Neighbourhood working: Emerging NHS models and lessons from international exemplars

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Executive Summary

England's health and care system stands at a pivotal juncture. The Fit for the Future: 10 Year Plan for Health in England has set a clear direction: a fundamental reorientation of the NHS away from a model centred on acute hospitals towards one rooted in the community. This strategic vision, underpinned by three core shifts - from hospital to community, from sickness to prevention, and from analogue to digital - is a necessary response to the unsustainable pressures facing the NHS.

The launch of the National Neighbourhood Health Implementation Programme marks the transition from policy ambition to operational reality. As this new model of care scales, we offer our analysis of **the three emerging structural archetypes for neighbourhood working** that we see taking shape across the country:

1. **GP-led:** models built from the ground up by primary care, often evolving from Primary Care Networks (PCNs) or federations, characterised by agility and deep community roots.
2. **Community or Mental Health-led:** models driven by community or mental health trusts, leveraging their expertise in out-of-hospital care and strong links with social care.
3. **Acute-led (Integrated Healthcare Organisation):** a model of vertical integration where a hospital trust takes a leading role in organising services across the full care pathway.

While each archetype has strengths and potential pitfalls, we reflect that ultimately the model that emerges in a local area will reflect two key factors: the unique needs of the population and the legacy dynamics within the local system.

The move away from a reactive, hospital-centric "sick care" model is not something the UK is alone in grappling with. Globally, there is a shift towards a proactive, community-centric model of care focused on prevention and holistic wellbeing. Recognising this, we have included case studies from pioneers in England and around the world. We provide an overview of the model and transferable lessons for England. We hope these examples will inspire and help leaders in England accelerate their own transformation journeys.

Introduction: the promise of neighbourhood health

The government's Fit for the Future: 10 Year Plan for Health in England represents a defining moment, articulating a vision that moves decisively beyond the 20th-century model of a hospital-centric system. The plan is constructed around three seismic shifts:

- **from hospital to community,**
- **from sickness to prevention, and**
- **from analogue to digital.**

At the heart of this future is the creation of a dedicated "Neighbourhood Health Service," designed to be more responsive, proactive, and closer to people's homes.

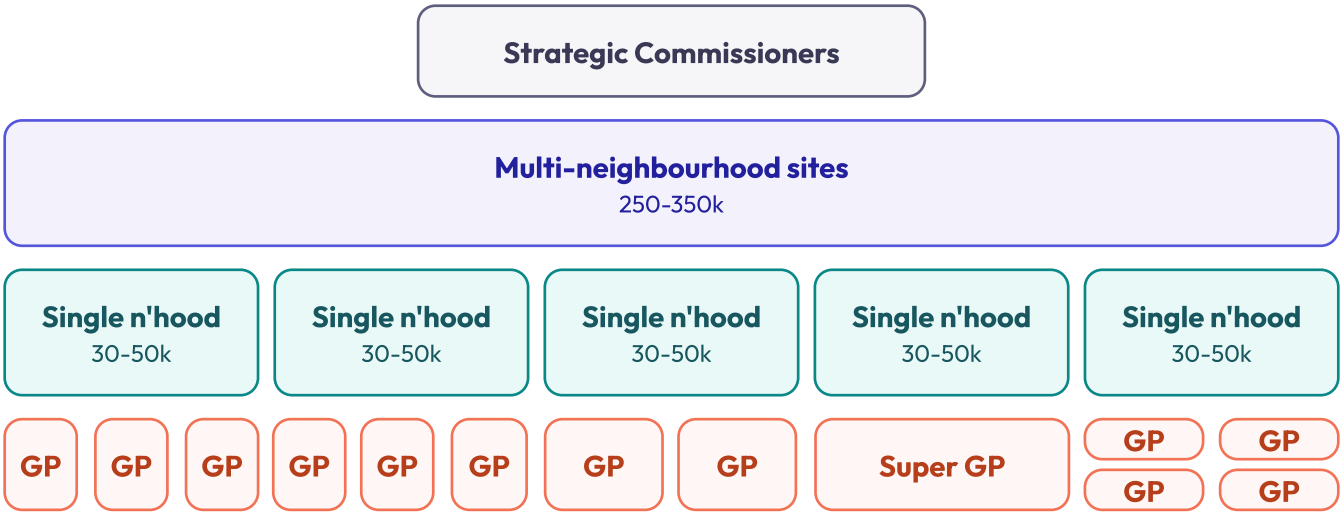
Drawing on NHS England's guidelines, Neighbourhood Health can be defined as: **a new way of working that brings together health, social care, and voluntary sector partners to deliver integrated, proactive, and personalised care for a defined local population of 30,000 to 50,000 people.**

