Stockon-on-Tees Neighbourhood Health Plan

Foreword

This Neighbourhood Health Plan sets out a shared ambition for how partners across Stockton-on-Tees will work together to improve health, wellbeing and independence of the borough's communities.

The plan brings together health services, social care, local government, the voluntary, community and social enterprise sector, and local communities around a common goal: supporting people to remain healthy, connected and independent for longer through prevention, earlier intervention, coordinated support and services closer to home.

Neighbourhood health is not a new service or a standalone programme. It is a different way of working, bringing organisations together around the needs of people and communities rather than organisational boundaries. The plan builds on existing strengths across Stockton-on-Tees and provides a framework for collective action, learning and improvement over time.

The changes described in this plan will not happen overnight. They will require strong partnerships, shared leadership and the meaningful involvement of residents and communities. By working together, we can create a more preventative, coordinated and sustainable approach that improves outcomes, reduces inequalities and supports people to remain healthy, connected and independent for longer.

1. Why neighbourhood health matters for Stockton-on-Tees

Stockton-on-Tees is a borough with many strengths, including strong communities, a vibrant voluntary, community and social enterprise sector, and significant local skills, assets and resilience. However, health and wellbeing outcomes can vary considerably between communities, with longstanding inequalities affecting people's opportunities to live healthy, connected and independent lives for longer. These differences mean that improving health and wellbeing requires partners to work with communities in different ways, including understanding local needs and circumstances, tailoring support to reflect the differing needs across the borough, and building on the strengths, assets, services and places that help people and communities to thrive.

Many people already access advice, support, activities and social connections through families, community groups, schools, Family Hubs, faith organisations, sports clubs and other local organisations. Neighbourhood health provides an opportunity to build on these existing relationships, networks and sources of support alongside formal health and care services.

Health and care are changing. The national direction is clear: moving care and support from hospital to community, from analogue to digital, and from sickness to prevention. The NHS 10 Year Health Plan for England, published in 2025, sets out this shift as a fundamental transformation in how health and care are organised and delivered. The National Neighbourhood Health Framework, published in 2026, provides a practical framework for turning this ambition into action locally, with a focus on prevention, earlier intervention, integrated neighbourhood working and care closer to home.

This direction also aligns with continued work across adult social care, including the continued emphasis on prevention, independence, personalised support and enabling people to live well in their own homes and communities. Together, these national policies provide a strong mandate for health, care and local government to work differently around the needs of local populations.

It is important that these changes work for the people of Stockton-on-Tees, helping them to live healthier lives. This plan seeks to describe how we can do this, working across partners and communities. For Stockton-on-Tees, this means moving beyond services working alongside each other towards partners working together around people, communities and populations. Residents do not experience their lives through organisational boundaries. Health, social care, housing, employment, financial security, mental health and community connections are closely linked, and the way we organise public services needs to reflect this.

A neighbourhood health and care approach provides an opportunity to:

- identify need earlier and prevent problems from escalating
- bring more support closer to home and into communities
- join up health, care, local government, voluntary, community and social enterprise (VCSE) and community support
- use population health data and community insight to understand and respond to local need, while recognising and building on the strengths, knowledge, skills and social connections that exist within local communities
- reduce duplication and fragmentation across services
- focus collective resources where they can have the greatest impact
- reduce inequalities by responding to the different needs and strengths of our neighbourhoods

This is particularly important as public services face increasing demand, financial pressures and more complex needs. No single organisation can address these challenges alone. Neighbourhood health provides a framework for partners to combine their expertise, resources and relationships with communities, to address and improve shared outcomes.

For Stockton-on-Tees, this is not simply about changing where services are delivered. It is about changing how we work together, moving from reactive and fragmented

responses towards earlier intervention, prevention, joined-up support and stronger communities.

2. What do we know about the Stockton-on-Tees population?

The Joint Health and Wellbeing Strategy provides the borough-wide direction for improving health and wellbeing and reducing inequalities in Stockton-on-Tees. It identifies the issues that matter most and sets out the shared ambitions of the Health and Wellbeing Board and its partners. The Neighbourhood Health Plan takes the next step. It asks how those ambitions can be delivered differently and more effectively at neighbourhood level.

2.1 Key health and wellbeing issues for Stockton-on-Tees

Stockton-on-Tees is a borough with many strengths, including strong partnerships, a vibrant VCSE sector, and communities with significant assets, skills and resilience. However, the borough also faces a number of significant challenges that affect both the health of residents and the demand placed on services. Understanding these challenges is essential to shaping a neighbourhood health approach that responds to local need, focuses collective effort where it can have the greatest impact and improves outcomes for residents. The following themes highlight some of the most important issues affecting health and wellbeing across Stockton-on-Tees.

- **Health inequalities remain one of the most significant challenges facing Stockton-on-Tees**

  While many Stockton-on-Tees residents enjoy long and healthy lives, outcomes vary considerably between communities. The difference in life expectancy between people living in the most deprived and least deprived areas remains one of the widest in the country, reflecting longstanding and persistent inequalities. These inequalities are evident across a range of health outcomes and continue to affect people's opportunities and ability to live a healthy life. Reducing these inequalities remains a central ambition for partners across Stockton-on-Tees.

