

<b>Meeting name:</b>	NHS West Yorkshire Integrated Care Board
<b>Agenda item no.</b>	21
<b>Meeting date:</b>	24 June 2025
<b>Report title:</b>	Integrated Neighbourhood Teams Blueprint
<b>Report presented by:</b>	Ian Holmes, Deputy CEO and Director of Strategy and Partnerships, NHS West Yorkshire ICB
<b>Report approved by:</b>	Ian Holmes, Deputy CEO and Director of Strategy and Partnerships, NHS West Yorkshire ICB
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Purpose and Action			
Assurance <input type="checkbox"/>	Decision <input checked="" type="checkbox"/> (approve/recommend/ support/ratify)	Action <input checked="" type="checkbox"/> (review/consider/comment/ discuss/escalate)	Information <input type="checkbox"/>
Previous considerations:			
<p>In November 2023, the ICB Board discussed performance against the requirements of the Primary Care Access Recovery Plan. This Blueprint has been developed from this point, though evolved in a dynamic context. The Transformation Committee has discussed the Blueprint on several occasions.</p>			
Executive summary and points for discussion:			
<p>The West Yorkshire Integrated Neighbourhoods Blueprint has been developed throughout 2024/25 based on significant engagement with clinical and non-clinical leaders across the system.</p> <p>The Blueprint sets out a strategic vision, which reflects widespread system consensus on our aim for neighbourhood teams and neighbourhood healthcare more broadly. Though the context has changed rapidly throughout the development process, the focus on providing holistic care to people, close to where they live, based on a population health management approach and tackling health inequalities remains central to our work. The key components set out in the Blueprint, which are the ingredients essential to delivering our vision, also remain the same.</p> <p>The Blueprint sets out five place-based plans for delivery over the short, medium and long-term. A plan for at-scale enablers, across WY, is also provided. Alongside this, the paper clarifies the current and emerging context, as well as an approach to delivery that aligns with our wider priorities for Integrated Neighbourhood Health, and areas for the Board to consider how this will be delivered.</p>			

<b>Which purpose(s) of an Integrated Care System does this report align with?</b>
<input checked="" type="checkbox"/> Improve healthcare outcomes for residents in their system <input checked="" type="checkbox"/> Tackle inequalities in access, experience and outcomes <input checked="" type="checkbox"/> Enhance productivity and value for money <input type="checkbox"/> Support broader social and economic development
<b>Recommendation(s)</b>
<p>The NHS West Yorkshire ICB Board is asked to:</p> <ol style="list-style-type: none"> <li>1. Approve the West Yorkshire Integrated Neighbourhood Teams Blueprint (appendix 1).</li> <li>2. Endorse the delivery approach for Integrated Neighbourhood Health, including oversight via the WY INH Board.</li> <li>3. Support the strategic direction outlined, and discuss how leadership will be provided to enable delivery, linked to section 5.3.</li> </ol>
<b>Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:</b>
N/A
<b>Appendices</b>
<ol style="list-style-type: none"> <li>1. Integrated Neighbourhoods Blueprint</li> <li>2. NHSE Guidance on Neighbourhood Health</li> </ol>
<b>Acronyms and Abbreviations explained</b>
<ul style="list-style-type: none"> <li>• A&amp;E – Accident and Emergency</li> <li>• COPD – Chronic Obstructive Pulmonary Disease</li> <li>• CYP – Children and Young People</li> <li>• DDaT – Digital, Data and Technology</li> <li>• HIU – High Intensity Users</li> <li>• ICB – Integrated Care Board</li> <li>• INH – Integrated Neighbourhood Health</li> <li>• INT – Integrated Neighbourhood Team</li> <li>• MDT – Multidisciplinary Team</li> <li>• NHS – National Health Service</li> <li>• PEO LC – Palliative and End of Life Care</li> <li>• PHM – Population Health Management</li> <li>• SDF – System Development Funding</li> <li>• UEC – Urgent and Emergency Care</li> </ul>

## What are the implications for?

<b>Residents and Communities</b>	The Blueprint brings significant scope to improve experience and outcomes for our residents and communities. The vision focuses on this and provides a shared area of focus to shape action across the system. The wider focus on INH offers the same scope, and it is through this that transformation and delivery will be driven across West Yorkshire.
<b>Quality and Safety</b>	Improving and addressing variations in quality of care is a key aim of this work.
<b>Equality, Diversity and Inclusion</b>	There is an opportunity through implementing the blueprint to specifically improve how we meet the needs of our diverse communities in West Yorkshire. Improving the experience and outcomes of care for our communities experiencing most inequality is a core aim of the blueprint and INH.
<b>Finances and Use of Resources</b>	It is acknowledged that resources and finance are a critical enabler of the blueprint and INH, and that there are various challenges to this at present. The blueprint sets out principles related to the use of finance, resources and capacity, whilst considerations around resource utilisation for INH are set out for Board discussion.
<b>Regulation and Legal Requirements</b>	N/A
<b>Conflicts of Interest</b>	N/A
<b>Data Protection</b>	N/A
<b>Transformation and Innovation</b>	This work is setting out to transform the current model of care and will seek to maximise innovative opportunities, including workforce and digital. INH will remain a key focus for transformation across our ICB, in line with local priorities and national policy.
<b>Environmental and Climate Change</b>	There is scope to make better use of the built environment and minimise our carbon footprint through a focus on estates and innovative models of care. In doing so, there is also scope to improve population health due to related issues.
<b>Future Decisions and Policy Making</b>	The blueprint and focus on INH should be considered for shaping and when taking future decisions.

<b>Citizen and Stakeholder Engagement</b>	This blueprint has been developed with widespread system engagement, including with Healthwatch, and is based on insights from previous patient engagement.
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## 1. Purpose

- 1.1. This paper sets out the West Yorkshire (WY) Integrated Neighbourhoods Blueprint for approval by the NHS WY Integrated Care Board (ICB).
- 1.2. The paper also describes the approach to delivery and oversight, with a particular focus on alignment with Integrated Neighbourhood Health (INH) and implications of the Model ICB Blueprint.
- 1.3. The NHS WY ICB Board are asked to:
  - Approve the West Yorkshire Integrated Neighbourhood Teams (INT) Blueprint (appendix 1).
  - Endorse the delivery approach for Integrated Neighbourhood Health (INH), including oversight via the WY INH Board.
  - Support the strategic direction outlined, and discuss how leadership will be provided to enable delivery, linked to section 5.3.

## 2. Context

- 2.1. The case for neighbourhood working is well established locally and nationally. Integrated Neighbourhood Teams (INTs) and INH are not radical departures from the previous focus but do present an opportunity to accelerate and scale our work.
- 2.2. A focus on greater integrated working at the neighbourhood level has the potential to drive significant improvements in meeting the needs of our people. It is broadly anticipated that INH will:
  - **Provide people with more personalised and holistic care.** By bringing together teams of professionals, and more closely aligning organisations that provide public services, people will receive higher quality care that better meets all of their needs, often at the same time and in the same place.
  - **Improve patient experience and increase satisfaction.** By optimising how teams and organisations come together, people will find it easier to navigate the health and care system. Handoffs between services and the need to tell their story multiple times will be reduced, and when onward referrals or signposting is required, this will be simpler due to the teams and services being more closely integrated.
  - **Improve the accessibility of services.** INH brings different aspects of care closer to where people live, including into their houses in some cases. People's proximity to the services they require will make access easier, whilst there is also scope to remove barriers to access (including those experiences

disproportionately by groups experiencing the greatest inequalities) through a concerted effort and working closely with trusted voluntary, community and social enterprise (VCSE) sector partners.

- **Reduce health inequalities.** By further decentralising care delivery, bringing together multidisciplinary partners to meet patient needs, and utilising our data capabilities, there is considerable scope for all neighbourhoods to identify populations experiencing significant inequalities and tailor community interventions to meet their needs.
- **Enhance community engagement and partnerships.** In shifting more care into neighbourhoods, and supporting neighbourhoods to meaningfully work with their local population, there is an opportunity to increase public involvement in how care is designed and improve how people and communities own their health outcomes.

### National Context

- 2.3. Nationally, the focus on neighbourhood-based transformation has been set out in successive reviews and policy. This includes through the new care models vanguard programme, the Fuller Stocktake Report, and the 2025/26 Neighbourhood Health Guidance.
- 2.4. The [2025/26 Neighbourhood Health Guidance](#) provides a framework for local application in establishing INH. It requires input primary care, social care, community health, mental health, acute, and wider system partners. Delivery is planned across a 5-to-10-year period, with an initial focus on improving how the NHS and social care work together to prevent people spending unnecessary time in hospital or care homes. An initial six core components are set out:
  - **Population health management**, which requires a person-level, longitudinal, linked dataset to be in place to enable population segmentation and risk stratification, to inform commissioning intentions and interventions.
  - **Modern general practice**, whereby there is an expectation to continue progress to date in improve access and continuity for patients, including through use of the NHS App and the Pharmacy First scheme.
  - **Standardising community health services**, where ICBs are required to ensure community service pathways are an integral part of the INH model, and commissioned in line with the standardising community health services framework.

- **Neighbourhood multi-disciplinary teams**, which covers the requirement to establish integrated neighbourhood teams of teams to deliver coordinated, proactive care to multiple patient cohorts.
  - **Integrated intermediate care with a ‘Home First’ approach**, setting out requirements for supporting the step up and step down of care, with interventions delivered at home as much as possible, focusing on rehabilitation, reablement and recovery.
  - **Urgent neighbourhood services**, whereby systems should standardise and scale urgent neighbourhood service offers for people with an escalating or acute need, to support better demand management and prevent the need for hospitalisation. This should be integrated with wider urgent pathways.
- 2.5. It is anticipated that INH will feature significantly in the forthcoming 10 Year Health Plan. This will likely bring together the “three shifts” from hospital to community, analogue to digital, and treatment to prevention, with the guidance for this year (set out in section 2.4), and set out longer term requirements for local systems to deliver the transition toward neighbourhood health.
- 2.6. The operating context of the ICB, and NHS more broadly, is changing at pace following recent announcements to refocus ICBs as strategic commissioners with a smaller number of staff and to disestablish NHS England.
- 2.7. The changing operating context, as set out in the Model ICB Blueprint, and forthcoming 10 Year Health Plan will provide the crucial context that determines how neighbourhood health priorities are delivered.

### Local Context

- 2.8. At the heart of our ICS Strategy and Joint Forward Plan is an emphasis on more joined up working, close to where people live, to deliver services in communities that drive improvements in healthcare outcomes and inequalities.
- 2.9. Our five Places have strong assets to build on – from local partnerships across providers, to neighbourhood footprints and priority population cohorts, and strong infrastructure. There are several good practice examples of working in this way.
- 2.10. There are significant pressures, and well reported challenges and dissatisfaction amongst patients around access to and waiting times for appointments. However, we see generally good performance amongst services that operate in communities (e.g. general practice and pharmacy) when compared nationally, and a positive patient experience when patients access care.

- 2.11. Whilst INT and INH development is not uniform, and each Place is at a different point, there is clear scope to improve our offer to ensure that patients across WY experience greater consistency.
- 2.12. There are significant areas of work ongoing across the WY partnership that are interdependent with our delivery of the Blueprint and INH priorities, including:
- In line with nationally announced changes in the focus of ICBs, there is rapid work underway to establish our future operating model.
  - Work within all places to develop place-based provider collaboratives that bring together primary care, community care and acute care providers with voluntary sector and local authority partners to enable move integrated care across pathways and boundaries. This will be a key vehicle to drive INH delivery and improve outcomes and efficiency, particularly given the direction set out in the model ICB Blueprint.
  - Our 2025/26 transformation priorities which covers clinical services reviews, led by the three provider collaboratives, and work and health, alongside INH.
  - The Urgent and Emergency Care (UEC) Blueprint, whereby there are common themes that can be delivered jointly to enhance efficiency and outputs, and an opportunity to ensure alignment in how both blueprints are operationalised to enhance care across pathways.

### **3. Blueprint Summary**

- 3.1. The Blueprint has been developed following a discussion held at the November 2023 meeting of the ICB Board. It was also agreed as one of the 2024/25 transformation priorities for WY.
- 3.2. It was developed through matrix, system-wide leadership, with oversight from the WY Fuller Delivery Board and a core steering group. Members of these groups have provided leadership, input, direction and connectivity across their places and associated networks. This has ensured that the document builds on our previous work, is designed collaboratively with strong clinical and professional engagement, that it reflects the views of all places and partners, and remains adaptive to a dynamic national context.
- 3.3. Prior to the ICB Board meeting, support has been obtained from a range of partners, including forums in all five places, the INH Board, the Clinical and Care Professional Forum, the Transformation Committee, the West Yorkshire Association of Acute Trusts Chief Executives group, and the Mental Health Learning disabilities and autism collaborative partnership Board.



3.4. The full detail of the Blueprint is set out in *appendix 1*. It focuses mostly on Integrated Neighbourhood Teams (INTs) and sets out:

- A shared vision for holistic, person-centred, equitable care that is delivered at neighbourhood level and focuses on improving outcomes, inequalities, and prevention, through matrix system working.
- The case for change, aligning to the national policy direction and shifts, local context, national and international evidence, and patient/public insights.
- An outline of the six core components of INH – Population Health Management (PHM), modern general practice, community health standardisation, neighbourhood multidisciplinary teams (MDTs), intermediate care, and urgent neighbourhood services.
- The core features of INTs that we should expect to see everywhere in WY, as well as the geographic footprints of the INTs.
- The enablers needed to deliver – workforce; digital, data and technology (DDaT) transformation; estates; and resources, finance and capacity. Aims are set out for each of the enablers, with more specific actions reflected in the place and WY delivery plans.
- Place-based delivery plans that articulate actions over 1-, 3- and 5-year horizons, as well as the at scale actions.
- An approach to delivery, measurement and monitoring, and oversight.

#### **4. Approach to Delivery**

- 4.1. Delivery of the Blueprint and INH will occur primarily through our five places in line with our current operating model. The WY INH Board will coordinate oversight and assurance of progress, identify strategic and at-scale opportunities, and provide a system forum to connect and share learning.
- 4.2. The Blueprint is a living document and will be adapted for delivery as the context evolves. This is particularly pertinent given the ongoing changes regarding the future function of ICBs, the role of new regional bodies in the health landscape (including on workforce and digital transformation) and provider collaboratives at place.
- 4.3. Progress will be accelerated throughout this year, learning from previous work, including where there have been barriers to progress, and focusing on areas where we can make an immediate impact. We will work closely with partners to ensure that the delivery model will be sustainable within the future architecture.

