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Designing a Neighbourhood Health Service

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The arguments and any errors that remain are the authors' and the authors' alone.

Interviewees

We would like to thank all seven interviewees for giving their time and candid insights to support this briefing paper.

- Professor Kate Ardern, Former Director of Public Health for Wigan Council
- Dr Michael Dixon LVO OBE, Chair of the College of Medicine and Co-Chair of the National Social Prescribing Network
- Professor Sir Sam Everington OBE, GP at the Bromley by Bow Centre and former Chair of the NHS Tower Hamlets Clinical Commissioning Group
- Paul Ogden, Senior Adviser, Local Government Association
- Amit Patel, Chief Executive, Community Pharmacy South West London
- Charlotte Ruthven, Senior Policy and Delivery Manager at the NHS Confederation
- Albie Stadtmiller, Chief Executive, Voluntary Action Camden

Design principles of a Neighbourhood Health Service

Leadership to drive neighbourhood-level change – including where leadership capacity has been freed up to think long-term about the services offered in a place and support change management.

- **Lesson 1:** Improving population health outcomes at a neighbourhood level requires those with tacit knowledge of their area to work with communities to promote bottom-up initiatives and establish an enabling environment for staff to engage in innovative modes of delivery. It is not always necessary for these leaders to be from NHS organisations.
- **Lesson 2:** Devolving power from senior leaders to frontline workers, and encouraging collaboration with communities, can facilitate health delivery centred on individuals and neighbourhoods, in turn improving health outcomes.

Understanding of the determinants of health – including through integrating data on the wider determinants of health, and between health providers, local government, research partners and the VSCFE sector.

- **Lesson 4:** Organisations with access to, and use of, patient data and intelligent analytical ability should engage in 'outside-of-the-box' collaborations with local service providers to develop knowledge exchanging platforms which can help providers to better understand patient profiles and risk. This should be used by service providers to proactively seek out vulnerable individuals and to allow for personalised health plans utilising community health assets.
- **Lesson 5:** Analysis of future demand projections should be used to develop workforce strategies at a neighbourhood level. This should take into account how ARRS roles can best be deployed to provide personalised care.

Creative deployment of workforce and neighbourhood assets – including how staff in PCNs can be deployed to work in neighbourhood teams or be based in other hyper-local settings, and how (physical and virtual) neighbourhood assets can be used to help deliver health services.

- **Lesson 6:** Neighbourhood Health systems should create "virtual neighbourhoods" that enable community assets to be systematically mapped and utilised to address the wider determinants of health, including to build meaningful relationships within a community and reduce social isolation.
- **Lesson 7:** Local authority and healthcare providers should take stock of local assets and creatively use spaces with high footfall to manage and deliver health and care services. The workforce in these settings should be positioned to have the greatest reach into local communities.

1. Introduction

The new Government have been clear on the need to decisively shift care out of hospitals and into communities, facilitated by the creation of a new NHS – what they call a 'Neighbourhood Health Service'.

At the heart of this vision, is a service offer that is more accessible, proactive and citizen-centred than the current model of primary care – based on multidisciplinary neighbourhood teams providing joined-up care. But this will only be achieved by being honest about, and directly addressing, long-standing barriers to change: including fragmented datasets; a workforce geared towards reactive interventions over health creation; an outdated GP estate, ill-suited to proactive care; and a deficit of leadership capacity to plan neighbourhood-level services.

This paper draws on examples of innovative practice across Britain to show what is already working, and how these examples can inform an approach to primary care genuinely centred on neighbourhoods – which acts in lock-step with the needs of citizens and takes into account the wider, social factors affecting health. Based on these examples, it proposes a core set of principles that should guide policymakers in designing Neighbourhood Health, with practical lessons to support implementation.

It makes the case for a future model of primary care in which, alongside delivery 'at scale' through PCNs and other provider collaboratives, there is also a highly responsive and proactive set of services available in 'hyper-local' areas: places that would be recognised by most citizens as 'neighbourhoods'.

2. The story so far

Closer integration of primary care – for example, to improve continuity of care and offer a more user-centred experience – has been a long-standing reform ambition within the NHS. Even in the year the NHS was founded, a pamphlet promised "special premises known as health centres" that would provide a wide range of services "on the spot" in primary care.[1] Through service integration, there is also potential to bridge the gap between primary and secondary care, by having consultants and other practitioners provide specialist consultations in 'scaled up' GP facilities,[2] enabling a shift from care in hospitals to care in the community.

