



Westmorland
& Furness
Council

Neighbourhood health plans: Work to date and next steps

Health and Wellbeing Board Development Session

1 October 2026

westmorlandandfurness.gov.uk



Health and Wellbeing Board: mandated neighbourhood responsibilities

The national framework sets a two-stage pathway from joint groundwork to an implemented, locally owned neighbourhood health plan



WHAT THE HWB MUST LEAD WITH PARTNERS

1

Outcomes

Work with communities, health and care organisations and wider partners to establish whole life-course outcome measures reflecting health and social care needs.

2

Joint approach

Start developing and embedding new ways of working with local government and wider partners for neighbourhood services.

3

Footprints and teams

Jointly shape the approach to natural-community footprints and integrated neighbourhood teams focused on high-priority cohorts.

4

BCF and enablers

Support alignment of pooled funding, organisational ownership and the data-sharing arrangements needed for identification and evaluation.

WHAT THE LOCALLY OWNED PLAN MUST CONFIRM

1

Purpose

How national NHS objectives and wider local goals for outcomes, inequalities and public service reform will be delivered.

2

Evidence

How local objectives are informed by the JSNA and other assessments considered necessary by the ICB, local authorities and HWB.

3

Operating model

Final neighbourhood geographies, organisational responsibilities, governance and operational partnership arrangements.

4

Alignment

How related initiatives align, with the agreed plan incorporated by the ICB into its refreshed five-year strategic commissioning plan.

HWB accountability: provide collective place leadership so the neighbourhood plan is locally owned, community-informed and connected to the JSNA, local priorities and wider public services.

A potential leadership model for developing the Neighbourhood Health Plan

Function	Lead
Overall neighbourhood vision	Local authority
Population needs assessment	Local authority
Community engagement	NHS, LA & VCSFE
Clinical model	NHS
Primary care transformation	NHS
Community services redesign	NHS
Adult social care integration	Local authority
Prevention priorities	Joint
Delivery oversight	Joint

This approach requires identified leads in each organisation with the capacity to lead the development of relevant areas of the plan in collaboration with partners.



Neighbourhood health plans – key assumptions to date

- We will use a **common set of principles** to shape our approach to neighbourhood health. These are drawn from development sessions held with the Westmorland and Furness Health and Wellbeing Board members and partners across the South Cumbria place
- Our neighbourhood health plans will be **designed around the needs of the population**
- We will build our neighbourhood health plans around our **existing Primary Care Network and Integrated Care Community footprints**, until such time as there is a need to review these (for example, linked to ICB boundaries and/or development of a locality model)
- We will use our existing **Integrated Care Community model** as the foundation for our neighbourhood health plans.
- We will describe **core common components** of neighbourhood health across all footprints, as well as identifying what is bespoke to specific footprints and why



Neighbourhood health plans – our initial approach

- Describe a vision for neighbourhood health
- Understand the needs of each neighbourhood – drawn from the JSNA and supplemented with wider data / insights
- Describe the population cohorts that we will support
- Describe the Integrated Care Community operating model
- Describe the role of partners in an Integrated Care Community
- Set out our key measures of impact



Approach to understanding population need

A blended evidence base for each ICC and PCN

BUILD ON

Utilise the existing JSNA

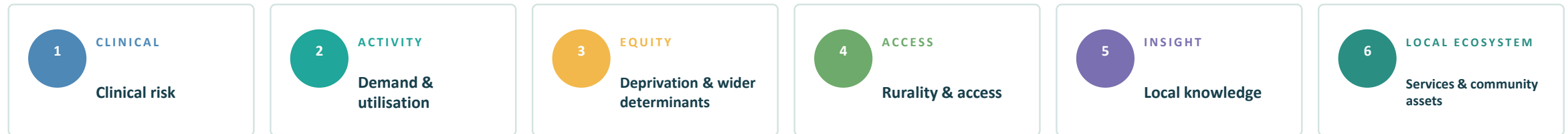
and develop a proportionate needs assessment for each ICC.

Use the data as a starting point

then combine it with the local service landscape, community assets and lived experience to test and refine priorities.

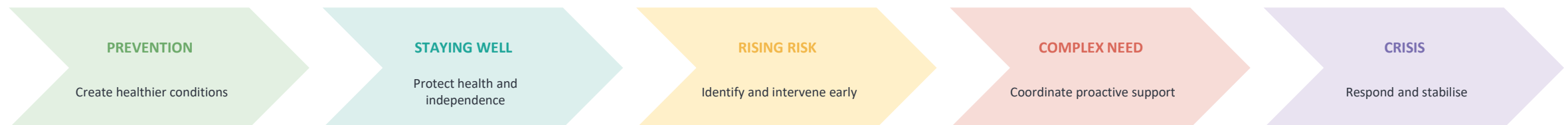
Combine six lenses

No single dataset, service view or area label is sufficient.



