Healthy Communities Together: Challenges Launching Experiments

HCT
Healthy Communities Together

Introduction

During the second phase of Leeds' Healthy Communities Together partnership, we were able to move beyond Adaptive Action, to design opportunities for marginalised community members to address the complex health inequalities they'd identified. By empowering local stakeholders from marginalised communities to co-design and implement healthcare variations, we aimed to test, learn, and feedback into the system in order to create sustainable change. The HCT project was able to plan, develop and resource these ideas: experiments, which would improve accessibility, focussing on primary care. However, the implementation of these experiments revealed several persistent and systemic challenges. This report outlines the common difficulties experienced in launching HCT experiments across the board, highlighting recurring themes that have impacted progress regardless of the specific nature or focus of individual initiatives.

COMMUNITY FUND

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The Experiments

Experiments were co-designed by community members following the Primary Care Adaptive Action in March 2023. After carrying out the Adaptive Action attendees were asked to look at the 5 A's of access: approachability, acceptability, availability, affordability & appropriateness. From the rich discussion held, ideas for pilotable changes in primary care were put into a top five list.

The ideas included:

- **Funding extra GP capacity for a period of time, with first come first served, queue in surgery to access the appointment in order to learn what this would do to waiting time and early morning phone rush.**

- **Supporting extra time in appointments in order for clinicians to ask further questions of marginalised community members to 'check back their understanding'. This experiment was led by our consultant partner Nifty Sustainability. The in-depth case study report can be found on our website**

- **Trialling a staff role: Welcome Workers, in Primary care waiting rooms, employed from marginalised communities, to improve welcome and care navigation.**

The preliminary work on experiment ideas can be found in Appendix 1. The fifth experiment was about communication needs in primary care and later became a focussed Adaptive Action on Translation services: the full report can be found on our website. Whilst some experiments were not continued, a sixth was designed around developing a fully tried and tested gold standard Trans and Non-binary training programme for health care; the full report can be found on our website

Challenges:

1. Leadership and Coordination Gaps

One of the most significant barriers has been leadership discontinuity. The departure of key personnel—particularly those responsible for coordinating experiment activities—resulted in substantial delays. In some instances, valuable institutional knowledge was lost due to inadequate documentation and knowledge transfer. This made it difficult for new team members to regain momentum, leading to the stagnation or discontinuation of several promising initiatives.

2. Resistance to Change

Systemic inertia within healthcare organisations has frequently obstructed efforts to pilot new approaches. Stakeholders—often under pressure from existing operational demands—expressed hesitation or outright resistance to adopting unfamiliar practices. This was experienced even when the risks had been minimised through HCT providing the funding HCT holding the employment responsibilities and HCT taking leadership accountability too. Change aversion, particularly in risk-averse environments like healthcare, has made it difficult to move beyond the planning phase of many experiments.

3. Competing Priorities and External Disruptions

Experiments often struggled to gain traction in the face of competing demands on partners' time and attention. External events such as public health emergencies, infrastructure changes, and ongoing service delivery obligations frequently diverted resources and focus away from experimental work. In one case the Primary Care partner was unable to support the experimental opportunity, as the experiment topic was adjacent to a staff training and supervision issue they'd identified. HCT experiments were unable to meet such needs as they were focussed on marginalised community member access to services. Even when stakeholders were enthusiastic in principle, shifting priorities left limited bandwidth to engage meaningfully in implementation.

4. Timeframes and Funding

Despite the experiments being co-designed with marginalised community members in 2023, and interested practices identified soon after, the iterative, adaptive nature of experimental work needed longer time to grow than was possible under the HCT funding structure. The HCT funding ended, in it's current form, June 2025. Funding allocated to the experiments: approximately £10,000 each project, could have supported valuable pilot projects lasting a month or two. More short-term experiments might have been successfully carried out; understanding the value of such 'quick and dirty' learning opportunities, were it not for some of the other challenges described in this report. Experiments were never intended to be long term strategies; to invest in infrastructure or sustain stakeholder engagement over time however these descriptors were often reflected back to the project as reasons not to give the proposals a try.

5. Structural and Bureaucratic Barriers

Administrative processes and governance structures within partner organisations were not always conducive to experimentation. Delays in securing approvals, navigating compliance protocols, and coordinating across institutions added layers of governance that slowed or derailed progress. These challenges were exacerbated when proposed experiments fell outside standard operational procedures.

Conclusion

Launching healthcare experiments through the HCT initiative revealed a range of systemic and organisational barriers. While individual experiment designs were often strong and always community-rooted, external and internal systems constraints impeded their execution. Only through systemic support can experimental initiatives achieve meaningful and lasting impact in transforming health outcomes.

Appendix 1: Five Experiments Notes in Development

Approach:

Experiment – we have gathered ideas from our population groups, we are asking primary care to come with us on a journey of experimenting with these ideas. Where could we try these things on a small scale to test their effectiveness? We want to remain agile and not tie ourselves into lengthy processes before we have proven our concepts.

The ideas are simple, they are human, they are things we already do in part and probably want to do more of. How can we empower staff across primary care to try work differently for a period of time and reflect on its impact?

Overarching principles through our work:

Equity not Equality

People have different starting points and one size fits all is not equality yet our systems are often rigid. We have been successful in designing systems better for certain access needs or elderly patients, how do we apply these principles to inclusion health groups?

User centred design

The people that use our systems know how to make them better; we must collaborate to make best use of our resources. We need to build practice around getting representative patient populations involved in designing our practices.

The NHS is for everyone

This is our starting principle – different access needs should be accommodated, and compassion should be at the start and end of our design.

Our Top 5 Ideas for Experiments:

Experiment 1: Checking back understanding

Marginalised communities tell us they often don't understand their conditions, medications or referrals. Could more time be given in appointments to take an open questions approach to assessing what someone has actually taken away from an interaction?

Experiment 2: Involving patients and patient representatives in design

Marginalised communities tell us that the way systems are design make them feel unwelcome. How do we zoom out and look at how people experience our systems?

Experiment 3: Welcome Workers

Marginalised communities tell us that they want to feel welcome and that barriers of literacy, language, screens, phones, desks, glass, security guards interrupt their ability to engage. What if we reimagined a patient journey through a surgery to include a dedicated welcome and navigation function? What if that person had lived experience or a community language so they could relate to the people they are helping?

Experiment 4: Registration

Marginalised communities tell us that there are multiple barriers to them registering, including ethnicity, ID, practice boundaries and temporary registrations. How can we embed a no wrong door approach?

Experiment 5: Communication Needs

Marginalised communities tell us that communication is a key factor in their poor health outcomes. We have been successful at recording and responding to some communication needs (hearing impairment, learning disability) but not others (literacy, language, chaotic lives). How can we use system one to better record and action communication preferences? For example, always call, text me, whatsapp voice notes, no letters.

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