The Royal Society of Medicine

Community for Health Equity

Session 6 report
‘Creating health equity through new pathways and innovation’

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Executive summary

This report captures learning from the sixth session of the Community for Health Equity programme, which focused on creating health equity through new pathways and innovation.

The session examined how new or improved pathways can be designed to reduce health inequalities in practice. It focused on the Innovation for Healthcare Inequalities Programme (InHIP), which was developed by NHS England and the Health Innovation Network to improve access to proven innovations and clinical pathways for underserved populations.

Across the session, participants explored a central delivery challenge: effective medicines, technologies and services can exist within the system while people with the greatest need remain least likely to access them. The discussion highlighted pathway design as a health equity issue. Access depends on where services are delivered, who is trusted to explain them, how data is used, whether workforce capacity exists and whether the intervention can become part of routine delivery.

Stuart Monk introduced InHIP and set out how the programme moved the Health Innovation Network's work from general access to innovation toward a more targeted focus on underserved groups. Wave 1 reached more than 34,000 patients in target cohorts, with over 3,000 patients benefitting directly from a NICE-recommended innovation. The programme worked with 38 integrated care systems and cost around £7m, equating to approximately £200 per patient reached.

A workshop asked participants to design their own InHIP-style project. The discussion reinforced the importance of starting with a defined underserved population and pathway gap, then working with trusted local partners to design, deliver, capture data and learn. Participants also reflected on the need to go beyond broad population labels and understand the specific communities, languages, experiences and trusted relationships that shape access.

Four case studies then showed how pathway redesign can work in different contexts: qFIT testing through a community hub in North Devon, cardiovascular health checks through community pharmacies in North East London, respiratory care linked to fuel poverty support in Cheshire and Merseyside and improved access to asthma biologics through pharmacist-led outreach in Buckinghamshire, Oxfordshire and Berkshire West.

Several themes emerged. Trusted community routes can reach people where traditional pathways miss. Pathway change requires both clinical and non-clinical partners. Local knowledge is essential, but projects need enough structure to support transfer and spread. Data needs to capture both numbers and lived experience. Sustainability depends on commissioner engagement, workforce capacity and clarity on which parts of a project can be embedded into routine practice.

The report concludes with suggested next steps for organisations and partners working across health and social care: start with a clear pathway gap and underserved cohort, design delivery around trusted local routes and plan for sustainability and spread from the outset

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.

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 the British Pharmaceutical Industry
Barts Health NHS Trust
Boehringer Ingelheim UK
Cheshire and Merseyside Cancer Alliance
Friends, Families and Travellers
Health Innovation Network
Health Innovation North West Coast
Health Innovation Oxford and Thames Valley
Health Innovation South West
Marie Curie
Merck
NHS England
North East London Integrated Care Board
Patient Information Forum
Picker Institute Europe
Royal Society of Medicine
Sister Circle
St Helens and Knowsley Teaching Hospitals NHS Trust
TTP plc
UCLPartners

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 data gaps, information design, partnership models, trust, funding decisions and delivery choices.

This session focused on a further delivery question: how can new or improved pathways be designed so that proven innovations, services and treatments reach people who are currently missed? This matters because innovation can widen inequalities when it is designed around people who are already able to navigate services. Equitable innovation requires attention to access routes, literacy, language, transport, digital confidence, trust and the practical conditions in which care is delivered.

NHS England's statement on information on health inequalities states that quantitative data and qualitative community insight should be combined to identify underserved population groups, understand barriers to access and inform service improvement. Core20PLUS5 provides a framework for focusing action on the most deprived 20 percent of the population, locally identified groups experiencing poorer access or outcomes and five clinical priority areas.

The Innovation for Healthcare Inequalities Programme provides a practical example of this policy being translated into pathway change. Developed by NHS England and the Health Innovation Network, InHIP was designed to improve access to clinical pathways and NICE-recommended innovations for underserved populations. Its first wave supported projects across 38 ICSs and showed how health innovation networks, NHS partners, community organisations, industry and local systems can work together around defined pathway gaps.

The session also took place in the context of the NHS 10 Year Health Plan, which places renewed emphasis on prevention, neighbourhood delivery, digital transformation, patient power and innovation. These shifts all depend on pathway redesign. They also increase the importance of designing pathways that work for people facing multiple barriers, rather than relying on standard routes into care.

A recurring lesson from the evidence base is that equity must be considered throughout design and implementation. Innovations are more likely to deliver equitable impact when they respond to the barriers experienced by underserved groups and are supported by stakeholder engagement, sustained funding, leadership, practical enablers and aligned organisational processes.

