Evaluation of the Health Equity Team Programme in Lewisham

Health Innovation Network South London

In partnership with Centric Community Research

April 2025

@HINSouthLondon

healthinnovationnetwork.com

Health Innovation Network South London

Centric

Foreword

Lewisham is on a journey to achieve health equity, and the Lewisham Health Equity Team programme has been an important part of our ongoing work to ensure that everyone in Lewisham has a fair opportunity to attain their highest level of health.

Following on from the publication of the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) and subsequent launch of the Lewisham Health Inequalities and Health Equity programme in 2022, this innovative initiative was developed. It built on learning from an initial Health Equity Fellowship in North Lewisham Primary Care Network and the BLACHIR report to bring clinicians and community groups together to work within teams to address health equity at neighbourhood level.

Though an ambitious and challenging undertaking, I am pleased to see what the Health Equity Teams have achieved in a relatively short space of time. The valuable learning that has been gleaned through the programme and this evaluation is of great benefit for ongoing health equity work in the borough.

It has been a privilege to witness the unwavering commitment of voluntary and community sector partners and primary care clinicians to achieve health equity for Lewisham residents, so I would like to thank all of the pioneering Health Equity Teams for their work.

I would finally like to pay tribute to a member of the programme team, Lisa Fannon, who sadly passed away before this evaluation was finalised. Lisa played an instrumental role in this work and leaves a strong legacy with all of those that she worked with in this programme.

Dr Catherine Mbema, Director of Public Health, Lewisham

About the Health Innovation Network South London

This evaluation was led by the Health Innovation Network South London (HIN) on behalf of Lewisham Council.

The HIN is the health innovation network for south London, one of 15 across England. We are the bodies uniquely established to connect NHS and academic organisations, local authorities, the third sector and industry, in order to increase the spread and adoption of innovation across large populations, at pace and scale.

The HIN is embedded within and understands south London's health and care system. We bring a wealth of experience in delivering real-world evaluations of health and care programmes in south London (and beyond) that provide insights and actionable recommendations.

Acknowledgements

The evaluation would not have been possible without the scale of input from the health equity teams. We thank all participants who took part in this evaluation who generously shared their experiences of the programme, and particularly the voluntary and community sector organisations, community champions and health equity fellows.

The HIN partnered with Centric Community Research (Centric) on the evaluation. They are a community-led research organisation, building the capacity and capability of local communities to get involved in research. We would also like to thank the following staff at Centric: Muhammed Rauf, Paul Addae and Sophie Johnson St-Vie for their input in the evaluation.

Finally, we would like to thank the programme management team: Dr Aaminah Verity (South East London Integrated Care Board), Dr Catherine Mbema (Lewisham Council), Jason Browne (Lewisham Council), Lisa Fannon (Lewisham Council), Naomi Alexander (Lewisham Council) and Piers Johnson (Lewisham Council).

Centric's Community Research Model

Centric recruit, train and upskill researchers from local communities who solve local problems through research.

- They are part of the communities being served.
- Their team has a diverse range of skills, cultural backgrounds and expertise.
- They have a bespoke ethics approval process that champions community consent and ownership.
- Their model has been designed and is run by community researchers themselves.
- Their programme is accessible and offers unique progression routes for community researchers.

COMMUNITY LED AND OWNED | **AUTHENTIC INSIGHT** | **CULTURALLY NUANCED**

Glossary

Term and acronym	Definition and meaning
Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR)	A joint research project between Lewisham and Birmingham City Councils. It has begun ground-breaking work to gather insights on health inequalities experienced by Black African and Caribbean communities.
Core20PLUS5	A national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.
Health Equity Team programme (HET)	An innovative model that aims to address health inequalities for the Black African and Black Caribbean community in Lewisham. This is the programme being evaluated.
Health Innovation Network South London (HIN)	The health innovation network for south London and the team commissioned to carry out the evaluation.
Hemoglobin A1c (HbA1c)	HbA1c is the haemoglobin in the red blood cells that has glucose attached to it. If the blood glucose levels are high the HbA1c will be high. If the blood glucose levels are low, the HbA1c will be low.
Human immunodeficiency virus (HIV)	A virus that damages immune system cells and weakens the body's ability to fight everyday infections and disease.
Primary care network (PCN)	They are groups of practices working together and with other local health and care providers (e.g., hospitals, mental health or community trusts, community pharmacies and charities) within what are considered natural local communities, to provide coordinated care through integrated teams. There are six in Lewisham.
South East London Integrated Care Board (SEL ICB)	The statutory NHS organisation in south east London responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the integrated care system area.

