The
Richmond
Group
of Charities

Putting People at the Centre: Making neighbourhood health work for people with multiple conditions

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Contents

Executive Summary

Neighbourhood health services have considerable potential to improve the lives of people living with long-term and multiple long-term conditions (MLTCs) – the people whom our member charities support. But it won't reach this potential if we focus on systems at the expense of people. For neighbourhood health to succeed, we can't allow conversations about NHS structures, governance, funding flows and estates to eclipse the needs of the people which the health system is there to serve. We must relentlessly focus on designing care around people, or we risk the neighbourhood health agenda becoming yet another laudable but failed initiative.

This is important because growing numbers of us are living far longer periods of our lives with long-term conditions – often multiple conditions which compound each other. This is driving increased demand on the NHS, resulting in poorer quality of life, and creating inequalities in access, experiences, and outcomes – putting people at risk of falling through gaps in siloed treatment pathways. People with multiple long-term health conditions is the group who experience the greatest burden of treatment and has the most to gain from a more person-centred, preventative model of care delivered in the community.

The learning in this report will help put the ambitions of neighbourhood health into practice and make sure they become a reality for patients. Reducing waiting times for elective care and improving GP access are key goals outlined in the Government's Neighbourhood Health Framework, but we should be cautious about overloading the neighbourhood health agenda in an already stretched context. Neighbourhood health cannot solve all the problems facing the NHS overnight, but it can make a difference to those at the sharp end of services.

People must be at the centre of decision making about their lives, with their experiences and aspirations shaping the conversation. If we are going to truly support people's needs, neighbourhood teams should not be envisioned as a group of NHS professionals working in a different context – but as a multi-sector team wrapped around the person, in which the voluntary and community sector and people themselves are equal partners.

So this is why we are doing neighbourhood health. How do we do it?

This report explores programmes across England which are already making a tangible difference to the care of people with long-term and multiple long-term conditions, working together at local level with the people at the centre of their care. Building on our own research into the lived experience of people with long-term and multiple conditions, we interviewed 12 innovative service providers from across a range of sectors and three people with multiple conditions.

The five tests for neighbourhood health services

This report is structured around The Richmond Group of Charites' five tests for the neighbourhood health.

These tests are based on the common challenges that people with MLTCs tell us they face: a lack of care coordination, an overwhelming treatment burden, unaddressed interactions between mental and physical health, and unmet social needs.

We believe that the five tests enable us to assess whether these challenges are being addressed and provide a helpful lens through which to view, plan, and transform the experience of care and improve health outcomes.

The five tests are:

1. **Proactive:** Not waiting for things to go wrong, but actively anticipating crisis, and supporting people to stay well.
2. **Coordinated:** Services and professionals talking to each other, reducing treatment and administrative burdens.
3. **Cross-sectoral and holistic:** Bringing together the strengths of clinical and community support, to address a problem holistically.
4. **Equitable:** Focused on the needs of people currently not well supported by existing models, reducing discrepancies of access, experiences and outcomes, and focusing on building trust.
5. **Person-centred:** Responding to what matters to people, which is mostly likely to be a combination of clinical and non-clinical concerns.

What local leaders should do

We hope that local leaders will draw from our practical learning on how to get started on successful neighbourhood approaches. The 12 areas we interviewed did not wait for significant additional resource or complete datasets – they focused on the art of the possible. The common principles present across these programmes are:

- They centre on the lived experience of people and communities, supporting people to participate in conversations about their own health.
- They start with a clear focus, with a cohort of people whose experience it is in their gift to change.
- They seek to address the aspects of care that are most often neglected in our siloed health system; the user interface, communication, continuity of care, and support with self-management.

None of the places we interviewed had a model that perfectly exemplified all five of our tests, but they all lean into these elements of support in multiple ways. **To build neighbourhood working we put forward the following recommendations for local leaders:**

- **Use the best available data,** from all sources, as a starting point to target those most in need of support, rather than wait for the perfect datasets and risk stratification tools.
- Start in a place where you have some control within your available resource and build from a **contained and focused cohort** whose needs can clearly be better met – rather than waiting for others to address persistent systematic barriers which are not within your gift to change. Instead, identify **workarounds to practical barriers**, such as identifying strategies to manage data sharing challenges, tapping into social investment to unlock resource, and finding practical ways to address cultural and system barriers to joint working.

- **Build the best cross sector team to address your local challenges** – with an equal role for non-clinical staff, enabled to play to their strengths, and participation from people with lived experience. Teams that have made the most progress have combined the reach of the NHS with the responsiveness and flexibility of the Voluntary, Community and Social Enterprise (VCSE) sector.
- **Value and invest in relationships** and connection, with both patients and staff from other disciplines, to build trust and support coordination of care.
- **Work with communities and community organisations** – valuing and resourcing the infrastructure that enables them to make a full contribution. Recognise people as active partners in their own care and support, involving them in the co-production of neighbourhood health plans.
- **Recognise and address cultural and system** barriers to joint working, such as approaches to risk and governance, and in locally owned neighbourhood health plans.
- **Create space and time** to work differently – build in flexibility, space and time to arrange things around people, not systems
- **Measure what matters** – assess real impacts in people's lives, being realistic about how change happens.

This will mean different things in different places, according to the needs and assets of neighbourhoods themselves. This should be embraced and celebrated, but the consistent golden thread is that people must be at the centre of this transformation.

What national leaders should do

National leaders should unlock barriers for local leaders and set clear expectations on ways of working with the person at the heart.

- **The central focus of neighbourhood health should be improving care for people who have the worst experience and outcomes and the greatest need for preventative, community services** – in particular people living with multiple long-term conditions. National leaders should recognise that outcomes will only change if care is shaped around the needs and voices of people and communities. Person centred care, shared decision making, and holistic non-clinical support should be the primary objective rather than system-centred outcomes.
- **Encourage and enable local leaders to start somewhere**, recognising that they probably won't have the perfect data or data capabilities to design the perfect cohort and intervention. National policy and oversight should be more permissive than prescriptive and enable local leaders to act on their local need. Encourage local leaders to ask the **'so what?'** question: What will we do differently for people whose needs are currently not well met? Give services sufficient time to develop trust and embed change. **Encourage the use of deprivation data, and community insights** as routes into understanding where action is needed.
- **Measure and report on what matters.** Patient reported outcome measures, and ways of capturing whether services deliver on people's own priorities, should be used to determine whether neighbourhood health services are working.
- **Dismantle incentives that encourage focusing solely on 'easy to reach' patients** (such as overall waits, or overall number of tests performed) and instead incentivise outreach to people who tend to lose out on prevention offers.

- **Ensure the non-clinical workforce, including the social care workforce, is planned for alongside clinical staff in future workforce plans.** These roles will be central to delivering different models of care, that are more holistic, more proactive, better coordinated, and more continuous, and better at tackling inequity.

- **Address the barriers to data sharing among local services** by creating clear guidance and practical tools that can be used at local level, and creating headroom and back stop to enable pragmatism in the face of risk-aversion, where needed. The Neighbourhood Health Framework positively commits to standardising data sharing between neighbourhood health services and hospitals, but this should be inclusive of all partners in Integrated Neighbourhood Teams (INTs) including non-clinical services.

- **Foreground partnerships in guidance and funding.** Focus funding, guidance and change management support on the connection points between organisations and systems: data sharing, care coordination, social prescribing, alliance contracting, and outreach. Make partnership funding the norm, not the exception.

- **Make equalities monitoring and impact a condition** of funding and support and build it into all service innovation and delivery, supporting areas to better understand their impact on health equity and whether their interventions are reaching marginalised communities.

If done correctly, in the ways we outline, neighbourhood health could achieve what previous policy initiatives have failed to: shift from a system that reacts to crisis to one that anticipates and prevents crisis. The opportunity provided by neighbourhood health is huge, and we stand ready to play our part in delivering this radical and long-overdue shift in the way care is delivered.

Introduction

Neighbourhood health services have considerable potential to improve the lives of people living with long-term and multiple conditions. For neighbourhood health to succeed, we can't allow conversations about NHS structures, governance, funding flows and estates to eclipse why we are spending considerable time and capacity doing this, and who we are doing this for. These are necessary conversations, but they should be enablers to the real change being made for people with complex needs.

> ***"Start with the patient in mind, instead of focusing on…what your system does, and tweaking your system all the time."***
>
> *Marie Curie*

This is important because growing numbers of us are living far longer periods of our lives with long-term conditions – often multiple conditions which compound each other. This is driving increased demand on the NHS, poorer quality of life, and inequalities in access, experiences, and outcomes – putting people at risk of falling through gaps in siloed treatment pathways. People with multiple long-term conditions is the group which experiences the greatest burden of treatment and, has the most to gain from a more person-centred, preventative model of care delivered in the community.

We are pleased to see the Neighbourhood Health Framework advise that Integrated Neighbourhood Teams (INTs) should prioritise people with multiple conditions and "organise services around the person with more convenient, personalised and joined-up care".[1] The learning in this report will help put these ambitions into practice and make sure they become a reality for patients.

