Item: 18

NHS
North East and North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD 3 JUNE 2025	
Report Title:	**Integrated Neighbourhood Health (INH)**

Purpose of report

The purpose of this report is to provide assurance to the Board on the development and implementation of the Integrated Neighbourhood Health (INH) model in North East and North Cumbria. It reflects both regional progress and national alignment, building on previous Board development sessions, local place based collaboration and updated planning guidance. It also sets out the short and medium term priorities and next steps to support a shift toward place-based, preventative and person-centred care.

Key points

2025/26 NHS planning guidance sets out requirements, aims and objectives for the development of INH;

- This report sets out progress on INH development across NENC
- INH has been previously discussed at a Board Development session on 25th April 2025 and regular updates are provided to the Living and Ageing Well Partnership
- At a locality level the current place subcommittees are the main forum to bring partners together to develop local blueprints for developing and implementing INH models
- The recent ICB blueprint indicates the potential for possible alternative delivery models in the future and this will be further clarified through the forthcoming NHS 10 year plan.

Risks and issues

As the neighbourhood health programme moves into a more structured project management phase, a number of risks and issues are beginning to come into sharper focus. These will need to be actively managed as the programme scales up.

- **Governance arrangements** are currently being reviewed to ensure there is the right balance between assurance, delivery and genuine partnership working. At present, there are multiple routes through which elements of the programme are governed, and greater clarity is needed to support progress.
- There is also a need to **strengthen alignment across related programmes** – both within health and across wider public services – to avoid duplication and ensure we are all pulling in the same direction.
- **Reductions in Better Care Fund allocations** may have a direct impact on the delivery of the INH model. As BCF-funded services vary by area, any changes could affect what integrated neighbourhood teams are able to provide, potentially widening variation across boroughs.
- Continued **engagement with Local Authorities** will be critical in accelerating the development of Integrated Neighbourhood Teams, particularly given their role in community support and social care.

- Ongoing **system pressures** – including financial constraints, long waits, and pressures in primary and community services – may affect the pace of progress. These will need to be kept under review to ensure capacity and capability are in place to deliver the programme's ambitions.
- Finally, the **future role of system partners** as lead providers of neighbourhood health remains an area for further discussion, and is expected to be clarified through the ICB transition process and the forthcoming 10-Year Plan.

Assurances and supporting documentation

A number of safeguards are in place – and others are being developed – to help address these risks and support delivery:

- Oversight of the programme is being maintained at system level through the **Living and Ageing Well Partnership Board**, which brings together key partners and provides collective ownership of progress and priorities.
- There is a strong emphasis on **close working at locality level**, with Local Delivery Teams working alongside Local Authorities, NHS Foundation Trusts, Primary Care, and the VCSE to shape local delivery in line with shared ambitions.
- The programme will be formally incorporated into the **ICB's project and programme management framework**, providing structure and accountability, while allowing space for local flexibility.
- The development of a **Community Dashboard** reflecting key metrics across providers and localities highlighting unwarranted variation and informing a strengthened oversight function.
- Nationally, the **reinforced role of INH in recent NHS England guidance**, and the direction expected from the forthcoming **10-Year Plan**, provide a mandate and policy framework for continued progress.
- Going forward, we expect to agree a clearer **set of system-wide assurances**, including:
    - Defined outcomes and success measures linked to neighbourhood health priorities;
    - A standardised approach to tracking progress across localities;
    - A clearer articulation of the role of Place Committees and Providers in future delivery;
    - Shared metrics to monitor impact and variation;
    - And an updated governance map to ensure alignment and reduce duplication.

Supporting documentation

- Appendix 1 – Population of Focus
- Appendix 2 – Urgent Care Statistics for the Population of Focus
- Appendix 3 – Strategic Planning Session: UECN and LAWP
  Appendix 3 – Slide deck illustrating the ICB approach to neighbourhood health (Board development workshop April 2025)

Recommendation/action required

The Board are asked to:

- **Note** the significant progress made by Local Delivery Teams in developing multi-disciplinary approaches to neighbourhood health with partner organisations.
- **Agree** the proposed direction of travel and the formal establishment of a Neighbourhood Health Programme to oversee and support accelerated implementation across the ICB footprint.
- **Receive** a further update later in 2025, following publication of the NHS 10-Year Plan, to ensure continued alignment with national policy and emerging guidance.

