The Royal Society of Medicine

Community for Health Equity

Session 5 report
The Elephant in the Room: Trust, Trustworthiness and Support

Community for Health Equity

Session 5 Report The Elephant in the Room: Trust, Trustworthiness and Support

Executive summary

This report captures learning from the fifth session of the Community for Health Equity programme, which focused on trust, trustworthiness and support in partnerships between the NHS, industry, patients, communities and wider system partners.

The session examined why collaboration between the NHS and industry remains essential to addressing health inequalities, while also being difficult to discuss openly. It explored the cultural, structural and historical factors that shape trust, including concerns about conflicts of interest, transparency, profit motive, power dynamics and the legacy of previous behaviour. It also examined what makes partnerships trustworthy in practice: shared purpose, visible governance, patient benefit, honest communication, clear roles and sustained relationships.

The session brought together perspectives from industry, NHS England, health innovation, clinical and patient-focused organisations. The discussion was shaped by national policy insight, practical system experience, clinical perspectives and reflections on how partnership feels at the frontline. This helped avoid treating "the NHS" as a single voice and instead highlighted the different roles NHS organisations can play in enabling, shaping or delivering partnership work.

The first part of the session used Lego Serious Play to help participants explore trust, distrust and unity through visual models. This created a practical way to surface assumptions that are often difficult to name directly. Participants identified shared goals, particularly patient safety and improved outcomes, while also recognising that scepticism remains more visible in public healthcare settings than within industry.

The second part of the session focused on building trusting partnerships. Participants discussed how trust is formed between individuals, then extended to organisations. They identified clear benefits from effective partnerships, including better patient outcomes, access to innovation, stronger evidence and improved reach into underserved communities. They also identified barriers, including lack of transparency, annual funding cycles, unclear routes into partnership, inconsistent communication and the difficulty of sustaining relationships through organisational change.

The final presentation examined trustworthiness in the context of health technology and artificial intelligence. Drawing on human factors, human-centred AI and wider technology ethics, the discussion showed that trust in innovation cannot be assumed from technical performance alone. Technologies need to be designed with staff, patients and communities, introduced with clear communication and evaluated in relation to their impact on skills, relationships, safety and equity.

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Executive summary

Across the session, several themes emerged. Trust is relational, but partnerships need process to survive beyond individual relationships. Transparency is necessary, but it has to be visible to frontline staff, patients and communities. Mutual benefit is legitimate, but only when patient benefit is explicit and governance is clear. And NHS and industry partners need better routes to start conversations from a shared patient problem, rather than from a product, proposal or funding opportunity.

The report concludes with suggested next steps for the Community for Health Equity, including developing a partnership readiness checklist, strengthening brokerage between NHS and industry partners, creating clearer guidance for first conversations and applying a trustworthiness lens to digital and AI-enabled health innovation.

Programme overview

The Royal Society of Medicine (RSM) and the NHS have a shared commitment to reducing health inequalities, as outlined in the NHS Core20PLUS5 initiative and the NHS 10 Year Plan. The Community for Health Equity (CHE) Programme builds on this partnership, recognising that healthcare industry professionals (pharmaceutical, biotechnology and medical technology companies) possess unique resources and expertise that can support NHS goals. This includes supporting the adoption and spread of innovation, and improving how equity considerations are built into value propositions, evidence generation and implementation. This includes supporting the adoption and spread of innovation, and improving how equity considerations are built into value propositions, evidence generation and implementation.

By engaging industry, patients, clinicians and other stakeholders this programme aims to bridge gaps between commercial innovation and public health NHS needs. The RSM, as an independent professional body, provides a neutral convener platform where industry, NHS leaders and other stakeholders can dialogue and co-create solutions. This alignment ensures that NHS leader's priorities – such as equitable access to medicines and advancing national strategic goals – are informed by industry insights, while industry is guided toward addressing unmet needs in underserved communities.

Ultimately, the initiative seeks to deliver tangible health improvements on the ground through a series of targeted engagements and outputs.

Co-development and status

This report has been co-developed with programme members. It reflects perspectives shared during the session and does not represent formal policy positions of the Royal Society of Medicine or participating organisations.

