The Inclusive Research Collaborative

An Evidence-based Case for New Infrastructure in South London

An Elysium London White Paper

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Author Positioning and Context

This paper is grounded in five years of practice working across communities, research institutions, and funding systems in South London. It brings together my own experiences, observations, and the testimony of senior leaders who shared insights that validated patterns I had encountered.

My career in public health research began in 2020, at the height of the COVID-19 pandemic. Trust in public health institutions was at a historic low, shaped by uncertainty, enforcement, and rapidly shifting public health guidance. Existing health inequalities were sharply exacerbated, with communities experiencing structural deprivation bearing disproportionate impacts. In parallel, the murder of George Floyd and the emergence of the Black Lives Matter movement intensified scrutiny of institutional power, racism, and accountability. These dynamics deepened the divide between communities and institutions at a moment when there was limited research infrastructure capable of responding to the disproportionate impacts on Black, Asian and ethnic minority communities.

I entered the field as a community researcher within what would later become Centric Community Research, an organisation founded on principles articulated by Dr Shaun Danquah in *Rethinking Research* and *History and Methods of Community Research Literature Review* (Addae, P. and Danquah, 2021). The organisation sought to redistribute power across the research lifecycle by building the capacity and capability of communities to identify priorities and lead the design and delivery of research projects in their localities. This approach inverted conventional models that take predefined briefs into communities, and instead centred trust, authorship, and knowledge production within communities themselves. These principles fundamentally shaped my understanding of how public health research in South London should be conducted and continue to inform my practice.

As my role developed from community researcher into senior leadership positions spanning business development and directorship, I encountered the same challenges from a different vantage point. While public commitments to inclusion and community-centred research were widespread, institutions repeatedly struggled to operationalise those commitments in practice. This was evident in funding and commissioning processes, in the positioning and valuation of community-based knowledge, and in the limits placed on meaningful representation within research systems. Over time, these issues revealed themselves not as isolated failures, but as structural patterns resulting from the absence of infrastructure that embeds inclusion as a core function rather than an afterthought.

This paper is written from that vantage point. It reflects sustained work across communities, institutions, and decision-making spaces since the COVID-19 pandemic, and focuses on South London as a hyper-local case study to examine these patterns and to propose a structural response through the Inclusive Research Collaborative.

Abstract

This paper argues that, despite sustained focus on inclusion across the United Kingdom's research and innovation landscape, practice remains fragile, inconsistent, and structurally constrained. Drawing on national evidence and five years of practitioner experience across academic, clinical, local authority, and community settings in South London, this white paper examines the systemic patterns that inhibit meaningful inclusion. The analysis identifies four structural failures; procedural dominance, absent stewardship, incoherent standards, and tokenistic involvement each rooted in the absence of dedicated infrastructure capable of sustaining relationships, learning, and accountability over time (NIHR, 2023; Wellcome, 2020; Mockford et al., 2012).

In response, the paper proposes an Inclusive Research Collaborative: a practitioner-led intermediary designed to steward standards, maintain relational continuity, strengthen methodological practice, and support cross-sector capability-building. The Collaborative provides an integrated architecture through which inclusive research can function as a sustained system responsibility rather than a project-bound aspiration. The paper concludes by setting out the pathways through which this model can be realised, the structural challenges of doing so, and the practitioner-led work already underway to build the foundations of inclusive research infrastructure in South London

Executive Summary

Inclusion is now an expectation across the UK's research and innovation system, yet practice remains fragile, inconsistent, and structurally constrained. In South London, a region combining world-class academic and clinical capability with some of England's deepest health inequalities, these contradictions are particularly visible. Despite expanding commitments to equity, research systems have not adapted to support meaningful participation.

Drawing on five years of practitioner experience across health, academic, local authority, voluntary-sector, and community settings, this paper identifies four recurring structural failures:

1. **System Processes that Inhibit Innovation and Community Leadership:** Funding, procurement, ethics, and risk management practices prioritise institutional fluency over contextual legitimacy, constraining adaptive, community-led, and inclusive research.
2. **No System-level Ownership for Inclusion:** Responsibility is dispersed across teams with limited mandate and high turnover, resulting in collapsed relationships, lost learning, and inconsistent practice.
3. **Incoherent Standards and Variable Methodological Quality:** "Community Research" and "Inclusive Research" now span models of widely different rigour, with no shared benchmarks to distinguish robust practice from weak or extractive approaches.
4. **Representational Inclusion Without Proximity:** Involvement is frequently symbolic rather than substantive, with professionalised PPIE structures that elevate recurring participants while those most affected by inequality remain peripheral.

Together, these patterns show that inclusion has not failed because of weak intent, but because of the absence of infrastructure capable of holding relationships, standards, and accountability over time.

The Proposed Response: An Inclusive Research Collaborative (IRC)

The paper proposes a structural response to these failures: a practitioner-led Inclusive Research Collaborative designed to hold inclusive research as a sustained system function rather than a series of disconnected projects. It makes the case for a practitioner-led intermediary, the IRC, and sets out the pathways through which this function can be developed, tested, and sustained in South London. The IRC is conceived as enabling infrastructure, providing stewardship, methodological coherence, workforce development, and continuity of learning across institutions and funding cycles. Positioned between academic institutions, NHS systems, local authorities, funders, and community organisations, its role is to stabilise relationships, strengthen standards, and translate community insight into decisions that carry institutional authority, allowing inclusive research to move from episodic activity to durable system practice.

Implementation Approach

The IRC model can be advanced through several complementary routes: phased practitioner-led development through organisations working across strategic health inequalities priority areas, building evidence and deepening partnerships through live delivery; adoption of individual elements of the model within specific institutional or geographic contexts, such as shared standards, relational accountability mechanisms, or tailored capacity-building programmes; and a dedicated cross-sector partnership to test the full IRC model as an integrated intermediary. Elysium London, the consultancy from which this paper originates, was founded to operationalise the principles the IRC model describes, building inclusive research standards, practical guidance, and cross-sector capability through commissioned training, advisory, and early research collaborations with NHS bodies and university faculties. The IRC, in its full form, remains the longer-term systemic expression of that work.

