

Integrated Neighbourhood Working

VCSFE Forum

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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



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

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

Neighbourhood Footprints – Re-confirmed July 2025



Two integrated neighbourhoods – Runcorn and Widnes:

- Recognised by communities and politicians.
- 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.
- 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 Framework 17th March 2026

Neighbourhood health framework - GOV.UK



Cheshire and Merseyside

What is changing?

- Major shift in how health and care are delivered locally
- Creation of a national neighbourhood health service, organising health and care around local communities rather than institutions.
- Organises services around natural **neighbourhoods of ~30,000–50,000 people**
- Moves care **closer to home**, focusing on prevention and early support
- Brings together:
 - NHS (GPs, community and mental health services)
 - Local authorities (social care, public health)
 - **Voluntary, community, faith and social enterprise (VCFSE) services**
- Aims to reduce fragmentation and improve outcomes by working as **integrated neighbourhood teams**
- Central to the NHS 10-Year Health Plan, enabling three major shifts:
 - Hospital → community
 - Treatment → prevention
 - Analogue → digital
- **Joint leadership between the NHS and local government, working with VCSE partners through Health & Wellbeing Boards**
- Aim: **more accessible, coordinated and preventative care closer to home**, reducing fragmentation and hospital pressure

What systems must deliver

Five national minimum goals (with metrics to 2029):

- Improved health outcomes & reduced inequalities
- Better access to general practice
- Improved planned care experience
- Improved urgent & emergency care
- Higher patient & staff satisfaction

Mandatory minimum set of neighbourhood interventions over three years:

- Improve routine care
- Strengthen proactive care for people with complex needs
- Provide better alternatives to hospital-based care

Phased implementation:

- 2026/27: agree neighbourhood footprints, early service changes, pooled funding
- 2027–2029: full neighbourhood health plans and scale-up National support via the **National Neighbourhood Health Implementation Programme (NNHIP)**

What does this mean for Voluntary Services?

Opportunities

- Formal recognition as **core partners**, not “add-ons”
- Strong **alignment with voluntary sector strengths**:
 - Prevention, wellbeing, social prescribing
 - Tackling loneliness, inequalities and wider determinants of health
- Potential access to:
 - Co-location in neighbourhood health centres
 - Co-design of services

Risks & Implications

- Inclusion is **not automatic** – depends on local arrangements
- Funding is **not ring-fenced** for the voluntary sector
- Risk of being involved too late unless engagement happens now
- Greater expectations to show impact, collaborate, and work at neighbourhood scale

Key message:

Early involvement and a strong collective voice are essential for voluntary services to shape neighbourhood health rather than simply deliver within it.

What does this mean practically?

Working differently with the system

- Be involved in co-design, not just delivery of commissioned services
- Engage earlier with ICBs, Primary Care Networks and councils as models are designed
- Influence decisions on neighbourhood priorities, pathways and services

Working differently with each other

- More collaboration across voluntary organisations at neighbourhood level
- Reduced duplication; clearer joined-up offers to communities
- Possible lead-provider, alliance or coordinated models

Greater emphasis on impact

- Clearer articulation of outcomes and contribution to neighbourhood health
- Demonstrating value while staying community-led and relationship-based

Key message:

Voluntary services will be expected to act as equal partners in neighbourhood health, working earlier, more collaboratively and more strategically to shape services—not just deliver them.

Halton Neighbourhood Programmes



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, spanning primary care, community health services, local authorities and VCFSE organisations

VCSFE Specific:

- VCFSE partners providing prevention, early intervention and continuity beyond clinical contact
- A clear role for voluntary and community organisations in supporting independence and reducing avoidable escalation

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.

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 (UTCs)
- Gather insights from patients and General Practice / UTC workforce to inform pathways, model, resources, and enablers.
- Agree a clinical model across including clinical governance, workforce, IT, and which embeds signposting / care navigation.
- Scope and test risk stratification tools in General Practice and Urgent Treatment Centres
- 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 UTCs
- 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.
- Potential Phase 2 to include mental health and voluntary sector services.

Children Programme - Children & Young People MDT



Aim: 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.



Integrated Health & Social Care Teams – Progress in Halton



- 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%)**
- General Practice, Community Nursing & Adult Social Care team leads come together to identify areas for development.
- Scoping / baselining of current services. Reviewed best practice examples from C&M are more widely.
- Pilot to validate patient lists re cohort 1 & identify improvement areas e.g. communication of Packages of care / under community nursing.
- General Practice contractual elements aligned: PCN DES requirements & 2026/27 local scheme to support General Practice engagement.
- Agreement from Partners that system needs to work differently – not about commissioning additional resource.
- However - Application to Better Care Fund for additional co-ordination resource for the neighbourhood team – awaiting outcome.
- Digital enabler identified : PACO Connect (Patient and Care Optimiser) to support Multi Disciplinary Teams ways of working.
- Draft service criteria, pathway and suggested neighbourhood team in development.
- Working with Public Health Team to develop engagement plan with public, patients and staff.

Next Steps & Questions.....



In practice, VCFSE organisations already support neighbourhood health by:

- Supporting prevention, proactive care and coordination
- Working with people with early or moderate frailty, addressing isolation, confidence and low-level needs before escalation
- Providing relational, community-based support that complements Primary Care Networks and community services
- Acting as connectors for people with multiple needs, supporting navigation, engagement and joined-up care

This approach supports independence, improves experience, and reduces avoidable escalation into urgent and acute services.

Next steps.....

- Questions?
- Concerns
- How best to get involved?