Financial contributions and independence

We would like to thank Bayer plc, which has financially supported the delivery of this programme through a sponsorship agreement. Bayer plc provided insights to inform the initial scope of the programme, with no further involvement in the content, programme, or organisation of this meeting.

We would like to thank our Industry Members [AstraZeneca, Boehringer Ingelheim, Gilead, Merck Group, Novartis and Pfizer] for their financial support of this event.

Organisations represented across this session

Association of British HealthTech Industries
Association of the British Pharmaceutical Industry
Brook
Cheshire and Merseyside Cancer Alliance
Faculty of Pharmaceutical Medicine
Friends, Families and Travellers
Gilead Sciences
Health Innovation Network
Health Innovation Oxford and Thames Valley
Macmillan Cancer Support
Marie Curie
North Central London Cancer Alliance
Novartis
Patient Information Forum
Patients Association
Pfizer
Royal Society of Medicine
Royal Surrey County Hospital
TTP plc
UCL
UCLH

Context and background

Health inequalities are shaped by differences in health status, access to care, experience of services and outcomes. They are systematic, avoidable and influenced by deprivation, geography, protected characteristics, exclusion, discrimination and wider determinants of health. Previous sessions in the Community for Health Equity programme have examined how these inequalities are reproduced through definitions of need, data gaps, access routes, digital design, patient information, partnership models and decisions about investment.

This session focused on one of the most sensitive delivery questions in the programme: how can the NHS and industry work together on health equity in ways that are legitimate, transparent and trusted?

The scale of health inequalities means no single organisation holds all the capabilities required to respond. NHS organisations hold statutory responsibility, clinical insight, population health data and delivery infrastructure. Industry partners can bring research, evidence generation, implementation support, pathway insight, innovation capability and investment. Patient organisations, community groups and VCSE partners bring lived experience, trust, reach and practical understanding of barriers that formal systems often miss.

National policy increasingly recognises this need for collaboration. NHS England's Memorandum of Und erstanding on partnership working sets out the importance of relationships between the NHS and the life sciences sector, while recent NHS and ABPI guidance has emphasised that effective partnerships require clarity of purpose, robust governance, transparency and alignment with NHS priorities.

Collaborative working between the NHS and industry requires careful management of conflicts of interest, transparency and governance. Even where current governance is strong, participants recognised that perception can lag behind practice. For industry, this creates a requirement to demonstrate trustworthiness, with transparency about incentives and limits. For NHS partners, it creates a requirement to distinguish legitimate collaboration from influence that could compromise independence or patient benefit.

The session also took place in the context of wider NHS reform. The NHS 10 Year Health Plan places significant emphasis on prevention, neighbourhood delivery, digital transformation, patient empowerment and innovation. These shifts depend on collaboration across organisational boundaries. They also increase the importance of trust: between sectors, between services and communities and between people and the technologies used in their care.

Trust, mistrust, distrust and trustworthiness are distinct but related concepts. For health equity work, this means partners need to demonstrate trustworthiness through behaviour and outcomes, rather than assuming trust can be built through communication alone.

The session also connected trust with procurement, social value and innovation funding. NHS commercial and procurement frameworks increasingly ask organisations to consider value beyond price, including social value, equity and wider system impact. These mechanisms could help support more equitable healthcare delivery, but only where evaluation criteria, partnership design and accountability are aligned with patient benefit and distributional impact.

The central question for the session was therefore how the Community for Health Equity can help partners move from broad support for collaboration to practical, trustworthy and equity-focused partnership working.

[1] The King's Fund, *What are health inequalities?*
[2] NHS England. *Memorandum of Understanding*
[3] England NHS Confederation and Association for the British Pharmaceutical Industry (ABPI). *Accelerating transformation: How to develop effective NHS-industry partnerships*. 25 November 2025.
[4] NHS England. *Managing conflicts of interest in the NHS*
[5] Richmond J, Anderson A, Cunningham-Erves J, Ozawa S, Wilkins CH. *Conceptualizing and Measuring Trust, Mistrust, and Distrust: Implications for Advancing Health Equity and Building Trustworthiness*. Annual Review of Public Health. 2024 May;45(1):465-484.
[6] NHS Innovation Service. *Commissioning and adoption-Procurement frameworks*
[7] NHS England. *NHS Social Value Playbook: NHS Commercial guidance on applying social value in the procurement of NHS goods and services*.

