West Yorkshire Integrated Neighbourhood Health Update

1. Purpose

1.1. This paper provides an update to the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC) on the progression of the WY Integrated Care Board (ICB) priorities for neighbourhood health.

1.2. It does so by providing an overview of the context, summaries of progress in each of our five places (Bradford district and Craven, Calderdale, Kirklees, Leeds and Wakefield) and at scale work across WY, and setting out next steps.

1.3. The West Yorkshire Joint Health Overview and Scrutiny Committee are asked to:

- Note the progress made across in delivering our neighbourhood health priorities.
- Note the national reforms set out the planning and delivery approach and the implications of these, as described in section 2.9.
- Note the next steps set out in section 4.

2. Context

2.1. Neighbourhood health is one of the governments flagship priorities for the health system. It is a key driver of the “hospital to community” shift set out by the Secretary of State for Health and Social Care.

2.2. It is about delivering more proactive care, closer to where people live, underpinned by population health management, tackling inequalities, and making best use of our collective resources.

2.3. There are significant changes being made to the health and care architecture, alongside reforms to the planning and delivery remit and responsibilities which directly impact neighbourhood health. This is set out in more detail in sections 2.9 and section 4 specifically, and will be important to consider throughout.

<u>National Context</u>

2.4. Neighbourhood-based transformation has been set out in successive reviews and policy documents, including the New Care Models Vanguard Programme, the Fuller Stocktake Report, the 2025/26 Neighbourhood Health Guidance, and the 10 Year Health Plan.

2.5. The 10 Year Health Plan places neighbourhood health at the centre of NHS transformation. It sets out a vision to end a ‘hospital by default’ approach, establish a Neighbourhood Health Service with Neighbourhood Health Centres in every community by 2035, and brings together the three key shifts: from hospital to community, analogue to digital, and treatment to prevention.

2.6. The Neighbourhood Health Guidance provides the immediate focus and priority for health systems to deliver, and sets out the following six core components:

- **Population health management**, which requires a person-level, longitudinal, linked dataset to be in place to enable population segmentation and risk stratification, to inform commissioning intentions and interventions.
- **Modern general practice**, whereby there is an expectation to continue progress to date in improve access and continuity for patients, including through use of the NHS App and the Pharmacy First scheme.
- **Standardising community health services**, where ICBs are required to ensure community service pathways are an integral part of the INH model and commissioned in line with the standardising community health services framework.
- **Neighbourhood multi-disciplinary teams**, which covers the requirement to establish integrated neighbourhood teams of teams to deliver coordinated, proactive care to multiple patient cohorts.
- **Integrated intermediate care with a 'Home First' approach**, setting out requirements for supporting the step up and step down of care, with interventions delivered at home as much as possible, focusing on rehabilitation, reablement and recovery.
- **Urgent neighbourhood services**, whereby systems should standardise, and scale urgent neighbourhood service offers for people with an escalating or acute need, to support better demand management and prevent the need for hospitalisation. This should be integrated with wider urgent pathways.

2.7. This guidance was later complimented by the 10 Year Health Plan, and mor recently the Medium Term Planning Framework. Overall, national policy sets our initial focus on establishing the foundations for delivery for priority cohorts of patients and in specific clinical areas, as the basis of wider collaborations, with full delivery planned over 5-10 years.

2.8. The National Neighbourhood Health Implementation Programme (NNHIP) was launched to support rapid rollout of neighbourhood health in 43 sites. It is an accelerator programme for 43 places in England to go further, faster in implementing neighbourhood health with an initial focus on adults with multiple long-term conditions and rising risk, through a "Test-Learn-Grow" approach. There are no additional resources for the 43 NNHIP sites.

2.9. Reforms that have been set out to the national planning process and future architecture of the health and care system are central to neighbourhood health delivery. In summary:

- The ICB is accountable for developing a needs assessment informed, outcomes focused Five-Year Strategic Commissioning Plan, through which we will set our commissioning intentions.
- Health and Wellbeing Boards (HWBBs) are accountable for developing neighbourhood health plans, which will be required to set out areas of

focus and delivery detail, with further guidance pending. In West Yorkshire, HWBBs are already taking a proactive and leading role in the development of plans and delivery of neighbourhood health priorities.

- Providers are accountable for developing individual and integrated delivery plans.

2.10. It will be crucial that all strategies and plans are triangulated to work together to deliver our shared system neighbourhood health priorities.