Contents

Executive summary

Executive summary

Lewisham Council commissioned the Health Innovation Network South London to undertake a summative, largely qualitative, evaluation of the Health Equity Team programme.

The Health Equity Team programme implementation

- The programme was piloted for just over 18 months in Lewisham, with joint oversight from Lewisham Council and the South East London Integrated Care Board.
- Six health equity teams were formed, bringing together Black-led voluntary and community sector organisations and primary care health equity fellows to address locally identified health inequalities in Lewisham.
- Teams developed a rich understanding of place and community through population level data analysis and community engagement.
- They delivered a range of activities, including health fairs, health promotion workshops, culturally tailored programmes and workforce training.

70+

Community champions

2500+

Residents reached

Teams experienced some co-production challenges initially, albeit there was a clear consensus about how to achieve meaningful co-production in the future.

Effective collaboration, leveraging community resources and strong relationships facilitated project delivery.

Executive summary

Action for Community Development & Aplos Health Primary Care Network

- Community health and wellbeing awareness programme
- Focus on mental health, long-term conditions and racism

Downham Dividend Society Community Land Trust, Social Life & Sevenfields Primary Care Network

- Community based research and listening
- Mobile health clinics and targeted health promotion events

Holistic Well Women & Lewisham Alliance Primary Care Network

- Community outreach and mental health workshops
- Local form filling events offering health checks, advice and educational tutorials

Red Ribbon Living Well & North Lewisham Primary Care Network

- Community survey on health concerns and barriers
- Health hubs and checks
- HIV stigma training

Therapy 4 Healing & Modality Primary Care Network

- Community listening and engagement
- Health fairs and events
- Evidence-based complementary health clinic

360° Lifestyle Support Network, Mabadiliko & The Lewisham Care Partnership

- Community-led, culturally-tailored group consultation programme for Black and Asian people living with type 2 diabetes

Executive summary

Programme impact and learnings

- The Health Equity Team programme directly addressed the opportunities for action highlighted in the Birmingham and Lewisham African and Caribbean Health Inequalities Review. It made direct investments in Black-led organisations and community champions, and improved access by bringing healthcare services directly to the community.
- A cohort of health equity leaders were developed throughout the programme, reigniting a health equity focus in primary care. They played a pivotal role in starting to transform care pathways, while growing personally and professionally as population level health leaders.
- The programme evaluation revealed broader learnings, highlighting the need to focus on defined outcomes, enhance programme management and prioritise sustainability.

Recommendations

- The evaluation providers key insights to guide future iterations and maximise the programme's potential in addressing health inequalities in Lewisham.
- The recommendations focus on three core areas:

Strengthening partnership working for health equity teams

Improving health and wellbeing outcomes for Black African and Black Caribbean residents in Lewisham

Streamlining programme processes and learning

About the programme and evaluation

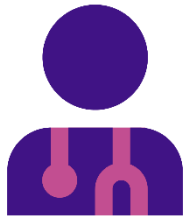
About the Health Equity Team programme

The Health Equity Team (HET) programme is an innovative, integrated care, partnership model that aims to address health inequalities for the Black African and Black Caribbean community in Lewisham.

The programme brought together Black-led voluntary and community sector organisations and primary care health equity fellows to form health equity teams for each of Lewisham's six primary care networks (PCNs). Teams were tasked with co-producing a project to address locally identified health inequalities. The model was piloted for just over 18 months, with joint oversight from Lewisham Council and the South East London Integrated Care Board (SEL ICB).

The programme sits within Lewisham Council's Health Inequalities and Health Equity Programme 2022-24. This broader strategy is supported by SEL ICB funding and is the key programme of work to support, prioritise and implement the recommendations from the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR).

Programme timelines



October 2022

Health equity fellows were recruited for their PCNs. This was led by the SEL ICB community of practice lead, with fellow's contracts held by individual PCNs. In-house training took place from October to January 2023, and external training was delivered January to December 2023 by King's College London.

March 2023

Voluntary and community sector organisations were commissioned by Lewisham Council's public health team to partner with the community, health equity fellows and the PCN. Their contracts were managed by Lewisham Council.

June 2023

Most teams were formed, bringing together the voluntary and community sector organisations and health equity fellows to co-produce and implement a health inequalities focussed project.

September 2024

Health equity team programme pilot ended.

About the evaluation

Lewisham Council commissioned the HIN to undertake a summative, largely qualitative, evaluation. The evaluation aimed to inform the recommissioning of the HET programme, due to start in 2025.