Notable ideas have been put forward to promote service integration in primary care: by Lord Darzi in his review of healthcare in London 'A Framework for Action' published in 2007,[3] and Dr Clare Fuller in her 'Stocktake' of primary care published in 2022.[4] 'Framework for Action' focuses on the creation on "polyclinics" that would act as "one-stop shops" for community services, including community mental health, antenatal and postnatal care, and advice on healthy living and the self-management of long-term conditions. The Stocktake, meanwhile, focuses on designing services to better anticipate the needs of different patients, including through use of multidisciplinary, neighbourhood teams.

2.1 Primary care at scale

In implementing Neighbourhood Health, there will be a strong impulse to consider how the existing model of primary care, centred on general practice, can be scaled to facilitate more sophisticated patient triage and a wider service offer based on population footprints of 30,000 to 50,000 or more – the current scale of primary care networks (groups of GP practices that are specifically funded to work in partnership).[5]

Neighbourhood Health guidance published by NHS England in January, for example, recommends building on existing instances of cross-team working, through primary care networks (PCNs), other provider collaboratives and collaboration with the VCFSE sector.[6] Other policy papers have similarly called for a "scaled model of General Practice" to create strategic capacity to plan neighbourhood-level services.[7]

Lord Darzi's work on polyclinics argued for scaled GP practices that would become home to other services to meet the majority of routine healthcare needs, and set an ambition for them to become the "main stop for health and wellbeing".

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[1] Max Thilo, *What the NHS Can and Cannot Learn from the Singaporean Health Care System* (Social Market Foundation, 2024).
[2] Sean Phillips, Robert Ede, and David Landau, *At Your Service* (Policy Exchange, 2022).
[3] Ara Darzi, *A Framework for Action* (Healthcare for London, 2007).
[4] Claire Fuller, *Next Steps for Integrating Primary Care: Fuller Stocktake Report* (NHS England, 2022).
[5] Phillips, Ede, and Landau, *At Your Service*.
[6] NHS England, 'Neighbourhood Health Guidelines 2025/26', Webpage, 29 January 2025.
[7] See, for example, Chris Thomas and Harry Quilter-Pinner, *Realising the Neighbourhood NHS: A New Deal for Primary Care in England* (IPPR, 2020); Phillips, Ede, and Landau, *At Your Service*.

As research by *Reform* has shown, however, there are limitations to delivering primary care at this scale: for example, many PCNs lack the clarity of vision required to achieve genuine multidisciplinary working, and the roles they hire are insufficiently focused on proactive care.[8]

Responsive to local communities

There is also a risk that in scaling up general practice, the vision of a health system that is truly centred on and responsive to the needs of local communities, and which provides services in recognisable neighbourhood and high street settings – such as community pharmacies, family and mental health hubs, and local authority-owned premises – could be deprioritised.

Interviewees pointed to the fact that high street providers, such as community pharmacies, are more likely to be situated in areas of high deprivation, to employ practitioners who reflect the demographics of the populations they serve, and see patients more than anyone else in the primary care system (e.g. through their retail offer and unplanned drop-ins). For example, more than 93 per cent of patients living in areas of highest deprivation live within a mile of a pharmacy, compared to 71 per cent in areas of lowest deprivation.[9] The median number of visits to a pharmacy is much higher, on average, than the median number of visits to general practice each year.[10]

Risk appetite

There was also agreement among interviewees that it is at this neighbourhood-level where some of the most transformative innovations in primary care will arise. As such, a further risk of simply prioritising deliver of primary care at scale, to populations in the tens of thousands, is that there will be less appetite to design services differently or trial new approaches to health creation based on hyperlocal need.

2.2 Multidisciplinary working

Through the introduction of the Alternative Roles Reimbursement Scheme (ARRS), which allows PCNs to claim reimbursement on the salaries of 17 new roles designed to boost capacity in general practice (some of which were not previously available) there has been a significant diversification of the primary care workforce.[11]

The ARRS reform is explicitly focused on general practice and last year was expanded to allow practices to use the additional funding to hire GPs, at an estimated cost of £82 million.[12] Interviewees for this paper were clear that in developing a Neighbourhood Health service, there is scope to think more creatively about how roles could be deployed across a wider range of non-GP primary care settings, in ways that could also support workforce development, morale and retention. As one put it, “a change can be as good as a rest”.

