists of functional content projections based on the aggregated clinical activity across all partners within the building, including:

- consultation and examination rooms
- treatment rooms
- interview and counselling rooms
- multidisciplinary team and group rooms
- imaging and diagnostic rooms
- virtual consultation rooms

Building design principles

Net zero by design

Neighbourhood health centres are conceived as next generation; future-proofed community assets designed from the outset to support a net zero NHS. They will be local exemplars of low carbon public infrastructure.

Each centre is delivered as a highly efficient, all-electric, net-zero energy building that meets or exceeds the NHS Net Zero Building Standard (https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/), regardless of scheme scale or capital value, with an aspiration to achieve Passivhaus standards (https://www.passivhaustrust.org.uk/what_is_passivhaus.php) where appropriate. The design approach prioritises exceptional building fabric performance, smart ventilation, smart energy control and modern low carbon heating systems, ensuring consistently low energy demand and a healthy internal environment.

Where relevant, schemes should consider heat network zoning regulations (https://www.gov.uk/government/collections/heat-network-zoning) and any requirements or opportunities to connect to local heat networks, working with local authorities and other partners to understand, plan for and future-proof designs for potential connection, where this supports wider place-based energy strategies.

Wherever feasible, neighbourhood health centres should have on-site renewable generation, solar-ready roofs, smart energy systems and the capability to integrate with local microgrids and energy infrastructure. Whole life carbon is assessed from concept through to operation, with modern methods of construction (MMC), circular materials and design-

for-disassembly forming the baseline expectation. To maintain performance long after handover, each centre will have a structured soft landings (https://www.england.nhs.uk/neighbourhood-health-centres/) process, seasonal commissioning, ongoing energy monitoring and verification, and transparent reporting aligned with NHS sustainability obligations.

The relevant distribution network operator (DNO) should be engaged early to confirm grid capacity and connection requirements, recognising that constraints may affect feasibility, phasing and cost.

The key design principles are:

- concept and modelling
- MMC and low carbon materials
- construction (reduced embodied carbon)
- operational optimisation
- end-of-life reuse and disassembly

Buildings resilient to severe weather

Neighbourhood health centres are designed with resilience at their core, recognising that flooding, overheating and extreme weather events are becoming more frequent and are already disrupting access to healthcare, particularly for those in deprived and vulnerable communities.

Each centre is designed to protect access to essential care as well as provide safe, stable and supportive spaces during climate-related events; with safe access routes, alternative entry points and the ability to maintain essential operations if surrounding conditions deteriorate. In doing so, they help protect the most vulnerable communities and reduce health inequalities driven by environmental risks.

By including flood mitigation, heat resilience and operational continuity among their core design principles, neighbourhood health centres will form a national network of climate ready assets for now and well into the future, helping secure the NHS's ability to serve communities, especially the most deprived.

Schemes should undertake a climate change risk assessment at an early stage, informed by the NHS England climate adaptation framework (https://www.england.nhs.uk/publication/climate-adaptation-resources/), to identify and mitigate risks to access, operation and service continuity.

Flood risk and continuity of access

From the earliest stage of site appraisal, every neighbourhood health centre assesses and mitigates flood risk, incorporating measures that protect both the building and the people who rely on it. This includes raised thresholds; resilient ground floor layouts; sustainable drainage systems; rainwater attenuation; and landscape features designed to slow run off and reduce local flood pressure. Mechanical, electrical and digital infrastructure is positioned and protected to ensure that services remain operational even during severe weather.

Overheating, heat stress and healthy internal environments

Overheating is now a serious and predictable risk for public buildings and the populations they serve. Each neighbourhood health centre is designed to build out heat stress primarily through passive design measures including high performance insulation and glazing, external shading, optimised building orientation and controlled solar gain, and natural ventilation strategies.

Internal environments will be monitored and regulated to maintain comfortable conditions throughout the year, supporting clinical delivery and wellbeing for patients and staff.

Mechanical cooling systems should only be introduced where the risk of overheating cannot be adequately mitigated through passive measures alone and where they are clinically required to support safe care delivery. Those that are installed must be highly energy efficient, use low carbon technologies and designed to minimise operational energy demand and associated emissions.

Recognising the increasing prevalence of overheating in existing housing, particularly in poorly insulated or densely occupied homes, neighbourhood health centres may also act as community cooling spaces during extreme heat. Their accessible, welcoming and climate-controlled environments provide a safe refuge for residents at greatest risk, strengthening the role of the centres as local anchors that protect health, wellbeing and social resilience.

Social value: community hubs that strengthen place and wellbeing

Neighbourhood health centres are designed as anchors of social value, supporting healthier, more connected and more resilient communities. They do far more than host clinical services: each centre provides accessible, welcoming spaces where people can meet, learn, socialise and access wider support that shapes health, education and opportunity.

Larger centres include flexible community rooms, spaces for group activities and places where voluntary and community organisations can convene and collaborate. Centres may also host local social enterprises, such as advice services, community cafés and local arts, sport and wellbeing groups, creating pathways into employment, training and prevention while keeping value circulating within the local economy. Centres may also co-locate with leisure and wellbeing facilities to bring multi-purpose health provision and support under an integrated neighbourhood health service umbrella.

Where enterprise or commercial space is provided, priority should be given to local businesses and social enterprises, particularly those rooted in or supporting more deprived communities.

Outdoor areas are designed as active, inclusive public spaces that promote physical and mental wellbeing. This may include outdoor gyms, walking loops, gardens, children's play areas and seating that encourages social interaction, making the centres welcoming places to spend time, not simply places to receive care. Thoughtfully designed landscapes help connect the centre to its neighbourhood and support everyday physical activity.

Where located on or near high streets, neighbourhood health centres can play a key role in revitalising town centres by increasing footfall, supporting local businesses and reinforcing the high street as a focus for community activity.

Information, digital access points and signposting hubs provide residents with tools to navigate issues that influence health – from housing and benefits to family support, education and employment. By embedding these functions within a trusted local setting, neighbourhood health centres help reduce inequalities and create lasting social value across generations.

Together, these features make each centre a vibrant asset for the community, strengthening social networks, supporting local enterprise and contributing to the wider social, economic and environmental wellbeing of the neighbourhood it serves.

Infection prevention and control: flexible and resilient design

Infection prevention and control (IPC) is essential for safe, resilient and flexible service delivery within neighbourhood health centres and is embedded in the design approach from the outset.

The design of centres supports a move away from fixed, infection-defined spaces towards adaptable, capability-led environments, where clinical function is aligned to environmental capability and supporting infrastructure. Standardised rooms and building services enable spaces to flex between uses as service demand and infection risk change, while ensuring that activities are only undertaken in environments that meet the appropriate clinical and IPC requirements.

Learning from the Covid-19 pandemic has informed a design approach that supports service continuity during periods of heightened infection risk. Centres are planned to enable the operational separation of patient pathways where required, including through direct access from public zones to clinical areas and the ability to cohort patients, and the flexible reconfiguration of space without disrupting routine preventative, diagnostic and community-based care.

This approach supports a scalable response to surges in demand, maintaining a positive patient experience, protecting staff and service users and ensuring that IPC requirements are met without unnecessarily restricting service delivery.

Digitally-enabled, networked and operationally intelligent centres

Digital infrastructure is fundamental to the neighbourhood health centre model. Each neighbourhood health centre is designed as a digitally mature, interoperable and data intelligent facility that is seamlessly connected to shared care records, the NHS App and system-wide digital platforms. Crucially, every centre is digitally linked with all other neighbourhood health centres in its locality, creating a networked estate where space, activity and service availability are collectively visible and intelligently managed across the neighbourhood.

This connectivity means that each centre spans far beyond its physical footprint. Real-time utilisation and occupancy data flows across the whole neighbourhood health centre network enable dynamic space sharing, co-ordinated scheduling and cross site service optimisation. Patients can be directed to the right place first time; staff can work flexibly across multiple centres; and ICSs can actively manage capacity, throughput and extended hours using live operational intelligence.

Smart building technologies – including occupancy analytics, environmental sensors and interoperable room booking systems – provide continuous insight into how space is used and how services are delivered. This supports more efficient deployment of multidisciplinary teams, reduces bottlenecks and ensures that every centre and every room across the network contributes to the overall productivity of neighbourhood care.

Digitally-enabled clinical models, including virtual consultations, mobile diagnostics, community monitoring and shared team spaces, are supported by standardised, plug and play technology across all bookable environments. Where appropriate, digital twins and common data environments enhance lifecycle performance, enabling predictive maintenance, asset optimisation and ongoing reductions in energy use and carbon. This data environment also creates opportunities to support learning health system approaches over time, enabling continuous improvement in how and where care is delivered.

Together, this creates a digitally connected, operationally intelligent neighbourhood platform, where the estate actively supports integrated working, modern care pathways and the NHS's long-term productivity and sustainability ambitions, enhancing productivity, sustainability and patient and staff comfort.

Design guide

External spaces

Patients, staff and visitors to neighbourhood health centre will make their first impression of it from the building's façade and external space. Their appearance, therefore, needs to be well maintained and welcoming.

To accommodate the requisite number of services that make up either a core neighbourhood health centre or the larger core+/core++ models, all are likely to be 2 storeys in height. They could be standalone developments or form the base of much higher mixed-use developments.

The centres entrance level will contain public shared spaces and community spaces that will become an internal part of the public realm, and clinical spaces that need privacy and will be shielded from public view. This sets up a need to design external spaces that can create a public and a private area(s) inside and outside the centre.

External layouts should also allow for the safe access, positioning and servicing of mobile diagnostic units, where deployed, ensuring these can be integrated without compromising public realm quality, accessibility or operational safety.

The therapeutic value of external spaces, such as gardens and courtyards, as physical and, as importantly, visual amenities is a proven component in creating healthy buildings for patients and staff. Every neighbourhood health centre is also expected to contribute positively to community development and local biodiversity.

The role of the centres as essential community assets will be strengthened by developing participatory landscapes for play, exercise, education, creative (for example, activities for example, art) sport and gardening or contribute towards townscape spaces. Cost savings achieved by delivering a programme 'at scale' using standard components will be reinvested into such landscapes.

Schemes should maintain and enhance local biodiversity following local planning policy and, where applicable, meet statutory biodiversity net gain (BNG) requirements (https://www.gov.uk/government/collections/biodiversity-net-gain), using high-quality landscape design to deliver both ecological and health benefits. Business cases should ensure sufficient provision is made within the cost plan to achieve and maintain landscape quality throughout the project lifetime. Nature-based solutions should be prioritised wherever possible to deliver health, biodiversity and climate resilience benefits.

Key components for external spaces are:

- gardening
- sport
- creativity
- art
- education
- exercise
- play

Travel and access

Neighbourhood health centres will be planned to promote sustainable travel choices and enable convenient access for all members of the community. Site selection and design should prioritise strong public transport links, safe and direct pedestrian routes, and high-quality cycling infrastructure, including secure cycle storage and facilities that support active travel. Centres should be easy to reach without a car wherever possible, reducing reliance on private vehicles and encouraging healthier, low-carbon modes of travel.

Parking provision will be informed by local planning policy and the available public transport in the area, recognising the differences between inner-city locations with good public transport access and rural or suburban settings with limited connectivity. Parking should be sensitively integrated into the site and offer affordable electric vehicle charging facilities. Designs should avoid isolating the building behind extensive surface parking and incorporate landscaping to create a welcoming, accessible environment.

Travel and external access arrangements must be developed in partnership with a disability reference group, including people with sensory, physical and cognitive disabilities, to ensure that routes, drop-off points and building entrances are inclusive and intuitive. Opportunities to share parking or travel infrastructure with neighbouring organisations should also be explored early in the design process.

Bulidings

Neighbourhood health centres are based on a library of repeatable rooms and room clusters that can be assembled in different functional configurations to meet the clinical brief.

The adaptability of these centres throughout their 50+ year planned life and beyond is essential and every project will consider how the building will need to change over time.

Neighbourhood health centres will accommodate known NHS models of care from the outset but have the flexibly to adapt to new models throughout their operational life. Designers should consider whether the space could be converted, in part or whole, to other potential uses such as housing or commercial.

Each neighbourhood health centre will have a shared entrance space that acts as the focal point for welcome and orientation and the front door for access to all services operating in the building. This public zone will have digital check-in, a single shared reception desk and clear signposting, creating a simple and consistent experience for all visitors. From this shared space, people will move into the clinical areas and the wider community facilities, including spaces such as group rooms and community support rooms.

The proposed form of tenure, will enable a 'neutral' public zone, providing the accommodation for all public functions such as welcome, information, waiting and public toilets. Tenure and 'plug in, plug out' adaptability will mean that the public zone will be separate from the clinical, social and third party clusters.

Layouts and wayfinding strategies recognise that neighbourhood health centres are public buildings with public responsibilities yet contain mainly private functions. Patients and staff will be able to move around the building, and find their way easily and enjoyably, understanding how the centre works and gaining a sense of control.

Healthcare buildings will have qualities that reflect and promote a healthy lifestyle for patients, staff and visitors:

- well-tempered environments that provide patients, visitors and staff with those elements that are essential to our health, such as fresh and gently moving air, well balanced temperatures, good acoustics, high levels of day light penetration, sunlight without glare and the use of contrasting and changeable levels of lighting
- materials and finishes that have a zero or very low volatile organic compounds content and low embedded carbon
- healthy environments, wherever possible, that assist us in our daily lives to maintain a healthy lifestyle, for example, good food, social interaction, access to sunshine, nature, exercise and the arts

The building is constructed using good materials and finishes that maintain their quality. A level of detail in the design communicates that care and thought have gone into making the building fit for the patients and the staff.

Neighbourhood health centres provide a collaborative environment in which staff can work and learn together in multidisciplinary teams in safety, while also supporting their morale. The relationship between workplace design and wellbeing is an essential component in improving productivity, recruitment and retention.

Planning principles

New-build neighbourhood health centres will be planned on a standardised structural grid. This enables the clustering of rooms in an interchangeable configuration to maximise adaptability – the 'long life, loose fit' approach to their design, and offers opportunities for MMC, off-site manufacture and the development of standard product and mechanical, electrical and plumbing (MEP) assemblies.

We have chosen a grid of 8.1m x 7.2m as this size can accommodate a wide range of clinical and social functions. Local solutions may adapt the form of the building to suit site constraints, adhering to the building principles set out in this specification.

A standard set of room sizes from the revised HBN 00-03; Clinical and clinical support spaces (https://www.england.nhs.uk/publication/designing-generic-clinical-and-clinical-support-spaces-hbn-00-03/) (2026) can accommodate all required functions in various configurations, again to ensure long life adaptability and to maximise the advantages of assembling these buildings from a standard set of high-quality components. For the programme to benefit from scalability and repeatability, designs will use these standard room sizes wherever possible.

Within HBN 00-03; Clinical and clinical support spaces (https://www.england.nhs.uk/publication/designing-generic-clinical-and-clinical-support-spaces-hbn-00-03/) there are 2 sizes for consulting and examination rooms: 13.5 or 16 square metres. The latter can provide 3-sided couch access or, by aligning the couch against one wall, leave additional space in the room

for escorts or family accompanying a patient or to place mobile equipment. When planning a centre, the appropriate ratio of 13.5 to 16 square metres sized rooms to meet the brief requirements should be considered, as well as how this fits efficiently within the chosen grid spacing.

To meet net zero carbon requirements and deliver the required percentage of MMC, an all-electric approach to the provision of building services is adopted. This increases the size of plant areas and primary distribution risers and horizontal runs. To provide sufficient depth for above ceiling services a repeatable floor to floor height of 4,000mm will accommodate floor to ceiling heights of circa:

- 2.55m in double loaded corridors
- 2.7m in consultation and examination and treatment rooms
- 3m in group and therapy rooms and single loaded primary circulation routes

Columns are standardised as a zone of around 450 millimetres square to allow for differences in structural methodologies, and layouts should be planned so that columns do not land within offices, consultation rooms or circulation areas, MEP zones and manufactured partitions. 150mm partition walls are used in the examples developed to meet acoustic, fire safety, robustness and MCC requirements. The walls around the stair and lift cores are at least 250mm to support consistent riser positioning, modular core walls and prefabricated structural/stability elements.

Riser positions should be consolidated into 2 to 4 major stacks, sized for prefabricated MEP riser frames. These should be in the centre of the race-track solutions (typically where support clinical rooms are located) to allow service distribution to the wings or quadrants without having cross-overs and maximise standardisation. 1,800mm corridor widths are included throughout to support MEP services distribution routes.

Adopting standardised assemblies for the shell and core design include but are not limited to:

- circulation cores; lifts and stair modules
- façade modules and assembles
- horizontal and vertical service zones
- defined allowance for future plant capacity

The incorporation of these strategies is reflected in the planning, circulation and engineering allowance percentage uplift in the schedule of accommodation.

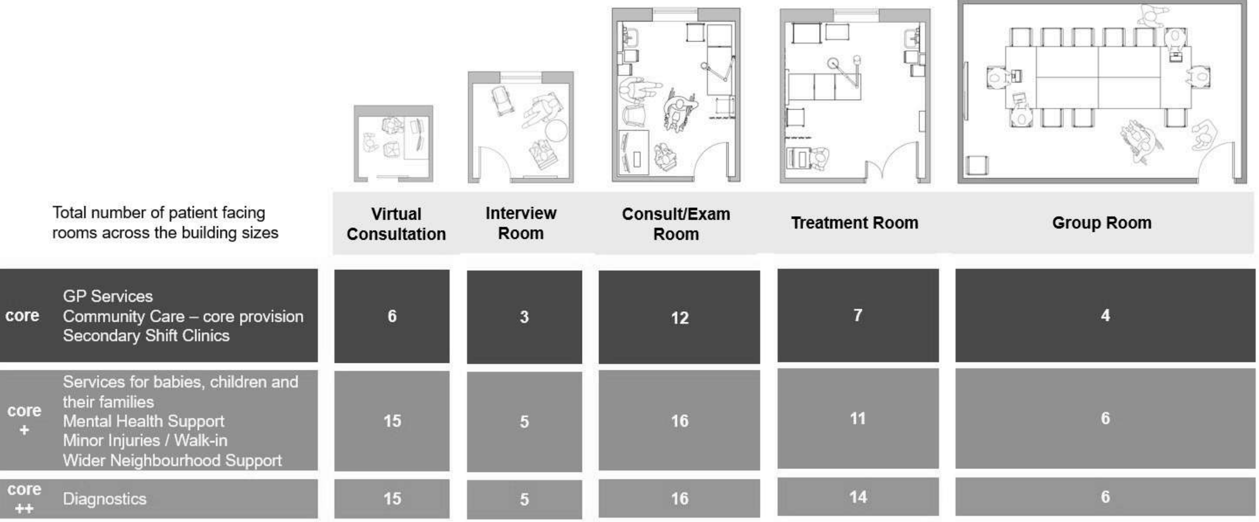
Room assemblies

The standard rooms will be assembled to provide maximum flexibility of use in the clinical zone between general practice, community care and secondary care clinic rooms. Placing clinical rooms on an outside wall and the supporting rooms in a central core reduces the length of the clinical building zones.

These planning principles and room assemblies deliver a building that is inherently flexible, as the public circulation or waiting areas are 'neutral' under the landlord's control, separated from the 'plug in, plug out' health, social care and community components that can agilely respond to change.

Figure 1 illustrates the indicative number of patient-facing rooms by room type for a typical core, core+ and core++ model. The numbers within it are drawn from the published schedule of accommodation and show how spatial provision increases as the service offer expands. Rooms have been deliberately selected for multi-use, with flexibility built in to maximise utilisation while remaining closely aligned to the types of services expected to operate within each space. This approach avoids unnecessary oversizing and ensures that rooms are proportionate, functional and fit for purpose. The diagram is intended to demonstrate the underlying rationale that services can be delivered via these typical rooms within the schedule of accommodation, timetabled on a sessional basis to increase utilisation of the rooms, rather than being owned full time by a particular service.

