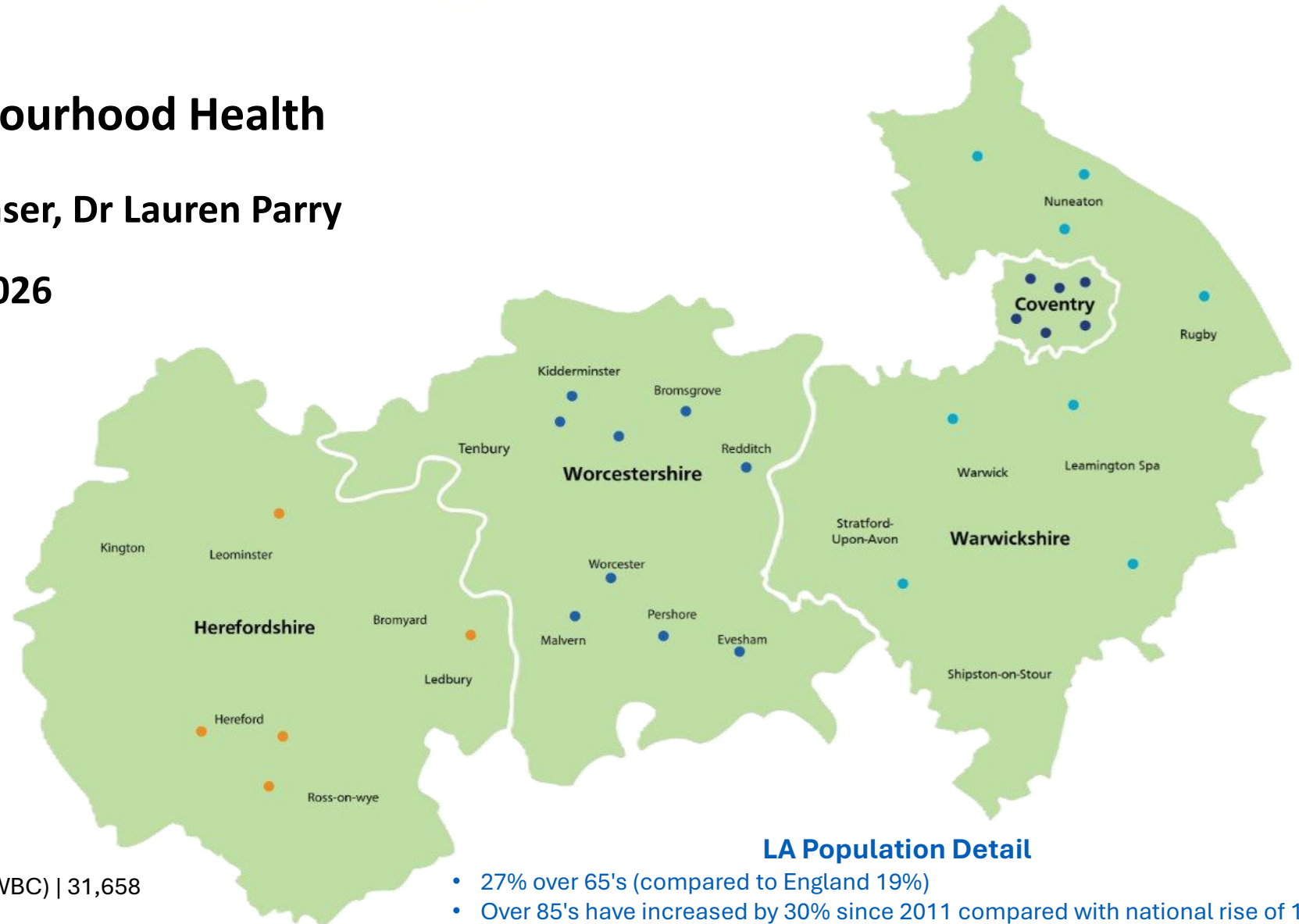


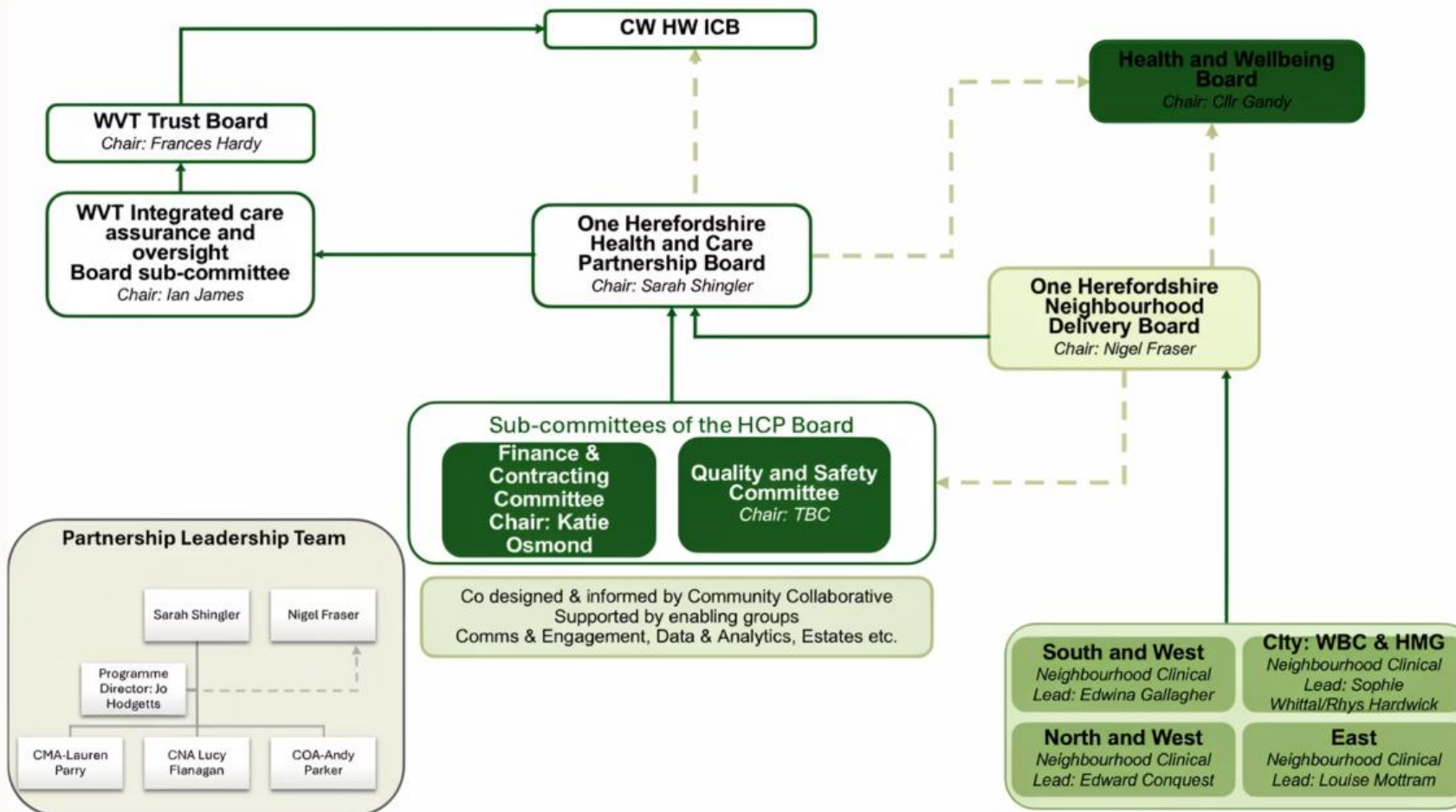


Herefordshire Neighbourhood Health

Sarah Shingler, Dr Nigel Fraser, Dr Lauren Parry

29 June 2026





Neighbourhood Health Vision Statement for Herefordshire

"Together we're creating a Herefordshire that is the best place to grow up, thrive, grow older and die well — enabled by Integrated Neighbourhood Teams, empowered communities, where the person's goals or needs are prioritised."

Signed and committed to by our partner organisations:



