Digital Care Hub

Run by social care providers
for social care providers.

Neighbourhood health services and the role of social care data

21st May 2026

Digital Care Hub

House Keeping

- This webinar is being recorded
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- **Please put your name and organisation in the chat**
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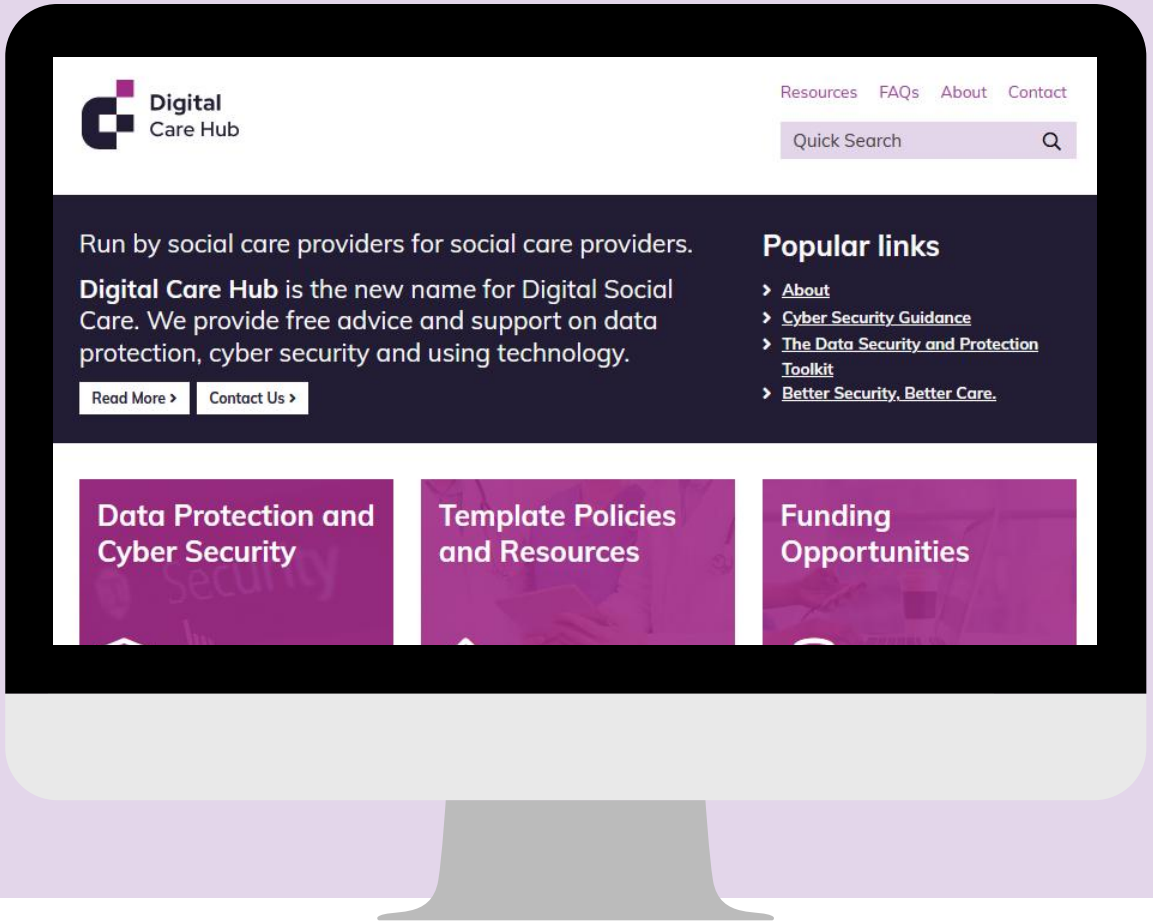
Digital Care Hub – who are we?

Digital Care Hub is a **not-for-profit organisation**.

We help care organisations use **digital technology confidently and safely** through **practical guidance, resources, and tools on data protection, cybersecurity, and digital transformation**.

Our work supports over 20,000 care providers across England to adopt digital tools securely, improve quality of care, and build digital confidence across the sector.



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Agenda

Time	Agenda Item	Name
13:00 – 13:05	Welcome and Housekeeping	Michelle Corrigan
13:05 – 13:15	National scene setting	Caroline Day
13:15 – 13:30	What does NHH mean for social care?	Melanie Weatherley
13:30 – 13:50	NHH In action – Insights from a pilot site	Louise Bestwick
13:50 – 14:10	Report Insights	Claire Kennedy
14:10 – 14:25	Q&A	
14:25 - 14:30	Care provider top tips, conclusions & close	Fiona Florey

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Caroline Day

Policy Lead - Health and Social Care Integration
DHSC

Department of Health & Social Care

Department of Health & Social Care

NHS England

Neighbourhood Health National Policy Overview

21st May 2026

Digital Care Hub Webinar

These slides cover

1. Overview of Neighbourhood Health

2. Progress updates on:
    - Neighbourhood Health Framework
    - Delivery Models
    - Neighbourhood Health Centres
    - Workforce

What is Neighbourhood Health?

