

BOB ICB BOARD MEETING

Title	BOB ICB Developing our foundation for neighbourhood health		
Paper Date:	05 May 2025	Meeting Date:	13 May 2025
Purpose:	Information and approval	Agenda Item:	11
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Executive Summary			
<p>The 2025/26 Planning Guidance and associated NHSE Neighbourhood Guidelines asks ICBs to work towards the delivery of a neighbourhood health model. This will bring together statutory health and care services alongside the voluntary sector to create healthier communities, helping people of all ages live healthy, active, and independent lives while improving their experience of care, and increasing their agency in managing their own care.</p> <p>This paper provides an update to the Board on how the neighbourhood agenda is progressing across BOB and proposes the establishment of a BOB System Neighbourhood Programme.</p>			
<p>The Board are asked to:</p> <ul style="list-style-type: none"> Note the progress that has already been made by the place teams who have been driving the multi-disciplinary approach to neighbourhood working for several years. Agree the direction of travel and the establishment of a BOB System Neighbourhood Programme that will coordinate the progress and support the accelerated implementation of the neighbourhood working across the ICB footprint. 			
Conflicts of Interest:	Conflict noted: conflicted party can participate in discussion and decision		
The ambition outlined in this paper describes the organisation of NHS services which will impact on organisations that members of the Board lead/work for. The perspective of these members is an important aspect to development and delivery of our plans			
Date/Name of Committee/ Meeting, where last reviewed:	Not Applicable		

BOB ICB Developing our foundation for neighbourhood health

The Context

1. In 2024, the newly elected Government set out a mandate for reform of the NHS which included a commitment that the NHS must evolve into a neighbourhood health service¹ with care available closer to people's homes enabling three key shifts of hospital to community, treatment to prevention and analogue to digital.
2. In January 2025, both the [NHS Operating Planning guidance for 2025/26](#) and associated [Neighbourhood Health Guidelines](#) recognised a neighbourhood health approach will reinforce new ways of working in the NHS, local government, social care and their partners, where integrated working is the norm and not the exception.
3. It is expected the publication of the NHS 10-Year Plan will set out a fuller vision for neighbourhood working as a foundation for reform across the NHS. The guidance asks ICBs and partner organisations to progress neighbourhood health in 2025/26 in advance of the publication of the NHS 10 Year Health Plan and defines the steps that the NHS must take to deliver the new model of care. It sets out the expectation for systems to develop neighbourhood health models.
4. There are six '**core components**' that the local systems are expected to consider in 2025/26:
 - a. *Population health management (PHM)*: Systems should create a linked dataset for population health outcomes, risk stratification and strategic resource allocation which includes health and social care data.
 - b. *Modern general practice*: ICBs should implement the modern general practice model that involves streamlining access, making it easier to connect with the most appropriate healthcare professional or service.
 - c. *Standardised community health*: Community health services should address physical, mental health and social care needs in a joined-up way. Services should be commissioned and integrated as part of a neighbourhood health plan that improves access and overall experience for people and carers.
 - d. *Neighbourhood multi-disciplinary teams (MDTs)*: MDTs will deliver proactive, planned, and responsive care based on individual need and the opportunity for greatest impact. Using a care coordinator, teams are often organised around population cohorts with specific, often complex needs. Together they offer a range of coordinated services. Team composition will vary according to need and skill mix.
 - e. *Integrated intermediate care with a 'Home First' approach*: Systems should provide therapy led short-term rehabilitation and reablement services. Access will be directly from community or as part of discharge planning using a 'home-first' approach. Good case management systems and outcome evaluation will underpin service change.
 - f. *Urgent neighbourhood services*: For people with escalating or acute health needs, systems should have a standardised and scaled urgent neighbourhood service, aligned and planned around local demand to ensure integrated support to local

¹ [Build an NHS Fit For the Future - GOV.UK](#)

populations, managed through a single point of access (SPOA). This service will link with urgent and emergency care services and link with local step-up and step-down pathways.

5. There is an immediate focus for the NHS on preventing long and costly admissions to hospital and improving timely access to urgent and community care by focussing on people with the most complex needs.
6. The publication of the Model ICB Blueprint also helpfully clarifies the opportunity for ICBs to lead on the commissioning of neighbourhoods – working with local teams to confirm population needs, setting a strategy to inform appropriate resource allocation to improve local outcomes, and agreeing and evaluating a contractual framework that supports change.

An evidence base for change

7. In addition to the national context, recent analysis completed as part of the *Pathway to Sustainable Healthcare* project, has identified further benefits for accelerating the existing work on neighbourhood health already underway across the BOB system. The analysis identified opportunities to:
 - a. Reduce unwarranted variation in our current models of care and deliver outcomes that could, in part, be achieved through a more standardised approach to interventions that support a shift to a community and primary care based models. This includes the implementation of multi-disciplinary, proactive and coordinated care for people with complex care needs; and improved home and community support models such as proactive rehabilitation schemes, remote monitoring, and early interventions.
 - b. Developing a more systematic approach to prevention by slowing or stopping deteriorations in health. The analysis pointed towards a particular focus on cardiovascular disease (CVD), obesity and diabetes.
8. The analysis shows there will be increased costs associated with increases in demand if proposed interventions are not adopted. A neighbourhood approach will be one of the important ways to progress these ambitions over the medium term (5 years) and develop services that target specific local population needs or pressures, thereby reducing or avoiding forecast costs over the medium term.

