



**May 2026**

# Providers and Neighbourhood Health

FROM HOSPITAL-CENTRIC TO POPULATION HEALTH

NIGEL EDWARDS

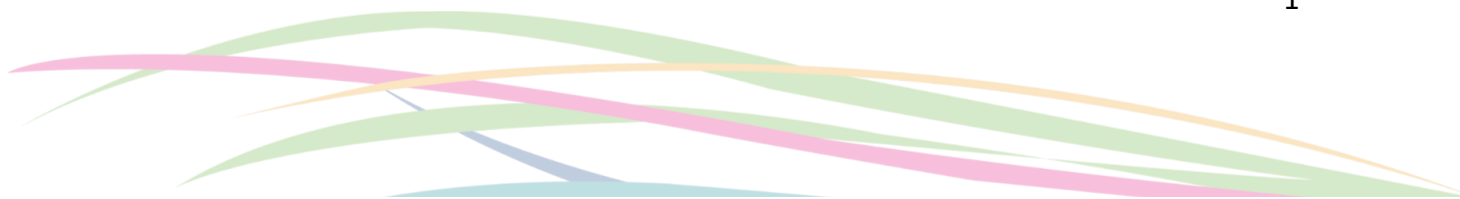
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## Table of Contents

Introduction .....	3
Context .....	3
The new contracting architecture and national targets.....	4
A broader vision for hospitals.....	5
Opportunities for change .....	6
Outpatient care .....	6
Inpatient and emergency care .....	7
Changing care models .....	8
Resetting consultant and GP relationships .....	8
Advice-first models and service redesign .....	9
Delivering care closer to home .....	9
Community diagnostics and extended roles .....	10
Using data and insight to manage care .....	10
Specialist support to community teams.....	10
Intensive support and step-up/down services .....	11
Aligning specialists with neighbourhoods .....	12
Population health and MDT models.....	13
Simplifying and redesigning community services .....	13
Coordinating virtual wards and system capacity .....	14
Prevention and wider determinants .....	14
New ways of working .....	14
Relationships, behaviours and collaboration.....	14
Working with neighbourhoods .....	14
Transitions of care and managing demand.....	15
Enablers .....	16
Workforce implications.....	16
Data, analytics and infrastructure .....	16
Policy and system alignment.....	17
Finance, incentives and transition .....	17
Supporting system integration.....	18
	1





# NAPC

Leadership .....	20
Conclusions .....	20





## Introduction

This paper looks at how providers need to adjust to work effectively with neighbourhood health models. It is based on interviews with leaders from trusts, NAPC experts and on evidence from research and international experience.

There are cultural challenges and some very significant redesign of important processes and operating models including major change in job plans for consultants and perhaps the rethinking of the entire job planning model in use for the last 20 years. The financial mechanisms to support this are not in place and the performance management regime for providers is not aligned to this agenda. This represents a significant leadership challenge and while we spoke to trust leaders who understand this and are taking their organisations in this direction there is a concern that our sample is skewed and the incentives to carry on with business as usual are strong.

## Context

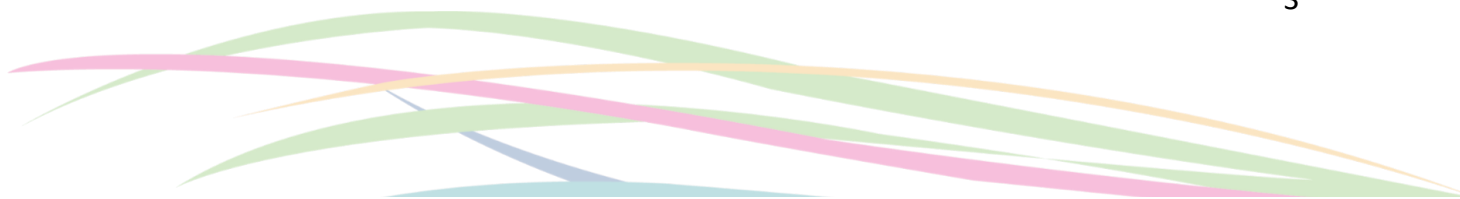
Large provider trusts will have an important role in the development of neighbourhood health, but the opportunities have received less attention than other aspects of the model.

NHS England's [Neighbourhood Health Guidelines](#) has a section on the contribution of secondary care to neighbourhood health that outlines three main areas of activity for hospitals:

Supporting continuity of care	Enabling new service models	Integrating frailty services
Specialists (respiratory, diabetes, stroke, cardiology) should provide input to neighbourhood MDTs through joint clinics, digital connections, or alternative pathways that bypass A&E	Hospitals should support virtual wards, single points of access, and community diagnostic centres with clinical advice and oversight.	Hospitals must develop frailty-attuned services that connect with community provision and support complex discharge.