Why This Matters Now

South London is entering a new phase of system reform. The NHS 10 Year Plan, neighbourhood-based working, and the shift toward hyperlocal, place-based approaches are raising expectations for inclusive research that is embedded, relational, and responsive to community need. Yet the commissioning, governance, and assurance mechanisms through which research is funded and delivered remain largely unchanged. As investment and expectation increase, the absence of dedicated infrastructure, such as the kind of intermediary proposed in this paper, risks reproducing fragmentation at greater scale, placing additional strain on local actors and limiting the system's ability to translate inclusive research into sustained impact on health inequalities.

Readers interested in the core structural argument may wish to begin with Sections 3-5, which outline the systemic patterns, the proposed infrastructure, and the pathways for realising the model.

Contents

Key Definitions Used in This Paper

These definitions are provided to make the system argument as clear and readable as possible.

- **Inclusive research:** An equity-centred, partnership-based approach to generating knowledge that restructures who participates, how decisions are made, and whose knowledge counts. It requires coherence across the research lifecycle and accountability to both communities and institutions.
- **Community-centred / community research:** Research that starts from community experience and priorities, with people affected by an issue helping to shape questions, methods, interpretation, and legacy. It relies on local knowledge, trusted relationships, and shared benefit, rather than treating communities as data sources.
- **Practitioners / practitioner-researchers:** People who apply inclusive and community-centred research methods in practice, typically working across community organisations, VCSE bodies, public institutions, or consultancies. In this paper, the term refers to those leading or facilitating inclusive research and engagement, rather than academic theorists alone.
- **Infrastructure (in this context):** The structures, roles, processes, and relationships that allow inclusive research to happen consistently rather than as one-off projects. It covers how responsibility, resources, and decision-making are organised and sustained over time.
- **System function:** A role or responsibility a system needs in order to work, regardless of which organisation holds it. Here, inclusive research is treated as a system function that requires clear ownership, continuity, and resourcing.
- **Intermediary infrastructure:** An independent but connected mechanism that sits between institutions and communities, enabling translation, stewardship, and continuity. It does not replace existing organisations but carries cross-cutting responsibilities that currently fall between them.
- **Stewardship:** Active responsibility for standards, relationships, and integrity over time, beyond individual projects or roles. It includes noticing where inclusive practice is drifting or being diluted and working with system partners to realign it.
- **Institutional fluency:** The practical ability to navigate how institutions work such as policies, incentives, risk cultures, and informal decision-making, and to translate community insight into forms that can influence priorities, commissioning, and governance.
- **Procedural dominance:** A pattern in which organisational procedures, risk processes, and compliance requirements consistently outweigh relational, contextual, or equity considerations. It leads systems to protect process over people and narrows what is possible in inclusive research.

1. Introduction & Conceptual Foundations

This white paper sets out the structural case for new inclusive research infrastructure in South London and proposes the Inclusive Research Collaborative (IRC) as the mechanism to deliver it. Inclusion is now a core expectation across the UK's research and innovation system. Funders mandate lived-experience involvement; universities promote co-production; NHS bodies emphasise community-led design. Yet despite this widespread commitment, inclusive practice remains predominantly project-bound and structurally fragile. It is visible in strategy documents but weakly embedded in the systems that govern research priorities, commissioning, ethics, and delivery.

Practitioner Foundations and Rationale for This Paper

This paper emerges from five years of work in inclusive and community-centred research in South London, particularly through Centric Community Research, where I moved from delivery roles into a directorship. Across programmes, partnerships, and commissioning contexts, the same pattern recurred: strong intent, credible insight, and meaningful community engagement were repeatedly undermined by short commissioning cycles, fragmented accountability, and the absence of structures to hold inclusive practice over time.

These observations are consistent with and reinforced by the analysis set out in History and Methods of Community Research Literature Review (Addae, P. and Danquah, 2021), which traces how community-led inquiry cycles through innovation, marginalisation, and reinvention without sustained institutional support. Across both practice and the literature, the problem is consistent: knowledge is generated and relationships are built, but learning is not retained, responsibility is not held, and insight struggles to travel across funding cycles and institutional boundaries.

This paper also builds on Strategic Frameworks for Inclusive Research (Rauf, 2025), which set out conceptual models for relationships, credibility, access, and participation and argued that, without mechanisms capable of holding relationships, credibility, and learning between commissions, inclusive practice remains fragile. Where that work focused on conceptual clarity and signalled the need for such mechanisms, this paper advances the analysis into system design, making the case for the Inclusive Research Collaborative as infrastructure through which inclusive research can be governed, sustained, and treated as a system capability rather than repeatedly rebuilt through isolated projects.

Limitations of Current Inclusive Practice and Infrastructure

A substantial UK evidence base explains this fragility. Ocloo and Matthews (2016) show that many participation structures operate within unequal power dynamics, offering voice without influence. Systematic reviews by Mockford et al. (2012) and Brett et al. (2014) show that involvement often generates inconsistent or limited impact, with benefits confined to individual projects.

NIHR's Going the Extra Mile review (2015) highlights the absence of stable infrastructure capable of sustaining partnerships, relational continuity, or methodological integrity. These issues are structural, not incidental: they reflect how the UK organises, funds, and governs research involvement.

Research Culture and the Case for Structural Reform

These challenges sit within broader weaknesses in research culture. Wellcome's What Researchers Think About the Culture They Work In (2020) identifies inequitable environments, fragmented incentives, and limited support for relational or community-engaged research. Short funding cycles, publication pressures, and institutional risk cultures repeatedly displace inclusive practice.

Subsequent UKRI and NIHR statements (2021–2023) reinforce the need for system-level reform through improved governance, incentives, and equity standards. Collectively, this literature shows that inclusion cannot depend on goodwill or isolated panels; it requires institutional arrangements that embed responsibility for inclusive practice within the system itself.

Implementation Science: Why Infrastructure Matters

Implementation-science research further demonstrates the importance of supportive infrastructure. The PARIHS framework (Kitson et al.) shows that effective implementation requires alignment of evidence, context, and facilitation. Without organisational environments designed to sustain inclusive methods, research evidence rarely translates into practice.

