THE NEUROLOGICAL ALLIANCE

A vision for neuro neighbourhood health

Delivering integrated, specialist-informed care closer to home

July 2026

A Vision for Neuro Neighbourhood Health

Delivering integrated, specialist-informed care closer to home

Contents

Acknowledgments

We are grateful to all those who contributed to this report, including people affected by neurological conditions, carers, clinicians, voluntary sector partners and system leaders, whose insights and experiences have been invaluable in shaping this work.

Summary

At least 1 in 6 people in England have a neurological condition. Neurological conditions are among the country's largest and most complex areas of health need. Yet care for this group remains fragmented, slow and difficult to navigate. The NHS shift to neighbourhood health, organising care around people and places rather than institutions, creates a major opportunity to change this if neurological care is explicitly included.

This report defines neuro neighbourhood health as specialist-informed care and support for people with neurological conditions delivered locally, proactively and holistically, informed by risk stratification and with clear, continuous links to specialist expertise.

In practice, this means GPs, allied health professionals, mental health practitioners and voluntary sector partners working as integrated teams; more prevalent conditions managed in primary care; routine monitoring and rehabilitation delivered in community settings; and fast-track pathways for people with rapidly progressive conditions requiring urgent access to respiratory support, palliative care or specialist review.

The balance between neighbourhood, community, specialist and supra-specialist provision will vary according to the condition, complexity and stage of disease. Specialist centres remain essential for complex diagnosis, advanced treatment and clinical oversight, but specialist expertise should remain actively connected throughout pathways through outreach, virtual MDTs, shared care arrangements, specialist community services and structured advice and guidance, enabling care to be delivered closer to home without creating separate neighbourhood and specialist pathways.

Integrated Neurology Systems provide the infrastructure through which neighbourhood, community, specialist and supra-specialist services can work as a connected system of care.

Six enablers are critical to delivery: a workforce with the capacity, support, skills and hybrid roles to bridge community and specialist care; voluntary and community organisations recognised and funded as core partners; co-production with people affected by neurological conditions; connected data and governance systems; commissioning that rewards coordination and prevention; and equity built into service design from the outset.

National and local action is required to make this vision a reality. DHSC and NHS England should develop a Modern Service Framework for neurological conditions, publish outstanding service specifications and workforce plans, maintain national clinical leadership through the current period of structural change and ensure leadership is in place within new Department of Health and Social Care structures. Integrated Care Boards should designate neurological conditions as a priority cohort, appoint named leads, commission end-to-end integrated pathways and invest in community neuroscience capacity.

Neurological conditions are not a niche issue but a test of whether the NHS can deliver integrated, person-centred care for people with complex, long-term needs. If neighbourhood health works for neuro, it will work for everyone.

Making it happen

Department of Health and Social Care (DHSC) and NHS England

Priority	**Action**
National framework	Develop a Modern Service Framework (MSF) for neurological conditions[1] within this Parliamentary term, setting a clear national

[1] https://www.neural.org.uk/neuromsf/

	ambition for neurological health and providing a roadmap for delivery.
Standards and transformation	Publish and implement national neuro standards and outputs, including outstanding service specifications (neurosurgery, paediatric neuroscience, specialised rehabilitation), the Adult Neurology Service Specification, and outputs from the National Neuroscience Transformation Programme, before the end of 2026.
Workforce	Plan and invest in the clinical neuroscience workforce required for neighbourhood delivery[2], including community, specialist and hybrid roles within the 10-Year Workforce Plan. This should include investment in digital capability, data literacy and technology-enabled care to support virtual MDTs, shared care, population health management and emerging technologies.
Leadership	Maintain national clinical leadership and oversight for neurological conditions as responsibilities transition into DHSC.
Data and improvement	Develop and make publicly available national neurological datasets, outcome measures and improvement metrics to monitor access, experience, outcomes and inequalities.

Offices for Pan-ICB Commissioning

Priority	**Action**

[2] Neurological Alliance (2025) A clinical neuroscience workforce fit for the future https://www.neural.org.uk/delivering-a-clinical-neuroscience-workforce-fit-for-the-future-in-england/

Integrated system leadership	Establish and support Integrated Neurology Systems to connect neighbourhood, community, specialist and supra-specialist services through shared pathways, workforce planning, MDTs, education and quality improvement.
Service coordination	Develop shared protocols, advice and guidance, virtual MDTs, referral pathways and escalation arrangements to ensure specialist expertise remains connected to neighbourhood delivery.

