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Date: 05/03/2026

Dear Member

ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE - WEDNESDAY, 11 MARCH 2026

Please find enclosed the paper for agenda item 9 – Neighbourhood Health- for consideration at the meeting on Wednesday 11 March 2026. This report was not available when the main agenda was published.

Agenda Item No
9 **Neighbourhood Health (Pages 1 - 22)**

Yours sincerely

Benjamin Watts
Deputy Chief Executive

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From:	Diane Morton, Cabinet Member for Adult Social Care and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Adult Social Care and Public Health Cabinet Committee – 11 March 2026
Subject:	Neighbourhood Health and Kent County Council
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None

Summary

1. The purpose of this paper is to **inform, advise and promote discussion** as to how we corporately best respond to the opportunities and challenges arising from the NHS adoption of a Neighbourhood Health approach. Key to this will be consideration of Actions the Council may wish to undertake with a view to both improving the health and wellbeing of the people of Kent and supporting financial sustainability through delivery of the Prevention Framework.
2. The NHS Ten Year Plan fundamentally requires three shifts: hospital to community, treatment to prevention and analogue to digital. The Neighbourhood Health approach is central to the plan, espousing a local joined up and holistic approach to improving health. While there is little new in this approach, the NHS believe a clear focus supported by pilots and a shift of resources will enable delivery at scale and will yield health benefits. Moreover, there is a sense that the current model is ineffective and unsustainable, failing to deliver the health outcomes we wish to see.
3. There are however short-term challenges that will limit this ambition. The NHS must deliver challenging waiting time targets in hospitals as well as manage resource constraints. Firstly, this will limit the opportunity to shift resources from hospital to community. Secondly, the pressure around capacity and sustainability in acute hospitals means that the first priority for Neighbourhood Health will be to reduce hospital admission and bed use.
4. Positively, there is much overlap (but some difference) between targeted interventions that will reduce hospital admissions with those that will reduce the need for residential care. There are benefits in the Council supporting and aligning with NHS colleagues in areas where such win-wins are likely.

Additionally, there are opportunities to better engage with the wider NHS around prevention, which will help us achieve health improvement goals.

5 The model being developed in Kent is broadly in line with others nationally. There is a focus on those at highest risk of admission with both proactive support to prevent deterioration and acute community interventions to provide an alternative to acute admissions. East Kent hosts a national pilot site. An Integrated Care Board (ICB) wide Clinical Reference Group has defined target group, interventions and model of care and a Neighbourhood Health Programme Board, with wide membership, will oversee all work in this area.

6 The approach proposed in this paper has been discussed at, and agreed corporately. An internal officer group is being established to coordinate action by council officers, ensuring appropriate input and representation at key system partner groups that are delivering Neighbourhood Health.

Recommendations

The Adult Social Care and Public Health Cabinet Committee is asked to NOTE the report and COMMENT on the outlined approach.

1 Introduction

1.1 This paper discusses the range of definitions of Neighbourhood Health and what it might embrace. It considers what the expectations of the NHS Plan are in the short to medium term as a narrower focus where priority will be avoiding bed days.

1.2 It considers how this rests with wider NHS challenges as well as the challenges faced by Kent County Council around the Prevention Framework and system sustainability.

1.3 The paper then details thinking and progress within the Kent and Medway ICB including models and interventions and the Neighbourhood pilot in East Kent. Crucially it considers the opportunities to Kent County Council and how we might wish to engage and respond.

2 Definition and Description.

2.1 The King's Fund[1] helpfully describe Neighbourhood Health as encompassing many different ideas, policies and approaches to delivering health and social care. These include:

- Integration
- Prevention

[1] What Is Neighbourhood Health? | The King's Fund

- Personalised care
- Care delivered closer to home.
- Community-led approaches to care
- Place-based care.

2.2 From this it can be seen that the King's Fund recognise a broad definition of what Neighbourhood Health could include and that none of these approaches per se is a departure from current advocated practice. They further suggest a broad overlapping three-part typology where Neighbourhood Health includes: -

- The way health care services are delivered to patients.
- The way wider services come together at local levels to improve health and wellbeing.
- The way communities play central roles in the design and delivery of services**.**

2.3 While the above represents a comprehensive and considered view of Neighbourhood Health, the Policy background against which this needs to be considered tends to drive thinking towards a more restricted approach driven by challenges to NHS sustainability, if current models persist. This pragmatic approach is reflected in recent NHS documents.

2.4 Ahead of the publication of the 10 Year Health Plan[2], to accompany the 2025/26 NHS planning guidance.

2.5 The guidelines outline six core components of neighbourhood health:

- Integrated teams for people with complex needs
- Urgent community response and virtual wards
- Improved access to general practice
- Continuity of care for those who need it most.
- Strengthened core community services.
- Better use of population health data and digital tools

2.6 Although none of these components are entirely new, the guidelines aimed to bring them together under a single vision for neighbourhood working. They also reinforced the idea that neighbourhood health is not just about clinical care; it is about connecting people to wider public services and community support to address the broader factors that affect health, such as housing, employment and social isolation.

2.7 However, the guidelines suggested that this way of working should be considered a mid- to long-term goal, as opposed to a short-term priority. The immediate focus on the urgent health care needs of 'high priority cohorts' (people who have moderate to severe frailty, people living in a care home,

[2] NHS England published its neighbourhood health guidelines

people who are housebound or at the end of life) was reiterated in the medium term planning guidance published in October 2025. A Model Neighbourhood Framework was expected to be published in November 2025 but is still awaited.

