Community Voices: An Invitation to a Different Type of Conversation

Why This Discussion and Why Now?

I have worked in the voluntary, community, health and care sector for over 30 years and over the past decades there have been many policies, strategies, guidance – both local and national – and indeed legislation about empowering / serving / involving / engaging / patients, people, communities, people with lived experience, the public, carers – paid and unpaid, patient / person centred care; yet and with the best intentions there remains a visible disconnect between the policy ambitions with implementation plans for working with people and communities to address health and wider inequalities and the daily realities of the people at the receiving end of these policies and implementation plans.

The new Integrated Neighbourhood proposals offer a genuine opportunity to do things differently and reframe the challenge entirely by Strating from somewhere else. That starting point needs to be is rooted in stories alongside the data that people and communities have entrusted to us. It requires a system that is relational where people approach the work with humility and curiosity, rather than pre-determined assumptions that may be just taken-for-granted in business-as-usual. It calls for an architecture designed to favour localised and devolved decision-making over centralised control; for processes that will enable networks and connections to replace hierarchy; and for an ambition that is defined by their closeness to local people,— their daily realities, their services, their environments — so that transformation is shaped with them; in their image rather than simply delivered to them.

The Existing Narrative: Neighbourhoods as imagined from the Centre

The current national narrative – and implementation plans – places neighbourhoods as the unit of change that will support prevention, early intervention and personalised care. Its ambition is to build a system that is rooted in local communities rather than hospitals – therefore bridging health, social care and community around where people live. It is heartening and impressive to see the level of engagement undertaken to develop the 10-year plan which collected over 250,000 contributions from health and care staff, people, communities as well as health and care organisations.

However, in the excitement and desire to start implementing these plans and to 'deliver', there is a risk that we go down the next iteration of familiar pattern where 'neighbourhoods' become some sort of administrative units: defined by 2D maps, population figures, postcode boundaries or aligned to organisational footprints; where

the architecture and construction assume stability and trust are assumed to be the norm whereas the reality is the lack of safety, security and trust are the reality that people and communities experience on a daily basis.

Part of the challenge lies in the fact that neighbourhoods and communities are not the same thing — and what each term means depends entirely on who is asking the question. For systems and institutions, a neighbourhood often appears as a neatly bounded geography, something easy to draw and align with service footprints. But for local people, neighbourhoods are lived through relationships, kinship networks, cultural and spiritual anchors, histories of migration, and the everyday geographies of belonging or fear. Communities, meanwhile, may sit within or cut across multiple neighbourhoods; they may be connected by identity, faith, experience or interest — and they are not always harmonious or unified. Naming these distinctions matters. When systems collapse neighbourhood and community into a single administrative category, they risk erasing complexity and designing structures that – with the best intention can harm - do not reflect the daily reality of people's lives.

Thus, if we are to address these assumptions, we have to be conscious and intentional in nurturing a system map that is drawn by people whose friendships, relationships culture and spirituality define community and neighbourhood – while also acknowledging that communities are diverse, intersectional, and sometimes conflicted. This is not about reproducing separation or idealising homogeneity but about creating spaces where people with different identities and experiences can shape what matters to them. It means valuing outcome measures not for their measurability but the value and meaning they bring to people and communities; where data is captured for understanding instead of reporting; where lived experiences and community stories are treated on a par with 'hard data'; where local people and communities are positioned as co-authors and co-architects because they carry the burden of inequity and are at the receiving end of system policies, plans and services.

If we are to nurture a human centred system, we have to have courage in naming the challenge which is that current systems and patterns that we are working within are not benign; they reinforce the conditions of the inverse care law whereby those who 'have' end up with 'more' and those who 'don't have' end up with 'even less'. The COVID pandemic is a perfect illustration of this where institutional information systems, decision-making structures and 'official communications' repeatedly failed to consider how people worked, worshipped, lived, cared, grieved and carried on; how institutional racism and ever-widening inequalities resulted in the disproportionate impact on our

racialised and minoritised communities. Community Voices COVID Inquiry Submission highlighted the stories, the impact on individuals, families and communities, the system response and the aftermath.

Thus, if we are not conscious and intentional about this, if we cannot unlearn and undo we will be in danger of re-designing neighbourhood systems using the same tools and assumptions that produced the hurt and harm in the first place.

The Counter-Narrative: What communities know, and systems often ignore

The lived experience documented by Community Voices — from COVID-impacted households to families and neighbourhoods still carrying the profound legacy of the Grenfell Tower Fire — reveals something deeper and more urgent: people's families, direct relationships and communities are, and have always been, the first responders.

In the early hours and days of the Grenfell Tower Fire Disaster, it was residents, neighbours, local mosques, churches and other faith places, volunteers and Community Champions who supported and often led the rescue efforts, sheltered survivors, and sourced food, clothes and medicines long before formal agencies mobilised. The same pattern was evident during the pandemic: Community Champions, faith groups, mutual aid groups and local leaders stepped in to protect those at highest risk, provide accurate information, counter harmful narratives, and create spaces of trust and care when national systems faltered in the early days. Across both crises, the lesson is consistent. Systems arrive late, and when they do arrive, they often speak a different language entirely — one that struggles to recognise the emotional landscapes, cultural and spiritual needs, trauma histories, and relational infrastructures that enable communities to survive, heal and support one another. The examples above, reaffirm a truth that communities have been naming for years: they know what they need long before the system learns how to listen.

