

Collective barriers identified so far: where they came from

Collective barriers identified so far

We are not starting from a blank page. The barriers being used to support the Neighbourhood Health workshop have been drawn from several sources of local and system insight. These include:

- a local partner survey 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;
- ICB commissioning intentions and Neighbourhood Health planning materials;
- national guidance on Neighbourhood Health and Integrated Neighbourhood Teams.

Together, these sources suggest that the challenge is not simply to create new teams or pathways. The bigger challenge is to remove the barriers that currently stop people, communities and professionals from getting the right support in the right place at the right time.

Why these barriers matter

Neighbourhood Health aims to support people earlier, closer to home and in a more joined-up way. However, local partners have identified a number of barriers that make this difficult in practice.

Some of these barriers are experienced directly by people and families, for example unclear pathways, repeated handovers or difficulty accessing support. Others are experienced by staff and organisations, for example capacity pressures, information-sharing constraints, unclear governance or limited visibility of what support already exists.

The workshop will use these barriers as a starting point. Participants will be asked to test whether they feel accurate, identify anything missing, and consider which barriers most need to be addressed for the chosen cohort.

Barrier 1: Fragmented pathways and repeated handovers

People can move between services without clear ownership or resolution. Support may be available, but the route into it is not always clear. This can lead to repeated referrals, delays, duplication and people having to tell their story multiple times.

This barrier has been highlighted through local partner insight, the Health and Justice work, and the GP Collaborative discussion, which described fragmented pathways and system “churn” as a significant source of inefficiency and unmet need.

Barrier 2: Limited visibility of available support



There are many services, community assets and voluntary sector offers across Northern Devon, but they are not always visible to residents or professionals. GPs, hospital clinicians, community teams and other partners may not know what support exists, who it is for, or how to connect people to it.

This means that what appears to be a “gap” may sometimes be a lack of visibility, connection or navigation rather than a complete absence of support. This was strongly reflected in local discussion about the need to map services, pathways and the strength of connections between them.

Barrier 3: Reactive support rather than earlier, proactive help

Current models often respond once need has escalated, rather than identifying people at risk earlier and supporting them before crisis point. This is inconsistent with the direction of Neighbourhood Health, which emphasises prevention, proactive care, population health management and earlier intervention.

ICB planning materials describe the need for Integrated Neighbourhood Teams to identify people at greatest risk, proactively review and support interventions, and help people stay healthy and independent at home.

Barrier 4: Information sharing, digital and data barriers

Partners need to be able to identify people at risk, coordinate support and evaluate impact. This requires practical data-sharing arrangements, shared digital records, population health data, risk stratification and clear information governance.

At present, data and information-sharing arrangements are not always in place or easy to use across organisational boundaries. This limits the ability to coordinate care, support proactive identification, and understand whether interventions are working.

ICB materials identify data-sharing arrangements for patient identification and evaluation as a key requirement for Neighbourhood Health development.

Barrier 5: Workforce and capacity pressures

Services are already under significant pressure. Practices, PCNs, community teams, social care, VCSE partners and wider services all have limited headroom to take on additional transformation work.

If Neighbourhood Health is experienced as another layer of meetings, processes or expectations, it risks adding burden rather than reducing pressure. The GP Collaborative notes highlight rising workload, demand-capacity mismatch, workforce constraints and the need for a phased, realistic approach.

Barrier 6: Unclear roles, ownership and governance

Neighbourhood Health requires partners to work together across organisational boundaries. This raises practical questions about who leads, who coordinates, who makes decisions, who holds responsibility, and what happens at neighbourhood, PCN, collaborative, local authority, ICB or wider system level.

The GP Collaborative work identified the need to clarify roles across the Collaborative Board, PCNs and practices, and to develop governance and

organisational infrastructure that enables primary care to operate at scale and influence system decisions.

Barrier 7: VCSE capacity and integration

Voluntary, community and social enterprise partners are essential to Neighbourhood Health, particularly in relation to prevention, social connection, wider determinants of health and practical support. However, VCSE support is not always consistently connected into pathways, referral routes or decision-making structures.

Meaningful VCSE involvement requires visibility, sustainable capacity, clear routes into support, appropriate resourcing and a shared understanding of roles. ICB materials identify community and VCSE capacity and capability as a key system enabler for Neighbourhood Health.

Barrier 8: Inequalities and exclusion

People with the greatest need may also face the greatest barriers to accessing support. This may include people affected by poverty, rural isolation, poor transport, digital exclusion, mental health needs, housing insecurity, disability, caring responsibilities, involvement with the criminal justice system, or multiple long-term conditions.

The risk is that Neighbourhood Health improves services for people who are already easiest to reach, while those who are least visible remain excluded. This means the design process needs to keep asking whose experience is missing and who should benefit most.

