Shaping Neighbourhood Health:

Community Insights, Findings and Recommendations for Kensington, Chelsea and Westminster; October 2026.

Introduction

Health, Local Authority, and Voluntary, Community & Social Enterprise (VCSE) partners across Kensington, Chelsea and Westminster (bi-borough) are working together to develop a neighbourhood health approach that brings services, communities and local assets together around defined neighbourhood areas. The aim is to improve how organisations work together at a local level, making support more joined-up, preventative and responsive to the needs of residents.

To support the development of this approach, a bi-borough engagement programme was undertaken to gather insight from residents, understand community priorities, and explore how neighbourhood health can best support people and communities within the places they live.

Content

1. **Approach**
2. **Key Questions**
3. **Findings – Key Themes**
4. **Summary of Recommendations**
5. **Acknowledgements**
6. **Demographic data**

One Westminster and Kensington and Chelsea Social Council (KCSC), with analytical support from the Bi-borough Community Intelligence Tool developed by Bloom Health. For all enquiries, please contact the Author - **Liam Pywell (He/Him)**, **liam@kcsc.org.uk.**

Approach

The engagement programme was guided by three principles. First, creating safe and trusted spaces where people felt comfortable sharing their experiences, views and ideas through organisations, networks and settings where relationships already existed. Second, using a shared description of neighbourhood health and a common set of engagement questions to provide consistency across the programme while allowing conversations to reflect local priorities and experiences. Third, building on existing networks, relationships and engagement forums rather than creating new structures, recognising that partners could collectively achieve a broader and more diverse reach than any single organisation working alone.

Feedback was gathered through a range of approaches, including community conversations, focus groups, surveys, Patient Participation Group (PPG) discussions and partner-led engagement sessions. Activity was delivered by VCSE organisations, NHS, and Local Authority colleagues and partners across both boroughs.

In total, **42 engagement activities** were delivered, engaging **805 residents**. In addition, **30 pieces of written information and evidence** were received and reviewed as part of the programme.

All engagement outputs, including written submissions, meeting notes, survey responses and feedback from engagement activities, were uploaded into the bi-borough Community Intelligence platform to create a single library of evidence. The in-built analysis tool was then used to conduct a the thematic analysis to identify recurring themes, priorities and areas for consideration across the submitted evidence. All AI-generated outputs were subsequently reviewed, refined, quality-assured and validated by KCSC and One Westminster to ensure the findings accurately reflected the evidence gathered and provided a complete, accurate and balanced representation of participant views.

The development and delivery of the engagement programme was supported by the Bi-borough Strategic Participation Group. This group brings together colleagues from across the local health and care system who lead community engagement and participation activity. The group played a key role in shaping the approach, sharing intelligence and insight, and supporting the delivery of engagement activity through their respective organisations, networks and communities.

Key Questions

What is the current understanding of neighbourhood health and the role of the INT?

There is a broad understanding that Neighbourhood Health involves health, social care, housing, community and voluntary sector organisations working together around the needs of local people within a defined geographical area. Residents commonly described a model that is local, joined-up, person-centred, and focused on supporting the whole person rather than responding to individual issues in isolation.

However, there was little to no knowledge of the term ‘Neighbourhood Health’ and ‘Integrated Neighbourhood Team’ prior to the activity people engagement in. Furthermore how the model will operate in practice is unclear, with questions remaining about who will be part of the team, how it will work alongside existing services, how it will be organised and funded.

What is the right size and geographical footprint for an INT?

Participants consistently favoured an INT footprint that feels local and reflects how people identify with their neighbourhoods. Many described neighbourhoods as recognisable places with established local identities, such as Church Street, Pimlico, Queen's Park, North Kensington, or Earl's Court. For some, this was as specific as a bus route with areas feeling off limit that involved walking.

While views varied, there is support for a footprint of up to three wards as a practical scale for delivering neighbourhood health. The preferred model was a multidisciplinary team large enough to bring together a range of services, but small enough to maintain local knowledge, build trusted relationships, and provide continuity through named contacts who understand the communities they serve.

How will people access the Integrated Neighbourhood Teams (INT)s?

Participants consistently described access as needing to be simple, local, and flexible. People expected to access support through trusted routes such as GP practices, community venues, outreach services, and home visits, alongside telephone and digital options where appropriate. There was a strong preference for multiple access routes, including self-referral and referrals through trusted voluntary and community organisations, rather than a single gateway.

A recurring theme was the need for a clear route into the service, with a named contact or single point of coordination who can help people navigate support. Participants wanted access arrangements that are easy to understand, locally based, and accessible to people who face barriers related to language, culture, disability, or digital exclusion.

What support should the INT provide?

Participants viewed the INT as a coordinating service that brings together support across health, social care, housing, welfare, and community services. The strongest and most consistent message was the need for a named coordinator or single point of contact who understands an individual's circumstances, helps navigate services, and reduces the need to repeatedly explain their situation.

There was also a clear expectation that the INT would address the wider factors affecting health and wellbeing, including housing, debt, benefits, social isolation, and mental wellbeing. Support should be person-centred, culturally competent, and trauma-informed, with effective information sharing between professionals to improve continuity of care and reduce duplication.