- **People are living longer but spending too many years in poor health**

  As the population grows and ages, more people are living with long-term conditions, frailty and complex health needs. Healthy life expectancy remains significantly lower than overall life expectancy, meaning many residents spend a substantial proportion of their lives living with poor health, disability or reduced independence. Many of the conditions contributing to poor health can be prevented, delayed or better

managed through earlier intervention to support healthier behaviours or provide effective support.

- **Poor mental health remains a significant challenge throughout life**

  Mental health is an important component of overall health and wellbeing and can influence people's quality of life, relationships, education, employment, physical health and their ability to live independently. Poor mental health affects people of all ages and can have far-reaching impacts on individuals, families and communities. These impacts are not experienced equally. People experiencing disadvantage, social exclusion or poverty are often at greater risk of poor mental wellbeing. Improving mental health requires a strong focus on prevention, early intervention and accessible support within communities.

- **The wider conditions in which people live, grow, work and age continue to shape health outcomes**

  Health and wellbeing are strongly influenced by the wider conditions in which people live. Poverty, financial insecurity, employment, education, housing, access to services, social connections, community safety, and the local environment all influence people's opportunities to live healthy lives. Despite many local strengths, some communities continue to experience significant disadvantage, creating unequal opportunities and poorer outcomes. Improving the health and wellbeing of communities requires action across the wider determinants of health alongside action within health and care services.

- **Inequalities in childhood can influence health, wellbeing and life chances across the life course**

  Experiences during pregnancy, infancy, childhood and adolescence lay the foundations for lifelong health, wellbeing and opportunity. In Stockton-on-Tees, too many children face disadvantages that limit healthy development and future opportunities, with inequalities often becoming established early in life. Early intervention, prevention and coordinated neighbourhood support can help ensure every child gets the best start in life, creating the foundations for lifelong health, resilience and prosperity while reducing inequalities for future generations.

- **Some people and families experience multiple and interconnected challenges and are more likely to experience fragmented support**

  Some people experience multiple and interconnected challenges including poor mental health, disability, caring responsibilities, debt, housing issues, substance misuse and social isolation. These factors can interact, with each challenge compounding the effects of others, creating complex circumstances that often

cannot be addressed through a single service response. People with multiple needs may be in contact with several organisations at the same time and experience support that feels fragmented or difficult to navigate. More coordinated approaches are needed to respond effectively to these interconnected issues.

- **Increasing demand for adult social care and support for independence**

  Demand for adult social care and support continues to grow as more people live longer with complex health conditions, frailty, dementia and other needs that can affect independence and quality of life. Supporting people to remain healthy, connected and independent for as long as possible is becoming increasingly important. This will require continued focus on prevention, reablement, community-based support and helping people access the right support at the right time.

2.2 What are communities telling us?

We have brought together community feedback and intelligence from a range of recent engagement and consultation activity, including the Joint Health and Wellbeing Strategy 2025–2030, Anti-Poverty Action Plan, Active Stockton consultation, Pride in Place feedback and Community Health & Wellbeing Champions**.** Taken together, these sources provide a consistent picture of the issues that matter most to local people and the changes they would like to see in their communities.

Six broad themes emerge:

- **Reducing poverty and financial insecurity**
  Financial pressures are affecting many households, including people in work. Rising costs of food, energy, housing, childcare and transport can have a significant impact on health and wellbeing. Communities want practical support when they need it, but also longer-term solutions through better employment opportunities, skills, income maximisation and affordable housing. Stigma associated with poverty, benefits and food support can also prevent people from seeking help.

- **Improving mental health, wellbeing and social connection**
  Loneliness and social isolation are important concerns, particularly for people who may already be vulnerable or disconnected. Communities value opportunities to meet, participate in groups and activities, and build relationships, alongside access to formal mental health support. There is a strong desire for earlier, more accessible and community-based approaches that promote wellbeing and prevent problems from escalating.

- **Creating safer, healthier and more connected neighbourhoods**
  People want neighbourhoods where they feel safe, included and able to lead healthy lives. Concerns about crime and anti-social behaviour can affect how people use and experience their local areas. Residents also value good-quality green and public

spaces, opportunities for physical activity, access to healthy food and affordable, reliable transport that enables people to access services, employment and social opportunities.

- **Improving access to services, information and support**
  People can find health and care systems difficult to understand and navigate, particularly when they have multiple or complex needs. Communities want services to communicate better, work together and provide clearer information about what support is available and how to access it. Digital services can improve access to information and support, but face-to-face and other non-digital routes remain essential for people who experience digital exclusion, disability, low literacy or lack of confidence online.

- **Supporting children, families and healthy ageing across the life course**
  Communities want children and young people to have the best possible start in life, including access to early help, mental health support, youth activities, skills and affordable childcare. In older age, people want to remain healthy, independent and connected for as long as possible. More coordinated support is also needed for people living with long-term conditions and for unpaid carers.

- **Strengthening community participation, trust and co-production**
  Residents want to be more than recipients of services. They want to have a meaningful role in identifying local issues, shaping solutions and influencing decisions. Trusted community organisations and local leaders are seen as important partners in reaching communities and understanding local needs. Building trust will require visible action, accountability and demonstrating how community feedback has influenced what happens locally.

A consistent message is that healthier communities depend on more than health services alone. People want places that support health and wellbeing, services that are easier to access and navigate, stronger social connections, and genuine opportunities to influence decisions about their communities.

