Neighbourhood Health

Health & Adult Social Care Scrutiny Committee

22nd September 2026

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
- 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
- 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

Neighbourhood Health Framework: Core Principles

- Integrating services so that they are organised around people's lives
- Improving long-term outcomes for people through a focus on prevention, relying less on expensive crisis management
- Devolving 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

Neighbourhood Health Framework *(DHSC, 2026)*

Neighbourhood health framework - GOV.UK

Neighbourhood Health Framework: Stage One (2026 – 2027)

- Under the guidance of the Health & Wellbeing Board:
  - Agree neighbourhood footprints around natural communities for the future development of Integrated Neighbourhood Teams
  - Agree plans to establish Integrated Neighbourhood Teams focused on high-priority cohorts, including how devolving care budgets could work in their area
  - Work towards developing and agreeing a locally owned neighbourhood health plan for implementation from 2027 onwards

Neighbourhood Footprints

- Currently co-terminus with Primary Care Networks (PCNs) - agreed as a starting point for work to commence
- Collaborative work to re-visit & test effectiveness and resonance to criteria set out within the national framework
- Using as opportunity to explore all potential options:
  - Existing working arrangement framed around PCNs
  - Grouping local authority wards into neighbourhoods
  - Combining a blend of elements of the two preceding points
- Reviewing current arrangements to inform recommendation to Health & Wellbeing Board

Neighbourhood Footprints
Diagnostic toolkit for assessing options

- Puts the community at its heart – consists of recognisable, ‘natural’ communities
- Contained within a single place boundary (BCP Local Authority)
- Uses GP practices as a building block
- Avoids fragmented or disconnected geographies
- Balances practical delivery with community identity enabling the neighbourhood team to have a deeper understanding of their local population
- Fosters equitable resource allocation based on population need
- Reduces overlaps that confuse residents and professionals (recognising no solution will be perfect and cross boundary access will always occur)

Neighbourhood Footprints
Diagnostic toolkit for assessing options

- Other factors set out within the national framework to be considered as part of the options appraisal focus on:
- Inclusion of a range of services and statutory, non-statutory and community assets for people living in those communities
- What works best for the local place, 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
- Balancing population size and level of need to ensure health inequalities are not concealed within larger geographical areas (30,000 – 60,000 population)