"Neighbourhood health puts the **person at the centre** of how we deliver their health and care, by organising **services** so they can **work together** to **serve a defined local population**." *Neighbourhood Health Framework, March 2026*

This includes:

- **Services people need close to home** / on the high street: e.g., GPs, Community Health Services, Urgent Care, Diagnostics, and Outpatients.
- **Public services:** e.g., Adult and Child Social Care, Public Health Services, Housing, Employment Support, and Welfare.

We are supporting systems with the first foundational steps

Guidance documents are setting expectations and supporting systems with implementation:

Medium-Term Planning Framework	• Published October 2025. Sets out the high-level requirements for the NHS over the next 3-5 years. • Describes the priorities to establish a Neighbourhood Health Service at pace • Sets out the steps that ICBS and relevant NHS providers should take from April 2026.
Neighbourhood Health Framework	• Published March 2026. Set national expectations on the minimum aims all ICBs will need to focus on for the next three years, working in partnership with local government and others. Sets out the actions local systems will need to take in 2026/27 to develop the foundations for neighbourhood working. Defines what should be included in neighbourhood health plans and who should be involved.
Fit for the future: towards population health delivery models	• Published March 2026. Sets out how ICBs and providers will work together differently to deliver models of care that are personalised, proactive and joined-up. • Describes three new population-based delivery models that will be rolled out from this year.
Neighbourhood Health Centres Guidance and Specification	• Published April 2026. Sets out both the strategic framework and the planning requirements for how providers, ICBs and NHS England regions should organise their estates to develop Neighbourhood Health Centres (NHCs). • The guidance sets out 7 criteria that ICBs and regions must meet when planning future upgrades and new NHCs.

We are accelerating progress through the National Neighbourhood Health Implementation Programme

National Neighbourhood Health Implementation Programme	• A large-scale change programme designed to help systems (NHS, LAs and wider partners) to accelerate progress in implementing neighbourhood health on the ground. Currently covering 43 places with an initial focus on transforming care delivery for adults with multiple long-term conditions and rising risk.

On 17th March, we published the Neighbourhood Health Framework

The **purpose** of the Neighbourhood Health Framework is to:

- **Empower local leaders to develop and scale neighbourhood health** by setting out how ICBs, local authorities, Health and Wellbeing Boards and other partners should collaborate to deliver neighbourhood health services.
- **Provide immediate clarity and consistency** to support joined-up partnership working between ICBs and local authorities and their partners.
- **To set national expectations on the minimum aims and objectives of Neighbourhood Health Services.** Whilst it is important that reforms are locally-led, as local authorities and ICBs are best placed to design services for their local populations, we have heard that there are many common-sense actions that could work well everywhere.

The framework sets out the **actions local systems will need to take in 2026/27,** to build the foundations for developing local neighbourhood health plans

It outlines **what should be included** in neighbourhood health plans, and **how local systems should work in partnership** to develop these plans**.**

We know that delivering a Neighbourhood Health Service will be an **incremental process** as local understanding develops and national reforms progress.

We plan to update the framework in future, to reflect this learning.

The framework sets out five national minimum goals and objectives to deliver successful neighbourhood health services.

1) Improve health outcomes with a focus on high-priority cohorts*

- helping people to stay healthier, manage escalating conditions and maintain greater independence for longer
- better identification of people coming to end of life and improved access to services
- better diagnosis and treatment for people with long-term conditions
- improving quality of and access to care for children and young people

2) Improve access to general practice

- making sure clinically urgent patients are seen on the same day
- faster access for routine GP care;
- improved patient satisfaction with access

3) Improve experience of planned care

- reduce variation in referrals to outpatient services
- better co-ordination of outpatient activity

4) Better urgent and emergency care performance

- better co-ordination of reactive care for high-priority cohorts
- reduced need for hospital admissions
- better co-ordination of discharge process and capacity planning

5) Improve patient and staff satisfaction with NHS services

- take a proactive approach, where the patient feels in control of their care
- ensure teams working within neighbourhoods feel more motivated in their work

*High priority cohorts:

- people with frailty
- care home residents
- housebound patients
- those receiving end of life care
- Those with:
  - CVD
  - Diabetes
  - COPD
  - Dementia
  - Mental health conditions
- children and young people
- any other cohort identified by local areas

Fit for the future: towards population health delivery models – published March 2026 - sets out how the population-based delivery models introduced in the 10 Year Health Plan can be used by integrated care boards and providers to overcome these obstacles

Commissioning for a population will align objectives across providers and incentivise the shift of care into the community and towards prevention