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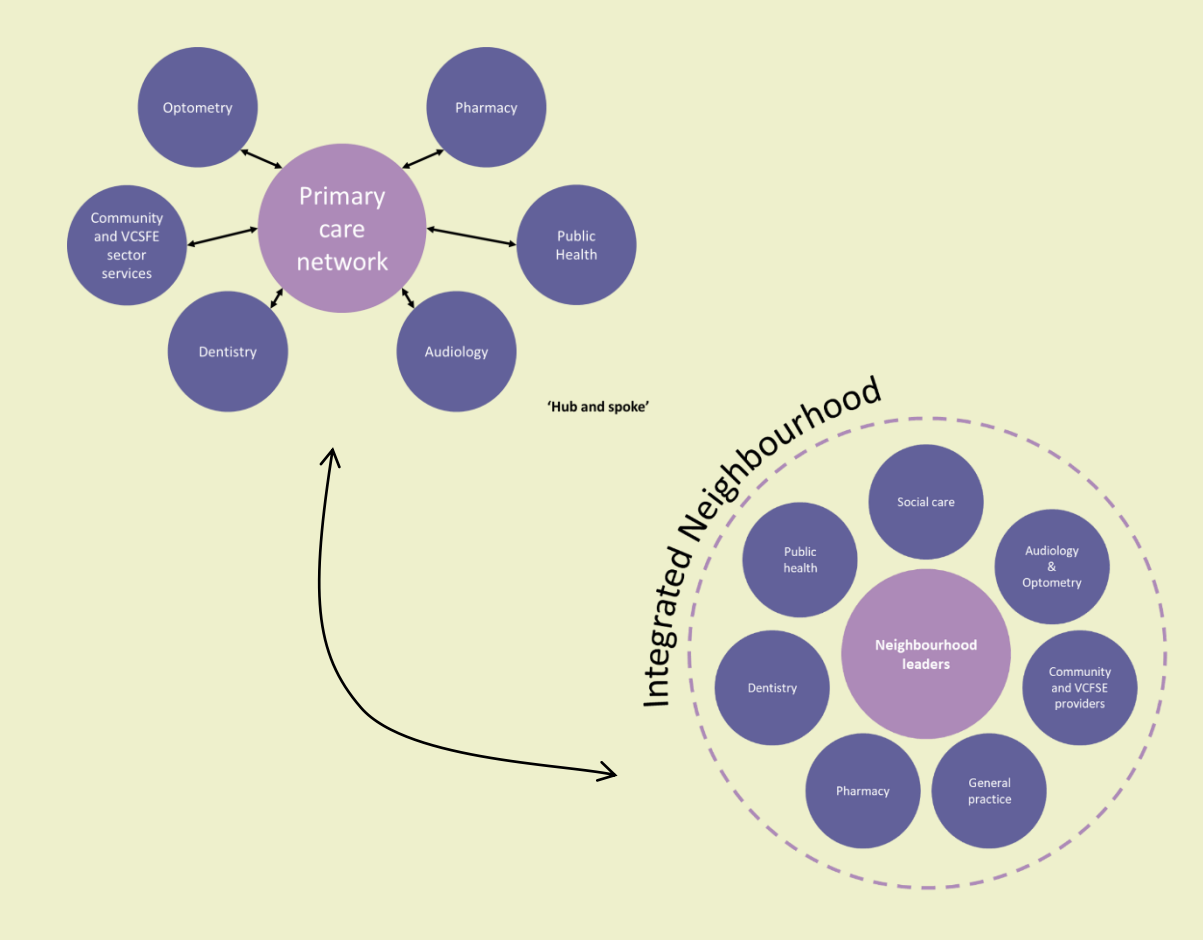
[8] Rosie Beacon, Patrick King, and Florence Conway, *Prescription for Prevention: A New Model of Primary Care* (Reform think tank, 2024).
[9] London Borough of Camden, *Innovation in Community Pharmacy and Future Ambitions*, 2024.
[10] Lucas A. Berenbrok et al., ‘Evaluation of Frequency of Encounters With Primary Care Physicians vs Visits to Community Pharmacies Among Medicare Beneficiaries’, *JAMA Network Open* 3, no. 7 (July 2020).
[11] Beacon, King, and Conway, *Prescription for Prevention: A New Model of Primary Care*.
[12] Nick Bostock, ‘Government Plans 1,000 More GP Jobs This Year with £82m ARRS Expansion’, *GP Online*, 1 August 2024.

One interviewee gave the example of a model being piloted to enable paramedics to rotate through a variety of care settings as part of the same role – including working in primary care and community-based teams – to immediately support patients in these settings and reduce unnecessary hospitalisations.[13] They pointed to the potential for GPs and other clinicians to rotate into settings that are rooted in specific neighbourhoods, including leisure centres and local authority-owned buildings, the offices of local businesses and schools.

The Fuller Stocktake likewise argues that primary care systems will need to work in different ways to develop and flexibly deploy workforces capable of meeting future demand – including by introducing roles that "de-medicalise" care and can address the wider determinants of health in communities. It cites innovative employment models already in use, such as "joint appointments and rotational models" which "promote collaboration rather than competition".[14]

Crucially, a Neighbourhood Health Service could as the Stocktake says, help develop a workforce that proactively contributes to health as well as meeting expressed clinical demand.

