Department of Health & Social Care

NHS England

Policy paper

Neighbourhood health framework

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Applies to England

Contents

This publication is available at https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework

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.

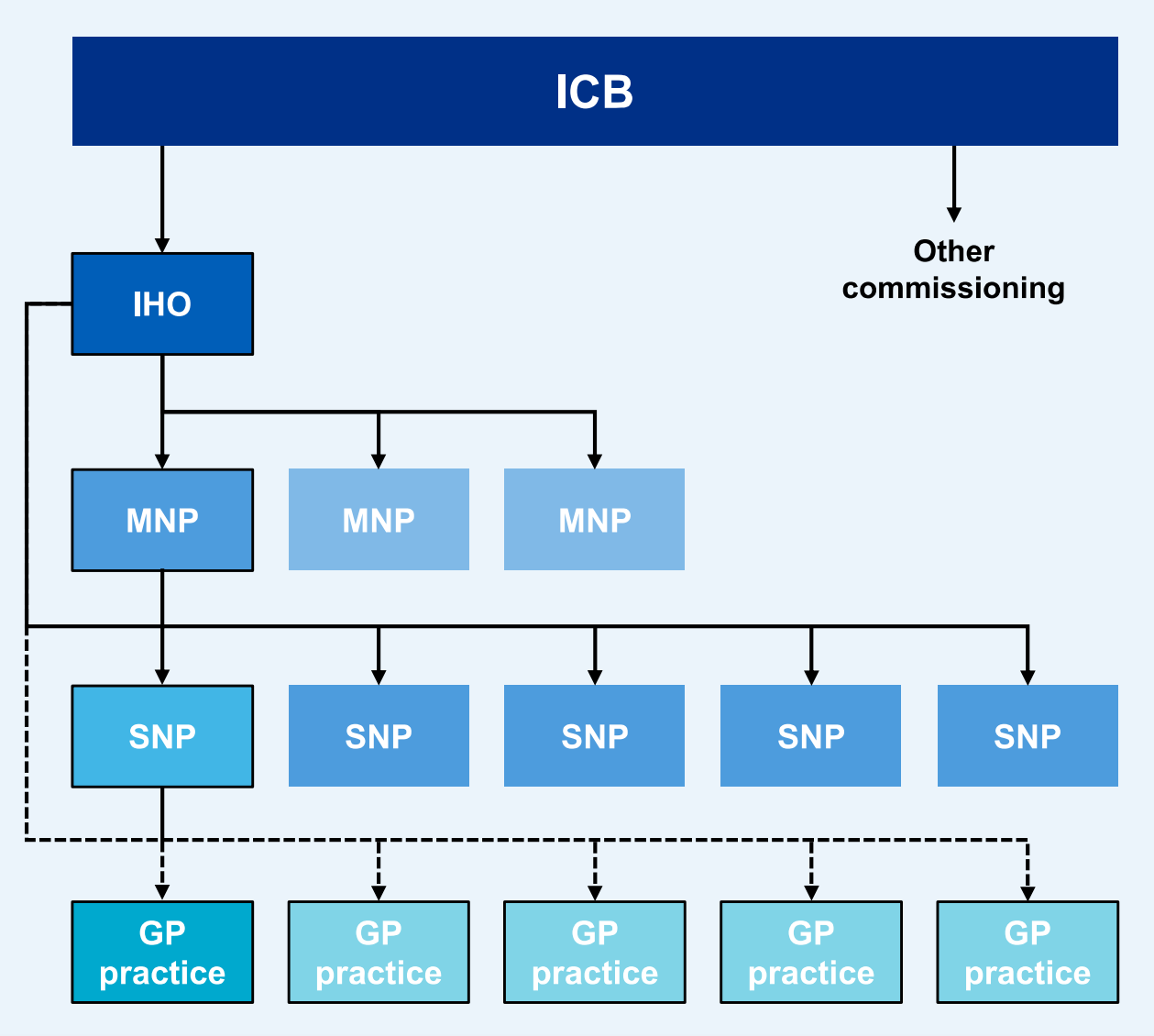
Figure 1 below demonstrates how these population-based contracts could fit together in a system where all 3 contractual mechanisms are in use - though many systems will have different arrangements where IHOs are not constituted.

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



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.