Greenhalgh's work on co-creation and research impact (2015–2016) reinforces that durable relationships, shared governance, and long-term facilitative capacity are essential for research to influence real-world systems. These conditions cannot be met through temporary advisory structures or project-specific PPIE mechanisms.

Taken together, these insights frame inclusive research not as an engagement activity but as infrastructure, a system function requiring continuity, stewardship, and facilitation.

Structural Inequalities and the Importance of Place

Efforts to build inclusive research infrastructure must be grounded in the structural determinants of health. The Marmot Review (2010; 2020) shows that health inequalities follow a predictable social gradient shaped by socio-economic conditions, race, class, and early-life disadvantage. These inequities are systemic, avoidable, and reproduced through structural arrangements.

Bambra's Health Divides (2016) demonstrates how local political economy and neighbourhood deprivation generate sharp geographical disparities. South London, marked by both exceptional capability and deep inequality, exemplifies the need for research infrastructure that is place-anchored, relational, and sensitive to local context.

2. Existing Infrastructure

2.1 The South London Research Landscape

South London occupies a distinctive position within the United Kingdom's research and innovation landscape. It brings together several of the country's most influential institutions, including King's College London, Guy's and St Thomas' NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, and the wider King's Health Partners Academic Health Science Centre each operating at significant scientific, clinical, and organisational scale (King's Health Partners, 2024; NIHR, 2023). Surrounding these institutions are six boroughs; Lambeth, Southwark, Lewisham, Croydon, Wandsworth, and Merton among the most ethnically diverse and socioeconomically unequal in England (Trust for London, 2023; ONS, 2022).

The analysis that follows focuses on system patterns rather than ranking or performance-managing individual organisations in South London. My current and potential professional collaborations across the region make a neutral, ecosystem-level lens both appropriate and necessary. Where specific organisations are named later, they are included only as illustrative examples of how particular capabilities are currently dispersed, not as evaluations of their performance. The observations that follow synthesise recurring patterns from five years of practice and should be read as structural reflections on the ecosystem as a whole, not as assessments of any single institution or model.

2.2 Key Actors in South London's Inclusive Research Ecosystem

South London's inclusive research ecosystem comprises a diverse constellation of institutional, civic, and community actors, each carrying different mandates, incentives, and constraints. Understanding how these actors interact is essential before analysing the structural patterns that limit coherence and sustainability.

1. **Academic Institutions:** Universities such as King's College London and St George's, University of London act as anchor institutions. They generate research output, set methodological norms, and shape professional cultures, including how inclusion is framed, incentivised, and evaluated. Their internal reward systems and governance structures create powerful signals about what counts as legitimate evidence and meaningful engagement (Wellcome Trust, 2020).
2. **NHS Trusts and Integrated Care Systems:** NHS bodies hold statutory responsibility for clinical research, patient involvement, and population health improvement. Through research networks, quality-improvement programmes, and engagement structures, they play a pivotal role in determining which communities are reached, which methodologies gain institutional legitimacy, and which insights translate into service change.
3. **Local Authorities and Public Health Teams:** Boroughs such as Lambeth, Southwark, and Lewisham commission community-led research, convene cross-sector partnerships, and shape local health strategies. Their proximity to residents and VCSE organisations positions them as important intermediaries between institutional ambition and community reality.

4. **Funders, Foundations, and Charitable Agencies:** Place-based foundations, philanthropic funders, and charitable agencies increasingly influence the regional research agenda. They often provide flexible capital, support experimentation, and act as early adopters of participatory or community-led methodologies (Banks et al., 2019).
5. **Voluntary, Community, and Social Enterprise (VCSE) Organisations:** Grassroots groups, faith institutions, mutual-aid networks, and youth-led organisations form the civic infrastructure. They hold deep relational capital, cultural legitimacy, and contextual knowledge. Qualities that formal institutions frequently lack (Freire, 1970; Wallerstein et al., 2018). Their contributions to research range from co-delivery and advisory roles to leading their own inquiries.
6. **Intermediaries and Practitioner-Researchers:** Practitioner-led organisations and consultancies operate as bridges between institutions and communities. These intermediaries translate between systems, manage relational dynamics, and facilitate forms of inquiry that neither institutions nor communities can easily deliver alone (Rauf, 2025).

Collectively, these actors form an ecosystem characterised by substantial capability, significant interdependence, and considerable complexity. Yet, as subsequent sections argue, their interactions are shaped by persistent system-level patterns that constrain coherence, sustainability, and genuine power-sharing, limitations that prevent inclusion from becoming a structural, rather than symbolic, feature of research practice.

3. Patterns of Structural Failure in South London's Inclusive Research Ecosystem

The conceptual foundations established in Sections 1 and 2 manifest in practice through four structural patterns observed across South London's research ecosystem. Despite significant expertise, inclusive research continues to fail in predictable ways. These failures are not isolated incidents; they reflect a structural architecture that cannot hold relationships, learning, or methodological integrity over time. The four patterns below outline the system logic that undermines inclusion. Each would justify more detailed analysis, but for the purposes of this paper they are set out in headline form, with an emphasis on their shared structural effects rather than exhaustive illustration.

3.1 Pattern One: System Processes That Undermine Inclusion

Across funders, universities, NHS bodies, and local authorities, core systems structurally disadvantage the relational practices required for inclusive research. These processes reward institutional fluency rather than proximity to community realities, a pattern identified in participatory research literature (Banks et al., 2019; Mockford et al., 2012).

- **Funding and Commissioning Systems:** Funding processes rely on institutional language, rigid methodological framing, and bureaucratic sequencing. This privileges well-resourced organisations while excluding those embedded in communities (Addae and Danquah, 2024b). NIHR's Going the Extra Mile review (2015) highlights how rigid funding structures and institutional incentives restrict meaningful engagement and penalise organisations without established fluency.
- **Ethics and Governance Processes:** Ethics systems designed for traditional academic research constrain adaptive, community-led inquiry (Addae and Danquah, 2024a). Greenhalgh et al. (2022) note that emergent insight triggers lengthy amendments that stall momentum, weaken trust, and prioritise compliance over meaningful responsiveness.
- **Administrative Delays and Institutional Risk Culture:** Procurement delays, opaque governance decisions, and institutional risk aversion repeatedly disrupt timelines. Wellcome (2020) shows that fragmented internal processes erode organisational memory and create cycles of reversals and stalled progress, disproportionately harming organisations serving communities with the greatest need.