These insights will help inform the development of neighbourhood-level priorities and action to improve health and wellbeing, ensuring that the Neighbourhood Health Plan builds on what communities have told us and the community assets and strengths already present across Stockton-on-Tees.

3. Our neighbourhood health model

The Stockton-on-Tees neighbourhood health model provides a shared framework for how partners will work together to improve health, wellbeing and independence across

the borough. It brings together our vision, principles, neighbourhood footprints, priority outcomes and initial priority cohorts.

3.1 Our vision

Stockton-on-Tees will work as a partnership to develop a collaborative neighbourhood health approach that aims to identify need earlier, coordinate support around residents, strengthen community-based provision, build on the unique strengths, assets and relationships within communities, and enable people to remain healthy, connected and independent for longer.

Our Neighbourhood Health approach is a whole-system, place- and strengths-based approach to improving health, wellbeing and independence. It is not an NHS transformation programme or a healthcare delivery model owned by a single organisation. It is a shared approach, bringing together health and care, social care, local government, VCSE and community organisations around the needs of local people.

The approach will build on what is already working across Stockton-on-Tees, bringing partners together around a shared ambition to improve outcomes, reduce inequalities and help people remain healthy, connected and independent for longer.

3.2 Our working principles

Our neighbourhood health model will be guided by four core principles:

- **Shared leadership and accountability**: partners will work together around the needs of local people and communities, with collective responsibility for improving neighbourhood outcomes and reducing inequalities.
- **Focus on outcomes and local need**: we will use local data, evidence and community insight to identify priorities, focus collective effort and measure the difference we make to people's health, wellbeing and independence.
- **Decisions and support closer to communities**: wherever possible, we will bring decision-making, resources and support closer to where people live, enabling local partners and communities to respond flexibly to local needs and opportunities.
- **Learn, listen and improve**: we will work with residents, communities and partners to understand what is working, learn from experience and continuously improve how we work together.

The approach aims to move the system from reacting to illness towards prevention, early intervention and enabling people to live well for longer. Success depends on stronger integration between primary care, community services, mental health, acute care, social care, local government and the VCSE sector.

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A central component of this approach is Population Health Management (PHM). Partners will use shared data, insight and intelligence to understand populations, identify inequalities and unmet need, and target resources where they can have the greatest impact. This will support the identification of initial priority cohorts and enable partners to work collectively to deliver measurable improvements in outcomes.

3.3 Our neighbourhoods

'Neighbourhood' can mean different things to different people. For residents, it may be shaped by where they live, work, go to school, access services, spend time, or the communities and relationships that are important to them. We recognise that people do not necessarily identify with a particular neighbourhood footprint, and we do not intend to describe where people belong.

For the purposes of the Neighbourhood Health Plan, we have developed a set of **operational neighbourhood footprints** to help partners plan, coordinate and organise services, understand population need and target collective action. These footprints provide a practical basis for partnership working but are not intended to define people's identity or determine where they access services and support.

The proposed neighbourhoods reflect the recognised towns and communities across Stockton-on-Tees and provide a practical and recognisable way of grouping smaller areas within the wider borough.

The neighbourhood footprints across Stockton-on-Tees are shown in the table below, with their populations:

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These footprints provide a shared operational framework for partners, while recognising that different programmes, services and communities may operate at a more granular level or across more than one neighbourhood. The footprints can therefore be used flexibly according to local need and the purpose of the work.

The Neighbourhood Health profiles are shown in Annex 1. Neighbourhood profile data will continue to be reviewed and developed over time.

3.4 Priority outcomes

The Neighbourhood Health Plan is built around three key reform agendas set out in the national Neighbourhood Health Framework, making these relevant to the borough. Together, these provide the framework for delivering our vision and supporting a more preventative, integrated and community-based approach to health and care across Stockton-on-Tees.

These reform agendas are significant, and change will not happen overnight. The plan sets out a long-term vision, with action implemented through a staged approach that allows improvements to be tested, embedded and sustained in future ways of working.

This may mean prioritising pathways, population groups or wider determinants of health and wellbeing in different years, in response to local need, outcomes and learning. It may also mean initially focusing activity in particular neighbourhoods where population need, inequalities or current outcomes indicate that collective action could have the greatest impact.

- **Reform agenda 1: Improve services for people who need routine health and care, so neighbourhood health benefits everyone**

The first reform agenda is about making neighbourhood health visible and meaningful to the whole population, not only those with complex needs. It focuses on how people access and experience routine care, reducing frustration, delay and variation and making it easier for people to access the right support.