Figure 1 – indicative number of patient-facing rooms by room type for a typical core, core+ and core++ model



Total number of patient facing rooms across the building sizes		Virtual Consultation	Interview Room	Consult/Exam Room	Treatment Room	Group Room
core	GP Services Community Care – core provision Secondary Shift Clinics	6	3	12	7	4
core +	Services for babies, children and their families Mental Health Support Minor Injuries / Walk-in Wider Neighbourhood Support	15	5	16	11	6
core ++	Diagnostics	15	5	16	14	6

(https://www.england.nhs.uk/wp-content/uploads/2026/04/indicative-number-of-patient-facing-rooms-by-room-type-v2.jpg)

The image presents a table showing the indicative number of patient-facing rooms across a neighbourhood health centre, broken down by room type and building size or service scope.

Across the top of the diagram are five room types, each illustrated with a simple floor-plan icon:

- virtual consultation rooms
- interview rooms
- consult / examination rooms
- treatment rooms
- group rooms

Down the left-hand side, the table is divided into three service levels, shown in progressively darker blue shades:

Core services

This level includes GP services, community care (core provision), and secondary shift clinics.
For this service mix, the building includes:

- 6 virtual consultation rooms
- 3 interview rooms
- 12 consult or examination rooms
- 7 treatment rooms
- 4 group rooms

Core+ services

This expanded level adds services for babies, children and their families, mental health support, minor injuries or walk-in services, and wider neighbourhood support.
At this scale, the building includes:

- 15 virtual consultation rooms
- 5 interview rooms
- 16 consult or examination rooms
- 11 treatment rooms
- 6 group rooms

Core++ services

This level represents the largest and most comprehensive offer, with diagnostics added to the Core+ services.
At this scale, the building includes:

- 15 virtual consultation rooms
- 5 interview rooms
- 16 consult or examination rooms

- 14 treatment rooms
- 6 group rooms

Overall, the image shows how room numbers increase as service scope expands, particularly for treatment and diagnostic-related spaces, while maintaining a consistent mix of consultation, interview, and group rooms.

Product assemblies

In new-build schemes, a standardised kit of parts underpins consistent internal layouts and operational efficiency across the programme, while providing sufficient flexibility for the building form and external envelope to be locally designed in response to environmental conditions, urban context and community identity.

The ProCure Framework (https://future.nhs.uk/connect.ti/ProCure23/view?objectId=251027173) (on the Futures collaboration platform; login required) product range will be the starting point but will require continuous review and continuous refreshing to minimise embedded carbon and eliminate volatile organic compounds in products as a pass or fail approach to materials.

Facilities management

Strong facilities management practices will be built into the programme to support the digital and smart building strategy. These practices will be enabled through the NHS digital toolkit and the buildings digital asset management solution, which will provide a consistent way to manage building and asset information from design through to day-to-day operation.

This approach will avoid teams working in silos. Instead, it will encourage joined-up, evidence-based decisions that focus on practical outcomes and long-term performance.

The main design team should be supported by asset management (digital) specialists, operational estates and facilities management (EFM) teams and building information management (BIM) experts. This wider team will ensure buildings are designed to be operated, not just designed and handed over, reducing risk and improving long-term value.

Neighbourhood health centres will have a single point of day-to-day control, providing both real-time visibility and strategic insights into overall performance across the building, estates, facilities and engineering teams' activities and business processes.

Neighbourhood health centre teams, including the building contractor, will provide a detailed commissioning strategy prior to practical completion of the building works. The plan will adequately evidence commissioning, sign-off processes and training; handover of quality documentation; ensure minimal defects and later disruption to the service via an early agreed soft landings approach; and identifying specifics that need to be introduced to the FM teams, centre manager and end users.

As part of scheme development and operation, neighbourhood health centre teams should consider proportionate security and counter-terrorism measures appropriate to the scale, use and risk profile of the site. While many centres may fall below the statutory thresholds of the Terrorism (Protection of Premises) Act (https://www.legislation.gov.uk/ukpga/2025/10/contents), schemes should be informed by relevant national guidance and undertake appropriate risk assessment, including consideration of safe access and egress, public zone management, physical mitigation measures where appropriate, and operational procedures to support preparedness and response.

This approach will maximise the reliability and availability of critical building assets by integrating with other key control systems, exploiting data to automate workflow, optimise internal and external 'resources' and drive compliance and reporting.

Fire safety

Neighbourhood health centres will be designed to ensure the safety of all users. Compliance with the functional requirements of the Building Regulations 2010 (as amended) may be demonstrated using HTM 05 02: Fire safety in the design of healthcare premises (https://www.england.nhs.uk/publication/fire-safety-in-the-design-of-healthcare-premises-htm-05-02/), read alongside Approved document B (Fire Safety), volume 2. Buildings other than dwellings. (https://www.gov.uk/government/publications/fire-safety-approved-document-b) It is acknowledged that based on the patient dependency not all aspects of the HTM guidance may be applicable to all neighbourhood health centres and so reference to both will be required.

Each neighbourhood health centre must have a site-specific fire strategy, prepared by a competent person such as an independent expert adviser (AE), authorised person (fire projects – see HTM 05-01: Managing healthcare fire safety (file:///C:/Users/S7ZMFJBH/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/8EFOPSEP/Health%20Technical

01:%20Managing%20Healthcare%20Fire%20Safety)) or fire engineer if fire engineering is involved (see HTM 05-03, part J: Guidance on fire engineering of healthcare premises (https://www.england.nhs.uk/publication/fire-safety-in-the-nhs-health-technical-memorandum-05-03/)). The fire strategy will be robust and flexible enough to ensure safety at all times.

As a minimum, this strategy must reflect or address:

- the level of patient dependency. This will significantly influence the fire strategy: for example, where patients may be given local anaesthetics, that may impinge or their mobility and means of escape
- any local fire hazards such as the use of medical gases or the risk of arson
- space adjacencies, compartmentation, detection and alarm requirements, means of escape
- business continuity in case of fire
- ongoing maintenance of fire elements and the fire performance of the building fabric

The strategy will be robust and flexible enough to ensure safety at all times. Each neighbourhood health centre will provide an individual, site specific, fire strategy report which considers the patient dependency, local fire hazards, adjacencies, compartmentation, alarm requirements and fabric performance requirements.

The Building Safety Act 2022 (https://www.legislation.gov.uk/ukpga/2022/30/contents), and particularly the classification of a “Higher Risk Building” may apply to these buildings if forming the base of a residential development. Refer to NHS Estates Technical Bulletin (NETB) No. 2024/2, Building Safety Act (2022) – application to healthcare buildings (https://www.england.nhs.uk/wp-content/uploads/2024/08/prn01337-nhs-estates-technical-bulletin-2024-2.pdf) for guidance.

Standalone 2storey healthcare buildings are typically not higher risk buildings, but the building safety act (BSA) duty holder competence and strengthened building control requirements still apply.

Area zoning: public spaces

The civic nature of neighbourhood health centres means that their ‘public’ areas will provide much more than basic clinical waiting and circulation space. There will be active, flexible spaces that promote ‘wellness’ and community activity rather than purely functional content. Public zones will provide:

- welcome meet and greet space
- check in and reception
- vertical and horizontal circulation
- waiting areas
- patient toilets
- changing places or toilets
- interview rooms
- multifunctional group rooms
- gardens

The public zone can also be used to support wider place making ambitions, and organisations should consider how this space could accommodate locally appropriate community uses. For example, entrance areas could be designed to host social enterprise cafés, community kitchens, informal gathering spaces or small education or digital access points. While these elements are not included in the core schedule of accommodation, local partners may choose to incorporate such features so public spaces maximise shared value for the benefit of the neighbourhood and support community outcomes.

A principal feature in neighbourhood health centres is connecting these spaces in both tenure and socially, recognising that these centres will be a focus within their communities for a wide range of activities. These design principles support the ambitions to address the social determinants of health through fostering strong community cohesion and empowerment.

The entrance itself will be easily identified, accessible and present positive first impressions for patients and staff, with a priority given to the provision of green spaces viewed from circulation and waiting areas.

Discrete areas can be secured when not in use while allowing other areas to be used as normal without enhanced security measures.

Consideration will be given to colour palettes and the user experience of these areas. They will be welcoming, calming and attractive places, shaped by the community, and not overly clinical in appearance.

Rooms that are multifunctional, including for use as a meeting space, group therapy room or education space, can be located in the public zone and may be designed for community use outside normal working hours. There is scope in the accompanying layouts (https://www.england.nhs.uk/publication/neighbourhood-health-centres/)to open up the group rooms to create a larger hall that the community can use.

The public will be able to easily access all spaces within the public zone. Access control to all spaces in the public zone will be minimal to allow their easy access by the public, but the capability to keep these spaces under active and passive surveillance is important.

Area zoning: clinical spaces

Clinical areas will be organised to optimise flexible use between tenants. Access to distinct clinical areas will be through the public zone and not through another clinical area to maintain future building flexibility and effective patient flow. Clinical zoning and circulation strategies should support the operational separation of patient cohorts where required, without constraining routine service delivery.

Direct access into a clinical 'hot zone' enables several rooms to be physically separated for the consultation and treatment of patients suspected of having contagious diseases. For information on building these principles into projects at briefing stages, refer to the Pandemic Preparedness Strategy: building our capabilities (https://www.gov.uk/government/publications/pandemic-preparedness-strategy-building-our-capabilities). The layouts show consideration for direct access into the family services spaces and mental health support rooms on the ground floor where this is required locally.

Clinical spaces within neighbourhood health centres include:

- clusters of consultation and examination, treatment and interview rooms
- diagnostic rooms, such as phlebotomy
- counselling and group therapy spaces
- multidisciplinary team rooms (team bases)
- therapy spaces

Clinical spaces in the larger models may also include

- imaging rooms: for the core++ example provided these are simple diagnostic rooms such as for ultrasound and utilising mobile x-ray equipment. Local activity modelling may adjust this to suit the modality required for site-specific needs
- enhanced procedures or minor operation suites

The use of remote consultation is increasing, and current sizing assumptions are based on a third of consultations being delivered virtually. This proportion should be confirmed locally using existing evidence and realistic future ambition. When sizing a neighbourhood health centre, teams should plan for a minimum of a third of consultations being remote unless partners agree a higher proportion.

The key considerations for accommodating digital consultation are that:

- it must not result in an overall increase in the space required for digital or physical consultation and examination
- the provision of digital consultation rooms must not reduce the quality of the working environment for clinical staff

The inclusion of digital consultation rooms or dedicated e-consultation pods will enable virtual appointments to take place on site without occupying rooms designed for face-to-face care.

Our ambition is for all clinical spaces, wherever possible, to benefit from natural light and views to nature.

Centralised waiting areas will be as close to the clinical area as possible to minimise and simplify the patient journey. The space metric for the waiting area allows for a variety of seating arrangements and seating types to support seating choice and allow seating to be incorporated specifically for those who may need assistance. Given the diversity of individuals, medical conditions and family group dynamics, no single type of seat or seating configuration can accommodate everyone who uses a waiting area.

Clinical support areas will be distributed throughout the building so that they can be used flexibly, where appropriate, between clinical units. These will include the following functional content:

- dirty utilities
- clean utilities and stores
- general storage
- specimen toilets

Area zoning: staff spaces

The integration of health, community and social care services and neighbourhood teams within neighbourhood health centres will make them an optimal location for the creation of robust multidisciplinary teams, providing integrated services and combined care pathways.

Staff accommodation is designed to support flexible, integrated ways of working, enabling teams to operate in small, functional neighbourhoods within the wider neighbourhood health centre, rather than fixed organisational silos. These work neighbourhoods support multidisciplinary collaboration, shared ownership of space and proximity to clinical and community settings, while retaining the flexibility to adapt as service models evolve.

Staff areas will consist of the following types of space:

- modern, flexible workspace areas
- small meeting rooms, interview rooms and quiet spaces within open plan neighbourhood workspaces
- remote consultation rooms
- training and development rooms, identified as part of the clinical brief (though there is scope for meeting rooms to fulfil this function)
- social spaces providing kitchen, dining and welfare facilities
- toilets and showers
- locker space and sufficient storage, which is critical to ensuring the building's flexibility and that personal belongings are not left in clinical or other bookable spaces
- refreshment facilities and staff toilets in clinical areas

Office areas will be shared between organisations and co-located as much as possible, in flexible open plan configurations with some limited enclosed offices or pods for privacy or senior management. Agile working spaces that provide the following functionality will be provided: touchdown workstations for peripatetic staff, spaces for socialising, spaces for collaborative working and quiet working, and informal meeting facility.

Social spaces will be centralised and shared, creating a welcoming atmosphere that can be used for informal working arrangements and meetings as well as staff dining and rest.

To achieve these aims the neighbourhood health centres will look carefully at the serviced office model, which invests in a high quality shared social space for all the tenants and:

- provides a meeting place for rest and refreshment, informal working, meetings and interviews
- enables the dynamic chance encounters between disciplines
- sets the users and the staff on an equal footing

Area zoning: engineering and facilities management spaces

Consider the requirement for facilities management (FM) and engineering areas and ensure that they are tied in with an in-depth FM strategy. FM and engineering spaces include:

- cleaners rooms, including stores
- waste stores
- receipt and dispatch areas and technical areas; how and when goods/waste are distributed/collected around the building in a discreet manner will be considered as part of the operational principles and policies
- centre management and security facilities
- comms and server rooms
- risers and plant room

Providers should refer to the wider suite of NHS technical guidance when developing or adapting clinical spaces. This includes the relevant Health Building Notes and Health Technical Memoranda (https://www.england.nhs.uk/estates/), the NHS Net Zero Building Standard (https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/) and requirements linked to the Terrorism (Protection of Premises) Act (https://www.england.nhs.uk/publication/nhs-estates-technical-bulletin-netb-no-2025-1/). These documents offer detailed design and engineering expectations that sit alongside this specification and should be used to inform safe, resilient and future-ready neighbourhood health facilities.

Refurbishment schemes

Refurbishment schemes offer an important route for systems to expand neighbourhood health provision by making better use of existing estate. While the constraints of inherited layouts, structural arrangements and building condition will inevitably shape what is achievable, all refurbishment projects should apply the core principles of the neighbourhood health centre model to the fullest extent feasible. Refurbishment proposals should also consider opportunities to preserve and respond sensitively to the historic environment and local cultural heritage where relevant.

Considerations that should guide any redesign or reconfiguration of existing facilities are:

- utilisation and operating model
- digital connectivity
- net zero planning
- flexible and multi-use space

- clinical spaces and practical constraints
- inclusive by design

Utilisation and operating model

Refurbished centres should operate to the same utilisation expectations as new-build facilities. This includes extended operating hours and planning to achieve 80% utilisation of bookable spaces, supported by shared rooms, flexible scheduling and service models that maximise occupancy patterns.

Digital connectivity

All refurbishment schemes must ensure that facilities are digitally-enabled and fully connected to other neighbourhood health services, shared care records and system-wide digital platforms. Digital infrastructure should support the same core functions as new-build centres, including interoperable room booking systems, virtual consultation capability and participation in network-wide operational intelligence.

Net zero planning

Refurbishment projects should be supported by a credible plan to achieve net zero by 2040, with clear steps towards reducing operational and embodied carbon. Where full building fabric upgrades are not immediately viable, schemes should identify and implement practical near-term measures such as modernising building services, improving insulation and airtightness, upgrading lighting and ventilation systems, and planning for future integration of low carbon heating.

Flexible and multi-use space

Space in refurbished centres should be designed to be multi-use, adaptable and capable of supporting a range of clinical and non-clinical functions. Flexibility is crucial for longevity and allows the building to remain effective as service needs change. Wherever possible, layouts should be rationalised to create simple, legible and reconfigurable spaces that support a bookable room model.

Clinical spaces and practical constraints

It is acknowledged that full reconfiguration of clinical zones may not always be possible or cost effective in refurbishment settings due to structural and engineering constraints. However, all projects should seek to optimise clinical flow and flexibility in line with the principles of the neighbourhood health centre model. Providers are advised to refer to HBN 00-03: Clinical and clinical support spaces (https://www.england.nhs.uk/publication/designing-generic-clinical-and-clinical-support-spaces-hbn-00-03/), which outlines appropriate space parameters and standardised room types that support adaptability, quality and long-term efficiency.

When planning refurbishment or reconfiguration, providers will need to understand how their existing rooms and layouts compare with the functional requirements of a neighbourhood health centre. To support this process, Table 1 below illustrates how current spaces can be mapped against the recommended schedules of accommodation. This will help identify where existing rooms align well with the model, where adaptation is feasible and where alternative solutions may be required to deliver safe, flexible and efficient clinical environments.

Refurbishment schemes should, where feasible, support flexible infection prevention and control arrangements that enable service continuity during periods of increased infection risk.

When planning refurbishment or reconfiguration, providers will need to understand how existing rooms and layouts compare with the functional requirements of a neighbourhood health centre. To support this process, the table below illustrates how current spaces can be mapped against the recommended schedules of accommodation.

The example in table 1 is based on extended opening days and hours, together with an assumed 80% utilisation of rooms, to deliver the annual number of appointments for a service using the activity modelling tool (https://www.england.nhs.uk/publication/neighbourhood-health-centres/). This approach supports an objective assessment of whether existing accommodation aligns with the model and helps identify where adaptation, reconfiguration or extension of the building may be required to deliver safe, flexible and efficient clinical environments.

In the example shown, it has been assumed that the existing building does not include pods or dedicated virtual consultation spaces. Where this assumption does not hold, or where there is sufficient flexibility within the wider building, some of these functions may be accommodated within flexible work areas. This can enable integrated team working, supported by access to small meeting rooms, interview spaces and quiet rooms.

Existing building room types (example only)	**Existing number of rooms**	**NHC (core ++)** Room requirement	**Future need of rooms**

Virtual consultation	0	15	+15
Interview	4	5	+1
Consultation and examination	10	16	+6
Treatment room	5	14	+9
Group room	3	6	+3

Inclusive by design

Refurbishment schemes should adopt inclusive, approachable and dementia-friendly design principles, recognising the needs of an ageing population and the central role of neighbourhood centres in frailty pathways. This includes intuitive wayfinding, accessible entrances, supportive lighting and acoustics, clear colour cues, and the creation of calm, welcoming environments that reduce anxiety and support people with sensory or cognitive impairments.

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HEALTH AND WELLBEING BOARD

Report subject	**BCP Council Suicide Prevention Action Plan**
Meeting date	29 June 2026
Status	Public Report
Executive summary	This document presents the 2026 BCP Suicide Prevention Action Plan for Bournemouth, Christchurch and Poole Council. The plan is informed by an evidence-based framework and outlines actions for council colleagues, alongside shared priorities to be delivered through pan-Dorset partnership working. The draft plan has been considered by the Health and Adult Social Care Overview and Scrutiny Committee on 19th May 2026, and the resulting feedback has been taken on board in its development.
Recommendations	**It is RECOMMENDED that the Health and Wellbeing Board:** 1. Approves the BCP Council Suicide Prevention Action Plan as a programme of work to be led by BCP Council officers, with support from partner organisations as needed. 2. Notes the Pan-Dorset Suicide Prevention Framework. This has been co-produced with organisations across Dorset providing a structure for organisational action plans such as this BCP Council Action Plan. 3. Notes that Dorset system-wide suicide prevention activity is underway, complementing the BCP Action Plan. The system-wide work is jointly led by BCP Public Health and Dorset Healthcare University Hospital Foundation Trust, ensuring a sustained, coordinated approach that strengthens alignment, avoids duplication, and maximises collective impact across the system.
Reason for recommendations	For the H&WB Board to be aware of the work being led by BCP Council officers and for partner organisations to support where appropriate the BCP plan and complementary Dorset wide actions to reduce suicides.