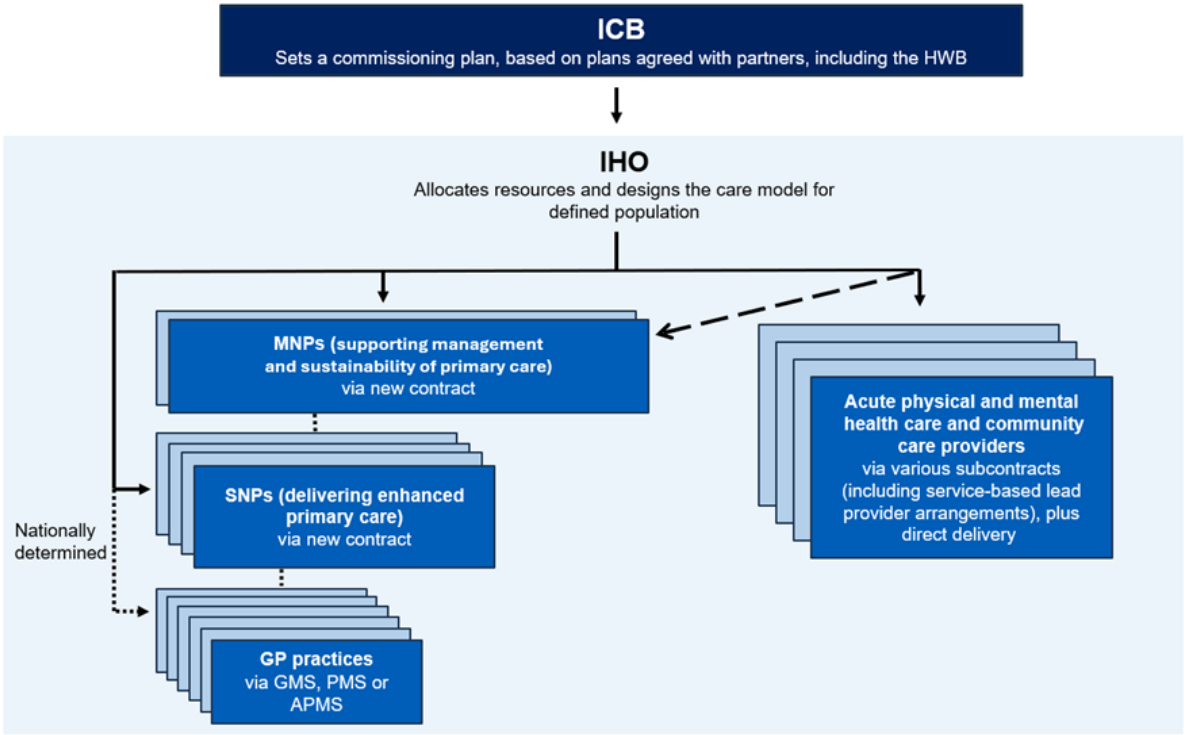
The three contracts have complementary roles:

- ***Single neighbourhood providers (SNPs)*** will deliver services for people with similar needs.
- ***Multi-neighbourhood providers (MNPs)*** will deliver and coordinate consistent services across multiple neighbourhoods.

Leading to → Greater integration of care delivery

- ***Integrated Health Organisations (IHOs)*** will allocate resources and design services to support implementation of new models of person-centred care that will improve health outcomes, patient and staff experience and efficacy of care.

Leading to → Alignment of incentives and allocative efficiency



Adult social care is not "linked into" these model — you are expected to be embedded in how care is delivered locally. You are a fundamental part of these new models.

Neighbourhood Health Centre (NHCs) programme update

In the Autumn budget, the Government announced its commitment to deliver 250 Neighbourhood Health Centres, with 120 delivered by 2030.

26th March:
Wave 1 of NHCs announced

- 27 site upgrades across England
- Up to £50m spent
- Predominantly deprived areas
- Open by 2027

15th April:
NHC Guidance published

- Sets out how ICBs and NHS England regions should approach developing NHCs

Already underway:
work on future waves

- **End of May**: estate strategy returns
- **Summer 2026:** pipeline development
- **Autumn 2026:** PPP market engagement
- **First half of 2027**: first sites

What are Neighbourhood Health Centres?

Neighbourhood Health Centres will be seen as the place to go for most health needs in every community.

They will bring together GP services with a mix of community, LA and voluntary sector services, allowing staff to join up care which is better for patients.

They will be open at a minimum of 12 hours, 6 days a week.

General Practice and PCN staff

Core general practice services

Mix of group and individual consulting rooms, touch down and phone booth for phone consultations

Community Health and INTs inc social care staff

Core community health as well as INTs starting with frailty and complex cohorts and staff from multiple organisations / partners

Mix of team rooms, consulting rooms, and touch down.

Mental health services

Such as primary care-based mental health services and talking therapies

Babies children and their families including services to support healthy development and emotional wellbeing, and child-friendly spaces.

Other hubs E.g. women's hubs, debt advice, Work and Health Hub, healthy living hubs

Clinics

Larger consulting rooms for ENT, gynae, and other community clinics

Minor Diagnostics

Kit including blood / PoC testing, USS, echo, spirometry etc

UTC / minor injuries

Waiting area / treatment rooms

Out of hours

Team dealing with general access out of core hours – using existing rooms

Shared spaces

Mix of group consulting rooms (20 people), team meeting rooms (5 and 10 people), kitchen / break area, touchdown areas, showers / changing, clear / dirty utility

**Blue boxes represent the minimum requirements for designation as a NBH. White boxes represent maximalist options. There will be a variety of models in between.*

On 15th April, we published the Neighbourhood Health Centre Guidance

The **purpose** of the Neighbourhood Health Centre Guidance is to:

- **Provide policy intent and a practical planning instruction** for neighbourhood health centre (NHC) development in the current planning period.
- **Set out the strategic framework for how ICBs and NHS England regions, working with providers, should identify and develop NHC schemes to support neighbourhood health:** the archetypes to consider, estate planning, pipeline development and funding routes.
- **Instruct ICBs and NHS England regions on the planning work now required to develop a coherent pipeline of NHC schemes.**

The guidance mirrors the principles of the broader capital framework of long-term planning certainty, transparent rules-based approaches, local leadership and a commitment to maximise the value of existing NHS and public estate.

