Grounded

Community-Led Reflections And Solutions To Systemic Health Inequalities

Insights on BLACHIR Implementation Progress in Lewisham (2023–2025)

S.I.R.G

Putting you first

Commissioned by

Lewisham

NHS

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Acknowledgements

Social Inclusion Recovery Group CIC (SIRG) extends its heartfelt gratitude to everyone who made this community engagement possible. This work is grounded in the voices, wisdom, and lived experiences of Black African and Black Caribbean residents across Lewisham and Birmingham. It stands as a testament to the strength, resilience, and leadership that exists within our communities.

This report was made with the community.

We are deeply grateful to all who took part in interviews, workshops, discussion forums, and podcast recordings. Your stories, insights, and experiences are the foundation of this engagement report. Thank you to the youth, elders, grassroots organisations, community leaders, and everyday residents who trusted us with your truths.

We also honour the exceptional efforts of our volunteers, outreach facilitators, youth mentors, and local partners who brought care, commitment, and cultural integrity to every stage of this process.

In Dedication to Lisa Fannon (1969–2025)

This report is dedicated to the memory of Lisa Fannon, whose unwavering commitment to racial justice, compassion, and community voice helped shape this work. Lisa was a powerful advocate for equity in Lewisham, a trusted collaborator, thoughtful public health professional, and consistent ally in community-led efforts to challenge systemic injustice. She listened deeply, acted with integrity, and always centred the dignity and wellbeing of those most affected by inequality.

Lisa championed grassroots knowledge and helped lay the groundwork for authentic, resident-led learning through her support of the Birmingham and Lewisham African Caribbean Health Inequities Review (BLACHIR).

Her legacy lives on in the principles guiding this report: truth-telling, accountability, and community-led change. We honour Lisa by continuing the work she believed in, justice that is real, sustained, and led from the ground up.

Rest in power, Lisa.

Foreword

Since its inception, SIRG has taken on the role of community advocates. Part of that advocacy work has involved engaging the Black community on BLACHIR, two years after its publication and specifically, its own community commissioned engagement work. This report is more than an extension of BLACHIR; it is a declaration of truth, testimony, and transformation. It reflects the lived realities of Black African and Black Caribbean communities in Lewisham Borough, who have long been experts in their own experience, but too rarely architects of systemic change. The fundamental premise of this work relies on the simple but powerful truth: that the people most impacted by injustice already hold the knowledge to dismantle it.

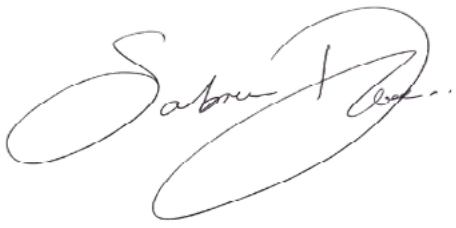
When we invited communities to engage with the Opportunities for Action (OFA) as set out in the original BLACHIR report, we knew we had to do things differently. We could not repeat the extractive models of engagement but needed to actively listen, not for policy soundbites or endorsement, but for wisdom that will challenge the norm. That is exactly what we received: bold, grounded, and urgent calls for accountability, visibility, and real foundational change.

What you will find in these pages is not simply feedback. It is a blueprint for a community-authored mandate for equity. Our communities are not asking for charity, they are demanding justice that will disrupt the status quo.

I carry a deep sense of responsibility and gratitude for the honesty shared with us. These conversations were often painful. They raised difficult questions for all service leaders, policymakers, and professionals. And rightly so. If we are serious about racial equity, we must sit with discomfort, confront complicity, and invest in co-designed, long-term solutions.

This report is certainly not the end of a process, but a recommitment to one. It is our duty to make sure these voices are not only heard but acted upon, with transparency and care. We invite everyone reading this to do the same.

Healing requires more than listening; it requires action.



Sabrina Dixon
Chief Executive


KEY RECOMMENDATIONS
Health bodies should work with Black African and Black Caribbean communities to co-develop accessible services
BLACHIR REPORT 2022
KEY FINDINGS
RECOMMENDATIONS
and discrimination should
gnised as drivers of ill health.
BLACHIR REPORT 2022
BLACHIR
KEY RECOMMENDATIONS
Data collection around ethnicity should be improved to help tackle health inequalities.
BLACHIR REPORT 2022
KEY FINDINGS
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Executive Summary

This BLACHIR Engagement Report presents findings from a community-led engagement on the 2022 BLACHIR Opportunities for Action (OFA), focusing on Black African and Black Caribbean residents in Lewisham. The report examined whether these OFA continue to reflect lived experience and what further action is now required.

Between June 2023 and May 2024, over 270 community members (elders, youth, parents) and experts shared lived experiences of health inequalities through forums, interviews and podcasts. Their evidence provides a detailed picture of how health inequalities are experienced across generations.

The report shows that the priorities identified in the original BLACHIR report remain grounded in lived experience. Residents continue to experience unequal access to healthcare, education, housing and public services. These inequalities are shaped by racism, economic insecurity, cultural inaccessibility and systems that are difficult to navigate.

Across all themes, community members described how these barriers accumulate across the life course. Children and young people face unmet educational and emotional needs. Working-age adults experience delayed diagnosis, financial strain and limited access to appropriate care. Older residents encounter isolation, digital exclusion and difficulty navigating health and care systems. These experiences reflect structural challenges in how services are designed and delivered.

Several system gaps were identified consistently, including the absence of robust race-based data, fragmented service pathways, cultural barriers within health and mental health provision, and engagement models that do not build long-term trust.

Groundwork for Change

Community members highlighted three essential foundations for making the OFA real in practice: research, training and resources.

They questioned research that repeatedly gathers their stories without visible change, calling for disaggregated, action-oriented, community-led approaches that help dismantle inequality rather than simply describe it.

They emphasised that training must be anti-racist and trauma-informed, grounded in lived experience and delivered consistently across sectors so that it changes everyday practice in services.

Finally, they were clear that without long-term investment, even the strongest ideas cannot be sustained: systems rely on community-led care while offering little stability, recognition or funding in return. Sustainable funding for Black-led and grassroots organisations, trusted spaces, infrastructure for participation and staffing that reflects community needs are therefore essential.

The Priorities

Together, these findings show that health inequalities persist, not because of a lack of policy intent, but because services, data, leadership and engagement models do not yet operate in ways that communities can access, trust or shape.

From this, four priorities should guide future action:

- Services should be delivered through trusted community settings.
- Health literacy requires sustained and properly resourced investment.
- Black leadership must have decision-making authority within public systems.
- Community engagement must be continuous and embedded in delivery.

These priorities set out how public services, commissioning arrangements and partnership models need to function if they are to reduce inequality rather than reproduce it. They provide a framework for aligning statutory systems with the community-led approaches that residents already trust and use.

A Call for Collaboration

The recommendations in this report set out how the identified priorities can be implemented across health, education, housing and community services. Delivering them requires coordinated, long-term action across systems.

While some recommendations require national action, this report prioritises actions within the direct influence of Lewisham Council and the South East London Integrated Care Board (SEL ICB). National recommendations are included to ensure structural alignment and long-term equity.

These are some of the key actions that can be taken to support delivery:

- Sustained partnership with Black communities, so that lived experience continues to shape priorities, delivery and evaluation.
- Funding models that support long-term collaboration, rather than short-term or project-based engagement.
- Governance arrangements that give Black leadership decision-making authority within health and public service systems.
- Commissioning approaches that embed community-led organisations as delivery partners, not consultees.
- Service design that reflects cultural realities and local context, improving access, trust and uptake.
- Performance and accountability frameworks that include community-defined measures of success, alongside clinical and operational indicators.

This engagement identifies the structural causes of continuing inequality and the conditions that public systems need to put in place to address them.

Introduction

The Black African and Black Caribbean communities make up 23% of Lewisham (BLACHIR, 2022).

These communities are often marginalised and overlooked within broader societal discussions. In this context, residents came together to share insights into their lived experiences and reflect on the implications of the BLACHIR report. Through a series of community forums, podcasts and interviews, they voiced pressing concerns about health, community life, education, and overall wellbeing. These engagements moved beyond one-off consultations, creating space for honest dialogue and generating practical, community-informed solutions.

The OFA, as proposed in the BLACHIR report, provided a framework for these conversations, allowing the community to engage with policy proposals and directly influence the discourse on health disparities and social inequalities.

At the heart of these discussions was the shared understanding that systemic racism and discrimination feature in all aspects of their lives. From healthcare to education, public service interactions to housing, residents of these communities face barriers that are not just individual but structural.

They are fully aware that race-based inequalities are a deep-rooted and long-standing lived experience for most in their communities, often spanning generations. Despite their generational persistence, community members firmly believe that these challenges can be dismantled, and that meaningful change must be community-driven, supported by service providers, local organisations, and policymakers.

Shaped by the voices of the residents of Lewisham, this report offers practical recommendations for change. These recommendations are grounded in the real experiences of community members and reflections of their daily reality.

The input of community residents has guided both the structure and content of the report, building on the findings of BLACHIR and continuing the conversation, one that started prior to 2022, between the community, policymakers, and commissioners. It calls for action that addresses root causes and removes the barriers that stand in the way of equity and justice.

About the BLACHIR Report

In 2022, BLACHIR set out to understand why Black African and Black Caribbean communities continue to face some of the starkest health inequalities and to identify what could be done differently.

The review brought together published evidence, professional insight, and lived experience to expose how racism, poor housing, limited access to care, and systemic neglect, shape and impact people's health throughout their lives. It described the problem of health inequality and offered 39 OFA, based on eight themes, to guide local change.

This engagement report returns to those OFA, to bring them back to the community for reflection, challenge, and insight. We asked; Do these opportunities still speak to people's experiences? What do they feel is missing? What needs to be rethought or restated?

Scan the QR code to view the BLACHIR Report

Methodology

Our methodology was grounded in a participatory, community-led approach that prioritised trust, highlighted the lived experiences of residents, and removed barriers to ensure the process was inclusive.

Data collection spanned a mix of methods including:

9 public community forums

Held across Lewisham, these sessions engaged a total of over 270 participants (average of 30 per forum) and were intentionally designed in a way that encourages open dialogue with residents, making it easy for them to participate and share their views.

8 thematic podcast episodes

These episodes featured subject-matter experts from public health, education, housing, elderly care and mental health sectors.

1 podcast episode with a public health official

This provided a response from national public health bodies to community concerns and helped situate the findings within current policy frameworks.

160 community interviews

The community interviews were semi-structured and remained very conversational to gather insights from across generations, genders, and ethnicities, and covered different migration experiences and housing situations.

Participant Profile

To reflect a broad spectrum of experiences, participants were engaged through a purposive, relationship-based approach. Community facilitators worked through trusted networks, grassroots groups, and local leaders to involve elders, young people, parents, carers, frontline workers, students, and long-standing residents. While formal demographic data was not collected in every session, facilitators actively sought generational, ethnic, and experiential diversity, consistent with the project's open, community-led approach.

Approach to Analysis

Data was analysed using an inductive thematic approach. Rather than applying a pre-set framework, themes were drawn directly from the issues raised by participants. These were then mapped against the original OFA to assess where community feedback aligned, expanded, or challenged the original priorities. The analysis used the language and framing of participants themselves, incorporating verbatim quotes to reflect their lived realities. Triangulating across multiple data sources strengthened the consistency, viability, and credibility of the findings, while maintaining the integrity of the community voice.

The Cost of Inaction

Delaying addressing health inequalities not only incurs a human cost but also has significant and long-term economic, social, and institutional consequences. In the UK, successive reports have evidenced that inaction on systemic disparities in healthcare, education, and economic conditions disproportionately affects low-income families.

This chapter brings together recent research and parliamentary evidence to present a clear picture: the longer inequality is ignored, the higher the cost, financially and socially.

