Supplementary written evidence submitted by NHS Providers (PHS0616)

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £115bn of annual expenditure and employing 1.4 million people.

Key messages

- We welcome the Inquiry's focus on preventing ill health and on the social and environmental factors that enable healthy communities to flourish. It is vital that rates of ill-health in society are prevented and reduced, in order to reduce the unprecedented pressures facing NHS services.
- Our evidence specifically highlights a need to enable NHS trusts to address health inequalities and the impact of major health conditions within the wider prevention agenda. Health inequalities are complex and systemic, with far reaching consequences for people, communities and NHS services. We recognise that all aspects of the Inquiry are interrelated and NHS trusts have a role across them all.
- NHS trusts play a key role in prevention and the Inquiry would benefit from understanding the experiences of trust leaders in this field to date, as well as their future plans. Though not solely responsible for achieving change, NHS trusts can effectively enact primary, secondary and tertiary prevention interventions. They act as anchor institutions in the communities they serve, with opportunities to positively influence the wider determinants of health and as key partners in integrated care systems (ICSs). Furthermore, accessible and high-quality NHS services can enable individuals to lead healthy lives and live well with long-term conditions.
- In our response, we share case studies from NHS services that have implemented effective preventative interventions aimed at reducing health inequalities.
- We also highlight the obstacles and barriers that inhibit change. Greater, and more coordinated action is required across government to tackle the multi-faceted nature of health inequalities and to promote, and invest in, a more preventative approach to healthcare. This requires consideration of the key role played by a broad range of public services from education, housing and criminal justice. Greater resource and investment are required too for public health and social care services. Importantly, NHS trusts must be better supported to deliver, with increased resourcing for prevention.

Introduction and background

1. Health inequalities are the unfair and avoidable differences in health outcomes between individuals and groups. Inequalities exist by deprivation, ethnicity, gender, age and other factors. Intersectionality (the interconnected nature of personal characteristics that can lead to discrimination) can potentially exacerbate inequality. In recent years, life expectancy rates in England have stalled, with the gap widening between the most and least deprived areas[1]. Health disparities are caused by economic inequalities and the wider determinants of health, such as housing, employment, education, and air quality; which are attributable to approximately 50% of health outcomes in society[2]. The circumstances in

[1] Health Equity in England: The Marmot Review 10 Years On, The Health Foundation, February 2020
[2] Different perspectives for assigning weights to determinants of health, University of Wisconsin, February 2010

which people are born, work and live influence their ability to lead a healthy life. The importance of a cross departmental commitment to addressing health inequalities, is therefore vital.

2. In this written evidence to the Health and Social Care Select Committee's Inquiry into Prevention in health and social care, we will outline the valuable role NHS trusts can, and do, play in shaping the prevention agenda to improve the lives of individuals with long-term conditions and to reduce health inequalities. While the NHS cannot control the wider determinants of our health, it represents a key player in national and local decision making to improve the health of the nation.

Health inequalities – what is the scale of the challenge facing NHS trusts?

3. It is estimated that inequalities cost the NHS £4.8 billion annually[3] and NHS treatment would be 15% lower if health inequalities were removed[4]. Individuals living in poor health are more likely to use health services on a regular basis, access services late, present with a greater complexity of need and are more likely to require hospital admission. There are inequalities in access to healthcare services, with fewer GPs per head (adjusted for level of need)[5] and lower rates of admission to elective care[6] in more deprived areas. Ill health can be prevented if treated early, but delayed access can store up problems that increase pressure on secondary care within NHS trusts in the longer term. For example, people living in the most deprived area are 1.7 times more likely to attend A&E compared to those in the least deprived areas[7]. Mental health trust leaders have cited financial hardship, housing and cuts to local services as causes of increased demand on mental health services[8].

4. Inequalities are formed and embedded at an early stage in life, highlighting the importance of taking preventative action during maternity, childhood and adolescence. Children in the most deprived areas are twice as likely to be obese or overweight in comparison to those in the least deprived areas[9]. As a society, we are storing up problems for the future if these inequalities are not addressed, for example obesity in childhood is linked to a range of later health conditions (heart disease, type 2 diabetes, breathing difficulties, and mental illness). Elsewhere we have called for increased focus on prevention and early intervention in childhood through embedding whole system solutions within schools and children's services[10].

