

BOARD MEETING

Title	Neighbourhood Health Programme Board terms of reference		
Paper Date:	02 July 2025	Board Meeting Date:	08 July 2025
Purpose:	Discussion	Agenda Item:	13
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Executive Summary

NHS England requires systems to work together to:

- Apply a consistent, system-wide population health management approach for different population cohorts
- Design and deliver the most appropriate care for each cohort, enabling people to live independently for longer
- Continue to embed, standardise and scale the six initial core components of a neighbourhood health service
- Ensure capacity and structures across providers are aligned to best meet demand
- Improve coordination, personalisation and continuity of care for people with complex needs
- Tackle health inequalities when developing their neighbourhood health service.

This paper explains the approach that the BOB system is taking to address neighbourhood health.

Action Required

The board are asked to discuss the proposals.

Conflicts of Interest:	Conflict noted: conflicted party can participate in discussion and decision
The Neighbourhood Health Programme will have an 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 priorities and plans.	

Date/Name of Committee/ Meeting, Where Last Reviewed:	This paper has been discussed at Place Partnership meetings.
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Developing neighbourhood health services

Summary of the Terms of Reference for the ICS Programme

02 July 2025



NHSE requirements 2025/6: **Neighbourhood Health Service**



Systems should work with partner organisations to:

- Apply a **consistent, system-wide population health management** approach for different population cohorts
- Design and deliver **the most appropriate care for each cohort**, enabling people to live independently for longer
- Continue to **embed, standardise and scale** the six initial core components of a neighbourhood health service
- Ensure **capacity and structures across providers are aligned** to best meet demand
- Improve **coordination, personalisation and continuity** of care for people with complex needs
- **Tackle health inequalities** when developing their neighbourhood health service

Neighbourhood Health: **A consistent and equitable approach**



BOB ICB set out an ambitious vision for neighbourhood health in its 2024 Primary Care Strategy, following wide engagement with partners and the public. Following its publication, a considerable amount of innovative neighbourhood working is now underway in the Places across the BOB and Frimley systems.

