LEICESTER, LEICESTERSHIRE AND RUTLAND

SYSTEM HEALTH INEQUALITIES FRAMEWORK

Version: Draft 10.1

Date: March 2021

Date	Version	Status	Author	Notes
December 2020	Initial	Early Draft	Mark Pierce and Steve McCue	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 11/12/20 LLR Population Health Management Advisory Group on 15/12/20
January 2021	Version 5	Draft	Mark Pierce and Steve McCue	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 07/01/21 LLR CCGs Governing Body meetings in common (confidential) on 12/01/21 Clinical Executive on 14/01/21 LLR NHS System Executive on 19/01/21
February 2021	Version 7	Draft	Mark Pierce, Steve McCue, Viv Robbins, Jo Atkinson, Aloma Onyemah and Lucy Wilson	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 04/02/21
February 2021	Version 9	Draft	Mark Pierce, Steve McCue, Viv Robbins, Jo Atkinson, Aloma Onyemah and Lucy Wilson	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 18/02/21
March 2021	Version 10.1	Draft	Mark Pierce, Steve McCue, Viv Robbins, Jo Atkinson, Aloma Onyemah and Lucy Wilson	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 04/03/21 LLR CCGs Governing Body meetings in common (confidential) on 09/03/21

Leicester, Leicestershire and Rutland (LLR) System Health Inequalities Framework

Contents

Foreword to be included by ICS Chair

1. Purpose

The aim of the Leicester, Leicestershire and Rutland (LLR) Health Inequalities Framework is to improve healthy life expectancy across LLR, by reducing health inequalities across the system. The purpose of this Framework is therefore to:

1.1. Provide a system mandate for action to address health inequalities across LLR

1.2. Establish a collective understanding of the terms 'Inequality', 'Inequity' and 'Prevention' in relation to population health, across all parts of the LLR Integrated Care System (ICS)

1.3. Strengthen a whole system collaborative approach to reduce (and remove entirely where possible) avoidable unfairness in people's health and wellbeing in LLR

1.4. Establish the high-level principles of how LLR ICS partners will approach the work of reducing health inequity at system level

1.5. Recognise the framework will be implemented and agreed at system level, with much operational, political and community action taking place at 'place' and 'neighbourhood' level[1] . It is the systems' minimum ask of Place in relation to reducing health inequalities.

1.6. Set out some key actions that can be delivered at system level with support through the ICS, with recognition that some actions will be primarily for individual organisations e.g. the NHS or the Local Authority however many requiring partners to work together.

[1] LLR is divided into three "Places"; Leicester City, Leicestershire County and Rutland County, all of which align to upper tier local authority boundaries. Within each 'Place' smaller geographic areas known as 'Neighbourhoods' (also known by other terms such as 'districts' or 'communities') are used.

2. Introduction

2.1. Health and wellbeing is not just the concern of the NHS. The health and wellbeing of people is an asset to individuals, to communities, and to wider society. Good mental and physical health is a basic precondition for people to take an active role in family, community and work life. Although there is growing concern about stalling life expectancy, the existing wide inequalities in health outcomes tend to be overlooked. Improving healthy life expectancy enables people to live in better health for longer. Ensuring they can contribute to society. A workforce that remains fit, healthy and working for longer can contribute to a productive economy and decrease the costs of supporting an ageing society. However, health inequalities undermine these benefits.

2.2. Health inequalities can be found along a social gradient, with those living in the most deprived areas having the worst outcomes. Inequalities can be found even within areas that might be regarded as affluent. Therefore using a 'levelling up' approach will have an impact on the majority of the population. Evidence shows that having a more equitable society benefits the whole population, not just those living in the most deprived areas or currently experiencing the worst outcomes. [1] [2] [3] [4]

3. What are healthinequalities?

"*Health inequalities are the **preventable, unfair and unjust differences** in health status between groups, populations or individuals that **arise from the unequal distribution of social, environmental and economic** conditions within societies*" (NHS England) [5]

3.1. Those living in the most disadvantaged areas often have poorer health outcomes, as do some ethnic minority groups and vulnerable/socially excluded people. These inequalities are due to a combination of factors including income, education and the general conditions in which people are living. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are ill. This is known as the inverse care law.