The Poverty Divide

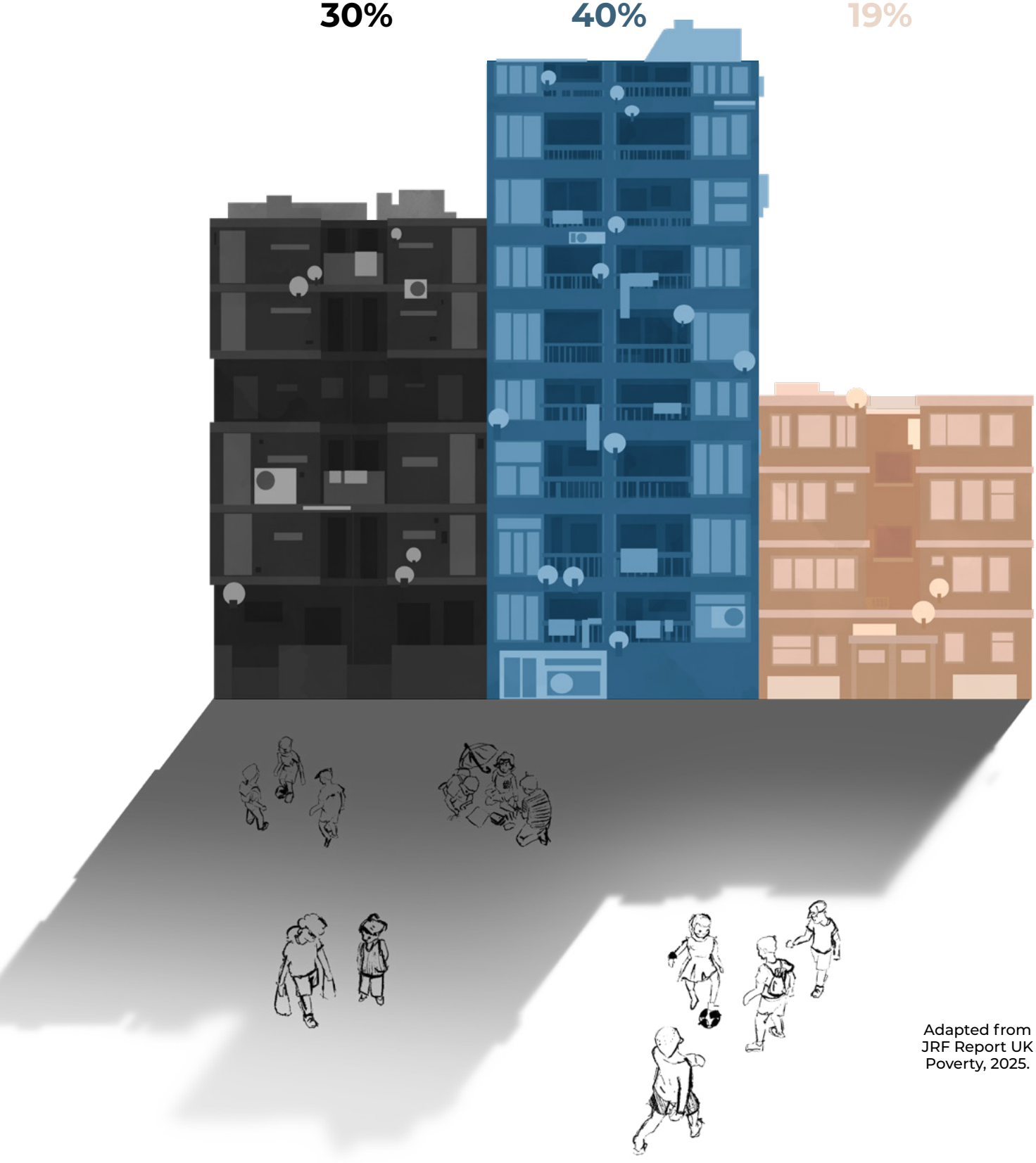
Child poverty rates in the UK are rising, with particularly stark consequences for racialised groups. According to the Joseph Rowntree Foundation (2025), children in Black Caribbean households faced an elevated risk of living in poverty (38%). More than one-quarter of Black African households (26%) and other ethnic groups (28%) were also in very deep poverty, defined as income below 40% of the median, compared to 8% of children in white households.

Persistent very deep poverty, defined as lasting at least three years out of four was five times more likely to occur among Black African and Bangladeshi households (10%) than among white households (2%). These disparities are not new, nor are they improving significantly. Poverty rates among Black African headed households increased only one percentage point since the last decade, but they have consistently been approximately twice as high (between 46% and 51%) as poverty rates among white households.

These figures are not marginal, they are systemic.

As a result of these and other drivers of poverty, deeper and longer experiences of poverty can lead to worsened life outcomes such as poorer health and early mortality.

Households in poverty by ethnicity



Adapted from JRF Report UK Poverty, 2025.

The Compound Risk

Poverty intersects directly with educational disadvantages and health risks, particularly among children and people with caregiving responsibilities. Azpitarte & Holt (2022) note that England's school system is failing children with Special Educational Needs and Disabilities (SEND), with exclusion and lack of support disproportionately affecting children from the lower-income strata and ethnic minority backgrounds.

Carers, many of whom belong to these low-income or racialised households, also face compounded health risks. As reported by CarersUK (2021), a high proportion of carers struggle with mental and physical health problems. The cumulative impact of stress, overwork, and financial insecurity adds significant strain on an already overstretched health and care infrastructure.

The Institutional Cost

The Health and Social Care Committee (House of Commons, 2025) identifies health inequalities as a direct cost to the NHS and to the wider economy. Its findings show that unmet social determinants of health continue to drive avoidable differences in health outcomes and that these differences are likely to have increased further following the COVID-19 pandemic.

The Committee estimates that health inequalities account for £4.8 billion in NHS expenditure each year and approximately £30 billion in lost productivity associated with ill-health, reduced workforce participation, and early exit from employment. These figures reflect the economic footprint of preventable disease, long-term conditions, and uneven access to effective care.

The Marmot Review (2020) provides national-level estimates of the same cost burden. It places productivity losses linked to health inequalities at £31–33 billion per year, with a further £20–32 billion arising from lost tax revenue and increased benefit payments. These outcomes are linked to a set of structural conditions operating across the UK economy:

1. Stagnating and declining wages.
2. Rising inequalities in wealth between regions.
3. Increasing poverty levels among those in work.
4. Persistently low levels of social mobility.

Health inequalities cost the UK billions each year

The Frontline Impact

A 2024 report by Schmuecker and Bestwick, primary school staff estimated that, on average, 48% of their pupils had experienced hardship since the start of the school year. Primary and community healthcare staff reported similar concerns, with 57% of their patients having faced poverty-related hardship and mental heath challenges within the past 12 months.

Anxiety and depression are increasingly linked to structural economic insecurity. Clark and Wenham (2022) state that the UK's cost-of-living crisis is increasingly a crisis of mental distress. Households already on the margins of poverty experience the highest levels of psychological harm yet remain the least able to access appropriate mental health support.

The trend of medicalising the consequences of poverty without addressing its root causes leads to inefficiency and burnout across public services, deepening mistrust and pushing families further from the systems meant to support them.

Structural inequality thus reproduces itself in new forms, affecting not just physical health outcomes but societal cohesion and intergenerational opportunity.

48% of primary school pupils experienced hardship since the start of the 2024 school year.

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What Collaboration Looked Like

The Advisory Board

The Advisory Board has been established to provide accountability for SIRG's role in the engagement process and to ensure that the priorities of the Health Equity Teams (HET) informed both operational decisions and wider strategic planning. The Board was made up of representatives from the six Black-led voluntary and community sector organisations that formed the first wave of HET. Meeting monthly online, it became a trusted space for teams to share updates, reflect on progress, and discuss challenges openly.

After the establishment of the Board, it became clear that there was a need for additional support and a "sounding board" function from a trusted, neutral source. In practice, this meant that SIRG took on a role supporting organisations with mobilisation within the community, troubleshooting conflicts between HET partners and their Health Equity Fellows (HEFs), and addressing confidential or sensitive issues. This extra layer of support strengthened relationships, enabled earlier resolution of problems, and increased the chances of delivering successful outcomes.

The Advisory Board also acted as a peer-learning and collaboration platform. HET members regularly shared insights from their community engagement, exchanged learnings on project delivery, and helped disseminate events and initiatives. This cross promotion and mutual attendance at activities increased visibility, strengthened community trust, and amplified the impact of individual projects.

Strategically, one of the Board's key contributions was the joint selection and prioritisation of six OFA from the BLACHIR report, which were then fed back to Lewisham's public health team. This ensured that the work on the ground directly shaped borough-wide health equity priorities and demonstrated the value of coordinated community-led input into public health strategy.

Health Equity Teams and Health Equity Fellows

As part of its community advisory role, SIRG invited the Health Equity Teams (HET) to provide advice and constructive challenge regarding their BLACHIR community engagement work. In practice, its role as a community advisory board evolved into a support space for members facing delivery and partnership challenges. The Community Advisory Group fulfilled a distinct developmental role by shaping the priorities of the Opportunities for Action (OFAs) through lived-experience and grassroots insight.

The HET are multi-agency partnerships between Lewisham's six Primary Care Networks (PCN), NHS clinicians, and Black-led voluntary and community sector organisations, including SIRG, Action for Community Development, Downham Dividend Society CLT/Social Life, Holistic Well Women, Red Ribbon Living Well, Therapy 4 Healing, 360° Lifestyle Support Network, and Mabadiliko. These teams coordinate resources, clinical expertise, and community engagement to deliver locally tailored health equity projects responding to the BLACHIR Opportunities for Action. HET activities include mobile health clinics, targeted screenings, culturally tailored health workshops, workforce training, multi-service health hubs, and outreach in trusted community spaces. This aims to improve access to primary care and preventative services, strengthen trust between the NHS and communities, and influence redesignes of care pathways to be more culturally competent.

The Health Equity Fellows (HEF) are clinicians embedded within each PCN, trained to lead on health equity and act as a bridge between primary care and community partners. These Fellows use population health data to identify local priorities, co-design targeted interventions with Black-led organisations, and deliver GP and workforce training shaped by community insight. Their work developed a cohort of clinical leaders skilled in population health, strengthened GP engagement with community initiatives, and drove service changes such as culturally sensitive hypertension protocols and community-led diabetes programmes.

Together, HET brought system resources and multi-agency coordination, while HEF brought clinical leadership and the ability to embed equity into primary care systems. Working in partnership with trusted, Black-led organisations, they co-created culturally relevant, evidence-based interventions that increased service uptake, reduced inequalities, and built lasting trust between communities and the health system.

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Scan the QR code to view the HET evaluation report

Community-Led Groups

Working alongside community organisations has brought genuine strengths to this report. These organisations, deeply rooted in their neighbourhoods, hold trusted relationships and understand both the culture and history that shape how people engaged. Their involvement created space for honest conversations and improved the quality of feedback. Their presence increased participation from local residents and surfaced valuable ideas for improving services.

SIRG provided coordination across this delivery model, linking community organisations, Health Equity Fellows, and statutory partners. This included supporting mobilisation within neighbourhoods, addressing partnership challenges, and managing sensitive issues that could not be handled through formal reporting structures. This enabled problems to be identified and handled at an early stage, reducing disruption to the engagement and maintaining confidence among participating groups.

Through its participation in statutory forums, including the Health Inequalities Workstream and the Lewisham Health and Care Partnership Board, SIRG created a route for community concerns to be raised within system-level discussions. At the same time, Lewisham Black Voluntary Network (LBVN) meetings enabled direct engagement between residents and statutory representatives, allowing specific issues to be discussed in person.

Feedback from community organisations and residents indicated that formal reporting processes did not always provide clear or accessible information about how decisions were being made or how community input was being used. This limited the ability of participants to track progress or respond to emerging priorities.

A more consistent and community-designed approach to sharing outcomes back to residents, including clear summaries and regular feedback sessions through LBVN, would support transparency, sustained engagement, and continued community involvement in health equity work.

This report demonstrates that working with community-led organisations adds important value, deeper understanding and greater local relevance in public health.

What We Heard

The forums and interviews captured broad experiences and priorities. In many cases, the podcast findings echoed what was heard in the forums. Where the podcasts differed, they added sharper critique, challenged the limits of the OFA, and highlighted system-level barriers. Taken together, the forums, interviews, and podcasts supported triangulation by showing what participants raised, how systems responded, and how accountability and change were understood across the programme.

Across the forums, residents spoke openly about the challenges they face from racism in public services to gaps in maternity care, mental health, education, and everyday wellbeing. Equally, they shared ideas for change. These were practical, actionable proposals: changes to policy, better training, improved access, and community-led solutions designed by and for the people they serve.

The findings are organised under the original eight BLACHIR themes and grouped under five headings: implementation, recommendations, research, training, and resources. The final three have been consolidated across themes to minimise repetition and support clarity.

1 Racism and discrimination

This theme evoked some of the most strongly held views from the community.

Across the forums, people highlighted how racism and discrimination are embedded in everyday experiences. These issues are underpinned in all other themes, evident in the language used by institutions and the way services are delivered. There was a shared understanding that racism is not a side issue, but a defining determinant of health, wellbeing, and opportunity.

Community members voiced concerns about how change is being implemented, who is responsible, and what anti-racism would look like in practice. For many, this theme was not simply about injustice, but about being made invisible by the very systems meant to protect and support them. They believed the system was not constructed to serve the needs of Black people but was intended to embed the Black community as workers and service providers.

OFA

1 Local Councils and Health and Wellbeing Board Partners

Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.

2 Local Councils and Children's Trusts

Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.

3 Local Councils and Health and Wellbeing Board Partners

Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.

4 Local Councils and Education Partners

Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

OFA implementation

One of the clearest concerns raised was the proposal to remove colour language from ethnic coding. Community members feared that this change, though presented as inclusive, would erase identity, undermine the ability to monitor racial disparities, and dilute efforts to tackle racism meaningfully. They questioned who made this decision, who is accountable, and how it would be evaluated.

Community members expressed concern that such a drastic shift, removing language in the name of equality, reflects a wider trend of depoliticising race without addressing the underlying determinants of inequality. There were also questions about transparency: people wanted to know how national public health bodies communicate their anti-racist stance and how that stance is made visible in both policy and practice.

> **Removing 'Black' from ethnic coding risks erasing a crucial aspect of identity and lived experience.**

> **This OFA risks undermining antiracist efforts by obscuring the specific challenges faced by Black individuals.**

Recommendations

There was a strong call to keep race visible in data and to ensure this data is actively used to inform service design based on real population needs. The community emphasised that race-based data must do more than reflect identity; it must drive accountability in commissioning and evaluating services. Without meaningful use, race data risks becoming performative rather than transformative. Public Health bodies and Local Authorities are urged to recognise the cultural and historical significance of the term “Black” and to protect it as both an identity marker and a tool for accountability.

The community stressed that any anti-racism approach must be co-designed with the community, with clear individuals and roles made responsible for delivering it. Participants called for urgent development of timelines, accountability structures, and consistent feedback loops with the community.

Regarding adverse childhood experiences (ACEs), racism must be recognised as a form of trauma, especially for children and adults with special educational needs and disabilities (SEND). The community warned that without swift, clear action, these vulnerable children remain exposed to unaddressed racial trauma with lifelong consequences.

There was also a call to place responsibility on the broader system. How will employees at every level be expected to contribute to eradicating racism? How will they be held accountable? Recommendations included embedding anti-racism policies in recruitment, procurement, and co-design processes. A systemic approach to these policies is essential to achieve measurable impact.

Short-term:

- Ensure race-based data collection is consistent and used to directly inform service commissioning and evaluation.
- Co-design anti-racism strategies with community involvement, clearly defining roles and accountability.
- Develop urgent timelines and feedback mechanisms that involve the community throughout implementation.
- Recognise racism as trauma in frameworks addressing adverse childhood experiences, with special focus on children and adults with SEND.
- Embed anti-racism principles across all public sector recruitment, procurement, and service design.
- Implement accountability measures that hold all public system employees responsible for contributing to anti-racism efforts.