What are the main challenges and needs that people would expect the INT to address?

Participants identified persistent challenges in accessing support, including difficulties obtaining appointments, long waiting times, fragmented services, and poor communication between organisations. Many described frustration at having to tell their story multiple times and experiencing a lack of continuity between professionals and services.

Alongside these service-level issues, people highlighted wider challenges affecting health and wellbeing, including housing insecurity, financial pressures, social isolation, language barriers, and digital exclusion. Participants saw the INT as an opportunity to provide more coordinated, joined-up support that addresses both immediate needs and the wider determinants of health.

Findings – Key Themes

To better understand the insights generated through the engagement programme, the Community Intelligence Tool was used to undertake a thematic analysis of all engagement findings. This enabled a deeper exploration of the issues raised most consistently across communities, helping to identify the ten most important themes relating to the development of INTs and the wider Neighbourhood Health model.

For each theme, this section presents **what we heard** from residents, explores the **implications for policy and practice**, and identifies any **tensions or gaps in understanding**. The analysis reflects both the frequency with which themes were raised and the strength and consistency of views expressed across different communities, locations and engagement activities. There is significant overlap between some themes. This has been intentionally retained, as it demonstrates the strength and consistency with which certain issues were raised across the engagement programme, which is later reflected in the cross-cutting recommendations set out later in this report.

1. Joined-up care

What the theme is about

Joined-up care describes a local health and care system where services coordinate seamlessly around the person, so individuals do not have to repeat their story, duplicate tests, or navigate multiple organisations in isolation. Residents expect information to flow across hospital, primary care, housing, social care, and community services, with visible signs to patients that coordination is real and effective.

What we heard

Residents repeatedly emphasise that care should feel joined up, not siloed. They describe the need for consistent information sharing, fewer repeated explanations, and smoother transitions between hospital and community care. Several sessions describe practical manifestations of non-joined-up care: having to explain circumstances to multiple professionals, delays in follow-up, and tests or information not being shared promptly.

A named or single point of contact is repeatedly called out as crucial to achieving joined-up care. Residents want one identifiable professional to coordinate their care, follow up, who they can contact directly, especially when experience complex needs. Housing and wider determinants are frequently tied to coordination needs, underscoring that joined-up care cannot be purely clinical without aligning with housing and social supports.

Key implications for practice and policy

Residents judge joined-up care by outcomes they can experience: reduced repetition, clearer care pathways, and visible coordination between health and social supports.

Trust and uptake of the Neighbourhood Health concept hinge on demonstrations of coordination—especially through a reliable single point of contact and accessible communication channels.

Gaps or tensions

While the theme is widely endorsed, several documents flag the challenge of implementing true interoperability within budget and governance constraints. There is some tension between the desire for rapid, patient-facing coordination and the realities of funding and system reform.

The shift to a Neighbourhood Health Team model is still perceived as evolving in many settings; residents want early and ongoing involvement, with feedback loops showing whether changes are making a difference.

2. Access to services and easier access

What this theme is about

Access to services and easier access describes how people find and obtain health and care support, including how easy it is to reach services, learn what exists, and move from initial contact to receiving help. It includes multiple routes (in-person, phone, GP, community settings) and a preference for clear information, timely responses, and approachable entry points that reduce barriers to help-seeking.

What we heard

Core need: Residents emphasise easier, quicker, and more straightforward routes to access help, with attention to reducing delays and confusion about where to turn for support.

Multi-channel access: A mix of entry points (GP practices, community venues, home visits, telephone lines, drop-ins) is repeatedly highlighted as important to reach diverse groups and those with digital barriers.

Trust through simplicity: Clear information, predictable access routes, and a named contact or point of entry help build trust and confidence in using local health and care services.

Barriers identified: Digital exclusion, complex referral pathways, long waits for appointments, and repeated explanations to multiple staff were repeatedly cited as obstacles to timely access.

Local settings and familiarity: Access is more effective when offered in familiar community spaces (e.g., GP practices, community centres) or through pathways that feel local and approachable.

Key implications for practice and policy

Clarity and simplicity in access routes: Services should present a clear, easy-to-navigate map of how to access help, with multiple entry points and straightforward referral pathways.

Local and human entry points: Prioritise access in familiar, local environments and ensure staff are trained to guide people to the right service without unnecessary hurdles.

Balance digital and non-digital pathways: Maintain and support non-digital access options (phone, in-person, walk-in) alongside digital channels to prevent exclusion.

Timeliness and responsiveness: Reduce waiting times for appointments and enable prompt responses to enquiries to prevent disengagement.

Consistent information and signposting: Provide accurate, up-to-date information about services, hours, and how to access them, including opening times and contact details.

Gaps, tensions and uncertainties

Digital exclusion versus digital expansion: While digital tools can streamline access, there is persistent concern about leaving behind those without digital access or literacy.

Variation across settings: Access experiences vary by practice and locality; some settings appear more ready to offer walk-in or same-day access, others more reliant on referrals and booked slots.