Integrated Care Boards (ICBs) and Health and Wellbeing Boards

Priority	**Action**
Priority cohort	Ensure neurological conditions are explicitly recognised as a priority cohort within neighbourhood health plans
Planning and commissioning	Embed neurological conditions within neighbourhood models, local plans and Joint Strategic Needs Assessments (JSNAS), reflecting population need across the life course
Accountability	Ensure clear accountability and board-level oversight for neurological conditions within neighbourhood health, including at least annual reporting on access, outcomes, inequalities and patient experience.
Leadership	Appoint a named clinical and/or strategic lead for neurological conditions within the ICB to drive coordination and accountability
Data and insight	Use data and lived experience to inform commissioning, identify gaps and address variation in neurological care

Workforce	Invest in community clinical neuroscience workforce and MDT capacity, including implementation of the Adult Neurology Service Specification and mapping provision against population need.
System connectivity	Establish clear pathways between relevant services across organisational boundaries, including shared care protocols, referral routes, advice and guidance, virtual MDTs and outreach models.
Community support	Commission and sustainably fund community-based support for people affected by neurological conditions, including information, navigation, peer support, self-management and practical assistance, recognising VCFSE organisations as core partners in neighbourhood health delivery.

Neighbourhood leaders (PCNs, place-based teams, provider collaboratives)

Priority	**Action**
Capability	Build capability within neighbourhood teams to deliver neurological care through training, advice and guidance, virtual MDTs and ongoing specialist support.
Coordinated care	Deliver coordinated, person-centred care, including named care coordinator for people with complex needs, proactive management and continuity across transitions.
Co-production and inclusion	Design inclusive, co-produced services involving people affected by neurological conditions and VCFSE partners in design, delivery and evaluation.

System connectivity	Establish clear pathways between relevant services across organisational boundaries, including shared care protocols, referral routes, advice and guidance, virtual MDTs and outreach models.
Community support	Commission and sustainably fund community-based support for people affected by neurological conditions, including information, navigation, peer support, self-management and practical assistance, recognising VCFSE organisations as core partners in neighbourhood health delivery.

Specialist providers

Priority	**Action**
Specialist support	Extend specialist expertise into neighbourhood settings through outreach, specialists embedded in community teams, advice and guidance, virtual MDTs and shared care models.
Oversight	Maintain clinical oversight for complex and rare conditions, including clear pathways for review, escalation and ongoing specialist input.

Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations

Priority	**Action**
Strategic partnership	Act as strategic partners in neighbourhood health delivery, supporting design, delivery and evaluation.
Community support	Strengthen capacity to deliver community-based support through sustainable funding and commissioning (including through ICBs), including information, navigation, peer support and practical help.

Introduction

Neighbourhood health is one of the central delivery ambitions of current NHS reform. It aims to move care closer to home, strengthen prevention, improve coordination and make services easier for people to navigate.

For people affected by neurological conditions, this ambition is highly relevant. Neurological conditions are often lifelong, fluctuating and complex, and affect all ages. They require support from multiple services across primary care, community care, specialist neurology, secondary care, rehabilitation, mental health, social care and the VCFSE sector. Yet too often, people experience these services as fragmented, reactive and difficult to access.

This report sets out a vision for neuro neighbourhood health: a model of specialist care that brings more proactive, coordinated support into communities.

The report describes why neurological conditions must be explicitly included in neighbourhood health implementation, what could reasonably be delivered at neighbourhood level and the steps needed to make this model work.

Methodology

The methodology and objectives of this report were developed in collaboration with a working group of Neurological Alliance members, including representatives from paediatric, adult, rare and more prevalent neurological conditions.

This report draws on analysis of current public policy, stakeholder interviews, roundtables with clinicians and system leaders, and insights from people with lived experience. It is grounded in analysis of national policy, NHS service specifications and transformation tools, alongside condition-specific evidence on access, inequalities and workforce pressures.

30 people attended our Roundtable in March 2026 including voluntary sector representatives, clinicians, people affected by neurological conditions, neurologists, occupational therapists, specialist nurses, physiotherapists, rehabilitation consultants, psychologists, psychiatrists and system managers.

Eight interviews were conducted in February and March 2026. This included representation from rehabilitation medicine, neurology, people with lived experience, physiotherapy, neighbourhood health programme coaches and public health. Further written feedback was received from primary care representatives.

Participants highlighted both system design challenges and frontline realities, including workforce constraints, fragmented pathways and variation in access to care.

The approach reflects both system-level design requirements and the realities of delivering care across primary, community and specialist services.

Insights consistently pointed to fragmentation and lack of coordination of care, workforce and capacity constraints, limited involvement of neuro teams in neighbourhood planning and inconsistent involvement of people with lived experience.

Why this matters now

Neighbourhood health sits at the centre of NHS reform[3], aiming to deliver more care closer to home, strengthen prevention and improve coordination across services. It reflects a long-standing ambition to move away from fragmented, hospital-centric care towards integrated, person-centred models.

This shift is happening in the context of growing system pressure. Primary care, which underpins neighbourhood health, is under increasing strain. As of March 2026, 63.67 million people were registered with GP practices in England, an increase of nearly 14%

[3] NHS England and the Department of Health and Social Care (2025) Fit for the future: 10 Year Health Plan for England https://www.england.nhs.uk/long-term-plan/ (Access 16 April 2026)

since 2015.[4]. 2.5 million GP appointments per year relate to headache and migraine alone[5].

