London Health and Care Partnership

NHS

A neighbourhood health service for London: **The Target Operating Model**

Developed in partnership between London's five integrated care boards, NHS England London Region, and the wider London Health and Care Partnership (London Councils, Greater London Authority, UK Health Security Agency, and the Office for Health Improvement and Disparities in London), with support from Londonwide Local Medical Committees.

May 2025

Foreword: **A neighbourhood health service for London**

The neighbourhood health service in London builds on two simple ideas – we need to do things better, and we need to do better things.

Health and care is increasingly being overwhelmed by demand, public satisfaction is dropping, and health inequalities growing - even though as a country we are spending more on healthcare than ever before.

In jointly producing these documents:

- **The Case for Change in London**
- **The Target Operating Model for London**
- **The Proposed Next Steps to Support Implementation**

we have heard from clinicians, professionals, patients, carers, community leaders and elected representatives about the many opportunities to improve how we work together.

Through recent deliberative engagement across the capital, Londoners have reinforced their desire for more accessible and consistent care, using new technologies where appropriate, whilst remaining sensitive to individual and community needs. This is in turn supported by a national direction focused on increasing investment in prevention, community-based care, and harnessing the power of digital.

Balancing these ambitions is not easy, but our proposed model and the actions we believe will deliver it, incorporate existing learning, best practice and proposals from across North West, North Central, North East, South East and South West London. All focus on improving population health, improving the sustainability of health and care services, and addressing health inequalities across age groups.

One challenge in describing the neighbourhood health service is that it is about delivering coordinated health and care in a way that many people assume it is already delivered today – until they or a loved one experience a significant healthcare need. The Target Operating Model for London sets out ten core areas (supported by an eleventh, around managing the transition), where we are jointly committing to enabling a neighbourhood health service for every neighbourhood in London. This means in every place in London, we work together across:

- primary, community, mental health, and specialist services;
- children and young people's and adults' social services;
- public health, housing, and wider public services;
- voluntary, community, and faith groups;
- and with patients, carers, families, and communities themselves – all to improve individual and community health and wellbeing.

We believe we will get further and faster, by developing this new way of working together than we will alone. And yet, unleashing the existing potential within our teams, communities and technology will not be enough on its own.

Through this process, London is committing to moving our collective focus into addressing the causes of ill-health and poor wellbeing, and not just becoming better at responding to symptoms. We have talked about this for a long time. To achieve it now will require radical changes in how we plan, develop, deliver, fund and evaluate the impact of our services and relationships across London.

We recognise that in committing to these aims, we do not yet have all the answers. How we express ourselves can be as important as what we say. In the accompanying documents, we speak of the need for an existing organisation in each borough, determined by the partners in that borough, to host the necessary functions to enable neighbourhood working at scale. The term "Integrator" is the best we have come up with, so far. What is critical in this context is that we will not achieve the required scale of change without significantly expanding the support to those working on the frontline and ensuring the sustainability of every part of our health and care system, including but not limited to our hospitals, our GP practices and community pharmacies, social services and the voluntary and community sector in London.

To be successful we know we will need to do this not just in the coming year, but in successive years – and not just in London, but nationally, working with professionals and communities to make difficult decisions around how to prioritise limited resources and how to ensure the best chance of success.

The documents we can share today are, at best, ones which set out key questions we need to answer. They will change and evolve as we develop our responses.

However, only by working in partnership will we be able to face the broader challenges affecting all parts of London and the country as a whole: to create something in London that is genuinely better and more sustainable in meeting the needs and aspirations of the communities we serve.

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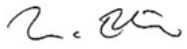

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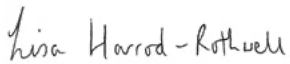

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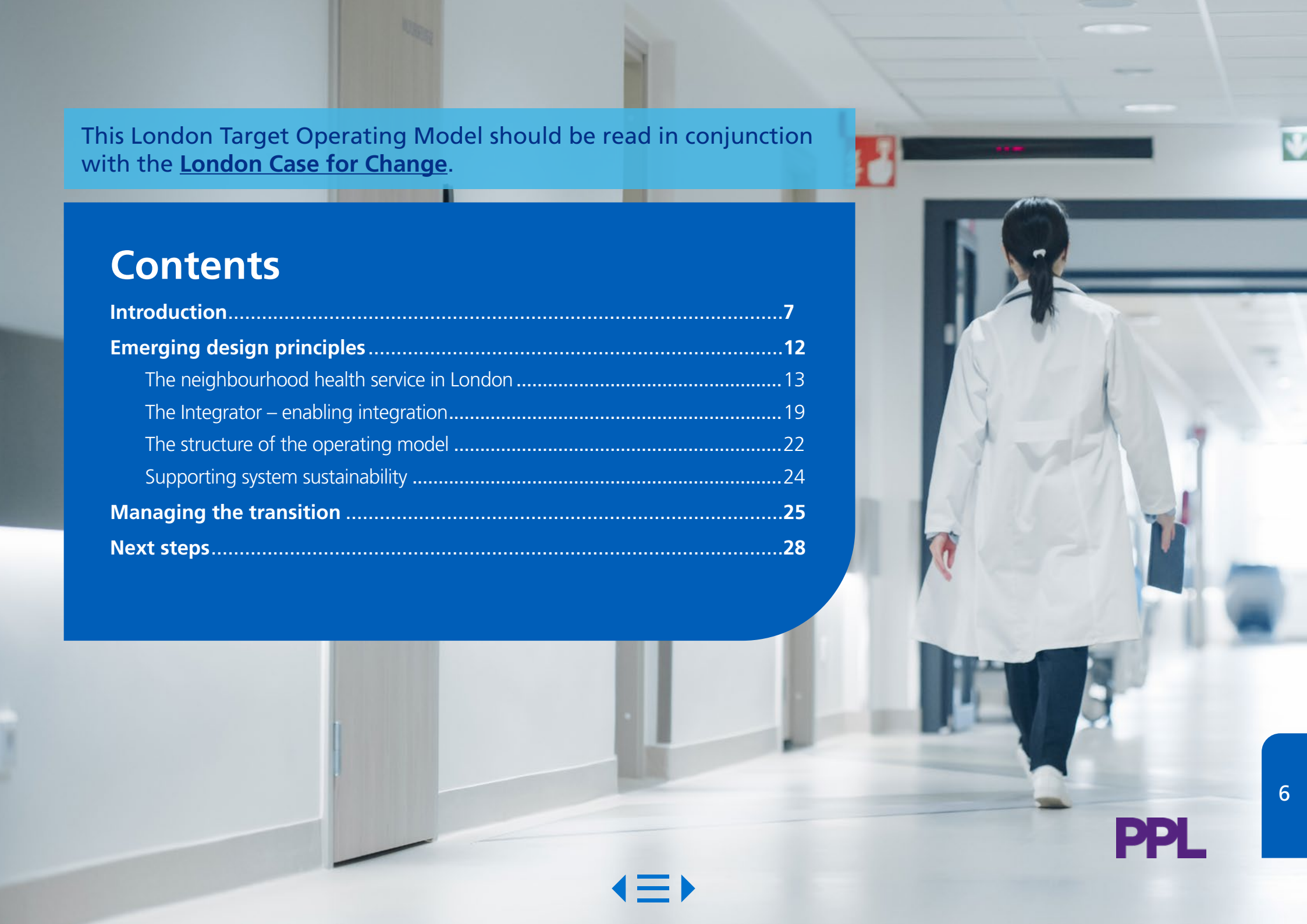


This London Target Operating Model should be read in conjunction with the **London Case for Change**.