Prevention

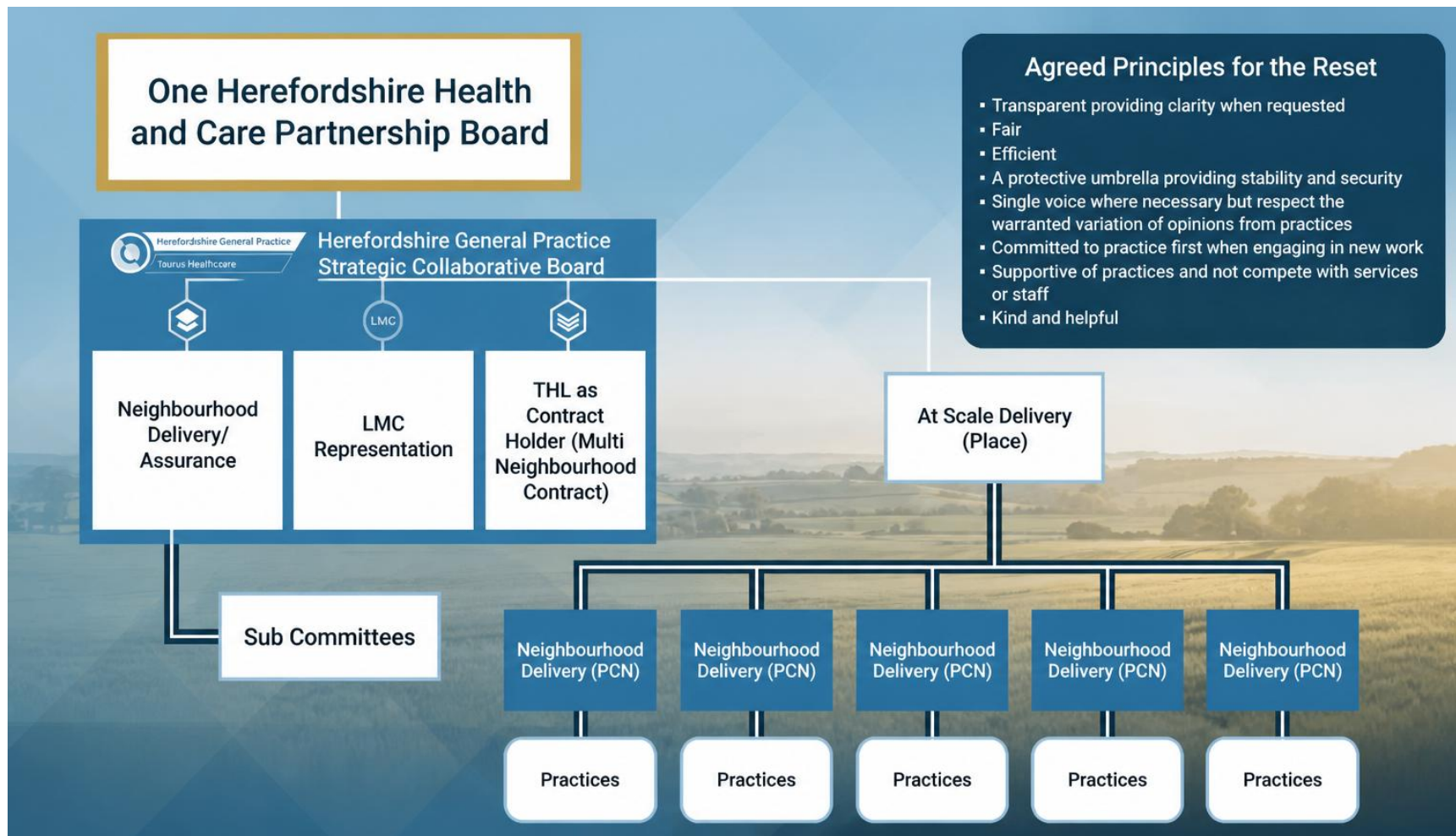
Coordination

Digitally and Data Led

Children & Social Value

Integration

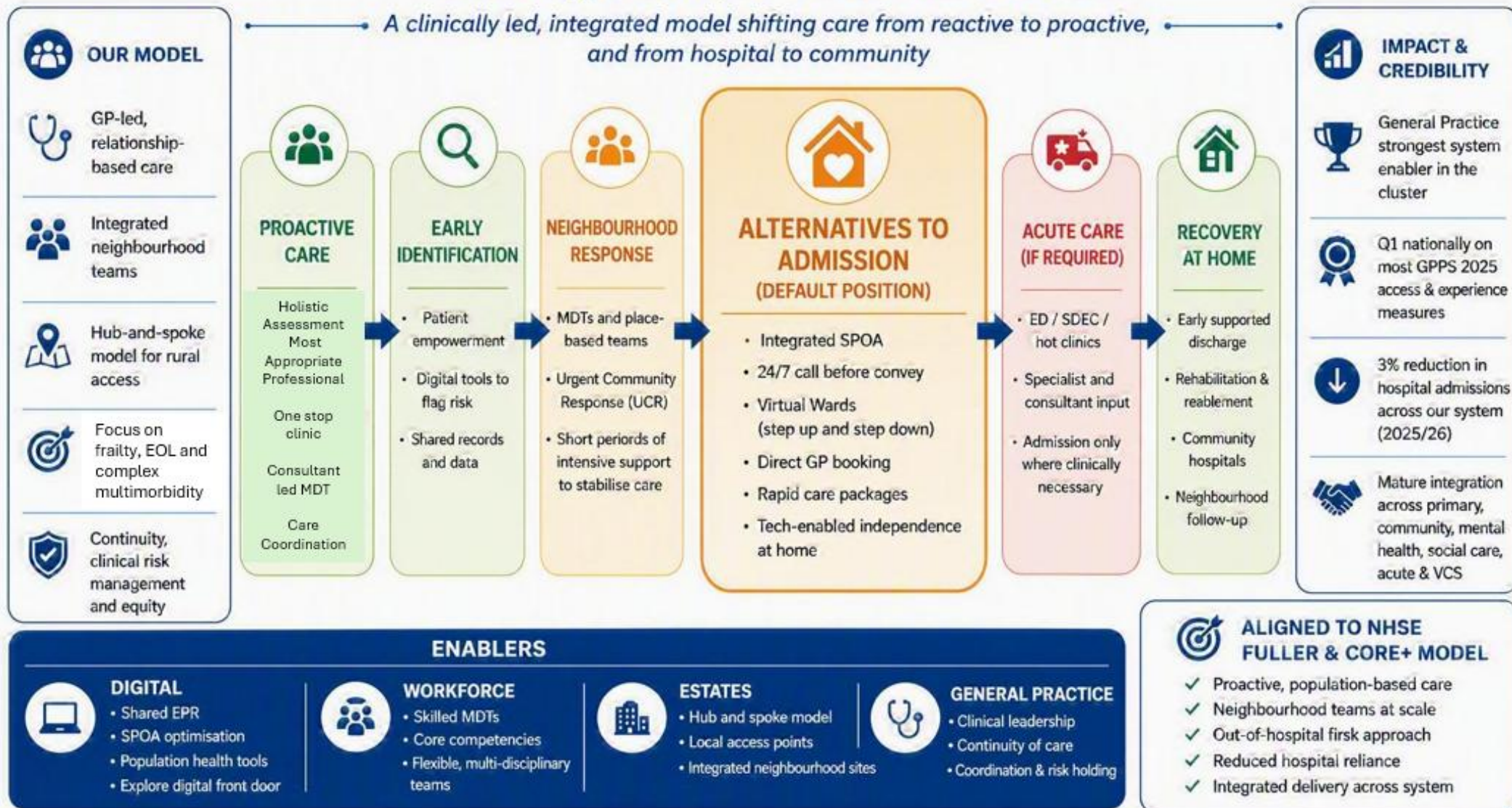
Citizen Voice & Empowerment



Herefordshire Neighbourhood Model of Care

Delivering proactive, GP-led care closer to home

A clinically led, integrated model shifting care from reactive to proactive, and from hospital to community



Working in partnership with our communities through Our Pride of Place Programme – building stronger, healthier, more resilient neighbourhoods.

One Herefordshire Neighbourhood Estates Strategy

Delivering integrated, accessible care – closer to home for everyone

CONTEXT

Herefordshire is a highly rural county (200,000 population across 2,180 km²; 66.5% rural), with limited public transport—particularly between market towns and outside core hours. These constraints make delivering care closer to home essential.

We will develop a distributed, integrated estate model that supports new ways of working while sustaining all 19 GP practices as vital local access points.

STRATEGIC AIM

To create a sustainable, integrated neighbourhood health system that:

- Improves population health outcomes and reduces inequality
- Strengthens community resilience
- Enables care closer to home through modernised estate and service models
- Aligns with the national Neighbourhood Health Centre (NHC) framework

