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Neighbourhood Health in Cheshire and Merseyside

Cheshire East Health and Wellbeing Board

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Cheshire and Merseyside ICB

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Background

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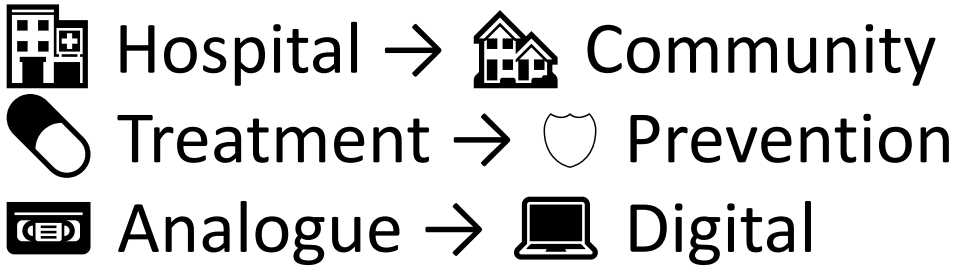
- National priority to move care closer to home to improve access, experience and outcomes.
- Increasing complexity of need requires an integrated response from the health and social care system.
- Delivery of the three key shifts:



National Ambition

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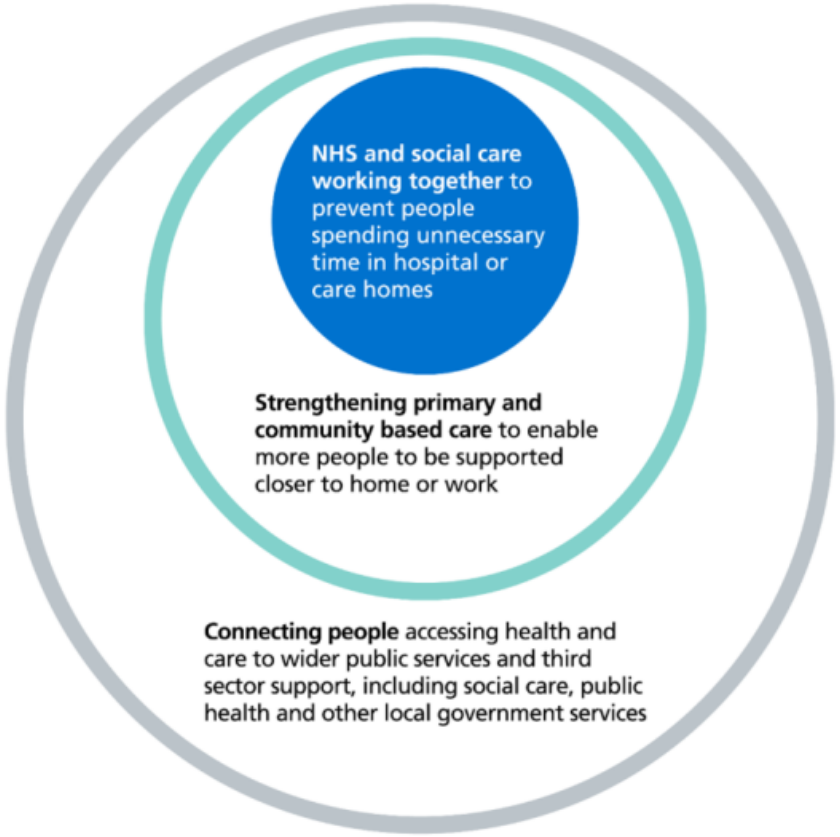
Create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency to manage their own care.



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Six Core Components of an effective neighbourhood service

1. Population Health Management
2. Modern General Practice
3. Standardising Community Health Services
4. Neighbourhood Multi-Disciplinary Teams
5. Integrated intermediate care with a 'Home First' approach
6. Urgent neighbourhood services

Priority for 2025/26 for these components is:

- Standardising the six core components
- Bringing together different components into an integrated offer
- Scaling up
- Rigorously evaluating the impact of these actions

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The 10-year plan and neighbourhood health

- Neighbourhood health centres
- Comprehensive community hubs
- One stop shop hubs
- Shift in capital investment
- Digital enablement
- Single digital patient record
- Prevention
- Public health measures
- Expand mental health services
- Care at home where possible
- NHS Workforce plan

Vision: Neighbourhood Health in Cheshire and Merseyside

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Make healthcare better by bringing it closer to where people live

Health and care providers working together to help people before they get really sick and make it easier for everyone to get care

Integrated neighbourhood health teams will work with local people and other organisations so everyone can be healthier and have the same chance to stay well

What we mean by neighbourhood working

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Neighbourhoods -A specific geographical area or community that resonates with residents, that local services, organisations and communities can coalesce around to address needs and improve outcomes. This is broader than integrated neighbourhood teams and includes ongoing partnerships with community groups, residents, and local stakeholders to address a wide range of community issues, including community development and systemic improvements.

