IVAR we listen, and learn together

Listening to what really matters

Four stories of how communities shape health and wellbeing

Connecting Health Communities, 2023-25
November 2025

CONNECTING HEALTH COMMUNITIES *with* **IVAR**

Authorship and acknowledgements

This report has been written and edited by Sonakshi Anand and Rebecca Moran, and the following people from the four partnerships whose stories we are sharing: Alice Lacey-Campbell, Alison Langley, Campbell Flack, Candy Brown Claire Glover, Farwa Hasan, Fenn Porter, Fiona McCarron, Hayley Antipas, Helen Cibinda-Ntale, Helen Codd, Helen O'Donnell, Jason Griffiths, Jessica Johnson, Lorraine Gray, Louise Grainger, Maria Wallace, Marissa Westwood, Mary Idowu, Matthew Atkinson, Nobesuthu Chaibva, Ravi Vyas, Sally Yeoman, Tasleem Sadiq, and Wayne Longshaw.

It is based on interviews and field research carried out by the authors with Alex Parker, Annie Caffyn, Charlotte Pace, Helen Garforth, Katie Turner and Vita Terry. Quotes are taken from interviews with the authors in the four areas we worked with, and from the field research notes from workshops and steering groups.

We would like to thank the steering groups in each area and everyone who took part in Connecting Health Communities (CHC) 2023−25 for sharing their experiences of the programme so freely and openly. Particular thanks for sharing photos of yourselves and your work.

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Introduction

What would it mean if loneliness and social isolation in St Helens were addressed openly and collectively, rather than left unseen? How can Wandsworth respond when South Asian women are not accessing vital cervical screening? How can support for childhood obesity in Dudley move beyond clinics to become part of everyday life? And what does it take for a GP practice to feel welcoming to the East Timorese community in Crewe?

These are the questions that the four areas involved in the Connecting Health Communities (CHC) programme, namely Cheshire East, Dudley, St Helens and Wandsworth, have been exploring. Run by the Institute for Voluntary Action Research (IVAR) and funded by the National Lottery Community Fund, the programme creates the conditions for communities, Voluntary, Community and Social Enterprise (VCSE) organisations and system partners to work together to understand inequality and co-design change. By taking local action, building on lived experience, and ensuring buy-in from senior leaders, the programme facilitates co-production at a grassroots level, with learning that can be shared widely across health systems.

The programme shows what genuine partnership looks like: VCSE groups trusted as equal players, people with lived experience shaping decisions, and statutory partners shifting their culture from consultation to collaboration. In doing so, equity and inclusion become more than just policy language – they become integral to how health and care are designed and delivered.

About this report

This report documents the journey and learning from the four areas we supported between April 2023 and July 2025. Their stories show how service design changes for the better when the lived experience of communities, and of those working alongside them, is heard; and when partners across sectors work together to act on what they hear.

From addressing loneliness, social isolation and stigma in St Helens; to increasing uptake of cervical screening in Wandsworth; to family-centred approaches to tackle childhood obesity in Dudley; and to working towards increasing rates of TB screening with Crewe's East Timorese community, the initiatives capture both the diversity of local challenges and the shared potential for change.

Following the case studies, we draw attention to some of the broader lessons that have been learnt from across the four areas.

About Connecting Health Communities

At IVAR, we've been supporting cross-sector partnership working that delivers improved health outcomes for over 20 years. We understand health inequalities are driven by various determinants of health, such as housing, income, employment, education, social isolation or disability – all of which affect people's access to good healthcare. Partnerships determine what 'health inequalities' mean for them, and how they intend to tackle them through cross-sector partnership working.

Our focus is on supporting local leaders to deliver improved health outcomes for vulnerable groups and strengthening the foundations of partnership working by:

• Building the evidence base and case for change
• Adapting systems and structures
• Initiating and introducing new services
• Identifying and achieving opportunities for a more sustainable and fairer model of healthcare

Central throughout the programme is developing opportunities to engage residents, people with lived experience, community groups and voluntary organisations in the design, commissioning and delivery of health and care services.

Read more about our aspirations for this work, our principles, and the local area work involved in Appendix one.

Glossary

Integrated Care Board (ICB)
A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area.

Integrated Care System (ICS)
NHS organisations (including Clinical Commissioning Groups), in partnership with local councils and others, taking collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

Primary Care Network (PCN)
Groups of GP practices in their local area, working together with community, mental health, social care, pharmacy, hospital and voluntary services to provide health and care services. An ICS is formed of many PCNs, each serving communities of around 30,000−50,000 people.

Voluntary, Community and Social Enterprise (VCSE)
We use the term 'VCSE' to describe organisations belonging to the charitable sector, third sector, voluntary sector, non-profit sector, Non-Governmental Organisation (NGO) sector and civil society.

Addressing loneliness, social isolation and stigma in St Helens by listening, learning and shifting power
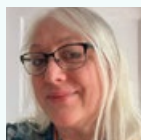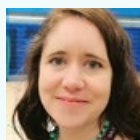
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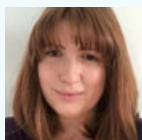
Alice Lacey-Campbell
Public Health Specialty Registrar, Integrated Health and Social Care, St Helens Borough Council
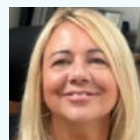
Claire Glover
Operations Manager, St Helens Wellbeing Service, City Health Care Partnership CIC

Helen Cibinda-Ntale
Head of Health and Wellbeing, Torus Foundation

Sally Yeoman
Chief Executive, Halton & St Helens Voluntary and Community Action

Wayne Longshaw
Director of Integration, Mersey and West Lancashire Teaching Hospitals NHS Trust

In St Helens the Office for National Statistics (ONS) data was telling us a clear story: 11% of residents felt lonely 'often or always' − above the national average.[1] This has a real-world impact on people's health. Social isolation and loneliness are associated with higher rates of depression and high blood pressure, and they can lead to higher rates of premature mortality.[2] In St Helens, self-harm hospital admissions among 10- to 24-year-olds were nearly double the national figures.[3] Nine percent of children reported low happiness levels, compared to a national average of 5%.[4] This is why St Helens Place-Based Partnership and the local Inequalities Commission identified loneliness and social isolation as local priorities.

The data, however, didn't tell us who was most affected, or why. We knew we needed to go deeper to understand the specific causes of loneliness and isolation locally, and what would help. The CHC programme was an excellent opportunity to bring together cross-sector organisations[5] to explore this issue in more detail.

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1 https://www.ons.gov.uk/visualisations/dvc1262/alwaysoftenmap/index.html
2 Local Government Association (2020), Loneliness, social isolation and Covid-19.
3 OHID (2022), Child Health Profile: St Helens.
4 Good Childhood Enquiry (2020), The Good Childhood Report 2020.
5 Our steering group had representation from St Helens Borough Council, Public Health, Inequalities Commission, Torus Foundation, YMCA St Helens, St Helens & Knowsley Hospital Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust, Halton & St Helens Voluntary and Community Action, St Helens Wellbeing Service, City Healthcare Partnership CIC and Healthwatch St Helens.