Our Dorset

Neighbourhood Health & Wellbeing Programme Update

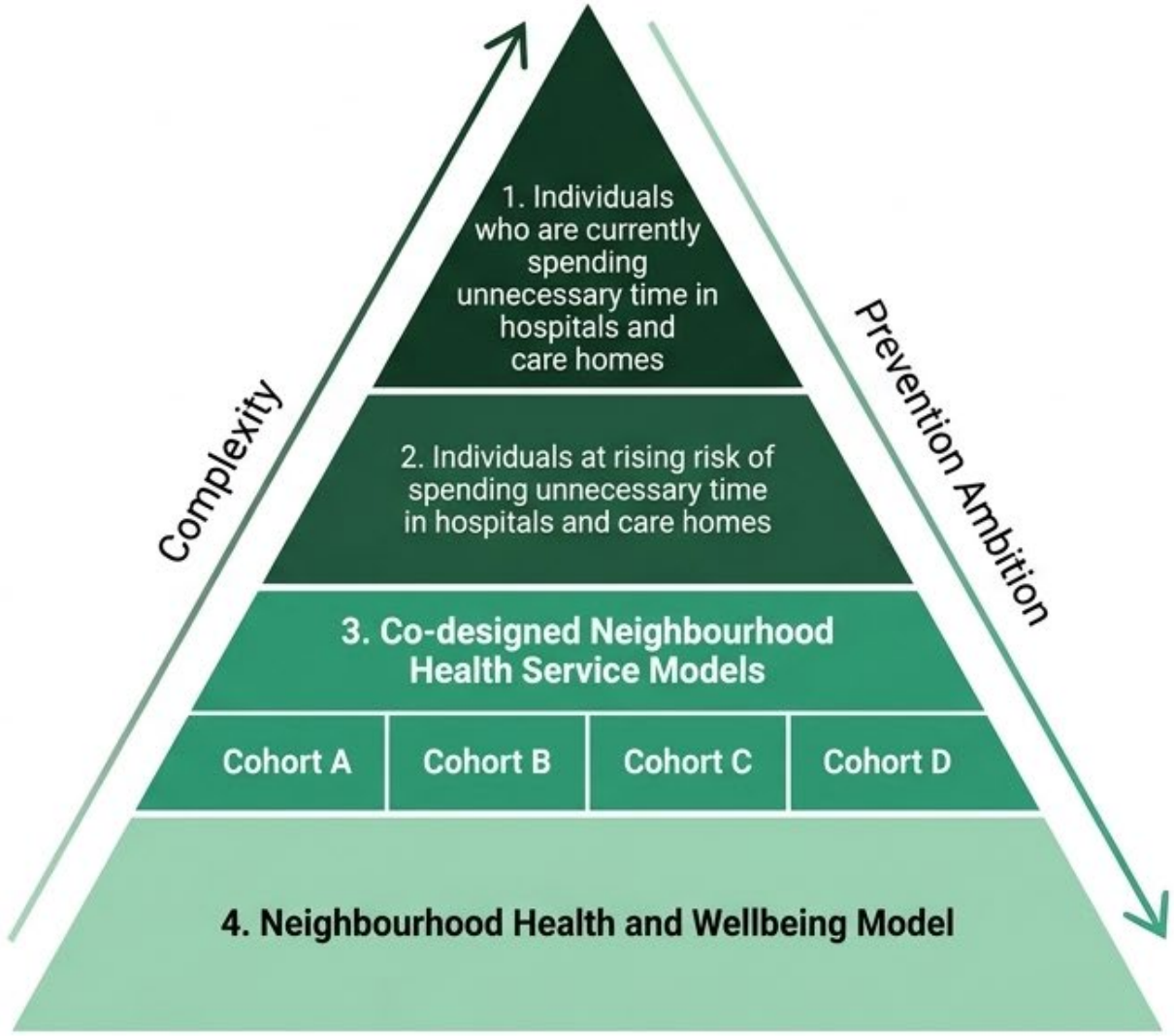
Dorset Neighbourhood vision

‘Working together to create healthier, thriving communities, with care and support where you live, when you need it.’

Ambition is for a Neighbourhood Health Service that...

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

Programme links the logic model and population health improvement



Neighbourhood Programme: evolution to date

Building from local neighbourhood work and targeted cohort programmes towards a sustainable model for Integrated Neighbourhood Teams (INTs)

BUILD THE TEAM

Local foundations

- Triumvirate leadership across LA, PC and community
- Local initiatives established and developed
- Building relationships and foundations for neighbourhood working

HIMSU

High users of services

- Focused work with cohorts identified as high users of multiple services
- Understand the needs and experience of people with high service use
- Develop and test local interventions to better coordinate support

NNHIP

Targeted cohort focus

- Dorset focus on high / very high frailty markers and high / very high risk of falls
- All 18 INTs signed up to the national programme
- Focus on care planning and TEPs, polypharmacy, care co-ordination and local cohort interventions

OPERATING MODEL

Developing the future way of working

- Build on learning from local and national programme activity
- Develop the practical model for how INTs organise and work together
- Continue to test, learn and evolve a sustainable neighbourhood approach

The work is evolving from local foundations and targeted cohort learning → test and learn → a practical, sustainable neighbourhood operating model.

Translating theoretical integration into tangible, on-the-ground reality

A range of practical activity is already underway across INTs, with different approaches emerging to reflect local need and priorities.

BUILDING THE TEAM

Building relationships, connections and the foundations for integrated working.

Shared Culture

- Lunch & Learns
- Service directories
- Work shadowing, joint training & skill sharing

Structural Alignment

- Co-location opportunities
- Integrated nursing team pilots
- Insulin SOP & Continuing Health Checks

INTEGRATING CARE AROUND PEOPLE

Developing and testing practical ways of working around individuals and cohorts.

