The Royal Society of Medicine

Community for Health Equity

Session 3 report
‘Connection Sprint’

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Session 3 Report 'Connection Sprint'

Executive summary

This report captures learning from the third session of the Community for Health Equity programme, which focused on how partnerships can be formed and mobilised to support action on health inequalities.

The session used a structured connection sprint format. Participants rotated through facilitated, time-limited table discussions, each focused on a specific equity challenge or capability. At each rotation, stakeholders were asked to articulate three elements: the problem or population group they were focused on, what they could offer, and what they needed from others to progress. This created a rapid matching environment where complementary roles and shared priorities could be identified in real time.

Across the programme to date, a consistent theme has emerged. Health inequalities are widely recognised, well described and strongly reflected in national policy, but progress still depends on whether organisations can work across boundaries to turn intent into delivery. This includes connecting service insight, patient voice, implementation support, funding routes and innovation capability around clearly defined problems. Presentations highlighted four complementary enablers of progress. First, partnerships between the NHS and industry can support pathway redesign, earlier diagnosis and improved implementation when they are structured around patient benefit, time-limited objectives and robust governance. Second, innovation funding and capability programmes can help individuals and teams move promising ideas towards deployment, particularly where they are designed to address health inequalities from the outset. Third, practical implementation models can help staff translate a broad commitment to equity into concrete action within everyday services. Fourth, patient partnership is strongest when it is built into the design of how people work together, rather than added at the point of consultation.

The session reinforced that good partnership does not happen by default. It depends on clarity of purpose, transparent governance, accessible routes into collaboration and visible commitment to trust, inclusion and shared accountability. These conditions are particularly important where organisations bring different incentives, expertise and forms of power.

Taken together, the session suggested that external collaboration is most valuable when it helps delivery teams do something they would otherwise struggle to do alone. This may include creating headspace for service redesign, strengthening implementation discipline, improving access to communities who are often missed, or supporting the development of innovations that better reflect unmet need.

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 discuss and co-create solutions. This is supported by the RSM's long-standing role in bringing together professionals across clinical disciplines, sectors and career stages, enabling engagement between organisations that would not routinely work together. In this session, that convening role was applied through the connection sprint format, with the intention of supporting participants to move beyond discussion towards forming practical partnerships. Early indications suggest that this approach has led to new relationships and initial project ideas being taken forward beyond the session.

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.

Programme overview

Organisations represented across this session

Action Against AMD
Association of the British Pharmaceutical Industry
AstraZeneca
Blood Cancer UK
Boehringer Ingelheim UK
Brook
Central London Community Healthcare NHS Trust
Cheshire and Merseyside Cancer Alliance
Coventry and Warwickshire Partnership NHS Trust
ESP Foundation
Faculty of Pharmaceutical Medicine
Friends, Families and Travellers
Gilead Sciences
GSK
Hampshire and Isle of Wight Healthcare NHS Foundation Trust
Health Innovation Network
Homeless Link
LGC Group
Macmillan Cancer Support
Midlands Partnership University NHS Foundation Trust
National Voices
North Central London Cancer Alliance
North West London Integrated Care Board
Novartis
Novartis UK
Patient Information Forum
Patients Association

Context and background

Health inequalities remain a longstanding and systemic feature of health and care in England. They affect health status, access to services, experience of care and outcomes, and are shaped by deprivation, geography, discrimination, exclusion and wider social determinants.[1] Across the NHS and wider policy landscape, there is increasing recognition that reducing these inequalities requires more than identifying variation. It requires action through service design, commissioning, implementation and partnership working. This framing has been reflected across the earlier sessions in this programme, which emphasised that inequities are often reproduced through delivery choices, access routes and information design rather than policy intent alone.

National policy provides a strong foundation for this work. Core20PLUS5 offers a practical structure for focusing effort on the most deprived populations and locally identified groups facing poorer access, experience and outcomes. NHS England's statutory guidance on working in partnership with people and communities also makes clear that engagement should inform planning, design and decision-making rather than sit at the margins of delivery. Alongside this, the NHS 10 Year Health Plan has reinforced the importance of patient power, neighbourhood delivery, prevention and digital transformation, all of which have direct implications for equity.

The challenge is how organisations act on them. Previous sessions in this series[2] highlighted that systems are often better at describing health inequalities than changing how services respond to them. They also showed that progress depends on combining evidence, frontline insight, community knowledge and practical implementation choices.