It also set an expectation that hospital senior leaders participate in joint neighbourhood health taskforces alongside other system partners and that there should be joint workforce planning across organizational boundaries, with flexible deployment of hospital staff where needed most.

This is fine as far as it goes but it fails to pick up other elements of in the guidance that have important implications for acute providers and, based on our interviews with hospital CEOs,



system leaders and NAPC experts, it seems to lack ambition and fails to capture the opportunity for hospitals to make a major contribution to the neighbourhood model, especially those that are also providers of community services. Consequently, the guidance under-estimates the changes in culture, systems and ways of working that may be required and would leave hospitals poorly equipped to become integrated health organisations, if that is their ambition.

From our interviews and drawing on international experience we have identified several areas where providers can make a positive difference and where they should be focussing. These develop some of the ideas in the guidance but also point to the need for a more systemic approach to changing culture, systems, processes and relationships as well as the sort of service redesign advocated in the guidance.

## The new contracting architecture and national targets

Since completing our interviews new guidance has been issued which provides some additional ideas about the direction of travel and how providers should respond. The Neighbourhood Health Framework and the accompanying NHS England guidance ‘Fit for the Future: Towards Population Health Delivery Models’ introduce a new contracting architecture that materially changes the strategic context for providers. This creates a direct institutional pathway for capable providers to take on population-based accountability.

Three nested population-based contract models are being introduced:

<p><b>Single Neighbourhood Providers (SNPs)</b></p>	<p>A SNP will deliver integrated neighbourhood team services within a defined neighbourhood, enabling primary care to take on new neighbourhood services beyond existing GP contracts.</p>
<p><b>Multi-Neighbourhood Providers (MNPs)</b></p>	<p>A MNP will co-ordinate delivery across multiple neighbourhoods, use their scale to design and commission services, fill gaps where SNPs cannot deliver, and introduce risk-gain sharing arrangements to incentivise prevention of avoidable non-elective admissions.</p>
<p><b>Integrated Health Organisations (IHOs)</b></p>	<p>An IHO contract holder will hold a whole-population health budget for a geographically defined population, take on responsibility for resource allocation and service planning across the whole care pathway, subcontract to <b>MNPs</b> and <b>SNPs</b>, and will manage the distribution of savings and losses across the system.</p>

IHO eligibility requires designation as an Advanced Foundation Trust. NHS England will designate the first wave of eligible providers in Spring 2026, initially drawing on high-performing foundation trusts. This transforms the conversation from aspiration to operational planning for leading trusts: the institutional pathway is open now. PCNs may also evolve into SNPs, changing the nature of the primary care entities that hospital specialists and community services work alongside – moving from relatively loose network structures to entities with population-based contracts, defined outcomes and accountability upward to an MNP or IHO.

The Neighbourhood Health Framework introduces specific, quantified national targets that create direct provider accountability and move the discussion from aspiration to mandatory performance.

This includes:

- a **25% outpatient diversion rate** for at least 10 high-volume specialties by March 2027;
- a **10% reduction in follow-up outpatient appointments** by March 2027;
- a **10% reduction in non-elective admissions and bed days** for frailty, care home residents, housebound patients and end of life cohorts by March 2029;
- a contribution to **82% four-hour ED performance** by March 2027 rising to 85% by March 2029;
- a reduction in **category 3 and 4 ambulance conveyances** for high-priority cohorts;
- and a new **Discharge Ready Date (DRD) metric** measuring the proportion of adult patients discharged on their DRD and the mean days from DRD to discharge for those who are not.

The Framework also calls for Best Start Family Hubs focused on 0–5 year olds, to be co-located with neighbourhood health services; a new ‘Experts at Hand’ SEND offer requiring joint ICB and local authority planning; and Young Futures Hubs for early mental health support for young people.

## A broader vision for hospitals

While traditionally many hospitals have been seen as somewhat isolated from the system around them, many now have realised the benefits of close working with their local health services and the wider community. A number of leaders we spoke saw a key strength of their hospitals as being deeply rooted in their communities as care providers, employers and as ‘anchor institutions’. The neighbourhood health model and place-based partnerships create opportunities to build on this and make a difference to the population.

They also thought that the demographic and epidemiological trends will result in the current model of hospitals having to expand to an extent that is unsustainable in terms of finance, workforce and the current model of care. They realise that many of the solutions for this are outside the scope of the hospitals remit and require the whole local care system to work together in new ways that include the hospital as a key partner.

The new contracting models, the emerging role of an integrator function supporting place-based partnerships seen in some areas and the need for a system response to the requirements in the new guidance all suggest re-enforce this conclusion. Providers need to actively engage with the emerging neighbourhood health models and place-based partnerships if these targets are to be delivered and the growing level of demand can be accommodated.