With a growing and ageing population, alongside rising levels of long-term conditions and complex co-morbidities, demand for general practice is expected to increase further. Health Foundation modelling[6] indicates that an additional 6,500 full-time equivalent GPs will be needed by 2031/32 to meet this demand.

These system pressures are already being felt by people affected by neurological conditions. Many report difficulties accessing specialist care, limited follow-up and a lack of coordination between services. My Neuro Survey 2024[7] found that over 4 in 10 people do not know who to contact between appointments, highlighting a clear gap in continuity and care coordination, a core function that neighbourhood health is intended to address.

"I live in Bedfordshire and my doctor is in Hertfordshire, so accessing services on the NHS is a nightmare due to funding in different areas. What I don't understand is it's NHS England." – Person affected by a neurological condition.

At the same time, inequalities in access and outcomes remain deeply embedded. People's experience of care varies widely depending on geography, deprivation and demographic factors, with delays and barriers compounding disadvantage over time. Barriers such as language, trust and communication needs were repeatedly highlighted as drivers of unequal outcomes.

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[4] British Medical Association (2026) Pressures in general practice, https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice (Accessed 1 May 2026)

[5] Rightcare (2019) RightCare: Headache & Migraine Toolkit optimising a headache and migraine system https://gettingitrightfirsttime.co.uk/wp-content/uploads/2024/07/rightcare-headache-and-migraine-toolkit-v1.pdf (Accessed 1 May 2026)

[6] The Health Foundation (2022) Projections: General practice workforce in England https://www.health.org.uk/reports-and-analysis/reports/projections-general-practice-workforce-in-england (Accessed 16 April 2026)

[7] The Neurological Alliance (2025)

Neuroscience services are fragmented and concentrated in specialist centres, leading to inequitable access, inefficient pathways, over-reliance on tertiary care, and avoidable deterioration and admissions. Where there are specialist community services, workforce capacity has not kept up with demand, and there can be waits to access intervention.

Neurological conditions represent a significant and growing challenge for the NHS. Neurological conditions are now the leading cause of ill health and disability globally[8]. They affect millions of people across the life course with impacts that extend far beyond healthcare into education, employment and social participation.

This complexity is further compounded by the fact that a significant proportion of neurological conditions are rare, meaning expertise is dispersed and pathways are often less well established. The scale of unmet need is substantial. Findings from My Neuro Survey 2024 show that only one in three people feel the care they receive meets their needs, while almost half do not feel supported by the health system. More than a quarter were unable to access a neurologist or specialist nurse in the past year. Access to mental health support is particularly limited, with 69% of those who needed neuropsychiatry unable to access it, alongside 62% for neuropsychology and 48% for counselling. Three quarters of respondents report that their condition affects their ability to work or study, six in ten are struggling financially, and many carers are providing high levels of unpaid care with limited support.

Many people with neurological conditions experience a complex interaction of cognitive, emotional, behavioural and social impacts that can affect relationships, education, employment, independence and participation in everyday life. These needs often fall between traditional service boundaries, with people reporting difficulties accessing support that recognises the combined neurological, psychological and social consequences of their condition.

[8] Steinmetz J, Seeher K, Schiess N et al. (2024) Global, regional, and national burden of disorders affecting the nervous system, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021 The Lancet Neurology, 23, 344-381

Children and young people experience similarly significant challenges, including difficulties with learning, energy, mood, communication and participation in everyday activities. Many do not feel involved in decisions about their care, and carers report increasing difficulty accessing support as children get older. The long-term impact of neurological conditions experienced during childhood and adolescence is also often poorly recognised, with insufficient consideration given to how neurological conditions can affect development, education, social participation, independence and future life opportunities over time.

They are also highly relevant to the shift towards neighbourhood health. Neurological conditions are typically long-term and complex, often requiring ongoing management rather than episodic intervention. They rarely sit neatly within a single service or pathway, instead requiring coordinated input across health services, social care and voluntary, community, faith and social enterprise (VCFSE) organisations. The system often struggles to bring these elements together in a coherent way.

At the same time, the system is not yet prepared for what is coming next. Advances in diagnostics, disease-modifying therapies and digital technologies are transforming neurological care, creating new opportunities for earlier diagnosis, more effective treatment and improved long-term management[9]. However, these advances also require stronger pathways, more coordinated care and a workforce with the capacity and capability to deliver them.

For rapidly progressive neurological conditions, delays in diagnosis, treatment, equipment provision or care coordination can have profound consequences over a very short period

[9] The Neurological Alliance (2026) Future-proofing neurology services What emerging treatments mean for people, services, and policy in England, https://www.neural.org.uk/wp-content/uploads/2026/03/The-Neurological-Alliance-Future-proofing-neurology-services-report-180326.pdf (Accessed 1 May 2026)

of time. In these conditions, deterioration may occur over weeks or months rather than years, requiring neighbourhood systems that can respond rapidly, flexibly and proactively.