Acronyms and abbreviations throughout report explained

BCF – Better Care Fund
INH – Integrated Neighbourhood Health
INT – Integrated Neighbourhood Teams
LAWP – living and Ageing Well Partnership
UEC – Urgent and emergency care

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Link to ICP strategy priorities (please tick all that apply)	
Longer and Healthier Lives	✓
Fairer Outcomes for All	✓
Better Health and Care Services	✓
Giving Children and Young People the Best Start in Life	✓

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Essential considerations	
Financial implications and considerations	The ICB finance team support the local implementation of INH through the LAWP and through membership of the local; place committees. Funding for the neighbourhood health programme will largely be through reconfiguration of existing resources including the local review of community contracts. The ICB investment profile for 25/26 has included a number of 'left shift' investment s that support the development of neighbourhood health.
Contracting and Procurement	The key area of focus for the contracting and procurement team is the continued review of existing community contracts and the recent Board development workshop highlighted the need for a potential system review of the contracts including activity and outcome measures to ensure the contracts retain sufficient flexibility to support the development of INH.
Local Delivery Team	All of the LDTs are leading the local development of INT through the place subcommittees, some of which are developing into Neighbourhood health partnership boards as the key local forum for developing local models. The LDTs are also fully represented at the overarching LAWP meeting.
Digital implications	The role of digital both in terms of rapid access to data and shared records as well as the role of digital tools as enablers of neighbourhood health continue to de developed. This is in line

	with the ICS digital strategy and a focussed work stream will be established to explore the current provision, and opportunities for digital tools to enhance the INH approach.
Clinical involvement	Clinical leaders are actively engaged through Local Delivery Team partnerships and are helping to shape local delivery plans, particularly in relation to frailty and urgent community response. Clinical leads from the Ageing Well network are also key members of the Living and Ageing Well Partnership Board, which provides system-level oversight and informs the design of Integrated Neighbourhood Health (INH) models.
Health inequalities	Tackling health inequalities is central to the INH model. Local Delivery Teams have drawn on population health data to identify at-risk cohorts, and several areas have prioritised frailty, complex co-morbidities, or access to urgent care based on evidence of inequality or unwarranted variation. Further work is planned to support more consistent use of population health intelligence to inform both cohort selection and service design.
Patient and public involvement	Engagement with patients and carers was a key theme in the joint meeting of the Urgent Care Network and Living and Ageing Well Partnership. A commitment was made to co-design future service models with patients and communities, including shaping communication strategies that support understanding of changes in care access and coordination. Further local engagement will take place as blueprints are finalised.
Partner and/or other stakeholder engagement	The development of INH has been led by Local Delivery Teams working closely with local authorities, NHS providers, primary care, VCSE organisations, and wider stakeholders. Formal engagement routes include Place Sub-Committees, Integration Groups, and system-wide forums such as the Living and Ageing Well Partnership Board. Each locality has taken a collaborative approach to shaping its local delivery model, informed by shared priorities and population data.
Other resources	Delivery of the INH model will require dedicated programme support, consistent data and digital infrastructure, and capacity within both clinical and operational teams to embed new ways of working. The ICB is incorporating this programme into its wider project management framework to ensure alignment of support and oversight, and to track resource needs including estates, digital enablers, and workforce development.

Integrated Neighbourhood Health

1. Purpose

The purpose of this report is to provide assurance to the Integrated Care Board on the development and implementation of the Integrated Neighbourhood Health (INH) model in North East and North Cumbria. It reflects both regional progress and national alignment, building on earlier development sessions and updated planning guidance. It also sets out the short and medium term priorities and next steps to support a shift toward place-based, preventative and person-centred care.