Integrated Neighbourhood Teams - Developing Integrated Neighbourhood Teams will be part of how we deliver care at a neighbourhood level more broadly to both children and young people and adults. INTs go beyond multi-disciplinary working by fully integrating representatives from health (primary, community, acute and specialist) social care, and the voluntary sector into a single, place-based team to deliver seamless, coordinated care within a defined area. Working within geographical footprints of 30-50k population, services will include physical and mental health.

Multi-disciplinary working - Representatives from different disciplines coming together to share expertise, coordinate care, and contribute their specific skills to address the needs of an individual/family or group. Collaboration tends to occur at key points, such as MDT meetings, reviews, or case discussions and individuals typically maintain separate roles, responsibilities and different back-office functions.

The Model Neighbourhood – Driver Diagram

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Principles

Neighbourhood delivered place-led, Cheshire Mersey enabled

Builds on strengths of people and communities

Acts on the social determinants of health and gets to the root cause of problems

Names, not numbers (residents/patients and colleagues)

Scope

All-age services:

Start with 25/26:

All NHS primary and community services – including community mental health

Aim for:

All public health services

Adult Social Care

Community Services

VCFSE Services

Social Prescribing

Full delivery:

Public Services – Housing; DWP Employment Support; Police, Fire, Probation Services; Schools

Key Features

Start with:

30-50k population

Integrated leadership and accountability in Place and neighbourhood

Aim for:

Services aligned to neighbourhood geographies

Co-located integrated neighbourhood teams

Pooled public service budgets and shared outcomes frameworks

Budgets reprofiled to prevention and proactive care

Enablers

Local Leadership through Place-based partnership boards and identified lead provider organisation

Digital – NHS app as well as local and national innovation

Population Health Management system (CIPHA)

One workforce approach

One Public Sector Estate and better use of NHS Estates

Shared leadership development

Impact

Examples:

Start with 25/26

Reduced utilisation of acute, residential and crisis-based services:

- A&E Attendances

-Non-Elective Hospital Admissions

-Admissions to Residential Care

-Out of Area Placements

From 2026 onwards- Aim for reduction in:

-Pupil Referral Units

-Police Call Outs

-Households in Temporary Accommodation

Improvements in key public service measures:

-School readiness;

-Self-reported well-being

Neighbourhoods in Cheshire and Merseyside

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Proposed neighbourhood health areas

Place	Number of Neighbourhood Areas	PCNs	Number of LA Localities
Cheshire East	8	9	8
Cheshire West and Chester	9	9	4
Halton	2	2	4
Knowsley	4	3	4
Liverpool	13	9	13
Sefton	8	2	3
St Helens	4	4	7
Warrington	5	5	4
Wirral	6	6	9
Total	59	49	56

Integrated Neighbourhood Teams – key features

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Use data/intelligence such as CIPHA to help with early identification and prevention

Each team will serve a local area with about 30,000 to 50,000 residents

They will include essential services like GPs, Mental Health, Community Nursing and Therapies, Children's Services (including pre- and post-natal care), Health Visiting, Social Prescribing, Community Pharmacy

They will also have a dedicated lead organisation at Place level e.g. GP practices, community providers, or local council

Staff will follow a "no wrong front door" policy—people can access support digitally, by phone, or in person, and will be directed to the right service

Wherever possible, services will be based in shared locations (or hubs) with a single reception

There will be transparency of resources within each INT, coordinated by the Place-based Partnership . Places will work with the provider collaborative as they develop the core community service offer

INTs will connect flexibly to services that work at a borough or regional level

They will also be able to access specialist services through hospitals and other specialist providers as needed

Clear use of digital tools to engage patients, connect community assets and drive efficiency for staff

Need for broader integration of all providers: pharmacy, dentistry and optometry and inclusion of secondary care (hospital providers)

Recognition of differences in how people access and interact with different care providers

Impact measures

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NHSE has set out some key metrics to measure the impact of neighbourhood health. As a Cheshire and Merseyside system, we will need to consider how we evolve and translate these national metric into outcome focused neighbourhood dashboards

- Avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life
- Streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up
- Maximising the use of community services so that better care is provided close to or in people's own homes reducing emergency department attendances and hospital admissions, and where a hospital stay is needed, reducing the amount of time spent away from home and the likelihood of being readmitted to hospital
- Reducing avoidable long-term admissions to residential or nursing care homes
- Reducing health inequalities, supporting equity of access and consistency of service provision
- Improving people's experience of care, including through increased agency to manage and improve their own health and wellbeing
- Improving staff experience
- Connecting communities and making optimal use of wider public services including those provided by the VCFSE sector
- Desire for **community-relevant outcome metrics**, not just clinical indicators.
- Need for **storytelling and qualitative insights** alongside quantitative data.

