City & Hackney
Population Health Hub

2025 impact report

City and Hackney Population Health Hub

The Population Health Hub (PHH) aims to **reduce health inequalities** and **improve the health of our population**.

We do this by providing expertise and support in a range of key areas - including data and insight, community engagement and resident participation and evaluation and learning. We provide resources, 1:1 support and programmes for people to participate in.

We can't do this alone: **our vision is for everyone across the system to play a role. We work to increase awareness of what's needed, support others to take action, and advocate for change.**

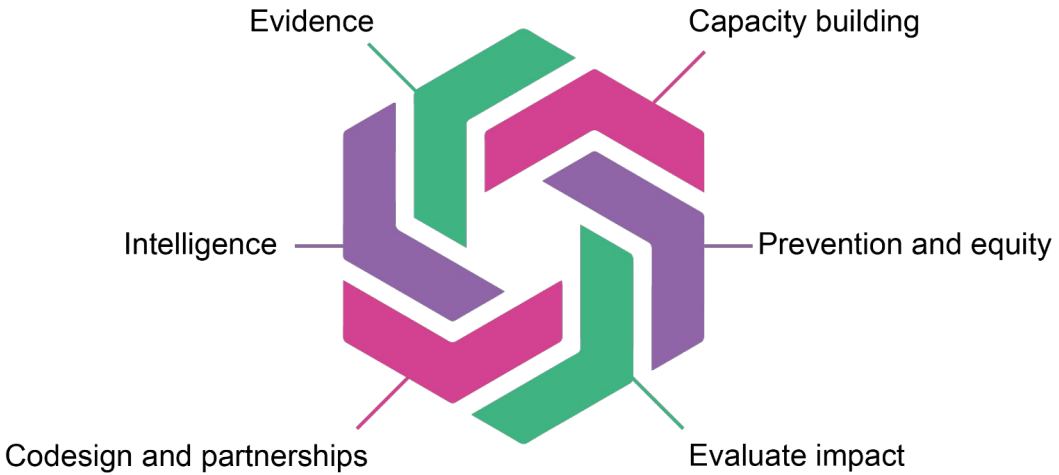
Through our work we aim to leave **skills** in teams and provide people with the **confidence to work differently**, so that together, we can achieve our aim.

How does the Population Health Hub work?

We work to proactively identify what the system needs…

…and also work in partnership on requests for support from stakeholders across the system

Supporting partners, teams and individuals to find joy and sense of purpose in their work



City & Hackney
Population Health Hub

How can the Population Health Hub contribute to the long term impact of reducing inequalities and improving population health?

Awareness: teams and residents are aware of drivers of population health and inequalities and how to take action on these

Action: teams and residents have the confidence, skills and capacity to take action to improve population health, reduce inequalities and move focus towards prevention

Advocacy: teams feel able to champion taking a population health approach, and taking action on health inequalities and moving focus towards prevention

Trust: communities feel more valued and that their best interests are considered by institutions

- System partners understand more about drivers of population health and inequalities
- System leaders have shared understanding and responsibility on prevention and have committed to taking practice actions to embed this
- Teams are aware of the PHH and know what support it can provide (and are supported with alternatives if they want support but PHH don't have capacity to provide)
- Teams are aware of other relevant work happening in the system, and can build partnerships to increase impact. Teams are aware of available resources across the system
- Teams feel they have the skills and are confident to identify and take action on inequalities
- Teams can identify how to build inequalities into routine work - and what needed to do this
- Teams feel they have the skills and are confident to evaluate the impact of their interventions to reduce inequalities
- Increase in focus and resources on prevention and inequalities
- Residents and communities have increased trust in statutory sector services

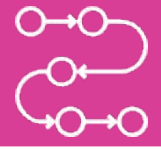
Objective 1:

Awareness

Teams and residents are aware of the drivers of population health and inequalities and how to take action

What have we done to increase awareness?

on workforce development

What did we do?		What is different?
	**Lunch and Learns**	Monthly lunch and learn sessions (on evaluation, equity, how to carry out literature reviews, how to carry out qualitative research).	Approximately 85 people have attended lunch and learns, from a variety of different teams across City and Hackney. Partners are using resources developed, and PHH is known as a source of support.
	**Social connections showcase**	Evening showcase to make connections, share learning, and build enthusiasm and commitment around building social connections at our annual showcase event.	Over 100 people attended and over 85% of attendees made at least one new connection. Local organisations showcased their work and attendees fed back on the valuable learning opportunity. A new funding programme will further support organisations building social connections & addressing social isolation.
	**MATCH equity programme**	Support to Healthy Weight, CYP mental health and asylum seeker teams to understand inequalities and need in their area including resident insight.	Teams have taken on the MATCH process and learning from their experience into their routine work.