Observed Impact from Practice

In practice, communities experience repeated consultation without clear feedback, visible change, or sustained involvement in decision-making. Research activity is often highly visible at the point of engagement but opaque in its outcomes, making it difficult for communities to see how participation leads to improvements in services, policy, or lived conditions. Over time, this reinforces distrust and disengagement, particularly among communities already facing structural disadvantage. For institutions, this results in research that meets technical requirements but delivers limited progress on health inequalities.

3.2 Pattern Two: Absence of Stewardship and the Dissolution of Learning

Even where strong work begins, there is no organisational architecture to sustain it. Responsibility for inclusion remains dispersed, weakly mandated, and peripheral, a problem well documented in involvement research (Ocloo & Matthews, 2016) and national culture analyses (Wellcome Trust, 2020).

- **Fragmented Organisational Ownership:** Inclusion is spread across disconnected teams, engagement, EDI, research offices, programme leads, with no end-to-end accountability. Wellcome Trust (2020) shows that such fragmentation prevents learning from accumulating and leads to repeated cycles of reinvention.
- **High Turnover and Loss of Relational Roles:** Programmes with strong early foundations often stall when key staff leave. NIHR (2015) identifies reliance on individual relational champions, rather than embedded roles, as a core structural weakness that repeatedly collapses trust and continuity.
- **Short Commissioning Cycles and Unstable Infrastructure:** Commissioning cycles are short, renewal processes opaque, and internal priorities shift rapidly, often mirroring fragmented, time-limited programmes from major funders. Greenhalgh et al. (2022) emphasise that instability disrupts relationship-building and forces organisations to rebuild engagement from scratch.

Observed Impact in Practice

In practice, relationships with communities are repeatedly built and then lost as staff move on, funding ends, or roles disappear. Communities experience cycles of engagement that begin with trust-building and end abruptly, often without explanation or continuity, leading to frustration, disengagement, and scepticism about future involvement. For institutions, this results in the loss of relational capability they have already invested in, alongside the erosion of local knowledge that cannot be easily documented or transferred.

3.3 Pattern Three: Incoherence in Standards, Quality, and Practice

One component of inclusive research in South London has been the growth of community-led and participatory approaches; however, this expansion has not been matched by consistent standards. “Community research” now describes methods of widely varying rigour, a pattern evidenced repeatedly in national reviews (Mockford et al., 2012; Brett et al., 2014; Banks et al., 2019; Addae and Danquah, 2021).

- **Variable Quality Under One Label:** Many organisations use the term “community research” while delivering extractive or superficial practices: minimal training, narrow cohorts, short-term engagement, and limited analytical depth. Banks et al. (2019) and Addae and Danquah (2021) identify this as a structural misunderstanding rather than an isolated weakness.
- **Lack of Consistent Methodological Standards:** Participatory methods are deployed inconsistently across the UK. Mockford et al. (2012) and Brett et al. (2014) show that inconsistent involvement practices produce variable impact with no mechanisms to differentiate strong practice from weak delivery.

- **Narrowing of Insight Through Recurring Participants:** A recurring-participant dynamic, where the same individuals appear across panels and studies, narrows epistemic range and limits access to genuine lived experience. Greenhalgh et al. (2016) show that without governance and methodological clarity, co-creation becomes vulnerable to drift and bias.

Observed Impact from Practice

In practice, inclusive research is delivered unevenly, with approaches ranging from deeply relational work to minimal or tokenistic engagement, often under the same label. Communities encounter inconsistent expectations, processes, and levels of influence, making participation unpredictable and, at times, damaging to trust. For institutions and funders, the absence of shared standards makes it difficult to assess quality, compare outcomes, or learn systematically from what has been delivered. As a result, inclusive research becomes fragmented rather than cumulative, weakening its credibility as a mechanism for addressing health inequality at scale.

3.4 Pattern Four: Tokenistic Inclusion and the Professionalisation of PPIE

When system processes, weak stewardship, and inconsistent standards accumulate, they produce a predictable final pattern: tokenistic inclusion and the professionalisation of lived experience.

- **Representation Over Proximity:** Institutions often recruit people who match a demographic category rather than those with genuine proximity to the issues under study (Ocloo & Matthews, 2016). Madden and Speed (2020) describe this as the flattening and commodification of lived experience, where demographic presence substitutes for meaningful insight.
- **Selective Institutional Uptake of Community Insight:** Even when co-design or participatory processes are used, institutions often adopt only the elements of community insight that fit existing priorities, risk thresholds, or resource constraints. This selective listening limits genuine influence on decisions, weakening trust and reducing the transformative potential of participation.
- **Professionalised PPIE and Recurring Lived-Experience Roles:** Panels and projects often rely on a small recurring cohort of individuals who become fluent in institutional norms but increasingly disconnected from the realities of those most affected (Madden & Speed, 2020; Brett et al., 2014). This narrows insight and risks reproducing structural inequity.

Observed Impact from Practice

In practice, community-generated insight is frequently captured but weakly translated into institutional decision-making. Research findings are documented and disseminated, yet struggle to influence commissioning, service design, or policy change, particularly where they challenge existing priorities or operational norms. Communities are left unclear how their contribution has shaped outcomes, while institutions accumulate evidence without the mechanisms or incentives required to act on it. Over time, this creates a cycle in which knowledge production increases but impact remains limited, reinforcing scepticism about the value of participation and doing little to shift underlying health inequalities.

