



# NEIGHBOURHOOD

MODEL OF HEALTH AND WELLBEING

# A VISION FOR NEIGHBOURHOOD HEALTH AND WELLBEING IN NORTHERN IRELAND

## POLICY FRAMEWORK

March 2026



Department of  
**Health**

An Roinn Sláinte

Mánnystrie O Poustie

[www.health-ni.gov.uk](http://www.health-ni.gov.uk)



**RESET** 

STABILISE | REFORM | DELIVER

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## Ministerial Foreword

It is widely recognised that shifting more care into primary and community settings is essential to the future of health and social care in Northern Ireland. Evidence from successful neighbourhood-based systems elsewhere shows that when people receive earlier support closer to home, outcomes improve, reliance on hospitals decreases, and quality of life is enhanced. Preventing avoidable deterioration is not only better for individuals, but also critical to managing the pressures facing our entire system.

I have been clear about the financial and operational challenges we face, including the need to reduce long waiting lists and high levels of unmet social care need. One of the most effective ways to address this is to prevent needs escalating or people joining those lists in the first place. That means intervening earlier in an individual's journey, strengthening primary and community care, and shifting the focus and the investment towards upstream support.

In the Reset Plan published on 9 July 2025, I committed to developing a new neighbourhood model for primary, community and social care. This model is central to delivering meaningful change, improving access to services, strengthening prevention, and supporting better continuity across organisational boundaries. This document sets out the vision and design principles for the Neighbourhood Model of Health and Wellbeing. It marks the first step in a long-term reform programme that will reshape how services are planned, how resources are allocated, and how professionals work together, with voluntary and community sector partners and the public. All parts of the system will need to adopt the neighbourhood ethos and embed its principles in their everyday practice. Delivering this change will require new forms of partnership at neighbourhood level, grounded in a shared identification and understanding of local needs. It will also require a gradual but deliberate rebalancing of resources out of secondary and more intensive care and into community-based provision focussed on health and wellbeing. I am committed to driving this shift so that our services are positioned to meet both current and future demand.

Much good work is already under way across Northern Ireland, reflected in the strong response to the Call for Evidence which I am publishing alongside this document. In addition, the learning from the Live Better approach tested last year provides strong foundations. But the scale of the challenge means we must go further. Providing care earlier and closer to home is essential, not only to ease pressure on hospitals and formal social care, such as homecare and care homes, but also to ensure people receive better, more timely support throughout their lives.

The change outlined in this document is neither optional nor partial, it is comprehensive and fundamental to the sustainability of our system. Now is the moment to act. I encourage all partners across health, social care and beyond to work together, with the public and with purpose, to build a neighbourhood-centred system that brings care closer to those who need it, tackles health inequalities, and secures a high-quality, safe and sustainable service for generations to come.

**Mike Nesbitt MLA**  
**Health Minister**

## A Commitment to Change

In July 2025 the Health Minister published the [Health and Social Care NI Reset Plan](#) which includes the following commitment to neighbourhood care:

***By March 2026, working with partners we will have developed a new neighbourhood model for primary, community and social care, which will deliver greater levels of care for citizens, including children and families, in their communities, alongside a funding plan to support delivery from April 2026.***

***This model will see Community Pharmacy, GPs and their Federations, Voluntary and Community organisations, Trusts, independent providers, other statutory bodies and Local Government working closely together in formal partnership to provide integrated care.***

Between August 2025 and February 2026, the Department's neighbourhood team met with organisations and individuals involved in the provision of health, social care, voluntary and community services across Northern Ireland, the Republic of Ireland and Great Britain. Through the medium of workshops, meetings and visits a vision for neighbourhood health and wellbeing in Northern Ireland has been developed.

This document sets out the vision for a new neighbourhood approach to health and wellbeing and provides an operating and funding model to support implementation. However, the changes envisaged in this document and the Reset Plan can only be delivered with the ongoing support of partners from across sectors, and with the input of service users, individuals with lived experience, carers and the wider population.

The ongoing development of the neighbourhood model will seek to build on wider changes to the Health and Social Care system's culture and approach of working with the public and communities as partners, envisaged by the [People To Partners](#) and This is Our Health<sup>1</sup> initiatives, which recognise the value of lived experience, see the public as active collaborators in service design, decision making and improvement and as active participants in maintaining and improving their own health.

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<sup>1</sup> The HSC Reset Plan set out a commitment to start a new dialogue with the public through a new public health programme 'This is Our Health'.

# KEY FACTS AND FIGURES



£8.4 bn - Budget 2025/26



Over **76,000** HSC Staff (December 2025)



**300 +** GP practices and **1,400 +** GPs (excluding locums) with **2m +** registered patients (31 March 2025)



Over **520,000** inpatient and day case admissions (2024/25)



Over **760,000** attendances at **Emergency Departments** (2024/25)



**465** care homes providing over **12,000** nursing and residential care packages (June 2024)



Over **23,000** people receiving more than **294,000** hours of home care each week (2023)



Over **500** community pharmacies in NI (31 March 2025)

**45m +** prescription items dispensed by community pharmacies (2024/2025)



Around **4,000** VCSE organisations with a health focus (2024)

## Why do we need a Neighbourhood Model of Health and Wellbeing?

Northern Ireland's Health and Social Care system is experiencing sustained and significant pressure.

Too many people face long waits for outpatient appointments, access to GP or other primary care services, need homecare and care home placements in growing numbers, or have to be treated in busy Emergency Departments. It is clear that the current system cannot continue to meet demand in its present form.

There are a number of reasons for this. Demographic change, the ongoing impact of the Covid 19 pandemic, advancing clinical technologies, greater acuity of need and persistent budgetary constraints are all driving increased demand and rising costs.

Delivery of health and social care services is too often fragmented, with teams and organisations working in parallel rather than in partnership. This separation makes it harder to coordinate care effectively and can lead to duplication, inefficiency, a mismatch of service provision and need, and additional administrative burden. As a result, staff experience unnecessary pressure, the journeys of patients and those with care needs can feel disjointed, and outcomes are often poor.

The current system, including its use of resources, is also weighted too heavily towards hospital-based care, with many opportunities for early intervention and community-based support not fully realised. General practice in particular faces increasing challenges in its role as gatekeeper to accessing wider services, which can impact upon its capacity to provide high quality and timely care to patients.

These systemic issues have a direct impact on patients, those with care needs and their families and carers. Long waits for urgent and emergency care, delayed access to surgery, diagnostics and assessments, difficulties accessing GP appointments and high levels of unmet social care need all influence health and wellbeing outcomes, as well as satisfaction with, and confidence in, the system.

To meet present and future needs, a shift in both culture and approach is needed. The Neighbourhood Model of Health and Wellbeing offers a way to bring services together, strengthen community-based care, and ensure that the system is better designed around the needs of the people it serves.

## What is a Neighbourhood Approach to Health and Wellbeing?

A neighbourhood approach has been used by different systems around the world to describe similar, but not identical, ways of working.

It can include ideas, policies and approaches that focus on integration and coordination of services; prevention; personalisation of care; delivery of care closer to home; community-led approaches to care; place-based care focusing on a geographical area's specific needs; or care targeted at specific groups or cohorts.

Recent work by the King's Fund identified three different but complementary approaches to neighbourhood health, broadly summarised as:

- 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

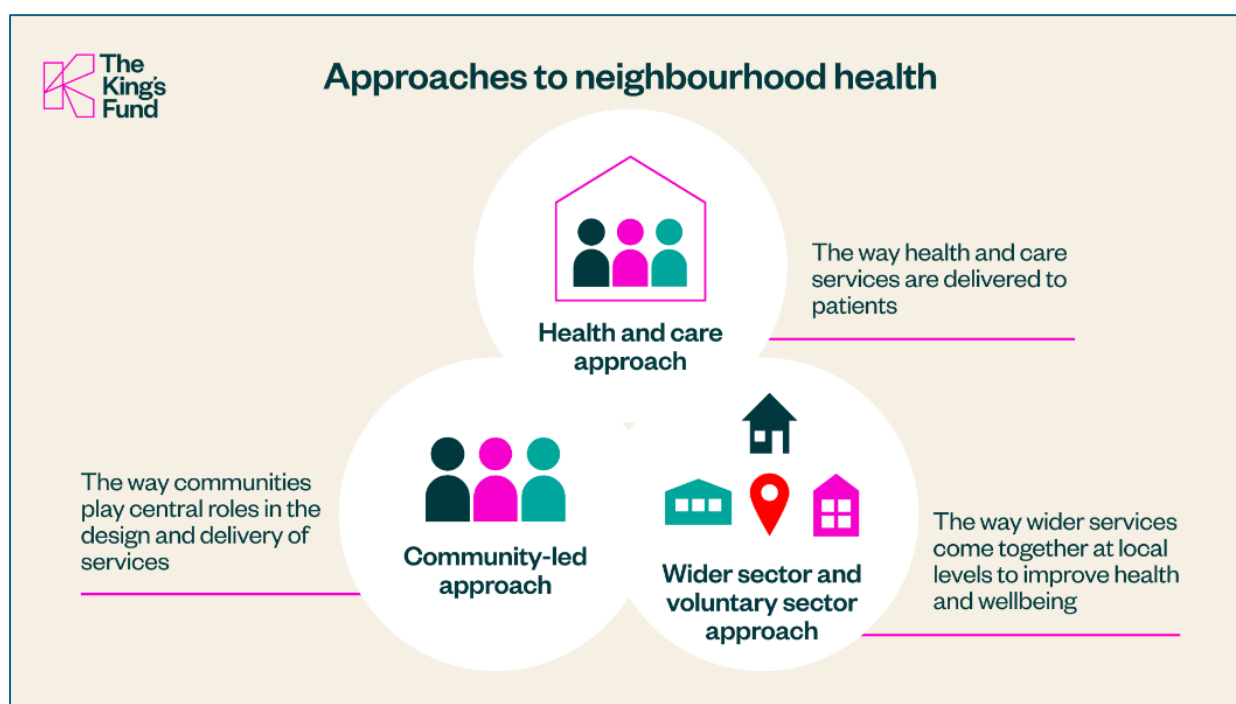


Figure 1: Approaches to Neighbourhood Care (Source: [What Is Neighbourhood Health? | The King's Fund](#))

Neighbourhood models of health and wellbeing are built on trusting relationships between service providers and with the communities they serve, developed over time and informed using local insight and data.