Resource pressures: Staffing and resource constraints may limit the ability to provide flexible access options or rapid follow-up in all contexts.

Information sharing constraints: While easier access relies on clear signposting, effective information sharing between services remains a challenge in some documents, potentially slowing referrals or follow-up.

3. Trust and a consistent point of contact

What this theme is about

Trust and a consistent point of contact covers the extent to which residents feel confident in health and care services and whether there is a reliable, named individual who serves as the ongoing touchpoint for their care. It encompasses the visibility of a consistent advocate or coordinator, the quality of relationships with health and care staff, and the sense that someone is genuinely listening and following through.

What we heard

The need for a named contact: Across multiple engagements, residents repeatedly emphasised the value of having one trusted person who knows their history, understands their circumstances, and can guide them through the system.

Trust built through listening, empathy and follow-up: Residents consistently linked trust to being listened to, treated with respect, and receiving timely follow-up or signposting to the next steps in their care.

Consistency of staff and continuity of relationships: Several accounts highlighted that continuity—seeing the same staff or a familiar team—helps people feel secure and understood, while turnover or frequent changes undermines trust.

Signposting as a trust signal: Clarity about who to contact, how to access services, and what will happen next was repeatedly described as strengthening trust, whereas unclear pathways erode confidence.

Cultural and language accessibility as trust enablers: When staff can communicate in preferred languages and demonstrate cultural competence, residents report higher trust and willingness to engage with services.

Data sharing and governance as trust determinants: Residents express concerns about information sharing, privacy, consent, and governance. Transparent governance around data and clear explanations of what is shared and with whom are identified as necessary to sustain trust.

Key implications for practice and policy

Clearly identified trust anchors: Implement a named, consistent point of contact for most residents, especially those with complex needs, to establish a reliable Trust anchor who can coordinate, follow up, and communicate clearly.

Visibility: Ensure residents can recognise and access their trusted contact across encounters and settings; provide name, role, and direct contact details where possible.

Responsive listening and timely follow-up: Train staff to prioritise listening, confirm understanding, and deliver timely next steps or referrals to sustain confidence in the system.

Language and cultural alignment: Embed multilingual staff and interpreters, and ensure cultural competency is integral to frontline relationships so trust is not undermined by language or cultural gaps.

Governance transparency around information sharing: Communicate plainly about how information moves between providers, with explicit consent processes and safeguards, to maintain resident confidence in data handling.

Gaps, tensions and uncertainties

Staffing stability versus scalability: Establishing and maintaining a consistent point of contact at scale can be challenged by staff turnover and resource pressures; there is tension between ideal continuity and practical workforce realities.

Governance versus speed: Balancing rapid access and information sharing with robust privacy and governance can slow processes if not well designed; residents want both speed and trustworthiness.

Variability across settings: Trust and access to a consistent contact vary by borough, practice, and community context, making a one-size-fits-all approach less feasible; local tailoring is needed.

Digital exclusion considerations: While digital tools can support trust, reliance on digital channels without non-digital options can undermine trust for people who struggle with tech or prefer human contact.

4. Digital access vs non-digital information

What this theme is about

This theme compares the role of digital tools (apps, online forms, portals) with non-digital information and access routes (face-to-face, printed materials, telephone, in-person signposting). It addresses

who can use digital channels, how reliable and trusted digital access is, and how services ensure inclusivity for people with limited digital literacy, language barriers, or access constraints.

What we heard

Widespread digital exclusion concerns: Many engagements highlight that a substantial portion of residents either cannot or do not use digital channels effectively, creating barriers to access when digital is prioritised.

Preference for non-digital pathways alongside digital options: Residents frequently express a desire for choices, where digital tools are useful for certain tasks but should not replace in-person or phone-based contact.

Language and accessible design shape digital needs: Language barriers and the need for accessible formats (easy read, pictorial materials, translation) strongly influence whether digital tools are usable and trusted.

Mixed experiences with specific digital tools: Some groups report useful aspects of digital tools (e.g., NHS App for information, reminders, or appointment management) but also identify barriers like password fatigue, navigation difficulties, or lack of devices; others describe digital tools as excluding those without devices or connectivity. others).

Signposting and information sharing: Clear guidance about how to access services, including where to go and who to contact, is consistently identified as a trust-building factor and a determinant of access, regardless of digital or non-digital channels.

Key implications for practice and policy

Maintain parallel digital and non-digital routes: Ensure that digital channels complement rather than replace non-digital options; provide robust telephone, walk-in, and in-person pathways alongside online services.

Prioritise plain language and accessible formats online and offline: Develop easy-read materials, translated content, and visual aids to accompany digital tools, so that information is comprehensible to diverse audiences.

Design inclusive digital tools: Build NHS App and other digital interfaces with language options, intuitive navigation, and consistent cross-provider information to reduce barriers and build trust.

Invest in digital champions and human support around tech use: Provide training and support for residents to navigate digital tools, including assisted completion and in-person help at trusted community venues.

Ensure consistent signposting across channels: Create harmonised, multilingual signposting that directs people to the appropriate entry points, whether digital or non-digital.