Across Stockton-on-Tees, partners will:

- Improve and standardise access to general practice, ensuring timely same-day response for urgent need alongside improved routine access
- Establish clear and consistent routes into services, reducing confusion about where to go and how to get help
- Develop care coordination and navigation functions, including single points of access, to direct people to the right support first time
- Reduce unnecessary referrals, duplication and administrative burden across organisational boundaries
- Improve continuity of care for those who need it most, particularly people with multiple long-term conditions
- Use community pharmacy as a core part of the neighbourhood access model
- Work with local people and communities, and their trusted organisations including Healthwatch, Community Health and Wellbeing Champions and VCSE organisations to identify local priorities, understand barriers to accessing support, improve access to services, and ensure local insight informs service design and improvement
- Reduce the number of adults whose long-term support needs are met through residential or nursing care admissions
- Improve the proportion of people receiving long-term support at home or with family
- Continue development of models of care that support people to access care at home rather than in a hospital setting, such as virtual wards and urgent community response
- Continue provision of enhanced health in care homes to support proactive management of patient deterioration, medicine optimisation, workforce development and digital solutions

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- Maximise capacity in reablement services such as community rehabilitation, overnight support services and therapy capacity, to maximise recovery and independence
- Expand access to Technology Enabled Care (TEC), telecare, remote monitoring and home adaptations to help people live safely and independently at home
- Ensure support for unpaid carers through respite, contingency planning, advice and identification
- Implement the Experts at Hand model across education settings to improve early access and early identification of need, via additional access to a range of education and health professionals for children and young people
- Improve continuity between 0–19 health services including health visiting, early-years settings, Family Hubs, schools and SEND services to improve school readiness and reduce developmental gaps through earlier identification and intervention
- Increase local specialist support for children and young people by expanding specialist provision within mainstream schools and strengthening pathways between mainstream, specialist, and special schools, helping more children remain within their local communities.

The outcome we want: All residents should experience reliable, accessible and joined-up everyday health and care, with simpler access to the right support at the right time.

- **Reform agenda 2: Improve proactive care for people who need it most**

The second reform agenda focuses on moving from reactive care to earlier, proactive and personalised support. It is a key mechanism for improving outcomes, preventing deterioration and reducing health inequalities.

Across Stockton-on-Tees, partners will:

- Bring professionals and community partners together around shared populations and neighbourhoods
- Use population health intelligence to identify people at greater risk and intervene to provide support earlier
- Provide more coordinated, person-centred support for people with complex or multiple needs
- Reduce duplication through clearer roles, shared approaches and better coordination across services
- Strengthen community-led solutions, making better use of local assets, voluntary organisations and community networks
- Ensure services provide proactive and targeted support to children, young people and families at greatest risk of poor outcomes, using neighbourhood intelligence and early intervention to prevent escalation and reduce inequalities
- Work with local people, carers, communities and their trusted organisations to identify need earlier, prevent ill health, reduce inequalities, and co-design

neighbourhood approaches for priority cohorts, ensuring support reflects local priorities, needs, strengths, and community assets.
- Continued reform of speech and language pathways for children and young people to improve early identification of need and timely access to support
- Implementation of cluster and multidisciplinary team working, organised around school clusters, plus improved single point of contact offers to increase access to coordinated and proactive support
- Support a move towards predictive data led planning, prevention and earlier intervention, away from reactive escalation across children and young people's health, care and education provision
- Ensure a needs-led approach to the provision of children and young people's health and care services, intending to support earlier resolution of concerns and strengthen collaboration between families, schools and services through Family Help locality arrangements.
- Improve the quality and timeliness of decision making through multi-agency child protection team arrangements

The outcome we want: People at greater risk of poor health or deterioration will be identified earlier and supported proactively, helping to improve health and wellbeing, reduce inequalities and support people to live healthier and more independent lives.

- **Reform agenda 3: Deliver better alternatives to hospital care**

The third reform agenda addresses the need to reduce avoidable reliance on hospital services by creating robust, responsive and trusted alternatives in the community. This means ensuring people can receive safe and effective care closer to home wherever appropriate.

Across Stockton-on-Tees, partners will:

- Expand and integrate Urgent Community Response (UCR) and rapid response services
- Develop Hospital at Home and Virtual Ward models, enabling acute-level care in people’s homes where appropriate
- Strengthen intermediate care, rehabilitation and reablement pathways to support admission avoidance and timely discharge
- Align neighbourhood services with ambulance and urgent care pathways, ensuring appropriate routes away from emergency departments, where clinically safe
- Improve discharge coordination and step-down capacity, reducing delayed discharges and loss of independence.
- Work with local people, carers, communities and their trusted organisations to understand how support can be delivered closer to home and within communities, helping to shape alternatives to hospital care that are accessible, coordinated and responsive to local needs

- Strengthen early identification and intervention through Health Visiting and School Nursing, ensuring children, young people and families receive timely support before needs escalate to specialist, statutory or hospital services
- Ensure easier access to specialist advice, clearer pathways, and improved integrated education, health and care working to support better outcomes for children and young people across Stockton-on-Tees
- Improve transition arrangements for young people moving from children to adult's services
- Ensure support is delivered closer to home and school, while strengthening mainstream and local capacity, with reduced escalation to statutory and specialist pathways, local SEMH and AP alternatives
- Bring specialist expertise closer to children and young people rather than requiring them to access a specialist service
- Reduce reliance on independent and out of area placements by expanding local children and young people's provision and specialist capacity

The outcome we want: People will receive safe, effective and timely alternatives to hospital care within their neighbourhood wherever appropriate, helping to avoid unnecessary admission, support timely discharge and maintain independence.

Together, the three reform agendas provide a clear direction for neighbourhood health in Stockton-on-Tees: better routine care for everyone; more proactive support for those who need it most; and better alternatives to hospital care.

They are complementary rather than separate programmes and will increasingly connect through Integrated Neighbourhood Teams, community-based services, population health management and stronger relationships with communities.