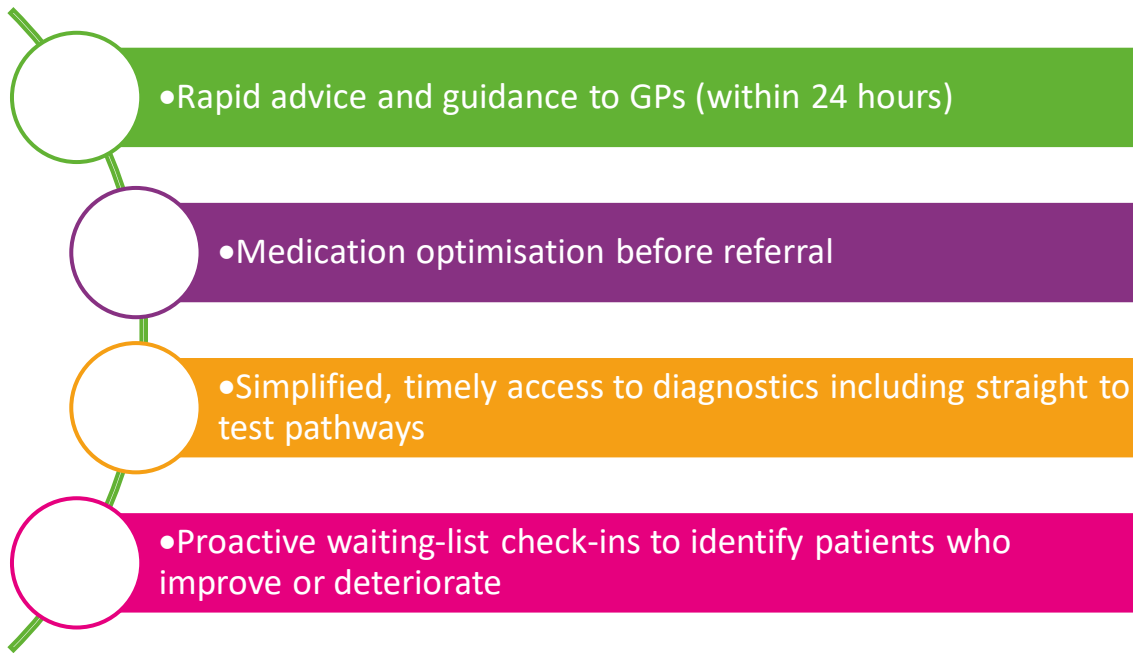
## Opportunities for change

### Outpatient care

There are significant opportunities in outpatient care. A neighbourhood of 50,000 people generates on average over 27,600 in-person first appointments and a further 4,300 tele-consultations. It also leads to over 52,000 follow up appointments in person and 12,500 done by phone. 12% of the total attendances are for AHP appointments, 8% Ophthalmology and 7% orthopaedics.

The 10 Year NHS Plan has an ambition 'to end hospital outpatients as we know it by 2035' and goes on to say 'Two-thirds of outpatient appointments - which currently cost in total £14 billion a year - will be replaced by automated information, digital advice, direct input from specialists and patient-initiated follow ups as we introduce a new digital front door to the NHS via the NHS App.'

The forging of new relationships with neighbourhoods offers an opportunity to accelerate work on rethinking outpatients. This is not about simply changing where patients are seen or just shifting work to primary care. It will include improved prevention and supporting patients and primary care to provide a different response to patient need. For example, a study in Oxfordshire found that 30-40% of routine referrals could be replaced or avoided by the provision of:



Various models of advice and guidance are being developed and are replicating this success, although the response time for requests may longer for routine care. The recently issued planning guidance envisages an expansion of the straight to test approach across a wider range of activity. There are also opportunities to expand patient-initiated follow-up (PIFU) with direct return pathways to specialists.

There is a significant opportunity here although whether more than a small proportion of the costs attributed to outpatients claimed in the plan can be saved or made cashable is doubtful.

## Inpatient and emergency care

The [guidance on neighbourhood health](#) frames reducing admission and length of stay as the key goal of the model – with the aim of reducing pressure on the hospital. This seems less than ideal as a way of engaging the wider community. The question for hospitals is how best they can support this goal through how they work with neighbourhood health services.

With a few exceptions (for example some diabetes services) the traditional hospital model has been reactive, providing care for emergency patients and consultation and treatment for patients needing specialist consultation and treatment when the demand presents itself. One result of this is that hospitals admit a substantial number of people with conditions where an upstream intervention or the availability of an alternative service could have prevented the need for admission. These include:

- Frailty, end of life care, falls, medicines related admissions
- Opportunities to manage some acute conditions in the community
- More proactive management of chronic conditions and preventing exacerbations

- Some emergency readmissions
- Some acute conditions where hospital at home, virtual wards or similar services can prevent the need for admission

There are related opportunities to reduce bed days either by not admitting these patients in the first instance or by providing home care, rehabilitation and other support for the long tail of patients waiting for discharge – although issues with the availability of social care reduces this.

