Cheshire West and Chester Integrated Neighbourhood Plan 2026

NHS healthwatch Cheshire West Voluntary Action Championing the community sector Cheshire West and Chester

Foreword

The Health and Wellbeing Board has agreed a clear and shared ambition for Cheshire West through its Health and Wellbeing Strategy 2026–2030:

- to reduce inequalities,
- increase years of healthy life, and;
- promote positive mental and physical wellbeing for everyone who lives and works in the borough.

Achieving this ambition requires more than aligned strategies; it requires a sustained shift in how partners work together to intervene earlier, address the causes of poor health, and deliver support that is rooted in Place (our Cheshire West Health and Care Partnership) and responsive to local need.

The Cheshire West Integrated Neighbourhoods Plan sets out how this ambition will be delivered in practice.

Integrated Neighbourhoods are central to delivering health and care priorities over the coming decade. By bringing together the NHS, the local authority and the voluntary, community, faith and social enterprise (VCFSE) sector around shared neighbourhood populations, they enable a move away from reactive, service-led responses towards prevention-focused, coordinated and person-centred support. This approach strengthens collective accountability for outcomes while enabling partners to work at the scale to improve inequalities and make the most impact.

The priorities of the Health and Wellbeing Strategy are embedded throughout this Plan and are operationalised through a clear life-course framework:

- Starting Well,
- Living Well and;
- Ageing Well.

This framework sets out how shared outcomes will be delivered locally, how partners will work differently, and how progress will be measured over time.

This Plan reflects the Health and Wellbeing Board's commitment to the improvement in outcomes for our population through strong partnership working. It establishes clear governance and accountability, a focus on neighbourhood-level intelligence and outcomes, and an expectation that communities and lived experience (via Community Partnerships and other mechanisms) will play an increasingly central role in shaping solutions. Integrated Neighbourhoods are not a short-term programme, but a long-term commitment to working differently across Cheshire West — grounded in Place, partnership and prevention — to ensure that people are supported to Start Well, Live Well and Age Well, and that improvements in health and wellbeing are shared by all communities between now and 2030 and beyond.

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Executive Summary

People living within Cheshire West can face health and wellbeing inequalities across their life course. While many residents experience good quality of life, outcomes vary significantly between communities, with disadvantage evident from early childhood through to later life. Rising child poverty, preventable long-term conditions among working-age adults, and a rapidly ageing population are increasing demand on health, care and community services. These challenges can only be addressed through proactive models and partnership working.

The Cheshire West Integrated Neighbourhoods Plan sets out a long-term, place-based approach to improving outcomes, reducing inequalities and strengthening prevention. It describes how partners across health, local government, primary care and the voluntary, community, faith and social enterprise (VCFSE) sector will work differently by organising delivery around neighbourhoods and communities, supported by shared priorities, governance and system enablers.

Vision and Strategic Alignment

The Plan is underpinned by a shared vision, aligned to the Health and Wellbeing Strategy 2026–2030:

"To reduce inequalities, increase years of healthy life, and promote mental and physical wellbeing for everyone in Cheshire West."

Integrated Neighbourhoods are the primary mechanism through which this vision will be delivered locally. They convert the Health and Wellbeing Strategy priorities into coordinated action at neighbourhood level, ensuring that this plan leads to tangible change for residents and communities.

A Whole-Life, Neighbourhood-Based Approach

Cheshire West has adopted a whole-life approach to Integrated Neighbourhoods, structured around three interconnected priorities:

- Starting Well – improving outcomes for children and young people through earlier identification of needs, coordinated multi-agency support for families, and prevention of escalation
- Living Well – reducing inequalities and preventing ill health among working-age adults by targeting prevention activity, supporting behaviour change and optimising long-term condition management
- Ageing Well – enabling older residents to remain independent, connected and healthy for longer, while reducing avoidable deterioration, crisis and reliance on hospital-based care.

This life-course model goes beyond national expectations focused primarily on frailty and admission avoidance. It reflects local insight into where early intervention and prevention can have the greatest long-term impact on outcomes and demand.

Localised Delivery, Informed by Insight

While priorities are set at Place level, the Plan recognises that delivery must be locally shaped. Integrated Neighbourhoods will use neighbourhood-level data and intelligence, partnerships, and lived experience. This approach enables neighbourhoods to respond to local need, while remaining aligned to Cheshire West's shared priorities, outcomes and governance. It balances consistency of purpose with flexibility of delivery, avoiding a "one-size-fits-all" model.

Community Partnerships, Primary Care and Hubs

Integrated Neighbourhoods will be delivered through close collaboration between Community Partnerships, Primary Care Networks (PCNs) and statutory health and care partners.

Community, health and care hubs are an enabler of the model. They provide accessible, neighbourhood-based spaces that support integrated working, prevention and improved access to services. Given the wide range of hub models already in place across the borough, Year One will include focused work to define a clear hub framework for Cheshire West. This will create clarity on scope and function, while retaining flexibility to respond to local context.

Governance and System Enablers

To support delivery, governance arrangements will be simplified and realigned. Integrated Neighbourhoods will be overseen by:

- the Health and Wellbeing Board as the primary system leadership and assurance body
- a dedicated Integrated Neighbourhoods Programme Board, replacing the Integrated Transformation Steering Group
- thematic Starting Well, Living Well and Ageing Well Boards, using existing forums wherever possible.

What Will Change in Year One

The first year of delivery focuses on establishing strong foundations and making integration visible. By the end of Year One, Cheshire West expects to see:

- earlier and more coordinated support for children, families and adults at risk of poorer outcomes, piloted in the communities where health inequalities are the greatest
- integrated neighbourhood ways of working established focusing on earlier intervention and prevention, delivered by wider staffing / VCSFE groups
- clearer routes to local support for residents through neighbourhoods and hubs
- improved use of shared data and insight to target inequalities
- a more comprehensive co-ordinated step-up model that provides support in the community for those with complex frailty related need
- stronger and more co-ordinated pathways for those with dementia and at the end of life.

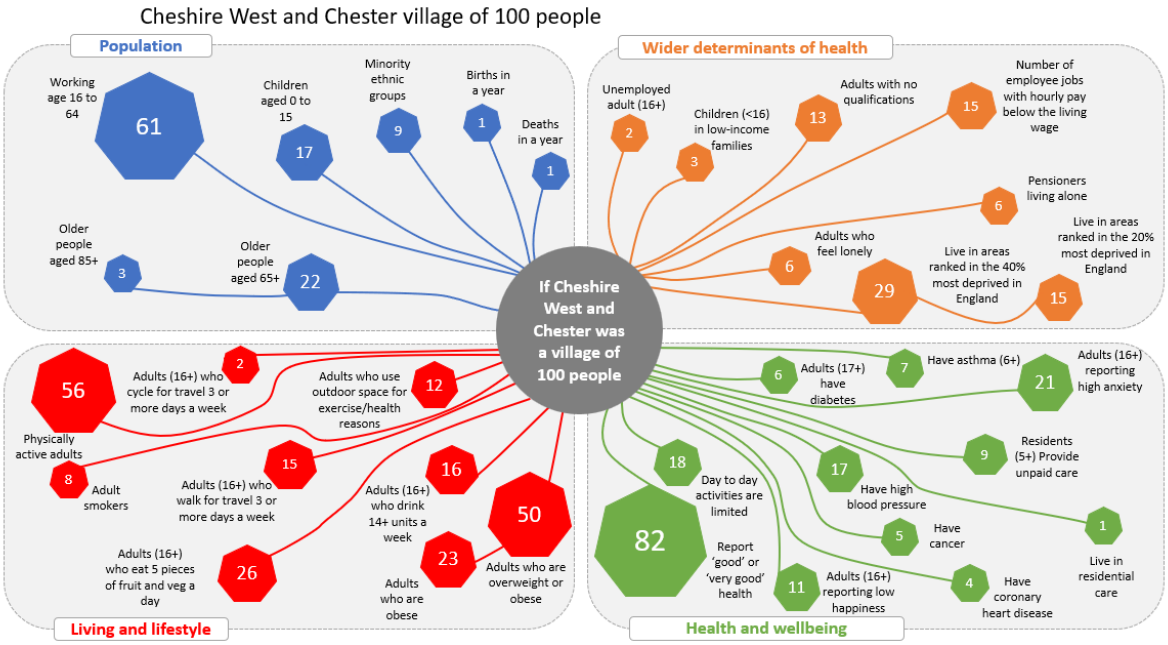
A Long-Term Commitment

Integrated Neighbourhoods are not a short-term programme. They represent a long-term commitment to working differently across Cheshire West — shifting the focus from treatment to prevention, strengthening community capacity, and embedding neighbourhood-based working as the default approach to health, care and wellbeing.

1: Introduction: Understanding the Cheshire West Context

Cheshire West is a diverse and distinctive borough, home to around 371,700 residents who live across a mix of urban centres, industrial towns, and rural communities. This unique geography shapes the experiences and needs of its population at every stage of life. As we move toward establishing Integrated Neighbourhoods as a core feature of how we deliver health, care and wellbeing, it is essential to understand the demographic and socio-economic landscape that will define our priorities and opportunities.

Figure 1: Village of a 100 People Infographic



The infographic above illustrates what the composition of Cheshire West and Chester would be like if it was a village of 100 people based on the information gathered from various data sets. Produced January 2026. (Unless stated, adults refers to 18+)

Children and Young People:

Cheshire West is experiencing a steady decline in birth rates, mirroring wider national trends. The proportion of the population made up of children and young adults is shrinking. However, for many of the children who are growing up in the borough, outcomes are becoming more challenging.