Gaps, tensions and uncertainties

Balancing speed with accessibility: Digital channels can speed up processes but may exclude people who lack digital access or confidence; deciding where to push digital solutions without leaving others behind remains a tension.

Variability by locale and provider: Some settings report stronger digital uptake and smoother online experiences, while others struggle with access and trust due to digital barriers; bespoke local tailoring is often required.

Governance and privacy concerns in digital contexts: Residents raise questions about how data flows between digital tools and services; ensuring transparent governance and consent processes is essential to sustaining trust.

5. Language and cultural competence

What this theme covers

This theme examines how language needs and cultural norms shape engagement, trust, and access to care. It includes interpreter availability, multilingual staff, translated and easy-read materials, and culturally aware communication styles as core drivers of meaningful involvement and positive experiences.

What we heard

Language access is a recurrent trust enabler: Several engagement activities emphasise that residents trust and engage more readily when staff can communicate in their language or when interpreter services are readily available. This includes explicit calls for support in preferred languages and visible interpreter options.

Interpreters and translation are not optional add-ons: Several accounts describe how reliance on ad hoc interpretation can undermine confidentiality and accuracy, and residents prefer professional language support where possible.

Cultural competence goes beyond translation: Participants consistently call for culturally sensitive communication, recognition of diverse cultural backgrounds, and staff who understand and respect different values, beliefs and practices.

Language considerations influence trust and continuity of care: Evidence consistently link language access to continuity, follow-up, and continuity of relationships, noting that language-aligned processes help residents feel secure in navigating care pathways.

Signposting and plain language are essential across languages: Across multiple sources there is emphasis on plain language, consistent wording, and signposting that can be understood regardless of language proficiency, supporting trust and access .

Key implications for practice and policy

Embed language access as a standard practice: Ensure interpreter services (in-person and remote) are readily available and visible in all touchpoints; prioritise support being provided by multilingual staff where feasible.

Prioritise culturally competent care navigation: Train front-line staff in cultural humility, awareness of diverse health beliefs, and respectful communication styles; involve community partners who reflect local diversity.

Normalise translation and easy-read across materials: Produce materials in multiple languages and formats (easy-read, visual aids) and ensure outreach messages are accessible to ESOL communities.

Ensure privacy and confidentiality in language support: Provide staff guidance on confidentiality when interpreters are involved and when decisions are made about who can translate or interpret.

Signposting in multiple languages: Create multilingual signposting that clearly explains access routes and next steps, reducing confusion for bilingual or non-English-speaking residents.

Gaps, tensions and uncertainties

Capacity and consistency of language services: There is potential variability in availability of interpreters or bilingual staff across settings, which can affect trust and access.

Balancing efficiency with accuracy: Interpreting and translations add steps to workflows; systems need to integrate language support without creating delays.

Diversity within communities: Languages and cultural needs vary widely even within boroughs; one-size-fits-all language strategies may miss smaller or newer communities.

6. Care closer to home / localised services

What this theme covers

This theme centres on delivering health and care in the places and ways that residents already use and trust locally. It emphasises local, human-led access routes, visible points of contact, and a design that reduces the need for people to travel to distant facilities. Key elements include named contacts, home visits, trusted neighbourhood venues, and joined-up care across GP, community health, and social supports.

What we heard

Local access and trusted contact as default expectations: Across multiple engagements, residents repeatedly asked for care to be accessible in neighbourhood settings with a named contact who understands their history and can guide them through local services.

Home visits and outreach in trusted local venues: There is strong emphasis on home-visit pathways and outreach in familiar community spaces (food banks, community centres, women's groups) to reduce barriers to access and build trust.

GP as the front door, plus local co-location: Many sources highlight a preference for the GP to act as a front door or gatekeeper, while still advocating closer integration which bypass the GP when it is more practical and streamlined to do so.

Signposting and multi-channel access at the neighbourhood level: Residents request clear, local entry points and straightforward signposting to navigate care locally, whether in person, by phone, or through community hubs.

Local, multi-agency involvement and co-design: Several activities highlight the value of co-design with local residents and partnerships with community organisations to tailor local services to neighbourhood needs.

Key implications for practice and policy

Establish visible, local access points with a named contact: Create or reinforce identifiable local gateways (in hubs like community centres, GP practices, or housing/benefits venues) with a named point of contact to coordinate care across services.

Prioritise home visits and trusted local outreach: Expand home-visit pathways and regular outreach in trusted neighbourhood settings to ensure high-need residents can access care without relying solely on digital or distant systems.

Maintain GP-led entry while enabling joined-up local care: Keep the GP as the accessible front door but ensure strong links to social care, housing, mental health, and community supports which bypass the GP when this causes unnecessary delays.

Strengthen multi-channel local signposting: Develop clear, locally meaningful information channels (face-to-face drop-ins, printed guides, multilingual signposting) that guide residents to local services and to the named contact.

Embed resident involvement in localisation efforts: Involve communities in designing local pathways, ensuring services reflect local demographics, languages, and cultural needs.