Evaluation objectives

This evaluation explored the implementation and impact of the HET programme through the following evaluation questions:

Implementation

- How has the HET programme been implemented overall? Were there **adaptations** made to suit the **specific needs** of different PCNs?
- How has the HET programme resulted in cross-sectional learning and **partnership collaboration** between PCNs and voluntary and community sector organisations?
- What were the **essential features** of both programme-level and team-level delivery that enabled success?

Impact

- Has the HET programme been successful in responding to **BLACHIR priorities**?
- Have and how health equity fellows become **leaders on health equity** within their PCN?
- Has the HET programme resulted in any **wider changes** to existing practices and/or any **wider learning**?

About the evaluation

Evaluation design

Evaluation activities took place between September-December 2024.

The HIN partnered with Centric Community Research to conduct the fieldwork with the voluntary and community sector organisations, given their strong community research expertise. Interviews were attended by both Centric Community Research and HIN to gain a holistic view.

Cross critical case and thematic analysis were employed, and recommendations were formulated in partnership with Centric Community Research and the programme management team.

Limitations

The evaluation is limited by patient perspectives, input from few community champions and robust quantitative data.

Key evaluation activities

Focus groups
- Programme management team
- Lewisham primary care leaders

Document review
- Programme level resources
- Impact reports and presentations

Interviews
- Six health equity fellows
- Six voluntary and community sector organisations
- One community champion
- One PCN community link worker
- One BLACHIR community partner



Implementation insights

Delivering the HET programme

The phased roll-out hindered co-production

The HET programme was rolled out in phases. After the fellows were recruited and trained, voluntary and community sector organisations were commissioned. Teams were then formed. From the outset, there was a disconnect between the voluntary and community sector organisations and fellows regarding the co-production of initiatives. Some voluntary and community sector organisations and health equity fellows had already independently designed projects, while some anticipated a more collaborative, joined up approach initially. This misalignment hindered the co-production process.

There was a clear consensus from the teams about how to achieve meaningful co-production.

Start the journey together, at the same time

They wanted the chance to get to know one another personally and professionally and understand the expectations of co-production. They wanted to be open and honest about their individual motivations.

Facilitate a round table discussion to co-produce their project

Teams wanted to avoid bringing fixed ideas, and to collectively write and design their approach instead.

Establish a clear partnership approach from the outset

Through open dialogue they wanted to agree expectations around roles, responsibilities, communication, and time commitment. This was to ensure alignment and facilitate smoother project delivery.

> “Let's start from the beginning together. Let's find out about each other's story. Let's find out about each other's (…) backgrounds and where we're coming from so that we can kind of work together.
>
> Health equity fellow

Effective collaboration was a critical success factor

Collaboration was a defining feature of the HET programme. Whilst a few teams developed an equitable and professional working relationship, the majority experienced challenges, with one team parting ways entirely.

There were several barriers to developing a successful partnership between voluntary and community sector organisations and health equity fellows. This ranged from fundamental structural and systemic issues, including the distribution of power, as well as differing communication and working styles. These challenges, in some cases had an emotional impact on individuals, underscoring the importance of incorporating a trauma-informed approach to provide appropriate support.

Many teams, overtime, established good working relationships. Key facilitating factors are outlined as follows.

Understand each other and commit to the programme's ethos

- Cultivate the right attitude and self-awareness.
- Understand each other's patches and strengths.
- Maintain a shared focus on the programme's ultimate goal.

Support from the programme management team and other stakeholders

- Inclusive communication and decision-making.
- Proactive conflict resolution and trust building.

Practical and standardised processes to enhance collaboration

- Early engagement and regular communication.
- Dedicated time for developing professional relationships.
- Structured project management.

> "She [voluntary and community sector organisation] took me around Lewisham…and gave me like a tour and like the history of kind of social prescribing and neighbourhoods (…) she really educated me from a community perspective.
>
> Health equity fellow

> "Everyone was happy because they can't do anything without consult[ing] me and I can't do anything without consult[ing] them. So we build this good (…) partnership.
>
> Voluntary and community sector organisation

Community levers and fostering strong relationships facilitated project delivery

A range of activities were delivered as part of the HET programme. This ranged from health fairs, health promotion workshops to culturally tailored programmes and workforce training. Recruitment and training of community champions was a consistent approach. Many also conducted community engagement activities to build relationships, map assets and understand local priorities. Individual team projects are showcased further in this document.