Figure 1: From 'hub and spoke' to integrated neighbourhoods



[13] NHS England, 'Rotating Paramedic Programme Wins Innovation in Primary Care Transformation Award', Press Release, 2 July 2018.
[14] Fuller, *Next Steps for Integrating Primary Care: Fuller Stocktake Report*.

3. Principles of Neighbourhood Health

There is a real opportunity, in developing Neighbourhood Health to reconsider what services could be planned and delivered in local areas based on genuine neighbourhood footprints, similar, for example, to local authority wards of around 5,000 people. This includes improving access, responsiveness to local residents and offering services that address the wider determinants of health, and are potentially less medicalised than conventional primary care.

To be effective, Neighbourhood Health must be grounded in close partnership between health providers in a local area, but also between community leaders and the full breadth of organisations that operate at this scale, and which have a strong understanding of their communities: including local authorities, pharmacies, faith groups, local businesses and the VCFSE sector.

In some cases, partnership will mean creating informal networks that enable joint-working between these groups – in others it will be having formal data-sharing arrangements in place, or building a workforce that can more easily rotate between different neighbourhood settings.

In some geographies, delivering a Neighbourhood Health Service will mean being creative about how to utilise assets that already exist in a hyper-local area, rather than developing an entirely new workforce or expanding the NHS estate. Interviewees referred to the importance of creating a “virtual neighbourhood” as well as a physical one: i.e. having a better awareness of the organisations and services that already exist in an area and creating tools (such as apps and online booking portals) to make them more accessible to patients.

Finally, the success of Neighbourhood Health Service will be determined by the presence of leaders who are supported and have the capacity to drive change at a hyper-local level: thinking strategically about the long-term needs of a neighbourhood; working to integrate the services and providers operating in their patch; managing change processes; and ensuring that feedback from residents is used to continuously improve services over time.

Figure 2: Design principles for a Neighbourhood Health Service

1) **Leadership to drive neighbourhood-level change** – including where leadership capacity has been freed up to think long-term about the services offered in a place and to support change management.
2) **Understanding of the determinants of health** – including through integrating data on the wider determinants of health, and between health providers, local government, research partners and the VCFSE sector.
3) **Creative deployment of workforce and neighbourhood assets** – including how staff in PCNs can be deployed to work in neighbourhood teams or be based in other hyper-local settings, and how (physical and virtual) neighbourhood assets can be used to help deliver health services.

3.1 Leadership

Interviewees were clear that driving long-term change in a local area often depends on the presence of inspiring leaders, who can galvanise people around an ambitious goal and have the headspace to think strategically about what it will take to deliver change. Other principles of Neighbourhood Health, creative deployment of workforce and neighbourhood assets, and awareness of the determinants of health, rely heavily on the presence of strong leadership.

Neighbourhood Health leaders should be well-embedded in existing networks, and have the backing, including devolved power and investment, from ICSs to be bold in driving change. However, interviewees suggested that existing avenues for local leadership, such as Health and Wellbeing Boards – which have a statutory role in integrating services between the NHS, public health and local government, and together with local Directors of Public Health produce Joint Strategic Needs Assessments, that consider the health and wellbeing needs of a population and future priorities – are significantly under-utilised.[15]

The leadership role of Directors of Public Health (DPHs) will, in general, be vital to the implementation of Neighbourhood Health, and ensuring that place-based considerations are properly fed in. Statutory duties already held by DPHs, such as to produce an independent annual public health report for their area, with recommendations for action,[16] should be seen as important enablers of a model that takes seriously the needs of specific communities.

Interviewees argued that current neighbourhood-level health strategies tend to be dominated by Primary Care Networks, which tend to take a top-down and GP-led approach, to the detriment of other primary care practitioners, such as dentists, pharmacists, audiologists and optometrists, and the wealth of other organisations which contribute to population health at this level – particularly local government and social care providers, and the VCFSE sector.

In future, place-based partnership and leadership (which takes account of local authority footprints) will be key to reorienting not just primary care, but all providers and sectors that support population health towards neighbourhood-level action. In particular, partnership is needed to ensure that the wider health and care system – including social care, outpatient and community providers – facilitate the shift from hospitals to community and neighbourhood-led delivery. This will require changes to the way PCNs operate – as well as wider system buy-in to allow for continuous frontline experimentation.

At a regional-level, as the devolution agenda progresses and mayors are empowered with additional responsibilities for health – as in the Greater Manchester Combined Authority, which since 2016 has had control of a combined health and care budget of £6 billion[17] – it is crucial these powers are pushed down to local and hyper-local areas, giving neighbourhood leaders the autonomy needed to respond to the specific needs of their communities.

