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INSIGHT • ANALYSIS • INTELLIGENCE

INSIGHTS

# Shaping neighbourhood health through a household lens

**CHAIRED BY DR MO ALI**

quantexa

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# Key Information

## ABOUT PPP

Public Policy Projects (PPP) is an independent organisation operating at the heart of health and life sciences policy delivery. We bring together senior leaders and practitioners in the public and private health and life sciences sectors to find realistic solutions to the most pressing issues relating to health and care delivery.

## ABOUT PPP'S NEIGHBOURHOOD PROGRAMME

PPP is convening a national coalition of leaders and experts to develop an impactful policy and events series dedicated to realising the vision of a Neighbourhood Health Service. This series aims to add value to the national and local debate on neighbourhood health by exploring issues that are not sufficiently addressed in existing forums. This programme will look beyond traditional health and care boundaries and provide neighbourhood teams with a unique platform to engage with a range of stakeholders. The series will focus on the practicalities of delivery — providing real-world route maps, case studies, and step-by-step examples of how local systems can move from strategy to implementation.

## ABOUT THIS REPORT

The findings of this report are based on a roundtable chaired by Dr Mo Ali, Managing Partner of GP Pathfinders. PPP has supplemented the findings with independent research, and quotes have been lightly edited for clarity.

Sponsorship for this report was provided by Quantexa. Quantexa is a global data, analytics, and AI software company pioneering Decision Intelligence. Quantexa helps private and public sector organisations turn fragmented data into trusted, contextual insights to support more confident decision making across areas such as risk, fraud, financial crime, security, and public safety. PPP has retained editorial control of the report and its findings.

# Foreword

**DR MO ALI**
**Managing Partner, GP Pathfinders**

At the heart of neighbourhood health is the idea that better outcomes will depend on our ability to understand people not only as patients, but as members of households, families and communities whose lives are shaped by wider social, economic and environmental factors.

National guidance and frameworks are increasingly pointing systems towards prevention, earlier intervention, integrated neighbourhood teams and more strategic use of population health insight. While the direction of travel is clear, the real test is not whether national policy can articulate the ambition, but whether local teams can interpret it in ways that make sense for their communities.

That is why I was encouraged by the discussion captured in this report. Across the roundtable, there was a strong sense that local leaders are not waiting passively for perfect conditions. They are working through complexity, testing approaches, building relationships and using the best information available to identify people at rising risk. In places such as Kensington and Chelsea, Westminster and Herefordshire, teams are already trying to translate national frameworks into practical models of care that reflect local need, local assets and local realities.

A key theme throughout the discussion was the importance of a household lens. Too often, services are still organised around individual episodes of care, single conditions or separate organisational responsibilities. However, people's needs rarely present so neatly. Housing insecurity, caring responsibilities, trauma, loneliness, deprivation and family circumstances can all shape health outcomes and patterns of demand. A neighbourhood model that fails to recognise these risks will ultimately recreate existing silos at a smaller geographic scale.

The opportunity is to build neighbourhood health around a more relational and contextual understanding of need. Connected data plays an important role, but only if it supports action. The value lies not in more dashboards, but in giving multidisciplinary teams the insight they need to ask better questions, coordinate support and intervene earlier. Equally, voluntary, community and local government partners must be treated as core contributors, not peripheral additions, because they often hold the relationships and trust that make neighbourhood working possible.

Local teams are operating under significant pressure, including constrained capacity, fragmented information and changing expectations from national policy. But the examples in this report show that progress is possible when systems are given enough flexibility to learn, adapt and build from the ground up.

# Key Insights

1. **Using a household lens to strengthen neighbourhood health design**
   Neighbourhood health models should move beyond a narrow focus on individuals and single conditions and instead incorporate the household and wider social context in which needs develop. This means designing pathways, case-finding approaches and multidisciplinary discussions that take account of caring relationships, housing, deprivation, trauma, and other factors shaping health outcomes. A household lens would help teams identify rising risk earlier and target support more effectively before needs escalate into crisis.

2. **The perfect should not be the enemy of the good**
   Local areas should not be expected to wait for fully mature linked data environments before beginning neighbourhood implementation. National and local leaders should support a pragmatic approach in which teams use the best available information to identify cohorts, test interventions, and build learning into delivery. At the same time, longer-term investment is needed in data linkage, analytical capability and tools that help neighbourhood teams understand household complexity and wider determinants more clearly.

