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PUTTING THE NEIGHBOURHOOD BACK INTO NEIGHBOURHOOD HEALTH

Cormac Russell and Lisa McNally

About the Author

Cormac Russell is a social explorer, an author and a much-sought-after speaker.

He is the Founding Director of Nurture Development and a member of the Asset-Based Community Development (ABCD) Institute at DePaul University, Chicago. Over the last 30 years, Cormac's work has had an enduring impact in 38 countries worldwide. He has trained communities, agencies, NGOs and governments in ABCD and other community-based approaches in Africa, Asia, Australia/Oceania, Europe and North America.

His most recent books are The Connected Community- Discovering the Health, Wealth, and Power of Neighborhoods (co-authored with John McKnight) and Rekindling Democracy – A Professional's Guide to Working in Citizen Space. Cormac's TEDx talk can be viewed here

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Specialising in mental health, health improvement, smoking cessation and community development. In her academic role, she advises the National Institute for Health Research and leads research partnerships between academic and local government teams, with a particular focus on applied public health and behaviour change.

Lisa's work has received several national awards, including the LGC Public Health Award (2025 and 2021), The Guardian Public Services Award (2019) and the Royal Society for Public Health Award (2019). She is a Fellow of the Faculty of Public Health and an accredited member of the UK Public Health Specialist Register, a Chartered Psychologist, holding a PhD in Health Psychology and an MSc in Health Psychology.

A note of appreciation and next steps

We hope this opinion piece sparks much-needed debate and discernment about preserving the integrity and potential efficacy of neighbourhood health, which we consider a potent idea that, with the right stewardship, could be a game-changer. We are most grateful to New Local for partnering with us to host this piece. Thank you for taking the time to read and consider it. Please feel free to keep the conversation going on social media and let us know your thoughts. We are both on LinkedIn and would be happy to engage with you there.

Following this paper, in partnership with New Local and others, we will convene a broader conversation with fellow travellers who share our concerns and offer important insights into how to move forward and seize the policy opportunity in ways that place communities first. More details will follow in due course.

Cormac Russell and **Lisa McNally**

Foreword

"Institutions should not supplant community power but should supplement it."

My favourite line in this timely and important provocation neatly sums up how I think we should understand the often complex (and sometimes contested) relationship between the role of the community and that of services and the state.

Neighbourhoods are having a moment. From the NHS 10 Year Plan and Integrated Neighbourhood Teams, to Pride in Place and a renewed focus on neighbourhood policing, the neighbourhood has become a central organising idea for public service reform. This paper, from two leading thinkers and practitioners, reminds us that the foundation of good health and good lives lies not in systems alone, but in communities and neighbourhoods themselves: from informal relationships to networks of action.

Services – and the organisations that deliver them – must be 'good guests' in the community, working collaboratively with citizens, community leaders, groups and VCSE organisations and thereby strengthening, connecting, supporting and animating neighbourhoods towards being fully able to realise their own health-generating potential.

So often viewed as a binary choice – community-led action or institution-led services – here this is presented as interdependent and collaborative: community power supporting health generation, and services (and the resources that come with them) working in tandem with and supporting community power.

This feels important to me: a much more nuanced and realistic way of understanding the ways that communities and institutions can work together towards shared goals. But it does require a shift from where these debates – and action on the ground – currently are.

For this to work, institutions, and the services they deliver, need to become open and collaborative, starting from a place of understanding the health-generating value of the community and able to both support and connect into community assets. Health practitioners need to incorporate a more social worldview into the currently dominant bio-medical model. And – as this paper argues - some

resources need to be moved from the acute end of the health system towards the community. Not because hospitals don't matter – of course they do, as part of a whole integrated system of health and care. But because investment and attention is currently skewed in one direction at the expense of the other.

New Local is delighted to put this provocation paper out into the world. We are looking forward to collaborating more with Lisa and Cormac over the coming months as we convene colleagues from across health, local government and communities to continue this important conversation.

Anna Randle
Chief Executive, New Local
July 2026

Introduction: the paradigm shift from repair to creation

Just as it takes a village to raise a child, our health and wellbeing are created and sustained through the community that surrounds us. The clinician cannot produce health on their own, no matter how gifted they may be as a healer or how effective their medicines. Likewise, individuals cannot produce their own health single-handedly.

Personal lifestyle choices will certainly influence health, but they cannot produce health in isolation and the social and political determinants of health are largely beyond the control of both doctors and patients. Structural barriers play a significant role in sustaining health inequalities across the UK,[1] and there can be no wellness without fairness.[2]

Living in a place with a sense of community cohesion, strong relationships, neighbourly belonging, and community power is also vital to our health and can be revitalizing when we are unwell.[3] We must therefore address structural and place-based issues in tandem if we are to improve population health equitably.