Understanding the challenge

We started by listening to the communities in St Helens, rather than jumping to solutions or thinking about new services or programmes we could offer straightaway. With support from IVAR, we created a set of open-ended questions to guide our conversations. And rather than hosting any large-scale public events, we held '*community conversations*' − in libraries with families and older people in Fouracre and with young people in the Town Centre − and conducted surveys through faith groups and GP surgeries. Through these, we learnt about both the structural and cultural reasons for the loneliness and social isolation experienced in St Helens, ranging from economic hardship, digital exclusion and lack of safe public spaces to social stigma, lack of trust in services and lack of aspiration. We also understood that loneliness cuts across age, identity, and circumstances. It is often invisible, and life experiences can tip someone into loneliness almost overnight, for example through bereavement.

We created space for local organisations to share what they needed from the system − for example, better coordination, less bureaucracy, and being treated as equal partners − so their day-to-day experience of supporting residents could directly shape the solutions.

Dr Andy Knox shares his experience of a different approach to being a GP.

Barriers

- **Loneliness cuts across age, identity, and circumstance:** It affects older people living alone, young people isolated by fear and lack of safe spaces, single parents who feel overwhelmed by judgement, and people in shared accommodation who feel disconnected.

  'Loneliness and social isolation are not just issues for people living alone; it's about connectedness.'

- **Services exist, but stigma is a major barrier:** Some people were unaware of the services available and/or didn't identify with them. This could be through lack of confidence, mistrust of services, or stigma,[6] which was mentioned in nearly every conversation:

  'We've got the services. But if people feel judged, they just won't come ... People don't want to walk into a place where they feel judged or pitied.'

- **The system needs to be more human, not just better coordinated**. Survey respondents spoke of being more curious, more relational, and more reflective of people's lived experiences. Language (e.g. 'deprived' or 'at risk') often prevented people from accessing services:

  'When service providers call this area 'deprived', it's like saying we're deprived.'

  'Sometimes we're the only person someone speaks to. If we don't ask the right questions, we [service providers] miss our chance.'


The St Helens' partnership

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6 Stigma in this context can be understood as the negative beliefs and/or assumptions that accompany loneliness and social isolation, which can affect whether people take up a service and how they are treated when they do.

Moving to action

Having listened to the community, it was very clear that we needed to look not just at community experience, but at how the system itself might be contributing to the problem. We also needed to understand more about the relationship between stigma, loneliness and social isolation. To help us with this, IVAR invited the pioneering GP Dr Andy Knox[7] along to our third partnership workshop. Through this talk[8] we began to see what stigma looks like in practice. For example:

- Assumptions in our referral processes about who is 'deserving'
- Forms that label people without asking who they are
- Services that unconsciously replicate bias
- The wording and choice of words for well-meaning communications

We reflected on how unconscious bias shapes who we include and who we ignore. We watched a film produced by Change Live Grow (CGL) which brought to life the impact that stigma can have on people's lives, and CGL also introduced us to the St Helens Together Against Stigma Charter to support this shift system-wide.
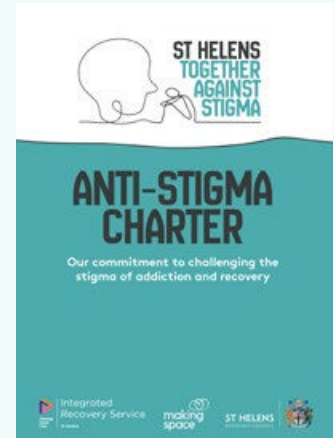
This led to a clear collective shift in our focus: to challenge stigma and perceptions not just through one campaign or pledge, but through everyday language, leadership, and practice, and by taking time to reflect on how stigma was impacting local service provision. Taking part in Dr Knox's session also helped people move from defensiveness to reflection:

'This work wasn't always comfortable. It meant holding up a mirror – to language, assumptions, and patterns we didn't always want to see.'

We realised that the local system, and everyone working within it, needed to:

- Use strengths-based, inclusive language and avoid terms that reinforce stigma
- Call out and challenge bias and discrimination within services
- Reflect on the biases that exist and how these are impacting service provision

'We needed to get leaders to stand up and say, "we are committing to challenge stigma in our organisations".'

'We needed to ask ourselves "how can we destigmatise those with complex needs"? Are we all too ready to show people the "red card"? … If someone looks a bit difficult or behaves in a difficult way, are we still inclusive with our practice?'

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7 Dr Andy Knox is a GP, Associate Medical Director and author of the book 'Sick Society: Reimagining how we live well together'. His expertise is in how societal and personal biases can foster a dehumanising outlook on specific communities, which allows inequity to persist.

8 Blog with insights from Andy Knox's talk: Why and how to tackle stigma and bias in partnership working

Having identified these goals, we spent the remainder of the programme thinking (and practising) how we could work together as a local system to meet them by:

- **Adapting the language we use**, for example, creating a pathway for people to be more connected with their communities without emphasising that the focus is on reducing loneliness and social isolation.

- **Investing in better communication about existing services** that are available, rather than focusing on increasing service provision.

- **Adapting the narrative and language that is used about the local area**, for example, by developing the idea of a '*Proud St Helens*' communication strategy to celebrate the local area, avoiding words such as '*deprived*'.

- **Increasing neighbourliness** by supporting efforts that bring communities, neighbours, and friends together in local areas to help build connections between people.

- **Investing in cross-sector collaborations** to ensure we have a more aligned and collaborative approach to our service delivery.

- **Improving access to services** by examining strategic issues such as the affordability of transport for people on low incomes who need to access services.

- **Delivering workforce training** across the entire St Helens system to standardise inclusive language and ensure anti-stigma practices are being embedded into day-to-day practice.

- **Encouraging local services to sign up to and embed the anti-stigma charter**.

- **Improving the quality of, and access to, community spaces** by reviewing the use of community buildings and spaces and identifying ways to make them more accessible and attractive for people.

Outcomes: What's changed?

From October 2024 to date, we have rewired how we see, listen, and act together. People are speaking differently about residents, about each other, and about what 'help' really means. Language that once labelled or excluded is being replaced by words that invite trust. Relationships between organisations feel less transactional and more like shared stewardship of a place and its people.

Our learning on systems and services: We learned that our systems often prioritise risk and efficiency over dignity and connection. We understood that *'relationships, not services, were the real infrastructure'*. For example, people spoke about a warmer welcome at the Come Together Hub, or a resident helping to run a session − small things that create significant shifts in trust and belonging:

> *'We have started seeing loneliness not as a problem to fix, but as a sign of deeper system issues such as disconnection, power imbalance, and the consequence of a fragmented and impersonal service landscape.'*

Creating spaces for learning: We have also learnt that creating honest dialogue, reflection sessions and co-learning can help frontline professionals who have felt disconnected, overwhelmed, or unsure how to challenge bias. For example, the workshops facilitated by IVAR gave people space to slow down, speak honestly, and hear what others were dealing with across roles, sectors, and communities.

'They [the workshops] *weren't just action planning sessions; they became spaces where people reconnected with the purpose and possibility of their work.'*

Finally, we saw that **systems don't change just because you ask them to** − they change when people inside them start to see differently, speak differently, and build new habits together:

- **Increased cross-sector collaboration:** Organisations that had been working in parallel began to align more intentionally around language, strategy, and service design:

'We've literally watched this web being created … almost like this tapestry being sewn of a picture of what's available in St Helens that we just didn't know was all there.'

- **Shift in mindsets and narratives:** Across the system, more emphasis is placed on strengths, trust, dignity, and shared ownership of solutions:

'We don't talk about people as "hard to reach" anymore – we ask whether we're easy to approach.'

