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JHOSC

NHS 10 Year Health Plan and Neighbourhood Health Delivery

March 2026

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National NHS 10 Year Health Plan: context

- The Government have said the health and care system needs to modernise and evolve to better meet people's needs.
- We have an ageing population, and a population that is living more years in poor health.
- We also have significant demand for unmet social need, and we don't always have the right services to support people.

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The NHS 10 Year Health Plan - The ‘three shifts’

- **From hospital to community**; better care, closer to home, including neighbourhood health, better dental care, quicker specialist referrals, convenient prescriptions, improved community mental health support.

- **From analogue to digital;** creating a better experience through digital innovation, with a unified patient record eliminating repetition, self-referrals via the NHS App, and improved online booking for equitable NHS access.

- **From sickness to prevention;** shifting to preventative healthcare by making healthy choices easier and supporting people before they get sick.

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What local people said

CHANGE NHS

Change NHS was a national consultation launched by the government in October 2024 to help inform the development of the NHS 10-Year Plan. Between **January and February 2025,** we held five engagement (two online sessions and three in-person), bringing together over **150** residents from across North Central London.

Care from hospitals to communities

- Moving care closer to home can be beneficial but must meet diverse needs.
- Residents need clear points of contact for any issues.
- Services must be well-supported, staffed, visible, inclusive, and responsive.
- Carers and families should be informed and involved.
- Recruiting and retaining community-based staff remains a key concern.

Making better use of technology

- Technology can enhance care but shouldn't replace human interaction.
- Offline options must always be available.
- AI can support some tasks but should be used wisely.
- A shared patient record with easy patient access is essential.
- E-consult systems need to be more user-friendly.

Focusing on preventing ill health

- Prevention should be a priority
- Health education is vital across all age groups.
- The NHS must provide timely support when needed.
- Collaboration with families and communities is essential.

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Community conversations

- Following the Change NHS conversations in 2024/25 we wanted to keep talking to local people about the 10 Year Plan and neighbourhood health.
- We've reached out to groups who may find it harder to influence us, from specific age groups, ethnic groups, orientations etc.
- We partnered with local VCSE to deliver conversations where residents are.
- Feedback to date has included:
- **Ensuring resources genuinely follow need, including prevention and VCSE:** Residents repeatedly worried that shifting care to communities would not be matched with funding, leaving VCSE groups asked to do more without support
- **Supporting staff across health, social care, VCSE and recognising unpaid carers:** Migrant, neurodivergent, LGBTQ+, and older adult groups all highlighted gaps in GP, mental health, and social care training and warned that without proper staffing and skills, carers (mostly women) would absorb the extra burden.
- **Clear, consistent communication so residents understand what neighbourhood care offers:** Across nearly every group, people said they were confused about who provides what and had often not seen local communication campaigns.
- **Using data intelligently while not losing nuance or lived experience:** Neurodivergent residents stressed that data-led pathways often overlook the reality of fluctuating needs, sensory barriers, and communication differences that never show in datasets.

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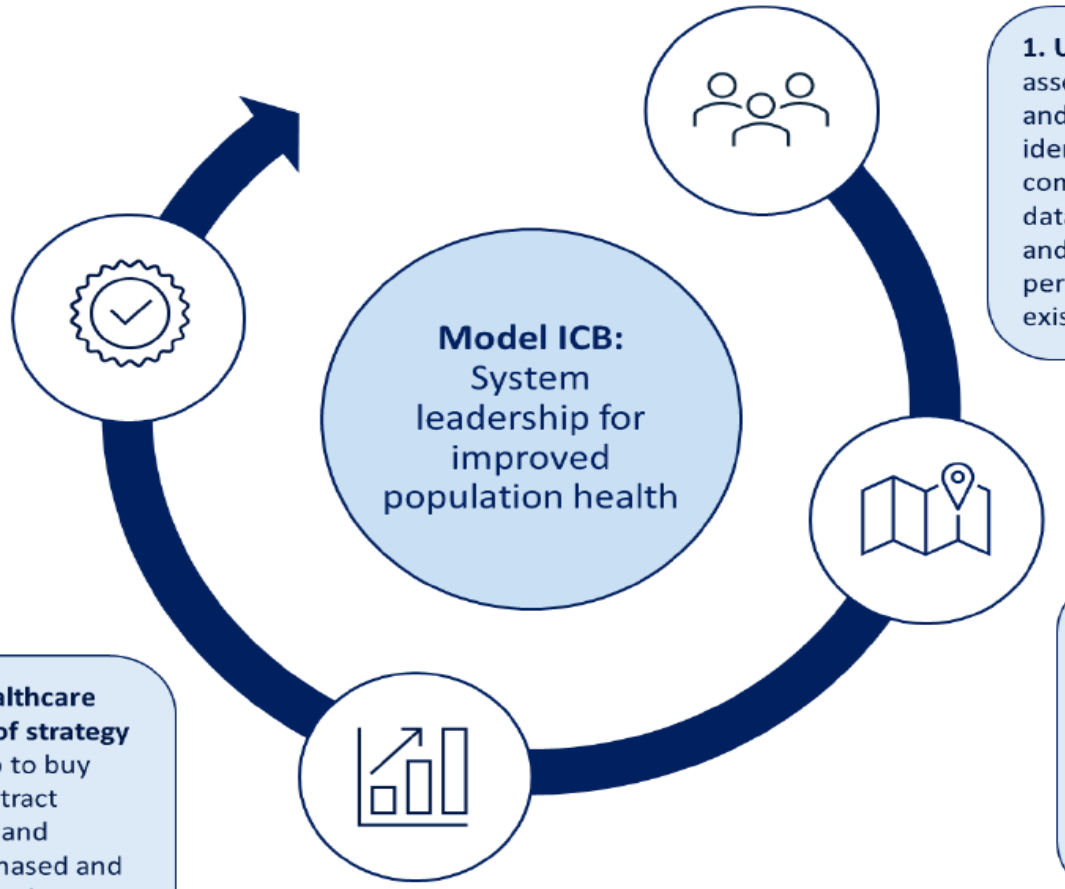
The ‘Model ICB’



