Integrated Neighbourhood Working

Health & Wellbeing Board

14th January 2026

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NHS Cheshire & Merseyside – Halton Place

Halton – Integrated Neighbourhood Model

One Halton	
One Halton's Ambition To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community based support and ensuring high quality services for those who need them	
Ambition	**Overarching Indicator**
Improvements in health	**Healthy Life Expectancy**
Reduce health inequalities	Overarching indicator is **Gap in Life Expectancy between the highest and lowest decile** (internal inequalities) as well as Life expectancy **gap between Halton and England/NW** (external inequalities)
One Halton Programmes	
Wider determinants	Starting Well Living Well Ageing Well
Integrated Neighbourhood Working	

Vision & Principles

Vision

Our vision for neighbourhood working is greater than just health and social care and moves beyond treating symptoms to addressing the underlying causes of poor health and wellbeing and supporting people to have a good life

Neighbourhood Footprints – Re-confirmed July 2025

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 on 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.
- ***Delivery of services at most appropriate scale – Place / Neighbourhood / Sub-Neighbourhood***

Neighbourhood health guidelines 2025/26

(NHS England 30 January 2025 NHS England » Neighbourhood health guidelines 2025/26)

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…..

Section 12 states:

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

Framework for Neighbourhood Health – Cheshire & Merseyside

Purpose

- Improve health outcomes
- Reduce inequalities
- Strengthen commun ity-based care
- Empower local teams and residents

Core Principles

Place-Based Integration

Services designed and delivered locally

Multi-Disciplina Teams (MDTs)

Collaboration acrose health and care sectors

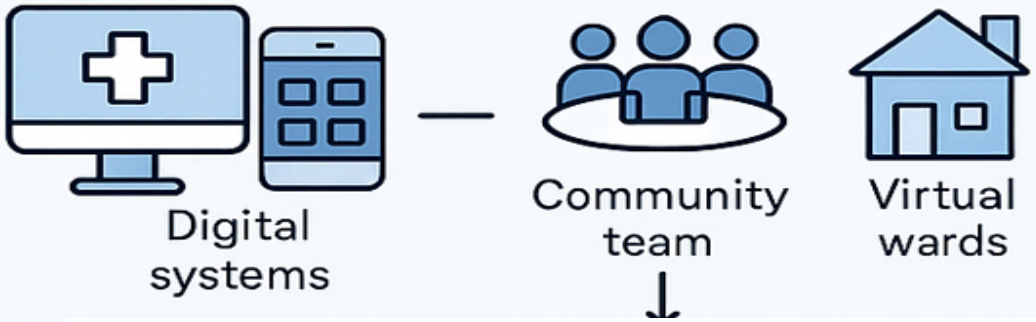
Community Empowerment

Residents as active participants

Data-Driven Decision Making

Using local health intelligence

Neighbourhood Health Service Model



Neighbourhood Size:

Populations of 30,000 – 50,000 people

How It Works

- Primary Care Networks (PCNs) at the centre
- Services coordinated across sectors
- Focus on prevention and self-care
- Links to Place-based partnerships and ICS

Monitoring & Evaluation

- Tracked via Beacon Indicators
- Regular reporting and feedback

Neighbourhood Health ICB/ Place Minimum expectations-25/26

- The Cheshire and Merseyside Neighbourhood Health Programme Board has developed a set of minimum expectations, detailed on the next slides
- An assessment of Place progress is included in the table. Place actions RED/AMBER /GREEN.
- Not all actions / deliverables are for Place, and some require further discussion.

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Population Health Management	Apply consistent Population Health Management using quantitative and qualitative data	System wide Population Health Management framework that can identify priority cohorts Combined Intelligence Population Health Action (CIPHA) and analyse data to support place activity	C & M Population Health Management Project group **Place clinical leads**	✓ **Enhanced Case Finding Tool**	
	Agree and define core priority cohorts for each place – **Chronic Vascular Disease (CVD) as the Cheshire & Merseyside wide cohort**	All places to identify their CVD cohort and develop delivery plan for risk stratification and activity plan Places to identify other cohorts aligned to their local priorities	**Place Single Point of Contact** **Place clinical lead** CVD Project support Support from C and M PHM Project group	✓ **Cohorts agreed re Frail / vulnerable**	