Portfolio Holder(s):	Cllr David Brown, Portfolio Holder for Health and Wellbeing
Corporate Director	Laura Ambler – Corporate Director for Wellbeing
Report Authors	Paul Iggulden – Public Health Consultant Tracy Hill – Head of Programmes, Public Health.
Wards	Council-wide
Classification	For Update or Information

Background

1. Suicide prevention is a local public health priority, with suicide rates in BCP remaining consistently higher than the England and regional averages ((Fingertips | Department of Health and Social Care, 2023).

2. When compared to our statistical neighbours, BCP has the second highest suicide rate. (Fingertips - Suicide Prevention statistical neighbours - Department of Health and Social Care, 2023). Every death by suicide represents a profound and potentially preventable loss of life, with far-reaching consequences for families, communities, and services.

3. Alongside the social impact, suicide also places a significant burden on society more widely. Research published by The Samaritans The economic cost of suicide in the UK (2024) estimates that the average economic cost of a death by suicide in England among working-age adults is approximately £1.67 million. This figure reflects a combination of direct costs associated with health and emergency services, indirect costs from lost productivity and earnings, and intangible costs linked to pain, grief, and suffering experienced by those affected. While no monetary value can capture the true loss of life, this evidence reinforces the importance of sustained, system-wide suicide prevention.

4. Significant work on suicide prevention has previously been undertaken across Dorset. NHS Dorset received national funding and recruited a Programme Lead. While dedicated funding enabled strong progress, momentum was lost when this funding came to an end and the programme subsequently stalled. There remains, however, a commitment across Dorset to progress this agenda and build on the positive foundations that were established.

5. An evidenced-based Suicide Prevention Framework has been developed during 2025-26 to support suicide prevention work across BCP and Dorset. The framework has been developed in consultation with partners across the Dorset system. The intention is for the framework to be adopted across key partner organisations and used to inform the development of individual organisational action plans.

6. This document provides an overview of the framework and the draft Bournemouth, Christchurch and Poole (BCP) Council suicide prevention action plan, which has been produced collaboratively with teams across the Council.

The National Context

7. A National Suicide Prevention Strategy for England 2023-2028 was published in September 2023. The overall ambitions set by the national strategy are to:

   - Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
   - Continue to improve support for people who self-harm.
   - Continue to improve support for people who have been bereaved by suicide.

8. The National Suicide Prevention Strategy is based on evidence, drawing on research, data analysis, and learning from current practice. It is informed by trends in suicide rates, risk and protective factors identified through public health surveillance, academic research and data, as well as evaluations of what interventions are most effective at preventing suicide and reducing self-harm. The strategy also incorporates insights from people with lived experience, recognising the value of qualitative evidence alongside quantitative data.

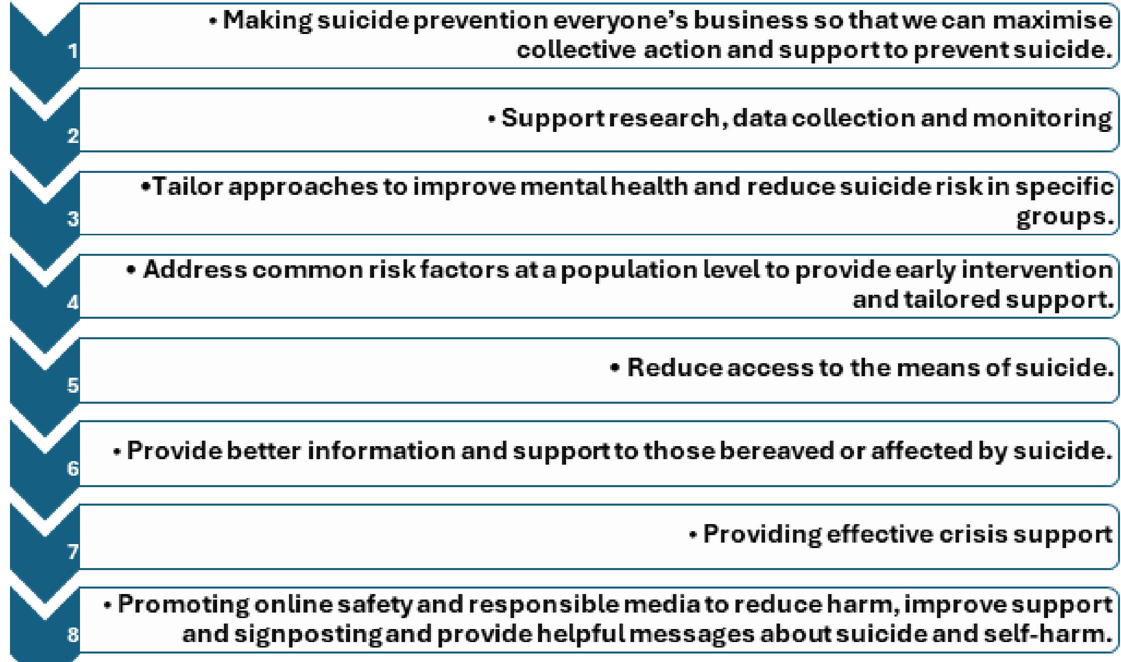
Pan-Dorset Suicide Prevention Framework

9. The Suicide Prevention Framework shown in Figure 1 below, is a Pan-Dorset framework that sets out eight priority areas for suicide prevention. It has been developed in alignment with the National Suicide Prevention Strategy and informed through consultation with teams across the council.

10. This evidence-led approach has shaped a comprehensive set of eight priorities that recognise suicide prevention as everyone's responsibility and emphasises the need for coordinated action across prevention, early intervention, support, and recovery to reduce risk and improve outcomes for individuals and communities.

11. Following development of the Suicide Prevention Framework, work has focused on developing a dedicated action plan for Bournemouth, Christchurch and Poole (BCP) Council.

Figure 1: BCP and Dorset Suicide Prevention Framework



The Local Context

12. The suicide rate per 100,000 persons in Bournemouth, Christchurch and Poole (BCP) has been consistently higher than the England average. The suicide rate has shown year-on-year increase since 2018-2020. The rate of suicide in BCP is the highest in the South west. The rate per 100,000 deaths was 15.6 in 2022-24, which is significantly worse than the England value of 10.9 deaths per 100,000 ((Fingertips | Department of Health and Social Care, 2023).

13. In comparison to BCPs statistical neighbours, BCP has the second highest suicide rate after Brighton and Hove (Fingertips - Suicide Prevention statistical neighbours - Department of Health and Social Care, 2023).

14. There is currently no Dorset-wide real-time suicide surveillance system. Dorset Police provide a monthly dataset that supports trend monitoring and the identification of clusters and hotspots, but it is limited by delays and incomplete data. Developing a nearer-to-real-time surveillance system is therefore a priority within the action plan.

Action Plan

15. The Suicide Prevention Action Plan is presented in Appendix 2. The Action Plan builds on existing work and aligns with the priorities set out in the framework. It sets out a clear programme of work, detailing organisational level actions to be delivered by BCP colleagues, alongside actions that may be delivered jointly with partners.

16. To inform the development of the action plan, a series of suicide prevention workshops and one-to-one meetings were held with teams from across BCP Council, including Housing, Adult Social Care, Planning and Children's Services, including Education. These teams played a central role in shaping the action plan. Draft versions were shared regularly to enable ongoing input, support the refinement

of priorities, and ensure that emerging themes and insights were reflected. A full list of stakeholders who contributed to this work is provided in Appendix 2.

17. While the action plan focuses on activity to be led by BCP Council colleagues, many of the actions align with wider system-level priorities and will involve work with local system partners, including elements of training and awareness and collection of nearer to real-time surveillance data. In parallel, suicide prevention work is underway with system partners, including: NHS Dorset, Dorset Healthcare University NHS Foundation Trust, University Hospitals Dorset NHS Foundation Trust, local colleges and universities and voluntary and community sector organisations. This co-ordinated approach will support alignment, reduce duplication and maximise collective impact across the system.

Governance and monitoring

18. The intention is that a BCP Suicide Prevention Delivery Group will be established to lead the implementation of the BCP Council Suicide Prevention Action Plan. The group will be chaired by Public Health and will include representation from teams that have contributed to the development of the action plan, ensuring continuity and shared ownership.

19. The primary purpose of the BCP Suicide Prevention Delivery Group will be to provide strategic oversight of the action plan, ensuring that actions are implemented effectively and in line with agreed priorities. The group will be responsible for monitoring progress, reviewing performance against the agreed plan, and evaluating the impact of actions taken. This will enable learning to be captured and used to inform future development, refinement of priorities, and any necessary adjustments to delivery.

20. The proposal, is that the Suicide Prevention Delivery Group will be accountable to the Health and Wellbeing Board, providing updates on progress, risks and outcomes, and ensuring that suicide prevention remains a priority within the broader health and wellbeing agenda.

Options Appraisal

Option 1 - proceed with the next steps detailed above.

Option 2 - do nothing and assume work will be picked up by individual teams.

Summary of financial implications

21. There are no financial implications arising from this report

Summary of legal implications

22. There are no legal implications arising from this report.

Summary of human resources implications

23. There are no human resources implications arising from this report.

Summary of sustainability impact

24. Suicide Prevention recognises that suicide risk is influenced by wider determinants of health, including poverty, inequality, employment insecurity, housing, social isolation, and access to services. By tackling these underlying factors, suicide prevention can contribute to sustainability. Preventative approaches, such as

workforce training, promoting social connection, and improving access to timely mental health support can help reduce demand on health and social care systems while strengthening economic resilience and community wellbeing.

Summary of public health implications

25. Suicide prevention has major public health implications because it addresses a leading cause of premature death while also reducing long-term social, emotional, and economic burdens on individuals, families, and communities. Effective suicide prevention can lower suicide rates and improve overall population wellbeing. Suicide prevention supports mental health as a core component of public health.

Summary of equality implications

26. An Equality Impact Assessment (EIA) conversation has taken place, the summary of which is provided below. A full EIA will be undertaken once the draft action plan has been finalised for approval by the Health & Wellbeing Board.

27. Implementation of the suicide prevention action plan recognises that suicide risk is not evenly distributed across the population and that different groups have distinct needs and experiences. Evidence highlights increased risk among specific groups, including middle-aged men, people with a history of self-harm, individuals in contact with mental health services, autistic people, pregnant women and new mothers, children and young people, those involved in the justice system, and certain occupational groups. Additional risk factors such as isolation, abuse, caring responsibilities, and socioeconomic disadvantage further compound inequality.

28. Acknowledging these differences enables BCP Council teams to adopt more targeted, inclusive and proportionate approaches to suicide prevention, ensuring that support reflects diverse needs across protected characteristics and wider vulnerable groups.

29. By increasing awareness, skills and confidence among managerial and operational staff, the change is expected to have a positive impact on service users, employees and the wider community. Staff will be better equipped to identify risk, offer timely support and signpost appropriately, helping to reduce stigma and barriers to accessing help.

30. There is potential for unintended negative impacts, such as distress, confidentiality concerns or inconsistent experiences if approaches are not inclusive but these risks are mitigated against through clear communication, robust safeguards, and trauma-informed, evidence-based approaches.

Summary of risk assessment

31. The current priorities and proposed actions within the draft action plan are considered to be low risk. The absence of an action plan with defined deliverables presents a risk, as it limits the council's ability to respond effectively and may contribute to continued increases in suicide rates. These risks will be mitigated through clear governance arrangements, named leadership, regular progress reporting, and ongoing engagement with key partners and stakeholders.

Background papers

32. None.

Appendices

33. Appendix 1 – BCP Suicide Prevention Action Plan
34. Appendix 2 - Stakeholders consulted to inform the development of the BCP Suicide Prevention Action Plan.

Appendix 1 - BCP Suicide Prevention Action Plan

Framework Priority 1 - Making suicide prevention everyone's business so that we can maximise collective action and support to prevent suicide.

Reference	Areas for action	Lead	Timeframe
1.1	Establish a Suicide Prevention Delivery Group within BCP Council to provide overall leadership, oversight and accountability for the delivery of this action plan.	Public Health	June 26
1.2	Raise the profile of suicide prevention across BCP and work with key stakeholders to visibly demonstrate commitment and shared responsibility, including consideration of a BCP Suicide Prevention Pledge to formalise commitment to delivering this agenda.	Public Health	September 26
1.3	Develop a communications plan to raise the profile of suicide prevention through both universal and targeted activity, including: • A blanket campaign alongside targeted communications for identified high-risk groups. • Alignment with national and international awareness days (e.g. World Mental Health Day, Safer Internet Day). • Opportunities to link suicide prevention messaging with wider campaigns addressing key risk factors, such as loneliness, substance misuse, women who have children taken into the care system, and harmful gambling, to maximise impact for high-risk groups. • Use of a range of venues and settings to extend reach. • Co-production with target audiences wherever possible to ensure messaging is relevant, sensitive and effective	Communications and Marketing	August 26

1.4	Develop a training programme for suicide prevention, including* • Map current Suicide Awareness Training available to BCP, include a breakdown of the target audience and any specific training needs. • Develop and roll-out tiered suicide prevention training offer.	Public Health People and Culture	June 2026
1.5	Implement training for line managers to strengthen their role in supporting staff wellbeing, ensuring wellbeing check-ins are embedded in 1:1s and that appropriate support is identified and accessed during performance review and management processes. Share examples of good practice to support continuous learning and encourage reflective practice across teams.	Public Health People and Culture	September 2026
1.6	Review learning from reflective practice approach being piloted in Housing Team and identify future options for wider implementation	Housing and Public Protection	September 26

*Please note – Some elements of the training offer will likely be delivered as part of a Dorset wide programme.

Framework Priority 2 – Support research, data collection and monitoring

Reference	Areas for action	Lead	Timeframe
2.1	Explore how to bring together data from multiple sources (including Rio, Mosaic, ONS) to develop an understanding of suicide risk across BCP into a dashboard format. This will support improved targeting and prioritisation of suicide prevention activity for groups experiencing higher levels of need. *	Public Health	October 26

2.2	Work Pan-Dorset to progress getting a nearer to real time suicide surveillance system in place.	Public Health	October 26
2.3	Improve local data and use national data on potential or emerging risk factors and priority groups, such as people experiencing harmful gambling, homelessness, domestic abuse, people from LGBT+ communities, care leavers, farming and armed forces communities and other high-risk groups.	Public Health	October 26
2.4	Establish information sharing protocol with key departments to ensure timely notification when suicide or self-harm is identified as a possible cause of death. This will enable appropriate and coordinated actions by relevant teams, including the provision of support information and liaison with affected schools, workplaces, or sites to deliver postvention support.	Public Health	September 26

*Please note – Developing our data flows to move nearer to real time surveillance data (currently monthly) will be progressed in partnership with Dorset Public Health Colleagues and system partners.

Framework Priority 3 - Tailor approaches to improve mental health and reduce suicide risk in specific groups.

Reference	Areas for action	Lead	Timeframe
3.1	Identify specific training needs, which may include: • Supporting frontline workers to identify self/harm suicide risks (moving away from risk prediction and risk stratification tools) • Voluntary Sector – management of immediate risk / follow-up for people who express a suicide risk. • Parents who have had children removed. • Line managers – to support wellbeing check ins during 121s and additional support which may be required.	Public Health	July 26

	• Review learning from reflective practice approach being piloted in Housing Team.		
3.2	Collaborate with Education Teams to support all schools and universities to have a suicide prevention policy, which includes postvention support if a school is affected by suicide.	Education and Skills	September 26
3.3	plore role and ability of the Adult Social Care Performance Quality Improvement Board in sharing learning from review panels, to capture shared learning from deaths linked to drugs / alcohol / safeguarding / Suicide.	Adult Social Care	October 26

Framework Priority 4 - Address common risk factors at a population level to provide early intervention and tailored support.

Reference	Areas for action	Lead	Timeframe
4.1	Identify and promote the support available through the Access to Wellbeing Campaign for staff, including role of wellbeing champions in terms of wellbeing and signposting.	People and Culture	December 2026
4.2	Embed suicide prevention awareness within MARAC, MATAC, safeguarding processes, housing, employment and debt advice services.	Adult Social Care / Housing and Public Protection / Public Health	December 26

Framework Priority 5 - Reduce access to the means of suicide.

Reference	Areas for action	Lead	Timeframe
5.1	Work with partners such as highways, bridges, railways and coast guard teams to identify and implement appropriate suicide prevention measures.	Public Health / Transport	January 27
5.2	Explore measures to improve medication safety particularly in situations where suicide risk may be higher.	Adult Social Care / DAAT	January 27
5.3	Review and strengthen the role of Public Health in assessing planning applications to 'design out' access to means of suicide.	Public Health	December 26

Framework Priority 6 - Provide better information and support to those bereaved or affected by suicide.

Reference	Areas for action	Lead	Timeframe
6.1	Work with teams and key partners to ensure appropriate plans and services are in place to support those bereaved or affected by suicide.	People and Culture	December 26
6.2	Carers - Define and communicate a clear post bereavement support package for carers bereaved or affected by suicide.	Public Health	December 26
6.3	Children and Young people - Develop a consistent approach across BCP to support education settings affected by suicide.	Education and Skills	September 26

*Other groups will be prioritised at a system level.

Framework Priority 7 – Providing effective crisis support

Reference	Areas for action	Lead	Timeframe
7.1	Explore current mental health crisis support offer and how it is communicated and promoted to identify if improvements can be made.	Public Health Communications and Marketing	September 26

Framework Priority 8 - Promoting online safety and responsible media to reduce harm, improve support and signposting and provide helpful messages about suicide and self-harm.

Reference	Areas for action	Lead	Timeframe
8.1	Review and summarise existing guidance and resources available to parents on supporting children exposed to self-harm and suicide-related online content and assess current routes of dissemination.	Education and Skills	January 27
8.2	Work with local media to support responsible reporting of suicide, improve signposting to support services, and promote positive mental health and wellbeing messaging.	Communication and Marketing	July 26

Appendix 2 – Stakeholders consulted to inform the development of the BCP Suicide Prevention Action Plan.

Team
Adult Social Care
Children's Safeguarding
Community Safety
Communication
Drugs and Alcohol Team (DAAT)
Education and Skills
Housing and Public Protection
People and Culture
Planning
Youth Justice Service

HEALTH AND WELLBEING BOARD

Report subject	**Better Care Fund 2026-27 Planning Documents/Better Care Fund 2025-26 End of Year Report**
Meeting date	29 June 2026
Status	Public Report
Executive summary	This report provides an overview of the planning document of the Better Care Fund (BCF) for 2026-27, as well as the 2025-26 End of Year Report. The BCF is a key delivery vehicle in providing person centred integrated care with health, social care, housing, and other public services, which is fundamental to having a strong and sustainable health and care system. The documents are part of the requirements set by Better Care England and the Department of Health & Social Care. These documents need to be jointly agreed and signed off by the Health and Wellbeing Board as per the planning requirements.
Recommendations	**It is RECOMMENDED that:** **The Health and Wellbeing Board retrospectively approve:** • **Better Care Fund 2026-27 Plan** • **Better Care Fund 2026-27 Narrative** • **Better Care Fund 2025-26 End of Year Report**
Reason for recommendations	NHS England (NHSE) requires the Health and Wellbeing Board (HWB) to approve all BCF plans and report, these are part of the national conditions within the Policy Framework. This includes planning documents at the beginning of a funding period, template returns reporting progress against the plans quarterly, and a report at the end of each financial year.

