

Creating neighbourhood Health

Planning requirements and approach for 2026/27
and beyond

An opportunity to strengthen our connections as a
system and build on integration

Our story so far..

Joint Health and Wellbeing and Integrated Care Strategic Priorities in a shared strategy



- **10 year plan will drive this work forward further and faster**
- **Neighbourhood planning guidance key lever for this**



Background

September 2025 – Original neighbourhood planning requirement was shared in previous Board paper on the future of HWB/ICP which came from the draft medium term planning guidance which suggested:

***Neighbourhood Health Plans** will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. The plan should set out how the NHS, local authority and other organisations, including social care providers and VCSE, will work together to design and deliver neighbourhood health services. DHSC will publish separate guidance to support their development.*

The plans are asked to be:

- *Outcomes focussed*
- *Accountable and transparent*
- *Evidence-based*
- *Multi-disciplinary*
- *Credible and deliverable*

This is a central government ask aligning all relevant departments – it is not an NHS plan. This is a neighbourhood plan that focuses on a person-centred approach, delivered by a multi-agency team.

Guidance for Neighbourhood Health Plans

Neighbourhood Health encompasses NHS, Local Government and wider partnership (including VCSE) roles and responsibilities in improving the health and wellbeing for their local communities

Neighbourhood Health plans will be overseen by Health and Wellbeing Boards in two parts:

DRAFT

A strategic plan covering:

- Agreement on neighbourhood footprints based on natural communities
- Priority outcomes for place and neighbourhoods (including NHS mandated, BCF and locally agreed measures)
- Transparency on scope of services
- Agreement on the development of INTs
- Clarity on leadership and accountability arrangements for delivery

An operational plan covering:

- Working partnership arrangements for delivery
- Timetable for addressing service alignment to neighbourhoods where needed (eg: PCNs)
- Timetable for implementation of INTs
- An audit of resources that apply to neighbourhood health and how they are organised
- Plans for the development of sustainable Neighbourhood Health leadership

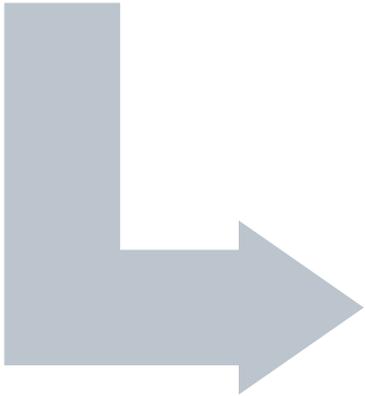
Action - Neighbourhood Health Plans

Drawn up by local government, the NHS, and partners
under the leadership of Health and Wellbeing Board

Operational
 Neighbourhood health
 plans

Underway – finalised by
 Place Q2 2026/27

- Clarity on footprints
- Show priority outcomes for both place and neighbourhood – NHS, BCF, local
- Agreement of plans for INTs
- Leadership and accountability for delivery
- Governance model through HWB, joint leadership



Strategic Plan
 April 2026

- To include full timetable for service alignment to neighbourhoods and implementation of INTs
- Plans for sustainability of neighbourhood health leadership
- Clarity on finance and resources

Better care fund:
 BCF will transform into a new *Integrated Care Funding Framework*, beginning in 2026/27.
 Neighbourhood health plans should set out how HWBs are planning to use this to help achieve their goals for neighbourhood health, with a specific focus on intermediate care and other services that involve integrated packages of health and social care to help people maintain or recover their independence.

All partners are expected to have clear accountability and roles within the delivery of integrated neighbourhood teams that focus on person centred care with clear commitment from the respective leadership teams.