Neighbourhood Health ICB/ Place Minimum expectations-25/26

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Standardise Core Components	Standardise and embed 6 core components	All places to develop or refine where established, their Multi Disciplinary Team approach for one priority cohort (adults and Children & Young People)	**Place Single Point of Contact**	**In progress**	
		Places to review their core offer for Intermediate Care and Community services against the Standardised Core Components standardisation document and NHSE guidance	**Place Single Point of Contact and team** **Place Clinical leads**		Awaiting further info from Provider Collaborative work.
		Identify key areas for Modern General Practice to support Neighbourhood activity-to include-improving Primary Care access/ Multi Disciplinary Teams to include Additional Roles Reimbursement roles	Modern General Practice Single Point of Contact **Place teams**	Same Day Access includes Modern General Practice access and aligned via Steering Group	
		Provider Collaborative to lead on Virtual Ward development Urgent Neighbourhood care services will be progressed through the Urgent & Emergency Care Improvement Programme	Provider Collaborative Urgent & Emergency Care Improvement Programme		

Neighbourhood Health ICB/ Place Minimum expectations-25/26

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Leadership and Governance	Establish effective joint senior leadership at place	Development of individual Neighbourhood Health Place governance structure to include meeting structure/ frequency and identification of key stakeholders	**Place Single Point of Contact**	✓	
		Development of Neighbourhood **draft** delivery plans for each Place with Local Authority and wider community partners, for implementation in 26/27	**Place Director**		**To be developed**
		Place representation at Cheshire & Merseyside Neighbourhood Health Programme Board	**Place Director/ or their nominated representative**	✓	
		Establish regular reporting/ assurance mechanism from place to Cheshire & Merseyside Neighbourhhood Programme Board	**Place Neighbourhood leads**	✓	
		Establish visible clinical leadership in all places	**Place Neighbourhood leads**	✓	

Neighbourhood Health ICB/ Place Minimum expectations-25/26

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Collaboration and wider enablers	Explore the use of neighbourhood buildings across all partners, including local government, following on from recent ICB-led estates strategy work - **Priority to be the two Neighbourhood pioneer sites**	All places to develop asset/ building mapping to identify suitable estate and identify gaps over NHS and other public estate	**Place Neighbourhood leads and ICB/ Local Authority estates teams**		**To be developed**
	Agreeing commissioning models, new funding flows and contractual mechanisms between the NHS and local authorities	Optimise the use of existing pooled or aligned budgets and develop joint finance Place framework for Neighbourhood monies as part of Place plans	Identify ICB/ place Neighbourhood finance leads		**To be developed**
	Explore short term tactical solutions to Data and digital issues whilst developing longer term optimum digital landscape- **Focus on pioneer sites first**	Pioneer sites to highlight current priority issues to Digital team	ICB digital leads Provider IT Leads from commissioned services **Place Neighbourhood leads**	**In progress**	
	Business Intelligence to coordinate the development of a common Neighbourhood dashboard across the 9 places-**Focus on pioneer sites first**	Business Intelligence team to work with 9 places to confirm the detailed data regarding the Neighbourhood areas and development of consistent reports for Neighbourhoods	ICB Business Intelligence leads **Place Neighbourhood leads** Local Authority Business Intelligence staff when necessary		

Neighbourhood Health ICB/ Place Minimum expectations-25/26

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Workforce Planning and Development	Workforce development for Neighbourhood models	Information for local workforce activity to be included within the Place Neighbourhood plans	ICB workforce lead **Place Neighbourhood leads**		**To be developed**
Monitoring impact and improvement	Cheshire and Merseyside wide Neighbourhood performance report	Populate the quarterly dataset for NHSE performance meeting. To co-ordinate with Planning and Performance team			