2.8 The 10 Year Health Plan for England[3], published in July 2025, sets out a long-term vision for transforming the NHS, with neighbourhood health playing a central role in its delivery. The plan is structured around three major system shifts, all of which neighbourhood health can help to deliver:

- From hospitals to communities
- From analogue to digital
- From treatment to prevention

2.9 The Plan went on to describe proposed local NHS structures to deliver Neighbourhood Health Services:

- **Integrated neighbourhood teams:** multidisciplinary teams that typically serve populations of 30,000 to 50,000 people, aligned with primary care networks (PCNs). They bring together professionals from across health, social care and the Voluntary Community and Social Enterprise (VCSE) sector. They are designed to support people with complex needs through proactive, co-ordinated care; to deliver urgent community-based services, such as hospital-at-home and virtual wards; to strengthen continuity of care; to improve access to general practice; and to use population health data to identify and support people at risk earlier. These teams already exist but there is not universal coverage. Additionally, the teams will identify as unified local teams with clear leadership and local accountability.

- **Neighbourhood health centres**: multi-service facilities that bring together services from across health, social care and the VCSE sector. They are intended to co-locate services that are often fragmented, making it easier for people to get the help they need without navigating multiple systems or locations. Again, neighbourhood health centres are not new. They will additionally however, be digitally enabled to shift from analogue models to promote citizen activation and self-help.

- **Community health and wellbeing workers (CHWWs):** these are non - clinical community-based staff working closely with people and families supporting households to manage their own health and wellbeing, and connecting them to local services such as housing, employment and social support. CHWWs are recruited from the communities they serve, which helps to build trust and cultural understanding acting as trusted

[3] The 10 Year Health Plan for England

links between communities and the wider health and care system. CHWWs are expected to be embedded within integrated neighbourhood teams. The prominence of CHWWs follows the success of Brazil's community health agent programme[4]. and the success of social prescribers. The inclusion of CHWWs in primary care teams is now being piloted in 25 locations in England.

2.10 Delivery will be supported by the introduction of two neighbourhood provider contracts, set to roll out from 2026. The **single neighbourhood provider** contract maps onto the primary care network (PCN) population footprint of 30,000-50,000, while the second type, '**multi-neighbourhood provider'** contracts, will be used to cover populations of 250,000 or more. The ambition here is to unlock new benefits of scale through joined up back offices, data analytics and quality improvement infrastructure. Multi-neighbourhood teams will need to be able to deliver an urgent response seven days a week, and out of hours, and run urgent care centres.

2.11 The **National Neighbourhood Health Implementation Programme (NNHIP)** is the implementation arm of the neighbourhood health vision. It is a large-scale change programme launched by the Department of Health and Social Care (DHSC) and NHS England to accelerate the rollout of neighbourhood health services.

2.12 In September 2025, DHSC announced the 43 local areas selected as the NNHIP wave 1 test sites[5]. They vary greatly in size and approach to delivering neighbourhood health. The pilot in East Kent is discussed below.

2.13 Test sites will not receive any additional funding but will be supported through coaching, expert guidance and collaborative learning The sites will build on existing good practice in their area to deliver a neighbourhood health service, initially focusing on supporting people with long-term conditions such as diabetes, arthritis or epilepsy, and in areas with the highest levels of deprivation.

2.14 The NHS Plan discusses the role of Health and Wellbeing Boards in this work. It raises concerns around the complexity of current governance systems for partnership working proposing that in the future, a neighbourhood health plan will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. The ICB will bring together these local neighbourhood health plans into a population health improvement plan for their footprint and use it to inform commissioning decisions. As a result, and to create clarity, it is proposed that Integrated Care Partnerships are abolished.

[4] Community Health Agent Programme, Brazil | Nesta
[5] 43 local areas selected as the NNHIP wave 1 test sites.

3. Local Action around Neighbourhood Health

3.1 The Primary Care Strategy for NHS Kent and Medway and our own Integrated Care Strategy aim to improve population outcomes at a local level and equitably improve access and experience for the people who require our care and support. The strategies describe how we will implement integrated teams to empower those with multiple or long-term conditions to help reduce or delay escalation of their needs. Ambitions align with the concept of Neighbourhood Health and the six core components outlined above.

3.2 Work on developing Integrated Neighbourhood Teams across the HCPs has commenced, but needs further strengthening across all partners, united by a common vision, design principles, outcomes and enablers. To that effect, the **Neighbourhood Health Programme Board** has been established which has membership from the Integrated Care Board, local government and system partners.

3.3 The Neighbourhood Health Programme Board in Kent and Medway will oversee the planning, implementation, and evaluation of neighbourhood health care initiatives to inform our commissioning decisions. The Board aims to improve health outcomes, enhance patient experience, and ensure the efficient use of resources. The main purpose of the board will be to provide collective leadership in progressing the development of the neighbourhood teams with a focus on local delivery.

3.4 Core Membership will include:

- NHS Kent and Medway
- Medway Council
- Kent County Council
- Kent & Medway Mental Health (KMMH)
- Kent Community Health Foundation Trust (KCHFT)
- Health & Care Partnerships
- Kent Local Medical Committee
- SeCAmb
- Voluntary Sector
- National Neighbourhood Health Implementation Programme Representatives

3.5 There are additionally supporting/subgroups such as Digital Neighbourhoods which are bringing health and social care together to explore integrated digital opportunities.