Local Context

2.11. Across West Yorkshire and within our five places, we have a long and proud commitment to working towards neighbourhood-based healthcare.

2.12. There are several examples of good practice that have been developed which, with a renewed policy architecture, provides an opportunity to build on and mainstream.

2.13. This year, system partners agreed to progress three transformation priorities, including INH. In the immediate term, we will focus on rolling out neighbourhood services for priority patient cohorts to reduce preventable unplanned demand and increase early identification and prevention. Each place has identified priority cohorts using local data and intelligence.

2.14. In June 2025, the Board of the ICB approved the Integrated Neighbourhood's Blueprint, following a significant period of engagement and development. It sets out place-based delivery plans across 1-, 3- and 5-year horizons, alongside at-scale enablers across WY.

2.15. Three of our places (Bradford, Leeds and Wakefield) were successful in joining the NNHIP. The NNHIP is focused on rolling out neighbourhood models for high priority cohorts, including patients with multiple long-term conditions, and other cohorts that are determined locally. Through the programme, places also have access to additional national support, have the opportunity to be early adopters of emerging models, and are expected to support the wider rollout of neighbourhood models of care delivery.

2.16. In addition to the specific focus on INH, there is significant work ongoing regarding the future operating model of the ICB and wider health and care system. We are aligning this work, including that ongoing within places, where work is focusing on developing place provider partnerships, and at WY which is focusing on the at at-scale requirements for strategic commissioning, including how we contract with place provider partnerships to deliver outcomes.

3. Delivering Neighbourhood Health in West Yorkshire

3.1. Neighbourhood health delivery is primarily place-based. All places have developed programmes of work to deliver this locally, with leadership and governance in place, and detailed oversight from the appropriate boards and place committees of the ICB.

3.2. Additional work takes place across West Yorkshire, via the WY INH Board, focusing the at scale strategic foundations of neighbourhood health, and sharing and scaling learning and good practice.

3.3. The following are key areas of that describe how, across WY, we are progressing on our neighbourhood health priorities in line with national policy and the 1-, 3- and 5-year plans we set ourselves in the Integrated Neighbourhood's Blueprint:

- **The establishment of neighbourhood footprints and Integrated Neighbourhood Teams (INTs).** All places have established their neighbourhood geographies, building mostly on Primary Care Networks (PCNs). INTs are multidisciplinary teams of professionals from across a range of health, local authority, and voluntary sector organisations, that work together to meet people's needs. They are an important part of delivering the broader neighbourhood agenda. Delivery of care models with an MDT intervention across health and other care partners is not a new area of work. No place is starting with a blank canvas.
- **Agreement of priority cohorts.** Using local evidence and data, all places have identified patient cohorts to prioritise for the initial roll out neighbourhood services. The cohorts are specific to each place, but generally include frailty, end of life, and long-term conditions. These are patient groups who would benefit from neighbourhood services and currently account for a disproportionate share of non-elective demand.
- **Development of Population Health Management (PHM) and data approaches.** All places have made significant progress in establishing the shared data flows and analytical tools required to understand service demand and population health, and are working with neighbourhood teams to support proactive care delivery.
- **Improving access to general practice.** Across WY, the majority of our practices have accessed or continue to access modern general practice access funding. This supports improvements in access to GP for patients through digital solutions, including online booking and telephony services, alongside more integrated working across primary care providers. Access to GPs and wider primary care services is a core foundation of neighbourhood health.
- **Continued development of strong partnership working.** All places have established collaborative ways of working with local authorities, health care providers, and non-statutory partners. This continues to evolve and will be crucial to neighbourhood health delivery.
- **Participation in the NNHIP**, as set out in section 2.14.
- **Allocation of £4.1m of non-recurrent Service Development Funding (SDF).** This is being used to support the foundations of and transition towards neighbourhood health, and incorporates various investments in places and across WY.
- **Developing an INH Outcomes Framework**, led through a system-wide population health management (PHM) expert reference group. This work

is focusing on how we quantify and affect the benefits we want to achieve collectively for the health of our population and system efficiency.

- **Developing the financial and contractual mechanisms** to deliver INH, including through work across the ICB as part of our future operating model to design the financial architecture for Place Provider Partnerships, and involvement in national forums that are responsible for developing the overarching approaches for single- and multi-neighbourhood providers.

3.4. In addition to the progress set out above in section 3.3., some indicative high level examples of progressing specific to each place is set out in appendix 1.

4. Next Steps

4.1. Continued delivery, building on the progress made in each place and across WY, is the foremost priority in moving towards the full establishment of a neighbourhood health service.