- 4.4. Throughout 2025/26 we will prioritise delivering neighbourhood based services for our priority population cohorts. Places have used local evidence to identify the following cohorts:
- Bradford District and Craven – adults with palliative and end of life care (PEoLC) needs, adults with frailty and/or dementia, children and young people (CYP) requiring input from specialist paediatric care, and all age high intensity users (HIU).
  - Calderdale – adults with frailty, adults with PEoLC needs, CYP with complex needs, and care home residents.
  - Kirklees – adults with frailty, people with a mental health issue that are HIU of A&E, adults with PEoLC needs, and pathway 1 patients that are ready for discharge.
  - Leeds – adults with frailty, people with advanced respiratory disease, CYP with complex mental health needs, and people with 3+ long term conditions and mental health.
  - Wakefield – adults with dementia, PEoLC needs, and Chronic Obstructive Pulmonary Disease (COPD).
- 4.5. Delivery and improvements for the patient cohorts set out in section 4.4. will be measured through the ICBs agreed “north star” metrics:
- To reduce preventable unplanned care utilisation, and
  - To increase early identification and intervention (of both, risk factors and actual physical and mental illness).
- 4.6. Across places, these patient cohorts account for a disproportionate share of unplanned care utilisation. This focus brings significant scope to improve care experience and outcomes, as well effecting overall demand and acute sector performance. This will support meeting our 2025/26 operational plan.
- 4.7. Considerable focus will also be on strengthening the foundations on INH, linked to the findings of our Blueprint and the six core components. We will leverage the deployment £5m System Development Funding (SDF) for INH to support this, using a transparent framework to invest in areas that will drive measurable delivery, improvements and system efficiencies and value for money in year.
- 4.8. The INH Board will oversee and support delivery in line with our north star metrics, as well as ensuring the efficient and effective allocation of SDF. The INH Board will also consider the development of a broader maturity framework that monitors our overall progress towards greater integrated working at neighbourhood level.

## **5. Board Considerations**

- 5.1. The approach set out describes how this work will be delivered. Delivery also requires an ongoing strategic commitment and active support from the Board, and the wider Partnership.
- 5.2. To support an informed and strategic discussion around delivery of the Blueprint in the context of our wider INH priorities, Board members are invited to consider:
  - How members can champion the INT and INH model, including locally and through engagement with various partners and stakeholders.
  - How we embed greater consistency, without becoming overly prescriptive and losing the importance and value of local context and warranted variability.
  - How to facilitate innovation and transformation that will accelerate INH, in the context of the shift towards the Model ICB Blueprint.
  - How we ensure alignment and capacity allocation across the organisation and system to drive INH.
  - How we can shift investment decisions to support neighbourhood care, whilst managing ongoing financial pressures and maintaining acute sector stability.
  - What actions could be taken to incentivise and drive collaboration across place and organisational boundaries, including for shared infrastructure such as digital, workforce development, and estates.
  - What level of assurance the Board requires, and through which mechanisms, to ensure that place-based INH implementation is both equitable and effective.
  - How the Board would wish to respond to differential progress across Places, considering the thresholds and levers for system-level support and/or escalation.
  - How to facilitate a more equitable focus on INH in the context of system planning and performance measurement, ensuring that INH metrics are robust and embedded.
  - How we will sustain an INH model.
- 5.3. These questions are intended to frame (rather than restrict) the discussion, to shape decision-making, and ensure that the Board enables and is assured of the accelerated, consistent, and impactful delivery of INH.

## **6. Recommendations**

6.1. The NHS WY ICB Board is asked to:

- Approve the West Yorkshire Integrated Neighbourhood Teams (INT) Blueprint (appendix 1).
- Endorse the delivery approach for Integrated Neighbourhood Health (INH), including oversight via the WY INH Board.
- Support the strategic direction outlined, and discuss how leadership will be provided to enable delivery, linked to section 5.3.

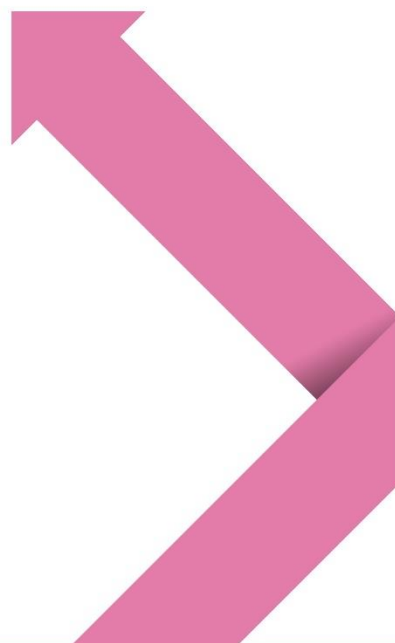


# Blueprint for integrated neighbourhoods

Working together for  
healthier communities



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## Foreword

This blueprint is the latest iteration of how we, as the NHS West Yorkshire Integrated Care Board, describe our ambitions for high quality care that is delivered in the communities and neighbourhoods that people live in. We would like to thank all colleagues, partners and members of the public that have contributed towards the development of this blueprint.

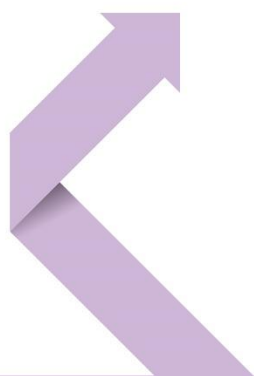
Integrated neighbourhood teams, and the Integrated Neighbourhood Health infrastructure that they are a part of, are not new. We have made progress in establishing these ways of working, but experience shows that this is not easy.

Our communities and neighbourhoods are all different, requiring different approaches and people to work together to meet their needs. Partnership working across professional and sectoral boundaries needs time to build strong relationships and culture. The change we will deliver requires a gradual shift in how our resources are deployed to provide new models of care with strengthened foundations, including in general practice and community health services.

All our neighbourhoods and communities have a wealth of assets: the people living in them, who we will work with as equal partners and support to take ownership of their health and wellbeing; the services, including health, voluntary sector services, and local authority; and more.

This blueprint sets out one important contribution to delivering the governments shifts from hospital to community, and treatment to prevention. It is part, alongside the neighbourhood health guidance, of how our Integrated Care Board will drive change to improve the health and wellbeing of our population, and tackle health inequalities.

# The case for integrated neighbourhoods and integrated neighbourhood teams



# The Case for Change

## Our vision

To work in partnership with our communities to improve health and wellbeing outcomes through the delivery of person centred, holistic and equitable care and support in local neighbourhoods, addressing physical, psychological, and social health needs. Integrated teams of professionals and organisations will work collaboratively to provide timely, seamless and high-quality services, underpinned by principles of prevention and reducing health inequalities.

## Purpose of our vision

Delivering joined up care close to where people live requires a shared vision that sets out what we are aiming to achieve for our population.

It creates the consensus that is necessary to deliver high quality neighbourhood teams and health services to our people through a matrix, multi-sector, and multi-professional approach.

As described nationally, there are several contributing factors that simultaneously necessitate a greater focus on integrated neighbourhood working, and drive the sense of an overly reactive health and care system. They include:

- Changing demographics (including an ageing and growing population), an increase in people living with one or more long-term conditions.
- The wider determinants of health (housing, work, education, social relationships and the local environment), which contributes more than three quarters of the impact on our health and wellbeing ([London South Bank University, 2023](#)).
- Suboptimal and siloed ways of working which result in additional capacity required to address issues ([The Health Foundation, 2024](#)) and have a negative effect on workforce morale and productivity.

- Disconnected services which leads to patients having to ‘tell their story’ multiple times to different services and not enabling care for the whole person.
- A health and care system that disproportionately focuses on hospital and emergency care when most of the activity happens in the community.
- Longer waiting times for services, which exacerbates the state of population health.

Neighbourhood working is a continuation of local, regional and national initiatives across successive governments that have aimed to bring Primary and Community Care closer together, including the development of integrated care and a more place-based approach to how services are organised.

By establishing this vision, and the work that follows, we will drive change to provide consistent access and standards of care, with the variation required to meet local population health needs and tackle inequalities.

## **Strategic Context**

Our Partnership has a long history of working together as equal partners and making decisions as close as possible to, and for, those living in our communities, as described in our [mission, values and behaviours](#).

Our [West Yorkshire Integrated Care Strategy](#) sets out the ambitions we hold as a Partnership. This blueprint will enable delivering those, and support our approach to planning through our [Joint Forward Plan](#). We will harness progress made in delivering previous strategies, overcome barriers encountered along that journey, and support the delivery of interdependent strategies and priorities including, for example, our transformation priorities, the Urgent and Emergency Care (UEC) Blueprint, equity and fairness and climate change.

The national policy context has evolved significantly in the last 12 months. Much of this provides an opportunity to accelerate our work. The [Darzi Report](#) offers a diagnosis of the challenges facing the health system and health of the nation, whilst the commitments set out by the Secretary of State focusing on a

neighbourhood health service, and the three shifts of “hospital to community”, “treatment to prevention”, and “analogue to digital” provide a vehicle to drive progress.

The national direction compliments that which was described in the [Fuller Stocktake Report](#) in 2022, and builds on the good progress that we made in relation to the 2023 [Delivery plan for recovering access to primary care](#).

In January 2025, NHS England (NHSE) published its [neighbourhood health guidelines for 2025/26](#). This outlines the priority areas and objectives for moving towards a neighbourhood health service. It also sets out 6 components of neighbourhood health to create a common understanding of what lies at its core. This is a pre-requisite to the [10 Year Health Plan](#), which will provide greater detail and enable systems and providers to move towards a neighbourhood health service.

More recently, a clear direction of travel has been established to refocus the operating architecture of the NHS in England. This includes refocussing the role of ICBs on strategic commissioning, accelerating the development of place-based provider collaboratives, disestablishing NHS England, and forming new regional health bodies. As we deliver on our neighbourhood teams and broader neighbourhood health ambitions, this Blueprint will provide a guiding framework that is adaptive to the emerging roles of different parts of the system, maintaining a clear view of what is important to people and enabling rapid progress.

## **What people are telling us**

This blueprint is informed by involvement intelligence from across West Yorkshire. We have used a variety of sources, including Joint Forward Plan engagement, annual involvement reports, 10 Year Health Plan engagement, and insights from Healthwatch (such as on primary care access and community mental health transformation).

By placing this at the heart of our work, we are ensuring that our focus is on what matters to people. As it relates to services that operate in neighbourhoods and communities, we repeatedly hear three key things:

### **1. It is too difficult to access our services.**

For most people, general practice is their preferred point of entry to the health system. But getting an appointment is hard. People tell us that there are not enough appointments available, long telephone waits for appointment booking, confusing processes and call systems, and variable online offers.

In some cases, people find our multiple service offers too complex to understand and difficult to navigate. Alongside challenges accessing general practice, some patients choose to attend A&E or same day urgent care, or ignore their health needs.

### **2. When people can access support, services are generally good and meet their needs.**

In these cases, it is not only about the clinical interventions. When asked about positive experiences, people reflect less on the specific service, and more on how they are provided, with consistency and reliability being particularly important. On the other hand, when services are less personal, patients find them less effective.

### **3. People living in our communities have a reasonably clear idea of what good would look like for them.**

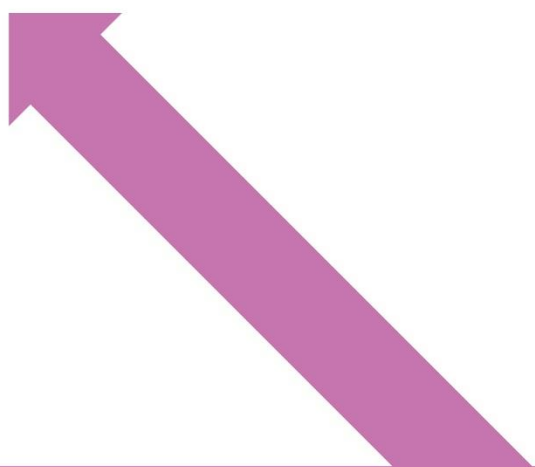
Although experiences are individual, there are common themes that people expect to see or feel when accessing our services, including:

- Personalised, compassionate and non-judgemental care delivery.
- A clear join up across services that addresses feelings of being passed around the system, which leaves people feeling frustrated, lost and disengaged from their care.
- Access to professional support, with recognition that this does not always need to be a doctor, but particular trust and understanding of the GP role.
- Options in how care is provided – particularly in terms of a choice regarding face to face or digital delivery.
- Services that are closer to people, including outreach clinics and more co-located, walk-in, “one-stop” centres.
- Clear communication and information, especially around why people are asked to provide information, and the role of services and professions.

Across WY, there are approximately 530,000 people living in areas ranked in the most deprived 10% of England. 20% of people are from ethnically minoritised communities. Barriers are faced by socially excluded groups, and all are at risk of experiencing significant inequalities. It's important that we consider this alongside the generalised findings, as inequalities exacerbate negative experiences of health and care, and are associated with worse outcomes.

We also hear from our workforce that working within the current context is putting them under increased pressure to deliver good quality services, when this is becoming increasingly difficult. Understanding the experience of our staff in greater detail is important as we deliver this blueprint.

# Delivering the vision





## Delivering the vision

Integration is the driving force of this blueprint. Better integration needs to occur at all levels of our system. Operationally, it will support teams to work together within neighbourhoods and ensure that the transition between neighbourhood services and the acute sector is more efficient, building on the work we have done to improve the primary to secondary care interface and extending this across other areas. Strategically, it will ensure that how we deliver transformation is aligned, including in how service change delivered by our provider collaboratives relates closely to integrated neighbourhood teams and services.

We know that delivering this shift requires actions from partners across the breadth of our system. We are committed to using this blueprint to break down historic barriers, with a clear focus on person-centred outcomes and what matters to people.

### **What good integrated neighbourhood working is**

Developing Integrated Neighbourhood Teams (INTs) will be part of how we deliver care at a neighbourhood level more broadly. INTs go beyond multi-disciplinary working by fully integrating representatives from health, social care, and the voluntary sector into a “team of teams” that delivers seamless, coordinated care within a defined area.

### **People and communities**

Individuals and groups of people who are bound together either by the local areas they live in, or characteristics they share. Our health and care teams will be built to wrap around their complete needs, and people themselves will be a central part, ensuring that decisions are made with and by them.



### **Neighbourhoods**

A specific geographical area or community that resonates with residents, where local services, organisations and communities can coalesce to address needs and improve outcomes. This is broader than integrated neighbourhood teams and includes ongoing partnerships with community groups, residents and local stakeholders to address a wide range of community issues, including community development and systemic improvements.



### **Integrated neighbourhood teams**

Representatives from different disciplines (for example, health, social care, voluntary sector) working together as a unit to deliver coordinated and person-centred care to individuals within a defined neighbourhood or locality. They will manage and deliver integrated clinical and operational services, provide continuity of care and work together to deliver shared outcomes. There is an emphasis on continuous collaboration around prevention and proactive care to improve outcomes, reduce duplication and address complex needs more efficiently. They will reach in and out of the other tiers for specialist input and care planning.



### **6 core components of neighbourhood health**

The recent [neighbourhood health guidelines for 2025/26](#) aligns with the direction set out in our vision. Multidisciplinary neighbourhood teams are one of the components. This blueprint will enable overall delivery of the six core components and ensure that they are delivered alongside our ICB transformation priority areas.

Places have considered each component within the context of the needs of their local population and the current configuration of services. They will also evaluate how effectively individual interventions link together to improve the way services are delivered for their local population and the outcomes people achieve.

Given local projections of future need and demand, systems are considering how to have the greatest impact on health and wellbeing outcomes for the local population as well as benefits for the system when prioritising resource allocation, strategic leadership and quality improvement efforts.

The 6 core components include:

### Population health management

- A person-level, longitudinal, linked **dataset of all health and social care data**, underpinned by **appropriate data sharing** and processing agreements, expanding to wider public services over time.
- A single system-wide population health management (PHM) segmentation and risk stratification method, e.g. Federated Data Platform.



### Modern general practice

- ICBs should continue to support general practice with the delivery of the **modern general practice model**.
- This model should streamline care, improve access and continuity, and provision of more proactive care.



### Standardising community health services

- Utilisation of the **standardising community health services publication** to maximise use of funding for local needs and priorities, including commissioning of community health services.
- Connect mental and physical health services to ensure complete provision, and link with the voluntary, community and social enterprise (VCSE) sector.



