2 July 2026

Partnerships for Neighbourhood Health Workshop

Summary Report: Drawn from breakout discussions, participant reflections and table outputs

place matters

In partnership with UK COMMUNITY FOUNDATIONS

Contents

Introduction and context

The Partnerships for Neighbourhood Health workshop, held on 2 July 2026, brought together community foundations, NHS and public-sector partners, impact-economy organisations, social investors and local voluntary-sector leaders to explore how place-based partnerships can support neighbourhood health in practice.

The workshop built on the themes of the Neighbourhood Health Policy Labs: the need to move from hospital to community, from sickness to prevention, and from short-term pilots to sustainable, locally rooted models capable of improving outcomes and reducing inequalities. Participants were asked to examine practical examples of collaboration at the intersections of health, communities, funding and place, asking what conditions make these partnerships work and what would need to change for them to spread.

A consistent message emerged: neighbourhood health is not simply a new service offer or a new set of buildings. It is a different way of organising around people, places and the wider building blocks of health. That requires trusted relationships, partnership infrastructure, shared outcomes, patient capital, practical data-sharing arrangements and a willingness to let communities shape both priorities and delivery.

"We are not delivering neighbourhood health to people – we are creating it with communities."

Workshop aims and objectives

The aim of the workshop was to bring together government, VCFSE leaders and funders to learn from and catalyse innovative approaches to building partnerships to deliver neighbourhood health, reaching beyond what the NHS or communities could achieve alone.

The objectives were to build cross-sector relationships, trust and confidence; learn from different models of neighbourhood health and their common success factors and enablers; and catalyse new partnerships and collaborations.

Workshop structure and agenda

The workshop opened with context from the Department of Health and Social Care and NHS England on the neighbourhood health vision, progress and opportunities for collaboration; followed by a panel on examples of current innovative partnerships. Attendees then moved through two structured breakout sessions, before reflection and close.

The first breakout, "Learning from the Intersections", focused on four live models: young people and mental health in Surrey; the Community Recovery Fund in Bedfordshire and Luton; targeting health inequalities in Wiltshire and Swindon and Essex; and NNHIP Wave 1 in Barking and Dagenham. The second breakout, "Building Forward", asked participants what learning should now be acted on, what commitments they could make, and what collective asks should be taken forward.

NHS vision and opportunities for collaboration

The DHSC and NHS England session located the workshop within the wider neighbourhood health agenda and the need to move from aspiration to practical delivery. Participants connected this to the same themes surfaced through the policy lab process: moving care closer to communities, shifting attention upstream toward prevention, and creating the conditions for local partnerships to act beyond what any single institution can do alone.

The central opportunity for collaboration was not framed as the creation of a parallel system, but as a way of connecting existing community infrastructure, statutory responsibility, local government leadership, funder capability and

social investment around shared priorities. Participants repeatedly emphasised that neighbourhood health must be built with communities, not delivered to them.

"Public services can hold onto expertise and decisions just as tightly as the voluntary sector can be protective about our own ways of working and funding."

Panel: Innovations from the Intersections

The panel introduced practical models that illustrated how neighbourhood health partnerships can operate at the intersections of clinical pathways, community infrastructure, prevention, funding and place. Models shared included the Northern Cancer Alliance, Well@Home in Cumbria, NNHIP Wave 1 in Barking and Dagenham, and the Social Finance and Macmillan model of blended funding for sustainability, accountability and outcomes.

The panel collectively set out one of the strongest workshop themes: evidence and delivery models already exist, but the enabling conditions for spread are inconsistent. Participants were particularly struck by the role of blended funding, governance around money, shared outcomes, community-held infrastructure and the practical difficulty of translating successful local models into investable and replicable propositions.