Portfolio Holder(s):	Cllr David Brown, Portfolio Holder for Health and Wellbeing
Corporate Director	Laura Ambler, Corporate Director for Wellbeing
Report Authors	Scott Saffin, Commissioning Manager – Better Care Fund and Market Management Becky Whale, Deputy Director, UEC and Flow - NHS Dorset
Wards	Not applicable
Classification	For Decision

Background

1. This report is a covering document for the content of the Better Care Fund 2026-27 Plan and the 2025-26 End of Year Report. The 2026-27 plan is made up of two documents that was submitted to Better Care England on Tuesday 19 May 2026. The documents were provided by NHS England and completed by officers in BCP Council and NHS Dorset. The documents are as follows:
    - Better Care Fund 2026-27 Planning Template
    - Better Care Fund 2026-27 Narrative

2. The 2025-26 End of Year Report was submitted to Better Care England on Friday 5 June 2026.

3. The BCF is a Programme spanning both the NHS and Local Government which seeks to join-up health and care services, to promote people's ability to manage their own health and wellbeing and live independently in their communities for as long as possible.

4. The BCF pooled resource is derived from existing funding within the health and social care system such as the Disabled Facilities Grant and additional contributions from Local Authority or NHS budgets. Additionally, grants from Government have been paid directly to Local Authorities i.e. Local Authority Better Care Grant, which is used for meeting adult social care needs, reducing pressures on the NHS, and ensuring that the social care provider market is supported.

5. The ICB discharge funding has been consolidated into the NHS minimum contribution to the BCF, forming one allocation with a value of £41,659,768 in 2026-2027.

6. Local authority discharge funding has been consolidated into the Local Authority Better Care Grant, formerly known as the Improved Better Care Fund, to form the minimum local government revenue contribution to the BCF, with a value of £16,578,901 in 2026-2027.

Better Care Fund 2026-27 Plan

7. The Policy Framework was published by the Department of Health and Social Care (DHSC) on 17 February 2026.

8. For 2026-2027, the Government have revised the objectives of the Better Care Fund as follows:

   - Objective 1: Reform to support the shift from sickness to prevention

   - Objective 2: Reform to support people living independently and the shift from hospital to home

9. The funding allocation for 2026-2027 is detailed in the Expenditure sheet of the planning document. Local Authority Better Care Grant has not received an uplift from 2025-2026 allocation and has remained cash flat since the 2024-2025 BCF planning period.

10. In 2026-2027, the NHS minimum contribution to adult social care has been uplifted by 4.4% (in line with the Spending Review 2025 commitment of an increase to the NHS's minimum contribution to adult social care via the BCF), Discharge and remaining ICB contributions by 2.1% in line with Community Services inflation growth

11. BCP Council and NHS Dorset are contributing at least the minimum amounts set by the DHSC. However, a £470,000 shortfall has been identified due to system pressures in our Intermediate Care services, that will need to be addressed by Quarter 2 2026-2027.

12. To address this, BCP Council Strategic Adult Social Care (ASC) Commissioning and NHS Dorset are currently reviewing several schemes and will work with system partners to address the shortfall. An update will be presented to the following Health & Wellbeing Board meeting.

13. For 2026-2027 there are three headline metrics to help local areas focus on impact and outcomes, aligning to the revised objectives of the Better Care Fund, and the Government's vision for neighbourhood health.

   - Emergency admissions to hospital for people aged over 65 per 100,000 population

   - Average length of discharge delay for all acute adult patients, derived from a combination of:
     - Proportion of adult patients discharged from acute hospital on their discharge ready date (DRD)
     - For those adult patients not discharged on their DRD, average number of days from DRD to discharge.

   - Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population

14. This plan shows the forecasted expenditure of all the schemes that are funded through the Better Care Fund.

Better Care Fund 2026-27 Narrative

15. Alongside the overall Better Care Fund 2026-2027 planning template, Health & Wellbeing Boards will need to submit a short narrative plan, providing details of:

    - The approach to meeting the objectives of the BCF, including priority outcomes and the changes they are planning to achieve those outcomes.
    - Key changes since the 2025-2026 Better Care Fund plan.
    - How the Dorset Integrated Care System (ICS) will collaborate to achieve ambitions.

16. The narrative is a collaboration with input from key stakeholders from BCP Council, Dorset Council, and NHS Dorset, with greater detail into the rationale of the ambitions of the metrics that are set in the BCF 2026-27 Planning document.

17. The narrative outlines key priorities across the ICS for 2026-27, including aligning services towards prevention, reviewing hospital discharge pathways, and promoting alternative pathways for urgent and emergency care.

18. Further details on the implementation of the BCF objectives, including how partners will collaborate to support the shift from sickness to prevention, with the FutureCare Programme and Integrated Neighbourhood Teams leading as examples. Additionally, it explains how the ICS will continue to help people remain independent for longer, reducing time spent in hospitals and long-term care, and utilising services such as reablement at home, integrated community equipment, care technology, and housing adaptations funded via the Disabled Facilities Grant.

Better Care Fund 2025-26 End of Year Review

19. This report is a covering document detailing the content of the Better Care Fund 2025-2026 End of Year Report. The report is made up of a single document template.
    The template is provided by NHS England and is completed jointly between BCP Council and NHS Dorset. The document is as follows.

    - Confirmation that National Conditions are being implemented.
    - Reporting of local performance against the BCF Metrics year to date.
    - Confirmation of expenditure.
    - Year-end Impact summary

20. The planning requirements dictate that this document is presented to the Health & Wellbeing Board on Monday 29 June for approval.

21. The health and social care landscape continues to challenge performance, but BCP Council achieved the 2025-2026 targets for:

    - Emergency admissions to hospital for people aged over 65 per 100,000 population

- Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population

Performance is not on track for:

- Average length of discharge delay for all acute adult patients, derived from a combination of:
  - Proportion of adult patients discharged from acute hospital on their discharge ready date (DRD)
  - For those adult patients not discharged on their DRD, average number of days from DRD to discharge.

Summary of Financial Implications

22. BCP Council and NHS Dorset will monitor BCF budgets and activity according to the 2026-27 Plan.

23. The plan provides a breakdown of spending by scheme type, source of funding and expenditure (See Appendix 1). A high-level view of this is detailed in the table below:

Source of Funding	Income
Disabled Facilities Grant	£4,522,369
Minimum NHS Contribution	£41,659,768
Local Authority Better Care Grant	£16,578,901
Additional LA Contribution	£2,182,000
Additional NHS Contribution	£15,679,163
Total	£80,622,201

Summary of Legal Implications

24. New Section 75 agreements, (in accordance with the 2006 National Health Service Act), will be put in place as prescribed in the planning guidance for each of the pooled budget components within the fund.

Summary of human resources implications

25. The services funded under the BCF are delivered by a wide range of partners some of whom are employed by BCP Council and many who are commissioned by BCP to deliver these services. There are no further human resources implications to note.

Summary of sustainability impact

26. Services are only sustainable if funding is available.

Summary of public health implications

27. The BCF is a key delivery vehicle in providing person centred integrated care with health, social care, housing, and other public services, which is fundamental to having a strong and sustainable health and care system.

Summary of equality implications

28. An Equality Impact Assessment was undertaken when the Better Care Fund schemes were implemented. Additional EIAs will be undertaken if there are any proposed future changes to policy of service delivery and or decommissioning of service(s) because of funding reductions.

Background papers

Better Care Fund Policy Framework 2026-2027

Appendices

Appendix 1: BCP Council BCF 26-27 Numeric Plan

Appendix 2: BCP Council BCF 2026-27 Narrative Return

Appendix 3: BCP Council BCF End Of Year Report 25-26

Health and Wellbeing Board

Report subject	**Health & Wellbeing Strategy**
Meeting date	29th June 2026
Status	Public Report
Executive summary	This report and associated documents provides; • An update on the development of a new Joint Health and Wellbeing Strategy for the Bournemouth, Christchurch and Poole • An updated draft of the BCP Joint Health and Wellbeing Strategy (version 3) for approval following public consultaion and feedback from the Health and Social Care Overview & Scrutiny Committee
Recommendations	**It is RECOMMENDED that:** **1. The Board note the progress made to date with the development of a new Health & Wellbeing Strategy** **2. The Board note that a public consultation has been completed on the draft strategy and that feedback from the public consultation has been reviewed and used to inform this final version of the strategy for approval** **3. The Board note that the draft strategy has received scrutiny and feedback from the Health and Social Care Overview & Scrutiny Committee and that feedback from this committee has been used to inform this final version for approval** **4. The Board is asked to approve the Health & Wellbeing Strategy for implementation, noting that strategy will be reviewed on a regular basis in response to any changes in national health policy and any significant changes in needs arising from the annual Joint Strategic Needs Assessment**
Reason for recommendations	It is a statutory requirement for the Health & Wellbeing Board to produce a Joint Local Health & Wellbeing Strategy. The previous Health & Wellbeing Strategy for Bournemouth, Christchurch & Poole was published in September 2020 and covered the period from 2020 to 2023.

Portfolio Holder(s):	Councillor David Brown, Cabinet Member for Health and Wellbeing
Corporate Director	Laura Ambler, Corporate Director for Wellbeing
Report Authors	Rob Carroll, Director of Public Health
Wards	All Wards
Classification	For Approval

Background

1. It is a statutory requirement in England under the Health and Social Care Act 2022 for Health and Wellbeing Boards to produce a Local Joint Health and Wellbeing Strategy.
2. The previous Health & Wellbeing Strategy for Bournemouth, Christchurch & Poole was published in September 2020 and covered the period from 2020 to 2023.
3. A new Health & Wellbeing strategy has been in development since December 2024 and public consultation on the draft strategy was completed at the end of March 2026. The feedback from the public consultation has been analysed and has been used to inform this final version of the strategy.
4. The draft strategy has also received scrutiny and feedback from the Health and Social Care Overview & Scrutiny Committee in May 2026. The feedback from this committee has been used to inform this final version of the strategy.
5. The Board is asked to approve the Health & Wellbeing Strategy for implementation, noting that the strategy will be reviewed by the Health & Wellbeing Board on a regular basis to take account of any significant changes in national health policy and in response to any significant changes in needs arising from the annual Joint Strategic Needs Assessment.

Progress to Date

6. During December 2024, Health & Wellbeing Board Members were asked to give their views of the priorities for a new BCP Joint Health and Wellbeing Strategy following a review of the latest data contained within the 2024 Joint Strategic Needs Assessment (JSNA). This was then presented to the Health and Wellbeing Board in January 2025, where the following priorities themes were agreed:
   - Children and Young People
   - Community Mental Health Transformation
   - Supporting Adults to Live Well and Independently
   - Housing
   - Cost of Living and Poverty
7. These were subsequently refined to the following health & wellbeing priorities:

- Starting Well
- Mental Wellbeing
- Living & Ageing Well
- Healthy Places & Communities

8. In addition, the Health & Wellbeing Board wanted to have a better understanding of the work that was currently taking place around these priorities across the system, with a view to ensuring that the function of the Board brings additional benefits, rather than increasing reporting or duplicating effort where it is not needed. To facilitate this, Health & Wellbeing Board members were asked to complete a mapping exercise over the summer of 2025 to capture the current or emerging activity, and a good response was received.
9. A draft BCP Health & Wellbeing Strategy was then presented to the Health & Wellbeing Board on the 6th of October 2025. The report and associated documents provided an update on the progress towards the development of the Health and Wellbeing Strategy, a draft strategy for comments and considerations from the Board and proposals for further stakeholder engagement on the strategy prior to finalisation.
10. A BCP Health & Wellbeing Board Workshop took place on the 24th of November 2025. The workshop included a presentation of the latest 2025 Joint Strategic Needs Assessment (JSNA) and the development of priority topics for a BCP JSNA Forward Plan. Board members were then asked to review and agree the draft BCP Health & Wellbeing Strategy strategic priorities and proposed actions, prior to public consultation.
11. The feedback and outputs and from the BCP Health & Wellbeing Board workshop in November 2025 were reviewed and a second version of the draft BCP Health & Wellbeing Strategy was produced. This second draft was presented along with a summary of key changes to the Health & Wellbeing Board on the 12th January 2026 for approval before public consultation.
12. A final draft for public consultation was then produced and a public consultation on the draft strategy took place between the 17th February to the 29th March 2026, generating approximately 120 local responses. These responses have been analysed and reviewed and have been used to inform this final strategy. A copy of the Public Consultation Report is attached at Appendix 2.
13. The draft strategy has also received scrutiny and feedback from the Health and Social Care Overview & Scrutiny Committee in May 2026 and feedback from this committee has been used to inform this final version of the strategy.

Summary of Key Changes

14. This section details some of the key changes that have been made to the draft Strategy (Version 2) following the public consultation and the scrutiny and feedback provided by the Health and Social Care Overview & Scrutiny Committee in May 2026.

15. The strategy has been reordered to improve structure and flow. Language has been simplified where possible to improve clarity, reduce jargon and to make the strategy more accessible and easier to read and follow. The references and summaries of existing and complimentary strategies have now been moved to an appendix at the end of the strategy.
16. A new vision has been developed based on the preferences and feedback on the two options that were presented in the public consultation.
17. The Targeted Approach section has been strengthened to include references to LGBT+ people who also experience significant inequalities in health and to provide further explanation and justification for taking a targeted approach. This section also now includes a definition of our 'priority neighbourhoods'.
18. The strategic priorities have been reordered recognising the critical importance of Healthy Neighbourhoods & Communities to health and wellbeing and the successful delivery of the other strategic priorities.
19. Strategic Priority 1 – Healthy Neighbourhoods & Communities. The proposed actions have been reduced and consolidated and include actions to improve health literacy and community resilience. The proposed action to reduce homelessness and increase the availability of good quality homes and environments that promote health and wellbeing now includes a reference to increasing the availability of affordable homes.
20. Strategic Priority 2 - Starting Well. The proposed actions have been edited to reduce jargon and reordered in response to the public consultation. This section now includes added actions in relation breastfeeding, employment pathways, active travel and children and young people with Special Educational Needs and Disabilities (SEND).
21. Strategic Priority 3 – Mental Wellbeing. The proposed actions in this section have been simplified and reordered in response to the public consultation. A new proposed action has been included to ensure mental wellbeing, including tackling stigma around this agenda, are addressed through workplace wellbeing offers.
22. Strategic Priority 4 – Living & Ageing Well. The proposed actions in this section have been simplified and reordered in response to the public consultation.
23. Measuring impact – indicators of self-reported wellbeing have now been added as additional mental wellbeing indicators in response to feedback received from the public consultation.
24. Making it happen – this section has been strengthened to clarify how the strategy will be delivered and funded to address delivery and funding concerns and to include an additional role for the Health & Wellbeing Board to incorporate lived experience and feedback from local residents to support ongoing evaluation and ensure services remain accountable and responsive to local needs. A statement has been added that the proposed actions within the strategy are expected to be delivered within current financial resources, to address concerns relating to how the strategy will be funded.

Neighbourhood Health Plan

25. The 10 Year Health Plan for England, published in July 2025, and subsequent NHS planning guidance, includes a new requirement for Health & Wellbeing Boards to produce a neighbourhood health plan by March 2027, setting out how the NHS, local authority and other organisations, will work together to design and deliver neighbourhood health services. It is envisaged that this plan will be informed by and build on the Health & Wellbeing Strategy.

Next Steps

26. The Board is asked to approve the Health & Wellbeing Strategy for implementation, noting that the strategy will be reviewed by the Health & Wellbeing Board on a regular basis to take account of any significant changes in national health policy and in response to any significant changes in needs arising from the annual Joint Strategic Needs Assessment.
27. Once approved, the strategy will be finalised, designed and published on the council's website and will be used to inform the development of a BCP Neighbourhood Health Plan for implementation from 2027/28.
28. It is proposed that a multi-agency partnership delivery group is established or identified to drive forward the delivery of each strategic priority and to report progress to the Health & Wellbeing Board. This may be a new or an existing partnership, recognising that there are already a number of partnerships in place that could drive delivery.
29. Progress against the agreed strategic priorities, actions and measures in the strategy will be monitored and reported to the Health & Wellbeing Board on a regular basis.
30. The strategy will be reviewed by the Health & Wellbeing Board on a regular basis to take account of any significant changes in national health policy and in response to any significant changes in needs arising from the annual Joint Strategic Needs Assessment.

Options Appraisal

31. Option 1- Approve the strategy and proceed with the next steps detailed above to ensure we meet our statutory requirements.
32. Option 2- do nothing- this is not an option as it is a statutory requirement to produce a Health & Wellbeing strategy.

Summary of financial implications

33. None. There are no direct financial implications arising from the draft strategy. The proposed actions within the strategy are expected to be delivered within current financial resources.

Summary of legal implications

34. It is a statutory requirement for the Health & Wellbeing Board to produce a Joint Local Health & Wellbeing Strategy.

Summary of human resources implications

35. None. There are no direct human resources implications arising from the draft strategy.

Summary of sustainability impact

36. A sustainability impact assessment will be undertaken once the strategy has been approved by the Health & Wellbeing Board.

Summary of public health implications

37. The purpose of the strategy is to identify and address local health and wellbeing priorities, improve health outcomes, and reduce local health inequalities.

Summary of equality implications

38. An Equality Impact Assessment has been completed to inform and support the delivery of the strategy.

Summary of risk assessment

39. The current strategic priorities and proposed actions within the strategy are considered to be low risk. Risks to the successful delivery of the strategy will be monitored and mitigated by the Health & Wellbeing Board and the BCP Placed-Based Partnership.

Background papers

The previous Health & Wellbeing Strategy published in September 2020 is available on the BCP Council website on the following link Health and wellbeing strategy | BCP

Previous papers on the development of the current draft Health & Wellbeing Strategy are available as part of the papers for the following Health & Wellbeing Board meetings on the BCP Council website:

21/10/2024 Health and Wellbeing Board 24 10 21 BCP Council HWB Refreshing the strategy.pdf

13/01/2025 Health and Wellbeing Board **Health and Well Being Strategy Update PDF 384 KB**

24/03/2025 - Health and Wellbeing Board Health and Wellbeing Strategy to Action through the Place Based Partnership

06/10/2025 - Health and Wellbeing Board BCP Health and Wellbeing Board Strategy (Draft)

12/01/2026 - Health and Wellbeing Board BCP Joint Health and Wellbeing Strategy Draft for Consultation

Appendices

Appendix 1 Draft BCP Health and Wellbeing Strategy May 2026 (Draft Version 3)

Appendix 2 Draft Health & Wellbeing Strategy Consultation Report April 2026

Appendix 3 Health & Wellbeing Strategy Equality Impact Assessment

Bournemouth, Christchurch and Poole's Joint Health and Wellbeing Strategy 2026-2031

DRAFT

V3 May 2026

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   3.2 Strategic Priorities
   3.3 A Targeted Approach
   3.4 Strategic Priority 1- Healthy Neighbourhoods & Communities
   3.5 Strategic Priority 2- Starting Well
   3.6 Strategic Priority 3- Mental Wellbeing
   3.7 Strategic Priority 4- Living & Ageing Well
4. Measuring Impact
5. Making it happen
6. Appendix 1 Key strategies and plans this Health and Wellbeing Strategy compliments and builds upon.

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1. Background

BCP Health & Wellbeing Board

The BCP Health and Wellbeing Board is a statutory partnership and formal committee of the Council where political, professional and community leaders from across the health and care system come together to improve the health and wellbeing of their local population and reduce health inequalities.

The Health and Wellbeing Board is made up of elected members and council officers, local NHS representatives, representatives from the voluntary and community sector and representatives from the police and the fire and rescue service. The Board holds regular meetings which can be observed by the public. The Health and Wellbeing Board also works closely with the BCP Community Safety Partnership, Safeguarding Adults Board and the Safeguarding Children's Partnership. The Health and Wellbeing Board uses development sessions, workshops and formal business meetings to identify strategic priorities and to drive work forward.