There is clear evidence that shifting care closer to home can deliver significant impact. For example, up to 90% of headache-related emergency attendances could be managed outside hospital[10], and matching best-performing areas could reduce emergency admissions by over 16,000 per year.

More broadly, a substantial proportion of admissions for long-term conditions are avoidable with proactive, community-based care. For many neurological conditions, this includes preventing complications such as falls, urinary tract infections (UTIs), aspiration and deconditioning that can lead to avoidable deterioration and hospital admission. For example, many neurological conditions cause bladder dysfunction, increasing the risk of UTIs. Despite being classed as an urgent care sensitive condition that should be managed at home or in the community where possible, they remain a leading cause of unplanned admissions for people with MS, accounting for over 23,000 bed days in 2023/24[11].

If an admission is required or unavoidable, length of stays can be reduced with proactive and specialist multidisciplinary community-based intervention. Given neurological conditions already drive significant system cost—including £325 million annually in emergency admissions for Parkinson's alone[12] and an overall economic burden of £96

[10] Goldstein JN, Camargo CA Jr, Pelletier AJ, Edlow JA. (2006) Headache in United States emergency departments: demographics, work-up and frequency of pathological diagnoses. *Cephalalgia*. 26(6):684-690. doi:10.1111/j.1468-2982.2006.01093.x

[11] MS Society (2025) A different path: Rethinking MS hospital care https://www.mssociety.org.uk/sites/default/files/2025-09/A%20different%20path%20-%20Rethinking%20hospital%20care.pdf

[12] HSJ Intelligence (2026) Parkinson's Admissions https://public.tableau.com/app/profile/hsj.intelligence/viz/shared/8P33NPXZY (Accessed 1 May 2026)

billion[13], there is a clear opportunity to improve outcomes while reducing pressure on acute services.

Taken together, these factors create a clear and urgent case for change. Neurological conditions are not only a major area of unmet need, but a critical test of whether neighbourhood health can deliver on its promise of more integrated, proactive and equitable care for people with complex, long-term conditions.

What neuro neighbourhood health looks like

It is clear from our discussions there is no one definition of neighbourhood health. The national framework[14] describes it as a way of organising services around people and defined populations, bringing together the support people rely on close to home, including general practice, community services, social care, public health and voluntary, community, faith and social enterprise (VCFSE) organisations, alongside access to diagnostics, urgent care and outpatient services where appropriate.

In practice, neighbourhood health is interpreted very differently across the country.

- For some, it is a "GP+" model that expands primary care with a few additional services.
- Some feel it represents a local population footprint of 30,000 to 50,000 people, serving as the foundational level for integrated health and care (Primary Care Networks) before scaling up to "Place" (250k–500k) and "System" (1m–3m) levels.

[13] Economist Impact Unit (2024) The Value of Action: mitigating the impact of neurological conditions in the United Kingdom https://assets.ctfassets.net/9crgcb5vlu43/3X482MJEP8rrLsLnlbqklK/2aa365d2899eb60f96d5d7a6a4c904e0/PDF_The_value_of_action__mitigating_the_impact_of_neurologi cal_disorders_in_the_United_Kingdom Accessed 16 April 2026

[14] Department of Health and Social Care (2026) Neighbourhood health framework https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework (Accessed 16 April 2026)

- For others, it represents a wider transformation: integrated, place-based care spanning health, social care and community support.

While many people with neurological conditions fall within current priority groups (frailty, multiple long-term conditions, palliative care, children and young people[15]), neuro is not yet identified as a national priority cohort. Without deliberate inclusion, it risks being overlooked.

As one roundtable participant said, "We haven't got a seat at the table… and we can't seem to permeate those messages through." This is reflected in early implementation, none of the neighbourhood pilots we engaged with had yet embedded neurological conditions explicitly.

"There's a very, very long list of things that you have to do… and neurology just isn't coming out as a priority." – Interviewee.

Neighbourhood health is sometimes equated with new "one-stop-shop" buildings[16]. While these hubs can improve visibility and access, real neighbourhood health is about how care is organised, not just where it happens. It depends on relationships, teamworking and shared pathways across GP, community, specialist and voluntary sectors.

Defining neuro neighbourhood health

Based on the evidence, and for the purposes of this report, neuro neighbourhood health is defined as:

[15] Many people with neurological conditions experience multi-morbidity, including cardiovascular and respiratory conditions, and are at increased risk of frailty and unplanned hospital admission. Conditions such as dementia are themselves neurological, while others (e.g. Parkinson's, multiple sclerosis, motor neurone disease and epilepsy) often involve progressive disability, complex long-term management and, in some cases, palliative and end-of-life care. Neurological conditions also affect children and young people, often requiring coordinated, multidisciplinary support across health, education and social care.

[16] NHS England (2026) Neighbourhood health centres https://www.england.nhs.uk/publication/neighbourhood-health-centres/ (Accessed 1 May 2026)

"Specialist-informed care and support for people with neurological conditions delivered locally, proactively and holistically, informed by risk stratification and with clear, continuous links to specialist expertise."