3.6 It has been agreed that pragmatically, Single Neighbourhood Teams in Kent and Medway be mapped to the existing 45 PCNs (Primary Care Networks). While most PCN footprints make geographical sense, around 11% do not align

well with geography. It is planned to address this over time, KCC Children services already map well to PCNs.

3.7 The final geography for the Multi-Neighbourhood Teams has not yet been finalized. There will likely be 9 or 10 and they will be developed with reference to both existing district councils and potential LGR structures. Services will be developed around these geographies.

3.8 Linked to this, work is at an early stage around estate considerations while the NHS is under some local and national political pressure to identify potential sites for Neighbourhood Health Centres. The first step will be to develop principles around siting, with a notional map informed by existing estate.

3.9 The ICB have developed a **clinical reference group** to define the right models and interventions that will be delivered in Kent and Medway. A Workshop was held to develop consensus on:

- How proactive, routine, and reactive care should be delivered.
- The population/footprint this should cover.
- The delivery teams responsible

3.10 While delivery models will vary locally, based on population need, the overarching clinical framework will be universal across Kent & Medway.

3.11 High risk groups in Kent are being identified using the concept of Patient Need Groups (PNGs) to identify those people with the highest need for health care. Initial focus will largely be on those at greatest need, i.e. PNG 10 and 11 who account for around 5% of the population. Around 2% of these will be care home residents or receiving end of life care. The further 3% will be frail and complex patients in the community.

3.11 It is explicitly recognised that more work will need to be done over time around the model for people with mental health issues as well as for children and young people. There is however, in line with NHS guidance, and expectation that initial focus and progress is around those groups that have the highest need for acute hospital inpatient care.

3.12 The framework model has **two key elements**:

- A **Proactive Service** focussing on patients at high risk of deterioration and needing complex and hospital care.
- An **Acute Care service** that will respond rapidly to provide an alternative to hospital admission in the acute phase

3.13 Additionally, in parallel to this work, local interests are considering the best model for **children in neighbourhood health** with considerations of the model developed in Imperial College.

3.14 Thinking further considers what initiatives will be delivered at Practice, Single Neighbourhood and Muti-Neighbourhood level.

3.15 Work is also underway on agreeing how success will be measured. Draft top line strategic outcome measures have been developed and are shown below.

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Neighbourhood Health Outcomes

NHS Kent and Medway

Neighbourhood Health and Care Strategic Outcome Domains			
Staff Activation and Productivity	**Patient Activation**	**Improving population health and wellbeing**	**Demand Management/ Reducing Costs**
Truly integrated teams and care delivered in right place by right service, leading to higher levels of staff satisfaction and engagement.  *Example outcome: improvement/high staff satisfaction*	*Patients engaged in health and self-management of care/ preventative care.*  *Example outcome: Improvement in self-management of LTCs*	*Improved health for most complex patients and wider populations. Reduced variation in outcomes across the geography.*  *Example outcomes: Increase in PROMs and PREMs, People dying in preferred place*	*Appropriate activity and spend across the system. Improved flow across the system.*  *Example outcomes: Reduction in unplanned admissions/ Cost per capita for healthcare*

These are in alignment with the Pioneer Site key outcomes below:

Key Outcomes

- increase in patient-reported outcomes (**PROMs**) and patient-reported measures (**PREMs**)
- increase in **people's activation** (confidence, skills, knowledge) to manage their long-term conditions
- improvement in **staff experience**
- reduction in **outpatient activity**
- reduction in **unplanned hospital admissions and Loss**

**In line with those received by NAPC*

Discussion/Agreement:
Do the themes within the strategic outcome domains appropriately reflect the key areas of neighbourhood health that we aim to measure? Are there any gaps or aspects that need further development or refinement before defining metrics?

Together, we can

Suggested Supportive Overarching Metrics

NHS

Domain	Suggested Outcome	Associated Metric	Current Level	Source	Frequency (Latest Data)	Comments
Staff Activation & Productivity	*Improvement in/high staff satisfaction*	I would recommend my organisation as a place to work - % Agree/Strongly Agree	59.24% KMICS	NHS Staff Survey	Annual (2024)	Need to understand if able to identify neighbourhood team staff from survey
Patient Activation	*Improvement in self- mgt of LTCs*	& confident/very confident in ability to manage any issues caused by conditions/illnesses	78% KM ICS	GP Patient Survey	Annual (2025)	Allows for national benchmarking
Improving Population Health & Wellbeing	*Example outcomes: Increase in PROMs and PREMs, People dying in preferred place*	% Positivity Friends and Family Test (e.g. Community/ Mental Health/ Inpatient/ Outpatient/AE)	97% Comm 88% MH 94% IP 95% OP 80% AE	FFT Analysis Site	Monthly (Aug 25)	Allows for national benchmarking and system/ more granular data
		% Deaths at Home	28.5% KM 28.4% England	Fingertips (Gov PHE Source)	Annual (latest data 2023)	National data so useable for benchmarking
		% dying in a KM Hospital who had chosen not to die in a hospital	1.5%	KMCR Ageing Well Dashboard	Live Data (13/11)	Locally held data from KMCR (not used for benchmarking outside of KM)
Demand Management and Costs	Reduction in unplanned admissions/ Cost per capita for healthcare	NEL admissions per 1,000 Population	8.33	KM BI Data Acute Activity	Monthly (Sep 25)	ACG Dashboard also available for this split by PNG
		Outpatient Activity per 1,000 Population	145.54	KM BI Data Acute Activity (SUS)	Monthly (Sep 25)	
		Cost Per Capita for Healthcare	TBC	ICB Finance	TBC	Being progressed currently