This model aims to dissolve the traditional boundaries between services, creating a single, coherent team around a shared community.

The neighbourhood provider landscape

The 10-Year Health Plan signals a decisive shift towards contracts designed for locality-based delivery. It introduces two new neighbourhood provider contracts, aiming to anchor provision in community-rooted structures:

- A **'single neighbourhood provider'** contract will cover PCN-sized populations - typically 30,000-50,000 people - empowering scaled primary care collaboratives or federations to lead integrated, data-driven care delivery.
- A **'multi-neighbourhood provider'** model will operate at a broader 250,000-plus population level. These contracts are intended for at-scale efforts like coordinating frailty responses or managing shared estates, estates, back-office functions and data analytics across multiple neighbourhoods.



These models are designed to give a clear role to organisations capable of scaling and coordinating care at neighbourhood level - whether GP federations or trust-based systems that have embraced vertical integration. The possibility for leading foundation trusts to become **Integrated Health Organisations (IHOs)** - with risk-adjusted, capitated contracts - opens the theoretical door to reinvesting efficiency gains into prevention, digital tools, capital development or local innovation.

What this means in practice:

- **Modular yet joined-up care:** the Plan accommodates a variety of provider structures - PCN collaboratives, federations, or more integrated trusts - recognising local nuance.
- **Financial incentive realignment:** risk-weighted capitation reshapes incentives, rewarding investment in upstream, community-based care rather than hospital throughput.
- **Strategic capability building:** providers appointed under these contracts will need the infrastructure and analytic power to deliver population health improvements at pace - and may need support to get there.

While the strategic direction is clear, the operational "how" is still emerging. As the National Neighbourhood Health Implementation Programme (NNHIP) gets underway, different structural forms are taking shape across the country. The next section offers a perspective on three likely archetypes for how these integrated neighbourhood teams will be formed and led, providing a framework for leaders navigating this complex but vital transformation.

Three emerging models for Neighbourhood Health

As neighbourhood working moves from concept to reality, distinct structural archetypes are emerging. Each has unique strengths and potential pitfalls. Understanding these models is crucial for leaders designing the right approach for their community.

Archetype 1: GP-led

These models are built from the ground up by primary care, often evolving from the collaboration and scale of Primary Care Networks (PCNs) or established GP federations. They are defined by their deep roots in general practice.

In practice (Sheffield Primary and Community Mental Health Service):

- **The model:** the Sheffield Primary and Community Mental Health Service is a partnership between Primary Care Sheffield, Sheffield Health Partnership University NHS Foundation Trust and Sheffield. The service is designed to support people with serious and enduring mental illness and other complex needs, whose needs cannot be met by Talking Therapies services, but that do not present the level of need for referral to secondary care services. The teams are mainly based in the 15 Primary Care Networks in Sheffield and they see patients mostly in these GP practices or through video or phone calls. The model is noteworthy for its scale - covering the whole of Sheffield.

- **Impact and outcomes:** the service has significantly improved access and outcomes for those with serious mental illness. There was a **nearly 90% increase in the mental health access rate for minority ethnic groups** in some areas (from 11.6% to 22%). Approximately **79% of patients**
- **remained well six months post discharge** and on average, patients reported a **+8.29 improvement in the Recovering Quality of Life (ReQoL)** measure.

