Information pack: funding call-out for improving health equity through a population health approach

Appendix 1 - Support from the GSTT Population Health Hub (PHH)

The GSTT PHH brings together expertise in public health, clinical care, management, improvement, advanced analytics and research. Funded by the Charity, it works closely with them to complement and build on existing projects and initiatives. The Hub supports and enables colleagues in the Trust to improve quality of care through data-driven population informed insights: to codesign new ways of working, and support implementation and evaluation of value based, integrated care.

One of the main areas of focus for the hub is to support Trust wide population health initiatives and enable those closest to the work to tackle health inequity within their services. This will support clinical groups to help deliver the GSTT 2030 strategic aim of 'Improving the Health of our Local Populations'

The PHH multidisciplinary team will provide support for the call-out by working with clinical teams to inform, develop, test and implement their ideas for improving services for patients and populations.

Supporting the Charity's health equity call-out complements the aims of the Hub, and provides an opportunity to align multiple programmes of work across the Trust and Charity to maximise impact. There are likely to be common themes across the different applications providing an opportunity for more joined up working between teams and opportunities for shared learning.

The Hub will support the initial call-out, application process and project delivery in the following ways:

Provide application advice

The Hub, with the Charity, will host drop-in sessions or individual appointments for applicants as they draft their full applications to help refine ideas and provide practical advice.

Shortlisting

The Hub will support the Charity with developing shortlisting criteria that are informed by population health principles. The Hub will also take part in the shortlisting process.

The Hub will provide a range of ongoing advice and support for successful applicants. This includes:

◆ an initial 'setting up for success' session for all project leads to help them get started,

◆ follow up sessions for project teams to share learning,

◆ a session towards the end of the project period to celebrate progress, success and share knowledge.

In between these sessions the Hub will provide practical support and advice with data, evidence synthesis, evaluation, co-production and codesign of new ways of working, tailored to the needs of the project (Figure 1).
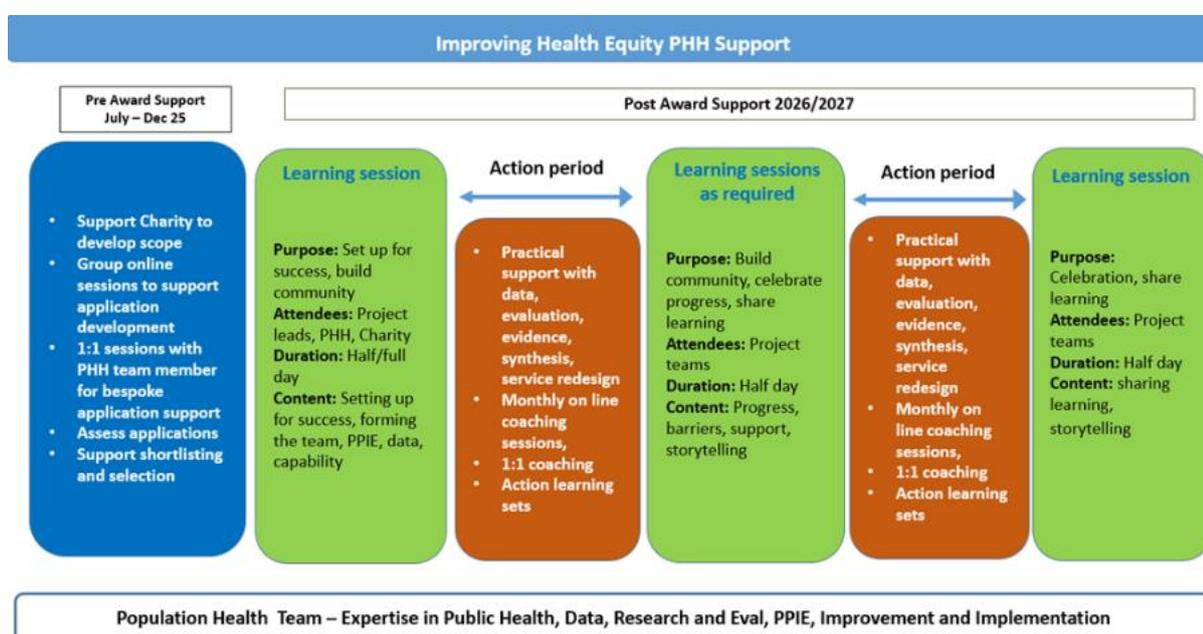

Figure 1. Population Health Hub Support

Appendix 2 – Health inequity in Lambeth and Southwark

2.1 An overview of the local population and their greatest health needs

South East London is home to one of the most densely populated and diverse communities in England, with its population growing by nearly a third since 2002. Around half of residents identify their ethnicity as other than White British, twice the national average, and the borough of Southwark has the highest proportion LGBTQ+ community in the country.

The average age in South East London is 36.2 years, notably younger than the national average of 40.8. The area is characterised by stark contrasts, with pockets of deep poverty alongside areas of significant affluence. Levels of household deprivation in education,

employment, health, and housing are higher than the national average. Notably, South East London also has the highest rate of violent crime in the city.

Lambeth and Southwark have a higher prevalence of diabetes, chronic kidney disease, and chronic respiratory disease compared to national figures. Lambeth also reports a higher prevalence of depression and dementia than Southwark, and both conditions exceed national prevalence rates (Figure 2).