These insights are not "engagement feedback." They are legitimate forms of evidence and expertise — grounded in lived experience, collective memory, trauma, care, and survival. The counter-narrative then becomes clear: if neighbourhood health, wellbeing and social justice are to be more than 'just talk', the system must be built from the ground up — shaped by community logic, community history, community pain, community leadership and community resilience. We already have a living example of what this looks like in practice. The Grenfell Health and Wellbeing Service stands as proof of what becomes possible when leaders consciously and intentionally step back from command and control instincts and instead act as a facilitator and enabler,

allowing survivors and bereaved families and communities, to shape the purpose, practices and ethos of care. Its success does not imply that every context mirror Grenfell – the shared devastation, the strength of existing faith networks, the deep bonds forged through trauma created a particular form of collective agency.

The King's Fund's People Power report highlights that this approach did not emerge from ideal conditions — the community was diverse, sometimes conflicted, and shaped by trauma and longstanding distrust — yet it demonstrated that humane and responsive care becomes possible when communities are treated as co-authors rather than recipients.

Grenfell Fire Disaster was unique, but the lessons are not: systems everywhere face similar issues of mistrust, fragmented services and insufficient cultural understanding. The transferable principle is not to replicate Grenfell's context, but to adopt its stance — listening deeply, listening with curiosity and humility, embracing community leadership, addressing power imbalances, and 'doing with' people rather than for them.

Culture Eats Strategy for Breakfast Lunch and Dinner

National policy imagines Integrated Neighbourhood Teams and, eventually, Integrated Health Organisations holding capitated contracts, delivering neighbourhood-based prevention, early intervention and personalised care. These ambitions are underpinned by three major shifts: from hospital to community; from analogue to digital, from treating illness to investing in prevention, early support and population wellbeing. Yet lived reality of people and communities are neither simple nor linear, they are complex and messy, they require structures that accommodate plasticity; design principles that favour emergence and iteration and are truly rooted in the evidence that 'wherever the challenges exist, the solutions lie there too' .

These shifts cannot land meaningfully if they are not founded on three paradigm shifts rooted in the culture of organisations and systems: from a structured bureaucratised approach to investment in relationships because outcomes depend on trust; from an extractive process of getting feedback to being ethically accountable to ensure that the interpretation of the experiences and stories of people is managed in an open and transparent way; from people and communities (including frontline workers) as passive participants in system design, development and delivery to active system challengers to stimulate wider conversations for change because challenge is a form of democratic participation. The requirements and cultural assumptions of starting from the design of systems and bureaucracies shapes the distribution of power in our system — and that

power then decides whose voices are amplified, whose needs are deprioritised, and ultimately, who experiences care as safety and who experiences it as harm.

Without confronting the tension and disconnect between system-defined visions of neighbourhoods and community-defined experiences, these shifts risk becoming technical solutions layered onto social problems that require relational, cultural and community-led responses that recognise and build upon everyday wisdoms and solutions despite – or rooted in - deprivations and inequalities.

This tension is not hypothetical. It explains why repeated reform cycles have failed to shift deep inequalities despite investment and well-intentioned ambition. The recent - Abolished to Perfection? – Nuffield Trust report underscores this wider point: structural reorganisation rarely, by itself, resolves the deeper systemic problems. On the contrary, it can destabilise local systems, create transition stress, and obscure the need for local accountability. The report makes clear *"structural changes are rarely the answer to the NHS's problems — but the idea that they might be is clearly compelling."*

What if? A different Starting Point for Integrated Neighbourhood Plans

If neighbourhoods are to become the organising unit for the next decade of health and social care reform, then the real provocation is this: what if we invested first in grassroots neighbourhood, community and faith infrastructure, so that communities had the capacity, capability and legitimacy to stand as equal partners? What if they—not the system—defined what a neighbourhood is, shaped the outcomes that matter, owned the data, and breathed life into that data with their stories?

We live in the real world and perhaps the reality is that some neighbourhoods are deeply divided, marked by fear, conflict and mistrust between group which is precisely why investment is needed. To build neighbourhoods that lead, we need to create spaces that promote conditions for connection, dialogue and shared purpose. It means supporting the slow, messy work of building relationships across differences. Only then can neighbourhoods truly name their priorities and take their place as equal partners in shaping the future.

What if the system's tools were rooted not only in compliance, extraction or performance management, but in curiosity, humility and the discipline of listening to learn and to act? What if outcomes expanded beyond the delivery of services, and began to recognise trust, belonging and safety as outcomes in their own right—because without them, no service, however well designed, can truly land?

What if we developed future clinicians differently, so that their training equipped them not only with biomedical expertise but with the skills, resources and emotional sensitivity to be deeply connected to the neighbourhoods they serve? What if they were enabled to practise a social model of health and wellbeing— one which recognises that isolation and disconnection is seriously harmful to the wellbeing of people and communities; one in which patients, carers and local residents are not passive recipients, but co-creators of care, meaning and healing?

And what if the architecture of the system is different? Imagine maps drawn not by postcode boundaries, but by relationships, networks and shared histories. Imagine priorities defined not by national templates, but by communities themselves—elders, faith leaders, youth workers, carers, cultural organisers, those who hold neighbourhoods together in normal and extraordinary times. Imagine outcome measures that also honour healing, dignity, trust and belonging. Imagine accountability structures where communities hold the system to account not through tokenistic feedback surveys, but through meaningful governance power, co-decision and co-ownership.

This is the provocation: what if the scaffolding of our health and care system was built not on institutional logic, but on the logic of community—its pain, resilience, survival, solidarity, story, memory and meaning? What if we began with the places where people – in their diversity, their intersectionality, their differences – belong, live, grieve, gather, worship, organise and rebuild? This paradigm shift will not only implement the aspirations of the 10 Year Plan but transform it completely.

The Invitation

The invitation is simple; it's an invitation to a different type of conversation; an invitation to co-create a counter narrative for change that calls for humility, curiosity, kindness because relationships, families and communities are the system and we are the structures that hold it back.

End

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