3.16. As with elsewhere in the country, the issue around funding these developments has not been resolved. There is a recognition that shift from hospital to community will be limited unless resources align with this shift and this is

problematic given the increasing financial and operational pressures on acute trusts including delivery of waiting time targets. This may limit large scale development locally.

3.17 KCC Public Health have developed a JSNA cohort model that might add value to understanding intervention impacts. This system dynamics model helps us understand how behavioural risk factors influence population health over time combining local population projections with epidemiological evidence on disease incidence and the impact of behavioural risks to estimate future life expectancy and the prevalence of long-term conditions.

3.18 The model covers a range of long-term conditions, including asthma, Chronic obstructive pulmonary disease (COPD), coronary heart disease, stroke, diabetes, heart failure, dementia, learning disability, severe mental illness, and neurological conditions.

3.19 Outputs relate to the whole population, not just those directly receiving an intervention, supporting a system wide perspective.

3.20 Beyond its forecasting capability, the model provides wider benefits by encouraging rigorous consideration of the underlying evidence base, identifying gaps in knowledge, and supporting structured engagement with subject matter experts to refine assumptions, sense check results, and prioritise future development.

3.21 The work the NHS is undertaking is against a backdrop of structural organisational change. This includes a shift in the role of ICBs towards commissioning and away from performance management. This is involving a degree of downsizing and the new structure of the ICB has been published. The ICB will lead on strategic commissioning as well as a potentially more nuanced role in commissioning of local acute services given proposed shifts of contracting model away from simple block contracts to a more activity driven model.

3.22 The current Health and Care Partnership (HCP) model, where local teams delivering commissioning are based around geographical footprints, in part driven by acute hospital catchments, is to end. Local commissioning, with a key focus on Neighbourhood Health will be led by a single new provider organisation, likely nested in an existing trust. Discussions are ongoing to consider how this new function will align with local populations.

4 Proposed Delivery Model for Kent and Medway

4.1 **Neighbourhood Health and Care Service (Proactive Care)** The focus for this work is on people who are living in Community and those who are living in Residential Facilities. While there are benefits to action in both in preventing hospital admissions, and indeed there are opportunities to work with care

homes to prevent unnecessary hospital admissions, gains to social care in terms of potential savings will be limited where the focus of endeavours is on people who are already in residential care.

4.2 Proposed Interventions that the service will deliver include:

- CGA (Comprehensive Geriatric Assessment)
- ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)
- DNACPR (Do not attempt cardiopulmonary resuscitation)
- Structured Medication Review
- Palliative Care
- Care Plan
- Expert patient group
- Self-Management

4.3 There is a strong evidence base behind the use of CGA showing reductions in admissions to hospital and residential care. Similarly, medication reviews are an effective component of CGA and of value in themselves.

4.4 The use of ReSPECT and DNACPR, often linked with palliative care, will prevent the unhelpful and unnecessary admission of patients to hospital were this has already agreed to be an inappropriate course of action.

4.5 THEW PCN (Total Health Excellence) PCN results using this approach to date look impressive citing A&E visits being reduced by 86%, Emergency admissions being reduced by 97%, Unplanned bed days reduced by 83% and Unplanned GP appointments reduced by 81%.

4.6 It is important however to better understand the methodology used in assessing local effectiveness as “before and after” measures in the same patients naturally show large changes.

4.7 **Neighbourhood Proactive Health and Care Service (Acute Care)** This element is linked to the approach above and will include many of the same interventions. It will build on existing services that are helping people to stay in their homes including the Rapid Home Visiting Service, Frailty Team, Care Home Team, Remote Monitoring and the Hospital at Home Team.

4.8 Central to it is a proposed Single Neighbourhood Access Point (SNAP). Patients with acute needs will be assessed and appropriately managed. Options will include ongoing support and monitoring for those who are stable, complex community interventions in the home in those requiring active treatment including IV therapy and night sitting, end of life care where required and the opportunity for escalation to Urgent Treatment Centre and admission if required.

4.9 For children registered with a GP practice, a hub model, such as that employed in Imperial College, brings more specialist expertise on child health within easy reach. Paediatric consultants from the local hospital join GPs and work together to care for children in their area.

4.10 The Child Health GP Hub model includes three different innovations:

- GPs have open access to children's health specialists at the acute hospital, with a phone line and email for advice.
- Child health GP Hub (specialist outreach clinics and multidisciplinary meetings with GP hubs every few weeks)
- Building relationships and working with champions in the community to improve the health of local populations

4.11 The East Kent application (serving the Folkestone area) was successful in becoming a **National Neighbourhood Health pilot site**. This allows access to support and a network of similar sites nationally but does not attract funding. It also does not exclude progressing local models elsewhere within the system.

