The Richmond Group of Charities

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

Executive Summary

June 2026

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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.