Neighbourhood Bid Applications – A reflection

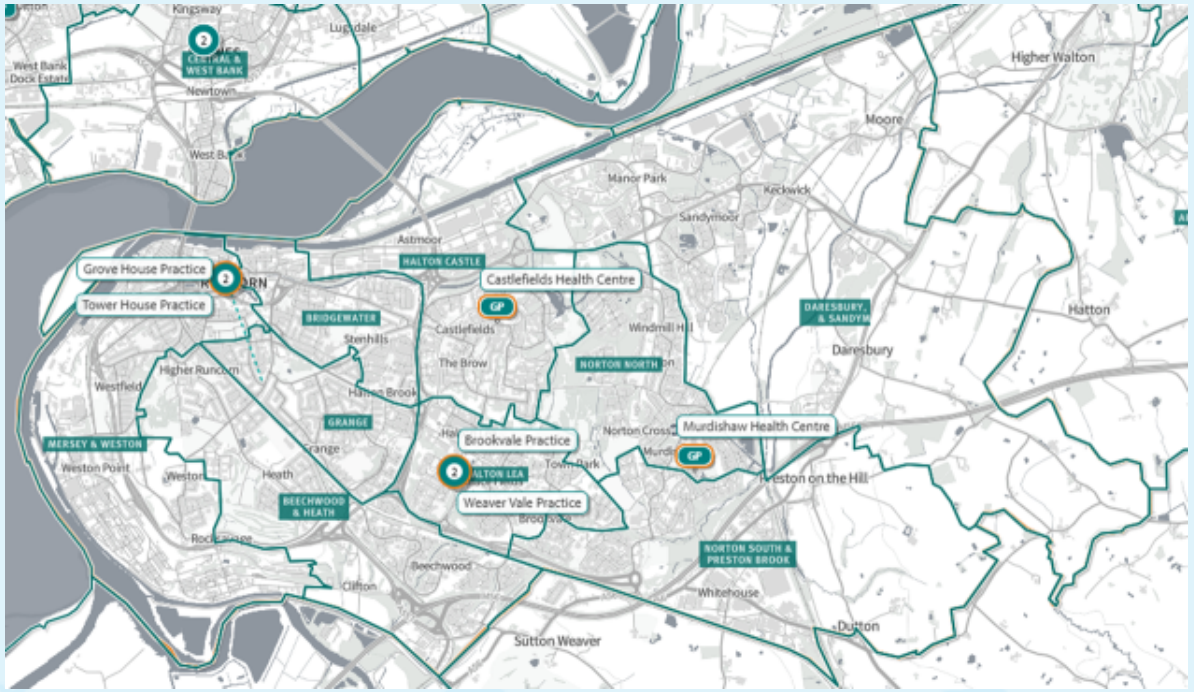
National Neighbourhood Health Implementation Programme

- National programme to test, learn and grow an approach to transform the health and care of neighbourhoods.
- Initial focus creating Neighbourhood Health systems and processes for adults with multiple long-term conditions and rising risk in 42.
- No additional funding, provided national coaching support.
- Initially 42 Places – to be expanded to all.
- EOI sought from Places - Unsuccessful application.
- **Positives: Brought Partners together to kick start programme: agreed priority & approach. Re-confirmed neighbourhood footprints.**

Runcorn Neighbourhood

The wards within Runcorn Neighbourhood are:

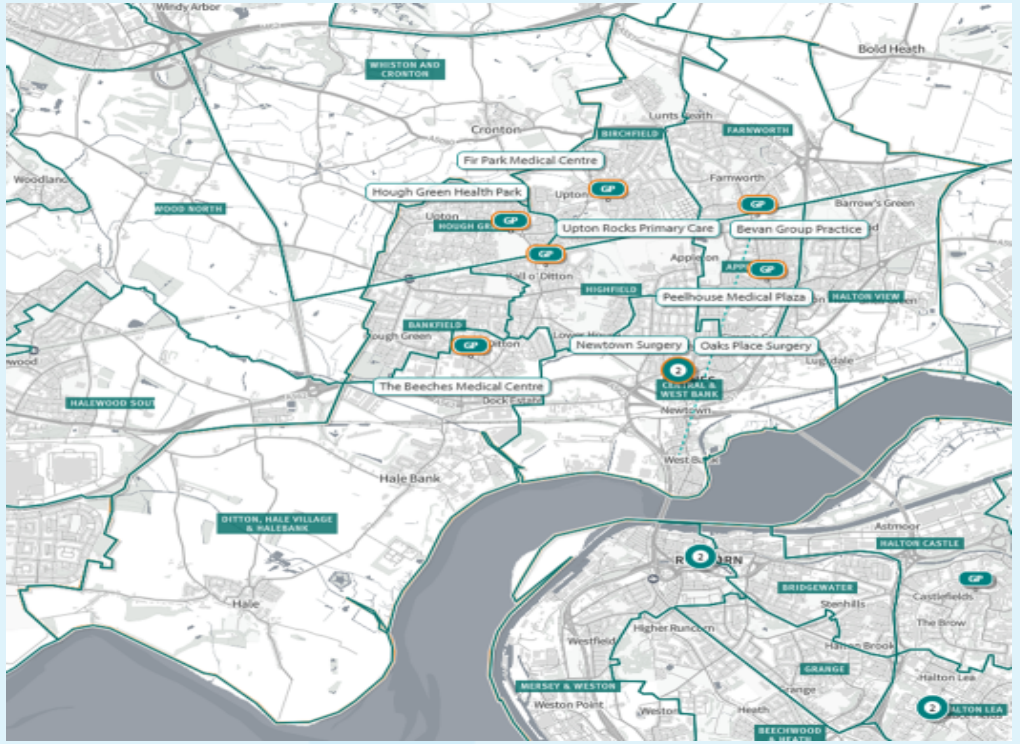
- Beechwood and Heath
- Bridgewater
- Grange
- Daresbury, Moore and Sandymoor
- Halton Castle
- Halton Lea
- Mersey and Weston
- Norton North
- Norton South and Preston Brook



