Community Pharmacy England

April 2026

Briefing: 006/26: Neighbourhood health framework

The Department of Health and Social Care published their Neighbourhood Health Framework on 17th March 2026. It sets out a new national direction for organising health and care services around 'natural' neighbourhoods and delivering more care closer to home.

Alongside this document, NHS England published a letter to Integrated Care Boards (ICBs) regarding next steps on neighbourhood health and a document providing guidance on the application of population health delivery models as part of implementing neighbourhood health.

Community pharmacy is referenced throughout the framework as a key part of primary and community care, with **future expectations** that pharmacies will become an **increasingly central 'first point of contact' for prevention, minor illness and medicines optimisation**.

This Community Pharmacy England briefing provides a summary of the key points in the documents of most relevance to LPC members, community pharmacy owners and their teams.

For those who want to know more about the Government's plans, we recommend reading the full documents:

Neighbourhood health framework

NHS England letter to ICBs – Next steps on neighbourhood health and new delivery models

NHS England – Fit for the future: towards population health delivery models

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Summary of key points within the framework

The framework describes the role that ICBs are expected to take to lead this transition through new commissioning approaches, stronger joint working with local authorities, and

the creation of **Integrated Neighbourhood Teams (INTs)**. The framework also anticipates **new provider models**, improvements to the primary/secondary care interface and investment in neighbourhood estates.

Purpose of neighbourhood health

The documents say neighbourhood health aims to:

- Improve outcomes and reduce health inequalities by focusing on prevention, risk stratification and proactive care.
- Organise services around people, not organisations, with better continuity and more convenient access.
- Reduce pressure on hospitals by strengthening community and out-of-hospital pathways.
- Cut duplication and waste through integrated planning and digital enablement.
- Support delivery of national NHS targets, including access, recovery and elective care.

The new model is designed to complement wider public service reform, including housing, children's services and local regeneration programmes.

National goals and metrics

The framework sets out five overarching national goals, each with supporting objectives and metrics to be met over the term of the Medium-Term Planning Framework and the 10 Year Health Plan period:

- **Improve health outcomes** for priority cohorts including frailty, end of life, long term conditions (CVD, diabetes, COPD, dementia, mental health), care home residents, children and young people.
- **Improve access to general practice**, including same-day care for clinically urgent cases and improved patient satisfaction.
- **Improve planned care experience**, with reduced variation, expanded community-based follow-ups and improved elective care pathway management.

- **Improve urgent and emergency care performance**, including fewer avoidable admissions, better discharge and reduced ambulance conveyances for low-acuity cases.
- **Improve patient and staff experience**, supported by new outcome and experience measures.

Local outcome measures will be set through Health and Wellbeing Boards (HWBs) to reflect Joint Strategic Needs Assessments (JSNAs).

Delivering neighbourhood health

Integrated neighbourhood teams (INTs) are a central feature of the model. They will bring together staff across GP practices, community services, mental health, social care and voluntary organisations to plan and deliver proactive and reactive care for defined neighbourhood populations. INTs may include community pharmacy representatives.

Initial priorities for INTs include:

- Frailty and end-of-life care.
- People with multiple long-term conditions.
- Children and young people (including special educational needs and difficulties reforms and paediatric pathways).
- Cancer survivorship.

The framework emphasises local flexibility around INT composition, leadership and delivery arrangements that will be determined locally.

ICBs and providers are expected to drive improvements in access and productivity across routine care by strengthening the way people move through the system. This includes enhancing access to general practice, supported by better digital tools and an improved interface between primary and secondary care, so that patients can navigate services more easily and receive timely support.

Diagnostics will become more readily accessible, enabling quicker clinical decision-making, while unnecessary bureaucracy between sectors will be reduced to free

up clinical time and remove system friction.

Alongside this, **shared care records and better data flows** will underpin more coordinated care, ensuring professionals across settings can work from the same information. Planned care pathways will also be redesigned, including through the creation of single points of access and expanding the delivery of follow-up appointments in community settings, helping shift more routine activity away from hospitals and closer to home.

Neighbourhood health models will be expected to offer **credible alternatives to hospital attendance and admission by strengthening out-of-hospital pathways**; these pathways may include services from community pharmacies.

This will also involve expanding **urgent community response capacity** so that timely support is available for people who would otherwise deteriorate and require emergency care. The use of 'virtual wards' will continue to grow, enabling more patients to be safely monitored and treated at home, while intermediate care (both step-up and step-down) will be increased to support recovery and prevent avoidable admissions.

The framework also highlights the need for **more effective mental health crisis options** within communities, providing support that is closer to people's lives and reducing reliance on hospital-based services.

These developments are designed **to reduce avoidable emergency department attendances and admissions** by ensuring that appropriate help is available earlier and in more suitable settings.

Commissioning and provider models

The framework sets out **three new population-based contracting options** that local systems may choose to adopt as they develop neighbourhood health arrangements. These include **Single Neighbourhood Providers (SNPs)**, which would be responsible for delivering integrated services for a single neighbourhood population of roughly 50,000 people, and **Multi-Neighbourhood Providers (MNPs)**, which operate at a larger scale—typically across populations of 250,000 or more—to coordinate services consistently across several

neighbourhoods.

At the broadest level, the framework also introduces **Integrated Health Organisations (IHOs)**, which would hold whole-population contracts, hold a whole population health budget for a geographically defined population and take on responsibility for resources and outcomes across entire care pathways, spanning primary, community, mental health and acute services.