Act across the full continuum

The greatest burden may be most visible, but prevention and early action matter across the life course, including children and young people.

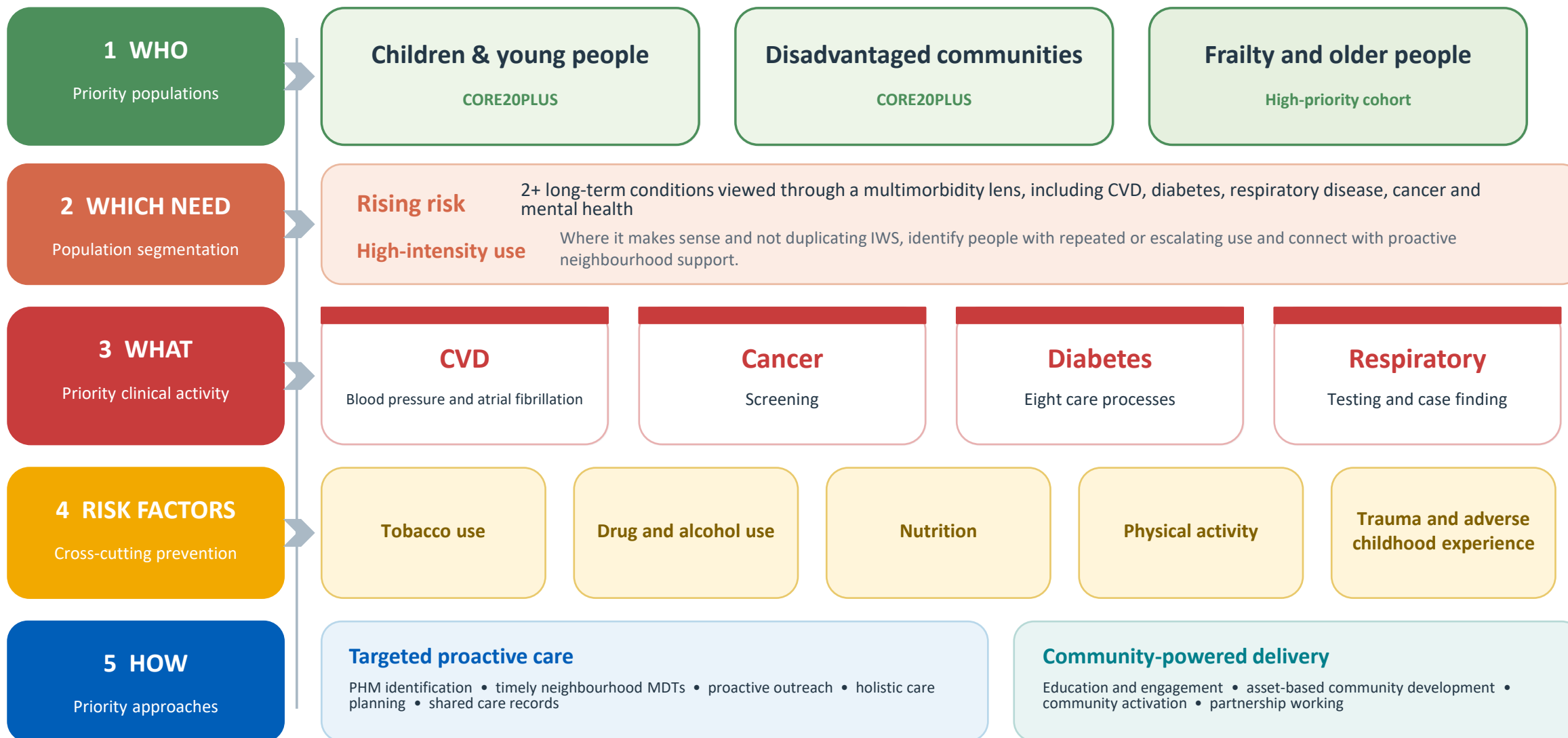


INTERPRET WITH CARE

ICC and PCN boundaries are a useful planning lens, but need varies within neighbourhoods. Read need alongside the local service and asset landscape: what exists, who it reaches, available capacity, connections and gaps.