Medium and long-term:

- South East London ICB and Public Health Lewisham should implement mandatory anti-racism and cultural competency training for frontline staff, with annual refresher requirements and accountability mechanisms.
- The Office for National Statistics and NHS Digital must reinstate ethnic coding across health and education datasets, with guidance and protections in place to prevent misuse.
- Develop local accountability frameworks (co-designed dashboards to track progress on OFA).
- Implement Black leadership pipelines (pathways into senior roles). This directly confronts institutional under-representation and embeds equity in leadership.

Podcast Findings

The first episode of the podcasts featured a long-standing community advocate (T.J.) who responded to the OFA on racism and discrimination, drawing on decades of professional practice in anti-racism work, statutory training, and grassroots organising.

T.J. acknowledged the value of the OFA but questioned whether they go far enough in addressing the underlying power structures that allow racism to persist. She challenged how institutions use the language of anti-racism without changing practice or demonstrating accountability. Language means little without a shift in power. Institutions are increasingly fluent in the rhetoric of anti-racism but resistant to redistributing power. She questioned the sincerity of inclusion efforts that centre optics over influence. Representation is not the same as participation, considering Black professionals are often placed in decision-making spaces with little authority to shape outcomes.

> **They bring you in as a Black face, but they have made up their minds. It is not about your input but it is about optics.**

> **If you remove 'Black' from the coding, you remove the ability to measure what is actually happening to Black people.**

A central concern in this theme was the disconnect between generations. T.J. reflected on how younger Black people are navigating more subtle, coded forms of racism, often without the language or support to name it. She described a growing emotional gap, where older people recognise institutional racism but feel exhausted to address it, while younger people feel it but struggle to articulate, recognise, and respond to discrimination. This, she argued, is why it is crucial to imbed anti-racist education early on in education and sustain its learnings throughout schools, youth services, and public institutions. Therefore, she strongly opposed the removal of racial categories in ethnic coding as suggested in OFA 1, calling it "a form of erasure". She also criticised terms like BAME as harmful, imposed, and institutionally convenient but not reflective of how people identify themselves.

While supportive of the OFA in principle, T.J. viewed them as a starting point rather than a complete response. She called for clearer mechanisms for accountability, ongoing community-led monitoring, and a stronger emphasis on redistributing power in reports and practice. For progress to be meaningful, control must shift to communities themselves. A successful implementation of OFA 3, for example, should therefore include investing in racial literacy training led by those with lived experience, rebuilding trust, and ensuring that communities lead not only in naming the problems, but in shaping the solutions.

> **The structures are still the same. You can change the words, you can change the staff, but if the community is not driving it, nothing is really changed.**

2

Maternity, parenthood and early years

This theme reflects the community's wish for (health)care that not only understands, but values the lived experiences of Black mothers, children, and families.

From pregnancy through to the early years of parenting, community members raised questions about how services are designed, who is consulted, and whether professionals are equipped to deliver care that is inclusive, informed, and sensitive to racialised trauma. A key message was that early years matter deeply, and the systems that serve mothers and children must be shaped by the communities they aim to support.

OFA

5 Local Councils and Health and Wellbeing Board Partners

Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.

6 Local Councils and Children's Trusts

Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.

7 Local Councils and Health and Wellbeing Board Partners

Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.

8 Local Councils and Education Partners

Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through appropriate support and protecting them from relocation or eviction.

9 Local Councils and Education Partners

Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

OFA implementation

Community members expressed concerns about how much input they could have in shaping new tools and services meant for them and their children. Since these tools are meant to collect informtion, there was strong desire for more than just consultation. They called for genuine co-design, with their cultural knowledge and lived experiences forming the foundation of these online tools and maternity and early years interventions.

There were also questions about the diversity of needs within the Black community itself, especially in relation to migrants, refugees, and those with no access to public funds. The community members asked whether these groups are actively involved in shaping services that affect them, since their access to care could be limited and challenging.

> **How can Black parents contribute to the design of online tools that reflect our cultural practices around childbirth and parenting?**

> **What specific services are in place for Black women who are migrants, refugees, or asylum seekers, and how will their unique needs be addressed?**

Recommendations

Community members emphasised the urgent need for targeted interventions that are scalable and capable of delivering measurable improvements for Black communities, particularly in reducing disproportionate disadvantages and inequitable outcomes. These interventions must be rooted in real-life experiences and developed in partnership with those most affected.

A key priority is the creation of culturally tailored services for Black mothers, recognising systemic failings in maternity care. Special focus should be placed on women who face additional barriers, such as insecure immigration status or lack of familiarity with healthcare systems, ensuring that care is accessible, respectful, and responsive to their unique needs.

There is a need to develop culturally specific weaning guidance and support structures that celebrate and honour diverse traditions surrounding birth and early parenting. These include the use of holistic practices such as doulas, herbal remedies, and cultural approaches to wellness. While recognising that not all holistic interventions can be formally integrated into health services, the community asserts the importance of choice and agency in care that aligns with cultural identity.

Service providers are called upon to move beyond standardised models of care by embracing cultural flexibility, especially during key moments when mothers are accessing services. Policy and practice should be co-created with local families and shaped by genuine cultural understanding and flexibility. Community members strongly underscored that Black women experience pain just like anyone else, and that their voices and needs must no longer be ignored or minimised within healthcare settings.

Short-term:

- Design and scale up culturally responsive, targeted interventions for Black families, with particular attention to maternal health.
- Develop and disseminate weaning and early parenting guidance that is culturally relevant and honours community traditions.
- Support the integration of holistic practices, including the use of doulas and herbal support, allowing space for community-led approaches even if not all can be formally adopted.
- Transition service delivery from standardised care to culturally flexible models, ensuring programmes are co-created with, and for, local families.
- Train healthcare professionals to recognise and address biases and ensure that Black women's expressions of pain and need are heard, validated, and promptly addressed.

Medium and long-term:

- SEL must work with Black-led organisations to co-design specialised maternity and paediatric services responsive to the needs of Black families.
- Introduce annual cultural safety audits (reviewing anti-racism and accessibility). This will ensure that early-years and maternity care are culturally safe, inclusive, and responsive to Black mothers.

Podcast Findings

This episode featured two community-based experts: A.M., who leads the local Maternity Voices Partnership, and J.C., an early years educator with decades of frontline experience in Lewisham.

A.M. welcomed the emphasis on community engagement within maternity services and the articulation of clearer commitments. At the same time, she highlighted that previous consultation exercises have often failed to translate into sustained change, leaving many women uncertain about whether their experiences will lead to improved care. Concerns were raised about cultural safety and informed consent in maternity services, with Black women's pain and voices continuing to be undervalued in practice.

> **It is so important not to just hear this information and sit on it. It is about actually seeing what's been done with what you said.**

J.C. reflected on the growing focus on culturally responsive and preventative approaches within the early years sector. He supported the call in OFA 6 for earlier engagement and migrant-inclusive tools, noting that early years settings play a critical role in identity formation, emotional development, and long-term wellbeing. He also reported that early childhood provision continues to be framed primarily as childcare. This narrow framing reduces opportunities to embed trauma-informed and anti-racist approaches into the foundation of services.

Both speakers pointed to examples of community-rooted and co-designed services that are already producing change. However, they warned that this progress remains uneven and often under-resourced. They called for stronger accountability, particularly around how community feedback is taken forward and incorporated.

The absence of cultural continuity within education was raised, including the limited presence of Black male educators in early years settings. This could undermine children's sense of belonging and representation. J.C. spoke about the missed potential in not recruiting and retaining more Black men in early years roles, describing it as a major gap in both care and aspiration for youth. Black boys are frequently misread or adultified in early years settings, leading to disproportionate disciplinary responses and missed opportunities for support.

A.M. shared parallel concerns regarding maternity care, where Black women's voices are often dismissed and pain is under-recognised. She stressed that despite increased awareness; many women still experience care that lacks cultural safety or informed consent.

Both speakers were clear: these are not isolated incidents but systemic patterns that point to persistent gaps in racial literacy and trauma-informed practice.

In relation to OFA 7, both speakers supported the call for better recording and reporting of ethnicity but highlighted that existing categories are often reductive and alienating. For example the experience of being forced to tick “Other”, signals erasure and contributes to mistrust. Without more nuanced and inclusive data, services cannot adequately respond to the full range of Black communities’ needs and many residents will continue to disengage from research and feedback processes.

I keep ticking ‘Other’ — because none of the boxes fit me.”

A.M. and J.C. expressed cautious optimism. They acknowledged that the OFA capture the right principles of co-production, cultural competence, and accountability, and pointed to examples where this is already working well. An important aspect raised was that implementation must be consistent, resourced, and measured against the experiences of the community. Progress is possible only if communities are placed at the centre, not only in consultation, but in decision-making and delivery.

There are now more spaces opening up where women can speak. And they are being heard – not always, but more than before. In some of the MVP work, we have seen real change where feedback has gone into redesigning the antenatal pathway.”

3 Children and young people

Across the forums, community members shared concerns about how Black children and young people are being supported not only in school settings and health and care services, but in how they navigate the world.

Parents and caregivers raised questions about access to guidance, culturally sensitive care, and safe spaces where young people feel seen, protected, and able to thrive. There was a clear call for long-term support that reflects the everyday realities of Black families and for these services to be designed alongside the communities.

OFA

10 Education settings supported by the Regional Schools Commissioner and local Councils

Provide guidance and support for Black African and Black Caribbean parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.

11 Local ICS, Mental Health Trusts & Council commissioned Healthy Child Programme Providers

Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.

12 Education settings supported by the Regional Schools Commissioner and local Councils

Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people.

13 Local Health and Wellbeing Boards and Integrated Care Systems

Address low pay and associated poverty for frontline workers who are of Black African and Black Caribbean ethnicity.

14 Local Directors of Children's Services and Strategic Children's Partnerships

Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.

15 Local Councils and climate change and air quality partners

Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.

OFA implementation

Many members asked how practical support like school transitions, youth provision, or access to healthcare will be implemented in ways that are culturally relevant, accessible, and sustainable, while some expressed concerns about visibility, follow-through, and inclusion.

> **How will you ensure that Black parents and children have access to information and support during the transition to secondary school and further education?**

Members also highlighted the importance of involving trusted local centres and Black-led organisations in the delivery of youth services, particularly when it comes to creating safe spaces and building trust through meaningful initiatives that engage young people. The youth are not hard to reach; they simply need to be met on terms that resonate with them.

16 Integrated Care Systems (ICS) and Health and Wellbeing Boards

Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Recommendations

Community members emphasised that the one-size-fits-all interventions do not work. This is reflected in disparities seen in education outcomes, overrepresentation of Black youth in exclusion statistics and criminal justice data, and disproportionality in health and care services.

The community called for services that are tailored to address the specific challenges faced by Black young people. Services should include focused interventions on mental health, sexual and reproductive health, and gender-based violence. There was a strong recommendation for partnerships with Black-owned businesses and grassroots organisations to keep initiatives grounded in lived experience and real outcomes. Forum discussions highlighted a deep sense of community responsibility, with families committed to building resilience and equipping the youth with tools to navigate economic hardship. This blend of institutional accountability and community ownership was viewed as critical for meaningful change.

There is growing concern about financial insecurity, especially among young people in families experiencing low wages and rising living costs. Economic hardship was linked to deteriorating wellbeing, prompting calls for poverty to be addressed as an integral part of youth support services. In response, families and communities have taken ownership by sharing budgeting skills, promoting financial literacy, and reviving traditional saving methods such as pardner to support each other through the economic crisis.

How are Black-led community organisations, leaders, and businesses being involved in providing safe spaces for Black youth?

Short-term:

- Develop targeted interventions addressing the unique challenges of Black youth, focusing on mental health, sexual and reproductive health, and gender-based violence.
- Foster partnerships with Black-owned businesses and grassroots groups to ensure initiatives reflect lived experience and achieve measurable outcomes.
- Support community-led resilience-building efforts by equipping young people with practical skills to manage economic challenges.
- Integrate poverty reduction strategies within broader youth support services to address financial insecurity and its impact on wellbeing.
- Promote financial literacy and the revival of community saving practices like pardner within Black families and communities.

Medium and long-term:

- To enhance the transition experience between secondary and further education, local education authorities should fund health literacy curricula in primary and secondary schools that incorporate practical skills such as navigating healthcare systems, booking GP appointments, and understanding mental health.
- Local Authority Commissioners should improve identification and referral pathways for youth carers in Black communities and offer tailored support options.
- Create intergenerational health hubs (community-owned wellbeing centres) that strengthen family and intergenerational wellbeing while fostering belonging for youth.

Podcast Findings

This episode brought together an intergenerational group of experts, including a safeguarding board member (S.R.) and Lewisham's Young Mayor (J.), who responded to the OFA with a mix of lived experience, professional insight, and local political engagement.

The OFA were recognised as addressing long-standing concerns, although questions were raised about their visibility and delivery more than two years after publication. While the priorities remain relevant, the experts stressed that delivery has been slow, inconsistent, or unclear.

> **Guys [are] stepping out in Nike and LV hats — but there's no bedsheet at home.**

Poverty and exclusion were described as both widespread and increasingly hidden. Both S.R. and J. spoke about the material realities that sit behind appearances, such as children's loneliness, food insecurity and overcrowded housing, and emphasised how economic hardship intersects with cultural pressure, shame, and invisibility.

S.R. challenged narratives that place responsibility solely on respective communities and called for greater recognition of structural drivers such as the lack of affordable housing, youth provision, and school reform. In relation to the commitments set out in the OFA, services were described as fragmented, disconnected, or tokenistic.