Teams reflected on the factors that challenged their project delivery. They identified issues around funding, clinical accountability, as well as the need for realistic community-led solutions that prioritise active participation and authentic community engagement over passive consultation. The need to optimise clinical resources, given the administrative burden, was also commonly reported.

On the contrary, successful delivery was enabled by:

Leveraging community expertise

- Data driven and deep understanding of community.
- Momentum and cultural competency from the voluntary and community sector.
- Multi-agency working, signposting and addressing the social determinants.

Engaging key stakeholders

- Involve community and health stakeholders early to bring them along the journey.
- Maximise and leverage community champion input.
- Build meaningful connections.

Effective programme design and delivery

- Draw on existing spaces and groups.
- Develop multiple patient recruitment strategies to maximise reach.
- Be agile, flexible and encourage iterative learning.

Community levers and fostering strong relationships facilitated project delivery

> Let's actually build a proper project. Let's sit down and say, 'where do we want to be in five years?'
>
> Voluntary and community sector organisation

> I (…) used all of the networks (…) that we have here and (…) we were able to access hundreds of people because it was a community event.
>
> Voluntary and community sector organisation

> We chose to engage residents in kind of pre-existing groups rather than trying to put on events and trying to get people to come, but we didn't want to do something new, we wanted to go to where the people already were.
>
> Health equity fellow

Impact and wider learnings

Opportunities for Black-led organisations to contribute to NHS service delivery, improving outcomes for residents

The HET programme worked towards addressing some of the fundamental areas that need to change to close the inequality gap and improve outcomes for Black African and Black Caribbean communities. There is a clear link to the BLACHIR opportunities for action (OfA) and specifically towards:

- Providing investment in Black African and Black Caribbean grass roots organisations (OfA 29 and 34).
- Partnering with them to co-create and deliver culturally appropriate and accessible support (OfA 35).
- Raising awareness and providing targeted services to increase access and uptake (OfA 27 and 35).

The initiatives delivered cut across the BLACHIR themes and achieved the following outcomes.

Improving access by bringing healthcare to the community	• Invested in and developed multi-service hubs and pop-ups in the community. • Provided an equal footing and addressed wider social determinants of health. • Leveraged existing resources and expanded their reach by engaging individuals and organisations from other localities.
The growth of community champions	• Pivotal and instrumental role in project execution. • Personal and professional development, including enhanced healthcare knowledge, strengthened community leadership skills and increased confidence.
Gains for voluntary and community sector organisations	• Direct investment in Black-led organisations. • Reported impact ranged from broadened and strengthened relationships, raised profile and cause awareness, scope to consider further funding.

Opportunities for Black-led organisations to contribute to NHS service delivery, improving outcomes for residents

> The investment we've put in, (…) hopefully that enables them to go on and secure different funding in different areas or come back and work with us again. But that growth is something that I just think you can't put a price on. It is priceless for me.
>
> Programme management team

> What was really, good, was about the community health champions, who we recruited locally, their learning process was great, you know, and seeing the change in them.
>
> Voluntary and community sector organisation

> It's like a one stop shop and it was in the community rather than in a clinical setting. Patients felt it was really useful.
>
> Health equity fellow

A cohort of health equity leaders were developed

The HET programme cultivated a cohort of clinical leaders equipped with a population health perspective to effectively address local health inequalities. Key outcomes reported are highlighted below.

Re-invigorating Lewisham PCNs' focus on addressing health inequalities	Contributing to care pathway transformation	The personal growth and development of health equity fellows
The health equity team model began to establish sustainable capacity within primary care to address health inequalities. It supported PCNs to: • Raise awareness of health inequalities. • Engender movement and cultural change amongst primary care leaders. • Prioritise managing the health of Lewisham residents through a health equity lens.	Fellows recognised that their work represents a gradual step towards systemic change and care pathway transformation. They observed that the seemingly small-scale adaptations implemented throughout the programme yielded a broader impact. These adaptations included: • Facilitating direct engagement between GPs and community initiatives. • Leveraging the expertise of community organisations to deliver training to GPs and encourage open dialogue regarding health inequalities. • Tailoring and adapting primary care resources to be culturally accessible. • Reassessing primary care procedures.	Fellows described their involvement in the programme as a profoundly transformative experience, with its significant personal and professional rewards. It supported them to live and spread their passion, make a wider difference, and build connections. Through this, they also learnt from each other and developed their leadership skills.