Presentations

This section provides a summary of presentations given during the session and key insights gained. These informed the later discussion and provided framing to think about the suggested next steps.

1. The elephant in the room: co-exploring trust and shared goals between NHS and industry

Dr Matt Dexter, Principal Front-End Innovation Specialist, TTP plc

Organisation overview

TTP plc is a technology and product development consultancy working across health, life sciences and medical technology. Dr Matt Dexter brought expertise in qualitative research, human factors, user insight and creative facilitation. His session used Lego Serious Play as a structured method to explore trust, distrust and shared goals between NHS and industry participants.

Presentation summary

Participants were first invited to build individual models expressing trust and distrust, before bringing these together into shared table narratives. This helped show that trust is understood in different ways across the room: as openness, shared direction, psychological safety, mutual understanding and confidence that partners will act in good faith.

The exercise also surfaced the tension at the centre of the session. NHS and industry partners may share a broad goal of improving patient outcomes, but that does not remove concerns around motive, power, transparency or commercial interest. Participants reflected that distrust often appears when the purpose of a partnership is unclear, when benefits are uneven or when people feel decisions have already been made elsewhere.

By asking participants to build a shared model of unity, the session moved the discussion towards what makes partnership possible. Common ground was strongest where the focus was patient safety, patient benefit and improving access for underserved communities. However, the exercise also showed that shared aspiration needs practical support through clearer communication, governance and follow-through.

Key insights

- Creative methods can help participants surface assumptions that may remain hidden in conventional discussion.
- Trust is experienced through both structure and feeling. Participants spoke about shared values, psychological safety, honesty and the confidence to share more sensitive information.
- Distrust often appears where motives are unclear, where communication is limited or where people feel partnership decisions are being made elsewhere.
- Patient safety and patient benefit provide common ground, but they need to be made explicit throughout the partnership.
- Different sectors experience the same relationship differently. Industry may see partnership as constructive and value-adding, while NHS staff may experience risk, scrutiny or uncertainty about permissibility.
- Unity requires more than shared aspiration. It depends on practical routes for communication, governance, accountability and follow-through

If you only read one resource: Lego Serious Play - Aligning stakeholders around complex challenges in MedTech and Pharma

2. Building trusting partnerships

Ms Sara Javid, Senior Policy Lead, NHS England

Organisation

Sara Javid brought a national NHS policy perspective to the session. Her contribution was important because it grounded the discussion in the operational realities of NHS partnership working, including governance, implementation, changing system structures and the need to translate evidence, data and policy into practical service and workforce change.

Presentation summary

The session began by asking participants to define trust. Responses focused on shared values, psychological safety, honesty, confidence and the ability to move in the same direction. When applied to NHS and industry partnerships, participants identified clear benefits from stronger trust, including better patient outcomes, improved access to innovation, stronger evidence for value and better reach into underserved communities.

The discussion then moved to the barriers that prevent trust from forming. These included limited understanding of how partnerships work, changing NHS structures, unclear objectives, suspicion around profit motive, lack of visible transparency and the legacy of previous industry behaviour. Participants also noted a disconnect between positive relationships with individual industry representatives and broader scepticism about the companies they represent.

The King's Fund Purpose, People, Process framework gave participants a practical way to reflect on current or intended partnerships. Discussion suggested that relationships between individuals are often the strongest part of partnership working, while process, governance, continuity and shared measures can be weaker. Participants also identified a need for clearer routes into partnership, including support to identify the right NHS contributors and to start conversations from genuine patient benefit.