Analysis for Coventry and Warwickshire Hospitals found that:

- **37%** of older people could avoid hospital attendance with better community access and decision-making.
- **38%** of patients could avoid admission through improved front-door support.
- **43%** of older patients could be discharged earlier with better coordination.
- Up to **1,600 additional users** could remain independent longer in the community.

An analysis of hospital activity by the [Strategy Unit](#) found that up to 34% of emergency admissions can be defined as potentially mitigatable and an even higher proportion of bed days.[1] This is a high end estimate as not all of the areas are within the control of hospitals - for example some derive from primary prevention or changes in prescribing practice in primary care. However, there are many where action by hospitals, the availability of home care, ambulatory care, other services or support to primary care by hospital staff could make a significant difference.

There is a high level of variation between areas ranging between 169 admissions in this category per 1000 weighted population in Wolverhampton to 34 in Bournemouth and so the scale of the opportunity will vary. There is also variation in the different components of mitigatable activity between areas. These different patterns of need will influence decisions about how hospitals direct their efforts in this area, and it also means that the pattern of services will be different in different places.

## Changing care models

### Resetting consultant and GP relationships

Neighbourhoods can provide an opportunity for trusts to work with the INT to develop new and more effective models of care.

An important theme found in our conversations was a desire to reset the relationship between consultants and GPs. This has some important elements:

Changing the traditional referral model from referral to one based more on discussion, joint problem solving and advice and guidance. It seems that for this to be most effective the referrer (usually a GP) should be in a dialogue with someone they know and have an ongoing collegiate relationship with. This is quite different from the proposed on-line hospital model where the consultant advice will be distant and provided by an unknown clinician.

## Advice-first models and service redesign

A well-established model that incorporates advice and other changes in the delivery model is the GI service in Northumbria.

This provides a single point of access for all GI requests with a dedicated 8 PAs of consultant time to provide advice and to direct requests to the right place. This is integrated with a team that can order appropriate blood tests, scans or endoscopy before first outpatient appointments to reduce follow-ups.

As the model developed it became clear that phlebotomy represented a bottle neck and the trust therefore invested in support to GP based phlebotomy services. The model is an advice-first approach and primary care can request specialist advice which often removes need for a face-to-face outpatient appointment; if clinic is needed the door remains open. Interestingly this model does not rely on complex referral forms and guidelines as the triage model and the ability to provide clinician to clinician feedback means that people quickly learnt how to use the system.

There may well be a spike in requests for support when introducing this approach and some thought may need to be given to who is permitted to ask for and advice or whether GP sign-off is required. However, the learning effects from well-delivered advice and the educational components means that early spikes in demand can be expected to settle down and overall activity levels will be lower and more appropriate after this. Reductions in activity create some issues related to funding that are considered below.<sup>1</sup>

## Delivering care closer to home

Neighbourhoods provide a focus for providing diagnostics, consultation and other services locally. Northumbria have developed neighbourhood delivery with GI clinics (notably liver services) relocated into community settings (GP practices, community hospitals, prisons) to improve access and reduce DNA rates. Other trusts have similar initiatives in other specialties.

Previous experience with remote outpatients has often been unsatisfactory with reduced clinic sizes, no interaction with local primary care and have been unpopular with consultants. The Northumbria model addresses these issues not least because the change is

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<sup>1</sup> NHS guidance on changing outpatients more generally can be found [here](#).

not simply relocating the legacy model to a more remote setting. Consultants now see more appropriate patients, interact with local GPs and a better environment than a traditional outpatient clinic (including a cup of coffee and a parking space). Other trusts that have implemented this type of model report that it has also helped to overcome the obstacle of transport for patients and reduced missed appointments which has a positive impact on inequalities of access.

As neighbourhood health centres are developed there are opportunities for hospital trusts to support these with imaging and diagnostics combined with same day /urgent care, urgent access to GP services and hot clinics reduce the need for routine and emergency referral to hospital. Buckinghamshire and Cornwall have both had success with variants of these types of models.

## Community diagnostics and extended roles

In several cases, community diagnostics and alternative pathways have been facilitated by working with GPs with a special interest working alongside consultants. These support the advice and guidance model and provide community-based investigation and treatment, with consultant oversight using local health centres, community hospitals or high street locations. Women's health centres provide a particularly successful example.

## Using data and insight to manage care

Hospitals can work with neighbourhoods to help manage their services more effectively by using insight and intelligence about patients based on data from the hospital and from the INT. Insights from the INT can help to identify and address issues of patients who frequently miss appointments and develop more effective ways of coordinating care for patients who have multiple appointments with different specialties.

Checking in on patients on the waiting list to see if their condition has changed, whether they need to be expedited or need a clinical review, whether there are particular issues that would mean that they should be given priority and to reduce wasted appointments was also found to be effective. Whittington Health use data about frequent emergency department attenders to identify people for an MDT approach with the voluntary sector which has significantly reduced their attendances.