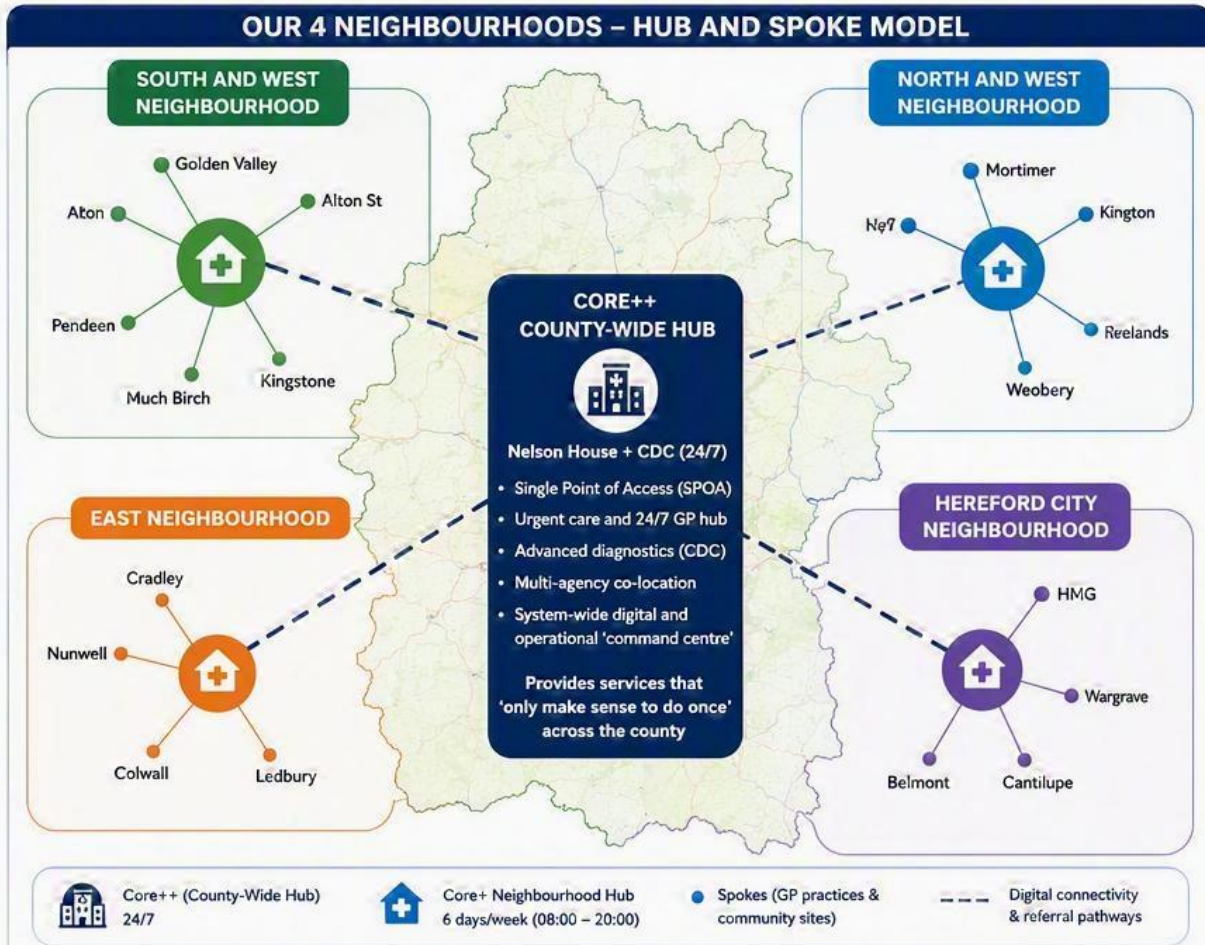
IN PARTNERSHIP WITH

Our Pride of Place

A 10 year regeneration initiative focused on community leadership, tackling deprivation, improving infrastructure, and strengthening local identity.

CORE PRINCIPLES

- Rural & Transport Equity**
Hub-and-spoke model ensuring strong local spokes alongside hubs to maintain equitable access
- Integrated Neighbourhood Working**
Co-location, shared digital systems, and flexible estate to enable MDTs
- Provider Commitment**
Capital investment aligned to provider revenue commitment and utilisation
- Practice Sustainability**
Development must support – not destabilise – general practice
- Data-Driven Outcomes**
Success measured through improvements in population health and community resilience



KEY FEATURES ACROSS THE SYSTEM

- Hub-and-spoke architecture aligned to national model
- Integrated Neighbourhood Teams co-located within hubs
- Flexible, shared estate targeting ≥80% utilisation
- Reuse and upgrade of existing estate (practices, community hospitals)
- Digital integration with shared booking and real-time data
- Community anchoring, aligned to Pride of Place regeneration

GAP ANALYSIS & PRIORITIES

- Strengthening voluntary sector presence in all hubs
- Ensuring digital parity across spokes
- Securing provider revenue commitment for shared estate use
- Demonstrating high utilisation modelling (≥80%)
- Expanding family hub integration in all neighbourhoods