Gaps, tensions and uncertainties

Balancing local accessibility with system fragmentation: Localised care can be hindered by fragmented IT systems, inconsistent governance, and variable local capacity; achieving seamless locally coordinated care requires careful alignment.

Workforce sustainability at the neighbourhood level: Providing continuous local contacts and home-visit staffing can be resource-intensive; turnover and capacity constraints may threaten continuity.

Equity of access across diverse neighbourhoods: What works in one area may not translate to another due to differing populations, languages, and geographies; local tailoring is essential but adds complexity.

Measurement of localised impact: Demonstrating the benefits of care closer to home requires specific metrics around wait times, travel burden, and patient-reported experience at the neighbourhood level.

7. Continuity of care

What this theme covers

This theme examines the ongoing, stable relationship between residents and their care ecosystem, including consistent points of contact, trusted providers, coordinated information across services, and smooth handovers between providers and settings. It encompasses continuity across GP practices, community health teams and social supports.

What we heard

Trusted, consistent relationships are valued: Residents emphasise the importance of having stable contact person who know their history and can coordinate across services over time.

Clear handovers and information sharing matter: Numerous accounts across activities highlight seamless information transfer between GP-led services, community teams, and social supports as being essential to avoid gaps and avoid duplication.

Signposting and entry points support continuity: Consistent guidance about how to move through services, where to go next, and who to contact reduces confusion and maintains ongoing engagement with care pathways.

Localised, multi-agency processes: The evidence from residents describe how local co-location, joined-up care, and community-based touchpoints facilitate ongoing management of care with less fragmentation.

Patient experience and outcomes tied to continuity: Several sources connect continuity of care with positive experiences, fewer missed appointments, and better adherence to care plans, particularly for groups with complex needs .

Key implications for practice and policy

Establish stable contact points and named coordinators: Create or reinforce consistent care coordinators or named points of contact who can shepherd individuals through the care journey over time.

Strengthen GP-led continuity with integrated support networks: Maintain GP as a central entry point while ensuring reliable connections to community health, social care, and housing supports to sustain a coherent pathway.

Standardise handover processes and information-sharing protocols: Develop clear, patient-centred handover routines that protect privacy while ensuring critical history and preferences are passed between teams.

Improve cross-channel signposting and follow-up: Ensure patients receive uniform, multilingual, plain-language information about next steps and who to contact across in-person, phone, and digital channels.

Embed continuity into governance and measurement: Include metrics on continuity indicators—e.g., consistency of named contacts, timeliness of handovers, and patient-reported continuity of care—in performance dashboards.

Gaps, tensions and uncertainties

System fragmentation vs. local resilience: Localised care can suffer from incompatible IT systems and governance differences, which threaten seamless continuity across settings.

Variability in capacity for ongoing coordination: Continuity relies on staff availability and stable roles; turnover and workload can undermine consistent relationships.

Balancing speed with stable relationships: Efforts to expedite access can undermine relationship continuity if they bypass known contacts or familiar pathways.

Equity of continuity across diverse populations: Ensuring the same level of continuous care for all communities, including ESOL and marginalised groups, requires targeted strategies and resources.

8. Housing and social determinants of health

What this theme covers

This theme recognises that health and wellbeing are shaped by living conditions and wider social factors, including housing stability, finances, debt, benefits, digital access, education, and social support networks. It calls for integrated attention to housing and welfare needs within health and care pathways, and for connections between health services and community or housing organisations.

What we heard

Housing insecurity and homelessness are seen as direct health determinants: Participants frequently linked housing conditions, temporary accommodation, and housing instability with poorer physical and mental health and with barriers to accessing care.

Financial hardship, debt and benefits shape access to care: Engagement regularly highlighted how benefits, debt and financial precarity influence people's ability to seek, access and sustain care, as well as their capacity to engage with digital or administrative processes.

Signposting to housing and welfare services is a recurrent need: Residents emphasised the importance of clear pathways and single points of contact that can connect health, housing and welfare advice, rather than forcing people to navigate multiple systems.

Wider determinants beyond housing are routinely raised in tandem with health: Participants linked digital exclusion, language barriers, employment, education, and social inclusion with health outcomes, underscoring the interdependence of housing with other determinants.

Community co-design emphasises local housing-related needs: Residents stress the need to design local services to reflect each community's housing circumstances, financial realities, and welfare needs with residents, housing officers and community organisations.

Key implications for practice and policy

Integrate housing and welfare navigation into health touchpoints: Ensure health settings routinely screen for housing stability, welfare needs, debt, and benefits access, with strong links to housing offices and welfare services.

Create connected, single-entry pathways for housing and health: Develop easily understandable routes that combine health advice with housing and financial support, reducing the burden on residents to chase multiple services.

Prioritise digital inclusion alongside housing support: Address digital barriers that compound housing and welfare access, ensuring that both offline and easy-to-use digital options exist for information and referrals.

Promote local co-design around housing-related health needs: Involve residents and community groups in planning how housing, welfare and health services collaborate locally, tailoring responses to each neighbourhood's circumstances.

Gaps, tensions and uncertainties

Data-sharing and governance between health and housing sectors: Coordinating information across housing offices, welfare services and health providers raises governance and privacy considerations that need careful management.