They bring together health, social care, the voluntary/community/social enterprise sector and local authority services to work collaboratively and with purpose at neighbourhood level. The approach emphasises day to day joint working by service providers for better access, early intervention and proactive and preventative care

locally. It also takes account of the wider determinants of health affecting the people in need of health and social care, such as housing, social connection, employment and the environment.

Most models involve neighbourhood teams that are enabled to work together to coordinate care, offering more joined up support that aims to help people in their area live healthier and more independent lives.

### Examples of Neighbourhood Models of Care

**Nuka System of Care in Alaska, USA** - Emphasises community-based, comprehensive care with a strong focus on preventative services and addressing social determinants of health. Recognised for its innovative organisational structure and its impact on improving population health, this model has been in place since 1999.

**Canterbury model in New Zealand** - emerged rapidly after the 2010/11 earthquakes and demonstrates successful integration of health and social care services. It focuses on joint working across different disciplines and clinical settings, and it highlights the importance of strong leadership and collaboration in achieving integration.

**Wigan, UK** - a citizen-led, asset-based approach to public service transformation in Wigan, England, composed of several smaller deals on healthcare, children, social services and community funding. It was introduced in 2011 and is aimed at creating new relationships between the council and residents by focusing on community strengths, fostering independence, and encouraging staff to redesign services in response to local needs.

**Manchester Primary Care model, UK** - Part of Greater Manchester's Integrated Care System (established 2016). It focuses on improving access, capacity, and sustainability in primary care. This involves a collaborative approach through Primary Care Networks (PCNs), integrated with community services, and supported by digital advancements. The model emphasises proactive care, early diagnosis and prevention, aiming for optimised access and a more sustainable system.

Figure 2: Examples of Neighbourhood Models of Care

In Northern Ireland, we recognise that communities across different geographical areas have distinct characteristics, strengths and needs. The needs of our communities are best met by recognising this diversity and capability, and by working collaboratively with a range of local partners across health and social care. In many places, this way of working is already emerging with great effect, supported by strong local relationships and effective collaboration.

Formal place-based approaches have also been tested, including the [Live Better](#) initiative, which was designed to help address health inequalities in Northern Ireland by bringing targeted health support to communities which need it most. We want to build on this and other examples of good practice, putting a framework in place to support a change in approach and foster collaborative work between providers at ground level.

## Benefits of a Neighbourhood Model of Health and Wellbeing

The Neighbourhood Model of Health and Wellbeing places local communities at the heart of how services are planned and delivered. It focuses on designing care pathways that meet more needs earlier, before needs escalate to the point of crisis, or care in hospital or away from home is required.

Evidence from effective neighbourhood models internationally shows that delivering care closer to home and strengthening partnership working across organisational boundaries can bring significant benefits. These include improved health outcomes, a greater sense of wellbeing, more reliable access to same-day urgent care, easier access to support services closer to home and better continuity for people with complex needs. Through whole-system collaboration and supporting earlier intervention, the model facilitates more effective management of long-term conditions, enhances prevention and promotes earlier detection of illness.

This can mean that people will experience greater satisfaction with services that listen, coordinate care effectively, respect personal preferences and promote and facilitate choice.

Transitioning more care into community settings can also help manage demand by reducing unplanned hospital admissions, emergency department (ED) attendances, ambulance conveyances, GP out-of-hours (OOH) appointments and admissions of adults to care homes or children into care, and by shortening hospital stays.

By optimising the use of existing services, embedding tested approaches like social prescribing and redesigning care pathways for community-based services, resources can be used more efficiently and sustainably, with reduced duplication, fewer care gaps, better value for money and improved outcomes.

In addition, stronger community resilience is built by empowering individuals and communities to manage health and wellbeing more proactively, addressing inequalities holistically and supporting local employment and economic regeneration.

What does neighbourhood working mean for individuals and the wider system?



Figure 3: Benefits of Neighbourhood working

## Developing the Model

To meet the commitment set out in the Reset Plan, the Department has been working to design a new neighbourhood model through a phased approach:

1. **Design Phase September 2025 to January 2026:** Agreeing the vision and underpinning principles for NI neighbourhood care and identifying best practices through a call for evidence.
2. **Build Phase January to April 2026:** Publishing policy guidelines and results of the call for evidence, establishing a neighbourhood development programme and systems for delivery.
3. **Implementation Phase from April 2026:** Starting implementation, supporting establishment of the integrated neighbourhood teams and systems for measuring outcomes, evaluating, investing, testing and scaling up good practice.

## Stakeholder Engagement

Early engagement with stakeholders has been a central tenet throughout the development of this Neighbourhood Model of Health and Wellbeing. From the very beginning the Department has tested concepts with a wide range of internal and external stakeholders, and the input, challenge and support received has been critical in helping to shape the model as set out in this document.

With the Health Minister, senior officials visited parts of the UK where neighbourhood models were being implemented. They also met with local GPs, GP Federations, the 5 Area Integrated Partnership Boards and its Regional Forum, community pharmacy contractors, the voluntary and community/social enterprise sector, the Patient Client Council and many others across health and social care to inform the development of the model.

This was supplemented by a broad range of bilateral meetings and visits to local areas already providing support for their local populations in line with a neighbourhood ethos.

## Call for Evidence

As part of this stakeholder engagement, the Department also ran a Call for Evidence, seeking examples of neighbourhood initiatives from across NI that brought together alliances of service providers in response to a specific need within a community or neighbourhood. A total of **183** responses were received from across the region, with more resources still being shared. A short summary is provided in Annex B.

The Call for Evidence Report is available on the Department's [website](#), alongside the responses received in the form of a compendium of good practice. This has been

used to inform and shape the development of the new Neighbourhood Model of Health and Wellbeing.

### Key Lessons to inform the Neighbourhood Model

The collective evidence from the Call for Evidence highlights several consistent lessons:

- Sustainable, long-term funding and adequate resourcing are essential to achieve lasting impact, maintain workforce stability, service continuity and effective partnerships.
- Treat community and voluntary organisations as equal partners in governance and delivery.
- Relationships and trust are as critical as structures and pathways.
- Home and community settings are often the true starting point of integrated care.
- Co-production increases uptake, relevance, and sustainability.
- Data-sharing agreements and outcome-focused evaluation are essential enablers.
- Local innovation works best when supported by regional policy alignment.
- Build on existing structures and trusted partnerships to accelerate implementation.
- Embed multidisciplinary teams inclusive of VCSE, community pharmacy, and lived experience.
- Invest in workforce development, digital integration, and shared data systems.

These lessons are repeatedly reinforced across different populations, geographies, and service models.

In addition, the learning from the [Live Better](#) approach, evaluation and recommendations will inform the development and delivery of the Neighbourhood model.

## Our Vision for a New Neighbourhood Model of Health and Wellbeing for Northern Ireland

It is clear from the evidence available and the input from stakeholders carried out during the design phase that there is an urgent need to drive forward real change, both in terms of how services are delivered in primary and community settings, but also to foster a true cultural change in how providers across sectors work together to meet the needs of their local population. This will not be an easy or short journey, and service providers will need to be supported in this change. It will require all participants across sectors to think about how they currently work and consider how they can adapt to embed the approach and principles outlined below, to work more collaboratively with partners to make the best use of the resources available to meet the needs of their local populations.

However, it is important to note that we are in no way starting from scratch; the evidence submitted by stakeholders through the Call for Evidence demonstrated that there are many teams and organisations already working collaboratively with partners locally. The key will be to build on the excellent foundations that already exist in Northern Ireland, to create a system that can scale up and adopt proven good practice and provide a clear framework and roadmap for the extension of this new way of working to become the new normal in all areas.