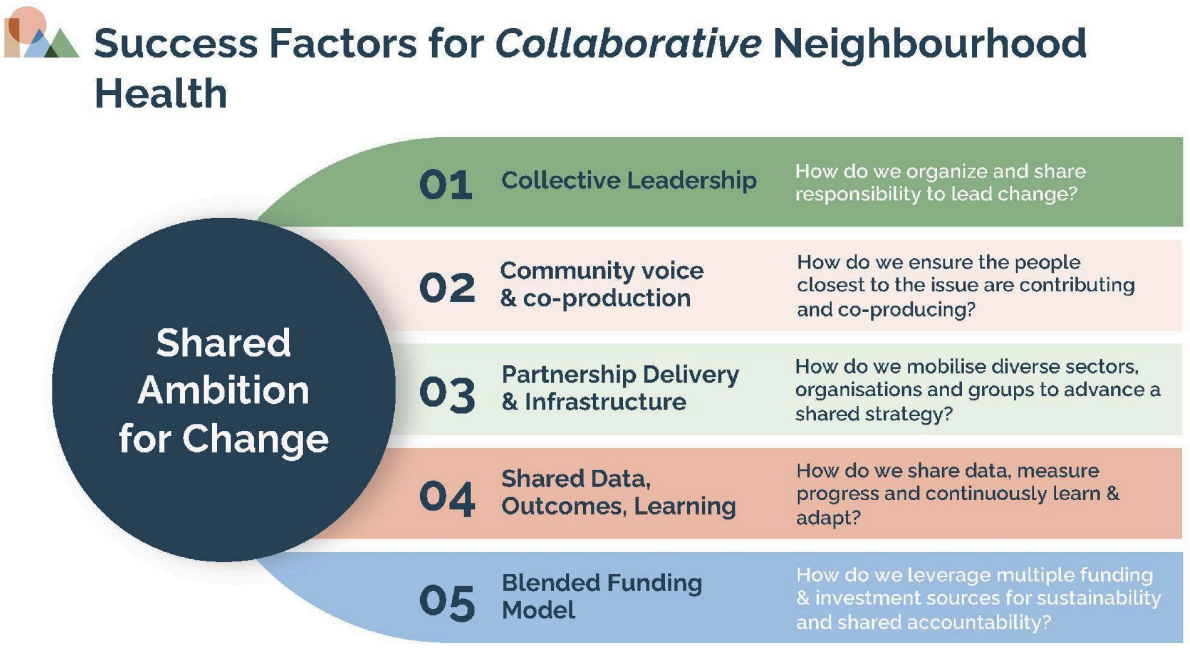
Social Finance and Macmillan's contribution was especially relevant to later breakout discussion because it demonstrated how philanthropic funding and social investment can work together, while also surfacing the central challenge of non-cashable savings. Participants recognised that improved outcomes may be real and measurable even when they do not immediately release money from pressured acute systems.

"Think of the social investment element as the opportunity to double-run [alongside grant funding]."

Breakout 1: Learning from the Intersections

Case study focus

Breakout 1 asked participants to consider one of four place-based examples in each group: young people and mental health in Surrey; the Community Recovery Fund in Bedfordshire and Luton; targeting health inequalities in Wiltshire and Swindon and Essex; and NNHIP Wave 1 in Barking and Dagenham. Discussions were structured around five success factors for collaborative neighbourhood health, as set out in the model below.



Key reflections

Collective leadership: Collaboration and collective leadership must be designed, not assumed. Participants highlighted trust, relationship-building, connector roles and the risk of over-reliance on individuals. Discussion highlighted the distinction between collaborative leadership (where the focus remains on own organisation or sector) and collective leadership focused on the whole. To achieve this requires boldness and courage, as it goes against the grain of normal ways of working.

"Having that expertise, sharing our responsibility, was so healthy – it just made everything easier."

