Direction and Purpose of York's Neighbourhoods – to inform Health & Wellbeing Board Planning for Neighbourhood Health Reform

Health & Wellbeing Board
21st January 2026

Peter Roderick, Director of Public Health, City of York Council
Dr Victoria Blake, General Practitioner
Director of Urgent Care, Nimbuscare
York Place Coach for Neighbourhoods
Pauline Stuchfield, Director, Housing & Communities, City of York Council/ Co Chair of the York Health & Care Collaborative

Health and Wellbeing Board role:

‘In the future, a neighbourhood health plan will be drawn up by local government, the NHS and its partners at single or upper tier authority level **under the leadership of the Health and Wellbeing Board**, incorporating public health, social care, and the Better Care Fund. The ICB will bring together these local neighbourhood health plans into a population health improvement plan for their footprint and use it to inform commissioning decisions.’

*Fit for the future – **10 Year Health Plan for England**, July 2025*

To support moving at pace, we will produce a **national neighbourhood health planning framework**, co-produced with the Local Government Association and local authority colleagues, setting out how the NHS, working in active partnership with local authorities and others, can plan for the delivery of the broader set of neighbourhood goals

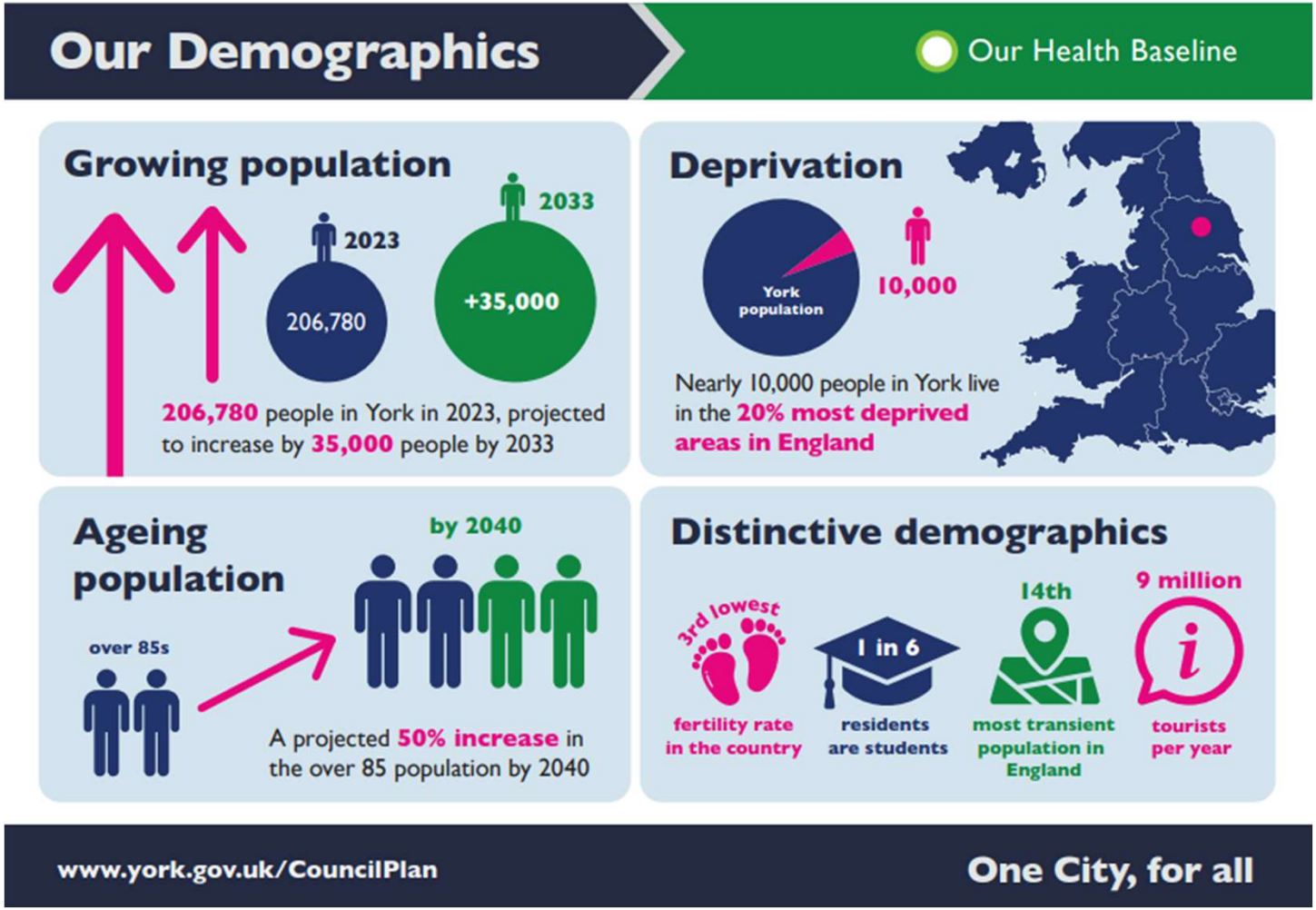
***NHS England Medium Term Planning Framework**, October 2025 (planning framework expected to be published January 2026)*