The number of children living in low-income families increased sharply over the ten years from 2014—from 12.6% to 17.8%—and the impact is visible across multiple aspects of their early life. Children experiencing deprivation are significantly more likely to face poorer oral health, fewer with a healthy weight, lower levels of school readiness, reduced educational attainment, and increased likelihood of being on safeguarding plans. These early inequalities create a foundation on which later health and wellbeing challenges can compound over time.

Working Age Adults:

Patterns seen in childhood continue into adulthood and are strongly linked to the borough's pockets of significant deprivation. Although Cheshire West is often perceived as broadly affluent, the reality is that deprivation is unevenly distributed and deeply concentrated in certain areas. These include the outskirts of Chester—particularly Blacon ward—the market town of Winsford, and the industrial centre of Ellesmere Port.

More than one-fifth of the local population lives within the top 10% most deprived areas in England, contributing to stark health inequalities. Life expectancy differs dramatically across the borough, with an almost 11-year gap for men and an 8-year gap for women between the most and least deprived communities.

Premature mortality is driven largely by cancer and cardiovascular disease, while mental health conditions—particularly depression—represent some of the most widespread and impactful long-term conditions among the working-age population. At the same time, the working-age population is expected to rise by 6% in the next decade, creating both new pressures and new opportunities for employment, wellbeing, and inclusive economic growth.

Older Adults:

Cheshire West's communities, particularly rural areas, are experiencing an increasing concentration of older residents, and this trend is set to continue. Across the whole borough, 22% of the local population is aged over 65, compared with 19% nationally. The number of people aged 75 and over is projected to rise substantially in the coming years.

This demographic shift brings specific challenges: the number of residents living with dementia is expected to increase by 13% in the next five years, with national evidence showing that people in deprived areas are twice as likely to develop the condition. Additionally, 17% more people are predicted to require 24/7 care.

Rural living, limited broadband access, and transport barriers can further exacerbate social isolation, loneliness, and difficulties in reaching services—issues that particularly affect older residents.

A Borough of Challenges and Opportunities

These insights highlight the complex and varied needs of Cheshire West's communities. They also underline why integrated, place-based approaches to health and care are not just desirable, but essential. While the challenges are significant—from inequalities in childhood to long-term conditions in working-age adults and rising demand for support among older people—they also present opportunities.

By working differently, more collaboratively, and more locally through Integrated Neighbourhoods, we can shape solutions that are responsive, preventative, targeted and rooted in the lived experiences of our communities. This is a moment to innovate—to build on local strengths, to listen to local partners and collaborate, tackle persistent

inequalities, and create a more connected and compassionate system of care for every resident in Cheshire West.

2: The National and Local Case for Integrated Neighbourhoods

Over recent years, the national direction for the NHS and local government has been shifting steadily toward more integrated, preventative and community-based models of care. Across England, Integrated Neighbourhood Teams (INTs) have been established as a central mechanism for transforming the way services work together to support people where they live. This national context provides the backdrop against which Cheshire West has developed its own Integrated Neighbourhoods Plan—a model that builds on strong existing partnerships and reflects the unique needs of local communities.

A National Movement Toward Integrated, Community-Centred Care

Neighbourhood-level integration is central to national policy, including the national NHS 10 Year Plan (2025), as a way to improve population health, reduce pressure on services, and help people live independently for longer.

Integrated Neighbourhood Teams shift care into communities by bringing together a wide range of professionals—from health, social care, housing, and the voluntary sector—to work around individuals and families. By coordinating priorities and resources, they reduce duplication, strengthen early intervention, and provide more holistic, personalised support. This strengths-based approach connects residents to local assets and has shaped how Cheshire West has designed its local model.

Building on Strong Local Foundations in Cheshire West

Cheshire West is well placed to adopt Integrated Neighbourhoods thanks to its long-standing culture of collaboration and innovation. Since the establishment of the Cheshire and Merseyside Integrated Care Board in 2022, the borough has developed robust joint governance arrangements and a clear record of innovative integrated working. This commitment is already yielding benefits, with a series of programmes demonstrating tangible improvements for local residents.

For example, the rollout of Community Response Hubs—front-line teams bringing together health, adult social care, reablement and VCSFE partners—has transformed the speed and quality of hospital discharge, a reduction in the use of statutory services and increased people's independence. Patients are spending fewer days in hospital and receiving more appropriate care when they return home. Similarly, a joint strengths-based approach for people with complex mental health needs and learning disabilities has increased access to independent living and more personalised support. Alongside this, the development of Community Partnerships, anchored in Primary Care Network neighbourhood geographies and led innovatively by the VCSFE sector, has strengthened local accountability and ensured that neighbourhood plans reflect the priorities of their communities.

These achievements have been supported by improved system alignment. Cheshire West benefits from co-terminus boundaries across its Local Authority, ICB Place,

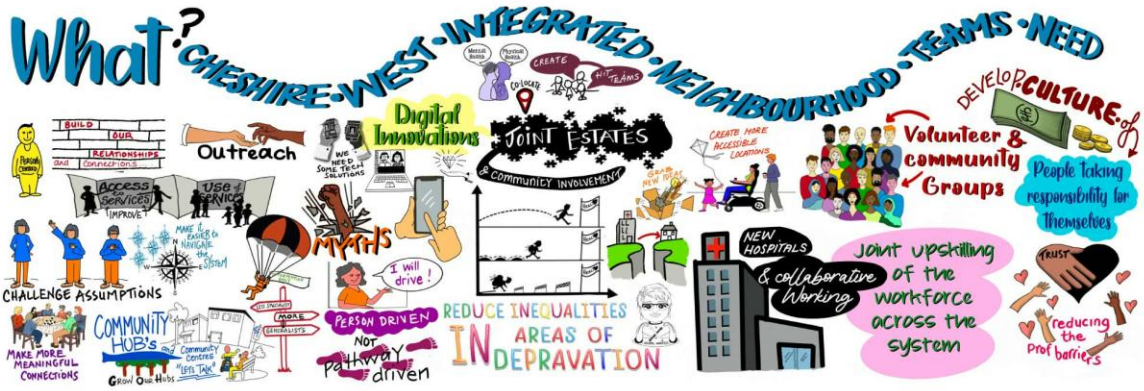
Primary Care Networks, and neighbourhood footprints. The combination of one ICB, one Local Authority, 43 GP Practices, two acute hospitals, a single community and mental health trust, and hundreds of VCSFE organisations provides a strong platform for integrated neighbourhood working to thrive. It is this collective readiness that has enabled partners across the system to commit to accelerating the development of our Integrated Neighbourhood Approach.

Developing a Shared Local Vision for Integrated Neighbourhoods

The national ambitions for neighbourhood working closely align with Cheshire West's existing priorities. Over the past six months, health and care partners have taken part in workshops and strategic discussions to shape a shared approach to Integrated Neighbourhoods, supported by a co-produced Health and Wellbeing Strategy and joint sessions to refine principles and readiness.

This work led to an agreed set of deliverables in early 2026 to move the model into practice. Throughout the process, partners have recognised that the current system must change: rising demand, inequalities and limited capacity highlight the need for a more proactive, person-centred, community-focused approach. By working differently and building on existing local strengths, Cheshire West can support people earlier, prevent ill health more effectively, and reduce reliance on reactive, treatment-based care.

Figure 2: Visuals from our joint Health and Wellbeing Workshop on Integrated Neighbourhoods:



Objectives and Vision for an Integrated Neighbourhood Future

The case for Integrated Neighbourhoods is therefore both strategic and practical. To translate this ambition into reality, partners have agreed three core objectives that will guide the programme:

1. To work together as Place partners to provide a more coordinated, integrated prevention and support offer.
2. To use shared intelligence to target resources, including pooled or aligned funding, where they can deliver the greatest impact on outcomes and inequalities.
3. To empower and support individuals holistically so they can make informed choices—together with families and carers—about their own wellbeing, while also enabling them to support others within their communities.

All of this is driven by a shared and uncompromising vision also embedded within the Health and Wellbeing Strategy:

"Reduce inequalities, increase years of healthy life and promote mental and physical health and wellbeing for everyone in Cheshire West."

This vision sits alongside the population priorities set out in the borough's Health and Wellbeing Strategy—from giving every child the best start in life, to tackling discrimination, building healthy communities, improving living standards, and aligning environmental sustainability with health equity. These priorities ensure that the Integrated Neighbourhood model remains firmly connected to what matters most for local residents. These directly reflect the Marmot Principles, providing an evidenced based framework to tacking health inequalities via the social determinants of health, as reflected within the 2026 Cheshire and Merseyside All Together Fairer Neighbourhoods Framework.

A Local Approach Rooted in Insight, Partnership and Continuous Learning

Delivering the Cheshire West Integrated Neighbourhood approach will require a new way of thinking and working. The first phase will take a "test and learn" approach,

focusing on specific neighbourhoods that are ready to move quickly and focussed on health inequalities.

These neighbourhoods will collaborate with the partner organisations most relevant to their population health needs and community connections / flows. For example, although our planning footprint is Cheshire West and Chester Local Authority area, neighbourhoods close to the border will need to collaborate with organisations based in neighbouring Local Authority areas e.g. within Cheshire East / Wirral etc. such as Mid Cheshire Hospital and Wirral University Teaching Hospital. By allowing natural neighbourhoods to flourish and sharing best practice, Cheshire West residents can also benefit from some of the great opportunities we have through programmes such as “Healthier Futures”, a new state of the art health and care facility at the Leighton Hospital site, that will be innovative, connected to local communities and digitally enabled. By focussing on local needs and priorities, each neighbourhood will have the freedom to progress delivery of this Plan in the most appropriate and collaborative way. Insights from early adopters will be shared across Cheshire West neighbourhoods, enabling others to progress at their own pace, whilst ensuring consistency of outcomes.