2. Introduction

Neighbourhood Health is fast becoming the defining organising principle for how care is delivered in communities. Reflecting the ambitions of the 2025/26 NHS planning guidance and the anticipated NHS 10-Year Plan, this report provides the board with an update on progress made locally and regionally across NENC, alongside a forward view on next steps. Integrated Neighbourhood Health (INH) is not a new concept, but we are now seeing momentum and clarity of purpose, with a more consistent framework being developed with our partners through Local Delivery Teams, provider leadership, and system-wide intelligence and data insights.

An Integrated Neighbourhood Health approach supports delivery of holistic care in the community, which is focused on co-ordinating care across different services for patients to best meet their care needs.

Services are provided by Integrated Care teams (INTs) comprising a group of professionals from across some or all of the following: primary care, hospital care, community care, mental health services, social care and local charitable and voluntary sector organisations who come together to deliver care for a group of patients within their area. The teams proactively identify patients who may need additional support to prevent later ill health and hospital admissions, through working with general practice to support the patient to live well in the community. Early, integrated and co-ordinated support for patients should lead to better joined up care, clear care plans to manage existing conditions and less need for hospital care. Depending on the patient needs a neighbourhood can have more than one INT, for instance, some areas may need an INT for their frail and elderly population and/or for complex mental health conditions.

Local delivery teams across the North East and North Cumbria are already working to support the development and provision of integrated services through INTs working across organisational boundaries and with local populations. They are consistently building on these developments with a view to improving and streamlining existing services or considering new models of care to ensure patients within our local areas are receiving the best possible proactive care.

3. Context and National Guidance - Policy into practice

The government's health mission is to move:

- from hospital to community
- from treatment to prevention
- from analogue to digital

The 25-26 NHS planning guidance, the Better Care Policy and the Neighbourhood Health guidelines highlight that the NHS 10-year plan will describe a ‘left shift’ to Integrated Neighbourhood Health which will involve the following:

- In 2025/26 the NHS and social care will work together to prevent unnecessary time in hospitals or care homes
- Over the next 5 years the NHS and Local authorities will work together to strengthen 'out of hospital' care and connect people to wider public services and third-sector support

INH 6 core components – Government guidance, (Neighbourhood health guidelines 2025/26 NHS England, January 2025), describes 6 Key components of INH which are set out below:

1. Population health management – This describes 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 a Federated Data Platform
2. 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.
3. Standardising community health services – This involves the utilisation of the Standardising community health services publication to maximise use of funding for local needs and priorities, including commissioning of community health services and connect mental and physical health services to ensure complete provision, and link with the VCFSE sector
4. Neighbourhood multidisciplinary teams (MDTs) – This describes Multidisciplinary coordination of care for population cohorts with complex health and care or social needs who require support from multiple services and organisations. This would involve a core team assigned for complex case management, with links to an extended specialist team. It looks to ensuring that there is a care coordinator assigned to every person or their carer in the cohort as a clear point of contact
5. Integrated intermediate care – This describes short-term rehabilitation, reablement and recovery services delivered under a therapy-led approach. It also looks at a 'Home First' approach to delivery of assessment and interventions, underpinned by step -up referrals and step- down planning directly between community and acute services.
6. Urgent neighbourhood services – This is looking to 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. It will 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.

4. Turning Guidance into Action – Using Data to Drive Local Priorities

National guidance is clear in its ambition: systems are expected to make neighbourhood health the organising principle for how care is delivered in communities. This means

building on what's already working locally, while adopting a more consistent, evidence-led approach across the board. The ask is fourfold:

- Bring greater consistency by applying the six core components of INH across all localities;
- Connect the different strands of work into a single, integrated offer for people with complex needs;
- Scale up what's working, so the approach becomes mainstream rather than the exception;
- And evaluate impact properly – not just in terms of outcomes for individuals, but value for money across the system.