## Specialist support to community teams

Specialist input into community-based teams that bring together primary, community and social care and the voluntary sector for frailty or for people who need high levels of support or who have rising risk levels are an effective way of bending the upward demand trend for admission and bed days. The Vanguard programme and other experiments have demonstrated the effectiveness of intensive support to nursing homes and using

geriatricians, specialist nurses, pharmacist advice and telemedicine links to improve care planning and to upskill and support staff.

Specialist input into MDTs for managing frailty and complex patients, providing expert input to advise on particular problem and virtual ward services will tend to be designed to operate at place where the larger population size gives some economies of care. However, the ability to communicate and work with INTs at a more local level and be able to rapidly respond to their needs will be a key element of what hospitals need to offer. This can work in the opposite direction with primary and community in-reach into hospitals to support discharge, care planning and other services.

## Intensive support and step-up/down services

While it will generally be the case that the neighbourhood will be able to deal with post-discharge care or other periods of higher needs some cases patients will need more intensive support than and teams serving a larger footprint will be needed. These will need to work very closely with the INT and GP practices with the intention of returning the patient to their home team as soon as possible. Trusts are well placed to provide this, particularly those providing acute and community services and two examples are shown in the boxes below.

### **Integrated Community Ageing Team (ICAT): Whittington**

Whittington Health operate a consultant-led multidisciplinary team - Integrated Community Ageing Team (ICAT) - specialising in Comprehensive Geriatric Assessments for patients who are registered with an Islington GP. This is usually carried out in the patient's own home, but 'Hot Clinics' are also offered where further investigations such as x-rays are required. The ICAT geriatricians and specialist pharmacists also provide visits and support to patients in Care Homes in Islington.

### **The Living Independently For Everyone (LIFE) service: Croydon**

This is an integrated, community-based health and social care team. It provides intensive, proactive, and goal-focused support for up to six weeks during periods of high need, helping residents avoid unnecessary hospital admissions or enabling early supported discharge. The service is delivered in partnership through the One Croydon Alliance, comprising NHS organisations, Croydon Council, and the voluntary sector.

LIFE operates with a Home First principle, ensuring residents return to their own homes following hospital stays. The service includes:

- **Wraparound support** for the first 7 days post-discharge, involving therapists, nurses, social workers, and care providers.
- **Active reablement** to restore confidence and independence in daily living.
- **Personalised recovery plans** tailored to physical and mental health needs.
- **Multi-disciplinary team reviews** to coordinate care for complex cases.

- **Step Up/Down intermediate care beds** for those requiring temporary residential support.

Since 2017 the integrated health and social care team of community nurses, physiotherapists, occupational therapists, social workers, reablement support workers and health and wellbeing assessors supports over 3000 Croydon residents a year back to health in the community.

## Aligning specialists with neighbourhoods

Some trusts are considering how they go beyond these changes and are developing models that align consultants and specialist nurses with neighbourhoods. Specialists would be given explicit responsibility for jointly working with INTs and local primary care to improve the overall population health for their disease area in addition to providing the traditional advice, consultation and treatment model.

The focus will be on improving the management of long-term conditions, but this could also form a key part of delivering the targets for reducing avoidable care home admissions. Providing remote monitoring, telemedicine support, training for care home staff and rapid response services are ways that larger providers can support neighbourhoods

The well-known [Connecting Care for Children model](#) (Imperial College) incorporates many of these features and the model is often well developed in diabetes (see for example Tower Hamlets) and frailty services. This model provides a very effective way of supporting primary care in improving secondary prevention and the management of long-term conditions.



1. Child health GP hub model (Imperial College)

## Population health and MDT models

**North Central London's Long Term Condition model** brings together a multi-disciplinary team of consultants supported by a care coordinator to work with PCNs to address patients with multiple long-term conditions. Patients are selected using primary care and hospital data based on their multimorbidity and risk level. The team use desk top reviews and MDT meetings to develop a joint management plan so that that patient has a single plan.

A GP lead acts as a connector to the wider PCN, and the care coordinator connects to the patient. At present not all GPs allow access to their records and these types of models will work better and avoid handing GPs additional tasks if the secondary care staff are part of the team.

The model is based on a year of care methodology and also has strong links to wider community and voluntary care services. The key objective has been framed in terms of improving health life expectancy and this means that younger patients have been prioritised in the first instance.

The model reflects the reality that in urban areas patients may have their care split between different hospitals – as well as different specialties.

This does not need to be limited to medical specialties, gynaecology, MSK, ENT and other high-volume specialties where advice and guidance can help to provide better approaches to care can also benefit from this approach.

Combining these approaches can have a very significant impact on the pattern of services. For example, Central Manchester Trust is aiming to shift ~75% of long-term follow-ups into neighbourhood teams, freeing hospital slots for new activity.