Resource intensity of local housing-focused work: Sustained housing and welfare integration can require ongoing staffing, funding, and cross-agency collaboration, which may face capacity constraints.

Ensuring equity across diverse neighbourhoods: Housing-related needs vary by area and community; one-size-fits-all approaches may miss local nuances and vulnerable subgroups.

9. Community networks and social prescribing

What this theme covers

This theme centres on how communities, VCSE organisations, and local networks connect people to health and wellbeing supports beyond traditional clinical care. It includes the role of social prescribing, community assets, peer support, and informal networks in shaping access, engagement, and outcomes.

What we heard

Social prescribing and community assets as bridges to care: Residents describe using local clubs, faith groups, volunteering opportunities, and social activities as entry points or complements to formal health services, helping people manage loneliness, mental health, and practical needs.

Local networks creating trusted pathways: Residents emphasise that neighbours, community workers, and local volunteers are often the most trusted navigators to information and services, enabling smoother access to care and supports.

Co-design and co-delivery with communities: Several engagements highlight the value of co-designing social prescribing schemes and networked services with residents and local organisations to ensure relevance, accessibility, and cultural responsiveness.

Signposting and multi-channel access through community hubs: Residents stress the importance of accessible entry points—case workers in community hubs, phone lines, and in-person drop-ins—that can connect people to social prescribing and community supports in a way that respects language and literacy needs.

Outcomes linked to engagement with social networks: The evidence from residents associate participation in community networks with improved wellbeing, reduced isolation, and better adherence to care plans, particularly for groups with complex or chronic needs.

Key implications for practice and policy

Scale and sustain social prescribing link workers and community connectors: Invest in dedicated roles that can broker connections between primary care, social care, and local community assets, ensuring consistent availability and clear referral pathways.

Strengthen partnerships with local assets: Formalise collaborations with community centres, housing organisations, voluntary groups, and faith institutions to map assets and create dependable routes into social prescribing.

Enable flexible, multilingual, and culturally appropriate access: Ensure social prescribing offers language- and culturally-responsive options, including group activities, one-to-one outreach, and digital/non-digital access points.

Foster ongoing co-design and evaluation: Embed resident involvement in designing social-prescribing offers and regularly review impact with community representatives to adapt services to local needs.

Integrate social prescribing with broader health and well-being strategies: Align community-network approaches with local health plans, housing, and welfare work to support holistic, person-centred care pathways.

Gaps, tensions and uncertainties

Evidence of measurable impact: While qualitative benefits are described, there is a need for clearer indicators that quantify reductions in isolation, improved access, or better health outcomes linked to social prescribing.

Resource and capacity constraints: Sustaining a robust network of community connectors and activities requires stable funding and workforce resilience, which can be challenging in some areas.

Equity in access across diverse neighbourhoods: Ensuring that all communities can benefit from social prescribing requires targeted outreach, culturally appropriate offer design, and effective translation services.

10. Information sharing, confidentiality and data protection

What this theme covers

The theme examines how residents' personal health and welfare information is shared across services, who has access to records, how consent is obtained and managed, and how confidentiality and data protection are safeguarded in Neighbourhood Health contexts. It includes governance, user understanding of privacy rights, and the everyday practicalities of multi-agency data sharing.

What we heard

Consent as gatekeeping to data sharing: Residents highlighted their preference to be asked whether different services should access to their records or to be discuss, with explicit emphasis that permission is required.

Shared records for joined-up care with safeguards: Many engagements describe using shared or multi-agency access to records to avoid duplication and speed access, while also stressing governance, consent, and data-protection safeguards.

Core emphasis on confidentiality, safeguarding and trust: Confidentiality and safeguarding are repeatedly highlighted as central to engagement and trust in services; trust is linked to clear protections around data sharing.

Governance language and practical needs: Several residents call for explicit information-sharing governance—defining responsibilities, consent processes, data sharing parameters, and explanations of privacy to be openly shared with them.

Key implications for practice and policy

Build explicit consent mechanisms into care design: Any information-sharing model should include clear, user-friendly consent prompts that explain what data will be shared, with whom, and for what purpose, with straightforward options to adjust consent preferences.

Establish transparent data-sharing governance: Develop and publish governance frameworks that define data access responsibilities, data minimisation, retention, and audit trails, ensuring privacy protections are visible to residents and staff.

Prioritise clear, multilingual, plain-language privacy information: Provide information about data sharing and privacy in accessible formats and languages to support informed choices, via signposting materials and engagement materials.

Integrate data protection with practical sharing needs: Balance timely, multidisciplinary data sharing with robust safeguards, ensuring staff understand what data can be shared, with whom, and under what consent constraints.

Safeguarding as an ongoing governance concern: Treat safeguarding as a live governance issue in data-sharing design, with clear escalation processes and dedicated safeguarding contacts.

Gaps, tensions and uncertainties

Variability in governance implementation: While governance needs are described, consistency across organisations and neighbourhoods may vary, posing implementation gaps.