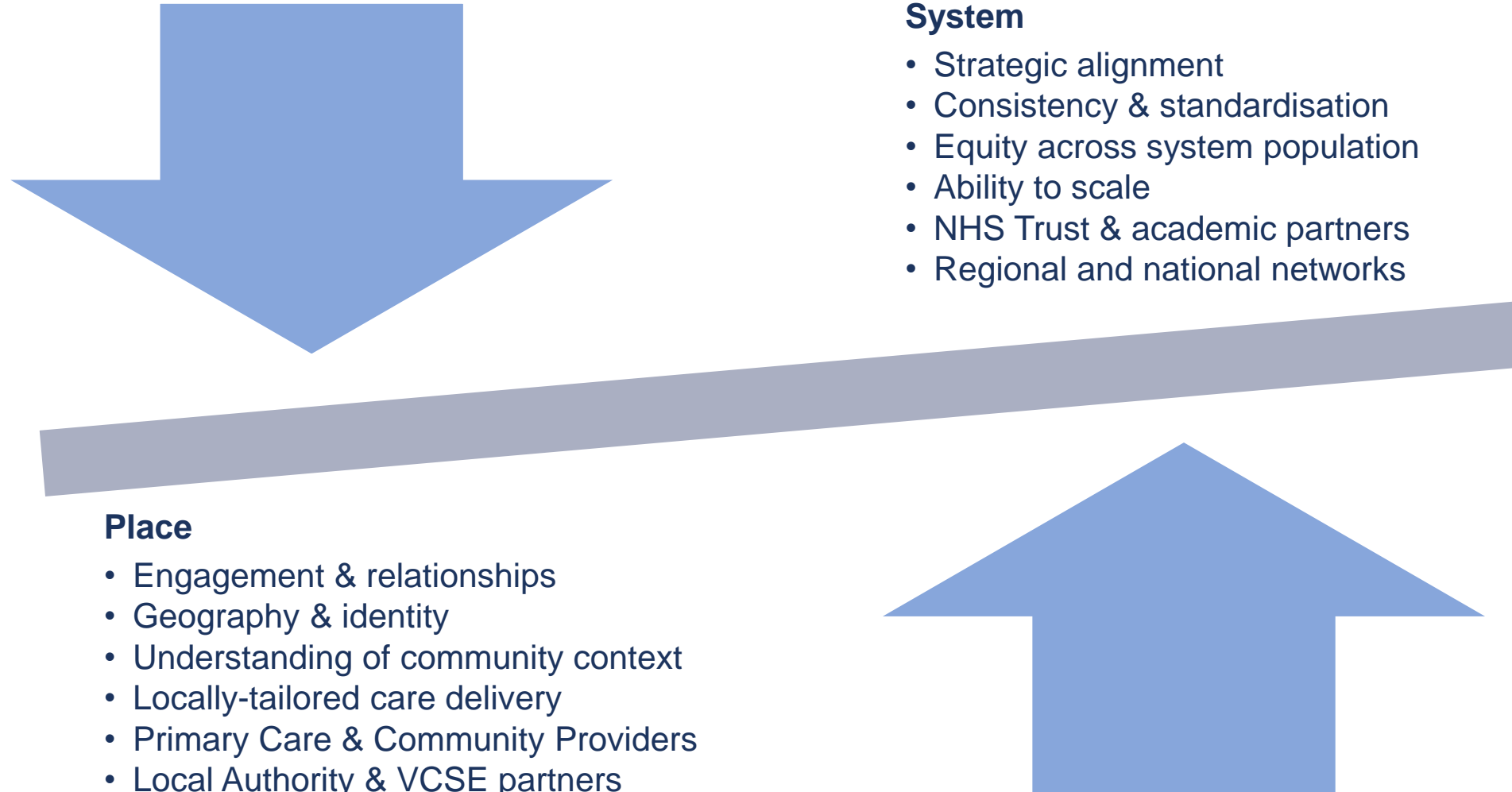
Population Health work at system and place-levels has shown significant health inequities and unwarranted variations in care provision affecting our population.

A move to a more consistent, evidence-based, outcome-focused approach is likely to be reinforced in the NHS 10-year plan.

In line with NHSE operating guidance, the BOB ICB Board has recommended that the neighbourhood programme should:

1. Deliver an equitable offer and universal set of health improving opportunities to citizens
2. Allow for local flexibility in delivery and a targeted response to population need
3. Build health resilience and life opportunity for citizens through the sustainable development of a range of community-based infrastructure, assets, partners and workforce

Neighbourhood Health: **Balancing place and system inputs**



Development and delivery; Enabling and support

We will set up a programme, with system partners that will aim to develop and implement neighbourhood services tailored around local population needs.

The Programme will have two fundamental parts that must work together. The aim is bring together the strengths and value of both the place and neighbourhood levels with the strengths and value from across the wider integrated care system.

Place led development and delivery of the neighbourhood model – focusing on a common set of population outcomes.

System-led support to enable the delivery of the neighbourhood model – focusing on the capabilities that are best defined or coordinated at scale to maximise the benefit.

Equitable neighbourhood health: **Four consistent outcomes**

We propose to prioritise the delivery of **four strategically-aligned, neighbourhood-based universal health outcomes** for our local populations and communities.

We understand that care is most effective when **built around the needs of the individual and delivered through community-oriented approaches** tailored to each local population. We support place and neighbourhood teams, working with a wide range of local partners, to develop and deliver these outcomes across the BOB system



1. Locally-tailored health improvement and **prevention of ill health**, including active community outreach



2. Accessible and coordinated local care for people living with common **long-term health conditions**



3. Person-centred care close to home for **people with complex needs** or frailty, and people towards the end of life



4. Sustainable community resources, capabilities and infrastructure for **effective and resilient neighbourhood health**

Supporting Neighbourhood development: **proposed activities**

A system level programme structure will coordinate activities and ensure aligned support to the local teams. It is proposed that the high level activities for 2025/26 include:

Core activities to enable neighbourhood development (delivered through matrix working at place and across the BOB system)		Timeline 2025/26
1.	Establish a common ICB and system vision, direction and definition for the neighbourhood health programme – focussing on the overall ambition for neighbourhood health, the expected impact and timescales and approach to coproduction with communities.	July
2.	Confirm and align plans for neighbourhood development, local delivery of outcomes and the system-wide enabling activities – developed through engagement with partners and stakeholders with a focus on 2025/26 activity	End Q2
3.	Support local stakeholders in each place to build the behavioural and cultural change required to deliver new ways of working – focussing on agreed common objectives, co-design of new ways of working and structures to deliver local priorities	Ongoing
4.	Map existing neighbourhood-relevant projects, services, assets and funding streams for each offer – Focussing on (i) local mapping relevant to delivery of the four outcomes, and (ii) system mapping of activities aligned to enabling workstreams	End Q3
5.	Collate local evidence to develop local population data packs that will support neighbourhood development and prioritisation – developed through joint working across local teams (including Public Health) with support ICB data teams	End Q3
6.	Confirm a common approach to the implementation of population stratification and segmentation tools - ensuring local experience, needs and challenges are acknowledged, allowing for evidence led population health-based planning	End Q3
7.	Develop high performing MDT working for agreed priority cohorts through information sharing improvements and informed by population needs assessments – focussing on an integrated approach to planning based around individuals' needs	End Q3
8.	Define existing contacting and commissioning opportunities to accelerate neighbourhood development – focussing on the co-development of processes, specific outcomes, interventions and delivery options with partners	Q3
9.	Develop short and medium term commissioning options – focussing on enabling and incentivising integrated working for specific populations and pathways - including costed specifications and delivery models for new services/interventions	Q4
10	Evaluate Progress – quantify the impact of the changes made against the agree expectations and ambition	2026/27 Q1

Supporting Neighbourhood development: **Assuring delivery**

Programme Board (bi-monthly)

Neighbourhood Health Delivery Group (monthly)

Four priority outcomes

Prevention of ill health

Coordinated care for people with Long Term Conditions

Person-centred care for people with complex needs

The capabilities for effective and resilient Neighbourhood Health

Place led reporting

- **Delivery the 4 core outcomes**
- **Development of neighbourhood health working**

Reporting against agreed delivery plans and quantified objectives. Sharing successes and learnings

Neighbourhood Health vision, strategy and engagement

Population insights and PHM - strategy and delivery

Primary, community and intermediate care services

Neighbourhood commissioning approach

ICB led reporting

- **Activities to support and enable the development of local neighbourhood health services**

Working in close collaboration with Place teams to deliver jointly agreed support to achieve consistent outcomes.
Each workstream to have clear workplan and deliverables.
Workstreams to stop or adapt as actions are delivered.

BOB Neighbourhood Health Programme Board

Summary of Proposed Terms of Reference



Purpose: This group will oversee and support the development and delivery of high-quality neighbourhood models which are evidence-based, person-centred, sustainable and supported by robust strategic commissioning.

Responsibilities of the programme board

- a. Provide leadership:** Provide governance, 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. Drive delivery:** Maintain a shared understanding of BOB neighbourhood models and delivery progress. Agree and receive updates on place and system level neighbourhood delivery plans. Share and cascade best practice.
- c. Clearly communicate:** Serve as a coordination point for stakeholder communication, co-production and engagement
- d. Enable development:** recognise and support the organisational development of neighbourhood teams. Enable the development of effective relationships across the health and care system, including NHS, social care, local authority, VCSE and academic partners, and the cultural shift required to work together in a new way
- e. Ensure robust data:** Identify and align existing data reporting and funding flows, and work with partners to steer and support the development of new data and insight tools where necessary
- f. Champion action on inequalities and involvement:** facilitate neighbourhood co-production, tackle health inequalities and evaluate preventative health intervention.
- g. Develop commissioning models:** Support asset mapping including, services, roles, funding, pathways and estates to enable local design and BOB wide development of commissioning models and contractual mechanisms across NHS and local authority to enable this work