[1] The King's Fund, *What are health inequalities?*
[2] NHS England, Equalities impact assessment: 10 Year Health Plan for England
[3] Tooman, T.R., Frost, H., Adams, R. *et al.* Excluded by design: a qualitative study of inequalities in health and social care innovation. *Int J Equity Health* **25**, 22 (2026). https://doi.org/10.1186/s12939-025-02751-5.
[4] McKenzie F, Hewitt C, Holmes HL, et al. BMJ Innov 2025;11:126–132.

Presentations

This session was led by the Health Innovation Network. The workshop and presentations showcase some of the projects led by local health innovation networks throughout the InHIP programme and are summarised in this next section.

1. Introducing the Innovation for Health Inequalities Programme (InHIP)

Stuart Monk, National Programme Director, Health Innovation Network

Organisation overview

Stuart Monk introduced the Health Innovation Network and InHIP. The presentation set out why pathway design matters for health equity and how InHIP used local needs assessment, trusted partners, delivery, data capture and evaluation to improve access for underserved groups.

Presentation summary

The presentation began with the role of the Health Innovation Network as a national network of 15 local organisations embedded in local health and research ecosystems. Its work focuses on finding, testing and implementing innovation in ways that respond to local need and can be prepared for adoption and spread.

InHIP was described as a shift in approach. Before 2022, much of the Network's work on access to innovation focused on the general population. InHIP moved this work through a health inequalities lens, recognising that traditional access methods, such as letters, GP searches or standard appointment models, often fail to reach underserved communities. The programme focused specifically on improving access to clinical pathways and NICE-recommended innovations for underserved groups.

Wave 1 worked with 38 integrated care systems, primary care, community pharmacies, industry and voluntary, community, faith and social enterprise partners. It reached more than 34,000 patients in target cohorts, with over 3,000 patients directly benefitting from a NICE-recommended innovation. The programme cost around £7 million, or approximately £200 per patient reached, and was designed with a clear theory of change and impact framework.

Key insights

- Pathway design is a practical health equity tool. It determines who is identified, who is contacted, who attends and who receives support.
- General access routes can miss underserved communities, particularly where trust, literacy, language, transport or service experience create barriers.
- Improving equity requires tangible intervention around defined pathway gaps rather than broad statements of intent.
- Local delivery needs both data and community insight to identify who is underserved, where barriers sit and which partners can reach people effectively.
- InHIP showed that national priorities can be translated into local interventions when systems have a clear framework, resource and trusted partners.

If you only read one resource: NHS England and Health Innovation Network, Innovation for Healthcare Inequalities Programme (InHIP): impact and learning report

2. Workshop: designing an InHIP project

Facilitated table discussion

Organisation

The workshop asked participants to apply the InHIP framework to a potential pathway redesign project. Tables worked through how to identify an underserved population, select a pathway or condition, work with trusted partners, design an intervention, capture data and learn from delivery.

Presentation summary

Participants discussed the need to begin with granular local understanding. Broad categories such as South Asian communities can hide important differences in language, culture, trust, faith networks and service experience. Some groups discussed the need to identify Bangladeshi, Pakistani, Black Caribbean, Gypsy, Roma and Traveller or other communities in more specific ways, then understand who those communities already trust.

The workshop also highlighted practical barriers that standard pathways often overlook. These included transport costs, long travel times, people without regular GP contact, negative experiences of services, health literacy, language, consent, digital exclusion and the time needed to build trust. Participants stressed that community ambassadors, faith leaders, pharmacists, libraries, hubs and local organisations can help reach people in ways traditional routes cannot.

Feedback from the scenarios reinforced the importance of local design. Participants emphasised community hubs, trusted leaders, trusted places, quality assurance, qualitative data and realistic timelines. They also noted that success may take longer than a short pilot period and that interventions need to be integrated into existing pathways if clinician behaviour and system practice are to change.

Key insights

- Granularity matters. Partners need to understand the specific communities, languages and access barriers involved.
- Trusted partners should be identified through local knowledge rather than assumed from organisational type.
- Health literacy, transport, service history and registration status can all affect whether a pathway is usable.
- Qualitative insight is needed alongside activity and outcome data to understand what changed and why.
- Projects need early thinking on how delivery will be integrated, sustained and adapted beyond the pilot.

3. Partnering with a community hub to improve access to qFIT testing

Marie-Joëlle West, Senior Portfolio Director, Health Innovation South West

Organisation

This case study focused on a North Devon project using a trusted community hub to improve access to qFIT testing and wider health support for people in deprived, rural and coastal communities.