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*Our **VISION** is for neighbourhoods across Northern Ireland where people are enabled and supported to live healthier, more independent lives.*

*With integrated neighbourhood teams of health, social care, VCSE and local council services working in partnership with local people and communities, focusing on identifying need, ensuring person centred support closer to home, improving outcomes, tackling health inequalities, managing demand on HSC services and building a resilient health and wellbeing system for the future.*

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## Design Principles

The following principles have been developed from the research and engagement undertaken during the design phase and provide a foundation for the Neighbourhood Model of Health and Wellbeing. They describe the characteristics of the model, which are key to successfully providing high quality neighbourhood care.

**Strong Relationships:** Local collective leadership and trusted working relationships, through integrated neighbourhood teams bringing together people delivering services and roles that have a high level of interaction with local people and each other.

**Connection:** A central theme is the importance of connection—between people, organisations, and communities. Neighbourhood team members acting as community connectors helping to build trust, improve access to care, and shift the focus from reactive treatment to proactive prevention.

**Community Development, Engagement and Co-Design:** Being inclusive and benefiting from the strengths, skills and resources already present in the neighbourhood. A role for social prescribing. Initiatives conceived and led by local groups and residents. A focus on providing person centred care.

**Primary and Community Care at its Heart - Personal, Connected and with Ability to Work at Scale:** Primary and community care service providers working together at scale over multiple practices and sites, utilising skills and assets, with practice underpinned by multi-disciplinary working, digital systems and data. Understanding the needs of their community with the ability to translate this into measurable improvements and demonstrate impact.

**Working with Purpose to Move Care Closer to Home:** Clinical pathways designed to effectively utilise the skills and assets in the neighbourhood to improve access to diagnostics and treatments for more complex care. Adopting proactive, anticipatory approaches to care, identifying people in most need of support, reducing or delaying their need to access care outside the neighbourhood.

**Maximising the Strength of Social Care:** Enabling and empowering social care to focus on an individual's abilities, assets and independence. Empowering people to live full lives by fostering autonomy, building on community resources and promoting wellbeing through personalised, collaborative support.

**Awareness of Impact of the wider Determinants of Health:** Working to reduce health inequalities by collaborating with partners to address indicators of ill health and connecting local people with wider public services and support.

**Supporting Growth and Improvement:** Neighbourhood teams supported to embed growth and improvement within their ethos, using data to understand the needs of their local population and applying skills to implement change effectively and scale up good practice. Effectively utilising funding from a range of sources to accelerate and change.

**Decision Making:** Ability to inform decisions that influence service provision and collaborative working within the neighbourhood.

**Realising the Opportunities from Digital and Data:** Identifying, resourcing and exploiting the opportunities that information technology, digital transformation and insights from data provide to drive better outcomes and experience.

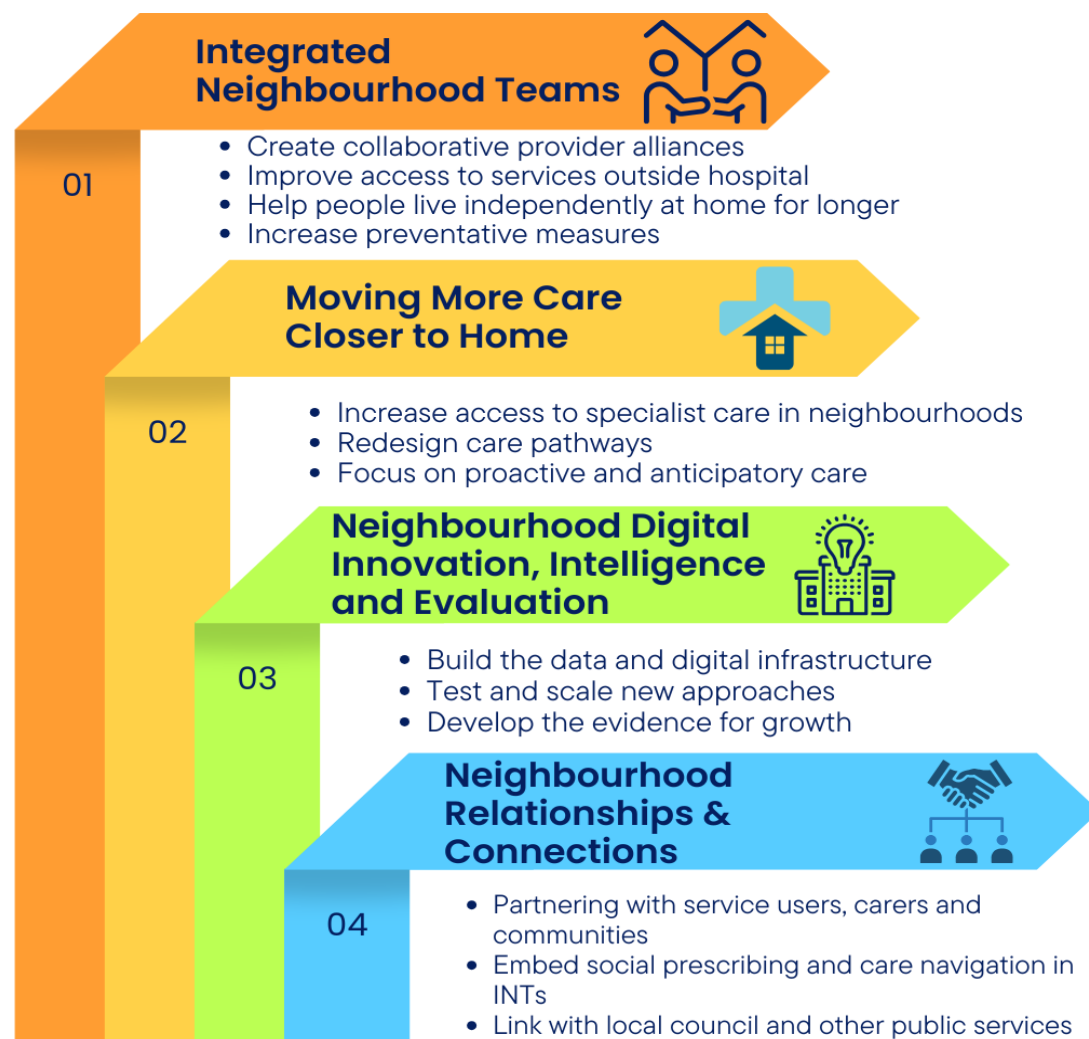
# The Neighbourhood Model of Health and Wellbeing

To make the vision a reality, we need a model that will both embed the neighbourhood principles into day-to-day working for service users and providers and drive the system-wide cultural change needed to move from reactive, hospital-centred care to proactive, preventative and community-based support.

The model will therefore need to support the development of new ways of working through provider alliances as well as redesigning clinical pathways, strengthening multidisciplinary collaboration, embedding social prescribing and investing in data, digital and innovation capability to enable earlier intervention and anticipatory care for high-risk groups.

A focus on building strong relationships within teams and with communities will be necessary, fostering shared ownership of outcomes and collective accountability. By addressing wider determinants of health and scaling evidence-based neighbourhood approaches, the model will aim to manage growing demand more sustainably, improve population health outcomes and build a more resilient, prevention-focused health and social care system for Northern Ireland.

The Neighbourhood Model of Health and Wellbeing will have four pillars:





## 1. Integrated Neighbourhood Teams (INTs)

The Neighbourhood Model will be supported by the establishment of 17 new Integrated Neighbourhood Teams (INTs) serving average populations of 115,000, operating within GP Federation footprints (see figure 4) within the 5 HSC Trust geographical boundaries.



Figure 4: GP Federation Map

This model will see INTs act as provider alliances, bringing together currently siloed professional teams and organisations with a clear service delivery focus. They will develop a thorough understanding of the populations they serve, the services and roles that each member of the team offers and agree the outcomes they want to deliver.

These INTs will work together as a team of teams to lead and drive the delivery of the neighbourhood's priorities to improve health and wellbeing for the people who live in their geography.

INTs will work together to:

- consider the needs of people across the life course who live in their neighbourhood, with an initial focus on older people, to help them to stay well, independent, at home and out of hospital when appropriate and possible.
- improve day to day access to GP, primary care, social care & community services and optimise the delivery of existing services.
- reduce unnecessary use of hospital services where care in the community and closer to home is clinically advisable.
- provide support and care early to prevent health problems becoming a crisis and optimise delivery of vaccination and screening programmes.
- work with Trusts to help reduce unnecessary bed days for medically fit patients ready for discharge.

Members of the INTs will connect at two levels: vertically through their networks of service providers working across the Trust area and region; and horizontally with providers in the smaller neighbourhoods within their footprint, which are the natural communities where people say they feel they belong.