The building blocks of good health – health is more than healthcare

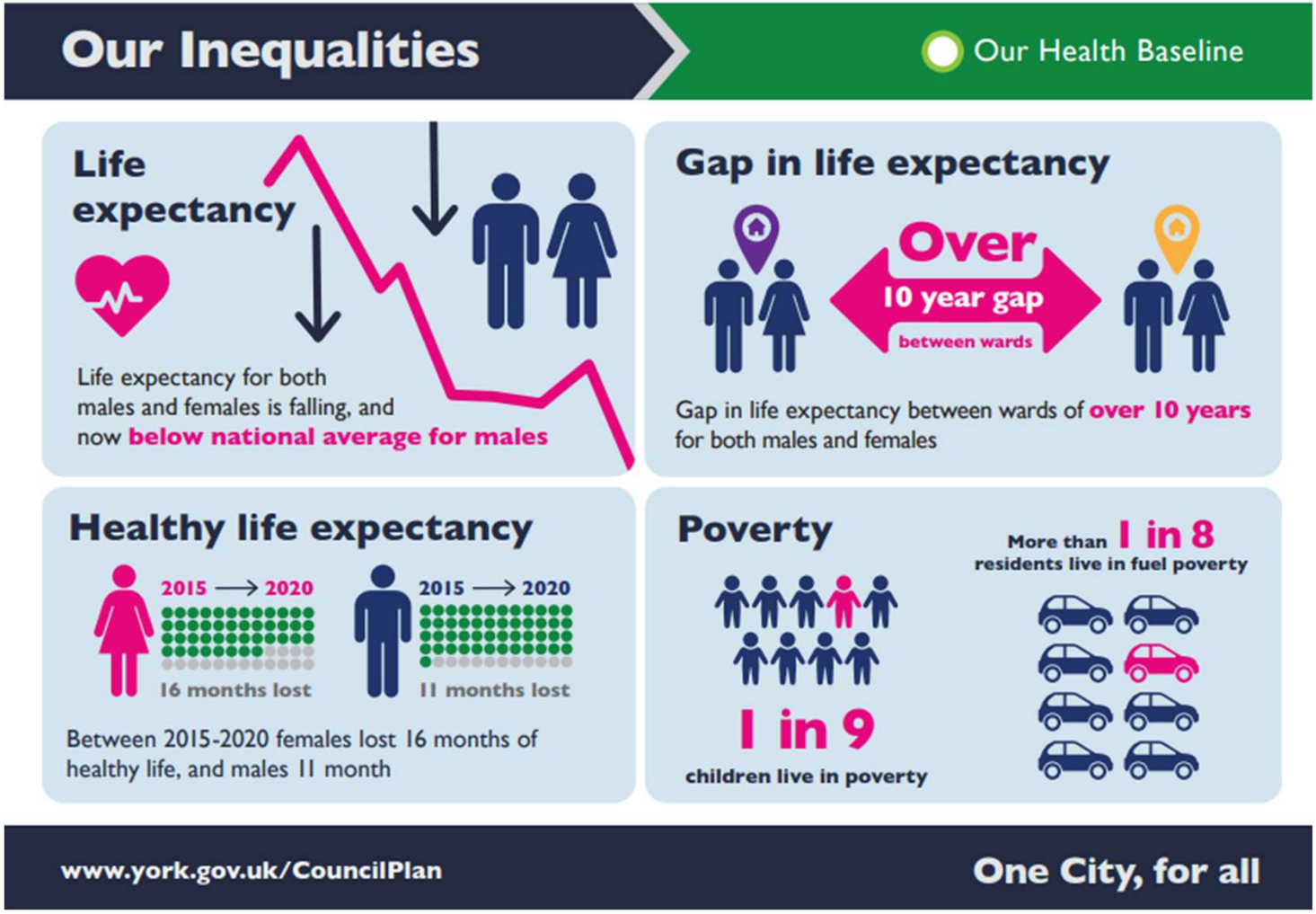
- Health is shaped far more by social and economic conditions than by healthcare alone.
- Eight key “building blocks” - including housing, money, work, education, food, transport, surroundings, and community - determine our health.
- The building blocks influence each other, so improving one (like housing or income) can strengthen many others.
- Unequal access to these building blocks drives avoidable health inequalities.
- **Improving health requires coordinated action across sectors, not just from the health system.**