4.12 The Kent, Surrey and Sussex Health Innovation Network (HIN) have given their support to help evaluate the impact of the pilot and share learning via the neighbourhood health programme board.

4.13 The pilot will test and operationalise the clinical model discussed above with focus on the high need groups.

4.14 The pilot area is co-terminus with the Folkestone and Hythe District Council area. It includes 113,000 residents living in rural, urban and coastal areas, including Romney Marsh. It supports the creation of a 'super neighbourhood team' serving up to 250,000 people, with potential to scale across the broader east Kent partnership (population 740,000).

4.15 The Pilot seeks to develop Integrated Neighbourhood Teams that will bring together everyone who cares for, or supports, a community, including staff from the NHS, Social Care and the voluntary sector, with collective responsibility and a focus on holistic, person centered care. Part of this is also looking at the community roles such as social prescribers, community navigation to reduce duplication and confusion for people. A single leadership team is planned drawn from Primary Care, Community Physical Health, Community Mental Health and the Local Authority with public health, social care and the voluntary sector teams who will join in different ways depending on local need.

4.16 District Health Alliances (DHAs) may be well placed to bring a local system strategic response to some challenges that may be faced by INTs. DHAs are comprised of representatives from local authorities, public health, NHS, VCSE and others. Their focus is on health inequalities and the wider determinants of health and maximising collaborative working across their membership. Of note

is that some DHAs are currently running pilots in their areas of highest need to coproduce upstream solutions to prevent ill health. There is likely to be a natural fit for some of these initiatives to be informed by the work of the relevant INTs. (Integrated Neighbourhood Teams.

4.17 Health Alliances however in general have a focus on areas rather than individuals. It is likely, at least in the short term that Neighbourhood Health will focus on identified individuals. There are also potentially differences in footprint and focus on coalface delivery that may make links suboptimal at present. As, when and if Neighbourhood Health embraces the wider definitions, then the opportunities for win wins with Health Alliances will increase.

4.18 We should however explore opportunities in the short term. DC colleagues would wish to see stronger and ongoing health links to support people with health and mental health issues to maintain housing tenure. Neighbourhood Health may help progress in this area.

4.19 Adult Social Care (ASC) are strongly involved in the East Kent pilot and are a key part of the Steering Group. ASC have been involved in actions around the analysis of the highest risk groups (PNG 10 and 11) as well as operational links into the INTs. Additionally, partners are working together on a social prescribing approach with digital platforms and community roles that support prevention. Work is required to understand the impact of social care interventions in preventing health admissions as well as the impact of health interventions on the need for social care.

4.20 The Pilot Steering Group has set up three workstreams aligned to each of the PCNs and a fourth Health Alliance focussed workstream. The Total Health Excellence (THE) West PCN is exploring the opportunities to enhance social care input, identified via CGA, to the proactive care of People in the highest need groups (PCN 10 and 11).

4.21 The Pilot wish to work with public health to understand the potential for proactive PH commissioned interventions e.g. around physical activity to impact on the need for admissions.

5. Challenges

5.1 Members will wish to understand some of the potential challenges in delivering effective neighbourhood health.

5.2 While much is written around the opportunity in tackling the wider determinants of health, pragmatically, as described in the 10 Year Health Plan, neighbourhood health policy has been deliberately designed to focus first on populations with multiple and complex needs.

5.3 By starting with those who have the **most complex needs**, the policy seeks to demonstrate the value of joined-up working, reduce avoidable hospital use, and

improve quality of life, while laying the foundations for broader transformation across the health and care system.

5.4 There are clear challenges to the **sustainability of current models** of health and social care driven by population demographics, notably ageing of the population and the increased effectiveness and complexity of clinical interventions.

5.5 However, there have also been questions around falling **productivity** within the NHS, and especially acute trusts, with increasing financial challenges. It is likely that even if optimally delivered, the Neighbourhood Health Model will only provide a partial, and possibly lesser solution to sustainability challenges alongside required improved productivity.

5.6 The 10 Year Plan recognises that the need to shift from hospital to community requires a concomitant shift in resources. Conversely, acute trusts are facing a highly challenging financial position with a need to deliver clear **improvements in waiting times** across emergency, elective and cancer care. It is of central importance to the government that the NHS delivers on waiting time targets. This requires full utilisation of resources and capacity making any meaningful shift of resources away from acute hospitals potentially problematic.

5.7 Nonetheless, trusts including those in Kent, are increasingly embracing their role as system leaders and anchors as well as exploring their contribution to tackling inequalities and enabling prevention.

5.8 There is much consideration around **how to best target neighbourhood health interventions** and what those interventions might be. Models tend to try and predict future need using historic health service utilisation and current pathology. The John Hopkins model[6] looks at 11 Patient Need Groups (PNGs) and has been embraced by a number of systems including Kent and Medway. The local population can be divided up according to need and can then be targeted.

5.9 A key issue is the **degree to which the models are truly predictive of future need.** Many of the people in the most severely morbid groups will be very unwell and many succumb over the coming months; others may be more fortunate and improve to the extent they no longer need services. In either event it is often only a small proportion of those identified as at highest risk who do actually present over subsequent years.

5.10 A second issue is the **difference between identifying who has a high need and who will benefit from interventions**. This is often especially true of those with the very highest needs. In the work Kaiser Permanente undertook on

[6] Johns-Hopkins-ACG-System_v13.0_PNG-Overview-v080322.pdf

preventing readmissions, the offered interventions where not effective in those at greatest risk of readmission[7].