Condition	Lambeth	Southwark	London	England
Depression	5.5%	5.0%	5.5%	5.3%
Diabetes	38.5%	35.6%	36.4%	33.7%
Asthma	12.4%	11.0%	12.2%	11.2%
Chronic Kidney Disease	37.7%	34.8%	36.8%	34.7%
Coronary Heart Disease	10.5%	9.5%	11.7%	12.0%
Chronic Respiratory Disease (COPD)	32.1%	31.2%	32.4%	31.1%
Stroke	3.2%	3.0%	3.2%	3.3%
Dementia	8.4%	7.9%	8.8%	8.0%

Figure 2. Comparison of prevalence of health conditions in the local area compared to London and England (JSNA, Southwark & JSNA Lambeth, 2025)

2.2 Applying a population health approach

A population health approach considers the health outcomes of a defined group of individuals. It is informed by data and based on evidence. Population health is considered within the context of an integrated health and care system, taking into account the wider determinants of health, health behaviours and lifestyles, and the communities we live in.

As this call-out is focused on services within the Trust, any proposal will inevitably focus on change within the services GSTT provides, while being mindful of the impact that the wider determinants of health can have on health behaviours and risk factors. The outcome of a population health approach should be a reduction in health inequity (unfair and avoidable differences in health across the population, and between different groups within society) with the result of improving health equity (ensuring everyone has a fair opportunity to attain their highest level of health).

2.3 The policy context

The 10 Year Health Plan for the NHS has reemphasised the three shifts that the Government wants the NHS to deliver: hospital to community; analogue to digital; sickness to prevention. Each project, as a minimum, should clearly describe how it addresses one

of the shifts. The Charity acknowledges that there is already significant Charity and Trust work underway in the analogue to digital shift and therefore this may have less specific focus in this call-out.
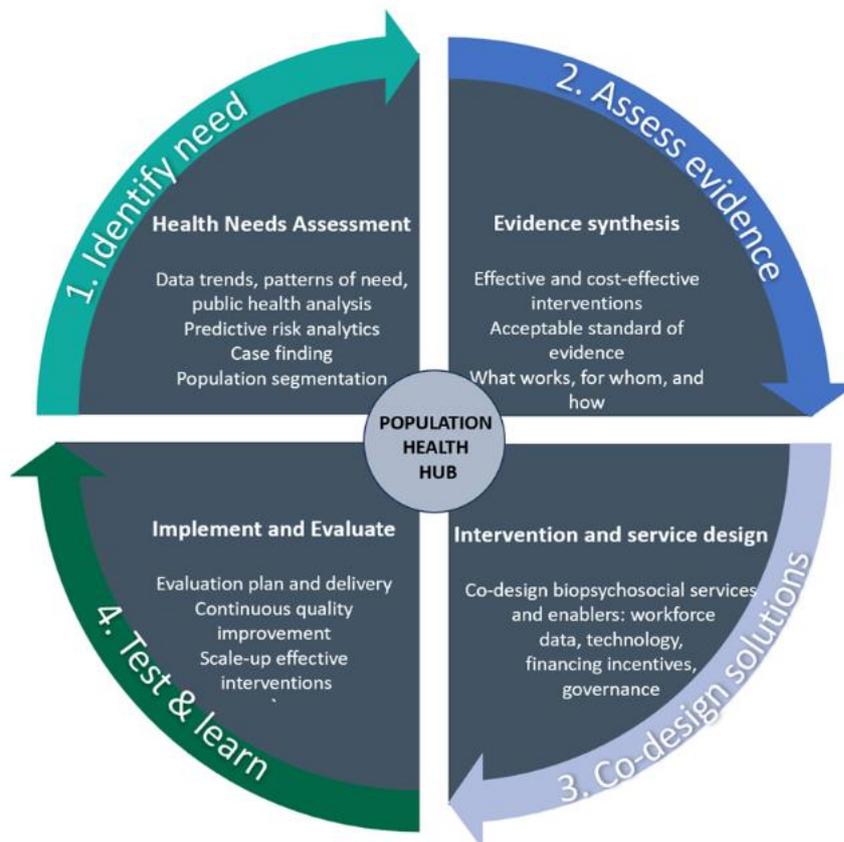
2.4 Defining the population health approach

Figure 3.The 'GSTT population health approach'

The population health approach can be summarised as *'data and evidence to impact'* and involves these practical steps:

- ◆ Identify the population and issue by using data to help understand the need
- ◆ Look and bring together evidence of what works
- ◆ Learn from what staff and patients are saying around the issue
- ◆ Bring a team around the issue including those closest to the work and representatives from the people we serve to inform what the change looks like
- ◆ Utilise improvement approaches, tools and mindsets to help understand the issue, develop changes together and to measure impact
- ◆ Think BIG, start by testing on a small scale to learn
- ◆ Bring people along by working together, inclusively and transparently

2.5 Case study – a community-based pilot for care of patients with liver disease

This project was funded by Guy's & St Thomas' Charity in 2022 under a prior funding call-out. There is a high prevalence of liver disease in Lambeth and Southwark particularly as this disproportionately affects lower socio-economic groups and those from ethnic minorities. As a result, there were long wait times for the liver service at the Trust. In response a new model of care was piloted to provide education and support (via multidisciplinary teams and contact with a dedicated Clinical Nurse Specialist) to General Practitioners, empowering them to effectively and appropriately triage, refer and manage chronic liver disease patients 'at home'. The pilot was successful in transferring the care of many patients with chronic liver disease from secondary care into primary care, reducing pressure on waiting lists and ensuring patients are treated in the right place, at the right time.

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