Getting this right depends on how well we understand our population and what matters most. That's where population health intelligence plays a key role. We're already using this intelligence to target support where it's needed most – both at system and local level. The focus for 2025/26 is on people aged 65 and over with complex needs, especially those living with frailty. This group makes up around 7% of the population but accounts for nearly half of hospital spend.

We're also using this intelligence to map out what services are currently available, where there are gaps, and how neighbourhood teams can join up around the people who need care the most. As Lord Darzi's recent review of the NHS put it, "one of the essential steps for integrated care is understanding your population using shared data".

This work will form the foundation for future delivery, helping us to scale neighbourhood health in a way that's evidence-based, locally owned, and sustainable.

5. Population of focus

In 25/26 the primary focus for INH in NENC will be people over the age of 65 with complex needs with a particular focus on those classified as frail. Appendix 1 provides a robust overview of the older population data across our region, specifically those aged 65 and over with complex needs – the primary cohort for INH delivery in 2025/26. This may include a range of co-morbidities including respiratory and diabetes care as well as other long term conditions.

Integrated Urgent and Responsive Care - The ICB is also seeking to identify opportunities to carry out better proactive, preventative and urgent responsive care Appendix 2 presents key metrics on urgent and emergency care usage by the population eligible for proactive care, building a clearer picture of avoidable demand across our system. These figures have been developed in partnership with Local Delivery Teams and provider leads, ensuring they reflect real-world activity. The insights confirm both the scale and nature of need – including the high number of non-urgent attendances and conveyances that could be prevented with earlier intervention. This data continues to guide our joint work on care coordination, urgent neighbourhood services and integrated intermediate care.

The INH team approach is closely aligned with the wider UEC and care coordination work.

Key Areas of focus agreed with system Partners

In May 2025 there was a joint meeting of the Urgent and Emergency Care Network (UECN) and the Living and Ageing Well Partnership (LAWP) where key areas of focus were agreed with system partners for further development.

The following shared aims and vision were agreed:

- Integrated Care Coordination (ICC) and urgent community response are central to improving patient outcomes and system efficiency.
- A single point of access (SPA) and multidisciplinary team (MDT) approach are essential for managing complex patients, especially those with frailty and long-term conditions.
- Neighbourhood health and urgent care are not separate agendas—they must be aligned and integrated.

In terms of care Coordination and Access it was agreed:

- There is consensus on the need to accelerate care coordination models (e.g., ISPAs) across all areas.
- Emphasis on ease of access for clinicians and patients—ideally through a single contact number and simplified referral pathways.
- Importance of standardising terminology and models across the region to reduce confusion and improve efficiency.

In terms of patient and public Engagement it was agreed as follows:

- Need for a communications strategy to manage public expectations and explain changes in service delivery.
- Importance of involving patients and carers in pathway design to ensure services meet real-world needs.

Appendix 3 provides a summary from the May meeting that captures the shared priorities and agreed actions from the joint meeting of the Urgent Care Network and the Living and Ageing Well Partnership held in May 2025

6. Turning Policy into Framework

The ICB is now working on continuing to ensure the national policy is proactively shaped into a local framework with focused delivery. Appendix 4 provides an overview of the detailed approach within the NENC ICB **Supporting Analysis: Strategic Overview of Neighbourhood Health and Frailty**

A presentation (Appendix 4) has previously been shared with Board members providing a strategic overview of our Integrated Neighbourhood Health (INH) approach, with a particular focus on older people with complex needs and frailty. It draws together the national policy context, regional population insights, and local planning activity, and maps these directly onto our 25/26 priorities.

The slides summarise:

- The national direction of travel, including the ‘shift’ towards community-based, preventative care described in the NHS 10-Year Plan.
- The six core components of INH and how they are being applied across our system.
- Population health intelligence showing the scale of need – particularly among older people living with frailty, high levels of deprivation, or loneliness.
- Local delivery plans, with examples from South Tyneside and Sunderland, highlighting integrated MDT approaches, care coordination, and urgent community response.
- Strategic enablers including outcome-based commissioning, workforce planning, data insight, and real-time monitoring through tools like RAIDR.
- Reflections from partners on risks, readiness, and the importance of turning ambition into actionable delivery.

