Towards a Model Neighbourhood: Next Steps on Implementing Neighbourhood Health

Published by PPL in partnership with the NHS Alliance (April 2026)

A Summary for LMCs

Overview

This document provides practical guidance for developing neighbourhood-based health and care services across England. It draws on learning from a range of health systems and organisations and sets out a framework for organising services around local populations rather than individual institutions.

PPL is a social enterprise and B Corporation that "works in partnership with the NHS, the wider health sector, local and central government, civil society, and communities to support lasting, positive change". The NHS Alliance is the independent membership body formed through the merger of NHS Confederation and NHS Providers.

The guidance is not prescriptive. It recognises that "neighbourhoods and communities are as diverse as the individuals who live and work in them: any one-size-fits-all solution will fail." Instead, it offers recommendations, responds to frequently asked questions, and shares examples of where the model is already working well.

The central aim is to deliver coordinated, proactive, person-centred care in community settings, while reducing fragmentation between services.

Neighbourhood health is positioned as a core element of wider NHS and social care reform, reflecting three major shifts in service delivery:

- From hospital to community-based care
- From treatment to prevention
- From analogue to digital

To succeed, these shifts must happen at scale and pace, supported by a whole-person, whole-needs, whole-system approach. The ability of neighbourhood models to adapt to local populations, services, geography, and social infrastructure will be a key measure of success.

Why this Matters

The document starts from the premise that, in most areas, health and care services remain too fragmented, reactive, and shaped by organisational boundaries and historic ways of working that no longer meet current needs.

Key challenges include:

- Inconsistent access to and experience of care
- Delays in care leading to avoidable harm
- Duplication of effort and gaps in provision
- Poor coordination between services
- Persistent and widening health and socio-economic inequalities
- Resources focused on symptoms rather than causes
- A lack of parity of esteem within and across services

Reducing health inequalities is identified as both a moral imperative and a practical necessity. It is central to the neighbourhood health model and critical for improving population health and long-term system sustainability. Inequalities are not treated as secondary issues, but as a primary focus for action.

The document also emphasises that these challenges cannot be addressed simply through increased funding or activity. Meaningful change requires the active engagement of staff, patients, carers, and communities. Sustainable transformation depends not only on improving access and productivity, but on reshaping the need for those services.

When implemented effectively, neighbourhood health can create a virtuous cycle: supporting people to stay well and independent, improving life outcomes, and reducing pressure on services. It also has the potential to enhance economic productivity and make frontline roles more rewarding by enabling staff to focus on what matters most.

Neighbourhood Care

A neighbourhood is defined as a clearly identified local population served by a coordinated network of health, care, and community services. This reflects the understanding that health outcomes are strongly influenced by wider social and economic factors such as housing, employment, and community support.

In a neighbourhood model, services operate as a system rather than in isolation.

Typical characteristics include:

- A defined local population
- A group of services responsible for that population
- Shared leadership and accountability
- Integrated ways of working
- A strong focus on community needs

The aim is to ensure care is:

- Easy to access through clear pathways
- Joined-up and centred around individuals
- Delivered early to prevent escalation
- Provided close to home where possible
- Focused on prevention as well as treatment, with continuity across different stages of life
- Holistic, bringing together multiple services

As the document notes:
"Neighbourhood health can feel very different to the service that people receive right now, but it is arguably not very different from what people expect."

Success is best understood through the lived experience of residents.

The Three Key Components

Neighbourhood care is built on three overlapping approaches: preventative, proactive, and reactive care. These are not separate services but interconnected ways of working within a single system.

Preventative Care

Focuses on reducing the likelihood of illness and improving overall health.

Examples include:

- Vaccination programmes
- Health promotion and lifestyle support
- Screening programmes
- Support for housing, employment, and social needs
- Community wellbeing initiatives

This approach recognises that many health issues are shaped by social and environmental factors.

In a model neighbourhood:

- Shared data is used to identify priority groups and needs driving poor health outcomes
- Partners align around shared goals linked to this data
- Community-based interventions address local needs
- Progress is tracked and support refined over time

Proactive Care

Focuses on identifying and supporting those at risk of poor health.