3. **Relational infrastructure is essential to effective neighbourhood working**
   Neighbourhood health depends on both formal service integration as well as roles and functions that can connect people, services and communities. Systems should strengthen connector roles such as social prescribers, navigators, community health and wellbeing workers, and other bridging functions that enable professionals to work more relationally and help people access the right support beyond clinical care. These roles are central to making integrated neighbourhood teams more effective in practice and to reducing the burden on overstretched frontline staff.

4. **The VCSE sector must be a core partner in neighbourhood health**
   Voluntary, community and social enterprise organisations should be treated as equal partners, not supplementary providers. Longer-term funding, strategic engagement and inclusive data-sharing are needed so they can contribute fully to care coordination and prevention, drawing on their trust, reach and local knowledge.

5. **Local government and cross-cutting public services must be built into neighbourhood partnerships**
   Neighbourhood partnerships should involve local government, local authorities and wider public services from the outset. Education, prison and probation services, housing and employment support all shape health outcomes and are essential to addressing wider determinants of health and coordinating support for people with complex needs.

6. **Shared learning and locally-led change remain critical to progress**
   Neighbourhood health will develop most effectively if local leaders, providers and partners can test new approaches, learn from one another and adapt models to their own context. National bodies should support this by providing flexible frameworks and aligned funding, rather than overly standardised solutions. Locally, systems should invest in leadership, peer learning, and cross-sector networks that enable successful practices to spread and reduce the isolation of individual neighbourhood initiatives.

# Roundtable findings

## WHY NEIGHBOURHOOD HEALTH NEEDS A HOUSEHOLD LENS

Neighbourhood health has become the clearest expression of the NHS' long-standing ambition to move care closer to home. There is growing recognition, most recently articulated through the Neighbourhood Health Framework, that better health outcomes will not be achieved through acute services alone, but through earlier intervention, stronger prevention, and more coordinated support delivered in community settings.[1] However, while the language of person-centred and place-based care is now well established, the models through which services are organised often remain rooted in a narrower view of need: one person, one condition, one service at a time.

This tension was a central theme throughout the roundtable. Participants reflected that, in practice, people do not experience their lives through separate clinical pathways. Individuals live within households, families and communities, with their health shaped as much by these relationships and circumstances as by any single condition or diagnosis. As was noted by delegates, many patients are still treated through fragmented, disease-specific approaches that fail to recognise them as whole people or account for the context of the households in which they live.

A neighbourhood model that focuses solely on the individual will reproduce silos at a smaller geographic scale. This has important implications for data, the workforce and service design. Current systems are still largely organised around individual patient records, organisational boundaries and condition-specific performance measures.

By contrast, a household lens offers a way to understand the wider context in which need emerges and escalates. It draws attention to the interdependencies that shape health and care demands, such as caring responsibilities, housing conditions, income and food insecurity, social isolation, trauma, and patterns of behaviour that can be reinforced across generations.[2] Participants argued that this "*missing middle*" between the individual and the wider place is often where the most meaningful opportunities for prevention exist.

