

# Neighbourhood Model of Health and Wellbeing (Northern Ireland, 2026)

## Members' briefing

The '[Neighbourhood Model of Health and Wellbeing](#)', launched on 31 March 2026, represents a major strategic reform of health and social care in Northern Ireland.

Its aim is to move away from a predominantly hospital-based system towards one that is preventative, community-focused and built around the needs of local populations.

The vision for the project is *"for neighbourhoods across Northern Ireland where people are enabled and supported to live healthier, more independent lives."*

This briefing is designed to help you understand how the Neighbourhood Model works and what it means for dietetics.

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## Why this policy has been introduced

The policy responds to sustained pressures across the system. Demand for services continues to rise due to demographic change, increasing complexity of need and long-standing capacity constraints.

The current model is no longer considered sustainable, and is placing considerable financial strain on Northern Ireland's budget. It also mirrors similar moves towards a neighbourhood-based approach in [England's 10 year plan](#).

The Department of Health is therefore prioritising a shift towards prevention, earlier intervention and stronger community-based provision, with a **gradual rebalancing of resources away from hospital care**.

## The Four Pillars of the Neighbourhood Model

The model places strong emphasis on relationships, local insight and understanding of population need.

Four key pillars underpin the model

- Integrated Neighbourhood Teams
- Moving More Care Closer to Home
- Neighbourhood Digital Innovation, Intelligence and Evaluation
- Neighbourhood Relationships and Connections

### *Integrated Neighbourhood Teams*

The creation of new groups called Integrated Neighbourhood Teams (INTs) will form the foundation of the neighbourhood model.

There will be

- 17 Integrated Neighbourhood Teams (INTs) across Northern Ireland.
- Each serving a population of approximately 115,000 people
- Aligned to GP Federation footprints within existing Trust geographies.

INTs are not new organisations or new forms of delivery. Instead, they are designed to be “provider alliances” where representatives of existing parts of the health service come together to identify local needs, share knowledge of existing services, redesign pathways where appropriate, and work collectively to improve outcomes for defined populations.

The membership of INTs may include:

- **Primary care providers**, primary care represented by a GP, community pharmacist, dentist & optometrist.
- **Independent care home/home care providers**, represented by a nominated care home or home care provider.
- **Trust community-based services**, represented by, for example, community nursing, allied health professional, mental health, social care/social worker.
- **Public Health Agency**, represented by a local lead with data and public health insight.
- **VCSE**, represented by a VCSE anchor organisation representative.
- **Social Prescriber**, new neighbourhood roles for social prescribers will be developed where required.
- **Local Council**, represented by a member of the local Community Planning Partnership.
- **Service User and Carer**, represented by members of the public appointed for this purpose.

Representatives will be **put forward for membership by their host organisations** and remain accountable to them and employed by them. Groups are flexible, and can start off with a smaller number of representatives and grow as need develops.

Governance arrangements will be led by the Strategic Planning and Performance Group, the part of the Department of Health which is responsible for planning, commissioning, and overseeing health and social care services to ensure they meet the needs of the population.

The policy paper for the Neighbourhood Model emphasises the need for collaborative agreements to be created and it appears that governance arrangements are still being developed while the groups are being put together.

For that reason, it's not yet entirely clear how each Trust will feed in to the INTs, or the extent of power these groups will have over how new services are developed. This is something we will be following over the coming months.

**Demographic focus for 2026/27:** This year INTs will deliberately prioritise the needs of older people, reflecting their high use of services and the growing pressures associated with an ageing population.

### *Moving More Care Closer to Home*

A central ambition of the model is to redesign care so that more advanced, specialised and proactive care is delivered closer to people's homes.

Primary care multidisciplinary teams, community nursing, **allied health professionals** and community pharmacy **have been highlighted as key enablers of this shift.**

This part of the plan will involve a **programme of prioritised place based and regional initiatives designed to scale up good practice**, and creating a pipeline to test and build the evidence for new approaches where needed.

