Graphnet
Transforming Care

THOUGHT LEADERSHIP

Neighbourhood health: we have the tools to make it happen.

Now we need to use them.

By Markus Bolton, Executive Director, Graphnet Health



Having worked in health technology for more than 40 years, I've seen numerous attempts to change how care is delivered. I've been advocating a shift away from hospitals and towards prevention for well over a decade, so it's encouraging to see neighbourhood health becoming a central part of national policy.

There is now widespread recognition that the NHS cannot continue operating in the way it does today. Hospitals are already working at capacity, growing numbers of people are living with complex conditions, and demand will continue to increase as the population ages. The direction of travel is right, although we have been here before, with successive initiatives promising more integrated services, earlier intervention and better use of the information already held across health and social care.

My concern is that we could spend another decade designing programmes and commissioning technology when much of what we need is already available. Delivering neighbourhood health need not be as difficult as it is sometimes made out to be, although it does require focus, local ownership and a willingness to change how services operate. Rather than waiting for another national programme to provide the answers, we should be looking at how existing capabilities can be used to identify people who would benefit from earlier support and give local teams the means to provide it.

Organising care around people rather than institutions

Much of the NHS's investment in digitisation has understandably focused on electronic patient records and systems supporting individual hospitals and other organisations. This has been necessary work, but neighbourhood health requires something broader because the services involved extend across primary care, community services, hospitals, mental health, social care and the voluntary sector.

What we need is a Care System Platform that brings together four complementary capabilities. Connected Care makes relevant health and social care information available to professionals across organisational boundaries, while Coordinated Care enables multidisciplinary teams to work from shared care plans and understand what other services are doing. Intelligent Care uses population health analytics to identify unmet need, target interventions and measure outcomes, and Engaged Care gives people a more active role in managing their health through digital tools, supported self-management and remote patient monitoring.

These capabilities need to work together if they are to make a meaningful difference. Identifying someone at risk of deterioration achieves very little unless there is a clear route into appropriate support, just as multidisciplinary working becomes unnecessarily difficult when professionals have no shared understanding of a patient's circumstances or the interventions already underway.

The emphasis should be on connecting information, care planning and ongoing support so that neighbourhood teams can work effectively across organisational boundaries without expecting patients to navigate those boundaries themselves.

Using population health intelligence to target support

One of the greatest opportunities for neighbourhood health is to change how we allocate resources. There can be differences of ten or fifteen years in life expectancy between neighbouring communities, yet services have traditionally been organised largely around geography, institutional boundaries and existing patterns of demand. If we are serious about reducing health inequalities and improving outcomes, we need to direct support according to patient need, using the information already available to understand where intervention could make the greatest difference.

Graphnet's population health analytics, supports seventeen million patient records across England. By analysing information from different care settings, local systems can identify people living with frailty, multiple long-term conditions or increasing complexity, including those who may not yet have presented to services. This gives clinicians and neighbourhood teams an opportunity to intervene before someone's health deteriorates to the point where hospital treatment becomes necessary, while helping commissioners understand how resources might be deployed more effectively.

Cheshire East provides a good example of how this can work in practice. Eight integrated Care Communities are using the CIPHA platform to identify residents at risk of deterioration and coordinate support through multidisciplinary neighbourhood teams. Between November 2024 and November 2025, 3,587 residents received proactive neighbourhood support, with more than 2,150 identified through enhanced case finding and 450 receiving comprehensive integrated care interventions.

The programme reported a 26% reduction in emergency admissions and a 14.6% reduction in A&E attendances, alongside up to £2.8 million in indicative secondary care cost avoidance. These results demonstrate the potential of combining population health intelligence with an operational model that enables professionals to respond, rather than treating analytics as a separate exercise concerned primarily with understanding demand.

Neighbourhood health also requires us to recognise that someone's medical condition is often only part of the problem. The Liverpool Community Respiratory Team, for example, combines support for people with COPD and asthma with services addressing housing conditions, welfare, fuel poverty and other social factors that contribute to poor health. Someone living in a damp property who cannot afford adequate heating may continue to experience respiratory problems regardless of how effectively their immediate symptoms are treated, making it essential to consider the wider circumstances affecting their health.

This is where multidisciplinary care planning becomes particularly valuable, enabling different professionals to coordinate their activity around the individual rather than treating each appointment, referral or admission as an isolated event.

Supporting people to remain well at home

Remote patient monitoring and supported self-management have an important role in making prevention part of routine care, particularly for people living with long-term conditions who may otherwise have limited contact with services between appointments.