This approach is underpinned by a culture of continual improvement. Neighbourhood teams will be empowered to design and deliver initiatives that reflect the needs of their communities, supported by system-wide infrastructure, data, and leadership. Existing Programmes that are interdependent with the development of Integrated Neighbourhoods, such as Intermediate Care or Best Start Family Hubs, will be aligned through strengthened governance.

By bringing together the national ambition for neighbourhood integration with the local strengths, relationships and priorities of Cheshire West, this chapter sets the stage for a model that is both ambitious and achievable—one that has the potential to transform health and wellbeing for communities across the borough.

3: Cheshire West Integrated Neighbourhood Priorities and Deliverables

The development of Integrated Neighbourhoods in Cheshire West has been shaped by engagement with residents, Elected Members, staff and partners, alongside detailed insight into the needs of our population now and in the future.

Whilst cognisant of the national strategic direction set out within the NHS 10 Year Plan, local engagement has made it clear that real impact requires a broader life-course approach that supports children and young people, working-age adults, and older residents. This means expanding beyond a national emphasis on frailty to include coordinated, early support for families, and a stronger neighbourhood-level focus on health inequalities, prevention and health and wellbeing improvement for adults.

As a result, Cheshire West has taken an innovative decision: Integrated Neighbourhoods will address the whole life journey, organised around three interconnected themes—Starting Well, Living Well and Ageing Well. This approach captures the national NHS ambition but also reflects local partner insight, local priorities and the practical realities of residents' lived experience.

Figure 3: The Lifecourse Approach

Each theme contains unique challenges and opportunities, and each is supported by a set of Year One deliverables designed to turn ambition into action.

Starting Well

This case study provides an example of the group of people we are trying to support through the Starting Well programme:

Case Study 1: Starting Well

Without Integrated Neighbourhoods

Amira, aged 4, lives with her mother Leanne and younger brother in Ellesmere Port. Leanne was juggling life as a single parent with insecure work resulting in financial pressure and her own anxiety. Amira attended nursery intermittently and had missed several health visitor checks. She had poor dental health and wasn't registered with a dentist, diagnosed with asthma and experiencing delayed speech. Leanne often felt that she was telling her story repeatedly to different professionals, without anyone understanding the full picture of what the family needs.

Over time, the family had contact with multiple services including health visiting, nursery staff, GP appointments and occasional A&E attendances for asthma. Each service responds to its immediate concern, but no one professional saw the whole picture. Opportunities to understand how issues such as low income, housing stress, mental wellbeing and access to childcare are affecting Amira's development are missed. Support remained fragmented, and Leanne found it difficult to navigate services or know where to turn for help.

With Best Start Family Hubs and Integrated Neighbourhood Working

Through the Best Start Family Hub approach, Amira's neighbourhood is using shared intelligence and local professional insight to identify families experiencing multiple, low-level challenges early. Information from health visiting, early years settings and primary care is discussed through local multi-agency coordination arrangements, supported by clear information-sharing agreements.

A practitioner from the Best Start Family Hub works with Leanne to complete an Early Support Assessment, taking a holistic, strengths-based approach that looks beyond health concerns alone. The assessment considers Amira's development, family relationships, emotional wellbeing, housing stability, income, employment and community support — applying a social model that recognises how wider circumstances impact outcomes for children.

An Early Support Plan is agreed with Leanne, with one named lead professional to bring professionals together and ensure actions are followed through. Health visiting, nursery and speech and language services are aligned around shared goals, reducing duplication and ensuring consistent messages. Leanne is supported to attend the Best Start Family Hub, where she accesses parenting support and mental wellbeing activities.

As part of the plan, the Best Start Family Hub offer a benefit checks to ensure the family is receiving all relevant financial entitlements. Leanne is also signposted to skills, training and employment support, helping her explore more stable work options and build longer-term resilience for the family.

Impact

With coordinated, early and whole-family support in place, Amira's speech and health improve, her nursery attendance becomes more regular, and she is more confident and ready to learn as she approaches school age. Leanne feels listened to and supported, with a clearer understanding of the help available and greater confidence in managing family life.

The Best Start Family Hub enables one joined-up plan, one relationship, and timely support, helping the family thrive while building stronger community connections and better outcomes for children in Cheshire West.

Case Study 1 – Starting Well: Summary (Before & After)

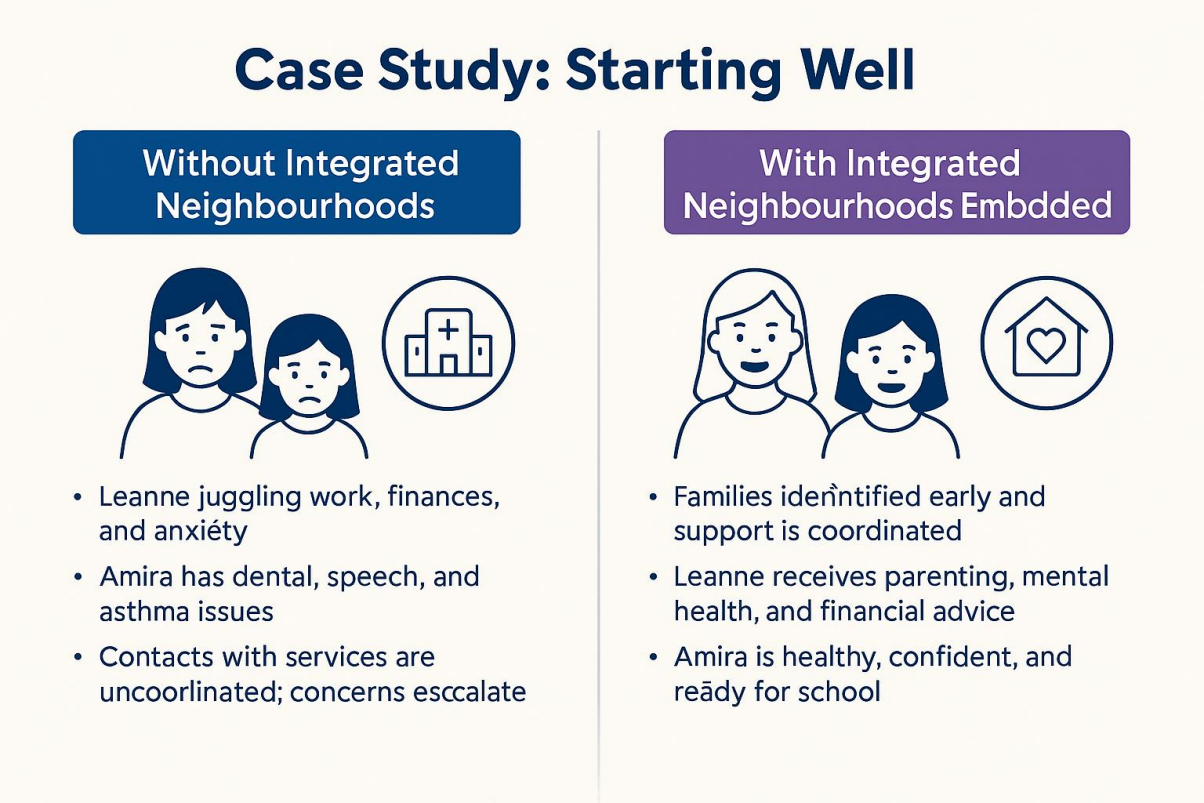
Before: Without Integrated Neighbourhoods

- Leanne is managing insecure work, financial pressures and anxiety without coordinated support.
- Amira has multiple unmet needs: poor dental health, asthma, delayed speech, and inconsistent nursery attendance.
- Different professionals see different pieces of the puzzle — no shared information, no coordinated plan.
- Support is reactive, issues escalate, and the family eventually enters statutory services.

After: With Integrated Neighbourhoods Embedded

- Shared data and insight highlight the family early through Multi-Agency Coordination.
- A single coordinator supports Leanne and ensures a joined-up approach.
- The Best Start Family Hub provides parenting support, mental health help, and financial advice.
- Nursery staff and health services work together; speech and language support is put in place quickly.
- Amira starts school healthier and more confident; the family avoids escalation into statutory services.

Figure 4: Starting Well Case Study



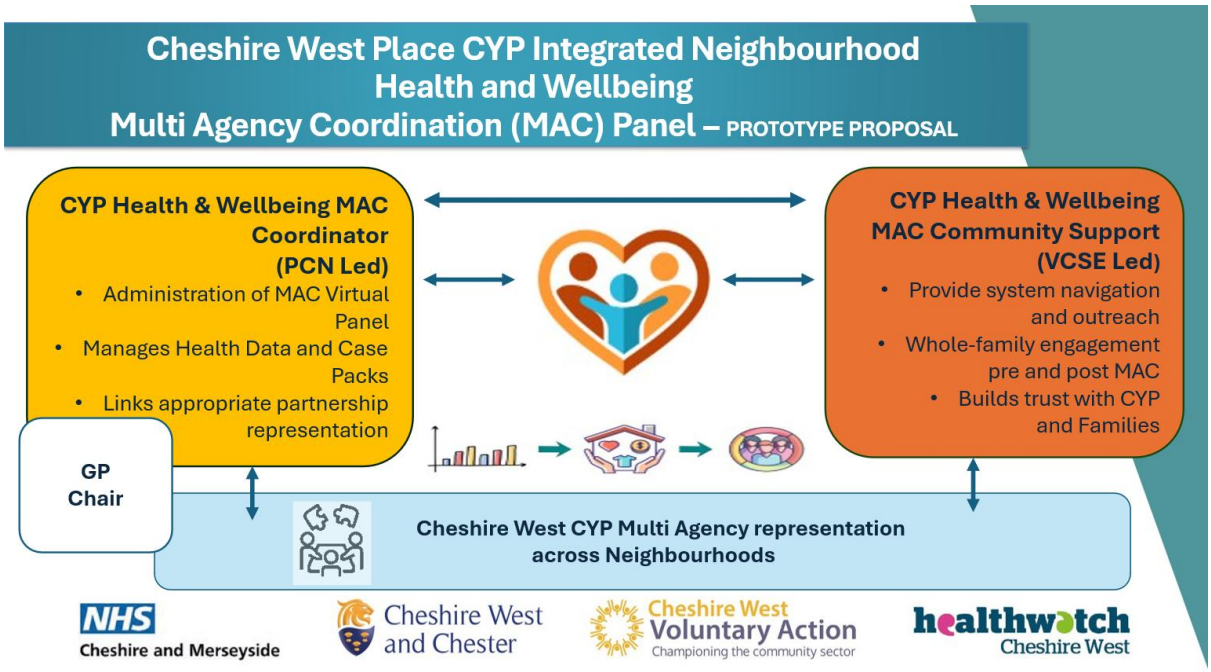
Children's early experiences lay the foundations for their long-term health, wellbeing and life chances. Yet in Cheshire West, many children live in complex households where risks accumulate subtly and often go unnoticed until difficulties escalate. Insight clearly shows that families may have repeated contact with health visiting teams, schools, primary care or emergency services, but without a mechanism that draws these insights together, the system may miss opportunities to intervene sooner.