### Neighbourhood multidisciplinary teams

- **Multidisciplinary co-ordination of care** for population cohorts with complex health and care or social needs who require support from multiple services and organisations.
- A **core team** assigned for **complex case management** with links to an extended specialist team.
- A **care co-ordinator** assigned to every person (or their carer) in the cohort as a clear point of contact.



### Integrated intermediate care

- Short-term rehabilitation, reablement and recovery services delivered through a **therapy-led approach**.
- **Home First approach** to delivery of assessment and interventions, underpinned by step-up referrals and step-down planning directly between community and acute services.



### Urgent neighbourhood services

- **Standardise and scale** services such as urgent community response and hospital at home, ensuring alignment with local demand, and with front-door acute services such as urgent treatment centres.
- Involve senior clinical decision-makers as part of a '**call before convey**' approach in ambulance services and enable healthcare staff and care home workers to access clinical advice without needing to call 999.



All places have undertaken a self-assessment of the six core components so that they are ready to embed, standardise, and scale up the core components of neighbourhood health, ensuring that provider capacity and structures are aligned to meet demand effectively.

## **Enablers**

We have identified four enablers that are essential to embedding the new model. These are:

### **Workforce transformation, organisational development, and culture**

Our workforce comprises a variety of highly and diversely skilled people working to provide services to our population every day. To deliver an integrated neighbourhood model that meets patient needs, it's essential that we enable partners to come together more regularly as part of integrated multidisciplinary teams. Although teams will vary in exact composition dependent on population need and the cohorts of patients served, it will be important that we develop 'teams of teams' with clear roles and responsibilities, that are recognised and valued across the system and have the capacity and capability to work in a different way to meet population needs.

### **Digital, data and technology transformation**

Digital, data and technological improvement, innovation and transformation will be central to ensuring that our approach to integrated neighbourhood services is optimal and future proofed. It can enhance process efficiency (such as in administrative functions and patient record systems), support evidence-based service planning through improved population health data and business intelligence systems and transform how care is delivered (including through embracing health technology, artificial intelligence, and more).

### **Estates transformation**

The buildings that people work in and deliver services from are crucial to our vision. Issues with the current estate is one of our most significant challenges and poses a risk to delivering the full benefits of this blueprint. It does not support the increased size of teams, nor the multiple services that patients need to support their health and wellbeing. To deliver our vision, estates transformation needs to support a move towards greater co-location, whereby we make best use of our collective spaces and enable service delivery from a variety of locations including community anchor organisations and develop fit-for-purpose facilities that can

accommodate multidisciplinary team (MDT) working and are accessible to communities.

## **Resources, Finance and Capacity**

The vision of our blueprint is a key part of the broader 'left-shift'. This is not necessarily about shifting investment from one part of the system to another, but more about how the collective resources in our system are deployed and work together to deliver care in communities and neighbourhoods. In the current operating context, a focus on cost-neutral transformation to support sustainability and working across multiple footprints to share capacity and resource in delivering our priorities will be important.

To support how we use our resources, we have agreed the following key principles:

**Spending well.** We will use this blueprint as a guide and to provide a rationale for investing our resources. For example, increasing local spend to invest in the local economy.

**Prioritising.** We will use the blueprint, alongside other key ICB strategic priorities, to ensure that the process for making decisions on resources, capacity and investment is robust and that those decisions contribute to the development of INTs.

**Progressive change.** We will ensure that our commitment to the "left-shift" of resources is continuous, but that it is delivered gradually, sustainably, and in an affordable way.

**Resource flexibility.** We are committed to, where the ICB has flexibility in the deployment of resources, including finances and capacity, using this to accelerate the development of neighbourhood teams and neighbourhood health.

**Devolution.** We will ensure that, as neighbourhoods mature, we move appropriately closer to devolving resources for planning and delivery to this level.

**Planning.** We will move towards, wherever possible, ensuring that longer term and sustainable funding is in place, with plans in place to support INT development over the medium to long term.

**Governance and ways of working.** We will work to establish the financial governance arrangements and ways of working that support us to think, work and take decisions as one, in line with the vision of this blueprint.

### **Our approach to delivery**

The vision itself helps to support delivery, with clarity on the model and core features, and a guiding framework for shared action.

Greater specificity on actions, though, is where this blueprint adds the most value. In our current model, responsibility and resources for delivering the majority of our ambitions for INTs, and integrated neighbourhood health (INH) more broadly, sits within our places.

Each place is well positioned to use data, evidence and insights to establish priority population cohorts for receiving integrated neighbourhood-based care from neighbourhood teams.

Working as places and at a system level, we will enable primary, community, mental health, acute specialist, local authority, VCSE and other partners to work together effectively at neighbourhood level. Acting as a bridge, places will help INTs function cohesively while maintaining flexibility to respond to local needs and adapt as neighbourhoods transition from development to delivery at a hyperlocal, but scalable level.

We will align delivery with other key strategic priorities, ensuring that our approach is efficient and effective, and reflective of a whole pathway approach. This particularly includes the UEC Blueprint, which has been developed alongside this work. Taken together, both blueprints provide a vision and plan that spans the spectrum of services that our population access.

In the current context, whereby there is a significant refocusing of the role of ICBs and responsibility of the wider health system, it will be crucial that our delivery approach is considered carefully in line with the future operating model.

### **What we want our Integrated Neighbourhood Teams to do**

Our initial focus for INTs is to provide proactive care for higher and rising risk populations, and to work with communities on preventing ill health. Based in neighbourhoods, INTs will be made up of a range of skills and expertise, including from primary care, VCSE and social care, to meet the holistic needs of their local populations. These INTs will be able to easily draw upon specialist input as needed across all levels (from hyper-local to regional).

In West Yorkshire, INTs will:

- **Tackle health inequalities** by using population health data to proactively identify residents within target populations and connect them into the services that they need to reduce the risk of escalating poor health and to stay well for longer. To address inequalities effectively, INTs need to be wider than health e.g. addressing social determinants like housing and be community-based.
- **Eliminate the need for referrals and hand-offs** through a combination of integrated working, including regular communication and reviews and the use of digital and knowledge management tools, that support population data analysis and enable person-based care information to be shared across services.
- **Work closely with residents and within communities** to develop a clear understanding of what local needs are and the services that are best placed to meet these needs. They will identify and collectively respond to any gaps that may emerge as these needs change over time.
- **Support and enable cross-system leaders** holding collective responsibility for ensuring that the infrastructure, systems and processes needed to deliver integrated neighbourhood working are in place and remain fit for purpose.
- **Provide holistic, person-centred care, closer to home** that draws upon a wide range of offers from across health, care, VCSE, housing, and other local services. Our INTs will take a strengths-based approach, so that residents are empowered to make decisions about their health and wellbeing, access the



services that are meaningful to them and receive faster and more effective support at times of crisis or increased need.

- **Ensure that all West Yorkshire residents receive the same standards of care**, wherever they live and whatever their individual needs.

### **Where are we now**

All five places have made significant efforts in developing their neighbourhoods. All have best practice examples of integrated working at a neighbourhood level. The challenge will be to scale from a set of projects to an embedded, systemic shift in the way of working to provide a tangible impact on patient outcomes, moving towards a preventative more integrated approach.

Designing the footprint of INTs needs to balance local population needs, existing healthcare boundaries, local assets and operational efficiency. All five places have clarified their neighbourhood footprints. Our neighbourhood footprints build on PCN geographies as recognised areas where collaboration already takes place.

There will be a total of **[X]** neighbourhoods across West Yorkshire, as follows:

***[Finalised INT map to be inserted into document before publication]***

### **Bradford District and Craven – To be confirmed**

- *Bradford District and Craven's integrated neighbourhood teams model will operate across localities, primary care networks and community partnerships, through a 'team of teams' based approach. The final footprints and number are to be confirmed pending local consultation and agreement.*

### **Calderdale – five neighbourhoods**

- Calder and Ryburn
- Central Halifax
- Lower Valley
- North Halifax
- Upper Calder Valley

### **Kirklees** – nine neighbourhoods

- Batley and Birstall
- Dewsbury and Thornhill
- Greenwood Network
- Spen Health and Wellbeing
- The Mast
- The Viaduct
- Three Centres
- Tolson Care Partnership
- Valleys Health and Social Care

### **Leeds** – thirteen neighbourhoods

- Armley
- Central North Leeds
- Cross Gates
- HATCH
- Inner South
- LS25 LS26
- Morley and District
- Otley and Aireborough
- Seacroft
- West Leeds
- Wetherby
- Woodsley and Holt Park
- York Road

### **Wakefield** – six neighbourhoods

- Brigantes
- Five Towns / Wakefield North
- Pontefract and Knottingley
- Trinity Health Group
- Wakefield Health Alliance

- West Wakefield

All five places understand their starting point on INTs, supported by the self-assessment of the six INH components, and have strong foundations to build on, including:

### **In Calderdale**

- Governance across the place-based partnership, which provides space for joint leadership and collaboration across all partners.
- Four identified priority cohorts: children with complex issues, end of life, frailty and care home residents.
- Memorandum of Understanding (MOU), data sharing agreements and governance that has been established between providers.

### **In Kirklees**

- Governance and support from the place committee and delivery collaborative.
- A focus on frailty as a priority cohort, with a well embedded frailty scheme already in place.
- Invested limited funding in Organisational Development (OD) support which will support system and neighbourhood workshops throughout 2025/26.

### **In Leeds**

- Four established place-based partnership priority transformation programmes that will support the delivery of neighbourhood health, with strong foundations from the 15 local care partnerships.
- Substantial data and population health management capacity and capability.
- Identified priority cohorts: people at the end of life with advanced respiratory disease, frailty, people living with 3 long term conditions and mental health issues, and global majority men with hypertension living in IMD-1 areas.

### **In Wakefield**

- Strong track record in delivering neighbourhood multidisciplinary teams, with an existing Connecting Care model in place.
- Robust population health management analysis capabilities in place, enabled through the linked data model.
- An established programme for the next two years, with a roadmap and plans, and oversight from the Transformation Delivery Collaborative.

### How Places will deliver the INT vision

Places have developed priority areas of focus for the short-, medium-, and long-term to reflect this – set out in the table below and appendices.

	Short (1 year)	Medium (3 years)	Long (5 years)
<b>Bradford district &amp; Craven</b>	<ul style="list-style-type: none"> <li>• OD and operational design work to align services at PCN and CP level.</li> <li>• Expand coverage of community MDT models.</li> <li>• PHM work on frailty, palliative and EOL care to inform service models.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify further cohorts to expand neighbourhood models.</li> <li>• Consider expansion of multi-service hub models.</li> <li>• Progress discussions on the role of local provider collaboratives.</li> </ul>	
<b>Calderdale</b>	<ul style="list-style-type: none"> <li>• Conduct population segmentation for priority cohorts to understand potential benefits and identify the required interventions.</li> </ul>	<ul style="list-style-type: none"> <li>• Deliver system development / OD support and identify the year-on-year programme for this.</li> <li>• Build the functions of INTs into current processes</li> </ul>	

	<ul style="list-style-type: none"> <li>• Conduct a self-assessment off all INTs.</li> <li>• Continue to deliver ongoing projects that support INT and INH working.</li> </ul>	<p>and standardise good practice across all.</p> <ul style="list-style-type: none"> <li>• Develop and deliver the high intensity user cohort intervention.</li> </ul>	
<b>Kirklees</b>	<ul style="list-style-type: none"> <li>• Review existing capacity and capability to align to INTs.</li> <li>• Identify the priority cohorts for each INT, and clarify the measurable improvements and interventions.</li> <li>• Mobilise the INTs around priority cohorts.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and deliver OD and workshops to support neighbourhood working.</li> <li>• Establish and mobilise an INT improvement process.</li> <li>• Develop neighbourhood level metrics and establish the baseline.</li> </ul>	<ul style="list-style-type: none"> <li>• Review metrics and measures of success to identify areas that are working well, and areas for improvement.</li> <li>• Grow the INT by identifying additional partners.</li> <li>• To have 9 full formed INTs delivering a best practice model.</li> </ul>
<b>Leeds</b>	<ul style="list-style-type: none"> <li>• Develop the shared Leeds Health and Care Partnership vision and mandate, and establish supporting programmes</li> <li>• Clarify the measures of success for the four priority programmes.</li> <li>• Establish the minimum INT meeting and</li> </ul>	<ul style="list-style-type: none"> <li>• Support test sites to deliver.</li> <li>• Create the OD programme to support the change.</li> <li>• Develop the core team to prevent patients moving around teams.</li> <li>• Measure impact, using the Leeds PHM approach.</li> </ul>	<ul style="list-style-type: none"> <li>• Continuous learning from the test sites to inform rapid scale up.</li> <li>• Creation of neighbourhood focused contracts.</li> </ul>

	space for each cohort. <ul style="list-style-type: none"> <li>• Identify test sites that will go further, faster.</li> <li>• Risk stratify the priority cohorts.</li> </ul>		
<b>Wakefield</b>	<ul style="list-style-type: none"> <li>• Agree the vision and priority cohorts.</li> <li>• Design the operational model for INTs.</li> <li>• Establish the metrics and embed evaluation.</li> <li>• Soft launch in September and full launch in November 2025.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop the specifications for the INTs.</li> <li>• Implement INT interventions for priority cohorts 2 and 3.</li> <li>• Develop the governance to transition to provider collaborative arrangements.</li> <li>• Broaden the INT offer to include the full population assessment of need, and embed dynamic interventions for most at risk cohorts</li> </ul>	<ul style="list-style-type: none"> <li>• Broaden the INT offer to include the full population assessment of need, and embed dynamic interventions for most at risk cohorts</li> </ul>

### **What we will deliver consistently**

Whilst places will focus independently on the four key enablers set out in this blueprint, there are several common challenges and opportunities that present consistency and/or efficiency benefits.

Throughout this year, and beyond, overseen by the West Yorkshire Integrated Neighbourhood Health (WY INH) Board and working with interdependent programmes, we will develop and deliver on a series of priorities, including:

## **Workforce, organisational development and culture**

- Recognising the direction of travel set out in the Model ICB Blueprint for workforce transformation, we will work with regional and provider partners to understand where this work will be designed and delivered.
- We will share findings of our engagement to ensure that the work required to enable INTs to work together effectively is still delivered. This should include profiling the current workforce to support neighbourhoods to understand their assets, the scope to upskill current staff, and identify the future workforce development needs.

## **Digital, data and technology**

- Support and progress the development of the shared care record, working across places and with the West Yorkshire digital team.
- Support the consistent development of data and Business Intelligence capability and capacity to support neighbourhood working and Population Health Management (PHM).
- Recognising the direction of travel set out in the Model ICB Blueprint for digital transformation, we will work with regional and provider partners to understand where this work will be designed and delivered.

## **Estates**

- Identify and act where there are common challenges to making more efficient use of our NHS and wider public estate to deliver services in neighbourhoods.
- Ensure ongoing connectivity to the wider infrastructure strategy.