- **A shift from 'how do we fix this for people?' to 'how do we do this with them?':** Community voices are now shaping support, with a more explicit focus on embedding lived experience, not as tokenism :

'It's given us this impetus to think about groups who aren't accessing our services already, and what can we do to make sure we reach out to those groups as well.'

- **System-wide commitment to addressing stigma:** We have increased our understanding about how stigma impacts loneliness and isolation, and how this can be challenged locally:

'We've changed the language that we use about certain groups or circumstances in line with the anti-stigma charter.'

'We have galvanised services to take on the anti-stigma movement themselves.'

There is now a commitment by services to embed the Anti-Stigma Charter in their work and support their organisations through training and leadership development. Critically, stigma is now seen not just as a community issue, but as a systemic responsibility. The work we did around stigma received national attention, resulting in a published case study by the Local Government Association and local press coverage.

The St Helens Wellbeing Service, commissioned through Public Health, brought together over 65 colleagues together for a FREDIE[9] event that explored how to reduce loneliness and stigma, while promoting respect and inclusion across the community and workplace:

'The key is to recognise our behaviours, our biases, discrimination, stereotyping, prejudices and the impact these behaviours have on colleagues. And when we witness inappropriate behaviours, we take on the role as ally to reduce these behaviours.'

What's next

This work has already changed how people talk about loneliness and belonging in St Helens and has rewired how services relate to the people they serve, giving communities a stronger voice in shaping what happens next. It has also reminded us that the best solutions often come not from experts, but from residents who've lived the reality − and still show up to help make it better. The real test will be whether this shift takes hold in the everyday work of volunteers, staff, and neighbours, not just those holding budgets. The early signs suggest we are beginning to move towards that more radical outcome.

For many of us, the most significant shift came from looking inward at our own role in supporting change, i.e. *'lets start with ourselves'*. This has led to a cross-sector commitment in St Helens to build more on existing practice with Halton & St Helens Voluntary & Community Action leading on much of this work already. As a group we are keen to take it further and deeper as a whole system. This includes:

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9 FREDIE stands for Fairness, Respect, Equality, Diversity, Inclusion, and Engagement.

- Embedding lived experience into strategic decisions, commissioning and leadership, not just consultations.
- Supporting grassroots, peer-led initiatives that build trust and connection.
- Reviewing commissioning criteria to include relational work, not just crisis responses.
- Extending training in inclusive practice across the system and building spaces for professionals to reflect on bias and share relational practices.
- Encouraging senior leaders to spend structured time in communities by visiting, and spending time with, community organisations.
- Connecting place-based strategy (housing, transport, planning) to health equity.
- Telling the story well, through a digital artwork that we are currently developing that reflects the full richness of the work.
- Continuing to challenge stigma and bias in every part of the system.

What this journey has shown us is that tackling loneliness isn't about rolling out more services. It's about creating the conditions where people feel seen, heard, and valued − by their neighbours, by their communities, and by the systems meant to support them. In St Helens, that means leading with trust, sharing power, and refusing to accept stigma as inevitable. The partnerships, language, and habits we've built are not quick fixes − they are foundations for a different way of working, one where dignity and connection are as important as efficiency. That's the work we'll keep doing, together.

Overall, this for us is not a one-off initiative, but part of a long-term approach to tackling the root causes of loneliness in St Helens. We hope that through strengthened cross-sector partnerships, enriched by the views of our communities, we can reduce isolation, challenge stigma, and improve health and wellbeing for everyone, because St Helens residents and the communities deserve it.

Increasing cervical screening in Wandsworth

Authors:

Campbell Flack
Head of Clinical Services, Wandsworth Place at Central London Community Healthcare NHS Trust

Candy Brown
Project Manager for Cancer Screening & Early Diagnosis, Royal Marsden Partners West London Cancer Alliance

Farwa Hasan
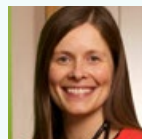GP Partner & Trainer at The Alton Practice

Fenn Porter
Interim Public Health Lead, Health Protection at Richmond and Wandsworth Council

Jessica Johnson
Healthy Communities Project Officer at Wandsworth Care Alliance

Maria Wallace
GP Partner at Putneymead Group Medical Practice and Cancer Clinical Lead for Wandsworth

Mary Idowu
Deputy Director, Partnerships and Inequalities (Wandsworth), NHS South West London ICS

Ravi Vyas,
Development Manager at Wandsworth Care Alliance

Tasleem Sadiq
Integration & Inequalities Development Manager at NHS South West London ICS

NHS Digital data showed that, in 2021, London boroughs had some of the lowest cervical screening coverage in England.[10] In Wandsworth, South London, cervical screening uptake was also particularly low among 25- to 49-year-olds and in areas of higher deprivation.[11] Prevention and early diagnosis are core components of the Wandsworth Health and Care Plan 2022−24 and the Wandsworth Joint Health and Wellbeing Strategy 2024−29. As a result, increasing the uptake of cervical screening has been a local priority.

IVAR's CHC programme was an ideal opportunity for us to understand and address the lower uptake of cervical screening among certain parts of the population and to work alongside the community to identify possible solutions.

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10 Average uptake: 62.2% in London and 62.6% in Wandsworth, compared to 70.2% average uptake in England. https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-annual/england--2020-2021#highlights

11 NHS England, 2023, NHS Cervical Screening Programme Audit of invasive cervical cancer: national report 1 April 2016 to 31 March 2019

Understanding the challenge

The first thing we did was to establish our cross-sector steering group, which included representation from Richmond and Wandsworth Council, South West London ICS, Royal Marsden Partners (NW and SW London Cancer Alliance), two local medical practices and the Wandsworth Care Alliance. Having agreed our terms of reference, we spent some time examining the local cancer screening dashboards to identify which groups within the Wandsworth population had the lowest uptake of cervical screening.

From our analysis, it was clear that our priority needed to be increasing cervical screening uptake specifically within the South Asian population. We were able to identify two Primary Care Network areas that had some of the lowest rates of uptake among the Asian community and served areas of high deprivation.

In March 2023, we hosted a partnership session that brought together cross-sector stakeholders and members of local South Asian communities in Tooting (where the event was hosted) to carry out some initial collective analysis of the barriers to attending cervical screening. The session surfaced some extremely rich insights, but it also highlighted the need to start with further community engagement to help deepen our understanding of the barriers and act as a useful resource to communities, giving them the opportunity to learn more and ask questions about the cervical screening process.

In the initial months, Wandsworth Care Alliance put significant time and resources into reaching out to a range of local groups set up by, and working with, members of South Asian communities. This process was used to help shape the offer in terms of what a workshop to understand barriers to cervical screening might look like, and to help us understand how best to engage with these communities. Some groups were reluctant to engage, and this was for a range of reasons, for example:

- Some groups had prior experience of health professionals coming to speak with them but had found it was not done in an accessible way. People often didn't know how to access the support that was available.
- Others were reluctant to host a session on the topic of cervical screening, feeling it was too sensitive a topic to have in a group setting.

Between December 2023 and March 2024, we organised a range of community outreach sessions so that we could hear directly from the affected communities. We wanted to understand why women from South Asian communities were reluctant to come forward for screening. We worked hard to identify organisations and groups whom we could work with to help us reach the community, and who could support us when it came to the point of disseminating the programme outputs. The involvement and leadership of several community leaders of local women's groups was critical, and they were instrumental in reaching out to women within their networks to encourage them to attend community engagement events.