Logic Model - DRAFT

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Input	Activities	Outputs	Short Term Outcomes	Medium Term Outcomes	Long term Outcomes
Data to identify need Population Health Management Tools and identified patient cohorts Coproduction with communities Integrated workforce Integrated digital record Understanding of the evidence base for interventions Focus on social determinants of health Shared public sector estate	Population Health Management approach Identification of priority cohorts Conversations with communities, community leaders and wider system partners Multidisciplinary integrated teams Person-centred care plans Evidence based preventative interventions Social prescribing interventions Evidence based medical interventions	**Primordial prevention** Number of people receiving housing support Number of homes receiving retrofitting for energy efficiency Amount of energy vouchers secured and distributed Number of people accessing employment support Number of families accessing benefits related entitlements **Primary prevention** Number of people accessing smoking cessation services Number of people accessing weight management services Number of people participating in physical activity programmes Number of people receiving routine vaccinations Increase in the number of people being proactively identified for targeted support **Secondary prevention** Number of people being proactively identified for targeted support Number of eligible people participating in the national screening programmes Number of high intensity user care plans Number of drug and alcohol service referrals Number of mental health service referrals **Tertiary Prevention** Number of frailty care plans Number of falls assessments and referrals for patients with a medium and high frailty score Number of medication reviews Number of people accessing disease rehab programmes	**Primordial prevention** Reduced risk of eviction or homelessness Reduced energy bills Sustained employment for 6-12 months Increased benefits related income **Primary Prevention** Reduced smoking prevalence Reduced obesity prevalence Increased physical activity levels Increased vaccination rates Reduced risk of communicable disease **Secondary prevention** Increased screening programme rates Reduce ambulance usage Improving access to GPs appointments Reduced A&E attendances Reduced disease specific emergency hospital admissions Increased uptake of drug and alcohol services Increased uptake of mental health services **Tertiary prevention** Reduced frailty scores Improved medication adherence Reduced disease specific emergency hospital admissions	**Primordial prevention** Improved school attendance Secure housing for 6-12 months Increased household income Increased rates of secure employment **Primary prevention** Reduced prevalence of CVD Reduced prevalence of respiratory disease Reduced prevalence of preventable cancers Reduced prevalence of diabetes Reduced prevalence of vaccine preventable diseases Increase in the percentage of cancers diagnosed at stage 1 and 2 **Secondary prevention** Increase in the percentage of patients who describe their experience of their GP as good Reduced waiting times for diagnostic procedures Reduced readmission rates Reduction in drug and alcohol use Sustained abstinence from drugs and alcohol **Tertiary prevention** Reduced disease complications Increased Quality of Life Scores Increased wellbeing scores Reduced falls related emergency admissions Reduced polypharmacy Reduced social care admissions	**Primordial prevention** Improved educational attainment Reduction in homelessness Reduced fuel poverty rates Improved energy efficiency of C&M Housing Stock Reduction in unemployment rate Reduced poverty rates Increased life expectancy Reduced gap in life expectancy **Primary Prevention** Increased healthy life expectancy Reduced gap in healthy life expectancy Herd Immunity for vaccine preventable diseases Increased 5-year cancer survival rates **Secondary prevention** Reduction in ED waiting times Reduction in ambulance response times Reduction in number of bed days Reduction in mental health bed days **Tertiary prevention** Reduction in medication costs Reduced disease specific mortality

Road map for 2025-26: Place Led; Cheshire & Mersey enabled

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Confirm Foundations in Place

- Confirmed neighbourhood footprints at c30 to 50k population covering whole locality
- All local partners align health and care service delivery to neighbourhoods
- INTs in all neighbourhoods
- Clear arrangements in place for working with partners in neighbourhoods – including all local authority services, VCFSE and Housing providers

By End of June 2025

Confirm Approach for NHSE Neighbourhood Components

- 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

NHSE Neighbourhoods Guidance 2025-26

Plus, confirmation of neighbourhood implementation of national model for MDTs for Children and Young People

By End of June 2025

Implement Population Health Management Approach

- PHM established and embedded: understanding of neighbourhoods through data and community connections driving preventative approach
- Processes in place for risk stratification. In 2025/26, the focus should be on adults, children and young people with complex health and social care needs who require support from multiple services and organisations (NHSE 2025/26 guidance)
- Dashboards established covering all aspects of neighbourhood delivery (to be developed with leaders at Place level and building on existing dashboards

By end of 2025/26

Confirm Road Map to reach Optimal Model

- Optimal model to be co-designed with Cheshire Mersey system, Places and other partners – first workshop 22/5/25
- Places develop roadmap to deliver optimal model (by end Q2 2025/26)

Road Map in Place by end of Q2 2025/26

Next steps

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- Establishing the governance for neighbourhood health
- Building a shared understanding of what neighbourhood health is
- Outcome of the national implementation bids – 42 Places will be selected
- Delivering the initial focus - Supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations (high intensity users and complex households)
- Building on the current position recognising some areas are more developed than others