Key insights

- Trust is carried by individuals, but partnerships require systems that can survive staff changes, funding cycles and organisational restructuring.
- NHS and industry partners often work to different timescales. NHS budgets and industry planning cycles can both be annual, while meaningful equity-focused work may require a longer horizon.
- Lack of transparency can be real or perceived. Both forms affect trust and need to be addressed through visible governance and communication.
- Participants identified a need for clearer routes into partnership. It can be difficult for industry to know who to approach, while NHS staff may be uncertain about what is permissible.
- The patient problem provides stronger common ground than return on investment alone. ROI can include money, reputation, learning, service improvement and patient outcomes, but conversations need to begin with shared purpose.
- A broker role could help translate between NHS, industry, patient and community partners, particularly where relationships are new or where the system is difficult to navigate.
- NHS contributions need to be understood in plural form. National NHS policy, local delivery, clinical leadership, procurement, innovation infrastructure and patient involvement all shape whether partnerships can be formed and sustained.

If you only read one resource: NHS and life sciences industry partnerships – collaborating to improve care

3. Trustworthiness in health technology and AI

Professor Julia Manning, Dean of Education, Royal Society of Medicine and Honorary Professor of Practice, Computer Science, UCL

Organisation

The final presentation examined trust and trustworthiness through the lens of human factors, digital health and AI. It moved the discussion beyond trust between organisations and into the question of what makes an innovation, system or technology worthy of trust.

Presentation summary

The presentation used human factors as a lens for understanding trust in complex health systems. Human factors methods focus on areas such as human error, situational awareness, mental workload and team assessment. Applied to digital health and AI, this shifts attention from whether a tool appears technically effective to how it affects the people expected to use it, work around it or depend on it.

The presentation also used STEM as a framework for considering Sustainability, Trustworthiness, Education and Meaning. This helped participants consider questions that may be missed when innovation is assessed mainly through adoption, performance or efficiency. For digital and AI tools, these questions include environmental impact, liability, explainability, staff confidence, clinical judgement and the effect on relationships between patients and professionals.

Participants heard examples of technologies being promoted or introduced without enough consultation with clinicians, staff or patients. This reinforced the distinction between a technology being trusted and being trustworthy. Trust is more likely where staff are involved early, patients and communities are consulted, limitations are clearly explained and responsibility for decisions remains visible.

Key insights

- Trustworthiness should be considered from the start of technology design, procurement and implementation.
- Human factors can help identify how system design, workload, communication and role clarity affect trust.
- Staff involvement should happen before patient-facing deployment, particularly where technologies affect clinical judgement, workflow or professional identity.
- Co-design should include patients, communities, frontline staff and the people expected to implement or be affected by the technology.
- Public consultation and feedback loops help show how views have shaped decisions.
- Liability needs to be clear, especially where AI tools influence clinical decision-making.
- AI may create new equity risks if claims about performance, compassion or personalisation are over-extended or if design choices reflect discriminatory assumptions.
- Trust in technology depends on more than adoption. It depends on safety, competence, honesty, reliability, communication and meaningful human oversight.

If you only read one resource: NHS and life sciences industry partnerships – collaborating to improve care

Discussion

Trust is human, but partnerships need infrastructure

A consistent theme across the session was that trust is fundamentally relational. Participants described trust as safety, honesty, shared values and confidence that people will do what they say they will do. This creates a challenge for NHS and industry partnership because formal partnerships are often held together by individual relationships.

When a trusted person moves role, the partnership can weaken quickly. This is particularly important in a period of NHS restructuring, workforce pressure and financial constraint. Participants noted that time invested in building relationships can be lost through staff turnover or shifting organisational priorities.

The implication is that trust cannot rely on individuals alone. Partnerships need clear documentation, agreed purpose, governance, communication routes, escalation points and handover processes. These do not replace relationships; they help relationships survive.

Transparency needs to be visible beyond the core partnership team

Participants returned frequently to transparency. The issue was rarely a simple absence of governance. In many cases, governance requirements exist, but they are poorly understood by people outside the immediate partnership.

This creates a perception gap. Frontline NHS staff may see industry involvement and feel uncertain about motive, influence or independence. Patients and communities may see a company name and have concerns based on past experiences or wider public narratives. Industry partners may feel they have followed the rules, while others still experience the arrangement as opaque.

This means transparency needs to be designed for wider audiences. Partnership agreements, funding arrangements, expected benefits, conflicts of interest and decision-making processes need to be communicated in a way that frontline staff, patient groups and community partners can understand.