Contents

Introduction

The Target Operating Model for the neighbourhood health service in London is designed to be read in conjunction with the accompanying Case for Change and proposed Next Steps for London (see page 28).

The breadth of the model and the length of this document reflects feedback from across London around the necessary enablers and the barriers to overcome if we are to develop a true neighbourhood health service across 32 boroughs and the City of London.

Whilst the model captures and synthesises significant existing good practice and learning from across London and the rest of England, we recognise this is only a starting point and not an end point. To be successful, this model will need to continue to evolve in relation to national, regional and local findings and direction.

However, in identifying the things we can agree now, as a region; those which we can progress immediately, as systems and places; and those priorities for shared development, to improve care across the capital; we set out under **Next Steps** a concise roadmap to make positive change happen, for all those who live and work in London.

Since July 2024 London's integrated care boards and London Health and Care Partnership (including the Greater London Authority (GLA), London Councils, NHS England and the Office for Health Improvement and Disparities) have been working in partnership and with a range of wider national, regional and local partners on developing the concept of a neighbourhood health service for all Londoners.

In this context, a neighbourhood health service means a service that provides high quality, coordinated, accessible care in every neighbourhood; for all ages, from babies, children and young people to working age adults and older people; for all levels of need, from those at risk of ill-health but not yet unwell to those already in receipt of long-term, complex health and care; in a way which works sustainably for the wellbeing of all our communities and the professionals who support them.

Central to this model has been feedback from Londoners, including through deliberative engagement delivered by Ipsos Mori and Imperial College Health Partners.

This research has highlighted public support for the concept of rolling out integrated neighbourhood teams (INTs) in London, including the greater use of technology to improve access, coordination and outcomes of care; but also the need for a consistent "base level" of health and care services, so that patients understand the system and do not see a change in quality and accessibility of care based on where they live. How to balance a consistent set of services across London with the ability of frontline teams to respond to specific individual and local needs is a key challenge for all places and systems in making this shift.

A recurring question in the development of the Case for Change in London and the Target Operating Model has been what will be different, not least, for individuals and communities themselves?

London has a long history of working together to solve shared challenges and, (as with other regions of England), has existing examples of statutory services and communities collaborating at neighbourhood level to address health and wider socio-economic inequalities.

The challenge for London, as elsewhere, is that despite all these efforts, those inequalities continue to grow. This, in turn, has contributed to increasingly unsustainable pressures across all aspects of the health and care system, including the NHS, local authorities and Voluntary, Community, Faith and Social Enterprises (VCFSEs). Today, too many Londoners continue to experience challenges in accessing the care they need, when they need it; and too many of our limited resources are consumed responding to healthcare needs when it is already too late, at the point where people are experiencing physical and/or mental health crises.

The Target Operating Model for London recognises the opportunity to build from where we are today across the 32 boroughs and the City of London as well as to apply lessons of the past. Associated lessons include:

a. Challenges across health and social care cannot be solved by the NHS or local government continuing to work as we do today.

Specifically, working jointly to identify and co-design key enablers over the last six months, we have identified specific needs in relation to: geography; workforce; relationships and interfaces; participation, working with communities; population health management, and addressing inequalities; information sharing; access and technology; governance, including aligning clinical, professional and managerial frameworks; metrics, and evidencing success; ensuring resources – ensuring they are able to flow to where they are needed; and supporting people through the change.

We believe addressing the related challenges and improving overall health and wellbeing will require an organisation in each of our place partnerships to host required functions and infrastructure. Organisations taking on this integrator role will support and enable places and London as a whole to operate efficiently and effectively as a neighbourhood health service and draw down, as appropriate, system, regional and national resources.

Given time and resource constraints, integrators will need to come from within existing partners operating at place level. Their role will not be to lead or dictate the local neighbourhood model, but to enable successful delivery.

This is likely to involve working closely, and sometimes formally, with other local partners providing complementary functions. Combined, this set of support functions will also need to be able to respond if there is any risk to the sustainability of health and care or access to neighbourhood health services within or across neighbourhoods including support to individual teams and practices if required.

The intention of the Target Operating Model is not to mandate which organisation from our existing partnerships will provide this support; it is not about creating new or competing organisational forms or expending limited local resources on competitive processes.

Places will be asked to work as partnerships to determine which organisation is best placed to act as the core integrator within that place, supplemented by other partners as appropriate. To support this, a core set of requirements will be developed, building on the model for London and emerging national guidance.

This will ensure not just a core offer around health services across London but a parallel core offer capturing how Londoners can expect those services to be coordinated around them.

b. Communities are at the heart of this change.

Alongside the three shifts – (of hospital to community, analogue to digital, and treatment to prevention) – will be the fourth shift from national to neighbourhood.

Achieving this will mean empowering individual patients, service users and carers, and neighbourhoods and communities themselves, to be partners in improving health, wellbeing and the wider drivers of inequality across the capital.

Some of what is described in the Target Operating Model may feel quite far away from how our structures operate today.

We do not underestimate the challenge of transitioning from historic and current ways of working to new models of community-centred and – led care. This will involve cultural, structural, contractual and wider societal changes and, as with everything else detailed in the model, will take time. But it will take even longer if we do not start today, and support each other wherever possible to achieve progress across London as a whole. As a senior leader within our acute sector commented as part of the co-design process: “This may be hard, but we don’t have a Plan B”.

c. A neighbourhood health service will not be possible without ensuring all Londoners have access to high quality and sustainable primary care services.

These services include those provided by general practice, community pharmacy, dentistry and optometry services. We recognise the value of existing models of primary care, but also that in areas such as general practice, London as a region is facing specific challenges in relation to workforce, estates and demand – which have continued to grow even as we provide more appointments than ever before. This is reflected in a loss of 20% of practices in the last decade.

As in many areas, these challenges affect everyone, but disproportionately those who are already living in the most deprived communities in London.

An enhanced offer of support to primary care in the context of the neighbourhood health service, is not about attempting to take over contracts or services, mandating specific models of primary care ownership and delivery, or ignoring existing support structures where these are already working well. Nor is it to ignore the role the whole system plays in making each part sustainable, and a good place for health and care professionals to work.

However, acknowledging the core role that primary care plays in neighbourhood delivery is also to acknowledge that we cannot proceed with implementing a neighbourhood health service without ensuring that primary care colleagues have access to the right level of support and services, wherever they are based in London, to enable INTs to function and thrive.

d. A neighbourhood health service will not be possible without the active involvement of social care and wider local government services.

Work is ongoing at a national level around the future of social care, but the aspirations of the neighbourhood health service today cannot be achieved without a practical transformation in the way in which health and adults' and children's social services work together in London, including those services commissioned from domiciliary and residential care providers.