This creates an important role for collaboration. Health inequalities often sit across organisational boundaries, while the capabilities needed to address them are distributed across NHS bodies, patient organisations, community partners, charities, academia and industry. Industry, in particular, can bring implementation support, project capacity, evidence expertise, pathway insight and innovation capability.

However, cross-sector working also raises legitimate questions around trust, transparency, incentives and governance. For external audiences, this is an important part of the context. Partnership is not inherently positive. Its value depends on whether it is well governed, clearly scoped and demonstrably focused on patient and NHS benefit.

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[1] The King's Fund, *What are health inequalities?*
[2] Royal Society of Medicine, *Epidemiology and Public Health Section*

Context and background

Recent literature reflects this balance. The King's Fund's report on NHS and life sciences industry partnerships argues that collaboration can improve care where there is shared purpose, appropriate governance and robust evaluation.[3] ABPI's 2024 Code of Practice and associated partnership guidance similarly emphasise transparency, disclosure and the need for projects to deliver clear benefits for patients or the NHS.[4] NHS Confederation and ABPI guidance on developing effective NHS-industry partnerships further sets out structured processes for scoping need, establishing governance and monitoring delivery. [5]

Alongside formal partnerships, there is growing interest in how innovation support programmes can help generate solutions that are both implementable and equity focused. NIHR's i4i THRIVE programme is one example of an attempt to bridge this gap by combining funding with entrepreneurial and implementation support, specifically for innovations that address health inequalities. This reflects a broader policy shift towards asking not only whether an innovation works, but who it reaches, who it excludes and what support is needed for it to succeed in practice.

The same principle applies to patient and community partnership. A growing evidence base points to the value of co-production, inclusive communication and patient partnership in shaping services and tools that are more acceptable, usable and equitable.

The Patients Association's Six Principles of Patient Partnership, guidance on co-production from the Health Equity Evidence Centre and wider literature on meaningful patient and public involvement all point to a common conclusion: people affected by service design need influence over how it is shaped.[6] Terms of reference, meeting design, language, reimbursement and decision-making processes are therefore not administrative details. They are part of whether partnership is real.

With this context in mind, this session focused on a practical question: how can diverse stakeholders be connected in ways that lead to meaningful collaboration on health equity projects? The connection sprint format was intended to create opportunities for matchmaking between those with needs, ideas, expertise and implementation capacity. For an external audience, that is the central rationale for this report. It captures presentations from the session and the partnership conditions and support mechanisms that matter if health equity ambitions are to translate into delivery.

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[3] the King's Fund, *NHS and life sciences industry partnerships*
[4] ABPI, *ABPI 2024 Code of Practice*
[5] NHS Confederation, *Accelerating transformation: How to develop effective NHS-industry partnerships*
[6] Health Equity Evidence Centre, *How to… A guide to co-production in the NHS*

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 recommendations and action to be taken.

1. Innovating together: how industry partnerships can support delivery

Presented by the Association of the British Pharmaceutical Industry (ABPI)

This presentation focused on how NHS organisations and industry can work together on defined projects that improve care, while maintaining trust, transparency and appropriate governance.

The Association of the British Pharmaceutical Industry explained its role as the trade association for research-based pharmaceutical companies, representing organisations involved across the medicines pathway from early discovery and clinical trials through to manufacturing, access and uptake. Within that remit, one area of interest is how industry collaborates with the NHS and patient organisations.

The presentation framed this through the idea of a triple win, where partnership can create benefits for:

- **patients**
- **the NHS**
- **industry**

The presentation noted that these arrangements were historically described as joint working and are now more commonly described as collaborative working. The distinction is subtle but important. Earlier definitions focused on patient benefit as the primary driver. More recent guidance allows the primary driver to be benefit to the NHS, provided patient care is at least maintained. In both cases, the core principle is that these are not routine commercial arrangements or substitutes for normal service funding.

Key points from the presentation

- Collaborative working should be built around a specific, defined need, such as improving a diagnostic pathway, redesigning a service model or addressing variation in care.
- Projects should be time-defined, with clear objectives, a clear governance framework and meaningful contributions from both parties.
- These partnerships are not intended to fund business as usual, such as simply paying for an existing role without a defined transformation objective.
- Governance is central. This includes the ABPI Code of Practice, NHS conflict of interest requirements and clear transparency obligations.
- Companies must publish a summary of the collaboration before the project begins, setting out who is involved and who benefits. A summary of outcomes should also be published at the end.
- Collaborative working does not require a competitive tender in every circumstance, though the need for fairness and a level playing field becomes more important at regional or national level.