Reducing waiting times for elective care and improving GP access are key goals outlined in the Government's Neighbourhood Health Framework, but we should be cautious about overloading the neighbourhood health agenda in an already stretched context. Neighbourhood health cannot solve all the problems facing the NHS overnight, but it can make a difference to those at the sharp end of services. This requires us to be realistic in our ambitions and for the pace and scale of change.

If we are going to truly support people's needs, neighbourhood teams should not be envisioned as a group of NHS professionals working in a different context – but as a neighbourhood team wrapped around the person, in which the voluntary and community sector and people themselves are equal partners. People's needs must be at the centre of decision making about their lives, with their experience and aspirations shaping the conversation.

Our 15 member charities have considerable experience of delivering support and listening to what people with long-term conditions say they need and want. They know how support can be improved and want to see disparate services joined up into a more holistic offer. Our members have also been working in local communities long before the current policy focus on neighbourhood health.

For this report we interviewed 12 innovative service providers and local system leaders from across a range of sectors, and three people with multiple conditions. We also convened a workshop with 20 system leaders from different sectors and discussed the emerging learning. We would like to thank these individuals for sharing their insights and perspectives.

These projects we interviewed are listed below, and further information on these 12 projects/programmes is available in the appendix of this report.

- Blackburn with Darwen Council, Public Health and health and wellbeing teams
- British Red Cross – High Intensity Use Services
- East Birmingham Integrated Neighbourhood Team (INT)
- Innovation Unit - Greater Manchester (GM) Mental Health Transformation
- Leamington Primary Care Network – Health coaching
- Macmillan Cancer Support – Neighbourhood Health Transformation Funds
- Marie Curie – proactively taking holistic end of life care to people from all backgrounds
- The National Association of Primary Care (NAPC) – Community Health and Wellbeing Workers programme (CHWWs)
- North Central London – Complex Long Term Conditions Pilot
- Parkinson's UK - Parkinson's Connect
- Slough - Proactive outreach from a GP service
- Stroke Association – Stroke support services

This report, and the research informing it, is structured around The Richmond Group of Charites' five tests for the neighbourhood health. In early 2025, we developed these tests, informed by our research into the common challenges faced by people living with MLTCs. The five tests are indicative that these issues are being addressed, providing a helpful lens through which to view, plan, and deliver this transformation in care, ensuring a laser focus on improving the experience of care for patients.

The five tests are:

1. **Proactive:** Not waiting for things to go wrong, but actively anticipating crisis, and supporting people to stay well.
2. **Coordinated:** Services and professionals talking to each other, reducing treatment and administrative burdens.
3. **Cross-sectoral and holistic:** Bringing together the strengths of clinical and community support, to address a problem holistically.
4. **Equitable:** Focused on the needs of people currently not well supported by existing models, reducing discrepancies of access, experiences and outcomes, and focusing on building trust.
5. **Person-centred:** Responding to what matters to people, which is mostly likely to be a combination of clinical and non-clinical concerns.

While most of the projects we interviewed pre-date the current neighbourhood health agenda, all had learning to share around delivering care that exemplifies one or more of the tests above, and how they have designed and delivered change.

What effective, person-centred services all have in common are:

- They focus on the lived experience of people and communities and support people to participate in conversations about their own health.
- They start with a clear focus, with a cohort of people whose experience it is in their gift to change.
- They seek to address the aspects of care that are most often neglected in our siloed health system; the user interface, communication, continuity of care, and support with self-management.

We asked local leaders their advice for those working to change the system. Their key messages were to be practical, to focus on people, and to take responsibility for outcomes, rather than transactions.

To be effective and sustainable, neighbourhood health must be appropriately resourced. However, these examples show how local leaders can make progress on neighbourhood working, without waiting for central direction, significant resource or complete datasets. The leaders we spoke to were consistently clear that we cannot keep waiting for all the enablers to be ready and must move forward with creating better models of care. The alternative to holistic, proactive, person-centred care, is crisis and exacerbation, over-relying on hospital-based models, tying ever more resource into urgent and unplanned care, and medicalising acute issues that would better be addressed upstream.

> ***"As a managerial or clinical leader in the NHS it can feel like I just haven't got time to talk about a healthy walking or loneliness group, which are really important, and we know it can make a huge difference if it is done well. The reality is that we're worried about are the 25 ambulances sat outside that hospital that have been waiting over 8 hours, because that's the thing that's flashing up."***
>
> *East Birmingham INT*

If neighbourhood health is going to succeed, national policymakers must take action to unlock barriers for local leaders and set clear expectations on ways of working with the person at the centre.

In the following sections of this report, our learning is organised against the five tests. Under each test, we explore; what the concept is and why it matters; key points of learning; and examples of where it is already delivering impact. The insights from this work don't neatly sit in just one of our tests, reflecting the complex interplay between them. Our recommendations for local and national leaders are set out at the end of this report.

People living with multiple long-term conditions (MLTCs)

One in four of us – an estimated 14 million people – are living with two or more health conditions, and this number is rising.[2] In an ageing population, living with MLTCs has become the norm, with prevalence rising to 68% in people aged 80 years and over.[3] When compared to the general population, people with MLTCs have poorer quality of life and a greater risk of premature death.[4] The burden of MLTCs is unevenly distributed,[5] with people in the most deprived areas acquiring MLTCs 10-15 years earlier than people in affluent areas.[6]

The Richmond Group of Charities' Taskforce on Multiple Conditions, which ran from 2018-2021, in collaboration with the Royal College of General Practitioners, and Impact on Urban Health,[7] carried out ethnographic research which identified a set of common problems facing people living with MLTCs[8]. This includes fragmented care, an overwhelming treatment burden on the person, unaddressed interactions between mental and physical health, unmet social needs which are driving escalating health problems, and clinical care often overlooking what matters to patients. The NHS was designed to treat episodes of illness rather than to manage long-term health conditions, and a model that does not account for the needs of people with MLTCs, or deliver holistic, joined-up care, is ill-suited to the changing needs of our population.

The growth of MLTCs is driving demand on the NHS. Over 55% of NHS costs (for hospital admissions and outpatient visits), and over 75% of the costs of primary care prescriptions, are for people with two or more conditions.[9] People with four or more conditions are 14 times more likely to have unplanned, preventable hospital admissions.[10]

1 Proactive

> **"If you can prevent somebody up front from accessing those [acute] services, then that releases capacity. So it's like being more proactive, really understanding need, wrapping care around the individual and building the wider support functions, so the better…integration with the voluntary sector is what will keep people happy, healthy, for longer in their place of choice at home."**
>
> *Macmillan Cancer Support*

Why it matters

If we want to drive a shift from a reactive crisis–response health system to one that is more preventative, we need approaches to care which are proactive and anticipatory. We need to identify those patients who are most at risk or whose health needs are escalating and put in place the right support to prevent crisis and enable people to exercise greater agency over their health.

All the services and teams we spoke to had developed models of care that were deliberate, planned and preventative. Their offers involved being proactive in identifying people who may need support, and offering it, rather than waiting for them to come to their service when their needs have escalated to a point of crisis. Expecting people to approach services tends to bake in inequity. For example, at the end of life, where inequalities of access to good palliative care are stark, proactive identification of those with needs related to the end of life leads to much more equal outcomes:

> ***"I'm proudest that the group of patients that we are now seeing are the people with needs who wouldn't have found us otherwise."***
>
> *Marie Curie*

We saw the importance of working with communities, to hear from them where needs aren't met, and how to overcome the gap between services and those who need support.

> ***"One of the things that we see is better engagement with the voluntary sector in the communities that are most distant from current healthcare, have least trust in healthcare, building up those relationships, it becomes a two-way relationship."***
>
> *Macmillan Cancer Support*

Starting with one cohort can help unlock resource and energy to move to others. Leaders recognised that a lack of capacity in the system makes it hard to implement proactive care models. In many of the projects, an external agency or partner had provided small amounts of extra capacity or funding to significant effect.

Where teams can access data to evidence where they have freed up crisis and acute capacity, social investment can provide a way of releasing funding and can lead to sustainable transformation. In addition, these models can create a helpful focus on outcomes and deepen relationships between system partners who can otherwise assume they are pulling in different directions.

1 Proactive

> *"The trust have actually commissioned us now [to continue with proactive identification and outreach]. They agreed to commission us 6 months before the pilot ended, actually, so they said, yes, they would take on ongoing commissioning. So it's no longer social impact funding, it's the hospital trust funding it."*
>
> *Marie Curie*

Key points of learning

- **Use the best data you can:** It isn't always possible to get hold of meaningful datasets and risk stratification tools. While guidance emphasises the need for robust data to inform population health management, our practitioners noted that 'You can't let the perfect be the enemy of the good' and used the best data that was available. Deprivation data is valuable in supporting identification of those with unmet needs as it can stand in for a whole host of needs.