Planning for NHCs must align with the **NHS Medium Term Planning Framework** and emerging neighbourhood health implementation plans.

The guidance should be read alongside the **Neighbourhood Health Framework,** which sets out the wider delivery expectations for 2026/27 and beyond.

It is also supplemented by the **Neighbourhood Health Centre Specification**, which supports the planning and development of new-build neighbourhood health centres.

The guidance sets out criteria for funding NHC Schemes

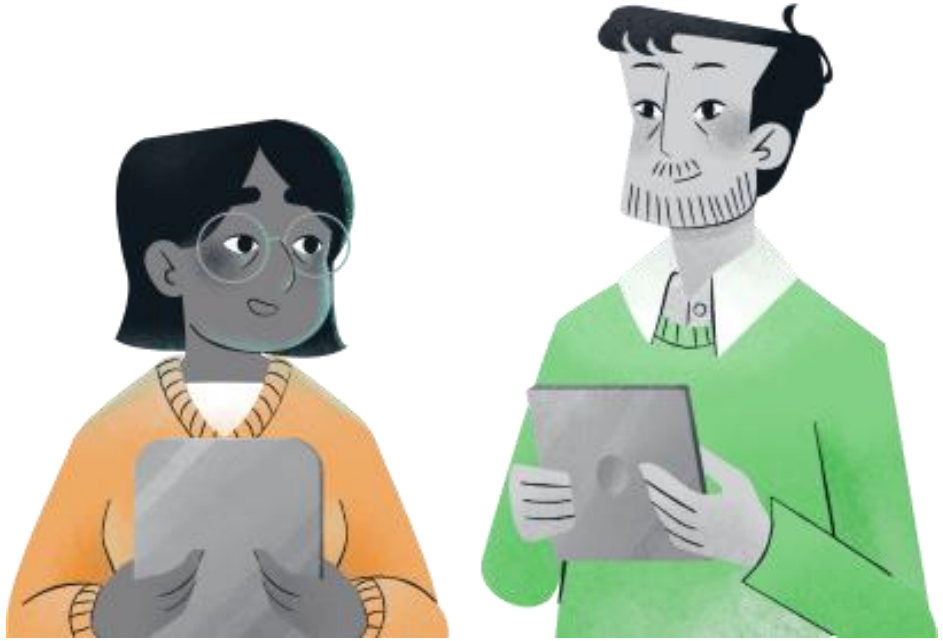
- Strategic Alignment with Neighbourhood Health Objectives
- Coherence between Neighbourhood Service Model, GP Provision and Physical Estate
- Intelligent strategic Estates Planning
- Deliverability and Pipeline readiness
- Financial Sustainability and Revenue Affordability
- Governance, Leadership and Partnership Maturity
- Local Strategic Alignment

Redesigning our workforce around neighbourhoods

Our aim is to make neighbourhoods **great places to work**, with strong leaders and teams skilled at **delivering proactive, preventative and personalised care** that improves health outcomes and stops the need for escalating. Staff will work together seamlessly across boundaries as part of multi-disciplinary **integrated teams** and their careers will develop fluidly through different parts of the system. People will experience better care, that is easier for staff to deliver.

What neighbourhood health means for adult social care providers

- ✓ **Care will be more joined-up — and digital will shape how that works day-to-day**
- ✓ **Providers play a key role in prevention, independence and avoiding hospital use**
- ✓ **This isn't just about new buildings or plans — it's about how care is coordinated in practice, and digital will increasingly enable how social care providers plug into neighbourhood teams**



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Melanie Weatherley, MBE

Co-chair, Care Association Alliance
Chair, Lincolnshire Care Association

Integrated Neighbourhoods

What risks and opportunities do they bring for providers?

Melanie Weatherley
Co-Chair Care Association Alliance

CARE ASSOCIATION ALLIANCE

Integrated Neighbourhoods – what are they, and what are the aims?