Activities include:

- Identifying high-risk individuals
- Developing care plans for patients with complex needs
- Supporting patients with long-term conditions
- Providing early intervention
- Coordinating care through multidisciplinary teams

The aim is to prevent crises and reduce avoidable hospital admissions. Success is measured through improved patient experience, reduced admissions, longer independent living, and better long-term condition outcomes.

Reactive Care

Remains essential but is delivered differently.

The system is expected to:

- Manage more acute care in community settings
- Avoid unnecessary hospital admissions
- Support earlier discharge from hospital
- Provide follow-up care locally or at home

Hospitals remain crucial but are no longer the default setting for care. Success is measured through reduced A&E attendance, improved GP capacity to focus on the patients who need them the most, faster access to appropriate care, better patient experience, and reduced costs to the NHS and social care.

The Neighbourhood Operating Model

The model is built on five core components:

1. Core Design Principles

- Population-led: organised around needs and assets of communities
- Prevention-first: prioritising early intervention and long-term outcomes
- Partnership by default: with shared ownership across organisations and sectors
- Subsidiarity: decisions made as close to communities as possible
- Outcomes-focused: success measured by impact, not activity
- A "team of teams" approach: bringing together people from across systems. Staff retain their professional or community identities but are aligned to and supported by neighbourhood based "teams of teams".
- Value for money through better use of existing resources (pooling and better deploying the information, data, professionals, volunteers, financial resources, infrastructure that we have, and investing in a targeted way)
- Building from existing local strengths (understanding the assets and best-practice which already exist locally).

The focus is on improving outcomes and experience rather than protecting organisational boundaries.

2. Clearly Defined Geography

Neighbourhoods should:

- Be geographically contiguous
- Make sense to communities
- Be large enough to deliver services cost effectively
- Typically serve ~50,000 people (as a guide)

They may require alignment with local authority boundaries. Neighbourhoods combine to form "places" (250,000–500,000 population).

3. Consistent Core Offer of Services

Neighbourhoods are expected to provide a consistent range of services and support across a defined geography or coordination of those services will become next to impossible.

Each neighbourhood should include:

- General practice
- Community health services
- Mental health services
- Social care
- Public health
- Voluntary and community sector support

4. Consistent Core Offer of Coordination

Coordination is a core service, not just an administrative task.

It requires:

- Proactive identification of need
- Care navigation
- Shared care planning
- Information and data sharing in planning and delivery
- Multidisciplinary working (with GPs central)

- Managing transitions between services
- Evolving responses based on needs and learning

This demands a move from command-and-control leadership to trust and empowerment, with system leaders working together to show consistency and commitment in changing historic ways of working and behaviours at all levels.

5. Enabling Infrastructure

Includes:

- Interoperable digital systems for information sharing
- A skilled workforce with capacity
- Suitable estates (supporting co-location). Options include hub and spoke models, repurposed and new purpose-built facilities (which may be funded privately)
- Clear governance arrangements
- Strong data and analytics capability from the outset
- Digital inclusion and non-digital access for those who need it

Without this, the model is unlikely to succeed. A warning is given to learn from the lessons of polyclinics, where services are located in the same building, but no work is undertaken to facilitate teamworking between the services.

Delivering Neighbourhood Health

"The journey to a whole-population, whole-needs, whole-system model will take time and will look different in different places, depending on existing services, partnerships and population needs."

A new ecosystem, is conceptualised as:

- ***Neighbourhood***: where relationships, services and outcomes are delivered

- ***Place***: where the overall model, priorities and progress are developed

- ***System***: where overall strategy, resource allocation, and assurance take place, supported by a neighbourhood contracting architecture

- ***Regional / National***: providing policy, standards, enabling infrastructure and support

Strategic Planning and Commissioning

Integrated Care Systems (ICSs) are expected to:

- Plan for defined populations
- Align resources with local needs
- Commission integrated services
- Monitor performance and outcomes

ICBs will focus on system leadership for population health, setting evidence based and long-term population heath strategy and working as healthcare payers to deliver this, maximising the value that can be created from available resources.

ICBs will increasingly commission for outcomes rather than activity; pooling funding, resources and assets where appropriate.

Success depends on stronger strategic leadership alongside greater delegation to place, providers and partners to design and deliver future models of care.