3.2. Health inequalities have been further exposed by the Covid-19 pandemic, which has taken a disproportionate toll on groups already facing the worst health outcomes. The mortality rate from the virus in the most deprived areas has been more than double that of the least deprived. In addition, some ethnic minority communities and people with disabilities have seen significantly higher Covid-19 mortality rates than the rest of the population. The economic and social consequences of measures to contain the virus have worsened these inequalities further, with people in crowded housing, on low wage, unstable and frontline work experiencing a greater burden and transmission of the virus.

3.3. There are always going to be differences in health, some are unavoidable e.g. as result of age or genetics but many differences in health are avoidable, unjust and unfair – it is these that we are concerned about and that this framework seeks to address. [2] [6] [7]

4. Inequalities vs equity

4.1 "Health inequalities" is the commonly used term, however we are actually referring to **health equity and inequities.** Therefore the terms are used interchangeably within this document and in the LLR system.

4.2. **Equality** means treating everyone the same/providing everyone with the same resource, whereas **Equity** means providing services relative to need. This will mean some *warranted* variation in services for different groups (see Figure 1).

4.3. It is important to note the difference in terminology between this work and those stated in the Equality Act 2010, although the terms relate to the same concept of equity. The Equality Act defines specific protected characteristics that require explicit consideration in any decision-making process, but this framework recognises the importance of identifying vulnerable groups that are not well reflected within these definitions (such as homeless people or those with caring responsibilities).

Figure 1: Representation of equality and equity using adapted bicycle example

Source: Reproduced with authorisation from Robert Wood Johnson Foundation (Better Bike Share, 2017)

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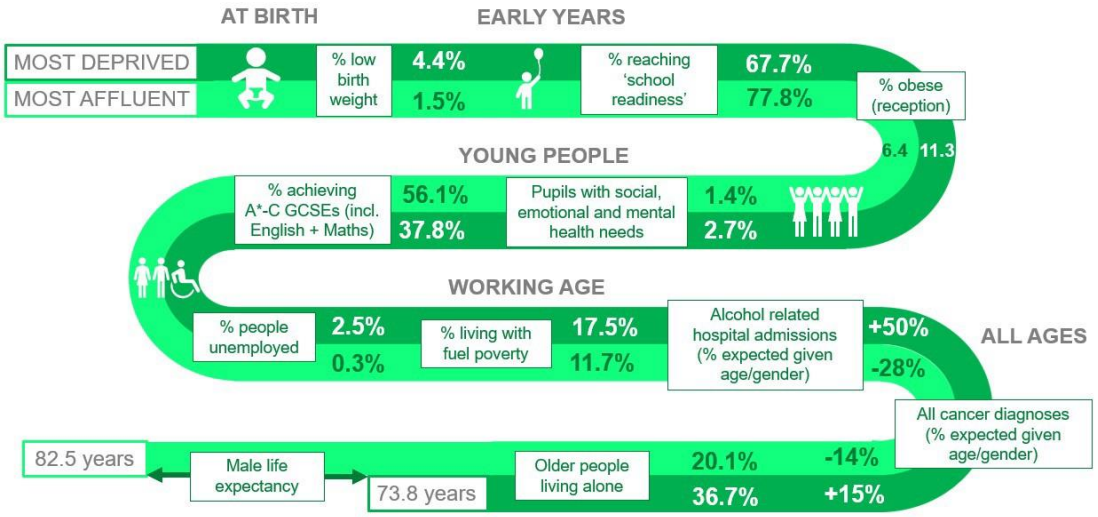
A tale of two babies illustrates our story of inequalities in LLR (see Figure 2). It is vitally important to recognise that no outcome is set in stone. However the story aims to illustrate the potential variation in the opportunities and difficulties two babies might encounter throughout their life based on the circumstances into which they are born.