1. Understanding local context – assessing population needs now and in future, including identifying underserved communities. Using population data, intelligence, forecasting and modelling; assessing quality, performance and productivity of existing provision

2. Developing long term population health strategy – setting system strategy and leading care pathway redesign to inform allocation of resources to maximise value based on evidence

3. Deploying levers of healthcare payer to ensure delivery of strategy defining what to buy, who to buy from and how to pay. Contract management & oversight and assurance of what is purchased and whether it is being delivered. Working with users to co-design and embed engagement in this process

4. Evaluating impact – day to day oversight of utilisation; real time monitoring and tracking of outcomes to understand return on investment; user feedback and evaluation

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How we're implementing the 10 Year Plan

- From digital to analogue – data improvements
- From sickness to prevention – neighbourhood health
- From hospital to community – virtual wards and self management

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From digital to analogue: Digital improvements

We are working with other ICS areas across London to make improvements to our use of digital technology and to bring health and care information together for better patient care, planning and research to help communities stay healthy.

London Care Record

- The London Care Record is a secure view of a patient's health and care information over time across different parts of the NHS and social care.
- It lets health and care professionals involved in patient care see important health information at the point of care wherever they are in London and some neighbouring areas.
- This helps patients get the best possible joined-up care as safely and quickly as possible, instead of having to tell their story over and over again.

London Secure Data Environment

- In London we have a new Secure Data Environment which securely bringing Londoners' health and care information together. London Secure Data Environment
- The SDE keeps patient data safe, using the highest safety standards. Data is encrypted, meeting NHS and social care standards. to ensure information is protected and more secure than ever.
- You also have the right to choose how your information is used to benefit you and others. You can find out more about how your data is protected and your rights

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Using data to improve the health of residents

- We will use data to **better understand who in our communities are at the greatest risk**, and have the greatest health needs. This will feed into neighbourhood model, identifying who needs to be helped by Integrated Neighbourhood Teams (INTs) at any given moment.
- **Data will be enable us to help us to diagnose people earlier** and offer proactive treatment, rather than treating people at crisis point
- **We can reduce health inequalities** by better understanding why some communities experience poorer health outcomes than others, and direct resources and investment to those areas
- **Better and more efficient insights through the London Secure Data Environment (SDE) will allow us to track access, experience and outcomes** in a more consistent way, using what we learn to adapt our approaches.

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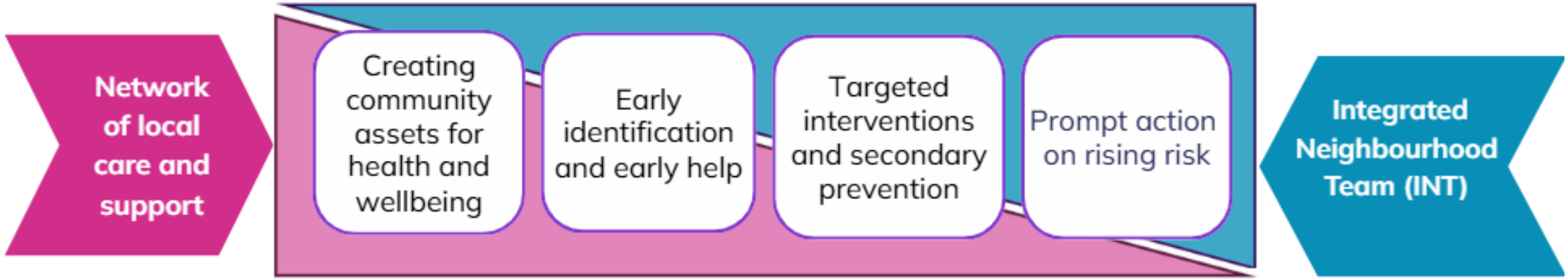
From sickness to prevention: neighbourhood health