3.5 Year 1 priority cohorts

Neighbourhood health will focus collective effort where it has the greatest potential to improve outcomes, reduce inequalities and prevent needs from escalating. In addition to the collective partner work on the three reform agendas as described above, partners have also agreed to focus on two initial priority cohort areas to test new ways of working together. These have been identified using population health intelligence and local knowledge, considering factors including health inequalities, unmet need, wider determinants of health, service demand, risk of deterioration and opportunities for prevention.

For **Year 1**, two initial priority cohorts have been identified across Stockton-on-Tees:

- **Cardiovascular, Kidney and Metabolic (CVKM) Disease**

Cardiovascular, kidney and metabolic (CVKM) disease represents a group of closely linked conditions and risk factors that contribute significantly to ill health, reduced quality of life, health inequalities and early death. These conditions have a significant impact on health outcomes across Stockton-on-Tees and contribute to health inequalities between communities. Bringing together cardiovascular disease, chronic kidney disease, diabetes, obesity and related risk factors provides an opportunity to take a more joined-up approach to prevention, early identification and ongoing management.

The Year 1 focus will be on identifying people at increased risk, including those with undiagnosed conditions, proactively managing risk factors and existing conditions, and supporting earlier intervention before needs escalate. The approach will seek to prevent ill health, improve the management of existing conditions, reduce inequalities, support people to maintain their health, wellbeing and independence, and reduce avoidable complications that can lead to poorer outcomes and increased demand on services.

Delivering this approach will require improved coordination across prevention, identification, treatment and ongoing management, bringing together health and care services, local people, communities and VCSE organisations around shared priorities. This will include using population health intelligence, community insight and neighbourhood partnerships to identify opportunities for earlier action and more coordinated support, while understanding and responding to the wider factors that influence health and wellbeing.

- **The top 1% of adults with complex and interdependent needs**

This cohort represents approximately 1% of the adult population in Stockton-on-Tees, who are living complex lives and often require support from multiple services. Many of these people experience a combination of health, care, housing, financial, family and social challenges that interact and increase their risk of experiencing poorer outcomes, inequality and loss of independence. These challenges often result in people having contact with multiple services and organisations, with support that can be fragmented or difficult to navigate.

The Year 1 focus will be on identifying and proactively supporting these residents through more coordinated, multidisciplinary approaches, with the aim of improving outcomes, quality of life and independence while reducing avoidable demand. This will include developing a shared understanding of those experiencing the greatest levels of need, complexity and risk, how need and complexity are identified, and where neighbourhood approaches can add the greatest value.

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Delivering this approach will require health and care services, local people, communities and VCSE organisations to work together around a shared understanding of need and risk. This will include bringing together population health intelligence, professional insight and local knowledge to better understand how health, care, family, community and wider social and economic circumstances interact, and to identify opportunities for earlier, more coordinated support.

4. Enablers

4.1 Neighbourhood Health Centres

Neighbourhood Health Centres can play an important role in supporting the delivery of neighbourhood health, providing a local focus for integrated working, improving access to services and enabling more proactive, preventative and coordinated support closer to home.

However, neighbourhood health is not defined by buildings or estate. It is fundamentally about how partners work together around the needs of local people and populations. The effectiveness of the neighbourhood model will depend on strong partnership working, integrated neighbourhood teams, community involvement, population health intelligence and services designed around local need.

As part of developing this plan, partners across the NHS, local authority and voluntary and community sector are working together to understand existing community assets, local population needs and the role that neighbourhood health centres could play in each locality. This includes considering how existing facilities could be better used, enhanced or connected, whether services could be brought together or relocated to improve access, and where future investment in estate may be required.

Estate will therefore support and enable neighbourhood health, rather than determine it. Any future development of neighbourhood health centres will be considered alongside the wider service and partnership changes needed to improve outcomes, reduce inequalities and strengthen community-based care across Stockton-on-Tees.

4.2 Digital and Data

Digital and data will be important enablers of effective neighbourhood health, helping partners to work with a shared understanding of local populations, coordinate support and reduce unnecessary administrative burden.

Our approach will focus on making information more connected, accessible and useful for decision-making, so that the right information is available to the right people at the right time. This will include:

- Better connected information: supporting continuity of care and ensuring relevant information can follow people across organisational boundaries.
- Interoperable systems: improving the ability of services and organisations to share and use information effectively.
- Accessible digital pathways: making it easier for residents to access services and support digitally, while ensuring appropriate alternatives are available for people who cannot or do not want to use digital routes.
- Population health intelligence: using data to identify need and risk earlier, understand inequalities and target support where it can have the greatest impact.
- Outcome-focused information: using data to understand whether neighbourhood approaches are improving outcomes and residents' experience, rather than simply measuring activity.

Partners will work to align digital priorities and information approaches across organisations, while ensuring that information governance supports appropriate and proportionate sharing.