Regional mayors and officials should have a strong awareness of the types of leaders who are likely to be involved in decision-making at this level – including Local Pharmaceutical Committees, Local Medical Committees, and civil society organisations – and proactively remove barriers that prevent joined-up decision-making, experimentation, and the redesign of neighbourhood-level services.

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[15] The King's Fund, 'Health and Wellbeing Boards (HWBs) Explained', Webpage, 22 June 2016.
[16] Department of Health and Social Care, *Directors of Public Health in Local Government: Roles, Responsibilities and Context*, 2023.
[17] The King's Fund, 'Population Health in Greater Manchester: The Journey so Far', October 2024.

NHS England guidance on Neighbourhood Health alludes to the importance of integrated, place-level leadership; this should be an explicit focus in designing Neighbourhood Health Systems.[18] As the NHS Confederation argues, partnerships at a place-level often begin with a "coalition of the willing, with local government playing an important role".[19] Interviewees also pointed to the power of umbrella organisations, like Voluntary Action Camden, which acts as an intermediary for decision-making bodies, service providers and funding organisations; has a strong understanding of place; and offers capacity building expertise and training.[20]

3.1.1 The Wigan Deal ('The Deal')

The Deal is a relationship-centred approach to local government delivery in Wigan which began in 2011 after austerity measures significantly cut local government funding. Its primary objective was to eliminate waste, reduce demand for services and improve the lives of citizens by transforming the delivery of public services, with strategy focused on building on the strengths and assets of individuals and communities.

To ensure the approach was successful, and that staff had the bandwidth to transform service delivery, the council had to develop a new working culture – requiring strong leadership from senior council employees. For example, senior staff and council leaders had to demonstrate to frontline workers and more junior staff that they would be supported when trying different modes of service delivery at a neighbourhood level and that there would not be a 'blame culture' if things went wrong. Evidence from a King's Fund analysis of The Deal revealed that direct messaging from managers, such as telling staff "we will back you", helped create a working environment which encouraged positive-risk taking and innovation, in turn helping deliver improved population health outcomes.[21]

Leadership provided the foundation on which workers could test innovative approaches. They had autonomy to work directly with citizens to test new ideas, take positive risks, and be flexible in how they delivered frontline services.[22]

The Deal also demonstrates that health creating-services can be efficiently delivered outside of NHS structures. Instead, what matters most is having leaders who know their areas well, and can work effectively with community and NHS organisations to challenge the status quo and improve outcomes.

The outcomes from the Deal reveal the positive long-term impacts that bold leadership, which encourages new ways of working, can have. Research found that £7.9 million of investment in "75 Big Ideas" – such as in Greenslate Farm, a group which hosts drug and alcohol community recovery and Wigan Warblers, who established singing and breathing groups to improve chronic lung conditions – under The Deal led to £12 a million return in social and economic benefits, and a further £6 million worth of external funding from investment groups.[23] Moreover, by February 2019, it was estimated that The Deal had saved

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[18] NHS England, 'Neighbourhood Health Guidelines 2025/26'.
[19] NHS Confederation, *From Place-Based to Place-Led: A Whole-Area Approach to Integrating Care Systems*, 2020.
[20] Voluntary Action Camden, 'About Us', Webpage, 2025.
[21] The King's Fund, 'A Citizen-Led Approach to Health and Care: Lessons from the Wigan Deal', June 2019.
[22] Ibid.
[23] Professor Kate Ardern and Cllr Keith Cunliffe, 'The Wigan Deal: Understanding Marmot Theory and Practice' (Healthier Wigan, n.d.).

Wigan Council £141.5 million through reduced demand costs and improved health outcomes.

Lesson 1: Improving population health outcomes and delivering services at a neighbourhood level requires those with tacit knowledge of their area to work with communities to promote bottom-up initiatives and establish an enabling environment for staff to engage in innovative methods of delivery.

3.1.2 South Ayrshire Radical Leadership

South Ayrshire adopted a collective leadership model in order to transform health delivery from a top-down to a locality-based approach. Council leaders explicitly acknowledged that the "current structure and systems in public service are constraining" leadership to act in a way which encourages bottom-up collaboration between council leaders and the community, and hinders their ability to engage in innovative, hyper-local service delivery.[24]

To overcome this barrier, the council adopted a "radical leadership" model which sought to provide employees with the power and support needed to improve outcomes, and also commit to working together with residents and community organisations to co-design local services.[25] According to Professor Hall, "radical place leadership is about refocusing professionals to see the person behind the unit of need and allow their frontline teams to build relationships rather than transact multiple times with the same individuals."[26]

For instance, a Team Around the Locality (TATL) approach was set up to deliver community health services at the neighbourhood level, focusing on utilising existing community assets and building on relationships between individuals and practitioners.[27] It is a strength-based model, which connects employees and services from health, social care, and the voluntary sector with individuals and communities.