For these initial workshops, the local groups through which they were organised were predominantly attended by women from Urdu and Hindi speaking communities. While we were therefore only reaching certain specific groups within South Asian communities, this gave us a starting point.

We held the engagement events in local community settings that the women were familiar with to encourage relaxed, informal dialogue. We ensured that representatives from public health, the Integrated Care Board, and local GP practices were all involved so that we were all hearing the same things. During the planning of the events, we wanted to ensure we created safe, inclusive spaces that lent themselves to discussing sensitive medical topics, so we did our best to consider the following factors:

• **Women are most likely to attend the events if the invitation comes from a known and trusted source:** Local community leaders were asked to reach out to their networks to invite women to attend the sessions. The sessions were held in local venues the women were familiar with and/or as part of existing coffee mornings that were taking place. Tea, coffee and snacks were provided, and the aim was for it to be a relaxed, informal set-up.

• **Cervical screening is a sensitive topic:** The sessions were organised so that we started with a GP talking through the cervical screening process in a combination of English, Hindi and Urdu. Women were invited to interrupt with questions at any point in the session and reassured that this was a confidential space for them to share and ask anything that was on their minds. They also had the opportunity to come and ask further questions after the session if they didn't feel comfortable speaking in front of the group, or there was not time for their questions.

• **Language barriers are likely to exist:** We were aware that there were multiple languages spoken in the community, including Gujarati, Hindi, Tamil, and Urdu, so we knew we'd need to identify translators and make time for the translation in the facilitation plan. For this reason, one of the local, multi-lingual GPs led the majority of the engagement sessions so that they could receive and answer clinical questions directly in someone's primary language.

• **People will ask questions:** While our primary purpose was to learn about the barriers to cervical screening uptake, it was agreed that some level of public health information would need to be prepared for the events to ensure we were able to share accurate and consistent information throughout our interactions with the community. This was another reason why the events were led by a GP who could directly answer questions and help to demystify the experience.

The Wandsworth partnership

Upon engaging with the community, we learnt about the following barriers that are preventing South Asian women from taking up cervical screening:

Barriers

- Lack of awareness regarding eligibility for free cervical screening.
- Negative past experiences, such as a traumatic birth, lead some to be fearful of screening.
- Public health information is not always reaching those who needed it, given that English is often a second language.
- Misconceptions exist about cervical screening impacting negatively on fertility.
- Embarrassment related to an assumption that the procedure will be carried out by the family doctor.
- Fatalistic beliefs, fearing that simply undergoing the test could itself bring about a cancer diagnosis.
- Caring responsibilities take priority over attending an appointment.
- Some suspicion regarding vaccinations and screening generally.

Moving to Action

Given these barriers, we realised that we had a large myth-busting task on our hands. However, we knew that providing in-person GP-led sessions was not a sustainable option given the pressures that GPs are already under:

'We know, from listening to the community, that the most impactful thing would be a face-to-face event with a clinician speaking their own language, but that's not realistic.'

Instead, we spent time creating a Frequently Asked Questions (FAQ) document that directly answers the common questions that arose during the community workshops, which can be shared in various languages. We are also working on a video to ensure the information is presented in as engaging a way as possible.[12]

In addition, we have learnt about the importance of training GP reception and administrative staff so that they understand some of the concerns people may have about cervical screening and can respond appropriately. For example, making sure they inform people that they can come and discuss the procedure first, and go through any concerns they may have, before attending the actual screening. This is particularly important given that they are often someone's first point of contact.

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12 There has been some delay in creating the video given a lack of clarity regarding funding.

Outcomes: What's changed?

Towards the end of the CHC programme, we have a body of evidence that we can use to help us to not only increase cervical cancer screenings but also apply to other screening programmes locally. We have also been introduced to new partners, and established relationships with cross-sector partners we did not work with before:

'It has helped improve collaborative working with system partners at a grassroots level.'

'It's been an opportunity to appreciate one another and understand each other's roles... This will certainly help us if we wanted to do further work together in the future.'

It has also reminded us, as clinicians, how important it is '*to treat the person in front of you and really listen to their needs and concerns*': the barriers people face, and the misconceptions they may hold about cervical screening, are real and have a significant impact on screening uptake. It has also shown how important it is to engage with communities rather than assume what's needed. It has clarified that the most effective way to engage with them is via existing, locally trusted contacts and community leaders:

'One may have assumed that we just needed to redo the website. So, we could have invested lots of money in that, only to learn that people aren't actually accessing the website, so it may have ended up being a waste of money.'

What's next

While the cervical screening landscape is changing − with the introduction of measures such as at-home screening kits as an additional option − the barriers surfaced through this work that could prevent women from being screened are still likely to prevail if preventative actions are not taken.

We have already begun taking steps to respond to what we learnt through this process, and work will continue in Wandsworth to reach out to other groups within the South Asian community:

- **Information for communities:** A multilingual video targeted at South Asian communities is being created by a local GP explaining the cervical screening process, and an FAQ landing page is being constructed from questions raised and answers provided at the community sessions carried out in 2024.

- **Information for healthcare staff:** We are developing an information resource for healthcare professionals to use at GP surgeries which will include the video, FAQs, the barriers identified and how to better support the community using these items. It will be trialled at one surgery initially, and any revised resources will then be rolled out to other GP surgeries in the borough. Administration and management teams at the surgery trialling the approach have also taken part in the Jo's Cervical Cancer Trust training.

- **Social prescriber training:** Two training sessions have been carried out with social prescribers from Enable and Surrey Physio detailing cervical, bowel, breast and lung cancer screening eligibility criteria with signposting information to share with patients regarding how to access these tests. We hope that this training will give the social prescribers the confidence to have opportunistic conversations regarding screening with their patients.

- **Engagement with other South Asian communities and other groups:** Work continues in Wandsworth, and we are aiming to engage with other groups within the South Asian community. Work will then focus on all other communities − including other ethnic groups living in Wandsworth, people with learning disabilities, LGBTQIA+ and those who have experienced sexual violence − with the aim of rolling out our offer to every other at-risk group.

IVAR
enquiries@ivar.org.uk
ivar.org.uk

Listening to what really matters: Four stories
of how communities shape health and wellbeing

20

Tackling childhood obesity in Brockmoor and Pensnett, Dudley

Authors:
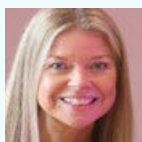
Helen Codd
Head of Communications, Engagement and Partnerships for Place, The Dudley Group Foundation Trust

Helen O'Donnell
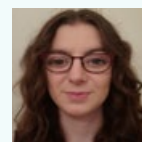Senior Health Improvement Practitioner, Dudley Council

Jason Griffiths
Chief Officer, Healthwatch, Dudley

Louise Grainger
Public Health Manager, Dudley Council

Marissa Westwood
Community Researcher, Dudley Council

In 2023, the Brockmoor and Pensnett Steering group was established, with responsibility for developing the area's placed-based approach to reducing health inequalities. The board identified the Brockmoor and Pensnett Ward in Dudley as an area of particularly high levels of deprivation. It had one of the highest age-standardised mortality rates in comparison to both Dudley and England as a whole.[13] In 2022/23 the ward also had among the highest childhood obesity rates in the borough, with 16.9% of reception-age children being classed as obese and 28.7% of year 6 children being classed as obese.