Presentation summary

The local needs assessment identified a rural and coastal context with an ageing population, high levels of poor health, economic inactivity linked to long-term sickness, travel barriers and structural isolation. Ilfracombe's wards were described as among the most deprived areas in England, with a 15-year difference in life expectancy compared with more affluent parts of Devon.

The trusted partner was Belle's Place, a volunteer-run community hub supporting people experiencing homelessness, vulnerable housing, isolation, complex health needs, drug or alcohol dependency and poor experiences of traditional services. The intervention used GP-led drop-in sessions at the community centre, combining health checks, qFIT, national screening, mental health, housing, rehabilitation and literacy support.

The project captured routine primary care data, patient interviews and staff experience. Over six months it delivered 84 appointments with 31 unique patients, with 61 percent receiving blood pressure checks, 12.9 percent receiving qFIT testing and 83.9 percent referred to additional services. The learning emphasised privacy, trust, local assets and unstructured, holistic clinics that made it easier for people to re-engage with care.

Key insights

- Community hubs can act as trusted gateways for people least likely to access traditional services.
- Flexible, unstructured and person-centred clinics can make engagement easier for people with complex needs.
- Linking health checks with housing, literacy, mental health and rehabilitation support can address wider barriers to pathway access.
- Privacy and clear communication are essential when working with people who may feel stigma or shame around services.
- Small-scale delivery can generate important learning on access, confidence and continuity in primary care.

If you only read one resource: Health Innovation South West, Improving access to personalised healthcare in coastal Devon

4. Health checks in community pharmacies to address CVD inequalities

Rachana Bhatt, Senior Implementation Manager, UCLPartners and Jagjot Chahal, Cardiovascular Disease Prevention Lead Pharmacist, Barts Health NHS Trust

Organisation

This case study focused on cardiovascular disease prevention through cholesterol point of care testing in community pharmacies across North East London and North Central London, with a focus on deprived and ethnically diverse communities.

Presentation summary

The presentation positioned community pharmacies as accessible places for prevention. In North East London, large numbers of people had already accessed NHS Community Pharmacy Blood Pressure Check services, creating an opportunity to offer cholesterol testing alongside blood pressure checks and provide a more holistic cardiovascular risk review.

The model relied on multi-organisational collaboration across Barts Health NHS Trust, cardiovascular prevention teams, ICBs, local pharmaceutical committees, UCLPartners, HEART UK and NHS England. Pharmacy contractors were selected based on participation in the NHS Community Pharmacy Blood Pressure Check Service, weekend opening and space to deliver testing. Pharmacy professionals received e-learning, practical equipment training, case studies, consultation tools and support materials, including blood pressure monitoring videos in 15 languages.

Between January 2025 and March 2026, 2,067 patients were tested across 59 pharmacies. Of these, 445 people, or 19 percent, were identified with QRISK over 10 percent or significantly raised lipids, 71 patients were initiated on statin therapy, 603 people had raised clinic blood pressure and 33.2 percent were within Core20. Patient feedback highlighted convenience, speed, local access and the value of advice that reflected cultural diets and working patterns.

Key insights

- Community pharmacy can provide accessible prevention routes for people who may struggle to use GP-led services.
- Point of care testing can support faster risk identification, immediate advice and onward referral.
- Patient and public involvement helped confirm that pharmacy was an acceptable setting and that walking distance mattered.
- Training and multilingual materials helped make the model more practical for staff and more accessible for patients.
- The model reached people from a wide range of ethnic and socioeconomic backgrounds, including communities at higher cardiovascular risk.

If you only read one resource: UCLPartners Health Innovation, Driving a step change in healthcare inequalities

5. Integrating respiratory care with fuel poverty support to reduce health inequalities

Rhiannon Clarke, Senior Programme Manager, Health Innovation North West Coast and Dianne Green, Lead COPD Nurse / Team Leader, St Helens COPD Service

Organisation

This case study focused on integrating respiratory care with fuel poverty support for people living with asthma or Chronic Obstructive Pulmonary Disease (COPD) in deprived communities. It showed how pathway redesign can connect clinical care with practical support for the wider conditions affecting health.

Presentation summary

The project used population health management tools and local data to identify people with respiratory disease who were also likely to be affected by fuel poverty. The aim was to move from reactive care toward proactive outreach by bringing together clinical teams, local partners and energy advice services around people at higher risk.