A cohort of health equity leaders were developed

> It was really good to have a dedicated person to do some outreach work and look at prevention as a positive thing, rather than something that there was no resource for (…). Reach[ing] out into communities who weren't coming to the practice. So the whole concept was invigorating.
>
> Primary care leader

> So personally, I love the job because sort of the networks across the local community, across the whole of Lewisham borough, with the other PCNs, and the other fellows. I thought that was it (…) was really great and actually just like professionally, personally that was a real positive for me.
>
> Health equity fellow

Wider learnings for the programme

Beyond their specific health equity team work, participants identified valuable programme learnings and opportunities to further improve health outcomes for Lewisham residents. These were primary centred around outcomes, programme management and sustainability.

A clearer focus on achieving defined outcomes

Project stakeholders emphasised the need for clearly defined key performance indicators and measurable outcomes, coupled with more rigorous monitoring to demonstrate return on investment. As part of this, there should be standardisation and alignment with primary care leaders.

Improving overall programme management

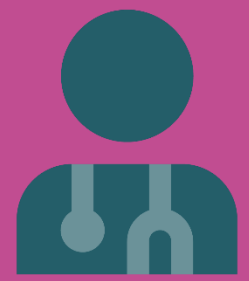
The first iteration of the programme provided valuable learning opportunities, revealing areas for improvement in programme management, particularly around aligning leadership aims, optimising monitoring meetings and enhancing programme visibility and impact.

Not losing sight of sustainability

Several perspectives on programme sustainability highlighted the importance of continued investment. Key considerations mentioned by participants included:

- Programme continuation to achieve its full potential and deliver lasting impact.
- Knowledge retention to safeguard against learning loss.

> “What more can we do to […] outwardly promote what we are doing, because I think this stuff […] snowballs.
>
> Primary care leader



Conclusion and recommendations

Conclusions and recommendations

The HET programme demonstrated the value in fostering partnership working between the primary care sector and voluntary and community sector organisations.

While the teams faced some implementation and delivery challenges and impact could not be robustly demonstrated across all projects, all participants recognised the value of enabling small voluntary sector, Black-led organisations to directly contribute to NHS service delivery to improve the outcomes of Lewisham residents.

The evaluation offers key learnings to guide future iterations and ensure the programme reaches its full potential to address health inequalities in Lewisham.

The recommendations were developed in collaboration with Centric Community Research and the programme management team. They aim to inform delivery of the second iteration of the programme and centre on three core areas:

1. Strengthening partnership working for health equity teams.
2. Improving health and wellbeing outcomes for Black African and Black Caribbean residents in Lewisham.
3. Streamlining programme processes and learning.

The programme management team is actively exploring ways to integrate and apply these recommendations in the next phase of the programme.

1. Strengthening partnership working for health equity teams

Improve programme roll out

To achieve a cohesive and equitable start, the programme should:

- **Foster shared understanding of the programme objectives and expectations** from the outset, especially around co-production.
- **Synchronise recruitment** of voluntary and community sector organisations and health equity fellows, if possible.
- **Refine the application** to assess an understanding and commitment to co-production principles, leadership and collaborative capabilities, and knowledge of the local community and health inequalities.
- **Continue the application support** to further build organisational capacity.
- **Broaden recruitment reach** to attract a diverse and larger pool of applicants.
- **Enhance pre-launch engagement** to address questions, concerns, and potential challenges proactively.

Support co-production

To achieve meaningful co-production, the programme should:

- **Offer joint training sessions** to build a shared understanding and skills.
- **Partner with independent experts to guide teams** in co-production principles and practices, ensuring equitable power-sharing.
- **Promote collaborative proposal development**.

1. Strengthening partnership working for health equity teams

Prioritise team onboarding

To build strong, collaborative partnerships and to avoid the silos observed, the programme should:

- **Convene a kick-off meeting** for teams to foster a shared vision.
- **Develop a comprehensive programme starter pack** that outlines expectations including: (a) programme vision and phases; (b) roles and responsibilities; (c) guidance for effective project management, decision making, budget management and joint reporting; (e) working hours expectations; (f) information on programme monitoring, outcomes and timeframes; and (g) a framework to build and maintain team trust.
- **Outline a clear rationale for pairing** voluntary and community sector organisations and fellows.
- **Support team formation by facilitating activities** that promote personal and professional understanding, opportunities to experience each other's work environments, open communication about working styles and preferences, and team reflexivity.

Invest in capacity building and trauma informed support

To enhance collaboration, the programme should:

- **Provide tailored training and structured peer support** to strengthen the skills and knowledge of voluntary and community sector organisations and fellows.
- **Offer independent trauma-informed support and supervision** to help address power dynamics and foster a safe and open environment.