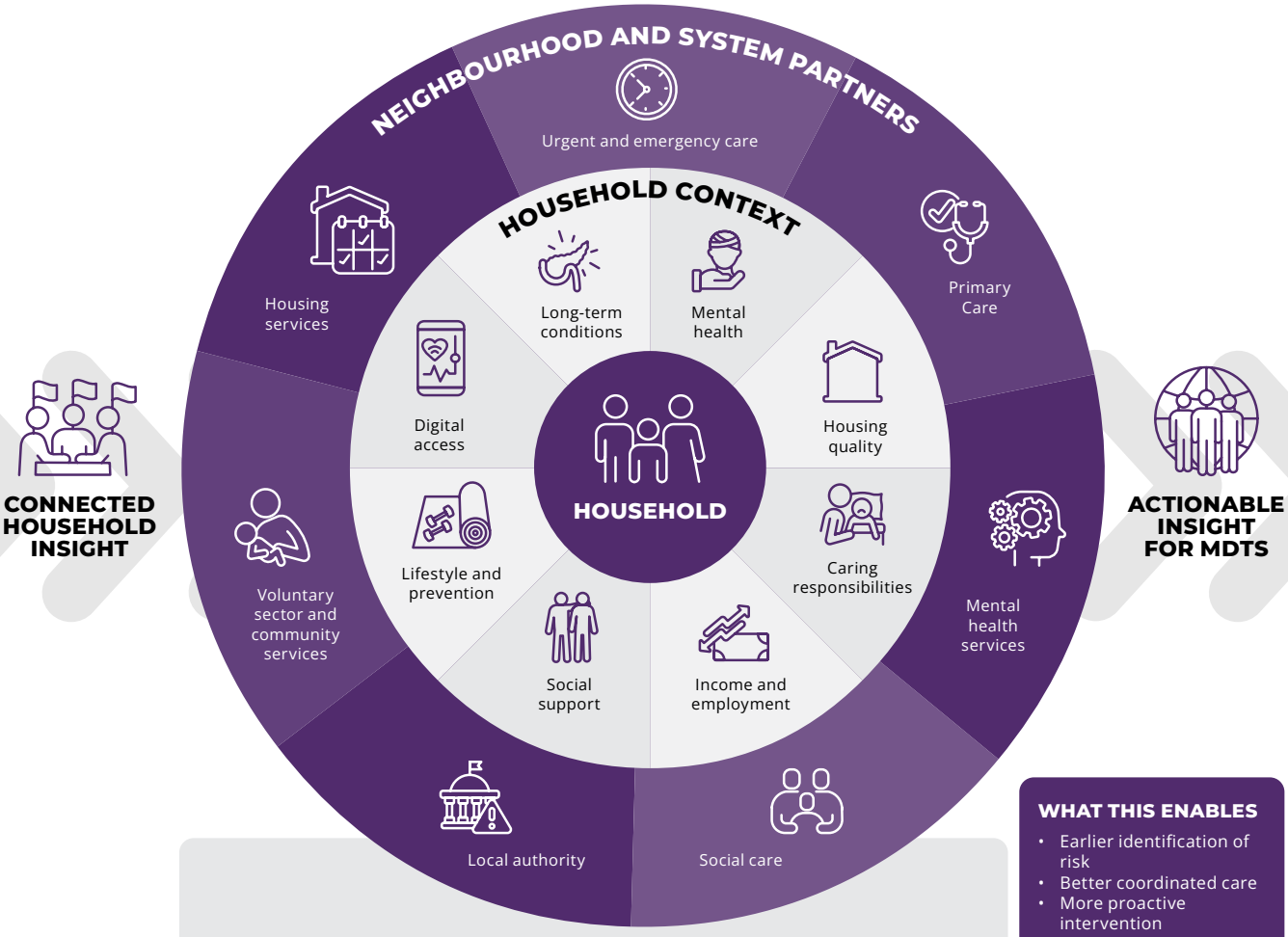
Taking a household lens also helps reframe the overarching purpose of neighbourhood health. Rather than simply coordinating services around people who are already in crisis, it enables teams to identify rising risk earlier, understand the drivers of vulnerability, and intervene before needs intensify. Examples discussed during the roundtable showed that when professionals combine clinical knowledge with a better understanding of household and social contexts, they are more likely to spot hidden risks, respond with more clarity, and avoid repeated or ineffective contacts with services.

A household lens is not an optional refinement to neighbourhood health, but a central and practical means of integrating care. It helps shift the focus from episodic, transactional care to a more relational model that supports prevention, independence, and resilience. It also provides a stronger foundation for multidisciplinary working, particularly when connected data can give multidisciplinary teams (MDTs) a more complete view of household, social and service-related factors that would otherwise remain fragmented across organisations.

## WHAT IMPLEMENTATION LOOKS LIKE ON THE GROUND

Roundtable participants shared a sense of optimism that, in many areas, neighbourhood working is already taking shape through practical efforts focused on integrated working. While models differ by place, participants described a shared determination to move beyond organisational silos and build teams around cohorts with rising levels of need, particularly those whose health outcomes are shaped by a combination of clinical, social and environmental factors.

## A HOUSEHOLD LENS APPROACH TO HEALTH AND CARE




**By understanding the whole household and working together across the system, we can improve outcomes and build healthier communities.**

**WHAT THIS ENABLES**

- Earlier identification of risk
- Better coordinated care
- More proactive intervention
- Support for prevention and independence
- Reduced avoidable escalation

This means bringing professionals together around a neighbourhood footprint, and equipping MDTs with clinically actionable insights and a connected view of household context that can support earlier, better coordinated intervention.