Cheshire West propose to address this through the creation of an Integrated Neighbourhood Health & Wellbeing pilot to change this trajectory. Funded through Cheshire and Merseyside Children's Programme, Beyond, and delivered across two Primary Care Networks operating as one neighbourhood footprint in Chester, the pilot focuses on bringing professionals together through regular Multi-Agency Coordination meetings. Partners will use combined population-level data to identify families experiencing a number of complex issues and intervene to try and prevent escalation.

Design workshops have identified important practical considerations: ensuring the 0–19 Starting Well Service data (including notifications of Accident & Emergency attendances) informs case-finding; aligning pathways with the Multi-Agency Safeguarding Hub and the Family Focus Programme; developing approaches to identify "hidden" children and families such as those from traveller communities or those who are electively home-schooled; and putting in place a shared information governance framework for safe, appropriate data sharing. This will involve accessing information and intelligence from wider services than traditional health and care but will include e.g. libraries, schools and other community groups.

These issues reinforce why Starting Well is a priority: early intervention prevents avoidable harm, reduces inequalities and strengthens family resilience. Integrated Neighbourhoods create the conditions for agencies to work together systematically around the needs of children and young people, whilst tackling early signs of issues relating to mental health, neurodiversity and learning disabilities as well as physical health.

Figure 5: Multi-agency Coordination in Cheshire West



Starting Well — Year One Deliverables:

- Establish a mission statement, population cohort and baseline dataset for the initial pilot in Chester.
- Create a shared information governance and consent model across all agencies.
- Integrate Starting Well data into a neighbourhood case-identification dashboard.
- Deliver Multi-Agency Coordination meetings with consistent processes.
- Align Multi-Agency Coordination activity with the Multi-Agency Safeguarding Hub, the Families First Programme and Best Start Family Hubs.
- Develop a targeted approach for identifying 'hidden' children/families.
- Establish a learning system with quarterly evaluation and shared learning across Cheshire West.

Living Well

This case study provides an example of the group of people we are trying to support through the Living Well programme:

Case Study 2: Living Well

Without Integrated Neighbourhoods

Mark, aged 52, lives in Winsford and works in a physically demanding job. He has high blood pressure, is overweight and struggles with low mood following redundancy during the pandemic. He sees his GP occasionally but finds it hard to make lifestyle changes that he can stick with. He is unaware of local wellbeing support and does not engage with preventative services.

Over time, Mark's health deteriorates. He attends A&E twice with chest pain, leading to anxiety and time off work. Each contact is treated as a separate episode, with limited follow-up beyond clinical advice. Opportunities for prevention, social support and community-based activity are missed, and Mark begins to feel disengaged from services altogether.

With Integrated Neighbourhoods Embedded

Under the **Living Well Integrated Neighbourhood approach**, Mark's neighbourhood has access to a **Neighbourhood Intelligence Pack** highlighting high rates of cardiovascular risk and mental health need among working-age men. The neighbourhood prioritises targeted prevention and brings together primary care, public health, community organisations and local employers.

Mark is identified through the multi-disciplinary neighbourhood team's use of enhanced case finding and offered support via a local **community and health hub to access support to manage his weight and increase activity levels**. He is introduced to a social prescriber who connects him to a men's wellbeing group, local walking activities and employment support to stay in work. His primary care team provide enhanced support to manage his blood pressure. Outreach services, including the **Living Well Bus**, are targeted to his area, making access easier.

Over time, Mark's physical health improves, his confidence grows and he feels more connected locally. He has fewer unplanned health contacts and is supported to remain in work. The neighbourhood sees reduced avoidable demand and better use of community assets, with prevention becoming part of everyday practice.

Case Study 2 – Living Well: Summary (Before & After)

Before: Without Integrated Neighbourhoods

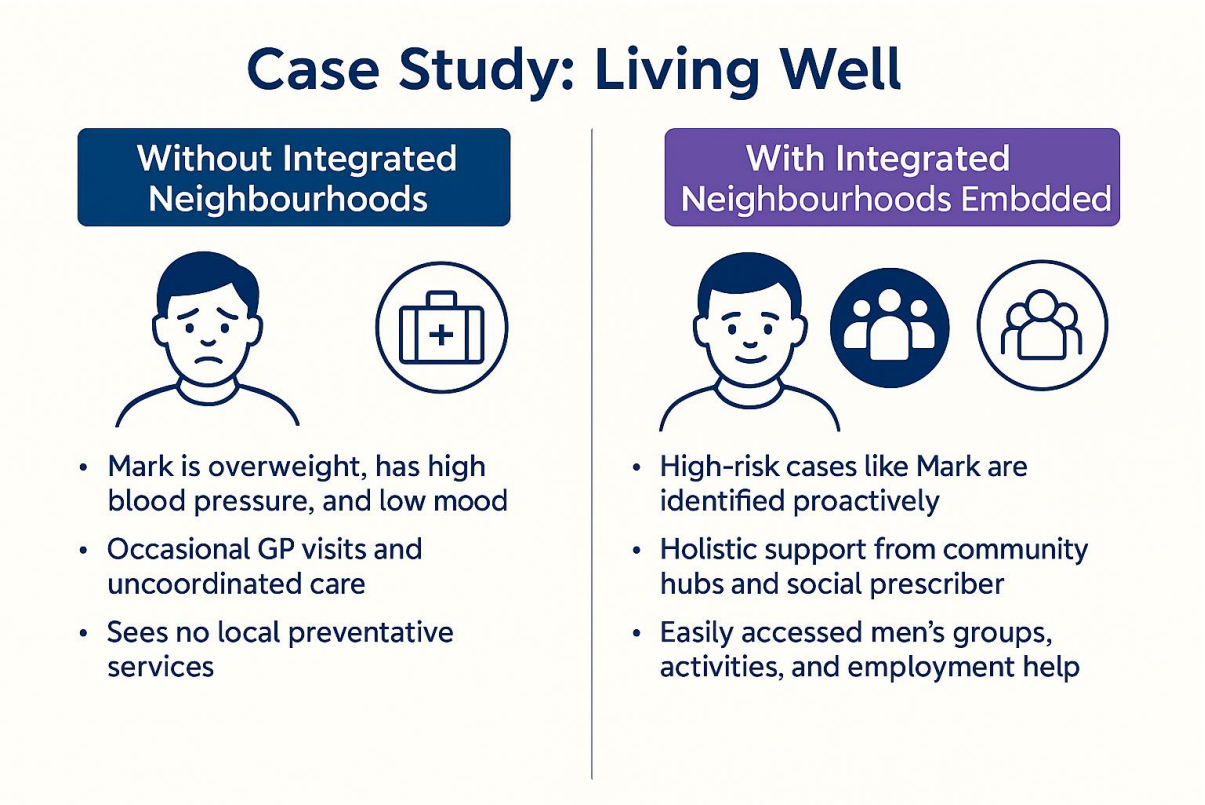
- Mark works a physically demanding job and lives with high blood pressure, low mood and weight-related issues.
- He attends his GP only occasionally and does not access any local wellbeing or preventative services.

- Health contacts are isolated and reactive — A&E visits for chest pain lead to anxiety and time off work.
- No one identifies the underlying risks or connects him to community support, so he becomes disengaged.

After: With Integrated Neighbourhoods Embedded

- Neighbourhood Intelligence highlights patterns of cardiovascular risk and poor mental wellbeing in men like Mark.
- Enhanced case-finding identifies Mark early, prompting coordinated support rather than crisis-led care.
- He is connected to a community and health hub offering weight management, activity support and local opportunities.
- A social prescriber links him with men's groups, walking activities and employment support.
- His primary care team proactively monitors blood pressure and wellbeing.
- Mark's health improves, he feels more connected to his community and avoids avoidable A&E attendances.

Figure 6: Living Well Case Study



The Living Well theme focuses on adults of working age, whose health and wellbeing (including mental wellbeing) are shaped by housing, employment, financial security, life choices (such as diet and exercise), health, neurodiversity and learning disabilities, social connection and access to community assets. Reviewing our collective intelligence has highlighted persistent inequalities within Cheshire West, with life expectancy varying sharply between areas with different scores on the Index of Multiple Deprivation.

It is clear that while the most deprived areas require intense focus, national evidence shows that interventions can have the greatest impact in areas ranked in the second and third levels of deprivation, where community engagement and capacity may be stronger. This underscores the need for prevention initiatives to be more targeted, accessible and rooted in neighbourhood insight at all levels.