Obesity and the link with poverty is particularly prevalent within the current context of the cost-of-living crisis and high unemployment rates. This made the ward a high priority for the board. They decided, initially, to focus on children in the context of their families, and their learning and education, and the aim was to explore approaches that may support a reduction in childhood obesity while also effecting wider positive change.

Before the start of IVAR's CHC programme, there had been a period of focused engagement around the future of the local GP surgery. It was clear from this that the local residents held firm views about what made their community strong and thriving, and they felt that over time, local facilities and services had dissipated. As such, the CHC programme provided an ideal opportunity to address the health concerns in the area and, at the same time, improve relationships with the community.

13 Taken from the 'Brockmoor and Pensnett Community Engagement' report, which summarised the feedback received during the Black Country Festival that took place in July 2024.

Understanding the challenge

From the outset of our engagement with the Brockmoor and Pensnett community, it was clear that childhood obesity was not a priority concern from the community's perspective. It was also clear that people didn't want their area to be referred to as 'deprived', or told that people in the community were experiencing 'health inequalities'. As such, in the spirit of truly listening to the community, we moved our focus away from childhood obesity specifically and focused, instead, on a much broader question: *'What would help Brockmoor and Pensnett residents to live happier and healthier lives?'*.

We were fortunate, early in the programme, to secure a secondment to a community researcher post. This gave us the capacity to carry out a range of community conversations, surveys and workshops to hear what people thought about the local area.

We dedicated our first partnership group session to getting to know more about the barriers and enablers to good health in Brockmoor and Pensnett. As a result of these listening events, we learnt about the background to the statistics. We discovered that there were some fundamental barriers to accessing healthcare:

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- People often didn't know what support was available in the local area.
- People often didn't know how to access the support that was available.
- Some people did not feel in control of their own future.
- Some people felt ashamed, or stigmatised, because of their situation or behaviour(s), and this was preventing them from engaging with pro-wellbeing activities.
- The cost of living, including food and transport, was a barrier to healthy living for many families, particularly those on a low income.
- Generational habits, behaviours and attitudes were influencing unhealthy choices and outcomes.
- Social isolation was contributing to poor mental and physical health, particularly among men in the area.

Conversely, we also noted that there was a strong sense of community and local pride in the area, which was a very positive factor. As a result, we decided that, rather than focusing on childhood obesity, we would tap into this energy by taking the time to showcase the range of activities and services available in the local area that could support people more generally to have healthier, happier lives. We felt this would not only raise awareness of groups and services, but would also be an opportunity to celebrate what the community has to offer.

Moving to action

During our second partnership group session, we arranged for over 40 local community groups, services and providers to showcase their offer, including Citizens Advice Bureau, Brockmoor Community Centre, Pensnett Girl Guides and Park Activators.[14] We also put on a range of free activities for children and families to enjoy, including sports games, dance sessions and blood pressure checks to encourage participation. The event was well attended, with 159 residents taking part. During the event, we spent a lot of time talking – and listening – to the community about what they love about their local area and what would help them live healthier, happier lives:

'It was wonderful to see so many people come together to celebrate what makes our community special. The event not only introduced residents to valuable resources but has also fostered new connections and partnerships that will benefit the area for years to come.'

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14 They are part of the Healthy Dudley initiative, which aims to provide community members with outdoor venues to engage in various activities.

In addition to the partnership event, we showcased the range of groups and services available to the community at the Black Country Festival in July 2024. Building on our experience there, we followed up by attending a subsequent Black Country Festival on 16 August 2025[15]. This highlighted a recurring emphasis in Dudley on children's activities, improved parks, community safety, and health and wellbeing, reflecting a consistent set of priorities across Brockmoor and Pensnett and previous engagement activities.

This showed us how important it is to keep focusing on these areas. People's priorities haven't changed much over time, and it's clear that things like parks, safety, and activities for children still really matter. It also shows how valuable it is to keep engaging with the community − local voices are helping shape what happens next.

We also wanted to understand more about children and young people's perspectives on how to live healthier, happier lives. To find out more, we facilitated a set of interactive focus groups with children in the three primary schools in the Brockmoor and Pensnett ward, and one additional primary school in close proximity to the ward.

Each of the events took a significant amount of time and energy to organise, given the importance of ensuring that they were well attended, tailored to the target audience, and offered opportunities for authentic conversations with the community to take place. We learned lots about running such events − we even set up a logo competition through three local primary schools to help increase engagement for one of the partnership events.

We were also able to use the events − and promote them within ward centres and groups − as an opportunity to share information with local community partners and GP practices.

Based on the insights we gathered from the community from both adults and children, we embraced the opportunity to network with local groups and services, and we identified and initiated or supported several activities that we felt would address some of the underlying issues impacting on the community's health:

- Promoting existing 'Places of Welcome' and 'warm spaces'.
- Inducting and training eight 'Community Champions' to help share information about local activities and opportunities with family, friends, neighbours, and via social media.
- Scoping the opportunity to pilot cooking workshops in the local community.
- Using the Commonwealth Games legacy funding to put on physical activities such as the Beat the Streets game across the ward.
- Connecting with community leaders and local sports clubs/groups to promote more accessible and social sports opportunities.
- Exploring existing groups in the area (e.g. Tough Enough to Care) to bring men together to share and connect. This is ongoing, and we are looking to promote groups that offer support across the wider area to people in Brockmoor and Pensnett so we can increase awareness of further support.

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15 Event feedback report

Outcomes: What's changed?

Our work so far has had a positive impact, not only on the people of Brockmoor and Pensnett, but also on our own way of looking at the different factors that affect health in the community, and on how the different services within the system work together to improve it. We feel we have made progress in the following ways:

- A better understanding of the barriers and enablers to living a healthy, happy life in Brockmoor and Pensnett.
- Improved relationships with the community and capacity to maintain these going forwards:

  'We have opened up the conversation for an ongoing dialogue between services and the community.'

  'We've now got a community researcher who is on the ground on a regular basis. We haven't just come in, done a couple of events, and gone again.'

- Improved professional networks and connections in the local area, which will support cross-sector, collaborative working in the future:

'If I need to know something now, I will email people. I'm not worried that they're not from the same organisation.'

- A set of activities and priorities that we can continue to take forward as part of the steering group's work in Brockmoor and Pensnett.

What's next?

For us, being part of the CHC programme has underlined just how powerful it is to connect people with community groups and create something that can act as a model for other areas. We've seen the value of having a community researcher embedded locally and the difference it makes when engagement is built to last. The Community Champions programme is in the process of being developed and has the potential to create opportunities for further community-led initiatives. We have also recognised how important it is to engage with children directly.

As a steering group, we're proud of how we've worked together. It hasn't always been easy but we've kept our focus on what was right for the area. That determination, the tenacity of our members, has been key. Now the priority is making sure that this isn't the end point but a pipeline into wider services, so the impact continues to grow.

We are keen to continue to listen to community members and hear more about what they would like to see happen in the area and how they would like to engage. We plan to continue recruiting into the Community Champion role, for the community researcher to have a regular presence in the local community, and to continue to discuss how we take some of the identified actions forwards. We are committed to continue to work with others to support what matters most to the community.

