NEIGHBOURHOOD

MODEL OF HEALTH AND WELLBEING

Three Year 2% Resource Guidance For Health and Social Care Trusts

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Department of
Health
An Roinn Sláinte
Männystrie O Poustie
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Northern Ireland Neighbourhood Health and Wellbeing
Three Year 2% Resource Guidance

Purpose and Status of this Guidance

This guidance sets out the Department of Health's expectations for Health and Social Care (HSC) Trusts to support delivery of the NI Vision for Neighbourhood Health and Wellbeing through a planned rebalancing of resources over a three-year period from April 2026. It should be read alongside the policy framework A Vision for Neighbourhood Health and Wellbeing in Northern Ireland, NI Neighbourhood Call for Evidence Report, Health and Social Care Reset Plan and the 2026/27 Strategic and Operational Planning Guidance.

It supports the core concept of right patient, right care, right place, setting expectations for financial planning and service redesign to enable the delivery of more care closer to home and to reduce avoidable reliance on hospital-based services.

Strategic Context

Neighbourhood Health and Wellbeing is a central component of the Reform pillar of the 2025 HSC Reset Plan. The NI Neighbourhood Model is designed to improve how the health and social care system manages demand by strengthening joint working across primary, secondary, community, VCSE and social care and integrating service delivery around neighbourhood populations. The Department has committed to a progressive transition of resources from hospital to neighbourhood delivered services. This document provides guidance on the scale, pace, and expectations of that change.

What action is needed?

HSC Trusts should plan for a move of approximately 2% per annum of hospital-based expenditure into neighbourhood-delivered services each year, over a three-year period commencing in 2026/27. With a focus on older people during this period, to inform their plans Trusts should work with the new Integrated Neighbourhood Teams (INTs) in their footprint to help:

- Identify the activities that will transition from hospital to neighbourhood delivered services;

- Describe how service delivery and service models will be redesigned;
- Outline the financial and workforce changes to deliver the change;
- Demonstrate movement of responsibilities and resources to neighbourhood delivered services; and
- Describe how they will work in partnership to agree and deliver these changes.

Trusts' plans should aim to demonstrate change relating to system and patient outcomes which include but are not restricted to:

System Outcomes	Patient Outcomes
• Reduce avoidable hospital admissions • Reduce ED attendances • Reduce NIAS conveyances to hospital • Reduce outpatient activity where appropriate • Increase proactive and anticipatory care • Improve hospital flow and discharge • Enable access to higher acuity care in neighbourhood settings	• More care at home • Improved independence • Reduced hospital attendance • Service user and carer improved experience of care • Increased access to specialist care in GP, MDTs, VCSE support and neighbourhood delivered services closer to home.

When developing their plans Trusts and INTs should include actions across five broad areas of neighbourhood moves, as set out below (summary table in Annex A).

1: Anticipatory & Proactive Community Care for Older People

Objective: Move resources to Trust-based community teams to provide more access to proactive care in neighbourhood settings and reduce hospital attendance.

Areas of Change: In collaboration with INTs, Trusts may wish to consider expanding their community-based services such as frailty, district nursing,

AHP, social care and mental health services. Planning could also include expanding existing models such as hospital at home and working with GPs, MDTs, and community pharmacies on enhanced care home support and with GPs on risk stratification to help prevent avoidable hospital admission. INTs should also work with their local VCSE members to develop a full range of services to support older people to maintain their independence.

2: Transfer Services to Integrated Neighbourhood Teams

Objective: Move full responsibility and resources for appropriate services to neighbourhood delivered services.

Areas of change: In collaboration with INTs, Trusts may consider transferring clinical responsibility and associated resources for activities that can be safely and effectively delivered in GP and other neighbourhood settings without reducing ease of access for patients.

3: Reduce Outpatient Attendance and Follow-ups

Objective: Reduce unnecessary outpatient attendance and follow ups.

Areas of change: In collaboration with INTs, Trusts may consider alternatives to traditional outpatient models, including patient initiated follow ups, virtual clinics and the relocation of follow up appointments into neighbourhood settings. Advice and guidance for GP practices and shared care arrangements may also have a role.

4: Redesign Clinical Pathways

Objective: Transition more clinical responsibility and resources to GPs, MDTs, and other neighbourhood delivered services to increase access to higher acuity care closer to home.

Areas of change: In collaboration with INTs, Trusts may consider working with GPs and INTs to redesign pathways to enable greater clinical responsibility in primary care, community pharmacy and other neighbourhood services, for example, through expanded community diagnostics, treatment services and engagement with local VCSE services. Planning may also include specialist outreach and remote specialist support delivered closer to home.

5: Improve Discharge and Hospital Flow

Objective: Enable people to return home as soon as they are medically ready.

Areas of change: In collaboration with INTs, Trusts may wish to expand their Discharge to Access, Hospital at Home, community nursing, community therapy and linked VCSE provision, and also work together to improve communication and coordination to support timely and safe discharge home.