The Health & Wellbeing Board has a statutory duty to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy to improve the health & wellbeing of the local population and to reduce health inequalities.

In January 2025, the Health and Wellbeing Board agreed a three-layered approach to the development of a new Health and Wellbeing Strategy:

- Adopt the Dorset Integrated Care Partnership Strategy – 'Working Better Together' as the framework for a Bournemouth, Christchurch and Poole Health and Wellbeing Strategy
- Ensure that the Health and Wellbeing Strategy contributes to the delivery of the Council's Corporate Strategy to deliver the corporate vision and ambitions for our local communities
- Ensure that the Health and Wellbeing Strategy contributes to the delivery of the NHS Joint Forward Plan

Health and Wellbeing Board members re-affirmed the following role of the Health and Wellbeing Board:

- Identify strategic priorities that we can champion, monitor and drive forward
- Convene system partners to share work programmes that progress and contribute to local health & wellbeing
- Support the inclusion of health and wellbeing in all policies
- Consider relevant data and metrics to monitor progress
- Focus on working together and co-production
- Sponsor the work of a Place Based Partnership and champion integration of services in local neighbourhoods

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1.1 BCP Placed Based Partnership

BCP started establishing a Place Based Partnership in October 2024 to drive strategy into action. The partnership confirmed its intention to act as an officer executive delivery group to drive delivery of the Health and Wellbeing Board's priorities. A workshop was held in February 2025 to shape the partnership and obtain a commitment to finalise membership and set up monthly partnership meetings by the end of the calendar year.

At the workshop it was agreed that the Place Based Partnership should:

- Add value and not duplicate existing governance
- Help to shape the forward plan for the Health and Wellbeing Board alongside the statutory functions
- Connect the Health and Wellbeing Board to neighbourhoods and communities
- Support a 'wellbeing' in all policies approach
- Work towards becoming a formal partnership which can receive and allocate delegated funding, shape integrated commissioning strategies and drive action

2. Strategic Context

The Health and Wellbeing Strategy sits alongside a number of accompanying strategies, action plans and evolving workstreams that are being delivered across the BCP area to improve health and wellbeing.

Key strategies and plans this Health and Wellbeing Strategy compliments and builds upon are included as an appendix to this strategy.

2.1 Principles of working

The Health and Wellbeing Board has agreed to adopt the following Poverty Truth Commission Access to Services Principles to underpin its work:

- Consistent and connected services from cradle to grave
- A whole person and a whole community approach
- Services when and where people need them that everyone can access
- Dependable and supportive relationships
- Everyone is treated with dignity and humanity.

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3. BCP's Health and Wellbeing Strategy 2026- 2031

BCP's Health and Wellbeing Strategy sets out how the Health and Wellbeing Board will work together to promote wellbeing, prevent ill health and reduce health inequalities across the BCP Council area. The strategy has been informed by the Joint Strategic Needs Assessment (JSNA) and shaped by consultation and engagement activity.

3.1 Vision

Our vision is to improve the health and wellbeing of our population, reduce inequalities and create vibrant, stronger and safer communities.

3.2 Strategic Priorities

Following a survey of members, the Health and Wellbeing Board identified five themed areas of focus for the strategy:

- Children and Young People
- Community Mental Health Transformation
- Supporting Adults to Live Well and Independently
- Housing
- Cost of Living and Poverty

These themed areas of focus have subsequently been developed into four Strategic Priorities:

1. Healthy Neighbourhoods and Communities
2. Starting Well
3. Mental Wellbeing
4. Living and Ageing Well

Our strategic priorities are high-level and informed by local data and evidence. These priorities seek to improve health and wellbeing for everybody but with a focus on narrowing inequalities for those with greatest need.

3.3 A Targeted Approach

If we are to reduce health inequalities, the actions we take must be implemented proportionately to the needs of different neighbourhoods and communities, with those most in need receiving the greatest support. In doing this, we recognise that these communities are at risk of poorer outcomes because of unfair social systems and the circumstances in which they live, rather than due to who they are or individual biological and lifestyle factors.

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Inequality also exists between people with different characteristics (including those protected by law) such as men and women, people from minority ethnic groups, people with disabilities and LGBTQ+ people. Some groups of people also experience significant disadvantages, due to the circumstances that they are facing, such as people experiencing homelessness.

One mechanism for supporting proportionate delivery is Core20PLUS5. The approach defines a target population, with the "Core20" representing the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) and "PLUS" population groups being defined according to local inequalities and need. In Bournemouth, Christchurch and Poole we refer to local areas in the 20% most deprived areas nationally as 'priority neighbourhoods'. This helps us to ensure that these areas are prioritised for actions and interventions and that universal services are scaled in proportion to the level of need or disadvantage.

Reducing health inequalities is a cross-cutting commitment that runs through all of our strategic priorities.

3.4 Strategic Priority 1 – Healthy Neighbourhoods & Communities

Our neighbourhoods and workplaces will make it easy for everyone to live well, with shared opportunities for health and happiness across our communities.

Proposed Actions

- Support the development of Integrated Neighbourhood Teams and Neighbourhood Health Services, improving local access to joined-up care and support in local neighbourhoods.
- Strengthen the voluntary and community sector to deliver impactful programmes that reduce health inequalities, alleviate poverty, improve health literacy and improve access to nutritious food.
- Reduce rates of serious violence, including violence against women and girls, and enhance perceptions of safety across all neighbourhoods.
- Reduce homelessness and increase the availability of affordable and good quality homes and environments that promote health and wellbeing.
- Foster connected communities to combat social isolation, build community resilience and enhance overall wellbeing.
- Embed health and wellbeing practices in workplaces, with Board Members actively championing initiatives that improve staff wellbeing and productivity.
- Support the delivery of BCP's Climate Action Strategy 2023-28 through increased active travel, enhancing green infrastructure and influencing planning decisions to minimise negative impacts.

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3.5 Strategic Priority 2 – Starting Well

Ensuring that Children and Young People up to the age of 25 have the best start in life and are supported to have good physical health and emotional wellbeing so that they can achieve their potential and live well into adulthood.

Proposed Actions

- Promote good mental wellbeing in children, young people and families and reduce self-harm through primary prevention and early support activities.
- Support the delivery of the BCP Children & Young People's Partnership Plan and the Best Start in Life Local Plan, so that babies, children and young people and their families are supported to have good physical and emotional wellbeing.
- To maximise opportunities to support children and young people at the earliest possible point, to prevent harm and encourage positive health behaviours, including promoting positive sexual health and social media use, averting knife and weapon crime, accessing employment pathways and supporting the prevention of harms from tobacco, vaping, drugs, alcohol and gambling.
- Support the delivery of the BCP Special Educational Needs and Disabilities (SEND) Improvement Plan through early intervention and support so that all children and young people with SEND have good physical and emotional wellbeing.
- Work with priority neighbourhoods and communities to reduce health inequalities by:
    - Supporting mothers who smoke to give up during and after pregnancy.
    - Improving and maintaining the uptake of breastfeeding.
    - Improving the uptake of child and adolescent vaccinations.
    - Improving oral health and hygiene in young children.
    - Improving healthy nutrition and everyday physical activity in young. children, particularly walking and cycling.

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3.6 Strategic Priority 3 – Mental Wellbeing

Prioritising prevention and emotional wellbeing, improving access to services, and reducing rates of suicide and self-harm.

Proposed Actions:

- Support improvements in access to, and uptake of, community mental health support services.

- Support Integrated Neighbourhood Teams (INTs) to jointly tackle physical, mental and social wellbeing in partnership with local organisations and communities.
- Work with key partners to reduce rates of suicide and self-harm.
- Promote the understanding that mental health is shaped by a range of wider factors, including social connections, housing, employment and physical health.
- Support mental health promoting communities, making mental wellbeing everyone's business through community development, training and peer support.
- Support people with poor mental health to connect to paid and unpaid activities.
- To ensure mental wellbeing, including tackling stigma, is addressed through workplace wellbeing offers.

3.7 Strategic Priority 4 – Living & Ageing Well

Adults and older people will be supported to live and age well and to stay connected and independent for as long as possible.

Proposed Actions

- Reduce hospital admissions due to falls in people aged 65 and over through increased primary and secondary prevention activities. This includes ensuring local people can be active at all ages, to maintain and improve strength and balance.
- Increase the number of BCP residents in our priority neighbourhoods and communities accessing LiveWell support services and increase the uptake of NHS Health Checks, to reduce inequality in healthy life expectancy.
- Champion and monitor the delivery of the Fulfilled Lives & Future Care Programmes to reform urgent and community care, provide more person-centred and home-based recovery services and promote independence.
- Reduce inequalities in the uptake of NHS screening & immunisation programmes.
- Champion and support the delivery of the Adult Social Care Prevention Strategy to keep people active and independent for longer, preventing or delaying the development of long-term social care needs.
- Work collaboratively with local partners and communities, to create and develop age-friendly communities and environments across BCP, supporting people to age well and live a good later life. This includes enabling people to stay connected, active and independent, reducing loneliness and isolation, and ensuring older people's voices, experiences and contributions shape local places and services.
- Reduce the harm caused by tobacco, drugs, alcohol & harmful gambling in priority neighbourhoods and communities.

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- Support the development of creative health approaches in supporting people to live and age well.
- Support the development of an adult social care and housing strategy that supports people to live and age well.
- Support the delivery of the Dorset Palliative and End of Life Strategy.

4. Measuring Impact

The Public Health Outcomes Framework, the proposed new Local Government Outcomes Framework and the BCP Corporate Strategy provide a comprehensive list of desired outcomes and indicators that can help to measure how well public health and wellbeing is being improved and protected in the BCP area. The Health and Wellbeing Board will focus on a selection of these indicators that a) require the most improvement and b) will best indicate progress towards the strategic priorities in this strategy. Progress against these measures will be reported to the Health & Wellbeing Board on an annual basis.

Strategic Priority	**Measures**			
Overarching	Healthy Life Expectancy at birth	Slope index of inequality in life expectancy at birth		
Starting Well	Breastfeeding prevalence at 6-8 weeks	Population vaccination coverage – MMR for one dose (2 years old)	Child health: Percentage achieving good level of development at 2-2.5 year review	Oral health: Percentage of 5-year-olds with experience of visually obvious dental decay
	Obesity: Year 6 obesity prevalence	Percentage of physically active children and young people	Under 18 conception rate	Hospital admissions as a result of self-harm age 15-19 years, crude rate per 100,000 (persons)

Mental Wellbeing	Depression recorded prevalence	Hospital admissions as a result of self-harm age 15-19 years, crude rate per 100,000 (persons)	Emergency hospital admissions for intentional self-harm	Rates of Self-reported wellbeing
	Suicide Rate (persons)			
Living & Ageing Well	Smoking prevalence in adults in routine and manual occupations (aged 18 to 64)	Physical inactivity: Percentage of adults who are physically inactive	Drugs and alcohol: Rate of alcohol specific mortality (per 100,000)	
	Alcohol related hospital admissions (per 100,000)	The proportion of new clients accessing the Live Well Service who live in the most deprived areas	Hospital admissions due to falls in those aged 65 and over	
Healthy Neighbourhoods & Communities	The number and value of grants/contracts awarded to the voluntary and community sector to reduce health inequalities	Percentage of residents who have a good satisfaction with life	Percentage of physically active adults	Reduce levels of police recorded serious violent crime
	Percentage of people who feel safe in their local area after dark/during the day	The number of people rough sleeping	The number of homeless households in bed and breakfast accommodation	Total number of sustainable passenger trips in the BCP area per year

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5. Making it happen

The Health and Wellbeing Board will be responsible for assuring delivery of the actions set out within the strategy. A multi-agency partnership delivery group will be established or identified to drive forward the delivery of each strategic priority and to report progress to the Health & Wellbeing Board. This may be a new or an existing partnership, recognising that there are already a number of partnerships in place that can drive delivery.

The Health and Wellbeing Board will provide additional focus and offer strategic direction to ensure that priorities and actions are co-ordinated and driven forward, with delivery co-ordinated by a BCP Place Based Partnership.

Accountability for the delivery of the strategy sits across all members of the Health & Wellbeing Board which will:

- Meet regularly as a board, holding each other and wider partners to account.
- Develop a forward plan to ensure all elements of the strategy are progressed and reported on.
- Receive reports on progress in delivering against the strategic priorities outlined in the strategy.
- Constructively challenge and support each other in relation to delivery, ensuring that all opportunities to improve health and wellbeing are maximised.
- Ensure a performance monitoring framework is in place to enable the board to assure itself of delivery.
- Produce a Joint Strategic Needs Assessment Annual Report, which will focus on progress against our key priorities, measures and inequalities across the BCP area.
- Review progress, emerging needs and strategic priorities on an annual basis.
- Incorporate lived experience and feedback from residents to support ongoing evaluation and ensure services remain accountable and responsive to local needs.

The proposed actions within the strategy are expected to be delivered within current financial resources.

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6. Appendix 1

Key strategies and plans this Health and Wellbeing Strategy compliments and builds upon.

6.1 Dorset Integrated Care Strategy

The Dorset Integrated Care Strategy – 'Working Better Together' is a collaborative plan to improve the health and wellbeing of the county's residents by integrating health and care services and provides the foundation for our place based Health and Wellbeing Strategy. Guided by the three overarching principles of prevention and early help, thriving communities, and working better together, the integrated strategy emphasises co-designing services with people and communities, building on community assets, reducing inequalities, and strengthening partnerships between the NHS, local government and the voluntary sector. The overarching goal is to enable people to live healthier lives by providing more accessible, personalised, and equitable care.

6.2 BCP Corporate Strategy - A Shared Vision for Bournemouth Christchurch and Poole 2024-28

The BCP corporate strategy sets out the Councils vision to create a BCP area *'Where people, nature, coast and towns come together in sustainable safe and healthy communities'*. It provides a single set of priorities for the whole council and sets the direction for the Council's policy and strategy development, service planning, budget setting and service delivery.

The strategy includes two priorities:

- Our place and environment: Vibrant places, where people and nature flourish, with a thriving economy in a healthy, natural environment.
- Our people and communities: Everyone leads a fulfilled life, maximising opportunity for all.

These priorities are underpinned by a series of ambitions, focus areas and progress measures which are reported on a performance dashboard A shared vision for Bournemouth, Christchurch and Poole | BCP

6.3 NHS Joint Forward Plan

Dorset's NHS Joint Forward Plan sets out the key health priorities that local health partners are working together to achieve. It is framed around five strategic pillars that provide a framework for making Dorset the healthiest place to live:

- Improve the lives of 100,000 people impacted by poor mental health
- Prevent 55,000 children from becoming overweight by 2040
- Reduce the gap in healthy life expectancy between the most and least deprived areas from 19 years to 15 years by 2043
- Increase the percentage of older people living well independently in Dorset

- Add 100,000 healthy life years to the people of Dorset by 2033

6.4 BCP Children & Young People's Partnership Plan

The BCP Children & Young People's Partnership Plan sets out a vision where Bournemouth, Christchurch and Poole are great places to live, where all children and young people have the best possible opportunities in life and are supported by the community to flourish and grow in order to succeed.

This plan outlines how partners will work together to help children and young people have the best chances in life and be supported by the community to grow and succeed in living their best lives.

The plan contains five main priorities for our children and young people:

- Feeling happy – Feeling at your best mentally, physically and emotionally
- Being safe - Having a safe place to live, study, work and play
- Feeling supported - Having people to turn to for help
- Being included - Being actively involved in the world and activities around you
- Feeling fulfilled - Being proud of yourself and feeling really happy with what you are doing in life

6.5 BCP Adult Social Care Strategy 2025-2028

The BCP Adult Social Care Strategy sets out BCP Council's direction for Adult Social Care over the next four years, outlining an ambitious plan where we will work to transform the services we provide, working in collaboration with partner organisations including health, housing, the voluntary and community sector and independent care providers, as well as people and carers who currently use services, their families and communities. The strategy sets out a vision of 'supporting people to achieve a fulfilled life, in the way that they choose, and in a place where they feel safe'.

The BCP Adult Social Care Strategy outlines 3 key areas of focus:

- Putting people, carers and families first - We will listen and build good relationships with people, so we understand what matters to them
- Living in a place called home - We will help people to connect with their family, friends and community, in a place where they feel safe and at home
- Developing how we work - We are creative and innovative with solutions and resources. We understand and measure the impact we are having

6.6 BCP Adult Social Care Prevention Strategy 2025-2030

This strategy outlines BCP Council's plan for developing a sustainable preventative approach in adult social care. It emphasises early intervention, the promotion of

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wellbeing, and collaboration with key partners to not only prevent the development of long-term needs, but also to enhance the overall quality of life for people living in Bournemouth, Christchurch, and Poole. The strategy includes 5 strategic priorities:

1. A change in culture
2. Living and ageing well
3. Individual resilience to build wellbeing
4. Supporting the workforce
5. Connecting Communities

6.7 Adult Social Care Transformation- Fulfilled Lives

The Fulfilled Lives programme has four priority projects aimed at improving outcomes for adults and their families within the BCP area through enhanced person-centered practice, and the provision of effective and efficient support solutions.

1. **How We Work** - To embed strengths and relational-based practice by implementing and embedding the 3 Conversations (3C's) approach, building on recent innovation sites and focusing on prevention. 3C's supports practitioners to think more preventatively and creatively in our work with people, moving from a mindset of 'assessing for services' towards a deeper understanding what matters most to people for them to lead a fulfilled life.
2. **Better short-term support** – Improving community access to reablement services, ensuring that anyone with reablement goals has the best possible chance to achieve them and maximise their independence- reducing their need for long-term support services.
3. **Self-directed support** - We will ensure more people have control of their own support by increasing the range of options for them to access their personal budget, including the creative use of Direct Payments or Individual Service Funds, reducing the need for more costly traditional services.
4. **Care and Support at Home** - Develop and implement a new 'Support at Home' provider framework, enabling people to stay as independent for as long as possible in their own home and reducing the need for admission to a residential care home.

6.8 BCP Community Safety Partnership Strategy

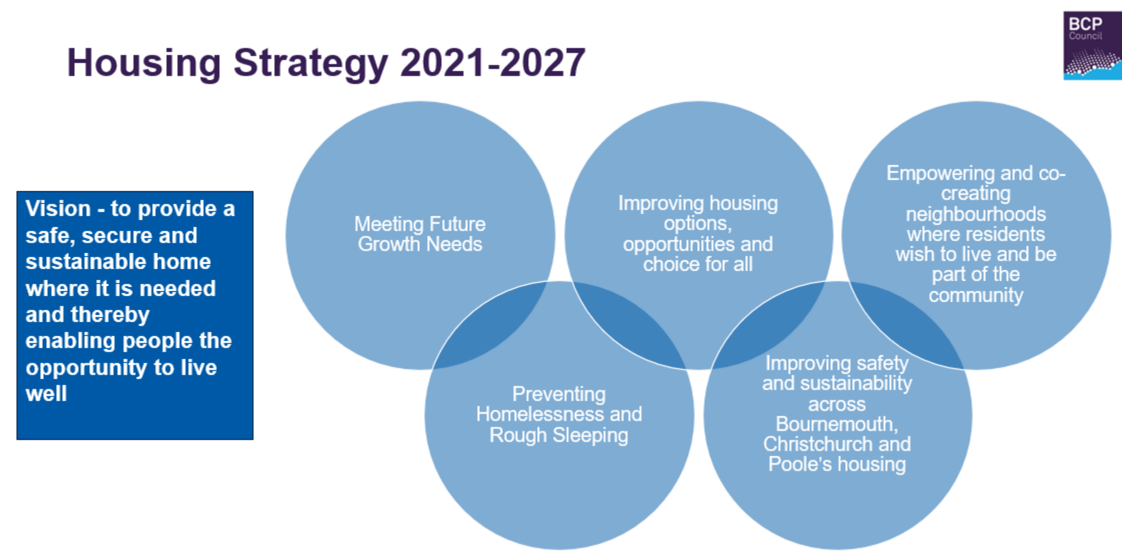
Safer BCP is the statutory Community Safety Partnership (CSP) for the BCP area. The Community Safety Partnership Strategy sets out the strategic priorities for the partnership using an evidence-based approach. These are:

a. To reduce serious violence
b. To reduce Violence Against Women and Girls (VAWG)
c. To reduce Anti-Social Behaviour (ASB), drug related ASB and crime hotspots

The CSP also leads on the duties under the Serious Violence Act, Domestic Abuse Act and Contest (Counter terrorism strategy), with associated strategies and partnership plans outlining roles and responsibilities.