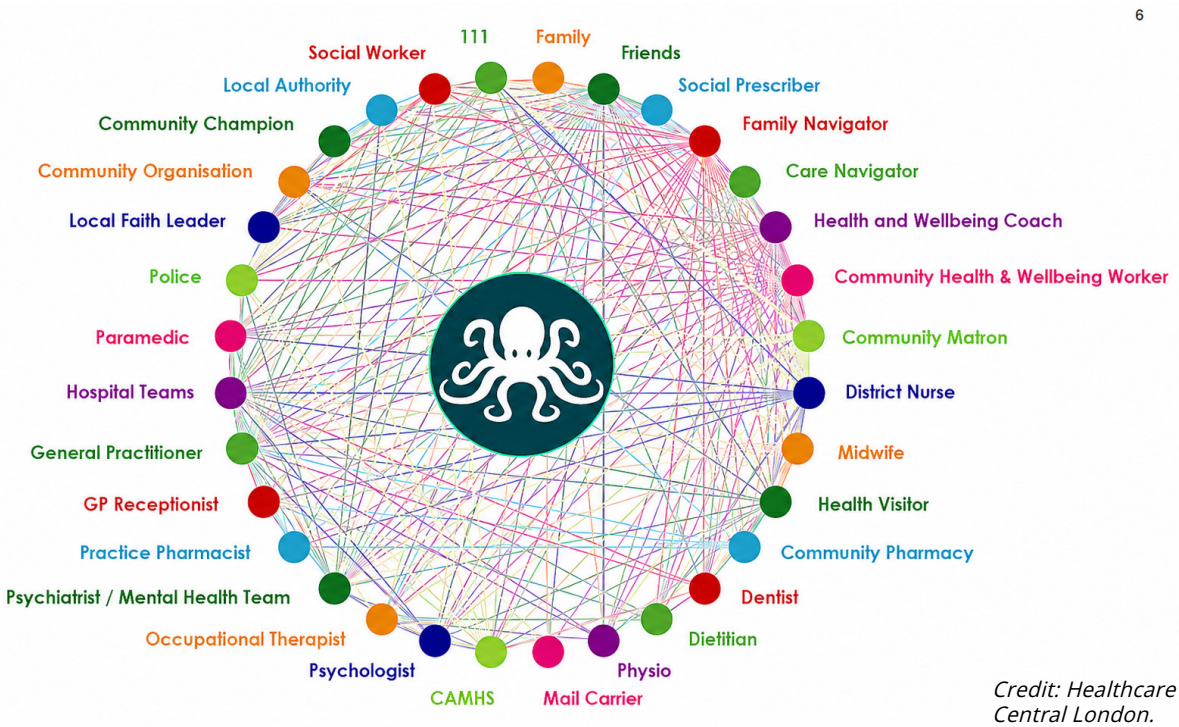
In Kensington and Chelsea and Westminster, for example, the neighbourhood approach is being developed through both the National Neighbourhood Health Implementation Programme (NNHIP) and a broader place-based partnership model. Participants described how local partners had already been working together around specific communities, including children and young people, people experiencing homelessness, and those living with frailty.[3] Building on that experience, they are now focusing their implementation efforts on adults with multiple long-term conditions who may be at risk of deterioration, using a rising-risk approach shaped by both clinical indicators and wider determinants of health.

Participants framed this work as a different way of organising existing capacity within the system, rather than a wholly new service. Local partners have placed integrated neighbourhood teams around identified cohorts, bringing together general practice, community services, mental health practitioners, and specialist input where needed. Their aim is to case-manage people differently – by responding to episodes of illness as well as understanding the wider context of their lives and intervening earlier to prevent further escalation.