What builds good health? | The Health Foundation

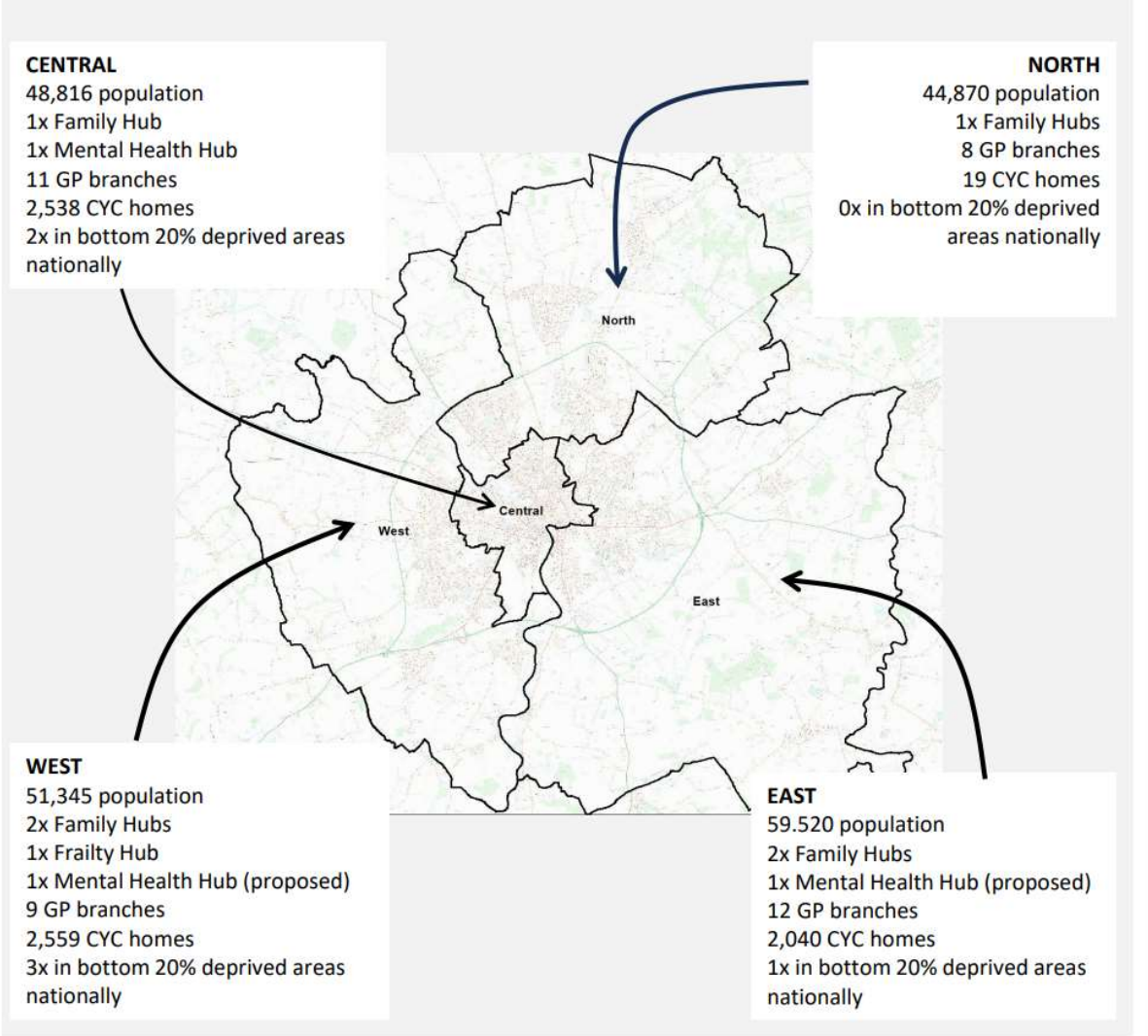
Addressing the wider determinants of health



Addressing the wider determinants of health



York's Neighbourhood Model



Building on our successes and strengths

We have successful local models to learn from and build on.

