Local Trust
trusting
local
people

Health starts in the neighbourhood

Reforming the system from the ground up

"Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society."
Sir Michael Marmot, The Marmot Review

Executive summary

The current healthcare model is unsustainable: spiraling demand is outpacing resources, health inequalities are widening, and too much money is being spent treating rather than preventing illness. We propose a fundamental shift toward a neighbourhood health approach that keeps people healthy in their daily lives, empowering communities and building on existing local assets and relationships. This involves three key reforms:

1. devolving healthcare budgets and establishing structures at the place level to pool and direct resources to neighbourhoods
2. delivering programmes through neighbourhood working to integrate statutory and community services, partner directly with residents, and target the areas in greatest need
3. creating a dedicated investment fund to rebuild social infrastructure in the most disadvantaged neighbourhoods.

COMMUNITY FUND

Introduction

The current model of healthcare is increasingly unsustainable. Demographic changes have created spiraling demand in a system with finite resources. A decade of austerity has depleted many of the services that keep people healthy in their communities. Health inequalities continue to widen, particularly in neighbourhoods without the necessary social infrastructure to collaborate with the health system or organise health-promoting activities (NHS Confederation, 2025). As identified by Lord Darzi (2024), too much money is being spent reacting to health issues in hospitals, and not enough on preventing them in communities in the first place.

We need a fundamental shift toward a 'neighbourhood health' approach that prioritises keeping people healthy in their daily lives, rather than treating illness in hospitals. The neighbourhood level is where most of the social determinants of health take root: factors like housing quality, local green spaces, and the social networks that promote good health (NHS Confederation, 2025). These social determinants of health are estimated to account for 55% of health outcomes, dwarfing the impact of the health care system (WHO, 2023).

Neighbourhoods are also where the most impactful interventions can be made, in collaboration with communities who are best placed to create good health (HCA, 2024). Across the country, communities are the source of many of the local activities, services, and networks – from sports clubs to food banks – that help people stay connected, active and healthy. This community provision has largely disappeared during the austerity period, with funding cuts concentrated in the poorest neighbourhoods widening health inequalities (Smith, 2023). Reversing these trends will require targeted support to the areas in greatest need.

Sustainable reform must lie in shifting both resources and responsibility out to neighbourhoods and communities, refocusing on the social determinants of health. Empowering neighbourhoods by building on the "assets, relationships, and infrastructure available" allows people to take a proactive approach to their own health in daily life (Naylor, 2025), while reducing pressure on acute and urgent services over time (Fuller, 2022). It also provides a meaningful scale for public service providers to integrate their support with wider civic and community activity (NHS England, 2021).

Roadmap

A successful shift to a neighbourhood health model that keeps people healthy in everyday life will require three key reforms.

The first is a shift to place-based collaboration and devolved healthcare budgets, establishing administrative and financial structures where public budgets can be pooled and redirected to the neighbourhood level. The next is a focus on neighbourhood working between public services and communities, to transform how communities engage with the health system and to ensure that resources are targeted to the areas in greatest need. Finally, there is a need for a dedicated programme of capacity building for 'doubly disadvantaged' neighbourhoods who lack the social infrastructure necessary to collaborate with the health system and deliver preventative community initiatives.

Together, these shifts will restructure healthcare around prevention and wellbeing, directing resources upstream to create the conditions for good health within communities. For citizens, this means being supported to stay healthy through services embedded in their neighbourhoods, easier access to joined-up care close to home, and a greater influence over the decisions shaping health in their communities. In the long-term, these recommendations will narrow health inequalities, reduce pressure on clinical services by preventing rather than treating ill health, and deliver sustainable cost savings by building preventative capacity in the areas that need it most.

Summary of Recommendations

1. **Place based funding**
    a. Commissioning budgets and decision-making power should be devolved to place-based partnerships which align with combined or local authority boundaries.
    b. Place-based partnerships should commit 5% of their budgets to community-led prevention and health creation initiatives delivered at the neighbourhood level: including core funding for VCSE organisations and dedicated funding for social prescribing referrals.
2. **Neighbourhood Working**

a. Neighbourhood working should form the basis of delivery within place-based partnerships, allowing statutory providers, the VCSE sector, and communities to co-deliver local health services.
b. Statutory providers should be held accountable for reducing health inequalities at the hyper-local level, in neighbourhoods of around 10,000 people.
c. Neighbourhood structures should adopt community-centred ways of working to engage citizens in health creation, use public assets for community benefit, and build the capacity of local people to deliver health and wellbeing initiatives.