- Organising care at neighbourhood level will enable more coordinated, proactive support and better outcomes.
- Dedicated multidisciplinary Integrated Neighbourhood Teams (INTs) will work alongside existing local health and care services to improve access, experience and outcomes for people and families with the most complex needs, particularly those who can otherwise become stuck navigating gaps between services.
- These teams will not replace the role of a person's GP, but will strengthen continuity and coordination around individuals and communities.



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From sickness to prevention: long-term conditions focus

- **The new role of strategic commissioner allows us better support those who have long-term conditions.**
- **Support available for long-term conditions:** We will strengthen the support available to people with long-term conditions, and identify people earlier and provide proactive, ongoing support before problems escalate. This includes better routine monitoring, earlier intervention when someone's health starts to deteriorate, and more consistent follow-up to prevent avoidable crises and hospital admissions.
- **Better self management will be a core part of long-term conditions services:** including education, health coaching, peer support and community-based approaches. This will help people understand their condition, recognise early warning signs, and access the right support at the right time, preventing deterioration and loss of independence.

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Example prevention outcomes

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Proactive identification and prevention

↑ Early community diagnoses
↑ Community diagnostic capacity
↑ Vaccination and screening
↓ Late-stage acute diagnoses
↓ Preventable disease progression

Coordinated care

↑ People with named care coordinator
↑ Single holistic assessments completed
↑ Shared care plans
↓ Fragmentation / duplication
↓ DNAs / cancelled appointments

Long Term Conditions management

↑ Patient / resident involvement
↑ Confidence in self-management
↑ Clinical target achievement
↓ Condition-specific complications
↓ Unnecessary outpatient appt.

Sustainable and effective workforce

↑ Staff satisfaction and wellbeing
↑ Time on direct patient care
↑ Workforce retention
↓ Staff burnout and sickness absence
↓ Vacancies

Preventing crises

↑ Community-based crisis response
↓ Non-elective admissions
↓ A&E attendances
↓ Care home admission

Equity, access and community connection

↑ Inclusion health group engagement
↑ VCSE referrals and community asset use
↑ Economic outcomes for working age
↓ Health inequalities/unwarranted variation
↓ Social isolation and loneliness

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From hospital to empowering communities

"Health is your right as well as your responsibility. People need to be empowered and supported more to take control of their own health and have the confidence to access the right services for them"

"My husband was picked up by their GP practice as being pre-Diabetic. They then went to a community venue where there was peer support, people could learn from each other and clinical people about diet and exercise and how to reduce the risk of Diabetes. We know it worked because his blood test results improved and risk went down."

"My wife had a gym referral and then discounted membership. We knew it worked because she got fitter. She could walk into the high street without getting out of breath, which was important to her"

"Establishing and building relationships is key to meaningfully engaging with communities. Needs to be organic and takes time."

"The way local health centres work is really improving. The opening hours are more flexible and they can refer you to other larger, local centres so you don't need to go to hospital and into voluntary sector organisations so you get a wider range of support."

Thoughts on Neighbourhood Health from our Community Advisory Group, October 2025

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Empowering people to take be involved in their health and wellbeing

- Evidence shows that **people who are more involved in their care have 18% fewer GP contacts and 38% fewer emergency admissions** than those with the lowest levels of engagement (North West London).
- Empowering people to take control of their care is about building confidence, trust and understanding, not just using digital tools. Many **people want to manage their health better but need the right support, information and relationships to do so**.

We will support people to take action earlier by:

- Running clear, accessible campaigns about **how residents can look after their health**
- Offering **better practical self-management support** for people living with long-term conditions.
- **Working with community organisations**, and empowering them to build community assets to better support residents
- Encouraging **face to face outreach, community settings and local networks** to reach people who may not engage with traditional services.