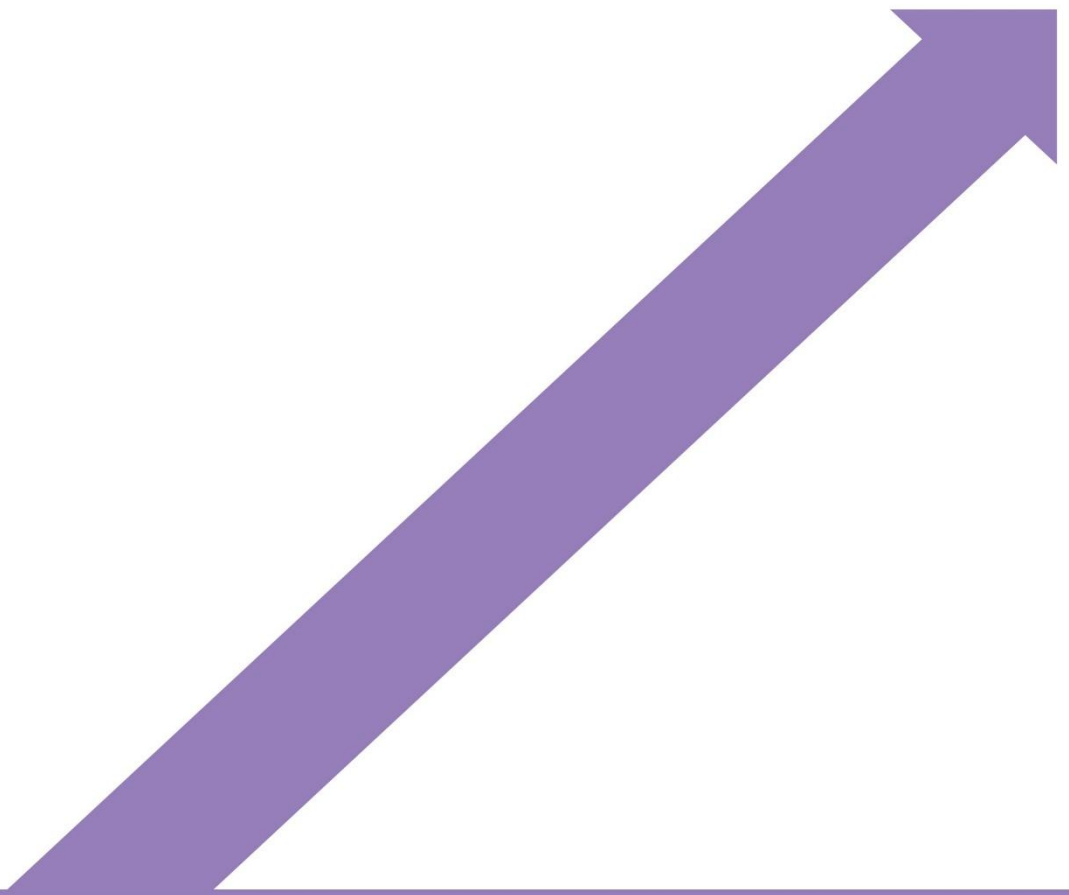
## **Finance, resources and capacity**

- Ensure the appropriate investment of in-year service development funding to support transformation that delivers INTs and INH. This will be used to strengthen the foundations of neighbourhood working set out in this blueprint and overseen by the WY INH Board.
- Scope and develop the financial frameworks, contract forms, and incentives that can support and enable mid- to long-term delivery.

- Identify the resources and capacity required to deliver, creating the vehicle to support development where there are issues.



**How will we know  
we have delivered  
our vision?**



## How will we know we have delivered our vision

There are several ways that we will understand whether we have delivered our vision, and how we are working towards it. It is vital that outcomes for patients are our central focus, whereby improving outcomes will signal progressive delivery. In addition, the experience of the health and care workforce that operate in neighbourhood teams will be a key indicator of maturity, alongside more process focused measures against the six core components and delivery of the priorities set out in this blueprint.

### Measuring Outcomes

In line with our 2025/26 approach to planning and prioritisation, we have adopted two guiding North Star metrics – one focused on reducing preventable unplanned care utilisation, and the other on increasing prevention and early intervention.

Each of the places have developed plans that focus on priority population cohorts that account for a disproportionate share of preventable unplanned care utilisation. The plans set out the interventions that will be delivered via neighbourhood teams, and the anticipated impact on reducing the growth in unplanned demand.

The priority cohorts differ on a place and neighbourhood-based footprint, and may evolve as INTs improve health and grow in capacity and capability.

### Principles for Integrated Neighbourhood Healthcare

Through our engagement across the system, there is a strong desire to build on our foundations of collaborative working across organisations and professions to improve outcomes for the West Yorkshire population.

The set of principles outlined below sets out our vision for how all partners will experience working together when we meet our collective vision. This will guide our work to deliver integrated neighbourhood healthcare, and indicate our progress:

- **Parity** – for all services and professionals involved in providing care in neighbourhoods, where the contribution of all partners important in a person's care is of equal value.
- **Proportionality** – to ensure that the extent of the integration and interface is reflective of the need, difference and level of involvement services and professionals play in providing care.
- **Pragmatism** – in how this is applied and evolves, recognising that places and organisations are at different stages of this journey, acknowledging that this will evolve, and that the improvements will take time.

### **What will neighbourhood governance look like in West Yorkshire**

The strategic direction and associated outcomes for INTs have been determined by the WY Integrated Care Board and Local Place Partnerships, while the INTs will be responsible for their delivery.

Locally, places will monitor their delivery of plans and priorities for INTs. Most places have agreed local governance and oversight arrangements, including specific programme boards, named SRO's and oversight through their place collaboratives and committees of the ICB. Through this, places will monitor the detail of the plans set out and delivery against the six core components of neighbourhood health.

At West Yorkshire level, we have established an Integrated Neighbourhood Health Board, which will hold overall responsibility for overseeing the development of INH. It will provide leadership and oversight to the areas of scale opportunity and additional work that it identifies, support the timely delivery of plans and priorities linked to the metrics, and ensure connectivity across other forums and programmes responsible for delivery, including place committees.

As the future operating model and system architecture is embedded it will be ensured that our approach to oversight is proportionate and aligned. This will consider the role of the ICB as a strategic commissioner and integrator, and the role of provider collaboratives at place.

## **Developing Integrated Neighbourhood Teams in West Yorkshire**

Each Place is in a different stage of developing their approach to integrated neighbourhood working. The following roadmap represents a starter for ten based on initial conversations for the decisions and activities that need to be co-developed with partners and residents locally to ensure neighbourhoods and services delivered are built around and address population needs.

Developing integrated neighbourhood teams in West Yorkshire – three phases:

### **Phase 1 – Test and design (year 1)**

- Have a clear shared vision, purpose and high-level outcomes.
- Pull together data from across health, public health and social care to achieve a clear view on existing neighbourhood footprints, community assets and population needs, including inequalities.
- Define geographies for neighbourhood footprints, including how primary care networks align with neighbourhood teams.
- Identify initial priority cohorts for integrated neighbourhood teams using population health approach.
- Define place metrics aligned to the West Yorkshire overarching north star metrics.
- Establish governance to ensure clear leadership and accountability, including risk management and clinical governance.
- Implement measures of success and monitoring approach.

### **Phase 2 – Refine, design and set up (years 2 to 4)**

- Identify and agree workforce, skills and resource requirements of integrated neighbourhood teams to meet population needs aligned to the West Yorkshire strategies.
- Assess whether the right resources are in the right place for integrated delivery. If things need to change, work out how – with population input.
- Collectively allocate resources based on identified need, exploring novel arrangements (for example, contracts and incentives) and removing historical integration barriers.

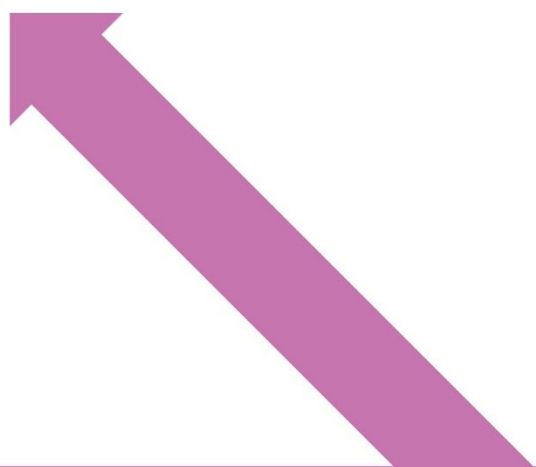
- Develop population health management approach to enable proactive identification and management of residents.

### **Phase 3 – Test and learn (year 5 onwards)**

- Embed integrated multi-organisational neighbourhood teams for a chosen population cohort in an agreed geographic footprint.
- Embed digital tools and knowledge that enable a shared, population-health driven approach.
- Facilitate cross-sector relationships and deploy collective resources to support workforce, digital solutions, estate utilisation and wider infrastructure.
- Share learning, capacity and resources across neighbourhoods, converging around best practice.
- Use established governance to continuously assess learning, progress and impact, and integrate into the development of the full integrated neighbourhood team's implementation.
- Based on learning, start shifting resources to enable expanded population coverage and increase resource proportion supporting prevention.

All three phases are underpinned by ongoing involvement and meaningful participation with partners and residents. This will enable cultural change and integrated neighbourhood teams to be built and flexed around residents' needs. We will make full use of the knowledge and skills of the teams across organisations and ensure that learning and experience is maximised and shared to continuously improve.

# Case studies



## Compendium of case studies

*[Finalised case study graphics to be inserted into document and onto the ICB website at the point of publication]*

## Appendix: Place Plans on a Page



**Place:** *Bradford District and Craven*

**Current Position**

*Should include information on the starting point/progress to date in establishing INTs for 2025/26, the number of INTs, the geographic footprints covered, population cohorts focused on, governance arrangements for oversight at place and delivery of INT working at neighbourhood level, etc.*

*Our approach for INTs in BdC builds on work we have undertaken over recent years to create an infrastructure that supports people to remain healthy and well in the communities where they live, and which improves individual and population health outcomes, addresses health inequalities and minimises the need for acute hospital care.*

*We have many successful elements of integrated models already operating between teams and sectors across BdC. There is some variation in maturity (for certain cohorts and geographies) that we are working as a priority to address and a core part of our delivery plan is achieving comprehensive coverage of INT models, informed by population health management analysis and with insights from all sectors working in local communities. This does not mean ‘one size fits all’ but an approach where priority population groups receive targeted holistic support and seamless transitions between services, and where the teams working in neighbourhoods are empowered to leading the design of local services in partnership with local communities.*

*Our neighbourhood-level ‘engine room’ for this will be our 12 PCNs and 13 Community Partnerships (CPs). Across most of our district, these have a shared footprint and collaborative leadership team, bringing together both the NHS perspective and wider neighbourhood social wellbeing through the local authorities and VCSE. Going forward, we want to enhance the alignment of community health services, where there are already a number of co-located teams with primary care, though it will take time to address workforce supply and estates to expand this across the whole district. We already have dedicated MDT models such as BDCFT’s Proactive Care Team (PACT) who work across our three inner city PCNs to provide more intensive short-term care and support for individuals at higher risk of unplanned admissions, and several similar models operating within our other PCNs. Our Healthy Minds programme is contributing on how community mental health services are integrated within the overall wider multi-agency neighbourhood model, ensuring proactive support and connections with more specialist MH care. In addition to statutory health services, we have strong input from the VCSE through our VCS Alliance, and organisations such as the Cellar Trust, Keighley Healthy Living (KLH) and HALE – who provide a range of dedicated services at the neighbourhood level such as for social prescribing, initiatives to reduce social isolation and mental health support.*

*Our PCNs and CPs nest within a larger BdC locality structure – with five localities covering the City of Bradford Metropolitan District Council area, plus one in North Yorkshire (covering Craven). A number of services will be coordinated at a locality level, where that brings ‘economies of scale’ and also as a mechanism for strategic coordination and partnership working between adult social care, health and wider public services.*

*We have undertaken a PHM analysis and population segmentation using our linked data set, which has identified our priority cohorts as: palliative and end-of-life care; frailty and dementia; physical disability; long term conditions (particularly for older adults); learning disabilities; people with SMIs; and children with complex health and care needs. Analysis has also been undertaken of the prevalence of LTCs and multi-morbidity – which has highlighted MSK, mental health conditions (such as depression), chronic respiratory disease, diabetes and CVD. Data packs have been developed for each PCN. A key design principle for our INT approach is that our models do not “over-medicalise” care, recognising that (especially for complex cohorts) psychosocial factors are often a significant contributor to health and wellbeing.*

*We are currently revising our place governance structures in relation to integrated neighbourhood health and care support (including INTs). The development of our overarching Health, Care and Wellbeing Strategy, which includes our plans for integrated neighbourhood health, is overseen by our Partnership Leadership Executive. We have a number of existing programme boards and SROs groups where more detail conversations and work are continuing, such as our Integrated Health and Care Workstream Group which is leading the design of urgent neighbourhood health services.*

**Priority Actions** *Note: should include the specific strategic actions that you will deliver to establish and embed INTs during 2025/26 and beyond.*

### Short-term

- *Build on the foundations established through our PCNs and CPs to further integrate and align services at the neighbourhood level – including through OD and operational design work in 25/26 with primary care, community health services, community mental health, and the VCSE.*
- *A range of more specific community MDT models for defined cohorts are already in place. Work with providers on achieving wider coverage and greater alignment of community services to neighbourhood footprints (models tailored to needs of local communities).*
- *Conclude development of the BdC Health, Care and Wellbeing Strategy – which includes overarching vision and multi-stakeholder approach for development of integrated neighbourhood health and care support. This will shape our workforce, digital and estates approaches for neighbourhood health and INTs going forwards.*
- *Establish baseline metrics and evaluation approach*
- *PHM work started relating to frailty, palliative and EoL care to inform future service models– and to test and learn from implementing the PHM approach. We will undertake similar work for complex children.*
- *Specific more local development conversations also underway within individual neighbourhoods e.g. an emerging Airedale Neighbourhood Model linked to the Airedale New Hospital Programme.*

### Medium-term

- *Building on the short-term actions, we will seek to identify further cohorts where there can be additional targeted development work to expand integrated neighbourhood models.*
- *Explore expansion of existing multi-service hub models to create more ‘one stop shops’ that bring together health services and wider community support.*
- *We will progress discussions with our local provider collaboratives around how providers can jointly lead transformation of neighbourhood services - in light of the ICB’s shift to strategic commissioning and structural changes expected later in 25/26*

### Long-term

- *These will be shaped by the implementation plans put in place following the Health, Care and Wellbeing Strategy, and informed by the national 10 Year Plan, the future functions of ICBs, and on-going development of local place provider collaboratives.*

**Enabling Actions** *Note: should include the enabling actions that support your short, medium and long term actions, as well as any other actions you think are required to enable INTs (either at place or system level).*

Workforce & OD	Our Workforce and OD approach is supporting the shift towards more staff increasingly working in multidisciplinary, integrated neighbourhood teams which span organisational and sectoral boundaries, enabled by digital and tech, and upskilling workforce in these areas. This includes bringing community teams together in 25/26 for series of local (neighbourhood-level) development sessions on PHM, MDT development and pathway redesign, which will also enable us to determine what new or alternative roles we may need to develop. We will also undertake OD inclusive of wider partners such as VCSE, education, police and fire so we build a holistic model across the breath of our communities, in addition to health.
Finance	Fundamentally a shift of resources is needed to support in the medium-term as hospitals become smaller and more specialist, out of hospital care (including integrated neighbourhood health and INTs) needs to expand and work efficiently to keep patients away from acute settings. We are already progressing this work through our “Closing the Gap” initiative, which has established principles for how we move funding and activity around the system. Going further, this will also include developing our model of value-based care and reducing growth into the hospital sector by an agreed % to invest in out-of-hospital care. We will consider, in the longer term, establishing a community investment standard so that growth funding in future financial plans can be diverted into integrated neighbourhood teams.
DDat	<p>Short term:</p> <p>Maintain and publicise our Shared Care Record reciprocal views between SystmOne and Cerner Millennium</p> <p>Stocktake of SystmOne Unit spread including Community, Palliative Care, GP Hubs and Out of Hours</p> <p>Stocktake of network connectivity in strategic sites and where shared connectivity already exists including VPNs, wi-fi (govroam/nhs wi-fi)</p> <p>Stocktake of Digital Patient interaction tools (all Care Settings, NHS App, PKB, Cerner Portal, PATCHS etc) including Digital Inclusion initiatives</p> <p>Stocktake of H&amp;SC staff Collaboration Tools (e.g. MS Teams – federation, consider route to consolidation of @nhs.net for all health users)</p> <p>Medium Term:</p> <p>Identify new Digital Requirements of emerging programmes</p> <p>Develop a safe and common approach to AI adoption and exploitation of available Rapid Process Automation tools</p> <p>Develop business cases and plans for new Digital delivery models including shared / open access to infrastructure/solutions/services (including the VCS/3rd Sector)</p> <p>Assess Workforce capability and develop outline maturity plan (skills)</p> <p>Long Term:</p> <p>Deliver Workforce Digital Maturity plan</p> <p>Deploy new / re-configured Digital Solutions across care settings in support of INT working</p> <p>Embed innovation into all service development planning</p> <p>Optimise shared infrastructure and access</p>
Estates	Effective use of all our community estate infrastructure is an important driver in supporting our integrated neighbourhood approach. Our intent is to have services as close to people's homes as possible. This encompasses NHS, local government and VCS assets, building in flexibility to change as services develop with new ways of working and the digital future. We will make optimum use of our estate across health and care to enable greater co-location of services and MDTs, and we have a number of existing buildings we intend to repurpose potentially as multi-agency hubs. Primary Care estate includes the seven LIFT (Local Improvement Finance Trust) sites, from which a range of primary and community services are already provided. We have identified estate that needs to be replaced as a priority when alternatives becomes available, including a number of community health centres. We intend to build upon our place estates strategy developed in 2024, and refresh the existing PCN estates strategies in 25/26.

