

CONFERENCE REPORT

REFLECTIONS ON CARE CLOSER TO HOME CONFERENCE

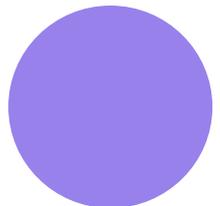
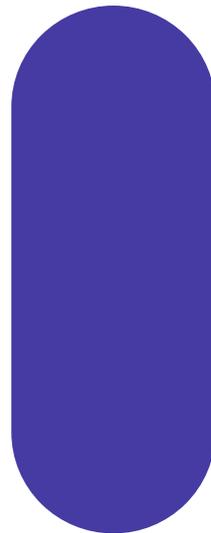
HELD ON

Tuesday 24th February 2026, London



**Primary Care
Network**

Northern Ireland Confederation
for Health and Social Care



Care closer to home: the shift we can no longer postpone

The Care Closer to Home Conference brought timely challenge and reflection for all of us working across primary and community care. The conference brought together around 600 delegates from across the UK, including 10 colleagues from Northern Ireland representing Primary Care Networks, Trusts and the Department of Health.

It posed a central question: are we shaping services around the people we serve, or around the system we inherited?

Lord Victor Adebowale opened with a reminder that, despite 90% of patient contact occurring in primary and community care, the wider system continues to invest its weight and visibility in acute settings. As he put it, “we built an illness system and called it a health system”, a statement that lands with particular resonance in Northern Ireland.

Lord Victor Adebowale
Chair, NHS Confederation



Creating the conditions for neighbourhood models to succeed

A consistent thread running through the conference was that neighbourhood working cannot rely, in Lord Victor's words, on "goodwill alone". While goodwill is abundant across primary care, integration will only succeed if it is intentionally designed and properly supported.

Neighbourhood hubs must be shaped by the communities they serve. As was said on the day, "they should never look the same." Local leadership, geography, existing relationships and community strengths all influence what will work. A one-size-fits-all model risks overlooking the very factors that make neighbourhood care meaningful. Integration also depends on time and clarity.

Teams cannot simply be asked to "work differently" without the space to build trust and without clear workplans that set out shared priorities and responsibilities. Relationships take time. Alignment takes time. If we want collaboration to be real and sustainable, that time must be recognised as part of the work, not an optional extra.

And there was a powerful reminder that “buildings can enable care... or divide it.” Estate is not neutral. The way space is configured either brings professionals together or reinforces separation. Thoughtful design can foster shared problem-solving and informal connection; poor design can entrench silos. Taken together, these reflections point to something important: neighbourhood working will not emerge simply because structures or policies change. It requires the right conditions, clarity, time, trust, leadership, and supportive infrastructure. If Northern Ireland is to progress meaningfully toward neighbourhood-level care, those foundations will matter just as much as the formal frameworks.

“
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”



Community partnership: essential, not optional

Speakers across the conference stressed the central role of communities and voluntary organisations. One comment captured the challenge starkly: “people feel consulted to death but struggle to see how their voice shaped decisions”. This is not criticism of intention; it is a reminder that engagement must be sequenced with transparency and feedback. Community involvement should be continuous and visible, grounded in the recognition that “the community is a co-producer of health, not a recipient of care”.

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For Northern Ireland, where the voluntary and community sector is both strong and stretched, this point is especially relevant.

Data, outcomes and what the system chooses to value

One of the most thought-provoking reminders from the conference was: “if we don’t change what we measure, we cannot change what we do”. Performance frameworks heavily shaped by acute activity inadvertently pull focus and resource away from prevention and community-based support.



Other sessions reinforced that:

- neighbourhood teams need shared data to identify risk early and support those most at risk of deterioration
- long-term funding arrangements are necessary to stabilise and mature neighbourhood models, not just initiate them
- clarity on outcomes, those that matter to people and communities, should guide collective effort
- Without alignment of measures, investment and priorities, system redesign will remain slow and inconsistent.