4.2. We are at a critical juncture with reforms to the organisation of the health and care system, and the policy and financial planning approach. It is therefore crucial that, as we set out our future intentions, we do so with a clear view of the current context and future operating model in mind.

4.3. The ICB will set out our Five-Year Strategic Commissioning Plan, which will include outcomes based commissioning intentions, by February 2026. This will be supported by detailed 1- and 3-year operational plans. From 2027/28 will contract for outcomes, in line with our Five-Year Strategic Commissioning Plan, that will be delivered through neighbourhood, provider, and provider partnership plans.

4.4. Neighbourhood plans are being developed within places, with leadership and oversight from the five Health and Wellbeing Boards. It is crucial that we acknowledge it is within this that much of the direction for action and delivery will be set.

5. Recommendations

5.1. It is recommended that the West Yorkshire Joint Health Overview and Scrutiny Committee:

- Note the progress made across in delivering our neighbourhood health priorities.
- Note the national reforms set out the planning and delivery approach and the implications of these, as described in section 2.9.
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Appendix 1: Indicative Progress Across Places

1. Bradford District & Craven

Priority Cohorts: Palliative and End of Life Care (PEOLC), Frailty and Dementia, and All Age Intermediate Care

Impact in scope: Potential for the PEOLC cohort to reduce A&E demand from 1.243 rate per 1000 population to 1.232, non-elective admissions from 0.853 to 0.848, and bed days from 8.703 to 7.850. For frailty and dementia benefits in scope include a reduction in A&E demand from 0.757/0.762 to 0.750/0.755, non-elective from 0.388/0.249 to 0.384/0.246, and bed days 3.843/1.467 to 3.805/1.453.

Highlights

- Selected as a first-wave NNHIP site
- New place partnership strategy published
- Series of multi-agency workshops underway to support partners within neighbourhood teams to develop the necessary ways of working.

2. Calderdale

Priority Cohorts: Frailty and PEOLC

Impact in scope: Potential to reduce emergency admission growth for frailty and PEOLC by, which could generate efficiency and outcome benefits for the system and patients.

Highlights

- Population segmentation completed with person-level linked data and risk stratification tools
- Case finding and case management tools funded and in development
- INTs are mobilising through co-created delivery plans, building on well established PCN boundaries, and forming wider partnerships including through an agreement with General Practice and Community Services for a neighbourhood MDT approach.

3. Kirklees

Priority Cohorts: Frailty, Mental Health (high intensity users), Children and Young People

Impact in scope: Based on modelling of frailty based A&E demand, there is potential to reduce demand and generate a non-cash releasing benefit of £138k. Modelling for other areas is underway.

Highlights

- INT mobilisation underway – 1 live, 3 by December 2025, and all 9 by September 2026
- 100% GP data-sharing agreements signed, with testing of a PHM tool linked to this underway.
- Interim INH data packs provided for neighbourhoods that have gone live or in the process of going live with additional data to be added from social care and Healthwatch, which will be used to plan service delivery in neighbourhoods.
- Dedicated care coordinator and VCSE roles recruited to support ongoing INT development.

4. Leeds

Priority Cohorts: People with Multiple Long-Term Conditions, and Frailty/Mental Health

Impact in scope: Modelling shows that the targeted proactive care population has a baseline A&E attendance of 790 (2024/25) and an unplanned bed days baseline of 4,659 (2024/25). There is potential to reduce this to 671 and 3,354 respectively, generating a non-cash releasing benefit of £564k.

Highlights

- Wave 1 NNHIP site, which will build on a strong foundation of proactive care work under the HomeFirst programme.
- All PCNs have agreed to adopt PHM approaches to deliver proactive care in neighbourhoods.
- Workforce ecosystem project launched with Leeds Health & Care Academy
- Further enhancement of the Leeds Shared Care Record and tech-enabled care (e.g., falls prevention).

5. Wakefield

Priority Cohorts: Chronic Obstructive Pulmonary Disease (COPD), Dementia, and PEOLC

Impact in scope: Potential to avoid 226 non-elective admissions, saving 2,736 bed days and 15 beds by March 2026.

Highlights

- Neighbourhood MDTs are being built from existing assets across six areas, with the core vision agreed across all.
- Innovative AI-driven PHM model predicting hospital demand, integrating housing and education data alongside.
- Working alongside Adult Social Care to progress progressing work on securing the appropriate bed base and extending the home first approach.