Barrier 9: Balancing consistency with local flexibility

Neighbourhood Health needs enough consistency to be understandable, fair and scalable, but enough flexibility to reflect different local communities, geographies and populations.

The GP Collaborative work describes the need for PCNs to enable equity rather than uniformity, allowing different areas to prioritise and deliver based on their specific local context.

Barrier 10: Policy, funding and contracting uncertainty

National policy, funding flows and contracting models are still developing. This creates uncertainty about future responsibilities, budgets, procurement, organisational ownership and delivery models.

Local partners therefore need to prepare for future Neighbourhood Health requirements while remaining flexible. ICB background materials describe 2026/27 as a preparatory year for developing neighbourhood plans, agreeing footprints, establishing Integrated Neighbourhood Teams for priority cohorts, confirming ownership of deliverables and putting data-sharing arrangements in place.

Local data and situational analysis summary

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Neighbourhood Health is being developed nationally, but it needs to be shaped locally. In Northern Devon, the national direction towards prevention, proactive care, integrated neighbourhood teams and care closer to home needs to respond to the specific needs, strengths and pressures of our communities.

This page summarises the local context that will be used to support the Neighbourhood Health workshop. It is intended as a short summary rather than a full evidence pack. The full supporting documents are available in the Supporting Documents section.

Northern Devon's local context

Northern Devon has significant strengths, including established relationships across partners, committed primary care and public services, active voluntary and community organisations, and existing examples of integrated working. However, the local context also creates particular challenges for Neighbourhood Health. These include:

- rurality and dispersed communities;
- transport barriers;
- an ageing population;
- social isolation and changing family support networks;
- housing and economic pressures;
- workforce constraints across health, care and community services;
- persistent inequalities in access, experience and outcomes.

The GP Collaborative workshop described these factors as contributing to high and growing levels of need that cannot be addressed through traditional models of care alone.

Population and system pressures

Local partners have identified a number of pressures affecting people, practices and the wider system. These include:

- increasing demand for same-day and urgent care;
- growing complexity among people with multiple long-term conditions;
- rising need linked to frailty, end of life care, mental health and wider social needs;
- pressure on social care and community services;
- avoidable escalation into urgent, statutory or specialist services;
- difficulty providing proactive support before crisis point.

The GP Collaborative notes describe a significant proportion of current workload as unmet need, avoidable demand or system inefficiency, rather than appropriate clinical activity.

What people and professionals experience now

Local insight suggests that people with complex or multiple needs may experience the system as fragmented and difficult to navigate. Common issues include:

- unclear routes into support;
- repeated handovers between services;
- people having to tell their story multiple times;
- thresholds that do not reflect the complexity of people's lives;
- limited visibility of community and VCSE support;
- support arriving too late, after problems have escalated;
- professionals not always knowing what help is available or who to contact.

The Health and Justice learning described the importance of making it easier for people to get what they need across health, mental health, housing, transport, social needs and community support, rather than being told “no” or “you are in the wrong place.”

Primary care and neighbourhood readiness

Primary care is central to the development of Neighbourhood Health, but practices and PCNs are already operating under significant pressure. The GP Collaborative work identified:

- rising workload and demand-capacity mismatch;
- fragmented pathways and system churn;
- unclear or changing referral processes;
- administrative burden and duplication;
- workforce challenges;
- limited transformation headroom;
- the need to organise at sufficient scale to influence system decisions;
- the need to balance collaboration with maintaining practice autonomy.

It also highlighted the opportunity to build on North Devon's mature and trusted working culture to develop a more coordinated, neighbourhood-based model of care.

The role of data and population health management

Neighbourhood Health will need to make better use of data to understand population need, identify people at risk, target support and evaluate impact. ICB background materials identify population segmentation, risk stratification, shared dashboards and data-sharing arrangements as important enablers for Neighbourhood Health. They also describe the need for local areas to confirm plans for robust patient identification and evaluation.

For Northern Devon, this means using data alongside professional insight, community knowledge and lived experience. Data can help identify patterns of need, but it will not be sufficient on its own. Local partners will also need to understand what support already exists, where pathways break down, and what people experience when they try to access help.

Local opportunities

Although the challenges are significant, Northern Devon also has important opportunities to build on. These include:

- strong existing relationships across partners;
- active community and voluntary sector organisations;
- committed primary care leadership;
- existing examples of integrated working;
- local knowledge of people and communities;
- opportunities to connect health, care, VCSE, housing, mental health, transport and wider support;
- national and ICB momentum behind Neighbourhood Health.

The GP Collaborative describes North Devon as well placed to respond proactively, with a strong history of collaboration and a shared commitment to improving outcomes for patients and sustainability for general practice.