2. Improving outcomes for Lewisham residents

Focussed action and sustainable practices are needed to improve health and wellbeing outcomes for Black African and Black Caribbean residents in Lewisham. In order to achieve this, the second iteration of the programme will need to:

Optimise resource allocation, for instance by introducing coordinator and administrative support for fellows to improve efficiency and oversight, allowing for better use of clinical resources.

Prioritise Black community needs, by maintaining a clear and explicit focus on improving outcomes for Black African and Black Caribbean residents and emerging Black populations locally. This could be achieved through following an asset-based approach that builds on existing social capital within the community and through fostering meaningful engagement and community participation, with consideration given to public relations activities.

Drive transformation in primary care, by creating opportunities for general practitioners to actively participate in shaping the programme, fostering a culture of change and buy-in, and empowering fellows to establish themselves as leaders in clinical spaces and sustain their influence beyond the fellowship programme.

Promote knowledge sharing and sustainability, by building a sustainable knowledge base and repository to facilitate shared learning within and outside the programme, as well as considering the intellectual property of initiatives developed.

3. Streamlining programme processes and learnings

The programme management team proactively optimised processes from the outset. This commitment to refining and improving will be essential as the programme carries on and could be extended as follows.

Revitalise programme oversight

To ensure programme success and long-term sustainability, the programme should focus on:

- **Empowered teams** (as described on slides 23 and 24).
- **Stronger leadership** to articulate ambitious yet attainable goals, and clearly communicate the rationale behind decisions, especially when top-down decisions are necessary.
- **Continued visibility** to showcase the programme's reach and impact by inviting external stakeholders to events to raise awareness, as well as publishing and promoting outputs for wider audiences.

Sharpen the focus and streamlining reporting

To maximise the programme's impact and ensure alignment with the BLACHIR priorities, the following elements should be prioritised:

- **Outcome-driven monitoring**, co-creating key performance indicators and monitoring strategies with stakeholders to clearly define desired outcomes and track progress.
- **Revamped monitoring meetings**, simplifying requirements, providing clearer upfront expectations to ensure focused discussions.

The strategic choice to focus on a single clinical area (i.e. cardiovascular disease) in the second iteration will also facilitate clearer identification of outcomes and more effective testing and comparison of different interventions. Collectively, this will help to identify and disseminate best practices.

Foster ongoing learning and improvement

To continue the investment in learning and programme development, the programme should:

- **Consider commissioning a developmental evaluation or learning partner** to offer critical insights into implementation, enable real-time iterations and maximise effectiveness.
- **Further empower community champions** by expanding methods to capture their learning and reflections, deepening their community leader capabilities.

The Health Equity Team projects

Action for Community Development & Aplos Health Primary Care Network

Action for Community Development is non-profit charitable organisation dedicated to empowering individuals and developing communities. Their mission is to promote community building and social transformation in diverse and under-resourced communities. They give impartial, reliable and professional training, information, career advice and guidance.

Aplos Health Primary Care Network comprises four practices:

- The Vale Medical Centre
- Sydenham Green Practice
- Woolstone Medical Centre
- Wells Park Practice

Aplos Health
primary care network

Action for Community Development & Aplos Health Primary Care Network

Action for Community Development and Apolos Health Primary Care Network delivered a community health and wellbeing awareness programme, focusing largely on mental health and long-term conditions.

Throughout October 2023 to March 2024, they:

- Recruited and trained 25 community champions.
- Promoted and disseminated event information through targeted outreach including the distribution of leaflets at key community spaces such as high street shops, community centers, and libraries to ensure broad visibility of events across the neighborhood.
- Engaged over 24 local organisations to participate in the health promotion events and showcase their services to increase healthcare access and signpost residents.

Seven workshops were delivered across the themes below. There was a consistent approach to intervene early, address stigma and discrimination, ensure cultural relevance and tailored content, and facilitate access through effective signposting to local services.

Mental health and wellbeing

Diabetes

Behaviour change

High blood pressure

Racism in public health

Downham Dividend Society Community Land Trust, Social Life & Sevenfields Primary Care Network

Downham Dividend Society Community Land Trust was founded to continue the wider regeneration work of Fusions Jameen's Black-led community self-build schemes. It considers the Downham community as an asset and its social bonds of economic value and promotes a community wealth building approach to tackle the intergenerational poverty and health inequalities.

Social Life was created by the Young Foundation in 2012, to become a specialist centre of research and innovation about the social life of communities.