## Simplifying and redesigning community services

In some cases, there will be a need for a simplification and de-layering of services – particularly in the community. When the workforce and services are mapped as part of the development of neighbourhood care trusts have been finding duplication and overlap across teams in areas such as care homes and discharge planning, multiple teams often performing similar tasks with slight variations and with sometimes confusing difference in referral criteria.

One CEO commented that community nursing has splintered into highly specialised teams (frailty, end-of-life, chronic disease, wound care, catheter teams, etc.), resulting in multiple uncoordinated visits and handoffs. She advocated for more holistic 'generalist' roles that span core community needs (e.g., combining cardiac, respiratory, diabetes and chronic care nursing) with a small, centrally held specialist resource for complex cases. Combining this with strategies to support self-care and training carers/patients to administer tasks (e.g., insulin injections) would create additional capacity to support this shift.

## Coordinating virtual wards and system capacity

The growing size of virtual wards and associated hospital at home models and the development of a wider range of community-based services raise some question about how this will interface with INTs and be coordinated. The development of ways to rapidly can communicate and mobilise services quickly and that have an overview of capacity and demand across the wider place area appears to be a potentially very useful idea being developed in a few locations, in some cases supported by technology to track capacity and facilitate.

## Prevention and wider determinants

Improved prevention is going to be a key part of place-based plans and of the work of INTs. Hospitals can do more in this area and not just in ensuring that secondary prevention is as good as possible. Central Manchester Hospitals has rolled out 'Make Every Contact Count', deployed health coaches deployed in outpatients to tackle lifestyle risks, social prescribing and smoking cessation and integrated Money Advice Bureau services into some of its community services.

## New ways of working

### Relationships, behaviours and collaboration

Education and relationship building are an important foundation for new ways of working. In Northumbria there are regular trust-facilitated GP education sessions and a medical director with primary care background on the trust board helps maintain primary care perspective. In other examples consultants provide teaching sessions, joint consultations and board rounds / MDT meeting with practices. Trusts have also experimented with hackathons for joint problem solving.

Changes in ethos are important. Careful choice of language and changes in clinician behaviour with an emphasis on collaboration (not deflection), providing concise management plans back to GPs, and consultants avoiding excessive 'to-do' lists for primary care (more on this below) are all important. One trust nicely summed up the approach - the question is 'how can I help' rather than just rejecting referrals because the patient does not fit the criteria or due to a lack of information without providing helpful feedback.

### Working with neighbourhoods

Understanding the capabilities and capacity of neighbourhoods will be important in terms of planning and development but also on a day-to-day basis to help to develop standardisation of services and to be able to adapt to the strengths and weaknesses of different areas. Accrediting practices, networks or neighbourhood clinics was being explored as a

mechanism for helping with this in a few cases. Trusts will need to adapt to the fact that neighbourhoods will have different needs, and a discussion is needed about what needs to be standardised and where local variation is desirable.

Part of improving relationships and supporting primary care is careful attention to the risk that new models further increase GP workload by reviewing the tasks GPs are asked to do post-referral or discharge. Some trusts were working on identifying the tasks that make the biggest impact to and simplify or automate them and to discuss who should be taking responsibility. A more fundamental review of the balance of work between primary care and hospitals may be necessary.

## Transitions of care and managing demand

Working together on transitions of care to integrate admission, discharge, and virtual ward processes with neighbourhood models was highlighted by several interviewees. An issue here is the need to deal with changes in admission thresholds and length of stay if there is a reduction in demand for admission or improvements discharge as the neighbourhood health services successfully prevent the admission of some of the patients they are focused on.

This can negate some or all of the gains from integration and this may be one of the key reasons why so many attempts and integrated MDT working fails to reduce the overall admission rate, even though it is clearly reducing this for particular individuals.

Capacity opened up by preventing one admission means that a hard pressed admitting doctor faced with a 2 way choice of 1) admit and deal with the patient on the post take ward round or 2) undertake the potentially onerous task of sending the patient home will tend to take option 1), which also carries less risk.

Rational people make rational decisions. Hospitals, emergency departments and acute medical specialties will need to much more active in managing this and supporting ambulance services, local emergency and urgent care services, community services, palliative care, nursing homes, etc and 111 in preventing conveyance, providing alternatives to admission and managing risk.

They may also need to increase the level of senior decision making to avoid the problem of '[what-if medicine](#)', and to ensure that there is easy access to services that can support the patient to go home safely.

## Enablers

### Workforce implications

All interviewees identified important workforce implications. Adopting a model where outpatients care is delivered in different ways and specialists start to work with neighbourhoods will require a major recasting of the job plans of many consultants.

Those in areas relating to the management of chronic disease will be most affected and traditional highly detailed approaches to job planning may be less appropriate as specialists are asked to take a population health approach to their role.

Indeed, much of the current model of time-based job plans may need to be rethought and replaced with higher trust models based on outcomes and contribution to the system. For example, should diabetes consultants have KPIs related to admissions, glycaemic control, etc. in the population served by the hospital.