OUR ESTATE MODEL

1 CORE++ (COUNTY-WIDE HUB) NELSON HOUSE + CDC (YEAR 1–2)

- 24/7 county-wide Neighbourhood Health Centre
- Single Point of Access (SPOA)
- Urgent care and 24/7 GP hub
- Advanced diagnostics (via CDC)
- Multi-agency co-location
- System-wide digital & operational 'command centre'

2 CORE+ NEIGHBOURHOOD HEALTH CENTRES (YEARS 1–4)

- Located in North & West, South & West, East and Hereford City
- Operate 6 days/week (08:00–20:00)
- Deliver MDT, preventative and population health-based services
- Flexible GP access alongside community, mental health & voluntary services
- Support group clinics (frailty, LTCs, children & families)

Act as local anchors for integrated care and community engagement.

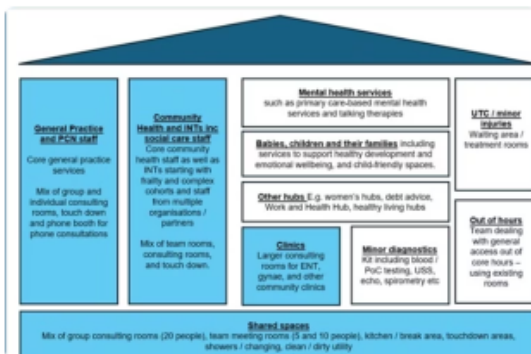
3 SPOKES (PRACTICES & COMMUNITY SITES)

- GP practices and community venues provide local "core" services
- Enhanced with:
 - Flexible rooms for visiting staff
 - Group consultation spaces
 - Digital connectivity to hubs
- Serve as:
 - First point of access
 - Base for Integrated Neighbourhood Team (INT) activity
 - Gateway into wider system services

Critical in maintaining accessibility in rural communities.

STRATEGIC IMPACT

- Deliver care closer to home despite rurality challenges
- Enable integrated, multidisciplinary working at scale
- Strengthen General Practice resilience
- Improve health outcomes and reduce inequalities
- Embed health services within community-led regeneration



Nelson House Community Hub

- 1,393 sqm (set over two floors)
- Top floor Corporate / office
- Lower floor clinical / training / meeting rooms

Clinical facility includes:

- 7 x standard clinical rooms
- 2 x minor ops rooms (20m²)
- 4 x therapy/interview rooms
- 1 x mental health suite

Services

- GP Out-of-Hours (OOHs)
- Falls Response Service
- Overnight Nursing
- Talk WellBeing Services: NHS Health Checks, Workplace Health Checks, WorkWell Health Coaching, Vaccinations & Immunisations
- ADHD Assessment & Review Service
- Community Referral Hub (SPA)
- Urgent Community Response
- Herefordshire Remote Health
- Infectious Disease Outbreak Management
- Special Allocation Service
- Diabetic Retinopathy Screening
- Cataract Surgery

Target Cohort

NATIONAL EXPECTATION: 1.5%

Part 1: Proactive, Planned & Personalised Care

- 3% of 65+ population with severe frailty or likely in last year of life
- Multiple long-term conditions
- Rising risk of acute deterioration

Part 2: Prevention in Priority Neighbourhoods

- People of all ages in LSOAs with disproportionately high avoidable emergency admissions
- Greater deprivation and unmet health and social needs

📍 **Total Cohort: 16,284** — 1.95% of registered population (Oct 2025)

Cohort Size by Area (Oct 2025 / Apr 2025)

Area	Patients 65+	Part 1: 3% of 65+	Part 2: 1.2%	Total Cohort	% of Reg Pop
H&W	200,741	6,023	10,261	16,284	1.95%
Herefordshire	55,236	1,658	2,679	4,337	2.1%

Part 1 Delivery Model

PROACTIVE, PERSONALISED & PLANNED CARE

PCN-Led Integration

PCNs lead an INT Forum to coordinate MDT-delivered integrated care.