Common co-horts & aligned ICC priorities for proactive care

A consistent population-led approach, targeted to need and delivered through neighbourhood partnerships



Bespoke cohorts to each ICC / PCN

Population and place archetypes across South Cumbria

WORKING SEGMENTATION: use PCN, neighbourhood and person-level data, not place averages alone

CONCENTRATED INEQUALITY

Barrow Together
Urban and coastal Core20 communities with concentrated deprivation and marked practice-level variation.

Priority: proactive detection, trusted outreach and consistent LTC care.

REMOTE RURAL ACCESS

Western Dales
Distance, cross-boundary working, farming and sparse services can shape access and late presentation.

Priority: local delivery, flexible outreach and coordinated care.

OLDER / DISPERSED

Mid Furness and Grange & Lakes
Older and dispersed populations where low deprivation averages can mask isolation, CVD risk and unmet need.

Priority: case-finding and rural connection.

NEED HIDDEN BY AFFLUENT AVERAGES

Kendal and parts of the Lakes footprint
Low area deprivation does not remove inclusion-health, housing, social isolation or access needs.

Priority: a PLUS-focused approach through trusted community settings.

CROSS-CUTTING COHORTS

Frailty • multimorbidity • high-intensity use • mental health • carers • housing insecurity • safeguarding • people not routinely engaging

Use PHM and professional insight to identify named people and households.

KEY INTERPRETATION

South Cumbria contains sharply different neighbourhood contexts. Combine clinical risk, utilisation, deprivation, rural access and local knowledge rather than using a single area label.

NEXT: use PHM and professional insight to find and target the cohort

The '1–2%' neighbourhood focus

Target intensive support, while strengthening prevention for everyone

1–2%

People with the highest complexity and vulnerability

The aim is to know this cohort, anticipate need and coordinate support close to home.

1

IDENTIFY

Use population health intelligence and professional insight to find people at greatest risk.

2

WRAP SUPPORT

Bring primary care, community, social care and VCFSE partners around one shared plan.

3

PREVENT ESCALATION

Act earlier to improve outcomes and reduce avoidable crisis and hospital use.



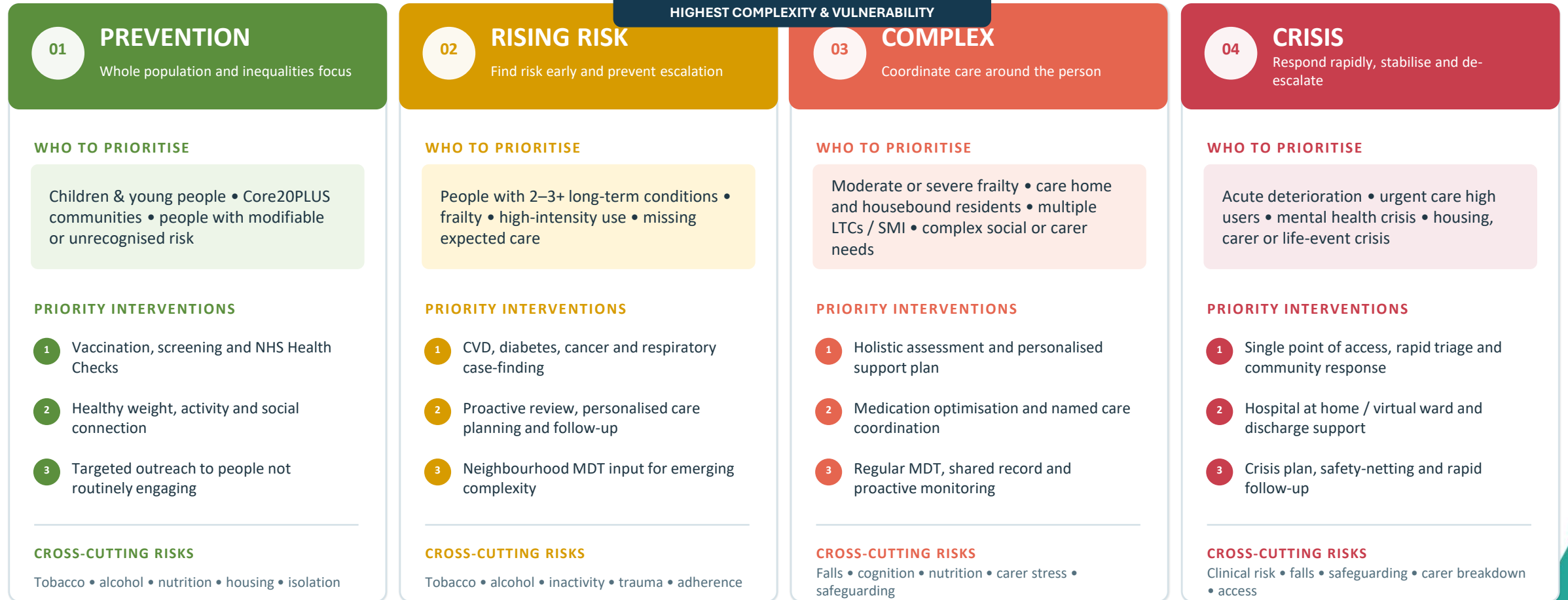
Important distinction This describes a population cohort to prioritise. It is not, by itself, a 1–2% funding formula.

