



# York VCSE Assembly Health and Care



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**4 February 2026**

# Moments of Change in Health and Care



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# Direction and Purpose of Neighbourhoods

## York VCSE Assembly

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## Introduction to neighbourhood health

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- The NHS 10-Year Plan puts neighbourhood health at the centre of care, shifting services out of hospitals and into local communities where people live. It focuses on prevention, joined-up teams, and easier access through community hubs that bring health, social care and VCSE support together.
- The King's Fund explains that “*neighbourhood health encompasses many different ideas, policies and approaches*” — from integration and personalised care to community-led action and place-based partnerships. These aspects aren't siloed; they overlap and evolve with local context.

[NHS England » Fit for the Future: 10 Year Health Plan for England](#)

<https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health>

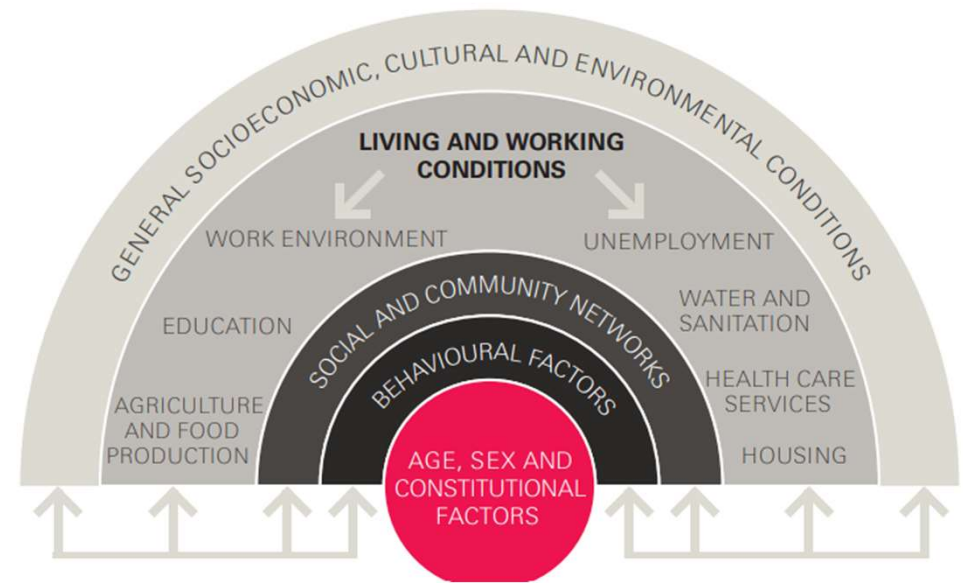
## Neighbourhood health – glossary of terms

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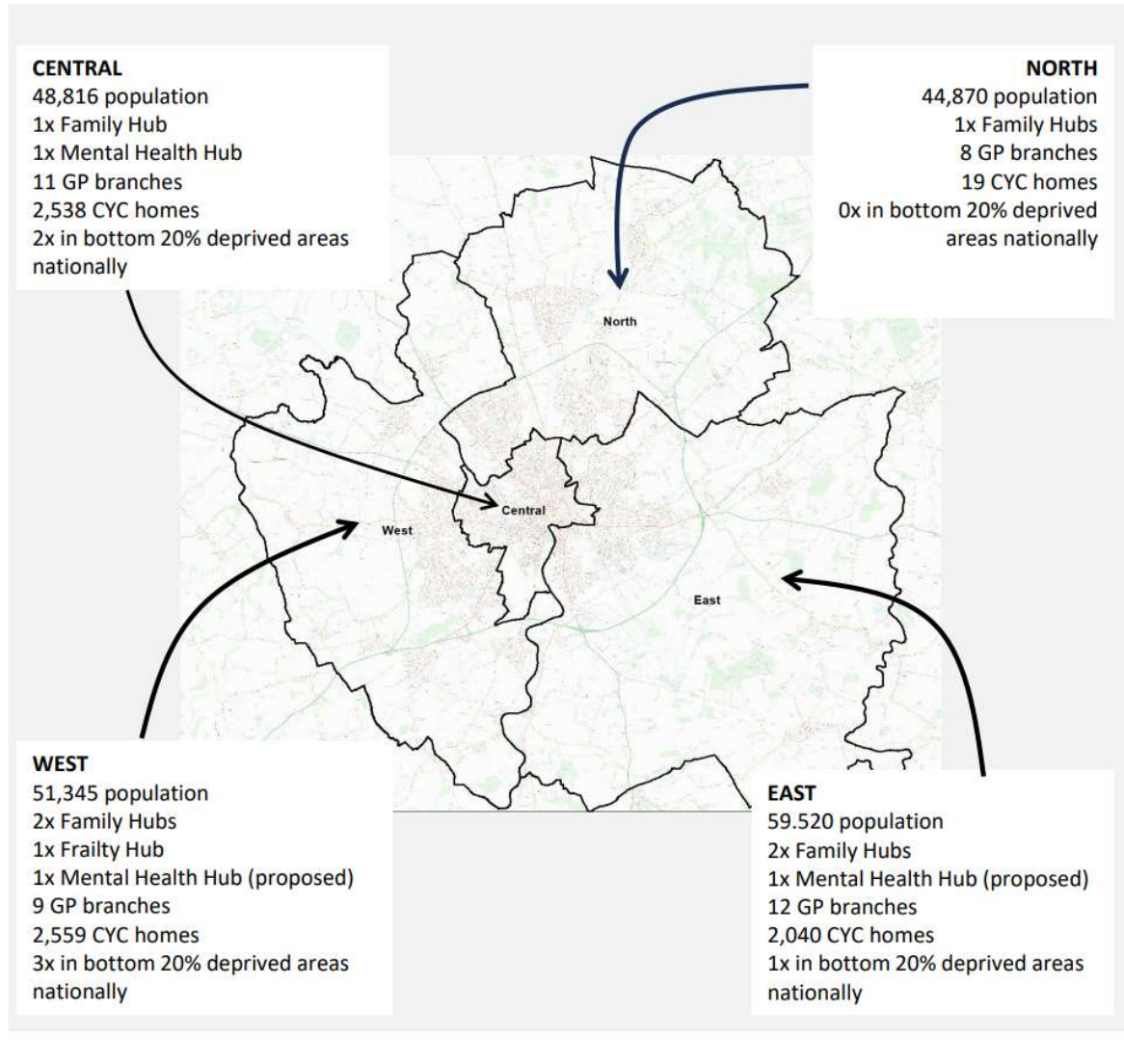
- **Neighbourhood:** A practical geography for organising joined-up health, care and community support, made up of several smaller, locally recognisable communities. In York, Neighbourhoods are defined around ward boundaries and are made up of populations of approximately 50,000.
- **Neighbourhood health:** A broad concept describing ways of working at neighbourhood level to improve health, wellbeing and equity, combining integration, prevention, personalised care, community partnerships and place-based action.
- **Neighbourhood working:** Partners from health, local government, community and voluntary sectors working together in neighbourhoods to improve outcomes and address inequalities.
- **Integrated neighbourhood team (INT):** A group of people from different sectors working together to support residents with complex needs for whom a single agency cannot support alone.
- **Health inequalities:** Unfair differences in health outcomes between different groups or areas.
- **Determinants of health (wider determinants):** The social, economic and environmental conditions that shape people's lives and health, such as housing, education, income and social connections.

