NHS Confederation

Resetting the relationship

Towards a social model of health creation and care

Local Trust PPL

April 2025

About us

NHS Confederation

The NHS Confederation is the membership body that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as thekey to improving population health, delivering high-quality care and reducing health inequalitites. For more information visit www.nhsconfed.org

Local Trust

Local Trust is a place-based funder supporting communities to transform and improve their lives and the places in which they live. We believe there is a need to put more power, resources, and decision-making into the hands of communities.

We do this by trusting local people. Our aims are to demonstrate the value of long-term, unconditional, resident-led funding, and to draw on the learning from our work delivering the Big Local programme to promote a wider transformation in the way policy makers, funders and others engage with communities and place. For more information visit www.localtrust.org.uk

PPL

PPL is a social enterprise and B Corp that exists to promote better health, wellbeing and economic outcomes across the UK, working with individuals, communities and the organisations that support them. For more information visit www.ppl.org.uk

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Key points

- Transformative change requires a major reset of relationships across the health and care system – from top-down management to trust-based collaboration – empowering frontline professionals and communities to shape and deliver local solutions that meet local needs.

- To move towards a genuinely preventative model of care, the health service will need to change how power and resources are distributed. That means giving neighbourhoods the tools and resources they need to support citizens to take a proactive approach to their own health. It is at the neighbourhood level that most of the social, economic and medical conditions of good health are to be found and where the most effective interventions can be made.

- This report summarises the findings from a national policy sprint on how the future neighbourhood health service creates the clearest path to better population health. The sprint was hosted by the NHS Confederation in February 2025 in partnership with Local Trust and supported by PPL.

- With a ten-year health plan under development, the policy sprint was a prime opportunity to define what a neighbourhood model of healthcare could look like and to work out how to embed it into the NHS in practice. The sprint's focus was on practical policy solutions and learning from what has worked before.

- Health systems must be reoriented around outcomes, not outputs, with fewer, simpler performance metrics based on population health and inequalities, not just process-driven outputs. Giving frontline teams greater autonomy, funding prevention-focused initiatives, and developing long-term outcome-based goals jointly with communities.

- Success depends on a ruthless consistency in messaging, funding and support from national bodies focused on tackling the greatest levels of need and committing to more radical approaches to change. This should include the development of a Neighbourhood Health Fund that prioritises social infrastructure and working between statutory services and communities to support health creation in the most deprived areas.

- Despite recent cost reductions to integrated care boards and providers there needs to remain a long-term commitment to true subsidiarity – devolving decision-making and resources to neighbourhoods and places – with a particular role for place-based leadership models for driving the collaboration and infrastructure needed for this to thrive.

- A successful shift to a neighbourhood health service depends on investing in the workforce – including training NHS staff in holistic, person-centred approaches; redeploying staff into community-facing roles; and supporting the development of new roles such as link workers, social prescribers and community convenors.

- The ten-year health plan must be bold and ambitious with its plans for a neighbourhood health service, and transformation must start from day one. If not, we risk deepening community mistrust, entrenching inequality, and missing a once-in-a-generation opportunity to build a more resilient, equitable and sustainable model of health and care.

Background

Our current model of healthcare is unsustainable. As Lord Darzi highlighted in his recent investigation into the NHS in England, public satisfaction with the health service is at a record low and there are serious issues affecting almost every aspect of health and care service delivery.[1] Demographic changes and a decade of austerity have driven the NHS into a cycle of short-term fixes and long-term decline, with ever-growing waiting lists and ever-rising inequalities in health.

Staff shortages, overflowing wards and corridor care are immediate challenges and require a swift response. But as the Secretary of State has acknowledged, fixing the NHS will take deep structural change and, in particular, a shift from hospital to community care and a move from a National Health Service to a Neighbourhood Health Service. Without that shift, the health service will stay stuck on a path from crisis to crisis.

In February 2025, the NHS Confederation, PPL and Local Trust brought a group of health system professionals and experts together with community leaders for a two-day policy sprint, to consider how this shift could be made through the ten-year health plan. All agreed that a new neighbourhood-focused model is the way out of the NHS and wider health systems' crisis, because neighbourhoods and communities are where most proactive health initiatives and ideas already happen.