It highlights a demonstrable bias in the way our current systems are set up to benefit, to a greater extent, those in more affluent circumstances. With determination and collaborative effort we can reduce this injustice

Figure 2: Difference in health indicators between the most and least deprived local areas of LLR, over the life course



Source: PHE Fingertips [8]

Notes: Most deprived area data reflects inner City areas such as Braunston Park and Rowley Fields. Most affluent area data reflects areas such as Market Harborough-Logan and Market Harborough-Welland However there will be further hidden inequalities within each place for example within Rutland the most deprived ward is Greetham. Where small area data is not available local authority-level has been used.

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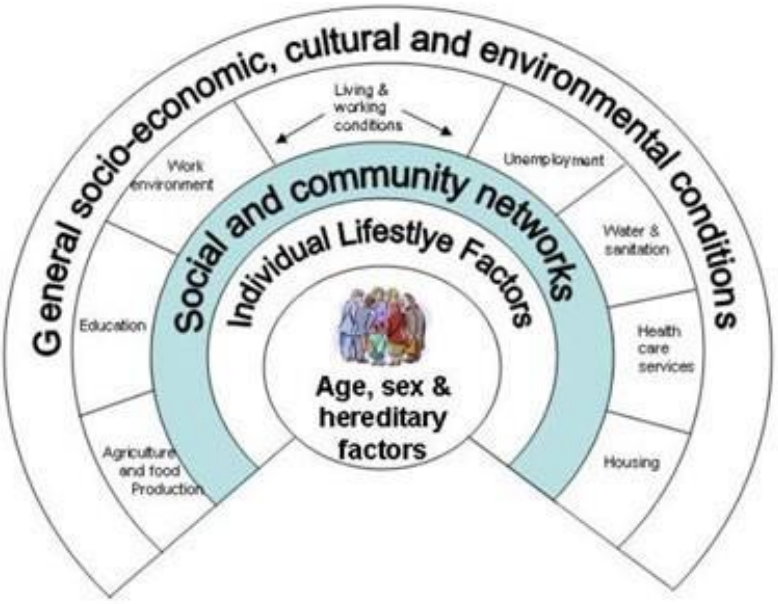
5. What is health?

5.1 Once we define health, we can understand why reducing health inequalities is a key piece of work for all partners within the ICS. Health is understood as;

"a state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness" (Marks, 2005) [9]

5.2 This framework recognises the above definition of health and the interconnected relationship between the elements of this definition. The work also adopts a social model of health influences, outlined in Figure 3 below. The social model of health identifies all but age, sex and hereditary factors as modifiable to change and therefore lying within the scope of this work, particularly in relation to primary prevention.

Figure 3: A Social Model of Health, Dahlgren & Whitehead (1991)



Source: The World Health Organisation. [6]

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5.3. The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes social inequality, an important driver of health inequalities. On a whole population level, the wider determinants of health (often known as the "causes of the causes") will have a much greater effect on reducing inequities in health compared to the NHS alone. Local Authorities, rather than the NHS, have influence and responsibility over some of the wider determinants such as education, housing, transport, clean air, licensing of food and alcohol outlets etc.

5.4. Local Authorities also have a key role in terms of fostering economic opportunity which is reflected in the supply and quality of jobs available in an area.

5.5. We can also see from Figure 3 that communities themselves are vital partners for the ICS members as they undertake this work – in terms of articulating lived experience of health inequalities and helping us co-produce solutions.

5.6. It's important to note that as an individual's health declines, the relative impact of NHS services on future health and life expectancy *increases.* By taking a preventative approach (working equally across primary, secondary and tertiary levels of intervention[2]) to delay and reduce the need for NHS treatment services the increasing demands on the health service can be managed appropriately. [1] [10] [11] [12]

[2] Primary prevention - Taking action to reduce the incidence of disease and health problems, through universal or targeted measures that reduce lifestyle risks and their causes

Secondary prevention - Systematically detecting the early stages of disease and intervening before full symptoms develop (e.g. taking measures to reduce high blood pressure).

