Neighbourhood diabetes nursing: local, proactive, integrated

Nicola Milne
Primary Care Diabetes Specialist Nurse Lead, Manchester

The publication of the *Neighbourhood Health Framework* in March marked a definitive paradigm shift in healthcare delivery across England (Department of Health & Social Care [DHSC] and NHS England, 2026a). For diabetes nursing care, this signals a move away from siloed acute care and clinic-based triage towards integrated, proactive support in the community.

Over recent years, as diabetes care has shifted from a glucocentric model to a holistic approach that encompasses multiple long-term conditions care (Milne and Kanumilli, 2026), we have often been reminded of a principle commonly attributed to the Canadian physician, William Osler – the importance of "treating the person, not the disease". The *Neighbourhood Health Framework* extends that principle, reminding us that place and community also matter. For optimal care delivery and outcomes, it is now imperative that we also "treat the postcode".

The framework gives practical shape to the Government's *10 Year Health Plan for England* (DHSC, 2025). At its heart is a clear left shift in care: breaking down institutional barriers and moving care delivery away from hospitals and into the communities where people live. It promotes the transition from a reactive, fragmented system into an integrated, localised service rooted in three core movements:

- **Hospital to community**: Shifting routine, urgent and specialist care into local settings to reduce avoidable pressure on acute hospitals.
- **Treatment to prevention**: Intervening earlier through risk stratification and proactive care to support healthier populations.
- **Analogue to digital**: Improving data sharing so multidisciplinary teams can identify, monitor and support people at higher risk.

With approximately one in five GP appointments occupied by non-medical social needs, such as loneliness, housing issues and debt (National Academy for Social Prescribing, 2024), the model looks beyond healthcare alone and recognises the importance of the wider social determinants of health. It emphasises collaboration between the NHS, the voluntary, community, faith and social enterprise (VCFSE) sector, local authorities and public health services.

The compelling need to integrate health and social care is underlined by the stark association between deprivation, place and type 2 diabetes. People living in the most deprived communities are around twice as likely to develop type 2 diabetes as those living in more affluent areas, and are at increased risk of other related complications (Diabetes UK, 2024).

When local conditions make the healthy choice the hardest choice, lifestyle advice risks becoming little more than a platitude. Place shapes metabolic health because it shapes how people move, shop, eat and live.

There are **six core components** in support of neighbourhood health (NHS England, 2025):

- **Population health management**: Using data to identify local health needs, target inequalities and prevent illness.
- **Modern general practice**: Improving access to GP surgeries through better digital tools, phone systems and triage.
- **Standardised community health services**: Unifying community nursing and therapy services so that care is consistent across regions.
- **Neighbourhood multidisciplinary teams (MDTs)**: Bringing together doctors, nurses, pharmacists, allied health professionals, social workers and mental health staff to coordinate care for people with complex needs.
- **Integrated intermediate care**: Providing rapid rehabilitation and recovery support to help people transition smoothly out of hospitals.
- **Urgent neighbourhood services**: Delivering

Citation: Milne N (2026) Neighbourhood diabetes nursing: local, proactive, integrated. *Journal of Diabetes Nursing* **30**: JDN429

"The introduction of the framework is not a minor administrative adjustment; it is a major opportunity to shift care towards a more proactive, prevention-focused model."

same-day care locally for minor injuries and illnesses to reduce pressure on emergency departments.

The infrastructure: a redesigned delivery landscape

The framework transitions healthcare delivery from individual provider boundaries to geographic footprints serving "natural" community populations of approximately 50 000 people.

At the heart of the framework is a proposed neighbourhood delivery model comprising key components that support the delivery of integrated neighbourhood care:

- **Integrated health organisation** manages the whole population health budget across a broad region.
- **Multi-neighbourhood provider** coordinates services across several neighbourhoods, typically covering populations of more than 250 000 people.
- **Single neighbourhood provider** leads local frontline care for a defined neighbourhood population of around 50 000 people.
- **Integrated neighbourhood teams (INTs)** bring together multidisciplinary frontline staff, including GPs, nurses, pharmacists, allied health professionals and social care colleagues.
- **Neighbourhood health centres (NHCs)** will be the new physical "one-stop shops" for local care. Open 12 hours a day, 6 days a week, these hubs will co-locate general practice with diagnostics and community services. The Government aims to establish 250 NHCs by 2035, targeting areas of highest social deprivation first.

Moving away from loose guidelines, the framework introduces hard national targets spanning 2026 to 2029 (*Table 1*). Specifically for diabetes care, the mandates include a 10% national increase in people receiving all eight essential care processes within a rolling 12-month period, alongside a 10% improvement in QOF-based clinical outcomes by March 2029. To meet these targets, diabetes nursing must move decisively beyond reactive appointment scheduling. Teams will need to use integrated digital records for real-time risk stratification and proactive community intervention in reaching previously underserved populations.

There are currently no known UK systems delivering all six core components of neighbourhood health in a coordinated, consistent way or at scale. However, in late 2025 the government launched 43 regional neighbourhood health service "pioneers", each working to develop INTs for defined local populations.