This presentation complements the main report and reinforces our confidence that local teams are building their plans on a strong foundation of data, policy alignment and multi-agency collaboration. It also highlights the importance of continuing to invest in population health, intelligence and measurement as a key workstream in 2025/26 and beyond.

7. Update on progress from local Delivery Teams

Whilst the ICB is developing a strategic framework for Integrated Neighbourhood Health (INH) – setting out areas for regional focus, support and alignment – delivery will, by its nature, be local. Neighbourhood teams and services will form the core of how INH is put into practice, shaped around integrated multi-disciplinary working. This work is being led and coordinated by our ICB Local Delivery Teams, in close collaboration with local commissioners, providers, and system partners.

The concept of integration is not new to our areas – each Place can point to strong examples of partnership working and integrated care. INH gives us an opportunity to build on these foundations and go further in improving the quality, coordination and responsiveness of care. Set out below are updates from local areas, outlining governance arrangements, key partners, progress so far, and anticipated milestones over the next three to six months.

Each of our Place teams has taken a slightly different approach to implementing Integrated Neighbourhood Teams and local models of working. To understand where things currently stand, a scoping exercise has been undertaken, speaking with multi-disciplinary groups across the patch. These conversations involved colleagues from a range of organisations and aimed to capture both what is already in place and what is planned against the six core components of the Neighbourhood model.

Locality updates:

The development of Integrated Neighbourhood Health (INH) across our system continues to reflect local context, priorities and readiness. Each Local Delivery Team (LDT) has made progress at a different pace, supported by the ICB’s broader strategic framework and the national six-component INH model. What follows is a locality-by-locality narrative update, structured around governance, partnership, progress, and next steps.

County Durham
Durham has established six INH localities, aligned with GP Federation footprints, since 2023. Each locality holds bi-monthly partner meetings and reports through the County Durham Care Partnership Committee, with voting representation from all system partners including the ICB, CDDFT, Durham County Council, TEWV, Primary Care, VCSE and Healthwatch. Durham benefits from a strong integrated culture, with several jointly funded posts and use of community intelligence such as the Community of 1,000 data packs. All localities are focusing on frailty as an initial cohort, using local data to inform priorities. Key projects include frailty MDT hubs in Easington and Sedgefield, which will pilot a 'Hull' model of care. A wider review of progress and next steps is expected following publication of the 10-Year NHS Reform Plan.

Newcastle
Neighbourhood Health in Newcastle is coordinated via the ICB Sub-Committee, chaired by the Acting CEO of Newcastle Hospitals. The work is rooted in system collaboration, with active engagement from Newcastle Hospitals, CNTW, Primary Care, the City Council, VCSE partners and the ICB. A major workshop in May 2025 used primary care, hospital, social care and JSNA data to identify priority populations and geographies. Next steps include a June follow-up session to agree delivery priorities, form task-and-finish groups, and develop a city-wide implementation plan. VCSE engagement will be led by Connected Voice, and there is a strong emphasis on tackling inequalities and co-producing a shared model.

Gateshead
Gateshead is also working through the ICB Sub-Committee, chaired by the CEO of Gateshead Health NHS FT. Key partners include Gateshead FT, CNTW, South Tyneside & Sunderland NHS FT, Harrogate & District NHS Trust, Primary Care, CBC Federation, Gateshead Council and VCSE partners. An initial session in January 2025 was followed by a second planned workshop in June, to agree population priorities, map existing initiatives and confirm delivery responsibilities. Gateshead anticipates forming task groups, creating a delivery plan, and formalising its neighbourhood model over the next quarter.

Hartlepool and Stockton
Governance in Hartlepool and Stockton is via Integration Groups reporting into refreshed Place-based Committees. Key partners include the ICB, both local authorities, North Tees FT, TEWV, VCSE, Healthwatch and Primary Care. INH here builds on a strong foundation of partnership working through BCF, EHICH and shared prevention plans. Collaboratives have now been established in both areas, with early terms of reference focusing on frailty and other cross-cutting conditions. The work will be refined in light of the 10-Year Plan, with further learning from South Tees used to inform consistency across Tees Valley.