The proposed definition reflects the national ambition to organise care around populations and deliver more coordinated support closer to home[17]. It reflects clinical pathways[18] showing that much care can be delivered locally with specialist support, while more complex needs require specialist input.

Risk stratification means identifying people who may be at greater risk of deterioration, crisis, hospital admission or unmet need, so that support can be provided earlier and more proactively. This may include factors such as rapidly progressive disease, frequent emergency admissions, falls risk, cognitive impairment, complex symptoms, mental health needs, social isolation, communication difficulties or significant care and support requirements.

Risk stratification should be informed by appropriate specialist neurological expertise and used to match people to the right level of support at the right time, rather than creating additional barriers to care. It should support proactive care planning, coordinated monitoring and timely access to specialist input when needs change, recognising that neurological conditions are often fluctuating and that levels of need may change over time. People with lower levels of need should continue to have access to timely advice, support and routes back into services when required.

For people, it should feel like "wrap-around care that flexes and meets long-term needs."

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[17] Department of Health and Social Care (2026) Neighbourhood health framework https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework (Accessed 16 April 2026)

[18] National Neuroscience Advisor Group (2024) Optimal clinical pathways https://www.nnag.org.uk/optimum-clinical-pathways (access on 16 April 2026)

Achieving this model requires a cultural shift, from episodic, reactive treatment to continuous, preventative, proactive, relationship-based support that responds to changing needs.

The core features are:

1. **Continuity and coordination:** Every person should have access to case management[19], including a named professional or team acting as a single point of contact, ensuring smooth navigation across services and consistent follow-up.
2. **Multidisciplinary community care:** Primary care, clinical neuroscience, Allied Healthcare Professionals (AHPs), rehabilitation medicine, mental health professionals, neuropsychology, neuropsychiatry and VCFSE partners work in an integrated team and appropriate access to specialist input and expertise. This should include regular neuro-focused multiagency multi-disciplinary team (MDT) virtual meetings at neighbourhood level for planning and assessment.
3. **Proactive and preventative support:** Regular reviews and risk stratification help detect deterioration early and prevent crises. Risk stratification is best undertaken with appropriate specialist neurological expertise and should be used to match people to the right level of support at the right time, rather than creating additional referral steps or barriers to care. This approach should support proactive, personalised care and timely access to specialist input when needs change.
4. **Responsive and urgent care pathways:** People experiencing rapid deterioration should be able to access fast-track assessment, equipment, specialist advice, palliative support and coordinated intervention without unnecessary delay.

[19] Kings Fund (2011) Case management: what it is and how it can best be implanted https://www.kingsfund.org.uk/insight-and-analysis/reports/case-management (Accessed 21 May 2026)

5. **Personalised, whole-person care:** Care reflects the interaction between neurological, physical, cognitive, mental, vocational and social needs. It focuses on supporting independence, participation, whole-family thinking and quality of life, not just clinical intervention.
6. **Care closer to home:** Wherever clinically appropriate, care is delivered in community settings, including people's homes, GP practices, neighbourhood health centres or digitally, reducing unnecessary hospital attendance while maintaining clear access to specialist expertise.
7. **Co-production and community insight:** Service design and evaluation are done with people living with neurological conditions, not just for them.
8. **Skilled, confident teams, with access to specialist expertise:** Neighbourhood staff are supported through education, training, mentorship, clinical supervision and access to specialist advice networks. Clear protocols should be in place for neighbourhood staff to know when and how to escalate to specialists from complex cases or when they feel something is beyond their skill set.
9. **Carer recognition and support:** Carers are proactively identified, involved in care planning and supported through access to assessment, respite, emotional support, information and financial advice.

What this means in practice is outlined below:

Core element	What this means in practice	Intended outcomes
Primary care-led management of high-volume	Conditions such as headache and migraine are appropriately managed in primary care, including diagnosis,	Fewer unnecessary referrals; reduced outpatient demand; faster access to appropriate care.

neurological conditions	medication optimisation and preventative treatment.	
Ongoing condition management delivered locally	When certain conditions (e.g. Functional Neurological Disorder, multiple sclerosis, epilepsy) are being well-managed[20], they could receive routine monitoring, prescribing and periodic review through community teams, with appropriate access to specialists embedded throughout.	Improved continuity of care; earlier intervention; reduced avoidable deterioration.
Rehabilitation and reablement as a core offer	Community access to physiotherapy, occupational therapy, rehabilitation medicine, dietetics, psychology and speech and language therapy, supporting mobility, communication, cognition, wellbeing, falls prevention and independence. Specialist neurorehabilitation teams should provide coordinated rehabilitation, including spasticity management and access to botulinum toxin where appropriate, with clear pathways for people with complex or rapidly progressive conditions.	Maintained function; reduced disability progression; fewer hospital admissions.