Specialised Clinics

- Group clinics – leg clubs & diabetes
- Multi-disciplinary Falls Clinics
- Carousel Clinics / Jurassic Hub

Targeted Pathways

- CYP MDTs
- AHPs at the Social Care front door
- Community cancer & peri-operative pathways
- High Intensity Service Users

LEARNING & IMPACT

Building the evidence to understand what is changing and what makes a difference.

Quantitative Evaluation

- Intervention & Cohort identification
- Performance measures development
- Impact and evaluation frameworks

Qualitative Impact

- Impact reporting through Stories of Difference

BUILD → TEST → LEARN → EVOLVE

Co-production - at the heart of the work

Our Dorset

Recognising People as Assets
Valuing lived experience. Facilitating individuals and teams to uncover their inherent strengths and contributions.

Building on Existing Capabilities
Acknowledging and leveraging the diverse, pre-existing skills and capabilities within our communities.

Mutuality & Reciprocity
Enabling participation on equal terms. Prioritising creative, active listening and shared benefit.

Peer Support Networks
Fostering shared humanity. Deliberately dismantling 'them and us' dynamics to build an 'all of us' culture.

Breaking Down Barriers
Creating psychological safety. Validating real-world experiences, acknowledging struggles, and tackling inequalities head-on.

Facilitating Rather Than Delivering
Valuing all forms of expertise. Creating safe, collaborative spaces to explore solutions, rather than dictating them.

Our Dorset

Targeted Cohort Update

Summary recap

Cohort identified	Cohort Size (01/02/26)	INT Cohort Sizes
• Frailty – High / Very High • Falls – High / Very High Risk • Not Palliative	• Total – 2350 • Dorset – 1193 • BCP – 1337	• Average – 141 • Largest – 265 (Shore Medical) • Smallest – 57 (Blanford)

Cohort Approach & Infrastructure

Cohort proposal and reporting framework developed to support oversight and consistency across INTs.
Programme "ask" shared and discussed with teams.
SNOMED coding approach established to support tracking, reporting, and outcome measurement.

INT Engagement & Mobilisation

All INTs signed up to the NNHIP cohort work.
Initial queries regarding PCNs signing up on behalf of INTs are being clarified.
INT Leadership Meetings are shaping the delivery approach, funding allocation, and operational impact on teams.

Emerging Delivery Model

Programme remains in the early stages of development, responding directly to cohort requirements and neighbourhood priorities.
Existing initiatives are already supporting the fourth INT "ask" through:

- Increased integrated working
- Identification of quick wins for the frailty cohort
- Strengthening neighbourhood prevention and proactive care

Examples of emerging local initiatives that align to cohort

- Jurassic Ageing Well Hub
- Frailty & Falls Networking Events
  Bringing together Health, Social Care, and VCSE partners
- Improving insulin management within care homes
- Joint Frailty MDT approaches
- FaME delivery models (both in-person and remote)

Treatment Escalation Plan (TEP)

- Multi-organisation meeting completed with agreement reached to progress towards a single TEP approach across organisations.
- Agreement to adopt the DorsTEP model, adapted from the Somerset TEP framework.