5. Certain individuals and groups are more likely to experience health inequalities, as differences in health status are affected by socio-economic factors and deprivation, geographical and regional differences, and the protected characteristics or inclusion health status of an individual. For example, males in the most deprived areas are 3.8 times more likely to die from avoidable causes[11]. Maternal mortality for black women is four times higher than white women[12]. Individuals with a learning disability die, on average, 16

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[3] The costs of inequality, Journal of Epidemiology and Community Health, May 2016
[4] Estimating the costs of health inequalities, Frontier Economics, February 2010
[5] Level or not? Comparing general practice in areas of high and low socioeconomic deprivation in England, The Health Foundation, September 2020
[6] Place-based approaches for reducing health inequalities, Public Health England, September 2021
[7] Inequalities in Accident and Emergency department attendance, England: March 2021 to March 2022, Office for National Statistics, October 2023
[8] Mental Health Services: Addressing the care deficit, NHS Providers, March 2019
[9] Obesity statistics, House of Commons Library, January 2023
[10] Written submission to the Department of Health and Social Care's *Mental health and wellbeing plan* consultation, NHS Providers, July 2022
[11] Socioeconomic inequalities in avoidable mortality in England (2020), Office for National Statistics, March 2022
[12] Black maternal health, Women and Equalities Committee, April 2023

years earlier than the general population[13] and 49% of deaths of those with a learning disability are avoidable, compared to 22% in the general population[14]. People with a severe mental health illness are at greater risk of poor physical health[15] and die on average 15-20 years earlier[16]. These groups will require targeted interventions and support, including from NHS services.

6. Deprivation increases the likelihood of individuals having a long-term condition, which are likely to be more severe and are more likely to exist alongside other long-term conditions ("multi-morbidity")[17] - 28% of people in the most deprived areas have four or more long-term conditions[18]. There is also a higher prevalence of ill health among Pakistani, Bangladeshi, and Black Caribbean individuals in comparison to white individuals[19]. More than 60% of emergency patients admitted to hospital have one or more long-term condition[20]. Inequalities also exist in the investment and level of priority accorded to different long-term conditions, particularly the sustained lack of equity between physical and mental health conditions. Diagnoses for mental health conditions take longer and are fewer, despite often presenting alongside, and being interrelated with, physical health conditions[21].

Role of NHS trusts in preventing health inequalities

7. The causes of health inequalities are complex, but it has been estimated that 20% of health inequalities are attributable to the ways in which health services are designed and delivered, and to the quality of clinical care received[22]. This statistic importantly reinforces both the importance of cross departmental investment in initiatives to address health inequalities (80% being estimated to occur due to other factors), and the important role that health and care systems have to play.

8. Research has found that poverty status is linked to worse quality and experiences of healthcare services[23]. Individuals from deprived areas are more likely to face barriers in accessing services – such as cost, transport, communication style, digital exclusion. Patients who report negative experiences of healthcare services may be deterred from accessing care in the future, or they may delay access which will worsen their health[24]. It is therefore imperative that the reduction of health inequalities is core to the work of all NHS services and organisations. Investment in population health, primary care and preventative approaches is key to ensuring the long-term sustainability of the NHS, to reduce the pressure on services.

9. Action on prevention can be categorised in three main ways: primary, secondary and tertiary prevention. The aim of primary prevention is to stop illness or disease before it occurs. Secondary prevention focuses on minimising the impact of the illness or disease that has already occurred, to slow progress and avoid possible re-occurrence. Tertiary prevention acknowledges that some individuals will live with long-term conditions that cannot be reversed, and so aims to manage the condition and improve quality of life.

