LISTEN / DESIGN / DECIDE

Time to talk neighbourhoods

An indicative series that turns local experience into an agreed model and a practical first test.

Use protected listening with residents and frontline teams in weeks 1-4, mixed design workshops in weeks 5-9, and authorised decision-making throughout weeks 0-12.

Suggested mixed workshop: 24 people

6 residents/carers; 4 community or VCSE partners; 6 primary, community or social care staff; 4 specialist, acute, mental-health or ambulance staff; and 4 delivery, finance or commissioning leads.

Listening: weeks 0-4

Session	People and focus	Output
W0 / 90 min Sponsor mandate	NHS/council sponsors, clinical leads and resident co-chair: scope, resources, authority and influence.	Design brief, decision owners and engagement support.
W1 / 3 x 90 min Community listening	Residents, carers, young people and underserved groups: what matters, what works and access barriers.	Priorities, stories and missing voices.
W2 / 2 hours Assets and strengths	VCSE, education, care homes, housing and public health: trusted places, support and capacity.	Asset map, gaps and connections to protect.
W3 / 2 x 90 min Frontline practice	Nursing, social care, therapists, GPs and pharmacy: hand-offs, duplication, workload and safety.	Current journeys and quick improvements.
W4 / 2 hours Clinical interfaces	Primary, community, acute, mental-health and ambulance clinicians: referrals, diagnostics and responsibility.	Options, disagreements and capacity needs.

Residents shape the questions. Every listening group receives the findings and next questions.

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SHARED DESIGN / WEEKS 5-12

Design together. Close the loop.

Session	Work together on	Output / decision
W5 / half day Shared priorities	Residents, frontline teams, specialists and analysts combine assets, experience and population data.	Shortlisted cohorts and selection criteria.
W6-7 / 2 half days Pathway design	Early adopters, residents, clinicians and managers design one pathway, responsibilities and costs.	Current/future journey and operating specification.
W8 / half day Rehearsal	Staff, residents and safety, finance, data and workforce leads test ordinary, crisis, rural and out-of-hours scenarios.	Revised model, risks and delivery conditions.
W9 / 90 min Community return	Original listening groups and people not yet reached test changes, access and acceptability.	Corrections and resident-defined success measures.
W10 / 2 hours Decision forum	Authorised sponsors, clinical/finance leads and resident co-chair review investment, risk and impact.	Approve, amend or defer with reasons and owners.
W11-12 / 2 hours Launch readiness	Delivery team, early adopters and resident reference group confirm capacity, escalation, training and baseline.	Go/no-go for a 90-day test, with stop criteria.

Make the feedback visible

Within five working days: “You said / evidence showed / we decided / still open”. Review decisions fortnightly.

GOVERNANCE / EVIDENCE AND DECISIONS

A working model needs clear authority.

Before design, agree the purpose and footprint, community influence, sponsor, resources, authority, safety boundaries and decision route.

Build the model in four steps

People and place: assets, trust, lived experience and inequalities. One cohort: current journey, gaps and outcomes. Working model: responsibilities, capacity, access and escalation. Test and adapt: costed trial, measures, resident feedback and the next version.

Level / rhythm	Authority and focus	Boundary
Delivery Weekly	Pathway lead with frontline and resident input: workflow and small tests within scope.	Escalate changes to safety, resources or access.
Design / clinical Weekly as needed	Clinical lead with primary, community, specialist and care representatives: options, hand-offs and standards.	Record dissent and use evidence or independent review if unresolved.
Place group Fortnightly	Authorised sponsors, clinical and finance leads, and resident co-chair: priorities, dependencies and delegated spend.	Set quorum, conflicts process and separate budget-holder approvals.
Reserved decisions Planned gates	Relevant ICB, provider or council authority: contracts, new commitments, reconfiguration and material risk.	Book formal approval, scrutiny and engagement dates early.

Record the question, evidence, options, impact, authority, owner, deadline and review trigger for every decision. Clinical choices, staffing, budgets, contracts and relationships develop in parallel.

NEGOTIATION / READINESS AND PACE

Resolve the difficult choices early.

Community and political consent

Explain who benefits first. Test rural travel, access and concerns about service loss. Keep elected members informed through agreed routes.

Money and incentives

Agree who funds extra community work, transition costs and recurrent delivery, and who benefits from changed hospital activity.

Clinical and workforce confidence

Clarify accountability, supervision and protected time. Negotiate responsibilities with GPs, providers and staff representatives.

Contracts and authority

Map commissioning and contract dependencies. Fund the first test and schedule consultation or service-change decisions.

Readiness determines the pace

Position	Indicative timing	Response
Established	8-12 weeks + 90-day test	Use trusted relationships, credible data, staff capacity and delegated authority.
Developing	12-20 weeks + 90-day test	Build missing community links, data, funding and capacity; narrow the first test.
Fragile / contested	20-36+ weeks; test when ready	Fund relationship and evidence work. Resolve trust, leadership, footprint, safety and budget blockers.

Review at week 0, week 5 and before launch: resident legitimacy, trust, clinical agreement, authority, workforce, data, funding and delivery history. Make workload shifts, stranded costs and effects on carers and social care visible. These are TMPM planning ranges.

INDICATIVE PRIORITIES / LOCAL VALIDATION

Choose the first pathway deliberately.