Sevenfields Primary Care Network comprises eight practices:

- Ashdown Medical Group – Burnt Ash Surgery
- Ashdown Medical Group – Downham Family Medical Practice
- ICO Health Group – The Moorside Clinic
- Novum Health Partnership – Baring Road Medical Centre
- Novum Health Partnership – Rushey Green Group Practice
- Oakview Family Practice
- Park View Surgery
- Torridon Road Medical Practice

DCLT

SOCIAL LIFE

Sevenfields
Primary Care Network

Downham Dividend Society Community Land Trust, Social Life & Sevenfields Primary Care Network

Downham Dividend Society Community Land Trust, Social Life and Sevenfields Primary Care Network collaborated to a maximise community assets and tackle health inequalities. Across June 2023 to September 2024, their project was delivered in four phases.

Key project components and highlights:

- Four local residents recruited as community champions, building on the existing network of champions locally.
- Rich understanding of place and community developed, underpinned by listening in depth to residents, employing accessible research methods and analysing local data.
    - Key findings: Loneliness, isolation, and stress are increasing. Housing and financial pressures are significant. Health requires a holistic approach. Disparate community power and activism, and the impact of local history.
- Trauma informed approach implemented, partnering with the Deborah Ubee Trust to provide team emotional and wellbeing support and a resident health and wellbeing workshop.
- Nine interactive events and mobile health clinics were delivered to improve access to healthcare and promote wellbeing.
- Team expertise and passion leveraged, with a specific focus on the health of the Caribbean, Sri Lankan and Tamil community, housing and trauma, stress management, healthy eating and roller-skating and gardening.

Holistic Well Women

Holistic Well Women is a non-profit grass-roots organisation dedicated to empowering community health and well-being, with a primary focus on women. Their mission is to foster positive change through a range of activities and services that extend beyond traditional boundaries.

Lewisham Alliance Primary Care Network

Lewisham Alliance Primary Care Network comprises six practices:

- Burnt Ash Surgery
- Lee Road Surgery
- Lewisham Medical Centre
- Nightingale Surgery
- Triangle Group Practice
- Woodlands Health Centre

Holistic Well Women & Lewisham Alliance Primary Care Network

Holistic Well Women's delivery model centred on cultural appropriateness, holistic care and early intervention. Creative and social approaches to address wellbeing was a common thread throughout.

They delivered a mental health awareness campaign, including a series of workshops and courses covering topics such as mindfulness, self-care, healthy living, and gardening. Participants reported:

- Improved wellbeing and reduced isolation.
- Increased understanding and access to mental health support.
- New and strengthened support networks.

Outreach community engagement was conducted alongside, as well as their champion and community leader programme, with sessions on trauma informed approaches, cultural awareness and BLACHIR.

Lewisham Alliance provided a weekly, multifaceted form filling service in a local shopping centre. Key features of their model included:

- A dedicated outreach team involving social prescribers, care coordinators, mental health workers, trained community volunteers and clinical staff.
- Health checks, advice and mental health and wellbeing support provided alongside form filling activities (e.g. personal independence payment forms).
- Educational tutorials on topics such as mental health, arthritis, diabetes and hypertension.

200+

Patients engaged in the service and educational tutorials

82%

Encountered problems with form filling before

Red Ribbon Living Well & North Lewisham Primary Care Network

Red Ribbon Living Well is a community organisation for individuals affected by and living with human immunodeficiency virus (HIV), mental health, family experience domestic violence and other comorbidities illness. The group was founded in 2009 by members who recognised a need for peer support in the community, and it has grown from its grass-roots beginnings.

North Lewisham Primary Care Network comprises nine practices:

- Amersham Vale Practice
- Clifton Rise Family Practice
- Deptford Medical Centre
- Deptford Surgery
- Grove Medical Centre
- Kingfisher Medical Centre
- New Cross Health Centre
- Queens Road Partnership
- Vesta Road Surgery

Red Ribbon Living Well & North Lewisham Primary Care Network

Red Ribbon Living Well and North Lewisham Primary Care Network co-produced a three-pronged project drawing on population health management data, community and Red Ribbon Living Well expertise and input from primary care network stakeholders.

Health equity and wellbeing champions

26 champions were recruited and trained on topics such as HIV prevention and testing and local health inequalities and services. Champions also received additional accredited training.

140 local residents surveyed to understand health concerns and barriers to healthcare access.

Coordination and data gathering at community health hubs.

Community health hubs

678 individuals attended nine health hubs over the 12-month period. Hubs took place in strategically identified community spaces to increase access.