Tertiary prevention - Helping people to manage the impact of ongoing illness or injury (e.g. chronic diseases, permanent impairments) to improve as much as possible their ability to function, their quality of life and their life expectancy. [12] [22]

6. How I can find out more about health inequalities in LLR?

6.1. A detailed analysis of local demographic and health data demonstrating the extent of inequality is available through local JSNA (Joint Strategic Needs Assessment) reports produced by each Public Health Team. Local JSNA's are available via the following organisational links:

Leicester City:

https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-information/jsna/

Leicestershire:

https://www.lsr-online.org/leicestershire-2018-2021-jsna.html

Rutland:

https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment/

Leicester, Leicestershire, and Rutland Integrated Care System Principles of Approach to Reducing Health Inequalities

7. Principles

As an ICS we are committed to taking action in order to reduce health inequalities across LLR. Our work in this area will be guided by the following set of principles.

Principle 1

Reducing Health inequalities is a key factor in all work conducted within the ICS – it is *everyone's* business. Reducing health inequalities and improving health equity should run through all work programmes at all levels as a "golden thread" from system to place to neighbourhood. Appropriate training and support will be given to enable people to think and act in ways that lead to reductions in health inequity.

Principle 2

The Integrated Care System (ICS) will adopt a Population Health Management[3] and balanced approach to Prevention (across all three tiers[2]) as core principles for their work together in order to reduce health inequalities. Prevention is key to managing future demand for health and care services. Prevention is also essential for improving health equity as the burden of disease is borne unfairly by those who are more deprived, marginalised or in a minority.

Principle 3

A focus on tackling the wider determinants of health. Primary prevention includes a focus on and increased investment in reducing inequalities in lifestyle risk factors (smoking, diet, exercise, alcohol consumption etc), mental wellbeing, housing, income, education, working conditions and the wider environment.

Principle 4

A focus on parity of esteem between mental and physical health - reducing inequalities in mental health will be prioritised to the same extent as reducing inequalities in physical health.

[3] Population Health Management approach involves the effective use of routinely collected data to provide meaningful insights on the population being served. This approach allows for proactive care planning by understanding the role of wider determinants of health and making best use of collective resources to improve the health of the population now and in the future. [3]

Principle 5

Public sector ICS partners will act as 'anchor institutions'[4] **in LLR** to promote health equity and reduce health inequalities through offering "social value". This approach includes supporting the system workforce to be more representative of the demography of the LLR population.

Principle 6

Investment in services will be proportionate to the needs (the ability to benefit) the people using those services (the principle of "proportionate universalism"). This means that although there will be a universal offer of services to all, there will be justifiable variation in services in response to differences in need within and between groups of people. Where we find variation in services that is not justified by the variation in need we will take action to "level up" the way the services are offered and outcomes achieved. While levelling up is generally a good thing, levelling down is not. So applying focus and resources in one area and targeting those resources to make them most effective will be appropriate, however, diverting those resources from somewhere they were also needed in order to improve health outcomes will not be.

Principle 7

We will use data – both qualitative and qualitative - to better understand the health inequalities that exist in LLR and how they affect people. We will draw upon the best evidence to select and implement effective action to reduce inequalities and to evaluate the impact of our services. Where services are failing to reduce inequity, or (by accident) are increasing it, the services will be adjusted or changed completely.

Principle 8

We will draw on the assets and strengths of communities and individuals to reduce health inequality and inequity. Our services will always try to listen to what really matters to people rather than focusing solely on "what is the matter" with them. We believe in the ability of people to develop effective solutions to challenges once the services we offer have been matched equitably to need.

Principle 9

The "**Health and Equity in all Policies**" approach[5] will help foster the process of ensuring the health and health equity perspectives are a core part of the ICS way of

[4] "Anchor institutions are large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively 'anchored' in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land". [21]

[5] "Health in All Policies is an approach on health-related rights and obligations. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences

doing its business. This is particularly important on the wider determinants of health such as housing, education, employment etc.

Principle 10

We will take effective action at key points of the life course dependant on need ("from the cradle to the grave") to reduce health inequality and inequity. This means a specific focus on giving children the best start in life, prevention of ill health (including primary prevention), the promotion of wellbeing and resilience as key principles of our work. This approach will also address the intergenerational cycle of health inequalities across LLR.