What is included in the 2% figure?

The following hospital services are excluded from the 2% calculation due to either their non applicability to a Neighbourhood model, non-recurrent ringfenced funding nature, or fixed costs which could not at this stage be released:

- Tertiary services – costs associated with services provided regionally, largely but not exclusively by Belfast HSC Trust for adults and children. Some examples of this are cardiac surgery, plastic surgery, specialist paediatric services, infectious diseases, child and adolescent psychiatry, complex learning disability services and regional ICU.
- Non-recurrent funds provided for elective waiting list initiatives.
- Community hospital inpatients, as these are effectively already community despite being within the hospital budgets and there will be potential to align these to Neighbourhood in any case.
- Independent sector, which is largely non-recurrent funding and waiting list initiative funding. Again, Neighbourhood will influence these funds going forward.
- Depreciation/amortisation and support costs, such as estate management, Trust executive leadership, legal, laundry, portering and a range of overheads.

With this accepted, the ambition is for Trusts to realign services from hospital to the neighbourhoods to an initial total value of approximately £50 million per annum in each of the next three years. This figure will rise as the Neighbourhood model expands and moves into other areas of care. Trusts' expenditure will be monitored to demonstrate how this 'move' is being delivered. Trusts that use their budget to commission services from non-trust

providers (e.g. GPs, CPs, VCSE, Independent Care Providers) will be able to count this spending against their shift providing it supports new or additional community-based services.

Metrics, governance and reporting timelines

The Strategic Planning & Performance Group (SPPG) will work with Trusts and INTs to define the financial and other outcome measures that will be monitored, recognising the need for a developmental approach over the 3 years. Trusts should ensure there are appropriate governance arrangements, including executive leadership, clinical leadership and programme management to oversee delivery of their plans.

Prioritising and scaling up good practice for neighbourhood delivery

To assist planning the NI Neighbourhood Development Programme Board[1] will work with them and other stakeholders to co-design and develop additional regional guidance to help identify, prioritise and scale up good practice aligned with the Neighbourhood Model for Health and Wellbeing and the five neighbourhood moves.

Conclusion

This policy guidance aims to support Trusts and INTs to prepare for a fundamental change in how health and social care resources are deployed in Northern Ireland and a focus on more neighbourhood delivered care. By the end of the three-year period, the Department expects neighbourhood health and wellbeing to be embedded as the default approach to planning and delivering care closer to home.

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[1] The NI Neighbourhood Development Programme is a Department-led multi-stakeholder group convened to establish and support Integrated Neighbourhood Teams and the enabling infrastructure for neighbourhood working that delivers more access to services and care closer to home.

Annex A - FIVE NEIGHBOURHOOD MOVES

	Neighbourhood Move	Objective	Potential areas of change
Move 1	**Anticipatory & Proactive Community Care**	Move resources to Trust-based community teams to provide more access to proactive care in neighbourhood settings and reduce hospital attendance.	In collaboration with INTs, Trusts may wish to consider expanding their community-based services such as frailty, district nursing, AHP, social care and mental health services. Planning could also include expanding existing models such as hospital at home and working with GPs, MDTs, and community pharmacies on enhanced care home support and with GPs on risk stratification to help prevent avoidable hospital admission. INTs should also work with their local VCSE members to develop a full range of services to support older people to maintain their independence.
Move 2	**Transfer Services to Integrated Neighbourhood Teams**	Move full responsibility and resources for appropriate services to neighbourhood delivered services.	In collaboration with INTs, Trusts may consider transferring clinical responsibility and associated resources for activities that can be safely and effectively delivered in GP and other neighbourhood settings without reducing ease of access for patients.
Move 3	**Reduce Outpatient Attendance and Follow-ups**	Reduce unnecessary outpatient attendance and follow ups.	In collaboration with INTs, Trusts may consider alternatives to traditional outpatient models, including patient initiated follow ups, virtual clinics and the relocation of follow up appointments into neighbourhood settings. Advice and guidance for GP practices and shared care arrangements may also have a role.

Move 4	**Redesign Clinical Pathways**	Transition more clinical responsibility and resources to GPs, MDTs, and other neighbourhood delivered services to increase access to higher acuity care closer to home.	In collaboration with INTs, Trusts may consider working with GPs and INTs to redesign pathways to enable greater clinical responsibility in primary care, community pharmacy and other neighbourhood services, for example through expanded community diagnostics, treatment services and engagement with local VCSE services. Planning may also include specialist outreach and remote specialist support delivered closer to home.
Move 5	**Improve Discharge and Hospital Flow**	Enable people to return home as soon as they are medically ready.	In collaboration with INTs, Trusts may wish to expand their Discharge to Access, Hospital at Home, community nursing, community therapy and linked VCSE provision, and also work together to improve communication and coordination to support timely and safe discharge home.