3.5 Synthesis of Patterns

The four patterns identified in this section describe a single, interlocking system failure. Research priorities are shaped at distance from lived context; relationships are built and lost through short-term roles; inclusive practice is delivered without shared standards; and community-generated insight struggles to influence institutional decision-making. Together, these dynamics produce a system in which inclusion is repeatedly attempted but rarely stabilised. This diagnosis mirrors national evidence on research culture, including findings from NIHR and the Wellcome Trust, which highlight how short funding cycles, fragmented incentives, and weak support for relational work systematically displace inclusive practice despite widespread commitment (Wellcome Trust, 2020; NIHR, 2023).

This structural absence is becoming more visible in practice. As national and system-level priorities increasingly emphasise inclusive, place-based, and community-centred research, through frameworks such as UKRI's structural EDI agenda, NHS Core20PLUS5, and ICS population-health missions, expectations on local actors have intensified (UKRI, 2022; Department of Health and Social Care, 2025; NHS England, 2022). However, the underlying commissioning, governance, and assurance mechanisms through which research is delivered remain largely projectised. National funders and local institutions reinforce one another in this pattern. Short, project-bound funding cycles, programme logics, and assurance requirements are set upstream by national bodies and then mirrored in local commissioning, governance, and workforce arrangements (Wellcome Trust, 2020; NIHR, 2023; Addae and Danquah, 2024b).

The result is a growing mismatch between what organisations are being asked to do and the structures they are given to do it. This places increasing strain on delivery partners and raises the risk that inclusion is enacted unevenly, episodically, or as a compliance requirement rather than a sustained practice. Communities most affected by health inequality remain marginal to the decisions shaping research priorities and investment, while institutions rely on temporary fixes, individual champions, or exceptional effort to deliver inclusive work. Over time, this constrains the system's ability to make progress on entrenched health inequalities.

4. The Case for New Infrastructure

The patterns outlined above show a consistent structural reality: South London holds significant research and civic capability, but lacks the infrastructure to translate that capability into equitable, community-rooted practice. Inclusion appears in strategies and project plans, yet it is not governed, stewarded, or anchored through a coherent institutional arrangement. This section explains why internal reform cannot resolve that gap, and why dedicated inclusive research infrastructure offers a credible route to system-level change.

4.1 Why Current Systems Cannot Deliver Inclusion Through Reform Alone

Current systems have attempted reform through dedicated initiatives, among them NIHR's Research Inclusion Strategy, the INCLUDE project, and the Race Equality Framework, but the structural patterns outlined above show why these efforts repeatedly fail. Two system-wide limitations make reform-from-within insufficient:

1. **Fragmented Governance Prevents Coherence:** Responsibility for inclusion sits across dispersed teams, engagement, EDI, research offices, programme leads, none with system-wide authority. Without a central steward to set expectations, monitor practice, or protect learning, progress remains episodic and easily lost (NIHR, 2023; Wellcome Trust, 2020).
2. **Institutional Incentives Contradict Inclusive Practice:** Academic promotion pathways, NHS service pressures, and commissioning cycles reward short-term outputs rather than long-term relational practice. Even committed staff are structurally pulled toward procedural compliance and away from community proximity (Wellcome, 2020; NIHR, 2023).

These are not organisational shortcomings; they are systemic design features. In a system built to reward process over proximity, reform cannot embed inclusion as a sustained function. This is the gap new infrastructure would be designed to fill.

4.2 The Strategic Gap: What the System Currently Lacks

Across South London's research landscape, four system-critical functions remain absent:

- **A recognised authority on inclusive research practice** - Able to define standards, convene partners, and steward relational capability across institutions.
- **Infrastructure for cumulative learning** - Retaining community insight, methodological development, and evidence on what works in specific places.
- **A workforce development pipeline** - Preparing community researchers, practitioner-researchers, academics, clinicians, and system leaders for equitable collaboration.
- **Mechanisms for system-level accountability** - Ensuring commitments to inclusion translate into durable shifts in commissioning, ethics, and the implementation of methodological practice.

These functions cannot be absorbed into existing organisations without becoming secondary to their core missions. Universities prioritise publication and grant capture; NHS bodies prioritise service pressures; local authorities prioritise statutory obligations; funders prioritise programme portfolios; VCSE organisations prioritise immediate needs. No institutional actor holds the mandate, positioning, or continuity to carry these functions alone.

4.3 The Strategic Imperative for New Inclusive Research Infrastructure

The analysis above points to a clear structural requirement. Inclusive research cannot be sustained through dispersed responsibility, short-term projects, or institution-specific initiatives alone. What is missing is a dedicated system-level infrastructure capable of holding functions that no single organisation is currently mandated, resourced, or positioned to sustain. Such an infrastructure would operate as a backbone within the research ecosystem. It would not replace existing institutions, but strengthen them by providing continuity, coordination, and stewardship across research design, delivery, and learning. In particular, it would need to perform five core system functions:

- **Stewardship:** Governance, standards, and quality assurance for inclusive research across the South London ecosystem.
- **Methodological Development:** Advancing inclusive research models through practitioner developed models and established academic traditions such as CBPR and implementation science (Wallerstein et al., 2018; Kitson et al., 1998; Addae and Danquah, 2021).
- **Workforce and Leadership Development:** Building multidisciplinary capability across community researchers, practitioner-researchers, academics, clinicians, and system leaders.
- **Collaborative Delivery:** Demonstrating rigorous, co-produced research through live projects that model high-quality inclusive practice.
- **System Learning and Accountability:** Retaining relational memory, synthesising evidence on what works, and ensuring insights drive system-level change.

Taken together, these functions form a coherent institutional architecture: one that treats inclusion as a long-term, relational, and strategic responsibility, rather than a task dispersed across overstretched teams.

4.4 Illustrative Practice Patterns Across South London

The five system functions outlined above are not absent in South London. Elements of stewardship, methodological expertise, delivery capability, workforce development, and community engagement already exist across universities, NHS organisations, local authorities, and VCSE infrastructure bodies. National bodies including NIHR and Wellcome have repeatedly highlighted the presence of such distributed capability, while also noting its uneven development and limited integration (NIHR, 2015; Wellcome, 2020; Wallerstein et al., 2018).