Community voice and co-production: Tables distinguished between genuine co-production and lighter-touch engagement. Community voice was strongest where residents and grassroots organisations were involved in decision-making, not simply consulted after priorities had been set. Participants also emphasised the importance of language: For example, "building blocks of health" opened different conversations from technical language such as "social determinants" and conveying prioritising people over systems by using small but telling language shifts such as replacing "discharge" with "people returning home". Prevention is being used to mean different things, from early diagnosis and treatment to wider wellbeing, social connection and stopping people entering the system at all.

"The most important lesson was the ability to speak two languages – the language of the NHS and the language of the community. Sometimes you need a translator."

Partnership delivery and infrastructure: Community-owned infrastructure needs to be strong enough to hold local trust, but connected enough to statutory systems to influence commissioning and delivery. Participants warned against both extremes: building community infrastructure outside the system without statutory bridges, or absorbing community-led work into statutory structures in ways that remove its trust and flexibility. The "backbone function" of partnership- convening, governance, shared learning and relationship infrastructure- emerged as a distinct activity requiring deliberate investment. The workshop strongly supported spreading what works, but cautioned that models must not become generic or lose the place-rootedness that made them effective in the first place.

"Infrastructure is not an add-on to neighbourhood health - it is core to it."

Shared data, outcomes and learning: Tables independently identified agreeing what to measure as one of the hardest problems to crack. They also noted the

huge disparity between how the NHS and the community sector measure and value outcomes. Participants called for shared outcomes to be agreed before delivery starts, with proportionate evidence expectations that allow community storytelling and local knowledge to sit alongside NHS and local-government metrics.

"Incentives and accountability are built around acute care, and ICBs and clinicians are held to acute rather than preventative targets."

Blended funding: Stable, multi-year funding was repeatedly identified as essential. Patient capital, evergreen funding (open-ended investment vehicles that pool capital from multiple investors but have no fixed termination date) and five-year-plus test-and-learn approaches were seen as more compatible with neighbourhood health than repeated short-term funding cycles. Participants also recognised that social investment works best as an addition to grant and public funding, not as a replacement for it.

"If government invested £250 million, philanthropy and social investment could match that with a billion pounds of investment – that could totally transform everything."

Breakout 2: Building Forward

Breakout 2 moved from reflection to action. Participants were asked what they were motivated to do personally or organisationally, what would make the biggest difference if adopted across places, and what collective commitments or asks should now be taken forward.

Commitments generated

Participants made a range of commitments to action, some of which they will take forward immediately either individually or in partnership. Others will take more time and wider collaboration to progress.

Examples of commitments include:

- **keep articulating the power and impact of local grassroots voluntary sector to every audience, and raise awareness of community foundations amongst ICBs**
- **follow up collaboration and signposting between VCS organisations in attendance with a view to building coordinated capacity rather than competing for the same local funding pots.**
- **share existing data-sharing frameworks and outcomes-measurement materials and follow up with DHSC on ways to support patient-focused outcomes (e.g. metrics, commissioning practices, funding timeframes).**
- **make sure local community-led decision making happens in investments**
- **take seriously the need to invest in effective social infrastructure**

Several commitments focused on local and regional government. Participants wanted to engage more directly with local authorities, mayoral combined authorities and devolved or regional structures, recognising that place is where health, employment, skills, housing, policing and communities intersect. A collective ask to government at mayoral combined authority level was suggested, including around data platforms and capacity to leverage philanthropy.

Wrap Up:
What we'd like to see more of and potential next steps

The workshop closed with a clear appetite to move from describing the promise of neighbourhood health to creating the conditions that allow it to work in more places. Participants did not call for a single national model to be replicated everywhere. Instead, they wanted to see more deliberate investment in the relationships, infrastructure, funding and learning systems that allow locally rooted partnerships to grow, adapt and sustain impact over time.
Three priorities stood out as areas where attendees would like to see more ambition and practical action:

1. More blended funding models.

Participants wanted to see funding models that bring together philanthropy, community foundations, social investment, public funding and health-sector resources in ways that support prevention and social infrastructure over the long term. This includes patient capital, multi-year investment and approaches that recognise value even when savings are not immediately cashable within acute systems.