What have we done to increase awareness?

on collection and use of data

	What did we do?		What is different?
	**Reporting on outcomes**	Developed a new collaborative mechanism for outcomes reporting, including engagement to develop and share a narrative summary of what is working well and what is working less well to meet the needs of our residents.	Teams are using the outcome summary to inform planning. We are now using this model to inform use of the North East London (NEL) outcomes framework.
	**Inequalities summary resource**	Drafted a summary of local inequalities across the building blocks of health for partners to use - both with professionals and residents.	Teams are using the inequalities summary to inform their work, and communication with residents.
	**Neighbourhood data summaries**	Developed summary data and insight packs for each City & Hackney Neighbourhood.	Neighbourhood teams are using the data summaries to understand local insight and population needs, and to help establish priorities.

Case study: Social Connections Showcase



> It was soooo good. A truly joyous, inclusive, community focused evening, filled with passion, compassion and inspiration!

> Just wanted to say a huge congratulations for the brilliant Social Connections event, it was such a fantastic gathering of people doing amazing work! I found it very inspiring.

> Thank you for organising an encouraging event with lots of food (for thought as well as the actual food!). I felt there was genuine wish to make connections and community there which was as a result of the leading and guidance of the team behind it.

Objective 2:

Action

Teams and residents have the confidence, skills and capacity to take action to improve population health, reduce inequalities and focus on prevention

What have we done to improve effective action?

on collection and use of data

	What did we do?		What is different?
	**Data collection**	Facilitating the East London NHS Foundation Trust (ELFT) teams to better understand why we need to collect equalities data and how to use this to identify and address inequalities. ELFT provide range of mental health, wellbeing and community health services across East London.	Four ELFT teams are improving their equalities data: committed to improve the robustness of their data on equalities dimensions (faith, sexuality, ethnicity) and use this to improve equity of their services.
	**Maternity dashboard**	Developed Homerton maternity equity dashboard showing maternity outcomes by equalities dimensions.	The Homerton maternity dashboard to be used by the Maternity Quality and Safety Meeting and the Maternity Partnership Board: a baseline, an increasing risk alert system and to monitor progress in reducing inequalities. We are also using this model to support dashboard development in other areas e.g. women's health.

What have we done to improve effective action?

on workforce development

Our website

We have developed a website with many resources for teams to support action on inequalities. Over each 3-month period, we get ~360 views of this (over 200 unique users).

	What did we do?		What is different?
	**Evaluation**	Developed and disseminated an evaluation toolkit and support package.	Teams have robust evaluation frameworks and feel more confident to conduct these.
	**Cost effectiveness evidence**	Collated existing resources on cost effectiveness and drafted how to use guide, and self-assessment flowchart to facilitate use of these resources. We have identified teams to test this with.	Teams have access to resources on cost effectiveness to feed into planning and embed evidence on cost effectiveness into their work. We are also working with NEL to embed this into their refreshed commissioning plans.
	**Health literacy**	Developed a framework, a toolkit, and supported different teams with embedding health literacy in their work. We are also testing community approaches with a small grants scheme on health literacy.	We have used this with different teams including First Contact Practitioners and Youth Hubs (Health Spot), to better communicate with residents.

What have we done to improve effective action?

on community centred approaches

	What did we do?		What is different?
	**Equity in Cardiovascular disease (CVD) and Healthy Weight**	Facilitated partners to identify key actions on addressing poorer CVD outcomes in Black communities = interventions embedding CVD education, screening and physical and wellbeing activities in existing community groups.	Increased access to culturally tailored activities to improve heart health. Case studies included in London Million Healthy Hearts Playbook. New projects in place e.g. to improve healthy weight for CYP, people with LD, adults with multiple health conditions.
	**Resident participation**	Used results of C&H engagement review to facilitate a cross-partner community of practice on resident participation. There were 60 attendees over 3 events: with presentations about faith and health, community development approaches in physical activity.	Teams feel more confident in resident participation- from building skills and connections in this area, and sharing case studies and challenges.
	**PCN inequalities work**	Secured £180K (annually) of Health Inequalities money for PCNs/neighbourhoods. Supported sharing across neighbourhoods and building skills in using data and evaluation via the Neighbourhoods Community of Practice.	19 projects delivered, from befriending to health fairs to youth gym sessions to housing coordinators in GP surgeries.

Case study: working with the Welcome Hackney team

MATCH project to improve mental health support for people seeking asylum and those with insecure immigration status

1. Established working group to bring people from across the system together to collaborate, share knowledge, and make a plan for change.
2. A literature review and comprehensive review of existing data informed the project.
3. Identified gaps and barriers in service provision, and centred resident insight and lived experience.
4. Facilitated links to local mental health services and mapped out relevant and accessible support pathways for this group.
5. Facilitated the team to identify and prioritise change ideas, and with a plan for how to implement these.