- **Start with a defined and manageable cohort:** Many people don't get the care they need, so it's not hard to find groups who need better care. It's best to start somewhere plausible and identify what can be done within available resource, than to continually analyse which cohort to work with first. The Neighbourhood Health Framework provides a steer on initial cohorts to focus on, but practical considerations had driven many decisions: such as; We can visit these 150 households, we can talk to these newly diagnosed people, we can invite these patients to a four-week behaviour change class. In some cases, the scope of projects was very explicitly defined by resource.

- **Non-clinical staff have a key role to play:** Charity partners, health coaches, mental health peer support workers, and others were critical in identifying those who would benefit from more proactive care and conducting the first tier of outreach, enabling clinicians to focus on those in the greatest need of their support.

- **Small scale additional resource can catalyse action, and social investment also presents a potential solution.** Social funding models that deliver health and wellbeing outcomes can free up resource that is currently stuck in crisis demand.

- **Small scale changes can unblock the bigger shifts:** By starting somewhere, with a small change, areas had managed to unlock capacity to plough into further change.

- **Proactive care helps to reduce inequalities:** By looking at the data that helps illuminate need, and then focusing on where need is not being met, we can start to break down inequity.

Examples of where being proactive is delivering impact

- In Leamington Primary Care Network (PCN) the GP practice searches its records to identify people who might benefit from health coaching.

- In Slough, a GP practice identifies households (not just individuals) who have not engaged with routine health checks and appointments for screening and vaccinations and offers them additional help. The simple change of offering a text message service for blood pressure measurements freed up enough clinician time to start home visits for people who had previously not responded to invitations for preventive interventions:

> *"In July this year, I sent something like 400 text messages. I had 198 come back, and 191 of them were normal. So I only had to act on 7 blood pressures out of that group. We saved 191 appointments. But not only that, we've also saved people taking time off work."*
>
> *GP leader, Slough*

- Blackburn with Darwen Council identifies people who would most benefit from physical activity and are most affected by conditions exacerbated by inactivity, and then builds an intervention around them.
- Community Health and Wellbeing Workers focus on the 20% most deprived households within a neighbourhood, using NHS data to identify and visit those who have complex needs.
- Parkinson's Connect reaches out to people newly diagnosed with Parkinson's, offering holistic and flexible support to help people manage the emotional and practical impacts of living with a serious progressive condition.
- There are numerous examples of external partners financing more proactive approaches; Marie Curie made a Band 6 nurse available to help identify and contact the right people for its holistic end of life care project; a health coach in Leamington PCN was funded through a small grant from Sport England; and Greater Manchester worked with the Innovation Unit, a small not for profit change support agency, to codevelop a mental health support system.

MACMILLAN CANCER SUPPORT

Macmillan Cancer Support is working in collaboration with Social Finance and West Herts Teaching Hospital in West Herts, where a Community Interest Company (CIC) was created as an investment vehicle with an outcomes-based contract with the trust to deliver a Proactive Anticipatory Care Service for people with frailty. The approach uses a repayable grant mechanism, which means that the NHS will pay back the funds only when it demonstrably reduces acute hospital spending.

> ***"In theory, what that can do is de-risk the change, and enable some thinking, some innovation locally. So we've got a matched cohort against the population that go through the service, and if we see an improvement in a range of measures, so, like, non-planned use and all that and electives, then they will pay back through the CIC. The CIC will then pay Macmillan over time".***
>
> *Macmillan Cancer Support*

2 Coordinated

"People can receive poorly coordinated care when they have more than one long-term condition and end up being sent around lots of… different hospitals. Sometimes they may have one core risk factor for their health issues such as obesity, which has caused diabetes, hypertension, ischemic heart disease, and so on. So, by bringing specialist advice to the patient in a more agile way, we're trying to avoid waiting times, duplicative or low-value contacts, but still bring an ambition about being treating that person target."

North Central London (NCL) – Complex Long Term Conditions Pilot

Why it matters

A lack of care coordination is perhaps the most tangible problem with current models of care. We have seen how it contributes to poor overall experiences of care and poor outcomes, with people living with MLTCs describing the enormous burden of coordinating different hospitals, GP, pharmacy, and providers of treatments at home. Some could not get support for their multiple needs:

"My sister has early onset dementia, and it has been very difficult to get the right support for her. Our GP says you can only get a ten-minute appointment, and you can only talk about one problem. That is just not enough when you are trying to figure out what support a person with early onset dementia and her family need."

Rose, living with MLTCs and caring for people with long-term conditions

Data sharing across and between services was regarded as the biggest obstacle to improving coordination in our interviews. Some areas had created systemic solutions to support data sharing. Most were operating workarounds, involving lengthy approval processes for limited data access requests, bespoke consents, and staff being put on honorary contracts of different organisations to get access to records. Often the difficulties were as much about trust and relationships as practical or technical barriers:

"When we started to unpack, what is getting in the way here?…It wasn't actually that the technical solutions weren't possible, it was actually that a lot of the digital leaders who have been outside of this journey working with the voluntary sector were not being assured that it would be safe and secure, and that there would be the necessary kind of safeguards."

Innovation Unit, GM Mental Health Transformation

"Parkinson's Connect is up and running and already providing crucial support to thousands of people with Parkinson's and their families. Government support to help unlock the data agreements and streamline this process would be hugely beneficial. It would allow us to roll out our Parkinson's Connect system more quickly, to more hospitals, supporting more people affected by the condition."

Parkinson's UK

2 Coordinated

The prize of better coordination for people is clear, but local leaders also wanted to reduce duplication and administration. Solutions identified range from simple low tech approaches such as coordination meetings (for example those convened by the North Central London clinicians for people with complex long term conditions), through to fully fledged shared records (as per one Life After Stroke Service), and care coordination roles supporting those with complex needs (the British Red Cross High Intensity Use Service).

> ***"They do tend to be cohorts of people that get lost or fall between the gaps, and maybe have had a number of interactions with different services, in terms of attendances. But because they haven't necessarily got an outcome that resolves the crux of the issue, there needs to be time to build relationships and build trust, because in many respects, they will have lost some confidence."***
>
> *British Red Cross, High Intensity Use Service*

Much of the work to improve coordination is achieved through offering people greater continuity of care – which, in turn, is known to be linked to better engagement and outcomes for people.[12] Several services offered people a single point of contact and coordination as they navigated through a complex range of services.

Ultimately, people expect that, at whichever point they access the health and care system, they should get help with their priority needs. This is in line with the principles the Innovation Unit aimed to realise through the mental health transformation work in Greater Manchester: No wrong front door, one assessment, one shared plan across different providers, that has been agreed with the person themselves. In Greater Manchester, this led to dramatically improved outcomes and experiences for patients and wider benefits for the system.

Key points of learning

- **Data sharing remains a barrier:** Some areas have managed to create systemic solutions to support data sharing across and between services, while most operate work arounds.

- **National action on data sharing could help to address these barriers:** For example, Parkinson's UK is asking the Government to unblock the data sharing barriers that get in the way of rolling out their holistic support offer to those newly diagnosed.

- **Non-clinical staff have a key role to play:** As well as supporting coordination, non-clinical staff can also help offer continuity. To maximise their contribution, non-clinical staff must be valued and embedded as part of INTs from the outset, being given parity of esteem with clinicians, and factored into national and local workforce planning.

- **Start small and build trust and relationships:** Teams that made progress on this focused on relatively small numbers of people first, for example working with one clinician who understood the value of partnership working or visiting a small group of households. Starting with a manageable cohort of those most in need of support to navigate systems will allow progress to be made, even while work goes on to address the more fundamental system issues.

- **Poor coordination happens in all sectors:** Lack of coordination exists in the the Voluntary, Community and Social Enterprise (VCSE) sector too, and community offers should be made more visible and accessible to practitioners in the statutory sector as well as to people and communities. In some areas, VCSE alliances have been formed to address this, with lead providers attending Integrated Neighbourhood Teams (INT) meetings with a remit to connect out to the wider community sector, and regular coordinating and information sharing meetings among community organisations of all sizes. There are existing models of coordination within the VCSE sector, which can be drawn upon to support coordination of care, but this work needs to be resourced.

Examples of where coordination is delivering impact

Many teams focused their work on coordinating different professionals and support around people.

- In East Birmingham, the INT discusses complex cases, and coordinates its response around the individual, reducing pressure on practitioners and ensuring fewer people fall between the cracks of fragmentation, handovers and delays. This has resulted in reduced unplanned use of primary (-32%) and community (-15%) services, and A&E attendance (-15%), inpatient stays (-26%) and outpatient attendance (-25%).
- In North Central London, physicians working from two acute hospitals coordinate the care of people living with long-term conditions using specialist services, and support primary care to achieve better outcomes.
- Marie Curie's primary care based palliative care intervention coordinates responses for people approaching the end of life, before they are forced to access emergency support.
- The British Red Cross High Intensity Use service employs non-clinical staff who provide flexible advocacy and care coordination to frequent users of A&E services to help them manage the complex web of support available to them.
- The Stroke Association offers people a single point of contact through Life After Stroke Coordinators who ensure that a coherent plan is made for the person's recovery, and that this plan is documented and shared across all relevant services. This reduces the need for people to repeat their stories.