This approach is increasingly reflected in wider neighbourhood development. For example, NHS England London reports that place-level partnerships are being used as the key layer for developing neighbourhood health, with integrated neighbourhood teams intending to improve population health and reduce inequalities at place level. The report also describes 'integrator' arrangements bringing together primary care, community, mental health, acute, local authority and voluntary, community, faith and social enterprise partners to support delivery at a neighbourhood level.[4]

This approach is closely tied to relational models already being developed in different places. In Westminster, participants referred to the 'octopus model,' (illustrated below) while in Kensington and Chelsea, they described a neighbourhood navigation model built on similar principles.[5] Although the terminology differs, both models seek to create stronger links between health services, local authorities and communities, with community relationships acting as the 'glue' that holds integrated working together. This emphasis on relational infrastructure is vital as the success of neighbourhood health will depend equally on the quality of connections between statutory services, voluntary organisations and local residents, as well as formal team structures.

A similar pattern emerged in Herefordshire, where local leaders described a test-and-learn approach to implementation. There, neighbourhood development has been supported through a locally commissioned framework for general practice, intended to help primary care networks begin building integrated neighbourhood teams. Participants noted that one of the main challenges has been helping local partners see this as a practical enabler of neighbourhood working, rather than a separate programme. To support this, local teams have focused on leadership development, organisational development




*Credit: Healthcare Central London.*

and cohort identification, while also trying to simplify the language and expectations around neighbourhood health.

The Herefordshire example also highlighted the pragmatic reality of implementation. Rather than waiting for perfect linked data, teams have used the best information available to begin identifying people at rising risk, including those with multiple long-term conditions and previous hospital admissions, as well as people living in areas of higher deprivation and poorer outcomes. This has allowed them to begin testing changes in practice, even while acknowledging the immaturity of the underlying data.

These local examples underline that implementation is as much about culture and operating models as it is about structure. Neighbourhood health requires services to work differently with one another and to rethink the types of support people need. Contributors emphasised the importance of MDTs who can bring together clinical expertise with community knowledge, as well as smaller collaborations formed around particular problems. One example involved joint visits by a nurse and a housing surveyor to local authority homes, allowing health concerns and housing issues to be addressed together rather than in parallel. This illustrated how neighbourhood implementation can move beyond coordination between health services alone and begin to reflect the wider determinants that shape demand.

What these examples collectively show is that implementation on the ground is iterative, relational and highly context specific. There is no single blueprint for neighbourhood health. However, the places represented in the roundtable shared several common features:

- A focus on rising risk cohorts
- A willingness to work with imperfect information
- The development of integrated teams around defined populations
- A growing recognition that community and household context must be built into decision-making from the outset

## THE PRACTICAL BARRIERS TO NEIGHBOURHOOD DELIVERY

While participants were optimistic about the potential of neighbourhood health, the discussion made clear that delivery is held back by persistent, interconnected barriers. These are not simply technical issues. They reflect deeper challenges in capability, culture, funding, information-sharing and system design that make it difficult to turn the ambition of integrated, preventative care into routine practice.

The practical barriers to neighbourhood delivery should be understood in the context of current national guidance. NHS England's Strategic Commissioning Framework sets out a clear expectation that ICBs will take a more strategic, evidence-based role in planning and reshaping services to improve population health and reduce inequalities.[7] However, the Medium Term Planning Framework for 2026/27 to 2028/29 is equally clear that this work is taking place within a demanding planning environment that requires systems to deliver operational performance and transformation in parallel.[8]

Delegates outlined that many local areas face a tension between the ambition of neighbourhood reform and the practical capacity available to implement it. For example, reports show that analytical capability in health and care is currently fragmented and under pressure at the very moment when neighbourhood health, strategic commissioning and wider service reform all require stronger local intelligence and planning capacity.[9]

Participants highlighted cumulative challenges in delivering neighbourhood health. Fragmented data, limited local capability, misaligned

### WHY NEIGHBOURHOOD WORKING REMAINS DIFFICULT IN PRACTICE

**The fragmented nature of data sharing:** Neighbourhood teams and MDTs still lack a connected household view across GP, community, mental health, local authority and urgent care data, limiting their ability to identify rising risk, understand context and prevent avoidable demand.

**Searching for data perfection:** Neighbourhood delivery can stall when systems wait for ideal datasets, complete interoperability, or a fully mature analytical model before beginning implementation. Teams should work with the best information available, using it to identify likely cohorts and refine the approach over time.

**Uneven distribution of analytical expertise and capacity:** Many local systems may have access to large volumes of data but lack the workforce, skills and leadership capacity needed to translate that information into practical insight for neighbourhood teams.