- Four projects were delivered by VCS organisations to test effective ways of boosting wellbeing and mental health for people in asylum seeker hotels. Projects will be used to understand the challenges faced by this group better and team will continue the bringing together of MH practitioners together and offer ongoing training.
- The team committed to make sure that the delivery of the projects contribute to more systemic change and reflects feedback from (funding initially from MATCH but WH team have identified funding for a second year of this work, which will introduce direct referral routes for mental health professionals).

> "I think it's conceivable that we would have done something similar…but I don't think there's any way that I would have had the buy-in or kind of that push from MATCH to be making sure that it's thinking systemically and making the link back to the rest of the system."

> "I think that the projects that are funded are really interesting projects in and of themselves, but they're also designed to have some kind of lasting impact for people, which is a nice outcome of all of this. For example, one of them is working with women, equipping them with employability skills and capabilities that will outlast the project."

> "The win of having so many people invested in the process is huge."



Credit: *Ada Jusic Illustration*

Objective 3:

Advocacy

Teams feel able to champion taking a population health approach, taking action on health inequalities and focusing prevention

What have we done to embed population health advocacy?

on community centred approaches

	What did we do?		What is different?
	**Group support on periods**	Commissioned group support sessions for women with difficulty with their periods, and embedded community advocates in the women's group consultations programme.	109 people (often with experience of gendered violence, chronic pain, menstrual health challenges or social isolation): life satisfaction increased 30%, sense of worthwhileness increased 30%, 97% improved pain management & relaxation skills, 95% felt less isolated.
	**Post-natal support**	Supported midwives from Hackney communities to develop and deliver postnatal support sessions.	Six workshops delivered by midwives in partnership with physiotherapists, 34 attendees - over 90% reported being more confident in managing their pelvic health.
	**Partnerships**	Convene population health and health inequalities strategic partnership to mobilise local action on health inequalities and population health.	Teams have taken on the MATCH process and learning from their experience into their routine work.

> *I feel it's helping me focus on a more positive path…an integral part of community emotional and mental health assistance which really is needed in today's society.*

Case Study: MATCH Maternity Project

on community centred approaches



MATCH equity support

Worked closely with partners leading or participating in the MATCH process to support increased understanding of how to embed health equity and take action on health inequalities.

MATCH programme area leads are taking the MATCH approach further in future work; MATCH projects “inspire [residents] to think about their health”; MATCH CVD project has helped women advocate for their health and exercise independently.



Objective 4:

Trust

Communities feel more valued and that their best interests are considered by institutions

What have we done to increase trust?