Widnes Neighbourhood

The wards within Widnes Neighbourhood are:

- Appleton
- Bankfield
- Birchfield
- Central and West Bank
- Ditton, Hale Village and Halebank
- Farnworth
- Halton View
- Highfield
- Hough Green

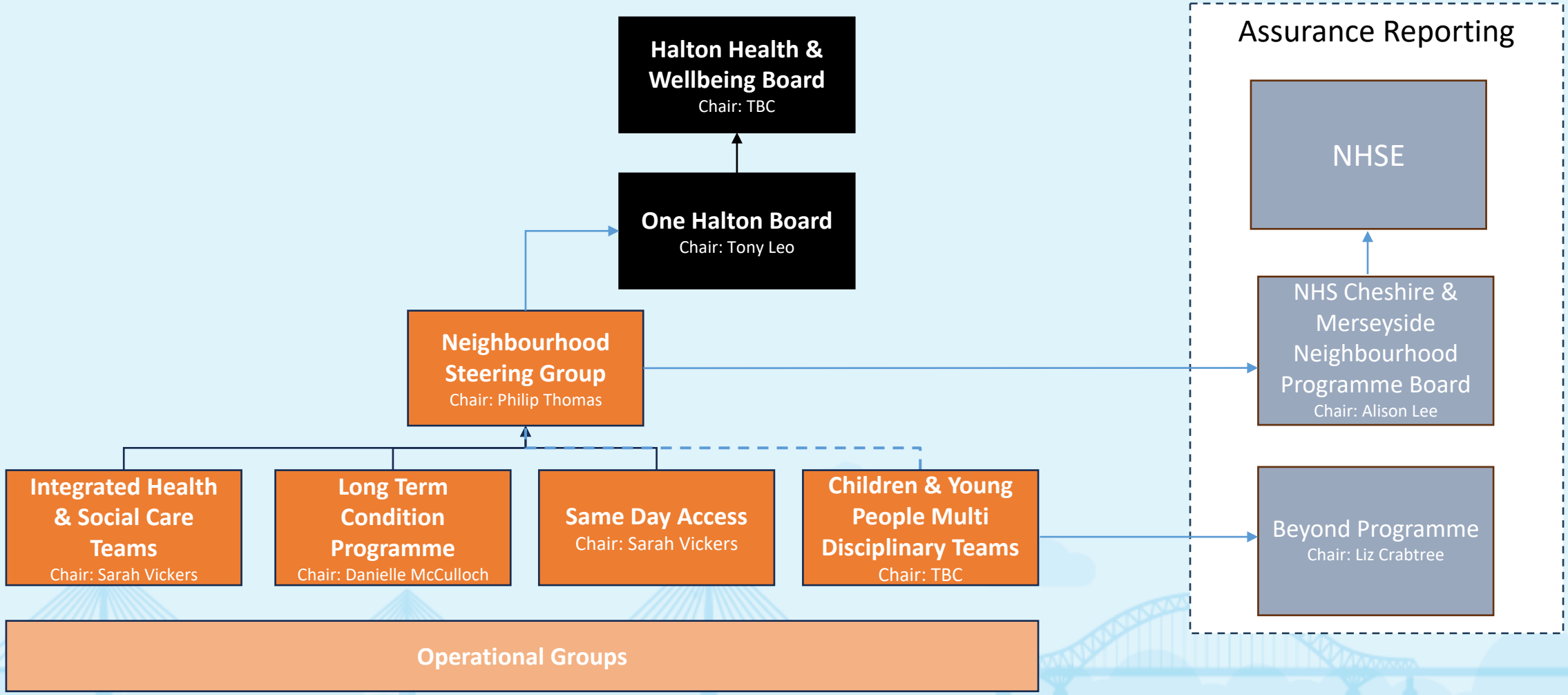


Neighbourhood Bid Applications – A reflection

CYP Bid - £35k seed funding

- Beyond Programme leading deployment across all nine Cheshire & Merseyside places.
- Goal: To accelerate the implementation of consistent, community-based, and joined-up care models for CYP, aligned with wider neighbourhood health and Core20PLUS5 priorities.
- Neighbourhood models to be built around early identification and prevention, local delivery, co-production with CYP and families, and data-driven planning, ensuring that children and young people—particularly those with complex needs—receive coordinated, equitable support closer to home.
- "***The panel felt that while the proposal reflects a clear commitment to improving outcomes for children and young people, it does not yet sufficiently demonstrate how the proposed approach meets the delivery expectations set out in the programme framework" "Whilst we are not in a position to provide the seed funding, we would be very happy to work with you to refine your plans and shape them into a clear and robust mobilisation plan***."

Governance Structure & Delivery Arrangements



Programme Updates

Adults Programme	Children Programme
Integrated Health & Social Care Teams	Children & Young People Multi Disciplinary Teams
Long Term Conditions (LTC)	
Same Day Access	

Adult Programme - Integrated Health & Social Care Teams

Aim: To collaboratively develop and implement Integrated Health & Social Care Teams, adopting the key principles of Integrated Neighbourhood model.

Objectives:

- To develop a neighbourhood model to support adults with moderate and severe frailty via:
  - Integrated delivery of care for patients who are known to health & social care services (cohort 1) &
  - Pro-active case finding of patients with a rising risk and unknown risk (cohort 2)
- Improve experience of care and outcomes for individuals and communities.