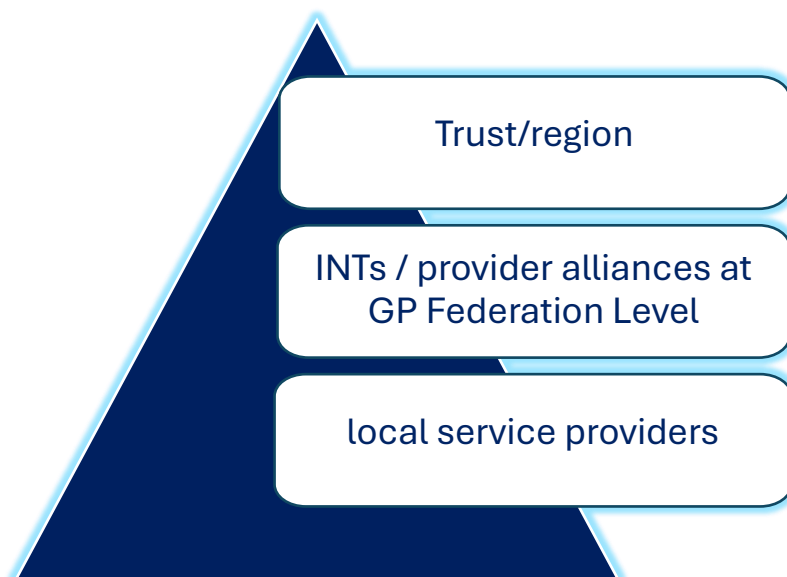


Figure 5: Integrated Neighbourhood Teams

Each member of the INT will represent a group of providers that offers services to people within their footprint. They will meet and work together but will be employed by their host organisation and have their INT role included in their job description for HSC organisations, or contractual agreement for independent sector providers, outlining their responsibilities.

Consideration will be given to roles that may be needed within each INT such as a clinical lead, manager and/or administration.

The membership of INTs may include:

- **Primary care providers**, primary care represented by a GP, community pharmacist, dentist & optometrist.
- **Independent care home/home care providers**, represented by a nominated care home or home care provider.
- **Trust community-based services**, represented by, for example, community nursing, allied health professional, mental health, social care/social worker.
- **Public Health Agency**, represented by a local lead with data and public health insight.
- **VCSE**, represented by a VCSE anchor organisation representative.
- **Social Prescriber**, new neighbourhood roles for social prescribers will be developed where required.
- **Local Council**, represented by a member of the local Community Planning Partnership.
- **Service User and Carer**, represented by members of the public appointed for this purpose.

Membership of each INT can be adapted to reflect local priorities, potentially with a smaller core team coming together at the outset and expanding as the work programme develops.

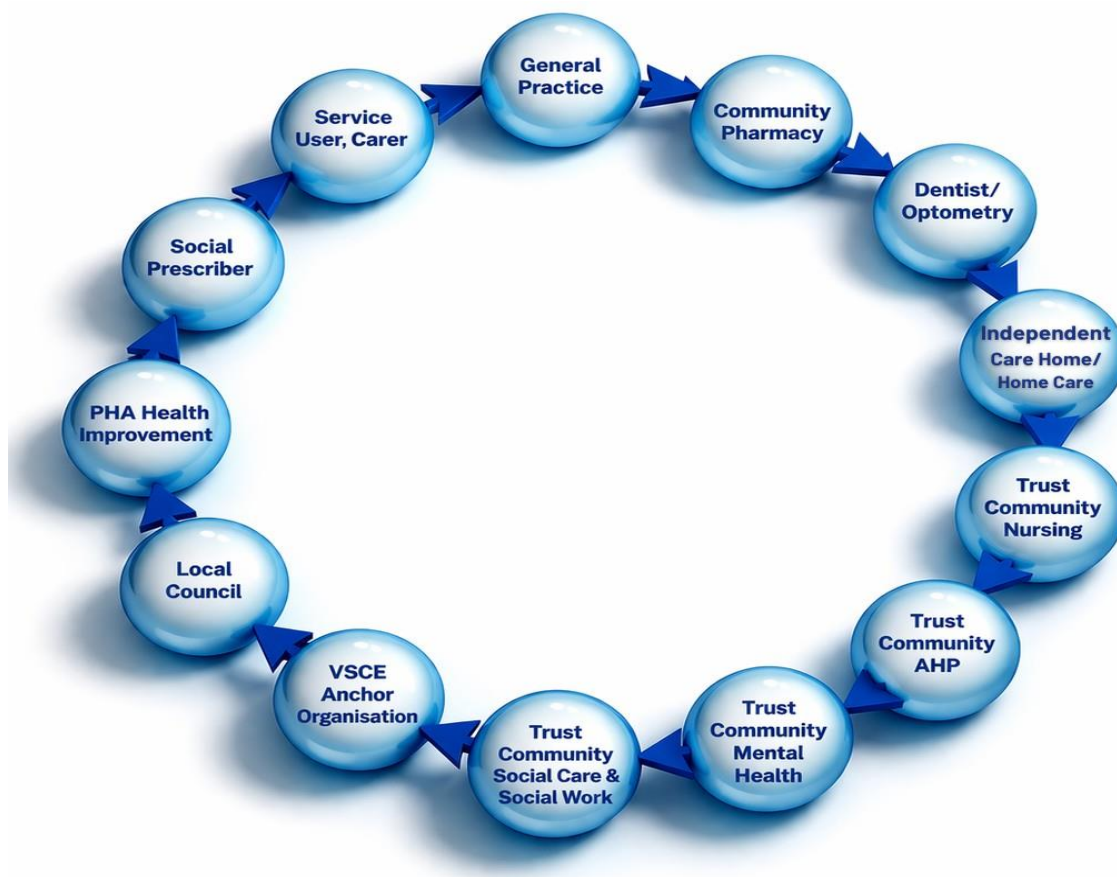


Figure 6: INT Membership

## Governance of the INTs

The Department of Health's Strategic Planning and Performance Group (SPPG) will be responsible for the governance of the INTs. Individual INT members will come from different organisations, and as such are not formally obligated to work together. Teams will therefore need a form of collaborative agreement that sets out their scope, responsibilities and accountabilities to ensure success.

In line with the principles of good governance a robust framework is needed to ensure the INTs can operate with clear accountability within a defined geographical footprint and population. They will need agreements to underpin their joint work, offer safe clinical practice with clarity over clinical responsibilities and conflicts of interest, ensure lawful data sharing, have clarity on scope of practice, set out clearly identified outcomes and measurements and ensure effective use of resources, while allowing a level of local decision making to enable joint working.

The importance and value of collective leadership was emphasised by stakeholders during the design phase, and the governance of the INTs will be based on shared leadership.

Each service provider member of the INT will be accountable to their own employer and/or statutory body, where relevant. They will have access to resources and budgets within their organisations and can be expected to discuss collectively within the INT how to get best value from these and how they should be deployed to achieve the INT's core objectives.

A structured development programme will be required to ensure INTs are appropriately supported and enabled to meet and work together to carry out their functions.

## Development of the INTs

The development of the INTs will begin in April 2026, when representatives from the various service providers will be invited to come together to initiate the process. This initial engagement will mark the start of an inclusive and coordinated effort to establish a network of INTs across Northern Ireland, with the shared aim that all teams are meeting regularly by the end of the year. Over the following months, all INTs will participate in a structured development programme that will be delivered in phases. Some areas may naturally feel more ready to begin than others but regardless of their starting point, each INT will be supported to assess its readiness and progress at a pace appropriate to its local context.

Throughout this period, INTs will receive support to help them build strong relationships, develop a shared identity, and foster a culture of joint working grounded in neighbourhood responsibility. This will be provided through a blend of educational, coaching and facilitation approaches, helping teams deepen their understanding of the needs of their local population and the contributions each provider brings. INTs will also be guided in developing clear approaches to collaboration, enabling them to work collectively to improve the health and wellbeing of their populations, manage demand, and deliver against their core objectives.

When INTs start to meet and work together, they will be encouraged to focus on improvements for specific population groups within their locality, informed by data-driven priorities. As the teams mature their areas of focus will broaden and membership may adapt over time to support this evolution and ensure the team remains aligned to local needs and priorities.

## Area Integrated Partnership Boards

The five shadow Area Integrated Partnership Boards (AIPBs) were launched between October 2024 and March 2025 to support the development of integrated care in NI.

With the introduction of the Neighbourhood Model of Health and Wellbeing, the role and function of AIPBs will adapt to help strengthen service provision and ensure strong cohesion with local planning and integrated cross system working going forward. It is anticipated that AIPBs will see the service aspects of their role pivoted towards INTs and their planning functions moving to formally support community planning through the provision of expert health and care input to Community Planning Partnerships. These changes will be further developed and implemented over the coming months.



## 2. Moving More Care Closer to Home

The second pillar of the Neighbourhood Model of Health and Wellbeing is the strategic design and redesign of health and social care systems, so that more advanced, specialised and proactive care is delivered closer to people's homes, reducing reliance on hospital-based services, the need for traditional homecare or a move into nursing or residential care where this is not the wish of the patient or service user.

This will involve a programme of prioritised place based and regional initiatives designed to scale up good practice and create a pipeline to test and build the evidence for new approaches where needed. Where possible a "once for Northern Ireland" approach should underpin this to avoid unwarranted variation across Trusts and INTs, although it is accepted that some local flexibility may be necessary aligned to more localised need.

This will mean planning and redesigning clinical pathways so routine and scheduled care (outpatient appointments, diagnostics, elective procedures and reviews) increasingly happens in community and primary care settings, with higher acuity care retained in hospitals.