01

Identify Target Cohort

02

Clinical Validation

03

Direct Care Delivery

04

Wrap-Around Provider Support

Direct Care Includes

- Frailty Assessment (Rockwood)
- Palliative Care Register
- End of Life care planning
- Advance Care Planning
- Holistic Assessments incl. CGAs
- Medication Reviews
- Named Care Coordinator
- Social Prescribing referral
- Post-ED/admission review
- Extended appointments

Expectations: Jun 2026–Jun 2027

4.5k

Frailty Assessments

250

CGAs

250

ReSPECT/ACPs

Target Cohort Summary

Metric	H&W	Herefordshire
Part 1: 3% of 65+	6,023	1,658
Part 2: 1.2% weighted pop	10,261	2,679
Total Cohort (Part 1 & 2)	16,284	4,337
% of Registered Pop	1.95%	2.1%



Case Study – INT Hereford City Neighbourhood



Complex multimorbidity, self-neglect poor housing environment, high risk of admission, has capacity



ETOH, Dementia, epilepsy, hemiparesis COPD, poor mobility, severely frail, chronic pain.



What matters to him: staying in environment with his pets



Challenges: Dismissed carers, taken to court re housing, making unwise decisions and then high use of services



MDT discussion: GP, ASC, OAMH, WVT Therapies, WVT District Nursing, WVT LTC ACPs, Social Prescriber, Care Coordinator



Outcome: only positive relationship is DNs – assign DN as care coordinator, core competencies, joint visit with ASC and MH



Learning: extension of roles and remit required for complex patients, extension of visit time enables efficiencies as a whole system