OFA 12, which calls for targeted educational approaches to improve academic outcomes for Black African and Black Caribbean children, was discussed in detail. While Lewisham introduced a borough-wide pledge and toolkit for embedding race and racial equality in schools, both experts stated that fewer than half of school leaders who signed the pledge are actively using it. They described the initiative as often reduced to a "tick-box exercise" with little accountability or follow-through. They stressed that many school heads continue to be uncomfortable with anti-racism work, particularly when it empowers students to question and challenge their own outcome narratives. The conversation called for stronger enforcement, including potential legal accountability.

> **In no other profession can you be well paid for bad outcomes. Yet that's exactly what's happening in schools.**

S.R and J. stressed the need for more equitable partnerships between local authorities and Black-led organisations, such as Youth First, with a shift from consultation to co-creation. In relation to OFA 15, they raised concerns about how engagement is often conditional, with Black-led groups invited to participate only on pre-defined terms, limiting their ability to lead or innovate.

Concerns were raised regarding the implementation of OFA 11, 13, and 14 when it comes to transparency and accountability in local authority spending. J. emphasised the need for residents to remain engaged in decision-making and to press for detailed, quantifiable reporting on how budgets are spent. Especially for public funds, allocated by councils, police, and service agencies to improve outcomes for Black communities.

They highlighted a lack of local employment opportunities for young people, warning that without clear equity in planning and procurement, communities will continue to be locked out of growth. Communities must stay at the table and “hold their hands to the fire” not just to demand better, but to insist on a return for the investment they already make through taxes, labour, and lived presence.

A clear call to action also emerged around addressing the persistent lack of cultural understanding across public systems. S.R. and J. expressed frustration that institutions often misinterpret or overlook the lived realities, values, and strengths of Black communities. They urged councils and service providers to work in culturally responsive ways, co-design solutions with community input, and invest in ongoing training to embed equity and cultural intelligence throughout policy and practice. Without this shift, even well-funded interventions risk missing the mark.

Both experts emphasised the importance of lived experience in shaping policy and practice. They called for impact measures that reflect whether interventions are improving outcomes for children and young people in ways that are meaningful to those directly affected.

Our situation’s not improving, so that money’s going somewhere.”

“I feel the BLACHIR report is a vital piece of research that highlights the previously hidden challenges faced by the Black community in the UK. Moving forward, it is important that we continue to hold those in charge accountable and ensure they are doing all they can to close the gap in inequality.”

Jentai Gen-One

Former Young Mayor of Lewisham 2023-2024

4

Ageing well

Elderly Black residents shared thoughtful and often personal reflections on how services perceive and respond to their needs.

Whether it is access to health checks, culturally sensitive care, or mental health support, the message was consistent: ageing should not mean being overlooked. The community stressed that services for elderly must be respectful, culturally grounded, and shaped by the realities of those they serve, particularly in communities where historical mistrust still shapes engagement with health systems.

OFA

17 Regional NHS England teams and Local Public Health Teams

Provide targeted and culturally appropriate screening services for Black African and Black Caribbean older adults.

18 Local Public Health Teams

Campaign to raise awareness and increase uptake of community-based NHS health checks in Black African and Black Caribbean older adults.

19 Integrated Care Systems

Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.

20 NHS England and Integrated Care Systems

Support initiatives to improve uptake of vaccinations in older Black African and Black Caribbean people, focusing on areas of higher deprivation.

21 Local Health and Wellbeing Boards and Integrated Care Systems

Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

OFA implementation

Members of the community questioned whether services were truly reaching elderly Black residents. Accessibility was raised repeatedly not just in terms of physical access, but whether services feel welcoming, respectful, and appropriate for their community.

There was concern that some campaigns and screening services, while well-intentioned, might not consider the full context of Black elders' experiences, including intergenerational trauma and the legacies of exclusion in healthcare systems.

> **How will you ensure that vaccination campaigns reach Black elders who may be hesitant due to historical mistrust of the healthcare system?**

Recommendations

Community members called for interventions that recognise the structural inequalities affecting older Black adults alongside the cultural values that shape their lives. Suggestions included campaigns promoting routine health checks, targeted vaccination programmes in high-deprivation areas, and support systems reflecting the real experiences of ageing within Black communities.

Trusted spaces such as the Hummingbird Club were described as central to how this work should happen. They expressed a desire to be co-drivers of initiatives rather than passive recipients, actively shaping solutions that reflect their lived realities and address their community's needs.

What specific campaigns are being developed to raise awareness among Black elders about the importance of routine health checks?

Forum participants emphasised the urgent need to tackle the system's lack of cultural understanding of older generations, especially migrants who have historically been excluded. Many older residents navigate a system unfamiliar to them, where values and service delivery remain misaligned with their needs.

Short-term:

- Design and deliver interventions that address both structural inequalities and cultural values influencing the wellbeing of older Black adults.
- Promote routine health checks and targeted vaccination efforts in high deprivation areas relevant to older Black communities.
- Build authentic partnerships with the community, leveraging trusted spaces like the Hummingbird Club for co-design and engagement.
- Ensure older residents are active co-creators in planning and monitoring services, valuing their lived experience as central to decision-making.
- Address cultural misunderstandings within systems serving older migrants and excluded groups by improving training and service adaptation.

Medium and long-term:

- Integrated Care Systems (ICS) and community health services should reinstate mobile health clinics in high-need areas such as Forest Hill, prioritising routine check-ups and preventative care to enhance accessibility and optimise public health messaging throughout communities where there are significant disparities in health needs.
- Pilot community health navigator roles (peer guides supporting access to services) that reduces isolation and improves access for elders through trusted, culturally informed support.

Podcast Findings

This episode featured B.G., a Lewisham resident with extensive expertise in public health and decades of community advocacy around health inequalities. In responding to the OFA, B.G. focused on how ageing is experienced in Black communities and how current systems engage with older residents.

B.G. supported the life course approach set out in OFA 5 and linked it to the need to address long-term patterns of exclusion affecting older Black Caribbean residents.

> **They don't know much, if anything, about Black Caribbean people in old age... That really made my stomach turn.**

However, she highlighted whether implementation would reach the structural depth required to undo what she called "decades of structural neglect". She pointed to the near-total absence of older Black Caribbean residents in health research and strategic planning, calling it a form of institutional erasure. The health inequalities she raised, namely high rates of diabetes, poor dementia care, and unmet needs at the end of life, are not new. She describes them as shaped by generations of racism, poverty, and systemic exclusion from preventative care.

OFA 17, 18, and 19 emphasise culturally appropriate services and mental health access, B.G. noted that awareness initiatives alone are unlikely to address entrenched inequalities and that targeted investment is required to reach those most affected. Public health providers must invest unequally for equal outcomes.

The conversation also tied OFA 20 to real-world distrust in health services, especially around vaccination. B.G. explained how current incentive models in GP practices often prioritise flu jabs over chronic condition management, therefore further undermining trust, especially after the COVID-19 pandemic.

> **If I would have had a stroke and I am lying in bed, you're going to come and offer me a flu vaccination? Come on. What are the priorities here?**

Digital exclusion and service design are additional barriers. New systems requiring patients to use GP apps or online booking services exclude many Black elderly. The focus of OFA 21 on interventions must therefore be grounded in real usage data and lived experience, not assumptions of access. B.G. reflected on how gentrification has pushed Black elders into deprived areas without adequate infrastructure. Due to the lack of services in their own area, Black elderly give up on GP services altogether, often leading to preventable deterioration in health. She described centres such as Calabash and Hummingbird as essential to physical and mental health, cultural connection, and intergenerational support. Yet, these spaces are "hanging on by a thread".

Importantly, B.G. pushed back against narratives of passivity in later life. She described how walking groups, intergenerational care, and healthier living are already being led by Black elders but are rarely acknowledged in formal systems.

Overall, B.G.'s analysis affirms the OFA but calls for sharper implementation, better data, and an improved redistribution of power. Without these, the risk is that older Black adults remain underserved.

> **They are still here. Still learning. Still leading. If we treat them like that, we might start seeing different outcomes.**

5

Mental health and wellbeing

Mental health emerged as a key area of concern across the forums, with community members calling for services that truly understand the weight of racial trauma and the ongoing impact of systemic discrimination.

The community stressed that mental health is not just an individual issue but is shaped by histories of exclusion, mistrust, and cultural disconnect. People called for trauma-informed, culturally rooted approaches that are developed with the community and delivered through trusted, safe spaces.

OFA

22 Local Public Health and Community Mental Health Trusts

Coproduce awareness campaigns for Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self referral in collaboration with carers, families, health services, community and faith centres.

23 Local NHS providers and Community Mental Health Trusts

Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.

24 NHS Mental Health Providers and Commissioners

Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.

25 Local Health and Wellbeing Boards and ICS Partnerships

Promote cultural competency training within healthcare services, the criminal justice system, and the police force.

26 Local Health and Wellbeing Boards and Integrated Care Systems

Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

OFA implementation

Across discussions, the design and delivery of mental health (awareness) work was closely linked to how far communities were involved in shaping it. Services were described as too often being designed for Black communities rather than with them, which was seen to limit relevance and trust. Community members

How are Black community leaders and organisations being involved in the development of mental health awareness campaigns in Lewisham?

emphasised that meaningful engagement begins with ownership, yet many campaigns were described as largely developed by statutory bodies and external providers. Mental health interventions often remained clinical or institutional in nature, failing to reflect the places and people Black communities turn to when they are struggling, such as faith groups, cultural spaces, and local advocates.

Recommendations

Strong support was expressed for mental health campaigns that are community-led and grounded in language that reflects lived experience and cultural identity.

Many said that using everyday language such as “wellbeing” makes it easier to start conversations than clinical terms that still carry stigma. What mattered most was feeling that these campaigns were shaped by the realities of their lives rather than imposed from outside.

> **How are you ensuring that mental health services use language that resonates with Black communities and reduces the stigma around seeking help?”**

Racism came up repeatedly as something that affects how people feel, cope, and seek help. It was described as part of what causes distress in the first place, such as housing, schooling, work, and how services treat people. This framing led to a call for racism to be addressed as a structural harm that requires system-wide intervention rather than isolated responses.

Because of this, participants felt that small changes to existing services are not enough. They talked about the need for mental health systems to be redesigned with communities, so that support reflects how people actually experience and manage stress, trauma, and care.

There was also a strong feeling that any changes made by the NHS need to be judged by whether they improve equity for Black communities, rather than by whether they simply roll out new programmes or structures.

Short-term:

- Develop mental health and wellbeing campaigns that are community-led and use culturally resonant language to reduce stigma.
- Implement practical approaches that recognise racism as a core driver of mental health inequalities and treat it as structural trauma.
- Co-lead a comprehensive audit and redesign of mental health services with voluntary sector partners and affected population groups.
- Ensure NHS mental health service reforms are rigorously evaluated for equity, preventing further widening of disparities in Black communities.
- Foster whole-system interventions to address structural racism within mental health care delivery.

Medium and long-term:

- PHL, in conjunction with SLAM/CAMHS, must consider commissioning grassroots organisations to optimise mobilisation of activity and deliverables. For example, the launch of Walk and Talk peer-support groups for young men in local parks and trusted community spaces.
- ICBs and Local Authorities should consider embedding a rolling grants programme to commission culturally grounded, non-clinical mental health spaces for young people, developed and led by Black community organisations.

Podcast Findings

This episode featured J.M., a Lewisham-based mental health practitioner and advocate with extensive experience in community-based care, public health, and Black-led service delivery. Her reflections focused on the gap between the intent of the OFA and the capacity of current systems to deliver them.

J.M. referred to the language of the OFA as aligned with community need, while describing the existing service infrastructure as limited in its ability to respond to what is being asked. The language is there, but "they are asking something from a system that cannot respond that way. It is not designed to." This reflects a wider trend in health planning, one where policy ambition is not matched by structural change.

The framing of Black communities as "hard to reach" was directly questioned. J.M. stated that services consistently failed to provide safe, accessible, and culturally and context-sensitive support. What appears to be low uptake is often the result of years of built-up mistrust and exclusion, rather than disinterest or disengagement.

> **We weren't hard to reach; there was just no in-reach.** ”

OFA 23, which calls for trauma-informed and culturally competent care was discussed in relation to practice. J.M. referred to Family Health ISIS, a Black-led organisation that offered advocacy, early intervention, and culturally safe care, as evidence of what works. Family Health ISIS addressed stigma, both internal and external, surrounding Black residents who needed mental health support. She connected fear of services and silence around suicide directly to the absence of trusted institutions such as this one. Its closure, despite its clear impact, showed how community-rooted responses are still de-prioritised and underfunded. Faith settings were identified as critical spaces, but also as places of spiritualisation of mental health. She emphasised that they are untapped spaces for culturally sensitive dialogue and support for the implementation of these OFA.

J.M. was critical of how the current system continues to criminalise distress, a reality that actively obstructs the successful implementation of the OFA. The over-use of Community Treatment Orders (CTOs), over-diagnosis of psychosis, and the quick escalation from unmet needs to involuntary detention are not incidental but structural patterns. These patterns are rooted in racism, not only as bias, but as an embedded practice within current services.

> **You say no to something, and suddenly you are non-compliant. You are not the expert in your own care anymore.**

OFA 26 includes a commitment to improve language in service delivery. J.M. welcomed this but stressed that meaningful change requires specificity, and that specificity depends on better mental health data. This presents a further challenge: “What data is being collected and how? And how precise are the questions, particularly around identity?”

> **You cannot measure wellbeing through the lens of illness alone, and yet that is still the standard.**

She highlighted that assessments still rely heavily on Eurocentric frameworks, and that wellbeing continues to be measured largely through a lens of illness. Without disaggregated data and a broader, community-informed understanding of mental health, accountability becomes impossible, and engagement from the community remains limited.