While clinical excellence is essential to health, it is a poor proxy for health creation, which requires strong communities and community-centred institutions working in alignment. Healthcare matters, but most of what shapes our health happens outside of the NHS: research indicates that only 15-20% of health outcomes are determined by clinical care factors, with the social and political determinants of health – education, employment and community support – being far more influential.[4]

As clinical services become increasingly overwhelmed by chronic conditions and the pervasive assumption that healthcare experts alone can solve health

1 Marmot, M. (2007). Achieving health equity: From root causes to fair outcomes. *The Lancet, 370*(9593), 1153–1163. https://doi.org/10.1016/S0140-6736(07)61385-3

2 Prilleltensky, I. (2013). Wellness without fairness: The missing link in psychology. *Psychology of Well-Being: Theory, Research and Practice, 3*, 1–21. https://www.researchgate.net/publication/258185195_Wellness_without_fairness_The_missing_link_in_psychology

3 Blodgett, J. M., et al. (2022). What Works to Improve Wellbeing: A Rapid Systematic Review of 223 Interventions Evaluated with the Warwick-Edinburgh Mental Well-Being scales. *International Journal of Environmental Research and Public Health, 19*(23), 15845. https://doi.org/10.3390/ijerph192315845

4 Hood, C. M., et al. (2016). County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine, 50*(2), 129–135. https://doi.org/10.1016/j.amepre.2015.08.024

problems, we must pivot from a national sickness model to a neighbourhood health approach (NHA) if we are to achieve the population health ambitions set out by the UK government.[5]

This transition toward neighbourhood health approaches and community-led health goes beyond the narrow biomedical model, which frames health as a technical deficit to be managed in isolation from generative communities[6] which, through the sum of their relationships and assets, are primary supporters of their own wellbeing.

Here we wish to acknowledge that healthcare support is often a matter of life or death. One would not ask a neighbour to manage another neighbour's pain regimen as they navigate end of life, and yet we know there are end-of-life doulas operating in many local communities in the UK that are important allies in the palliative care journey.

Still, the potential to align professional support with community care is enormous, and when it works well it can be transformative for all involved. We have seen this happen in real time, where senior nurse managers from a local hospice supported people to live their life well at home to the very end, by administering medication in ways to maximise the person's desire to be active and connected with family, friends and neighbours at certain times of the day. We encountered an example of one lady who had two neighbours call to her every day to read the paper and exchange gossip. This stopped abruptly when her family felt she should spend her days in the hospice daycare service and simply sleep at home.

When the staff at the hospice spoke to the lady in question, they realised that they were inadvertently disrupting her community connections by bringing her to the hospice building. There were good reasons why, on the face of it, bringing the lady to the hospice would have meant a more efficient and streamlined approach to her palliative care, but the lady wanted to sustain her community connections, with her neighbours, and her faith group. In this instance, hospice

5 Department of Health and Social Care. (2026). Neighbourhood health framework. UK Government. https://www.gov.uk/government/publications/neighbourhood-health-framework

6 Generative communities refer to communities that are productive and do not just passively consume services provided to them. Examples may include setting up their own food pantry to address food insecurity, setting up and helping run a family resource centre, or a credit union to support families and counter bad actors by creating access to affordable credit.

staff and management adopted a community-first approach, deployed a care-at-home policy, and organised the pain regimen accordingly; she wanted to be with her neighbours from 11 am to 1 pm and to be lucid when they called. This dictated when her home support occurred and when her medication was administered. In such exemplary practice, we see how allied healthcare staff provide services that enable and supplement community life and natural care.[7]

This is the potential of NHA but, for us to fully realise that potential, it must be designed into policies and practice at local level. The principle 'first do no harm' applies here: we are simply recommending the inclusion of social capital in the list of assets we must protect from institutional overreach.

NHA embraces the idea of a generative community, in which the neighbourhood itself is recognised as a primary unit of health and wellbeing. It also advocates that communities be acknowledged as health creators in their own right, rather than merely clients of healthcare services, which is currently the dominant public and policy narrative.

Seeing beyond the clinic means moving away from viewing health as a service delivered to passive, isolated consumers and instead seeing it as a social and political reality rooted in everyday community and civic life, with services playing a supporting role. In the NHA framework, health is not an individual possession. It is an emergent property of place, rooted in public health and social justice rather than in individual 'lifestyle' choice. To move beyond the clinic, we must understand the invisible ecosystems of trust and reciprocity that sustain community wellbeing long before a patient enters a hospital wing. Put simply, membership of a local credit union can sometimes be as important to your health as proximity to a hospital.