Neighbourhood Working is not new, but Neighbourhood Health is different:

- **Improve people's health and care outcomes, reduce health inequalities and help them stay well at home**
- **Organise services around the person with more convenient, personalised and joined-up care**
- **Reduce pressure on more acute services - including hospitals and care homes**
- **Cut waste and duplication**
- **Help the NHS deliver against core targets**

https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework#the-providers-of-neighbourhood-health

Neighbourhood Health – Goal 1
Improve Health Conditions for:

We are experts here:	We can help with these groups	May be less direct involvement	It depends - can we influence

• people with frailty
• care home residents
• housebound patients
• those receiving end of life care
	• those with:
	  • CVD
	  • diabetes
	  • chronic obstructive pulmonary disease (COPD)
	  • dementia
	  • mental health conditions
		• children and young people	• any other cohort identified by local areas

Neighbourhood Health – Goal 4: better urgent and emergency care performance

Urgent Care Avoidance:	Reduced Ambulance	Discharge Coordination
• make sure there is better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community	• have fewer ambulance call-outs for the least urgent cases, with appropriate diversion to relevant urgent care provision in the community.	• ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.

Neighbourhood Health – Other Goals – across the system but not directly ASC, but will benefit our service users

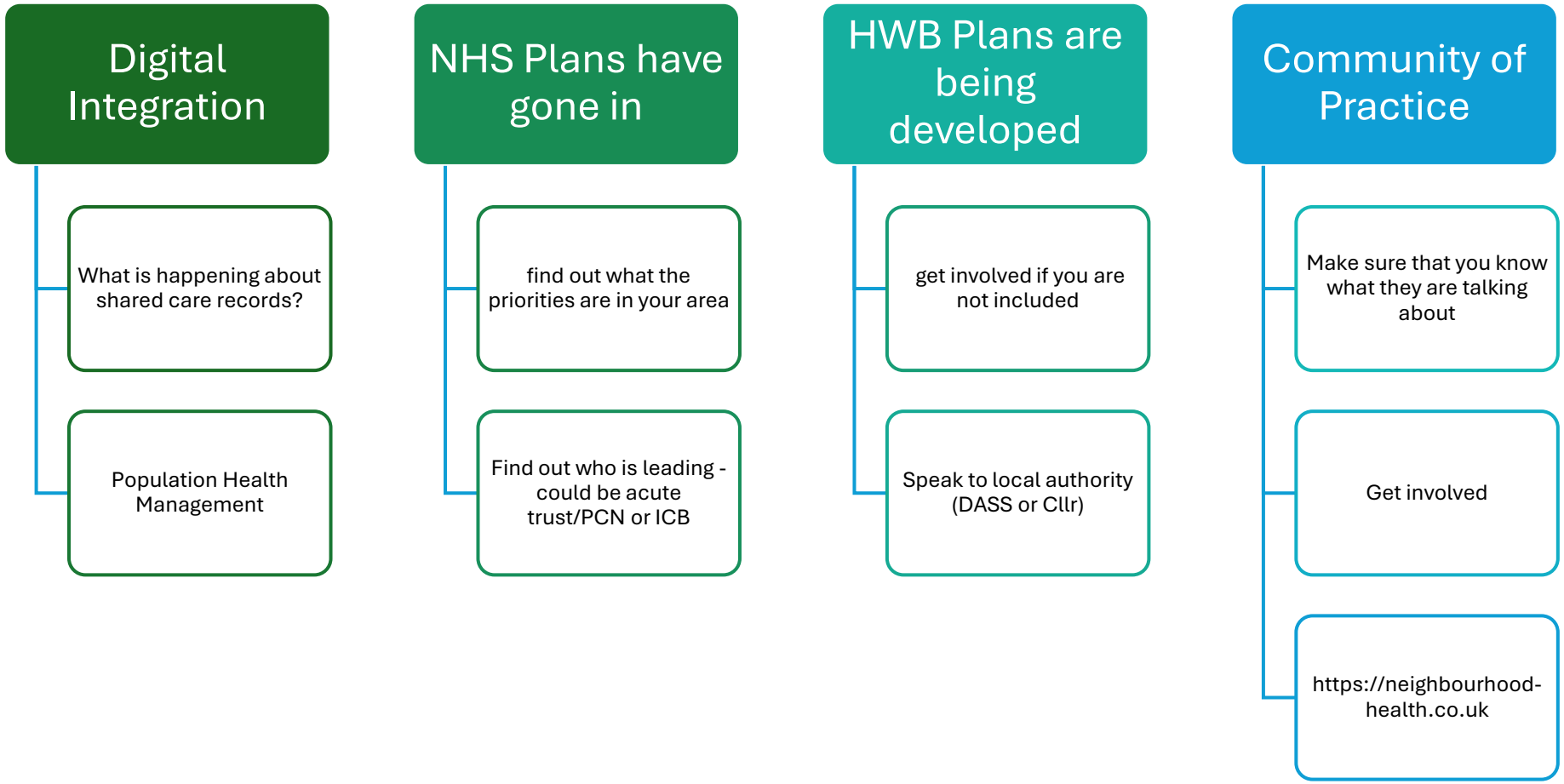
Goal 2:

Improve access to general practice

Goal 3:

Improve experience of planned care

What is happening now and how can we join in?