Mapping Our Path to a Single, Unified DorsTEP

Action Required: System Mapping Baseline

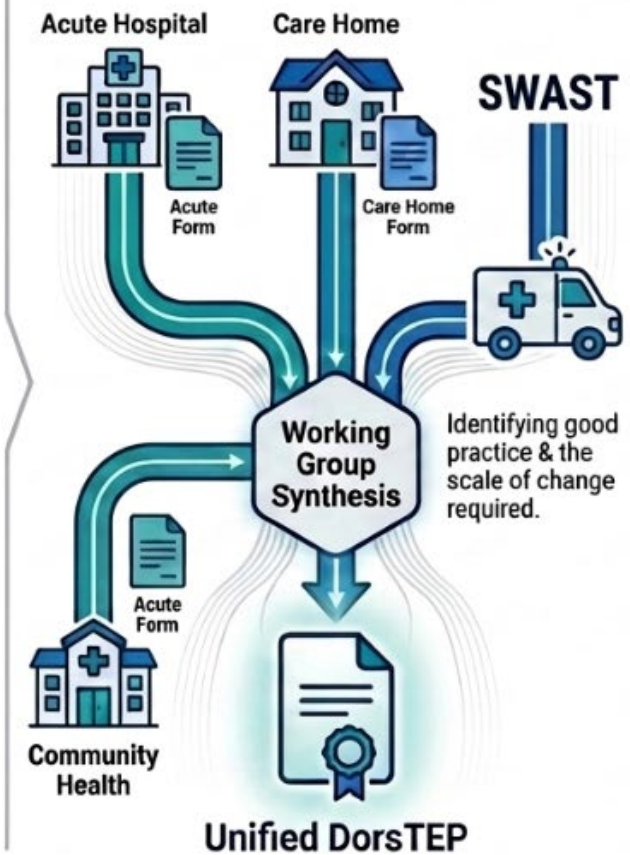
Complete the attached framework to capture how local TEPs are currently:

- Developed & Recorded
- Shared across teams
- Reviewed over time
- Co-designed with individuals and families

Shared Agreement for Single TEP in Dorset

- Agreed at multi-organisational meeting in March.
- Commitment to a single DorsTEP.
- Framework agreed, developed from the Somerset version.

The Convergence Engine



Enabling the Future System

Your mapping data directly shapes three critical transition workstreams:

Education & Communications
Designing targeted training to support a safe, phased rollout across all clinical settings.

Digital Transition
Architecting the technical infrastructure for a single system-wide digital format.

Partner Accessibility
Ensuring instant, single-source-of-truth access for critical frontline partners, specifically SWAST paramedics and Care Home managers, to enable highly coordinated care.

Current Focus

- Mapping current organisational processes and approaches
- Developing a detailed implementation and transition plan to support safe, joined-up delivery across the system

Care Planning

Embedding DorsTEP into the Dorset Care Plan Model

Visibility & System Coordination

Emergency Department (ED)

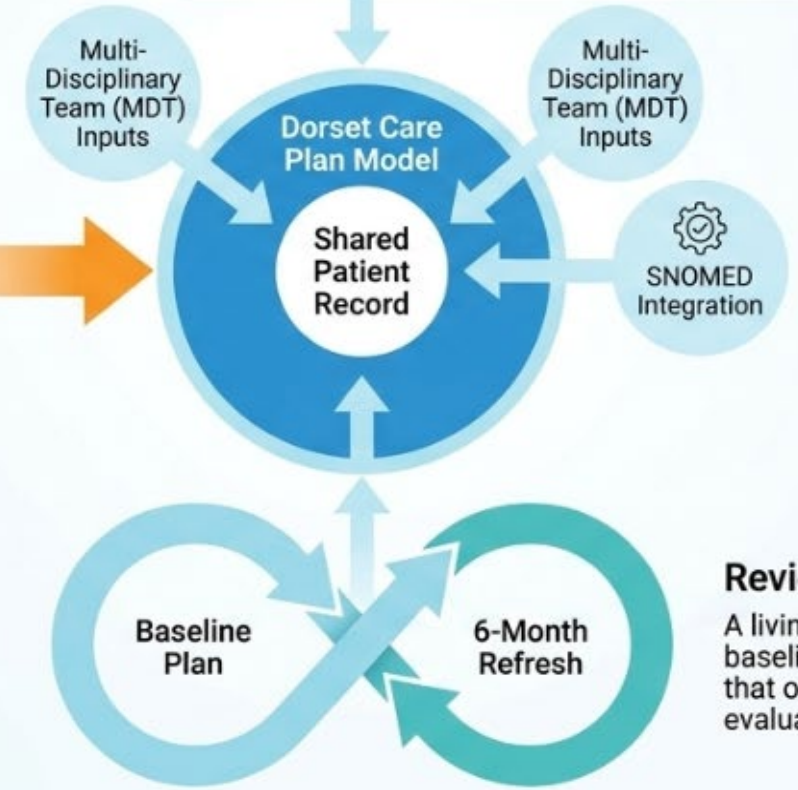
Active system alerts improve critical visibility in acute settings, ensuring care preferences are immediately known and coordinated across boundaries.