Working to increase rates of tuberculosis (TB) screening in Cheshire East

Authors:

Alison Langley
Community Link Worker, Pathways Community Interest Company

Fiona McCarron
Consultant Midwife, Mid Cheshire Hospitals NHS Foundation Trust

Hayley Antipas
Public Health Development Officer, Cheshire East Council

Lorraine Gray
Patient and Public Involvement Manager, Mid Cheshire Hospitals NHS Foundation Trust

Matthew Atkinson
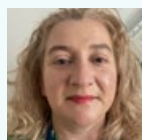Consultant in Public Health, Cheshire East Council

Nobesuthu Chaibva
TB Specialist Nurse, Cheshire and Wirral Partnership NHS Foundation Trust

In 2015, Cheshire East Council undertook a Health Needs Assessment (HNA)[16] to better understand the health and wellbeing needs of the East Timorese[17] community living in Crewe. It identified two particular issues: higher rates of tuberculosis (TB) and low GP registrations. The HNA recommended increasing the uptake of TB screening and increasing the number of GP registrations within the East Timorese community.

The council developed an action plan based on the HNA findings, but progress on this was significantly affected by the Covid-19 pandemic. IVAR's CHC programme came at a fortuitous time, as it provided space, time and resources to address the health and wellbeing needs of the East Timorese community.

During the two years of the programme, we were fortunate to have representation from the public sector and the VCSE sector on the Steering Group, including: Cheshire East Council (specifically public health, community development and family hubs); Mid Cheshire Hospitals NHS Foundation Trust; Eaglebridge Primary Care Network; Cheshire and Wirral Partnership; Central Cheshire Integrated Care Partnership; Wishing Well; Healthwatch; Pathways CIC; and East Timor Action Group (ETAG).[18]

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16 HNA: Timor-Leste European Migrants and Families in Cheshire, Public Health England, 2015.
17 East Timor, or officially the Democratic Republic of Timor-Leste, is a small country occupying half an island in Southeast Asia.
18 A formal Community Interest Company (CIC) of the local East Timorese community.

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Understanding the challenge

Facilitated by IVAR, the partners first came together in June 2023 to reignite energy for this work with the East Timorese community. We started by revisiting and updating the 2015 HNA, and this was completed in March 2024.[19] This gave us up-to-date insight into the experiences of community members in Cheshire East.

Throughout the CHC programme, we took the time to engage with the East Timorese community to better understand the barriers they face when it comes to accessing health and care (in particular primary care), and this in turn deepened our understanding of the barriers the East Timorese community faces in relation to accessing TB screenings.

19 HNA for the East Timorese population of Cheshire East, Cheshire East Council, March 2024.

Barriers

- **Lack of awareness and/or education about the UK's health system:** Some people in the East Timorese community are not sure when it's appropriate to access a GP, and some are not aware that GP services are free.

- **Stigma:** TB is a stigmatised disease within the East Timorese community because it is *'felt to be a disease of poverty'* (given its association with low income and overcrowding). As a result, many people are *'reluctant to discuss it'*. Also, TB often comes with a dual diagnosis of HIV or syphilis, which increases the stigma associated with the disease.

- **A less visible community:** Many people who arrive from East Timor hold a Portuguese passport and so are often noted as Portuguese or simply 'Asian – other'. This means they *'do not show up in the data'*, making it difficult for us to identify the population's size and needs. In addition, we found that people in the community *'very much keep to themselves'* and, as such, they are very unlikely to attend the type of support groups where we usually meet people.

- **Language:** The main language spoken by East Timorese people is Tetum. However, we learnt that there are not only different Tetum dialects, but some of the community speak Indonesian or Portuguese. We also found that literacy levels were quite low within the community. As such, we realised that current public health information is simply not reaching all members of the community.

- **Gender:** We knew anecdotally that gender was impacting on how receptive someone may be towards registering with a GP and attending TB screenings (men were more likely to be registered with a GP), and we encountered other gendered dynamics through our engagement with the community (for example, the football tournament as part of the Independence Day celebrations was only for boys and men).

- **Availability:** Many people from the East Timorese community work long, unsociable hours and are often on zero-hour contracts. This can make it hard for them to attend health checks and appointments.

- **Reactive approach to health:** We learnt that many East Timorese people take a reactive, rather than proactive, approach to their health. In other words, *'they wait until the very last minute'* and *'only reach out to services when they are ill'*. This explained why the community can often be reluctant to register with a GP and attend health screenings, and why many East Timorese women present late to maternity services.

Moving to action

A key aim of the programme was to build a relationship with the East Timorese community through a number of events and engagements. We hosted a community lunch, attended the community's 'Independence Day' celebrations, and engaged with people through small events or gatherings to showcase the range of services available to them.

We also hosted a partnership workshop in October 2024, which helped us to connect with other key services, raise awareness of the challenges faced by the East Timorese community, and bring new energy to the work.

Understanding the barriers enabled us to consider how best to plan community engagement events, and to communicate public health information. For example, we deliberately chose not to primarily focus on TB at any of our engagement events given the stigma that we found to be associated with the disease:

> *'We would love people to engage with the TB service, but we realised this could be a bit off putting if that was the focus of an event ...'*

Rather than hosting large-scale, one-off events, we delivered micro events that provided greater flexibility in terms of venue, time and focus − for example, an event at the local Family Hub to increase the likelihood of us reaching women and children:

> *'We learnt that the* [community] *work quite long, often unsocial hours, and that affects when we can put events on ... so that led us to try a few smaller events rather than one big thing ... we tried to go where people are a bit more.'*

> *'We tried a variety of different venues, days and times in the hope that we would get that buy in from different people in the community.'*

Challenges and lessons learned

This work was challenging, perhaps more than we expected it to be. One of the biggest hurdles faced related to the community engagement: *'I honestly thought the community would just come flooding through the doors'*, one member of the partnership remarked. Initially, we were able to get 30−35 people attending events, but this significantly dropped partway through the programme. Some of the reasons for this included:

- The departure of a council officer who had had a strong existing relationship with the community.
- A feeling that the community had already participated, so why was further engagement required.
- A sense that the community felt 'targeted' and did not necessarily understand why we were focusing on them.

Despite the challenges, we learnt so much through the process. Several insights surfaced over the two years, some of which we were able to respond to in real time and nearly all of which we are able to apply to other work in Cheshire East.

Key Insights

- **The value in identifying respected institutions:** We learnt that the community highly respects the local council and the Church. Where possible, we used the Council's logo to give credibility to information and events, and we sought support from the local priest to help deliver some of our key messages to the community on our behalf.

- **Health and wellbeing are not primary concerns:** The East Timorese community were concerned with issues other than health, including employment, housing, and benefits. We used the CHC programme as an opportunity to provide information about a range of services to the community, not just those related directly to health and wellbeing:

'It is important to see TB as a result of wider inequalities. Sometimes, we just tend to focus on symptoms, but starting with wider inequalities has been a good place to start.

- **Casual engagement is powerful:** There is power in engaging with communities in informal settings and taking information *to* people. We identified existing events and opportunities to engage with the community:

'The Independence Day was a great opportunity to catch people where they are … it was an informal setting where they didn't feel like they were under the spotlight …'

- **Trust is essential:** Trust is key when engaging with communities and presenting health information. Where possible, we used existing connections within the community to help advertise events and understand more about the community's needs:

'They were a trusted face and someone they were willing to speak to … I think having that link made a massive difference in terms of engagement.'

- **It is really important to carefully handle changes to the team or steering group** – ensuring that handover processes support continuity of engagement:

'I think it would have been really useful if there'd been some preparation work done with the community between the original engagement officer leaving and the new one incoming.'