Another challenge is that prevention activity across Cheshire West is extensive but fragmented and inconsistent. Primary Care, public health, the VCSFE sector and community organisations undertake significant prevention work, yet these efforts are not always coordinated, and frontline staff are often unaware of the full range of available support. Traditional public sector datasets do not always reflect the full impact of prevention work, and that alternative measures—such as social value—are at time overlooked.

Most importantly, every organisation makes countless contacts with residents who are at risk of developing preventable disease, yet these interactions do not consistently translate into proactive support or behaviour-change interventions. To realise the potential of integrated neighbourhood teams, we must ensure that every contact counts, and we support and progress wider prevention objectives that will also improve outcomes and ensure people are enabled to live fuller lives, including improving access to elective care and growing intermediate community services in key speciality areas.

Living Well is therefore a priority because it provides the greatest opportunity to reduce health inequalities, delay or avoid the onset of disease, and improve wellbeing across the population. Integrated Neighbourhoods allow prevention to be designed and delivered in partnership with communities, based on shared intelligence and collective resources.

In Year One, each neighbourhood will receive an Intelligence Pack outlining current and future needs to help teams set prevention priorities and identify required expertise, including support from partners such as optometrists, dentists, pharmacists, community groups and employers.

Cheshire West will also better coordinate mobile outreach services—like the Living Well Bus, Falls Bus and mobile libraries—so they reach communities with the greatest inequalities and support evidence-based prevention, including test beds in Winsford and Ellesmere Port.

We will review support for people with long-term conditions (include mental health conditions, neurodiversity and learning disabilities), using evidence to help them stay healthy and independent. By bringing together GP practices, pharmacies, community

services, social and wellbeing services, specialists and local communities, we aim to create more proactive care such as in diabetes or heart failure, using technology, proactive planning and medication reviews.

Living Well — Year One Deliverables

- Provide each neighbourhood with Intelligence that will help highlight local needs, trends, prevention mapping and case studies.
- Delegate elements of prevention planning / decision-making to neighbourhood teams and support co-design with local communities, led by Community Partnerships.
- Develop improved and tailored ways to support those living with long term conditions to optimise their wellbeing.
- Develop a unified communications toolkit for NHS frontline staff and partners such as Brio Leisure to Make Every Contact Count.
- Coordinate / target outreach offers including the Living Well Bus, the Countess of Chester Falls Bus and mobile libraries.
- Implement evidence-based public health initiatives across neighbourhoods focusing on those with greatest inequalities.
- Establish test beds to prototype new prevention approaches.

Ageing Well

This case study provides an example of the group of people we are trying to support through the Ageing Well programme:

Without Integrated Neighbourhoods

Dorothy, aged 84, lives alone in a rural village near Tarporley. She has early dementia as well as a number of long-term conditions, mobility issues and limited digital access. Her daughter lives 40 miles away. Dorothy struggles to navigate services and often relies on emergency help when things go wrong.

She experiences several falls at home, resulting in ambulance call-outs and short hospital stays. Each episode is dealt with in isolation, and follow-up support is inconsistent. Dorothy becomes increasingly anxious and isolated, and her daughter finds it difficult to coordinate support across health, social care and voluntary services. Eventually, Dorothy's independence declines rapidly, leading to multiple hospital admissions and consideration of residential care.

With Integrated Neighbourhoods Embedded

Through the **Ageing Well Integrated Neighbourhood approach**, Dorothy's neighbourhood has strengthened links between primary care, community services, the **Community Response Hub** and voluntary organisations. Using shared intelligence, Dorothy is identified as at risk of deterioration through enhanced case finding

Dorothy is supported through a coordinated neighbourhood response. A falls prevention programme is delivered locally, and assistive technology is installed to improve safety at home. A community connector helps Dorothy access a nearby **community hub**, providing social contact and practical support. Her daughter has a single point of contact through a care co-ordinator and clearer information about services. When her long-term conditions deteriorate she is supported by her care co-ordinator and advanced care plan to be stepped up into a community bed for treatment and recovery, before being discharged back home for rehabilitation.

As a result, Dorothy remains independent at home, with fewer emergency hospital admissions and improved quality of life. The system benefits from reduced crisis response, better coordination and more proactive support focused on what matters most to Dorothy and her family.

Case Study 3 – Ageing Well: Summary (Before & After)

Before: Without Integrated Neighbourhoods

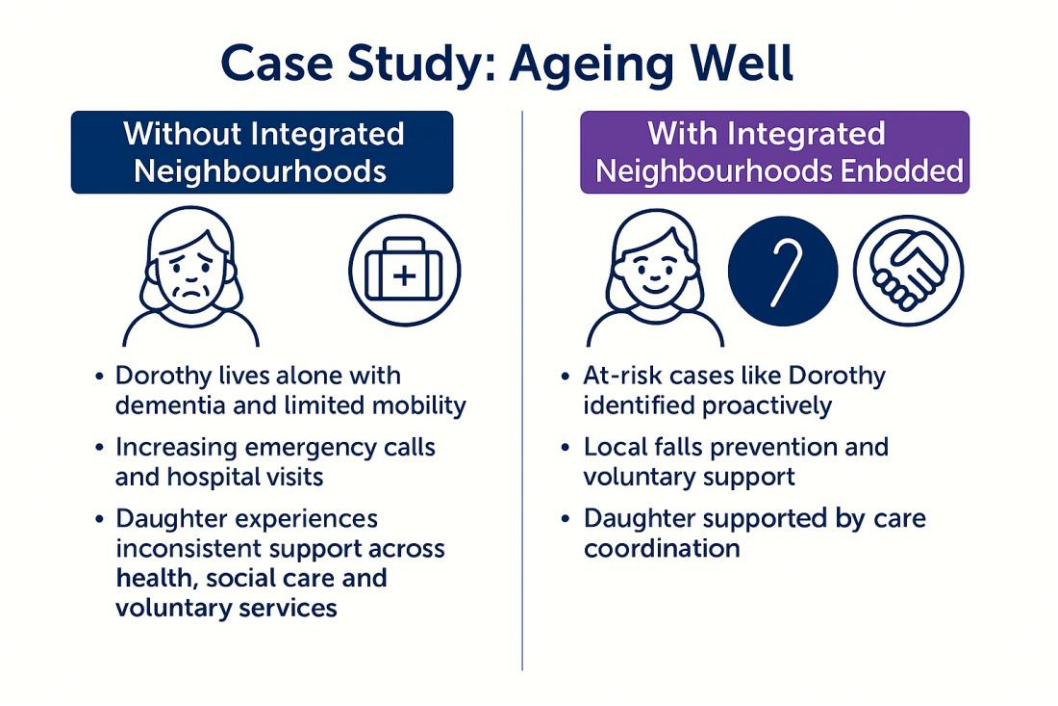
- Dorothy lives alone in a rural area with early dementia, multiple long-term conditions and limited mobility.
- She finds services hard to navigate and often needs emergency help when things go wrong.
- Multiple falls lead to ambulance call-outs and short hospital stays, each treated in isolation.

- Follow-up support is inconsistent, increasing Dorothy's isolation and anxiety.
- Her daughter struggles to coordinate fragmented health, care and voluntary sector input from a distance.
- Dorothy's independence declines, leading to repeated admissions and potential residential care.

After: With Integrated Neighbourhoods Embedded

- Shared neighbourhood intelligence identifies Dorothy early as being at risk of deterioration.
- Primary care, community services, the Community Response Hub and voluntary organisations coordinate support.
- A local falls-prevention programme and assistive technology help Dorothy stay safe at home.
- A community connector links her with a nearby community hub for social contact and practical help.
- Her daughter has a single care-coordinator contact and clearer information about available support.
- When needed, Dorothy can be "stepped up" into a community bed for treatment and then return home with rehabilitation.
- Dorothy maintains independence for longer, has fewer emergency admissions, and experiences better coordinated, proactive care.

Figure 7: Ageing Well Case Study



The Ageing Well theme recognises the growing proportion of older residents living in Cheshire West and the importance of supporting them to remain as independent, connected and healthy as possible. Significant work is already underway, including the development of Community Response Hubs, Virtual Wards, enhanced case-finding through multidisciplinary team working, the development of the Let's Talk model and emerging Community Hubs that provide a more accessible "front door" for residents seeking support.

Families frequently bear the burden of coordinating between organisations and staff do not always feel confident referring into VCSFE organisations, even when these services provide vital non-clinical support, such as befriending.

Digital access remains uneven, with significant potential for better use of assistive technology, smart support and artificial intelligence to promote independence. Furthermore, integration varies geographically: areas such as Northwich and Winsford are already functioning in a more integrated way between their primary, community and specialist services, while other neighbourhoods need clearer alignment between roles, pathways and expectations.

Key pathways—particularly falls, dementia and end-of-life care—require stronger neighbourhood-based coordination. There are opportunities to test new approaches where professionals are keen to co-locate and collaborate around a shared population.

Ageing Well — Year One Deliverables:

The Ageing Well programme for Cheshire West is underpinned by an already agreed Neighbourhood Frailty Plan, and focuses on three core areas: Falls Prevention, Dementia, and End of Life (EOL).

A well-established and engaged whole-system Frailty Operational Group oversees this work. This group brings together Falls and Dementia workstreams, primary care, geriatricians, university partners, regional leads and Aqua, providing strong system leadership and clinical engagement. In addition, the Age Friendly Group supports wider older people's engagement and related activity.

Falls Prevention

- Re-establish and strengthen local strength, balance, and education programmes.
- Adopt a targeted approach based on data
- Consider future plans to progress a test bed site.