Key policy documents:

[Medium term planning framework - delivering change together 2026/27 to 2028/29](#)

[Strategic commissioning framework](#)

DHSC guidance expected to explicitly set out the requirements

Data and intelligence

- Data sharing is crucial for a high functioning neighbourhood and system – both across NHS bodies and crucially between NHS bodies and other partners such as local government, social care providers and VCSE delivery partners.
- PHM steering group now re-established to work as system to draw together data priorities
- Understand neighbourhood data
- Draw together conversations on data linkage and PHM tools – to ensure we are working collaboratively to move things forwards
- Will support ongoing infrastructure needs for neighbourhood and place through C&P PHM workplan, including actions for C&P analysts group
- *One version of the truth*

Who:

Delivering this ambition will require a new commitment to partnership working across local partners, with the needs of neighbourhoods placed front and centre. This includes:

- local authorities as commissioners of public health services, adult social care, children's services and as champions for better population health, including housing and other services
- ICBs as strategic commissioners of NHS services
- GPs and other healthcare professionals, public health professionals and social work professionals, who understand people's health and care needs
- the voluntary sector who build trust with local communities, shine a spotlight on lived experience, and support people who need it most

Partners should work together to develop and deliver services, whether that's a service within a neighbourhood to serve the specific needs of a local population, or a service across neighbourhoods to provide support at scale.

N.B. the national neighbourhood health improvement programme (NNHIP) is providing us with key best practice examples we can draw upon for ideas i.e. Cornwall

NHS Planning for the next 3 years: 2026/27 – 2028/29



In implementing neighbourhood health, the immediate focus must be on:

- improving and tackling **unwarranted variation** in GP access for the whole population
- reducing **unnecessary non-elective admissions and bed days** from high priority cohorts – people who have moderate to severe frailty, people living in a care home, people who are housebound or at the end of life
- enabling patients requiring planned care to receive **specialised support closer to home**

Plans should also include establishing integrated neighbourhood teams, ideally contract-based, working with local authorities and starting in areas of highest need.

From April 2026, ICBs and relevant NHS providers should:

1. identify **GP practices where demand is above capacity** and create a plan to help decompress or support to improve access and reduce unwarranted variation
2. ensure an understanding of current and projected total service utilisation and costs
3. **create an overall plan to more effectively manage the needs** of these high priority cohorts and significantly reduce avoidable unplanned admissions. These plans should be consistent with national standards for urgent community response services, which require 7-day availability and rapid response. Systems should ensure funding and commissioning covers a minimum 12 hour “community urgent care” offer, supervised by senior clinical decision-makers and operating at a multi-neighbourhood level.

Local ICBs must confirm how this will be resourced and delivered

Four National frameworks & archetypes are being produced (expect in Nov 2025?):

Draft **model neighbourhood framework**, incl definitions, goals and scope of neighbourhood health, priority actions for 2026/27

National **neighbourhood health planning framework**, co-produced with the LGA and LA colleagues, setting out how the NHS, in partnership with LAs and others, can plan for the delivery of the broader set of neighbourhood goals

Model system archetypes - outline different archetypes for the commissioning and provision of NH services, including the 3 new contract types: single and multi-neighbourhood provider contracts, and integrated health organisation contracts

Model neighbourhood health centres archetypes - describe different archetypes of provision of NH services that can be used to inform the better utilisation and enhancement of existing estates and new-build solutions

Key messages:

- **An opportunity to strengthen our connections as a system and build on integration**
- This is about neighbourhood *delivery* by all partner services to a clear set of outcomes.
- This will require some detailed collaborative planning to deliver.
- All partners are expected to have clear accountability and roles within the delivery of integrated neighbourhood teams that focus on person centred care with clear commitment from the respective leadership teams.
- This is fundamentally about making a material positive impact for our residents by working together, on the ground, in a coordinated way.

Proposed plan:

- **Strategic ask** – due by April 2026 - work on our governance model within HWB and how we have individual organisational and collective accountability for neighbourhood delivery and how this will translate into the joint leadership of neighbourhood teams. How we use the financial tools and resource at our disposal to deliver neighbourhood care.
- **Operational ask** – due by Q2 2025/26 led by Place Partnerships - do we truly understand what services are available now, how do we align them differently over time to deliver a core set of outcomes.
- Over to Place Partnerships to describe the role Partnership Boards will play in delivering the above.