**Systems remain fundamentally transactional:** Professionals operate under pressure, with limited time to explore the broader context of someone's life. As a result, critical issues may go unnoticed because the system is not designed to support relational curiosity or shared follow-up.

**Vital sector partners remain marginalised:** Voluntary and community sector organisations lack access to relevant data and are funded through short-term arrangements, limiting their effectiveness and the wider system's ability to create a household view of citizens.

funding, transactional service models, and weak integration of community partners – each challenge reinforces the other. Progress will hinge less on finding a single technical fix and more on building the practical conditions in which neighbourhood teams can act. Teams need enough shared information to make informed decisions, enough trust across sectors to work together, and enough flexibility to learn by doing.

## FROM TRANSACTIONAL CARE TO RELATIONAL CARE

A central insight from the roundtable was that neighbourhood health requires a shift in the underlying model of care, rather than a service redesign. Participants repeatedly contrasted a transactional model, in which care is organised around episodes, conditions and professional tasks, with a more relational approach that sees people in the context of their households, communities and wider circumstances. In this sense, neighbourhood health is not simply about creating new structures, but about supporting more person-centred, coordinated and context-aware care. The latest guidance explicitly positions neighbourhood health around more person-centred and coordinated support, with implementation shaped around local population needs rather than a single fixed service model.

What enables that shift is a combination of connected insight, new roles and different ways of working. Participants argued that contextual,

connected insight should support rather than replace relational care, helping practitioners understand the household, social, and service-related factors that shape need.

Attendees also described relational care as requiring a more biopsychosocial understanding of need. A person may present repeatedly to services with what appears to be a clinical issue, while the underlying drivers may lie in housing instability, trauma, loneliness or other psychosocial pressures. NICE guidance on domestic violence and abuse, for example, underscores the importance of frontline staff being able to recognise indicators of abuse, ask appropriate questions safely and sensitively, and link people into multi-agency support pathways rather than treat the presenting episode in isolation.[10]

## FROM TRANSACTIONAL TO RELATIONAL CARE

**Why neighbourhood health requires a different underlying model of care**

### TRANSACTIONAL CARE

**Medicalised, episodic:** Care responds to a presenting episode or condition.

**Condition-led:** Needs are separated into clinical, social and psychological silos.

**Fragmented visibility:** Wider drivers of need can remain invisible.

**Task-driven:** Heavy caseloads and defined tasks leave little space to explore context.

**Likely result:** Repeated contacts, escalation and inefficient use of services.

**Presenting issue may hide wider drivers**

- Housing instability
- Trauma
- Loneliness
- Abuse & safeguarding

### WHAT ENABLES THE SHIFT

**Connected insight:** Data connectivity helps build context across household, social and service factors.

**Biopsychosocial approach:** People's needs are layered and interconnected.

**Connector roles:** MDTs, social prescribers, community health and wellbeing workers provide continuity and follow-through.

**Relational infrastructure:** VCSE partners, workflows and MDTs make relational care operationally possible.

**Shift in logic** from transactions delivered to isolated individuals > to care shaped by relationships, environments and shared responsibility.

### RELATIONAL CARE

**Person, household and context:** Care is organised around the whole person and their wider circumstances.

**Continuity and trust:** Relationships become a core component of effective care.

**Joined-up support:** Statutory services and community support work together.

**Earlier, more appropriate action:** Teams can intervene before needs escalate.

**Likely result:** Prevention, better coordination and reduced avoidable pressure elsewhere in the system.

**Relational care combines human relationships with connected insight to surface hidden need, support earlier intervention, and improve outcomes.**

Relational care also depends on infrastructure that makes it operationally possible. Connector roles such as social prescribers, navigators, community health and wellbeing workers, alongside stronger MDT workflows, can provide the continuity and follow-through that transactional systems often lack. Participants further emphasised the importance of the voluntary and community sector as part of this relational infrastructure, given its reach into communities, trusted relationships and understanding of wider determinants. When these elements are in place, teams are better able to intervene earlier, coordinate support more effectively and reduce avoidable escalation elsewhere in the system.

## WHAT DATA SHOULD ENABLE

The real value of connected data lies in enabling action. For neighbourhood teams, and especially for MDTs, connected data can help bring together information that is typically dispersed across and beyond health and care. This can give teams a more complete and contextual view of individuals and households, helping them identify needs earlier, make more confident shared decisions, and intervene in a more coordinated way. Connected data is the central means through which neighbourhood models and MDTs can become more proactive, efficient and person-centred.