For Londoners with long-term and often complex needs, the majority of the workforce and the daily contacts with health and care services are through such care providers. We cannot create an integrated neighbourhood team, or even a set of team of teams, without understanding their role, supporting cross-skilling and upskilling, and more effective information sharing – including with VCFSE delivery partners.

Equally, in relation to the role of public health, housing, economic and community development, the environment and wider local service delivery, we need to acknowledge both the critical role of local government and the specific financial pressures affecting all local authorities in London.

At the heart of the Case for Change and the Target Operating Model is the recognition of the impact of current inequalities and challenges within the NHS on other public services, as well as the opportunities to work together to build a more sustainable future for all.

Within the Target Operating Model are shared principles and practices we can agree now; areas which will benefit from working together as a regional partnership; and areas which specifically will need to be planned, managed and delivered within each place and neighbourhood.

What unites them and what unites us is an unashamed focus on delivering improved outcomes for all of London's communities. By working with our existing systems and place partnerships, providers and communities themselves to an aligned vision and set of enablers, we have an opportunity to ensure not only that the Government's vision for a neighbourhood health service is realised in London, but that all Londoners will benefit from this.

This means a fundamental transformation of our health and care systems to a fairer, more equitable and more effective model of delivery – one which prevents as well as proactively responds to ill-health and which promotes wellbeing, building on the best of what we have today.

Emerging design principles

The neighbourhood health service in London

The Integrator – enabling integration

The structure of the operating model

Supporting system sustainability

The neighbourhood health service will balance the provision of consistent, high quality and accessible local care with the flexibility required to improve population health and address inequalities across London.

Without this shift, any improvements in the funding or delivery of individual services across health, local government and wider partners will continue to be overwhelmed by inexorable growth in activity and demand.

To achieve this shift, we need to improve outcomes for babies, children and young people, for families, working age adults, and for older people – a whole population approach.

We will need to respond to public concerns and current challenges around accessing everyday care, in the way which both patients and professionals tell us they want to see. At the same time, we need to improve support to prevent ill-health, and to improve co-ordination for those living with complex needs. We need to do all of this for all of our communities, including the most underserved and those currently suffering the worst inequalities. And we have an opportunity to build on existing models which are already bringing to life the concept of integrated neighbourhood working beyond the traditional medical model.

Within the Target Operating Model, the neighbourhood health service extends beyond the concept of INTs, but INTs are one of the main delivery vehicles for improving coordination and outcomes of care within each place and neighbourhood.

In London, INTs will be based on a "team of teams" approach. This will enable meaningful, coordinated working on a human scale, whilst affording the flexibility and authority to adapt and integrate specialist input wherever required.

Within this model, there will be a core of professionals who we anticipate will be engaged in a number of different integrated team settings, across all age groups, levels and complexity of need.

This core group includes general practice and wider primary care, community services, mental health, and acute specialists; public health; adults' and children's social services; and housing teams. We are experiencing rising demand for social care across all age groups, and domiciliary and residential care providers, (who are not part of current integrated arrangements in most places), will need to be a core part of teams working with those with complex needs, be those short or long-term.

Voluntary, community and faith groups already play an important role in communities – including as advocates, and as providers of support, services, and as hubs for engagement and delivery – but have been severely impacted by the funding pressures affecting all local services. They need support to be able to operate effectively alongside statutory services.

Addressing economic inequality and inactivity will also require increased joint working with employment services, enabled by changes locally and nationally, and alignment with plans for economic development and growth across London.

All of this will require a combination of upskilling, cross-skilling and strengthened awareness of the roles and contributions that professionals and organisations play.

Critically, communities and community leadership will be a core enabler in identifying and addressing population health priorities, assets, and needs. This includes in the development of new models of care that are able to respond to legitimate concerns around the impact of adopting new technologies, information and data sharing in care delivery.

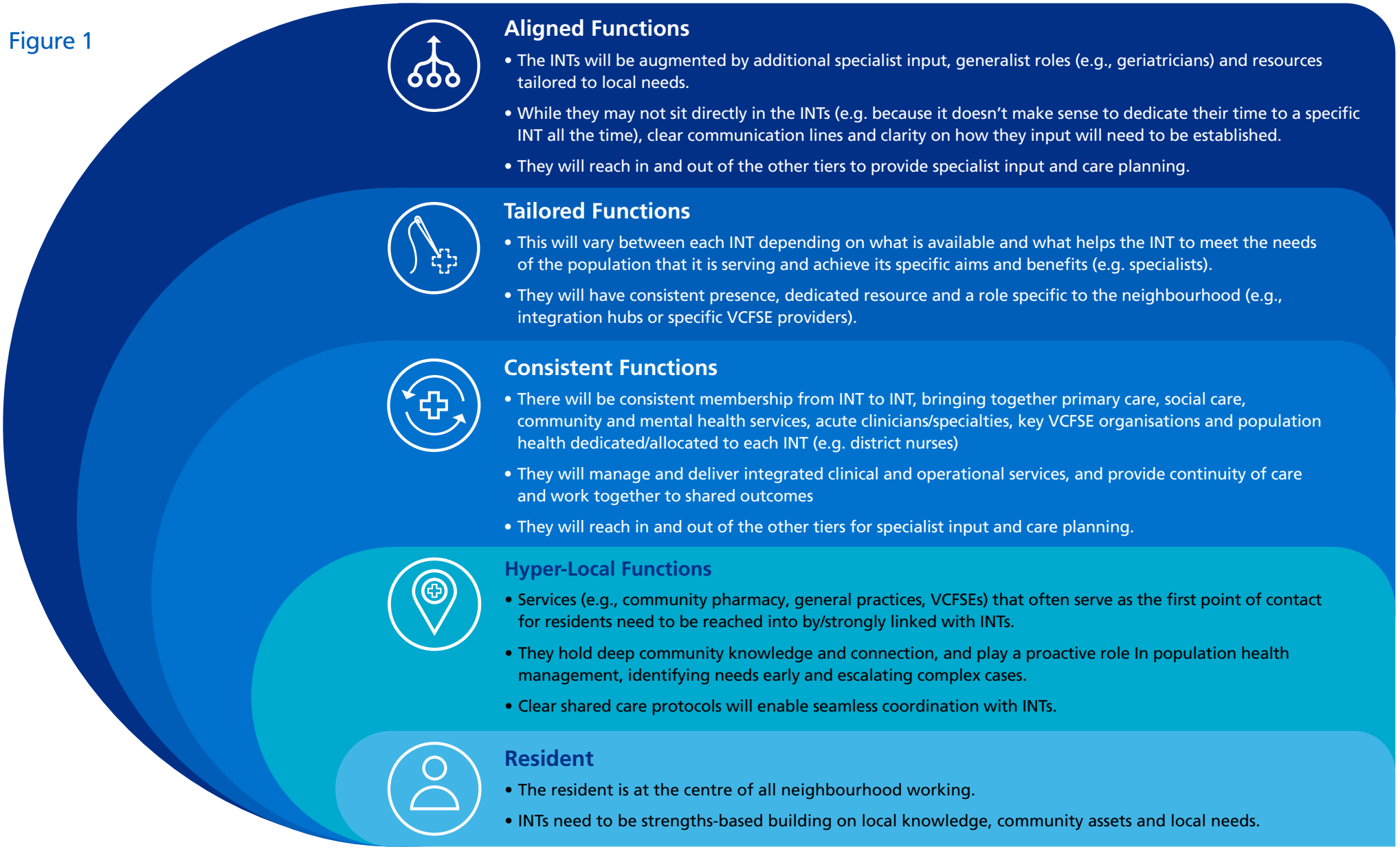
Figure 1 on the next page provides an indication of how health and care functions might wrap around individual residents and communities, but it is important to note that this is indicative only.