- Develop Neighbourhood Multi-disciplinary teams and ways of working which may include Multi Disciplinary Team meetings and technological solutions.

Directly aligns with the Neighbourhood Guidance Core Components:

A Population health management
B Modern General Practice
C Standardising community health service
D Neighbourhood multidisciplinary teams

Adult Programme - Integrated Health & Social Care Teams Continued…

Achievements to date:

- Steering Group, Operational Group & plan established with engagement from all partners.
- Priority patient cohorts agreed:

  Cohort 1 : Known to Health & Social Care services (Moderate or severe frailty)

  Cohort 2: Rising or unknown Risk **(**Enhanced Case Finding Tool Criteria: Age 55-75yrs, No nursing home flag, probability of hospital admission >40%)
- Primary Care Network Contract - Capacity & Access Improvement requirements aligned to programme.
- Initial focus on General Practice, Community Nursing & Adult Social Care teams working together identify areas for development.
- Scoping / baselining of current services.
- Adaption of Sefton Target Operating Model to support identification of re-design requirements.
- Pilot underway to validate patient lists of to support cohort 1 workstream & identify improvement areas.
- Initial improvements identified: to improve communication of packages of care and under care of community nursing, to GP to support delivery of care.
- Commenced discussions to implement PACO Connect (Patient and Care Optimiser) to support Multi Disciplinary Teams ways of working.

Adult Programme - LTC

Aim: To collaboratively develop and implement Long Term Condition Management models of care for adults of Halton, adopting the key principles of Integrated Neighbourhood model.

Objectives:

- Shared responsibility across partners for designing and delivering Long Term Conditions models in Halton.
- Develop and agree a programme mandate.
- Define key measures and regularly track progress and impact.
- Involve a broad range of voices to shape plans and define success.
- Robust Governance
- Review and identify a best practice model, align workforce within existing resource to test proof of concepts.