6.9 BCP Housing Strategy 2021-2027

The BCP Council Housing Strategy (2021–2026) sets out a clear vision to make Bournemouth, Christchurch and Poole one of the best coastal places to live, work, invest, and play. It focuses on delivering affordable, high-quality homes, promoting equality, and ensuring housing services meet the diverse needs of local communities. Central to this strategy is a commitment to improving health and wellbeing by addressing the wider determinants of health through safe, secure, and sustainable housing. This aligns closely to the Health and Wellbeing Strategy.



6.10 Homelessness and Rough Sleeping Strategy 2021-2025

The BCP Council Homelessness and Rough Sleeping Strategy (2021–2025), developed in collaboration with the Homelessness Partnership, sets out a bold vision to end homelessness across Bournemouth, Christchurch, and Poole by ensuring everyone has a safe and secure place to call home. The strategy emphasises prevention, rapid rehousing and person-centred support, recognising that homelessness is a complex issue intertwined with health, wellbeing, and social care. Through multi-agency collaboration—including health services, housing providers, and voluntary organisations—the strategy promotes early intervention and trauma-informed approaches to help individuals rebuild their lives. Health and wellbeing are central to its delivery, with initiatives such as supported emergency accommodation, multidisciplinary teams and lived experience groups ensuring that services are responsive, inclusive, and

focused on long-term recovery and resilience. The Strategy is currently under review and will be complete by March 2026.

6.11 Homewards

BCP Council is one of six trailblazer regions participating in *Homewards*, a transformative five-year programme led by Prince William and The Royal Foundation, aimed at ending homelessness by making it rare, brief and unrepeated. Locally led and rooted in collaboration, the BCP Homewards Coalition brings together over 90 organisations- including businesses, charities, and educational institutions- to co-design and deliver innovative solutions. The initiative complements BCP's Homelessness and Rough Sleeping Strategy by enhancing prevention, expanding access to housing, and supporting employability, particularly for young people and those with care experience. It also aligns with the Council's Health and Wellbeing Strategy by addressing the social determinants of health, promoting stability, and fostering resilience through secure housing, meaningful employment, and community engagement.

6.12 NHS 10 Year Plan

Our Health & Wellbeing Strategy reflects the recent publication of 'Fit for the Future' – the government's 10 Year Health Plan for England which sets out an ambition to reinvent the NHS through 3 radical shifts:

- hospital to community
- analogue to digital
- sickness to prevention

Development and implementation of neighbourhood health services lies at the heart of the plan that embodies prevention as a primary principle and promotes care in settings as close to home as can be.

6.13 Dorset Nature Recovery Strategy (2025)

The Dorset Local Nature Strategy is a 10-year partnership-led plan to restore and enhance nature across Bournemouth, Christchurch and Poole and the wider Dorset area. It sets out a shared vision and priorities to reverse biodiversity decline, protect and connect green spaces, and support wildlife recovery, while also improving access to nature for communities.

Developed collaboratively with councils, Natural England and local organisations, it identifies key habitats, species and locations for action, and provides a framework to guide planning, land management and wider decision-making, ensuring a coordinated approach to creating a healthier natural environment for people and wildlife.

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Health and Wellbeing Strategy Consultation Report

April 2026

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Methodology

- The survey ran from Tuesday 17 February to Sunday 29 March 2026
- The survey was available online at https://haveyoursay.bcpcouncil.gov.uk/en-GB/projects/healthandwellbeingstrategy
- Hard copies of the survey and draft Health and Wellbeing Strategy were available in libraries

Health and Wellbeing Strategy

We would like to hear your views on our draft Health and Wellbeing Strategy 2026-2031.

This sets out how the Health and Wellbeing Board will work together to promote wellbeing, prevent ill health, and reduce health inequalities across Bournemouth, Christchurch and Poole.

The strategy is based on evidence from the Joint Strategic Needs Assessment (JSNA) and shaped by feedback from consultation and engagement activities.

What we're focusing on

We have identified **four Strategic Priorities** for improving health and wellbeing across Bournemouth, Christchurch and Poole:

- **Starting Well**
- **Mental Wellbeing**
- **Living and Ageing Well**
- **Healthy Neighbourhoods and Communities**

For each strategic priority there are a series of proposed actions and a small number of key indicators that we can measure to know that we are making a difference.

Documents

Read the draft strategy here.
Summary Document
Printable survey document

Key dates

Consultation starts: 17 February 2026

Consultation ends: 29 March 2026

Who's listening

Health and Wellbeing Board

Councillor David Brown - Portfolio Holder for Health and Wellbeing

Useful links

Communication

The consultation was promoted widely through a variety of channels including:

- Local media coverage
- The council's social media channels
- The Council's e-newsletters
- Staff newsletters
- Posters and information in all BCP Council libraries
- Officer LinkedIn Blogs
- CAN Chief Executive's Blog
- A promotional video presented by Councillor Brown
- Public Health Stakeholder lists including GP Bulletin, NHS Dorset Internal News, Active Dorset, Access Wellbeing, Dorset Healthcare and Dorset County Hospital

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Response

- There were 120 online responses to the survey.
- No paper copies were received.

Are you responding as	Number
A resident living in the Bournemouth, Christchurch and Poole area	106
Someone who studies or works in the Bournemouth, Christchurch and Poole area	27
A representative of a voluntary or community organisation	15
A member of a local group with a specific interest in health and wellbeing	10
An employee of BCP Council	9
A representative of a local provider of health and care services	7
A representative of a local business	5
Other	4

There is some overlap between groups e.g. someone may be a BCP resident and work in the BCP area or for BCP Council

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Responses

Responses were submitted by the following Health and Wellbeing Organisations

- CoCreate Dorset CIC
- Active Dorset CIC
- Alzheimer's Society - Local Systems Influencing Team
- The Breastfeeding Network
- BH Live Active
- Bournemouth Heart Club
- Bournemouth Jewish Support Services
- Christchurch Community Partnership
- Community Action Network
- Dorset Local Nature Partnership
- Fit for Walking Bournemouth
- The Handyvan Service
- LiveWell Dorset
- Tricuro
- Access Wellbeing

Respondent profile

Age group

Age group	Survey	Census
16-34	6%	28%
35-44	14%	15%
45-54	21%	15%
55-64	30%	15%
65-74	22%	22%
75+	8%	4%

- Percentages shown; some categories combined due to small numbers
- Census comparisons are included for context; the sample is not intended to be fully representative

Sexual orientation

Sexual orientation	Survey	Census
Straight / Heterosexual	90%	96%
LGB+	10%	4%

Ethnicity

Ethnicity	Survey	Census
White: British	84%	44%
White: Other	12%	52%
Other	4%	4%

Sex

Sex	Survey	Census
Male	32%	48%
Female	68%	52%

Religion

Religion	Survey	Census
No Religion	56%	44%
Christian	37%	52%
Other	6%	4%

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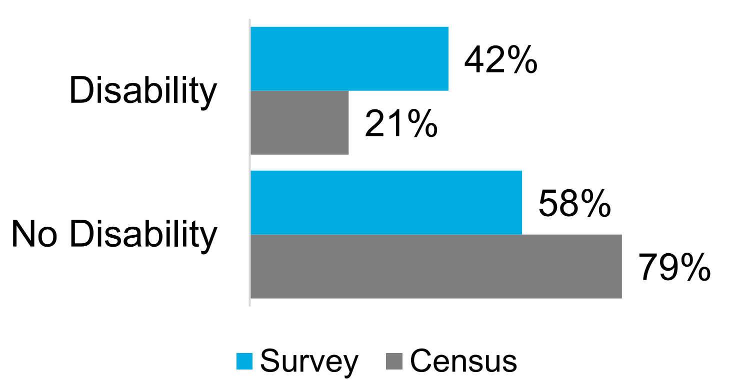
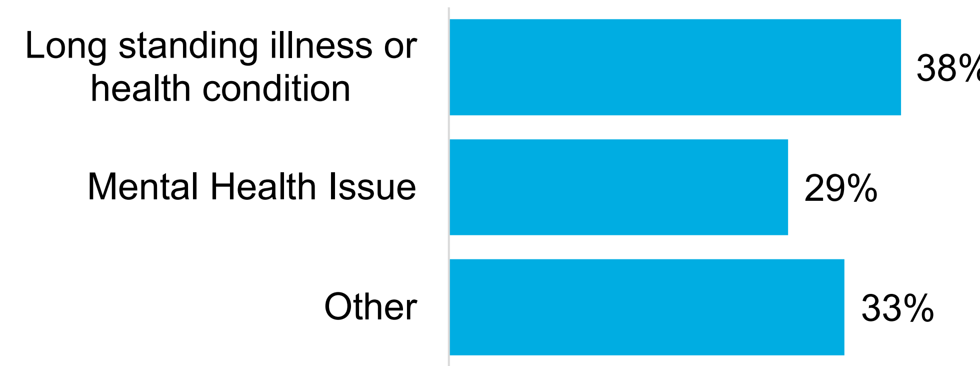
Respondent profile

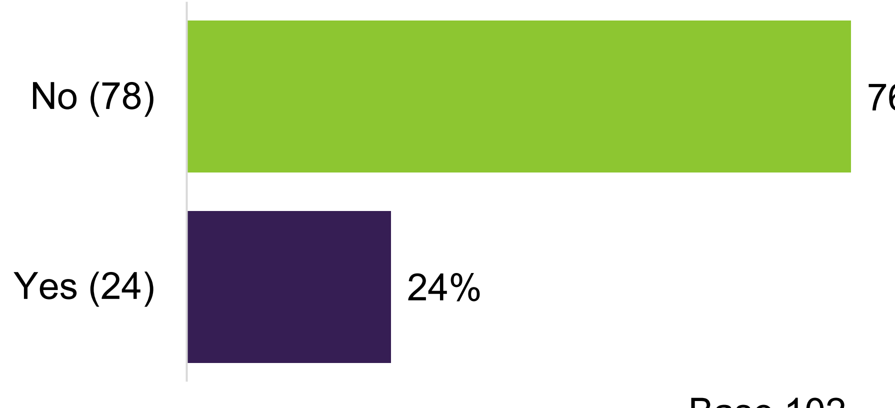


If yes, please describe:

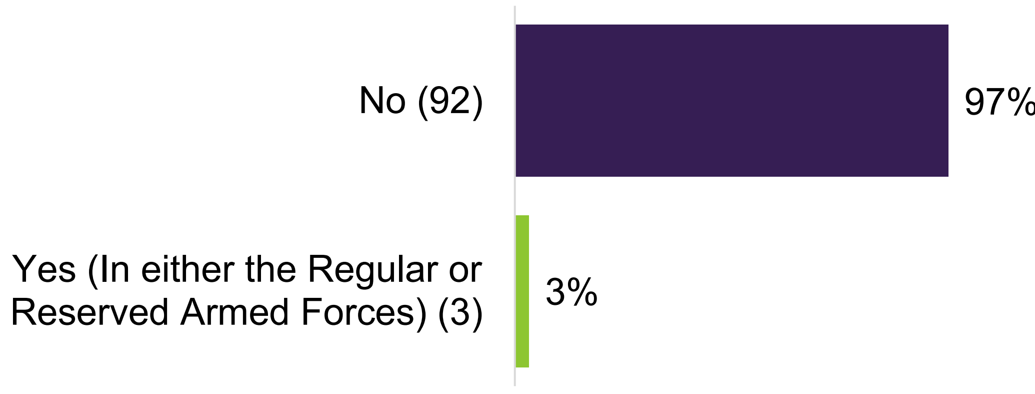


(Other included physical, visual and hearing impairments, and neurodiversity.)

Do you have any children or young people under the age of 18 living at home?



Are you, or have you ever been a member of the armed forces?



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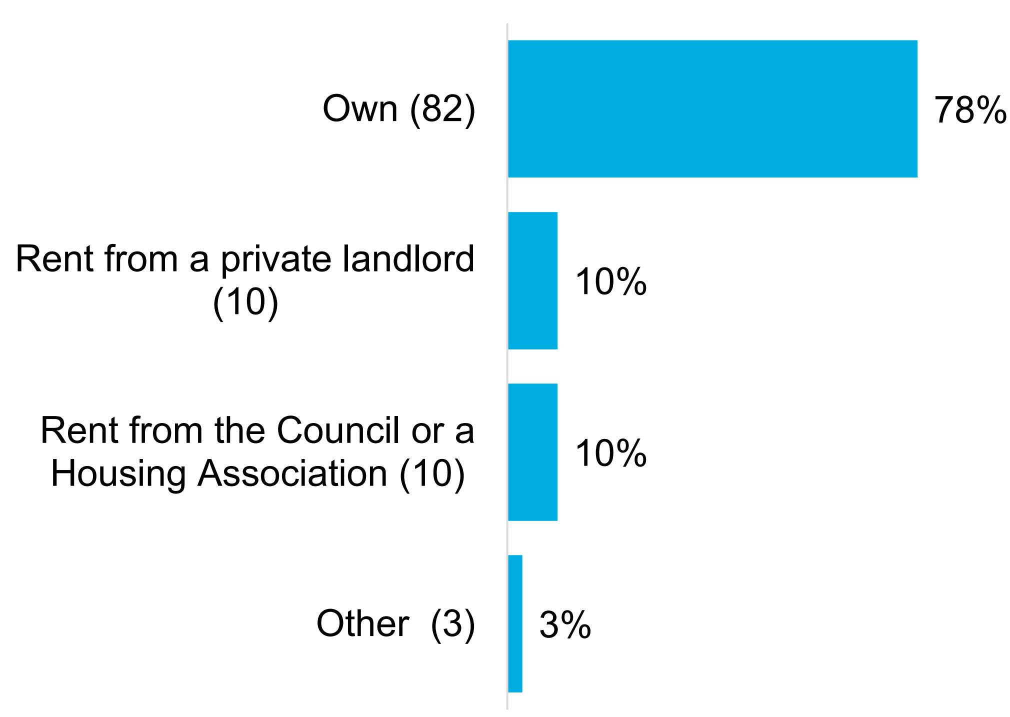
Respondent profile

Do you own or rent the property where you currently live?



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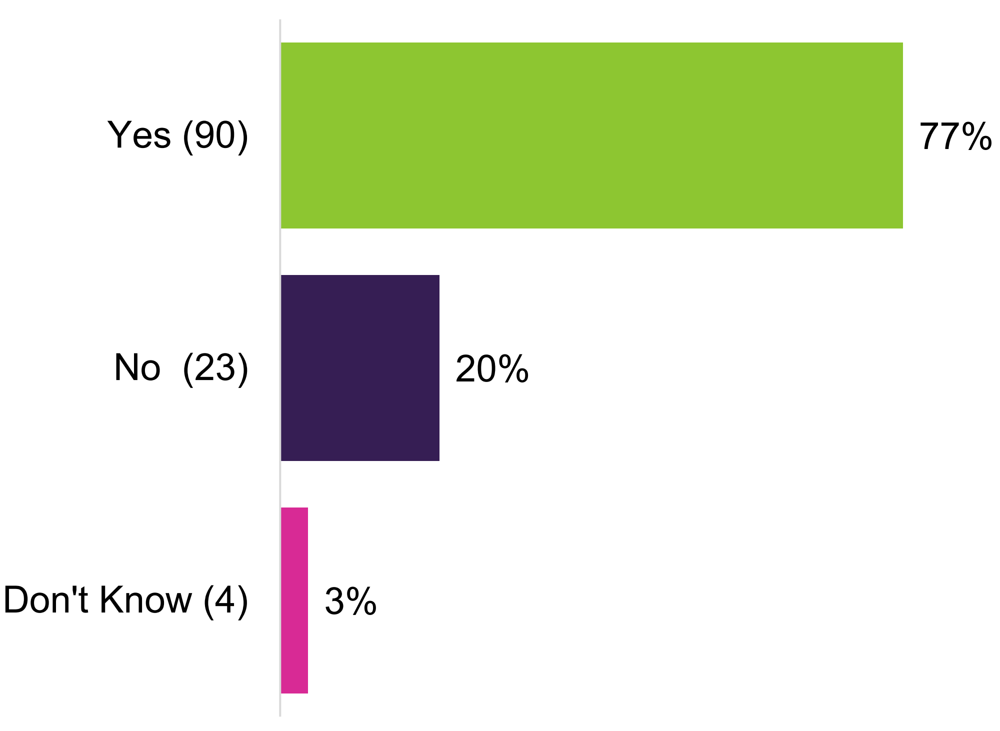
The Draft Health and Wellbeing Strategy

Most respondents (77%) said that the draft Health and Wellbeing Strategy was clear and easy to understand



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The Draft Health and Wellbeing Strategy

Key reasons the strategy felt unclear:

Clarity and plain language	Some respondents felt the strategy was **written primarily for professionals** and used technical language that some residents may find hard to follow.
Length and wordiness	Several respondents felt the **strategy was lengthy** and could be more concise, which made it harder to engage with.
Lack of clear actions and objectives	Respondents were **unclear about what the strategy would deliver**, and said the goals, actions and measurable outcomes were not set out clearly.
Structure and flow	Some respondents felt the **strategy's structure and ordering were not clear**.
Process focused	Some respondents felt the **strategy focused more on frameworks** and committees than on what it would mean for residents.
Delivery and affordability	Some respondents questioned **how the strategy would be delivered** and whether it would be affordable given current **financial pressures**.

25 comments received on this question

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The Draft Health and Wellbeing Strategy

If you answered "no" please tell us why? Example comments:

"It needs to be easier for the general public to understand - this feels like a document for professionals"

"Too wordy and complex"

"I understood the strategy but for the people I work with - the language is too in-depth, requires an excellent understanding of English, and not personal to them i.e. why does this strategy impact on me"

"It contains a lot of jargon, overlapping strategies, and technical language that most residents wouldn't naturally understand without simplification"

"Not clear on your objectives or areas"

"It appears to be a collection of unmeasurable platitudes and unstructured"

"No explanation of how any of this is affordable with the council tax increase swallowing people's wages as well as other bills"

"I think it would be better reordered there's a lot of strategy / and links with other plans before you actually get to the health and wellbeing strategy priorities. Might benefit from a one-page summary about the strategy"

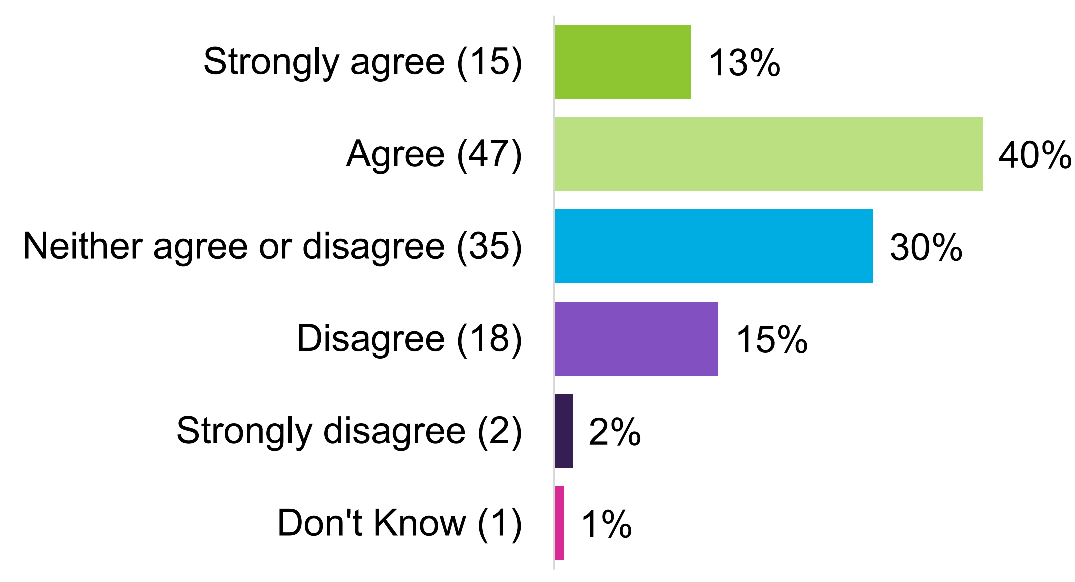
DRAFT

The Draft Health and Wellbeing Strategy

To what extent do you agree or disagree that the draft Health and Wellbeing Strategy will help to improve health and wellbeing in Bournemouth, Christchurch and Poole over the next five years?