Alignment of functions in the real world will depend on a range of variables including the population, geography, workforce, local assets, and needs. Nor does this approach necessarily imply wholescale organisational or structural change. It is much easier to begin by enabling people to work together differently, rather than to start with trying to reconfigure organisations. The opportunity in all places is how to apply the principle of having individuals, residents and communities at the heart of our health and care system to questions around how best to organise available resources to meet local needs.

Figure 1 is indicative of functions and services we anticipate will be required within a "team of teams" model of integrated neighbourhood delivery.

Neighbourhood care in London will be delivered by a Team of Teams

Figure 1



Our existing place partnerships and leaders will be responsible for leading the shift from planning and commissioning to operationalising neighbourhood delivery, building on existing local models, best practice and shared design principles.

This will commence, where not already agreed, with defining clear membership, sub-structures, and shared roles and responsibilities within each concentric "tier" of the local INT model. The aim is to ensure that professionals can operate within and across the right spatial levels, with geographic coherence, and with respect to capacity and demand in each place. This includes:

- **Residents:** Starting with the premise that for the resident, care provision across the different teams, (from those operating hyper-locally to those at place, system and regional levels), should feel seamless and that they, their carers and loved ones are a part of this team in creating better health outcomes.
- **Hyper-local functions:** Services that often serve as the first point of contact for residents and that have deep knowledge and understanding of the communities in which they are based. This includes general practice, community pharmacy, community nursing, domiciliary and residential care providers, and local VCFSE partners, amongst others.
- **Consistent functions:** Bringing together dedicated, multidisciplinary health and care staff across an INT who can meet the majority of the demand from the local population; provide coordinated and personalised care; and continuity of care (both relational and informational) to those who value and would benefit from it. These will be consistent functions offered across all INTs within a place, and will be able to deliver at a "minimum efficient" scale. They will reach in and out of other levels of delivery as needed to meet the needs of the resident.
- **Tailored functions:** Tailored functions may vary from INT to INT according to the needs of the identified populations that each is serving locally. They should have consistent presence, dedicated resource and a role specific to the neighbourhood.
- **Aligned 'specialist' functions:** INTs must be able to embed specialist professional input from acute trusts and other specialist providers to provide seamless care, conduct multi-disciplinary case reviews, and ensure effective ongoing management of care across care settings. The make-up of supporting specialist resources should flex around the needs of the local population that each INT serves, and needs to be part of formal consultant job plans.

To deliver this will require:

a. **Clear and shared understanding of the roles of different members and teams and a minimal level of bureaucracy regulating how people and patients move between them:** This includes having streamlined approaches to communicating, discussing, and sharing responsibility for an individual's care. It means that the design of the team should, where possible, allow for the development of stable professional relationships between INT members and key professionals in the wider system. For example, aligning a named consultant to work with one or more INTs to provide specialist advice and support, consultation services, and input to population health.

b. **Alignment between the size and composition of the INT and wider teams with the needs and the characteristics of the places they serve**: This will require a phased plan for the redistribution of resources, and an understanding in the short term of what can be achieved within existing organisations and structures through a commitment to mutual aid and support. A neighbourhood health service will still need hospitals and care homes, but will require a workforce that can operate effectively across different care settings and from the population level to the level of individual needs. This shift is as much cultural and behavioural as it is structural, and will need to start with existing clinicians and professionals being empowered to work in a different way.

c. **Aligned and tailored services should be positioned to flexibly respond to changes in local demand:** Including through released capacity which can be ramped up or down to ensure the right support is available in the right place at the right time. Whilst some changes will take time to translate into reduced demand, others (such as secondary prevention, or a transformation in how we provide outpatient services) have the potential to free up resources much more quickly. We need to ensure these resources support increased focus on proactive and preventative care, creating a "virtuous circle", rather than just being re-absorbed back into existing service models.

d. **Shared purpose and aligned outcomes:** Successful partnerships need to be anchored in a limited number of clear shared goals. Existing neighbourhood partnerships demonstrate the importance of a unified vision to align efforts across health and care. These partnerships focus on population health management, reducing health inequalities, and encouraging trust amongst providers. The **Relationships and Managing the Transition** modules of this operating model provide more detail on this.

e. **Mutual understanding of roles and responsibilities**: Effective teams need a good understanding of others' roles and scope of practice, cutting down bureaucracy and ensuring that solutions can be found for patients more easily. It requires high levels of trust, and permission to work differently when it is in the direct interests of patients, service users, and communities.

f. **Regular structured engagement:** Time and processes are required to allow reflective practice, the ability to link as required, as well as in more formal multi-disciplinary planning and delivery sessions. Streamlined professional collaboration improves coordination, minimises duplication, supports timely interventions, and can also help to create psychological safety which is highly associated with team effectiveness. INTs will need to be enabled by tools

and processes that facilitate seamless communication between professionals, patients, service users, and carers, ensuring alignment on care delivery and messaging both for individual patients and across a neighbourhood and community as a whole.

g. **Shared accountability frameworks:** Developing metrics that evaluate the effectiveness of relationships between INTs and system-wide providers, focusing on outcomes such as reduced care fragmentation and improved patient satisfaction.

h. **Clear evaluation mechanisms:** Regular reviews of specialist service alignment with INTs should be incorporated into borough level governance, ensuring continuous improvement.

i. **Policy and funding alignment**: National and regional policies will need to support the pooling of resources and shared accountability, incentivising collaboration across organisational boundaries. Local flexibility is needed around contracting and resource flow at both system and place levels to enable cross-organisational working today, and longer-term investment in the new ways of working of the future.

j. **Interoperable IT systems:** Establishing seamless data-sharing capabilities to support real-time decision making and coordinated care, including identification of specific patient cohorts and needs, and monitoring of the effectiveness of INTs.

k. **Leadership development:** Equipping leaders across INTs and system-wide providers with the skills to foster trust, navigate organisational boundaries, and champion collaboration.

l. **Shared principles:** Defining baseline expectations for relationships between INTs and system-wide providers, including shared governance and integration of specialist services.

m. **Organisational development:** Support for the significant cultural change required to enable more coordinated and empowered frontline teams across organisational and sectoral boundaries.

n. **Space for local adaptation:** Allowing flexibility to address unique community needs, such as tailoring mental health services to specific demographic groups.

The Integrator – enabling integration

In London, place will be the key enabling layer for developing the neighbourhood health service, and the INTs which will sit at its core, supported by our integrated care systems (ICSs) and regional infrastructure.

Existing place partnerships will provide the leadership and local accountability for planning, delivering and evaluating improved population health and reduced inequalities.

Working within each ICS, place partnerships will be responsible for agreeing the footprints of neighbourhoods based on local evidence and data, including existing capacity and demand, and mapping of local assets and needs.