We have established integrated neighbourhoods across Cambridgeshire and Peterborough



Expected delivery requirements in our places for the neighbourhood health model

1	Improving people's health and wellbeing in the broadest sense and in a way that addresses health inequalities
2	Improving uptake of specific preventative measures
3	Improving access to core general practice services
4	Supporting people with one or more long term condition to live happier and healthier lives
5	Improving access to specialist opinion and diagnostics in an efficient and cost-effective way across many specialities, not just for those with long term conditions
6	Looking after people with complex needs, particularly older people, those with frailty and those at the end of life

DHSC and NHS England are establishing the headline goals for neighbourhood model (due for release in November). Our current expectation of these goals is depicted left.

The delivery of the goals requires differential input and leadership from within our places, with oversight by the Health and Wellbeing Board. For example:

- Goals 1 and 2 may best be led by public health on behalf of each place with vaccination and immunisation; screening, obesity/diabetes prevention services, smoking, alcohol reduction programmes in each neighbourhood.
- Goal 3 is a core planning requirement of the NHS.
- Goal 6 is a multi-partner endeavour in supporting people to stay independent for as long as possible at home, ensuring a focus on people's capacity to do what matters to them, learning from the strength-based approaches routinely adopted in social care.

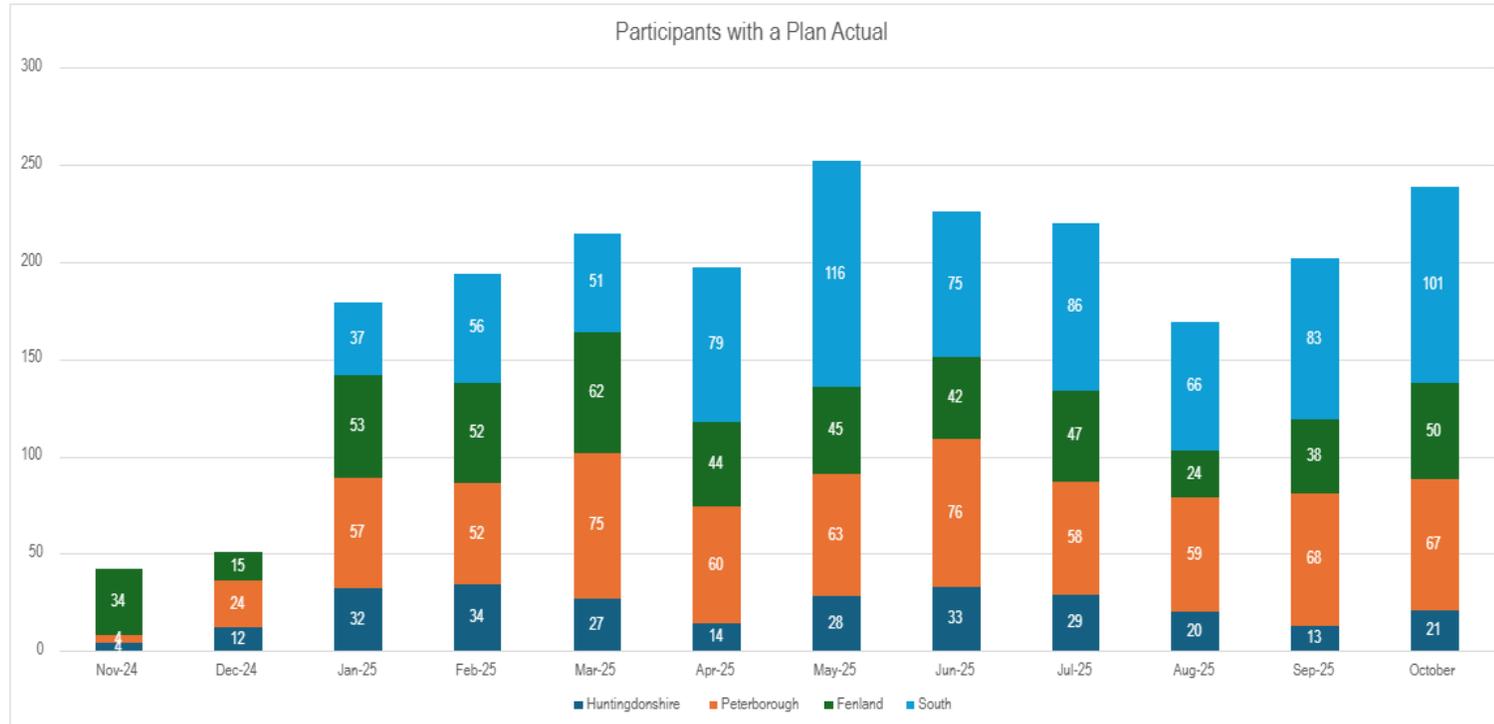
The planning underway in each place will need to cover our contribution to these elements.