Principle 11

Accountability for delivering on system wide health inequalities will be an ICS system accountability. However it is acknowledged that upper tier local authorities have a statutory duty to reduce health inequalities at the place level. Governance of system level principles and actions will be via the Health and Care Partnership.

Governance of place–based plans and strategies will be via Health and Wellbeing Boards. Governance of plans and actions at footprints beneath place level will be agreed between local partners using the most appropriate structures consistent with effective representation and oversight.

Much of the implementation of programmes to reduce health inequalities will occur at place. Within the requirements of system, places will be expected to influence the priorities for their populations. This is about understanding the population, how factors such as education, economy, housing, health etc are impacting on local communities and ensuring local engagement and co-production of any strategies or plans. The challenge is partners coming together to understand that impact, prioritising and developing programmes in collaboration with local communities (particularly communities who are most deprived and disadvantaged) is essential to strengthen community resilience and adverse social circumstances.

Principle 12

Actions will be undertaken at the most appropriate level of the ICS where they can be most effectively owned and delivered. Governance of different types of action will be determined in some cases by how statutory responsibility devolves from central government. Housing, education, and licensing rest with Local Authorities for example, while commissioning responsibility for most hospital services will lie with the local CCGs and their successors.

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of public policies on health systems, determinants of health, and well-being. It also contributes to sustainable development". [22] [12]

High level system actions to reduce health inequalities in Leicester, Leicestershire and Rutland

8. System actions

8.1. Introduction

We can see that health inequalities are the result of a complex range of interrelated causes – and "the causes of those causes". In some cases actions will be primarily in the hands of one partner. In other cases, reducing inequity will require close collaboration between several organisations across the system. The ICS partners are committed to taking action at all levels:

- System level – across the whole LLR area
- Place level – across the area covered by our Upper Tier Local Authorities (Leicester City Council, Leicestershire County Council, Rutland County Council) and led by Health and Wellbeing Boards
- Neighbourhood or locality level – smaller (though locally meaningful) populations within the wider Upper Tier boundaries.

At each of these levels the partners within the ICS – not just the NHS and the Local Authority, but the voluntary and community sectors too – will come together to plan in ever finer detail the actions they are going to take, individually and collectively, to reduce health inequity.

Priorities will be determined at place level and are likely to include;

1. A focus on the first 1,000 days of life as these determine outcomes across the whole life course. Action will be determined by the needs of each place.
2. Improving healthy life expectancy through early intervention and prevention including actions relating to the wider determinants of health. Actions will be determined by the needs of each place.
3. Using the lived experiences of people to inform our plans and actions.
4. Each organisation having an executive nominated lead for health inequalities who will be responsible for driving this agenda forward in their own organisation
5. A SMART approach to delivering actions at Place

The actions below are high level actions we will work on together because they will support effective work to increase health equity at all levels of the ICS or because they represent important health inequities faced to some degree in all parts of the system.

Below are the high-level system actions, detailed plans on action to reduce health inequity will be agreed at place level. The development, delivery and evaluation of place –based plans will be led by Directors of Public Health and Health and Wellbeing Boards. The plans will be based on local data and intelligence – qualitative and quantitative – derived from Public health, Local authority services, the NHS, other public sector partners, and communities themselves.

The most detailed implementation plans and actions will be developed by partners working together at a very local level (Neighbourhood or locality level). Multi-Disciplinary Team working, the sharing of information and engagement of individuals and communities around their assets and strengths will ensure that action is direct, person-centred and sensitive to feedback and revision from the integrated teams and the people those teams serve.

8.2. Strategic System Actions

Action 1

Places will be expected to translate the system level principles to their specific populations in the most appropriate way that meets their local needs. This is likely to take a wider determinants of health angle, acknowledging that much of this work happens at this level.

Action 2

We will agree a proportionate universalism approach to invest decisions across the ICS. This would allow actions to be universal, but with a scale and intensity that is proportionate to the level of disadvantage. ICS organisations will create a financial framework for addressing health inequalities with agreed investment in transformation of priority areas and investment based on need. NHS anticipates that any allocation of transformation and development funds being used to support the ICS will have reducing health inequalities as a high priority .