Directly aligns with the Neighbourhood Guidance Core Components:

D Neighbourhood multidisciplinary teams
B Modern General Practice
C Standardising community health services
F Urgent Neighbourhood Services
A Population health management

Adult Programme - LTC Continued…

Achievements to date:

- Programme foundations established
- Stocktake and opportunity mapping
- Stakeholder workshop held to present programme and capture input.
- Strategic direction agreed: Subgroup endorsed high-level delivery plan with focus on Respiratory with two initial priorities for 25/26:
    - End to end Respiratory review (Joint with Warrington Place): New model of care adopting and integrated approach to Respiratory for prevention, detection and management of all respiratory conditions. Initial focus is on COPD, Asthmas and then wider pathways.
    - Develop proactive Care management approach for consideration and implementation in 26/27 - focusing on COPD
- Respiratory joint project group established, baseline information gathered
- Primary Care Networks progressing plans: e.g. Widnes Heart Failure in delivery. Runcorn Children & Young People Respiratory Hub, Chronic Kidne Disease proactive care

Adult Programme - Same Day Access

Aim: To collaboratively develop and implement a Same Day Access Integrated Neighbourhood Model.

Objectives:

- Support the implementation of the Modern General Access Model and interface with the Urgent Treatment Centres.
- Gather insights from patients and General Practice / UTC workforce to inform pathways, model, resources, and enablers.
- Agree a clinical model across Primary Care Networks including clinical governance, workforce, IT requirements, and which embeds signposting / care navigation.
- Scope and test risk stratification tools in General Practice and Urgent Treatment Centres and implement an agreed methodology.
- Implement cross –organisational booking between General Practice and Urgent Treatment Centres.
- Scope & test workforce models which may include rotation of staff between General Practice and the Urgent Treatment Centres.
- Develop a communication and engagement plan to support patients in understanding how best to access on the day care.
- Review and develop appropriate clinical pathways.
- Develop Phase 2 to include mental health and voluntary sector services.

Directly aligns with the Neighbourhood Guidance Core Components:

A Population health management
B Modern General Practice
C Standardising community health service
D Neighbourhood multidisciplinary teams
F Urgent Neighbourhood Services

Adult Programme - Same Day Access Continued…

Achievements to date:

- Programme Group & plan established with engagement from Urgent Treatment Centres and Primary Care Networks / General Practice.
- Standard Operating Procedure agreed to support cross-organisational booking
- Cross-organisational booking established in Widnes via GP Connect. Paused in Runcorn due to Urgent Treatment Centre winter pressures and digital challenges.
- Regular discussions with Practices & surveys, regarding access improvement which has supported implementation of Modern General Practice Access Model in all Practices & clinical triage in 6/14 Practices, allowing learning to be shared.
- High Intensity User Pathway implemented, includes practice identification of patients and discussion at multi disciplinary team to facilitate referral for support.
- Pharmacy First pathway established with Halton Place the highest referring Place across Cheshire & Merseyside. Discussions underway to support Urgent Treatment Centres to also refer into Pharmacy First.
- Supported Urgent Treatment Centre and Practices to align ways of Care Navigation to support patient flow including communication and updates on the Musculoskeletal pathway, Community Blood Pressure approach and Mental Health Services
- On the day patient flow model developed.
- Risk stratification discussions held, Practice clinical triage models shared and reviewed against Manchester Clinical Triage model to assess alignment.

Children Programme - Children & Young People MDT

Aim / Proposal: To collaboratively develop an Multi Disciplinary Team for Children & Young people, to bring together professionals with insight and intelligence into this cohort, supporting identification and coordinated support.

Cohort:

- with complex needs that would benefit from integrated, collaborative and co-ordinated support.
- whose needs span more than one professional cohort and may sit outside commissioned service acceptance threshold/criteria for specialist support – resulting in them being "bounced" around the system.
- with physical health and/or social challenges for them/their family.
- may have suspected neurodiversity and/or emotional wellbeing concerns.

Organisational Reporting

- Adult Programmes: Steering group established, bi-monthly highlight reports
- Children's Programme - Starting Well?
- Reporting into One Halton. Role of board ?
- Role of Health & Wellbeing Board?
- Neighbourhood Health Programme Board – ICB Led system, multi-agency board: monthly highlight reports & visit

Next Steps?