Building on good practice across BOB

9. The introduction of Primary Care Networks (PCNs) in 2019, and the subsequent ambition for Integrated Neighbourhood Teams (INTs) as part of the [Fuller Stocktake](#) in 2022 means that the concept of neighbourhood working is not new. The BOB Primary Care Strategy, published in 2024 set an ambition to roll out INTs more comprehensively across our population.
10. Recognising that each Place team had taken a different approach to the implementation of INTs and Integrated working, we have recently undertaken a local scoping exercise to understand local progress and achievements. As part of the scoping exercise, we have met with a multi-disciplinary group, representing a range of organisations in each area to understand both progress and plans to implement the six components of the Neighbourhood model.

11. The scoping exercise has shown valuable progress and variation across Buckinghamshire, Oxfordshire and Berkshire West Places, summarised below:

Current neighbourhood working in BOB – a summary	
Buckinghamshire	
<ul style="list-style-type: none"> • 6 neighbourhoods have been defined with circa 100,000 population. • Population health assessments are underway, led by public health colleagues mostly using Thames Valley and Surrey (TVS) Shared Care Record data. • Various MDT pilots have been running allowing for learning and shared good practice. MDTs have focussed on children and young people, CVD and frailty. • Multiple rapid response, intermediate care, home independence teams in place. Work completed on discharge process has strengthened relationships. 	
Oxfordshire	
<ul style="list-style-type: none"> • Significant experience of developing neighbourhood MDTs, focussed on areas with greatest health inequalities. Working closely with Public Health colleagues to use data to support decision on neighbourhood footprints. • Currently 7 active MDTs for frailty focused on urgent care. Other active INTs. Current model is funded through Better Care Fund (BCF). Less than 50% population covered. • Health and Wellbeing workers employed in areas of greatest deprivation. • Undertaken extensive work on Discharge to Assess and Home First. 	
Berkshire West (BW)	
<ul style="list-style-type: none"> • Currently convening partners to collectively agree a common approach • TVS insights tool is available in 100% of practices, making PHM a possibility. Focus has been on segmentation to support triage. Ambition to increase usage an increase coordination with social care. • MDT working has been in place in parts of BW for more than 4 years. Different models in place. Community wellness programme is seen as good practice • Berkshire Healthcare Foundation Trust (BHFT) are actively involved in discussions about neighbourhood MDT approach. 	

12. The scoping exercise also identified areas where system support would be valuable. These included:

- Access to consistent health data set and corresponding analysis
- Facilitating data sharing between organisations
- Brokering clarity of vision for Neighbourhoods in BOB, recognising local variation according to local needs.
- Clarity on expected outcomes and success measures for neighbourhoods
- Support for Organisation Development such as relationship building, defining roles and responsibilities.
- Resources to support mapping of existing services, funding flows, workforce capacity to support closer alignment a reduced duplication.

Establishing a BOB Neighbourhood Health programme

13. We are proposing to initiate a programme to support the consistent implementation of the ambition of the national neighbourhood health guidance, and to coordinate the realisation

of the expected benefits. Dr Ben Riley, Chief Medical Officer will be the SRO for the system programme.

14. A formal Programme Board will be established to support the coordination of system activities and the existing Place project teams. The Programme Board will have a cross organisation and multidisciplinary membership to ensure a holistic approach. The first meeting is expected to take place in mid-May.
15. It is expected that priorities for neighbourhood working in 2025/26 will be developing and planning the infrastructure, information flows and ways of working required to support cohorts of people with complex health and social care needs who require support from multiple services and organisations at a neighbourhood level. This focus aims to prevent people from spending unnecessary time in hospitals or care homes (as per national guidance).
16. Where possible, neighbourhoods may also focus on opportunities to prevent the deterioration of health and may wish to identify specific population cohorts that will benefit from the coordinated multidisciplinary approach.
17. The purpose of the Neighbourhood Programme will be to accelerate a more integrated neighbourhood level approach to coordinating and delivering services that meet local needs. Specifically, the Programme Board will:
 - a. Provide governance, a programme scope, common vision, frameworks for stakeholder co-production and outcomes, as well as system level evaluation for neighbourhood working, including clarification of a common language.
 - b. Convene the three places to share and cascade best practice and lessons learnt, and serve as a coordination point for stakeholder communication, co-production and engagement.
 - c. Support the organisational development of neighbourhood teams to enable the development of effective relationships across the health and care system, including NHS, social care, local authority, voluntary, community and social enterprise (VCSE) and academic partners, and the cultural shift required to work together in a new way.
 - d. Seek to identify and align existing data reporting and funding flows, commissioning models and contractual mechanisms across NHS and local authority to enable this work.
 - e. Work with partners to steer and support the development of new data and insight tools required to facilitate neighbourhood co-production, tackle health inequalities and evaluate preventative health interventions.
 - f. Support the asset mapping work which includes, services, roles, funding, pathways, and estates.
 - g. Provide a framework for shared responsibility of assurance.
18. Terms of Reference will be agreed before the end of May.

Next steps

19. The BOB ICB Board are asked to note the progress that has already been made by the place teams who have been driving the multi-disciplinary approach to neighbourhood working for several years.
20. As we seek to make our approach more consistent across BOB, the Board are asked to agree the direction of travel and the establishment of a BOB System Neighbourhood Programme that will coordinate the progress and support the accelerated implementation of the neighbourhood model across the ICB footprint.
21. Updates on progress of the Neighbourhood model will be shared formally with the ICB executive. The proposed system governance is still to be defined. Meanwhile we commit to updating the ICB Board on progress regularly.