We are Building Integrated Neighbourhood Teams with insight, not just intent.

→ **Shared Themes:**
- ✅ Wraparound support
- ✅ Early intervention
- ✅ Single access points
- ✅ Community-based delivery

Model	Key Features to Adapt
Family Hubs	Co-location of services for early years, parenting support, and safeguarding
Mental Health Hub	Cross-sector collaboration (NHS, VCSE, council), single front door for access to help
Frailty Hub	MDT working between health, social care & community services for proactive early support

Our York Model is all-age within localities - connects with children and families, Mental health, family hubs, SEND hubs, frailty.

Exploring roles and functions

Neighbourhood Partnership Board (North, East, West and Central) – *sets the strategy*

A group in each Neighbourhood with representation from each part of the local System (health, local authority, VCSE - and ideally including citizen/resident representation) which:

- has a core understanding of the wider determinants of health impacting their population
- agrees and owns the strategic focus and priorities for their Neighbourhood
- takes responsibility for planning the programme of work for their Neighbourhood, including lived experience at every possible opportunity
- is responsible for the development of their Neighbourhood operating model, and reporting progress/challenges and sharing learning via York Health & Care Collaborative and York Health & Care Partnership

Integrated Neighbourhood Team – *supports the population*

A multi-agency team in each Neighbourhood that collectively case-finds (using a Population Health Management approach) and proactively case-manages and coordinates care for a defined caseload of people with complex health, care and social needs who require multi-agency input to address the wider determinants of health. The INT should:

- develop a personalised and holistic care plan for each person on their caseload, with input from the person (what matters to me)
- work together to coordinate care for each person with a view to maximising role generosity, reducing any duplication of effort, and focusing on early intervention and prevention to improve outcomes and efficiencies
- focus on addressing the wider determinants of health for people with complex conditions and needs

Agreeing a consistent approach

- York Health and Care Collaborative have agreed a consistent approach to INT development to help neighbourhoods to get their work off the ground, based on a set of criteria for neighbourhoods to focus on.
- This criteria builds on national guidance, the NHS Medium Term Planning Framework, and where we think the gaps in the York health and wellbeing system are.

Principles for neighbourhood working:

- INTs should use a Population Health Management approach to identify the cohort of individuals they want to work with. This should address the wider determinants of health, as well as specific health issues.
- Using data and intelligence, risk stratification should be undertaken to determine which individuals would benefit from a multi-agency approach to support their health and care needs.
- Think – what matters to you in your neighbourhood, what is the data telling you? What does your community need? Who would benefit from more joined-up, holistic support?
- Neighbourhoods should think about how they will evidence outcomes from the start – early clarity on outcomes gives everyone a shared direction in a complex, multi-agency environment.

Funding and the left shift

Cost saving may not be the thing that brings us to this work – but…
it is a key enabler for growing sustainable neighbourhood models

Supporting people who have high use of health and care resource, due to medical and social complexity, is key in the left shift of resource from acute to community.

We need to get ahead of the growth curve. As our population grows and ages, more preventative, proactive, integrated and holistic responses are a more efficient way to use our limited resource – rather than allowing failure demand to grow and consume higher levels of resource.

This is challenging –

- Large scale left shift is very difficult
- Taking costs out of reactive / urgent capacity is very challenging – released capacity is always absorbed by unmet demand
- We don't have investment for double running

We can approach this with –

- An iterative approach – start small, see the impact, redirect resource
- Focusing developments where there is evidence and impact
- Redirecting growth – using PHM to help us

We are all responsible for getting the most from our York pound for the benefit of our residents

NHS Medium Term Planning Framework says…

From April 2026 ICBs and Providers should -

- ensure an understanding of current and projected total service utilisation and costs for high priority cohorts
- create an overall plan to more effectively manage the needs of these high priority cohorts and significantly reduce avoidable unplanned admissions.

An example…
average cost of a non elective hospital admission for York's population, by multi morbidity segment

Multi Morbidity Segment	£
None	1,504
Low	1,890
Moderate	2,585
Complex	3,287
Severe	3,828

What is Population Health Management?