INT boundaries in London will therefore not automatically be defined by existing primary care network (PCN) footprints, except where these boundaries align with recognisable neighbourhoods. Once a consistent set of geographic neighbourhoods is agreed, if PCN boundaries do not align, those PCNs will need to consider either re-aligning to these footprints or developing with the place partnership arrangements capable of operating effectively across more than one INT.

Each place will be responsible for nominating an "Integrator" organisation from within that place to host the identified integration functions required to enable primary, community, mental health, acute specialist, local authority, VCFSE and other partners to work together effectively at neighbourhood level.

In some places, these functions will be hosted within a single organisation with the capacity and capability to support neighbourhood working across all neighbourhoods. In others, integrators may work with one or more local partners to provide the range of required support. In this case, it will remain important that there is a clear line of organisational accountability to the place partnership for ensuring the neighbourhood health service can function effectively, efficiently, and sustainably across the place as a whole.

The integrator will be vital to ensuring the effective delivery of INTs working within place partnerships, operating at a level of scale to allow sufficient organisational resources, capacity and capabilities to be available across all associated neighbourhood teams, whilst drawing on the local knowledge, experience and relationships from local professionals and communities.

This role cannot operate in isolation or remove individual responsibility and accountability from partnering local organisations.

However, it can help in:

a. **Bridging fragmentation:** Responding to the reality of currently fragmented services by addressing the practicalities of collaboration across sectors, organisational and professional boundaries, building necessary interfaces and relationships, and ensuring cohesive and equitable care for all Londoners at the neighbourhood level.

b. **Flexing to local needs:** Enabling INTs to adapt to the diverse needs of local communities whilst maintaining alignment with overarching place and system priorities.

c. **Promoting consistency:** Ensuring that a consistent, core community offer from London's health and care providers is matched by a core integration offer in each neighbourhood, enabling those services to be effectively coordinated around individual and community needs.

d. **Facilitating population health improvements at local and hyper-local level:** Providing access to real-time population health data, drawing down on regional and place infrastructure, to enable INTs to target interventions in proactively and preventatively addressing health inequalities and needs.

e. **Enabling shared learning:** Facilitating cross-borough collaboration, spread and scaling of successful practice, ensuring continuous improvement and increasing alignment to the most efficient and effective models of local care.

f. **Mediating challenges and ensuring inclusive decision-making:** Including providing support to develop relationships, trust and mediate conflicts; and enabling communities and community leadership to be at the heart of successful INT development and delivery.

g. **Providing essential infrastructure:** Including aligning people, finance, governance, risk and outcomes management across existing sectoral and organisational boundaries, in a way which is consistent and cost-effective, and ensures integrated neighbourhood delivery is mainstreamed.

h. **Improving sustainability:** Having the ability to offer additional support options to any part of the partnership, including at individual practice level, experiencing difficulties which threaten the sustainability of the INT and the local neighbourhood health service as a whole.

We believe this role will require an organisational host that is:

- **drawn from existing institutions** within the place partnership.
- **organisationally mature and able to operate at a scale** sufficient to manage related budgets and provide required infrastructure, including around data sharing, workforce, estates and digital.
- **senior and experienced enough to be credible and influential** across the partnership, to build trust amongst partners, navigate and support the partnership as it develops, whilst recognising that this role is about hosting and facilitating, not leading (which will be the responsibility of place partnerships, working with local communities themselves).
- **able to operate in alignment with the geographical footprints** of the INTs it supports.
- **part of the landscape across those INTs –** an organisation with "skin in the game" but which is prepared, where appropriate, to ignore short-term self-interest for the interests of the partnership and population as a whole. This will require not just a change in culture but a clear understanding of roles at all levels, including that of organisational boards, in enabling this shift.

It is equally important to understand what this role cannot do.

- This is not about duplication or introducing extra layers of senior leadership, management, or assurance. We cannot afford this, and any resources which can be made available across local partnerships need to be tightly focused on supporting improvement of frontline delivery, working, as appropriate, with existing place and system teams.
- This is about delivery, not planning or decision-making. The integrator will work within system and place leadership structures, including with primary care and local government, and in partnership with all local providers, to ensure that agreed local strategies and priorities for improving health and wellbeing are being translated into day-to-day delivery of services and care.
- This is not about taking away from individual roles and responsibilities within integrated neighbourhood working, including existing contract holders. There is a recognition across our systems that we have not, and are unlikely to, succeed in scaling INTs without some form of core organisational infrastructure and organisational support; but, equally, no set of integrating functions will be viable without the active engagement of professionals and local communities, ownership, and leadership from across all local partners, including the ICB, NHS providers, local authorities and VCFSEs.
- This is not about integration around "just the top of the pyramid". It is a whole population approach which focuses on improving the lives of all Londoners, including children and young people, working-age adults, and older people, whatever their current assets or needs.

The intention of the Target Operating Model is not to mandate who the integrator should be in each place.

The model is designed to help set out requirements for enabling integrated teams to function effectively at neighbourhood and place level. As part of the next phase of implementation, if agreed, this will facilitate the definition of requirements which all integrators will need to be able to demonstrate to partners that they can meet.

Examples of organisations that could fulfil this role in each place in London include, but are not limited to, community providers, vertically integrated acute trusts, local authorities, or any other existing organisations capable of operating at the scale and with the local connections to support related INTs to succeed.

In some places, this may require the integrator to work formally with other partners to guarantee the full range of supporting capacity and capabilities required within that place.

The determination of this should be made locally, by the place partnership, in consultation with all relevant stakeholders, based on what is required for the partnership to function effectively and sustainably in improving population health and tackling inequalities across related neighbourhoods and communities.

The Target Operating Model articulates, in ten modules (plus an eleventh around the management of the transition), the key functions to enable a neighbourhood health service and its constituent INTs across all parts of London.

This is designed to support place partnerships and individual partner organisations to determine the necessary functions, where they are already well established and where development is needed to deliver within a future neighbourhood health model.

These functions are grouped as follows:

1. **Geography:** defining our neighbourhoods
2. **Workforce:** developing our teams
3. **Relationships and interfaces:** enabling joint working
4. **Participation:** working with communities
5. **Population health management:** addressing inequalities
6. **Information sharing:** building our shared view
7. **Access and technology:** making interaction easier
8. **Governance:** working together safely and efficiently
9. **Metrics:** evidencing success
10. **Resource allocation:** powering the change

and **Managing the transition:** from national to neighbourhood

The intention across each of these sets of functions is to agree on what we can agree on now, as London; to agree what is for local determination at system and place level; and to develop clear plans for those areas which remain to be addressed collectively if we are to manage this change effectively.

Please visit the full London Target Operating Model to get a closer look at these key areas

1 Geography

2 Workforce

3 Relationships and interfaces

4 Participation

5 Population health management

6 Information sharing

7 Access and technology

8 Governance

9 Metrics

10 Resource allocation

Supporting system sustainability

System sustainability includes the sustainability of acute, primary, community, mental health, adults and children's social care, together with the voluntary and community sector and private care.

We recognise that across the public, private and VCFSE partners, and within individual households, neighbourhoods and communities, there are growing financial pressures which threaten the best intentions to develop more holistic, person-centered and community-centred care and services.