3. **All Neighbourhoods Thriving Fund**
    a. A £500m All Neighbourhoods Thriving (ANT) fund over 10 years should be established specifically to invest in the social infrastructure of doubly disadvantaged neighbourhoods.

Defining 'Place' and 'Neighbourhood'

'Place' refers to the physical and social environment where people live, work, and interact, and its impact on their health and well-being. In the healthcare system, it describes an area in which health and other services are integrated. Place-based partnerships have been formed at different scales but often align with local or combined authority boundaries.

A **neighbourhood** is a geographically localised area within a larger city, town, suburb or rural area. There is no standard definition for a neighbourhood, but it typically corresponds with the built environment and where people feel a sense of identity. While the health system might consider an area of 50,000 people as a neighbourhood, our experience suggests that neighbourhood units should be no larger than 10,000 people to reflect the scale at which most people live their lives and access local services (Tyler et. al, 2019). Nonetheless, these scales can coexist if frontline staff are empowered to work flexibly across geographical areas.

Recommendation 1: Place-based Partnerships

Place-based partnerships are collaborative relationships between the institutions and people responsible for delivering health services and improving wellbeing in a place, including NHS trusts, GPs, local authorities,

VCSE organisations, social care providers, and communities (NHS England, 2021). They are formed to integrate and deliver health services more effectively: aligning resources between statutory providers toward shared goals, developing strategic plans for joined-up services which address both medical and social needs, and working more closely with communities (NHS England 2021).

By allowing communities a seat at the table to co-produce their care, place-based partnerships help health systems "respond to local characteristics" by addressing the social determinants of health (Charles et al., 2021). They are also more likely to mobilise communities in a meaningful way, with multiple organisations working to connect with communities and actively using their feedback to improve services (Charles et al., 2021).

Place-based partnerships operate at the ideal scale to improve local health in cooperation with communities (Marmot et al., 2020). Many existing partnerships align with local authority boundaries because they provide a meaningful definition of place, bring in existing accountability and delivery structures, and allow for the integration of health and social care services through Section 75 partnerships and Better Care Fund agreements (DHSC, 2024).

The Health and Care Act 2022 has given Integrated Care Boards (ICBs) the power to delegate budgets and functions, though this is not yet a legal requirement. The extent of resource and power transfer to places has varied greatly, but systems like the West Yorkshire ICS have devolved nearly its entire £5 billion budget to place committees (Naylor and Charles, 2022). **We propose formalising this by devolving budgets and decision-making power to place-based partnerships which align with combined or local authority boundaries.** These partnerships would receive formal budget holding and commissioning powers from ICBs, enabling them to set strategic direction based on input from statutory providers and communities.

Battersea Alliance

Battersea Alliance, a coalition of voluntary and community organisations emerging from Battersea Big Local, has invested over £600,000 in the past five years into funding community activities that address isolation, loneliness, and mental health issues. They focus on prevention before medical intervention is needed.

The Alliance is collaborating with statutory bodies, including their local authority and Integrated Care Board, to pilot a preventative health programme which will engage individuals with community activities without requiring a GP referral. Their work demonstrates how community organisations can extend the reach and effectiveness of statutory health services. Recent analysis suggests that every £1 invested by the Alliance has created £5 worth of health-related benefits for their community (Battersea Alliance, 2024).

Refocusing on Neighbourhoods through Targeted Funding

A key function of place-based partnerships should be directing resources to neighbourhoods, building the conditions for good health into the environments where people live, work, and gather. This means shifting from a dominant medical model of treatment and referral to one where communities themselves are resourced to deliver health-supporting activities. To implement this shift, **we recommend a statutory requirement that place-based partnerships commit 5% of their budget to community-led prevention and health creation initiatives delivered at the neighbourhood level** (Locality, 2024).

This builds on the precedent established by the Hewitt Review's recommendation that health systems allocate at least 1% of their budgets to prevention. It also recognizes that community-led approaches are uniquely positioned to engage those most at risk – particularly those facing complex conditions and barriers to access – making them essential to reducing health inequalities and closing the participation gap in prevention (Bos et al., 2023, Rong et al., 2023).

One way that the NHS has envisioned this upstream shift is through the long-term expansion of social prescribing (NASP, 2023). Social prescribing is a practice used by health professionals to connect people with non-clinical services, often within the local voluntary and community sector, to improve their health and wellbeing (Buck and Ewbank, 2020). It has been found to reduce system pressures by decreasing GP appointments and hospital and A&E admissions, particularly for high-risk patients (TPHC, 2025).