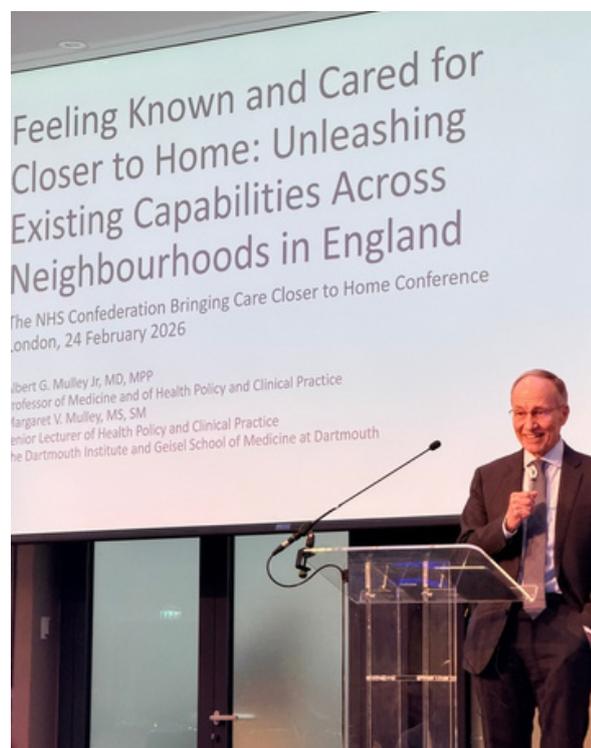
Leadership, alignment and the opportunity for Northern Ireland

Throughout the event, speakers returned to leadership, not in a hierarchical sense, but as a collective responsibility. The comment that “the NHS is crying out for leadership, not management” was offered as an invitation, not a criticism. Perhaps the most resonant challenge came from the neighbourhood integration discussions: “alignment is key, and everyone must be held to account for it”.

For Northern Ireland, this means:

- aligning ambition with resource
- aligning neighbourhood working with estate, workforce and data strategies
- aligning system priorities with what matters most to people
- aligning communities as partners, not consultees
- all of this must be done respectfully, collaboratively and with awareness of the pressures facing every part of the HSC system.

“ **reassuring to see that many of our challenges are not unique to Northern Ireland** ”
~Dr Lloyd Gilpin



Moving Forward as NIPCN

The conference left us with a clear and energising message: care closer to home is not simply a programme of work, it represents a significant system shift. Here in Northern Ireland, neighbourhood working is still in development, but the direction of travel is clear. This is a formative moment. It calls for courage, coordination, and above all, trust.



As NIPCN, we remain deeply committed to:

- supporting the thoughtful development of locally-led neighbourhood models, shaped around the needs and strengths of our communities
- strengthening meaningful partnerships with the community and voluntary sector from the outset
- championing continuity of care, recognising that sustained therapeutic relationships aren't a "soft" aspiration, but a clinical intervention in their own right
- encouraging alignment and mutual respect across all four pillars of primary care, even where historic contractual arrangements or structural barriers can make collaboration challenging
- keeping the person, as Lord Victor so powerfully reminded us, "in the room in every decision", at the centre of system design and improvement

Continuity deserves particular emphasis as this development work progresses. The evidence base is compelling. Strong relational continuity in general practice has been associated with reduced emergency admissions, fewer avoidable hospital attendances, improved medication adherence, earlier cancer diagnosis, and, most importantly, lower mortality. International studies have demonstrated that patients who experience consistent care from a known GP are less likely to die prematurely. That is not a marginal gain; that is lives saved.

Beyond measurable outcomes, continuity improves safety by reducing fragmentation and duplication. It enables earlier recognition of subtle change in frailty, mental health, safeguarding, and long-term conditions. It supports prevention because conversations deepen over time. It strengthens shared decision-making because trust already exists. And it sustains clinicians, anchoring professional purpose in relationships rather than transactions.

In a time of increasing multimorbidity and complexity, being known, and knowing, matters profoundly. As neighbourhood models are shaped, continuity must not be an unintended casualty of redesign. It should instead be deliberately protected and strengthened as one of primary care's greatest assets.

Equally, if neighbourhood development is to succeed, all four pillars of primary care will need to learn to work together in new ways. Contracts may differ. Pressures certainly vary. Historical silos exist. But the needs of patients do not recognise those boundaries. The opportunity now is to design collaboration intentionally, building shared purpose early, creating mechanisms for joint working, and recognising that collective impact will always exceed isolated effort.

Dr Lloyd Gilpin, Chair of Eastern FSU attended the conference as a member of the NIPCN management committee and reflected that "It was a very positive conference and particularly helpful in seeing General Practice in the wider context of working together with other professional colleagues to provide patient care and that "Delivery at scale is suitable and appropriate for some aspects of care but requires stable practices as the foundation"

The opportunity before us is real. So too is the need for collective, evidence-informed, thoughtful leadership, leadership that is ambitious yet sensitive, developmental rather than imposed.

We look forward to continuing this work together: constructively, pragmatically, and with genuine shared purpose as neighbourhoods take shape.

~Dr Siobhan McEntee