5.11 There is a **potential that systems embrace poor quality, biased, non- peer reviewed evaluations of local schemes** without due scrutiny. There are many existing areas with well publicised claims of success in preventing admissions. These are often counter intuitive given the nature of offered interventions and suggest gains that far exceed the often-modest improvements seen in well conducted and peer reviewed randomised controlled trials. It is highly likely some simple interventions will reduce admissions, for example where these are a matter of applying sound process e.g. use of the ReSPECT tool and these should be appropriately used. ASC may wish to consider how well they use the document.

5.12 There have been useful reviews of what interventions in integrated care reduce hospital activity for patients with chronic diseases[8] which are much more measured around what is possible and are clear around what sort of patients are likely to benefit.

5.13 Nonetheless, in some areas models have been in place long enough and at sufficient scale to look at **population wide impacts**. This is important as the population being considered is the whole geography rather than a selected group and a neighbour population over the same time period can be used as a control group. Early examination, not subject to peer review, of data from Birmingham has suggested their neighbourhood health model has had substantial impact on admissions.

6. Opportunities

6.1 This section outlines to Cabinet Committee what KCC can best do in this space both to support the NHS in their endeavours and to deliver prevention more widely to the people of Kent with a focus on ASC and public health outcomes including avoidance of residential care admissions and spend.

6.2 While caution is required, alongside careful interpretation around what evidence says around the benefits of integrated care in preventing hospital admissions, there are a number of opportunities that should be realised.

6.3 While the Neighbourhood Health approach as outlines in the NHS plan focusses on potential gains for the NHS, it fits well with KCC ambition around preventing the need for adult social care as described in the Prevention Framework. While published evidence is quite nuanced in terms of specific

[7] Evaluation of an intervention targeted with predictive analytics to prevent readmissions in an integrated health system: observational study | The BMJ
[8] Does integrated care reduce hospital activity for patients with chronic diseases? An umbrella review of systematic reviews | BMJ Open

outcomes, and the evidence around what prevents residential care admissions differs in detail from what prevents hospital admissions, there is considerable overlap and opportunities where interventions can yield savings to both the NHS and Adult Social Care.

6.4 Evidence is unequivocal and strong around the benefits of a range of pharmaceutical interventions in preventing adverse **cardiovascular disease outcomes**. These include hypertension ascertainment and management, which is a key focus for local action. There are likely further opportunities in wider use of statins in older people based on their absolute 10-year risk of CVD and more thinking is needed as to how to enable this. Optimal ascertainment of atrial fibrillation (AF) is also crucial in stroke prevention.

6.5 Public health will continue to work with NHS partners, including acute trusts, to help optimise CVD prevention. ASC will wish to explore their role in identifying people who may benefit from statins and perhaps AF treatments.

6.6 **Comprehensive Geriatric Assessment (CGA)** is an approach to holistically supporting the needs of older people and is strongly advocated and widely used by colleagues leading on medicine for older people in Kent.

6.7 There is a good evidence base around its impact in delivering different outcomes in different locations and evidence suggests it can have an impact on residential care admissions[9].

6.8 There has been much work done in this area locally but there is still a need for a systematic approach to identifying who will benefit and then delivering the assessment and interventions.

6.9 ASC will wish to ensure they play a full role in the CGA process. There is a likely need to consider what the priority target groups might be given limits to capacity. ASC will also wish to support in the ascertainment of people who might benefit from Structured Medication Reviews[10].

6.10 This is a complex area with an increasing evidence base that is often equivocal. There is evidence around a positive impact of Allied Health Service interventions and a focus on functional gain in older people who have been unwell. It is important however to understand the specifics of interventions offered in a given trial and this is often unclear.

6.11 On balance there is likely sufficient evidence to recommend ASC fully engage in ensuring reablement is available to all who need it with clear pathways around discharge and consideration of identification within the community

[9] https://www.researchgate.net/publication/366522428_Delivering_patient-centered_care_outcomes_of_comprehensive_geriatric_assessment_across_healthcare_settings
[10] https://link.springer.com/article/10.1186/s12877-025-05680-8

6.12 The evidence from Kaiser (above,) while not an RCT, provides strong evidence around the true benefits of **targeted support following discharge**. The data set used was huge and patients had an average age of around 65. The study found an absolute reduction in readmission of around 3% in those with a 25-45% chance of readmission and some reduced mortality but no significant impact on those with an over 45% chance of readmission i.e. the most severe group.

6.13 Of note the specific intervention was quite light i.e. initial rapid physician follow up then phone contact. It is not clear how this might be generalised to Kent. There is a sense amongst some experts that the Kaiser model is already very efficient compared to the NHS and this has been argued as a reason that the gains seen are modest and application to the NHS may produce more gains.

6.14 This work is important in preventing readmissions and while there is no evidence around the impact on Social Care need in the Kaiser work, there is a sense from Home First work that there may be some impact on the need for ongoing care. On balance ASC will wish to prioritise support for this group if required.

6.15 There is a link between the development of **incontinence** and carer breakdown and loss of independence.

6.16 It is important that within Neighbourhood Health that some priority is given to the prevention and management of incontinence.

6.17 ASC will wish to optimise engagement in supporting carers of people who are incontinent and to ensure NHS referral and support where required.