South Tees and Darlington
In South Tees, all PCNs have committed to implementing INH models focused on wound care and frailty. The governance arrangements flow through the South Tees Strategic Oversight Group and local Place Committees. Partner organisations include the ICB, local councils, CDDFT, South Tees FT, TEWV, and local VCSE groups. The area has trialled a front-of-house frailty pilot and maintains a Single Point of Access. Darlington has aligned with this approach and is progressing work on frailty through its Integrated Discharge model, enhanced reablement pathways and a responsive MDT approach. Further work will build on PCN input and align with discharge and Home First strategies.

Northumberland and North Tyneside
While updates for these localities were still being finalised at the time of writing, emerging content from their draft POAPs confirms active development of INH models. Both areas are aligning work to the six-component framework, and are currently focused on defining footprints, establishing governance, mapping frailty pathways, and agreeing outcome metrics. Partners include the ICB, local authorities, NHCT, CNTW, Healthwatch and VCSE. Early milestones include forming MDT structures, reviewing data needs, and setting up engine room functions to support delivery. Further updates are expected following completion of their system mapping and strategy development work.

South Tyneside and Sunderland
These areas have also made progress across the six components, as outlined in their draft Appendix 10 submission. South Tyneside has begun rebuilding MDT working and is aligning this with emerging governance via the ICB Sub-Committee. Sunderland has more established MDT models and is advancing initiatives in urgent neighbourhood services, reablement and PHM. Both areas are working with Newton Europe to explore system optimisation. A key priority over the next six months will be to clarify delivery plans and finalise milestones across intermediate care, urgent care integration and local PHM priorities.

North Cumbria
A finalised update from North Cumbria is still awaited. It is anticipated that this will include development of frailty-focused pathways, integrated MDT models and shared PHM approaches consistent with the rest of the system. This will be included in future iterations of this report.

7.1. Summary of LDT Updates

It is clear from reading the summary updates above and the local blueprints, that all our local areas can demonstrate successful integrated working and that work to develop the INH framework and linked INTs continues to build upon these strong foundations. There are some areas where integration is more mature in its development and implementation, for example, in Durham where there are integrated commissioning teams and joint appointments between the ICB and the Local authority. INH will support each of our localities to become ever more sophisticated and innovative in their approach to integrated working and resulting improvements in patient care and services.

It is evident from population health and other data sources that a key focus for our local areas needs to be care of people over the age of 65 with complex needs, especially those classified as frail. However, data also identifies other patient cohorts who could benefit from improved integrated service approaches, for example, people with respiratory conditions and people with Mental Health conditions. Some local areas are already focussing on respiratory conditions but very few would appear to be looking at Mental Health, this will be considered as part of future plans, recognising that local areas have been required to specifically focus on the frail elderly in 25/26.

Currently, none of our local areas appear to be looking at using the INH approach for the provision of services for children and young people, even though integrated working for

children and young people with complex needs is already well established across NENC. This will also be an area of focus for local delivery in future years.

It is apparent that each of our local areas have used population health and other data sources to identify the patient cohorts that they are planning to focus on. It may be worth considering a more sophisticated data set to support such prioritisation going forward. This would be in line with the emerging future role of ICBs in respect of population health and epidemiology as key strategic commissioning functions.

It may also be helpful to clarify where responsibility for different activities might sit, whether at system wide or locality level. For example, in the production of data, direction of travel and access to support.

8. Neighbourhood Health Providers – National Direction and Local Approach

The recent Model ICB Blueprint introduces the concept of a Neighbourhood Health Provider (NHP) – a term now gaining traction nationally, but still light on detail. It points to a future organisational form that could take a lead role in delivering neighbourhood-based, integrated care, covering a broad set of functions: from primary and community care, to elements of mental health, VCSE, and potentially acute services. It also suggests responsibility for enablers like estates, workforce and digital infrastructure.