The group's task was to work out what must be done now to turn the promise of a shift from hospital to community care into practice in a way that improves public health, reduces inequality and also helps to reduce pressure on GP and NHS resources over the short, medium and long term.

The policy sprint could not have come at a more opportune time. With a ten-year health plan under development, this was an opportunity to define what a neighbourhood model of healthcare could look like and to work out how to embed it into the NHS in practice. The sprint's focus was on practical policy

solutions and learning from what has worked before. Participants shared ideas for how to reset the relationship with citizens and communities, through better service design, local capacity building and community leadership.

This report summarises participants' conclusions and recommendations, which have become even more relevant and urgent. In March 2025, the government announced that it would dissolve NHS England, that integrated care boards would be required to halve their running costs, and that providers must cut their corporate growth since the pandemic. These decisions will mean less central capacity and a greater need for local systems to stand on their own.

Unless these "fundamental reforms to the British state", as noted by the Prime Minister, translate into better health and wellbeing for British people, they will have failed.[2] If they are to work, they must equip neighbourhoods with the authority, funding and infrastructure they need to respond to local health and care needs.

What is a neighbourhood?

Neighbourhoods vary in size. They range from a few houses to a residential area of 50,000 people and above. People tend to define their own neighbourhood in ways that reflect the local geography and history where they live. For their purposes, public services tend to define neighbourhoods on larger scales, often based on statutory or service boundaries. For example, a primary care network reflecting its constituent GP practices or a district council area within a larger local authority footprint. But this seldom represents a neighbourhood that local communities and residents might identify with.

Building a singular consensus around geographic borders in this context is likely to be an impossible task. Instead, statutory services need to focus on 'thinking neighbourhood' in all they do, including taking time to understand the local population, to engage them in developing insight and data, and in leading on local change. This may mean infrastructure and planning are done at a larger scale, but design must be targeted and driven by local knowledge.

The government's commitment to a neighbourhood health service is hugely welcomed. However, through our policy sprint and working with members across the NHS, we believe 'integrated neighbourhood working' more closely reflects what is happening and should be happening and is better understood across the different sectors that play a core role in the future of healthier communities.

Why a neighbourhood model of care?

It would be easy to mistake the shift the government calls for as a transfer of services from hospitals to GP surgeries. GPs, district nurses and other community-based clinicians play a huge role in keeping local populations well, provided they get the financial security and decision-making power they need.

But medical professionals are only part of the picture, as treating illness is one part of what keeps people healthy. Health and wellbeing are shaped not only in hospitals, surgeries and pharmacies, but at schools and workplaces, in parks and leisure centres, in homes and care homes and on high streets and public transport.

It is at the neighbourhood level that most of the social, economic and medical conditions of good health are to be found. It is at this level where the most effective interventions can be made, such as better sports facilities, social support and air quality.

To move towards a genuinely preventative model of care, the health service will need to change how power and resources are distributed. That means giving neighbourhoods the tools and resources they need to support citizens to take a proactive approach to their own health, whether that means readier access to medical care close to home or offering more help to stay active, eat well and manage addiction.

Some parts of the NHS are already moving in this direction. Participants at the policy sprint pointed to examples in Dorset and Derbyshire, where local integrated care boards (ICBs) are beginning to invest in neighbourhood working to build up local capacity. The successes they have shown what is possible when communities are trusted to lead. Over time, neighbourhood interventions reduce pressure on high-cost acute and urgent services, moving away from a dominant medical and hospital-centred model of healthcare provision.[3]

What needs to change?

One of the biggest problems with the current health and care system is its limited ability to shift focus from short-term fixes to long-term health. Resources are tied up in meeting central performance targets, which often means responding to immediate pressures and firefighting, without being able to plan comprehensively for the future. The government has already taken hugely welcome steps to reduce the number of national priorities to improve patient care, increase productivity and manage budgets effectively, but more can be done.