  "We can be the constant in people's lives, walking alongside people"

  Stroke Association
- Regarding data coordination, in Bath and North-East Somerset the Stroke Association:

  "...have an advanced model, whereby we are actually part of the multidisciplinary team, and we all see and share the same data. ... We are now benefiting from this massively in terms of the level of support we are able to provide stroke survivors.... This means we are all truly part of the same team, and the people we support are fully benefiting from the holistic perspective we add into the MDT [multidisciplinary team] conversation."

  Stroke Association
- In East Birmingham INT the council funds Neighbourhood Coordinators who corral and cohere formal and informal community offers and ensure they address areas and issues of greatest need.

> ***"Once you're introduced to the offer, we're never going to pretend we don't know who you are, so we're having a relationship with you. It's not just a slice of life. You'd sit together as an MDT and look at a case that was referred back in and say, well, it looks like, Charlotte, you've met this person before, why don't you go and see what they're up to and see how they're getting along?"***
>
> *Innovation Unit, GM Mental Health Transformation*

2 Coordinated

The
Richmond
Group
of Charities

Not all care that meets the five tests set out in this report necessarily takes the neighbourhood as its primary anchor point. **Diagnosis Connect** is a digitally enabled service, pioneered by The Richmond Group of Charities and taken forward in partnership with government and the NHS, that will connect people with long-term conditions to specialist charity support at the point of diagnosis.

By enabling direct referrals to trusted voluntary sector organisations, it is intended to strengthen the bridge between clinical care and the psycho-social support services that charities provide in a proactive and equitable way, not relying on people to find their way to information and support unaided. In the context of neighbourhood health, Diagnosis Connect is an example of how systems can embed VCSE expertise into care pathways; helping people access personalised information, social connection and practical support from the outset, thus making care more holistic through partnership.

When coupled with preventative, neighbourhood-based support, this approach has the potential to accelerate self-management and reduce unplanned service use. By pro-actively equipping people with accurate, trusted information and tailored guidance, it aims to improve long-term mental and physical health outcomes, reduce inequalities, loneliness and isolation, and support people to live well with their condition.

3 Cross-sectoral and holistic

> “The GP sat next to her community partners, who sat next to her acute colleagues, who sat next to social care. And we would say ‘actually, we’re all seeing the same people’. What we’ve lost over the years though, you know, is the way we work, the buildings we operate out of, the structures that we put in place, they have unintentionally created division and fragmentation.”
>
> *East Birmingham INT*

Why it matters

Providing holistic support goes beyond coordinating care, to ensuring that care responds to people’s needs in the round. It is vital to get the right professionals in the room, and onto the team, to enable support to respond effectively to what is going on in a person’s life.

We heard from people who did not experience this kind of care, and it led to direct and lasting harm:

> ***“When I was on a hospital ward for my physical health, nurses insisted on taking away the medicines I take every day for my mental health, despite me telling them that this could have serious consequences. The nurses literally told me ‘what do you know, you are only the patient?’….But I was right. My medication was stopped suddenly, and my blood pressure plummeted as a consequence.”***
>
> *Sarah, living with MLTCs*

Holistic care requires partnerships between and beyond statutory providers, as no single service can fully respond to real-life challenges, particularly where these are complex. This requires bringing together colleagues from different NHS providers (such as primary and community care), social care and public health teams based in councils, and partnerships with VCSE organisations. Cross-sectoral working has enabled areas to shift away from over-medicalisation of non-medical, often social challenges. The Government’s Neighbourhood Health Framework recognises the need for a “truly collaborative effort between all partners” but is light on how system leaders could overcome some of the practical and cultural barriers to collaboration with the VCSE.

Strong relationships between practitioners from different disciplines are needed to make holistic practice work. Successful projects usually started from a small set of strong relationships and built outwards. For instance, a clinical leader who understands the need for emotional and practical support after diagnosis and connects their patients with Parkinson’s UK, or a Stroke Association colleague who has worked on an NHS stroke recovery ward and takes those relationships with them into the community.

For VCSE organisations holistic working is often second nature, and motivations for cross-sectoral working are primarily about extending their reach, highlighting the importance of having voluntary sector colleagues as a trusted part of multidisciplinary teams (MDTs).

3 Cross-cultural and holistic

> *"There's a lot of magic here, potentially. Because we are already really good at providing holistic care. If you just let us into your MDT teams, there could be so much good stuff done, because... we already do that. The challenge we've got is we're not necessarily doing it for the people who most need that care."*
>
> *Marie Curie*

For statutory partners, working beyond traditional service boundaries generally presents more of a challenge.

> *"They (A&E staff) are more clinically led. There's no getting away from that. And actually, that's right, the NHS should be doing the clinical stuff. You know, it makes total sense, but it's taken... quite a shift culturally for the NHS to hand over [support for high intensity users], and actually recognise that...there are social circumstances, social challenges that result in this service use, and that they're not the best people to take forward solutions to resolve those issues"*
>
> *British Red Cross, High Intensity Use Service*

Key points of learning

- **Relationships are key:** Unpacking how to build strong relationships is crucial. To do this:

  Build connection organically: Start with the relationship you have – to a clinician, to a commissioner or community group – and then travel along their relationships to build out.

  Invest in connection: Value and fund the contribution of people, organisations and infrastructure that are good at connecting. Invest in the places and spaces where connection can happen – including co-located spaces, work hubs, and meetings.

  Commission for connection: Expect providers to come together and explain how they will strengthen each other and reach people. Short-term contracts and ongoing national reforms impact relationships that take time to build – the system should recognise this and break down barriers to relationship building across organisational silos.

  Recruit and manage great connectors: Recruit staff who understand how to connect and who bring connections. Proactively ask staff about how they are connecting.

- **Partnerships must be deep and wide:** VCSE organisations need to work most closely with statutory partners – who are often larger, national organisations – to build further partnerships with community organisations that can support the most marginalised communities. Fostering relationships can enable 'warm handovers' from more formal services into communities that can nourish and support individuals.

3 Cross-cultural and holistic

> ***"And so, when introducing to another service, the HIU support worker will know that service prior and will visit them to explain that they will be bringing a client and ask that they make a bit of fuss with this person. And so they come through the door, and they have that trust so that the trepidation of going somewhere and joining something is removed and it feels safe.***
>
> *British Red Cross, High Intensity Use Service*

- **Value all perspectives:** Non-clinical perspectives are critical to holistic support and must be valued. This includes social workers, VCSE staff, peer supporters, unpaid carers, and people themselves.

> ***"When something life changing like this happens, you don't just need the best possible medical treatment. You need to hear from people who know what they are talking about, who can help you understand how to live a life with the impacts of illness and treatment…I now volunteer for a group that supports people undergoing this kind of surgery. And now, the doctors in the hospital tell patients about us, and that they can call us, and that we can talk to them."***
>
> *Sue, living with MLTCs*

- **Governance and risk management are important**: Given the different legal and regulatory frameworks under which different practitioners operate, all partners in holistic programmes need to adjust their ways of working and define a new shared approach to governance and risk management. The Neighbourhood Health Framework sets out a requirement for Integrated Care Boards (ICBs) to work with Health and Wellbeing Boards and their partners to develop a locally owned neighbourhood health plan, and this is an opportunity to embed such collaborative ways of working.

Examples of where cross sector and holistic working is delivering impact

- East Birmingham INT brings together NHS colleagues from various sectors with social care professionals, to ensure those with the highest need for holistic solutions are well served.

- In Greater Manchester a more holistic approach to addressing mental health issues between primary care, community mental health, social care, housing, psychiatry and the VCSE, had led to improved outcomes. Experts inside the mental health trust also supported mental health support workers to hold and manage risk.

> ***"People want to feel better connected into the world. They want to feel safe and secure and trusted. They want to have choice and control. These are not clinical outcomes. It fundamentally starts with this focus on real outcomes for people, and that just kind of shapes everything, doesn't it? It's a kind of fundamental rewiring of what we're here for, and the way that we work then kind of follows from it."***
>
> *Innovation Unit, GM Mental Health Transformation*

- The Public Health and health and wellbeing teams in Blackburn with Darwen built a powerful alliance of organisations straddling health, local authority, the physical activity sector, and community groups with the aim of getting people moving more. They offered training to GPs, mental health teams, family hubs, social prescribers, physical activity professionals and small community groups to help create a culture that could outlast any individual project.

> ***"When developing a campaign like this, you need to build the team…identify the key players that are going to enable it to happen so they can help influence the decisions that are being made. Share it in the right places, gather interest and link it to wider priorities and strategies"***
>
> *Blackburn with Darwen Public Health*

4 Equitable

Why it matters

Neighbourhood models won't deliver the desired outcomes if they only reach those who are already empowered and able to navigate the existing system. Crisis demand will only reduce if proactive, coordinated models reach those who are benefiting the least from existing models of care. Interviewees were asked how they ensured that their new ways of working reached those who are most in need of better care and support – people who face socially determined circumstances that make it harder for them to prioritise their health and access the care and support they needed. People living with deprivation are likely to develop conditions 10–15 years before people who are less deprived and there is a higher prevalence of chronic ill health in poorer neighbourhoods.[14]

All interviewees emphasised their desire to address inequity through their approaches but in practice, few places were routinely collecting the data needed to fully understand their impact on health equity. Many were therefore not confident about whether their intervention reached marginalised communities. This is understandable, given some of the previously noted challenges around data sharing, but data collection and sharing on equity issues must be improved. All were able to articulate how their approaches could contribute to addressing some of the known barriers to groups affected by health inequalities, by working to credible and coherent theories of change around addressing equity.