Pros

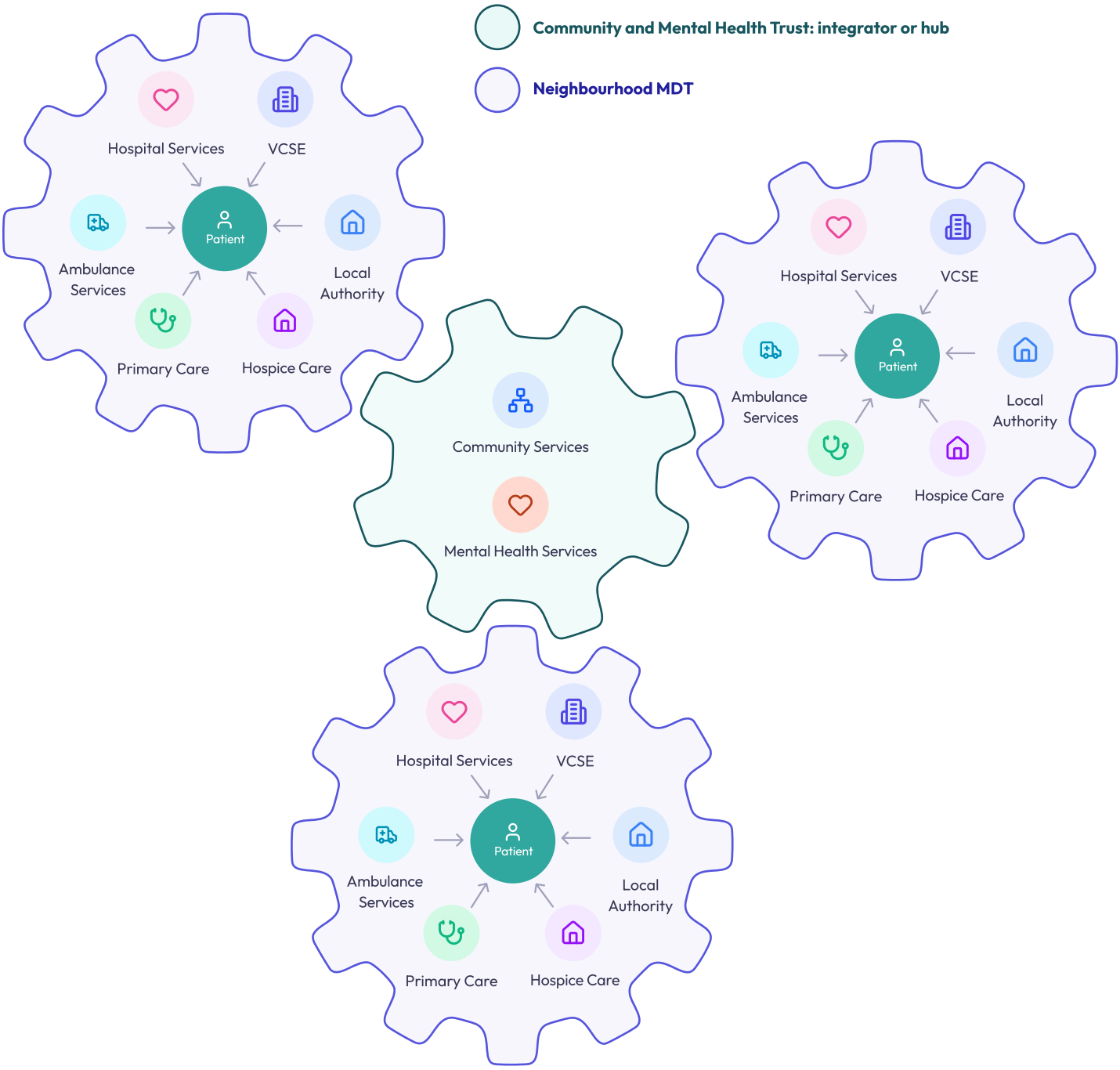
- **Community-rooted:** inherently grounded in the communities they serve, with strong, long-term patient relationships.
- **Agile and responsive:** often able to innovate and adapt quickly to local needs without the bureaucracy of larger organisations.
- **Clinically credible:** led by GPs, ensuring strong clinical leadership and buy-in from primary care colleagues.

Cons & 'watch outs'

- **Variability:** can lead to inconsistency between different PCNs or federations if not supported by a system-wide framework.
- **Scaling challenges:** may struggle to scale back-office functions like data analytics, workforce development, and digital infrastructure without support.
- **Engaging the System:** can find it challenging to engage and influence larger NHS trusts and system partners.