The ABPI working together guidance provides a useful foundation for this. It emphasises clarity of purpose, integrity, independence and transparency, alongside written agreements covering patient benefit, roles, responsibilities, timeframes, outcomes, financial or non-financial support, public acknowledgement and disclosure.

Patient benefit is the strongest shared starting point

Participants found that partnership conversations were strongest when they began with a shared patient problem. This helped shift the conversation away from suspicion and toward practical delivery.

Starting with a product, funding proposal or organisational offer can reinforce mistrust because the purpose of the conversation is unclear. Starting with a patient population, an access barrier, a health outcome gap or a pathway problem creates a stronger basis for partnership. It also helps clarify which partners need to be involved.

This links to earlier sessions in the programme, which showed that equity-focused work needs specificity. Broad ambitions to improve health inequalities can be difficult to act on. A clearly defined problem, population and mechanism of change makes partnership more practical and more measurable

NHS contributions need to be plural and specific

Feedback on previous sessions has highlighted the importance of drawing out NHS contributions. This session showed why that matters.

The NHS perspective in partnership is not a single view. National policy teams can clarify rules, priorities and system expectations. NHS England can support frameworks and signals for partnership working. Health innovation networks can provide brokerage, implementation support and patient involvement expertise. Clinical teams can describe practical pathway barriers and service pressures. Cancer alliances, trusts and Integrated Care Boards (ICBs) can connect partnership to population health priorities, commissioning and delivery. Frontline staff can identify whether a proposed solution is workable in practice.

This matters because industry partners often need to know which part of the NHS they are engaging with and what that person or organisation is able to decide. It also matters because trust can break down when a conversation with one NHS contact is assumed to represent system permission or readiness.

Partnerships are more likely to progress when the NHS contribution is clear: who owns the problem, who can support design, who can approve activity, who can implement, who can evaluate and who can sustain the work.

Mutual benefit needs clearer language

The discussion surfaced a recurring discomfort around industry benefit. Participants recognised that industry partners have commercial objectives and that this can trigger suspicion. However, participants also challenged the idea that commercial benefit automatically compromises patient benefit.

The more constructive framing was mutual benefit with clear safeguards. A legitimate partnership should be able to explain what patients gain, what the NHS gains, what industry gains and how independence is protected. The patient benefit must be explicit, but the industry benefit should also be transparent. Attempts to obscure it are more likely to create suspicion.

This framing aligns with NHS and industry partnership guidance, which emphasises shared purpose, transparency, governance and measurable outcomes. It also aligns with the concept of social value in procurement, where decision-making can consider broader economic, social and environmental benefits alongside cost.

Trustworthiness is an active practice

The technology discussion reinforced that trustworthiness is active, demonstrable and ongoing. It cannot be claimed through branding, performance metrics or compliance statements alone.

For partnerships, trustworthiness means doing what has been agreed, communicating honestly when things change and being clear about incentives, limits and risks. For technology, it means involving users early, testing in real contexts, understanding workflow, making limitations visible and assessing effects on equity, skills and care relationships.

This is particularly important for AI-enabled technologies. AI can affect clinical judgement, patient experience, workflow, liability and staff capability. Responsible adoption therefore requires human factors, public involvement, clinical engagement and governance that reflects the complexity of the technology.

Suggested next steps

The suggested next steps below reflect where participants identified opportunities to strengthen trust, trustworthiness and support across NHS, industry, patient and community partnerships.

The session highlighted three practical suggestions for organisations and partners working to strengthen trust, trustworthiness and support across NHS, industry, patient and community partnerships

1. Build a practical framework for trustworthy partnerships

Partners would benefit from a simple way to test whether the foundations for trustworthy collaboration are in place before work begins.

Action

- Develop a partnership readiness checklist covering patient benefit, target population, shared purpose, partner roles, governance, conflicts of interest, evidence, evaluation and transparency.
- Structure first partnership conversations around the patient problem and what each partner can contribute.
- Use a simple transparency statement setting out who is involved, what each partner contributes, what each partner gains and how patient benefit will be assessed.

2. Build collective understanding of community roles, community-led approaches and innovative engagement models

Partnerships are more likely to progress when partners can navigate the system, identify the right NHS contributors and connect different forms of expertise around defined equity challenges.