A recent inspection of adult services in South Ayrshire found that majority of people in the locality experienced positive outcomes from the delivery of health and care services; and that people had a generally positive experience of health and social care.[28] Further, the report also commended the leadership in the area, highlighting that it was committed to change and improvement and that there were "good, trusting relationships at a senior level".[29]

Lesson 2: Devolving power from senior leaders to frontline workers, and encouraging collaboration with communities, can facilitate health delivery centred on individuals and neighbourhoods, in turn improving health outcomes.

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[24] New Local, '"When People Believe They Have Power, Magic Starts to Happen": Katie Kelly on Radical Leadership', July 2024.
[25] Local Government Association, 'Case Study: Lochside Neighbourhood Group', December 2016.
[26] Professor Donna Hall, 'Radical Place Leadership - How We Can Change Public Services for the Better', February 2024.
[27] Steven Kelly and Phil White, *Meeting of South Ayrshire Health and Social Care Partnership*, 2023.
[28] care inspectorate and Health Improvement Scotland, 'Joint Inspection of Adult Services: Integration and Outcomes, South Ayrshire Health and Social Care Partnership', March 2023.
[29] care inspectorate and Health Improvement Scotland.

3.2 Awareness of the determinants of health

To design services that are responsive to and effectively prevent ill health, providers working in a neighbourhood must have an acute awareness of the demographics and population health of their area, as well as the wider determinants of health. Aggregating data and developing insights from a variety of sources can help leaders develop targeted interventions at a neighbourhood-level.

However, as interviewees noted, in many parts of the health system, there are long-standing challenges around data controllership and how data is shared between organisations – particularly general practice and other providers of primary care (like community pharmacy, optometry, audiology and dentistry) and between NHS providers, local authorities and the VCFSE sector. Nonetheless, there are pockets of excellence where places and organisations have collaborated to integrate data and design prevention-oriented services.

3.2.1 Cheshire and Merseyside Secure Data Environment (SDE)

In response to the COVID-19 pandemic, the NHS, local government and University of Liverpool joined together to develop an intelligent, cloud-based centralised data system, which enabled a connected approach to population health management.[30] Owing to the urgency of the pandemic, the key stakeholders were able to overcome normal hesitancies and act proactively to establish the Combined Intelligence for Population Health Action platform. The CIPHA proved to be critical for the successful delivery of the first mass global Covid-19 testing pilot scheme in Liverpool, and was recognised as the 2021 Bionow Healthcare Project of the Year.[31]

The project has since transformed into a wider platform of population health management as part of the Cheshire and Merseyside SDE. The platform provides almost instantaneous person-level intelligence for combined action by clinicians, managers, and public health practitioners. It covers a connected population of 2.7 million and includes 375 NHS partner organisations (including GP practices and NHS trusts) and nine local authorities.[32]

The sharing and use of data more effectively across Cheshire and Merseyside is helping to provide better services for the population's needs at a neighbourhood level. For example, the St Helens Warm Homes for Lungs project used the data dashboard to identify and support 85 patients. The patients were referred for wellbeing and warm home support, with 14 individuals also being seen by the Pulmonary Rehabilitation team and 18 joining the COPD Telehealth Service. A total of 65 patients received £500 payments from household support funds.[33]

Additionally, data from the dashboard is used to stratify and prioritise patients on waiting lists. The waiting list stratification tool links primary, community and mental health data with waiting list data, to enable prioritisation for residents most at risk of adverse outcomes, deprivation and other protected risk factors. It enables health and care workers to support the ordering of waiting lists and informs care providers which patients may benefit from a 'waiting well' initiative.

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[30] University of Liverpool, 'CIPHA Health Data Platform and University Partner BiVictriX Therapeutics Triumph at Bionow Awards', April 2022.
[31] Ibid.
[32] Cheshire and Merseyside NHS and North West Secure Data Environment, 'Cheshire and Merseyside Secure Data Environment: FAQs', December 2023.
[33] Ibid.

This project demonstrates the importance of making data join-up work, and how valuable data can be for designing proactive health plans outside of general practice. Whilst GPs currently have controllership of data, it is imperative that other partners within primary care can also use data to support and configure services around population groups.

For instance, an interviewee for this paper told *Reform* about a project where loyalty card data has been used to analyse and predict future health risks. In this case, data was used to predict women at risk of ovarian cancer, and early results suggested that this analysis of shopping habits at pharmacies and supermarkets can indicate early warning signs which are often missed by GPs.