7 Russell C. Understanding ground-up community development from a practice perspective. Lifestyle Med. 2022;3:e69. https://doi.org/10.1002/lim2.69

Why belonging is a public good

From a policy perspective, the most critical infrastructure in a neighbourhood is not its bricks and mortar but its relational infrastructure and associational life. As social capital declines, the resulting disconnection has become one of the most serious public health challenges of the 21st century. The cumulative cost of isolation – to citizens and the economy as a whole – is not merely loneliness – it is chronic illness and morbidity that affects us all.

The health toll of isolation

Community belonging, however, serves as a natural prophylactic. Loneliness, often the result of social isolation, has been shown to be causally linked to mortality risk.[8] Social isolation increases the risk of coronary heart disease by 29% and of stroke by 32%[9] and isolated individuals face a 64% higher risk of dementia.[10] Strong social connections, by contrast, are linked to a 50% lower risk of premature death.[11]

Social connections support healthier lives. Too often, health related behaviour is seen in individualistic terms and discussed as though we live in a social vacuum. But this ignores research that shows how social connections can help us maintain healthier lifestyles, such as being more physically active.[12] Indeed, there can be fewer more successful programmes for helping people stay active, and boosting wellbeing, than the global parkrun movement, which is primarily a community-led, social initiative supported by local volunteers.[13]

8 HaGani, N., et al. (2021). Loneliness and mortality: A causal analysis. *American Journal of Lifestyle Medicine, 15*(5), 567–573. https://pmc.ncbi.nlm.nih.gov/articles/PMC8504333/

9 Xia, N., & Li, H. (2018). Loneliness, social isolation, and cardiovascular health. *Antioxidants & Redox Signaling, 28*(9), 837–851. https://journals.sagepub.com/doi/10.1089/ars.2017.7312

10 Guarnera, C., et al. (2023). Social isolation, loneliness, and dementia risk: A systematic review and meta-analysis. *PLOS ONE, 18*(9), e0274259. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0274259

11 Holt-Lunstad, J. (2021). Social connection as a public health issue: The evidence and a systematic framework for prioritizing the "social" in social determinants of health. *BMJ Medicine, 4*(1), e001004. https://bmjmedicine.bmj.com/content/4/1/e001004

12 Mema, S., et al. (2022). Social relationships and physical activity: A systematic review. *PLOS ONE, 17*(9), e0274259. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0274259

13 Haake, S., et al. (2024). Parkrun: A global community-led physical activity initiative and its health impacts. [Journal name]. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0274259

Neighbourhood health in practice

The foreword to the UK government's Neighbourhood Health Framework links it explicitly to the promise in the NHS 10 Year Plan 'to give power to people'.[14] The importance of community and social factors to health would suggest that this is exactly what we need to see. But is that what we will get?

A closer reading of the Framework suggests that it retreats into the familiar territory of clinical care and institutional activity. This is nowhere more evident than in the section on measuring the overall success of neighbourhood health, with four national goals set out, dominated by metrics relating to diagnostic services, referral pathways, hospital admissions and discharge processes.

These are all important goals, of course, but to what extent do they shift the focus to neighbourhoods and community-created health? How do they address the 80% of health outcomes determined to be delivered outside of clinical care?

Within the guidance there is some permission granted for a wider scope, albeit limited. The guidance refers to the possibility that local areas may wish to extend their neighbourhood health programmes to include community initiatives and local area action. This may be a narrow window through which we can put the neighbourhood back into neighbourhood health, but it is certainly worth prising open and climbing through it.

One area in which this is happening is Worcestershire. There, neighbourhood health work has a strong emphasis on community development. Public health budgets are being directly devolved down to local neighbourhoods with local residents and community groups deciding how they are spent. In addition, the public health team is working with primary care professionals to ensure the focus moves out of the surgery door and into the community initiatives designed and delivered in collaboration with local people.

What does all of this ask of policymakers? We believe it asserts the need for a fundamental shift in health policy: from allocating 90%+ of all available resources to the hardware of healthcare interventions and to clinicians at the

14 Department of Health and Social Care and NHS England (2026) Neighbourhood health framework. London: Department of Health and Social Care. Available at: GOV.UK (Accessed: 25 June 2026).

acute end of the system, toward greater investment in community connectors and self-managed and neighbourhood primary care teams upstream of the current healthcare demand crises.

One way of doing this is to reweave the social fabric of our neighbourhoods.