Concerns to be aware of

- ICB reorganisation
- Primary Care/NHS Trusts
- Local Focus – may be children and young people
- Invisibility - care providers may be seen as part of Local Authority or VCSFE
- Change in LA/NHS relationship

LACK OF INCLUSION IN DIGITAL INTEGRATION

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Louise Bestwick

Chief Executive
Bradford Care Association

BCA
Bradford Care Association

BCA
Bradford Care Association

Neighbourhood Health in Action: The role of social care

Louise Bestwick – Chief Executive, Bradford Care Association

Bradford INH Pilot & BCA Role

- Bradford is a pilot site for NHS Integrated Neighbourhood Health, with learning being applied across the district
- Pilot site for NHS Digital Neighbourhoods
- BCA has been integral from the outset
- Representation at the Act as One Committee (Place Board)
- Active involvement in:
  - Integrated Neighbourhood Service Delivery Group
  - Operational delivery groups
  - Business case development
- Supporting development Place Provider Partnerships
- Shift towards devolution of community budgets to place

What Neighbourhood Health looks like in Bradford

- Neighbourhood footprints based on 25–80k populations
- Built around PCNs and Community Partnerships
- 14 integrated neighbourhoods across Bradford District & Craven
- Development of Integrated Neighbourhood Teams (MDTs)
- "Team of teams" approach
- Focus on proactive, preventative, person-centred care closer to home

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National guidance increasingly explicit on the role of social care

Priority cohorts align strongly with social care:

Frailty and dementia

Care homes

Housebound individuals

End of life care

Strong alignment with Bradford's local priorities

Social care is a core delivery partner

National Guidance – Social Care & Priority Cohorts

Role of Social Care - MDTs

- Social care is central to MDT working
- **Key contribution:**
  - Insight into the individual
  - Early identification of deterioration
  - Advocacy for people and families
- **Supporting:**
  - Referrals into MDTs
  - Ongoing coordination of care
- Social care often knows the person best

What This Looks Like in Practice

- Locality Home Care Providers Joining MDTs (Frailty Focus)
- Increasing Provider Participation in MDT Discussions
- Aligning Existing Care Provision to Integrated Neighbourhood Footprints
- Strengthening Relationships Between Providers and Neighbourhood Teams- Networks
- Outcome-

  Improved Coordinated Care with the person at centre.

Role of Social Care-Delegated Health

- Delegated Health Activities are a key future role for social care
- **Opportunities:**
  - Prevention and early intervention
  - Reduced duplication
  - Person at the centre of care
- **Will require**:
  - Clear governance and data sharing
  - Workforce training and support
  - Sustainable remuneration and clear funding flows
- As budgets are devolved to place: Opportunity to develop enhanced roles and new ways of working

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What This Looks Like Locally in Practice

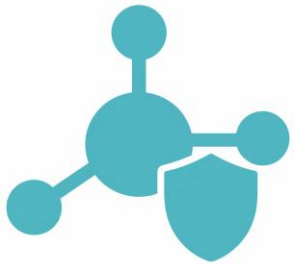
Exploring:

- End of life enhanced care worker roles in care homes
- Strengthening skills in:
  - Early identification
  - Advanced care planning
  - Coordination of care
- Supported by- new training offer, Telemeds, community funding, whole system GSF approach.

Provides a model for:

- Future delegated health delivery at scale
- A more integrated, proactive role for social care

Digital & Data – Key Enabler and Risk



- Digital and Data Are Fundamental to Neighbourhood Health
- Enable Population Health Management, Proactive Care, Joined-up Working, and Safe Data Sharing
- Give Teams Better Insight Into Need and Risk, Support Earlier Intervention, and Strengthen MDT Working
- Help Teams Work as One, Reduce Duplication, and Stop People Having to Repeat Their Story
- Support Metrics, Reporting- Measuring Outcomes & Impact
- However:
  - Interoperability Challenges Remain
  - Access to Shared Records Is Still Inconsistent
- Digital Is a Critical Enabler
- But Without Progress, It Becomes a Major Barrier

Real Example

Opportunities & Barriers

- Pilot: Home care providers supporting Skin Integrity Management Delegated Health
- Opportunity:
  - To upskill and develop the workforce
  - Potential to improve outcomes and reduce pressure on community nursing
- Barrier:
  - Poor interoperability and no shared care record access
  - Workarounds like password-protected spreadsheets are not scalable
  - Scale of training the Workforce
  - Small joint co-hort
- Impact:
  - Slows integration, creates duplication, limits scale, ultimately project paused.

Digital Foundations for Providers

- Completion of the DSPT
- Supports :
  - NHSmail
  - Digital Social Care Records
  - GP Connect
  - Cyber Resilience
- Prepare for:
  - Digital ReSPECT
  - Shared Care Records
  - Data sharing & Reporting
- Build digital workforce confidence & competence
- Utilise BSBC support

Call to Action

- Engage with your Local H&C System:
  - ICB
  - Local authority
  - Neighbourhood Health Teams
- Seek involvement in MDTs
- Understand local priorities
- Be digitally ready and confident

Key Takeaways & Conclusion

- Social care is central to delivery
- Digital is a key enabler—(and current barrier)
- Success depends on:
  - Collaboration
  - Data sharing
  - Workforce development

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Thank You!

Any Questions?