Dementia

Cheshire West is aligned to the National Dementia 100-Day Plan and has three active system-wide frailty projects:

- Dementia pathway development (Aqua-supported).
- Polypharmacy in Care Homes, focusing on the relationship between dementia diagnosis and medication.

- Supporting people with dementia who have a package of care, with an emphasis on reducing deterioration and delaying escalation of care.

Three further projects are ready to progress:

- Dementia Nurse expansion options appraisal.
- Oral Health & Dementia.
- Additional workstreams to follow national direction on Cancer & Frailty, blood biomarkers and further polypharmacy activity.

End of Life (EOL)

A place-based needs assessment has been undertaken and the local EOL workstream is in the process of being re-established.

Other Related Deliverables to be actioned:

- Development of Step-Up resource within Intermediate Care.
- Contribution to the Admission Avoidance workstream, aiming to maximise and standardise Intermediate Care and Admission Avoidance services.
- Community Home First re-procurement maximising the good practice already established and bringing the organisations together for more trusted assessment and handover.
- Enhanced Health in Care Homes (EHCH) is led at the ICB Cheshire & Merseyside level; local authority partners are progressing tech-enabled care home pilots.
- Social Isolation Grant work continues to re-establish these services.
- The ICB work with the Acute Trusts is intended to support frailty-attuned care in acute settings, reducing deconditioning and ward moves, alongside acute outreach by geriatricians.

Community and Health Hubs

Accessible, neighbourhood-based physical spaces play a vital role and directly support the national NHS 10 year plan transformation shift from hospital to community and from treatment to prevention. They provide a visible and practical way of bringing integrated working to life for residents, communities and frontline staff.

Cheshire West already benefits from a wide range of community assets, including children's centres, libraries, GP surgeries and community centres operated by both statutory partners and the VCFSE sector. As neighbourhood working and Integrated Neighbourhood Teams become the default way of operating, the importance of these physical co-located spaces increases.

Community hubs create the conditions for professionals and volunteers from across sectors to work together locally, provide accessible venues for preventative and early-intervention services, and offer visible, welcoming drop-in spaces that improve access to a wider range of support.

They can act as gathering points for professionals of different organisations to come together to co-ordinate care and share intelligence as well as providing locations for community capacity to grow.

Defining the Community and Health Hub Model

As Integrated Neighbourhoods develop, it is important to be clear about the breadth of different types of community hubs that already exist across Cheshire West, and the different roles they currently play. Across the borough, hubs range from informal community spaces and asset-based venues to more formal health and care-led or co-located service sites. Each has emerged in response to local context, need and opportunity, and together they represent a significant strength within the system.

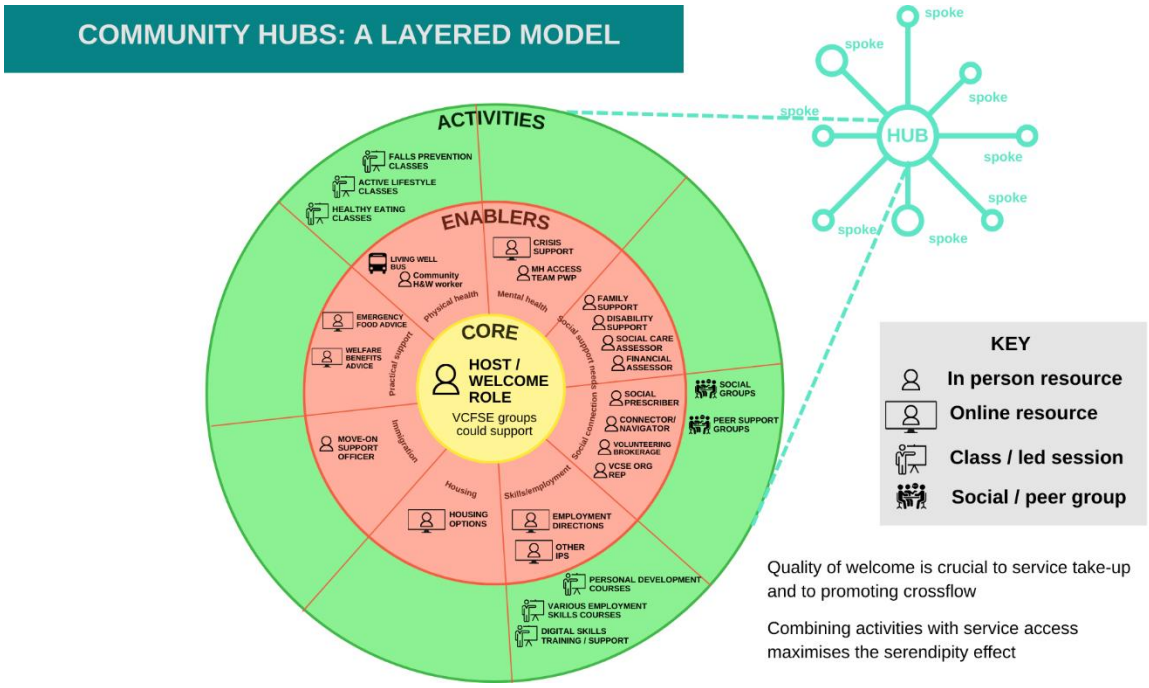
However, this diversity also creates a risk of inconsistent understanding and expectations. Without clear intent and shared definitions, the term “hub” can mean different things to different partners, making it harder to plan, invest, govern and evaluate activity consistently. As Integrated Neighbourhoods mature, there is therefore a need to move from a broad, descriptive use of the term towards a clear and agreed hub model, while retaining the flexibility required to respond to local circumstances.

For this reason, Year One will include focused work to define the Community, Health and Care Hub model for Cheshire West. This will set out clear intentions, scope and expectations, including:

- the different types of hubs and the functions they are expected to support
- the role of hubs within Starting Well, Living Well and Ageing Well
- how hubs support integrated working, prevention and access at neighbourhood level
- the relationship between hubs, Integrated Neighbourhood Teams, Community Partnerships and statutory services.

This work is not intended to create a single, rigid model, but to provide shared clarity and a common language across the system. By establishing clear definitions early in Year One, Cheshire West will ensure that community, health and care hubs are aligned to Integrated Neighbourhood priorities and used effectively as part of a coherent neighbourhood-based approach to improving outcomes and ensuring that there is no wrong front door to any of our Services.

Figure 8: Community Hubs Layered Model Proposal



Across the life course, hubs can play distinct but interconnected roles.

- For Starting Well, a good example is the creation of Best Start Family Hubs. These will provide trusted, accessible environments where families can engage with support earlier, where services can align around children and young people, and where community activity can strengthen family resilience.
- For Living Well, this is currently achieved through initiatives such as Let's Talk. Let's Talk sites support prevention and wellbeing improvement by bringing together outreach services, advice, community activity and local assets in places that people already use and trust.
- For Ageing Well, this is best demonstrated through the in-train Community Response Hubs which include both physical co-location of professionals and virtual collaboration with specialists to help older residents to remain independent, offering coordinated community-based services, following unplanned admission to hospital. The next stage is to expand this approach to include co-ordination and proactive intervention prior to unplanned hospital admission, as an individual's condition deteriorates, so that people can retain their independence for longer.

There are further hub examples across the borough we intend to continue to learn from and build on. Models such as Lache Community Centre, Kelsall Wellbeing Hub, the emerging Great Sutton Health and Wellbeing Village, the Winsford "Crook Lane" development and the early development of the Northwich Community Hub (Barons Quay) demonstrate the opportunities that come from co-locating community activity with health and care services. Further innovation with the community is planned within

the new Leighton Hospital site through the “Healthier Futures” Programme, where shared learning and best practice will be critical. However, there is still work to do.

Developing sustainable community, health and care hubs requires strong community development capacity, lived-experience insight and practical front-of-house support. Some areas will need coordinated investment in buildings and help to identify organisations able to hold leases or manage facilities. Cultural change and cross-sector buy-in remain essential, and progress must align with wider system developments such as asset rationalisation, Best Start Family Hubs and emerging Pride in Place boards.

By developing a joint framework, we will truly see a common language and partnership approach to how, where and at what pace these Hubs will progress, with local residents seeing the benefit.

4: Working Together at Neighbourhood Level

The Role of Community Partnerships

Integrated Neighbourhoods rely on meaningful collaboration between residents, communities and local partners, built on relationships and shared priorities rather than a service-led model. Cheshire West's nine neighbourhood footprints, delivered through Primary Care Networks and Community Partnerships, already bring partners together around local priorities. Seven Partnerships currently operate (with the three Chester PCNs acting as one), supported by Cheshire West Voluntary Action to strengthen VCFSE involvement and wider engagement.

Community Partnerships provide a strong starting point, but delivering the full ambition—across health, care, prevention and wider determinants—requires their role and membership to evolve and align closely with PCNs and statutory partners. Avoiding duplication and enabling joint decision-making are critical.

This Plan proposes a phased approach: Partnerships will continue to lead neighbourhood insight and priorities while governance, leadership and resources are aligned across PCNs and wider partners to enable a fully integrated, place-based model.

Reviewing Community Partnerships in Year One

As Integrated Neighbourhoods move from design into delivery, it will be essential to ensure that Community Partnerships are configured in a way that enables effective neighbourhood-level delivery. While Community Partnerships provide a strong and established foundation, the introduction of Integrated Neighbourhoods represents a step-change in ambition, requiring closer alignment between community-led structures, Primary Care Networks and statutory health and care partners.

For this reason, the first year of delivery will include an early, purposeful review of Community Partnership membership, role and ways of working. This review will focus on ensuring that Community Partnerships are able to support Integrated Neighbourhood priorities by bringing together the right mix of partners for their local context, with the capacity, influence and connectivity required to move from discussion into action.

