

Design principles of Neighbourhood Health identified by North Devon stakeholders

Draft principles for testing and refinement through the One Northern Devon Neighbourhood Health workshop

12 draft design principles

These draft principles are intended to be tested with partners. They are not a final set of principles, but a starting point drawn from local engagement, Health and Justice learning, primary care discussions, ICB materials and national Neighbourhood Health guidance.

No.	Draft principle	What it means in practice
1	No wrong door - "no, but this way"	People should not simply be told they are in the wrong place. If one service cannot help, partners should help connect the person to the next best route.
2	Design around the person's whole life, not just their presenting issue	Health, mental health, housing, money, transport, relationships, caring responsibilities and community connection should all be considered where relevant.
3	Build on what already exists before creating something new	Start by mapping existing services, community assets, VCSE support and relationships, then identify what needs connecting, strengthening or filling.
4	Make the system easier for staff as well as residents	Neighbourhood Health should reduce friction, duplication, unclear routes and avoidable work; it should not add another layer of meetings or bureaucracy.
5	Prioritise people least well served by the current system	Focus on people whose needs are not well met by existing thresholds, pathways or access routes, not only those easiest to identify or engage.
6	Use data, professional insight, community knowledge and lived experience together	Data should help identify need and variation, but design should also be shaped by staff, residents, VCSE partners and people with lived experience.
7	Share power and decision-making with the people and partners closest to the issue	Decisions should not be dominated by the largest organisations; primary care, VCSE, communities and smaller partners need meaningful influence.
8	Create clear roles, routes and responsibilities	People and professionals should know who does what, how to access support, how to escalate, and who is coordinating when needs cross boundaries.
9	Enable local flexibility within a shared neighbourhood approach	The model should have enough consistency to be coherent and fair, but enough flexibility to reflect different communities, assets and needs.
10	Test, learn and adapt rather than wait for a perfect model	Start with practical tests of change, evaluate what happens, and adapt the model based on evidence, experience and impact.
11	Make prevention and earlier support real	The model should identify risk earlier, intervene before escalation where possible, and support people to stay well at home and in their community.
12	Be honest about constraints and escalate what cannot be solved locally	Some barriers will need ICB, system or national action. The workshop should identify local actions and wider asks clearly.

Design principles identified so far

We are not starting from a blank page. The design principles for Neighbourhood Health in Northern Devon are being developed from a combination of local partner insight, Health and Justice learning, primary care discussions, ICB planning materials and national Neighbourhood Health guidance.

The principles below are deliberately more specific and behavioural than generic integration principles. They are intended to describe how partners should design and work together, not just what the programme values in broad terms.

Sources informing these principles

- local partner survey insight on collaboration for people with complex needs;
- themes from the Devon Neighbourhood Health workshop;

- learning from the Health and Justice work in Ilfracombe;
- the Northern Devon GP Collaborative / PCN workshop notes;
- ICB commissioning intentions and Neighbourhood Health planning materials;
- national guidance on Neighbourhood Health and Integrated Neighbourhood Teams;
- local conversations about the purpose of Neighbourhood Health, including the need for clearer pathways, better flow and a "no, but this way" approach.

Why these principles matter

Neighbourhood Health will not succeed simply by creating new structures or meetings. It will need to change how partners behave together, how decisions are made, how support is connected, and how people experience the system.

The principles are designed to help partners test whether proposed actions are genuinely moving towards a better neighbourhood model, or whether they are drifting back into organisational priorities, existing constraints or fragmented ways of working.

Principle 1: No wrong door - "no, but"

People should not simply be told that they are in the wrong place. If one service cannot meet a need, the system should help people find the next best route. This means moving from signposting as a passive act to active connection, warm handovers and shared responsibility for helping people navigate support.

Source basis: This principle comes strongly from local Health and Justice learning and local Neighbourhood Health conversations, where partners described the need to stop people experiencing repeated "no" responses and instead help them move towards the right support.

Principle 2: Design around the person's whole life, not just their presenting issue

Neighbourhood Health should recognise that people's needs are not neatly separated into health, care, mental health, housing, transport, money, relationships or community support. The model should make it easier to understand and respond to the full context of a person's life where this affects their health, wellbeing or ability to access care.

Source basis: This principle is reflected in national and ICB ambitions to integrate care around the individual and what matters to them, and in local discussions about people needing support across health and wider social needs.

Principle 3: Build on what already exists before creating something new

The first response should not always be to create a new service. Partners should start by understanding what already exists, including services, community assets, VCSE support, informal networks and local relationships. The task is then to connect, strengthen, simplify or fill gaps where needed.

Source basis: This principle comes from local discussions about the need to map services and pathways, and from the recognition that some perceived gaps may actually be issues of visibility, connection or navigation.