[20] FEACHEM, R. G., SEKHRI, N. K. and WHITE, K. L., 2002. Getting more for their dollars: a comparison of the NHS with California's Kaiser Permanente. *BMJ*, 324(7330), pp. 135-143.

Specialist community support for complex conditions	Local community neuro teams deliver coordinated respiratory care, physiotherapy, equipment provision and specialist symptom management for people with rapidly progressive or complex conditions. This may include severe mental health presentations.	Improved quality of life; reduced crisis presentations; more care delivered in the community.
Access to equipment provision	Assessment for and provision of appropriate equipment (inc. splinting) in a timely way.	Improved independence, Reduction in care needs or secondary complications.
Improve integrated psychological and social support	Neighbourhood teams should include or link directly to appropriate counselling, mental health and social care services, with clear referral routes to neuropsychology and neuropsychiatry and joint planning. Specialist neuro teams should include adequately resourced clinical neuropsychology or clinical psychology expertise as a core part of the multidisciplinary team, working collaboratively alongside other professionals. No person with a neurological condition should be denied mental health support due to their neurological condition.	Improved mental health and wellbeing; improved access to employment and education; improved carer and family support; improved engagement in rehabilitation; reduced unmet need; better overall quality of life.

Medication optimisation and monitoring	Pharmacists, GPs and specialist nurses undertake regular medicine reviews (as appropriate).	Improved treatment effectiveness; fewer side effects; reduced unplanned care.
Support for daily living, independence and participation	Provision of aids, adaptations, equipment and strong links to VCFSE and peer-support services to maintain independence, social integration, cognitive support and community engagement.	Increased independence; reduced isolation; delayed need for intensive care.
Proactive health checks and structured reviews	Routine neighbourhood-based reviews, adapted from the NHS Health Check, covering neurological symptoms, mental health, vocational health, medications and functional ability.	Earlier detection of risk; better prevention (e.g. stroke, complications); more coordinated care.
Rapid response to prevent crisis or admission	Timely local access to specialist advice, self-management support, assessment and intervention when needs change, supported by clear care coordination, a named point of contact and responsive community-based services that can adapt to changing needs, helping avoid escalation to emergency care.	Fewer emergency admissions; reduced secondary complications; reduced pressure on urgent and emergency services; improved experience of care.

Fast-track support for rapidly progressive conditions	People with rapidly progressive or life-limiting neurological conditions can access coordinated fast-track pathways for respiratory support, gastrostomy, equipment, community nursing, palliative care and specialist review, supported through shared protocols and rapid escalation routes.	Reduced avoidable harm and crisis admissions; improved quality of life; faster access to essential support; better coordinated care.
Integrated palliative and advance care planning	Palliative care and advance care planning are introduced early where appropriate, integrated with neurology and neighbourhood teams rather than reserved only for the final stages of life.	Improved quality of life; better supported decision-making; fewer avoidable crises and hospital admissions; improved symptom management; improved end of life care experience.
Support for carers	Neighbourhood teams proactively identify carers and connect them to carers' assessments, practical education, peer support, respite services, welfare advice and practical training support.	Improved wellbeing and sustainability of unpaid care; reduced carer burnout; improved stability of care at home.
Timely diagnostics, genetics and	Neighbourhood teams support timely referral for diagnostics, genetic testing and access to relevant clinical trials or	Earlier diagnosis; improved access to innovation; reduced

research signposting	emerging treatment pathways where appropriate.	inequity in access to emerging treatments and research opportunities.
Transitional pathways from Paediatric to adult services	Young people with neurological conditions and disabilities, and their families, receive proactive, planned and developmentally appropriate support, including a defined and resourced transition pathway. Adult services recognise the long-term impact of neurological conditions acquired or experienced during childhood and adolescence, with ongoing review and support that reflects changing needs over time rather than assuming needs identified at transition remain static.	Improved continuity of care and experience; Better health outcomes and wellbeing; Improved quality of life.
Self-management support	Support to manage symptoms, live with a long-term condition prevent deterioration and gain insight, using strategies, education and working in partnership including peer support.	Increased confidence; Self-efficacy and control; Maintain independence; Reduced health and social care utility.

What must continue beyond the neighbourhood level

The boundaries of what should and should not sit within neighbourhood health are not arbitrary. They are already defined, in part[21], through the NHS England Specialised Neurology Service Specification[22], which sets out a networked model of care spanning community, secondary and specialised services.

Service specifications for complex rehabilitation, paediatric neuroscience and neurosurgery are currently in development.

This model makes clear that while much neurological care can and should be delivered closer to home, specialist and highly specialised services remain essential for safe, high-quality care. These services are not separate from neighbourhood health, but integral to it, providing the expertise, infrastructure and oversight that neighbourhood teams rely on.

The specification describes a system organised across Integrated Neurology Systems, where core services (including community and general neurology care) are delivered locally, but are explicitly connected to specialised centres that provide advanced diagnostics, treatment and clinical leadership.