It will also involve planning and redesigning clinical pathways so routine and scheduled care increasingly happens in community and primary care settings, as well as strengthening anticipatory and proactive care, particularly for high-risk groups.

### *Neighbourhood Digital Innovation, Intelligence and Evaluation*

The third pillar of the model is a neighbourhood innovation programme which will provide the data and digital infrastructure, innovation pipeline and evidence to support system wide change.

A **neighbourhood-level data framework** will be developed to enable teams to better understand local need and target interventions. There is a commitment to enhance data tools, capabilities and data sharing arrangement to support the work of the INTs and to collaborate with organisations outside the health sector to facilitate this. There is also an intention to build a culture of continuous improvement and innovation through embedding quality improvement methodologies.

### *Neighbourhood Relationships and Connections*

The policy places a **strong emphasis on building strong relationships** and trust between partners. Partnership working is a central ethos, including seeing people as assets and partners in managing their own health. Systems and processes will be developed to allow INTs to function as a system rather than a collection of services.

As part of this work, social prescribing will be embedded from an early stage.

### *How the model will be funded*

The model isn't being delivered through 'new' money. It's mainly funded through a planned shift in existing resources within the health and social care budget, and some funding from government sources that are dedicated towards transforming public services.

The policy aims to move approximately 2% of hospital-based spending into community services each year. And a small proportion of the annual HSC budget will be set aside to

help run the programme, including supporting some administration and practical support for the INTs.

A number of projects which will support Neighbourhood working will receive investment from the Executive's Transformation Fund, a pot of ring-fenced funding to support reform and redesign of public services across Northern Ireland.

## What happens next?

Implementation begins in April 2026, and in the first year of the programme there will be a focus on older people.

Throughout 26/27 the Programme Board will steer and oversee progress across the four pillars:

- Establishing the INTs and supporting them to start working towards their goals of reducing unnecessary hospital stays, understanding local need, improving access to primary care and supporting early intervention.
- Testing new approaches which support moving more care closer to home, and refocus care from hospital to community.
- Establishing the digital, data and improvement infrastructure, and the neighbourhood evaluative framework.
- Setting up systems and processes that develop strong relationships, and embedding a regional approach to social prescribing.

## What this means for you

This policy represents a significant cultural shift. It represents a number of opportunities for dietetics, and may lead to changes in how some services are delivered in the long-run.

Things to consider:

- **There's unlikely to be any dramatic, immediate shifts in dietetic services.** The model is designed to encourage a gradual move towards more community-based delivery, and there is an emphasis on scaling what already works and learning from best practice throughout the country.
- In the first year of the policy there will be a big focus on **meeting the needs of older people**, especially initiatives which help to keep people well for longer, and avoid or reduce hospital stays. For dietitians who work in this area, there may be more opportunities to suggest new service models, and emphasise the role of nutrition within existing programmes.
- The model specifically highlights the need for **greater multi-disciplinary working and person-centred care**, areas that dietetics already excels in. Dietetics as a profession should be prepared to position itself not only as key contributors to this new way of working, but as **leaders** in the space, and ready to share evidence of existing good practice and successful initiatives which could be adopted more widely.
- The policy places a **strong focus on treating people close to home**, and on **prevention-based initiatives**. As funding is gradually transitioned from hospital services out to more community and prevention care, we may start to see more roles

or opportunities in these spaces. This is something to be mindful of when considering your long-term career planning and continuing professional development.

- There will be a **strong focus on meeting the needs of the local population**, for example, the unique challenges faced by a very rural area, or an area of high deprivation. This offers opportunities for innovative and creative ideas, but may also risk unequal provision and a “postcode lottery”. We will be paying close attention to the development of the model and advocating for measures to be put in place to lessen the problems this could present; and we will also be seeking feedback from our members to understand fully how this is working in practice.

If you have any further questions, please contact Sarah Lavery, BDA Policy and Campaigns Officer – Northern Ireland, [s.lavery@bda.uk.com](mailto:s.lavery@bda.uk.com)