- **53% agreed**
- **17% disagreed**

Responses were more often in agreement than disagreement.



Base 118

DRAFT

The Draft Health and Wellbeing Strategy

Key views on why the strategy will (or won't) improve health and wellbeing:

Implementation of the plan	Respondents questioned **how the strategy will actually be delivered in practice**, gatekeeping, and mismatch between ambition and reality on the ground
Lack of detail around actions	Some felt that the **strategy sets out aspirations but not clear actions**, interventions, timelines, or what will practically change for residents
Resourcing and Funding	Doubts about **affordability, long term funding**, investment levels, pressure on budgets, and concern about council tax or costs outweighing benefits
Performance and trust	Respondents want to see **how progress will be tracked**, shared and acted on. Confidence in the strategy depends on clear measures, **openness about what is or is not working**, and accountability
Equity and inclusion	Some concern was expressed that **some groups were overlooked** (autistic and disabled people, older people and carers, SEND, dementia, digital exclusion, gender safety).
Voluntary and community sector	Some recognised that **delivery depends heavily on voluntary and community organisations**, with calls for meaningful involvement, expertise, and sustainable resourcing
Prevention	Broad **support for prevention in principle**, with calls to strengthen early intervention, physical activity, walking, place-based approaches and wider determinants of health

64 comments received on this question

DRAFT

The Draft Health and Wellbeing Strategy

Would you like to comment on your answer? Example comments

"While the objectives sound good they are hard to realise in practice, particularly those which are not in the councils gift or require fundings"

"There is no mention of tailored support for autistic people…"

"how will access to services improve?…"

"Looks good on paper but actions and measurements will determine outcome"

"Needs significant investment. Needs to be achieved by working with both statutory agencies and voluntary and community sector groups (who need funding and long term funding agreements)"

"The principles are great - but it's in the execution that it is really matters. It's all too woolly…"

"It will encourage healthy neighbourhoods and communities to both promote and support people to live well and age well. Prevention and early intervention, education and training is at the heart of this"

"To fulfil all that is written will be a mammoth task and expensive. Has it been calculated?"

"Not sure the plans will reach all those needing it"

DRAFT

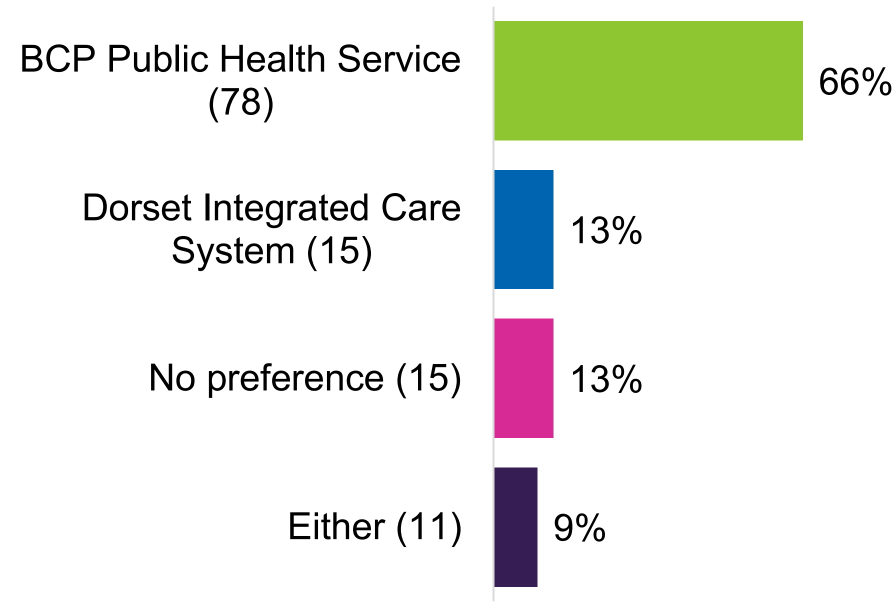
The Vision

Respondents were given two vision statements to choose from

- **Dorset Integrated Care System** - "Dorset Integrated Care System works together to deliver the best possible improvements in health and wellbeing."

- **BCP Public Health Service** - "Our mission is to improve the health and wellbeing of our population, reduce inequalities and create vibrant, stronger and safer communities. We actively engage and empower communities, working together to foster healthier, happier and safer lives."

Which vision statement should we use as the basis for the Bournemouth, Christchurch and Poole Health and Wellbeing Strategy?



Most respondents preferred the BCP Public Health Service vision (66%)

Base 119

DRAFT

The Vision

Key themes on the two choices provided:

Integrated Care Board Vision	Public Health Service Vision
Views on Option 1 were more often negative than positive.. Some respondents see it as **vague and overly formal**, with language that is written for health professionals and partners rather than BCP residents. References to the Dorset Integrated Care System are described as **confusing, inaccessible and meaningless** for BCP Residents, and the terminology could quickly become outdated. Overall respondents felt it was not aspirational, did not say anything meaningful and **focused too much on care systems rather than public health outcomes that affect everyone**.	Feedback on Option 2 was generally more positive. It is seen as **more accessible and easier to understand**, using plainer English and a friendlier tone. Respondents value its **clearer focus on outcomes**, particularly around reducing inequalities and strengthening communities, and was viewed as clearer about the priorities. However, some still feel it is too long, too wordy or unrealistic, with **concerns that it does not recognise financial constraints** or explain how action will be delivered, or who will lead it.

50 comments received on this question

DRAFT

The Vision

Key themes on vision statement generally

Trust, credibility and delivery	**Unsure about vision statements**. Many are concerned by words without action and say a vision only matters if it leads to real change and can be delivered
Clarity for residents	**Clear demand for short, plain English wording** that speaks directly to residents, avoids jargon and is easy to understand
Meaningful and outcome-focused	Desire for **a vision that clearly states priorities and outcomes**, not vague aspirations or system descriptions
Realism and fairness	**Concerns about unachievable ambitions**, resources, and the need for fairness across Bournemouth, Christchurch and Poole

50 comments received on this question

DRAFT

The Vision

Example comments on the vision:

"Both statements to me feel like an empty promise statement. For me I would want it worded differently to make me actually believe what you are offering"

"Option 2 is more accessible and understandable in clear language"

"I think the word 'education' needs including somewhere to foster the idea that supporting health and wellbeing has a personal element to it to create a change"

"Both options appear to focus on unachievable goals. No mention is made of the cost of implementation or what budget provision has been included for"

"Vision seems a bit irrelevant, both are fine but does it make a difference"

"I think actions will speak louder than words at this stage. People have been visioned out and now want to see results"

"Don't like the wording in option 1 - 'works together.' Option 2 is more easily understood"

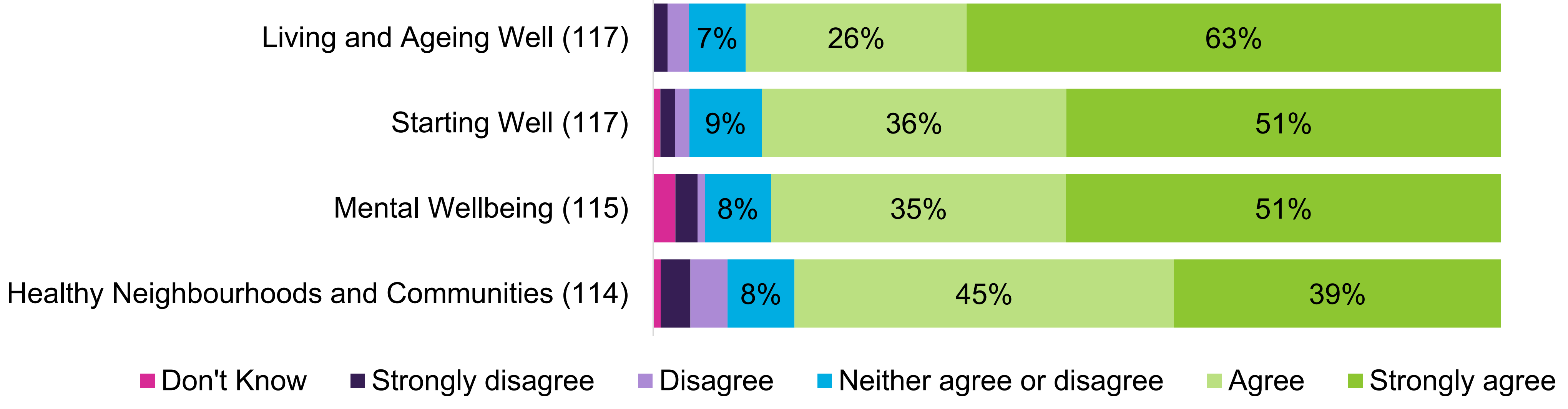
"Neither of them actually say anything. They are just vague statements"

"The first is short and the second too long. Perhaps something in between?"

DRAFT

Strategic Priorities

Respondents were asked to what extent they agree or disagree with each Strategic Priority



- Most responses fall under ‘agree’ or ‘strongly agree’, with variation by priority.

DRAFT

Starting Well

106 respondents ranked the Starting Well actions in the following order

#1	Promote good mental wellbeing in children, young people and families and reduce self-harm	2.8 average
#1	Support the delivery of BCP Children & Young People's Partnership Plan and Families First Programme, so that children and young people are supported by the community to flourish, giving them the best possible opportunities in life, and ensuring they grow and succeed	2.8 average
#3	To maximise opportunities to support children and young people at the earliest possible point, to prevent harm and encourage positive health behaviours and choices, including promoting positive sexual health and social media use, averting knife and weapon crime and supporting the prevention of harms from tobacco, vaping, drugs, alcohol and gambling	3 average
#3	Support the delivery of the BCP Special Educational Needs and Disabilities (SEND) Improvement Plan so that all children and young people with SEND have bright futures, fulfilled lives and are part of their local communities	3 average
#5	Work with priority neighbourhoods and communities to reduce health inequalities by: Supporting mothers who smoke to give up during and after pregnancy, Improving the uptake of child and adolescent vaccinations, Improving oral health and hygiene in young children, Improving healthy nutrition and physical activity in young children.	3.3 average

Note:
Average score = the average rank given by respondents (1 = highest priority).
Lower scores indicate higher priority.

DRAFT

Starting Well

Key themes on the Starting Well priority:

Early intervention and prevention	Respondents felt that problems should be addressed earlier in childhood and family life rather than managed at crisis point**. Early support is seen as key** to reducing later mental health issues, SEND demand and wider social problems.
SEND priority and clarification	Respondents would **like SEND to be a clear priority**. Comments highlight the need for earlier intervention, better support in schools, clearer definitions and thresholds, and adherence to recommendations, alongside concern about escalating need and budget pressures.
Physical activity, active travel and environment	Respondents often highlighted the need for everyday physical activity from an early age, particularly walking and cycling. **Safe streets, clean public spaces and a well-maintained physical environment** are seen as fundamental to health, independence and mental wellbeing, not add-ons.
Early years, breastfeeding and family support	Support for babies, under fives and parents is raised. Some respondents call for more breastfeeding support, recognition of parental care, and accessible **community-based help such as Sure Start style hubs** to support families early and reduce inequalities.
Support for young people aged 16 to 25	Many comments highlight a **gap in support for older young people,** particularly those affected by Covid. Employment pathways, paid opportunities, help with costs and clearer offers of support are seen as crucial to improving mental wellbeing and future prospects.
Housing, poverty and cost of living	Some respondents felt **Housing insecurity, poverty and the cost of living are a root causes of poor outcomes** for children and young people. Respondents feel these issues are not sufficiently addressed despite their influence on health, education and life chances.

37 comments received on this question

DRAFT

Starting Well

Example comments on the Starting well priority

"From observation of young families, I believe that many of the SEND needs, mental health issues etc, social problems need to be tackled at source, rather than managed when they occur…"

"…Although breastfeeding prevalence is noted as a measure, there is no other mention of it in the strategic priority which may be a missed opportunity for reducing health inequalities"

"Increased interventions earlier on could prevent some young people needing SEND"

"…Encouraging regular walking needs to start as soon as we take our first steps. Children and young people can benefit not only from the long-term health and wellbeing benefits of walking but also overcoming the challenges of the risks and dangers of navigating the street environment…"

"Housing and poverty issues not addressed in the above"

"These are all important actions, particularly around mental wellbeing and early intervention. However, the strategy would be strengthened by recognising the role that the physical environment plays in health outcomes. Safe, clean and well-managed public spaces are fundamental to supporting mental wellbeing, reducing harm and encouraging positive behaviours. Where environments are perceived as unsafe or poorly maintained, this can directly undermine these priorities, particularly for children and young people"

DRAFT

Mental Wellbeing

101 respondents ranked the Mental Wellbeing actions in the following order

#1	Support improvements in access to, and uptake of, community mental health support services	2.2 average
#2	Support Integrated Neighbourhood Teams (INTs) to jointly tackle physical, mental and social wellbeing in partnership with local organisations and communities	2.6 average
#3	Work with key partners to reduce rates of suicide and self-harm	3.5 average
#3	Support mental health promoting communities, making mental wellbeing everyone's business through community development, training and peer support	3.5 average
#5	Support people with poor mental health to connect to paid and unpaid activities.	4 average
#6	Health and Wellbeing Board members to ensure mental wellbeing, including tackling stigma around this agenda, are addressed through workplace wellbeing offers	5.2 average

Note:
Average score = the average rank given by respondents (1 = highest priority).
Lower scores indicate higher priority.

DRAFT

Mental Wellbeing

Key themes on the Mental Wellbeing priority:

Delayed access to support	Respondents described long waiting times, unclear referral routes and difficulty accessing timely mental health support. Several felt **help was only provided once needs had escalated to crisis**, which they felt reduced the effectiveness of support.
Link between activity and mental health	Respondents frequently highlighted the **relationship between physical activity and mental wellbeing**. There were calls for exercise, active travel, leisure access and everyday movement to be central to mental wellbeing approaches rather than seen as additional or optional.
Prevention before crisis	There were calls for **greater focus on prevention, resilience and early support** to reduce the number of people reaching crisis.
Nature and environment	Respondents **welcomed the inclusion of green and blue space and nature-based activities** as cost effective ways to support prevention and recovery.
Value for money and funding	A small number of respondents raised concerns about **funding being spent on administration** or infrastructure rather than frontline mental health support.
Measuring access and service performance	Some respondents felt there should be **better monitoring of access, waiting times and outcomes**, not just crisis indicators.

33 comments received on to this question

DRAFT

Mental Wellbeing

Example comments on the Mental Wellbeing priority

"Improving access to community mental health services is the most important action, as timely support can prevent escalation to crisis"

"Currently I would say that Mental health support is severely lacking in BCP. I've tried to access this myself and for my daughter - we're always on waiting lists - never actually contacted and supported"

"Encourage low cost , low impact nature-based activities in the community"

"All of there items are not able to be disagreed with - please make things simple though so that the maximum of spending goes on services rather than admins"

"Need to stress access to physical exercise has a role in mental health. Again active travel, bike loan schemes, leisure access should all be a part"

"Focus on wellbeing not illness - the solution is within local communities to help themselves with investment from the system"

"Mental health support is not very well advertised and more need to be done to address this"

"Activity helps mental health to improve"

"…the strategy would benefit from greater recognition of the role that the physical environment plays in mental wellbeing. Public spaces that feel unsafe, poorly managed or degraded can negatively impact how people experience their local area and their overall sense of wellbeing. To support this priority in practice, it is important that the condition, safety and management of public environments are considered alongside service provision and community initiatives"

"I am surprised that in the impact measurement it is mainly crisis points measured, there is no mention of measuring access to MH services including S2W, Access Wellbeing and REC"

DRAFT

Living and Ageing Well

102 respondents ranked the Living and Ageing well actions in the following order

#1	Reduce hospital admissions due to falls in people aged 65 and over through increased primary and secondary prevention activities	3.8 average
#2	Increase the number of BCP residents in our priority neighbourhoods and communities accessing LiveWell support services and increase the uptake of NHS Health Checks	3.9 average
#3	Champion and monitor the delivery of the Fulfilled Lives & Future Care Programmes to reform urgent and community care, provide more person-centred and home-based recovery services and promote independence	4.7 average
#4	Reduce inequalities in the uptake of NHS screening & immunisation programmes	5.1 average
#5	Champion the delivery of the Adult Social Care Prevention Strategy to prevent the development of long-term social care needs	5.5 average
#6	Create more Age-friendly communities and spaces, where people are supported and enabled to age well and live a good later life	5.8 average
#7	Reduce the harm caused by tobacco, drugs, alcohol & harmful gambling in priority neighbourhoods and communities	6 average
#8	Support the development of creative health approaches in supporting people to live and age well	6.2 average
#9	Support the development of an adult social care and housing strategy that supports people to live and age well	6.7 average
#10	Support the delivery of the Dorset Palliative and End of Life Strategy	7.4 average

Note:
Average score = the average rank given by respondents (1 = highest priority).
Lower scores indicate higher priority.

DRAFT

Living and Ageing Well

Key themes on the Living and Ageing Well priority:

Need for clear actions	Many comments say the **strategy is too vague and lacks clear actions** or explanations of how outcomes will be achieved. Respondents want simple, practical steps rather than high level aspirations.
Access, mobility and public spaces	Respondents feel **ageing well depends on being able to get around safely.** This includes well maintained pavements, paths, crossings, benches, safe walking routes, cycling options and accessible public transport. Poor infrastructure is seen as a direct barrier to health, independence and social connection.
Prevention and physical activity	Respondents emphasise **prevention rather than cure**, with frequent calls for exercise, walking, swimming, gyms and everyday physical activity to be central to the strategy.
Loneliness and community connection	Many responses **highlight loneliness as a major issue and feel it is not addressed strongly enough**. People want more focus on community spaces, transport, activities and neighbourhood design that help residents meet others and stay connected.
Perceived unfairness of priority areas	Some respondents **object to actions being limited to priority neighbourhoods**, describing this as discriminatory or unfair to older people living elsewhere. There is a preference for universal approaches rather than targeted ones.
Housing and support for older people	Respondents repeatedly raise the need for **better housing options**, funded care packages, hospital discharge support, reopening day centres, and access to advice services such as Age UK. Dementia specific action is also requested.
Transport linked to independence	**Public transport, active travel and the ability to travel without a car are repeatedly described as essential**. Without this, other actions are viewed as meaningless.