Archetype 2: Community or Mental Health-led

These models are typically driven by a community or mental health trust, which acts as the 'integrator' or backbone organisation, convening partners and providing infrastructure.



In practice (Team Up Derbyshire):

- **The model:** Team Up Derbyshire is a system-wide integrated neighbourhood team approach focused on the 30,000 people in Derbyshire living with moderate or severe frailty. It is noteworthy for its scale and its dual focus on both proactive, anticipatory care and a rapid, reactive Urgent Community Response (UCR) for housebound patients. It is not a new service, but a "teaming up" of existing services from general practice, community and mental health, social care, and the voluntary sector to create additional capacity and keep people out of hospital wherever possible.

- **Impact and outcomes:** the model has delivered dramatic results. In one year, its Home Visiting team made over 24,000 visits, leading to **2,367 fewer ambulance call-outs** and **1,467 fewer short hospital stays for the over-65 population** compared to the previous year. The model's success is reflected in the views of its staff, with **95% recommending the service**. One staff member captured the essence of the model's impact: “It allows people to stay in their own homes, in familiar surroundings near family or friends and it stops filling up hospitals, allowing more urgent care to happen in hospitals or allow space for elective care”.

Pros

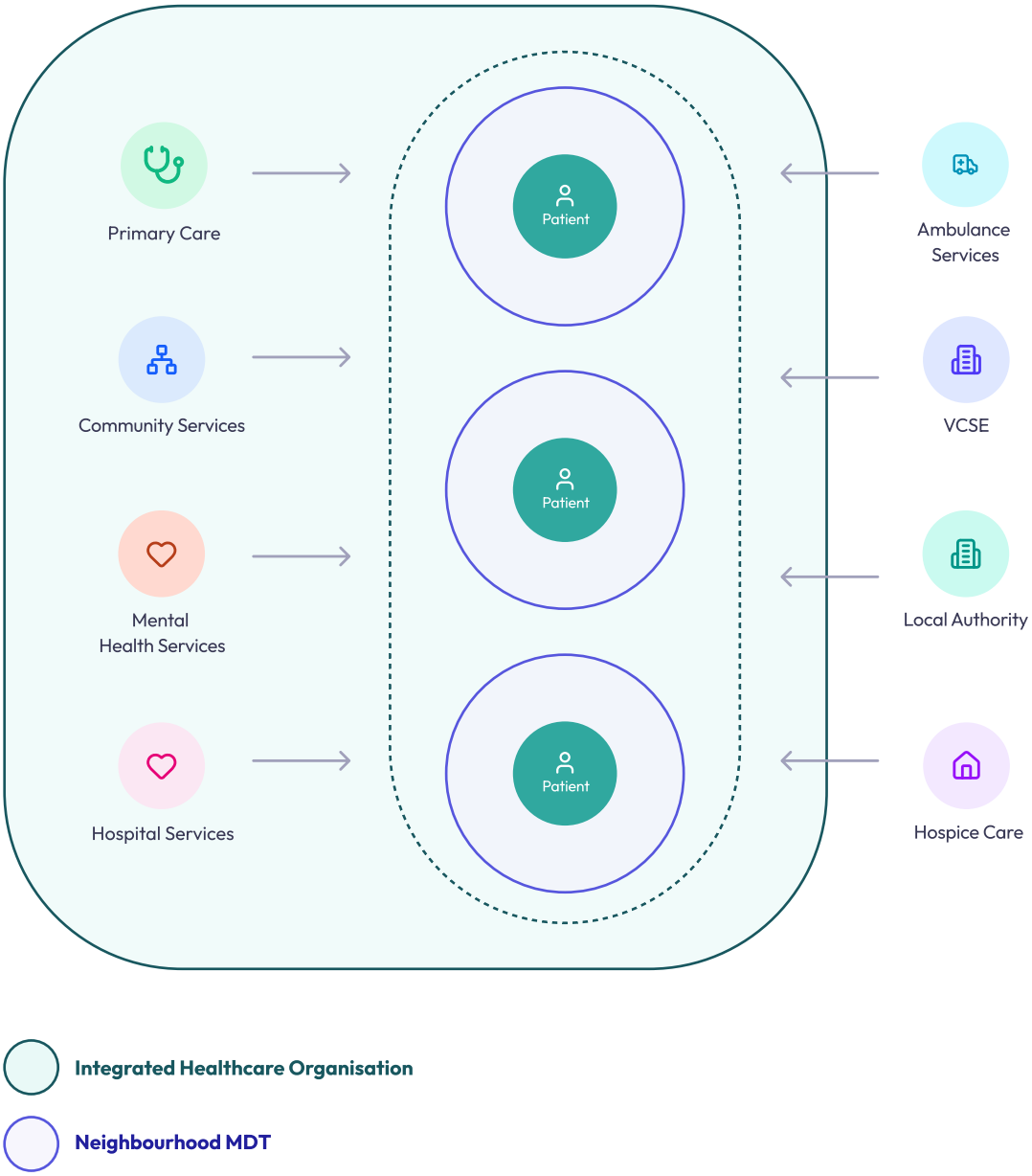
- **Expertise in Community Care:** deep understanding of out-of-hospital pathways and strong existing relationships with social care and the voluntary sector.
- **System-wide perspective:** able to plan and deploy resources across a larger footprint than a single PCN, promoting consistency.
- **Workforce and infrastructure:** can leverage the trust's existing workforce, estates, and corporate functions to support neighbourhood teams.

