NHS England Neighbourhood Health Guidelines for 2025/26

The **Neighbourhood Health Guidelines** set a framework for how systems can move towards a community-centric model of healthcare delivery, working towards achieving the **three strategic shifts** set by the government for the NHS in 2024. In keeping with other recent NHSE publications, these guidelines are **deliberately short and permissive**, enabling systems to build services tailored to local needs, existing infrastructure and relationships.

Systems will be supported by NHSE regional teams to set specific goals for the upcoming financial year, with the overall focus being to **set the foundation for the neighbourhood model which can be scaled in the future**. A **national implementation programme** will support one exemplar place in each ICB to develop its model building on existing work and best practice, plus a small number of **learning and evidence sites** that will test implementation at scale.

Enabling delivery in 2025/26

Complex health and social care needs

- Individuals with complex health and social care needs comprise **~7% of the population** and are associated with **~46% of hospital costs**
- 2025/26 should **focus on sub-cohorts of this population** where there is greatest potential to improve independence, outcomes and free up resources to focus on prevention

Best practice

- Systems should support **personalisation and continuity of care**, including improving self-agency
- Supported by **a Single Electronic Health and Care Record** used in real-time by health and social care staff
- **Apply learnings from existing and emerging models** of successful neighbourhood collaboration e.g. women's health hubs and 24/7 mental health centres

Evolution of the model

- ICSs should consider how to **evaluate impact** of changes
- Embrace the **Test and Learn** approach to enable continuous improvement, building on good practice
- A **formal evaluation framework** will be developed

Healthcare inequalities

- Apply PHM methods to **design and deliver tailored care models** for each population cohort
- Tackle health inequalities, building on the foundations outlined in the **Fuller Stocktake**

The 5-10 year vision

1. **NHS and social care working together** to prevent unnecessary time in hospitals or care homes (focus for 2025/26 is on this step)
2. **Strengthening primary and community-based care** to enable support closer to home or work
3. **Connecting people** to wider public services and third-sector support

Critical elements for effective implementation

- **Mechanism for joint senior leadership** in each place to drive integrated working
- **Collaborative high-support, high-challenge culture**, supported by shared values, objectives, organisational structure and lines of accountability
- **Visible clinical and professional leadership** and management at all levels, to co-develop the model
- **Effective processes** to enable collaboration
- **Maximise funding arrangements**, including pooled funding, to facilitate partnership working

Supporting elements

- A **flexible workforce model**, built on a user-centred approach, and designed on joint demand and capacity modelling and workforce mapping
- Explore use of partners' **neighbourhood buildings**
- **Secondary care** must support initiatives such as community clinics, Single Point of Access, Community Diagnostic Centres, and frailty services

6 core components of an effective neighbourhood service

Population health management

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

Modern general practice

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

Standardising community health services

- Utilisation of the **Standardising community health services publication** to maximise use of funding for local needs and priorities, including commissioning of community health services
- Connect mental and physical health services to ensure complete provision, and link with the VCFSE sector

Neighbourhood multidisciplinary teams (MDTs)

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

Integrated intermediate care

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

Urgent neighbourhood services

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