Digital Care Hub

Claire Kennedy

Joint Chief Executive
PPL

PPL

Neighbourhood health services and the role of social care data

Navigating Neighbourhood Health

A guide for social care providers

Thursday 21st May 2026

Meeting the moment of challenge and change

Neighbourhood health starts with the recognition that physical and mental health, care and related services remain too fragmented, too reactive, and too shaped by organisational boundaries and historic ways of working.

A health and care system under strain…

Rising complexity, fragmentation, workforce pressures, and reactive models of care are exposing the limits of today's system.

Neighbourhood health as a critical response…

A shift towards prevention, coordination, and whole-person support delivered through "teams of teams" across communities.

Harnessing a digitally transforming care sector…

As care becomes increasingly digital, neighbourhood health will depend on connected data, interoperable systems, and trusted infrastructure.

This presentation will provide insights around neighbourhood health, recognising the importance of the care delivery, digital infrastructure, and data across social care and the care providers at the sector's heart.

Cutting through the noise around neighbourhood health

The "North Star" of neighbourhood health is improving health and wellbeing of individuals and communities.

> **…fundamentally reorganising care around people, communities and health outcomes.**
>
> *Towards a Model Neighbourhood,*
> PPL in partnership with the NHS Alliance *(2026)*

Too often, neighbourhood health gets lost in policy language and one-size-fits-all solution will fail.

This work brings together a set of "design principles" to support "whole-population, whole-system and whole needs models of integrated care" that flex to local settings and need.

So, what does that mean in practice?

Care that comes to you

Not the other way around – at home, in the community, where people live.

Someone who knows you

A named person who holds your thread across services, so you don't start from scratch every time.

Services that communicate and interoperate

Health, social care, housing and community — coordinated around the person, not siloed by organisation.

Acting before crisis hits

Spotting risk early and stepping in – rather than waiting for things to fall apart.

This isn't just an NHS agenda

Neighbourhood health sits at the heart of building stronger communities and addressing wider socio-economic inequalities. The NHS is one player in a much bigger team.

Social Care Providers

At the heart of neighbourhood health *– daily contact, holistic support, early detection of risk*

Primary Care & GPs

Clinical anchor; key worker for registered patients across the neighbourhood

Local Authorities

Housing, employment, children's services, public health, community assets

VCFSE Organisations

Social prescribing, trusted relationships, community capacity, peer support

Mental Health Services

Integrated into neighbourhood teams — not a separate referral pathway

Community & Acute Trusts

Shifting care out of hospital and closer to home — with social care making it safe

The neighbourhood health model brings together a set of core services, as a "team of teams" – *with a commitment to organising those services around the specific circumstances of individuals and families in the neighbourhood*

Three modes of care – social care is in all of them

Neighbourhood health organises support into three overlapping modes. Social care has a vital, distinct role in each.

Preventative

What it means:

Reducing the chance of becoming unwell *– focused on nutrition, isolation, housing, exercise, community connection.*

Your role:

Daily visits by care workers are a prevention programme, too often overlooked. *Spotting weight loss, mood change, unsafe home conditions — these are clinical signals.*

Proactive

What it means:

Identifying those at risk and acting before a crisis *– care plans, key workers, coordinated support.*

Your role:

Social care holds the most current picture of someone's daily reality. *Care provider data from the frontline is a critical evidence base for proactive care that we often miss.*

Reactive

What it means:

Responding when someone becomes a patient *– aiming to manage care at home, not in hospital.*

Your role:

Technology enabled care, virtual wards and 'hospital at home' are underpinned by social care delivery. *You make discharge safe, fast and sustainable.*

In a fully functioning neighbourhood health system, all types of care need to work together to maximise outcomes for individuals, families and communities...

How it all fits together

The neighbourhood model is built on four interlocking components. All four must be in place for it to work.

01

A Defined Geography

Around 50,000 people, geographically meaningful, aligned with local authority boundaries. Not too big for relationships; not too small for services.

02

A Core Service Offer

Consistent access to primary care, community health, mental health, social care, pharmacy and VCFSE – for every neighbourhood, every resident.

03

Coordination Infrastructure

Named key workers, shared care plans, single access points, micro-huddles and joint visits. The connective tissue that makes the model real.

04

Enabling Infrastructure

Shared records, co-located estates, interoperable digital systems, funding that follows the person – and governance that keeps data-sharing safe.

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

The Neighbourhood Health Simulation showed us…

As a tool, the Simulation is unique in allowing us to condense months and years of practice into a few short hours, to give us a sense of what the experience of the new way of working will actually feel like, and what it will (or won't) deliver.

Delivered over two days, demonstrating what neighbourhood care could look like…

A simulation environment constructed from scratch; mirroring operational realities and physical place…

Over 60 professionals from 40 organisations across the country participated…

> *They listened, showed empathy… I finally felt like I was getting support.*
>
> **— Resident**

> *Open communication and equal value between all contributors to the neighbourhood team is essential…*
>
> **— Frontline Professional**

> *It felt like someone was finally coordinating things.*
>
> **— Resident**

…that this will work

By the end of National Neighbourhood Health Service simulation…

The simulation provided a positive indication that integrated neighbourhood working can directly relieve system pressures, including reducing unplanned hospital admissions and improving GP access.