Transformation Matrix

Proposed Approach

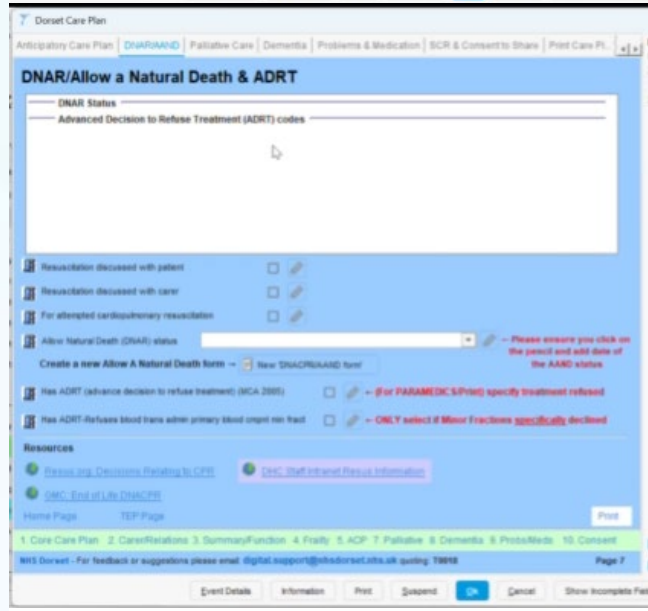
DorsTEP
(Treatment Escalation Plan)

DorsTEP is now embedded into the routine Dorset Care Plan, supporting holistic, personalized care conversations and continuous MDT updates.



Review Process

A living document approach. Structured baseline and 6-month reviews guarantee that out-of-date plans are caught, evaluated, and refreshed.



Medicines Management

Acute Interface

Current Focus: Collaborating with University Hospitals Dorset (UHD) regarding the insulin framework on patient discharge.

Next Action: Follow up with UHD leadership to agree, align, and sign off on a cohesive transition plan.

System Partnership

Current Focus: Expanding systemic alignment and shared protocols with Dorset County.

Next Action: Coordinate a strategic meeting with Dorset County stakeholders to explore and co-design a unified, system-wide approach.

Clinical Governance

Accountability: Led by Rav Ramtohal and Adam Nicholls.

Current Focus: Comprehensive review of high-risk medications across the care continuum.

Next Action: Agree on a standardised clinical approach and disseminate clear, actionable guidance protocols directly to all INTs.

Population Health & Data

Current Focus: Mapping Type 2 Diabetes (T2D) insulin prescriptions within local neighbourhoods.

Next Action: Interrogate prescribing data to isolate T2D individuals currently on insulin. Contact INTs directly to trigger targeted community reviews and proactive follow-up.

Using Data and DiiS to track and shape developments

Translating operational momentum into targeted acute pressure relief and preventative clinical outcomes