32 comments received on this question

DRAFT

Living and Ageing Well

Example comments on the Living and Ageing Well priority

"Not sure how you are going to prevent falls - needs to be spelled out more clearly"

"…recommend the inclusion of nature-based wellbeing opportunities to support both physical and mental health and wellbeing. As an example, conservation volunteering already takes place in the area within both the council and partner organisations which support physical health, positive mental health and reducing isolation and can help tackle inequalities"

"Implement exercise classes and access to healthier food for the elderly , prevention rather than cure. Community based mentor programmes to enable people to remain valued members of society for longer"

"So could we start with some housing options please? We need to make sure the elderly have proper care packages to come out of hospital with and that care is fully funded as required and for as long as required. We need to reopen centres which have been closed for daycare and age UK for advice and projects for socialising including minibuses and transport"

"Please consider the impact of public transport on the above. It is easy to become isolated in BCP if you cannot use a car or bike"

"This should cover all areas - not just priority areas"

"All of this is pointless if older people can't get around to meet up and access services. Basic things like putting benches back at the bus station and bus stops that have been removed, surfacing pavements so they can be walked on, providing safe routes for cycling and plenty of well marked road crossings with liveable neighbourhoods supporting local shops and community hubs are what will make for better old age. Anything else is just not accessible"

"Need more emphasis on maintaining paths and pavements so that older people can move about without falling and be able to exercise more"

DRAFT

Healthy Neighbourhoods and Communities

100 respondents ranked the Healthy Neighbourhoods and Communities actions in the following order

#1	Support the development of Integrated Neighbourhood Teams and Neighbourhood Health Services, improving local access to joined-up care and support	2.8 average
#2	Strengthen the voluntary and community sector to deliver impactful programmes that reduce health inequalities, alleviate poverty, improve health literacy and improve access to nutritious food	3 average
#3	Reduce rates of serious violence, including violence against women and girls, and enhance perceptions of safety across all neighbourhoods	3.2 average
#4	Foster connected communities to combat social isolation, build community resilience and enhance overall wellbeing	3.5 average
#5	Reduce homelessness and increase the availability of good quality homes and environments that promote health and wellbeing	4.3 average
#6	Embed health and wellbeing practices in workplaces, with Board Members actively championing initiatives that improve staff wellbeing and productivity	4.9 average
#7	Cut carbon emissions, reduce air pollution and increase active travel uptake	6.2 average

Note:
Average score = the average rank given by respondents (1 = highest priority). Lower scores indicate higher priority.

DRAFT

Healthy Neighbourhoods and Communities

Key themes on the Healthy Neighbourhoods and Communities priority:

Safety and perceptions	Some felt that the **strategy focuses too much on perceptions rather than actual safety**. Comments included the harassment of women, licensing of strip clubs, street prostitution, pavement safety, and enforcement in public spaces. Some comments reference legal duties and equality impacts.
Active travel concerns	**Concerns about cycle lanes, shared paths and e-scooters safety.** People report walking feeling less safe, especially for older people, children and dog walkers, and argue active travel is over-prioritised or unsuitable in practice.
Public transport and access	Support for **better bus services as an alternative to active travel**, including evening services, routes through low income and employment areas, and free travel for under 18s.
Housing affordability and homelessness	**Stable, affordable housing is seen as fundamental to wellbeing**, safety and community cohesion. Includes calls to prioritise housing supply, reduce rents and address homelessness more directly.
Funding	**Concerns that wellbeing actions need money**, residents have limited ability to pay, and spending should prioritise frontline services over administration.
Community cohesion	Comments about loss of community spirit and **the need for community hubs**, youth services and local spaces, with housing stability seen as the starting point.
Environmental priorities versus wellbeing	**Mixed views on carbon reduction**. Some question its relevance to health, others link pollution and noise to wellbeing.

33 comments received on this question

DRAFT

Healthy Neighbourhoods and Communities

Example comments on the Healthy Neighbourhood and Communities priority

"Safe, secure housing is key to people's health and should be prioritised. Safety is also extremely important".

"active travel isn't the answer - especially in autumn/winter/spring with adverse weather conditions. Could focus on cheaper public transport, addressing pollution due to road closures etc"

"carbon emissions doesn't fit well here"

"I think the subject of active travel is an interesting one, it has actually got more unsafe to walk in BCP because footpaths have become cycle lanes, pedestrians are now running the gauntlet with cyclists"…" .

"Agree that we have lost community spirit and mutual support. The start of building communities is affordable stable housing so that people can call a community home and not have to move away because of the cost of housing/insecure tenancies. Multi-purpose community hubs are needed, although I feel getting people to use them will be a challenge as we are no longer used to using these services. Need more youth services. The environment is very important, but I think we need to prioritise people's wellbeing - making good environmental choices will follow good wellbeing and being part of a community you care about."

"We should be enhancing safety - not just the perception of safety".

"Neighbourhoods and communities must play a central role in all parts of this strategy, as well as this priority. Care closer to home, prevention of ill health and stronger support will help people living, longer, healthier, happier and more fulfilling lives"

"I completely agree with all of above. I think they need a foundation of good public and active transport, equitable access to green spaces/tree coverage, community resources (e.g. sport and culture opportunities) and good family education".

"All this social stuff needs money to do it. Many people do not have a bean to spare".

DRAFT

If there are any ways you think the draft Strategy could be improved, please tell us. In particular, let us know if you think anything is missing and should be included in the Strategy.

BCP Council

Key themes for improvement

Mental Health and Crisis Support	Respondents asked for a **stronger focus on mental health recovery**, suicide and self harm, crisis support, and tackling stigma.
Clarity on Delivery and Actions	Requests for **clearer delivery plans,** fewer vague ambitions, who is accountable, timelines, and how progress will be measured.
Prevention and Responsibility	**Emphasis on prevention over treatment**, routine checks, self care, healthy eating, physical activity, and behaviour change campaigns on vaping and screen time.
Transport and Access to Healthcare	**Transport as a key barrier to healthcare and activities**, including cost, public transport, parking, and the role of active travel.
Listening and feedback	People **want the council to listen more**, show what changed because of consultation, and keep residents involved using practical examples and stories.
Priority Neighbourhoods	Concerns about fairness and **how priority neighbourhoods are defined**, plus wider inequality and who gets prioritised.
Funding	Concerns about lack of **funding, showing costs and budgets**, and whether money is being spent on the right things.

62 comments received on this question

DRAFT

If there are any ways you think the draft Strategy could be improved, please tell us. In particular, let us know if you think anything is missing and should be included in the Strategy.

"Audits of commissioned services for wellbeing and mental health - this must become mandatory"

"One of the main barriers in all areas of the strategy is transport. Many suitable venues/activities are not on or are not well served by public transport links, especially in the evenings"

"It's all words and not definitive action, how you do some of the priorities identified is unclear"

"…There needs to be more focus on avoidance of ill health, rather than treatment and cure. Funds must be diverted from secondary care to care closer to home. We must work hard to reduce health inequalities, inequality of opportunities, and support family life"

"By prioritising this strategy are other BCP Council's areas going to suffer?"

"The inclusion of priority neighbourhoods is discriminatory as people within non-priority neighbourhoods require the same help"

"Making services as much as possible non-digital. This is not what people want and you need to have drop in places to get things done"

"Exactly how you intend to support and improve. Exactly who you are planning to fund to do these things".

"Presumably the big problem is lack of money? How will this strategy be implemented given the shortfalls in funding and the current strain the NHS, education and other services are under?"

"ASK the people you are trying to help, what they feel they need. Don't be governed by facts and figures. You are dealing with people"

"With the high per cent age of bad parenting in our area revert back to having medical, dental and eye check ups in schools"

DRAFT

Are there any other comments or observations you would like to make?

Actions and plain English	Many respondents emphasised the need for clearer, simpler, and more accessible language in the strategy, with calls for a shortened, public-facing version that outlines specific actions and real-world impacts
Resourcing and delivering plan	There were concerns about delivery and implementation, with several people stressing that ambitions must be matched by practical action, resources, and realistic expectations
Barriers to participation	Hidden costs (e.g. sports equipment), transport, and parking for disabled people were mentioned, with suggestions for outdoor exercise equipment and improved public transport
Environment and Public Spaces	Environmental factors like air pollution and road noise were noted as missing from the strategy, despite their significant impact on health The importance of safe, well-managed public spaces was also highlighted.
Inclusivity	The importance of inclusion and equality was raised, with calls for more explicit support for minority groups (including LGBTQ+), boys and men. There were also concerns about the strategy’s focus on vulnerable groups at the expense of the wider population
Partnerships and voluntary sector role	Several responses stressed the need for joined-up, collaborative working across sectors, and for the voluntary and community sector to be recognised and resourced as a core delivery partner, especially in prevention and early intervention
Accessibility and communication	Digital exclusion, especially among older people and those on low incomes, was highlighted as a barrier, with suggestions for better communication and alternative access routes such as phone and physical hubs

31 comments received on this question

DRAFT

Are there any other comments or observations you would like to make?

Example comments

“This needs a shortened version which is easier to read and says what you're going to do to make it happen”

“Instead of prioritising active travel, which is only really feasible in the summer, could look into supporting cheaper public transport…”

“”The plan and its aims are very commendable and well thought out, if it is followed through and necessary resources are available”

“…Ensuring that public environments are safe, well-maintained and appropriately managed will be essential to achieving the outcomes set out in the strategy.”

“You need hubs and communication by phone and Internet as older people really don't use it”

“Simplifying the language and clearly summarising key outcomes would help make it more accessible and meaningful for residents”.

”There is also an opportunity to more explicitly recognise and support minority communities, including LGBTQ+ residents, whose experiences of health inequality, loneliness, and mental health challenges are often distinct. Making inclusion more visible would help ensure no groups feel overlooked”.

“These strategies sound great as long as they can be delivered.”

“The task and vision is enormous. Lots of concerns that impact the community. There needs to be joined up thinking and working collaboratively working across all of the sessions to bring sustainable change.”

“Hidden costs can also be a barrier - so needing sports wear/shoes, specialist equipment - even just a yoga mat can be beyond some people's budgets. Also be aware of digital exclusion, especially among older people and those on very low incomes.”

“Language needs to be more specific and clearer for people to understand”

DRAFT

What the feedback suggests

Feedback indicates the following areas may be helpful to consider as the strategy is finalised:

- simplifying language to improve clarity for residents, including reducing jargon and explaining system references.
- whether to provide a high-level delivery overview (responsibilities, indicative timeframes, funding and how progress will be reported).
- how feedback on perceived gaps could be reflected, where appropriate, including inclusion and accessibility for specific communities and protected characteristics
- publishing a short consultation response summary linking feedback to any changes made.

DRAFT

Equality Impact Assessment Form

Equality Impact Assessments (EIAs) help demonstrate how the Council fulfils its responsibilities under the Public Sector Equality Duty (PSED).

The Council is legally required by the Equality Act 2010 to evidence how it has considered its equality duties in its decision-making process.

The Council must have due regard to the need to -

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to -

(a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
(c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

A link to the full text of s149 of the Equality Act 2010 which must be considered when making decisions.

1	**What is being reviewed?**	The Health and Wellbeing Strategy
2	**Details about the decision:**	The Health and Wellbeing Strategy sets out how the Health and Wellbeing Board will work together to promote wellbeing, prevent ill health, and reduce health inequalities across Bournemouth, Christchurch and Poole. The strategy is based on evidence from the Joint Strategic Needs Assessment (JSNA) and shaped by feedback from consultation and engagement activities. **The Strategy focuses on four Strategic Priorities** for improving health and wellbeing across Bournemouth, Christchurch and Poole: • **Healthy Neighbourhoods and Communities** • **Starting Well** • **Mental Wellbeing** • **Living and Ageing Well** For each strategic priority there are a series of proposed actions and a small number of key indicators that will be used to measure progress and impact. The Strategy has been shaped by a public consultation. Responses showed overall support for the priorities, along with helpful feedback on where improvements are needed. This includes making the document clearer, easier to understand and ensuring it reflects the needs of all

		communities, including those who experience poorer health or face barriers to access.
3	**Service Unit**	Public Health and Communities
4	**People & roles involved in the process**	Paul Iggulden, Public Health Consultant Sarah Webb, Public Health Consultant Vicky Edmonds, Service Unit Equality Champion
5	**Relevant meeting date(s)**	21 May 2026
6	**Who are your key stakeholders?**	Key stakeholders include residents, service users, carers, voluntary and community organisations, and statutory partners. Consultation Feedback: 120 responses were received from a range of people and health-based organisations, including: • People with long term health conditions or disabilities • Older residents • Parents and carers • People with mental health needs • Voluntary and community organisations • Health and care professionals Overall, responses showed: • General support for improving mental wellbeing and reducing inequalities • Strong support for early help for children and young people, including SEND support • Recognition of the value of community based and voluntary sector support • Feedback that the Strategy should be clearer and easier to understand Some barriers were also identified, including digital access, transport, cost of living and access to services. These may affect some groups more than others. The open consultation received views from a range of people, but the respondent profile is not fully representative of the local population. Older people, women, White British residents and people with disabilities are overrepresented, while younger people, men and some ethnic groups are underrepresented compared with Census data.
7	**What are the different needs and experiences of these protected groups?** age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation, sex members of the armed forces community, socio-	**Age:** Older people may experience challenges related to mobility, access to (digital) services and transport, and may benefit from more age friendly environments. Younger people may require early intervention, mental health support and opportunities to improve life chances. **Disability:** People with physical or mental health conditions may experience barriers when accessing services, including waiting times, accessibility of buildings and transport, and navigating systems. **Sex:** Some individuals may experience issues related to safety and perceptions of safety within communities. **Race and ethnicity:** People from different ethnic backgrounds may experience inequalities or barriers in accessing services.

	economic status, children in care and care-experienced young people, carers, local businesses, any human rights issues	**Sexual orientation:** LGBTQ+ residents may have specific needs, particularly in relation to inclusion and mental health support. **Pregnancy and maternity:** People who are pregnant or new parents may require support for maternal health, breastfeeding and early years services. **Carers:** Carers may experience pressures related to their caring responsibilities and may require additional support and recognition. **Socio economic status:** People on lower incomes may be disproportionately affected by the cost of living, housing affordability, transport and access to services. **Religion or belief, children in care, care experienced young people, armed forces:** People in these groups may well experience health inequalities as a result of difficulties in accessing services and poorer experiences, leading to adverse health outcomes. .
8	**What are the positive equality impacts from your decision?**	The Strategy is expected to have positive impacts by reducing health inequalities through prevention and early support, improving mental wellbeing, and helping people to live well at all stages of life. It supports access to community-based services, strengthens support for children and young people, and helps older people maintain independence. The focus on partnership working and community engagement supports more inclusive service design and delivery, particularly for protected groups and those facing disadvantage. Overall, the Strategy supports improvement across the six Equality and Human Rights Commission domains. It is expected to contribute to better health outcomes, improved living standards and increased participation by addressing wider factors such as education, employment, housing and community support. Actions to support safer communities and reduce isolation also contribute to personal wellbeing.
9	**What are the negative equality impacts from your decision?**	The purpose of the Strategy is to ensure that everyone has access to services and opportunities that support them to start well, maintain good mental wellbeing, live and age well, and benefit from healthy and safe neighbourhoods and communities. As such, few negative equality impacts are anticipated. However, consultation feedback suggested that the focus on priority neighbourhoods may need to be clearly explained to ensure the approach is well understood, particularly by those living in areas not identified as priority areas. It will be important to ensure that delivery of the Strategy is accessible to all residents and does not rely solely on digital approaches, so that everyone is able to engage. Clear and inclusive communication will also support understanding of the Strategy and help ensure it is accessible and relevant to all communities.
10	**Will colleagues be impacted?**	As the Strategy is predominantly externally focused, limited impacts on staff are anticipated. However, there may be a need for some staff training to support understanding of equality, inclusion and accessibility in delivery.
11	**How are you going to mitigate against the**	To help minimise any potential negative impacts, delivery partners will be encouraged to take the following actions:

	negative impacts identified?	• Provide a clear, plain English and accessible Strategy • Use clear messaging and inclusive communication • Offer non digital ways to access information and services • Monitor the impact on different groups, including those within and outside priority areas • Strengthen links with voluntary and community organisations • Encourage partners to consider transport, affordability and accessibility in delivery • Continue to engage with and directly seek views from groups whose views are less often heard • Continue to provide training on cultural awareness and unconscious bias that recognises protected groups and the needs of local residents.
12	**How will you monitor the impacts, both positive and negative?**	The impact of the Strategy will be monitored through: • Ongoing oversight by the Health and Wellbeing Board • Monitoring of health inequalities and key outcomes • Feedback from people using services • Public reporting of performance indicators linked to the strategy
13	**Summary of Equality Implications**	The Health and Wellbeing Strategy is expected to have a positive impact on equality by improving health outcomes and reducing inequalities across Bournemouth, Christchurch and Poole. It supports prevention, mental wellbeing and inclusive, community-based services. Consultation findings show strong support for the priorities, alongside helpful feedback on improving accessibility, communication and delivery. The feedback also highlights that some groups may experience barriers related to digital access, transport and the cost of living. There is also the potential for outcomes to vary if delivery of the Strategy is not clear and inclusive Actions are in place to improve accessibility, strengthen engagement and ensure services are shaped with communities. With these in place, and ongoing monitoring, the overall impact on equality is expected to be positive.

Version	Date	Description of Changes / Updates
1.0	22/05/2026	First draft completed after discussion on 21/05/2026.
2.0	11/06/2026	Second draft following review by Public Health colleagues

BCP Health and Wellbeing Board - Work Plan

Updated: 15 March 2026

	Subject and background	Anticipated benefits and value to be added by HWB engagement	How will the scrutiny be done?	Lead Officer	Report Information
29 June 2026					
	Health and Wellbeing Strategy		Committee Report	Rob Carroll, Director of Public Health	Added in consultation with the Chair
	Draft Suicide Prevention Action Plan		Committee Report	Paul Iggulden, Consultant in Public Health	Added in consultation with the Chair
	CQC Assurance Outcome		Verbal Update	Laura Ambler (move to end of the agenda or AOB as outcome not yet known)	Added at meeting on 9 March 2026
	Neighbourhood Health Plan & Programme		Committee Report	Becky Whale & Mark Harris, NHS Dorset ICB	Added at meeting on 9 March 2026
	Better Care Fund 2026-27 Planning Documents and Narratives		Committee Report	Scott Saffin, Commissioning Manager – Better	Standing Agenda Item

	Subject and background	Anticipated benefits and value to be added by HWB engagement	How will the scrutiny be done?	Lead Officer	Report Information
	Q4			Care Fund and Market Management	
12 October 2026					
	Gambling Harms Needs Assessment				Deferred from June agenda
	Neighbourhood Health Plan Framework & Footprints				Added in consultation with the Chair
	Integrated Neighbourhood Team update				Added in consultation with the Chair
	Creative Health Strategy				Added in consultation with the Chair
11 January 2027					

	Subject and background	Anticipated benefits and value to be added by HWB engagement	How will the scrutiny be done?	Lead Officer	Report Information
5 April 2027					

Future items to be allocated to meeting dates				
Changes to hospitals, role of hospitals and responding to the needs of Communities	To consider the changes going on in local hospitals to include significant changes in mental health provision.		TBC – highlighted by Richard Renaut	Consider whether update to Board or possible Council wide briefing?
Fuel Poverty due to withdrawal of allowance	To monitor this issue	Committee Report	TBC	Suggested by SC Update – date tbc
Update from the Urgent Emergency Care Board	To receive an update	Committee report	TBC	Requested at meeting on 13/1/25
Neighbourhood Health Plan	To receive an update	Committee Report	TBC	Added at the Board meeting on 12 January 2026

Dates for the 2026/27 Municipal Year

- 29 June 2026 at 2pm
- 12 October 2026 at 2pm
- 11 January 2027 at 2pm
- 5 April 2027 at 2pm