At this stage, however, there is no clear definition of what an NHP is, how it would relate to existing providers, or what governance and accountability structures might look like. Early commentary has rightly highlighted the risk of confusion or duplication unless roles are clearly articulated.

The national direction appears to favour more place-based, vertically integrated models, with options such as alliance or lead provider arrangements being explored. While this could offer opportunities to align delivery and reduce fragmentation, it's important that any future model retains the essential contribution of general practice and smaller providers – particularly where there is a risk of marginalisation.

Given the strength of our existing partnerships at locality level, our working assumption is that the functions of a Neighbourhood Health Provider will evolve from current local arrangements, rather than require a wholesale shift in provider form. This means:

- Building on relationships already in place between PCNs, federations, community and mental health providers, local authorities and the VCSE;
- Recognising the statutory role of general practice and its leadership within neighbourhood teams;
- Ensuring that any future model reflects local readiness, relationships and resource – rather than imposing a uniform structure;
- Staying close to national developments, including the forthcoming **10-Year Plan**, and adapting in line with further guidance as it emerges.

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We will continue to work with partners to shape what this could mean in practice, but at this stage our recommendation is to retain flexibility, continue to strengthen local delivery partnerships, and position ourselves to influence and respond as the policy picture becomes clearer.

The development of Integrated Neighbourhood Health is now moving from planning into delivery. What this report shows is that we are building from a strong position: a clear national mandate, committed local partnerships, and a growing depth of population intelligence that is helping us to target the right care, at the right time, for those who need it most.

While there is still work to do—particularly around governance alignment, resource coordination, and the evolving role of Neighbourhood Health Providers—we are confident in the direction of travel. Local Delivery Teams are already taking action, and system-level enablers are in place to support further progress.

Our focus over the next six months will be on maintaining this momentum, embedding local blueprints, and refining our commissioning and measurement frameworks. Ongoing engagement with partners, patients and the public will remain central to the way we shape and deliver neighbourhood health across the North East and North Cumbria.

9. Next Steps

Key next steps for the second half of 2025 include:

- Finalising and publishing local INH blueprints for each LDT.
- Developing a commissioning framework for INH, with frailty as a test case for outcome-based models.
- Clarifying the role and potential form of future 'Neighbourhood Health Providers' in anticipation of national guidance.
- Enhancing strategic enablers, including digital infrastructure, workforce development, measurement and population health intelligence.
- Embedding real-time dashboards (e.g. frailty, urgent community response) to support service delivery and improvement.
- Facilitating joint service planning workshops at place level focused on urgent and proactive care.
- Continue to progress frailty and care coordination workstreams.
- Use existing data and insights to target interventions and avoid assumptions.
- Plan a follow-up joint session to review progress and refine priorities.

10. Conclusion

The development of Integrated Neighbourhood Health is now moving from planning into delivery. What this report shows is that we are building from a strong position: a clear national mandate, committed local partnerships, and a growing depth of population intelligence that is helping us to target the right care, at the right time, for those who need it most.

While there is still work to do—particularly around governance alignment, resource coordination, and the evolving role of Neighbourhood Health Providers—we are confident in the direction of travel. Local Delivery Teams are already taking action, and system-level enablers are in place to support further progress.

Our focus over the next six months will be on maintaining this momentum, embedding local blueprints, and refining our commissioning and measurement frameworks. Ongoing engagement with partners, patients and the public will remain central to the way we shape and deliver neighbourhood health across the North East and North Cumbria.

11. Recommendations

The Board are asked to:

- **Note** the significant progress made by Local Delivery Teams in developing multi-disciplinary approaches to neighbourhood health with partner organisations.
- **Agree** the proposed direction of travel and the formal establishment of a Neighbourhood Health Programme to oversee and support accelerated implementation across the ICB footprint.
- **Receive** a further update later in 2025, following publication of the NHS 10-Year Plan, to ensure continued alignment with national policy and emerging guidance.

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