Key areas of development will include:

- Shared care record and information-sharing approaches
- Digital support for care coordination and Integrated Neighbourhood Teams
- Digital pathways that support improved access, triage and planned care
- Population health dashboards that support local decision-making and action, not simply reporting
- Cross-organisation dashboards to support multi agency, integrated ways of working
- Develop approaches to better understand, capture and evaluate the contribution of prevention, community-based support and VCSE activity, helping partners understand what support is available, who it is reaching, the outcomes it is achieving, and where there may be gaps or opportunities for further investment

4.3 Finance

Partners across Stockton-on-Tees, specifically the ICB and the Local Authority, have a formal pooled budget arrangements in place in the form of the Better Care Fund. This enables partners to collectively plan, commission and oversee investment in integrated health and care services.

The pooled budget supports a shared commitment to improving outcomes through prevention, early intervention, Home First principles and neighbourhood-based care. Funding decisions are agreed jointly, and resources are aligned to shared priorities,

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ensuring that investment can be directed towards services that deliver the greatest benefit across the whole system rather than individual organisations.

Robust joint governance arrangements, including the Health and Social Care Collaborative, the Pooled Budget Partnership Board and oversight through the Health and Wellbeing Board, provide assurance that financial resources are used effectively, performance is monitored collectively, and investment decisions support continuous improvement, value for money and the delivery of agreed population outcomes.

This pooled budget arrangement provides a framework for consideration of additional pooled budget models between partners, to further develop neighbourhood health services, enabling health, social care, housing and VCSE partners to work more seamlessly around local populations.

By sharing financial risk and responsibility, partners can invest collectively in preventative, community-based services that help people maintain independence, reduce unnecessary hospital and care home admissions, and receive coordinated support closer to home. The further development of these approaches will be a focus of the first year of the neighbourhood plan.

5. Governance and Accountability

The Stockton-on-Tees Neighbourhood Health Programme will be overseen through a **multi-agency Neighbourhood Health Steering Group**, bringing together key partners from across the local health, care and community system, including:

- Northeast and North Cumbria Integrated Care Board (NENC ICB)
- Stockton-on-Tees Borough Council
- Hartlepool and Stockton Health (H&SH) GP Federation
- Primary care networks
- University Hospitals Tees (UHT)
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- Voluntary, community and social enterprise (VCSE) sector
- Healthwatch and other relevant health, care and community partners.

The Steering Group is an equal partnership, chaired by the GP Federation, and meets monthly to provide collective leadership and coordination for the neighbourhood health programme.

Its role is to bring partners together around shared population outcomes, supporting the development and implementation of more integrated, preventative and community-based approaches. The group will:

- maintain a shared vision and direction for neighbourhood health
- agree priorities and outcomes based on local population need and inequalities
- support coordinated action across organisational boundaries

- provide collective leadership and shared ownership of neighbourhood health
- identify and help address barriers to delivery
- ensure that community and resident perspectives inform the development of neighbourhood approaches; and
- monitor progress and use learning to inform continuous improvement

The Health and Wellbeing Board will provide strategic oversight of the Neighbourhood Health Plan, ensuring that it remains aligned with the Joint Health and Wellbeing Strategy and wider priorities for Stockton-on-Tees. The Steering Group will provide regular updates to the Board on progress, emerging issues and outcomes, enabling the Board to provide strategic challenge, support and advocacy where required.

Alignment with other local plans and programmes

The Neighbourhood Health Plan is intended to provide a shared framework for partnership working at neighbourhood level and will need to align with, and support the delivery of, wider local strategies and programmes. These include the Joint Health and Wellbeing Strategy 2025–2030, Family First Partnership and wider children's social care reforms, the adult social care strategy, the anti-poverty strategy and the inclusive growth strategy. These plans share important objectives around improving outcomes, reducing inequalities, supporting families and communities, promoting independence and addressing the wider determinants of health.

- **Pride in Place**

  The Neighbourhood Health Plan recognises the important contributions that neighbourhood regeneration, community development and resident involvement make to improving health and wellbeing. Through the Pride in Place programme in Central Stockton-on-Tees and Portrack, partners are working with residents and communities to identify local priorities, build on community strengths and shape long-term investment. Many of the emerging issues, including supporting young people, creating safer communities, strengthening local pride, improving the local environment and increasing opportunities for residents, are factors that influence health, wellbeing and inequalities.

  The Neighbourhood Health Plan and Pride in Place Plan will be delivered in a coordinated way, ensuring that insight, community intelligence and learning are shared across programmes. This will help align activity where priorities overlap, strengthen engagement with communities, build on local assets and trusted relationships, support joined-up partnership working, and maximise the impact of investment. The Pride in Place approach also provides opportunities for learning that can be applied to neighbourhood health approaches, particularly in relation to community-led decision making, asset-based working and understanding what matters most to local communities. As neighbourhood health develops across the borough, this learning will help inform how partners work with residents and communities to improve health, wellbeing and independence.