# 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.**



# 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
<b>Family Hubs</b>	Co-location of services for early years, parenting support, and safeguarding
<b>Mental Health Hub</b>	Cross-sector collaboration (NHS, VCSE, council), single front door for access to help
<b>Frailty Hub</b>	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.**

## Neighbourhood Partnerships – Progress to date

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- Agreed York's neighbourhood model with all partners
- Neighbourhood Partnerships under way! Involving VCSE leads, CYC leads, primary care, ICB leads and other partners
- Drafted York's neighbourhood operating model for feedback – see next slide
- 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

## York's Neighbourhood Operating Model

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

A group in each Neighbourhood with representation from each part of the local System including health, local authority, VCSE, co-produced with residents 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 including:
  - Prevention - identifying the prevention agenda at population health level
  - Complex case finding - identify a cohort of residents to be prioritised and then to case find for existing INTs
- advises the commissioner on the the long-term programme of prevention work for their Neighbourhood
- is responsible for reporting progress/challenges and sharing learning via York Health & Care Collaborative

### **Integrated Neighbourhood Team – supports *the population***

A multi-agency team in each Neighbourhood that collectively case-finds in collaboration with the Neighbourhood Partnership Boards (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

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- 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:**

- Neighbourhood partnership boards and 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.

## What is Population Health Management?

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*“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.
- **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
<b>Health inequalities and wider determinants of health – <i>addressing holistic needs</i></b>	<ul style="list-style-type: none"> <li>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.</li> </ul>	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.
<b>Individuals with multiple Long-Term Conditions - <i>managing complexity</i></b>	<ul style="list-style-type: none"> <li>Effective Long Term Condition management can often unlock the door to managing other complexities, including social turbulence, individuals are dealing with.</li> <li>Multiple LTCs compound clinical and social risk factors</li> <li>Proactive LTC management enables earlier, preventative intervention, meaning we can tackle rising risk.</li> </ul>	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.
<b>Individuals who would benefit from multi-agency support and care planning – <i>rooting care in neighbourhoods and addressing the wider determinants of health</i></b>	<ul style="list-style-type: none"> <li><b>Integrated neighbourhood team development sits at the intersection of health, social care, community services, and the voluntary sector.</b></li> <li>Ensuring ensuring the right people are benefitting from multi-agency care planning should be at the heart of neighbourhood work.</li> </ul>	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.

## Caroline's story

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

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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.**

## How York Place (ICB) wants to support the VCSE in neighbourhood development

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### **Set out a roadmap for VCSE involvement to include detail on:**

- How and why local VCSE input must be explicit across neighbourhood, place and system levels, with VCSE partners supported to coordinate engagement and ensure diverse voices shape priorities and delivery.
- Ensure that when investigating shared intelligence systems, that community held insight can sit alongside clinical and system data.

### **Set out our commissioning principles for multi-neighbourhood providers to adhere to, to support VCSE involvement and sustainability**

- Recommend moving away from short-term, stop start funding. Promote stable investment to enable prevention, innovation and continuity.
- To help small, local charities and community groups do more good work, funding systems need to be easier, fairer, and better suited to their size — for example by using grants and partnerships instead of complex contracts.

*What more can we do to support you?*

# Roundtable Discussions

**We want the VCSE sector to be part of the conversation about how we develop the neighbourhood model here in York:**

- How is your organisation involved in developing the neighbourhood model in York?
- What more is needed to enable the VCSE sector to be part of the conversation?

**How do we ensure that we best use the knowledge in the VCSE sector to inform developments:**

- What sort of information does your organisation currently collect?
- How do we better support joint information / data sharing between the VCSE sector and other parts of the system?

# Feedback

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# Close

## Next meeting:

25 March, 10am - 12pm, Main Hall

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