"A data-driven tool or methodology that refers to ways of bringing together health-related data to identify a specific population that health and care systems may then prioritise for particular services." Kings Fund

NHS England's Population Health Management "three pillars" are: **Know**, **Connect**, **Prevent**:

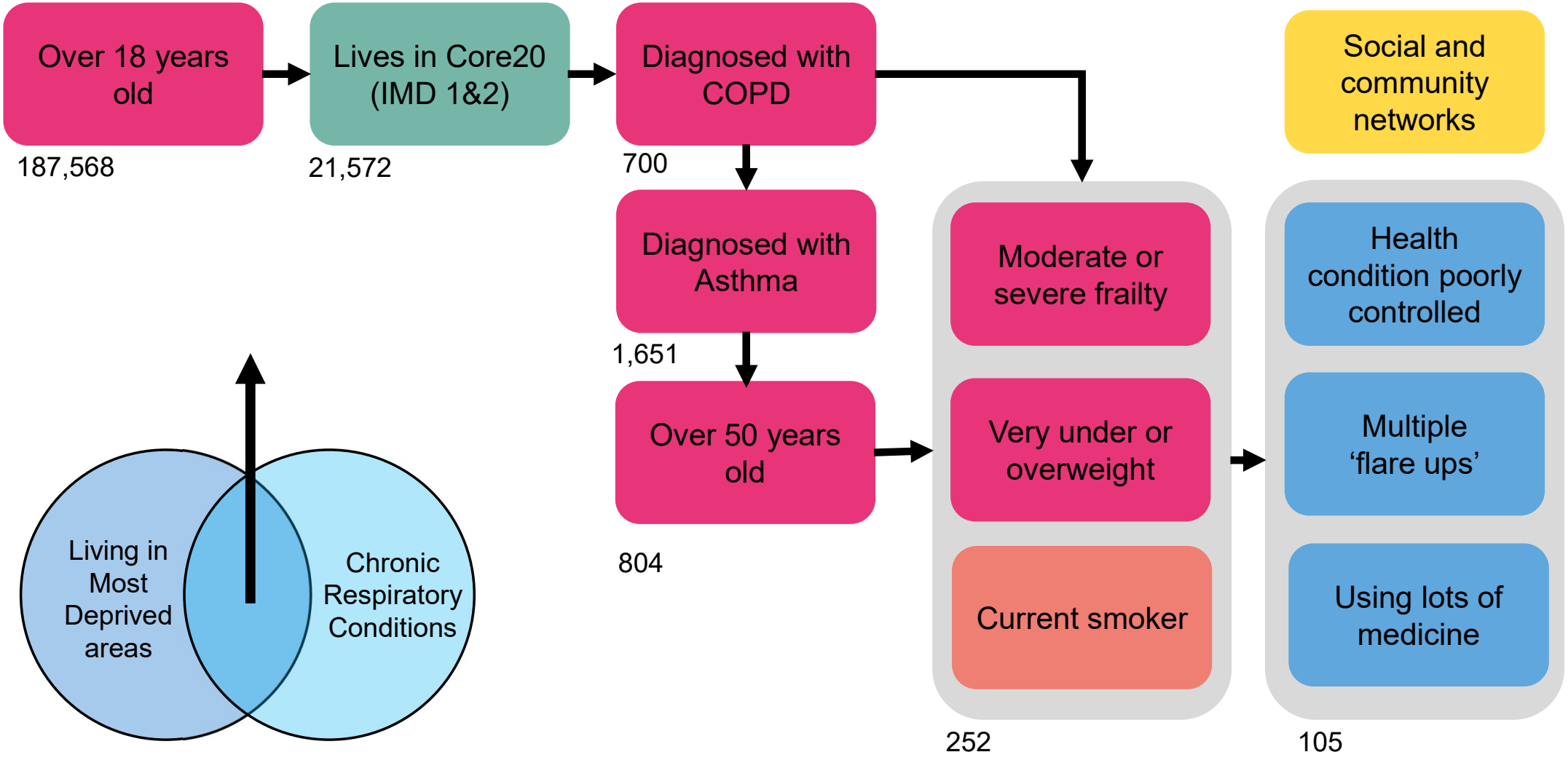
- ***Know*** — use data & evidence to understand the health needs of different population groups, including the wider determinants of health.
- ***Connect*** — build collaborative working across system partners (NHS, local authorities, community organisations) to coordinate care. – **INT development**
- ***Prevent*** — design and deliver preventative, personalised care to reduce future risk.