The intervention brought existing services together around people who needed them most, instead of creating a wholly new service. Common elements across the pathways included a defined role to create patient lists and contact people, clinical review and onward referral to holistic services. A patient case study illustrated how respiratory support, financial advice, benefits back-payments, prescription savings, heating support and a new boiler could combine to improve safety, warmth and confidence.

The programme referred 608 patients to the household fund and supported practical measures such as radiator reflectors, LED lightbulbs, damp assessments and benefit entitlement checks. The project reported a 10 percent reduction in GP use following the intervention. Discussion focused on clinical capacity, the importance of care coordination, maintaining up-to-date knowledge of local services and the potential role of neighbourhood working in scaling trusted relationships.

Key insights

- Respiratory pathway redesign can address wider drivers of poor health, including cold homes, cost pressures and fuel poverty.
- Population health data can help identify people who need proactive support before crisis-driven care is required.
- Care coordination and local service knowledge are essential when pathways rely on multiple clinical and non-clinical partners.
- Existing services can be joined together more effectively when roles, referrals and patient lists are clear.
- Qualitative case studies can help show the full value of interventions that standard clinical metrics may miss.

If you only read one resource: Health Innovation North West Coast, Toolkit unveiled to tackle fuel poverty

6. Improving access to asthma biologics via pharmacist-led outreach and a hub-and-spoke service

Eleanor Kilsby, Senior Programme Manager, Health Innovation Oxford and Thames Valley

Organisation

This case study focused on improving access to specialist severe asthma review and NICE-approved asthma biologics for people living in areas with high deprivation and health inequality across Buckinghamshire, Oxfordshire and Berkshire West.

Presentation summary

The local needs assessment showed that people with uncontrolled severe asthma were being missed by existing identification, assessment and referral routes for specialist review and therapies. Existing pathways relied heavily on overstretched GP teams, with low engagement among populations experiencing deprivation, travel barriers to tertiary centres and bottlenecks in tertiary pharmacy services.

The innovation was an outreach model involving Integrated Severe Asthma Care specialist pharmacists working directly within GP practices. The model supported faster identification of suitable patients, improved referral routes and stronger shared learning between primary and specialist care. Local clinics, early, weekend and late appointments, translation support and follow-up calls for missed appointments were used to reduce access barriers.

The project also highlighted implementation challenges, including complex data sharing agreements and variable GP practice engagement, which created patchy datasets. Reported learning included the value of specialist pharmacists in bridging primary and specialist care, the importance of local knowledge from GP practices and the need to adapt timing, location and communication around patient need. The project reported over £400,000 in healthcare utilisation savings.

Key insights

- Specialist pharmacist outreach can help identify patients who are missing from standard referral routes.
- Local clinics can reduce travel barriers and make specialist review more accessible.
- Data sharing and variable practice engagement need early attention because they affect delivery and evaluation.
- Flexible appointment times, translation support and follow-up calls can improve access for underserved populations.
- Pathway redesign can support both better access to innovation and reduced avoidable healthcare utilisation.

If you only read one resource: Health Innovation Oxford and Thames Valley, Case study: Integrated approach transforms lives of more people with severe asthma

Discussion

Pathway design determines who is reached

A consistent theme across the session was that inequity can be created by the way pathways are designed. Standard access routes often assume that people are registered with a GP, can read written materials, can travel to appointments, can respond to letters, can use digital systems and have enough trust to engage. For many underserved groups, these assumptions are unreliable.

The practical implication is that pathway redesign needs to begin with the access barrier. This may be a gap in identification, invitation, communication, location, timing, referral, follow-up or ongoing support. Defining the pathway gap clearly helps partners identify which intervention is needed and which organisations need to be involved.

Trusted routes are part of the intervention

The case studies showed that trusted routes are more than a way to advertise a service. They are part of the intervention itself. Belle's Place, community pharmacies, local respiratory services, GP practices, faith groups and community connectors all created forms of access that felt more acceptable, familiar or practical for different groups.

Participants cautioned against assuming that any community partner will be trusted by any group. Trust needs local specificity. Language, generation, ethnicity, faith, culture, past service experience and local relationships all shape who can reach whom. This makes local knowledge essential at the earliest stage of pathway design.

NHS contributions need to be visible and connected

The session showed multiple NHS contributions to pathway change. Health Innovation Networks provided implementation infrastructure, brokerage and evaluation support. ICBs and system partners supported governance and local prioritisation. GP practices, community pharmacies, specialist teams and respiratory services delivered clinical components. Local authorities and wider partners supported non-clinical needs such as fuel poverty, housing and community engagement.