It also means strengthening anticipatory and proactive care, so high-risk groups receive early, tailored support locally, keeping people safe, well, independent and living with purpose in their communities. For example, a care pathway where people with serious illness or at end of life are identified early and supported by multi-disciplinary teams to manage symptoms, plan and receive coordinated care in the place they call home, with access to specialist care when needed.

It can mean moving full clinical responsibility and resources from one part of the system into one or more neighbourhood services. It also involves a role for INTs and Trusts working together to help reduce unnecessary bed days for medically fit patients ready for discharge.

Primary Care Multidisciplinary Teams (MDTs), community nursing and midwifery, AHPs, social work, social care and community pharmacy services are key enablers of shifting advanced care out of hospitals and into the community. The current strategic expansion of MDTs around general practice and GP Federations is bringing together physiotherapists, mental health practitioners, social work assistants and social workers, alongside practice nurses, advanced nurse practitioners and general practice pharmacists, to manage both every day and more complex needs locally. This model increases clinical capacity in the community, improves continuity of care and helps reduce unnecessary referrals to secondary care and other more intensive care.

Beyond their established and trusted role in medicine supply and pharmaceutical advice, the Pharmacy First initiative empowers pharmacists in hundreds of community pharmacies across Northern Ireland to assess and treat conditions such as sore throats, Urinary Tract Infections, shingles and minor ailments without a GP appointment, freeing GP and urgent care capacity and providing accessible care closer to home. Expansion of this initiative and the inclusion of community pharmacists in redesigned clinical pathways will further enhance access closer to home.

The Call for Evidence includes many examples of services designed to offer more care closer to home, including:

- NI Pears - a primary care based optometric service to manage patients with acute non-sight threatening eye conditions, reducing demand for secondary care, and facilitating care closer to home for patients.
- GP elective care - services including dermatology and women's health clinics offered at GP Practices, reducing variability and referrals to secondary care.
- Hospital at Home - a multidisciplinary team providing hospital level care to frail and older people living in the community.
- INTERACT - an initiative from the NI Ambulance Service to address Frequent Service Users, by engaging with other services involved in their care, signposting, and making onward referrals to the most appropriate care services to meet their individual needs.
- Inclusion Works - supporting people with complex disabilities to develop skills to work, learn, and engage in their community, enhancing their health and wellbeing.
- IMPACTAgewell - providing tailored, preventative care to older people in their own homes, and connecting them to local community support.



### 3. Neighbourhood Digital Innovation, Intelligence and Evaluation

The third pillar of the model is a neighbourhood innovation programme which will provide the data and digital infrastructure, innovation pipeline and evidence to support system wide change.

This will bring existing analytics expertise, digital platforms, innovation and improvement resources from across Northern Ireland's health and social care system together, to help INTs understand the needs of their populations and support the redesign of care pathways at scale to deliver more care, and provide care in different ways, in neighbourhoods. Data and technology will provide an information thread supporting collaboration and enabling INTs to deliver proactive, preventative, and personalised care closer to home, improving health outcomes and system efficiency.

It will also involve partnering with academia, industry, charities, local councils, innovation and research organisations and other Departments and sourcing funding to explore opportunities to accelerate neighbourhood development while strengthening the evidence base for neighbourhood working. Another aspect will be a focus on building connections with neighbourhood models in other countries. The key components will be:

#### Neighbourhood data framework

A neighbourhood-level data framework will bring together population health data, service activity and wider determinants of health for each INT. This includes measures of need (for example, demographics, deprivation, disease prevalence, long-term conditions) alongside metrics on demand, access and usage of services across health, social care and community provision where available. Integrating these data sources will provide richer insight into unmet need, inequalities, patterns of service use and emerging pressures, enabling INTs and system leaders to prioritise interventions, target prevention and plan services around local populations. It will enable INTs to identify and proactively work with vulnerable patients and those at risk of becoming unwell to avoid unnecessary hospital admissions and to support them to return home in a timely and safe manner.

#### Digital and data skills and capabilities for integrated working and care delivery

Digital tools and systems are needed to enable INTs to meet, communicate, work together effectively and introduce digitally enabled models of care. They will use data and technology to support proactive, preventative, and personalised care closer to home, and better support collaboration across organisational boundaries. This will include secure platforms for virtual and hybrid meetings, shared workspaces, access to agreed neighbourhood intelligence and directories of local support. Information sharing will be underpinned by robust governance, data protection and role-based access, ensuring that information is shared safely, appropriately and proportionately to support joined-up care while maintaining public trust. It may include scaling virtual

wards, deploying remote telemonitoring technologies and introducing virtual models of care.

We will increase the number of digitally enabled and data confident citizens through increased accessibility and a consistent offer, whilst providing them with the skills and support needed for digital inclusion and improving digital and data literacy. This will be delivered in partnership with local councils, voluntary and community sector organisations and existing digital inclusion programmes, aligning with and signposting to established initiatives, creating new training provision as required.

### A pipeline of continuous improvement and innovation

Support is needed to build a culture of continuous improvement and innovation across neighbourhoods, to embed implementation science and quality improvement methodologies, helping the system to test, adapt and scale new ways of working, including using technology, digital solutions and AI as appropriate. Practical support will include coaching, improvement collaboratives, access to analytical and evaluation expertise, and tools to measure impact. By building improvement capability and change readiness within INTs, learning will be shared, successful approaches spread, and neighbourhood models can evolve in response to local need.

### Strategic partnerships and networking

A key enabler is working with partners from sectors outside the HSC to collaborate on projects of mutual interest. This may involve securing targeted seed funding drawn from, for example, social finance, research, innovation and invest-to-save mechanisms to test new approaches and demonstrate impact, effectively creating a pipeline of evidence based and costed practice intended to redesign care pathways and inform commissioning decisions. Opportunities will also be sought to share knowledge and learning between Northern Ireland and other countries at different stages of maturity in neighbourhood working.

### Neighbourhood research and participation in clinical trials

Research should be embedded within practice within the INTs, enabling service providers, communities and local people to shape and participate in studies, building the evidence base for new ways of working. Increased access to clinical trials would also help widen access, improve equity and ensure innovation benefits the needs of the communities they serve.



## 4. Neighbourhood Relationships & Connections

The fourth core pillar of the Neighbourhood Model of Health and Wellbeing is a deliberate focus from the beginning on partnership and relationship-building within Integrated Neighbourhood Teams, with people and communities, and between health and social care services and the wider public sector.

This model can only be delivered by seeing people as assets and working with them as partners. Working in partnership enables people to actively shape the world around them. It harnesses the meaningful connections to family, community, organisations

and institutions, enabling people to imagine a different and better life, and to care, take responsibility and create opportunities for others to do the same. It means engaging with people about what health means to them and how they can help us to help them when they most need us. This change in culture and approach, which promotes collaboration and agency, supports people to live well and stay well by sharing power, responsibility and accountability.

The INTs will act as provider alliances and their effectiveness and ability to join up their caseloads will depend on trusted, collaborative working arrangements built on shared purpose, values and culture, mutual respect and collective accountability. Establishing clear ways of working, regular meetings, planning and transparent decision-making processes enables teams to function as a system rather than a collection of services.

This pillar also emphasises strengthening relationships between neighbourhood teams and the communities they serve. Meaningful engagement, adopting asset-based approaches, ongoing dialogue and working with people as partners in their care, ensure services reflect local need and builds public trust.

A critical element is systematically connecting teams with services addressing the wider determinants of health, including housing, welfare advice, employability, education and community safety. The AIPB model of the future will seek to enable referral pathways and partnership working with local councils and the services they offer relating to prevention, health and wellbeing. Closer working between INTs and voluntary organisations will also enable coordinated support that goes beyond clinical care and “traditional” care methods and options.

Embedding social prescribing and care and support navigation within neighbourhood teams at an early stage will provide a practical bridge between health services and community assets. Some models include link workers that help individuals access community groups, financial advice, physical activity programmes and peer support, reducing isolation and preventing escalation of need. The Call for Evidence included examples of social prescribing to inform a regional approach, including:

- SPRING Social Prescribing Project and SPRING Enhanced Rural Prescribing Project by the Health Living Centre Alliance;
- Connect North by the Northern Health and Social Care Trust in partnership with Age NI; and
- mPower by the Southern Health and Social Care Trust.

Work is also taking place under the Department’s adult social care reform programme to develop and implement a comprehensive preventative adult care/support framework, which reduces or removes the need for traditional homecare provision, or complements homecare provision.

Together, this relational infrastructure underpins sustainable neighbourhood transformation.

## Funding Model

The economic outlook for the health service over the next year is extremely challenging. There is already significant existing investment in secondary, primary and community care services. There is therefore a need to rethink how health and social care is provided to ensure that the resources that are available can be used to make a greater impact.

The shift left to a Neighbourhood Model of Health and Wellbeing will realise benefits for patients, service users and the system by caring for more people closer to home and reducing duplication. Given the financial position, it is unlikely that there will be much additional resource made available to support this new way of working. However, from 2026/27 there will be a refocusing of care from hospital to community with commensurate redirection of funding, with an aim to move 2% each year from hospital based spend to community spend, delivered through the new neighbourhood model and the INTs.