Funding and Contracts

There is a strong financial case for neighbourhood health, including economic benefits such as keeping people in employment or supporting their return to work after periods of ill health. Community-based care is often more cost-effective than hospital delivery.

Financial models should support collaboration rather than competition, with the aim of removing barriers to joint working.

This may involve:

- Shared budgets across organisations
- Integrated contracts for SNPs and MNPs, and potentially Integrated Health Organisation (IHO) models where a provider assumes responsibility for a whole population health budget
- Flexible funding arrangements, including changes to funding flows and payment mechanisms (including Better Care Fund mechanisms)

- Outcome-based incentives

Effective models using existing contracting arrangements often use a prime and sub-contractor structure.

Alliance contracts are also highlighted as a strong option. These involve partnership governance across participating organisations, with mechanisms to build consensus on resource allocation and to resolve conflicts. They set out how services will be planned and delivered, as well as how performance and resources will be managed.

Upfront investment will typically be required, with returns realised over time. Funding approaches include budget top-slicing to support in year spending and partnerships with social investors (including larger charities).

Co-production between commissioners and providers is essential to ensure plans are realistic and sustainable.

Leadership and Partnership Working

Health and Wellbeing Boards and local government provide system leadership, democratic legitimacy, and population insight.

Neighbourhood health is a shared endeavour between the NHS and local authorities. It brings together health services, social care, public health, and wider partners to improve outcomes and reduce inequalities. Through Health and Wellbeing Boards, systems are expected to develop local neighbourhood health plans. These plans should integrate priorities, reflect local needs, and enable coordinated action at place level.

Place Partnership Boards operate at the level between Integrated Care Systems and individual neighbourhoods, bringing together commissioners and providers and representatives of the local population.

Leadership is collaborative and relationship-based, not hierarchical.

Key early steps include defining neighbourhoods within a Place, identifying the population health priorities, and aligning resources and teams accordingly.

The Integrator Role

The "integrator" translates strategy into frontline delivery, coordinating services across the neighbourhood.

The integrator role should not be seen as being about leadership or control. Any integrator must be prepared to act against its own organisational interest if the future of neighbourhood care requires it. This is a key difference between an organisation

'taking over' services, and an integrator enabling existing providers to work together differently.

Potential integrators include NHS trusts, local authorities, GP federations, or partnerships.

Typical responsibilities include:

- Coordinating care pathways and development of the "team of teams"
- Aligning service delivery
- Managing transitions and interfaces between services and continuity of care
- Population health management, including providing necessary information and data
- Information sharing between organisations with support to Place governance through effective reporting on progress.

Emerging guidance around the selection of an integrator include:

- Drawn from existing institutions within the Place partnership, organisationally mature and with "skin in the game"

- Credible across the partnership, able to build trust amongst partners and ready to host and facilitate as opposed to takeover or lead

- Capable of supporting the required infrastructure, including around budgets, data sharing, workforce, estates and digital, operating across the Place

- Operating in alignment with the geographical footprints of the INTs it supports.

The Role of Primary Care

Primary care is a key element to the neighbourhood health model, acting as both the first point of contact with healthcare services for most people and a central point for coordination of resulting care. It is expected to operate as part of a wider "team of teams", working closely with other system partners to deliver proactive, coordinated and person-centred support.

General practice sits at the heart of this model, combining clinical leadership with population insight to identify need early and proactively, support continuity of care, and help coordinate responses around individuals and families.

For neighbourhood health to succeed:

- It must create the conditions for those working in primary care to have the time, space and resources to engage meaningfully with patients, carers, families and fellow professionals.
- Improving access must be accompanied by wider capacity and capability building, including around social prescribing and the management of long-term care.
- Issues in current primary care estate, technology and the ability to develop and retain the primary care workforce need to be addressed hand-in-hand with wider healthcare transformation at a neighbourhood level.

The guidance recommends:

- A clear plan within places and neighbourhoods to enhance primary care sustainability, as core to neighbourhood health delivery

- A recognition in constructing integration of the concerns of primary care around loss of autonomy and being taken over by larger institutions

- Models that reflect the opportunities and assets of community pharmacy, dentistry and optometry, whilst recognising that general practice plays a specific role in co-ordinating neighbourhood care

- A consistent approach across neighbourhoods to the way in which primary care services are accessed and co-ordinated with wider system partners.