Frequency and reporting: Bimonthly system meetings, with highlight report submission (Full terms of reference documents to follow for discussion at first meeting)

Programme Outcomes:

- Robust understanding and management of population health needs
- Effective neighbourhood working (integration and MDT)
- Commissioning of services aligned to our population needs
- Prevention of ill health (define quantified priorities locally)
- Improved management of complex needs (reduced NEL demand)

Membership:

- To be discussed at ICB Board but is expected to include representation from Health, Local Authority, VCSE, patient representatives and other key stakeholders

Supporting information

Delivering equitable neighbourhood health outcomes (to be further developed with partners)

Neighbourhood Health outcome	Population segments (Johns Hopkins)	Opportunities to improve population health	Indicative priority areas to improve health & system sustainability (Priority
1. Prevention & community outreach	Low need (1-4): People living independently without significant health issues currently	<div>1. Cardiovascular disease (including CKD)</div> <div>2. Diabetes</div> <div>3. Obesity</div> <div>4. Dementia</div> <div>Plus CYP: Family First Partnerships</div>	<ul style="list-style-type: none">• A consistent, evidence-based but local-tailored approach for case finding and monitoring people with key risk factors (i.e. BP, lipids, undiagnosed AF/CKD, obesity, inactivity, isolation, safeguarding risks, smoking, alcohol & substance use)• Tailored community outreach through pharmacy, meds optimisation and locally-delivered health checks• Neighbourhood Family First Partnerships• An equitable and sustainable weight management pathway
2. Accessible and coordinated care for people with long-term conditions	Moderate need (5-9): People with a dominant health condition that is generally well managed	<div>Proactive implementation of care plans</div> <div>1. More productive LTC care models including significant opportunity in UEC</div> <div>2. Scope for reconfiguration of services to reduce fragmentation and duplication</div>	<ul style="list-style-type: none">• Shift from outpatient model to MDT neighbourhood care for most long-term diabetes, CVD, chronic respiratory and general paediatric care• Universally available UCR/virtual ward capacity and capability• Standardised delivery of discharge pathway 0 and 1 and Discharge to Assess models based on evaluation data
3. Person-centred care for frailty and complex health needs	High need (10-11): Patients who have several conditions and/or frailty	<div>Top four opportunity segments based on greatest variation in expenditure between population cohorts and expected growth:</div> <div>1. Frailty</div> <div>2. Multi-morbidity with high complexity</div> <div>3. Lower complexity segments</div> <div>4. Dominant psychiatric condition</div>	<ul style="list-style-type: none">• Targeted and proactive multi-morbidity and frailty interventions in ageing populations to maximise health resilience and prolong independence• MDT-delivered shared care for high need patient cohorts• Clear routes to access specialist input and EOLC at home• Integrated frailty pathway to improve continuity of care and minimise inappropriate clinical interventions and admissions• Standardised community nursing and rehab (incl. neuro-disability)
4. Enablers, capabilities and infrastructure for N’hood Health	Essential for all population cohorts	<div>1. Reduction in service fragmentation and discontinuity of care</div> <div>2. Reduction of unwarranted variation / local gaps in care access and provision</div> <div>3. Cross-system optimisation of community estates & digital infrastructure</div> <div>4. Minimisation of non-productive work (especially at organisational interfaces)</div> <div>5. Optimisation of available workforce</div>	<ul style="list-style-type: none">• A strategic commissioning and finance plan for N’hood health (with system support for implementation from April 26)• ICS-wide primary and community care collaborative business, contracting & service delivery structures• Standardised 7-day community nursing service offer• Multi-partner PC & Community estates development plan• N’hood data, QI & insight tools (enabling sharing of innovation)• Evaluation capability for innovative / preventative care• Digital tools and service-interface solutions• N’hood workforce plan (including clinician job planning)