Key points of learning

- **Use the best data you have to target those most in need:** We heard of some great examples of using data to modify approaches (as listed on page 21)
- **Combine the reach of the NHS with the responsiveness of the VCSE sector:** The most promising practice used the NHS's near universal dataset and reach (the vast majority of people are registered with a GP) to identify those who might need specific support, in combination with the creativity and flexibility of the VCSE sector to provide a personalised response to engage people where they were. These models had managed to move beyond a one-size-fits-all approach, offering support that looks different from one community and one person to the next.

> ***"One size won't fit all. You don't provide a universal service just because you offer the same thing everywhere. Strokes are so very different, and people and their communities and places are so very different. You need to tailor your responses if you want to actually reach people in meaningful ways."***
>
> *Stroke Association*

4 Equitable

- **Offer support, don't wait to be asked:** Despite not always having effective data, practitioners were able to reach those who had previously been unserved or underserved by traditional models by taking a more proactive approach that focused on building relationships with those furthest from services and restoring trust.

- **Partnership working is critical:** Partnership working enables partners to pool data and insight on marginalisation and unmet need and enables people to be supported by organisations they already know and trust. Inequalities are often rooted in mistrust and a lack of strong relationships between services and their users,[15] and bias and misinformation can flourish on both sides of these divides.

- **Incentives are often misaligned:** Often incentives within health systems, and to a lesser extent around VCSE contracts, can encourage focus on those who are easiest to help by measuring output targets. These can pull attention and resource away from those who need more tailored support.

Examples of where an equitable approach is delivering impact

- The Complex Long-Term Conditions pilot in North Central London recognised that by focusing on clinical complexity - which is usually correlated with older age - they were at risk of neglecting younger people living with deprivation or social complexity. They built additional criteria into the model they use for identifying people to support with care coordination.

- A health coach working in Leamington PCN used NHS data to identify people signed off work where mental health issues were involved and then developed a specific health coaching programme to support them to return to and stay in work, with good outcomes.

- The Public Health and health and wellbeing teams in Blackburn with Darwen used ward-level data to target the communities bearing the heaviest burden of preventable ill health. It then localised the We Are Undefeatable campaign (developed with Together and Active Future, Blackburn with Darwen Council, The Richmond Group of Charities and funded by Sport England), working with 16 'story tellers', identified through the 'Active Blackburn with Darwen' network of grassroots organisations and groups, to champion physical activity and movement as a route to better wellbeing, through real-life stories of local residents.

- In a small, highly deprived, ethnically diverse area in Slough, proactive home visits helped a local GP practice reach large numbers of households who had not engaged with routine health checks and appointments for screening and vaccinations, often finding it was a lack of trust or practical barriers that got in the way.

- The Community Health and Wellbeing Workers (CHWWs) supported by the National Association for Primary Care (NAPC) often find that practical needs must be addressed before health prevention initiatives are welcomed. Working with such roles allows the delivery of holistic support that can respond to clinical and non-clinical needs at once – including around key social determinants of health such as housing, finance and education. CHWWs visit deprived families with the invitation to enter an open-ended dialogue, rather than focusing on a healthcare transaction.

> ***"Some people accept help right from the beginning...You can't earn everyone's trust all at once but as time goes on the drip effect means that more residents see the benefits to those who are engaging and gradually more and more residents accept the CHWWs support. It can take a year or more before some will let their CHWW in but the CHWWs continue to try at least every month"***
>
> *National Association of Primary Care, CHWW programme*

5 Person-centred

> “I really believe that to live well you have to take some responsibility for your life. Doctors sometimes feel like they ‘do unto the patient’, but actually they need to get better at working with people, and supporting them to live as well as possible. That way you can also plan together for any crisis situation or problems, rather than scrambling around in the moment when things go wrong.”
>
> *Sue, living with MLTCs*

Why it matters

Making care person-centred is ultimately about shifting away from models of care that ‘do to’ people towards models that ’do with’ people. To be effective, neighbourhood health must enable people to be active partners in their own care. Better patient outcomes will only be achieved if people and communities are supported to understand where services can help them, and what they themselves can do to live good lives.

Services and support need to be designed to build upon and maximise people’s own strengths and capacity, and to give them choice and control over their care and their health.

> ***“Parkinson’s Connect empowers patients to become more informed. It helps them and their families better understand their condition and get the most out of their appointments, while also saving clinical time.”***
>
> *Parkinson’s UK*

Building support around the outcomes that matter to people – including dignity, choice, control, belonging, and connection – requires us to rethink the relationship between health and care services and their users. Person-centred approaches often seek to connect people to self-sustaining forms of community and support.

In some areas, support is open ended and flexible – with no set number of contacts before ‘discharge’– but the end goal remains to enable someone to move on with a “warm handover” to peers, or communities.

> ***”There’s no referral in and there is no discharge. Each CHWW is allocated carefully around 120 selected geographically adjacent households and will proactively reach in and support them with no end date”***
>
> *NAPC CHWW programme*

> ***“It is hard to have to learn living with health problems all on your own. It is so much better to have the help of other people. It’s people helping people. That sounds simple, but is actually quite profound. I was contacted by the husband of a woman who had to have this surgery. And he said ’since she has spoken to you, I have my wife back. She was not herself at all, until she heard about your experience, and how you have learned to cope. Now she is herself again.”***
>
> *Sue, living with MLTCs*

5 Person-centred

Professionals in all services need to be challenged and supported to recognise patients and service users as partners in their care and support. This included creating space for people to set the agenda and focus on the things that matter to them, requiring patience and humility from professionals.

> ***"We are sitting with the person, co-producing SMART goals, and a very effective plan of support. So, 'what matters to you'? It might be something really small to start with. That gets that small win over the line, builds the confidence, builds the support, builds the relationship for us to tackle the more difficult things that need to be addressed."***
>
> *British Red Cross, High Intensity Use Service*

> ***"I had a lady a few months ago now, who came because she wanted to lose weight, and then from really talking to her, it then turned out that she had a really, really untidy, cluttered house. And because she had a really untidy, cluttered house, it kind of made everything else really difficult. So by the time we got to the end of the session, her goal was to start decluttering a small part of her conservatory. And then by the time she's come to the next session, she'd done that. And that had improved her headspace when she was working, so that was the way in, but it could go anywhere. It all depends on the patient."***
>
> *Health coach, Leamington PCN*

Key points of learning

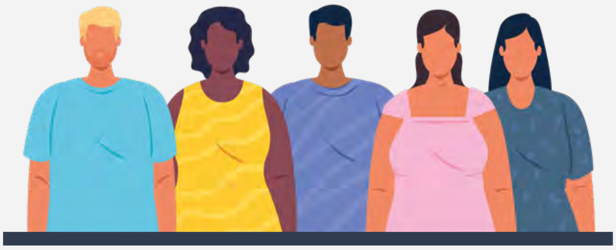
- **Get eye to eye with communities:** Effective person–centred care requires a mindset shift, particularly – but not exclusively – within statutory services towards listening to and working with communities. The term "person–centred" care can be misconstrued as implying a focus only on individuals, but person–centred support that is delivered in communities needs to be shaped with those communities, drawing on their assets, listening to their insights around the challenges, and responding to their priorities.
- **Take your time:** Person–centred working takes time. While clinical staff may not have sufficient time to do this work, non–clinical staff can and should be given time to work with people at their own pace. The time devoted to supporting a person's self–management efforts paid off in developing people's skills and capacity to better manage their own health in the long term.
- **Invest in information and advice:** Investing in better information and advice for people was a cost–effective way of unlocking more agency and better health or system literacy across populations, allowing more personalised and in–depth support to be reserved for those who most need it.
- **Keep roles flexible:** Staff working in person–centred ways need flexibility, so that whoever is best placed to contact an individual is empowered to do so, and can take ongoing responsibility for working with them across different services. Creating separate roles and ways of working for each function is not helpful for people's complex and changing needs. This way of working can be a challenge for statutory services and can present challenges for risk management and professional boundaries, but it is vital. These approaches require teams to hold risk together, freeing up professionals to act with flexibility and creativity.
- **Support community infrastructure:** While people can find their way towards self–sustaining support, they often do so via community organisations that are themselves under significant pressure. While community support is often given freely, the processes of sustaining and connecting it to services is not. VCSE organisations should be commissioned and funded in ways that do not lock them into transactional ways of working impeding their ability to work in person–centred and flexible

ways. The VCSE sector delivers services but is also a strategic partner in building trust and developing person-centred approaches.