Other System Partners

Neighbourhood health depends on effective collaboration across multiple sectors. The guidance highlights several key points in this regard:

- Local government continues to play a central role in neighbourhoods through democratic leadership and accountability, deep understanding and insight into local communities, and responsibility for commissioning and delivering services fundamental to health and wellbeing, including social care, public health, housing and community support. These services are critical to addressing the wider determinants of poor health.
- Hospitals, community providers and mental health services can make their greatest contribution by enabling clinicians and other professionals to build time into job plans to engage fully in neighbourhood delivery models. Although changes to job planning may create additional short-term pressures, over time the reduction in "failure demand" and bureaucracy can increase capacity and improve job satisfaction.

- For hospitals, there is an opportunity to align consultants and other key staff in the specialties such as frailty or diabetes: moving away from thinking about interfaces between primary and secondary care towards joint planning and delivery, where each party continues to bring specific skills and expertise, but with a sum that is more than the parts.
- VCFSEs contribute data, insight, relationships and capabilities to prevention, early intervention and ongoing support. This ranges from identifying and targeting services to delivering activities such as social prescribing, peer support, community outreach and the provision of safe, accessible spaces that promote health and wellbeing. In operational delivery, the strength of the sector remains grounded in its flexibility, responsiveness and ability to build relationships, often engaging people where traditional services struggle to do so.

Delivering Successfully

Success requires a shift to genuine collaboration:

- Share information openly
- Adopt practical joint approaches
- Align resources to shared goals
- Support for innovation
- Prioritise collaboration over organisational control

Quality improvement methods (e.g. PDSA cycles) and learning from social movements can support delivery.

Success should be judged by:

- Improved access to and continuity of support and care
- Earlier intervention
- Better coordination
- Reduced escalation
- Improved experience
- Reduced inequalities
- Reduced cost of care

Measures need to reflect both resident experience and population outcomes, consistent with the Neighbourhood Health Framework and Local Outcomes Framework

Conclusion

Neighbourhood health represents a fundamental shift to a coordinated, preventative and proactive system centred on individuals and communities.

Its success depends on:

- A clear and consistent neighbourhood offer
- Empowered local teams
- Strong enabling infrastructure
- Aligned leadership
- Sustained behavioural change

The document's final FAQ section focuses on how neighbourhood health should be implemented. It explains how organisations can begin working differently, how risk and responsibilities are shared, how staff will need support to work in new ways and how services should develop over time.

The guidance emphasises starting practical work locally, using existing resources, and building systems gradually.

The greatest risks to implementation are identified as:

- Spending too much time defining structures before beginning work
- Focusing heavily on governance and organisational arrangements
- Lack of coordination between services
- Unclear understanding of how care will change for patients

The document emphasises the importance of maintaining progress while systems are being developed.

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OUR AIM: Coordinated, proactive, person-centred care in community settings while reducing fragmentation and inequalities.

WHY THIS MATTERS

Too many services **are fragmented,** reactive and shaped by organisational **boundaries.**

Key problems:

- Inconsistent access and experience
- Delays leading to avoidable harm
- Duplication of work and gaps in care
- Poor coordination between services
- Widening health and socio-economic inequalities
- Resources focused on symptoms, not causes
- A disparity of esteem across and within health and care services

Reducing inequalities is the moral imperative and the practical necessity at the heart of neighbourhood health.

THE THREE SHIFTS

Neighbourhood health reflects three major shifts in how we operate.

From **hospital** to **community-based care** → From **treatment** to **prevention** → From **analogue** to **digital**

THE OUTCOME

A virtuous cycle: supporting people to stay healthy, independent and well, improving life outcomes and reducing pressure on health and care systems—while making frontline roles more rewarding.

NEIGHBOURHOOD CARE

A neighbourhood is a clearly identified local population served by a coordinated network of health, care and community services.

Typical characteristics:

- ✓ A defined local population
- ✓ A group of services responsible for that population
- ✓ Shared leadership and accountability
- ✓ Integrated ways of working
- ✓ A focus on the needs of the community

People receive care that is:

- Easy to access
- Joined up around individuals
- Early to address risks
- Close to home
- Prevention as well as treatment
- Holistic and quality at all stages of life

THE THREE KEY COMPONENTS OF NEIGHBOURHOOD CARE

These overlapping components work together to maximise outcomes for individuals, families and communities.