Outcomes: what's changed?

- **Increased awareness of the East Timorese community in Cheshire East:** As a result of the CHC programme, we have a much deeper understanding and appreciation of the range of barriers that are impacting on the East Timorese community's access to primary healthcare. We are sharing this learning with colleagues outside the programme, and it is influencing our future work. For example, the midwifery team is using the learning to help train a team of midwives who will be providing a 'continuity of care' package to families from the most deprived areas in Crewe, including families from the East Timorese community. Another steering group member is planning to use the knowledge to help design a menopause toolkit:

  'I think we've raised the profile of this community amongst … health professionals and amongst my colleagues in social care … they're much more aware of this community now.'

- **Increased access to primary care:** We are aware of a handful of community members who have now registered with their GP and will hopefully take up TB screening. We are also confident that the community knows a lot more about what is on offer.

- **Information resources about TB:** The Cheshire and Wirral Partnership has published a webpage with information and guidance about the TB service available in the area: Tuberculosis (TB) Service.

- **Strengthened partnerships:** We are much better networked as professionals, and we feel we are in a much better position to support the community in the future:

  'Whilst we haven't drastically changed the risk of another TB outbreak, I think our response would be a lot better … I think we'd be in a much better place because we know more about where to go … how to reach people … and which professionals to turn to.'

What's next?

This programme will inform many aspects of our work – the *'learning is really cross-cutting'*. The challenges we faced with regards to community engagement made us reflect on the importance of investing in healthy places, rather than focusing purely on services that do not reach everyone in the community:

> *'I think it will have value beyond the East Timor work … it should help make all our services better.'*

Reflections and concluding thoughts

This phase of the CHC programme showed just how complex tackling health inequalities really is. Progress is not always linear and it didn't come from services alone, but from listening carefully, taking communities' experiences seriously, and working across sectors on what mattered most in people's lives.

In line with the existing literature base, we understood and witnessed first-hand that health inequalities are often the result of a complex interplay of social, cultural and economic factors. As a result, the solutions that were explored were often multifaceted in nature and required participants to truly understand the community's perspective:

'It wasn't just about accessing healthcare … If work and putting food on the table is your priority … everything else is going to be secondary.'

The programme also highlighted the importance of language, the need to sustain momentum, and the influence of power and ownership. The way challenges are framed can either reduce stigma or deepen it. Spaces that allow time for reflection keep people connected to purpose. And change lasts longer when ownership shifts closer to communities.

What can others learn from Connecting Health Communities?

Some conditions are essential to helping collaboration take root; how communities are engaged, how relationships are built and sustained, how power is shared. The following themes provide practical insights for anyone seeking to strengthen collaboration between communities and health systems. They offer a sense of what to pay attention to when tackling health inequalities within and alongside communities.

Start with shared values

When partners align around a common purpose, the focus shifts from problems to possibilities, strengthening both collaboration and relationships. Trust, accountability, clarity and being upfront about what can be delivered are key to making those relationships last. It is essential to recognise that involvement should extend beyond consultation, and that people with lived experience must be genuine partners in shaping decisions, not merely voices to be checked off.

Work with flexibility and openness

Projects rarely unfolded exactly as planned. The most valuable learning came when partners were willing to adapt and respond to realities on the ground rather than stick rigidly to early assumptions. An iterative, open mindset creates space for innovation and responsiveness:

'Don't be worried if your initial idea changes and the goal-post moves ... as you learn things, you're going to want to achieve different things.'

Engage communities as genuine partners

One of the most important lessons has been the need to move beyond surface-level involvement and to ensure lived experience genuinely shapes decisions. This requires safe, trauma-informed spaces and support for those sharing personal stories, so that those stories become a source of influence rather than extraction.

Building trust matters. Relationships grow stronger when work is built on existing foundations and involves people already recognised as trusted figures. A consistent presence on the ground shows commitment and care for the wider needs of communities, not just their health. Use, respect and build on the relationships that already exist. Show genuine care regarding all aspects of a community's needs, not just their health.

Because no community is a single voice, and different groups bring different perspectives and priorities, take time to understand these complexities. Engagement needs to be flexible: meeting people where they are, varied in timing and location, and respectful of privacy. Where possible, take your message to the community rather than expecting them to come to you.

Listen deeply and talk openly

We learned just how important it is to listen to a community's concerns and to take the time to respond to these when tackling health inequalities, rather than making assumptions about the causes or solutions:

'Don't come up with the challenge first and then impose solutions. That's basically like saying "we're fixing this problem that you never told us about".'

Open dialogue, even when difficult, creates trust and understanding between partners. Partnerships work best when hidden hierarchies are challenged, power is acknowledged, and spaces are actively facilitated so all voices can be heard and power can be shared:

'Be alert to hidden hierarchies and invest in facilitation that creates balanced, inclusive spaces where all voices can be heard.'

Use clear and positive language

Communities respond better to everyday, asset-based language over deficit-focused terms. Reframing conversations, for example, talking about 'healthy lives' rather than 'obesity' in Dudley, helped reduce stigma and build trust. In some areas, this meant addressing inequalities indirectly to match community priorities, while in others it involved tackling fears and misconceptions directly. Where new language was embedded into local systems, it helped reframe conversations more broadly.

Build reflective spaces that inspire action

Workshops became more than action planning; they gave people time to slow down, speak openly, and reconnect with colleagues across roles, sectors, and communities. This was an unusual but deeply valued experience, reminding participants of the purpose and possibility behind their work. When well designed, they were spaces for reflection, renewal, and collective action rather than routine meetings. Making space for values-based conversations, both in workshops and within organisations, proved essential for sustaining progress on health inequalities.

Projects also moved forward thanks to teams who were hands-on, creative, and genuinely cared about the communities they served. Persistence and practical commitment mattered as much as strategy:

> *'You need doers … having people who will roll their sleeves up, even if it starts snowing when handing out leaflets.'*

Invest time and capacity in collaboration

Partnerships found that collaboration wasn't just useful, it was essential. No single organisation can tackle the challenges alone, and progress often relies on recognising the wider links between health, housing, education, and the local economy. Working together gives partners a clearer understanding of each other's roles and helps build trust by hearing the same community voices. Recognise that making collaboration and partnership work well requires time and capacity, particularly when one considers the many other, at times competing, priorities that people have:

> *'It takes capacity to do this well and to coordinate all the activities and ensure people keep focused on our collective aims rather than focusing back on their internal aims and objectives … We've all got day jobs.'*

One of the reasons the CHC programme has been so appreciated by the partnerships is that it has provided areas with the capacity and resources needed to manage the operational load that collaborative efforts require. Having the support of an external facilitator helps remove any power imbalance or hierarchy that may have existed between partners otherwise:

> *'Without somebody coordinating all the stakeholders, the community stakeholders, the patient groups, the Care Alliance … sharing minutes and papers … I don't think we would have achieved as much.'*

Celebrate small wins

Even small steps forward, such as identifying trusted community members who can spread the word, are genuine progress. Small shifts not only energised teams but also opened doors to bigger outcomes. This sense of patience is not about lowering ambition but about recognising the value of steady progress:

> *'Small wins can lead to bigger ripples … I think we do need patience'.*

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Plan for the long term

Systemic change takes far longer than people expect, and progress often comes in uneven stages. Trusting the process, keeping going when things feel slow, and recognising the importance of continuity are essential for building momentum and laying the foundations for long-term change. Dedicated resources and skilled facilitation can help create space for coordination, balance power between partners, and keep everyone focused on shared goals rather than internal agendas:

'Massive systemic change doesn't happen as quickly as you might want it to ... Sometimes you just don't know what's going to happen until a few months or years later.'