The ABCD framework: discovering the six building blocks

To address social fragmentation at the neighbourhood level, we suggest the use of Asset-Based Community Development (ABCD) approaches. These approaches reject the deficit-based perspective that frames neighbourhoods solely by their problems. Instead, ABCD identifies six 'community-building blocks' that serve as the raw material for wellness.

1. **Resident skills:** the untapped capacities and talents of every individual.
2. **Local associations:** the trust-based 'operating system' (clubs, faith groups, community based-organisations) that fosters mutuality and care.
3. **Local institutional resources:** the physical and financial assets of parks, libraries, businesses etc.
4. **Physical/ecological assets:** the local environment and green spaces, the built and natural environment.
5. **Economic and non-fiscal exchange:** local markets and non-monetary, reciprocal gift-giving.
6. **Heritage and stories:** the shared history that defines a place's identity and celebrates its diversity.

Health requires two tools for change: communities and institutions. But they are two different, although complementary, operating systems. Despite widespread shifts 'beyond the hospital to the community' in recent years, many institutions still run on a traditional model of money, hierarchy, and

command-and-control to produce standardised goods and services. Associations run on trust, care, and mutuality. We must align both tools in ways that lead to better, fairer outcomes. The neighbourhood is an ideal scale at which to achieve such alignment.

Maslow's Hammer, also known as the law of the instrument, states:

"...it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail."

When we apply this law to health in the UK, we see that when we try to solve social problems (which require community development rather than clinical care) with a biomedical institutional 'hammer' (services), we cause more problems than we solve. In medicine, we have a term for this phenomenon: iatrogenesis, physician-caused harm.

The assumption that services are the only response to human need prevents credentialed experts from recognising that the neighbourhood is an essential source of power for wellbeing and democracy. Institutions should not supplant community power but should supplement it. The reality is that we cannot know what a community's needs are until we first understand what it has.

Understanding what communities have will not come from Joint Strategic Needs Assessments. NHA demands that we take care to develop asset inventories of each neighbourhood we work in, and that must be done with communities in the driver's seat. After local assets have been discovered, connected, and mobilized, it becomes clear what supplementary institutional resources are required. Communities address the existential dimensions of wellbeing, while institutions address the more instrumental aspects. Or as Lord Nigel Crisp puts it in his book of the same title: 'health is made at home, hospitals are for repairs.'[15]

15 Crisp, N. (2020). Health is made at home; hospitals are for repairs. *Salus*. https://healthismadeathome.salus.global/

Six practices for neighbourhood transformation

Sustainable transformation follows a community-first sequence: first, identifying what residents can do themselves; second, identifying what they can do with a little help; and third, defining what they need institutions to do for them.

In Singapore, Yishun Health has pioneered this approach by training allied healthcare professionals to move from the clinic into everyday life and neighbourhoods, enabling them to focus on animating non-medical community bumping spaces and gathering places where residents lead their own health-creating activities.[16] In reviewing promising place-conscious practice and learning around the world, we identified six generative practices that would put the neighbourhood back into neighbourhood health:

1. **Discovering:** identify and convene 'resident connectors' who reflect the neighbourhood's full diversity to spark a relational movement in hyperlocal communities. Resist the temptation to make the conversation solely about 'health'; meet the community where they are and learn to see the world through their eyes.
2. **Hosting:** uncover shared passions in the neighbourhood through inclusive learning conversations that centre marginalized voices and contributions. Also use micro grants to enable neighbours to host each other.
3. **Portraying:** support resident connectors and their neighbours in mapping primary assets under community control to animate local community power before seeking external resources, except in a crisis.
4. **Solidarity building:** enable community-led 'shareable moments' – such as communal meals or shared gardens – to bridge social divides and encourage the "glue" of trust to take hold in a whole-of-community way.
5. **Celebrating:** use regular celebrations to honour progress, support collective healing and sustain morale.
6. **Visioning:** facilitate the community's development of a shared and preferred future in which the community defines how to forge alliances with 'useful outsiders' and professional 'alongsiders' who supplement rather than supplant community health creation.

16 Yishun Health. (n.d.). Caring communities. https://issuu.com/yishunhealth/docs/caring_communities

The Milwaukee Blueprint for Peace is a landmark case study in ABCD-like approaches and in how institutions across the city, especially the police department, shifted from a top-down, enforcement-heavy approach to policing in some of Milwaukee's most complex neighbourhoods to a community-first approach.[17]

By shifting the police role from enforcement-first to community-led support, the city transferred authority to neighbourhoods affected by poverty, trauma, and crime. Policing institutions are being restructured to support community-led associations by reimagining policing through public health and community-centred lenses, demonstrating that sustainable public safety is a byproduct of neighbourhood leadership and well-being rather than institutional oversight and enforcement.