Whilst outcome data is awaited, international neighbourhood health models offer useful lessons:

- **The Canterbury model** in New Zealand is built on public-sector collaboration, shared clinical pathways and a single regional budget (Timmins and Ham, 2013). By aligning hospital and GP incentives, it enables rapid community response teams to help people remain at home safely.
- **The Buurtzorg Model** in the Netherlands uses small, self-managing neighbourhood teams of eight to 12 nurses (Buurtzorg, 2026). They provide clinical, personal and social care, drawing on family, friends and neighbours to support independence. The model has reduced bureaucracy, improved patient and staff satisfaction, and shortened overall care hours through proactive support.

If the NHS treats this framework merely as a re-badging exercise for existing primary care networks, it will fail. This is not a minor administrative adjustment; it is a major opportunity to shift care towards a more proactive, prevention-focused model.

For general practice nurses (GPNs) and diabetes specialist nurses (DSNs), this means moving beyond the familiar rhythm of clinic appointments shaped by who happens to come through the door. Instead, nurses will need to embrace proactive population health management. We will still treat the person in front of us, but success will increasingly be judged by the health outcomes of whole communities within a defined geographic footprint.

A welcome shift is the gradual erosion of the historic divide between primary and secondary care. Under the INT model, hospital specialists will be expected to work beyond acute trusts, bringing their expertise into community settings and strengthening MDTs.

Diabetes care already offers strong examples of integrated practice, such as the Portsmouth Super Six (Azman et al, 2026), DiaST (Milne, 2024)

and Leicester (Leicester Diabetes Centre, 2026) models. Under neighbourhood health, these styles of approach will become the norm. Psychology and social prescribing should be used more actively to address emotional distress, isolation, suboptimal housing and poverty, all of which contribute to poorer outcomes. For people living with frailty, mental health challenges or learning disabilities, closer teamworking will enable more effective support. This holistic, preventive vision reflects the core values of nursing.

If podiatrists, psychologists, pharmacists, dietitians, nurses and social care partners can share both a digital record and a physical space within NHCs, diabetes care will become more seamless. Done well, this will reduce fragmented referrals and help prevent those at greatest risk from falling through the gaps.

The convergence of metabolic care: the Cardiovascular Disease Modern Service Framework

The recently published *Cardiovascular Disease (CVD) Modern Service Framework* (DHSC, 2026b) adds further operational complexity to expanding nursing roles. Providing an early milestone in the Government's *10 Year Health Plan*, it shifts the NHS towards a more integrated cardiovascular, kidney and metabolic (CVKM) model of care. Its headline ambition is to reduce premature deaths from heart disease and stroke in people under 75 by 25% within a decade.

For diabetes nurses, this further blurs traditional clinical boundaries. Diabetes can no longer be managed separately from macrovascular risk. The framework emphasises earlier prevention, diagnosis and intensive treatment of metabolic and renal risk factors, including lipid optimisation, statin use and cardiorenal protection alongside glycaemic management. By embedding CVD prevention metrics into INT workflows, the NHS is effectively bringing diabetes and vascular care together. Clinically, this is logical; operationally, it adds further demands in data auditing, risk stratification and consultation time for primary care nurses.

Amid the focus on macrovascular risk reduction, we must also ensure that microvascular complications do not become the "Cinderella" of diabetes care. Glycaemic optimisation remains highly relevant and relies on the distinctive skills and experience of DSNs.

Table 1. Key national performance targets within the Neighbourhood Health Framework.

Focus area	Hard target mandate	Deadline
GP access	90% of patients requiring urgent primary care must be seen on the same day.	March 2027
Complex care	95% of individuals with complex healthcare needs must have a unified, digitally accessible care plan.	March 2027
Outpatient diversion	25% of outpatient activity must be diverted through single points of access across defined medical specialties which include diabetes and cardiology.	March 2027
Frailty care	A 10% reduction in non-elective, unplanned hospital admissions for the moderate-to-severe frailty cohort.	March 2029
Long-term conditions	A 10% improvement in evidence-based clinical outcomes for major chronic conditions (CVD, diabetes, COPD, dementia, and mental health).	March 2029

COPD = chronic obstructive pulmonary disease; CVD = cardiovascular disease.

The workforce question…

The Government's plan to transition chronic disease management into INTs assumes an abundant, flexible workforce. However, shortages among the DSN and GPN workforce have the potential to stall the rollout.

DSNs face competing demands: ongoing inpatient care, which will not reduce overnight; the timely rollout of life-changing technology for people with type 1 diabetes; and emerging disease-modifying therapies, such as teplizumab. Careful consideration will be needed to determine how best to deploy a limited workforce.