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Integrators

- Integrators are a key part driving Neighbourhood Health forward.
- As part of the Integrator criteria, they have been asked to create plans to engage with residents and the voluntary sector. The VCSE alliance in North Central London recently met with integrators in all NCL boroughs to discuss how to better involve the VCSE at the earliest stage.
- **Integrators are not replacements for existing Borough Partnerships, and report into Borough Partnerships.**

Borough	Integrators
Camden	Camden GP Fed and UCLH
Islington	Islington Council, Whittington Health, UCLH and Islington GP Federation
Barnet	CLCH and Barnet GP Federation
Haringey	Haringey Council, Haringey GP Federation and Whittington Health
Enfield	Royal Free Trust and North Mid and Enfield GP Federation

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Community Advisory Group engagement

Last year we formed a Community Advisory Group (a group made up of residents and VCSE orgs from NCL's five boroughs) to engage residents and community groups on NCL's approach to neighbourhood health.

As a result of engagement and feedback from the Community Advisory Group:

- The Model Outcomes Framework is more focused on community and resident experience
- We developed videos to show local examples of neighbourhood health (see slide 18).
- We have strengthened pillars '1 and 2' in our neighbourhood approach, to better incorporate more holistic support e.g. gyms, youth clubs, social prescribing and more.
- We are refreshing our VCSE commissioning approach to prepare for neighbourhood health commissioning.

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Test bed site for neighbourhood health

- Haringey is being used as a test borough to accelerate the pace of delivery of neighbourhood health services.
- This means they will trial new approaches to local healthcare, so that we can quickly learn what works well (and what doesn't) before other boroughs adopt similar methods. This work will begin during Q1 and move at pace.
- Haringey is in a strong position to take on this work. It has a mix of strong relationships, structures and community assets in its neighbourhoods programme already so can accelerate this approach at pace. In particular, the well-established MACC team already brings together partners across health, council and the voluntary sector, with several years of positive outcomes.
- **Every borough will continue progressing its own neighbourhood plans in parallel.** Our role as a strategic commissioner will be to share learning across all 13 boroughs, to ensure everyone benefits from work happening in different areas across different cohorts.

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Local delivery: What's happening in each borough

We have produced a video in each of the boroughs across North Central London to highlight what fantastic work is already underway. As we move forwards, we

See the links to these here:

- **Enfield's Health Hearts Service:** https://www.youtube.com/watch?v=myKlumg2BZI
- **Enfield's Ageing Well Service:** https://www.youtube.com/watch?v=QzFkBi_36JA
- **Haringey's MACCT service** https://www.youtube.com/watch?v=jmBOryIRxe0
- **Islington's Integrated Care Teams:** https://www.youtube.com/watch?v=O4t2NQpHnow&pp=**ygUbY2FtZGVuIG5laWdoYm91cmhvb2QgaGVhbHRo**
- **Camden's Kentish Town centre:** https://nclhealthandcare.org.uk/news/health-secretary-visits-james-wigg-practice-to-see-neighbourhood-working-in-action-2/

Enfield's Healthy Hearts service – Neighbourhood Health in action (medium edit)

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Local delivery: mental health integrated working

- In Haringey, we have just launched a pioneering **multi-purpose neighbourhood mental health centre** named in honour of Roger Sylvester - who tragically lost his life in 1999.
- The disused building has been transformed into a **hub for integrated mental health support, bringing together vital services from the council, NHS, and voluntary sector under one roof**.
- The co-located model reduces fragmentation and improves access to care by enabling professionals to work collaboratively around the needs of individuals.

Watch more here: https://www.youtube.com/watch?v=af4zw7E2Dfk

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West and North London approach

- We will be moving into a newly merged Integrated Care Board on the 1 April and as part of this we are operating in a changing health and care context.
- We spend around £12 billion a year on health and care across West and North London (WNL), for a population of approximately 4.5m people
- Most of this money is currently used when people are already unwell, in hospitals and crisis services. While this has helped manage short-term pressures over the years, it is not delivering fair outcomes and is unsustainable, with rising acute spend and increasing demand. We have an opportunity to change this.
- At our core, NHS West and North London will have a focus on reducing health inequalities. This is both a moral imperative and a practical necessity, and it is also the way we create the capacity for everyone.
- We have already been working with colleagues in North West London to work together to align our approach to neighbourhood health, learning from the experiences and approaches of both systems.

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Appendices

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National Federated Data Platform

The national NHS Federated Data Platform connects vital health information across the NHS, helping staff deliver better care for patients and work more efficiently. A connected NHS will allow teams to deliver their services seamlessly with patients at the heart.

The NHS Federated Data Platform safely connects information across the NHS, making it easier for staff and clinicians to do their jobs. Already funded and established it's designed to turn insight to action.

Benefits will be:

- Quicker access to critical insights
- More coordinated care
- Enhanced productivity
- Improved patient outcomes

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National Federated Data Platform

Find out more...

- An animation which simply explains NHS FDP and the impact on patients.
- This animation describes the benefits being realised by NHS Trusts in England that are currently using the NHS Federated Data Platform.
- This Privacy and Security animation that explains how the NHS FDP keeps information safe and secure.

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Thank you