What is missing is not activity, intent, or expertise, but coordination. These functions sit in different places, are governed by different incentives, and are rarely designed to operate together as a coherent system. As a result, inclusive research practice remains fragmented, dependent on local champions, and vulnerable to disruption when projects end or personnel change.

The table below illustrates how these core functions are currently dispersed across the South London research ecosystem. It is intended to demonstrate that while capability exists, no single actor is mandated or equipped to steward inclusive research as a sustained, system-wide responsibility.

IRC Capability	Organisation & Description	How This Capability Is Demonstrated in Practice	Evidence of Impact / Limits
1. Stewardship - Governance, standards, and quality assurance for inclusive research	**Black Thrive Global:** A well-established system-change partnership advancing improved outcomes for Black communities in Lambeth and, increasingly, across wider geographies.	Black Thrive brings partners together around shared priorities on racial inequity, cultivates collaborative approaches, and coordinates programmes that align statutory, VCS, and community stakeholders. Their convening role strengthens local system focus on structural determinants of inequality.	Black Thrive has shaped local agendas, partnership commitments, and investment priorities. Its stewardship function, however, is designed around a thematic and place-based mission, meaning it does not operate as a system-wide governance mechanism for inclusive research across South London.
2. Methodological Development - Advancing inclusive research frameworks and models	**King's Health Partners (KHP):** An Academic Health Science Centre bringing together King's College London with Guy's and St Thomas', King's College Hospital, and South London and Maudsley NHS Trusts to accelerate research, education, and clinical innovation.	KHP leads the development and application of robust research methodologies, including implementation science, complex evaluations, multi-site studies, and translational approaches that shape practice across South London. Their methodological infrastructures and academic capabilities are among the strongest in the region.	KHP provides significant methodological depth and research leadership, but its remit centres on clinical and academic priorities. Participatory, community-led, and equity-focused research approaches are present within pockets of work but are not configured as a unified, system-wide standard for inclusive research.
3. Workforce & Leadership Development - Building multidisciplinary inclusive research capability	**Community Southwark:** The borough's voluntary and community sector (VCS) infrastructure body, supporting charities, social enterprises, grassroots groups, and community leaders through governance, strategy, and capacity-building.	CS strengthens local organisations through training, leadership development, partnership brokering, and governance support. Their work enables VCS groups to participate more confidently in system conversations and cross-sector initiatives.	Their reach across the VCS ecosystem is significant, but their remit is broader than inclusive research specifically. They do not hold a mandate to develop community researchers, practitioner-researchers, or cross-institutional inclusive research leadership, leaving a gap that system-level infrastructure is required to address.
4. Collaborative Delivery - Live, rigorous, co-produced projects	**Impact on Urban Health (IoUH):** A major place-based health foundation funding long-term programmes across Lambeth and Southwark, focused on addressing structural drivers of health inequality.	IoUH commissions multi-partner initiatives that bring together communities, VCS organisations, NHS bodies, local authorities, and academic institutions. Their programmes frequently involve co-creation, shared delivery, and collaborative problem-solving across sectors.	IoUH has enabled significant collaborative activity and long-term investment in local systems. However, approaches to co-production differ across programme areas, and there is no single, cross-programme standard for inclusive research practice, highlighting the need for dedicated system infrastructure to hold coherence and methodological consistency.
5. System Learning & Accountability - Retaining relational memory and translating insight into change	**Healthwatch (e.g., Southwark, Lambeth, Croydon):** Statutory bodies responsible for gathering public experience of health and social care services and providing independent scrutiny of local system performance.	Healthwatch organisations collect citizen insight, publish public-facing reports, and provide a recurring accountability mechanism for how services are experienced on the ground. They offer one of the few stable channels through which community voices are formally brought into local health governance.	Healthwatch has played a valuable role in amplifying community voice and highlighting system issues. However, its statutory remit centres on service experience rather than research design or inclusive research practice. The confirmed closure of Healthwatch bodies removes an independent voice function and does not establish responsibility for system-wide learning, methodological standards, or long-term research accountability, leaving a gap that dedicated infrastructure like the IRC would fill.

This pattern is not unique to South London. National infrastructure programmes have been designed to hold bridging functions between research institutions and communities, and they have encountered the same structural constraints described throughout Sections 3 and 4. The Applied Research Collaborations (ARCs), successors to the NIHR-funded Collaborations for Leadership in Applied Health Research and Care (CLAHRCs, 2008), operate through university-hosted models subject to the institutional incentive structures, governance arrangements, and short funding cycles that this paper identifies as root causes of fragility (Soper et al., 2015; NIHR, 2024). The current cohort of 15 ARCs is ending in March 2026, with a Pan-London ARC not expected to be operational until mid-2026 (NIHR, 2025). INVOLVE, NIHR's dedicated public involvement body established in 1996, was absorbed in 2020 into a broader institutional remit (NIHR, 2015).

The gap identified above is not only a local coordination failure. It reflects a national pattern in which dedicated infrastructure, integrated into the same systems this paper has diagnosed, has not resolved the underlying structural conditions.

4.5 Synthesis

The patterns highlighted in section 4.4 reinforce a wider structural truth: capabilities exist across South London, but none are configured to operate as system-wide custodians. As the national precedents above demonstrate, this is not a gap that dedicated infrastructure programmes have resolved elsewhere. Existing systems are not failing because of weak intent or insufficient expertise; they are failing because no actor is mandated, equipped, or positioned to hold responsibility for inclusive research as a sustained system function.

This diagnosis carries particular urgency now. Public health and research reform are increasingly oriented toward neighbourhood-based, place-led, and community-centred approaches, reflected in Fit for the Future: the 10 Year Health Plan for England (Department of Health and Social Care, 2025) and the expansion of NHS England's neighbourhood-based working model (2025/26) through Integrated Care Systems. Significant new investment is flowing into these agendas. Yet without infrastructure capable of holding relationships, standards, learning, and translation over time, these reforms risk reproducing the same gaps at a greater scale.