on community centred approaches

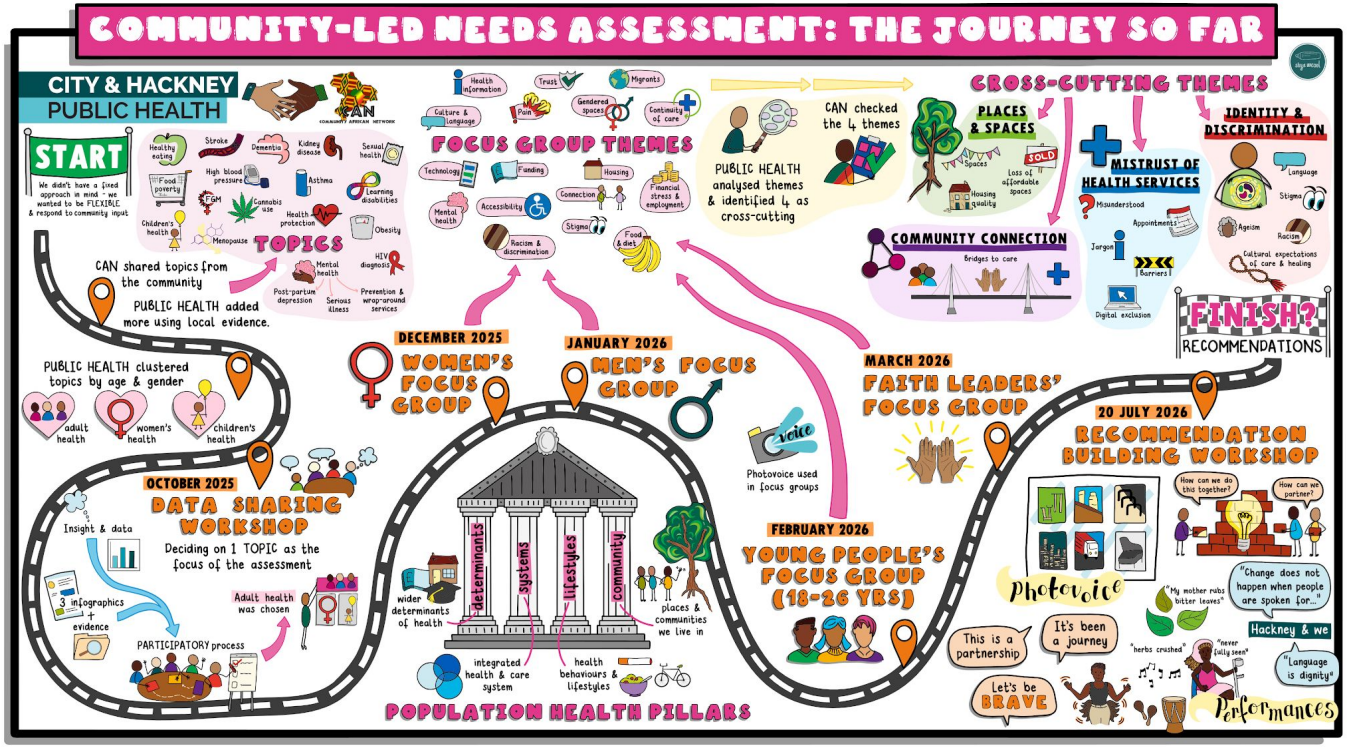
	What did we do?		What is different?
	**Hackney Thinking Spaces**	Supported evaluating the implementation and impact of Hackney Thinking Spaces - therapeutic community spaces, peer support and community led solutions to tackle systemic racism.	Gathered feedback from participants, facilitators and peer mentors; over 90% of participants found the spaces useful, safe and a place for healing and support.
	**Equity in CVD and health weight**	Worked with VCS to increase resident participation (making sure workshops are accessible).	The projects being led by community organisations, rather than clinical ones, meant it felt familiar, manageable, and trustworthy to residents, supporting both access and engagement.
	**Health literacy**	We are providing tailored training to teams (physiotherapists in primary care, schools and others) to be able to provide a more health literate service to residents.	We have supported the production of resources and supported team's work to make healthcare information more understandable, digestible and actionable for residents.

> *Simply sharing health information is not enough. People must trust the messenger before they engage with the message.*

Case study: Community-led needs assessment

PHH supported a **community-led needs assessment on Black adult health**, working with the wider Public Health team, Community African Network, and residents.

Several focus groups and workshops were held to work with the community to **share insight**, create a better understanding of **needs** and **available resources**, and **develop recommendations** for the system and community.





How are we achieving our aim?

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Health Hub

Case study

What has the MATCH programme achieved?

Awareness

- 70-80% of participants had increased knowledge of health inequalities
- Awareness of principles for anti-racist commissioning
- Better understanding and monitoring of maternity inequalities
- Increasing residents' awareness of health issues - better management of blood pressure

Action

- Action taken where most needed (healthy weight project for adults with learning disabilities, pregnant people)
- Making connections: "MATCH works across the system to embed equity into the culture"
- Sustainable actions: MATCH food poverty project successfully trialled a food pantry model
- 90% of participants feel able to repeat MATCH approach

Advocacy

- MATCH CVD project has helped women advocate for their health and exercise independently
- MATCH programme area leads are taking the MATCH approach further in future work
- MATCH projects "inspire [residents] to think about their health"
- Birth Bridge: community doula project supported 33 births, advocating for better maternity care for patients
- Peer support on difficult (heavy/painful) periods

Trust

- Work with VCS to increase resident participation (making sure workshops are accessible)
- Value from MATCH comes with how projects and partners work with communities: with intention, openness, meaningfully
- "Having these projects made me realise we are being looked after and listened to"

How are we achieving our aim?

- Lunch & Learn sessions
- Staff resources
- Health literacy programme
- Analytics support
- Outcomes reporting
- MATCH
- Collaboration, convening and facilitation

System partners are aware of how to address inequalities

Staff feel confident in planning action to narrow inequalities

System partners adopt a collaborative and participatory approach

Staff feel they can advocate for a population health approach

Improved population health and reduced inequalities

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Summary of evidence sources

PHH website

- Evaluation toolkit
- Health literacy toolkit

Participant feedback

- Lunch & Learns
- Social connections showcase

MATCH evaluation

- Group support on periods
- Postnatal support
- Equity in Cardiovascular disease
- Equity in Healthy Weight

Partner feedback

- Social connections showcase
- Reporting on outcomes
- Inequalities summary
- Neighbourhood data summaries
- Resident engagement

Partner feedback

- Data collection support
- Maternity equalities dashboard
- PCN inequalities funding
- Hackney Thinking Spaces
- Cost effectiveness toolkit

Find out more

- Click here for our **website**
- **Email us:** phh@cityandhackneyph.hackney.gov.uk