- **Work with the right people:** Recruit the right staff (focusing on characteristics, strengths and attitudes, rather than qualifications), and work with people with lived experience, to make sure organisations remain alive to the issues they are focused on.

> ***"We hire based on character rather than characteristics. We hire people that have empathy in abundance and understand confidentiality, we can't teach those but we can teach people how to code conversations and the other skills they use. We hire from the community for the community, ideally they live there but they need to have a connection to the community they are serving".***
>
> *NAPC CHWW programme*

- **Measure what matters:** Outcome measures often focus on the things that matter to systems, not to people. Patient reported outcome measures, and ways of capturing whether services deliver on the priorities people have set for themselves, will help these models be sustained in the long run. If an outpatient clinic or primary care service doesn't improve people's ability to manage their conditions, it is probably not creating much value.



Examples of where a person-centred approach is delivering impact

- Teams moved away from 'check lists' when assessing people's needs.

> ***"We are on a journey with this. Maybe in the past we would have worked with a check list, working through the different aspects of someone's life. But now, using a more person-centred approach, we ask much more open ended questions, for example: How are you coping after your stroke?"***
>
> *Stroke Association*

- Flexible roles are exemplified by the British Red Cross's High Intensity Use Service support workers, who, depending on the person's needs, may variously act as advocates, care coordinators, social prescribers, coaches, or mental health support workers.
- One of the small groups supported by a public health grant in Blackburn with Darwen took people foraging, for materials to make wreaths, spending time in nature and then crafting together. The activities were led by a group supporting people who live with mental ill health, often after bereavement. The team found that spending this time paid off in terms of improvements in participants' wellbeing and connectedness.
- NAPC suggest that all health and care services should be measured based on this outcome: "How would you rate your ability to manage your own health and wellbeing?" using a scale from 1 (not able) to 4 (very able).

Recommendations

Based on the range of evidence presented in this report, we summarise our findings into the following recommendations. We hope that leaders both nationally and locally will draw on the learning from these projects, which demonstrate that integrating care around people is not only possible but far more effective than a system that is fragmented, siloed and reactive.

What local leaders should do

Most of the learning we distilled throughout this report is aimed at local leaders, with the explicit emphasis on how they can get started applying the five tests in their neighbourhoods. Locally, teams have been pragmatic and proactive - recognising the opportunity that will work in the context of their neighbourhoods.

- **Use the best available data,** from all sources, as a starting point to target those most in need of support, rather than wait for the perfect datasets and risk stratification tools.
- Start in a place where you have some control within your available resource and build from a **contained and focused cohort** whose needs can clearly be better met – rather than waiting for others to address persistent systematic barriers which are not within your gift to change. Instead, **identify workarounds to practical barriers,** such as identifying strategies to manage data sharing challenges, tapping into social investment to unlock resource, and finding practical ways to address cultural and system barriers to joint working.
- **Value and invest in relationships** and connection, with both patients and staff from other disciplines, to build trust and support coordination of care.
- **Build the best cross-sector team to address your local challenges** – with an equal role for non-clinical staff, enabled to play to their strengths, and participation from people with lived experience. Teams that have made the most progress have combined the reach of the NHS with the responsiveness and flexibility of the VCSE sector.
- **Work with communities and community organisations** – valuing and resourcing the infrastructure that enables them to make a full contribution. Recognise people as active partners in their own care and support, involving them in the co-production of neighbourhood health plans.
- **Recognise and address cultural and system** barriers to joint working, such as approaches to risk and governance, and in locally owned neighbourhood health plans.
- **Create space and time** to work differently – build in flexibility, space and time to arrange things around people, not systems
- **Measure what matters** – assess real impacts in people's lives, being realistic about how change happens. Recognise **people as active partners** in their own care and support and involve them in the co-production of locally owned neighbourhood health plans.

We recognise that in practice this will mean different things in different places, according to the needs and assets of neighbourhoods themselves. This should be embraced and celebrated, but the consistent golden thread is that people must be at the centre of this transformation.

What national leaders should do

While neighbourhood health will look different in different neighbourhoods and needs to be delivered locally according to local need – there are national decisions and improvements that must happen to facilitate success and make neighbourhood health sustainable. This is about enabling local areas to achieve success for their areas, as opposed to having identical structures in place across the country. National leaders should unlock barriers for local leaders and set clearer expectations on ways of working with the person at the heart.

- **Ensure the non-clinical workforce, including the social care workforce, is planned for alongside clinical staff in future workforce plans.** These roles will be central to delivering different models of care, that are more holistic, more proactive, better coordinated, and more continuous, and better at tackling inequity.

- **The central focus of neighbourhood health should be improving care for people who have the worst experience and outcomes and the greatest need for preventative, community services** – in particular people living with multiple long-term conditions. National leaders should recognise that outcomes will only change if care is shaped around the needs and voices of people and communities. Person-centred care, shared decision making, and holistic non-clinical support should be the primary objective rather than system-centred outcomes.

- **Encourage and enable local leaders to start somewhere**, recognising that they probably won't have the perfect data or data capabilities to design the perfect cohort and intervention. National policy and oversight should be more permissive than prescriptive and enable local leaders to act on their local need. Encourage local leaders to ask the **'so what?'** question: What will we do differently for people whose needs are currently not well met? Give services sufficient time to develop trust and embed change. **Encourage the use of deprivation data,** and community insights as routes into understand where action is needed.

- **Measure and report on what matters.** Patient reported outcome measures, and ways of capturing whether services deliver on people's own priorities, should be used to determine whether neighbourhood health services are working.

- **Dismantle incentives that encourage focusing solely on 'easy to reach' patients** (such as overall waits, or overall number of tests performed) and instead incentivise outreach to people who tend to lose out on prevention offers.

- **Address the barriers to data sharing among local services** by creating clear guidance and practical tools that can be used at local level, and creating headroom and back stop to enable pragmatism in the face of risk-aversion, where needed. The Neighbourhood Health Framework positively commits to standardising data sharing between neighbourhood health services and hospitals, but this should be inclusive of all partners in INTs including non-clinical services.

- **Foreground partnerships in guidance and funding.** Focus funding, guidance and change management support on the connection points between organisations and systems: data sharing, care coordination, social prescribing, alliance contracting, outreach. Make partnership funding the norm, not the exception.

- **Make equalities monitoring and impact a condition** of funding and support and build it into all service innovation and delivery, supporting areas to better understand their impact on health equity and whether their interventions are reaching marginalised communities.

Lastly, this learning is iterative. Going forward, local and national leaders should consider how to future proof neighbourhood health. Neighbourhood health is being, and will continue to be, developed and delivered in the context of new policy developments and structures. Approaches and collaborations need time to become embedded and rooted so that they can improve care and outcomes for people and communities. Developing neighbourhood health around the person and their needs – as opposed to as a health service structure – means recognising that people's health and support needs change over time, as will the support structures surrounding them. The opportunity provided by neighbourhood health is huge, and we stand ready to help deliver if for the people who can benefit the most.

The Richmond Group of Charities

age UK
Alzheimer's Society
Arthritis UK
Asthma + Lung UK
Breast Cancer Now
British Heart Foundation
British Red Cross
Diabetes UK Know diabetes. Fight diabetes.
Macmillan Cancer Support
Mind
MS Society
Parkinson's UK
Rethink Mental Illness
Royal Voluntary Service
Stroke Association

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List of case studies

Blackburn with Darwen Public Health and health and wellbeing team

The public health and health and wellbeing teams at Blackburn with Darwen Borough Council locally adapted We Are Undefeatable, a national campaign powered by The Richmond Group of Charities which aims to tackle physical inactivity amongst people living with long-term conditions. Using public health data to understand which long-term conditions were most prevalent in different neighbourhoods, the council recruited a diverse group of local ‘storytellers’ whose lived experience would resonate with their communities. This approach helped people see themselves in the message, and made the campaign feel relevant, credible and place-based.

The local campaign connected people, via a local public health website, to activities and services available nearby and also helped primary care teams and other professionals to have more confident conversations about “movement as part of living well”, not as an extra.

Through a place-based partnership, Together An Active Future, the council established a borough-wide physical activity and health improvement network, which included partners such as mental health services and family hubs which are not traditionally seen as physical activity providers. Initiatives such as walk leader training and early years balance bike support, helped non-traditional partners to embed physical activity into their everyday work.

To expand the range of community provision, the council invested £100,000 in a physical activity fund, which enabled local providers to pilot long-term condition-specific sessions over 12 months. The council supported communications, helped connect groups into relevant pathways, gathered insight about barriers to access, and worked with providers to plan sustainability beyond the funding period.

The programme combines a strong equity lens with practical system-building: using data and lived experience to make prevention relatable, creating “no wrong door” routes into community support, and investing in relationships and capacity so that more residents, especially those living with long-term conditions, can move more, feel better, and access support that fits their lives.