The neighbourhood health service, in concept and in delivery, cannot be a panacea to all of the socio-economic challenges facing communities. However, within our Target Operating Model, there are opportunities to:

- **Ensure the arrangements we are developing at place level, including around having an integrator in each, provide the required support for parts of the system facing specific challenges, including individual local practices**.

This is not about taking over practices or contracts, but ensuring that those that are at risk have access to infrastructure and support to mitigate those risks, and that neighbouring communities can continue to have access to core services as part of INTs. The priorities for this support and the options for practices will be co-developed further with primary care colleagues as part of the next phase of this work.

- **Recognise the criticality of the voluntary and community sector.**

Work locally and as a region on a commissioning strategy that will develop longer term and stable arrangements which enable VCFSE organisations in London to play a full part in supporting improved outcomes across all neighbourhoods and communities.

- **Work with local authority colleagues to develop the relationship between the neighbourhood health service and improving access to, and the sustainability of, social care.**

Specifically, this is about working jointly to prevent ill-health and promote independence to improve individual outcomes whilst addressing growing activity, demand and financial pressures across the NHS and local government.

- **Better manage activity and flow across all parts of the health and care system.**

Working with acute, community and mental health providers alongside wider primary care and other healthcare providers, to ensure that all communities have access to the services they need to support their health and wellbeing, now and in the future.

Managing the transition

The implementation of a neighbourhood health service and associated INTs across London's region, five systems, and 32 places will require:

Clear leadership, support and accountability at all levels.

Within each place, partnerships will agree a lead organisation as host for the functions required to manage the transition and provide ongoing operational and delivery support to INTs. Addressing operational challenges, such as workforce capacity, data-sharing, and physical infrastructure, will be essential to ensure service continuity during transitions. Key functions for integrators will include identifying solutions to workforce variability and considering how interoperable digital tools can be deployed in ways that align with practical, local delivery; as well as managing the resourcing of neighbourhood teams alongside sustaining existing service delivery.

These functions cannot be delivered by any one organisation alone, but will require a core of organisational support and resourcing to deliver. In the absence of significant additional funding from outside of places and systems, such functions will need to harness existing assets and resources within our core community-based providers and teams.

As part of this development, we will ensure these organisations have the capacity to identify and support elements of the neighbourhood health service in distress including working with primary care partners to provide options to practices that are at risk of failure. This is not about taking over contracts or practices, but providing additional local options to mitigate the risks of failure and to coordinate a system response where support is required.

Strong and consistent leadership roles will be established at regional, system and place levels to provide oversight, alignment, and direction for transitioning to a neighbourhood health service. This includes agreeing Senior Responsible Officers (SROs) at each spatial level to navigate multi-agency change, supported by leadership development programmes to minimise disruption. Systems will consider how to balance strategic oversight with sufficient local autonomy to ensure transitions are responsive to local needs; as well as how to bring together clinical, professional and operational leadership at all levels.

Structured processes for managing change will reflect the need for a phased, co-designed change management approach. Existing place-based partnerships will provide the forum for collaborating on decision-making around resource allocation and service design, including identifying local priority areas and aligning with system and regional strategies.

Cultural alignment and collaboration across sectors will involve overcoming previous silos and legacies of competition and building trust between partners. This will be supported by targeted organisational development to embed collaborative practices and active engagement with VCFSEs and communities. Further exploration will be needed on sustaining this cultural change whilst empowering local voices in service planning.

Place partnerships will lead on measuring progress and continuous learning, in line with identified key metrics (as described further in the Metrics module of this operating model). Robust evaluation frameworks and continuous learning mechanisms are needed to monitor progress, identify challenges, and refine transition processes. Places will work with systems to embed rapid feedback loops that enable real-time adaptation, whilst ensuring shared accountability for outcomes across partners.

Development of infrastructure within each of our places to build neighbourhood operational capacity and enable local delivery.

We will invest in recruitment and training to address workforce gaps and build multidisciplinary capabilities. This will include exploring innovative solutions to workforce variability, such as shared staffing models or rotational programmes.

We will "draw down" data sharing and digital capabilities, including overcoming barriers through use of evolving London-wide architectures and local mandating of interoperable platforms that allow seamless access to information across INTs.

We will align physical and digital infrastructure across providers to support integrated neighbourhood working, including ensuring that local professionals and teams can access resources wherever they need them within neighbourhood footprints.

We will implement agreed, shared evaluation frameworks with clear, outcome-based metrics to track progress, focusing on leadership effectiveness, collaboration, and service integration.

Collaborative structures for shared learning and adaptation.

Structures will be established to accelerate change and enable consistency of progress across London based on:

- **At a regional level:** Shared forums for regional collaboration to disseminate best practice and align change efforts. The London Health and Care Partnership will provide overall leadership and support to the transition and to identifying opportunities and resolving shared issues across London's five systems and 32 places.
- **At a system level:** London's ICBs and Integrated Care Partnerships (ICPs) will work to align neighbourhood approaches with system-wide strategies, facilitate improved resource allocation, and streamline governance to avoid duplication or gaps in delivery. Systems will enable effective coordination whilst promoting local innovation.
- **At a place level:** Place based partnerships will drive the implementation of the neighbourhood health service through the development of INTs covering all parts of the population and prioritised within each age cohort based on evidence and data around population health inequalities and needs. Through the establishment of an integrator at place level, places will enable the implementation and operation of INTs across London, aligning local, system, regional and national assets and priorities.

Next steps

The neighbourhood health service in London

Next steps for implementing the Target Operating Model in London

1. What can we agree now across London?

Enabling integration

a. **In London, place, co-terminus with the London boroughs, is the key enabling layer** for developing a neighbourhood health service and the INTs at its core, working with system teams.

b. **Place partnerships will provide the leadership and overall accountability** for planning, delivering and evaluating improved population health and reduced inequalities with each place.

c. **Each place partnership will nominate an organisation from within that place to host the functions required** to enable primary, community, mental health, acute specialist, local authority, VCFSE and other partners to work together better at neighbourhood level, as described in the Target Operating Model for London.

d. **Nominated integrators will also work with others locally to provide additional support to any part of the partnership**, including within the health service at individual practice level, experiencing difficulties which threaten the sustainability of the INT and the local neighbourhood health service as a whole.

Geography

a. **The footprints for integrated working in London will be defined by recognisable communities and neighbourhoods and population health needs**, as determined jointly by place partnerships working with local communities themselves.

b. **Where local statutory boundaries, including those of current PCNs, align with such natural communities, the boundaries may be co-terminus**. Where boundaries do not align, re-alignment to these footprints or development of local arrangements capable of operating efficiently and effectively across them will be required.

Participation

a. **We will establish consistent messaging to support the future of neighbourhood health and care across London**, developed with direct input and support from communities and partners, providing clarity for all Londoners around what will be the same across London; what will vary by system, place and neighbourhood; and why.

Population health management

a. **We will implement a core, standardised, London-wide, all-age approach to classifying the needs of local populations,** enabling professionals and people themselves to easily identify and proactively respond to individuals in their community. We will build on learning from existing diagnosis-based, case-mix methodology to support consistent local population segmentation across all practices and neighbourhoods in London.