Speed versus protection tension: Balancing rapid information sharing for joined-up care with strong privacy safeguards remains a contextual challenge across settings.

Clarity on rights and choices for residents: Residents may need clearer explanations of rights (e.g., what happens if consent is refused or can be revoked) and easier mechanisms to exercise them. This aligns with emphasis on plain-language information and governance needs.

Summary of Recommendations

As part of the thematic analysis process, the Community Intelligence Tool was also used to generate recommendations against each of the ten key themes. These recommendations were reviewed and then combined, resulting in a set of cross-cutting recommendations for Neighbourhood Health implementation.

The recommendations below set out these overarching recommendations, alongside key actions that support their implementation.

1. Strengthen Neighbourhood Care Coordination and Continuity

Develop a neighbourhood-based model that ensures residents experience coordinated, joined-up care across health, care, housing and community services.

Key actions

- Provide a named care coordinator or single point of contact for residents with complex or ongoing needs.
- Establish multidisciplinary care planning, shared records (where appropriate), patient-held care summaries and robust handover arrangements to support continuity across organisations.
- Ensure housing, welfare and wider support needs are embedded alongside health needs within coordinated care planning.
- Regularly demonstrate and communicate to communities how joined-up working is improving outcomes and experiences.

2. Create Simpler and More Equitable Access to Services

Ensure residents can easily understand, access and navigate local services regardless of age, language, confidence or digital skills.

Key actions

- Create simple, clearly communicated access routes supported by trained navigators who can help residents access the right service without unnecessary referrals, delays or duplication.
- Maintain multiple access routes, including face-to-face, telephone, outreach, walk-in and digital options.
- Ensure services are designed around groups experiencing the greatest barriers to care, including people facing digital exclusion, language barriers or sensory impairments.
- Monitor timeliness and responsiveness to reduce waiting times and delays between first contact and support.

3. Deliver Care Closer to Home

Increase the availability of support through neighbourhood-based services, at home, through trusted community settings and proactive outreach approaches.

Key actions

- Expand outreach and service delivery through community centres, faith venues, libraries, voluntary organisations and other trusted local locations.
- Increase home visiting and proactive outreach for residents who face barriers to attending appointments.
- Co-locate health, care, welfare and community support services where possible.
- Strengthen links between GP practices and wider neighbourhood support networks.
- Involve local communities in designing neighbourhood-based delivery models.

4. Improve Communication, Information and Signposting

Provide residents with clear, consistent and accessible information about services, support and next steps.

Key actions

- Provide clear, consistent and plain-language information about services, eligibility, care pathways and next steps, ensuring residents know what support is available and who to contact.
- Make information available through multiple formats, including printed materials, telephone support, face-to-face engagement and digital channels.
- Develop consistent signposting across organisations and sectors to reduce confusion and improve navigation.
- Use regular communication and feedback mechanisms to keep communities informed about services and changes.

5. Embed Language Access and Cultural Responsiveness

Ensure services are designed and delivered in ways that are linguistically accessible and culturally appropriate.

Key actions

- Provide interpreters as a standard part of service access
- Produce translated, Easy Read and accessible materials for key communications.
- Strengthen recruitment and use of multilingual staff, community connectors and culturally appropriate outreach approaches.
- Deliver cultural competence and cultural humility training for frontline staff.
- Work with community organisations to co-design culturally relevant approaches to communication, engagement and service delivery.

6. Strengthen Community Networks and Social Prescribing

Make greater use of community assets, voluntary organisations and peer support to improve health and wellbeing.

Key actions

- Invest in social prescribing and community connector roles, supported by strong partnerships with voluntary, community and faith organisations and a clear map of local assets and referral pathways.
- Support peer-led and community-led approaches that reduce isolation and improve wellbeing.
- Ensure social prescribing offers are culturally appropriate, accessible and designed with local residents.
- Monitor and demonstrate the impact of community-based support on health, wellbeing and social connectedness.

7. Address Housing, Welfare and Wider Determinants of Health

Recognise and respond to the wider social factors that influence health outcomes and people's ability to access support.

Key actions

- Embed routine identification of housing, welfare, debt, financial hardship and social isolation within neighbourhood health services, supported by integrated referral pathways and staff able to connect residents to appropriate support.
- Establish formal links between health, housing, welfare and community organisations to provide coordinated support.
- Provide accessible and multilingual information about housing, welfare and financial support services.
- Monitor the impact of neighbourhood health approaches on wider wellbeing outcomes, not solely clinical outcomes.

8. Enable Safe Information Sharing and Integrated Working

Support joined-up care through effective information sharing while maintaining trust, confidentiality and resident choice.

Key actions

- Develop shared information-sharing arrangements supported by clear governance, standardised consent processes and transparent explanations of how information is used.
- Provide residents with accessible, plain-language information about privacy, consent and their rights regarding data sharing.
- Ensure staff understand information governance, confidentiality and safeguarding responsibilities.

- Monitor resident confidence and understanding of information-sharing arrangements and use feedback to improve practice.

9. Build Trust Through Relationships, Listening and Follow-Up

Place trusted relationships and resident experience at the centre of neighbourhood health.