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6. Risks and Mitigation

Risk	Impact	Mitigation
Neighbourhood health is seen as an NHS-only programme	Council, public health, social care, housing and VCSE priorities are not fully embedded.	Confirm partner sponsorship and HWB stewardship; frame neighbourhood health as a whole-system and whole-council priority.
Governance becomes fragmented or duplicative	Slow decisions, unclear accountability and duplication of meetings.	Use existing governance wherever possible; confirm the Health and Wellbeing Board as the system stewardship forum and the Hartlepool Neighbourhood Health Strategy Group as the conduit for governance, action and delivery coordination; and agree a range of Task and Finish Groups to drive forward the agenda in a clear way across all partners
Insufficient resource or unrealistic expectations of new funding	Delivery becomes unaffordable or displaces statutory duties.	Align BCF and existing resources where appropriate to do so; agree risk appetite; prioritise cohorts where impact is greatest. Scope additional investment opportunities wherever possible including national and local opportunities.
Neighbourhood health becomes focused on buildings or centres rather than outcomes	Partners may invest time and capacity in estate discussions before agreeing the service model, priority cohorts and resident outcomes.	Confirm that centres are an enabler, not the aim; prioritise use of existing assets, outreach, digital routes and community venues; require evidence of need, affordability and added value before any new estate proposal is pursued.
Data sharing and information governance barriers delay proactive care	Partners cannot identify risk, coordinate care or evaluate impact effectively.	Agree data-sharing requirements early; use existing platforms and IG agreements; escalate unresolved issues.
Integrated neighbourhood teams add complexity rather than simplify services	Residents and staff experience confusion, duplication or additional referral routes.	Design around resident journeys; map pathways; use co-production and staff feedback to test usability.

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Health inequalities are not sufficiently targeted	Neighbourhood health benefits people already able to access services, widening inequality.	Use JSNA, IMD, equality and practice-level data to target micro-neighbourhoods/mission critical areas and underserved groups.
VCSE capacity is insufficient to support expectations	Community-led prevention and engagement cannot be sustained.	Develop VCSE infrastructure, commissioning clarity and realistic partnership expectations.

7. Monitoring and Evaluation

The Stockton-on-Tees Neighbourhood Health Steering Group will be responsible for overseeing the implementation and delivery of the Neighbourhood Health Plan. This will include monitoring agreed outcome measures and performance indicators, reviewing progress against the delivery plan, and identifying and escalating risks where required.

The Group will also monitor the achievement of key milestones to ensure delivery remains on track, while supporting continuous learning and reflection to inform future programmes of work. The Group will also seek to develop a broader understanding of the contribution that prevention, community-based support and VCSE activity make to neighbourhood health outcomes. Over time, this will include exploring how information and intelligence can be used to better understand the support available within communities, who it is reaching, and the difference it makes to residents, helping to inform future commissioning, investment and service development.

The Group will ensure that the Neighbourhood Health Plan remains responsive to changing resident needs, emerging evidence, and opportunities to improve health and care outcomes for the people of Hartlepool. Through regular review of performance, outcomes and stakeholder feedback, the plan will continue to evolve to maximise its impact.

The governance framework established through the Group provides a structured approach to assurance and accountability. Regular progress reviews and outcome reports will be presented to the Health and Wellbeing Board, enabling it to maintain strategic oversight of the Neighbourhood Health Plan and hold the Group accountable for delivery against agreed objectives and outcomes.

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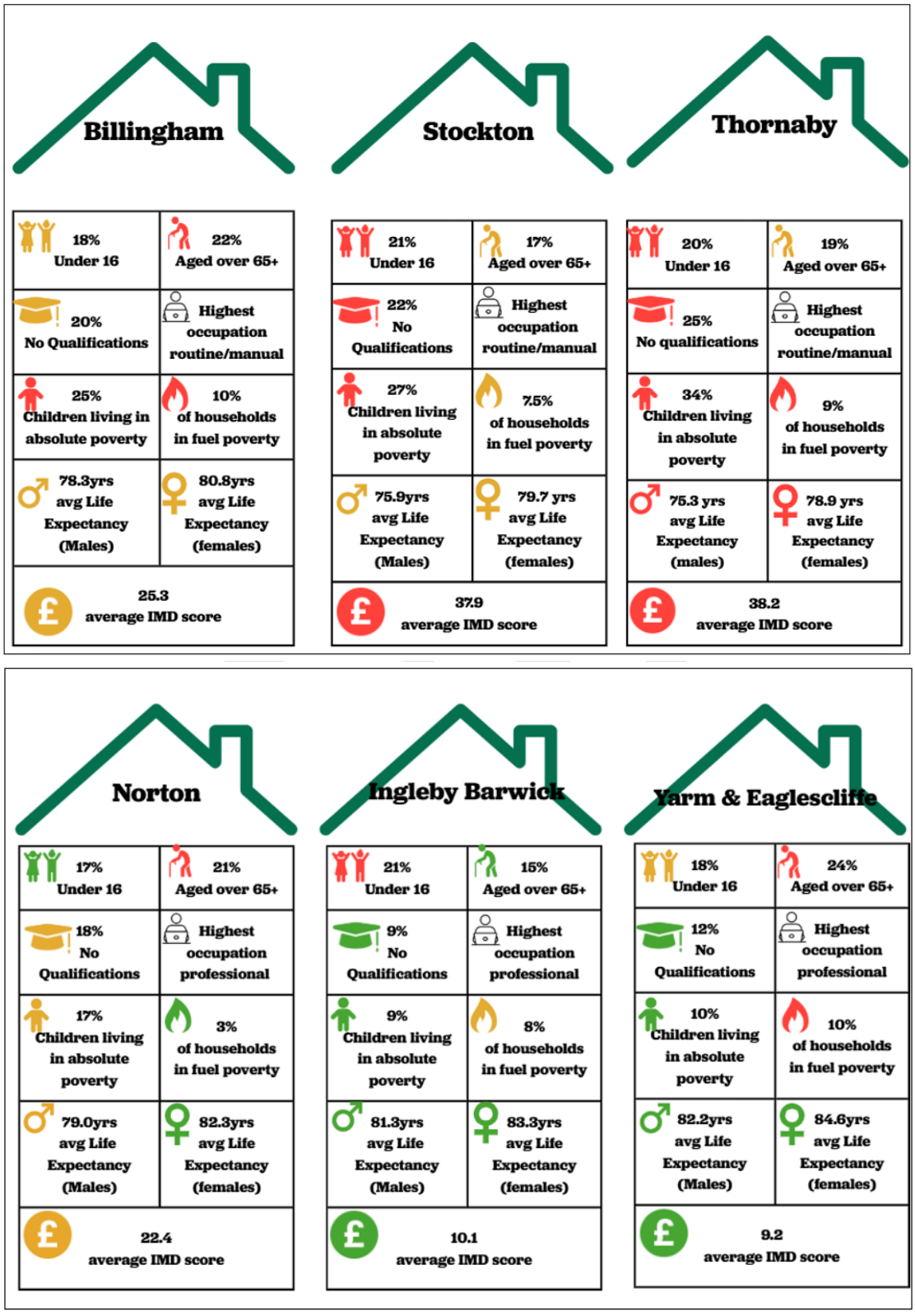
Annex 1:


Billingham
18% Under 16
22% Aged over 65+
20% No Qualifications
Highest occupation routine/manual
25% Children living in absolute poverty
10% of households in fuel poverty
78.3yrs avg Life Expectancy (Males)
80.8yrs avg Life Expectancy (females)
25.3 average IMD score
Stockton
21% Under 16
17% Aged over 65+
22% No Qualifications
Highest occupation routine/manual
27% Children living in absolute poverty
7.5% of households in fuel poverty
75.9yrs avg Life Expectancy (Males)
79.7 yrs avg Life Expectancy (females)
37.9 average IMD score
Thornaby
20% Under 16
19% Aged over 65+
25% No qualifications
Highest occupation routine/manual
34% Children living in absolute poverty
9% of households in fuel poverty
75.3 yrs avg Life Expectancy (males)
78.9 yrs avg Life Expectancy (females)
38.2 average IMD score
Lower Higher
Better Worse
Better Worse
Better Worse
Better Worse
Norton
17% Under 16
21% Aged over 65+
18% No Qualifications
Highest occupation professional
17% Children living in absolute poverty
3% of households in fuel poverty
79.0yrs avg Life Expectancy (Males)
82.3yrs avg Life Expectancy (females)
22.4 average IMD score
Ingleby Barwick
21% Under 16
15% Aged over 65+
9% No Qualifications
Highest occupation professional
9% Children living in absolute poverty
8% of households in fuel poverty
81.3yrs avg Life Expectancy (Males)
83.3yrs avg Life Expectancy (females)
10.1 average IMD score
Yarm & Eaglescliffe
18% Under 16
24% Aged over 65+
12% No Qualifications
Highest occupation professional
10% Children living in absolute poverty
10% of households in fuel poverty
82.2yrs avg Life Expectancy (Males)
84.6yrs avg Life Expectancy (females)
9.2 average IMD score
Lower Higher
Better Worse
Better Worse
Better Worse
Better Worse

Annex 2: National Neighbourhood Health Improvement Programme Pilot

Stockton on Tees were part of the national integrated neighbourhood team pilot programme in 2025-26 which brought together NHS partners, Stockton-on-Tees Borough Council, VCSE organisations and wider system stakeholders to test a more integrated, preventative model of care at neighbourhood level, with the aim of learning from this approach and building successful approaches into its neighbourhood plan.

The programme was jointly led across the NHS and Local Authority, with strong involvement from primary care, community, acute and mental health services, alongside public health and VCSE partners. Delivery was supported through a shared governance structure aligned to place-based arrangements.

The core aim was to move from fragmented, reactive service delivery towards a coordinated approach that identified need earlier, wrapped multi-agency support around residents, reduced duplication across organisations and made better use of collective NHS, local authority and community resource.

The pilot is tested a proactive, neighbourhood-based model of care, initially focused on residents aged 50–65 with three or more long-term conditions.

Using GP lists and population health management data, individuals were identified who were likely to benefit from a more coordinated, whole-person approach. With consent, they were contacted by a member of the local team and offered a longer, relational conversation to understand what matters to them, not only clinically but socially and practically.

Integrated Neighbourhood Team (INT) discussions were held, bringing together relevant professionals from across NHS services, local authority teams, community and VCSE organisations around that individual. The intent was not referral and signposting alone, but shared problem-solving and coordinated action across organisations.

This represented a shift from service-led pathways to a single, coordinated approach where resident's needs were understood once and responded to collectively.

Early delivery demonstrated that the model was both practical and valued. INT discussions have enabled:

- Shared understanding of complex need across organisations
- Direct connection between services without multiple referrals

- Warm handovers and coordinated actions agreed in real time
- A stronger focus on social and practical barriers alongside clinical need

The programme has established strong foundations and early delivery, with clear system appetite to work differently. This learning will be fed into the broader neighbourhood programme and INTs will be implemented to support identified cohorts as part of the broader programme of work.

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