Principle 4: Make the system easier for staff as well as residents

Neighbourhood Health should reduce friction for the workforce as well as for people using services. It should make pathways clearer, reduce duplication, improve communication and reduce avoidable work. It should not become another layer of meetings, referrals or bureaucracy that adds burden without improving outcomes.

Source basis: This principle is strongly supported by the GP Collaborative notes, which highlighted workload pressure, duplication, demand-capacity mismatch and the need for INTs to support practices rather than add additional burden.

Principle 5: Prioritise people least well served by the current system

The model should focus on people and communities who face the greatest barriers, poorest outcomes or least effective access to existing support. This includes people whose needs do not fit neatly into current thresholds, who experience multiple disadvantage, or who are less visible in service data and engagement processes.

Source basis: This principle reflects the ICB and national focus on reducing inequalities, the OND inequalities agenda, and local learning from people with complex and intersecting needs.

Principle 6: Use data, professional insight, community knowledge and lived experience together

Data can help identify patterns of need, risk, variation and outcomes, but it should not be the only form of knowledge used in design. Staff insight, community knowledge, VCSE intelligence and lived experience should all shape the model and help interpret what the data means in practice.

Source basis: This principle is drawn from ICB materials on population health management, segmentation and risk stratification, and from local learning about the need to involve patients, communities and partners with direct experience.

Principle 7: Share power and decision-making with the people and partners closest to the issue

Neighbourhood Health should avoid being dominated by the largest organisations or by those already holding the most formal power. Primary care, VCSE partners, communities, smaller organisations and people affected by the model need meaningful influence in design, delivery and learning.

Source basis: This principle reflects the learning from Health and Justice work, local discussions about power and legitimacy, and the GP Collaborative concern that primary care needs to organise at sufficient scale to influence system decisions.

Principle 8: Create clear roles, routes and responsibilities

People and professionals should know what support is available, how to access it, how to escalate concerns, and who is coordinating when needs cross organisational boundaries. Clarity should apply across neighbourhood, PCN, practice, OND, ICB and wider system levels.

Source basis: This principle is supported by the GP Collaborative notes on the need to clarify roles across the Collaborative Board, PCNs and practices, and by ICB requirements to confirm organisational ownership of planned deliverables.

Principle 9: Enable local flexibility within a shared neighbourhood approach

A local Neighbourhood Health model needs enough consistency to be understood, governed and evaluated, but enough flexibility to reflect the assets, needs and geographies of different communities. Equity does not always mean uniformity.

Source basis: This principle comes from the GP Collaborative notes, which described PCNs as enabling equity rather than uniformity, and from ICB delivery planning that allows local variation in pace, starting point and emphasis within a common pathway.

Principle 10: Test, learn and adapt rather than wait for a perfect model

Neighbourhood Health should be developed through practical tests of change, evaluation, learning loops and adaptation. Partners should be willing to start, learn from implementation and refine the model rather than waiting for all conditions to be perfect.

Source basis: This principle is reflected in ICB materials on test-and-learn approaches, maturity assessments, impact evaluation, learning loops and development over time.

Principle 11: Make prevention and earlier support real

The model should identify people at risk earlier, support people to manage their health and wellbeing, and intervene before avoidable escalation where possible. Prevention should be built into pathways, workforce practice, data use and community support, not treated as a separate aspiration.

Source basis: This principle is strongly aligned with national Neighbourhood Health guidance, ICB commissioning intentions, population health management and local ambitions to keep people healthy and living well at home.

Principle 12: Be honest about constraints and escalate what cannot be solved locally

Some barriers can be addressed by local partners, while others require ICB, system or national action. The model should distinguish clearly between local actions and wider asks, including issues such as data sharing, funding, contracting, governance, workforce, digital infrastructure and policy uncertainty.

Source basis: This principle draws on the PCN workshop notes and ICB materials, which identify policy, contracting, governance, data-sharing and resource uncertainty as important implementation barriers.

Summary draft design principle statement

A shorter combined version could be:

Neighbourhood Health in Northern Devon should be designed around people's whole lives, with a no wrong door approach that builds on existing community assets, makes support easier to navigate, prioritises those least well served, shares power and knowledge across partners, supports earlier intervention, and develops through testing, learning and honest escalation of barriers that cannot be solved locally.

How these principles will be used in the workshop

The workshop will use these draft principles as a starting point. Participants will be asked to:

1. test whether these principles feel right for Northern Devon;
2. identify anything missing, unclear or too generic;
3. agree the principles that should guide the local model;
4. use the principles to describe the desired future experience for the selected cohort;
5. test whether proposed actions and next steps are consistent with the principles;
6. identify where proposed changes drift back into organisational priorities, existing constraints or fragmented ways of working.