The NHS's New Public Management (NPM) approach is at the root of this problem. It results in the NHS's performance being assessed through outputs such as appointments, operations and diagnostic tests, rather than on the basis of population health outcomes: how well people feel and how able they are to function. Performance management of short-term outputs crowds out the improvement of longer-term outcomes which is essential to putting the NHS on a more sustainable footing.[4]

Sprint participants repeatedly identified this prioritisation of output metrics over real health outcomes as a major barrier to improving the NHS. It distorts incentives in a variety of ways, including discouraging the delegation of decisions and resources to local areas for fear of being held accountable for targets outside the control of the centre. This hinders frontline workers from operating flexibly in response to the patient in front of them. It also hinders the adoption of innovative practices, which may promise to positively impact population health, but not in a way that would be captured by centralised targets.

Participants also highlighted a mismatch between what the NHS is equipped to provide and what people and communities need. Over the past decade, communities across the country have seen routine disinvestment in the facilities, services and amenities that improve health and address its social determinants: parks, leisure centres, Sure Start centres and so on.[5] This trend

has been most marked in the poorest areas of the country and there is a 19-year gap in healthy life expectancy between England's most and least deprived communities.[6]

The health system is not well equipped to respond. When a small amount of support or resource does become available for community-led initiatives, it often comes with strings attached – non-recurrent, single-year funding that disincentivises local autonomy and innovation. This leads to frustration, disempowerment and in some cases, mistrust. People feel 'done to', without any sense of control or ownership over initiatives to address their own health and wellbeing.

How can we shift towards a neighbourhood-based model?

Shifting to a neighbourhood model of care will mean resetting the relationship between the NHS, wider public sector and communities. The reset needed is from a top-down public management approach to one based on trust, delegated responsibility and consistent funding and support. The aim must be to ignite self-efficacy: giving staff on the frontline and the communities they serve confidence, capacity and power to identify local problems and develop their own solutions.

First, there must be a major shift towards decentralisation – delegation in the NHS and the wider public sector. Public servants at every level must be trusted and supported to act on their knowledge of local needs, and this is especially important for those who work on the frontline. It is vital that they feel empowered to take the actions key to improving population health. Opening up the space for grassroots innovation will help shift resources to the interventions that matter most locally.

Second, trust must be rebuilt between the health service and the communities it serves, by giving citizens a say in the decisions that affect them. This means power sits with communities; where communities are not receiving the care, they should expect to see change. But distrust and alienation have built up over several decades and are now deep-seated:

> "We can't wait until [trust] develops naturally – trust will follow the devolution of resources. This produces the need for a forceful shift of resources down that begins with top-level leadership."
>
> Policy sprint participant

Forging this new relationship will require tough decisions to be made on the redistribution of resources, both within the NHS itself and between the health service and communities, potentially "from acute to prevention; from the public sector to communities". While we can expect resistance to such a radical shift, evidence from areas where pots of flexible local funding already exist indicates that it could have a transformative effect on the nation's health.

One example is the Battersea Alliance, which supports 30 community groups and has helped launch over 20 new local projects focused on early intervention and wellbeing.[7] An independent social return on investment study estimated £5 in social, economic and health benefits for every £1 invested.[8]

In Bradford, a GP-led health and wellbeing service supported patients who frequently attended appointments but had no defined medical need.[9] The GP team identified each person's underlying, unmet issues then drew up a tailored plan of responsive support, often in tandem with local schools and housing providers. Evaluations have shown the scheme has made a positive difference to the health of service users and pressures on local services.

These and countless other examples prove that building trust and shifting power are not secondary to solving the current crisis in NHS demand – they are a major part of the solution. When communities and frontline workers have the autonomy to tailor responses to local challenges, they can intervene earlier and more effectively than a top-down, centralised system ever could. Getting people out of waiting rooms and into community settings helps those who previously felt let down and excluded by formal health provision to feel listened to and cared for. Dealing with problems before they become severe improves patients' health and quality of life and reduces pressures on urgent care service.[10]

Putting neighbourhoods at the heart of healthcare is no minor tweak to NHS governance. It is, as one policy sprint participant noted, "a fundamentally different type of working." For the health service, this requires a "focus not on processes, structures and procedures, but on organisational culture and how the organisation operates." It also requires the NHS to redefine itself as "part of an ecosystem aimed at improving health and wellbeing outcomes, not the only organisation with this aim." These require a dramatic shift in NHS culture.