What is therefore required is a form of infrastructure capable of holding inclusive research as a sustained system function rather than a series of disconnected initiatives. This includes a mechanism for stewardship, standard-setting, translation between community insight and institutional process, and the accumulation of relational and methodological learning over time. Section 5 introduces the Inclusive Research Collaborative as a proposed expression of this need, setting out the operating model, core capabilities, and governance arrangements required for such an intermediary, alongside an honest account of the pathways and challenges involved in realising it within the South London ecosystem

5. The Inclusive Research Collaborative (IRC)

The preceding analysis suggests that inclusive research in South London fails in patterned ways not because of weak intent or lack of expertise, but because no actor is mandated and resourced to hold key functions across projects and institutions. The gap is not another initiative; it is a missing system function: stewardship, standards, relational continuity, and translation between communities and institutions.

The Inclusive Research Collaborative (IRC) is proposed as a practical, testable configuration of that function: a small, practitioner-led intermediary that works between institutions and communities, rather than as a new programme or statutory body. It is envisaged as an independent, not-for-profit organisation that delivers and co-delivers research projects and stewards inclusive research standards across the system. Its core purpose is to:

- **Stewardship:** Standards, relationships, accountability, and ethical coherence.
- **Translation:** Practitioner-led bridging between community insight and institutional process.
- **Capability-Building:** Developing workforce capability, partnerships, methodological depth, and relational infrastructure across sectors, including more culturally grounded and innovative approaches to engagement and delivery.

Crucially, the IRC is not presented here as a finished solution. This paper argues that the model can be advanced through multiple complementary routes, each tested against the real institutional conditions of South London, and that the foundational work to build this infrastructure is already underway.

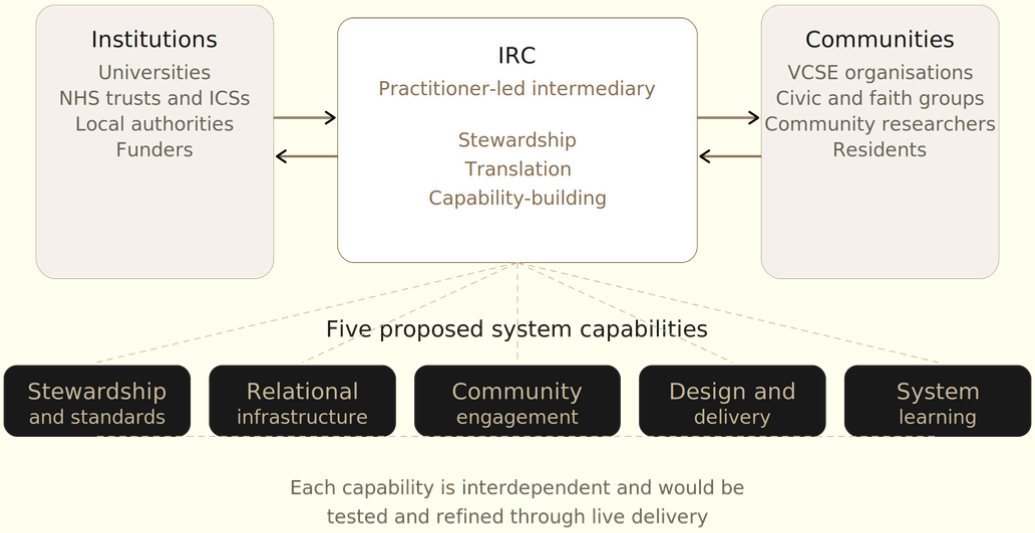
5.1 Operating Model

The IRC would operate through a mixed-delivery model built around four operating principles, drawn directly from the patterns described in Section 3. These principles describe the operational logic the model would need to embody rather than a detailed delivery plan; they define the conditions under which the IRC would be tested and the design constraints that would govern its development.

- **Practitioner-Researcher Leadership:** A practitioner-led core (anticipated as around 2–3 FTE equivalent) anchors translation between communities and institutions, and carries day-to-day responsibility for stewardship, standards, delivery and learning across the IRC's portfolio.
- **Distributed Delivery:** Instead of building a large new delivery organisation, the IRC delivers and co-delivers a small number of projects itself and with universities, NHS bodies, local authorities and VCSE partners, supporting and quality-assuring work that is jointly designed from the outset.
- **Structured Learning and Adaptation:** Each project is designed with clear review points where partners examine what is and is not working, and adjust methods, engagement and governance accordingly. Learning is deliberately carried from one project into the next.
- **Relational Integrity as a System Function:** Trust, continuity, and contextual legitimacy are treated as core operational requirements, not optional extras. The IRC provides a single point of continuity for communities across the IRC's portfolio, even as institutional partners and project teams change.

Figure 1. Proposed model of the Inclusive Research Collaborative (IRC)

The IRC is proposed as a practitioner-led intermediary positioned between institutions and communities, carrying three core functions: stewardship of standards and relationships, translation between community insight and institutional process, and cross-sector capability-building. The five system capabilities below represent the functions the model would need to hold, each interdependent and designed to be tested and refined through live delivery. This architecture does not replace existing organisations but provides the connective infrastructure currently absent from the system.



5.2 Core Capabilities of the IRC

To address the gaps identified in Section 3, the IRC would need to hold five interdependent capabilities:

- **Stewardship and Standards:** Developing and applying a grounded minimum set of inclusive research standards and practices across the portfolio, and producing training and practical tools that partners can use to implement them within their own projects and governance structures.
- **Relational Infrastructure and Trust Networks:** Mapping and strengthening existing trust networks in selected South London neighbourhoods, actively brokering connections between institutions and trusted community actors, and maintaining continuity of relationships across projects.
- **Community Engagement Mechanisms:** Designing and testing engagement approaches that are culturally competent, locally rooted and relational, and embedding these across the IRC's portfolio so that participation is a natural part of how work is shaped, delivered and reviewed.
- **Design, Delivery, and Methodological Support:** Supporting partners in the design and, where appropriate, direct delivery or co-delivery of research with academic, NHS/ICS, and VCSE partners, while helping them embed inclusive methods within existing governance and delivery structures.
- **System Learning and Translation:** Curating learning across projects into concise, decision-oriented outputs and feeding this back into local commissioning, organisational practice and the ongoing design of the IRC itself.