In particular, the review will consider:

- Membership and representation, ensuring consistent and meaningful involvement from Primary Care Networks, NHS providers, Local Authority services and relevant VCFSE organisations / community leaders and the local population themselves particularly those that face the greatest inequalities / health and wellbeing challenges.
- Clarity of role, including how Community Partnerships contribute to identifying priorities, shaping activity and supporting delivery within Integrated Neighbourhoods

- Alignment with Integrated Neighbourhood governance, ensuring clear lines of connection between neighbourhood forums, Place-level oversight and statutory decision-making
- Ways of working, including how data, intelligence and lived experience are used to inform priorities and how progress and impact are understood locally, in a broader way than just short-term change to statutory service activity.

A Localised, Insight-Led Approach Aligned to Cheshire West Priorities

Integrated Neighbourhoods in Cheshire West are underpinned by a clear set of Place-level priorities, agreed through the Health and Wellbeing Strategy and this Integrated Neighbourhoods Plan. These priorities provide the shared strategic direction for the whole system, focusing on improving outcomes across the life course, reducing inequalities and strengthening prevention. However, while the priorities are set at Place level, the activity required to deliver them will vary significantly between neighbourhoods.

For Integrated Neighbourhoods to be effective, neighbourhood teams and partnerships must be empowered to use local data, intelligence, relationships and lived experience to determine what action is most needed in their area, and how best to respond. This includes understanding local population characteristics, patterns of inequality, service use access, community assets and emerging risks, and using this insight to identify the focused activities that will make the greatest difference locally. Integrated Neighbourhoods are therefore expected to be insight-led and place-responsive, rather than applying a uniform set of interventions across the borough. This approach should therefore not stifle established local relationships and innovation, will reflect community connections and flows and allow delivery at a local level, where this is demonstrating improved outcomes.

Figure 9: How Integrated Neighbourhoods Work

Integrated Neighbourhoods align place-level priorities with neighbourhood-level insight, enabling local partners to take targeted action that improves outcomes while maintaining system coherence.

This approach requires each neighbourhood to involve the partners best placed to deliver its priorities. While some organisations—such as Primary Care Networks, Local Authority services and NHS providers—will always be central, wider partner involvement will vary depending on local needs. Some areas may need stronger VCFSE involvement, while others may work more closely with housing, education, employment or specialist services. Integrated Neighbourhoods will remain flexible, engaging the right partners for the right issues rather than relying on fixed membership. The Neighbourhoods Plan sets out consistent priorities, deliverables and outcomes, but will allow for each neighbourhood to develop how to deliver them, supported by a clear framework for collaboration and governance.

Strong links between neighbourhood insight, neighbourhood action and Place-level oversight are essential to understand impact, share learning and address variation. By combining clear Place-level priorities with local decision-making, Integrated Neighbourhoods create the right balance of consistency and flexibility, supporting improved outcomes, reduced inequalities and a model that reflects what matters most to communities across Cheshire West.

5: Governance – Enabling Integrated Neighbourhoods to Thrive

As Cheshire West moves from planning into delivery, strong, coherent and fit-for-purpose governance becomes essential. The ambitions set out across Starting Well, Living Well and Ageing Well can only be realised if system arrangements are aligned, streamlined and explicitly designed to support neighbourhood-level action. The transition to Integrated Neighbourhoods therefore marks a significant moment — not simply a shift in operational practice, but a re-orientation of how decisions are made, how oversight is provided, and how accountability is exercised across Place.

To support this transition, Cheshire West is undertaking a comprehensive review of its existing Place governance arrangements. While the foundations of partnership working are strong, the move towards a life-course, neighbourhood-centred model requires governance that is simpler, more connected and easier to navigate for partners, providers and communities. The intention is to ensure a clear line of sight between strategic ambition, neighbourhood insight, operational delivery and outcomes, reducing duplication and improving transparency.

As part of this review, the Integrated Transformation Steering Group (ITSG) will evolve into a dedicated Cheshire West Integrated Neighbourhoods Programme Board. This reflects the shift from programme-based transformation activity towards Integrated Neighbourhoods as the core operating model for Place. The new Steering Group will provide focused strategic oversight of the Integrated Neighbourhoods programme, ensuring alignment across partners, unblocking barriers to delivery and maintaining a clear connection between neighbourhood learning and Place-level decision-making.

In parallel, governance at Place level will be simplified and consolidated. Subject to agreement, this will include amalgamating the Place Committee function into the Health and Wellbeing Board, strengthening the HWBB's role as the primary forum for system heath and care leadership, accountability and assurance for population outcomes. This change will reduce duplication, clarify decision-making routes and ensure that Integrated Neighbourhood delivery remains firmly anchored to the Health and Wellbeing Strategy.

A further key element of the redesigned governance model is the establishment of Starting Well, Living Well and Ageing Well Boards. These Boards will provide thematic oversight across the life course, bringing together partners to focus on outcomes, priorities and delivery within each theme. Wherever possible, existing forums and boards will be utilised or adapted, rather than creating new structures, ensuring continuity, efficiency and effective use of partner capacity. These Boards will act as the main mechanism for coordinating activity, reviewing progress and resolving issues within each life-course priority.

Figure 10: Governance Model

Alongside these changes, a review will be undertaken of the enabling and supporting groups that underpin delivery — including those focused on data and intelligence, workforce, estates, digital, finance / contracting, and communications and engagement. This review will ensure that enabling arrangements are appropriately aligned to Integrated Neighbourhood priorities, clearly connected to decision-making forums, and focused on removing barriers to neighbourhood-level delivery rather than creating additional processes.

6: Outcomes – Measuring Impact and Strengthening Place-Based Delivery

Delivering meaningful outcomes for residents and staff is at the heart of the Cheshire West Integrated Neighbourhood Programme. The ambition expressed in earlier chapters—supporting people to Start Well, Live Well and Age Well—must ultimately be demonstrated through measurable improvements in health, wellbeing, equity and experience. For this reason, outcome monitoring will form a central part of how the programme is governed, how priorities are refined, and how success is understood across the Place.

To support this, the Cheshire West and Chester Council Insight and Intelligence Team and the Cheshire and Merseyside Business Intelligence Team are working closely with Cheshire West Place partners to develop a comprehensive set of outcome measures tailored to the Integrated Neighbourhood model. These measures will reflect both the national priorities for integrated care and the broader, life-course vision that Cheshire West has chosen to adopt and align with / include Health and Well Being Strategy metrics where appropriate. Once finalised, these outcomes will be incorporated into an Integrated Neighbourhood Dashboard, enabling partners to track change over time and adjust priorities based on real-time intelligence and emerging needs within neighbourhoods.

The dashboard will focus on several core domains that reflect the complexity of residents' lives and the system's ambition:

- Use of Statutory health and care Services: track GP, hospital and social care activity to assess whether neighbourhood approaches reduce avoidable demand and support earlier, community-based care.
- Deterioration & Long-Term Conditions: Monitor early signs of deterioration—such as frailty, emerging mental health needs or new long-term condition diagnoses—to understand the impact of preventative, proactive support.
- Wider Determinants of Health: Include measures on housing, education, employment, socio-economic conditions and other factors that shape wellbeing across the life course.
- Social Value: Capture the contribution of community assets and the VCFSE sector, including volunteering, participation, engagement and local asset growth.

In addition to ensuring that the outcome metrics utilised are relevant to Place Partners and local people, it will be essential to ensure that the focus of the Integrated Neighbourhoods Plan still meets the aims of the National Priorities, as well as system partner challenges. The national metrics below will form a crucial part of local monitoring, ensuring that the delivery to this plan meets both Cheshire West health inequalities and nation-wide priorities.

Goal 1 Health Outcomes	Goal 2 Access to general practice	Goal 3 Access to Planned Care	Goal 4 Access to Urgent Care	Goal 5 Improve patient and staff satisfaction
Focus on high-priority cohorts (frailty, care homes, housebound, end of life, long-term conditions, mental health, dementia, children and young people) and other cohorts identified by local areas. Key objectives by March 2029:	90% of clinically urgent patients seen the same day by March 2027.	5% diversion of referrals via single points of access for ten high volume specialties by March 2027, supporting RTT recovery.	Reduce non-elective admissions and emergency department (ED) attendances for high-priority cohorts (defined as severe frailty, in a care home or housebound end end of life).	Introduce new patient experience and outcome measures with year-on-year improvement.
10% reduction in nonelective admissions/bed days for frailty and housebound cohorts.	Routine GP access and satisfaction baselined in 2026–27 with local goals set by ICBs in the interim	10% reduction in follow-up outpatient activity by March 2027, with neighbourhood-based follow-up for priority cohorts and cancer metrics aligned with the National Cancer Plan.	Contribute towards 82% ED four-hour performance by March 2027, moving to 85% in the longer term.	95% of people with complex needs to have a care plan by 2027.
10% increase in identification of people approaching end of life and a 10 per cent reduction in their nonelective admissions/bed days.			Reduce category 3/4 ambulance conveyances for high-priority cohorts by expanding urgent care response.	New staff experience measures introduced in neighbourhoods with annual improvement trajectories.
10% improvement in clinical outcomes for major long-term conditions where warranted, and 10 per cent increase in diabetes patients receiving all eight care processes.			Improve discharge efficiency (more patients discharged on their ready date; quicker discharge where delays occur)	
10% reduction in outpatient appointments for under16s and significant progress on reducing community waits.			Improve discharge efficiency (more patients discharged on their ready date; quicker discharge where delays occur)	