These services are characterised by:

1. **Highly specialised clinical expertise**, including consultant-led subspecialty care (e.g. epilepsy, movement disorders, neuromuscular, neuroinflammatory and cognitive neurology), often supported by regional or national multidisciplinary teams.

[21] The Adult Neurology Service Specification and specialist neuroscience centres provide an important framework for defining specialist care beyond neighbourhood health, specialist expertise is also delivered within District General Hospitals (DGHs), including by neurologists and wider neuroscience professionals working outside tertiary centres.

[22] NHS England (2025) Specialised neurology services (adult) https://www.england.nhs.uk/wp-content/uploads/2025/08/specialised-neurology-services-adults-service-specification-august-2025.pdf (Access 16 April 2026)

2. **Complex diagnostics and clinical decision-making,** requiring access to advanced investigations (e.g. MRI, neurophysiology, neuropsychology, genomics) and specialist interpretation, particularly where diagnosis is uncertain or conditions are rare or atypical.
3. **Specialist treatments and technologies, including interventions with higher clinical risk or** complexity (e.g. disease-modifying therapies, immunotherapies, infusion treatments, neuromodulation and surgical interventions), requiring formal governance and MDT oversight.
4. **Delivery at regional or national scale**, including specialist paediatric and transitional services, ensuring sufficient expertise, infrastructure and continuity across the life course.

Crucially, specialist services must remain visible and accessible within neighbourhood models. This includes ongoing specialist input throughout the pathway through outreach, virtual MDTs, shared care arrangements, advice and guidance, and specialist rehabilitation support. Neighbourhood, community and specialist services work as a connected system of care.

In practice, this includes:

Specialist diagnosis and classification, including complex epilepsy, Parkinson's, neuromuscular conditions and neuroinflammatory disease, as well as paediatric-onset neurological conditions where early, accurate diagnosis is critical to long-term outcomes.

Advanced diagnostics, including neuroimaging, neuropsychology, neurophysiology (e.g. EEG, EMG), and access to genomic or specialist testing pathways and relevant clinical trials.

Initiation and oversight of high-risk or advanced treatments, such as disease-modifying therapies for multiple sclerosis, immunotherapies, infusion therapies, and emerging gene or precision treatments, with shared care where appropriate but retained specialist accountability.

Neurosurgery and interventional procedures, including epilepsy surgery, deep brain stimulation and other complex interventions requiring specialist centres.

Specialist inpatient care and tertiary clinics, providing access to acute neurology input, complex investigation and management, and coordination of care for people with severe or rapidly changing needs

Specialist rehabilitation medicine and complex neurorehabilitation, from a multi-disciplinary team including inpatient and outpatient rehabilitation for people with neurological disability (e.g. brain injury, spinal cord injury, progressive conditions), alongside ongoing specialist input into long-term rehabilitation pathways.

Management of complex or treatment-resistant symptoms, for example refractory epilepsy, advanced Parkinson's or complex spasticity management (including treatments such as fampridine or botulinum toxin where appropriate).

Highly specialised multidisciplinary care, including access to neuropsychiatry, neuropsychology, specialist rehabilitation and rare disease expertise, often delivered through regional or national centres. Specialist rehabilitation may also be delivered locally as part of a defined pathway with access to regional specialist rehabilitation services and expertise.

Rapid access pathways for people with rapidly progressive neurological conditions, including specialist respiratory care, nutritional support, assistive communication, palliative care input and complex symptom management under specialist oversight.

Key enablers for neuro neighbourhood health

Delivering neuro neighbourhood health relies on six interlinked enablers: a skilled workforce, strong VCSE partnership, lived experience in design, robust data and governance, supportive commissioning, and equity by design. These are the conditions that turn aspiration into reality.

Workforce

The workforce is the most immediate constraint and the most critical enabler. Success depends not only on workforce capacity, but on clear roles, shared competencies and effective collaboration and education across services.

"We need a hybrid model… neurologists need to reach out into the community." – Roundtable attendee.

A hybrid, networked workforce model is essential. Neighbourhood teams should be supported to provide proactive, person-centred care closer to home, while remaining connected to specialist expertise throughout an individual's care journey. Specialist expertise should remain accessible across the pathway through outreach, shared care arrangements, advice and guidance, virtual multidisciplinary team meetings, joint clinics and regular shared learning. Specialists must reach into the community, and neighbourhood teams must have structured access to their expertise.

This should include input from neurologists, rehabilitation medicine physicians, specialist nurses, allied health professionals, neuropsychologists, neuropsychiatrists and other specialist practitioners, alongside condition-specific expertise where required, such as respiratory, nutrition and palliative care services. Such arrangements enable neighbourhood teams to deliver care confidently while ensuring timely access to specialist assessment, intervention and review when needs change.

The neuroscience workforce already faces significant shortages and uneven distribution. Reform must therefore include investment in workforce growth, competency frameworks, interdisciplinary education and ongoing professional development. Given workforce turnover and changing service models, education cannot be a one-off exercise but must be embedded within the system to ensure skills and knowledge are maintained over time.