Cons & 'watch outs'

- **Risk of top-down approach:** can be perceived as another NHS reorganisation imposed on primary care if not genuinely co-designed with GPs from the outset.
- **Acute interface:** may face challenges in influencing acute hospital pathways and securing the shift of resources from hospitals to the community.
- **Maintaining localism:** must work hard to ensure that a trust-led model remains responsive to the hyper-local needs of individual neighbourhoods.

Archetype 3: Acute-led (Integrated Healthcare Organisation)

This model involves vertical integration, where an acute hospital trust takes on a broader role, often merging with community and/or mental health providers to create a single organisation responsible for a population's health across the full pathway.



In practice (Somerset):

- **The model:** In Somerset, there is a single integrated trust spanning acute, community, and mental health services for the entire ICS population. This model is noteworthy for the sheer breadth of services delivered by a single organisation, making it uniquely positioned to drive integration across the whole system. The trust supports multidisciplinary neighbourhood teams that bring together primary and community services with voluntary sector partners to deliver an 'integrated out of hospital offer'. The guiding principle, as stated in the Somerset Integrated Health and Care Strategy, is to "Work together on the basis of what is best for our population, then best for our system and finally best for our organisations".

- **Impact and outcomes:** This integrated approach is already showing results. A Complex Care Team, working within this model across three PCNs, has **supported over 21,000 people** in two years, helping to **reduce unplanned hospital visits by 14%**. In mental health, the Open Mental Health alliance, partnered with the Foundation Trust, has contributed to a **30% reduction in mental health admissions** across all ages in a three-year period.

Pros

- **Seamless pathways:** has the greatest potential to create truly seamless care pathways between hospital and home, breaking down the traditional commissioner-provider split.
- **Resource and influence:** can leverage the significant scale, resources, data analytics, and specialist expertise of a major hospital.
- **Financial alignment:** a single, capitated budget for the whole population creates a powerful incentive to invest in prevention and community-based care to reduce costly hospital activity.

Cons & 'watch outs'

- **Cultural dominance:** a powerful hospital-centric culture could stifle a truly preventative, community-first mindset.
- **Disempowering partners:** risks marginalising primary care and the voluntary sector if they are not treated as equal partners in governance and decision-making.
- **Complexity of integration:** merging large, complex organisations with different cultures and systems is a huge and often disruptive undertaking.

Summary: Choosing the right path, which model is best?

The three archetypes - GP-led, Community-led, and Acute-led - provide a framework for understanding the emerging structural forms of neighbourhood health. However, a crucial question for local leaders remains: which one is right for us?

The answer is that there is no single correct model.