This will fundamentally challenge traditional ways of thinking about consultant productivity, particularly in medical specialties; just seeing more patients is not what is required, seeing fewer for longer to sort out difficult issues will generally add more value.

There are some unanswered questions about the training implications for some of the changes in the clinical models described by interviewees in particular a different model for outpatients and increased virtual care. The balance between generalist and specialist skills in the workforce will need to change and while deep specialist knowledge will remain vital the ability to deal with complexity and multimorbidity and deal with the whole patient, not just one body part or system, will become more important.

Personality and training gaps influence referral volumes and willingness to work outside traditional settings and some staff may need help to adapt to the new models. It does appear that some of the most interesting examples are somewhat dependent on clinicians with high levels of drive and excellent interpersonal skills. Helping people who don't fit this mould will be important, for example they can have an important role providing on-line advice and triage.

### Data, analytics and infrastructure

Creating shared records and enabling population health analytics is a clear priority, and trust digital teams are already playing a central role. However, the capability required for IHO designation goes considerably further than shared records. The guidance specifies that IHO contract holders must be able to develop a deep and dynamic understanding of local population need using joined-up person-level data; understand health utilisation and optimal costs of delivery; use detailed activity and cost data for medium-term planning;



identify interventions that increase value and minimise risks; design workforce and skill mix against a capitated budget; and use real-time data to identify individuals at rising risk.

This is a substantive population health analytics and actuarial capability that few trusts currently possess in full. Building it is not simply a digital infrastructure task: it requires analytic staffing, data science capacity, actuarial partnerships and a governance framework for cross-organisational data access.

Trusts with IHO ambitions will need to treat this as an investment priority now, since designation will require demonstrated capability rather than aspiration.

Using the estates and property management expertise and in the case of trusts with community services their often-extensive property portfolio to support the development of neighbourhood services is another area where trusts are working to develop local care models.

## Policy and system alignment

There is some misalignment of policy in that providers, particularly hospitals are not held to account for population health. There is less emphasis on participation in the wider system and the recent changes to performance management, the revival of a new form of foundation trust model and a move away from system control totals re-enforce this.

In contrast, France and the Netherlands both have models that incentivise hospitals to adopt population health and prevention strategies. Portugal has created integrated health units of which the hospital is a key element. Sweden, Finland and Denmark have structural and policy mechanisms to encourage collaboration with primary care and have a population health focus. This will need to be addressed.

The March 2026 guidance represents a significant step in this direction. The IHO contract model will directly incentivise hospitals to invest in community-based preventative care by giving them a population health budget and making them financially responsible for the consequences of failing to shift care upstream.

## Finance, incentives and transition

Perhaps the most important enabler is the area where there is the most uncertainty is how to align payment mechanisms and the financial imperatives driving trusts with the vision of creating neighbourhood healthcare. The issue of stranded fixed costs is well understood but the solutions are not.

The 10 Year Plan regularly quotes savings from new models of care based on an assumption that all costs can be saved when care is shifted. Long term financial frameworks that allow fixed costs to be restructured over time proved to be an effective method of dealing with this issue as part of the closure of the large asylums but the capital investment, potential for

land sales and the other elements of that policy which oiled the wheels are not generally available.

An interesting approach has been adopted by West Hertfordshire NHS Trust which has developed a social impact bond to provide funding for longer term investment to target preventative care for frail people.<sup>2</sup>

The March 2026 guidance introduces two instruments that begin to address this impasse.

#### Risk-gain sharing arrangements

- Initially on an upside-only basis, these arrangements are being developed to incentivise neighbourhood providers (including MNPs) to reduce avoidable non-elective admissions for high-priority cohorts. This is a concrete near-term mechanism, not merely a future ambition.

#### Nationally developed financial flows

- These flows are being designed to shift resources from acute into community and neighbourhood care, with NHS England committing to co-designing these payment approaches for all ICBs during 2026/27.

For IHO contract holders specifically, the model gives an explicit mechanism for brokering the distribution of savings and losses across providers to where resource delivers most value for patients – a structural solution to the stranded cost problem rather than a workaround.

In other cases, some interviewees described a collective decision to direct almost all growth to community and primary care but given the cost improvement targets set in the current planning guidance this has the potential to create unachievable short-term cost saving targets.

## Supporting system integration

The Neighbourhood Health Framework makes explicit an important governance dimension that providers need to engage with carefully. Health and Wellbeing Boards (HWBs) are assigned collective leadership over neighbourhood health planning – not ICBs alone.

By 2026/27 all HWBs must develop neighbourhood health plans (for 2027/28 onwards) that encompass NHS metrics, adult social care metrics, children’s services, public health and

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<sup>2</sup> <https://www.westhertshospitals.nhs.uk/about-us/news/first-its-kind-partnership-revolutionise-community-healthcare-uk>

wider public service reform programmes. This represents a significant elevation of local government's formal role in NHS service planning.