1. Innovating together: how industry partnerships can support delivery

The presentation also highlighted evidence and case studies intended to show the potential value of partnership. This included ABPI's analysis of NHS-industry partnerships, which found that organisations partnering with industry were more likely to prescribe in line with NICE recommendations. The speaker was careful to note that this demonstrates correlation rather than causation and may partly reflect the characteristics of organisations that are already more improvement focused.

One case study described a pathway developed in response to an identified gap in diabetes detection and management among patients admitted with cardiovascular conditions. The NHS team led the clinical pathway design and delivery, while an industry partner supported the development and implementation of the pathway. This included providing additional capacity, expertise and early-stage support to enable the pathway to be established and delivered within a defined timeframe. The example illustrated how partnerships can help create the headspace and resource required to design and implement pathway changes that clinical teams may not be able to deliver alongside day-to-day service pressures.

Practical guidance and tools highlighted

The second half of the presentation focused on practical resources now available to support partnership development. These included guidance, checklists and templates designed to help organisations move from interest in partnership to implementation.

The presentation described a three-stage model:

- **Scoping**. Identify the unmet need, the evidence base, the intended impact and whether the proposed activity fits the collaborative working model.
- **Set-up**. Establish the project team, governance structure, objectives, timelines and project initiation document.
- **Implementation and monitoring**. Deliver the project, track progress, manage any changes and report outcomes transparently.

If you only read one resource

Partnering for progress: a data-driven analysis of NHS-industry partnerships

2. Invention for Innovation: building equity-focused innovation capability

Presented by NIHR i4i THRIVE

This presentation focused on the role of targeted funding and capability support in helping innovations addressing health inequalities move closer to implementation.
NIHR's Invention for Innovation programme was positioned within a broader landscape of innovation support, including links with SBRI Healthcare and other national initiatives. The central point was that while there are many funding opportunities in the system, there are fewer programmes that combine financial support with structured development for people trying to build and commercialise early-stage innovations. The i4i THRIVE programme was presented as a response to that gap.

What the programme offers

- grants of up to £150,000
- support for academics, clinicians and early-stage innovators
- mentoring, peer support and networking
- online and in-person entrepreneurial training
- a focus on patient benefit
- explicit emphasis on health inequalities

The programme was launched in 2025 and asks applicants to show how their innovation aligns with NHS priorities, particularly through the Core20PLUS5 framework and wider ambitions to reduce inequalities. Applicants are also expected to think about environmental sustainability and support for net zero goals.

Key points from the presentation

- There is no shortage of ideas in this space, but there is a shortage of support that helps innovators translate ideas into viable, implementable solutions.
- Health inequalities should not sit at the margins of innovation design. They should shape what is developed, how it is tested and how success is defined.
- Data needs to be used more effectively to understand where inequalities exist and whether innovations are helping to narrow them.
- Innovators need stronger incentives and support to make deeper commitments on equity, rather than treating it as a light-touch criterion.

The speaker noted that the first round attracted nearly 100 applications across a wide range of clinical areas, with eight applicants selected from across the UK. Participants are supported using the European EntreComp framework, which focuses on entrepreneurial capability and continuous improvement.

Opportunity highlighted

The next round, THRIVE 2.0, is open from **12 March to 17 April 2026**.
This presentation added an important dimension to the session. While the ABPI presentation focused on partnership as a route to implementation, THRIVE focused on the earlier stages of innovation development and the support needed to create solutions that are relevant, scalable and equity-focused from the start.

If you only read one resource

i4i THRIVE

3. Invention for Innovation: building equity-focused innovation capability

Presented by Cheshire and Merseyside Cancer Alliance

This presentation focused on a practical challenge that is well recognised across the system. Many people understand what health inequalities are but feel less clear about what to do about them in their own role.

Health inequalities were described as a problem the system is good at mapping, measuring and publishing, but less good at embedding into everyday decisions. For many teams, equity still feels like something owned by strategy or policy functions rather than part of day-to-day care design. The Cheshire and Merseyside Cancer Alliance introduced the 123 approach as a response to that gap.

Core proposition
The 123 approach is a behavioural change model built around a simple principle: **change one thing.**

Rather than asking people to solve health inequalities in the abstract, the model asks them to identify one concrete, feasible change within their own sphere of influence that could reduce exclusion or improve access.

Examples given included:
- changing how information is shared
- redesigning a process that filters some people out
- adjusting how appointments are offered
- identifying and addressing assumptions that disadvantage underserved groups

The three elements of the approach
1. **Training**. CPD-accredited training focused on understanding barriers and making a practical pledge to change one thing.
2. **Tools and frameworks**. Resources that help participants identify where barriers exist and what realistic changes are possible.
3. **Support and shared learning**. Ongoing networks and support to help people implement their change and maintain momentum.