The National Neighbourhood Health Implementation Programme (NNHIP) is actively encouraging systems to develop and test models across these archetypes. The goal is to extract rich learning from this diversity, not to identify a single winner.

Inevitably, the model that emerges in a local area will reflect two key factors: the unique needs of the population and the legacy dynamics within the local system. The health needs of rural Cumbria are vastly different from those of inner-city Camden, and the chosen neighbourhood model must be designed to meet those specific challenges.

At the same time, we must be clear-eyed about the influence of existing structures. In a system with a historically powerful hospital-centric culture, for example, there is a risk that an acute-led model could inadvertently stifle a truly preventative, community-first mindset. For any model to succeed, all partners - from general practice and the voluntary sector to social care and mental health - must be treated as equals in governance and decision-making.

Finally, there is a practical reality to address. Running effective neighbourhood teams requires a significant amount of convening and organising. Functions like managing pooled budgets, employing staff across different organisations, and procuring shared digital technology all need a home. In a landscape where the role of the Integrated Care Board (ICB) is contracting to focus on strategic commissioning, these essential back-office and enabling functions cannot be duplicated across dozens of organisations - both from the perspective of excess cost and complexity. Establishing "do once" functions at the right scale - likely at the 'place' or borough level - will be critical to creating an efficient and sustainable foundation for neighbourhood health, regardless of the leadership model chosen.

Learning from international exemplars

A global shift is underway to move healthcare systems away from a reactive, hospital-centric "sick care" model, which is ill-suited to the rising burden of chronic disease, towards a proactive, community-centric paradigm focused on prevention and holistic wellbeing. Insights from leading international exemplars reveal how this transition is being navigated through diverse, yet principled, approaches.

These top-performing nations, while operating different system structures (public insurance, social insurance, and a national health service, respectively), demonstrate that successful transformation is not tied to a single structure but to a shared commitment to universal coverage and strong primary and community care and localised prevention.

Pioneering health systems around the world offer powerful, distilled lessons on the core ingredients of success for an NHS with Neighbourhood Health at its cornerstone. By understanding what makes these models work, leaders in England can accelerate their own transformation journeys.

Model name and description	**Core transferable lessons for neighbourhood teams**	**Neighbourhood archetype model most closely matches**
Primary Health Networks (Australia) Australia is strengthening community care through a federalised system of 31 regional Primary Health Networks (PHNs), which are responsible for assessing local needs and commissioning integrated services. This is complemented by major national reforms in areas like aged care, designed to support people to remain healthy and independent in their own homes for longer.	**The value of devolved commissioning:** giving regional teams the responsibility, resources, and accountability to assess local needs and commission integrated services. This enables neighbourhoods to design care that reflects their population's specific health and social context, while aligning with wider national reforms.	**GP-led:** devolved commissioning and system coordination through primary care collaboratives.

Canterbury (New Zealand) The Canterbury health system in New Zealand is renowned for its successful journey in shifting the focus of care from the hospital to the community, even in the face of a devastating earthquake. The transformation was driven by a powerful, system-wide philosophy of "one system, one budget". Leaders recognised that despite working in different organisations, they were all serving the same population with a finite pool of resources. This mindset was operationalised through two key innovations. First, they scrapped activity-based hospital payments, moving to fixed budgets that incentivised efficiency rather than throughput. Second, they created "HealthPathways" - local, evidence-based care guidelines co-developed by hospital specialists and GPs. These pathways clarify when a patient can be managed in the community and what needs to be done before a hospital referral is made, building trust and a shared clinical language across the system.	**Empower the frontline:** devolve autonomy to skilled professionals to unlock quality and efficiency.	**Acute-led (Integrated Healthcare Organisation):** hospital and community under one capitated system.
Jönköping (Sweden) Sweden's Jönköping region offers a powerful example of cultural transformation. For decades, its system has been driven by continuous quality improvement, famously personified by the 'Esther' model. 'Esther' represents any patient with complex needs, prompting providers across hospital, primary, and social care to collaborate seamlessly by always asking, 'What is best for Esther?'. This patient-centered philosophy, focusing on co-production with patients and cultural change rather than top-down reform, has successfully reduced hospital admissions and readmissions.	**Design every process around the patient's journey:** relentlessly focus on creating a seamless, coordinated experience.	**Community/Mental Health-led:** shared learning culture and collaborative, community-based teams.