These models are not mandatory, and ICBs will be able to adopt them flexibly based on local circumstances and readiness. Their intended purpose is to support better alignment of incentives across the system, encourage investment in prevention, reduce fragmentation and duplication, and enable more effective delivery of neighbourhood-level care.

While these new provider forms have the potential to reshape how services are coordinated, **the framework confirms that existing national contracts—such as those for general practice, community pharmacy, dentistry and optometry—will continue to be set nationally**. However, they may interface with the new arrangements through delegated commissioning, subcontracting or partnership models where appropriate, ensuring that core primary care services remain integral to the broader neighbourhood health architecture.

Estates and Neighbourhood Health Centres (NHCs)

The framework outlines a national ambition to create **250 Neighbourhood Health Centres by 2035**, forming a more coherent estate from which neighbourhood-level services can operate. These centres will bring together general practice, community services, social care and voluntary sector provision in a single, accessible location, helping to streamline access and improve convenience for local populations. They are also intended to strengthen digital capability and diagnostic capacity within neighbourhoods, ensuring services are delivered from modern, fit-for-purpose facilities that support new models of care.

The initial phase of development will focus on repurposing existing NHS buildings, with planning led locally by ICBs and local authorities working through Health and Wellbeing Boards. This work will be aligned with wider place-based development and growth

strategies to ensure estates planning reflects broader community priorities.

Workforce Expectations

The shift to neighbourhood health will require significant changes to the way the workforce is organised and supported. The model places strong emphasis on multidisciplinary working, with professionals from across primary, community, acute and social care expected to collaborate more closely and share responsibility for delivering joined-up care. The framework aims to reduce long-standing boundaries between sectors by strengthening professional collaboration and building shared leadership at neighbourhood level.

Financial Framework

From 2026–27, ICBs will be required to **gradually rebalance spending from acute services towards neighbourhood-level provision**. National financial changes will support this transition by updating NHS trust block contract arrangements and introducing stronger incentives for prevention and for reducing unnecessary emergency activity.

Neighbourhoods that bring forward credible plans to reduce demand and shift care closer to home will receive additional support to implement them.

Flexibilities will also be made available for systems wishing to trial population-based or outcomes-based contracts where these could drive better value and more integrated care.

The overall intention is to enable systems to redesign services within existing financial envelopes, with progress driven through the reallocation of current resources rather than the creation of new NHS funding streams.

Implementation Timeline

Stage 1: 2026–27 – Minimum Requirements

During the first phase, ICBs must establish the essential foundations for neighbourhood health. This includes agreeing the geographical footprints for neighbourhoods and developing initial plans for Integrated Neighbourhood Teams. They must also set out local approaches to improving access to general practice, describe how elective pathways will

be managed at neighbourhood level, and ensure they can meet community wait targets of 18 weeks and eliminate 52-week waits.

Work will begin to redesign urgent, rehabilitation and reablement services to support care closer to home, and systems will need to put in place appropriate governance and data-sharing arrangements to underpin the new model.

Stage 2: 2027–29 – Full Neighbourhood Health Plan Development

In the second phase, ICBs, local authorities and wider partners will work through Health and Wellbeing Boards to produce a **comprehensive neighbourhood health plan**. This will set out the full governance and provider arrangements required to deliver neighbourhood-level care and demonstrate alignment with wider public service reforms. The plan must also clarify the roles and contributions of statutory, voluntary and community partners across each neighbourhood. Once finalised, the neighbourhood plan will need to be incorporated into each ICB's refreshed **five-year strategic commissioning plan**.

The implications for community pharmacy

Community pharmacy is referenced throughout the framework as a key part of primary and community care, with **future expectations** that pharmacies will become an increasingly central "first point of contact" for prevention, minor illness and medicines optimisation.

The framework emphasises that pharmacies are "one of the most accessible parts of primary care" and are optimally placed to deliver a whole range of prevention, minor illness and medicines-related services with direct prescribing to community pharmacy being explicitly referenced.

Yet while the Government's ambition is clear that pharmacies should become the first professional contact for a much wider range of patient needs, including helping to ease pressure on general practice and improve access, there remains limited detail on how and when commissioning arrangements will evolve to support this shift.

As neighbourhood health becomes the organising principle for local care, community pharmacy faces both opportunity and uncertainty: the framework highlights the sector's

accessibility and potential contribution across prevention, urgent care and long-term condition management, but it leaves unanswered questions about how pharmacies will be positioned within emerging neighbourhood governance structures and new provider models, including Single Neighbourhood Providers, Multi-Neighbourhood Providers and Integrated Health Organisations.

There is also risk that commissioning reforms, changes to funding flows and the drive to rebalance investment from hospitals into community-led services may not translate into sustained or equitable funding for pharmacy unless the sector is explicitly included in local plans.

The success of independent prescribing and expanded clinical roles will depend heavily on digital integration, access to shared records and local workforce investment—all areas where delivery is still uncertain.

The transition to neighbourhood health therefore represents a critical period in which strong advocacy and engagement will be essential to ensure that community pharmacy is fully recognised, resourced and embedded within future models of care. LPCs are already involved in local neighbourhood health discussions; however with LPC resource being limited, assessing the appropriate time to engage fully and quantifying the resource to invest to maximise opportunities is challenging when there are a number of unanswered questions and elements of risk.