Early diagnosis is key to improving survival chances and so should be encouraged whenever possible. This example demonstrates that the places which individuals have frequent contact with, such as the local supermarket and pharmacy, may have the data and knowledge of their users which can be applied to improve health outcomes. There is a clear role for these organisations to play in the development of proactive and patient-centred care.

Lesson 4: Organisations with access to, and use of, patient data and intelligent analytical ability should engage in 'outside-of-the-box' collaborations with local service providers to develop knowledge exchanging platforms which can help providers to better understand patient profiles and risk. This should be used by service providers to proactively seek out vulnerable individuals and to allow for personalised health plans utilising community health assets.

3.2.2 Berkshire, Oxfordshire and Buckinghamshire Integrated Care Partnership

Data analysis can also be used to tailor workforce strategy so that health services can better meet the needs of the population. This approach was adopted by Berkshire, Oxfordshire and Buckinghamshire Integrated Care Partnership. They commissioned support from data analysts to help develop an online workforce planning tool for their PCNs.[34] Quantitative and qualitative data was evaluated by subject matter experts who then provided different PCNs with tailored insights as to how best to meet workforce needs in one, three and five years into the future. In particular, the data was used to inform targeted interventions for how to maximise the use of ARRS roles.

Ensuring that data is used to support workforce planning will be a crucial next step in delivering an effective Neighbourhood Health System. In particular, this will be important for understanding how health care professionals outside of general practice, such as link workers, and community health and wellbeing workers can be most effectively used to improve population health, working at a hyper-local level.

Lesson 5: Analysis of future demand projections should be used to develop workforce strategies at a neighbourhood level. This should take into account how ARRS roles can best be deployed to provide personalised care.

[34] Fuller, *Next Steps for Integrating Primary Care: Fuller Stocktake Report*.

3.3 Creative deployment of workforce and neighbourhood assets

Interviewees were clear that much of what exists at a neighbourhood-level and makes a valuable contribution to health does not easily "map onto" NHS services, meaning valuable community assets and parts of the local workforce are either overlooked by commissioners, or not well-integrated with mainstream services. Some pointed to the example of local authority-run leisure centres which now operate as holistic "health and wellbeing hubs", but are neither recognised nor well utilised by the NHS.[35]

Similarly, at a neighbourhood scale, some of the most important contributions to health are made by non-clinical parts of the workforce and the voluntary sector, including "community connector" roles;[36] link workers;[37] citizen leaders;[38] and community health and wellbeing workers.[39] There is an opportunity to think creatively about how the healthcare workforce can be better distributed across community settings, where they are more accessible to patients (e.g. completing shifts in community pharmacies, schools, and health hubs), in addition to having a greater number of clinical roles co-located in PCNs.

Both of the case studies below demonstrate the potential in having a stronger awareness of what exists at a neighbourhood scale, to ensure these assets are well-utilised and integrated with existing services.

3.3.1 Compassionate Frome

The Frome Model of Enhanced Primary Care (FMEPC) sought to transform population health and reduce emergency admission to hospital by deploying an enhanced model of primary care, focusing on delivery at the neighbourhood level. The FMEPC was created by the Frome Medical Practice and embraced the 'House of Care' model of person-centred care planning, ensuring that all care plans were developed using principles of personalised care.

One of the things that made the FMEPC successful was the creation of Compassionate Frome. This is a community service which proactively and systematically identified vulnerable people and sought to link them with, and develop new and existing, community assets. In particular, the project targeted people impacted by loneliness, and whose loneliness conditions negatively impacted on their physical and mental health.[40]

The project mapped and leveraged social networks and community assets such as befriending services, peer-support groups and exercise classes. It also looked to identify any gaps in community services and where new services would benefit the community, Compassionate Frome helped with recruitment, legal work and provided the funding needed to kickstart these initiatives. They used 'community connectors' to signpost people to community services, and 'health connectors' who helped set health and wellbeing goals.

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[35] Local Government Association, 'London Borough of Sutton: "MSK Hubs" Rehabilitation Delivered at Community Leisure Centres', Webpage, 20 June 2023.
[36] Mind Tower Hamlets, Newham and Redbridge, *Community Connectors*, 2025.
[37] NHS England, 'Social Prescribing Link Workers', Webpage, 2025.
[38] Chris Naylor and Dan Wellings, *A Citizen-Led Approach to Health and Care: Lessons from the Wigan Deal* (The King's Fund, 2019).
[39] National Association of Primary Care, 'Community Health and Wellbeing Workers (CHWWs)', Webpage, 2025.
[40] Local Government Association, 'Somerset County Council: Using Social Prescribing to Promote Self Care', November 2018.