Nonetheless, the current approach to social prescribing in the NHS is fundamentally constrained by issues of inequality and capacity. Simply put, we have invested a lot of money into link workers but far less in the

community services and activities they are meant to link people to. Because the success of social prescribing relies on referring people to community resources that many disadvantaged neighbourhoods lack, it cannot effectively address health inequalities (Calderón-Larrañaga et al., 2021; NHS Confederation, 2025). This is particularly concerning because the neighbourhoods suffering from the greatest health inequalities have the lowest levels of social infrastructure in the country (APPG for left-behind neighbourhoods, 2022).

In addition, voluntary and community organisations often do not receive funding from NHS bodies when patients are referred to their services (Munro and Dayson, 2025). In a 2019 survey of social prescribing link workers, 74% identified a lack of funding and services in the community as their primary challenge (NALW, 2019). To address these capacity constraints, **we recommend a requirement that all local VCSE organisations receive funding for the services they are asked to provide for social prescribing referrals** (Munro and Dayson, 2025).

Beyond this, real transformation will require a less medicalised approach, towards a system that is embedded in local relationships and supported by long-term investment in community infrastructure. As Hewitt (2023) argues, upstream and preventative investments are vital to build the conditions for good health into everyday life. On this basis, **we recommend that place-based partnerships provide core funding for local VCSE organisations to support and build their trusted, holistic, person-centred support.** This should be as part of hospital discharge pathways, community support for frequent A&E attendees, and general illness prevention and health creation services (Locality, 2024). Funding for social prescribing referrals and VCSE organisations could be drawn from ringfenced budgets for community-led prevention and health creation at the place level.

Another strategy which has seen success in trials from Westminster to Cornwall is the use of Community Health and Wellbeing Workers, recruited directly from communities to look after a given number of households and proactively connect them to health and wellness services. These workers are distinct from link workers: they operate on smaller scales, develop more personal and direct relationships, and proactively engage communities rather than waiting for a GP referral (NAPC, n.d.).

While duties for health systems to improve population health and reduce health inequalities are already legislated for in the Health and Social Care

Act (Marmot et al, 2020), substantial resource in the NHS is dedicated to meeting short-term performance targets oriented around appointments and waiting lists (NHS Confederation, 2025). The changes outlined will help to rebalance this focus by shifting resources to prevention, realigning the health system with long-term goals around improving population health rather than short-term crisis management.

Recommendation 2: Neighbourhood Working

The Fuller Stocktake (2022) set out a vision for a new model of integrated primary care delivered by Integrated Neighbourhood Teams (INTs), which bring together GPs, trusts, social care providers, local authorities, social prescribers, and the VCSE sector within a given neighbourhood (usually around 50,000 people). INTs exist to coordinate care across multiple providers, allowing citizens to access support that addresses both medical conditions and underlying social factors. In Derbyshire, INTs prevented 2,300 ambulance callouts in a year by connecting frail older people with formal health visiting and informal community support to assist with loneliness and daily tasks (NHS England, 2023).

Another positive step towards parity with communities has been the creation of voluntary sector alliances within Integrated Care Systems, allowing the VCSE sector to contribute to the design and delivery of services from their governance down to their delivery in neighbourhoods (Dickie, 2023).

While these both represent useful delivery models, the broader goal should be to **embed neighbourhood working as a core principle of health care delivery under place-based partnerships**. This means supporting neighbourhood-level structures – whether INTs, local partnerships, or other models – that bring together statutory services, the VCSE sector, and residents to deliver coordinated care, build on community assets, and improve population health.

Additionally, a key accountability for all statutory health partners working in neighbourhoods should be the reduction of health inequalities at the hyper-local level (10,000 people). The use of geo-spatial data to identify areas with the poorest health outcomes, alongside mechanisms to devolve resources to these communities, can allow for targeted and co-produced interventions in the areas with greatest need (Local Trust, 2024). This approach also

strengthens the ability of these communities to organise health-promoting activities and collaborate with the health service in the long-term.

One Croydon Alliance

The One Croydon Alliance has brought together the local NHS, Croydon Council and AGE UK to improve care pathways and prevent ill health. This alliance is underpinned by multidisciplinary neighbourhood teams of GPs, health and social care workers, specialists, and voluntary and community groups.

The Alliance's strategy centres on both empowering communities and delivering services through them. Since 2019, their Local Voluntary Partnership scheme has funded over 70 grassroots initiatives with grants up to £5,000, supporting projects from community gardening to choirs that reduce social isolation and help residents stay active. Recent initiatives have seen expanded funding, with eight community organisations granted between £5,000 and £50,000 over three years to deliver mental health support.