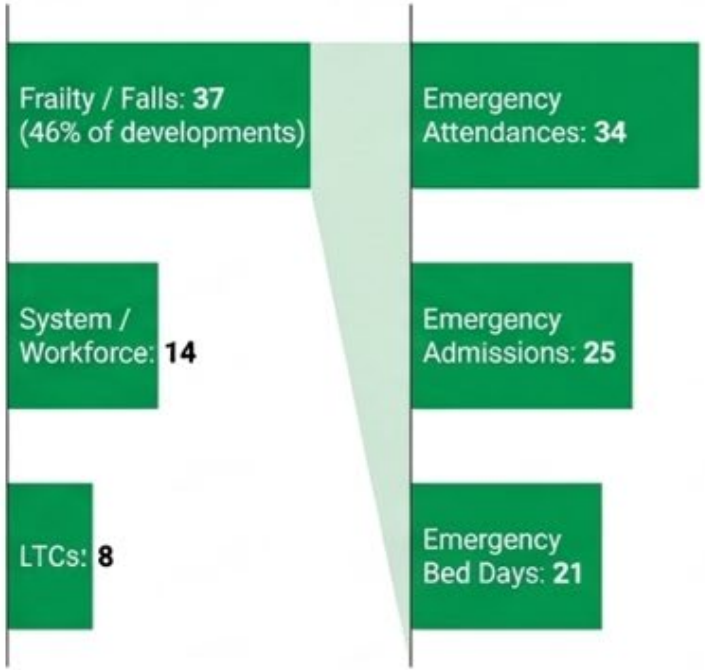
Overall Programme Delivery Status

Momentum Ring

Total Initiatives: **80**
In Progress: **52 (65%)**
In Scoping / Feasibility: **20 (25%)**
Completed: **7**
Paused: **1**

Strong operational momentum with 90% of planned initiatives either delivered or actively underway across BCP INTs.

Strategic Focus & Alignment



INT activity is tightly aligned with urgent system pressures, prioritising frail elderly populations to prevent avoidable hospital admissions and acute care dependency.

NNHIP Frailty Cohort Metrics

BCP Cohort Size: 1,136 individuals
(Frailty / Falls / Not Palliative)

53.8%
▲ +3.4% increase Feb to Aug
System Care Plan Coverage (12 Months)

37.9%
▲ +6.7% increase Feb to Aug
System Structured Medication Reviews (SMR)

Example INT Data capture

Bournemouth East	**80%** Care Plans (+17% gain)	**70%** SMR (+28% gain)
Poole Central	**42%** Care Plans (+3.9% gain)	**30%** SMR (-0.6% drop)

System-wide clinical proactive care is steadily accelerating. Leading neighbourhood teams demonstrate significant, rapid gains in preventative care planning, setting the benchmark for system-wide scaling.

Our Dorset

Next Steps

Developing how the Neighbourhood Core Team will work

The Integrated Neighbourhood Team Framework

Model Architecture

- **Core Team = Day-to-Day Delivery:** The anchoring operational group with unified leadership and clear accountability for a defined neighbourhood population.
- **Petals = Extended Partnership:** A dynamic, structures network of specialise and community working with the the core.
- **Physical Integration:** Opportunities for teams operate from a common base where possible, anchored around a localised Neighbourhood Health Centre.

Operational Enablers

- **'No Wrong Door' Access:** A population-based approach ensuring seamless entry into the care ecosystem regardless of the initial touchpoint.
- **Multidisciplinary 'Team of Teams':** Delivering whole-person care that simultaneously addresses physical, mental, and social needs with support from acute specialists.
- **Shared Digital Infrastructure:** Operating from a single, shared record to eliminate the need for internal referrals between neighbourhood partners.

Developing
How the Neighbourhood Core Team will work

The neighbourhood core team is accountable for the whole neighbourhood population

The **intensity** of their responsibility will depend on the patients need as defined by their tier

Tiers	% of pop.	Level of need	Prioritised type of care
Tier 1	**1%**	**Very high need** Multiple Long-Term Conditions, Frailty, High Intensity Users, Social Vulnerability	**Proactive**
Tier 2	**2%**	**High need** Significant Long Term Condition burden or non-medical risks, not yet as complex as Tier 2 but with clear risk of escalation	**Proactive**
Tier 3	**17%**	**Moderate need** Stable and may have Long Term Conditions but rising risks, who can benefit from early interventions	**Early Intervention**
Tier 4	**80%**	**Low need** Minimal clinical complexity and low risk of deterioration	**Prevention**

Next steps

Continuing delivery while developing and testing the future neighbourhood model

SEP → DEC

01 **CONTINUE**

INT initiative development & implementation

- Progress existing local initiatives and interventions
- Continue to share learning, opportunities and emerging practice

02 **FOCUS**

NNHIP cohort development

- Continue the cohort focus
- Discuss and develop Tier focus work, intervention ideas and opportunities