The project resulted in significant reductions in unplanned admissions to hospital.[41] Between April 2013 and December 2017, emergency admissions increased across Somerset by 29 per cent; in comparison, emergency admissions in Frome decreased by 14 per cent.[42] Evidence also revealed that 94 per cent of patients felt more able to manage their health and wellbeing, and 81 per cent of patients experienced an increase in wellbeing.[43] Additionally, the project realised significant savings in healthcare costs. In Frome, healthcare costs fell by 21 per cent, whereas across Somerset they rose by 21 per cent.[44]

The Compassionate Frome project reveals the importance of identifying local assets and ensuring residents are aware of what is available to them. It also demonstrates the impact of linking people to community services, and leveraging services to improve social connections.

Finally, it demonstrates the value of meaningful and personalised relationships between healthcare professionals and residents. One interviewee for this project discussed the concept of “frequent flyers” – individuals who regularly use services and go to places such as the pharmacy. Here, they naturally develop relationships with professionals, enabling them to notice health changes and intervene where necessary. Capitalising on these relationships and enabling healthcare professionals outside of general practice to deliver a range of services will be a vital part of an effective Neighbourhood Health Service.

Lesson 6: Neighbourhood Health systems should create "virtual neighbourhoods" that enable community assets to be systematically mapped and utilised to address the wider determinants of health, including to build meaningful relationships within a community and reduce social isolation.

3.3.2 Andover Health Hub

The Andover Health Hub is multi-agency space providing healthcare at a hyper-local level for residents. Initially, the space was used as a vaccination centre during the COVID-19 pandemic. However when the council began a major regeneration project, including the development of a council-owned, mixed-use shopping centre, leaders from the ICB, PCN and council worked together to transform the vaccination centre into an easily accessible health hub with care co-ordinators and health care assistants working closely together.

The hub opened in January 2023, just a month after the vaccination centre closed. It offers blood pressure checks, COVID vaccinations, and an NHS health check for people aged 40 to 74 which looks for early signs of kidney disease, stroke, type two diabetes, dementia and heart disease.[45] Additionally, it has also developed a programme of groups and activities – such as weigh management and smoking cessation – to further support and improve health and wellbeing outcomes.

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[41] Abel et al, ‘Reducing Emergency Hospital Admissions: A Population Health Complex Intervention of an Enhanced Model of Primary Care and Compassionate Communities’, *British Journal of General Practice*, 2018.
[42] Ibid.
[43] Relationships Project, ‘Case Study: Frome Model of Enhanced Primary Care’, n.d., accessed 10 March 2025.
[44] Ibid.
[45] Local Government Association, ‘Andover, Hampshire: Health Checks at a Town Centre Hub to Relieve Pressure on NHS Services’, March 2023.

Since its inception, it has seen positive results. Only six weeks into opening, it conducted over 1,000 health checks.[46] Of those health checks, 30 per cent were residents from deprived communities. The absence rate for these checks was much lower than the national average: with a 'did not attend' rate of only 5 per cent, compared to a national average of 20 per cent in other settings.[47]

The Andover Health Hub is an important example of the benefits of bringing health services closer to residents. It demonstrates how using spaces which are convenient to people, such as shopping centres, can help to improve people's relationship with health services and, in turn, enable people to achieve better health and wellbeing outcomes.

Lessons from the success of the Andover Health Hub indicate how the places people have regular connections with should be used to deliver primary care services. For instance, in England, 89 per cent of the population in has access to a community pharmacy within a 20 minute walk.[48] Places like this, with higher footfall and levels of accessibility, should be capitalised on to bring primary care services closer to patients.

Lesson 7: Local authorities and healthcare providers should take stock of local assets and creatively use spaces with high footfall to manage and deliver health and care services. The workforce in these settings should be positioned to have the greatest reach into local communities.

[46] Local Government Association.
[47] Ibid.
[48] Todd et al, 'The Positive Pharmacy Care Law: An Area-Level Analysis of the Relationship between Community Pharmacy Distribution, Urbanity and Social Deprivation in England', *BMJ Open*, August 2014.

4. Conclusion

In shifting care from hospitals to the community, there is also an opportunity to be bold in creating the conditions for services to be reconfigured, in radically different ways, depending on the area – resulting in care that is much more responsive to the needs of citizens.

Government will not be able to dictate what Neighbourhood Health looks like in every patch. Instead it has a vital role to play in aligning the building blocks common to the areas that currently have the most advanced offer of Neighbourhood Health: leadership capacity to plan neighbourhood-level care, an emphasis on data integration and the development of real-time data insights; and creative deployment of the workforce and assets that exist in a place.

The aim should be to create a baseline of Neighbourhood Health capability in each area, upon which services can be configured in the way that is most appropriate to local need – supporting delivery of high-quality, proactive care, outside the four walls of general practice.

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