From participants' discussion of the cultural shift required, the following four elements emerged:

1. More trust

Building a neighbourhood model means giving teams across the system time to build relationships and develop shared approaches in the NHS, local government and the voluntary, community and social enterprise (VCSE) sector.

Attendees at the event shared multiple examples of how they have shifted to embedding relational models of working through investing in support and training for staff to embed different ways of working. While policy can change overnight, embedding this in practice requires high-trust partnerships and understanding of one another, and these take time.

The West Hertfordshire Teaching Hospital has found that basing staff in the community rather than hospitals for two days per week is highly beneficial. Providing additional time and space for GPs, secondary care consultants, project managers and analytical support to meet regularly "as one team" is another way the team has embedded trust and autonomy in the service.

Creating time and space for this kind of change matters. It boosts employee satisfaction and wellbeing, in a context where many staff feel burnt out or that they are failing the communities they serve. This becomes a cycle of failures. High levels of stress and burnout significantly impact trust and productivity in the workplace.[11] Burnout, a state resulting from chronic stress, negatively affects employee performance, creativity and overall wellbeing.[11] This, in turn, erodes trust between colleagues, leading to further declines in productivity.

When staff feel that they have fulfilling and purposeful jobs, creativity, collaboration and shared ambition follow.

2. More consistency

Neighbourhood models have tended in the past to be the brainchildren of exceptional, innovative leaders. When those leaders move on, new ways of working are often abandoned. That undermines confidence and makes it hard to embed new ways of working.

Change needs long-term, consistent funding and messaging, backed up by an organisational commitment to neighbourhood health and care at every level. Without that, new models of care will not be embedded. As one participant put it: "Funding must last long enough to support the change." For many parts of the NHS, this should be seen as 'core business'.

3. Accountability based on outcomes, not outputs

Frontline staff need greater autonomy to respond to the needs of their communities as they see fit. This does not mean removing all NHS targets, many of which are vital to monitor and maintain a high-quality care. It means recognising, as the government has started to do, that heavy-handed performance management and narrow performance metrics often have the effect of constraining rather than improving health outcomes.

Improved population health outcomes and reduced health inequalities should become the key metrics for measuring health services. Funding and other incentives should be aligned to achieving such outcomes, both in the short and long term.[12] Under this system, frontline workers would measure their impact based on the health outcomes of the citizens and communities they serve, as opposed to targets imposed from above.

4. A single shared mission

A shared mission to end health inequality through neighbourhood working would provide staff, citizens and the wider public sector with clarity and an impetus to drive the transition forward. Looking at ways of working and responsibilities that start with collective aims and shared accountability creates

a ‘one team’ approach. But as participants repeatedly emphasised, a shared mission must be backed by shared action to work.

For example, Dorset’s ICB brought people together locally to show them health data for their community, linking it with the social and economic determinants of health. This catalysed a neighbourhood response:

> “When the people were aware that their life expectancy was different from someone else living down the road, that’s when they got angry.”
>
> Policy sprint participant

Where the NHS comes together with the local authority to identify local people’s priorities and where it works with that community to develop a plan to address them, it builds the trust, integration and infrastructure necessary for long-term change.

What would all this look like in practice?

Although a neighbourhood-based model of health and care is decentralised by definition, bringing it into being must be supported by central government and its arm's-length bodies.

Recommendations for central government

1. Strengthen investment in the most deprived neighbourhoods with a Neighbourhood Health Fund

The success of a neighbourhood health service is dependent on the quality of the assets, networks and organisations that exist in neighbourhoods. This is the social infrastructure: the local spaces, groups, organisations and networks that provide people with the capacity and skills they need to act collectively to improve their health and wellbeing.

Yet these are the very things that have been eroded over the past decade, particularly in the most deprived parts of England. Local Trust research shows that social infrastructure is not evenly spread across England.[13] "Doubly deprived neighbourhoods" suffer from the twin disadvantages of low levels of social infrastructure and high levels of deprivation. These neighbourhoods also have some of the worst health outcomes in England, even when compared to similarly deprived neighbourhoods which have a basic level of social infrastructure. Without the provision of community centres, support groups and sports clubs that create and maintain health locally, these areas are unlikely to benefit from the improvements to population health and reduction in demand that a neighbourhood-based health service would bring.