The Queen's Nursing Institute of Community Nursing's landmark *General Practice Nursing Today* workforce report has highlighted the vulnerability of the neighbourhood strategy in terms of workforce pressure (Leary et al, 2026). Its findings point to an existential demographic challenge: 55% of registered GPNs have been on the NMC register for more than 20 years. This is a highly experienced but ageing workforce, now approaching a major retirement cliff. The report warns of unsustainable pressure, driven by systemic failures, lack of

"Success will depend on rapidly implementing shared data systems that allow community and primary care teams to update a single care plan in real time."

protected clinical time and significant pay and conditions inequity. For example, although the government announced a 3.5% pay rise for salaried GPNs in 2026/27, independent GP contractors are not required to pass this on (Royal College of Nursing, 2026). Expecting potentially exhausted, underpaid senior nurses – already delivering more than 102 000 long-term condition appointments each week – to absorb the data-heavy demands of population health management without standardised employment frameworks will be challenging.

Diabetes UK has similarly called on the Government and NHS to invest in a healthcare professional workforce with the expertise to prevent and treat diabetes, obesity and multimorbidity (Diabetes UK, 2025). This investment must include not only recruitment, but also effective training and support, with backfill funding to compensate teams and practices for staff time spent in training.

Structural barriers also remain alongside workforce pressures. Success will depend on rapidly implementing shared data systems that allow community and primary care teams to update a single care plan in real time. It will also require the removal of rigid financial contracts and separate funding streams that create competing organisational interests, instead of a shared budget.

Finally, if the Neighbourhood Health Framework is to succeed, diabetes nurses must help shape it, rather than simply participate in it. As Diabetes UK has highlighted, the model relies on strong clinical leadership to drive innovation, and nurses are central to that leadership. We should have a clear role in delegated neighbourhood budgets, local care pathway design, the progression of proactive care and the work of reducing health inequalities in our communities.

The transition will be challenging, requiring cultural change, rapid digital integration and sustained workforce investment. But, if delivered well, the framework offers the greatest opportunity in decades to elevate diabetes nursing – moving the profession from reactive clinical care to proactive, community-wide leadership. ■

Azman N, Cummings M, Cranston I et al (2026) The Super Six model of diabetes care: 15 years on. *Diabetes & Primary Care* **28**: 17–21; https://bit.ly/4pq9vZR (accessed 15.07.26)

Buurtzorg (2026) *Buurtzorg model*. Available at: buurtzorg.com (accessed 13.07.26)

Department of Health & Social Care (2025) *Fit for the future: 10 Year Health Plan for England*. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future (accessed 13.07.26)

Department of Health & Social Care, NHS England (2026a) *Neighbourhood Health Framework*. Available at: https://www.gov.uk/government/publications/neighbourhood-health-framework (accessed 13.07.26)

Department of Health & Social Care, NHS England (2026b) *Cardiovascular disease (CVD) modern service framework (MSF): a cardiovascular-kidney-metabolic approach. The strategic vision and delivery model*. Available at: https://www.gov.uk/government/publications/cardiovascular-disease-modern-service-framework (accessed 13.07.26)

Diabetes UK (2024) *Type 2 diabetes in deprived and ethnic minority communities. Written evidence submitted to the UK Parliament Health and Social Care Committee*. Diabetes UK, London. Available at: https://committees.parliament.uk/writtenevidence/129467/html/ (accessed 13.07.26)

Diabetes UK (2025) *Delivering diabetes care in a neighbourhood health service*. Diabetes UK, London. Available at: https://bit.ly/4pk5buU (accessed 13.07.26)

Leary A, Punshon G, Brady L, Ball K (2026) *General Practice Nursing Today*. London: The Queen's Institute of Community Nursing, London. Available at https://qicn.org.uk/wp-content/uploads/2026/05/General-Practice-Nursing-Today-2026.pdf (accessed 13.07.26)

Leicester Diabetes Centre (2026) *Diabetes Model of Care Toolkit (2012–2025): Transforming Care Pathways*. Leicester, Leicestershire and Rutland ICB. Available at: https://www.leicesterdiabetescentre.org.uk/news-blog/diabetes-model-of-care-toolkit (accessed 13.07.26)

Milne N (2024) Engaging with and optimising care for people under age 50 years with type 2 diabetes: The DiaST model of care. *Diabetes & Primary Care* **25**: 193–8; https://bit.ly/4hftY1a

Milne N, Kanumilli N (2026) How to undertake a multiple long-term conditions review. *Diabetes & Primary Care* **28**: 109–12; https://bit.ly/4wQ7tER

National Academy for Social Prescribing (2024) *How do Social Prescribing Link Workers support the work of GPs and take pressure off the health system?* NASP, London. Available at: https://bit.ly/4helozF (accessed 13.07.26)

NHS England (2025) *Neighbourhood health guidelines 2025/26*. Available at: https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26 (accessed 22.07.26)

Royal College of Nursing (2026) *GP nursing pay: what the DDRB announcement means for you*. RCN, London. Available at: https://www.rcn.org.uk/news-and-events/news/uk-gp-nursing-pay-what-the-ddrb-announcement-means-for-you-260326 (accessed 13.07.26)

Timmins N, Ham C (2013) *The quest for integrated health and social care A case study in Canterbury, New Zealand*. The King's Fund, London. Available at: https://bit.ly/4vzL6SX (accessed 13.07.26)