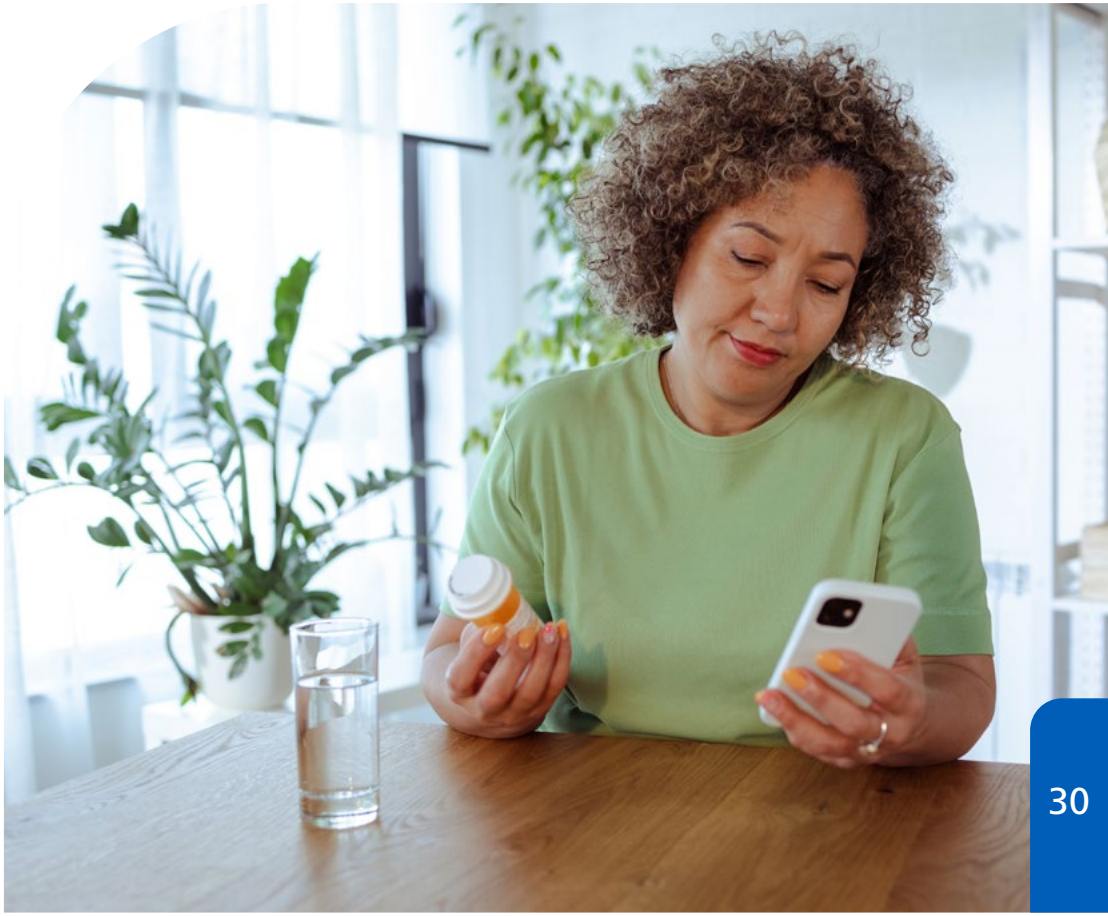
Access and technology

a. **We will work jointly to implement a 24/7 "gateway" to neighbourhood teams** harnessing digital and other channels to enable people to access care simply, in a way which works for them.

b. **We will adopt a consistent approach to managing patient flow,** which considers both clinical and social factors and aims to ensure seamless integration with primary, community, urgent and specialist care services. To enable this, we will require interoperability between systems in use across health and care in London.

Information sharing

a. **We will develop OneLondon to provide a consistent, standardised, and accessible view of person's healthcare history**, essential for providing informational continuity and quality of care.



2. What are the suggested priorities for place/system development?

Enabling integration

a. **Agreeing who will host integration functions locally** including supporting INTs and future local resilience, together with the relationship to the place partnership.

Geography

a. **Finalising the footprints of London's neighbourhoods based on local evidence and data,** including existing capacity and demand, local assets, and needs.

b. **Developing an identified set of priority cohorts** (covering babies, children and young people; working-age adults; and older people), with interventions within each neighbourhood which apply a core offer for all Londoners and tailor and supplement this to reflect the individuals and communities who live, work and receive care there.

Participation

a. Developing localised, contextualised messaging describing "what the neighbourhood health service means for you" within each borough.

b. Ensuring effective community representation and leadership in decision-making around neighbourhood care.

Relationships and interfaces

a. **Developing options around co-location where it makes sense,** including exploring opportunities within existing and recognisable neighbourhood "hubs" as venues for shared delivery.

b. **Ensuring key partners including domiciliary and residential care providers are part of the process** of co-designing and INTs.

Population health management

a. **Bringing together population health management insights and asset and resource analysis** to identify gaps and overlaps in current neighbourhood provision, to inform shared planning and resource allocation.

b. **Developing mechanisms to incorporate lived experience and qualitative feedback** into planning processes involving communities, staff and other stakeholders to help ensure that interventions and approaches reflect and respond to lived realities.

Governance

a. **Developing consistent neighbourhood governance structures** which support and empower local clinicians, professionals, and communities whilst ensuring alignment with broader goals.

Access and technology

a. **Clear signposting systems**, agreed and facilitated by cross-sector partners, will help to reduce confusion and improve access to services.

Metrics

a. **Mapping data associated with each population segment at a granular geographical level** (eg within individual lower super output areas (LSOAs), to build a picture of need across a locality as well as "what good looks like" in terms of outcomes for local communities.

b. **Understanding geographic trends, variation, and drivers** including measures of engagement/disengagement with health and care services.

3. What do we need to prioritise further across London in the next six to twelve months?

Enabling integration

a. **Working with primary care to articulate the support offer to ensure consistent, high quality and sustainable services across London,** recognising the critical role general practice and wider primary care services will play in enabling the neighbourhood health service.

b. **Working as five systems to co-develop a Strategic Commissioning Model for London,** including the scope of services within the INT core offer, investment principles, and use of aligned incentives to enable all ICBs to move towards this for 2026/27.

c. **Building the value case with local authorities,** understanding the relationship between demand pressures across health and care in London both to improve individual outcomes and start to relieve activity, demand and financial pressures across health and care.

d. **Developing aligned delivery plans across all five London systems** enabling year one of the neighbourhood health service.

Workforce

a. **Developing integrated workforce planning with a focus on shifting and expanding the workforce "upstream"** into proactive care through recruitment, skills development, and making full use of the depth and breadth of health and care professionals and experts-by-experience within local areas.

b. **Working with primary care colleagues to maximise the impact of existing resources** including the Additional Roles Reimbursement Scheme (ARRS) funding; GPs with Extended Roles (GPwER); current and new community-based roles.

c. **Developing the "team of teams" model for integrated neighbourhood working** including how best to align relationships within and across different spatial levels, including through embedding specialists where appropriate and rapid access to specialist help whenever needed.