Specifically:

The NHS in LLR will develop and agree a new strategic long-term model of primary care funding distribution and investment to “level up” funding based on population need rather than historical allocation**.** This strategy will not destabilise local primary care.

Action 3

The ICS will establish a defined LLR resource to review health inequalities at the system level. This will be a virtual partnership between the NHS, the local authorities and local universities. It will aim to make available an enhanced capacity and capability for data processing and analysis to support a better understanding of inequity across LLR. It will gather and share best practice in effective interventions, it will provide teaching and training to all levels of staff in undertaking health equity audits. It will facilitate local research. It is acknowledged that Public Healthteams

with partners will deliver the health inequalities support at a place and neighbourhood level.

Specifically:

a) Proposal for establishment of an LLR health inequalities specified resource to be presented to System Executive by 30.09.21

Action 4

All decision makers within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it.

Specifically:

a) Health Inequity and Inequality training will be mandatory for all executive decision makers in each organisation by 30.11 21
b) We will work locally and regionally to develop appropriate and robusttraining packages relevant to roles.

Action 5

System partners will work together to understand the full effect of the COVID-19 pandemic on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. Whilst the specific programmes, metrics and evaluations will be agreed at place level for the most part, the LLR system will be looking to understand and encourage action around the following points:

- Identifying those communities and groups of all ages and across protected characteristics which have been most affected through the pandemic as a result of pre-existing vulnerabilities and disadvantages
- Undertake proportionate additional work to ensure vaccine uptake is equitable
- Ensuring a primary prevention focus to recovery that considers the wider determinants of health and causes of the causes including education, employment, housing and poverty
- Promote parity of esteem between the importance of both mental and physical health to those groups worst affected by the pandemic and the consequences of lockdown.

Action 6

All partners will work to improve the completeness and consistency of their data to enable a better understanding of health inequity both at all levels of the ICS. This predominantly relates to the collection of data on ‘protected characteristics’ under the Equality Act. The aim is to most appropriately reflect population need including levels of deprivation, vulnerability and the experience of different groups (including the use of qualitative methods).

Specifically:

(a) Key partner organisations to develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records by 30.07.21
(b) We will risk stratify our population using combined data sets to identifyvulnerable groups and individuals in order to offer proactive, holistic care through Integrated Neighbourhood Teams involving a variety of system partners.

Action 7

The ICS will support the creation of health equity dashboards at place and system-level using agreed metrics to establish baseline information on health inequity and ensure systems are in place to measure progress appropriately. These dashboards at each level will help ensure accountability against our plans and targets to remove or reduce health inequity through all the work we do.

Specifically:

a) Each organisation will have adopted a standard health equity audit tool for completion at the planning phase of each project by 30.10.21
b) Training in undertaking these audits and common corrective actions that can be implemented to reduce inequity will be mandatory for relevant staff in each organisation – confirmation to System Executive by 30.10.21
c) Each Place in the LLR system will have a health equity dashboard with agreed metrics and benchmarked baseline performance by 30.10.21

Action 8

A form of Health Equity Audit (HEA) will be undertaken for projects delivered at all levels of commissioning, service redesign and evaluation within the ICS. These will occur at the planning stage of project work, at a scale that reflects a proportionate approach to work being conducted. Action to reduce health inequity will be taken based on audit findings (at a minimum considering the protected characteristics of the Equality Act 2010) will appropriate reviews planned where necessary.

Action 9

The ICS will develop an action plan, which develops the potential of the NHS and other partners to lead by example and act as an anchor institutions to drive change around a preventative approach and reducing health inequalities that focuses on what the collective LLR public sector can do in the areas of work opprotunities, use of buildings and purchasing by 1.7 2021

How will we know if this work is succeeding across LLR? If this framework is successful in driving effective action, we expect to see the following outcomes;

- A reduction in health inequities
- An increase in healthy life expectancy

- A reduction in premature mortality
- A workforce that is representative of the LLR population
- Population reported outcomes

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