The recent announcement of a 'plan for neighbourhoods', a £1.5 billion programme to invest in 75 areas, is hugely welcome but we need to ensure health and wellbeing is at the heart of this fund.[14] Future investment needs to target hyperlocal community needs and ensure key health and wellbeing outcomes for local people are prioritised.

A Neighbourhood Health Fund would target foundational investment into these communities. Each neighbourhood would identify a key health and wellbeing outcome that local people regard as a priority and which could be improved by community action, with support from the NHS and wider public sector. This 'focus outcome' will be decided on the basis of in-depth community engagement and consultation, alongside qualitative and quantitative data on neighbourhood health. NHS and public sector partners would then support each neighbourhood to develop a holistic plan to address that priority, with particular emphasis on building social infrastructure. Funding would be linked to progress to encourage collaboration and long-term planning.

2. Approach devolution with health in mind

For neighbourhood-based health to work, power and resources must be brought as close as possible to the communities whose health we are seeking to improve. Central government must provide clarity about what devolution within the NHS will look like in the context of recent changes and ensure that it complements local government devolution plans.

The NHS should work with local government to align plans and avoid duplication. Where appropriate, Section 75[15] and Better Care Fund agreements should be used to align decision-making between local authorities, NHS bodies and other providers for funding and commissioning health and social care services (improving integrated commissioning). Given the core role of primary care, section 75 reform will be required to ensure primary care and local authorities can pool budgets with shared health and wellbeing focused goals.

The Better Care Fund was designed to support integrated care at local level. But in practice, many areas report tension between ICBs and councils, as funding is increasingly channelled toward acute pressures rather than long-

term improvement. Resetting this process and these relationships would send an important signal to local government that the neighbourhood health service represents a real shift in focus towards genuinely person and community-centred care.

3. Implement a new model of national planning and regulation

Shifting to a neighbourhood-based health service will take time. The government should develop a set of five-year goals as stepping stones toward the ten-year plan, focusing on improving population health and reducing health inequalities.

These goals should reflect local and national priorities, with input from integrated care systems (ICSs) and their communities. They should align with the four statutory purposes of ICSs:[16]

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

ICBs would be expected to engage with community leaders and organisations to develop these priorities, ensuring they reflect local needs as well as national ambitions. This approach would help ground the UK's national regulation and guidance in its neighbourhoods' realities and aims.

4. Communicate a clear and coherent vision of neighbourhood health

To win public support for the shift to neighbourhood health, we need consistent messaging. The people who work in and who use the NHS all need to understand what is changing and why, recognising work that work is already underway, building on the aspirations set out for neighbourhood working by NHS in the 2025/26 operating guidance.

To that end, the most important thing for the government to convey is that the new neighbourhood health service will combine a core national offer with flexible local responses. Everyone will continue to be guaranteed access to foundational healthcare. But neighbourhoods will also be supported to tailor local services to meet their specific needs, with the overall aim of reducing inequality and improving the social determinants of health.

There will be a need to explain that the shift to neighbourhood working is happening because access to high-quality care is not spread evenly across the country. The poorest neighbourhoods with the least social infrastructure are those which feel most let down and excluded from good health and high-quality care.

Communication approaches will need to be multifaceted, but with the right support, GP leadership within the neighbourhood should play a role in helping citizens (and their registered lists) understand what the change means for them and how local services can support them in a more holistic way.

The neighbourhood health system must be presented as the right solution: shifting resources and capacity within the system to address health inequalities and make sure every citizen and neighbourhood gets access to the right care to live healthier, happier and longer lives.

Recommendations for the NHS and ICBs

A major survey from the NHS Confederation of integrated care system (ICS) leaders has found that while nine in ten are committed to shifting more care out of hospitals, there are widespread concerns that a lack of long-term investment and planning is holding them back.[17] The government estimates that it will take around two years to bring the functions of NHS England back under the control of the Department of Health and Social Care (DHSC). In the meantime, NHS England must lay the groundwork for a neighbourhood health service and ICBs as strategic commissioning:

1. Measure success in outcomes, not outputs

Participants in the policy sprint overwhelmingly agreed that NHS performance management should prioritise population health measures over operational targets. Some core national metrics will still be needed to ensure national-level scrutiny and consistency of care, but the overall approach should be simpler, more flexible and more focused on prevention and early interventions.