The starting order below balances potential system benefit over 12-24 months with the feasibility of a bounded first change. It is a set of TMPM hypotheses, not comparative ROI evidence.

Pathway	Potential / feasibility	First practical scope
1 Frailty, falls and care homes	High potential where escalation or delayed recovery is common. Medium feasibility, higher with response capacity.	Shared planning, medicines review, rapid support and recovery.
2 Heart failure / cardiovascular	High for selected unstable cohorts. Medium; needs specialist capacity.	Deterioration routes and coordinated follow-up.
3 Respiratory: COPD / asthma	High where exacerbations and emergency use are common. Medium; needs diagnostics and rehabilitation.	Defined-group review, self-management and specialist access.
4 Diabetes / cardiometabolic	Medium near-term potential, higher longer term. Medium-higher feasibility.	Focused review, recall, prevention and blood-pressure follow-up.
5 Mental and physical health	Possible crisis-use benefit, with substantial uncertainty. Lower-medium feasibility.	One cohort or hand-off with specialist accountability.
6 Multiple LTCs / complex needs	High where fragmentation and repeated use overlap. Lower-medium feasibility.	One coordinator and shared plan across demonstrators.
7 Cancer support / diagnostics	Variable cost effect; high outcome importance. Navigation easier than diagnostics.	Support and navigation while preserving urgent referral.
8 Weight management / prevention	Limited near-term cash effect, longer-term potential. Access easier than expansion.	Link prevention, food, activity and specialist support.

Suggested scoring: system benefit 30%, feasibility 25%, equity/outcomes 25%, evidence/confidence 20%. Safety, unmet need and mandatory commitments can override the order. Avoid double-counting shared cohorts; essential care continues throughout.

SERVICE DESIGN / A FIRST DEMONSTRATOR

Connect the network around the person.

Trusted places

Home and carers, schools, nurseries, shops, salons, faith settings, care homes and housing.

Neighbourhood team

GP, pharmacy, community nursing, social care, therapies and coordination.

Specialist network

Mental health, diabetes, cardiovascular, respiratory, cancer, diagnostics, maternity and children's services.

Response and recovery

Community response, clinical advice/111, crisis support and hospital/999 when required. Connect rehabilitation, reablement, voluntary support and transport.

Across every route: mental wellbeing, medicines, prevention, carer support, accessible transport, and digital and human access. Populate the map with owners, locations, hours and capacity. Urgent and cancer routes remain directly accessible.

Example: frailty and falls

Step	What must work
Identify	Use GP, nursing and care-home insight, clinical risk review and what matters to the person.
Plan	Name the coordinator and clinical owner; agree the personalised plan, medicines and carer support.
Respond	Agree warning signs, response routes, community support and safe hospital escalation.
Recover	Connect rehabilitation, reablement and home support with an accepted handover and plan review.

Define one neighbourhood and explicit inclusion/exclusion criteria. Agree staffed hours, response standards, escalation cover and capacity before launch. Track experience, goals, continuity, carer burden, emergency use, bed days, access, staffing, costs, safety and equity.

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EVALUATION / TEST AND EXPAND

Use intelligence to change decisions.

Need and inequalities

JSNA, deprivation, age, ethnicity, disability, diagnoses, unmet need and resident or carer insight.

Flow and capacity

Referrals, waits, emergency use, bed days, community workload, workforce, assets and travel times.

Options and trade-offs

Compare realistic alternatives, capacity limits and who bears the cost.

Evaluation and learning

Use a baseline and comparator where feasible. Track reach, outcomes, experience, safety and costs.

Net cost saving

Avoidable costs - added recurrent costs - transition costs. Separate better outcomes, released capacity, cost avoidance and cash savings. Count cash only when budgets change.

When	What to test or decide
Before day 1	Confirm scope, clinical ownership, capacity, baseline, funded delivery and agreed stop criteria.
Days 1-30	Review access, hand-offs, workload, reliability and early experience weekly.
Days 31-60	Show the actual journey to residents and the next adopter. Report exclusions, problems and adaptations.
Days 61-90	Assess safety, acceptability, delivery and early signals. Continue, adapt, expand or stop.
Months 6-12	Test sustained impact and economics before larger rollout.

SOURCE CONTEXT / 10 SEPTEMBER 2026

Evidence and use of this proposal

An England-focused companion to the TMPM neighbourhood vision. The timetable, decision rhythm, readiness ranges, pathway order and scoring are TMPM proposals requiring local validation. No local financial dataset was supplied; clinical and economic appraisal follow cohort selection.

Reference framework

10 Year Health Plan for England: community care, prevention and digital services.

Neighbourhood Health Framework, March 2026: the national framework used by the source proposal.

NHS England neighbourhood guidance 2025/26: population intelligence, teams and care interfaces.

NICE NG44: community influence, assets, inclusion, relationships and feedback.

NICE NG56: personalised care and coordination for multimorbidity.

10 Year Health Plan for England

Neighbourhood Health Framework

NHS England neighbourhood guidance 2025/26

NICE NG44: community engagement

NICE NG56: multimorbidity

Turn the series into a local plan

Agree sponsorship, community participation and the first decision before booking the workshops. Fit the pace and first test to the evidence of local readiness.

Talk to TMPM

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