The speaker argued that this matters because many staff are overwhelmed by the scale of the problem, uncertain where responsibility begins and ends, or concerned about getting it wrong. A practical and bounded model helps turn equity into something manageable and actionable.

Key points from the presentation

- Equity becomes more real when it is tied to actual decisions, processes and interactions.
- Small changes can matter when they are deliberate, visible and accountable.
- Trust with communities is strengthened when feedback leads to tangible change, even if modest.
- The point of lived experience is not simply to create empathy. It is to reveal where systems and assumptions are producing avoidable disadvantage.
- Examples discussed included barriers to cancer screening for women facing cost, isolation, cultural barriers or language barriers. These were used to show how design decisions can quietly favour those already well served by the system.

The presentation suggested that the strength of the 123 approach lies in reframing equity. It becomes part of how quality is understood and delivered, rather than an additional burden sitting alongside core work.

If you only read one resource

123 approach

4. What good partnership looks like: developing terms of reference with patients

Presented by the Patients Association

The final presentation focused on how to make partnership with patients and communities real in practice, using the example of terms of reference and group design.

The presentation challenged a common assumption that terms of reference are mainly about meeting management. Instead, the speaker argued that they are a practical expression of whether people are genuinely being invited to shape the work as partners.

The starting point was clear. If organisations want to hear from people whose voices are often missing, they need to think carefully about how partnership is structured from the outset. This means being explicit about ownership, power, accessibility, language and trust.

Key points from the presentation

- Patients and communities know what makes services hard to access and what gets in the way of people engaging.
- Partnership cannot be genuine if organisations arrive with a finished document and ask people to comment on it after the fact.
- Terms of reference should support shared ownership and be revisited regularly.
- Accessibility is practical as well as conceptual. Meeting times, reimbursement, language and format all matter.
- Trust and transparency are becoming more important in a context where public confidence is fragile.

The speaker gave several practical examples of where simple changes can make a meaningful difference.

Practical examples discussed

- avoiding standard 9 to 5 meeting times where these exclude working people or carers
- ensuring there is a clear reimbursement process for patients contributing their time
- using plain English and avoiding unnecessary jargon
- involving patient partners in checking whether materials are actually understandable
- developing tools such as jargon-busting dictionaries to make participation easier

A particularly important theme was that patients are experts in the impact of illness and services on their lives. That expertise should shape the rules of engagement, not simply be invited into a framework already designed by professionals.

This presentation provided an important complement to the earlier sessions in the programme. Previous reports highlighted the importance of patient voice, inclusive information and co-production in reaching underserved groups and implementing change equitably. This session extended that argument by focusing on the partnership conditions that make meaningful involvement possible.

If you only read one resource

The Six Principles of Patient Partnership

Closing note

Closing note

The session used a structured connection sprint format, with participants rotating through facilitated, time-limited table discussions focused on specific equity challenges or capabilities, where they set out the problem or population group they were focused on, what they could offer and what they needed from others to progress.

Through this process, a consistent set of requirements for effective collaboration became clear. Stronger progress on health equity depends on five linked capabilities:

- the ability to form well-governed cross-sector partnerships around defined needs
- accessible routes to innovation funding and development
- practical tools that help staff act on equity within their own roles
- partnership models that give patients and communities genuine influence
- structured opportunities to connect these elements early, rather than trying to align them later

The session reinforced that progress is most likely where partnership is intentional, disciplined and designed around real delivery challenges.

Additional resources

Association for the British Pharmaceutical Industry (ABPI):

- NHS-Industry Partnership Case Studies Library
- ABPI 2024 Code of Practice
- Working together: a handbook for industry and patient organisation partnerships
- Partnering for progress: a data-driven analysis of NHS-industry partnerships

Aggarwal A. *Collaborate to innovate: Partnerships with industry can deliver for patients. British Society for Immunology, 20 December 2024.* https://www.immunology.org/news/collaborate-innovate-partnerships-industry-can-deliver-patients

Attal B, Leeding J, van der Scheer JW, Barry Z, Crookes E, Igwe S, Lyons N, Stanford S, Dixon-Woods M, Hinton L. *Integrating patient and public involvement into co-design of healthcare improvement: a case study in maternity care. BMC Health Services Research. 2025 March 7;25(1):352.* **https://doi.org/10.1186/s12913-025-12423-3**

Cheshire and Merseyside Cancer Alliance:

- How our 123 Approach is helping to confront health inequalities in cancer care
- Link to the training
- Cheshire and Merseyside Cancer Academy

Dews SA, Bassi A, Buckland S, Clements L, Daley R, Davies A, Evett S, Howland S, Kinloch E, Phillips B, Powell G, Preston J, Sterniczuk K, Bohm N. *Characterising meaningful patient and public involvement in the pharmaceutical industry research setting: a retrospective quality assessment. BMJ Open. 2023 August 23;13(8):e071339.* https://doi.org/10.1136/bmjopen-2022-071339

Dews SA, Corner L, Butfield R, Araghi M, Monelle H, Westergaard P, Moloney S, Wontor V, Campbell Burton A; *PPIE panel. Co-creating tools for embedding meaningful patient and public involvement and engagement in real-world data and evidence research in the pharmaceutical industry setting: a multistakeholder participatory co-design study. BMJ Open. 2025 February 17;15(2):e088914.* https://doi.org/10.1136/bmjopen-2024-088914

European Commission:

EntreComp: The entrepreneurship competence framework

Health Equity Evidence Centre:

How to: A guide to co-production in the NHS

Health Innovation Network:

- Forging a more equitable future through Patient and Public Involvement and Engagement
- Innovation for Healthcare Inequalities Programme Impact and learning report

Healthcare Leader:

- The power of collaborating with the VCSE to tackle health inequalities
- Partnership working with the voluntary sector

Hung L, Wong KLY, Rasekaba T, Ren LH, Douglass D, Slatter S, Berndt A, Blackberry I. *How can equity, diversity, and inclusion (EDI) principles be incorporated into research excellence with industry and community partners? Lessons learned from Canada and Australia on projects with a dementia focus. Research Involvement and Engagement. 2024 October 17;10(1):106.* https://doi.org/10.1186/s40900-024-00644-5

King's Fund:

- NHS And life sciences industry partnerships: collaborating to improve care
- Actions to support partnership: Addressing barriers to working with the VCSE sector in integrated care systems

Additional resources

Munce SEP, John T, Luong D, Mooney S, Stromquist L, Chambers K, Crabtree M, Diaz S, Dimitropoulos G, Henze M, Higgins A, Li E, Severino SM, Penner M, Pidduck J, Wan M, Williams L, Yates D, Toulany A. *Establishing Effective Patient Engagement Through a Terms of Reference to Foster Inclusivity and Empowerment in Research: Example From a Healthcare Transition Quality Indicators Project. Health Expect. 2024 December;27(6):e70113.* https://doi.org/10.1111/hex.70113

National Institute for Health and Care Research (NIHR):
Invention for Innovation (i4i) THRIVE (translate Healthcare Research through InnoVation and Entrepreneurship)

Nelson MLA, Saragosa M, Miller R. *The Third Sector in Integrated Care: Partner, Provider, or Both? International Journal of Integrated Care. 2024 July 22;24:9.* https://doi.org/10.5334/ijic.8149

NHS Confederation and ABPI:
- How to develop effective NHS-industry partnerships
- Partnering with purpose: how integrated care systems and industry can work better together
- Working together: Guidance to support transformative pharmaceutical industry partnerships with the NHS in Wales (Welsh NHS Confederation)

NHS England:
- Fit for the future: 10 Year Health Plan for England
- Working in partnership with people and communities: statutory guidance
- Core20PLUS5 (adults) – an approach to reducing healthcare inequalities
- Voluntary, community and social enterprises (VCSE)

NHS Providers:
Co-production and engagement with communities as a solution to reducing health inequalities

Office for Health Improvement and Disparities (OHID):
Inclusion health data and intelligence resource for England

Patients Association:
- The Six Principles of Patient Partnership
- Engaging patients to understand their experiences and expectations of rewards, recognition and remuneration for patient involvement
- Improving health equity for patients living with cancer and/or blood disorders
- Advancing Health Equity Through CORE: A New Approach to Inclusive Communication
- Removing barriers to shared decision making
- Being A Patient

Pope R, Zenonos A, Bryant W, Spiridou A, Key D, Patel S, Robinson J, Styles A, Rockenbach C, Bicknell G, Rajendran P, Taylor AM, Sebire NJ. *Real-world learnings for digital health industry-NHS collaboration: Life sciences vision in action. Future Healthcare Journal. 2024 August 8;11(3):100168.* https://doi.org/10.1016/j.fhj.2024.100168

Royal Society of Medicine:
- Community for Health Equity: Reaching the unreached
- Community for Health Equity: Implementing the 10 Year Health Plan

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