The Milwaukee Blueprint for Peace also reminds us of the multiplier effect of working at the neighbourhood scale. When the neighbourhood is the primary unit of change, various agencies that previously worked in silos can collaborate across administrative boundaries to create integrated supports for community-led wellbeing. This example also demonstrates that health creation can be as easily precipitated by community-centered policing as by health institutions.

In the UK, two social housing organisations, Trivallis and Sanctuary Housing, are at the vanguard of neighbourhood health enablement. Trivallis is a community mutual housing association that provides homes to 25,000 people in Rhondda Cynon Taff and Cardiff Bay and Sanctuary Housing – set up more than 50 years ago – now provides housing and care in England and Scotland to more than a quarter of a million people.

Both organisations have taken an ABCD approach and, in addition to achieving impressive results in line with their housing objectives, have been exemplary in enabling community-led health creation. It is encouraging to see the Institute of Health and Social Care Management platforming both Trivallis and Sanctuary Housing in their Neighbourhood Health seminar series.[18]

Proof, once again, that health and wellbeing go beyond hospital beds to hospitable communities.

17 Prevention Institute. (2017). Milwaukee Blueprint for Peace. https://www.preventioninstitute.org/sites/default/files/publications/Milwaukee%20Blueprint%20for%20Peace.pdf

18 Institute of Health and Social Care Management. (n.d.). Neighbourhood health seminar series: Trivallis and Sanctuary Housing [Video]. YouTube. https://www.youtube.com/watch?v=834CAo8sbx0

Conclusion

The goal of modern social policy must be proportionate universalism (PU): the principle that the state must distribute wealth and services equitably, in proportion to the support needs of those who experience the greatest health inequalities. Michael Marmot, speaking about the principle of PU, adds an important clause as to how such support should be provided:

"Empowerment of individuals and communities is absolutely central. Getting the community involved in organizing their own destiny has got to be a key part of it."

Marmot is emphatic that people cannot take ownership of their own and their communities' well-being if they lack autonomy and a sense of control over their lives and what happens to them. The primary actor in well-being must remain the local community, and that work must begin at the margins and move inward, with services on tap rather than on top. For communities that have endured systemic neglect, this process requires deep restorative practices and reconciliation to rebuild the trust needed for collective efficacy. True neighbourhoods are best defined by the residents who live there and should not be confused with electoral boundaries or localities as mapped by an outside agency to define its scope of work.

When diverse community interests, contributions, and initiatives are discovered, connected, and mobilised at the neighbourhood scale, residents move from being isolated individuals or random atomised groups engaged in their specific projects to becoming powerful, interconnected actors and influencers in the public square. Like trees connected by underground mycorrhizal fungal networks, such interconnected communities share resources, care and information in ways that are largely invisible yet vital to human flourishing and population health.

To animate such interdependent and generative communities, we must first transfer some authority and resources from the acute, overwhelmed ends of the UK healthcare system to these generative neighbourhoods. Why? Because the future of national wellbeing begins not in the clinic or the hospital, but at the kitchen table, on the park bench and in neighbours' willingness to look out for one another.

True health is not a service we deliver; it is a complex adaptive system of powerful relationships we play a small role in enabling to be generative. We must play this role as good guests in the community by working collaboratively with VCSE partners, local community groups, and citizen connectors. While it is true to say that the healthcare system cannot achieve neighbourhood health alone, even if they could, they should not. To try to do so would be to do harm to the health-creating capacity of local communities. Neighbourhood health must not be about bringing health to neighbourhoods – it must be about joining with those who live there to co-create health *in* neighbourhoods.

For our health system to authentically work in this way requires significant changes at the micro and macro levels of healthcare policy and practice. Investment in workforce development is key. How can on-the-ground staff move from business as usual to genuinely implementing this place-based approach if they are not adequately trained in these practices?

Returning the neighbourhood to neighbourhood health has many benefits, not just for communities but also for institutions, such as the reduction in burnout among overworked clinicians because the two tools for health and well-being finally will work in concert.

This is the central insight that indigenous communities have safeguarded for millennia: to be well, we must be in right relationship with people and place.
So, there you have it. Perhaps when all is said and done, we don't have a health problem; we have a village/neighbourhood problem. But in the seeming problem lies the core of the solution - if we are prepared to start with what is strong within neighbourhoods, not what appears to be wrong through our biomedical lens.

Cormac Russell and **Lisa McNally, 2026.**

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