Most people are familiar with the effect of something as simple as a step counter, which can encourage us to become more conscious of our activity and make small changes because we can see what we are doing. Applying the same principle to the management of conditions such as respiratory disease and diabetes offers considerable potential, particularly when patients are supported by clinical teams who can review their information and respond when necessary.

At HETT 2026, Sharon Boundy, Director of Transformation and Digital at NHS Thames Valley ICB, described how population health analytics, shared care records and remote monitoring are being brought together to support more proactive care. People can be identified through population health intelligence, contacted by a clinical team and offered monitoring where appropriate, with their readings contributing to the shared care record so that other professionals involved in their care can understand changes in their condition.

In East Kent, a proactive programme for people with frailty and complex needs reported approximately 69% fewer emergency department attendances and 70% fewer emergency hospital admissions among those supported. Patients also reported feeling more confident managing their health at home, suggesting that the benefits of this approach extend beyond reducing demand on acute services.

The opportunity is to organise support around the person rather than requiring them to manage a separate process for every diagnosis, while reducing the number of people who reach crisis unnecessarily.

Demonstrating benefits and making the financial case

As neighbourhood health programmes develop, we need to be rigorous about how we measure their impact, particularly given the understandable scepticism surrounding some of the benefits claimed for large-scale NHS transformation programmes.

We regularly see impressive figures for reductions in emergency admissions or A&E attendances, but these need to be presented in context. A programme reporting a 70% reduction in emergency attendances does not mean that demand across an entire hospital has fallen by that amount. It means that a particular group of patients receiving a defined intervention has experienced that reduction, and achieving a meaningful change across a whole health system requires multiple interventions targeting different populations.

When assessing the impact of programmes, we use real-world evidence approaches that compare patients receiving an intervention with appropriately matched patients who have not received it. By considering characteristics such as age, ethnicity and level of clinical need, then examining subsequent outcomes, we can build a more reliable picture of whether an intervention has made a measurable difference.

We also need a more sophisticated discussion about the financial benefits of prevention, particularly the distinction between reducing demand, avoiding future expenditure and generating cash-releasing savings.

If a prevention programme reduces the number of people attending A&E, that does not automatically mean a hospital can reduce its staffing or close a department. The immediate benefit may be fewer patients receiving care in corridors, less pressure on clinical teams and more capacity to treat people who genuinely need urgent attention. These are valuable outcomes, even if they do not translate directly into savings on a financial statement.

However, the financial argument changes when hospitals are already operating at capacity and facing the prospect of expanding their facilities to accommodate growing demand. If effective prevention programmes can reduce avoidable attendances by ten or fifteen per cent, that may help an organisation avoid or defer substantial capital expenditure that would otherwise be required to increase capacity.

This is an important consideration as systems look at how preventative services should be funded over the longer term, particularly where the benefits may emerge in different parts of the health and care system from those making the initial investment.

Making better use of what we already have

One of my frustrations with the current debate is that the technology required to support neighbourhood health is sometimes discussed as though it has yet to be invented, when substantial infrastructure is already in place and being used by health and care organisations across England.

CIPHA, Graphnet's Care System Platform, is being used across a group of nine integrated care boards, supporting a population of approximately 17 million people, with around 200 million records available through the platform and some 170,000 regular users. It brings together shared care information, population health analytics and capabilities for coordinating and supporting care across organisations, providing many of the functions needed to deliver neighbourhood health.

I am not suggesting that every area needs to use the same technology or adopt an identical operating model. Different systems have different starting points, and many already have elements of the necessary infrastructure in place. What matters is that local health and care organisations take ownership of those capabilities, understand where there are gaps and develop their systems alongside the professionals who will be using them.

There is a tendency within the NHS to look towards national programmes for the next major piece of digital infrastructure, but we cannot afford to wait indefinitely for every element of the solution to be delivered centrally. Local organisations should be making better use of what they already have, working with technology partners and frontline teams to develop services that meet the needs of their communities.

After more than a decade of discussing the shift towards prevention, I am encouraged that neighbourhood health is now receiving the attention it deserves. We have a growing body of practical evidence from organisations that are identifying people earlier, coordinating interventions across services and helping patients manage their health more

effectively at home.

The challenge is to build on that experience in a way that is sustainable and capable of reaching substantially more people. We need to understand what makes these approaches effective, how they can be adapted for different populations and what organisational and financial arrangements are necessary to support them over time.

I remain convinced that we have the means to make significant progress without waiting for another generation of national technology programmes. What is needed now is a greater focus on implementation, giving local teams the responsibility and practical support to turn the ambition of neighbourhood health into services that improve outcomes for patients and make better use of the resources available.

We have talked about shifting care towards prevention for long enough, and I would like to see us devote considerably more of our time and energy to making it happen.