Since launching in late 2024, the WorkWell programme has supported almost 2,200 people who were experiencing health-related barriers to work to stay in, or return to, work.

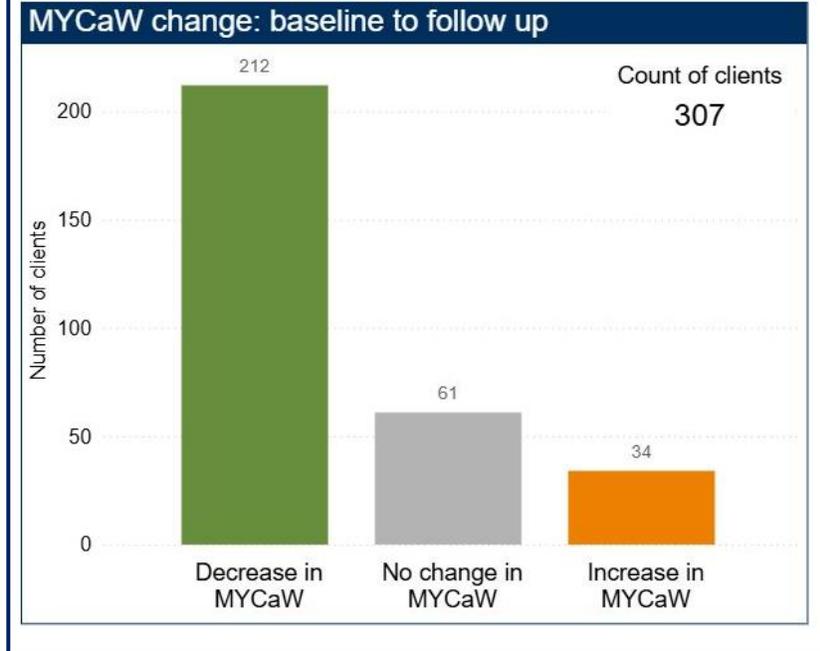


	TOTAL	P'BORO	FENLAND	HUNTS	SOUTH
Referrals Accepted	3928	1858	729	471	870
Participants with a plan	2186	663	506	267	750
Conversion rate	56%	36%	69%	57%	86%
Contracted Minimum Target	3000	850	634	666	1000

(data at 31 Oct 2025)



We've improved on what matters to participants – measured using a tool called MYCaW



Client Story



Background

Mandy came to WorkWell struggling with stress, mental health and overall burnout.

She had recently taken time away from work to focus on improving her overall wellbeing but requested support from the WorkWell programme in managing her mental health and burnout.



How we helped

Signposting to mindfulness and CBT

NHS resources on identifying and coping with burnout

Printable action plan to identify what good wellbeing looks and feels like inside and outside work, stresses and triggers and who to speak to for support

Discussed possibility of a phased return to work and how to go about this

Supported by coach throughout phased return



The outcome

Mandy's phased return went smoothly and after a few weeks she had managed to increase back to her full working hours.