## Mixed Funding Model

Building on existing funding for primary and community services, and additional inward investment in support of key projects, the Neighbourhood Model of Health and Wellbeing will be supported by a mixed funding model.

This will involve mobilising HSC funding to support INTs to develop and shift resources to deliver more care through their provider alliances and using invest to save opportunities and seed funding from external sources to accelerate improvement and growth. In addition, funding secured from The Executive Office Transformation Fund will help the HSC to build the staffing, digital infrastructure and systems needed for long term change in neighbourhoods.

There are four core key elements to this as set out below:

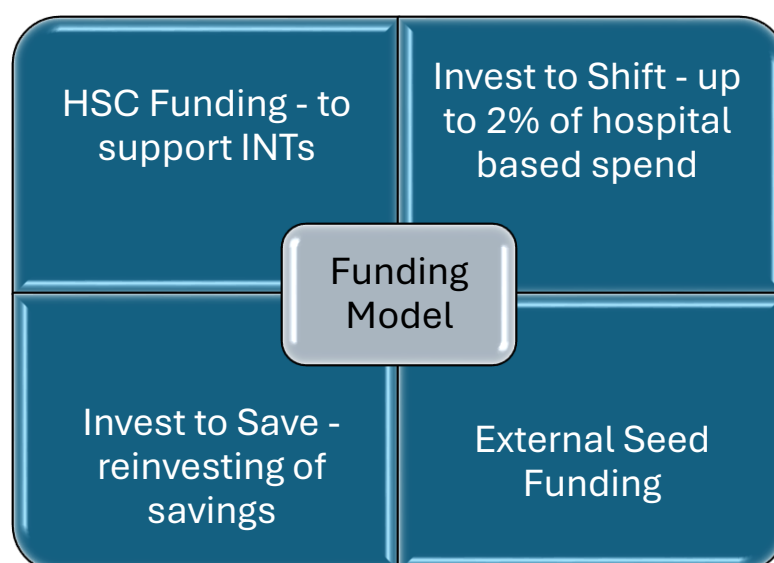


Figure 7: Funding Model

Funding Source	What does this mean? What will it fund?
<b>HSC funding to establish and run up to 17 integrated neighbourhood teams to support workplans including delivery of core functions.</b>	From 2026/27 a proportion of the annual HSC budget will be set aside for the neighbourhood development programme and the running of the 17 INTs.
<b>HSC invest to shift funding to enable delivery of more advanced and specialist services closer to home.</b>	From 2026/27 there will be a re-focusing of care from hospital to community with commensurate redirection of funding, with an aim to move 2% each year from hospital based spend to community spend, delivered through the new neighbourhood model and the INTs.
<b>HSC invest to save opportunities driven by the provider alliances.</b>	Invest to save approaches can be used to fund INTs' growth and development. For example, by providers working together on reducing prescribing costs and/or avoidable demand on acute and emergency services, avoiding escalation and improving wellbeing, savings realised could be reinvested locally to sustain local community-based support.
<b>External seed funding used to test neighbourhood initiatives at scale through social finance, innovation, research or other investment opportunities</b>	<p>From 2026/27 a programme of development projects will aim to accelerate the pace of change in service delivery in neighbourhoods, evaluate impact and build the evidence for sustainability. This will involve both scaling up recognised good practices and developing the evidence base for new approaches where gaps exist.</p> <p>Opportunities are being explored to work with funding partners, for example, social finance providers and industry, and to apply for innovation and research funding to test and evaluate the impact of new ways of working on service users, providers, system demand, population health and cost effectiveness.</p>

## New Investment

The health and social care system is benefitting from new investment from the Executive's Transformation Fund in support of a number of key projects that will support Neighbourhood working. The Primary Care MDT programme has been allocated £61 million over the next four years. This will run from 2025/26 to 2028/29 and will see MDTs completed in the seven existing GP Federation areas where implementation has already commenced, and expansion to a further five Federation areas.

A Transformation Fund bid is at an advanced stage for a significant investment to accelerate digital reforms in primary care, supporting an e-pharmacy programme that will introduce systems for both the electronic transfer of prescriptions and to digitise community pharmacy services. If funded, these programmes will have an impact on every person's experience of health and social care in Northern Ireland, making it quicker and easier to manage their prescribed medication, free up time for more clinical activity in general practices and enable an increased range of services to be accessed in community pharmacies.

Also at an advanced stage is another significant bid for Transformation Funding, matched by the National Lottery Community Fund. If funded, this will support the introduction of a new neighbourhood-based family support service across Northern Ireland, aimed at helping families to stay safe and well together and prevent the admission of children into state care or to enable some children to return safely home from care. The new service will be provided in partnership between statutory children's services and voluntary and community organisations.

In addition, Macmillan's Neighbourhood Transformation Fund has committed to investing up to £10 million, over the coming three to five years, to work in partnership with the Department to address frailty and provide end of life care with the tailored support needed.

A number of other opportunities are also being explored to work with partners in industry, academia, innovation and the charity sector.

## Working with Purpose: Getting Started

The publication of this document marks the beginning of the implementation phase. It describes the high-level operating and funding arrangements for Neighbourhood Health and Wellbeing that are the foundations to enable work to begin to establish this new approach to health and social care delivery in Northern Ireland.

In the first phase of implementation there will be progress across the four pillars of the model, with a deliberate initial focus on the needs of older people.

### A Focus on Older People

Older people are the highest users of health and social care. By 2047, the number of people aged 65 and over is projected to increase by some 50% and those aged 85 and over are projected to increase by over 120%. In addition, it is estimated that the number of people reaching retirement age will exceed those entering the workforce by 2040, placing unprecedented pressure on resources. Also, evidence suggests that Northern Ireland is on course to become the oldest region in the UK by 2050, this will intensify the demand for care.

A [report](#) published by the Commissioner for Older People in Northern Ireland in February 2026 indicated that access to services, in particular accessing healthcare services, was the biggest concern for older people. It also highlighted that the current system is failing older people because demand is rising relentlessly while capacity is not keeping pace. It was the conclusion of the Commissioner that demographic ageing is a whole-system challenge, not just a health one, and that tackling ageing pressures needs a joined-up, whole-government response. The report concludes that Northern Ireland now faces a clear choice: planned reform or collapse. In the words of the Commissioner “*We are all ageing. The system we allow to decline today is the one we will all rely on tomorrow.*”

PCC’s [What the Public Thinks \(2025\) poll](#) further found that a higher proportion of older people (65+) considered care and treatment in their own home and community to be important. Older people are less digitally engaged than other cohorts of the population, and are most likely to consider not being able to access their GP as an appropriate reason to attend an ED.

## Outputs for 2026/27

This is the start of long-term change, and a dedicated Neighbourhood Development Programme Board will help steer and oversee progress with the following outputs across the four pillars by March 2027:

### 1. Integrated Neighbourhood Teams

- Across Northern Ireland Integrated Neighbourhood Teams will be supported to establish clear ways of working, regular meetings, planning and transparent decision-making processes.
- They will begin to work together to:
  - consider the needs of people across the life course who live in their neighbourhood, with an initial focus on older people, to help them to stay well, independent, at home and out of hospital when appropriate and possible.
  - improve day to day access to GP, primary care, social care & community services and optimise the delivery of existing services.
  - reduce unnecessary use of hospital services where care in the community and closer to home is clinically advisable.
  - provide support and care early to prevent health problems becoming a crisis and optimise delivery of vaccination and screening programmes.
  - work with Trusts to help reduce unnecessary bed days for medically fit patients ready for discharge.

### 2. Moving More Care Closer to Home

- Plans will be developed for the re-focusing of care from hospital to community and will aim to move 2% each year from hospital based spend to community spend, delivered through the new neighbourhood model and the INTs.
- A programme of development projects will test new approaches to neighbourhood working, at scale, supported by seed funding from external funders.

### 3. Neighbourhood Digital Innovation, Intelligence and Evaluation

- The digital, data and improvement infrastructure to support INTs in their early stages will be established.
- A neighbourhood evaluative framework will be designed, informed by the development projects.
- Connections will be made with neighbourhood models in other countries.

#### 4. Building Neighbourhood Relationships and Connections

- Approaches that enable effective service user and carer involvement and engagement in the neighbourhood model will be adopted.
- Connections and referral pathways with local councils and voluntary organisations will be established to enable coordinated support that goes beyond clinical care.
- A regional approach to embed social prescribing within INTs will be developed and funding sourced.

## Acknowledgements

The Department would like to thank all those stakeholders who contributed to this work over the last number of months and who helped inform the development of the model through their attendance at workshops, meetings, and through facilitating presentations and visits to see existing examples of good practice.

In particular, the Department is grateful to all those who responded to the Call for Evidence, sharing their examples of good practice and the learning associated with those.

Engagement with stakeholders from across sectors will continue as this work progresses. Your support is welcome and greatly appreciated and will be essential in ensuring the success of the Neighbourhood Model of Health and Wellbeing.