These capabilities are designed to be tested and refined through live delivery, to understand what level of resourcing within an independent intermediary is needed for them to be sustainable.

5.3 Governance: Independent Intermediary Model

The IRC would operate as an independent intermediary, not hosted within or governed by any single institution. Governance arrangements would be co-designed with partners as the model develops, but the foundational principle is non-negotiable: the IRC must maintain critical independence from the institutions whose practice it seeks to influence, while working through and alongside existing statutory, ethical, and regulatory governance structures rather than replacing them. In practice, this means formal decision-making would sit with the IRC's own governing body, while institutional, community, and funder partners would participate through advisory and co-design structures that provide strategic oversight and challenge without directing the intermediary's priorities.

5.4 Realising the Model

The model described in Sections 5.1 to 5.3 is a response to a structural absence. No single initiative or funding decision will close the gap identified in this paper. What is required is a deliberate, cumulative effort to build the missing function into the way research is commissioned, governed, and delivered across South London. The vision set out here can be advanced through several complementary routes, each addressing a different dimension of the infrastructure gap. These are presented in order of immediacy, from work already underway to the longer-term conditions required for the full model to be tested:

- **Phased Practitioner-Led Development:** Continued development through practitioner-led organisations working across strategic health inequalities priority areas within communities and institutions, building evidence, refining standards, and deepening institutional and community partnerships incrementally through live delivery. This route grounds the model in operational reality from the outset, testing what works and what does not before the architecture is formalised at scale.
- **Adoption Within Existing Structures:** The adoption and testing of individual elements of the IRC model within specific institutional or geographic contexts, whether shared standards for inclusive and community research methods across a borough or ICS, relational accountability mechanisms between communities and public health institutions, or tailored capacity-building programmes for researchers across institutional and community settings.
- **Dedicated Cross-Sector Partnership:** A resourced partnership to test the full IRC model as described in this paper: an independent intermediary operating across a portfolio of projects with cross-sector partners, holding stewardship, translation, and capability-building as integrated functions rather than pursuing them separately. This route offers the most direct test of whether inclusive research can be sustained as a system function.

Progress would be measured by shifts in how inclusive research functions across the system: continuity in relationships between communities and institutions sustained across research projects rather than rebuilt each time; community-generated insight demonstrably influencing decisions in research design, commissioning, or service development; meaningful participation extending across the research lifecycle rather than being confined to consultation at predetermined stages; and measurable improvements in trust between communities and the public health institutions that serve them.

This paper is itself an expression of that trajectory. Elysium London, the consultancy from which it originates, was founded to operationalise the principles the IRC model describes, building inclusive research standards, practical guidance, and cross-sector capability through commissioned training, advisory, and early research collaborations with NHS bodies and university faculties. The IRC, in its full form, remains the longer-term systemic expression of that work.

5.5 Limitations and Challenges

The pathways outlined above do not operate outside the structural conditions this paper has diagnosed. They operate within them. Advancing the IRC model through any route requires working within the same short commissioning cycles, fragmented governance arrangements, and institutional incentive structures that Sections 3 and 4 identify as the root causes of the current gap. Practitioner-led development depends on securing commissions from institutions whose processes structurally disadvantage the relational practice on which this model is built, requiring practitioners to demonstrate their value through the very mechanisms this paper has identified as inadequate. Adoption within existing structures depends on institutional partners changing norms that have proven resistant to change across successive reform efforts. A dedicated cross-sector partnership depends on sustained investment from funders and system partners in a function that has not previously been resourced on these terms.

Fundamentally, building practitioner-led intermediary infrastructure requires occupying the space between communities and institutions with sufficient honesty to challenge both, while depending on both for the relationships and resources on which the work survives. Yet as the national precedents discussed in Section 4 demonstrate, intermediary functions developed through such partnerships have historically been absorbed, restructured, or dissolved as funding priorities shift. For an independent practitioner-led organisation that does not sit within or receive hosting from an established institution, the position is more precarious still. The organisational survival required to maintain long-term direction depends on the same commissioning environment that produces the short-cycle, project-bound patterns this paper has described.

The evidence base for the IRC model is at an early stage. The system-level functions it describes have not been demonstrated in practice by any single organisation, and this paper does not claim otherwise. What the paper offers is a structural diagnosis that the evidence supports, pathways to develop and test a model that the diagnosis demands, and the foundations of a practitioner-led effort to begin operationalising it. Whether that effort can be sustained will depend on the willingness of system partners to invest in infrastructure that holds inclusive research as a long-term function, and on whether commissioning, governance, and funding arrangements can adapt sufficiently to support work that does not fit neatly within existing institutional frameworks.

6. Closing Reflections

The IRC model, whether realised in its current form or through further iteration, establishes the core principles upon which a more inclusive research infrastructure for South London can be built. Elysium London is the vehicle through which that groundwork is being laid. The analysis in this paper, the precedents it has documented, and the practice on which it draws point to a single conclusion: this infrastructure will not be built by the system that currently lacks it. It will be built by those who understand the gap well enough to work within it, and who have chosen to begin. The underlying problem remains the same. The same communities are repeatedly consulted, the same insights rediscovered, and the same barriers documented. Inclusion remains concentrated in short-term projects rather than embedded in how research is funded, governed, and sustained over time.

The consequences fall on people, not systems. They fall on residents who develop long-term conditions a decade earlier than those in less deprived areas, who experience discriminatory treatment within services meant to care for them, and whose trust in research and health institutions erodes with each cycle of consultation that leads nowhere. This paper is written from within those communities, shaped by five years of embedded practice, and driven by the understanding that these structural failures are lived realities before they are analytical categories. The model proposed here was not designed at a distance; it was developed through the daily work of navigating the system it describes.

The analysis and the model are open to challenge, refinement, and collaboration. The IRC does not require universal agreement. It requires shared recognition that the current arrangements are insufficient, and collective commitment to test whether something better is possible. This paper is a contribution to building that infrastructure, carried forward through an organisation founded for this purpose. For those reading this, the work has already begun. The question is who will help build it.

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