A shift in public mental health from deficit-based models to strength-based, prevention-led, community-rooted approaches could be a workable solution. There is a need for sustained investment in what the community has already built. This includes co-production, investment in Black-led services, trauma-informed practice, and system-wide racial literacy. Co-production should not remain rhetorical. Without the redistribution of power, the OFA risk becoming another well-meaning but unfulfilled promise of change.


IMAGO
Be Your Own
Success
Story

The BLACHIR Report is the most comprehensive review of health inequalities affecting African Caribbean communities, drawing on overlooked data and valuing communities as assets. It calls for community-led decision-making, influence over research design, and solution-focused interventions that improve quality of life rather than relying on deficit-based models. Investment in underserved Black communities, and aligning services to residents' needs are essential to delivering the national goal that "there is no health without mental health" for Black African and Caribbean people.

Juney Muhammad
Independent Mental Health Promotion Consultant

6 Healthier behaviours

This theme explores how health and wellbeing can be supported through everyday behaviours, trusted relationships, and accessible community education.

Health messages were described as most effective when delivered by familiar voices in familiar places. The need for services that understand how structural racism impacts both individual behaviour and community health outcomes was paramount. There was a strong push for local ownership, long-term investment, and an approach to health that values lived experience as much as clinical knowledge.

OFA

27 Local Directors of Public Health

Work with Black African and Black Caribbean communities and organisations to cocreate and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.

28 Health Education England

Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.

29 Local Councils and Integrated Care Systems

Provide long-term investment for trusted Black African and Black Caribbean grass roots organisations such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.

30 Local Directors of Public Health

Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.

31 Research funding bodies such as NIHR

Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in ‘action research’ to concurrently deliver and evaluate interventions.

32 Local Directors of Public Health and nationally OHID

Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

OFA implementation

The community asked how community organisations, particularly Black-led and faith-based groups, are being engaged in delivering health education and preventative care. The community made it clear that programmes should not be parachuted in through top-down initiatives but must be co-designed with those already embedded in local life, the real experts on their own communities.

> **How are you partnering with Black faith based organisations to promote healthier lifestyle choices in the community?**

There was also interest in how trauma-informed practices would be integrated into these health behaviour efforts not as an afterthought or an add-on, but as a foundational pillar from inception designed with Black communities and those with lived experience.

Recommendations

Calls were made for more meaningful engagement with local organisations, not just in delivering programmes, but at the design stage. Interventions that reflect Black residents' lived experiences and values, including faith, food, family, and social support are necessary to address (un)healthy behaviours.

Residents emphasised the importance of explicitly recognising racism and discrimination as direct contributors to poor health outcomes. They advocated for approaches that are explicitly anti-racist and that confront systemic barriers head-on. To achieve this, they stressed the need for robust, transparent commissioning and procurement processes. This would enable fair access to funding, ensure accountability in service delivery, and align with community priorities. The importance of upholding the Duty of Care under the Equalities Act was highlighted to strengthen these processes.

There was consensus that cultural competence training for all health employees should be an ongoing, embedded practice as this was considered a golden thread of best practice.

How are Black communities engaged in the design and delivery of health literacy programmes, and what role do local organisations play?

Short-term:

- Engage local Black organisations meaningfully in both the design and delivery of health programmes, ensuring interventions reflect community values around faith, food, family, and social support.
- Explicitly embed anti-racist approaches that address structural barriers within commissioning and procurement processes.
- Ensure transparency and fairness in funding allocation, holding providers accountable and aligning services with community priorities.
- Uphold the Duty of Care in service design, as mandated by the Equalities Act to protect community interests.
- Design services with and by Black communities to ensure needs are met authentically and effectively.
- Implement ongoing cultural competence training for all health employees as an essential element of best practice.

Medium and long-term:

- Local health authorities should support the creation of WhatsApp broadcast lists (opt-in) to share appointment reminders and public health updates with community members, to optimise the acceleration of health messaging.
- Develop a shared learning platform (hub for data, evaluation, and practice exchange) encouraging collaboration and learning around prevention, wellness, and lifestyle improvement.
- Introduce a long-term Equity Impact Fund (ring-fenced for Black-led innovation) that sustains preventative, community-led health and wellbeing initiatives.

Podcast Findings

This episode featured two community experts: Q.W., the founder of the Queen's Walking Group, and M.W., a lead member of the Men's Walking Group. Both responded to the OFA with insight grounded in lived experience and long-standing community health work.

Q.W. and M.W. welcomed the OFA' focus on promoting healthier behaviours but emphasised that change cannot happen without practical, community-based support. Q.W. spoke about how Black women in her network were ready to take charge of their health but often lacked accessible entry points. Education, health literacy and public health outreach were such entry points, but they require culturally sensitive, peer-led support and not generic campaigns.

Her walking group, which grew from a small WhatsApp group to nearly one hundred members in just six weeks, has become a consistent space for physical movement, mental wellbeing, and collective care. Besides exercise, this space rebuild healthy routines and accountability in everyday life.

M.W. echoed the importance of belonging and consistency, especially for older Black men managing diabetes, hypertension, prostate cancer, and social isolation. His group, formed in a local park, offers a space where men can "walk and talk" away from clinical settings that often feel alienating.

> **Health isn't just about steps. It is about who is walking beside you."**

Both experts raised concerns about how health initiatives are delivered. While they acknowledged the efforts made under OFA 27 and 29, they felt programmes, like Up Up, were difficult to access and too often reliant on GP referrals that do not reflect community realities. OFA 29, the provision of long-term investments for Black-led grassroots organisations, is a welcome and much-needed commitment, but in practice often feels unimplementable. Q.W. described how she now carries flyers for local initiatives in her bag because "you have to meet people where they are, not where you wish they'd be."

Cost-of-living pressures were named as a critical barrier to healthier behaviours and successful implementation of the OFA. M.W. described how food prices have reshaped men's diets, making it harder to choose what is healthy over what is affordable. Q.W. added that nutrition advice often does not account for the cultural and economic context of the people it is aimed at.

They are always going to go for whatever they can get because no one is helping them stretch a pound.

Both experts agreed that lasting change requires information and communication that speaks the language of the people and understand where they are economically and culturally.

The experts also warned against framing health behaviours through a deficit lens. M.W. challenged assumptions that Black men lack discipline or interest in wellbeing, pointing instead to inherited trauma, systemic neglect, and a lack of culturally safe services. Both experts called for OFA 28 and 30 to be implemented with care, especially in faith spaces, which can either reinforce silence or serve as hubs for prevention, depending on who is leading.

Ultimately, both Q.W. and M.W. described behaviour change not as a matter of individual willpower, but as something shaped by design, access, and trust. Their experiences highlight what is possible when community-led initiatives are supported and when health is made part of everyday realities.

You don't need a field to grow food. You just need someone to show you where to start.

What Works

The Walking Men's Group of Lewisham (WMG) began with support from the Better Mental Health Fund, created in response to mental health challenges after the COVID-19 pandemic. Inspired by the positive effect of social connection on wellbeing, SIRG helped launch WMG with 360° Lifestyle Support Network. Starting with just 20 Black men for a six-week pilot, the group has grown to nearly 100 members in three years.

WMG uses walking and peer support as simple but powerful tools to improve mental and physical health. Walking promotes exercise, reduces loneliness, and opens space for honest conversation. The group builds community and encourages self-care, reducing mental health crises and providing ongoing support.

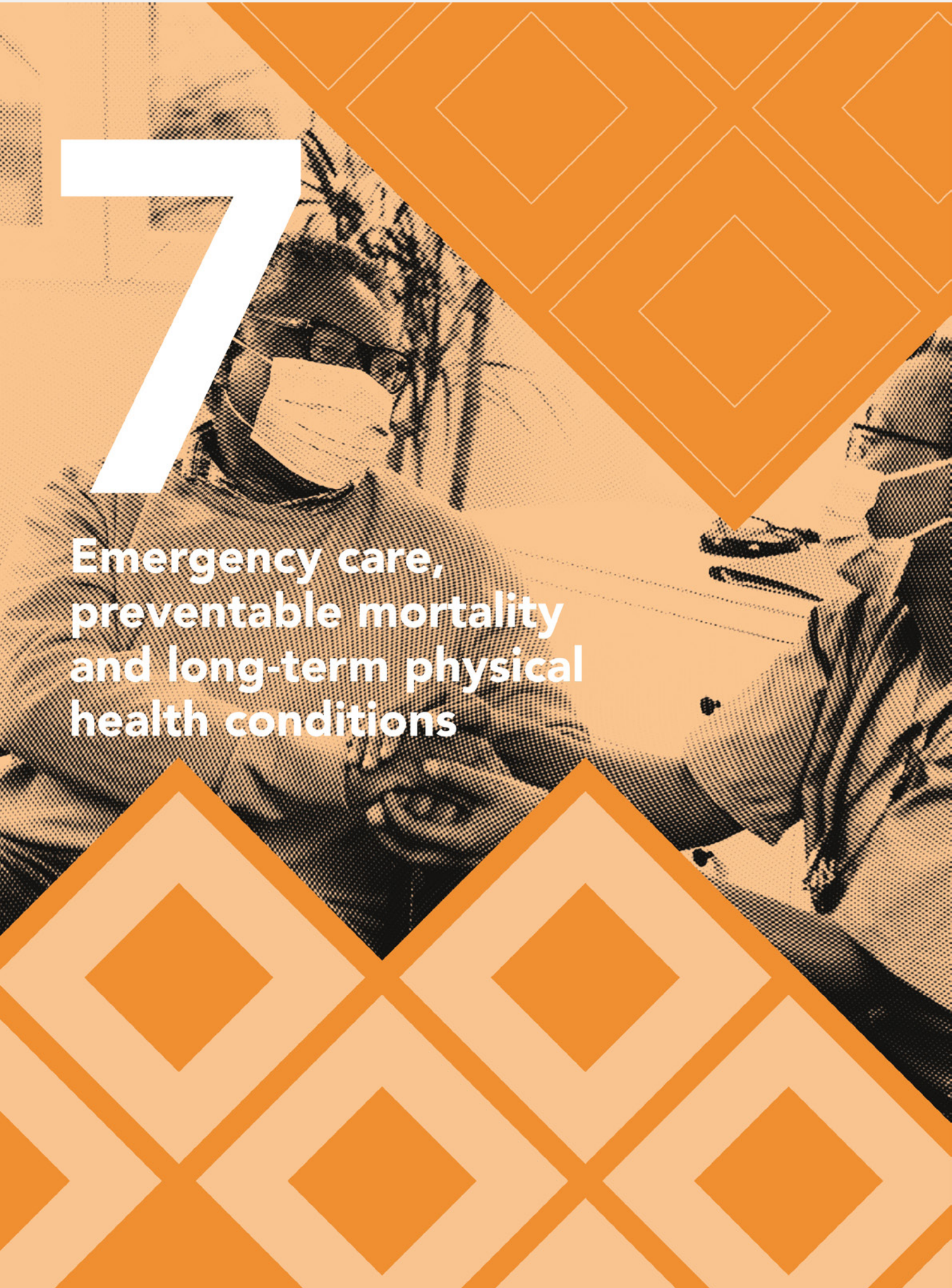
Over three years, WMG has hosted events such as expos, trips, and participated in large mental health campaigns. It now receives independent funding from Walking & Cycling Grants London, showing strong sustainability.

This group highlights how grassroots, community-led initiatives can leverage public funding to deliver culturally relevant, effective support, especially to communities often seen as hard to reach.

I love going on walks in the fresh air in a beautiful South London Park. The discussions we have on various topics help me learn more about life and to become the man I want to be.

I enjoy connecting with a group of men who are improving their lives and also helping the younger generation. We debate a diverse range of subjects and focus on making positive changes.

The group brings something out of me that helps me to move on in my life. It gives us men a chance to talk and discuss things and not sit behind closed doors.



7

Emergency care, preventable mortality and long-term physical health conditions

This theme generated some of the most detailed and consistent feedback from the community.

Long-standing challenges in accessing care for chronic conditions and during health emergencies were raised repeatedly, attributed to poor access, under-diagnosis, unsafe interactions, and a lack of culturally sensitive support. The discussion went beyond clinical concerns and pointed to a system where trust has been eroded and where adequate action is overdue. Experiences during the COVID-19 pandemic were highlighted as part of this context.

Fears about being overlooked or misdiagnosed, frustrations with medication systems and appointment access, and the toll of navigating services that do not reflect their lived experiences were discussed. Community members called for visibility, accountability, and equity, and made clear that any response must centre the realities of both younger and older generations.

OFA

33 NHS England, Integrated Care Systems and Local Councils

Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations.

34 Local Health and Wellbeing Boards and ICS Partnerships

Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments.

35 Local Directors of Public Health and NHS Prevention Leads

Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy.

OFA implementation

A major shared concern was the invisibility of action. Community members expressed that they often do not see the presence of Public Health or emergency services in their communities, in a way that feels familiar, respectful or reliable. They called for tangible engagement: outreach that is consistent, spaces that are safe, and services that meet people where they are, whether in barbershops, churches, or community centres. Accessibility and proximity are crucial; services must be in places people readily go to and trust.

> **Our community has no safe space outside their homes... this matter has to meet us where we are.**

The community also stressed the need for multi-generational responses. Older adults raised concerns about delayed care and overlooked conditions, while younger people and their parents spoke about the ongoing mistrust in healthcare systems and the desire for better prevention and education early in life.

> **What are we doing to change this thinking for the younger generation? It's not just the older generation, it is the same for the younger people.**

Recommendations

The forums generated a set of specific and urgent proposals. These included stronger support around stroke prevention and cardiovascular health, with clearer guidance and education for clinicians on prescribing and care delivery.

Particular concern was raised about the way uterine fibroids are addressed in Black women. Community members described fibroids as having a significant impact on fertility, quality of life, and emotional wellbeing, while often being treated as low-priority within health services. Despite the evidence showing that Black women are disproportionately affected by fibroids, the condition is frequently underdiagnosed or dismissed, contributing to mistrust and inadequate care. Black women feel that healthcare professionals do not take them seriously. Raising awareness among both healthcare providers and Black women about the prevalence and seriousness of fibroids is critical.