03 **DEVELOP**

Operating Model

- Workshops from September–December
- Develop the practical blueprint, opportunities and frameworks
- Test, learn and evolve the future way of working

Across all three areas: share ideas • identify opportunities • test what works • build on learning

Our Dorset

Stories of Difference

Poole Central INT Care Home MDT

Theme: *Frailty and Falls*

Neighbourhood Health & Wellbeing Programme

Overview

The problem

A cohort of 174 patients was identified including individuals with:

- *High or Very High Frailty*
- *High or Very High Falls Risk*
- *No palliative care marker*

It was recognised 41 of the cohort are Care Home Residents and Falls are the primary driver of admissions.

SMART goal

Specific – Create a collaborative approach to support improved management of Care Home Residents in Poole Central INT

Measurable – Consistent use and number of Dorset Care Plans (DCP) and TEPS completed

Achievable – DCP and TEP in place for all people with an identified care need.

Realistic – Engage individuals to understand what they need from their care.

Time Limited – 6 months to embed processes

Approach

Plan - Poole Central PCN took the lead on the review of the Care Home patients identified within the cohort as they are the usual care provider in this environment

Do - Monthly **Care Home MDT meetings**

- All admissions and deaths reviewed
- Use of Dorset Care Plans (DCP) and TEPs

- Inclusion of:
  - Pharmacists (polypharmacy review)
  - Care coordinators

Study - *Ongoing monitoring of the use of documentation and ensuring it is up-to-date*

Act - Improved documentation and proactive care planning. Include other partners in the MDT as appropriate

Result

Early Impact: Benefits are emerging, with further impact expected as the approach becomes embedded.

Key Benefits:

- Reduced unnecessary conveyances and admissions.
- Increased patient involvement in decisions about their care.
- Improved staff confidence and collaboration.
- Care delivered more consistently in line with patient wishes.

Early Impact:

One early example involved completion of a TEP for an individual whose previous hospital admission had not aligned with their wishes.

When they later became unwell, the agreed plan enabled care to be delivered in line with their preferences, avoiding an unnecessary hospital admission and supporting the individual, their family along with the services and staff involved in the care.

- Improved individual experience
- Avoided inappropriate conveyance
- Avoided unplanned admission
- Improved confidence for service to follow plan

Learnings

We have been working on integrating teams and reviewing the allocated patient cohorts for a while and it has been challenging. Bringing together a focussed MDT to improve collaboration and learning for the benefit of patients has been a genuine step forward.

Personalised engagement means a better experience for individuals and their families. The teams can follow TEP and adhere to the patients' wishes .

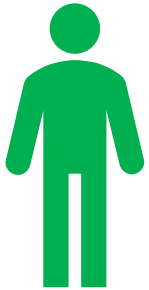
We also noted the following trends:

- *Loneliness and low mood is prevalent in Care Homes, often with high levels of associated medication.*
- *A Care Home had no admissions resulting from Falls and it was identified they have exercise classes.*

We plan to explore these links further.

Individual: Reducing High Intensity Use through co-ordinated care.

Key Themes: HIU / Co- Production / Collaboration / Reduced Ambulance Call Outs / Care Co-Ordination / MDT working



- 59 year old Male
- Multiple Long Term Conditions
- Poole Bay and Bournemouth INT.
- Diabetes, Visual Impairment, Mental Health concerns.
- Hand tremors.
- Unable to manage own Insulin leading to frequent ambulance call outs.
- High Intensity User.

High Intensity User MDT identified numerous services involved with this individual all working independently with no shared care

- A targeted extended appointment arranged.
- Identification of needs and barriers understood enabling Primary Care to proactively co-ordinate care across the system. Including diabetes specialist nurses, district nursing, ophthalmology and neurology.
- HIU status identified to all partners

- As a result of this co-ordinated and patient centred approach trust was regained between patient and system.
- Ambulance call outs reduced (0 calls between 18/2 and 11/3 from several times per week.
- Patient reported as feeling supported for the first time and no longer felt a burden to the system