6.19 Much progress has been made around **falls services,** and this remains important in preventing hip and other fractures with resulting loss of independence. There is a linked need to ensure appropriate intake of calcium and vitamin D in people at risk.

6.20 Local geriatricians are keen to explore system approaches to **improving physical activity** with a focus on older people. This should be linked to Active Kent, social prescribing, districts and boroughs and parishes. Most Health alliances have priorities around older people and also around physical activity, and we need to optimally join up around this challenge.

6.21 Public Health and Active Kent need to ensure that this area is seen as a priority and resourced if possible, including support to parishes and work with local leisure providers.

6.22 Additionally, there needs to be consideration at single neighbourhood level, how those with the highest complexity, in the first instance, might benefit from support and services to prevent falls.

6.23 The King's Fund definitions of Neighbourhood Health are far more expansive than just a short-term reduction in acute admissions.

6.24 We need to ensure people with **wider health needs** including around loneliness and finances are able to access support and health. While in some cases a digital solution is possible, there remains merit in ensuring wide access to social prescribing.

6.25 This is increasingly a challenge as resources are often being redirected to those with more severe needs. There remain however a disparate variety of social prescribing services across Kent and a clear defined operating model is needed.

6.26 An additional key focus of Neighbourhood Health is **the provision of acute community support** that will prevent the need for acute admission.

6.27 There have been a number of systematic reviews that help inform thinking in this area[11].

6.28 Broadly, best evidence demonstrates a benefit in these services in avoiding admissions with strongest benefit in people who have COPD and heart failure exacerbations rather than multiple pathology. The outcome of these trials should guide thinking rather than less robust studies where it may be hard to be sure that patients selected would all otherwise have been admitted.

6.29 Neighbourhood Health also offers opportunities around a system approach to social prescribing and opportunities to work together to get the right approach with a focus on shared directories, community role collaboration, and utilising platforms such as Joy.

6.30 There is also an opportunity to progress integrated digital projects such as Feebris.

7. Structures

7.1 There are limited resources available within the system and while a shift of spend from acute to community is mooted, this is hugely problematic given the expectations on acute trusts to deliver on access targets as well as manage challenging budgets.

7.2 It is reasonable then to assume there will be no or low additional resources and that initial work will need **optimal targeting of existing resources**. The need to move in a phased approach, due to limited free resources, offers the positive opportunity to evaluate pilots robustly with agreed control groups, and other robust methodologies, to better understand true impact.

[11] A systematic review to identify and assess the effectiveness of alternatives for people over the age of 65 who are at risk of potentially avoidable hospital admission | BMJ Open and Effectiveness of admission-avoidance hospital at home as alternative to routine hospital care in older adults: a systematic review and meta-analysis - ScienceDirect

7.3 At a time where there is high pressure on acute beds with a need to upstaff and open additional wards, there is likely to be benefit in **targeted admission avoidance schemes.** To be cost effective it is essential that systems are in place so that ONLY those who would otherwise have been admitted are managed by the service. There will be a natural tendency, at the margin, to refer people who would benefit but, in the absence of such a service, would never have been admitted.

7.4 Action to **Prevent readmission through action around discharge** is already resourced. There may be learning from the Kaiser Permanente approach above around those with a moderate to high risk of readmission in particular, with similar follow up locally. There are also opportunities around rehabilitation and reablement that are important and already recognised.

7.5 Again, teams already exist to support rehabilitation and reablement and could play a role in the Kaiser model if support needs are identified. There may be a role for ASC in this approach.

7.5 Any new model proposed will have a profound impact on existing **Community Services**. The Neighbourhood Health model will require optimal use of existing community health service capacity including nurses and therapists. These groups are already challenged with high workloads. Again, any shift of work away from people who have a current need for help will need to be strongly driven by evidence.

7.6 This would be, in large part, for example, the workforce who would need to deliver CGA. Work would be needed to establish who would be the priority group for support and how capacity could best be used. Even where benefit is likely, it may not be possible to support at scale given the reactive current service demands and capacity.

7.7 While more “upstream” the importance of the wider determinants of health must be remembered. A joined up and coordinated approach to **social prescribing** is important linked to all system partners.

7.8 There will be focus on Neighbourhood Hubs initially based on all existing system infrastructure and capacity, statutory and non-statutory. This could include the role of Family Hubs recognising that there may be limited overlap with current functions, in addition to libraries and social care centres.

8. The Health and Wellbeing Board

8.1 While definitive guidance is awaited, draft guidance suggests a central role for the Health and Wellbeing Board (HWB) including potential action by April 2026 through a leadership role in developing and delivering Neighbourhood Health Plans

8.2 In line with central NHS thinking, the approach to Neighbourhood Health Plans suggests an initial focus on the NHS short term priorities while recognising longer term priorities.