## **Success Measures**

*Places may wish to include population cohorts and expected outcomes delivered by INTs, milestones in establishing INTs linked to S-M-L actions, links to the gap analysis/maturity against the 6 core components, etc.*

*This is underway and will form part of the wider request by the ICB for integrated neighbourhood health metrics by mid-May. Our metrics will be based around tracking patterns of service utilisation and improvements for our population priority cohorts, initially for older people, frailty, palliative and EoL.*

**Place: Calderdale**

**Current position**

**Progress to date**

- We have a well-established community collaborative Programme Board comprising, health, care, voluntary, community sector providers, health and social care commissioners and public health this has acted as the operational driver for the development of Integrated Neighbourhood Teams across Calderdale.
- There are 5 Integrated Neighbourhood Teams or Partnerships (formed around the primary care network footprints).
- The development of INTs in Calderdale is overseen by the Calderdale System Leadership Group (CSLG) and developed by the Calderdale Cares Community Programme Board (3CPB). Developing INTs is 1 of 7 transformation priorities for Calderdale Cares Partnership 2024-26.
- Foundation blocks have been established in relation to MOUs between providers, data sharing arrangements, governance.
- Ageing Well service up and running (Frailty – mild to moderate) HSJ award finalist
- A data driven approach has been agreed to identify INT priority areas of focussed interventions, looking at addressing health inequalities and proactive, preventative support.
- We have established a vision and see an integrated neighbourhood team approach as integral to delivering the key components of integrated neighbourhood health.
- Wider sector approach - developed the role of local community organisations as ‘community anchors’ in two INTs areas that did not have this infrastructure to enhance community development, maximise investment into VCSE organisations and build capacity in localities.
- We are adopting a strengths-based approach for service delivery across all system partners led by the Local Authority
- PHM data model – linked dataset established to identify impactable cohorts to support INTs.
- Cross sector partners have evaluated Calderdale against the PHM maturity matrix and identified areas of work to progress this journey
- System development/organisational delivery plan drafted and in further development
- Identified a few metrics to start to track impact on system as INT ways of working develop throughout 25/26 – with flexibility linked to new insights and data.
- All 5 INTs are meeting regularly with partners
  - A data and information driven approach has been agreed for identifying INTs areas of focus/ priorities for their population. The availability of the data is provided by the Calderdale Intelligence Network.
  - The 5 INTs are supplementing the data with local intelligence of need through discussions across partners.
  - The five INTs continue to develop the ways of working in their area via the identification of priorities and by networking and engaging with the key partners and assets that provide support and services to the people in that area.
- Developed and delivered an induction plan for elected Member

<b><u>Priority actions -</u></b>			
	<b>Short term (By June 25)</b>	<b>Medium term</b>	<b>Long Term</b>
	<ul style="list-style-type: none"> <li>Population segmentation for 5 identified cohorts, understand the biggest impact (benefits realisation) &amp; identify interventions</li> <li>Cohorts of interests for Calderdale identified as               <ul style="list-style-type: none"> <li>CYP with complex issues</li> <li>End of Life</li> <li>Frailty</li> <li>Care Home residents</li> </ul> </li> <li>Re-visit the local provision mapping done in 2023</li> <li>Ensure any interventions are robustly evaluated, including patient and staff activation</li> <li>INTs to undertake a 25/26 self-assessment for INTs maturity</li> <li>Continue with ongoing projects               <ul style="list-style-type: none"> <li>Addressing high risk of admission for Frailty cohort – moderate to severe</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Delivery of the system development/ OD programme of support – identify the year-on-year programme</li> <li>Consider how we bring in the knowledge of the wider social care workforce/ provision – Domiciliary care/ care homes</li> <li>Build the functions of Neighbourhood MDTs described in the guidelines into current processes &amp; standardise the good practice of MDT working in all areas</li> <li>Strengthen providing citizen voice into the INTs including case studies</li> <li>Development of a case management tool</li> <li>HIU frailty cohort intervention designed and delivered</li> </ul>	

	<ul style="list-style-type: none"> <li>• Community mental health transformation aligned to INTs</li> <li>• LTC Areas of focus - CVD Prevention, Diabetes and Respiratory</li> <li>• April 25 - Wound care pathway</li> <li>• EOLC/ GSF lite</li> <li>• Undertake a gap analysis on CYP MDT guidelines</li> <li>• Continue to work with Local authorities and partners</li> </ul>		
<b>Enabling actions</b>			
	<b>Short term</b>	<b>Medium term</b>	<b>Long Term</b>
Workforce &OD	System development and OD programme of support		
Finance	Make use of opportunities offered the INH SDF funding		
DDaT	System level - Digital and BI capacity – ensuring alignment with the Digital and data strategy to enable “one version of the trust” across WY		
Estates	Utilisation and Modernisation Schemes will support increase in clinical space within General Practice by March 2026		

**Success measures**

- Cohorts of interests for Calderdale identified as
  - CYP with complex issues
  - End of Life
  - Frailty
  - Care Home residents
- These cohorts account for 5.3% of our population but consume 36.8% of NEL admissions and 56.6% of bed days- further work is underway to understand the impact to be made and the interventions.
- Continue to develop and monitor local patient and staff experience metrics, patient activation & early intervention and prevention metrics.

Calderdale have developed a maturity matrix for the development of neighbourhood partnerships - this was completed around 12 months ago by each neighbourhood and the intention is to re-visit in 25/26.



**Place:** Kirklees

**Current Position**

*Should include information on the starting point/progress to date in establishing INTs for 2025/26, the number of INTs, the geographic footprints covered, population cohorts focused on, governance arrangements for oversight at place and delivery of INT working at neighbourhood level, etc.*

- Baseline Assessment completed against the 6 Core Components of the Integrated Neighbourhood Health Guidelines (Jan 25). All components noted as yellow or amber. Each core component has an SRO identified and action plan in place. Senior Leadership identified across system partners.
- A significant number of community, MH services and VCSE support already wrapped around the 9 PCNs. Agreement for INTs to be established around PCN Geographical footprints which will result in 9 INTs being established across Kirklees
- Spent time on engagement and development through December and January including ICB Place Committee, Delivery collaborative and with PCNs to ensure all on same page with their understanding, guidance and agree a shared ambition.
- PCN data packs have been refreshed to support data enabled decision making around the Cohorts that would benefit the most from an INT in each neighbourhood. Currently understanding gaps in the data. First area of focus for all – frailty & supporting North Star metrics. A well embedded scheme in place to support frailty.
- Limited Funding approved for OD support to facilitate system and neighbourhood workshops in 2025/26.
- Governance- overseen by ICB Committee through Delivery Collaborative – evolve through Provider Collaborative. Existing priority in Kirklees H&C Plan.
- Barriers – Currently no access to linked data sets and some issues with data sharing on the back of GP collective action
- Challenges identified through the engagement process – ensuring enough capacity to move at pace (INT and Care Co-ordinator capacity), Data and OD.

**Priority Actions** *Note: should include the specific strategic actions that you will deliver to establish and embed INTs during 2025/26 and beyond.*

**Short-term**

- Organisations to review where existing roles could be repurposed to create the correct capacity to lead and deliver INTs.  
(INT Lead, Care Co-ordinators.)
- Continued engagement with system partners, including the VCSE Sector.
- Firm up required data and finalise INT data packs to support north star metrics – including exploring PHM tools further
- Utilising data, agree priority cohort in each INT based on non-elective admissions. Identify and prioritise individuals living in the top 20% most deprived areas or experiencing other health inequalities
- Present paper to ICB Committee in May to approve the approach to establishing INTs in Kirklees.
- Develop the integrated team around the priority cohort

**Medium-term**

- Neighbourhood level workshops with a focus on OD – ensuring staff feel empowered and have a shared purpose around INTs.
- Develop Neighbourhood level metrics and establish a baseline.
- Continue workforce engagement and training to support the culture change of working for the person and not the individual organisation.
- Establish a process for improving MDTs and mobilise.
- Active involvement of citizens and patients and the engagement of the wider community.
- Review approach against LTP once published in the summer – refine/adapt to meet any additional asks.

**Long-term**

- Review metrics/measures of success – what is working well, identify areas for improvement
- Grow the INT – identify additional partners that would enhance the INT model
- Align with guidance – review against the long-term plan/planning guidance, identify gaps and actions to address the gaps.
- Aim to have 9 INTs established across Kirklees, delivering a best practice model, reviewing data and KPIs and evolving over time through data enabled decision making.
- Take a continuous improvement approach, with the INTs evolving over time.

**Enabling Actions** Note: should include the enabling actions that support your short, medium and long term actions, as well as any other actions you think are required to enable INTs (either at place or system level).

Workforce & OD	<ul style="list-style-type: none"> <li>➤ Identify funding for OD support at a system and neighbourhood level</li> <li>➤ Identify capacity within the system to address workforce gaps outlined in the engagement process.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Neighbourhood level workshops with a focus on OD</li> </ul>	<ul style="list-style-type: none"> <li>➤ Remove barriers to silo working across sectors and organisations</li> <li>➤ For those working in INTs to recognise they are part of one.</li> </ul>
Finance	<ul style="list-style-type: none"> <li>➤ Identify funding for OD support at a system and neighbourhood level</li> <li>➤ Possible resource needed to support PHM and Risk Stratification</li> </ul>	<ul style="list-style-type: none"> <li>➤ Identify recurrent funding to secure the care coordinator roles that are currently being recruited via short term non-recurrent funding for 1 year.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Resource allocation for the 9 neighbourhoods supported through Provider Boards/Collaboratives.</li> </ul>
DDaT	<ul style="list-style-type: none"> <li>➤ Challenge in Kirklees around not having a linked data set – explore how/if we can overcome this.</li> <li>➤ Challenge - different patient record systems exist – difficult for staff to see a full patient record – explore how to overcome this.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Ensure linked data set available and BI support for interpreting and sharing</li> <li>➤ Explore available technology that could support the INT to work more efficiently</li> </ul>	<ul style="list-style-type: none"> <li>➤ Neighbourhoods able to access shared data sets routinely updated for joint priority setting.</li> </ul>
Estates	<ul style="list-style-type: none"> <li>➤ Explore estates in each neighbourhood that could potentially host some teams to co-locate if this is felt to be beneficial by the workforce in each INT.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Align this work with the WY Infrastructure Strategy to ensure investment is prioritised in the right places.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Shared approach to estates utilisation within the community</li> </ul>

## Success Measures

*Places may wish to include population cohorts and expected outcomes delivered by INTs, milestones in establishing INTs linked to S-M-L actions, links to the gap analysis/maturity against the 6 core components, etc.*

**\*\* Additional Neighbourhood Level metrics will be determined once the population cohort is agreed within each INT\*\***

Measure/Outcome	Measure	Target
Establishment of INTs	Count of the number of INTs mobilised in Kirklees.	Baseline: 0 INTs Target: 9 INTs (timescale tbc)
Improve experience of care (patients)	Bespoke questionnaire Patient Stories	On-going improvement (baseline to be determine)
Improve experience of providing care (staff)	Bespoke questionnaire Staff retention Staff sickness	On-going improvement (baseline to be determine)
Improve integrated care at a neighbourhood level	Improvement/increase in the number of MDTs	On-going improvement (baseline to be determine)
Improve population health and wellbeing outcomes	Timely identification of needs through risk stratification and diagnosis i.e. improvement in the identification of frailty and timely interventions	On-going improvement (baseline to be determine)
	Improvement in the number of holistic assessments undertaken i.e. Frailty Assessment, CGA	On-going improvement (baseline to be determine)
	Reduction in the number of falls for the target cohort	On-going improvement (baseline to be determine)
	Improve patient activation - patients have knowledge, skills and confidence to manage their health.	On-going improvement (baseline to be determine)
	Number of people with a Personalised Care and Support Plan	Baseline to be determine once patient cohort is agreed per individual INT. Increase/improvement to be agreed.
	Number of patients under the care of Proactive Care – utilise coding on patient record	Baseline to be determine once patient cohort is agreed per individual INT. Increase/improvement to be agreed.
System Benefits:  More efficient use of our resources / Reduce duplication to make best use of our limited resource.	Unplanned activity: ➤ Reducing non-elective admissions ➤ Reducing LOS ➤ Reduction in the number of re-admissions. ➤ Reduction in the number of A&E attendances for patients under the care of an INT.	Baseline to be determine once patient cohort is agreed per individual INT. Increase/improvement to be agreed.

## Place: Leeds Current Position

The model for INTs and neighbourhood health in Leeds will be developed through the four Leeds Health & Care Partnership Transformation Programmes overseen by the Partnership Leadership Team. There are good foundations to support this work with Leeds partners already working collaboratively within 15 Local Care Partnerships (LCPs) aligned to the footprints of the 19 PCNs. These footprints are fairly stable but vary in size, the populations of focus and the presence/leadership from partners for MDT meetings/working. Our ambition is to have 13 geographic neighbourhoods accounting for student populations and branch practices.

