Transforming Health Systems: Insights from Healthy Communities Together Leeds

HCT
Healthy Communities Together

Introduction

Healthy Communities Together (HCT) Leeds is a transformative program aimed at addressing health inequalities by fostering collaborative partnerships among the voluntary and community sector (VCS), the NHS, and local authorities. Funded by The National Lottery Community Fund and supported by The King's Fund, HCT Leeds focuses on improving health outcomes for marginalised communities, including Gypsies and Travellers, Sex Workers, Refugees and Asylum Seekers, and Trans and Non-Binary individuals.

HCT Leeds is funded by The National Lottery Community Fund.

1. Valuing Lived Experience

- **Move Beyond Consultation:** Lived experience must be embedded in governance, decision-making, and design—not used as a tokenistic afterthought.
- **Authentic Co-Design:** Inclusion means more than a seat at the table. Representation must come with power, support, and legitimacy.
- **Draw on Existing Expertise:** Community organisations already hold deep knowledge from years of engaging with marginalised groups. Leverage this, don't duplicate it.
- **Address Representation Gaps:** Less visible groups—such as sex workers, Gypsies and Travellers, trans communities, and asylum seekers—are often excluded from leadership. Prioritise facilitating their pathways into paid roles and strategic forums.
- **Tailored Engagement:** One-size-fits-all models fail. Diverse communities need distinct, culturally appropriate approaches to engagement.

2. Building Trust: Relational, Not Transactional

- **Trust Takes Time:** Relationships must be cultivated before asking for input. Engagement without trust leads to fatigue and superficial outcomes.

- **Safe and Trauma-Informed Spaces:** Many marginalised communities have histories of harm in healthcare. Ensure emotional safety, especially during engagement and storytelling.

- **Support Beyond Engagement:** Provide financial, emotional, and logistical support for participants. Avoid repeated requests to share trauma without tangible change.

3. Elevating Community Voices

- **Compensate Expertise:** Community wisdom is equal to academic insight. Pay people for their time and leadership.

- **Invest in Infrastructure:** Fund and resource underrepresented communities so they can participate meaningfully.

- **Fund Peer-Led Models:** Peer-led research and training build authenticity and long-term trust.

- **Create Leadership Pipelines:** Mentorship, training, and lower-risk routes into employment help close access gaps for marginalised individuals.

4. Addressing Systemic Barriers

Barriers to Access and Representation

- Services often remain physically and structurally inaccessible to those most in need.
- Institutional distrust, complex systems, and stigma prevent engagement.
- Superficial efforts or “checkbox” representation create harm, not inclusion.

System Rigidity and Fragmentation

- Health systems are complex, commercialised, and disconnected from community realities.
- A competitive culture undermines collaboration and perpetuates exclusion.
- Structural racism, colonial legacies, and hierarchical models limit progress.

5. Data & Accountability

- **Rethink Data and Success:** Move beyond financial and quantitative metrics. Include qualitative insight, lived experience, and community-defined outcomes in performance systems.
- **Close the Data Disconnect:** Data exists but is misused, ignored, or misinterpreted. Trust and act on community-led insight.
- **Visibility in Data:** Marginalised groups are often invisible in datasets. If you’re not in the room or the data, you’re not represented.

6. The Role of the VCSE Sector

- **Recognise and Resource VCSE Expertise:** These organisations already build trust and reach where statutory services fall short.
- **Stop Duplicating:** Health systems must build upon existing VCSE work, not replicate it with less culturally relevant impact.
- **Partnership, Not Extraction:** Move from extractive engagement to sustained, equitable collaboration.

7. Training & Workforce Inclusion

- **Comprehensive Inclusion Training:** Training must be reflective, in-depth, and ongoing—not limited to an hour-long session.
- **Trans and Non-Binary Inclusion:** Training must be co-developed with trans community members. Institutional commitment is essential for real change.
- **Support Marginalised Staff:** Structural barriers block access to senior roles. Develop role-specific pathways with targeted support and reduced risk.

8. Concrete Recommendations

Representation & Inclusion

- Embed lived experience roles within decision-making structures.
- Tailor engagement strategies to different communities, especially less visible groups.
- Support representatives with training, mentorship, and clear mandates.
- Challenge systems that delegitimise community-led research and data.

Structures & Culture

- Make inclusion and learning core, not optional.
- Embed representation into long-term strategies (e.g. 10-year health plans).
- Reimagine commissioning with equity and co-design at the centre.

Leadership & Accountability

- Make equity part of leadership induction and professional accountability.
- Build allyship and champion marginalised leaders into visible, paid positions.
- Foster a culture of learning, unlearning, and shared power.

Closing Reflection

To create truly inclusive health and care systems, we must move from episodic engagement to systemic transformation. This means investing in relationships, shifting power, embedding lived experience at all levels, and treating community insight not as supplementary—but as central.

The time for performative inclusion has passed. Equity demands action.

www.hctleeds.co.uk

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