Key actions

- Support staff to build trusted relationships through continuity, active listening, culturally responsive communication and timely follow-up.
- Ensure residents consistently know who to contact and what will happen next.
- Strengthen continuity wherever possible by reducing unnecessary changes in key contacts and maintaining relationship-based care.
- Use trust, patient experience and feelings of being listened to as key measures of success.

10. Embed Co-Design, Accountability and Community Feedback

Make residents, carers and community organisations active partners in the design, delivery and improvement of neighbourhood health services.

Key actions

- Involve residents, carers and community organisations in service design, implementation and evaluation.
- Create ongoing opportunities for residents and community organisations to shape services and receive feedback on how their views have influenced decisions and improvements.
- Monitor outcomes that matter to residents, including access, trust, continuity, wellbeing and experience.
- Report progress publicly and use community feedback to drive continuous improvement.

Acknowledgements

Thank you to all local NHS, VCSE and Local authority partners who held engagement events and support residents to share their views.

- BME Health Forum (Central London Youth Development Trust)
- Purls UK Harris Consultancy Service
- SPID Theatre
- Open Age
- Persian Care Centre
- Golborne Canalside Health Centre
- Abdul Mageed Educational Trust
- Kosovar Albanian Youth Against Violence (KAYAV)
- Voice Exchange

- Brompton Health Pan-PPG
- Earls Court PPG
- The Abingdon Medical Practice
- Dadihiye Somali Development Organisation
- Camford Medicals
- CNWL RBKC
- CNWL Westminster
- Nkechi Natural Path
- Health Advocates Health Forum (supported by BME Health Forum)
- Kulan Somali Organisation (supported by BME Health Forum))
- Tell It Network (supported by BME Health Forum)
- Strengthening Kensington Youth & Families CIC (SKYF)
- SMART
- Make It Happen (supported by BME Health Forum)
- Stanhope Mews Surgery
- HomelessNest
- The Abbey Centre
- For Women CIC
- Holland Park Surgery PPG
- Paddington Development Trust (PDT)
- Central London Healthcare (CLH)
- London Medical Associates (LMA)
- Ubuntu Pledge

Special thanks are extended to **Hannah Wrathhall (CLH/HCL)**, **Sharon Sridhara (West & North London ICB)** and **Faith William (LMA)** for their contribution as part of the small working group that helped design and the delivery of this engagement programme.

Residents and Communities

Most importantly, we would like to thank the **800+ residents** who took part in engagement activities. Their experiences, perspectives and ideas form the foundation of this report and will help shape the future development of neighbourhood health across Kensington & Chelsea and Westminster

Demographic Data Overview and Limitations

Demographic information was collected across all engagement activities using a range of approaches. The data available is not fully standardised, with some activities providing individual-level demographic data, some reporting aggregated figures, and others providing only narrative descriptions. As a result, the tables below represent the minimum quantifiable demographic profile that could be consistently extracted and combined from the available information.

Age

Age Group	Number	%
16-24	4	2.7%
25-34	9	6.1%
35-44	15	10.1%
45-54	18	12.2%
55-64	37	25.0%
65-74	39	26.4%
75+	26	17.6%

Total quantified responses: 148

Sex

Sex	Number	%
Female	112	70.9%
Male	46	29.1%

Total quantified responses: 158

Ethnicity (Grouped)

Ethnicity Group	Number	%
White (British, Irish, Other White, European)	42	28.8%
Iranian / Persian	40	27.4%
Asian / Asian British	32	21.9%
Black (African, Caribbean, Black British)	19	13.0%
Arab / Middle Eastern / North African	10	6.8%
Mixed Heritage	3	2.1%

Total quantified responses: 146

Area

Area	Number	%
Westminster	52	52.0%
Kensington & Chelsea	39	39.0%
Other boroughs	9	9.0%

Total quantified responses: 100

Long-Term Condition or Disability

Response	Number	%
Yes	28	56%
No	19	38%
Prefer not to say / Not stated	3	6%

Total quantified responses: 50

Caring Responsibilities

Response	Number	%
No	35	70%
Yes	13	26%
Prefer not to say	2	4%

Total quantified responses: 50

Additional Demographic Information Not Suitable for Quantification

The engagement reached a broad range of residents, although participation was weighted towards older age groups. Most quantified respondents were aged **55 and over**, with particularly strong representation from people aged **55-64** and **65-74**, alongside engagement with several groups of residents aged **70-90+ years**. Younger adults were also represented, though in smaller numbers.

The engagement also involved residents from a wide range of ethnic backgrounds, reflecting the diversity of local communities. Quantified responses included participants from **White British and White Other**, **Iranian/Persian**, **Asian and Asian British**, **Black African**, **Black Caribbean**, **Arab and Middle Eastern**, and **Mixed Heritage** backgrounds. Additional engagement activities involved communities including **Albanian, Chinese, Kurdish Iraqi, Filipino, Moroccan, Sudanese, Eritrean, Turkish, Portuguese, South American, Romanian, Egyptian, Ukrainian and Kosovar Albanian** residents, although these could not always be quantified consistently