> **Fibroids in Black women is a huge issue which is underplayed. I would love to see this highlighted.”**

> **My daughter asks me to go with her and she’s 30. She feels she is not listened to.”**

The community also expressed a strong desire for the creation of a Black-led digital health platform, such as a “Black UK Medic,” to provide culturally relevant health education, facilitate provider access, and strengthen community connections.

Short-term:

- Increase support and public health campaigns focused on stroke prevention and cardiovascular health tailored specifically for Black communities.
- Develop and deliver targeted clinician education programmes to improve understanding and management of conditions like fibroids, emphasising their impact on Black women's health and wellbeing.
- Promote awareness campaigns within Black communities about uterine fibroids to encourage early detection and timely care.
- Establish a Black-led digital health platform offering culturally relevant health information, provider access, and community networking opportunities to empower health literacy and engagement.
- Ensure that health services incorporate culturally competent approaches in managing conditions prevalent in Black populations, prioritising patient trust and effective communication.

Medium and long-term:

- ICB must reinstate phone-based GP appointment bookings and provide clear alternatives for patients unable to use online systems.
- Lewisham Council, in partnership with youth organisations, must fund and coordinate technical support buddy schemes, enabling young people to support older residents with NHS app usage and digital form navigation.
- South East London ICB and Healthwatch must consider commissioning co-designed multimedia materials (e.g., short videos, audio messages), explaining how to access NHS services, produced in African and Caribbean languages.
- Integrated Neighbourhood Teams (INTs) must embed trained community health advocates within surgeries to assist with navigating forms, booking appointments, and understanding diagnoses.

Podcast Findings

This episode featured J.J., a community development worker embedded in North Lewisham's Health Inequalities programme, who responded to the OFA drawing on frontline delivery and long-standing experience working in communities that statutory services have historically struggled to reach.

She described how North Lewisham pioneered a health equity model in response to COVID-19 to implement early intervention and prevention services for the local population. The introduction of Health Equity Fellows included the organisation of free, walk-in MOT-style health checks, covering BMI, blood pressure, diabetes, cholesterol, prostate cancer, and HIV, delivered in everyday places like churches, mosques and community centres.

> **We brought them in and gave them a full MOT… and through that, we were able to detect people that had pre-diabetes or were having diabetes. We could then direct them to where they had to go.**

OFA 35, focuses on fair and appropriate prevention services, was welcomed. J.J. noted that the challenge lies in sustaining and replicating what is already working. She noted that North Lewisham had been the pilot site for this work and that its success helped shape a borough-wide strategy. Still, she questioned why similar levels of resourcing and ambition were not visible across all localities. In her view, the expertise and access already exist within communities. The barrier is that systems continue to operate at a distance.

> **As soon as they start, you have got to be looking for the next lot of money… they always do that to us.**

On OFA 33, which calls for culturally appropriate data collection, J.J. highlighted that the current approach still lumps diverse communities into one category and treats Black communities as one homogenous group. She stressed the need for data that captures real cultural and national variation, particularly when it comes to understanding long-term conditions. "If you are Nigerian, it should say you are Nigerian," she argued, noting that meaningful service planning cannot happen without better data.

> **We were the pilot of the health inequalities programme... and because we did such a good job, that is now why you have got HEFs in all the other PCNs.**

In reference to OFA 34, which focuses on meaningful engagement, was also discussed. J.J. supported the proposals in principle but warned that unless they are matched by resourced, long-term planning, they risk becoming another short-lived cycle of outreach.

Throughout the conversation, J.J. challenged the idea that Black communities are disengaged from care. What appears to be low participation was often a sign that services are not going where people are, or they are designed without community input.

Whether in places of faith or Domino's, J.J. emphasised that trusted spaces already exist. The real test is whether services are willing to meet people there, actively listen to what is needed, and follow through on implementation. The OFA offer a strong and detailed blueprint, but their effectiveness depends on services being willing to operate in these spaces, invest in existing community infrastructure, and maintain consistent delivery over time.

8 Wider determinants of health

Although this theme did not receive dedicated responses in the forums, it remains a crucial structural lens through which to understand health inequalities.

Community members recognised that health outcomes cannot be separated from the social and economic systems that shape people's lives.

Health was placed at risk by housing insecurity, poor air quality, employment and income disparities, and experiences of discrimination in schools and public services. For Black communities, these risks intertwine and compound, resulting in systemic barriers that influence physical and mental health outcomes. The intersection of race with these wider determinants of health highlights how structural racism and marginalisation operate across these domains. creating an unequal access to resources and opportunities.

Addressing health inequalities requires a comprehensive approach that tackles these underlying social and economic conditions.

OFA

36 Local Health and Wellbeing Boards and Integrated Care Partnership Boards

Consider cultural and religious influences when developing interventions to address the wider determinants of health inequalities for Black African, Black Caribbean and Black Mixed ethnic minority groups.

37 Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations

Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.

38 Local Health and Wellbeing Boards

Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.

39 Local Health and Wellbeing Boards and Integrated Care Partnership Boards

Take action to address employment inequalities and issues around racism and discrimination in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high risk occupations.

Short-term:

- Develop cross-sector policies that address housing quality, employment opportunities, and environmental justice as central components of health equity strategies.
- Increase investment in community-led initiatives to improve living conditions and reduce environmental hazards disproportionately affecting Black communities.
- Implement anti-discrimination measures in education and public services to dismantle systemic barriers that impact health outcomes.
- Collect and use disaggregated data to better understand and respond to the complex ways social determinants affect health in Black populations.
- Foster collaboration between healthcare, housing, employment, education, and environmental sectors to create integrated solutions that address the root causes of health disparities.

Medium and long-term:

- ICS must pilot travel subsidies for patients with SEND and complex needs facing long commutes to access GP or hospital care.
- Create equitable funding pathways (micro-grants for grassroots projects), addressing structural inequity in funding and supports community economic resilience.
- Establish a Black Health Equity Institute (community-academic policy hub) to tackle systemic inequity through long-term research, policy, and cross-sector influence.
- Integrate health equity KPIs into local authority performance frameworks. Makes racial health equity a measurable requirement in council accountability.

Podcast Findings

This episode featured J., a youth worker and community organiser in Lewisham, who reflected on the OFA through the lens of lived experience and local action. His response focused on how the priorities set out in the OFA translate into power and decision-making on the ground.

J. supported the OFA' emphasis on representation and on addressing racism and discrimination in public systems, while questioning whether representation alone leads to change. The presence of Black service members alone is not enough. He pointed to the lack of adequate representation of Black voices on local NHS Boards and reflected on his own public appointment to the Youth Justice Board, describing it as rare. What matters is not just having a seat at the table, but being able to use that position to instigate necessary change and create meaningful impact.

> **For us to be in those spaces [police, NHS] and do well, the culture has to shift. Because the culture isn't set up for us to thrive or to be ourselves. You get in there, and before you know it, you are conforming.**

If systems want to understand culture, they need to trust those who live it. J. challenged the common pattern of consultation (only speaking with the community to “pick their brain”) without power. He called for a shift from surface-level engagement to genuine power sharing, where communities help set the agenda instead of only responding to it. For the OFA to be succesful, knowing what hurts is not enough; systems must also be clear and practical about what healing looks like. “We know what’s hurting us, but what is needed now is clarity around solutions, long-term planning, and the tools to make those solutions real.”

So, when they are creating these jobs for us in terms of cultural competency or whatever, we are the only ones who can feel it. Because we are the only ones who know how to build solutions.”

Mental health for Black men was raised as a wider determinant that is often left unspoken. Shame, silence, and pressure to perform strength often prevent men from seeking care until it is too late. He proposed reframing mental health through the lens of hygiene, a universal construct. This shift could create space for earlier conversations and more culturally grounded support.

Across the conversation, J. emphasised that communities are not waiting to be fixed. They are already doing the work, building spaces of support, care, and resistance despite the current systems, not because of them.

Think of mental health like hygiene, you know if you haven’t bathed, just like you know when you are not okay.”

Community Needs

Across All Themes

Throughout all eight themes, three topics have been identified as the groundwork needed to consolidate all efforts in the OFA:

1 **Research**

2 **Training**

3 **Resources**

What people brought into the room was shaped by years, sometimes decades, of experience with systems that listen but do not act and speak the language of equity but fail to resource it. These were not abstract issues. They were about trust, visibility, and being taken seriously.

Together, these conversations show not only what needs to change, but how current systems are experienced on the ground and where people feel unheard.

Research

Across all themes, community members raised deep concerns about how research is conducted, what is being measured, and whether it ever leads to meaningful change. While there was broad recognition of the value of data, many expressed scepticism about how it is gathered, who it serves, and what is done with it.

The community expressed clear discomfort with research-led approaches that fail to produce visible change. Many spoke of the exhaustion that comes from sharing their experiences repeatedly, only to see them disappear into reports without feedback, follow-up, or real acknowledgement. As one resident put it, “What other metrics are being used for those who may not fill out the questionnaire?”

Many questioned whether current research methods truly capture the complexity of their lives. There were calls for:

- Disaggregated data that reflects ethnic, national, cultural, and migration-based differences within Black communities.
- A shift away from broad ethnic categories that flatten identity and obscure systemic inequalities.
- Stronger community-led or action-oriented research models that are designed with and for the people of the community.

There were also questions on how research success is measured. Counting the number of programmes is not enough, as communities want to know whether those programmes work, how they are being evaluated, and who sets the standards for success. This was particularly relevant in areas such as mental health, maternity care, early years, ageing, and education, where poor evaluation can result in culturally inappropriate services being repeated or even expanded.

Crucially, there were repeated questions about why some issues remain under-researched. Why is there so little evidence around the experiences of Somali, Eritrean, or Ethiopian communities in Lewisham? Why is there limited understanding of why Black men delay or avoid GP visits? And how are we addressing the longstanding lack of research on SEND families and racial trauma?

Despite being willing to share, many participants expressed low trust in research, as their contributions have rarely led to meaningful change. They emphasised the need for greater transparency in how findings are used and clearer communication about what follows.

Above all, the message was clear:

Research should not just document inequality, it should help dismantle it.

Training

Training was described as a test of whether systems are serious about change. Community members were clear that box-ticking exercises do little to challenge harmful behaviours or shift practice on the ground. They spoke of professionals continuing to arrive unprepared, despite the availability of information, because little effort is made to apply it meaningfully within real-world contexts.

The concerns went beyond whether training takes place. People questioned what is being taught, who is delivering it, and whether it leads to any tangible difference. Across health, education, mental health, and public services, there was a strong call to move away from detached, generic approaches and towards training grounded in lived experience.

Key messages included:

- **Anti-racism and trauma-informed training**
  The community repeatedly called for training that directly addresses systemic racism and its impacts — including race-based trauma, intergenerational stress, and discrimination in care. This applies across the life course, from early years to elder support, and must be embedded in prevention, education, and emergency response.
- **Training led by those with lived experience**
  People were clear that training must be co-designed and delivered by those who understand what it means to navigate racism and exclusion within systems, not with consultants without connection to the communities affected. Participants called for more visibility of Black professionals in training, leadership, and service delivery.
- **Sector-wide, not one-off**
  The community raised concerns about inconsistencies in how training is delivered across settings, particularly between police, schools, health services, and local authorities. They called for a joined-up approach that recognises racism as a cross-sector issue, not something to be handled in isolation. Training must be consistent, repeated, and accountable.

There were also specific calls:

Early years staff should be equipped to recognise racism as trauma.

Mental health teams must be trained to “listen before they label”.

Maternity professionals need deeper understanding of how discrimination affects Black women’s experiences and outcomes.

Clinicians should understand how structural inequality shapes physical health, including the impact of poverty, vitamin D deficiency, and psychosomatic stress on Black residents.

The community highlighted that training is not only about transferring knowledge. It is about how people show up in practice, and whether that results in different choices, better care, and improved outcomes.

Resources

Behind nearly every concern was a shared truth: without long-term, meaningful investment, even the strongest ideas from communities or government will fail to become sustainable.

Community members described systems that rely heavily on community-led care, yet offer little back in terms of stability, recognition, or funding. They spoke about safe spaces being lost, outreach teams being understaffed, and programmes disappearing just as trust begins to build. The community is already doing the work, but they are doing it without the tools, support, or certainty to sustain it.

Key messages included:

- **Sustainable funding, not pilot projects**
  Across youth provision, maternity care, mental health, chronic conditions, and ageing, residents called for an end to short-term funding cycles. They want investment that supports long-term change, not one-off trials or awareness weeks.
- **Support for Black-led and grassroots organisations**
  These organisations are often closest to the community, most trusted by residents, and best placed to respond to local needs; yet they remain underfunded and over-relied upon. Residents stressed that praise is not enough. They need financial support, workforce development, along with a seat at the table that is not merely ceremonial, but one with teeth, capable of driving necessary change.

- **Investment in safe, familiar spaces**
  From community halls to faith centres and local networks, people want care to be available in places they already trust. These are the spaces where early intervention happens, where stigma is reduced, and where cultural context is understood without needing explanation.

- **Infrastructure to support participation**
  Co-design, cultural competency, training, advocacy, none of which can happen without resources. Residents want to see investment not just in services, but in the processes that bring them to life. That includes funding for translators, community advocates, and staff who can build long-term relationships across difference.

- **Staffing that reflects community need**
  People raised concerns about staffing levels. Effects are felt from delays in getting medications to the absence of outreach workers. They want more staff who are not only present but prepared, trained, representative, and able to walk alongside those navigating complex systems.