Streamlining metrics and aligning them with real-world impact would give local systems the flexibility to experiment, collaborate and learn. As NHS bodies focus on a wider range of population health outcomes, they will be more incentivised to collaborate with communities and other statutory services as they expand their remit beyond clinical care towards health creation and the social determinants of health.

2. Develop devolved, place-based budgets

Since the Health and Care Act in 2022, ICBs have had the power to delegate budgets and functions to place-based partnerships. These bring together a range of relevant bodies, including trusts, GPs, local authorities, the VCSE sector, communities and wider public service providers. But in many areas, these place-based partnerships still lack real decision-making authority.

Making meaningful decisions at a local level means devolving budgets as well as responsibilities. DHSC's 2022 white paper Health and Social Care Integration: Joining Up Care for People, Places and Populations, recommended a place-led model whereby the local authority and ICB would delegate functions and budgets to the board led by a single accountable "place lead".[18] The NHS should accelerate the adoption of a place leadership model, creating local boards to oversee local strategy, hold budgets and coordinate services across NHS units, local government and the voluntary sector. At an even more local level, responsibility for the delivery of services and coordination of holistic care with other organisations would rest with integrated neighbourhood teams operating at smaller spatial scales.

3. Develop capacity and resources for neighbourhood working

For a neighbourhood health service to be successfully implemented, both the staff who deliver it and the communities it serves need to receive support and resources to adapt to their new roles and responsibilities. This will involve:

- **Investing in training and development for NHS staff**

Staff need training in new, person-centred ways of working. This might include training for frontline staff in new person-centred and holistic ways of working, like the programme provided by Barking and Dagenham council to its customer service team.[19] There should also be a commitment to peer learning across every level of the service. Primary care expertise, and particularly GP leadership, will be key to bridging the growing gap between NHS and communities. Targeted training to strengthen the 'neighbourhood' role of GPs and their wider team to drive this work will be essential and help to improve citizens' perception of the NHS.

- **Redeploying NHS staff and invest in community leaders and practitioners to fill community-focused roles**

A neighbourhood health service would require many more community health workers than we currently have. While the long-term ambition of neighbourhood working entails a system where communities are actively involved in decision-making, and a large proportion of NHS staff have a part to play in neighbourhood teams as part of their job description, in the medium term it would require link workers, social prescribers, local area coordinators, conveners and integrators to bridge the gap between the NHS, communities, VCSE and the public sector.

It is essential that these workers are given time to build trust and establish meaningful relationships across neighbourhoods, community groups and organisations. Health organisations already embedded in communities, such as GP practices, will also play a vital role in supporting the growth of neighbourhood health initiatives. Additional Roles Reimbursement Scheme (ARRS) budgets already provide some of the investment to allow for community workers – this should be built on with a focus on outreach.

- **Targeting investment and support at the most disadvantaged communities**

The most disadvantaged neighbourhoods in England, where health inequalities are the most pronounced, often lack the civic assets and community capacity they would need to meaningfully engage with the public sector. In these places, even well-intentioned approaches such as social prescribing, are often unviable, because there are not enough services or activities to refer people to.

Place-based systems must actively invest in community development to build relationships between communities and statutory services and to support local capacity where it is lacking. At place-level, funding streams should be made more readily available to grassroots community groups with simple, straightforward requirements which minimise bureaucratic burdens. Given the strong and growing evidence base linking social capital to improved health and wellbeing, strengthening community infrastructure should be seen as a valuable end in itself.

What now?

The policy sprint produced clear conclusions and practical recommendations. These now need to be tested, refined and rolled out.

To that end, the NHS Confederation and Local Trust have launched an action research programme in six disadvantaged neighbourhoods to trial neighbourhood working models driven and led by communities.[20] The aim is to embed new ways of working and to kickstart more partnerships between communities and the statutory sector that produce tangible improvements to local health. We will share learning from these sites with government, NHS Confederation members and beyond.

At the same time, the NHS Confederation is building a proposal for a 'future operating model' in the context of the changes set out in March 2025. This new model will describe the functions and responsibilities required at each level of the system to deliver the three shifts and move to a neighbourhood health service.

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