Locally, neighbourhood teams target health inequalities through tailored community outreach. One team partnered with the Croydon BME Forum and Asian Resource Centre to deliver workshops aiming to reduce diabetes and hypertension risks among Black, Asian and Minority Ethnic communities, where these conditions are more prevalent. This approach engaged over 600 people through 15 events, training community champions and providing health checks in accessible settings (One Croydon, 2022).

Their collaborative approach has extended the reach of health services beyond their traditional, clinical settings, while creating a more responsive and cost-effective system which is able to address health inequalities and build longer-term wellbeing.

Ways of Working

To shift to a model of health creation, neighbourhood structures need to actively build in community representation, establishing strong links with community partnerships and individuals rather than exclusively focusing on formalised VCSE organisations. This is particularly important in neighbourhoods lacking social infrastructure and existing grassroots capacity.

More widely, neighbourhood structures need to adopt community-centred ways of working if they are to successfully improve population health and reduce inequalities (OHID, 2022).

These ways of working follow core principles:

- use an asset-based approach which leverages existing community resources and relationships to promote good health locally, addressing the social determinants of health (OHID, 2022)
- build trusting, long-term relationships with communities to get residents involved in health and wellbeing initiatives and the co-production of health services
- support community development by helping communities convene, identify shared needs, and build capacity where networks don't already exist (NICE, 2016).

These ways of working allow service providers in a place to use their resources, and existing resources, for community benefit. This includes commissioning practices and investments which build up the capacity of grassroots organisations (Naylor and Wellings, 2019), and a strategic use of NHS or council properties to build in space for communities. The Bromley-by-Bow Centre, merging a GP practice and community hub, has used part of its 3-acre estate to create a community green space and children's play area (Reed et al., 2019).

System partners should also look to use their estates and existing community assets to build relationships and improve access to care, including:

- co-locating the services of their respective organisations to ensure that people can access joined-up support
- partnering GPs with community centres to improve access and integration
- deploying NHS staff to community spaces to provide diagnostic services.

Underlying all of these changes is the need for a fundamental cultural shift that places greater trust in communities. This requires embedding working with communities as standard practice across public service reform – including through training, leadership development, and stronger roles for community voices in decision-making.

Recommendation 3:

All Neighbourhoods Thriving (ANT) Fund

In many ways, a strong neighbourhood health approach relies on what already exists in communities: health partners, local authority services, a thriving VCSE sector, strong social networks, and physical spaces that complement the formal health system. This is only possible with robust social infrastructure: "the framework of institutions and physical spaces that support shared civic life" (Local Trust, 2025).

In many neighbourhoods across England, this social infrastructure cannot be assumed. Local Trust has identified the neighbourhoods in England that face a double disadvantage in health: high deprivation, and weak social infrastructure. These areas, home to 2.3 million people, have low civic engagement and limited social networks. Their residents are more likely to suffer from 15 of the 21 most common health conditions, and life expectancy in these areas has declined since 2010 (APPG for left-behind neighbourhoods, 2022). This is part of a wider trend in growing inequalities in life expectancy between the most and least deprived areas of the country (Vriend and Gazzillo, 2024).

Even with mechanisms for place-based partnerships to fund preventative, community-led initiatives, the fundamental issue in these neighbourhoods is a lack of capacity. They lack the assets, networks, and existing organisations to apply for funding or organise initiatives. To reach these neighbourhoods and allow them to partner with formal health services will require foundational investments in their social infrastructure.

We propose establishing a £500m All Neighbourhoods Thriving (ANT) fund over 10 years specifically to invest in the social infrastructure of doubly disadvantaged neighbourhoods. This fund, delivered through local anchor institutions and administered by a relevant government department, would scale up social infrastructure and community capacity with the active involvement of communities, businesses, and organisations.

Long-term, stable investments will allow locally-driven initiatives to develop and over time, prepare the most disadvantaged neighbourhoods for partnership with the health service. Analysis by Frontier Economics (2025) predicts that this initial £500m would generate a return of £1.7bn, delivering health benefits directly by building social capital and strengthening the capacity of citizens to address the root causes of poor health.

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About Local Trust

Local Trust is a place-based funder supporting communities to transform and improve their lives and the places where they live. We believe there is a need to put more power, resources and decision-making into the hands of local communities, to enable them to transform and improve their lives and the places in which they live.

We do this by trusting local people. Our aims are to demonstrate the value of long term, unconditional, resident-led funding through our work supporting local communities make their areas better places to live, and to draw on the learning from our work to promote a wider transformation in the way policy makers, funders and others engage with communities and place

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Local Trust

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