Know the cohort • organise one team around the person • intervene before crisis

Proactive care across the neighbourhood continuum

One population health approach, with intensity increasing as need and complexity rise

Earlier intervention and prevention



COMMON NEIGHBOURHOOD ENABLERS

PHM risk stratification • proactive outreach • shared care record • named coordinator • integrated MDTs • VCFSE / social prescribing • equitable access

Core principle: match the intensity of support to need, while continuing prevention at every stage.

Does this approach to describing the needs of our population in each neighbourhood make sense?

Does our description of priority population cohorts make sense?



Current Integrated Care Community operating model

How it aligns to neighbourhood care in Morecambe Bay

ICC is the delivery vehicle for neighbourhood care • a collaborative function, not a standalone clinical service

01

Wider workforce

Health, care, VCFSE partners and community assets work as one integrated neighbourhood network.

02

Eight core components

ICC direct workforce delivers two components directly and works interdependently across the remaining four.

03

Population health practice

Local insight, mobilised communities and coordinated action shape support around population need.

What ICCs do in practice

Eight connected activities span prevention, coordination and response

Convene partners

Build social capital, trust and collaboration.

Engagement & intelligence

Use local population insight and health inequalities data.

Collaborative projects

Act across ICCs or with partners around shared goals.

Proactive case finding

Identify people at risk and coordinate holistic support.

MDT reviews

Bring professions and agencies together around complexity.

Care coordination

Put a coordinated plan in place before deterioration.

Targeted interventions

Respond to ward-level or cohort-specific need.

Incident response

Coordinate a local response during critical or major incidents.

Operating principle: ICCs connect local intelligence, community mobilisation and integrated delivery to shift support upstream and coordinate care around need.

Does our plan to build on the existing Integrated Care Community model make sense?



Neighbourhood metrics most relevant / interdependent to ICCs

A focused contribution framework for population health management, proactive care and neighbourhood MDTs

Measure at neighbourhood and priority-cohort level: frailty, housebound people and people with multiple long-term conditions.

01 Avoidable hospital use

- Non-elective admissions
- Non-elective bed days
- Type 1 ED attendances

National direction: 10% reduction in admissions and bed days for key frailty cohorts by March 2029.

02 Proactive care coverage

- People risk-stratified and identified
- Holistic assessment completed
- Agreed care plan in place

National target: 95% of people with complex needs have an agreed care plan by 2027.

03 Long-term condition outcomes

- Evidence-based CVD, diabetes, COPD, mental health and dementia outcomes
- Diabetes care-process completion

National direction: at least 10% improvement where warranted by March 2029.

04 Urgent care alternatives

- Category 3 and 4 ambulance conveyances
- Use of urgent community response, hospital at home and virtual wards

National direction: reduce conveyances and improve community management for priority cohorts by March 2029.

05 Experience and coordination

- Patient-reported experience and outcomes
- Continuity and coordination
- Staff experience of neighbourhood working

National measures introduced during 2026/27, with annual improvement trajectories.

06 Equity and local outcomes

- Outcomes by deprivation and inclusion group
- Variation between neighbourhoods
- Locally agreed JSNA and HWB priorities

Local goals should show measurable benefit and reduction in health inequalities.

ACCOUNTABILITY ICCs contribute through PHM, proactive case finding, MDTs and care coordination; delivery is shared across the wider neighbourhood partnership.

MEASUREMENT DEVELOPMENT The current measures are predominantly NHS-focused. A shared outcomes framework is needed to capture the contribution of social care, VCFSE partners and wider neighbourhood services.

Does our approach to measuring impact make sense?



Next steps

- All organisations to identify named individual who will lead their contribution to the Westmorland and Furness Neighbourhood Health Plan, by mid October.
- Westmorland and Furness Council to convene the working group to deliver the plan.
- By the next Health and Wellbeing Board;
 - Project plan to develop the Neighbourhood Health Plan agreed
 - Further refinement of vision for agreement
 - Initial data profiles, based on NHS data, compiled for each ICC area