Herefordshire Neighbourhood Health Workstreams 2025/26

1. Urgent Neighbourhood Services

2. Standardising Community Services

3. National Neighbourhood Health Improvement Programme

4. Modern General Practice

5. Integrated Neighbourhood Teams

6. Integrated Intermediate Care

7. Primary & Secondary Interface

8. Left Shift / Outpatient Transformation

9. Partnership with Community & VCSE

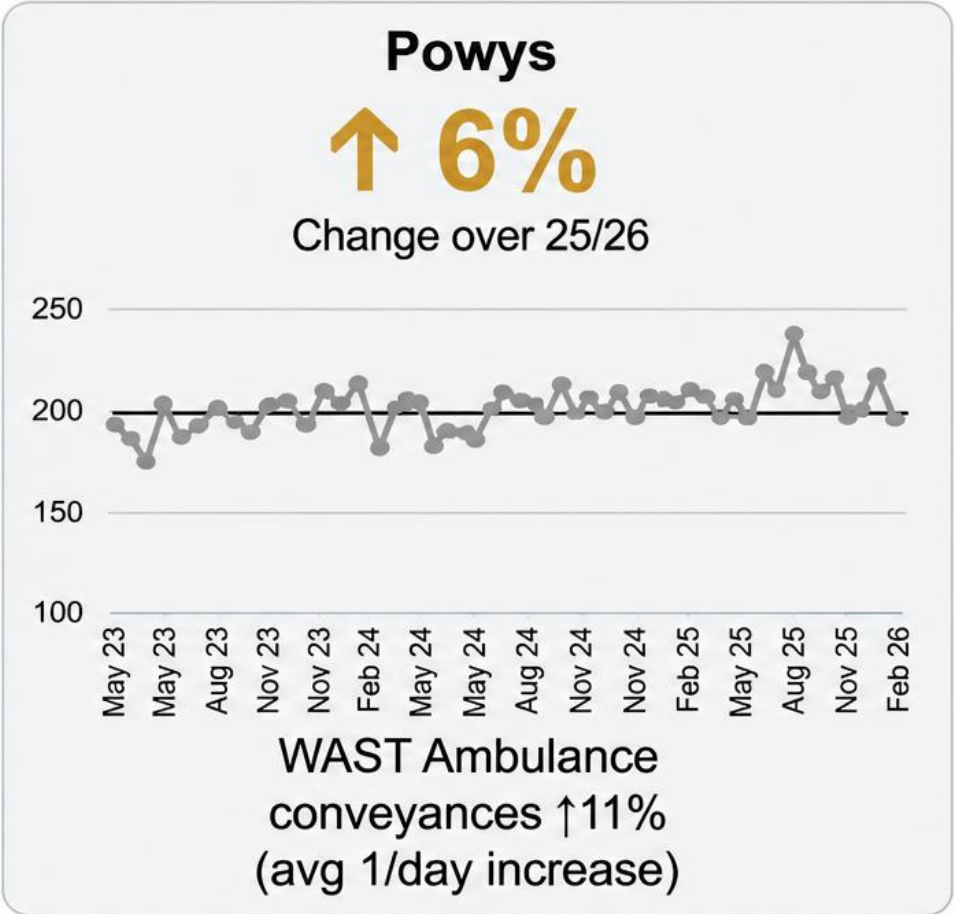
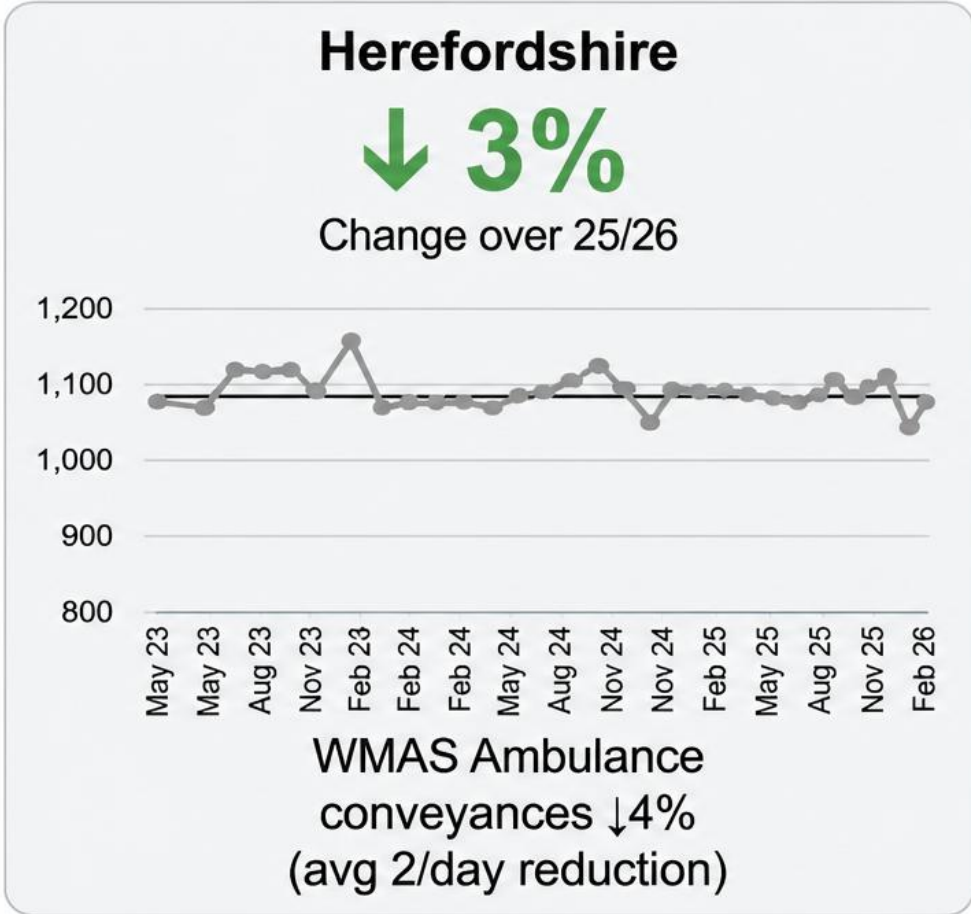
10. Palliative Care

11. Prevention & Health Inequalities

Enabling Workstreams
Estates
Digital and Data
Finance and Contracting



Emergency Admissions >0 LOS Dashboard – Herefordshire & Powys (Apr 21 – Feb 26)



— Mean

Data and Analytics

Two main areas of work

Integrated dataset development

Ambition: Working across partners to develop the tools to fully understand the needs, priorities and journeys of our local population.

Dashboarding to reflect what has happened

Ambition: to provide full oversight; providing assurance to Delivery Board of the changes in the big metrics, and the detail needed for workstreams to understand the headline metrics and the levers needed to drive them.

National Metrics Dashboard

High level visibility of the measures articulated in the NHF.

Neighbourhood Board Dashboard

Measures identified by Workstream SROs as being the key outcomes

Workstream Dashboards

Measures of progress in workstreams, balancing outcomes and outputs

Themed Insight Dashboards

Increased details on metrics, enabling drill-down and a deeper understanding of the performance

Connection to our PHM+ tool



Risks and Opportunities

⚠ Risks

- Neighbourhood Health infrastructure/ GP at Scale infrastructure
- Optics of repurposing existing GP contract resource
- Further and Faster but ahead of contracting safeguards
- Powys
- Ability to double run left shift

✦ Opportunities

- To drive digital and data capability
- Neighbourhood Health Centre increased capacity
- Community Diagnostic Centre
- Improve Care and make our health system sustainable
- Neighbourhood Health Investment Fund
- 24/7 Single Point of Access Hub