> **Potential next step:** Develop a short funding-opportunity map that cross-references the case-study areas and participating community foundations against the most relevant existing funding streams.

2. Greater investment in partnership infrastructure.

Participants emphasised the need to fund the backbone functions that make neighbourhood health possible: convening, trusted relationships, shared governance, data-sharing, shared measurement and the capacity to connect community-led work with NHS, public health and local-government systems. There is already funding available and/or planned that supports the neighbourhood health agenda. For example, National Neighbourhood Health Implementation Programme (NNHIP) Wave 1 and Better Care Fund, Macmillan Cancer Support and the Local Covenant Partnerships Fund (explicitly set up to build social infrastructure and relationships between local authorities and civil society).

> **Potential next step:** Explore opportunities for identifying and funding backbone organisations that can support genuine collective leadership and change, bringing together and communicating effectively with diverse partners on these issues.

3. Better mechanisms for shared learning and spread.

Participants wanted stronger ways to capture, translate and share learning from innovative practice across the country, while protecting the place-based relationships and community ownership that make local models effective. The emphasis was on spreading principles, conditions and practical tools rather than imposing generic templates.

> **Potential next step:** Capture and share learning from the Macmillan and Social Finance pilot and other relevant neighbourhood health activity, using it to inform the neighbourhood health framework and to help community foundations identify where they can contribute locally.

Attendees

Name	Organisation	Role
Adeola Dosunmu	CF - Essex	Grants Manager
Amerjit Chohan	Helpforce	CEO
Andrew Copland	Northern Cancer Alliance	Programme Manager (Primary Care, Early Diagnosis and Nb'hoods)
Annabel Yadoo	NHS England	Deputy Director, Strategy & DG chief of staff
Ben Jupp	NHS England	Director of Intermediate Care and Rehabilitation
Caroline Gadd	Social Finance	CEO
Carrie McKenzie	NHS England	Voluntary Partnerships & Neighbourhood Health Manager
Chimeme Egbutah	Luton Borough Council	Public Health Service Manager
Chris Clements	NHS Charities Together	Chief Operating Officer
Chris Naylor	Kings Fund	Senior Fellow
Dawn Bainbridge	CF - Bedfordshire & Luton	Head of Business Development
Dominic Jones	Achieve Good	Associate Director
Elspeth Paisley	Community Resources	Neighbourhood Health Lead, Barking & Dagenham
Emily Sun	Place Matters	CEO
Emma de Closset	UKCF	CEO
Emma Gooding	CF - Cornwall	Fundraising manager
Emma Pawson	GLA	Head of Health
Francesca Conlon	UKCF	
Heather McLean	MacMillan Cancer Support	Director of Community and System Partnerships
Jazz Boghal	West & North London ICB	Board member
Jenny Benson	CF - Cumbria	Director, Programmes and Partnerships
Joe Prendiville	Cabinet Office	Head of Place Partnerships, Office for the Impact Economy
Justin Sargent	CF - Somerset	CEO
Kate Shires	Department of Health and Social Care	Senior Policy Lead, Neighbourhood Health
Lela Kogbara	Place Matters	Director
Margaret Firth	CF - Wiltshire and Swindon	Head of Partnerships
Michelle Brown	Surrey County Council	Interim Head of Commissioning, Adults Wellbeing & Health Ptn'ships
Michelle Cooper	CF - Point North	CEO
Rachel McGrath	CF - Northamptonshire	CEO
Rebecca Bowden	CF - Surrey	CEO
Richard Ball	MacMillan Cancer Support	Senior Innovation Manager
Sam James	NAVCA	Integrated Care Lead
Sara Felix	Social Finance	Director of Engagement & Influence
Simon Morioka	PPL	Joint CEO
Tom Shirley	Department of Health and Social Care	Head of Strategy and Partnerships for Neighbourhood Health