7: Conclusion and Next Steps – Delivering Our Ambition Over 1, 5 and 10 Years

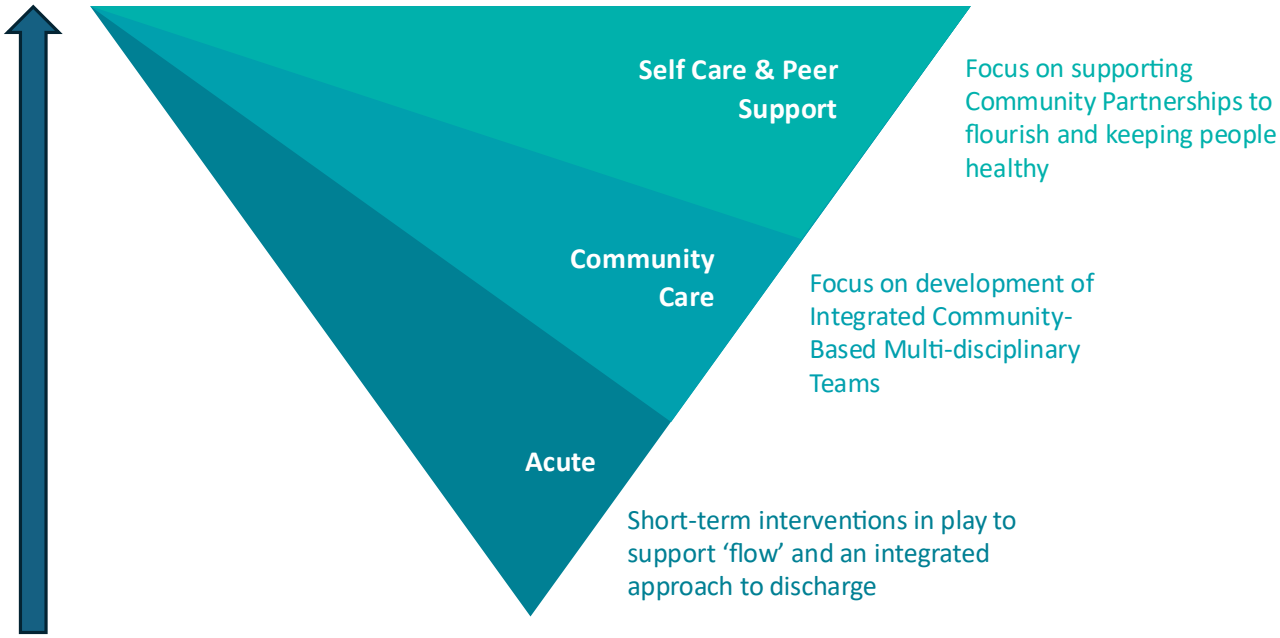
The Cheshire West Integrated Neighbourhood Plan sets out a bold and collaborative vision for transforming health, wellbeing and equity across the life course. While this plan provides the structure, the detail and the shared ambitions needed for change, it is our collective delivery—through neighbourhoods, communities and partnerships—that will determine its success.

To guide this delivery, the following section summarises the key next steps across three time horizons, the next:

- 12 months,
- 5 years,
- 10 years.

These horizons reflect both the scale of the challenge and the long-term nature of population change, while also recognising the need for early momentum and visible impact.

Figure 11: Cheshire West 'Care Triangle'



Next 12 Months – Laying the Foundations:

- Launch Year One programmes for Starting, Living and Ageing Well, including neighbourhood pilots, prevention test beds, better signposting, long-term condition support and improved dementia, falls and end-of-life pathways supporting by the Place enabler workstreams on estates, digital, workforce and communication / engagement

- Put governance in place to align Starting, Living and Ageing Well and strengthen Community Partnerships.
- Launch the Integrated Neighbourhood Dashboard with agreed measures, benchmarking and rapid-learning cycles.
- Strengthen Community Hubs (flexibly designed and delivered to meet multiple aims) by defining the model, supporting local pilots and deepening VCFSE involvement.
- Embed integrated working through consistent neighbourhood ways of working, improved prevention skills and lived-experience input.
- Align financial intent with a shared resource strategy and improved access to funding.

Next 5 Years – Scaling and Embedding:

- Full Integrated Neighbourhood Teams operating in every area, with strong VCFSE integration and improved staff morale.
- Mature network of Community Hubs tailored to each neighbourhood and evaluated for impact.
- Improved outcomes in broader wellbeing measures including school readiness, mental health, early deterioration detection, falls reduction and dementia prevention and support, also achieving local system pressures and national priorities.
- Prevention as routine, with strong community engagement and evidence-led prioritisation.
- Integrated digital and data infrastructure, including widespread assistive technology.

Next 10 Years – A Healthier, More Connected Cheshire West:

- Significantly reduced health inequalities across life expectancy, childhood outcomes and long-term conditions.
- A fully co-produced system were communities shape decisions locally.
- Prevention by default, with reduced deterioration and crisis.
- A stable, confident workforce supported by place-based career pathways.
- Technology-enabled, community-driven care, with seamless intelligence-sharing and strong support for independence.

Timescale	Starting Well	Living Well	Ageing Well	System Enablers	What Will Be Different
Mobilise, Prioritise & Test Oct 2026 - Mar 2027	• Agree priority cohort and neighbourhood focus. • Establish baseline data and outcome measures. • Map existing children and family support services. • Test multi-agency case discussions in one locality. • Produce recommendations and test out scale-up across locality(ies).	• Share neighbourhood level intelligence between PCNs and partners in priority areas. • Identify CYD secondary prevention priority pathway for development across health/care/voluntary sector and pilot new approach in 1-2 neighbourhood test sites. • Start to develop a shared communications approach across partners.- not sure what this means? Might need to describe what we are trying to achieve/address • Agree priorities for future prevention initiatives.	• Review and identify falls, frailty, dementia and admission avoidance service gaps. • Identify opportunities to strengthen existing provision through greater integration. • Understand the developing learning from the GP Plus scheme in terms of requirements for strengthening frailty / dementia offer and admission avoidance opportunities.	• Evolve Integrated Neighbourhood governance arrangements. • Identify opportunities to align with Cheshire and Merseyside approach where relevant and resource allows.	• Shared vision and governance arrangements established. • Priority populations and neighbourhoods identified. • Baseline intelligence available. • Stronger partnership working across statutory and community organisations. • Small-scale neighbourhood testing underway. • Clear implementation roadmap for future delivery.

Cheshire West Integrated Neighbourhoods Plan – Summary

Our Vision

To **reduce inequalities**, **increase years of healthy life**, and **promote mental and physical wellbeing** for everyone in Cheshire West through integrated, preventative, neighbourhood-level working.

Why We Need Integrated Neighbourhoods

Cheshire West faces persistent and widening inequalities across the life course:

- **Children & Young People:** rising child poverty (from 12.6% to 17.8%), poorer school readiness, and increased safeguarding need.
- **Working-Age Adults:** deep pockets of deprivation (over 20% in the top 10% most deprived nationally), significant life-expectancy gaps (11 years for men, 8 years for women), high burden of preventable disease and poor mental health.
- **Older Adults:** rapidly growing older population; rising frailty and dementia (13% rise in 5 years), rural isolation, and increasing care needs.

These challenges require a **localised, prevention-focused, multidisciplinary model**, delivering support *where people live*.

Our Local Approach

While national policy centres Integrated Neighbourhoods on frailty and admission avoidance, **Cheshire West is going further** by adopting a **whole-life, three-theme model**:

Starting Well – early identification of needs & prevention for children in complex households

Living Well – tackling inequalities & preventing illness in adults

Ageing Well – supporting independence, preventing deterioration & improving quality of life

This is delivered through **Integrated Neighbourhood Teams, Community Partnerships**, and an emerging network of **community hubs**.

What Will We Deliver in Year One?

Starting Well

- Launch the Integrated Neighbourhood Health & Wellbeing pilot
- Create shared information-governance and consent processes
- Develop a case-identification dashboard
- Work towards delivering 9 Multi-Agency Coordination meetings
- Align pathways with MASH, Best Start Family Hubs and the Family Focus Programme
- Implement an approach for identifying “hidden” children
- Begin system-wide learning cycles

Living Well

- Produce neighbourhood intelligence to support prioritisation and collaborative working
- Delegate some decision-making to neighbourhood teams
- Commence the development of an unified communications toolkit
- Coordinate outreach (Living Well Bus, Falls Bus, mobile libraries)
- Deliver evidence-based public health interventions
- Launch prevention “test beds”

Ageing Well

- Strengthen local falls-prevention programmes
- Develop the dementia pathway, including polypharmacy review, and reduce deterioration
- Progress new dementia initiatives
- Re-establish the End-of-Life workstream
- Develop a Step-Up Intermediate Care resource
- Strengthen Admission Avoidance, standardising community and intermediate care responses
- Re-procure Community Home First
- Expand Enhanced Health in Care Homes and social-isolation initiatives including digital

Governance & Enablers

- Revised Place governance aligned to the three themes
- Community Partnerships leading neighbourhood-level co-design
- Integrated Neighbourhood Dashboard tracking:
    - Statutory service use
    - Long-term conditions & deterioration
    - Wider determinants of health
    - Social value
    - National Framework Priorities and Local System Pressures
- Growing Community Hub network aligned to neighbourhood priorities
- Culture change: prevention at every contact, strong VCSFE partnerships, data-driven continuous improvement.

What Will Success Look Like?

In 12 Months:

Foundations in place, aligned governance, early pilots running, improved data sharing, stronger partnerships, and visible progress in neighbourhood test sites.

In 5 Years:

Fully operational Integrated Neighbourhood Teams across all communities, mature hubs, measurable improvements in prevention, earlier intervention, reduced inequalities and enhanced community resilience.

In 10 Years:

A transformed Cheshire West: prevention as standard, reduced health inequalities, empowered communities, seamless integrated care, and a healthier population across the life course.

Visual of Cheshire West Integrated Neighbourhood Plan