Action

- Develop a partnership readiness checklist covering patient benefit, target population, shared purpose, partner roles, governance, conflicts of interest, evidence, evaluation and transparency.
- Structure first partnership conversations around the patient problem and what each partner can contribute.
- Use a simple transparency statement setting out who is involved, what each partner contributes, what each partner gains and how patient benefit will be assessed.

3. Make digital and AI innovation easier to trust

Digital and AI tools can support better care, but trust will be weaker if staff, patients and communities do not understand how they work, how they affect care and who is responsible when something goes wrong.

Action

- Involve staff, patients and communities early, before, after and during the introduction of digital or AI tools into care pathways.
- Be clear about what the tool does, what it does not do, who is responsible for decisions and where human judgement remains essential.
- Give staff time and support to understand the tool before it is used with patients.
- Assess whether the tool could affect access, safety, confidence, clinical judgement or relationships between patients and staff and address identified risks before implementation and throughout its use.

Additional resources

- **NHS-industry partnerships – policy context and rationale; trust, transparency and patient-centred goals**
- NHS England. **Memorandum of Understanding**.https://www.england.nhs.uk/ourwork/part-rel/understanding
- NHS England. **Managing conflicts of interest in the NHS.** https://www.england.nhs.uk/long-read/managing-conflicts-of-interest-in-the-nhs/
- Aggarwal A. **Innovation with integrity: Why NHS-industry partnerships matter, and how conflicts of interest are managed**. The Association for the British Pharmaceutical Industry (ABPI), 6 March 2026.
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Trust and health equity (including patient insight)

- Health Innovation Network. **Forging a more equitable healthy future through Patient and Public Involvement and Engagement: Roundtable report**. Spring 2025. https://thehealthinnovationnetwork.co.uk/news/report-forging-a-more-equitable-future-through-patient-and-public-involvement-and-engagement
- Manchester University NHS Foundation Trust. **Principles of Patient and Public Involvement and Engagement in Innovation**. 2025. https://www.health.org.uk/sites/default/files/2025-08/Vocal%20PPIE_Full%20report_2025.pdf
- Health Innovation Yorkshire and Humber. **Accelerating innovation adoption and spread using patient insight**. 27 September 2024. https://www.healthinnovationyh.org.uk/news/accelerating-innovation-adoption-and-spread-using-patient-insight

Additional resources

- **King's Fund.** *What are health inequalities?*
- Richmond J, Anderson A, Cunningham-Erves J, Ozawa S, Wilkins CH. **Conceptualizing and Measuring Trust, Mistrust, and Distrust: Implications for Advancing Health Equity and Building Trustworthiness**. Annual Review of Public Health. 2024 May;45(1):465-484. https://pubmed.ncbi.nlm.nih.gov/38100649
- TTP. **Lego Serious Play – aligning stakeholders around complex challenges in MedTech and Pharma.** https://www.ttp.com/insights/lego-serious-play-how-medtech-and-pharma-teams-can-live-out-strategy-beyond-a-slide-deck
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Procurement frameworks and innovation funding

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Additional resources

- European Commission. **Benchmarking of innovation procurement investments and policy frameworks across Europe**. 2024-2025. https://research-and-innovation.ec.europa.eu/strategy/support-policy-making/shaping-eu-research-and-innovation-policy/new-european-innovation-agenda/innovation-procurement/benchmarking-innovation-procurement-investments-and-policy-frameworks-across-europe_en
- This benchmarking regularly tracks national policy frameworks and investments on innovation procurement across the 27 EU Member States, the UK, Switzerland and Norway.
- García-Altés A, McKee M, Siciliani L, Barros PP, Lehtonen L, Rogers H, Kringos D, Zaletel J, De Maeseneer J. **Understanding public procurement within the health sector: a priority in a post-COVID-19 world**. Health Economics Policy and Law. 2023 Apr;18(2):172-185. https://pubmed.ncbi.nlm.nih.gov/35894208/

Health Innovation Network

Local change, national impact

This report has been produced by the Health Innovation Network on behalf of the Royal Society of Medicine