National Neighbourhood Health Implementation Programme: Health & Social Care

Prepared by: Sarah Vickers – Programme Lead – Primary & Community Care

NHS Cheshire & Merseyside

Neighbourhood health guidelines 2025/26

(NHS England 30 January 2025)

Purpose: help integrated care boards, local authorities and health and care providers develop neighbourhood health services in 2025/26

Neighbourhood health model is intended to join up services in the community in a more effective way, particularly for people with more complex health and care needs, helping children thrive and supporting adults to stay independent for longer, improve health and wellbeing, and reduce avoidable pressures on health, social care and other public services.

Ask: for local systems to focus on supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations, developing and bringing together into an integrated service offer six core components of a neighbourhood health model

- Population health management
- Modern general practice
- Standardising community health services
- Neighbourhood multi-disciplinary teams
- Integrated intermediate care with a ‘Home First’ approach
- Urgent neighbourhood services

Neighbourhood health guidelines 2025/26 Continued…..

(NHS England 30 January 2025)

12. The focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. This cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs, according to NHS England analysis from adapted Bridges to Health data. It is likely that systems will initially prioritise specific groups within this cohort where there is the greatest potential to improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care, both improving outcomes and freeing up resources so systems can go further on prevention and early intervention. This approach is likely to focus on around 2% to 4% of the population. Examples of population cohorts with complex needs include:

- adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia)
- people of all ages with palliative care or end of life care needs
- adults with complex physical disabilities or multiple long-term health conditions
- children and young people who need wider input, including specialist paediatric expertise into their physical and mental health and wellbeing
- people of all ages with high intensity use of emergency departments

Why Implement the Neighbourhood Model?

- Neighbourhood Health - 10 Year Health Plan priority and Government ambition to:
  - shift care from hospitals to community,
  - analogue to digital,
  - sickness to prevention.

- No single agency working alone can adequately deal with the multiple and often complex issues impacting on the health and wellbeing of populations.

- Current ways of working mean resources are not deployed as effectively as possible, creating pressure across the whole health and care system.

- Leading to poorer experience of care and outcomes for individuals and communities.

- Requires the coordinated mobilisation of the assets in a community including communities themselves.

What do our Neighbourhoods look like?

Two integrated neighbourhoods – Runcorn and Widnes:

- Share the same footprints as Halton's Primary Care Networks (PCNs).
- Optimise strong existing neighbourhood working and partnerships with the LA, providers / services and voluntary sector, building on PCN development to date.
- Co-terminus with Halton Borough Council's boundary and aligned to Adult Social Care and preventative public health delivery.
- Recognised by communities and politicians.
- Aligned to the national Neighbourhood requirements & NHS Cheshire and Merseyside Neighbourhood Framework.
- Focused around a cohort of patients to deliver: improved management, pro-active care including risk stratification & advanced care planning, medicine rationalisation, access to wider third sector support.
- Clearly defined and measured benefits and outcomes for patients, carers and staff.

Who needs to be involved?

Patient Cohort

Cohort 1 : Known to Health & Social Care teams with multiple LTCs / Frailty.
Moderate or severe frailty (Rockwood Score 6-9)

Cohort 2: **Rising Risk - Identified via an agreed mechanism e.g. Data Into Action**
Vulnerable / Mildly Frail (Rockwood 4 & 5)

Later Phase
Cohort 3: Generally Well - Pro-active activities to prevent deterioration and support healthy aging.
Fit / Well / Managing Well (Rockwood 1-3))

Carers & Families

One Halton Partners

All Partners have a role:

- Primary Care including:
  PCNs, General Practices, GP Federations, Community Pharmacy, Optometry and Dental Services.
- Community Services:
  Community Matrons, District Nurses, Specialist Teams.
- Secondary Care Services
- Adult Health & Social Care Teams
- Public Health Services
- Third Sector Services
- Communities, Patients & Carers

Draft Timelines

Milestone	Date
Commence discussions with – Adult Social Care & PCNs / Practices	PLT June 2025 & July / Aug 2025
Establish Steering Group & agree TOR	Meeting 15/10/25
Identify resources to support: - Engagement by General Practice - Programme & Project support	31/10/25
Agree scope & aims of Programme	31/10/25
Agree delivery structure & arrangements including enabling functions (IT, Estates & Workforce)	31/10/25
Develop Programme Plan & documentation, identifying Phase 1 workstreams and future phases & include Projects, Milestones, Clinical Model, Pathway Development, digital, workforce & patient.	30/11/25
Ongoing Implementation, Delivery & Monitoring	Ongoing