## Delivery Plans for 2025/26

4 Leeds Health & Care Partnership Transformation Programmes		6 Neighbourhood Health model component	RAG Mar 25	Leeds plans for delivery by Mar 26
<b>Population Health Management</b>		● Population health management		Delivered by: Refine local searches to identify the cohorts for proactive care by LCP. Define local metrics to measure impact.
<b>HomeFirst Phase 2:</b> will deliver proactive care for target cohorts with the highest level of need that will require common interventions to reduce usage: <ul style="list-style-type: none"> <li>People at EoL with advanced resp disease</li> <li>People living with frailty at risk of falls</li> <li>3LTC Plus MH (SEISMIC)</li> </ul>		● Modern general practice		Delivered by: Support remaining practices with any further MGP funding and shared learning
<b>Community Mental Health Transformation</b> will roll out a city wide model for community mental health services for people with the highest level of need		● Standardising community health services		Delivered by: HomeFirst Phase 2: Targeted Prevention Community Mental Health Transformation CYP complex needs
<b>Childrens &amp; Young People</b> includes: <ul style="list-style-type: none"> <li>Management of high cost complex needs packages</li> <li>CYP Mental Health service review</li> <li>Early identification &amp; intervention of mental health needs in school age children</li> </ul>		● Neighbourhood multidisciplinary teams (MDTs)		Delivered by: HomeFirst Phase 2: Targeted Prevention Community Mental Health Transformation CYP complex needs
<b>Early Identification of Cardiovascular disease</b> through a focus on Hypertension: <ul style="list-style-type: none"> <li>Targeted cohorts (global majority males in IMD-1)</li> <li>Those at risk from GP medical history</li> </ul>		● Integrated intermediate care - 'Home First' approach		Delivered by: HomeFirst Phase 2: Targeted Prevention
		● Urgent neighbourhood services		Delivered by: HomeFirst Phase 2: Targeted Prevention

## Success Measures – TBC

	Number of People supported	Reduction in unplanned care usage	Staff & patient experience	Financial benefit
HomeFirst Phase 2			EQ5D baseline	
Community Mental Health Transformation				
Children & Young People with complex and mental health needs				
Earlier identification of CVD risk through a focus on hypertension				

**Priority Actions** *Note: should include the specific strategic actions that you will deliver to establish and embed INTs during 2025/26 and beyond.*

Short-term	Medium-term	Long-term
<p><b>Develop the shared LHCP vision and mandate and establishing delivery programmes</b> including:</p> <p><b>Measures of success + monitoring</b> for programmes</p> <p><b>Baseline Assessment</b> of collaboration conditions</p> <p><b>Implementation minimum MDT</b> meeting/space in each area for pro-active care for the agreed cohort/s.</p> <p><b>Agree test sites in neighbourhoods that will go further faster</b> – working through the blocks/enablers for MDT working</p> <p><b>Risk stratification</b> of priority cohorts</p>	<p><b>Designing the conditions collaboration &amp; joined up working with ‘test sites’</b>(anticipate up to 6 localities):</p> <p><b>OD approach</b> – with LCP to create common purpose</p> <p><b>Process review</b> – to reduce silos and boundaries between teams; free capacity to shift from reactive to proactive clinical work (25% of staff time).</p> <p><b>Develop a ‘core team’</b> - to reduce patients moving around teams, staff with clear roles and responsibilities to work collaboratively</p> <p><b>Specialist staff</b> - understanding of the specialist staff needed and how they work with/around a core team</p> <p><b>Shared care record</b> - further develop the Recovery Plan as a single read/write, real time care plan for multiagency input.</p> <p><b>Management of clinical risk</b> - Map and work through how clinical risk and accountability is effectively managed with increased joint working as a core team.</p> <p><b>Develop Partnership governance</b> – through the HomeFirst Board, Enabler forums &amp; Population Boards</p> <p><b>Measuring impact</b> - Using PHM approach via the Leeds data model to track changes in use of resource and outcomes for patients, staff and system resource</p>	<p>Learn from the ‘test sites’ to inform a framework for INTs/MDTs and rapid scale up across Leeds</p> <p>Creation of neighbourhood focused contracts to support the resources and governance to enable scale</p>

**Enabling Actions** *Note: should include the enabling actions that support your short, medium and long term actions, as well as any other actions you think are required to enable INTs (either at place or system level).*

Workforce & OD	Scope the support functions that are needed for INTs to work well (management / admin/ QI, data intelligence, other?)
Finance	Agree the programme benefits and financial impact. Establish a Benefits Realisation group to track delivery
DDaT	Scope if the Recovery Care Plan could work as a read/write single plan Understand the digital requirements of all programmes through business analysis
Estates	Work with the strategic Estates board to develop solutions to support the use of available public estate in the city

System review of where these support functions /resource sits now and what could be aligned to neighbourhoods Scope the roles /functions for ‘core team’ delivering neighbourhood health + who makes up the specialist team
Scope a framework / timeline for a Provider Alliance Contract to enable funding and governance changes for joined up working to meet complex needs
Further develop the capability of the Recovery Care Plan / single care plan Scope AI time saving functionality to release capacity to aid proactive care Develop delivery plans for other digital requirements
Scoping what co -located roles / services would enable and support MDT working of core teams and specialist input

Establish the core team within each LCP Find solutions to the on-boarding challenges for interagency working
Further develop a Provider Alliance Contract for a test year for 2026/27
Roll out of digital solutions to support the delivery of Neighbourhood Health
Developing an approach to paying for estates once

**Place:** Wakefield District

**Current Position**

Wakefield District Health and Care Partnership and its predecessor organisations have a strong track record in delivering Neighbourhood Multidisciplinary Teams (MDTs) with an existing Connecting Care model in place. Partners have reiterated their commitment in recent strategic and delivery plans with significant refocus since the pandemic.

Partners and stakeholders have been meeting to consider the vision and principles for Neighbourhood MDTs and to begin the design of what the operational teams will consist of in light of the new guidance and current population need, which can now be assessed to a greater degree through our Population Health Management Capabilities.

There is agreement that the key aims of Neighbourhood MDTs should be to deliver proactive, personalised interventions for people identified in at-risk cohorts with a view to supporting people to maximise their independence. The members of the MDT need to be broad ranging and include health, social care and the VCSE sector to ensure holistic responses.

WDHCP has developed robust population health management analysis capabilities enabled through our linked data model. Using the model and the guidance published by NHS England it is proposed that a cohort population of 3% is initially identified to include, end of life, COPD and dementia. This cohort makes up 3.7% of Wakefield population (or 4.6% of the adult population). This equates to 14,591 patients. Of this cohort, COPD patients account for 2.7% of the population, dementia 0.8% and patients on end-of-life care 0.5%. However, they account for 21.2% of all non-elective admissions in the last 12 months and 30.3% of non-elective bed days.

Our Neighbourhood MDT approach will be built from the geographical footprint of Primary Care Networks; there are six PCNs in Wakefield (details below).

We have developed a roadmap for the first two years of the programme to establish Neighbourhood MDTs. The first step will be to work with operational leads to describe the initial model and this group will meet on a regular basis over the coming weeks and months as the model is mobilised. We plan for a soft launch in September 2025 with a full launch in November 2025.

A Wakefield Place Neighbourhood Health programme with a series of workstreams is being developed. Initially the existing Transformation Delivery Collaborative will act as programme board for the overarching programme with emerging plans to transition these arrangements to a new provider collaborative by the beginning of 2026-27 at the latest under discussion.

We have recognised the interdependence with the wider neighbourhood agenda and the developing Wakefield District Plan is seen as the place that aligns the broader agenda in our place.

## Wakefield District Health and Care Partnership

### Primary Care Networks

Wakefield District has six distinct neighbourhood geographies covering the whole population.

Primary Care Network	Population size
West Wakefield	52,401
Trinity Health Group	53,368
Brigantes	58,625
Five Towns / Wakefield North	83,137
Pontefract and Knottingley	45,903
Wakefield Health Alliance (South)	58,158



## **Priority Actions**

### **Short-term**

2025-26 Q1:

- Agree a vision
- Agree priority population cohort
- Design operational model for neighbourhood MDTs
- Review existing arrangements
- Agree oversight arrangements
- Review data-quality
- Review of PCN priorities

2025-26 Q2:

- Review and refresh information sharing agreements
- Develop a holistic assessment tool
- Develop a detailed Standard Operating Procedure for MDTs in relation to initial cohort
- Staff engagement and stakeholder management
- Establish metrics and set up evaluation

2025-26 Q3:

- Soft launch implementation (September)
- Full launch implementation (November)

### **Medium-term**

2025-26 Q4

- Co-design and implement priority cohorts 2 & 3
- Develop population outcomes approach
- Develop governance model – transition to provider collaborative arrangements
- Assessment of financial implications and feasibility of budgetary delegation
- Build connections with wider Wakefield District Plan ambitions and workstreams
- Monitoring and evaluation

2026-27 H1

- Develop detailed specifications for Neighbourhood MDTs
- Strengthen and fully implement new organisational form (provider collaborative and relationship with strategic commissioner)

### **Long-term**

2026-27 H2 and beyond

- Broaden Neighbourhood MDT offer to include full population assessment of need and dynamic interventions with most at risk cohorts
- Neighbourhood MDTs driven developed and overseen by a provider partnership with allocated system resources
- Neighbourhood MDT approach to include delivery of wider health and Wellbeing vision to support community wellbeing
- Delivery for population outcomes

**Enabling Actions** Note: should include the enabling actions that support your short, medium and long term actions, as well as any other actions you think are required to enable INTs (either at place or system level).

Workforce & OD	Upskilling of relevant staff OD work on culture and system working	Development of new workforce roles	Create a one-team one-workforce 'Team Wakefield' way of working
Finance	Assessment of existing resources to carry out our Neighbourhood MDT working	identification of budgets which can initially be delegated to a provider partnership	Identification of whole population budgets with delegation to a provider partnership
DDaT	Ability to share care records and allow single assessments / trusted assessor approach	Refinement of PHM capabilities VCSE data sharing	Shared data with wider partners e.g. education, police etc
Estates	Spaces that will accommodate MDT working	Co-location spaces	Community health and care hubs

## Success Measures

### Service user experience

- Feedback on improved experience from service users

### Service utilisation

- Reduced non-elective admissions, reduced length of stay, improved A&E waits

### Behaviour and outcomes

- Cohort-tracking demonstrating changes in utilisation e.g. unplanned to planned
- Improvements in long-term public health measures e.g. life expectancy

### Coordination (process measures)

- Number of advanced care plans in place
- % of contacts with named clinician

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# Neighbourhood health guidelines

## 2025/26

[Publication \(/publication\)](#)

### Content

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- [Making a start on delivery](#)
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### Why a new approach is needed

1. There is an urgent need to transform the health and care system. We need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. More people are living with multiple and more complex problems, and as [highlighted by Lord Darzi \(https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england\)](#), the absolute and relative proportion of our lives spent in ill-health has increased.

2. Addressing these issues requires an integrated response from all parts of the health and care system. Currently, too many people experience fragmentation, poor communication and siloed working, resulting in delays, duplication, waste and suboptimal care. It is also frustrating for people working in health and social care.

3. Neighbourhood health reinforces a new way of working for the NHS, local government, social care and their partners, where integrated working is the norm and not the exception. Some places have already made progress in developing an integrated local approach to NHS and social care delivery. The full vision for the health system will be set out in the [10 Year Health Plan](https://www.gov.uk/government/publications/change-nhs-help-build-a-health-service-fit-for-the-future) (<https://www.gov.uk/government/publications/change-nhs-help-build-a-health-service-fit-for-the-future>), including proposals to help make this emerging vision for neighbourhood health a reality, informed by existing work and public, staff and stakeholder engagement.

4. This document sets out guidelines to help integrated care boards (ICBs), local authorities and health and care providers continue to progress neighbourhood health in 2025/26 in advance of the publication of the 10 Year Health Plan. The [appendix](#) provides more specificity around the initial 6 components of neighbourhood health to create a common understanding of what lies at its core, but the guidelines are deliberately short and permissive about how neighbourhood health should be implemented, setting out a framework for action that can be tailored to local needs.

5. Neighbourhood health aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care. This will be achieved by better connecting and optimising health and care resource through 3 key shifts at the core of the government's health mission:

- **from hospital to community** – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
- **from treatment to prevention** – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
- **from analogue to digital** – greater use of digital infrastructure and solutions to improve care

The [plan to reform elective care](https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/)

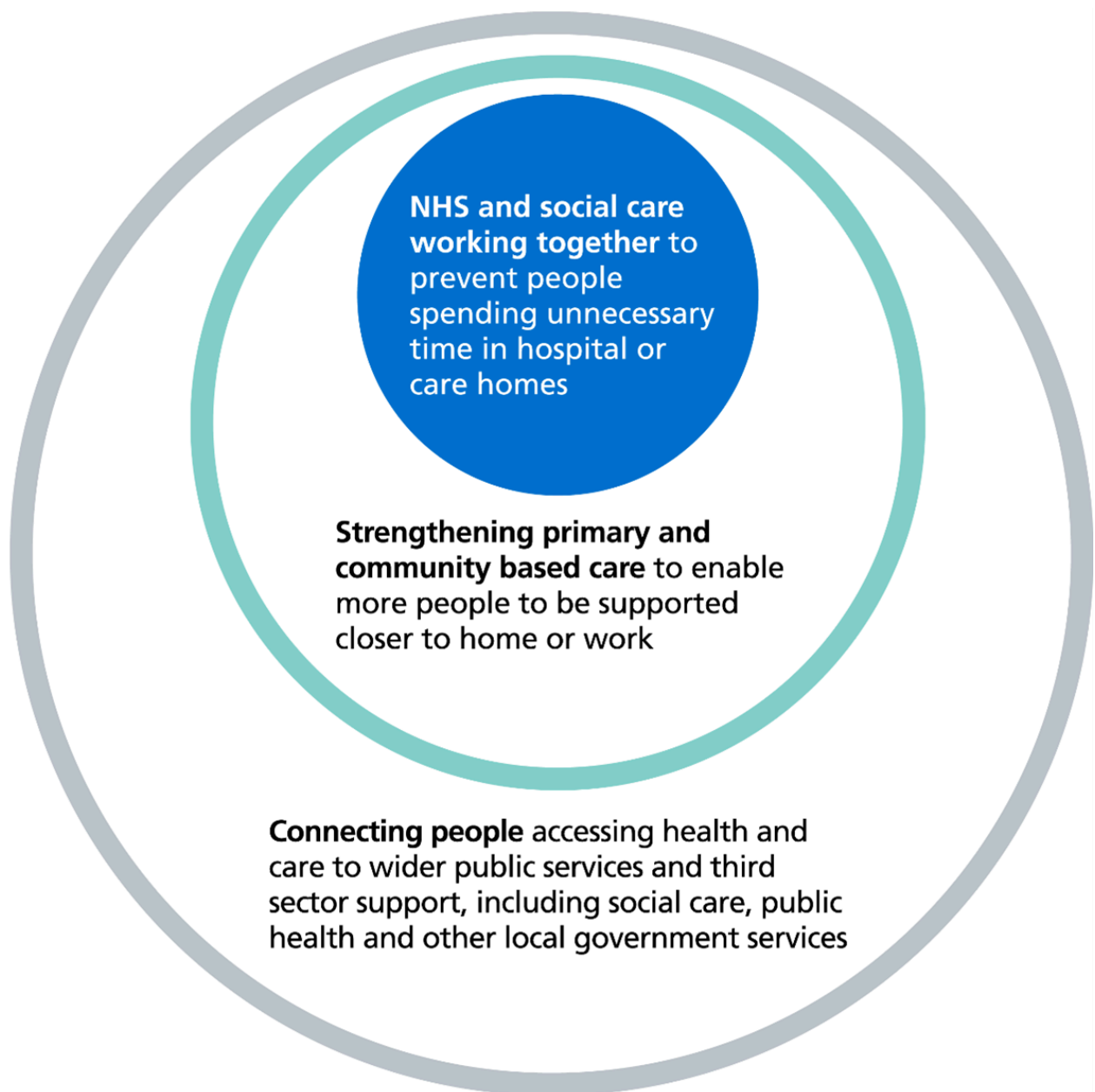
(<https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/>) is an example of this commitment in action, improving experience and convenience by providing more direct access to tests, scans and surgery in dedicated local centres and empowering people with more choice over when and where they will be treated, including through the NHS app.