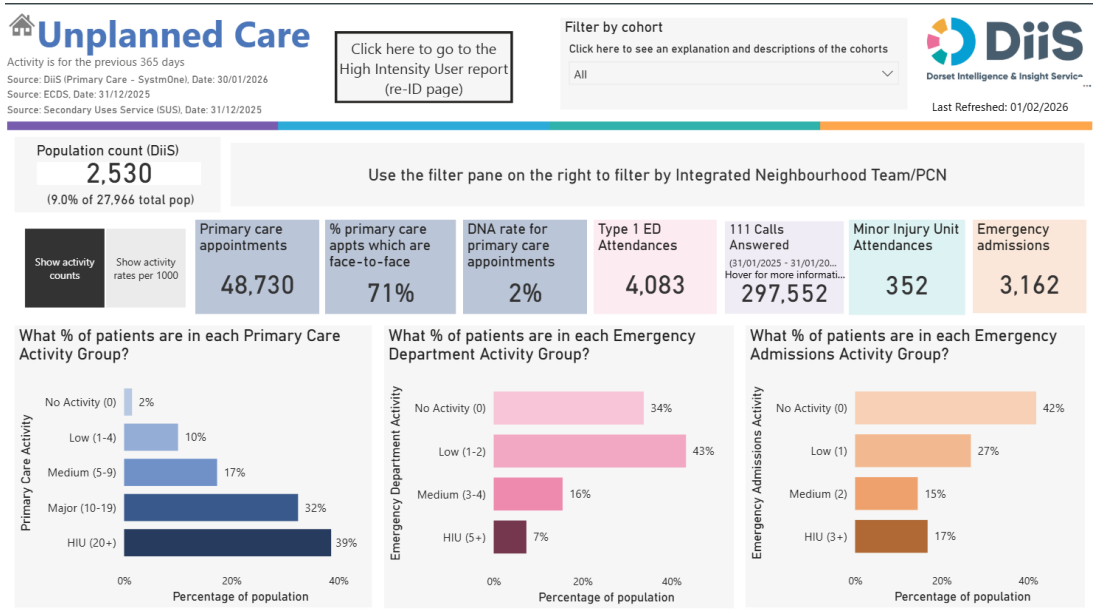
System: Identifying the NNHIP Cohort

Key Themes: NNHIP / Frailty / Falls / System wide

1: There has been a requirement to identify a cohort for the NNHIP programme. The challenge was to identify a cohort that would enable work to be developed across the system which aligned with the Dorset Neighbourhood programme as well as supported opportunities to develop interventions for the NNHIP programme.

2: A process of cohort identification utilising the cohort selection and unplanned care elements of DiiS enabled the programme to explore a number of different cohorts landing on a cohort that has the identifiers:
High / Very High Frailty
High / Very High Falls Risk
Not Palliative

3: The cohort was agreed upon due to the high levels of unplanned care and opportunities for interventions to be developed and tested that can make specific and lasting change.



4: All INTs were given the opportunity to sign up to delivering specific interventions with this cohort. Specific interventions are:

- Co-produced care plans for each individual in the cohort using the Dorset Care Plan (DCP) and the Treatment Escalation Plan (TEP).
- Medication Review with a focus on deprescribing
- Care co-ordination opportunities with a focus on working with wider partners
- Identification and delivery of opportunities for INT development

5: The programme agreed to fund each INT £150 per person in their cohort to support delivery and INT development

6: As well as the NNHIP evaluation the programme has a local recording, reporting and evaluation programme identified.

7: All INTs have signed up to work with this cohort.

Learning:

- The process has enabled a better understand of how we can cohort and the learning is being disseminated to INTs to support them in cohorting for smaller pieces of work. This includes illness specific cohorting and population health based cohorting.
- The process has galvanised shared thinking across INTs and development of common approaches across INTs
- Increased opportunities for evaluation and impact reporting have been identified.
- Development work to understand how we develop and used tools to support 'hypothesis' building which describes the outcomes we expect to achieve. (work in progress)
- Development work to understand how we use INT modelling to describe counterfactuals / comparator INTs for future interventions (work in progress)