At its core, this is not a call for charity. It is a call for fairness. Communities cannot be expected to carry the weight of broken systems without being resourced to do so. As one participant said:

> **We don't need new strategies. We need support for what's already working.**

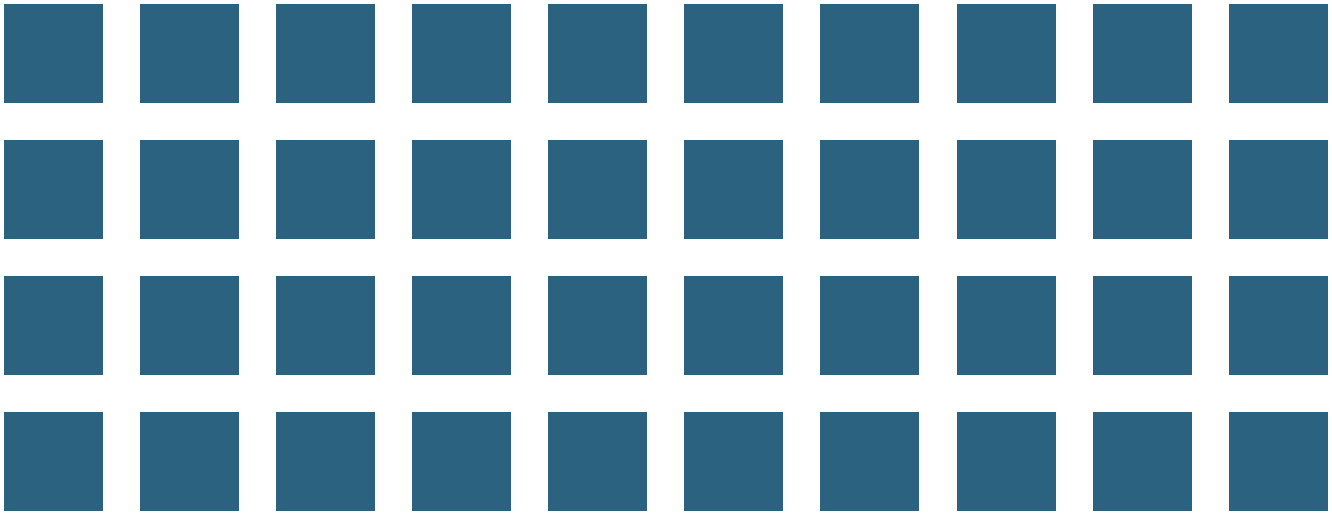
The Voice of Generations

Across 160 community interviews conducted for this engagement report, a clear thread emerged:

Health inequality remains a daily reality.

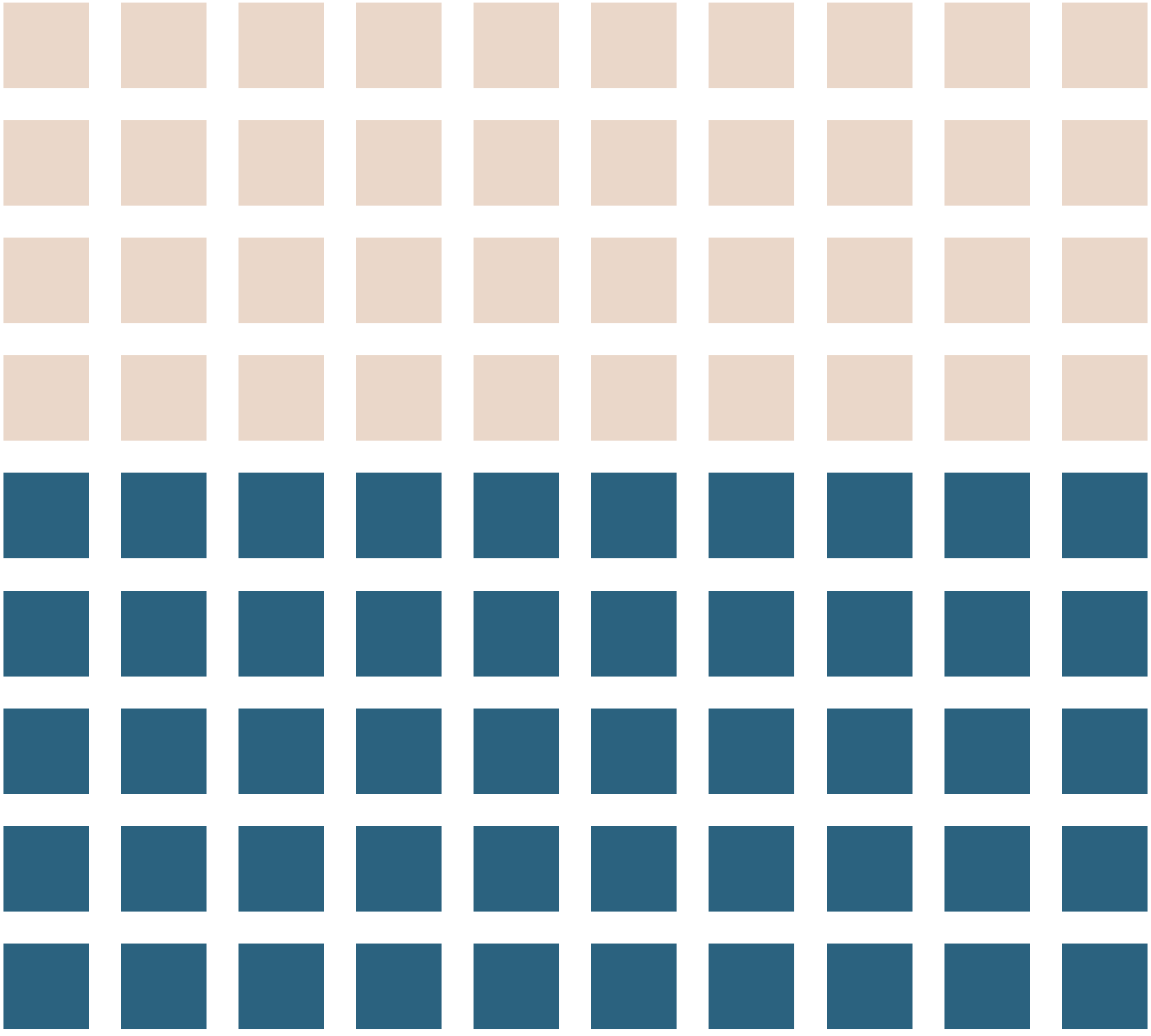
70 elders

90 young people



This chapter brings together reflections from 90 young people and 70 elders, offering a generational perspective on how unequal access to care is experienced, understood, and remembered.

These insights do not stand apart from the themes explored in the main engagement but rather they reinforce them, bringing the OFA into sharper focus through everyday lived realities.



Shared Realities

Both young and older participants spoke about unequal access to healthcare. Although they were at different life stages, the barriers they described were similar. Elders often recalled years of navigating services that were neither accessible nor responsive, facing delays, postcode restrictions, and the burden of self-advocacy. One woman explained she delayed care because her GP was too far and public transport too difficult: “It doesn’t feel like we’re meant to be seen quickly or seen at all.” Others noted the shift to digital systems had made things worse: “My GP stopped phone bookings, now it’s all online. I have to get my daughter to help, otherwise I just do not go.”

Younger participants, though newer to the system, had already observed and internalised similar patterns. Some had never visited a GP or had a routine check-up. One 16-year-old male living in temporary accommodation said: “Care feels like it’s for clean people, people with jobs and suits.” Others described watching their parents being misunderstood or treated as a risk. These early experiences shaped their expectations of care as something inaccessible, or even hostile.

> **Care feels like it’s for clean people, people with jobs and suits.”**
>
> **Male, 16, Sydenham**

Inequality was not only spoken about in terms of delayed care, but it was also seen in its consequences. Elders shared stories of peers who missed out on treatment or received diagnoses too late. Young people reiterated these concerns, pointing to the difficulty of finding mental health support that felt accessible or culturally appropriate. One explained: “They write things down, ask how I am, then bounce. Same thing every time.”

All generations understood health goes beyond the medical aspects. Poor housing, financial pressure, racism, and stress were all identified as health issues. Young people, in particular, described how these wider determinants affected their ability to sleep, eat well, or feel safe. Elders recognised the same patterns, tracing them over decades of living with inadequate housing and inconsistent care.

> **Sometimes it’s crisps and fizzy drinks for dinner. That’s all I can afford.”**
>
> **Male, 20, Deptford**

Connected Voices

Despite frustrations, the interviews reflected a sense of shared strength and purpose. Elders expressed confidence in the younger generation: “They have got a voice now. They speak up in ways we couldn’t.” Young people, in turn, acknowledged the persistence of their elders and were already stepping in to support them, helping with forms, translating at appointments, or sharing information with peers. “We could run tech buddy schemes to help our elders use the systems that are meant to help them.”

The solidarity was not symbolic; it was practical. One young woman shared, “I see what my mum went through, and I do not want that for my daughter.” Rather than seeing this resilience as something from the past, many saw it as something to carry forward. Together, these voices pointed to hardship, but also to a collective willingness to act.

This intergenerational perspective reinforces what has been heard throughout: communities are already identifying what needs to change and where efforts should be focused. While their experiences differ, young people and elders share a clear understanding of what gets in the way of good health and what could make a difference. The OFA set a useful frame, but these narratives add depth, pointing to approaches that are both practical and rooted in daily life.

The next section outlines the solutions that community members described, reflecting on the priorities, ideas, and contributions of those living with the consequences of inequality.

Bridging The Gap

Older participants repeatedly stressed the need for real, lasting investment instead of short-term fixes. The frustration was not just about poor access, but about being treated as if digital solutions alone could solve structural neglect. Online booking systems, automated referrals, and impersonal consultations left many feeling locked out of care.

Their proposals were simple, grounded, and actionable:

- Bring back mobile health clinics in areas like Forest Hill.
- Introduce walk-in Wednesdays at GP surgeries, with staff who know the community.
- Provide travel funds for patients registered far from home.
- Position trusted patient advocates inside practices to help navigate forms, bookings, and appointments; especially for elders who feel talked down to or overlooked.

These are ideas for smart innovation and easy implementation.

We don’t want another pilot.
We want someone to actually stay.”

Younger participants shared a clear-eyed view of the barriers their families face and proposed tech-smart, culturally grounded, and community-led responses to structural exclusion. In several case studies, they suggested:

- Creating WhatsApp groups to share appointment reminders.
- Setting up digital drop-in clinics at libraries, churches and youth centres.
- Producing explainer videos in African and Caribbean languages, helping families understand NHS systems.
- Running tech buddy schemes, where young people support older relatives in navigating health apps and online forms.

Making Space For Mental Health

Mental health was a priority across generations, but especially among young men. Their suggestions were informal but action-driven:

- Launching “Walk and Talk” groups in local parks.
- Producing community podcasts to open conversation.
- Creating safe spaces — informal, peer-led environments where young people could speak honestly without fear of judgement.

These reflections pointed to a gap in care but also to existing resilience. Many were already holding that space for each other, without professional support. One young woman shared:

> **There should be a number to call when life feels heavy, someone who sounds like your auntie giving real talk and care, not scripts.”**

Meeting People Where They Are

Whether young or old, participants wanted services to show up in the places that already hold trust such as faith centres, barbershops, community kitchens. Health messaging in these spaces was not just practical; it was about restoring dignity and respect.

One participant said:

> **You do not need to rebuild trust if you go where trust already lives.”**

Beyond Representation

There was shared concern about the lack of Black leadership in NHS structures. But participants went further than representation: they wanted roles with accountability. As one young man put it:

> **If you're creating cultural competency jobs, why not trust the people who live the culture to lead them?**

This was not about visibility alone. It was about decision-making power and whether those shaping services had lived knowledge of the communities they serve.

A Call To Action

Across generations, there was no shortage of insight or answers. What the community asked for was not more consultation, but commitment. To fund what has worked and what is working. To follow the lead of those already doing the work. To stop starting over. The task now is not to extract more stories, but to act on them.

Conclusion

This engagement report did not simply revisit the Opportunities for Action set out in the original BLACHIR report. It created space to test them against the realities people are living with now. By returning to Black African and Black Caribbean residents in Lewisham, the process brought lived experience back to the centre of how health inequality is understood and addressed.

Across interviews, forums, and podcast discussions, people described the same obstacles in different ways: difficulty accessing care, services that do not understand their lives, and limited influence over the decisions that affect them. These were patterns that shape how health, care, and trust are experienced day to day. These shared priorities give weight to the revised OFA.

Community members were clear that meaningful change depends on work that is long-term, locally rooted, and shaped by the conditions people face. In engaging with the OFA, they did more than endorse them. They pushed them further, drawing attention to digital exclusion, intergenerational care, and the mental health of young men as areas that require stronger focus. These concerns are not new and reflect a deeper understanding and continued relevance of how health inequalities operate across systems and life stages.

Finally, this report reaffirms that community insight is not supplementary; it is essential. The recommendations set out here come directly from lived experience and from people who know how services work in practice. They set a clear direction for what must take place next. With these insights in hand, the focus now turns to action and implementation, with accountability mechanisms in place to ensure that community priorities remain central.


LOVE

With Gratitude To:

Project Leadership & Content

Sabrina Dixon
Project Lead & Chief Executive, SIRG CIC

Assia Nait Kassi & Sabrina Dixon
Authors

Tania Tarraf
Communication Specialist

Podcast Contributors & Community Experts

Thank you to the powerful voices who shared their truth on the *"Same Place, Worlds Apart"* podcast series:

Callum Reddish
Podcast Co-Host

Akilah Muhammad, Barbara Gray, Donovan Grant, Dr Catherine Memba, Jacob Sakil, Jamal Robinson, Jentai Gen-One, Joyce Jacca, Juney Muhammad, Queen Joan, Susan Rowe, Tracey Jarrett
Guests

Your reflections brought clarity, courage, and deep community insight to this engagement report.