33 community and health care stakeholders collaborated, delivering integrated care and support, within a single space.

400 health checks performed, with 42% coded as CORE20Plus.

HIV stigma training

144 participants engaged in the co-designed HIV stigma and awareness training reaching both clinical and non-clinical staff.

Animation co-developed with people with lived experience to promote stigma free care.

Higher abnormal results were observed at the community health hubs, relative to standard NHS health check datasets.

98% would recommend the community health hub to others.

83% trust their GP surgery.

83% want improved primary care access.

76% would prefer health information and services to be promoted in public and community spaces.

Therapy 4 Healing & Modality Primary Care Network

Therapy 4 Healing was born in 2009 from a passion to 'service the community'. They work with many groups, organisations, companies and individuals to deliver our health and well being services across London and the south east.

Modality Primary Care Network comprises three practices:

- Bellingham Green Surgery
- South Lewisham Group Practice
- The Jenner Practice

Therapy 4 Healing & Modality Primary Care Network

Therapy 4 Healing and Modality Primary Care Network's partnership was deeply embedded in the community, prioritised and targeted health needs and established a health equity presence within the primary care network.

Community listening and engagement

- Community assets mapped and key data analysed.
- Listening at pre-existing community events, with 48 local venues attended, 95 community health outreach visits conducted, 1200 residents reached, and 159 residents interviewed.
  - Resident insights: Lack of GP access (digital exclusion and appointment system barriers), patient experience at point of access, appetite for socially prescribed complementary therapies.
- Local community champions and primary care network social prescribers engaged to support listening, offer health advice and signpost residents.

Health fairs and health promotion events

- Health fair hosted the Hummingbird Club as part of their Black History Month celebrations for Black African and Caribbean elders.
- Events delivered offered educational talks, blood pressure checks, complementary therapies and signposting information and resources from partnering voluntary and community sector organisations and community health services.
- Enhanced focus on hypertension, with a co-produced culturally sensitive blood pressure protocol, community organisation training workshop and re-designed practice systems.

Complementary health clinic

- 12-week evidence-based complementary health clinic with 72 sessions for 24 patients.
- Patients reported a reduced reliance on painkillers, improved mental health and a reduction in chronic pain levels.

360° Lifestyle Support Network, Mabadiliko & The Lewisham Care Partnership

360° Lifestyle Support Network was set up in 2021 by a brother and sister duo and aims to make healthcare more accessible for Black African and Black Caribbean individuals.

Mabadiliko is passionate about creating workplaces and communities that are inclusive and provide equity for all racial groups. Their primary goal is to create opportunities for open and honest conversations about race.

Lewisham Care Partnership comprises five practices:

- Belmont Hill Surgery
- Hilly Fields Medical Centre
- Honor Oak Group Practice
- Morden Hill Surgery
- St Johns Medical Centre

360 Lifestyle Support Network, Mabadiliko & The Lewisham Care Partnership

360° Lifestyle Support Network, Mabadiliko and The Lewisham Care Partnership co-produced and delivered a community-led, culturally-tailored group consultation programme for Black and Asian people living with type 2 diabetes.

The project was developed through extensive co-design with community members, community organisations and healthcare professionals. A Task and Finish Group helped shape the intervention's principles, content and delivery approach. Key features of the programme included:

- Cultural competency at the core of all materials and delivery.
- Integration of community knowledge and clinical expertise, drawing on lived experience.
- A focus on holistic wellbeing beyond medical management, with sessions covering nutrition, physical activity, emotional wellbeing, and medication.
- Building sustainable peer support networks and behaviour change.
- Empowerment of community members as champions, with training and support provided to eight former participants, building sustained community capacity.

Co-design insights

- Diabetes cultural stigma
- Lack of culturally appropriate dietary advice
- Limited access to community-based support
- Mental health is overlooked
- Systemic racism in healthcare

24
participants

9.5
mmol/mol average reduction in HbA1c

Reported behavioural outcomes

- Enhanced diabetes management understanding
- Improved dietary choices and portion control
- Increased physical activity and better stress management
- More proactive health-seeking behaviours

Reported wellbeing outcomes

- Increased confidence in self-management
- Stronger peer-to-peer support
- Better engagement with healthcare services
- Improved emotional wellbeing
- Enhanced cultural pride and identity

10th Floor, Becket House,
1 Lambeth Palace Road, London SE1 7EU

Closest station:
Waterloo

020 7188 9805

@HINSouthLondon

healthinnovationnetwork.com