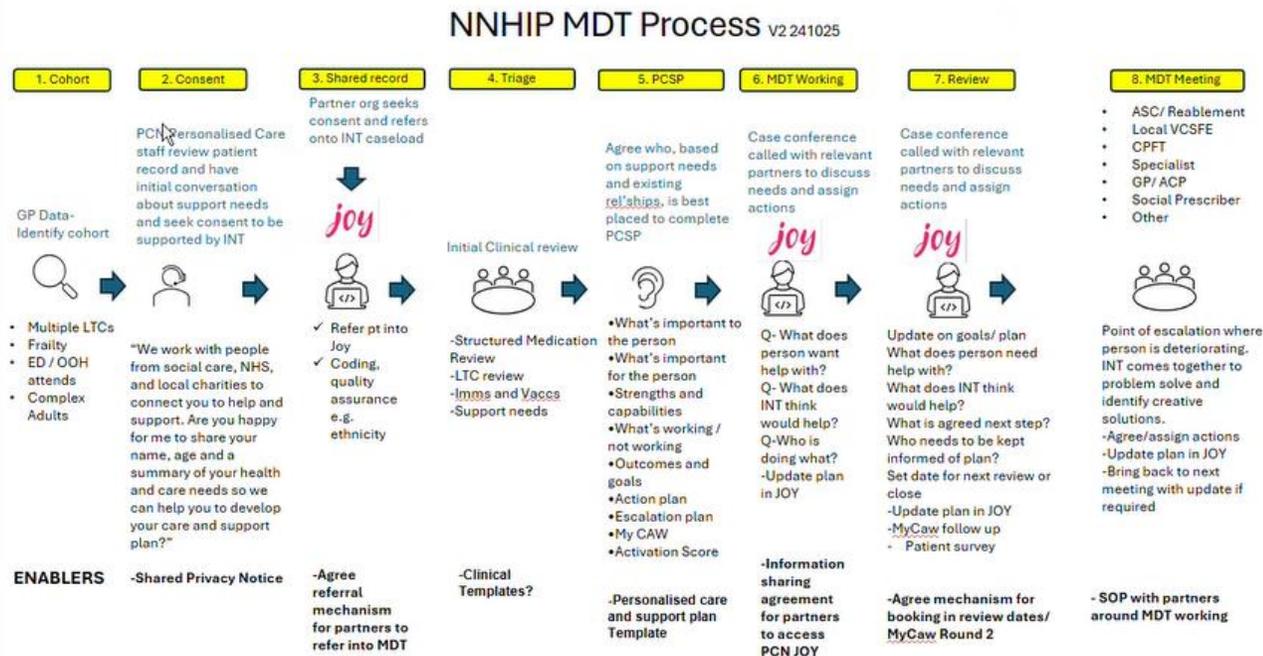
Mandy thanked her WHC for the knowledge, support, and empowerment she had been provided and the flexibility offered with her appointments.

Mandy had achieved her goals of improving her overall wellbeing and returning to her full role, and was successfully discharged from the programme.

We are wrapping proactive, personalised support around people with increasing frailty through multi-agency teams focused on wellbeing and activation

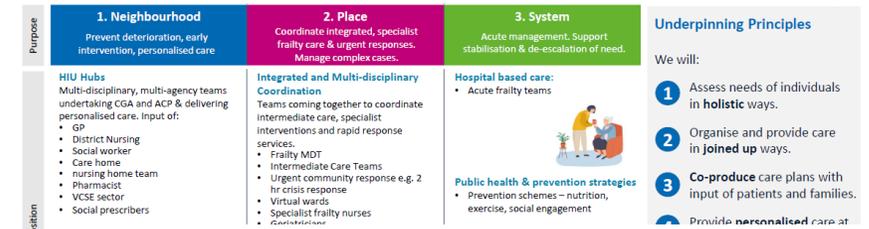
Building on new care models we co-designed with a wide range of system partners this year and learning through pioneer initiatives.