Community Venues & Hospitality

Calabash Centre
Venue

Lewisham Local
Community Venue

Cumming Up
Hospitality

Creative, Design & Media

Natalia Tkaczyk
Creative Design and Communications Manager

Community Advisory Support

We are especially thankful to the individuals and organisations who guided and strengthened our Community Advisory Board:

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Holistic Well Women

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Red Ribbon Living Well

Joseph Oladosu
Action for Community Development

Joyce Jacca
Health Inequalities Community Link Worker

Naomi Louise
Therapy 4 Healing

Tim Oshodi
Downham CLT

To Our Communities

To the hundreds of residents, who joined conversations, forums, and interviews: thank you for your trust and your courage.
To the youth mentors, outreach leads, and community builders who ensured no voice was left behind: thank you for holding space with care.
To the organisations who collaborated with integrity and purpose, thank you for showing what partnership truly looks like.

This report reflects your brilliance, your pain, your power, and your enduring belief in the possibility of a fairer, more just world.

To the Team at SIRG

Thank you for your bold vision, care-led practice, and deep-rooted belief in community-powered change. Your leadership has helped create not just an document, but a movement.

Together, we honour the past, act in the present, and shape a more equitable future.

Dr Catherine Memba, Callum Reddish, Sabrina Dixon

Jamal Robinson, Akilah Muhammad, Barbara Gray, Queen Joan, Donovan Grant, Jacob Sakil, Tracey Jarrett, Jentai Gen-One, Susan Rowe, Juney Muhammad, Joyce Jacca

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HIGHER RATES OF DEMENTIA

Appendix 1

Recommendations

For the purposes of this report, Local Commissioners refers to Lewisham Council and the relevant commissioning functions of the South East London Integrated Care Board (SEL ICB).

While some recommendations require national action, this report prioritises actions within the direct influence of Lewisham Council and the South East London Integrated Care Board (SEL ICB). National recommendations are included to ensure structural alignment and long-term equity.

Theme 1

- Ensure race-based data collection is consistent and used to directly inform service commissioning and evaluation.
- Co-design anti-racism strategies with community involvement, clearly defining roles and accountability.
- Develop urgent timelines and feedback mechanisms that involve the community throughout implementation.
- Recognise racism as trauma in frameworks addressing adverse childhood experiences, with special focus on children and adults with SEND.
- Embed anti-racism principles across all public sector recruitment, procurement, and service design.
- Implement accountability measures that hold all public system employees responsible for contributing to anti-racism efforts.
- South East London ICB and Public Health Lewisham should implement mandatory anti-racism and cultural competency training for frontline staff, with annual refresher requirements and accountability mechanisms.
- The Office for National Statistics and NHS Digital must reinstate ethnic coding across health and education datasets, with guidance and protections in place to prevent misuse.
- Develop local accountability frameworks (co-designed dashboards to track progress on OFA).
- Implement Black leadership pipelines (pathways into senior roles). This directly confronts institutional under-representation and embeds equity in leadership.

Theme 2

- Design and scale up culturally responsive, targeted interventions for Black families, with particular attention to maternal health.
- Develop and disseminate weaning and early parenting guidance that is culturally relevant and honours community traditions.
- Support the integration of holistic practices, including the use of doulas and herbal support, allowing space for community-led approaches even if not all can be formally adopted.
- Transition service delivery from standardised care to culturally flexible models, ensuring programmes are co-created with, and for, local families.
- Train healthcare professionals to recognise and address biases and ensure that Black women's expressions of pain and need are heard, validated, and promptly addressed.
- SEL must work with Black-led organisations to co-design specialised maternity and paediatric services responsive to the needs of Black families.
- Introduce annual cultural safety audits (reviewing anti-racism and accessibility). This will ensure that early-years and maternity care are culturally safe, inclusive, and responsive to Black mothers.

Theme 3

- Develop targeted interventions addressing the unique challenges of Black youth, focusing on mental health, sexual and reproductive health, and gender-based violence.
- Foster partnerships with Black-owned businesses and grassroots groups to ensure initiatives reflect lived experience and achieve measurable outcomes.
- Support community-led resilience-building efforts by equipping young people with practical skills to manage economic challenges.
- Integrate poverty reduction strategies within broader youth support services to address financial insecurity and its impact on wellbeing.
- Promote financial literacy and the revival of community saving practices like pardner within Black families and communities.
- To enhance the transition experience between secondary and further education, local education authorities should fund health literacy curricula in primary and secondary schools that incorporate practical skills such as navigating healthcare systems, booking GP appointments, and understanding mental health.
- Local Authority Commissioners should improve identification and referral pathways for youth carers in Black communities and offer tailored support options.
- Create intergenerational health hubs (community-owned wellbeing centres) that strengthen family and intergenerational wellbeing while fostering belonging for youth.

Theme 4

- Design and deliver interventions that address both structural inequalities and cultural values influencing the wellbeing of older Black adults.
- Promote routine health checks and targeted vaccination efforts in high deprivation areas relevant to older Black communities.
- Build authentic partnerships with the community, leveraging trusted spaces like the Hummingbird Club for co-design and engagement.
- Ensure older residents are active co-creators in planning and monitoring services, valuing their lived experience as central to decision-making.
- Address cultural misunderstandings within systems serving older migrants and excluded groups by improving training and service adaptation.
- ICS and community health services should reinstate mobile health clinics in high-need areas such as Forest Hill, prioritising routine check-ups and preventative care to enhance accessibility and optimise public health messaging throughout communities where there are significant disparities in health needs.
- Pilot community health navigator roles (peer guides supporting access to services) that reduces isolation and improves access for elders through trusted, culturally informed support.

Theme 5

- Develop mental health and wellbeing campaigns that are community-led and use culturally resonant language to reduce stigma.
- Implement practical approaches that recognise racism as a core driver of mental health inequalities and treat it as structural trauma.
- Co-lead a comprehensive audit and redesign of mental health services with voluntary sector partners and affected population groups.
- Ensure NHS mental health service reforms are rigorously evaluated for equity, preventing further widening of disparities in Black communities.
- Foster whole-system interventions to address structural racism within mental health care delivery.
- PHL, in conjunction with SLAM/CAMHS, must consider commissioning grassroots organisations to optimise mobilisation of activity and deliverables. For example, the launch of Walk and Talk peer-support groups for young men in local parks and trusted community spaces.
- ICB and Local Authorities should consider embedding a rolling grants programme to commission culturally grounded, non-clinical mental health spaces for young people, developed and led by Black community organisations.

Theme 6

- Engage local Black organisations meaningfully in both the design and delivery of health programmes, ensuring interventions reflect community values around faith, food, family, and social support.
- Explicitly embed anti-racist approaches that address structural barriers within commissioning and procurement processes.
- Ensure transparency and fairness in funding allocation, holding providers accountable and aligning services with community priorities.
- Uphold the Duty of Care in service design, as mandated by the Equalities Act to protect community interests.
- Design services with and by Black communities to ensure needs are met authentically and effectively.
- Implement ongoing cultural competence training for all health employees as an essential element of best practice.
- Local health authorities should support the creation of WhatsApp broadcast lists (opt-in) to share appointment reminders and public health updates with community members, to optimise the acceleration of health messaging.
- Develop a shared learning platform (hub for data, evaluation, and practice exchange) encouraging collaboration and learning around prevention, wellness, and lifestyle improvement.
- Introduce a long-term Equity Impact Fund (ring-fenced for Black-led innovation) that sustains preventative, community-led health and wellbeing initiatives.

Theme 7

- Increase support and public health campaigns focused on stroke prevention and cardiovascular health tailored specifically for Black communities.
- Develop and deliver targeted clinician education programmes to improve understanding and management of conditions like fibroids, emphasising their impact on Black women's health and wellbeing.
- Promote awareness campaigns within Black communities about uterine fibroids to encourage early detection and timely care.
- Establish a Black-led digital health platform offering culturally relevant health information, provider access, and community networking opportunities to empower health literacy and engagement.
- Ensure that health services incorporate culturally competent approaches in managing conditions prevalent in Black populations, prioritising patient trust and effective communication.
- ICB must reinstate phone-based GP appointment bookings and provide clear alternatives for patients unable to use online systems.
- Lewisham Council, in partnership with youth organisations, must fund and coordinate technical support buddy schemes, enabling young people to support older residents with NHS app usage and digital form navigation.
- South East London ICB and Healthwatch must consider commissioning co-designed multimedia materials (e.g., short videos, audio messages), explaining how to access NHS services, produced in African and Caribbean languages.
- Integrated Neighbourhood Teams (INT) must embed trained community health advocates within surgeries to assist with navigating forms, booking appointments, and understanding diagnoses.

Theme 8

- Develop cross-sector policies that address housing quality, employment opportunities, and environmental justice as central components of health equity strategies.
- Increase investment in community-led initiatives to improve living conditions and reduce environmental hazards disproportionately affecting Black communities.
- Implement anti-discrimination measures in education and public services to dismantle systemic barriers that impact health outcomes.
- Collect and use disaggregated data to better understand and respond to the complex ways social determinants affect health in Black populations.
- Foster collaboration between healthcare, housing, employment, education, and environmental sectors to create integrated solutions that address the root causes of health disparities.
- ICS must pilot travel subsidies for patients with SEND and complex needs facing long commutes to access GP or hospital care.
- Create equitable funding pathways (micro-grants for grassroots projects), addressing structural inequity in funding and supports community economic resilience.
- Establish a Black Health Equity Institute (community-academic policy hub) to tackle systemic inequity through long-term research, policy, and cross-sector influence.
- Integrate health equity KPIs into local authority performance frameworks. Makes racial health equity a measurable requirement in council accountability.

Appendix 2

Glossary

Adverse Childhood Experience (ACE)

A potentially traumatic event or experience during childhood, including exposure to racism, which contributes to long-term health and psychosocial consequences.

Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)

A comprehensive review conducted in 2022 exploring persistent health inequalities faced by Black African and Black Caribbean populations in Birmingham and Lewisham. It identifies root causes and outlines 39 Opportunities for Action (OFA) to address these disparities.

Black-led Organisation

Community or voluntary organisation primarily run and governed by Black individuals, delivering culturally relevant services informed by lived experience.

Child and Adolescent Mental Health Service (CAMHS)

The NHS services that provide assessment and treatment for children and young people, usually up to 18, experiencing emotional, behavioural or mental health difficulties.

Community Treatment Order (CTO)

A legal mechanism under the Mental Health Act allowing supervised community treatment.

Culturally Competent Care / Service

Healthcare and social service delivered with awareness, knowledge, and responsiveness to cultural practices, values, and needs of specific communities to reduce disparities and improve engagement.

Cultural Responsiveness

Adaptation and tailoring of services and interventions to reflect and respect the cultural identities and lived experiences of the communities served.

Disaggregated Data

Detailed population data separated by specific ethnic, national, or cultural groups rather than broad categories, enabling nuanced understanding and targeted service design.

Digital Exclusion

Barriers preventing individuals, particularly elders or those without digital literacy or access, from effectively using digital platforms for healthcare access and communication.

Established Community Partnership

A long-term collaboration between statutory health bodies and community organisations involving co-production, shared decision-making, and mutual accountability.

Health and Wellbeing

A holistic concept that includes physical, mental, emotional, and social health aspects, as understood and experienced within communities.

Health Equity

The absence of avoidable or unfair health differences across populations; achieving equitable health outcomes by addressing social determinants and systemic barriers.

Health Equity Fellow (HEF)

A clinician embedded within Primary Care Networks trained to lead and embed health equity initiatives, acting as a bridge between community organisations and healthcare providers.

Health Equity Team (HET)

Multi-agency partnership formed between Primary Care Networks, clinicians, and Black-led organisations to design and deliver targeted health equity interventions locally.

Integrated Care Board (ICB)

The NHS statutory body responsible for planning, commissioning, and funding health services across a local area, ensuring services meet population health needs and reduce inequalities.

Integrated Care Partnership (ICP)

A statutory collaboration between the NHS, local authorities, and other partners within an ICS that sets the shared strategic direction for health and care through an integrated care strategy.

Integrated Care System (ICS)

A partnership of NHS organisations, local authorities, and voluntary and community sector partners working together to improve population health, deliver joined-up care, and reduce health inequalities.

Integrated Neighbourhood Team (INT)

A multidisciplinary local team supporting coordinated community-based care.

Lewisham Black Voluntary Network (LBVN)

A network supporting Black-led voluntary and community organisations in Lewisham.

Life Course Approach

An approach to health interventions and policy recognising that health outcomes are shaped by factors and experiences throughout a person's life, including early childhood and ageing.

Lived Experience

Knowledge and insights gained through personal, first-hand experience of societal issues, such as racism or health inequalities.

Maternity Voices Partnership (MVP)

A local NHS-led group ensuring service user voice informs maternity care design.

Mental Health Wellbeing Campaigns

Initiatives aimed at improving mental health awareness, access, and support, particularly emphasising culturally appropriate and trauma-informed methods.

National Institute for Health and Care Research (NIHR)

The UK's major funder of health and care research.

Office for Health Improvement and Disparities (OHID)

UK government body responsible for public health improvement and reducing health inequalities.

Opportunities for Action (OFA)

Thirty-nine specific, actionable recommendations identified in the BLACHIR report to address health inequalities across eight thematic areas.

Peer-led Support / Peer Approaches

Interventions delivered or facilitated by individuals from the same community who share similar lived experiences, enhancing trust and engagement.

Physical Health Equity

Ensuring equal opportunity for all individuals to attain their highest level of physical health, by tackling social and systemic determinants.

Primary Care Network (PCN)

Group of general practices that collaborate with local health providers and communities to deliver integrated healthcare services.

Public Health Lewisham (PHL)

A team that focuses on improving population health, reducing inequalities, and preventing illness.

Racism as Trauma

Recognition of racism as a form of psychological trauma with significant effects on mental and physical health across generations.

Racialised Community

Group of people identified or treated differently due to their racial or ethnic backgrounds, often experiencing systemic marginalisation.