The Richmond Group and physical activity

We Are Undefeatable is The Richmond Group's physical activity programme, with National Lottery support from Sport England. It includes two key workstreams: delivering the leading behaviour change campaign, We Are Undefeatable, which inspires and supports people with long-term conditions to be active, and influencing policy and practice to tackle systemic barriers to physical inactivity.

The campaign centres lived experience storytellers to inspire people with long-term conditions to become physically active in ways which work for them. We have developed a range of resources – including the We Are Undefeatable app – which support people to move.

We also work with system leaders across England to bring We Are Undefeatable to life at place. We have worked in partnership with Together An Active Future, Blackburn with Darwen Council and others to adapt and deliver the We Are Undefeatable campaign locally. We are currently expanding our place-based partnerships to catalyse greater support for people with long-term conditions to be active. Physical Activity | Richmond Group

British Red Cross – High Intensity Use Services[16]

‘High intensity use’ (HIU) applies to patients who access Urgent and Emergency Care on an above average basis. Richmond Group member charity, the British Red Cross, provides an assertive outreach programme to support people that regularly fall through gaps in the health and social care system and wider services landscape. They are commissioned by a wide range of statutory services including ICBs, in all seven NHS England regions, and are now developing services across the devolved nations.

ICBs share a list of frequent attenders of A&E, which includes some basic information on the presenting reasons for attendance. The service is a holistic and strength-based, one-to-one coaching approach that is tailored to support people who experience complex problems, trauma and a profound lack of trust in professionals. It is a non-clinical, non-medicalised service that works with people to understand unmet socio-economic needs that may be exacerbating physical or mental health conditions and may lead the person to attend A&E. Everyone who is supported by HIU services starts from a ‘clean sheet’, so that from the moment they accept support they can create a new narrative which no longer focusses on what is ‘wrong with them’ but rather ‘what matters to them’. The service recruits staff who are embedded in their local community so they can ensure they are signposted to the appropriate services that will provide ongoing sustainable support. They apply trauma informed and person-centred approaches, listening to the person’s needs and wishes and supporting them to explore possible solutions. Staff typically carry a rolling, balanced caseload of around 12-15 individuals at any one time, based on need and complexity.

Although the HIU service was traditionally designed to support people who access emergency departments more than expected, it has been successfully expanded to include Mental Health pathways, Ambulance Trusts and Adult Social Care.

In 2025 British Red Cross High Intensity Use services reduced A&E attendances for people they worked with by an average of 64%, with 97% of people reporting improved wellbeing at the end of their support.

Community Care Collaborative
Right care, right time, right place
for the people of Birmingham and Solihull

East Birmingham Integrated Neighbourhood Team (INT)

Leaders from across primary care and the wider system in East Birmingham described the development of integrated neighbourhood working in an area with some of the highest levels of deprivation in England and intense pressure on primary care, hospitals and emergency services. The work began in the period immediately after the peak of the COVID-19 pandemic, when demand rose sharply, resources tightened, and it became increasingly clear that many people coming to general practice needed broader support than a GP appointment could provide.

Rather than waiting for a 'perfect' model or fully resolved governance, partners created a pragmatic operating structure at two levels. At a place level (around 250,000 people), a physical coordination hub was established in the area within the footprint of the local district general hospital, bringing together a multidisciplinary team from general practice, community services, adult social care, voluntary sector and mental health. This team focuses on preventing avoidable admissions and enabling earlier discharge, with shared access to records where staff are based in the hub. Alongside this, smaller (around Primary Care Network scale) INTs meet weekly, often physically co-located, to support people who are frequent users of multiple services, including those whose needs are driven by housing insecurity, substance use, low mood or social complexity.

The INTs are not just a signposting forum: they hold responsibility for individuals until problems are resolved, including through joint home visits and coordinated plans across agencies. The approach intentionally strengthens links to the VCSE, largely through social prescribing and council-led neighbourhood network coordination, and by giving the voluntary sector structured representation at place level.

Early evaluation suggests the model is significantly reducing demand across the system for people supported by INTs: GP appointments have reduced by around a third, and A&E attendance, inpatient spells, and outpatient activity have reduced. Those leading the work emphasised that maintaining shared purpose has been essential, and that keeping decisions grounded in what is best for patients has helped partners navigate the complexity of data-sharing, professional buy-in and shifting system priorities.

Innovation Unit: Creating person-centred, holistic, coordinated and community based mental health services in Greater Manchester – Living Well

The Innovation Unit is a not-for-profit consultancy that supports places with creating and implementing community based, sustainable models of support. Based on practice and learning from Lambeth, in South London, and supported by the National Lottery, they worked with different localities across the UK, and then later across Greater Manchester and Derbyshire, to better support the many people who need more support than the GP can offer but cannot access support from community mental health teams.

Working with people and their communities, health and care professionals, the VCSE sector, leaders and commissioners, they co-developed a mental health support system that gave people more access to holistic information, advice, treatment and support, including opportunities to connect with peer groups and community support. The new system offers integrated person-centred support that addresses wider issues such as financial, housing, isolation and connectedness, alongside clinical needs, as required. Multiagency teams, that include people with lived experience and the VCSE, share responsibility for case and risk management, actively supporting people to find creative solutions to their problems and reach their goals.

People are encouraged, rather than deterred from seeking support, and once you have made contact and worked with a professional you are never treated as a new or cold case again.

No wrong front door, fewer assessment and handovers, and more actual and ongoing support, are the main elements of the model they built. People report dramatically improved outcomes and experiences; staff report increased job satisfaction, and wider system benefits are already starting to emerge, including fewer referrals and shorter waiting for secondary care services.

Leamington Primary Care Network (PCN) – Health coaching

We interviewed a Health and Wellbeing Coach working across the eight practices in Leamington Primary Care Network, where a preventative, coaching-led model has been developed to support people with long-term conditions and mental health needs.

The work began with frustration. Dr Hussain Al-Zubaidi, a GP in the network, was concerned that general practice had become too focused on prescribing medication without addressing the behavioural and social factors driving ill health. With no initial funding, he began developing a lifestyle-focused offer in his own time. As patients experienced clear benefits, the practice invested in expanding the model.

At its core are ‘lifestyle clinics’: four one-hour group sessions delivered over four weeks. People can access the clinics through self-referral, referral from a healthcare professional, or proactive population searches. Care coordinators identify patients recently diagnosed with hypertension, raised BMI or mental health conditions and invite them to attend. This outreach has resulted in a genuinely mixed group of participants, rather than only the most confident or health-literate.

Sessions focus on goal setting, behaviour change, and food and nutrition, but are guided by participants’ own priorities and lived experience. Mental health improvements consistently emerge as one of the strongest reported outcomes. A month after completing the clinic, participants are offered follow-up calls and up to six one-to-one coaching sessions to sustain change.

The PCN has also partnered with WorkWell in Coventry to create a bespoke clinic for people off work with anxiety and depression, with early success in supporting people back into employment. Alongside this, community ‘Walk and Talk’ and ‘Run, Talk, Run’ groups, supported in part by council funding, strengthen social connection and wellbeing.

The Health and Wellbeing Coach is embedded within the GP team, with access to clinical records and more time than GPs to explore what is happening in someone’s life. Despite funding for only one coach across eight practices, the work demonstrates how primary care can move from reactive, medication-focused appointments towards proactive, relational and preventative support, with measurable improvements in wellbeing.

Macmillan Cancer Support – Neighbourhood Health Transformation Funds

The first of these funds is the West Hertfordshire (Herts) investment in the West Herts Neighbourhood Integrator which is a partnership between Macmillan Cancer Support, non-profit enterprise Social Finance and West Herts Teaching Hospitals NHS Trust.

Richmond Group member charity, Macmillan Cancer Support, is providing repayable finance to a dedicated investment vehicle (set up as a Community Interest Company "CIC"), which has an outcome-based contract with the West Herts Teaching Hospital to deliver a Proactive Anticipatory Care Service for people with frailty. The CIC includes local partners and residents in its governance, with the intention that it transitions to full local ownership over time.

The approach uses a repayable grant mechanism that funds an outcome-based contract which binds the NHS to pay for the cost of the intervention at the point that it reduces acute spend compared to a matched cohort within the local area.

Proactive anticipatory care hubs will be set up, consisting of multi-disciplinary teams with the explicit aim of supporting wraparound, person-centred, holistic care to 2,000 frail, older people across four neighbourhoods. The MDT includes primary care, prescribing, pharmacy, geriatricians, link workers, and community based support workers. Primary care lists are used to identify people who are at the highest risk of hospital activity, who then undergo a comprehensive geriatric assessment.

As part of the programme, a separate non-repayable grant has been provided by Macmillan Cancer Support to strengthen and build capacity in partnership with grassroots community organisations, which have been facilitated through an interfaith forum, aiming support at marginalised communities.

Similar programmes are also being set up in Dorset and Lincolnshire.

Marie Curie – proactively taking holistic end of life care to people from all backgrounds

We spoke to Marie Curie about two of their innovative service models. Both have in common that they don't wait for people or specialists who might be seeing people at the end of their lives to connect with palliative care. People of colour, people on low incomes, and people who are dying with conditions other than cancer, are much more likely to lose out on palliative care support in the community, and therefore much more likely to die in hospital or even in A&E, which is often not aligned with what they would have wanted.