Geography

a. **Developing shared understanding of how services are being used** and how this, in turn, is reflected in any future integrated models of neighbourhood and community-based care. This includes the prevalence, impact and management of activity where patients and service users are currently receiving health and care services in different parts of London, as well as activity flowing into and out of London from surrounding regions.

b. **Developing a common approach for working with primary care at scale.** For example, where current PCN boundaries do not align with natural communities or population health needs.

c. **Understanding how best to manage relationships with providers working on larger footprints** across ICSs and regionally, including but not limited to the London Ambulance Service and larger acute trusts.

Relationships and interfaces

a. **Modelling the impact of the shift to neighbourhood working** across London's current provider landscape. This includes key priorities such as reviewing the Outpatient model in London.

b. **Working with voluntary, community and faith groups to understand common opportunities and barriers,** and develop a shared approach to enable VCFSE organisations in London to play a full part in future neighbourhood teams.

c. **Strengthening mechanisms for sharing best practice across neighbourhoods and places.** This includes ensuring that learning and emerging evidence is used to support the scaling and spreading of "what works" in neighbourhood health and care.

Population health management

a. **Selecting and rolling-out a suitable framework to enable consistent practice level management of population health needs,** building on learning from existing diagnosis-based, case-mix methodology to support consistent local population segmentation across all practices and neighbourhoods in London.

b. **Working with partners to develop a London-wide approach to understanding how best to engage housing, employment, education, local policing, and economic development** functions and assets, building on existing local and system best practice.

Participation

a. **Co-developing relatable and accessible materials to enable active participation,** helping people understand their role in driving and realising the benefits of the change, working with existing networks and partners across our place partnerships, and building on the recent London-wide deliberative engagement.

b. **Developing adaptable communications templates and engagement tools** at national and regional levels, will help to ensure alignment in messaging and participation opportunities, whilst allowing for local customisation.

Resource allocation

a. **Understanding funding in relation to existing pooled and wider health and care budgets,** considering how best to deliver long-term sustainable support to communities within existing financial structures and arrangements, including use of delegation and subsidiarity.

b. **Linking plans for public sector estate and capital as a catalyst** for integrated neighbourhood working and improved outcomes.

c. **Developing guidance around refreshing alliance and place roles** to support this shift towards greater local autonomy in resourcing.

Information sharing

a. **Developing a London-wide data sharing framework** to enable integrated datasets to inform proactive health planning, encompassing wider determinants of health. A unified approach will include statutory and non-statutory organisations, such as VCFSE partners, and understanding how they can be included within data sharing agreements as appropriate.

b. **Developing principles and practice to enable Londoners to "own" their own care record and data** supporting a move toward greater levels of independence, strengths-based models, and patient activation.

Governance

a. **Developing clinical governance, resource and risk management** including protocols to oversee care quality and patient safety, mitigate clinical errors, and ensure patient safety across multi-organisation health and care delivery systems.

Access and technology

b. **Developing our approach to accessing INTs via a streamlined 24/7 "gateway"** including telephone and digital channels and support to those presenting in person, wherever they present (including at GP practices, pharmacies, and other community-based organisations) to be connected with the relevant neighbourhood teams and services.

c. **Developing a consistent approach to managing patient flow** which considers both clinical and social factors and provides as near as possible a seamless integration across primary, community, urgent and specialist care services.

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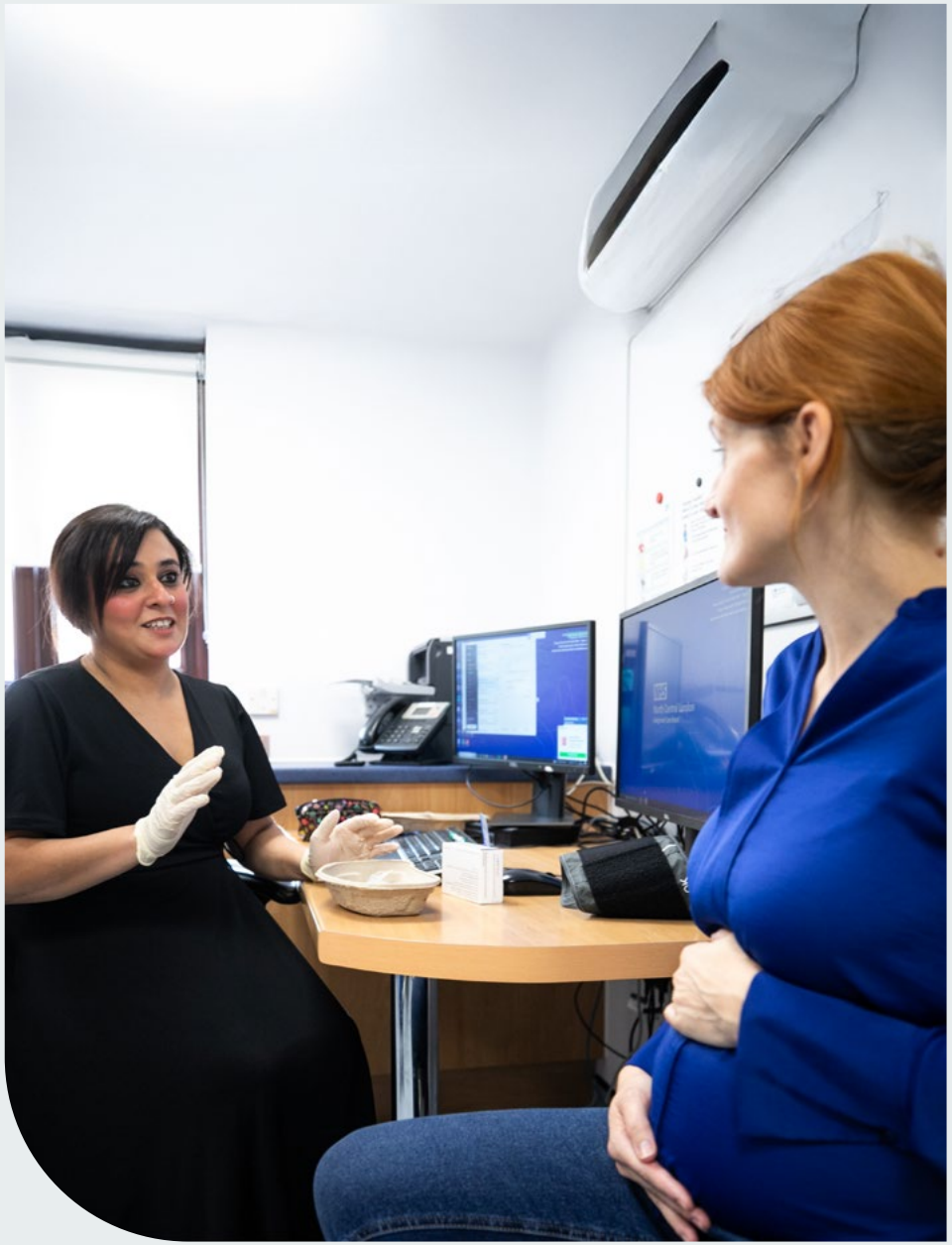

This document is part of London's broader strategy to deliver integrated, person-centred care at neighbourhood level. It should be read alongside the London Case for Change.

Accessibility

If you would like this document in an alternative format, please email **communications@selondonics.nhs.uk**

www.england.nhs.uk/london

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