Population Health Management Criteria for York Neighbourhoods

Working together to better support the people who our current System is failing through an all-age approach

Criteria	Rationale	Guidance
Health inequalities and wider determinants of health – *addressing holistic needs*	• Essential to consider because they directly shape the health of individuals and how effectively they can access care. PHM works best when it proactively identifies risk and targets interventions—and that is only possible if inequities are understood and addressed.	The type of health inequalities data and intelligence you focus on will be determined by the demographic of your neighbourhood. You may want to consider deprivation, ethnicity, housing, social isolation, geographical disparities, age and disability.
Individuals with multiple Long-Term Conditions - *managing complexity*	• Effective Long Term Condition management can often unlock the door to managing other complexities, including social turbulence, individuals are dealing with. • Multiple LTCs compound clinical and social risk factors • Proactive LTC management enables earlier, preventative intervention, meaning we can tackle rising risk.	The number and type of Long-Term Conditions that individuals have that you choose to focus on should be determined by the demographic of your neighbourhood and what the data is telling you.
Individuals who would benefit from multi-agency support and care planning – *rooting care in neighbourhoods and addressing the wider determinants of health*	• **Integrated neighbourhood team development sits at the intersection of health, social care, community services, and the voluntary sector**. • Ensuring ensuring the right people are benefitting from multi-agency care planning should be at the heart of neighbourhood work.	Using intelligence from partners, neighbourhood teams should meet to look at cohort lists and decide which individuals would benefit the most from multi-agency support and care planning.

What is Risk Stratification?



Caroline's story

"I haven't left my house for over a year"

Caroline has been out of work for many years due to multiple complex needs. Caroline lives with COPD and Osteoarthritis. She was housebound and struggled with social isolation.

Caroline's granddaughter looked after Caroline before she left for university, so there was a drop off in care.

Caroline was unable to leave bedroom due to respiratory difficulties and mobility issues, so has been unable to go downstairs or leave the house in over a year.

Mobility issues meant Caroline was struggling with personal hygiene.

Caroline had no hot meals for years and was living off sandwiches which meant her nutritional health was poor.

The drop off in care and social isolation meant that Caroline was suffering with her mental health.

Caroline once had a thriving social life, but now due to her physical and mental health worsening, has found herself trapped in her own home.

Caroline was identified as someone who would benefit from multi-agency support to address her multiple-complex needs. A proactive social prescriber, rooted in personalised care, has been able to transform Caroline's life.

A Social Prescriber visited Caroline in her home and continued to visit for the next four weeks to establish the relationship and build trust. A personalised care plan focussed on Carolines priorities was formulated:

Social prescriber worked with Caroline's surgery to offer COPD review closer to home. Correct medication prescribed and inhaler techniques practiced – Caroline now feels more able to leave the house.

Adult social care referral generated and care package put in place with a carer to support with personal hygiene and home cooked meals.

Home adaptations: now has a stair lift and OT has made adaptations around the home to make it safer for Caroline.

No eye test for years, Specsavers conducted home visit – new prescription, fewer risk of falls

Support with mental health through MH practitioner at surgery

Connections into community groups for peer support

Applied for bus pass and blue badge to support Caroline getting out and about.

4 weeks to establish relationship – time has allowed the Social Prescriber to build trust – important to consider as we move to neighbourhood prevention work – moving away from transactional interactions and focussing on personalised care.

Neighbourhood Partnerships – Progress to date

- Place Board and CYC Executive Agreement to adopt CYC Neighbourhood Model Principles & Frameworks
- Agenda for Executive on Tuesday, 4 November 2025, 4.30 pm (item 171)
- Partnerships under way!! Involving CYC leads, primary care, ICB leads and other partners
- Project management resources & workstream leads
- Core part of the council's transformation programme
- Establishing Governance Structures including co-production and VCSE
  - Task & finish groups:
    - Governance
    - Communication/Engagement/Co-production
    - Workforce
    - Digital
    - Data
    - Evaluation/Research

- Continuing to build relationships and share learning at York Health & Care Collaborative
- Review our combined data with neighbourhood insight packs

Next steps and York HWBB consideration

Guidance sets out the expectation that **HWBs provide the key forums for joint planning** with each of the upper tier local authorities, complemented at system level by working in partnership with strategic authorities discharging their new health duties.

Further detailed guidance is expected to clarify the role of HWBs in relation to developing neighbourhood health plans.

It is anticipated that clarification will be provided on:

- Leadership of the HWB to develop neighbourhood health plans
- The role of the HWB in agreeing the neighbourhood footprints
- The role of HWBs as the lead place-based decision making body
- The relationship between neighbourhood health plans as a part of existing joint commissioning arrangements and with BCF plans
- The proposed distinction between strategic neighbourhood health plans prepared by the HWB and operation plans developed by the place-based partnership or equivalent.