8.3 Initial proposed focus is likely to be: -

- improving access to core general practice services
- supporting people with complex needs, particularly older people, those with frailty and those at the end of life, to stay independent for as long as possible at home, working jointly with local partners to do so
- improving access to specialist opinion and diagnostics in an efficient and cost-effective way across many specialities, not just for those with long term conditions

8.4 Longer term ambition would be: -

- improving people's health and wellbeing in the broadest sense and in a way that addresses health inequalities.
- improving uptake of specific preventative measures
- supporting people with one or more long term conditions to live happier and healthier lives

8.5 HWB will continue to develop JSNA and Joint Local Health and Wellbeing Strategies (JHWS). By April 2026, it is suggested that HWBs should produce an addendum to the JLHWS to articulate an initial neighbourhood health plan at place level, setting out how services will be delivered across the place and within individual neighbourhoods to improve health and wellbeing of the local population, informed by the JSNA

8.6 Draft guidance suggests that in addition to reflecting the local authority and partnership's key priorities, the HWB should incorporate NHS national priorities when determining the range of local priorities for neighbourhood health for their place.

8.7 Draft Guidance suggests that existing governance structures (e.g., Health and Wellbeing Boards,) may need to be reviewed and adapted to support the new requirements of Neighbourhood Health planning, including clear lines of accountability, decision-making authority, and mechanisms for public engagement.

8.8 A comprehensive plan is likely to be required by April 2027 that will identify and address the health and wellbeing priorities of the local population; determine the wider partnership working that is needed to obtain maximum benefit from the full range of services and activities that contribute to the community's health and wellbeing; and determine how services are organised in individual neighbourhoods and across the place.

8.9 There will likely be changes to the Better Care Fund to align with this approach from 2026/2027. Neighbourhood health plans should set out how HWBs are planning to use the funding pooled as part of this framework to help achieve their goals for neighbourhood health, with a specific focus on intermediate care and other services that involve integrated packages of health and social care to help people maintain or recover their independence.

8.10 HWB membership may need to expand to reflect the national ask. The draft states that primary care providers, community health service providers, social care providers and the VCSE sector all have important and significant roles to play in neighbourhood health and that HWBs should consider how all four groups should be represented.

9. Implications, challenges, and opportunities for KCC

9.1 The approach proposed in this paper has been discussed at, and agreed corporately. An internal officer group is being established to coordinate action by council officers, ensuring appropriate input and representation at key system partner groups that are delivering Neighbourhood Health.

9.2 The development of Neighbourhood Health by health colleagues should be seen as an opportunity for KCC. While the initial focus is likely to be largely around prevention of hospital admissions (and shortening stays), much of the likely action in these areas will also positively impact on the need for and use of residential care and expensive domiciliary care packages with benefits to ASC. As well as for ASC, the focus on prevention is an opportunity for public health as there will be anticipation of a more activated population.

9.3 It is harder to see clear gains for other KCC directorates, but opportunities may arise should the focus on prevention shift to more wider determinants. Ongoing focus on the role of NHS partners as anchor institutions is an area of joint work that is important in delivering local employment and sustainability opportunities. There are also opportunities for Growth Environment and Transport (GET) to be involved in the developing prevention agenda.

9.4 One key opportunity would be the NHS embracing **Community Health and Wellbeing Workers,** as described above, which are discussed in the Ten Year Plan and which would deliver, within local communities support that aligns with KCC agendas including those of GET, ASC, Children, Young People and Education (CYPE) and PH. It is however not clear how strongly this opportunity is being embraced locally, although there is some focus nationally. There may be value in testing locally in a small number of communities linked to single and multi-neighbourhood teams.

9.5 Potential Council actions should be set, pragmatically, against a background where the key current NHS focus for Neighbourhood Health will be avoidance of hospital admissions.

9.6. The existing and ongoing input and support ASC are already giving at both Strategic level and in supporting the Neighbourhood pilot is strongly and positively recognised by NHS colleagues. There are opportunities to reduce social care demand and align work with delivery of the Prevention Framework.

9.7 Specific areas of focus could include support for comprehensive geriatric assessment, optimal reablement, and supporting the roll out of structured medication reviews and use of the ReSPECT tool.

9.8 Public Health will wish to support NHS colleagues in ensuring a sound methodology and evidence base underlines Neighbourhood Health as well as ensuring a focus on interventions that will reduce pressure on ASC.

9.9 Focus for Public Health, with NHS colleagues, should include the prevention of cardiovascular disease (CVD), and preventative services and interventions around falls, continence, and physical activity in older people. Public Health will continue to develop a system role in supporting partner activities including through Health Alliances, with acute trusts and through the Coastal Marmot work.

9.9 The NHS focus on high risk groups and reductions in hospital activity means short term opportunities in Neighbourhood Health for other Council teams may be less. Growth Environment & Transport (GET) may find opportunities in aligning community support workers with Neighbourhood teams as well as working with the NHS around their role as anchor institutions.

9.10 While Neighbourhood Health encompasses children and young people and work is starting in that area, much of the focus seems to be on shifting consultant expertise and complex management closer to home. It is not clear how this will impact on CYPE, however Family Hubs should be considered as sites for further community-based services.

9.11 There may be opportunities to work with the NHS on aligning estate in developing Neighbourhood hubs and Council infrastructure leads are already engaged with the NHS in considering wider issues around infrastructure.

10. Conclusion

10.1 In summary there are a range of actions that will both support the NHS in the delivery of their Neighbourhood Health objectives as well as aid delivery of Council Corporate priorities. These are briefly outlined in the previous section. Cabinet Committee members will likely be able to identify further and wider opportunities than those cited and these considerations are welcomed.

11. Recommendation:

11.1 The Adult Social Care and Public Health Cabinet Committee is asked to NOTE the report and COMMENT on the outlined approach.

12. Contact details

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