This range of NHS contributions matters because pathway redesign can fail when responsibility is unclear. Partners need to know who owns the problem, who can identify patients, who can deliver the intervention, who can manage risk, who can evaluate impact and who can support sustainability.

Local adaptation and scale need to be held together

Participants returned frequently to the tension between local adaptation and scale. Projects worked because they understood local communities, assets and barriers. However, their wider value depends on whether the learning can be transferred to other places.

The strongest route to spread may be to identify the common elements rather than copy the exact model. Across the case studies, common elements included local needs assessment, trusted partners, clear patient identification, flexible delivery, practical data capture, clinical review and routes into wider support. These are transferable, even where the local partner or service model needs to change.

Evidence needs to support learning, commissioning and sustainability

The session reinforced that evidence for pathway change needs to be both quantitative and qualitative. Activity data, uptake, referrals, prescribing and healthcare utilisation can show reach and impact. Patient stories, staff experience and community feedback explain why an intervention worked, what barriers remained and how it could be improved.

Commissioner engagement and budget ownership were seen as important for sustainability. Participants noted that many decision-makers want to see evidence that an approach has worked elsewhere before committing larger investment. This makes evaluation design, baseline data and transferable learning important from the outset.

Suggested next steps

The session highlighted three practical suggestions for organisations and partners working to create more equitable pathways through innovation.

1. Start with a defined pathway gap and underserved cohort

Pathway redesign should begin with a clear understanding of who is being missed, where the current pathway is failing and which barrier needs to be addressed.

Action

- Use local data and community insight to define the underserved cohort, pathway gap and access barrier.
- Avoid broad population labels where more granular understanding is needed, including language, culture, geography, service history and trust.
- Define the intended outcome clearly before selecting the intervention or delivery route.

2. Design delivery around trusted local routes

Interventions are more likely to reach underserved groups when they use trusted places, trusted people and practical access routes that fit local lives.

Action

- Identify trusted community, Voluntary, Community, Faith, and Social Enterprise (VCFSE), pharmacy, primary care or local authority partners through local knowledge.
- Deliver services in accessible locations and formats, with attention to language, literacy, privacy, timing, transport and digital access.
- Connect clinical support with wider services where the access barrier is shaped by housing, fuel poverty, isolation, literacy or other practical needs.

3. Plan for sustainability and spread from the start

Projects need to generate learning that can support commissioning, routine delivery and adaptation in other places.

Action

- Capture both quantitative data and patient or staff experience so impact can be understood in full.
- Involve commissioners, clinical leads, delivery teams and community partners early so there is a route from pilot to routine practice.
- Document the transferable elements of the model, such as needs assessment, trusted partner role, patient identification, clinical review, referral route, workforce requirement and evaluation approach.

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
- 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. https://www.abpi.org.uk/media/blogs/2026/march/innovation-with-integrity-why-nhs-industry-partnerships-matter-and-how-conflicts-of-interest-are-managed
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- McGlennon N. **Accelerating NHS transformation through industry collaboration**. Health Innovation East Midlands, 11 April 2025. https://healthinnovation-em.org.uk/news-and-events/blog/accelerating-nhs-transformation-through-industry-collaboration
- NHS England. **NHS commercial framework for new medicines**. 29 January 2025 (last updated). https://www.england.nhs.uk/publication/nhs-commercial-framework-for-new-medicines
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- Aunger JA, Millar R, Rafferty AM, Mannion R. **Collaboration over competition? Regulatory reform and inter-organisational relations in the NHS amidst the COVID-19 pandemic: a qualitative study**. BMC Health Services Research. 2022 May 13;22(1):640. https://link.springer.com/article/10.1186/s12913-022-08059-2

Trust and health equity (including patient insight)

- NHS England and Health Innovation Network, Innovation for Healthcare Inequalities Programme (InHIP): impact and learning report
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- 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
- The King's Fund, What are health inequalities?
- NHS England, Equalities impact assessment: 10 Year Health Plan for England

Additional resources

- 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
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Procurement frameworks and innovation funding

- NHS Innovation Service. **Commissioning and adoption-Procurement frameworks**. https://innovation.nhs.uk/innovation-guides/commissioning-and-adoption/procurement-frameworks
- NHS Shared Business Services. **Framework Agreements for the NHS**. https://www.sbs.nhs.uk/services/framework-agreements-categories
- NHS England. **NHS Social Value Playbook: NHS Commercial guidance on applying social value in the procurement of NHS goods and services**. 14 July 2025. https://www.england.nhs.uk/long-read/nhs-social-value-playbook
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Additional resources

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Local change, national impact

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