6. All parts of the health and care system – primary care, social care, community health, mental health, acute, and wider system partners – will need to work closely together to support people's needs more systematically, building on existing cross-team working, such as primary care networks, provider collaboratives and collaboration with the voluntary, community, faith and social enterprise (VCFSE) sector. In some parts of the country this is already happening, and much can be learned from these experiences. System\* leaders will need to work with partners across local communities, together creating a collaborative high-support, high-challenge culture, to develop a shared vision and outcomes, define population boundaries for neighbourhood health and introduce joint accountability arrangements.

\* Use of the term “system” in this publication refers to integrated care system.

7. In the coming months, drawing on learnings from existing work, the focus will be on creating the national and local conditions for different ways of working. The diagram below shows the aims for all neighbourhoods over the next 5 to 10 years. For 2025/26, through the standardisation and scaling of the initial 6 components, we are asking systems to focus on the innermost circle to prevent people spending unnecessary time in hospital and care homes. As core relationships between the local partners grow stronger, we expect systems to focus increasingly on the outer circles. This will involve exploring their own ways of building or reinforcing links with wider public services, the third sector and local communities to fully transform the delivery of health and social care according to local needs:

**Diagram showing the aims for all neighbourhoods over the next 5 to 10 years**



(<https://www.england.nhs.uk/wp-content/uploads/2025/01/Diagram-showing-the-aims-for-all-neighbourhoods-over-the-next-5-to-10-years.png>).

Image text:

- NHS and social care working together to prevent people spending unnecessary time in hospital or care homes.
- Strengthening primary and community based care to enable more people to be supported closer to home or work.
- Connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services.

Neighbourhood health is an important part of wider public sector reform. Previous estimates suggest around 1 in 5 GP appointments are taken up for non-medical reasons, such as loneliness or to seek advice on housing or debts. A less complex and simpler connection between health and wider local public services, as depicted in the outer circle of the diagram, has the potential to improve outcomes for people and wider public sector productivity, and to reduce pressure on GP surgeries, emergency departments, acute hospital services and providers of long-term social care. It is an opportunity to enhance the partnership between councils, local public agencies like job centres, the third sector and NHS partners, and to design much clearer pathways for non-medical support from the local public and third sectors.

8. NHS England regional teams, working with local government partners and informed by the evidence generated from existing work in systems, should work with systems to agree locally what specific impacts they will seek to achieve during 2025/26. We expect these to include, as a minimum, **improving timely access** to general practice and urgent and emergency care, **preventing long and costly admissions** to hospital and **preventing avoidable long-term admissions** to residential or nursing care homes.

9. This document provides further guidelines on neighbourhood health. These draw together key points from earlier guidance and build on existing local best practice. It should be read alongside the 2025/26 NHS operational planning guidance (<https://www.england.nhs.uk/publication/2025-26-priorities-and-operational-planning-guidance/>) and 2025 to 2026 Better Care Fund policy framework (<https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026>), so systems can make progress against the above aims in advance of the publication of the 10 Year Health Plan.

## **Making a start on delivery**

10. Many local organisations across England have collaborated over the past few years to develop great examples of one or more of the individual components that make up an effective neighbourhood health service. Many of these best practice examples have informed the development of national policy or guidance, including the Fuller Stocktake (<https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/>) and Intermediate care framework (<https://www.england.nhs.uk/publication/intermediate-care-framework->

for-rehabilitation-reablement-and-recovery-following-hospital-discharge/). The priority now is to connect those components and implement them system-wide, starting with frontline services for people with the most complex health and care needs.

11. While 2025/26 will be a challenging financial year for the NHS, local government and social care, the coming months offer a significant opportunity to build on current momentum for a neighbourhood health approach in order to ensure the ongoing sustainability of health and social care delivery. Systems are asked to do this by:

- **standardising 6 core components of existing practice** to achieve greater consistency of approach
- **bringing together the different components into an integrated service offer** to improve coordination and quality of care, with a focus on people with the most complex needs
- **scaling up** to enable more widespread adoption
- **rigorously evaluating** the impact of these actions, ways of working and enablers both in terms of outcomes for local people and effective use of public money

This will set the foundations for scaling and expanding the neighbourhood approach over the coming years.

12. The focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. This cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs, according to NHS England analysis from adapted Bridges to Health data. It is likely that systems will initially prioritise specific groups within this cohort where there is the greatest potential to improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care, both improving outcomes and freeing up resources so systems can go further on prevention and early intervention. This approach is likely to focus on around 2% to 4% of the population. Examples of population cohorts with complex needs include:

- adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia)
- people of all ages with palliative care or end of life care needs
- adults with complex physical disabilities or multiple long-term health conditions
- children and young people who need wider input, including specialist paediatric expertise into their physical and mental health and wellbeing
- people of all ages with high intensity use of emergency departments



13. Increasing coordination, consistency and scale in delivering health and social care to specific sub-cohorts should result in the following benefits over time:

- avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life
- streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up
- maximising the use of community services so that better care is provided close to or in people's own homes
- reducing emergency department attendances and hospital admissions, and where a hospital stay is needed, reducing the amount of time spent away from home and the likelihood of being readmitted to hospital
- reducing avoidable long-term admissions to residential or nursing care homes
- reducing health inequalities, supporting equity of access and consistency of service provision
- improving people's experience of care, including through increased agency to manage and improve their own health and wellbeing
- improving staff experience
- connecting communities and making optimal use of wider public services, including those provided by the VCFSE sector

14. Evidence from services and research

(<https://www.prucomm.ac.uk/assets/uploads/files/commissioning-for-integrated-service-delivery-at-place-initial-report-final-2.pdf>) has identified elements of partnership working that are critical for effective implementation of neighbourhood health:

- **a mechanism for joint senior leadership**, such as a joint neighbourhood health taskforce, **in each place** to drive integrated working, comprising senior leaders from the constituent organisations across health and care, including the acute hospital
- **a collaborative high-support, high-challenge culture**, which fosters strong relationships between all system partners, including the NHS, local government, social care providers and the VCFSE sector. This culture is supported by **shared values, outcomes, clear lines of accountability and definitions** for how services are organised at place and neighbourhood level (<https://www.england.nhs.uk/publication/designing-integrated-care-systems-icss-in-england/>) (aligning service delivery across organisations to agreed populations at these levels)

- **visible clinical and professional leadership and management**, at both system and place level, supported through the effective clinical and care professional leadership framework (<https://www.england.nhs.uk/publication/integrated-care-systems-guidance/#heading-13>). This includes **working in partnership with communities** (<https://www.england.nhs.uk/publication/integrated-care-systems-guidance/#heading-12>) (including people and carers\* with lived experience and local third sector organisations) to co-develop neighbourhood health locally, and to mobilise change
- **effective processes** (including communication channels, IT systems and information governance processes) and **training and workforce development** to enable collaborative working
- **making best use of all funding arrangements**, including those that are formally pooled, to facilitate partnership working

\* Wherever “carer” is used in this publication, it refers to both paid and unpaid carers, however there are key differences between the two. Unlike paid carers (professionals either employed by the individual receiving care, or via NHS or local authority funding or services), unpaid carers can be anyone – including children – who look after a family member, partner or friend who cannot cope without their support. The Care Act 2014 requires local authorities to assess, provide support and promote the wellbeing of unpaid carers.

15. Learning from work in 2025/26, alongside emerging research and innovation, will inform the future development of the neighbourhood health and care model as it extends to other population cohorts. This learning will also shape support offers to systems, and a more formal evaluation framework for the future delivery of neighbourhood health systems will be developed. We now ask systems to:

- consider how they will evaluate the impact of the changes they make in a systematic, consistent and scalable way to build the case for future expansion and link to the triple aim of improving population health outcomes, people’s experience of health and care services and value for money
- embrace the government’s “test and learn” approach (<https://www.gov.uk/government/speeches/reform-of-the-state-has-to-deliver-for-the-people>) to enable continuous improvement in real-time and build on existing good practice such as the NHS IMPACT Improving Patient Care Together framework (<https://www.england.nhs.uk/nhsimpact/>)

## Summary of requirements for 2025/26

16. Building on the foundations laid by the [Fuller Stocktake](https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/) (<https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/>), approaches to tackle health inequalities, such as [Core20PLUS5](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/) (<https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>) and [Core20PLUS5 for children and young people](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/) (<https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/>), outreach work and using data and local insights, systems should work with partner organisations to:

- **apply a consistent, system-wide population health management approach** which draws on quantitative data and qualitative insights to understand needs and risks for different population cohorts
- **use this information to design and deliver the most appropriate care for each population cohort** and to inform best-value commissioning decisions that empower frontline staff to provide more person-centred care, enabling people to live independently for longer
- **continue to embed, standardise and scale the 6 initial core components of a neighbourhood health service** (detailed in [appendix 1](#)) and ensure capacity and structures across providers are aligned to best meet demand

17. Best practice also suggests systems should consider:

- improving coordination, personalisation and continuity of care for people with complex needs, including increased agency in managing their own care, supported by:
  - a single electronic health and care record that is actively used in real-time by frontline health and social care staff
  - a care coordination function between the person or their carer and the wider multi-professional team supporting them if needed, working across organisational boundaries
- applying learnings from existing or emerging neighbourhood health models, such as [enhanced health in care homes](https://www.england.nhs.uk/community-health-services/ehch/) (<https://www.england.nhs.uk/community-health-services/ehch/>), the [24/7 neighbourhood mental health centres](https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/localising-and-realigning-inpatient-services/) (<https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/localising-and-realigning-inpatient-services/>), [women's health hubs](https://www.england.nhs.uk/publication/womens-health-hubs/) (<https://www.england.nhs.uk/publication/womens-health-hubs/>), [family hubs](https://www.gov.uk/government/collections/family-hubs-and-start-for-life-) (<https://www.gov.uk/government/collections/family-hubs-and-start-for-life->

programme) and the Health and Growth Accelerators (<https://www.england.nhs.uk/2024/12/world-leading-nhs-trial-to-boost-health-and-support-people-in-work/>), ensuring that services are delivered at an efficient and effective scale

**18. Systems should also tackle health inequalities**

(<https://www.england.nhs.uk/long-read/publication-of-nhs-englands-statement-on-information-on-health-inequalities/>) when developing their neighbourhood health service. This will include:

- getting the basics right (such as ensuring services are accessible to people with disabilities and implementing reasonable adjustments as needed)
- engaging with local communities and working with them as equals to design and deliver services, working particularly closely with specific communities that have been historically underserved
- analysing outcomes by population demographics, deprivation, age, ethnicity, disability (supported by the reasonable adjustment digital flag (<https://digital.nhs.uk/services/reasonable-adjustment-flag>)) and inclusion health groups (<https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/>).

## **Next steps**

19. ICBs and local authorities are asked to jointly plan a neighbourhood health and care model for their local populations that consistently delivers and connects the initial core components at scale, with an initial focus on people with the most complex health and care needs. More mature systems will be working to develop an integrated neighbourhood delivery plan across the 6 initial core components, published as part of Joint Forward Plans and informed by engagement with local communities, that includes:

- improving collaboration and enabling effective ways of working
- agreeing commissioning models, new funding flows and contractual mechanisms between the NHS and local authorities
- workforce planning and development
- evaluation
- exploring the use of neighbourhood buildings across all partners, including local government, following on from recent ICB-led estates strategy work

20. We will provide further details of a national implementation programme over the coming months, designed for all parts of the health and social care system involved in delivering neighbourhood health. The initial phase of this programme will aim to work with at least one place in every system. These places will already be demonstrating a more developed approach to delivery at local level, with clear

leadership across the ICB, local NHS and local authority. System partners in these places will be provided with facilitation support, as well as support to ensure robust evaluation and monitoring of progress. This test and learn approach will help to identify what is working most effectively and the conditions that are required to deliver a set of target outcomes. The national implementation programme will sit alongside a very small number of learning and evidence sites, which will test the model at scale, including its impact on flows in and out of an acute hospital.

21. We have shared case studies of existing good practice (<https://www.england.nhs.uk/publication/neighbourhood-health-case-studies-of-good-practice/>). NHS England regional teams, working with local government partners, will continue to have a key role in sharing and spreading emerging best practice and learning with systems.

22. We will continue to work with systems to co-develop the vision for neighbourhood health, focusing on removing barriers and creating the conditions for success. These guidelines will be kept under review as further learning emerges.

## **Appendix 1**

The foundations of a neighbourhood health service are already in place in many areas across the country. This appendix describes 6 core components (A to F) associated with an effective neighbourhood service, as identified from the current evidence.

### **Initial 6 core components**

Local systems will need to consider each component within the context of the needs of their local population and the current configuration of services. They will also need to evaluate how effectively individual interventions link together to improve the way services are delivered for their local population and the outcomes people achieve.

Given local projections of future need and demand, systems will want to consider how to have the greatest impact on health and wellbeing outcomes for the local population as well as benefits for the system when prioritising resource allocation, strategic leadership and quality improvement efforts.

#### **A. Population health management**

- Ensure there is a person-level, longitudinal, linked dataset encompassing:

- general practice and wider primary care
- community health services
- mental health
- acute care
- social care
- public health

Over time, this dataset should be broadened to include other data held by local or central government, including employment, education, safeguarding and housing status. It should be supported by appropriate data sharing and processing agreements. This should enable analysis of population health outcomes, biopsychosocial risk drivers and health and care system resource use. NHS England will continue to work with the National Data Guardian to support integrated care boards (ICBs) to navigate the necessary information governance requirements, but partners should already share existing data wherever possible.

- Apply a single, consistent system-wide population health management method to ICB analytics platforms to segment and risk stratify populations, based on complexity and forecasted resource use. Where systems do not already have an existing tool, they must work with the NHS Federated Data Platform team to select one which is compatible. In 2025/26, NHS England will work with ICBs to review the impact and evidence behind effective risk stratification to enable further signposting to validated tools.
- A population health management approach should be supported by a system-wide intelligence function (<https://www.england.nhs.uk/long-read/building-an-ics-intelligence-function/>) used to:
  - inform strategic commissioning and resource allocation
  - enable providers to work together to best organise their workforce to deliver health and care

Systems should ensure they complement these analytical approaches with wider quantitative and qualitative insight into groups that might be under-represented in NHS datasets, for example, people with severe mental illness or learning disability or autistic people. Implementation of the Reasonable Adjustment digital flag information standard (<https://www.england.nhs.uk/long-read/the-reasonable-adjustment-digital-flag-action-checklist-what-you-need-to-do-to-achieve-compliance/>) will also help analyse data for some of these population groups.

- Clinical data systems should have complementary functionality, including compatibility and integration between GP systems, digital social care records and other provider systems. This will support effective case finding, care navigation and risk-based prioritisation of proactive, planned, responsive and urgent care. This will also inform the design and work of neighbourhood multidisciplinary teams.