25%

fewer outpatient appointments

119,600 avoided / year

14%

drop in unplanned admissions

8,840 admissions avoided

£77m+

cost avoidance potential

per borough of 290k

11%

drop in GP appointments

utilising non-GP resources

100%

of residents felt better listened to

by end of Simulation Cycle 2

The simulation event was underpinned by a dynamic systems data model – allowing us track decisions made from frontline staff to the planning layer participants in real time

And that social care is not an add-on.

It is at the beating heart of change.

1. *Care providers – domiciliary and residential workers – are explicitly named as core neighbourhood team members in NHS guidance.*

2. *Care workers have more daily contact with those who need most support than anyone else – making them the most powerful early-warning network we have.*

3. *Without care provider data being shared with local authority and health partners, alongside shared records, the neighbourhood model is flying blind.*

4. *Social care eligibility, practice and thresholds were identified in the simulation as the biggest knowledge gap for other professionals. You carry expertise others lack.*

Neighbourhood health will fail if adult social care remains digitally fragmented, operationally disconnected, and treated as secondary infrastructure
– something our work around simulations has so clearly shown us.

The simulation showed...

28%

increase in VCFSE & social care activity during the NHS simulation, as coordination improved

"...a need to deepen understanding of the context and process of social care delivery, as that was often a gap in understanding for some professionals."

PPL

Digital and data is the keystone – not the afterthought

Neighbourhood health is fundamentally a data and coordination challenge – supporting the coordination of people, risk, support, and decision-making across home, communities, providers, health and care organisations, and VCFSEs.

Yet digital infrastructure alone does not change practice. Behaviour, training and culture must be tackled directly alongside it – with a focus on the person they are serving and supporting.

Shared electronic record

One record, with read/write for all partners including social care — with consent and clear governance.

Interoperability

Care management platforms (Nourish, Access, CareBlox etc.) must connect to NHS systems. This is non-negotiable.

Population segmentation

Data that identifies who needs proactive support — frailty, multi-morbidity, housing instability, isolation.

AI-assisted insight

AI to flag early deterioration, support triage and improve accessibility — partnering with, not replacing, professionals.

Governance that includes you

Information governance must explicitly cover VCFSE and social care partners — not just NHS bodies.

Digital inclusion

Non-digital residents must not be excluded. Analogue access must exist alongside digital routes.

"None of this is easy. But the simulation proved it is doable — and that it starts with mindset, not technology." — System Leader, NHS Simulation

Behaviour matters as much as technology

The simulation was unequivocal: giving people access to digital tools did not, by itself, change how care was delivered. What changed practice was culture, trust and explicit permission to act differently.

What Blocked Progress

✗ Defaulting to referral rather than joint working — even when shared records were available

✗ Hierarchy and risk aversion — staff waiting for permission to act differently

✗ Organisations prioritising resource control over resource sharing

✗ VCFSE and social care treated as peripheral rather than equal partners

✗ Rigid professional silos persisting despite shared purpose and goals

What Unlocked It

✓ Giving staff explicit permission and psychological safety to work differently

✓ Micro-huddles replacing long MDTs — building daily connection and shared purpose

✓ Resident voice embedded in real-time planning — resetting priorities from the ground up

✓ Leaders spending time in the neighbourhood, not just the boardroom

✓ Trust, relationship and mutual understanding of each other's roles across the whole team

Your practical starting points

Providers are already delivering neighbourhood health services – working preventatively, managing complexity, coordinating across services and communities. Wherever you are on the journey – here is where to begin.

Now – Connect

1. Find out who your local neighbourhood team is and ask to be part of it.

2. Join any existing data-sharing agreements — ask your ICB if you're not included.

3. Send a representative to neighbourhood micro-huddles. Your frontline insight is irreplaceable.

4. Check your care management platform: can it share data with NHS shared records?

Near-Term – Build

1. Work with ICBs to enable interoperability between your platform and NHS shared records.

2. Train frontline staff in population health thinking, social prescribing referral paths and risk escalation.

3. Co-design shared outcome frameworks that include social care metrics — not just clinical ones.

4. Nominate a named neighbourhood liaison in your organisation.

Strategic – Lead

1. Advocate for contracting models that pay for coordination, not just task completion.

2. Use your data to evidence your preventative impact and secure sustainable neighbourhood funding.

3. Build digital inclusion support for residents without connectivity or confidence.

4. Push for social care voices in neighbourhood governance — not just in delivery.

The opportunity and your place in it

Neighbourhood health is not an NHS reorganisation with a social care footnote. It is a whole-system transformation, with social care organisations and providers at its centre.

Belong

You are a named core member of the neighbourhood team – not a referral endpoint.

Connect your data

Interoperability with NHS shared records is essential. Your data makes the model work.

Shift culture, build skills

Technical infrastructure only delivers when behaviour, trust and empowerment change alongside it.

Claim your seat

Advocate for contracting, governance and leadership roles that reflect your true contribution.

If you have any additional insights, examples, or experience of neighbourhood care delivery – or want to discuss anything we've talked through today – please get in touch

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