## Annex A: Strategic Context

In December 2024, the Health Minister published his [Three Year Plan](#), designed to provide a roadmap out of decline and setting out a path for the future based on the three pillars of Stabilisation, Reform and Delivery:

- **Stabilisation** of services, including mitigating the inevitable deterioration of some services as a result of budgetary pressures.
- Accelerated **Reform** of our HSC so we make the strategic changes necessary to enable the system to address the health needs of our citizens. We must put the health system on a sustainable footing with a long-term vision supported by a viable plan to deliver it.
- **Delivery** of safe, sustainable, high-quality health and social care services as close as possible to citizens through primary, community, social and hospital care, with our services configured effectively and efficiently to meet demand for both planned and unscheduled care. This also means delivering for the workforce, who are the heart of the HSC.

Building on the Three Year Plan, the [HSC Reset Plan](#) was published on 9 July 2025, and is focused on 7 key areas:

1. Prevention and seeing the citizen as an asset in that task;
2. Investing in Primary Care, Community Care and Social Care; delivering mental, physical and social healthcare in a joined-up way;
3. Being as effective and efficient as we can with the resources we have;
4. Adopting a whole systems approach; to optimise the whole of NI's health and care workforce and estate, and to reduce the level of unwarranted clinical variation;
5. Maximising digital investment and the strategic use of data;
6. Exploiting opportunities for research, supporting early adoption of new medical procedures and treatments; with the opportunity to attract the inward investment this brings; and
7. Creating the system and structure that supports collaborative working and decision making.

The introduction of the Neighbourhood Model of Health and Wellbeing is a key cornerstone of the Reform pillar and implementation will aim to benefit from and align with a number of other Reset projects and strategic developments. Some of these are set out on the following pages.

## People to Partners

The People to Partners initiative is about shifting the relationship between health and social care services and the public from one of passive receipt to genuine partnership. It emphasises involving people and communities as active collaborators in service design, decision making and improvement recognising citizens as assets with valuable lived experience that can help them live well, stay well and shape services for the better.

## This is Our Health

The HSC Reset Plan seeks to start a new dialogue with the public through a new public health programme ‘This is Our Health’ designed to incentivise people to take action to maintain and improve their own health.

## Big Discussion

During 2025, the ‘Big Discussion – Whole System Flow’ programme explored the challenges contributing to HSC wide pressures, which are exacerbated in winter. It focussed on the growing needs of an ageing population with complex health conditions and led to 7 improvement projects covering topics such as frailty identification, keeping people well at home, avoiding admission to hospital for end-of-life care, frail elderly falls pathway and advanced care planning. As part of this work PCC explored with the public their experiences of the HSC and ‘system’ pressures, in their [What the Public Thinks report](#). These insights from the public strengthen and reinforce the need for the development of the Neighbourhood Model, and this recent programme will provide valuable learning for neighbourhood development.

## New Vision for General Practice

The Department has committed to working with GPs to develop a new vision for modern, sustainable General Practice at the heart of the Neighbourhood Model of Health and Wellbeing. This means harnessing clinical excellence, technological advancements and new ways of working, to provide accessible, high quality and safe services that support continuity of care for patients; and rewarding and fulfilling careers for GPs and wider practice teams that respects the needs and aspirations of the workforce.

## Primary Care Multi-Disciplinary Teams

Primary Care Multi-Disciplinary Teams (MDT) are providing more care closer to people’s homes and improving access to early support and diagnosis. By proactively managing patient need in their local GP practice setting through a multi-disciplinary early intervention approach we can improve patient outcomes, reduce the need for referrals and appointments elsewhere, and ultimately ease pressure on GP and hospital services. The MDT model remains key to stabilising and strengthening vital Primary Care services to ensure they can continue to locally provide high quality care to our people within the Neighbourhood Model.

## Community Pharmacy

Community pharmacy is one of the four pillars of primary care in Northern Ireland and provides vital services for local communities and neighbourhoods. The Department’s Community Pharmacy Strategic Plan 2030 and three-year Commissioning Plan 2025-2028 seek to deliver more clinical services within the community pharmacy network

and utilise the unique skills of pharmacy teams to offer safe, convenient and timely access to care in the heart of the community.

### Valuing Medicines Strategy

Published in September 2025 the Valuing Medicines Strategy highlights a high reliance on prescribed medication in Northern Ireland associated with rising financial and environmental cost. It makes several recommendations to improve the cost-effective use of medicines and to involve patients more in decisions about their care. It also recommends improved access to non-medical therapies alongside medical treatments through the continued roll out of multi-disciplinary teams in primary care and the introduction of a regional approach to social prescribing.

### Regional Mental Health Service

In July 2021 the Department published its ten year Mental Health Strategy 2021-2031. In line with the vision set out in the Strategy, a Regional Mental Health Service is being established to implement arrangements for joined up working across key mental health partners including Health and Social Trusts, community and voluntary sector and primary care services.

### Social Care Reform

A number of reviews have pointed to the need for change in how we deliver social care. In response, on 23 March 2026 the Department published the Reforming Adult Social Care and Support 10 year Strategic Plan and the first 3-year Delivery Plan which have been developed in collaboration with delivery partners, including those in the voluntary and independent sectors. The overarching aim is for a social care system that is focused on independence, choice and enabling people with support needs to live the lives they want to lead with meaning, purpose and connection with their family and community networks. In addition to traditional statutory care options, it is envisaged that the reformed system will include a community based preventative social care model that seeks to keep people safe and well for as long as possible in their own homes or a home of their choosing, without the need for statutory intervention.

### Making Life Better

Making Life Better (MLB) is the overarching strategic framework for public health through which the Executive committed to creating the conditions for individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives. It focuses on primary prevention and addressing the social determinants of health and inequalities. Under MLB, the Department leads on a number of strategies and action plans that are designed to help improve population health and wellbeing and target specific areas and population groups where health inequalities are most prominent in our society.

### Live Better

In support of MLB, Live Better was a place-based approach which was tested in two areas of Northern Ireland. It brought together the HSC family and the Community and Voluntary sector to address health inequalities. The recommendations and learning from Live Better will inform the development of the Neighbourhood Model. Further

information on Live Better, along with its Evaluation and Recommendation reports can be found at:

<https://www.publichealth.hscni.net/services-and-teams/public-health-services/health-and-social-wellbeing-improvement/live-better>

### Elective Care Framework (ECF)

The ECF is the Department's strategic plan to reduce waiting lists and reform the delivery of planned care by increasing capacity, improving productivity and redesigning elective pathways, to ensure a more sustainable system over the medium to long term. As part of this, work is being taken forward to support individuals on HSC waiting lists by helping them to manage their condition, maintain independence and remain economically active where possible.

### Open, Just Learning Culture

Over recent decades, several public inquiries have highlighted systemic failings within health and social care, particularly around openness, transparency, and accountability. These inquiries have consistently recommended fostering a culture of openness and candour to improve patient safety and to help rebuild public confidence.

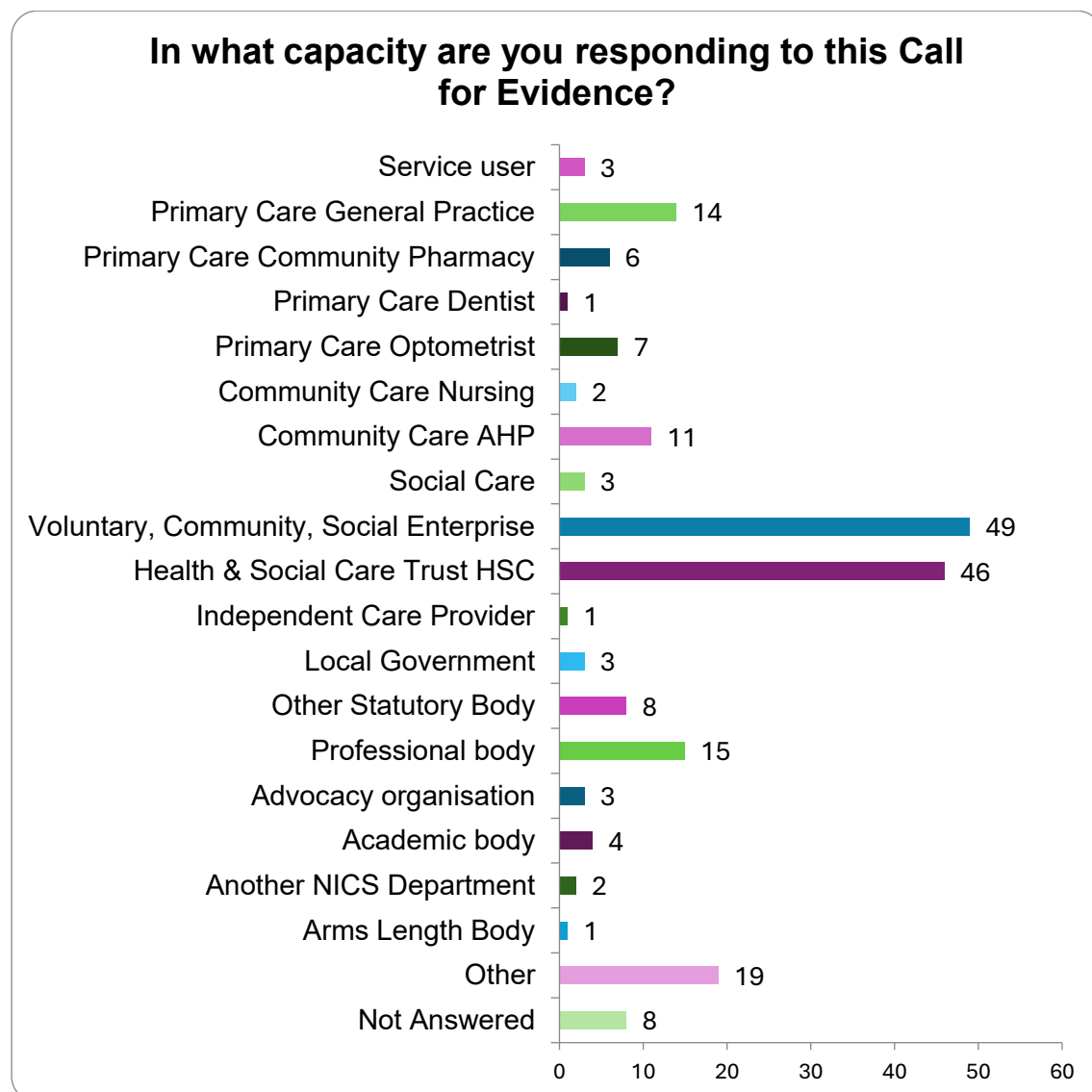
A well-supported workforce is central to achieving better outcomes for patients and service users. Evidence clearly demonstrates that staff who feel empowered, psychologically safe and valued are better equipped and more likely to deliver high-quality, compassionate care.