Ribera Salud (Spain) The "Alzira model," pioneered by the Ribera Salud group in Valencia, is a radical example of a fully integrated public-private partnership that aligns financial incentives around population health. Under the Alzira model, a single private provider is given a long-term contract and a fixed annual capitation payment for every person living in a defined geographical area. In return, the provider is responsible for delivering the full range of primary, secondary, and specialist care for that entire population. The provider only makes a surplus if it can keep its population healthy and out of expensive hospital settings. This creates a powerful, built-in incentive for prevention, efficiency, and integration. The model is underpinned by a unified digital system that provides a shared patient record across all services.	**Population-based budgets drive prevention:** a capitated budget creates the most powerful incentive to invest in community-based care.	**Acute-led (Integrated Healthcare Organisation):** vertically integrated public-private partnership.
Cityblock Health (US, New York) Cityblock Health is a US-based value-based care provider created to serve Medicaid and low-income populations in urban neighbourhoods. Founded in partnership with Alphabet's Sidewalk Labs, it operates through community "hubs" that combine digital tools, proactive outreach, and personalised care plans to support people with complex medical, behavioural, and social needs. Its model blends in-person community care teams with a digital platform that integrates data across hospitals, primary care, and social services. Cityblock's financial model is risk-based: it receives a capitated payment per member and is rewarded for reducing avoidable hospital use while improving patient outcomes and experience.	**Integrate physical and digital community infrastructure:** build neighbourhood hubs that blend multidisciplinary, in-person support with digital tools for outreach, coordination, and population analytics. Align financial incentives around prevention and holistic wellbeing, not activity.	**GP-led / Community-led hybrid:** strong community teams coordinated through digital infrastructure, similar to neighbourhood PCNs with federated governance.

Buurtzorg (Netherlands) The Netherlands has fostered ground-breaking, bottom-up innovation, most notably the Buurtzorg model of "neighbourhood care." This model empowers small, self-managing teams of nurses to provide holistic, person-centred care, stripping out layers of management and bureaucracy. This was enabled by market-based reforms that created space for such efficient providers to thrive.	**Empower the frontline:** devolve autonomy to skilled professionals to unlock quality and efficiency.	**Community/Mental Health-led:** clinically autonomous community nursing model with light central coordination.
Nuka System (US, Alaska) The Nuka System of Care, created and managed by the Alaska Native people, is a world-leading example of how to design a health system that is truly accountable to the community it serves. The system is founded on the principle of "customer-ownership." The Alaska Native people are not seen as passive recipients of care, but as owners of the health system, with a meaningful role in its governance and design.	**Co-design with your community:** build the system around community values and ensure genuine accountability.	**Community/Mental Health-led:** community-governed, integrated out-of-hospital model.

Summary: Structural change alone won't cut it

Crucially, these international examples show that structural change alone is insufficient. Success hinges on enabling factors like payment models that incentivise value over volume, strategic workforce development, interoperable digital infrastructure, and overcoming deep-seated cultural barriers between different parts of the health and social care system. Furthermore, the transition requires a re-evaluation of success metrics, as effective community care may initially reallocate costs towards more appropriate interventions rather than simply reducing hospital admissions.

Further reading

- Edwards, N. & Lewis, R.Q. (2024) "Integrated neighbourhood teams: lessons from a decade of integration"
- NHS Confederation, "Neighbourhood working in action: case studies showing the breadth of models and approaches to neighbourhood working in England"
- NHS England (2025), "Neighbourhood health - case studies of good practice"
- NHS England (2025), "A neighbourhood health service for London"
- NHS Providers (2025), "Delivering on ambitions for a neighbourhood health service"
- Sansum, J. (2025) "Delivering a neighbourhood health service: what the 10 Year Health Plan means for local integration"
- Reed, S., Oung, C., Lobont, C. and Fisher, R. (2025) "From hospital to community: International lessons on moving care closer to home." Research report, Nuffield Trust

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