However, most data infrastructures remain better suited to organisational accountability and single-service delivery than to MDT-based neighbourhood working. Information commonly held in separate systems is often difficult to connect in ways that make sense for MDTs. This means that neighbourhood health services can struggle to build a timely, context-rich picture of the people and households they aim to support.

Participants suggested that, if it is to support neighbourhood health effectively, data must enable at least four things:

1. **It must help systems identify rising risk earlier.** This includes recognising people with multiple long-term conditions or previous high service use, but also surfacing patterns that indicate likely deterioration before a crisis occurs.

2. **Connected data must help multidisciplinary teams understand context, not just activity.** A recurring theme in the discussion was that health outcomes are shaped by a much wider set of influences than traditional clinical records alone can capture. Connected data must be used to provide MDTs with context on housing, frailty, mental health, caring arrangements, deprivation, service access, and other social factors, all of which affect how need develops and where demand falls.

3. **It must support multidisciplinary decision-making.** Delegates discussed the importance of making information usable for the people delivering neighbourhood care, including those outside traditional NHS structures. This means moving beyond a narrow focus on technical linkage and asking what different members of MDTs need to act together.

4. **Data must also make visible the scale and significance of household complexity.** One of the most striking examples in the discussion came from work in Merseyside, where linked data across health and local authority services was used to build a clearer picture of vulnerable children and the households around them. This work highlighted the disproportionate impact that a relatively small number of complex households can have on overall health and social care demand.

Importantly, the roundtable also warned against setting the bar for data too high. While there was broad agreement that better linkage and interoperability are needed, those already delivering neighbourhood health stressed that it is possible, and necessary, to begin

with imperfect information. Waiting for ideal data can delay learning and reinforce a culture of inaction. Several participants described using the best data available to create an initial picture of need, test assumptions on the ground, and refine their approach as relationships and evidence develop.

The discussion also highlighted the importance of trust and inclusion in any data-enabled neighbourhood model. If the voluntary and community sector is expected to play a more comprehensive role in neighbourhood health, then data-sharing arrangements must reflect this. Voluntary organisations are often well placed to understand local needs and build relationships with people and families, but they may not have access to the same information as statutory partners or the means to evidence the impact of their work. A more effective data environment would therefore support more equitable participation across the full range of neighbourhood partners.

Ultimately, the roundtable questioned the core purpose of data in neighbourhood health. If its purpose is merely to provide more dashboards or satisfy institutional reporting requirements, it will do little to change health outcomes. However, if data is connected to reveal context, surface hidden risk, strengthen MDT-decision making and support earlier intervention, it can become one of the key enablers of a more relational and preventative model of care. Participants called for a fundamental shift from fragmented information about isolated service users to actionable insight about people, households and communities.

# Conclusion

The roundtable made clear that neighbourhood health will only fulfil its promise if systems move beyond narrow, service-led models of care and develop a fuller understanding of the contexts in which people live. Participants repeatedly returned to the importance of seeing individuals as members of households, families and communities whose health is shaped by a wide range of clinical, social and environmental factors. This broader lens is essential if neighbourhood health is to support earlier intervention, reduce avoidable demand and address inequalities more effectively.

The discussion also showed that many of the building blocks for this shift already exist. Local systems are beginning to test integrated neighbourhood teams, relational models of care and more pragmatic uses of data to identify rising risk and respond more holistically. However, progress remains uneven, held back by fragmented data, limited local capacity, transactional service models and the continued marginalisation of voluntary and community partners.

Throughout the discussion, a recurring theme was the need for neighbourhood teams to move from fragmented service views to a more connected household view of need, generating actionable insights that can strengthen MDT decision-making, support earlier intervention, and reduce avoidable escalation.

To succeed, neighbourhood health must be treated as more than simply another structural reform. At its core, neighbourhood health is a more fundamental way of understanding need and organising support that depends on stronger relationships, better shared insight, and the confidence to act before problems escalate. If systems can build on that principle, neighbourhood health has the potential to become a meaningful vehicle for prevention, integration and more person-centred care.

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*This roundtable was held under the Chatham House rule. As such, comments and insights are anonymised and attendance does not necessarily mean personal endorsement of specific points.*

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