Change rarely fits neatly within the life of a single programme. Recognise and plan for legacy early on, with practical steps like developing Community Champions or embedding learning into local commissioning. Sustaining change ensures that the energy, relationships, and insights built are not lost once external support steps back.

Looking ahead

The stories in this report remind us that partnership is not a destination, but a way of working. The issues each area faced will look different elsewhere. Still, the underlying process is what matters: slowing down enough to listen, treating voluntary and community organisations as equals, and being prepared to let communities set the terms of engagement.

Too often, partnership working is reduced to coordination between institutions. The case studies from the four areas show that this misses the point. The real test is whether the system is willing to be changed by the people it serves. That means giving lived experience the same weight as professional expertise, recognising the voluntary and community sector as part of the system rather than an add-on, and creating the conditions for relationships to grow over time.

For others wanting to work this way, the lesson is about what becomes possible. Partnerships built on trust and honesty generate the confidence to take risks, the resilience to ride out setbacks, and the credibility to engage people who might otherwise stand back. Those qualities are transferable to any system serious about reducing inequalities.

What these areas have shown is that health systems *can* work differently. They can move beyond consultation, resist the pull of quick fixes, and instead invest in relationships that outlast programmes and funding cycles. This requires patience, humility, and a willingness to let go of control. But it is also where the possibility of lasting change lies. The challenge now is to act on this learning and treat partnership not just as an aspiration but as the route to a fairer, healthier future for all.

Resources to help you get started

The path to partnership starts with dialogue: A blog on collaborative conversations, outlining how open, enquiring dialogue underpins the early stages of fruitful partnership working.

Not just ticking boxes: Four stories illustrating community-led health service design. It shares four case studies of community-led health service interventions, demonstrating how partnership work can move beyond superficial compliance.

Why and how to tackle stigma and bias in partnership working: This blog on inclusive collaboration presents leadership perspectives and practical strategies for addressing stigma and unconscious bias in cross-sector partnerships.

Talking points for cross-sector partnerships: Questions to Kick-Start Partnership Conversations. A resource offering questions to stimulate dialogue between sectors when developing partnerships

How can Polarity Management help navigate complexity in partnership working?: A blog on using the Polarity Management framework to help partnerships juggle competing priorities while working towards a common goal.

Moving to action and growing pilot projects: An infographic sharing insights into how to scale pilot projects and maintain momentum in collaborative settings.

"Don't Boil the Ocean" And other real-world tips for sustaining change: A blog on offering down-to-earth advice for maintaining momentum and achieving sustained change in partnership work.

How to build an effective partnership: A practical guide on setting out key elements for building effective cross-sector partnerships and meaningful collaboration

Know Your Numbers: How Local Action is Preventing Strokes in Cumbria: A blog that charts how a local partnership in Cumbria is using cross-sector action to prevent strokes, illustrating how place-based collaboration works in practice.

Bringing the 'right people' to the table: This infographic captures insights from cross-sector leaders on what needs to be in place to launch health-service delivery partnerships.

What does it take to build effective solutions and services for our communities?
A blog on service-design in partnerships, exploring what's required to build services that meet community needs, through collaborative and inclusive design.

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Appendix one: About Connecting Health Communities

Through Connecting Health Communities, we support cross-sector partnerships to address health inequalities within their local communities. We are funded by the National Lottery Community Fund. It is a 30-month facilitation support package to enable cross-sector partnerships to address health inequalities in Integrated Care Systems (ICS) and/or Primary Care Networks (PCNs) in partnership with the voluntary sector and communities facing health inequalities.

Our aspirations for this work

1

People with experience of health inequality are meaningfully involved in the co-design and co-production of health and care in and for their communities.

2

People and communities with experience of health inequality are trusted partners in decision-making about their health and wellbeing.

3

Activities that help people stay well and healthy happen in spaces and ways that communities feel ownership of.

4

VCSE organisations are recognised, valued and resourced to connect people in communities with each other for their health and wellbeing.

Our principles

Seven principles underpin and shape our approach to supporting cross-sector partnerships to engage meaningfully and productively in improving local health and care systems.

1
Building relationships for joint action

We create space for the building blocks of partnership working by connecting people; helping them listen to and understand each other; identifying a shared starting point for action; and setting realistic and achievable goals.

2
Acting as advocates for the community

Our entry point is to champion, promote and enable the voluntary sector to be a valued and influential partner in health and care design and delivery. In our work we privilege the perspectives and voices of people who are furthest from power.

3
Flexibility

We have a core offer that we adapt to work for each area we partner with. We notice when things aren't working and change our approach to meet the needs and circumstances of local partners.

4
Style of facilitation

We take an inclusive, fun and human approach – starting with who is in the room, acknowledging emotions and recognising past challenges. We then use creative methods to facilitate difficult, cross-sector conversations which lead to action. This helps to build capacity locally and is itself an act of influencing the local system, by modelling a collaborative approach to problem-solving.

5
Taking responsibility to maintain momentum

We play a convening role, holding the process and bigger picture for the partnership as collaborative working gets underway:
- We ensure that next steps are jointly agreed, and that follow-up actions are picked up.
- We tell the story of the work as it evolves, keeping people energised and motivated.

6
Local first and asset-based

We start with health inequalities at neighbourhood (PCN) level, understanding and building on existing approaches, energy and ideas. We then look at how whole systems (ICSs) need to change to address those inequalities.

7
Interest in policy and practice

We draw out implications from our work in local areas for both policy influence and practice development.

What does the local area work involve?

The programme is open to any cross-sector partnership in England that is seeking to work with their local community to address health inequalities. Up to four areas are selected for each round of funding. Since 2021, we have worked in 17 areas.

Connecting Health Communities involves the following core activities:

- **Steering group:** Each area identifies between six to eight stakeholders representing different sectors. This is a cross-sector group, responsible for driving the work forwards outside of the facilitated sessions.
- **Partnership workshops:** Up to six partnership group sessions are held within each area, which involve a much wider group of professionals and community stakeholders to shape and take forward agreed activity. These sessions usually involve around 30-60 people.
- **Smaller community-based sessions:** These *'community conversations'* provide spaces to engage local communities and open dialogue on specific health inequalities to explore shared concerns, possible solutions, and strengthen community ownership.
- **Champions Network:** Areas select representatives to take part in this network – a group of cross-sector leaders who are keen to develop their skills for collaborative and partnership working through peer learning. The aim of the Network is to develop confidence and competence to become system leaders and agents of change.
- **Financial support:** In addition to facilitation, modest financial support is provided to each area to enable community participation and to support the hosting of in-person events and workshops.

Key:

Current phase: 2024 – 2027
Phase Two: 2023 – 2025.
Phase One: 2021 – 2023

Northumberland
North Yorkshire
St Helens
Wirral
Sheffield
Cheshire East
Leicester & Leicestershire
Dudley
Birmingham
Buckinghamshire
Milton Keynes
Somerset
Wandsworth
Barnet & Enfield
Devon
East Surrey
East Sussex