To respond to this inequality, in Bradford, Marie Curie placed some of their staff in A&E to help identify people who might benefit from end of life care, advance care planning and holistic support for their and their family's needs. People are then looked after by a community-based, coordinated team that operates 24/7 and can support people and their carers in ways that work for them. This work was originally supported through a social impact bond funded by Macmillan Cancer Support and managed through Social Finance. The outcomes this work generated for people, but also for the hospital, meant that the work is now financed out of the hospital's budgets, because it was demonstrated that the intervention reduces unplanned admissions and lengths of stay and was therefore highly cost effective.

In Camden, North London, Marie Curie collaborate with a PCN led by Dr Tom Aslan, again to identify people who seem to be in the last 12 months of their lives. Based on an automated analysis of the GP record, possible patients are identified, and then discussed in a MDT, where appropriate contact is made and a holistic care planning conversation is offered, to ensure people and their families have all the clinical, practical, financial and emotional support they need and to prevent crisis and conveyancing to hospital.

The additional resource put in by Marie Curie is one Band 6 nurse who coordinates the work of the primary care team and any other staff who might need to support the person.

An evaluation of this work will be available in Autumn 2026, but already, those involved are confident that they are providing better, proactive, equitable, holistic, and cost-effective care to people in their own homes.

The National Association of Primary Care (NAPC) – Community Health and Wellbeing Workers (CHWWs) support and roll out[17]

The NAPC provides strategic leadership, practical implementation support, and a platform for national collaboration to the CHWW programme. The NAPC works closely with local systems to embed the CHWW model effectively locally, ensuring alignment with wider health and care priorities. Through training, resources, and ongoing networking, NAPC equips CHWWs with the tools they need to build trust, reduce inequalities, and activate communities from within.

CHWWs is a model which started in Brazil, where it is now the main delivery model for primary care with over 70% of the population having a CHWW. In England, the model was first implemented in Westminster, and there are now CHWWs sites across England, with the largest programme set up in Cornwall.

CHWWs are embedded in primary care teams and the community sector, to proactively assist in providing health and wellbeing services to those communities. They are based around a defined geography of 120–150 households which they visit a minimum of every month regardless of need. At these visits they deal with any pressing issues that members of the households themselves identify, as well as those the CHWW identifies, across their physical, mental and social health needs. CHWWs are recruited from their communities and build trusted relationships with their households and professionals and services on the patch.

Evaluation of the service in Westminster showed that the households who had contact with a CHWW were 47% more likely to have the necessary immunisations and 82% more likely to have cancer screenings and NHS health checks. These households saw a 7.3% drop in unscheduled GP consultations.

North Central London (NCL) – Complex Long Term Conditions Pilot

Around 430,000 people in North Central London are living with one or more long-term condition, with metabolic and respiratory illnesses, such as diabetes and asthma, making up 72% of these conditions.[18]

The model has been developed around the Year of Care methodology, an evidence-based approach which puts personalised care at the heart of delivery. All GP surgeries have signed up to offer a year of care for people living with long-term conditions that includes initial checks, care planning, and follow-ups. This focuses on personalised care and treatment to help people manage their conditions effectively and prevent health issues escalating wherever possible.

The service is funded by the Healthcare Alliance, an alliance of primary and secondary providers, and it uses Healthcare Alliance workforce to conduct operational support and evaluation.

The model of care involves a PCN working with a link consultant, clinical coordinator, and administrator to improve the management of patients with complex long-term conditions. One coordinator works across four PCNs. Teams use data from the LTCLCS and Healthy Intent dashboard to identify patients who require more intensive coordination, either because of service duplication, or because people have fallen through the cracks and aren’t achieving safe treatment targets.

The algorithm used prioritises people who experience complexity at younger ages, which captures a more deprived cohort, and complements other work going on in the system that is focused on frailty.

Parkinson’s UK – Parkinson’s Connect[19]

We interviewed colleagues from Parkinson’s UK, a member charity of the Richmond Group, about their Parkinson’s Connect programme which is available across a range of NHS Trusts in England, Scotland and Wales. Parkinson’s Connect puts people and their families in contact with support from Parkinson’s UK at the point at which they are diagnosed.

The service was conceived of following an audit which showed that many people come away from their diagnosis of Parkinson’s reporting that they didn’t get enough information, or they didn’t know where to turn to next. Often compounding these issues are long waiting times for Parkinson’s services. Parkinson’s Connect is designed to plug the gap and provide crucial support between a diagnosing appointment and the follow up appointment with a Parkinson’s specialist. Parkinson’s Connect aims to support people as soon as possible after diagnosis without overwhelming them, providing them with tools for self-management that they can explore and revisit at any time, with ways to access further support from the charity. Parkinson’s Connect was co-designed with people with Parkinson’s, their families, friends, carers and healthcare professionals.

Doctors and healthcare professionals refer individuals directly to the free service provided by the charity, with data about referrals monitored by the project team at Parkinson’s UK. People newly diagnosed with Parkinson’s can then access the charity’s support to help them better understand and manage their condition. This includes: health information; tips on living with the condition; online learning resources; a Parkinson’s adviser service and confidential helpline; and ways to connect with other people with Parkinson’s, families, friends and carers, across the UK and in their area. Parkinson’s Connect provides direct access to information about how people living with Parkinson’s can manage their symptoms and interact and advocate for themselves in a healthcare setting.

Data sharing has been the biggest challenge to expanding partnerships, as individual data sharing agreements must be negotiated and agreed between every individual NHS Trust/health board, a time consuming and rate-limiting process. But the service now partners with 25 healthcare teams to provide a pathway of support for people affected by Parkinson’s that starts from the point of diagnosis. Parkinson’s UK is looking to expand its network of partnerships to a further 13 healthcare teams by the end of 2026.

Slough – Proactive GP outreach

This case study draws on an interview with a GP leader at Kumar Medical Centre specialising in long term conditions and population health, who has developed a practical approach to improving prevention and continuity in a small, highly deprived, ethnically diverse practice. The work began after the COVID-19 pandemic, when the local population's health had deteriorated sharply and changes in general practice staffing and digital access had reduced continuity. With more professionals involved in care, tasks were being handed around, leading to fragmentation, while people with the greatest need were losing out on proactive support.

The approach starts with using a shared care record and a population health analytics tool to segment the whole population by need, not just by service use. Instead of a simple green, amber and red risk grouping, the population is divided into smaller needs-based groups designed for service delivery, with each person in one group at a time. This enables care to be redesigned around what people need and how they live, rather than around age, diagnosis templates, or who happens to present most often.

In practice, segmentation is applied at the front door of the practice to direct individuals to the most appropriate response after any red-flag symptoms have been assessed. Reviews shifted from date of birth scheduling to inviting people in order of complexity, so those at highest risk were seen earlier and more than once before winter. Lower need groups were supported through text-based monitoring, such as home blood pressure readings, reducing unnecessary appointments while increasing coverage for people who cannot easily take time off work. Workforce roles were also aligned so more complex patients saw senior nurses and pharmacists who could adjust treatment in one contact and support deprescribing where appropriate.

By reducing potentially avoidable appointments and matching capacity to need, the practice reported releasing meaningful capacity in the first year and completing a much higher proportion of chronic care reviews earlier in the year, with improved control for many patients going into winter. This then created time for prevention activity, including vaccination, screening and health checks, and for proactive outreach. After repeated invitations, the team reviews which households are not engaging across immunisations, screening and long-term condition reviews, and then carries out home visits to deliver checks and start supportive conversations across generations. The practice has also worked with the voluntary sector to improve digital inclusion and to run community led hubs offering accessible wellbeing and movement support, including targeted engagement of families at higher risk.

This shows how prevention can be made more equitable by shifting routine care to the lowest appropriate intensity, freeing time to focus on complex need, household level outreach, while bringing the whole practice team and local voluntary sector into a shared approach.

Stroke Association – Stroke support services

Richmond Group member charity Stroke Association's stroke support services are designed to help stroke survivors make the best possible recovery. They offer a range of services covering the whole stroke pathway. Their services are commissioned by the NHS or local authorities across the UK.

Upon referral, the Stroke Recovery Service provides person-centred support with Stroke Support Coordinators working with stroke survivors and their families to understand what is important to them. The service provides: a tailored stroke support plan; practical and emotional support; access to stroke-specific self-management tools and support; signposting to local support; representation and advocacy support; and peer and social support. Stroke Association recruit and train their Stroke Support Coordinators based on listening skills and a relational way of working.

How they work with the NHS varies according to place. In some areas they are told by a Stroke ward that someone is being discharged, in others Stroke Coordinators routinely attend board rounds on the stroke unit. Stroke Coordinators are sometimes part of the MDT and will meet regularly with them. For example, in Bath and North-East Somerset, they have an advanced model in which Stroke Coordinators play a full part of the multidisciplinary team, including seeing and sharing all the same patient information, and being able to add to it.

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