Our strategic plans, including the 3-Year Plan and the HSC Reset Plan, prioritise cultural transformation as a foundation for safer services, supporting and empowering our staff, and improving patient experience. The Department has been working to deliver these improvements through a comprehensive programme of cultural and legislative change. This includes through progressing a coherent package focused on openness, transparency and learning, including an Organisational Duty of Candour Bill, a regional Being Open Framework, and reform of the Serious Adverse Incident process.

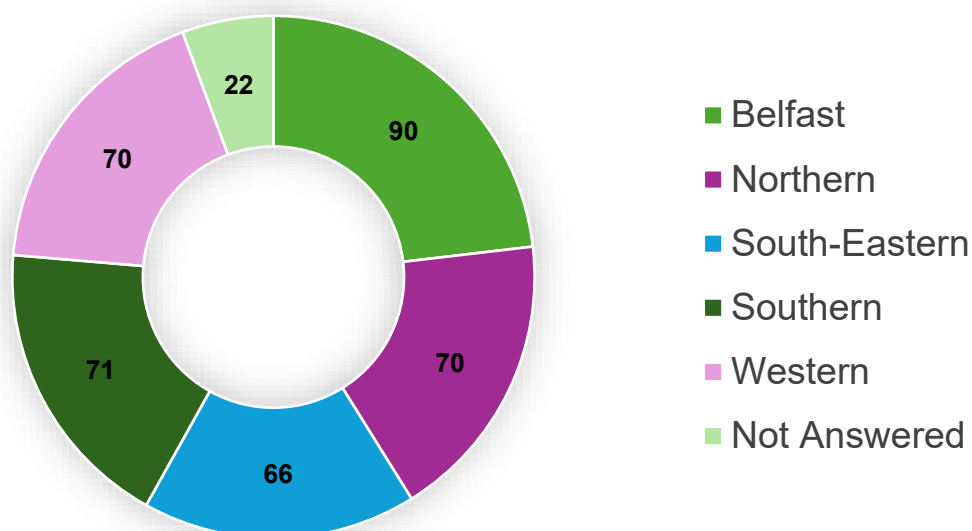
## Annex B: Call for Evidence Analysis

### Analysis of the Responses

We received a broad cross section of responses from the various sectors to the Call for Evidence, a significant number (nearly 50) were from the VCSE sector, followed by over 40 from HSC Trusts and over 20 from Primary Care.



### In what geographical area are you working?



## Common Themes

Across a wide and diverse range of initiatives—spanning health, social care, community development, education, and voluntary sector delivery—there is a striking level of consistency in what works, what limits impact, and what is required to scale success. Collectively, the evidence provides a strong, coherent foundation for the development of a Neighbourhood Model of Health and Wellbeing rooted in prevention, partnership, and place.

Across initiatives, there is a clear and consistent commitment to:

### 1. **Person-centred and strengths-based care, focused on outcomes that matter to individuals, families, and communities**

- **IMPACTAgewell®**  
GPs, community pharmacists, social workers and community organisations acting together to support older people at home.
- **Marie Curie**  
Hospice at Home provides nursing support for patients with palliative and end-of-life care needs and supports people to die with dignity in their preferred place of care.
- **SPRING Social Prescribing**  
Wide ranged community-based activities designed to improve people's health and wellbeing, with Social Prescribers taking time to listen, build trust, and co-design support based on personal goals.

## **2. Prevention and early intervention, particularly for populations experiencing the greatest inequalities**

- **Connected Community Care**  
Community centred approach to health and wellbeing which includes identifying those at risk of chronic conditions and providing personalised support for them so that they may effectively manage their lifestyle.
- **Healthy Hearts in the West**  
Cardiovascular disease awareness and prevention through community wide programmes and Community Pharmacy Vascular Risk Screening and Weight Management.
- **Diabetes Prevention Programme**  
Aimed at reducing blood glucose levels, and preventing diabetes complications, in patients.

## **3. Focus on health inequalities and social determinants of health (e.g. isolation, poverty, housing, trauma)**

- **Home2Hospital**  
Addressing transport poverty and rural access barriers.
- **MARA (Maximising Access in Rural Areas)**  
Focusing on people affected by rural poverty, transport barriers, and poor service access.
- **Our Generation**  
Supporting children and young people affected by transgenerational trauma, deprivation, and community.

## **4. Place-based, community-led approaches, recognising neighbourhoods as assets rather than delivery sites**

- **Glens Healthy Places**  
Designed specifically for rural villages with poor access to services, using local venues, volunteers and participatory budgeting.
- **ARC Healthy Living Centre**  
Created in response to deprivation and health inequalities in the local town; Vacant buildings, local skills and volunteer energy were transformed into a health and wellbeing hub.
- **Verve Healthy Living Network**  
Operates through neighbourhood health hubs in renewal areas, with local people trained as Community Health Trainers to support their own communities.

## **5. Co-production, with service users, carers, and communities involved in design, delivery, and evaluation**

- **DEEDS (Dementia Engaged and Empowered)**  
The management committee includes people with dementia and carers; Carers and service users help shape staff training and peer support models.

- CLARE (Creative Local Action Responses and Engagement)  
The model was created through community conversations with older people; Support is personalised and relationship-based, not time-limited or task-driven.
- Horizon's Bereavement Service – NI Children's Hospice  
A Bereaved Parents Advisory Group to ensure co-production and that services meet the needs of families.

## **6. Partnership working across primary care, community pharmacy, Trust services, VCSE organisations, and local government**

- BCCP (Building the Community Pharmacy Partnership)  
Bringing together community pharmacies and community organisations to co-produce and deliver community development projects to address health inequalities.
- West Belfast GP Federation - delivering integrate primary care at scale  
GP Pharmacy, GP Nursing and Primary Care Multidisciplinary Teams within GP Practices, working in partnership with Belfast Health and Social Care Trust and Community partners to deliver regional, local, emergency and elective services.
- NI PEARS (Primary Eyecare Assessment and Referral Service)  
Providing timely, patient-centred eye care closer to home, within Primary Care, reducing pressure referrals to secondary care hospital services.

## **7. Equity, with targeted approaches for older people, children and families, people with long-term conditions, and marginalised groups**

- NINES (NI New Entrants Service) Family Help Clinic  
Enabling asylum seeking families to access key services aimed at supporting needs and reducing vulnerabilities.
- TinyLife (Premature and Vulnerable Babies)  
Addressing inequalities in early childhood through specialist support delivered in hospitals, homes and community settings.
- Care Zone North Belfast  
Tackling suicide risk and poor mental health in one of NI's most deprived areas using community-led, place-based approaches.

These principles are evident regardless of age group, condition, or sector, indicating a strong shared direction of travel across the system.

## Annex C: List of Acronyms

AHP	Allied Health Professionals
AIPB	Area Integrated Partnership Boards
CDHN	Community Development and Health Network
CiNI	Children in Northern Ireland
DHCNI	Digital Health & Care Northern Ireland
DOH	Department of Health
ECF	Elective Care Framework
FSU	Federation Support Unit
GP	General Practice/Practitioner
HSC	Health and Social Care
ICS	Integrated Care System
INT	Integrated Neighbourhood Team
MDT	Multi Disciplinary Team
MLB	Making Life Better
NIAS	Northern Ireland Ambulance Service
NIHE	Northern Ireland Housing Executive
NICON	Northern Ireland Confederation for Health and Social Care
PCC	Patient Client Council
PCN	Primary Care Network
SPPG	Strategic Planning and Performance Group
VCSE	Voluntary, Community and Social Enterprise