"Hard to keep track of competence… it's not a static workforce." – Roundtable attendee.

Care coordination is central to this model. People with neurological conditions consistently report lacking a clear point of contact and often find themselves navigating fragmented services. Dedicated care coordination roles, supported by multidisciplinary teams and specialist expertise, are critical to delivering proactive, safe and joined-up care.

Community Health and Wellbeing Workers (CHWWs) can play an important complementary role by strengthening outreach, engagement and connections with community assets. They can help reduce inequalities, improve access and support people to navigate local services. However, they should complement rather than replace specialist care coordination and are most effective when embedded within multidisciplinary teams, supported by appropriate training, supervision and clear links to specialist services.

VCFSE partnership

VCFSE organisations often provide the navigation, education and support that make care workable, yet their role is still under-recognised and under-funded. They play a vital role in supporting self-management and helping people stay well for longer through trusted information, advice, peer support, advocacy, condition-specific education, wellbeing initiatives and community-based or online activities such as exercise and self-management classes. For many people with neurological conditions, these services

provide ongoing practical and emotional support between clinical appointments and help reduce isolation, build confidence and support earlier intervention when needs change.

"The bandwidth in our charities… it's incredibly challenging." – Roundtable attendee.

Neighbourhood models must shift from goodwill to formal, funded partnership. VCFSE organisations should be built into pathway design, care coordination and evaluation, with sustainable commissioning rather than ad-hoc grants.

Co-production and involvement

Co-production is a practical safeguard against models that look good on paper but fail in reality.

"When it goes well… it's one of the most effective things you can do." – Roundtable attendee.

People affected by neurological conditions, including families and carers, must shape services at every stage of care planning and delivery, including need assessment, pathway design, information, evaluation, ensuring the system reflects the complexity and diversity of lived experience across ages and conditions.

Data, digital and governance

Shared information and clear accountability prevent fragmentation at neighbourhood level.

"Networks need to be based on competence and process, not individuals." – Roundtable attendee.

Integrated Neurology Systems require connected governance, virtual MDTs, shared records and clear escalation routes. At neighbourhood and ICB level, teams across different providers should have appropriate shared access to patient records to support

coordinated, joined-up care. This aligns with the NHS 10-Year Health Plan commitment to a single patient record and will be essential to ensuring information follows the person, not the organisation. Digital tools should support relationships and integrated working, enabling teams to identify risk, coordinate plans and access specialist advice.

Commissioning and funding

Current funding flows often reward activity, not prevention. Neuro neighbourhood health needs commissioning that funds coordination, rehabilitation, specialist advice, and VCFSE input across organisational boundaries.

Integrated Care Boards (ICBs) and Health and Wellbeing Boards must explicitly include neurological conditions in neighbourhood plans, avoiding the assumption they will be picked up through other cohorts. Where budgets remain siloed, the services that prevent deterioration will stay under resourced. Funding should better follow the patient across pathways, rather than being tied to isolated episodes of activity or organisational boundaries. Current fragmentation between specialised, acute, community and neighbourhood funding can create gaps in ongoing care, monitoring and treatment delivery, particularly where elements of specialist care are delivered outside tertiary centres. More aligned commissioning and funding approaches will be needed to support integrated, proactive neurological care closer to home.

Equity and inclusion

Neighbourhood care will only reduce inequality if inclusion is designed in from the start. People with neurological conditions face barriers such as language, fatigue, isolation, cognitive and communication difficulties, and digital exclusion.

"There may be language barriers… lack of trust… a whole bag of issues." – Interviewee

"People with communication impairments are marginalised in these discussions." – Roundtable attendee.

Accessible communication, culturally competent practice and co-produced outreach are essential. Community Health and Wellbeing Workers and VCFSE partners can help build trust, improve engagement and ensure people are better able to access timely care, support self-management and participate in decisions about their health and care. More equitable and inclusive services can help reduce avoidable deterioration, improve experiences and outcomes, and ensure neighbourhood health reaches people who have too often been underserved by traditional models of care. Equity must be everyone's responsibility, embedded in how services are planned, delivered and measured.

Conclusion

Neighbourhood health represents a major opportunity to improve care for people with neurological conditions. It offers a route to move from fragmented, reactive services towards care that is proactive, coordinated and closer to home.

But this is not guaranteed. Without deliberate action, there is a clear risk that neurological conditions, despite their scale and complexity, will remain peripheral to neighbourhood health implementation.

This report shows that the foundations for change already exist. National frameworks, service specifications and clinical pathways set out what good looks like. The task now is to bring these elements together into a coherent, connected system that works in practice.

Neurological conditions are not a niche concern. They are a critical test of whether neighbourhood health can deliver for people with complex, long-term needs. If the model works for neuro, it is far more likely to work for the wider population.

The message is clear: neighbourhood health must include neurological conditions, and it must do so now.

Together

we are stronger.

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