PREVENTATIVE CARE

Reducing the likelihood of illness and improving overall health.

Examples:

- Vaccinations
- Health promotion
- Screening
- Support for housing, employment & social needs
- Community wellbeing initiatives

In a model neighbourhood:

- ✓ Use shared data to identify needs
- ✓ Align partners around shared goals
- ✓ Deliver home & community interventions
- ✓ Track progress and refine support

PROACTIVE CARE

Identifying people at risk and taking steps to stop, reduce or mitigate ill health.

Activities include:

- Identifying high-risk patients
- Care plans for complex needs
- Supporting long-term conditions
- Early support
- Multidisciplinary teamwork

Success looks like:

- ✓ Improved patient experience
- ✓ Reduced emergency admissions
- ✓ More time living independently and well
- ✓ Better long-term condition outcomes

REACTIVE CARE

Essential care when people become unwell—delivered in the right place.

We aim to:

- Treat more acute illness in the community
- Avoid unnecessary hospital admissions
- Support earlier discharge
- Provide follow-up care locally

Success looks like:

- ✓ Reduced A&E attendances
- ✓ Greater GP capacity for those who need it most
- ✓ Faster access to appropriate care
- ✓ Higher patient satisfaction and lower cost

THE NEIGHBOURHOOD OPERATING MODEL: FIVE CORE COMPONENTS

1 CORE DESIGN PRINCIPLES

- Population-led
- Prevention-first
- Partnership as default
- Subsidiarity
- Outcomes-focused
- Team of teams
- Value for money
- Build from where you are

2 A CLEARLY DEFINED GEOGRAPHY

Neighbourhoods should:

- Be geographically contiguous
- Make sense to communities
- Be of sufficient scale (~50,000 people)

3 A CONSISTENT CORE OFFER OF SERVICES

- General practice
- Community health
- Mental health
- Social care
- Public health
- VCFSE support

4 COORDINATION OF SERVICES

- Proactively identify need
- Care navigation
- Shared care planning
- Information & data sharing
- Multidisciplinary working
- Manage transitions
- Evolve based on learning

5 ENABLING INFRASTRUCTURE

- Digital systems
- Skilled workforce
- Buildings & facilities
- Governance
- Data & analytics

DELIVERING NEIGHBOURHOOD HEALTH

Neighbourhood	Where relationships, services and outcomes are delivered
Place	Where the overall model, priorities and progress are developed
System	Where strategy, resource allocation and assurance take place
Regional / National	Providing policy, standards, infrastructure and support

LEADERSHIP & PARTNERSHIP

- Built on collaboration, relationships and trust.
- Health & Wellbeing Boards develop local neighbourhood health plans.
- Place Partnership Boards bring together commissioners, providers and communities.
- Shared endeavour between NHS, local government, VCFSE and other partners.

PRIMARY CARE AT THE HEART

- ✓ 1st point of contact and care coordination
- ✓ Clinical leadership and population insight
- ✓ Part of the wider "team of teams"
- ✓ Needs the time, capacity, estate, tech and workforce to thrive

OTHER SYSTEM PARTNERS

Local Government	Hospitals & Providers	Mental Health & Community	VCFSE Sector
Leadership, insight and key services to address wider determinants	Enable staff time align specialties and work in partnership	Work together to deliver integrated, local support	Insight, relationships, flexibility and trusted community reach

DELIVERING SUCCESSFULLY

- Share information openly
- Adopt joint approaches
- Align resources to shared goals
- Support frontline innovation
- Prioritise collaboration

JUDGED BY:

- Better access & continuity
- Earlier intervention
- Better coordination
- Reduced escalation
- Improved experience
- Reduced inequalities
- Lower cost of care

WHAT TO AVOID

- ⚠ Spending too long designing structures
- ⚠ Focusing heavily on governance
- ⚠ Lack of coordination between services
- ⚠ Unclear impact for patients

Start practical work locally, use what you have, learn and build as you go.

Neighbourhood health: better for people, better for communities, better for the system.

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