NORTH: Neighbourhood Pioneer Programme

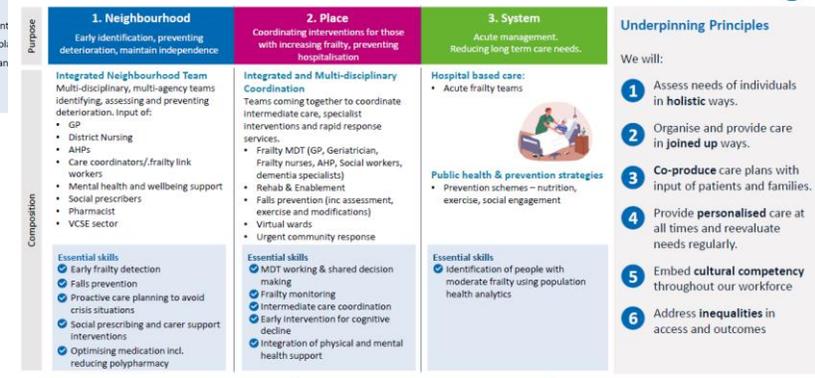


Person-Centered Thinking Tools - Helen Sanderson Associates

A severe frailty care model for consideration



A moderate frailty care model for consideration



SOUTH: Locality Wellbeing Forums



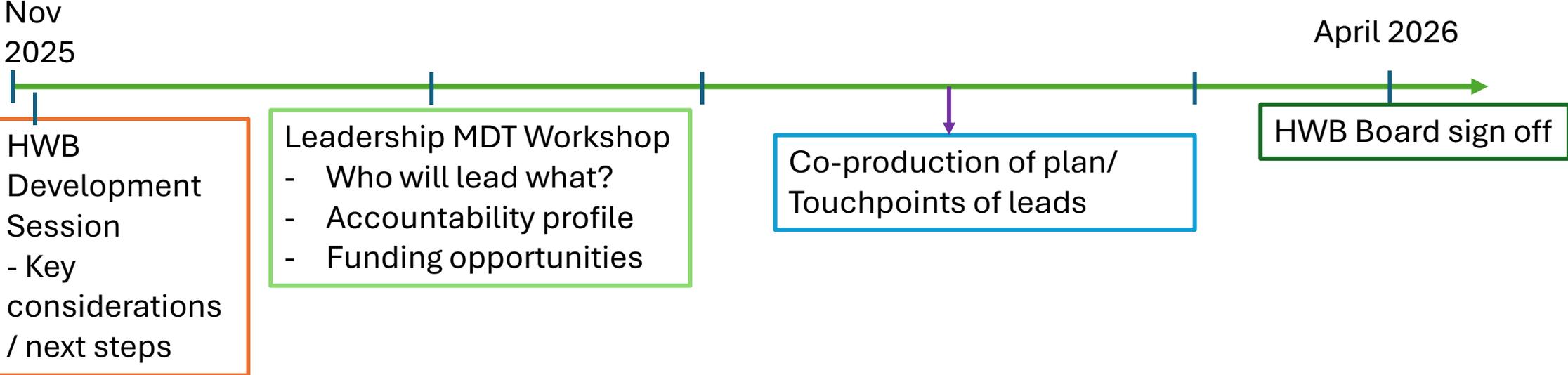
Key Questions:

- How do we approach this through genuine collaboration with a strategic plan that we all own?
- How will we drive the development of a collective data set that enables our MDTs at neighbourhoods to work effectively and enables the HWB to measure success and productivity?
- How do we align our planning and service provision to a neighbourhood model?
- How will we progress our commissioning of neighbourhoods together? (e.g. BCF/Section 75 and additional opportunities)

How will we collaboratively hold the pen?

DISCUSSION

STRATEGIC PLAN



OPERATIONAL PLAN