For providers, this means that engagement with local authorities is not simply about good relationships– it is now a governance requirement. Trust executives and non-executive directors need to be actively engaged in HWB processes and to understand the wider public service reform agenda (including Pathways to Work, WorkWell, housing, SEND and children's social care reform) that the Framework explicitly links to neighbourhood health.

Interviewees were very aware that their organisations need to think carefully about their approach to working with place and neighbourhoods. Hospitals must be embedded, not dominant as one interviewee put it and identified two different risks - hospitals staying disengaged from place-based work or overstepping and dominating efforts led by local authorities and community groups. There was a strong view that cultural humility is essential. As one interviewee put it 'The NHS must recognise that others (e.g. local authorities, voluntary sector) have long operated in place-based models. Hospitals should support, not commandeer, these efforts.'

Buckinghamshire hospitals have taken a number of steps to support the development of neighbourhood health including:

- Developing a **provider alliance** with GP Federation and council to hold neighbourhood contracts jointly.
- Appointed a **joint director of integrated care** (job share between trust and federation) to symbolise neutrality and shared ownership.
- Emphasis on **relationship-based leadership** rather than top-down directives
- **Joint estate development:** co-locating GP practices and community hospitals, creating shared receptions and facilities.
- **Investment in local VCFSE** organisations

Other trusts were adopting similar approaches.

Beyond this, several places are exploring the need for an integrator function that can provide support to neighbourhoods and act as an enabler.

NHS London has [published](#) their vision of this function. They see the integrator as operating at a level of scale to allow sufficient organisational resources, capacity and capabilities to be available across neighbourhood teams, whilst drawing on the local knowledge, experience and relationships from local professionals and communities.

Other parts of the system may be interested in this role and there could be opportunities for partnership with GP Federations or local government that providers might want to explore.

## Leadership

It is obvious that this agenda represents a significant leadership challenge. It calls for a different approach to trust leadership including a more outward looking and system focus. Traditionally, this is not something that has been incentivised and in a number of cases the people we spoke to were having to develop their models against the pressures pressing them in a different direction.

Historically big providers have been able to sit back and wait and see what might happen in the rest of the system while they focus on their immediate targets and internal concerns. There is little in the current system or performance management regime that changes this. The model cannot just rely on the type of innovative leaders we spoke to. Their approach needs to be generalised and the way that provider leaders are chosen and held to account needs to reflect the population health and neighbourhood focus of the system.

There is a similar leadership challenge for medical directors and the clinical directors of the specialties that will need to change and adapt this new approach. The changes to job plans needed are a major challenge on their own.

Insufficient attention has been given so far to this important area – but work is underway in pockets and places, through NAPC’s work with partners in systems to support local [leadership development](#). We are also working more widely with colleagues across the country in system and national roles – to help clarify the leadership and cultural conditions required to enable effective neighbourhood-based care.

Working with system leaders, practitioners, and subject matter experts, we are testing policy ambition against operational reality and identifying the practical conditions needed to support implementation.

The intention is not to propose a single national blueprint or another standalone leadership programme, but to provide a practical framing that helps systems clarify responsibilities, strengthen collective leadership, and support the transition from relationship-dependent working toward more consistent, scalable and accountable neighbourhood delivery.

The reality is that both local and national thinking and development will be required to evolve, and in some cases, more radically transform what it is to be a leader within a trust, alongside colleagues and communities across the local, regional and national eco-system.

## Conclusions

Large providers will cover multiple neighbourhoods and the process of adapting to the new landscape is complex.

There will be a particular issue for providers of community services that have often operated in ways that cut across neighbourhoods and have not always had the tight relationship with GP services that will be needed to make the model most effective.

There are also challenges for multisite or group trusts and some cultural and organisational challenges for hospitals with a substantial tertiary care and research role.

Rewriting job plans, changing the indicators of what constitutes productivity or organisational success, developing a population health mindset and building new and deeper relationships with neighbourhoods all constitute a significant challenge.

This is the first step to becoming an integrated care organisation, but only a first step, the scale of the changes to culture, systems and processes to make this change are very considerable. The mindset, orientation and operation model of hospitals are very different from that required by an integrated care organisation.

Some providers have not engaged with neighbourhood health and place-based partnerships as actively as they could. They have immediate pressing issues to deal with, and the agenda can seem less directly connected to their strategic priorities.

There is a growing acknowledgement that after years of undelivered rhetoric about shifting the balance of care that this time if it fails hospitals will be overwhelmed with demand they cannot accommodate or staff. The CEOs and directors we spoke to for this work recognise that this is not a tenable position and are thinking about how they can use their organisations knowledge and resources to make the model a success and to do this in ways that don't require them to be in charge. But our sample is biased, it is not clear how widespread this view is or how far there is the time, capability or inclination more broadly. It will be important that there is.