- Further guidance on using data to segment and risk stratify populations will follow in 2025, to complement existing resources (<https://www.e-lfh.org.uk/programmes/population-health-management/>) and the Population Health Academy ([https://future.nhs.uk/connect.ti/populationhealth?sm\\_newemail=](https://future.nhs.uk/connect.ti/populationhealth?sm_newemail=)).
- Learn more in case study 1: Linking data and embedding a single system-wide population health management approach (<https://www.england.nhs.uk/long-read/linking-data-and-embedding-a-single-system-wide-population-health-management-approach/>).
- Read case study 4: Transforming care through modern general practice and population segmentation (<https://www.england.nhs.uk/long-read/transforming-care-through-modern-general-practice-and-population-segmentation/>) to learn more about how automated stratification is integral to Brookside Group Practice's approach.

## **B. Modern general practice**

- ICBs are asked to continue to support general practices with the delivery of the modern general practice model (<https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/>), to deliver improvements in access, continuity and overall experience for people and their carers. This is a response to increasing demand and a foundational step to enable practices to move from a model of reactive to more proactive care.
- ICBs are expected to streamline the end-to-end access journey for people, carers and staff, making it quicker and easier to connect with the right healthcare professional, team or service, including community pharmacy, use of Pharmacy First (<https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/pharmacy-first/>) and digital self-service options such as repeat prescription ordering via the NHS app. This approach will accommodate the needs of different groups and patients and support continuity of care.
- People and their carers should have the ability to access services equitably (<https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/>) in different ways (online, telephone and in person) with highly usable and accessible online systems (the NHS app, practice websites, online consultation tools) and telephone systems. There should also be structured information gathering at the point of contact (regardless of contact channel) and clear navigation and triage based on risk and complexity of needs.
- Staff should have access to structured information about the complexity of the presenting complaint and need. This information should be organised

alongside population segmentation (including by age) and risk stratification information into a single workflow. This approach will support staff in efficiently navigating and triaging needs safely and fairly, including enabling risk-based prioritisation of continuity of care and optimising use of the general practice and wider multi-professional team.

- Read case study 3: Improving access and workforce wellbeing through a modern general practice model (<https://www.england.nhs.uk/long-read/improving-access-and-workforce-wellbeing-through-a-modern-general-practice-model/>) for more information about Lime Tree Surgery's approach, including using an online consultation platform and making use of Additional Roles Reimbursement Scheme (<https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/>) (ARRS) staff.
- Read case study 4: Transforming care through modern general practice and population segmentation (<https://www.england.nhs.uk/long-read/transforming-care-through-modern-general-practice-and-population-segmentation/>) to learn more about how Brookside Group Practice have used digital innovation to improve primary care and health outcomes.

### **C. Standardising community health services**

- Many community health services will play a key role in delivering neighbourhood health and care, and many of these services should be commissioned as part of an integrated neighbourhood health offer.
- When designing, commissioning and delivering neighbourhood health, ICBs and providers should be using the Standardising community health services publication (<https://www.england.nhs.uk/publication/standardising-community-health-services/>) (covering NHS-funded specialist support for people with physical health needs and neurodevelopmental services for children and young people). This will ensure funding is used to best meet local needs and priorities.
- Some people will have both physical and mental health needs, or drug and alcohol dependency. It is essential that care is planned to meet all health and social care needs and that service boundaries do not prevent seamless, joined-up care. Systems should continue to make use of the mental health Additional Roles Reimbursement Scheme (<https://www.england.nhs.uk/mental-health/working-in-mental-health/mental-health-practitioners/>), which is jointly funded with primary care, to improve primary care mental health and access to community-based mental health services for people of all ages, as well as through services such as NHS Talking Therapies for anxiety and depression



(<https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/>).

For children and young people, it's also critical to join up with mental health services (<https://www.england.nhs.uk/mental-health/cyp/>) and mental health support teams ([https://www.england.nhs.uk/mental-health/cyp/trailblazers/#\\_Mental\\_Health\\_Support](https://www.england.nhs.uk/mental-health/cyp/trailblazers/#_Mental_Health_Support)) in schools and further education. For people with co-occurring drug and alcohol dependency, services should engage with local authority commissioned substance misuse services. It will also be important to link in with VCFSE sector support for adults, children and young people around mental health, social isolation and substance misuse.

- Read more in case study 2: Addressing health inequalities faced by people with severe mental illness through mental health practitioners in primary care teams (<https://www.england.nhs.uk/long-read/addressing-health-inequalities-faced-by-people-with-severe-mental-illness-through-mental-health-practitioners-in-primary-care-teams/>).
- Read case study 5: Standardising community health services to address variation and improve outcomes (<https://www.england.nhs.uk/long-read/standardising-community-health-services-to-address-variation-and-improve-outcomes/>) to learn more about how North Central London ICS developed a core offer as part of a 5-year plan.

## **D. Neighbourhood multidisciplinary teams (MDTs)**

- The approach to establishing integrated neighbourhood teams has been well defined in the Fuller Stocktake (<https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/>). Such teams bring a wider range of expertise together, from across health, social care, VCFSE and wider partners to benefit a shared population. As part of this approach, there will need to be multidisciplinary coordination of care for population cohorts with complex health and care or social needs who require support from multiple services and organisations. They are expected to deliver proactive (<https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty/>), planned and responsive care, and prioritise care based on individual people's needs and the opportunity for greatest impact. Footprints should be designed to optimise neighbourhood working and partnership with local authorities. Detailed guidance on neighbourhood MDTs for children and young people (<https://www.england.nhs.uk/long-read/guidance-on-neighbourhood-multidisciplinary-teams-for-children-and-young-people/>) has been published.
- Functions include overseeing or delivering holistic joint assessments, case reviews and deployment of coordinated provision, medication reviews, care

planning for long-term conditions and personalised care and support planning (<https://www.england.nhs.uk/personalisedcare/pcsp/>), including social prescribing (<https://www.england.nhs.uk/personalisedcare/social-prescribing/>), comprehensive geriatric assessments and advanced care plans. For people with co-occurring severe mental illness, we would expect these functions to remain within core community mental health services. However, we would expect a joined-up approach to planning care for people with significant mental and physical health needs across teams.

- In best practice models, a core team is assigned for complex case management, with links to an extended team that enables access to additional specialist resource as needed. The composition of teams may vary depending on the population being served by the MDT and local prioritisation of clinical need. Teams could include GPs, specialist nurses or consultants (such as, specialist dementia nurses and secondary care clinicians, including paediatricians and geriatricians), district nurses, GP nurses, acute hospital consultants, allied health professionals, health visitors, mental health professionals, social prescribing link workers and social workers, home care staff, residential care home and nursing home staff, as well as wider system and community partners (such as from public health and the VCFSE sector).
- It is best practice to assign a care coordinator to every person or their carer in the population cohort as a clear point of contact to improve both their experience and continuity of care. The role could be undertaken by any member of the core team and will link into clinical triage and onward referrals as required. It will also set expectations with the person or their carer as part of the care plan process, so that all parties understand their part in improving outcomes.
- Case study 6: Strong working relationships as the bedrock of neighbourhood multidisciplinary teams (children and young people focused) (<https://www.england.nhs.uk/long-read/strong-working-relationships-as-the-bedrock-of-neighbourhood-multidisciplinary-teams-children-and-young-people-focused/>), highlights relevant learning from Connecting Care for Children.
- Learn more about Northamptonshire's co-produced model of care in case study 7: Working with communities to mobilise change through neighbourhood multidisciplinary teams (frailty focused) (<https://www.england.nhs.uk/long-read/working-with-communities-to-mobilise-change-through-neighbourhood-multidisciplinary-teams-frailty-focused/>).
- Read more in case study 8: Provision of person-centred holistic care delivered by neighbourhood multidisciplinary teams (high intensity use focused) (<https://www.england.nhs.uk/long-read/provision-of-person->

centred-holistic-care-delivered-by-neighbourhood-multidisciplinary-teams-high-intensity-use-focused/).

- Case study 9: Women's health hubs providing integrated care at neighbourhood level (<https://www.england.nhs.uk/long-read/womens-health-hubs-providing-integrated-care-at-neighbourhood-level/>), highlights learning about harnessing the skills of multidisciplinary teams.
- Case study 10: Strong relationships between system partners and multi-professional teams (palliative care and end-of-life care focused) (<https://www.england.nhs.uk/long-read/strong-relationships-between-system-partners-and-multi-professional-teams-palliative-care-and-end-of-life-care-focused/>) looks at an example of collaboration across primary care, community care and the voluntary sector.

## **E. Integrated intermediate care with a 'Home First' approach**

- Systems are asked to deliver short-term rehabilitation, reablement and recovery services (integrated intermediate care) taking a therapy-led approach (rehab or reablement care overseen by a registered therapist) working in integrated ways across health and social care and other sectors.
- Ensure referrals can be made directly from the community (step-up) or as part of hospital discharge planning (step-down (<https://www.england.nhs.uk/publication/intermediate-care-framework-for-rehabilitation-reablement-and-recovery-following-hospital-discharge/>)), applying a 'Home First' approach (<https://www.england.nhs.uk/publication/a-community-rehabilitation-and-reablement-model/>), with assessments and interventions delivered at home where possible and working closely with urgent neighbourhood services.
- Implement good operational case management systems and measure outcomes (with reference to the objectives and metrics set out in the Better Care Fund policy framework for 2025 to 2026 (<https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026>)) to ensure best use of resources.
- Read more about how this can work in practice in case study 11: Supporting effective collaboration for 'Home First' rehabilitation, reablement and recovery services through a system-wide reporting suite and common analytics dashboard (<https://www.england.nhs.uk/long-read/supporting-effective-collaboration-for-home-first-rehabilitation-reablement-and-recovery-services-through-a-system-wide-reporting-suite-and-common-analytics-dashboard/>).

## **F. Urgent neighbourhood services**

- Standardise and scale urgent neighbourhood services for people with an escalating or acute health need. This means ensuring urgent community response (<https://www.england.nhs.uk/community-health-services/urgent-community-response-services/>) and hospital at home (virtual ward) (<https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/>) services are aligned to local demand and work together (with access increasingly through a single point of access (<https://www.england.nhs.uk/long-read/single-point-of-access-spoa/>)) to deliver a co-ordinated service. These urgent neighbourhood services should align with services at the front door of the hospital, such as urgent treatment centres (<https://www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards/>) and same day emergency care (<https://www.england.nhs.uk/urgent-emergency-care/same-day-emergency-care/>), which are also increasingly accessed through a single point of access.
- As part of ambulance service improvement of See and Treat and Hear and Treat pathways, senior clinical decision makers in a single point of access should provide advice and referral to appropriate services either before ambulance dispatch or as part of a “call before convey” approach. Single points of access should also provide clinical advice to other healthcare professionals and care home workers, so staff avoid calling 999.
- As outlined in the integrated intermediate care section above, ensure step-up pathways (to prevent avoidable admissions) and step-down pathways (to support timely and effective discharge) use resources efficiently and effectively. Service footprints should be determined locally, balancing scale of delivery with building on local relationships to ensure smooth referral pathways into urgent and planned care services. Where footprints span multiple neighbourhoods, services should still operate in a way that feels like a seamless service for people and carers.
- Read more in case study 12: Clear lines of accountability and clinical governance structures to deliver effective urgent neighbourhood services (<https://www.england.nhs.uk/long-read/clear-lines-of-accountability-and-clinical-governance-structures-to-deliver-effective-urgent-neighbourhood-services/>).

## Secondary care contribution to neighbourhood health

Local acute services can provide significant contribution to the development of a neighbourhood health service. Home First and person-centred approaches need to be embedded throughout the health and care system so that appropriate risk-based decisions are always made, and hospital care only used when clinically

necessary. In this way, every part of the system works collaboratively to reduce the risks associated with a hospital admission and a lengthy hospital stay if admission is unavoidable.

Clinicians in hospitals can continue to work collaboratively with community-based teams to ensure that their patients benefit from a neighbourhood health service by:

- supporting continuity of care in the community for people under the care of a specialist hospital team such as respiratory, diabetes, stroke or cardiology. This might include providing specialist input to neighbourhood MDTs such as through clinics delivered jointly in primary or community settings, using digital technology and infrastructure, or by establishing pathways into the hospital which avoid the emergency department, for example, by using urgent treatment centres, same day emergency care pathways or outpatient clinics.
- supporting the development of hospital at home (virtual ward) (<https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/>), single point of access (<https://www.england.nhs.uk/long-read/single-point-of-access-spoa/>) and community diagnostic centres (<https://www.england.nhs.uk/long-read/community-diagnostic-centres/>)\*, including providing clinical advice and oversight as required.
- ensuring that frailty services are joined up in all settings, whilst maximising the delivery of these services within community settings. This will include the development of frailty-attuned hospital services (<https://www.england.nhs.uk/urgent-emergency-care/same-day-emergency-care/acute-frailty/>), ensuring they connect with community frailty provision to support integrated end-to-end frailty pathways, and support for care transfer hubs (<https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance>), which arrange support services to assist discharge from hospital for those with the most complex needs.

By delivering proactive, planned, responsive and urgent care close to or in people's own homes, effective local neighbourhood services will relieve pressure on acute services.

\* Community diagnostic centres are likely to be considered anchor sites between primary, community and secondary care, enabling direct referral for diagnostic tests from a range of providers and optimising onward referrals to a range of health care settings for adults and children. 170 community diagnostic centres will be open by March 2025, with more than one in each ICB. The development of neighbourhood health services should include close working with associated community diagnostics centres to ensure that pathways are streamlined.

## Planning for a flexible workforce

A flexible workforce working within and for local communities will be crucial for delivering neighbourhood health services.

To prepare for the move towards neighbourhood health, ICBs and local authorities are encouraged to connect as broadly as possible across their local communities to agree how best to use their collective local resources.

- Building on partnerships developed through the Better Care Fund, continue to develop **joint demand and capacity assessment, modelling and planning across health and social care**. This will provide a clear understanding of the capacity available to serve the local population across all providers and commissioners. This should include joint bottom-up mapping of existing workforce capacity, skills and capabilities across all partners and providers (including hospitals and mental health services) to optimise staff deployed across pathways, irrespective of organisational boundaries. This co-ordinated approach will help staff be deployed more flexibly where needed most, enable continuity of care, and create opportunities for streamlined joint recruitment, training and staff rotation across services.
- Take a user-centred approach to the design of teams, including job planning across different settings. This may include upskilling teams within the MDTs to **cover multiple functions that traditionally may have been delivered separately** so they are safely able to work in a more agile way and increase continuity for people and carers.
- **Ensure staff are aware of, and are involved in building, the local neighbourhood service model** to optimise the use of all services, including wider primary care, general practice, mental health, community health services, neighbourhood MDTs, social care services and “self-access” options where appropriate, supported by shared digital tools.
- Identify barriers and opportunities to **better enable productive integrated working** so that staff have the skills and tools to safely work across organisational boundaries and serve their local populations, ensuring best use of funding to meet local need, and improving workforce interactions and experience. This should include ensuring care workers can deliver delegated healthcare activities such as blood pressure checks and other healthcare interventions. The government has recently published new [guidance on safe delegation to care staff](https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Managing-a-service/Delegated-healthcare-activities/Delegated-healthcare-activities.aspx) (<https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Managing-a-service/Delegated-healthcare-activities/Delegated-healthcare-activities.aspx>).

## **Case studies**

These case studies (<https://www.england.nhs.uk/publication/neighbourhood-health-case-studies-of-good-practice/>) provide examples of existing good practice that forms the foundations of neighbourhood health.

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