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[13] Confidential Inquiry into Premature Deaths of People with Learning Disabilities, University of Bristol, March 2013
[14] LeDeR Learning from lives and deaths: People with a learning disability and autistic people, King's College London, 2021
[15] Health matters: Reducing health inequalities in mental illness, Public Health England, December 2018
[16] The Five Year Forward View for Mental Health, Independent Mental Health Taskforce, February 2016
[17] Long-term conditions and multi-morbidity, The King's Fund
[18] Understanding the health care needs of people with multiple health conditions, The Health Foundation, November 2018
[19] Quantifying health inequalities in England, The Health Foundation, August 2022
[20] A Covenant for Health: Policies and partnerships to improve our national health in 5 to 10 years, Filkin, G. et al., July 2023
[21] Mental health: Achieving 'parity of esteem', House of Commons Library, January 2020
[22] Different perspectives for assigning weights to determinants of health, University of Wisconsin, February 2010
[23] Poverty status is linked to worse quality of care, The BMJ, January 2020
[24] Action on patient safety can reduce health inequalities, The BMJ, March 2022

Prevention along these lines can either be universal or targeted to specific groups with higher levels of need (such as homeless communities, LGBTQ+ groups or ethnic minority individuals). This framing provides useful markers for NHS trusts to identify how they can take action across all three aspects of prevention.

10. Effective prevention programmes rely on partnership working between NHS trusts, local authorities, ICSs, primary care services, VCSE organisations and local communities. This enables joined-up person centred care that can be delivered at the right time and in the right place. NHS trusts are a key partner within wider system working, with experience in responding to local need and collaborating through provider collaborative arrangements and ICSs. Collaboration at scale presents an opportunity to address variation in services that currently exists. Trusts should seek to involve local communities in decisions relating to prevention, as it empowers individuals to have a greater say in their health and wellbeing, creates community cohesion and often engages individuals most at risk of poorer health outcomes[25]. There is also an important role for digital and technology as enablers for delivering care in home and community settings.

11. To address health inequalities, and invest appropriately in prevention, it is critically important that social care services are placed on a sustainable footing to help people to maintain their independence and avoid unnecessary hospital admissions or overly medicalised support. Public health services, which have been underfunded in recent years, must similarly receive appropriate investment. Between 2015/16 to the end of the decade, public health funding was cut by £531 million in cash terms[26] - undermining councils' efforts to improve the health and wellbeing of their communities and placing additional strain on the NHS.

Primary prevention: anchor institutions

12. NHS trusts act as anchor institutions within their communities with a large influence over the local economy and having a large staff base. The NHS can work to reduce health inequalities for the people who live and work in the places they serve not only through the services they provide, but in their role as employers, landowners, and purchasers of goods and services[27]. Trusts can therefore contribute to the wider determinants of health and act on primary prevention, which would reduce the demand for healthcare services in the long term. Population Health Management can also be a useful tool for focusing on the wider determinants of health, through data analysis of local need and working in partnership with a range of sectors to address the problems identified[28].

13. As of June 2022, 1.3 million people were employed in the NHS – making it one of the largest employers in the UK[29]. Inequalities can exist within the NHS workforce, particularly for lower paid staff members, who are more likely to have a long-term health condition[30]. Ethnic minority staff are more likely to experience discrimination in the workplace and are less well represented within senior roles[31]. Trusts can widen access to employment opportunities for groups that traditionally face barriers entering and progressing within the labour market and improve working conditions for staff. NHS England's (NHSE) recently

[25] Health Matters: Community-centred approaches for health and wellbeing, Public Health England, February 2018
[26] Health and local public health cuts, Local Government Association, May 2019
[27] Being an anchor institution: Partnership approaches to improving population health, NHS Providers, February 2023
[28] Population Health and the Population Health Management Programme, NHS England
[29] NHS Workforce, NHS Digital, April 2023
[30] Valuing the health and wellbeing of lower paid NHS staff, The Health Foundation, February 2020
[31] Workforce race inequalities and inclusion in NHS providers, The King's Fund, July 2020

published Equality, Diversity and Inclusion (EDI) Plan outlines action trusts should take to protect and improve staff wellbeing, contributing to the reduction of health inequalities.

14. Examples of the actions trusts are taking include:
    - Leeds Teaching Hospital NHS trust widened access to health and care careers in their locality by hosting career days in a local community centre, offering employability courses, and providing additional support for those who English is a second language. A total of 49 people from the local community were supported into roles within the trust[32].

    - East London NHS Foundation Trust has provided a commitment to embed social value principles into their procurement and contracting processes. This involved ensuring that their suppliers pay their staff the real Living Wage, which increased the average monthly wage of cleaning staff by £197 per month. The trust also increased the percentage of companies it contracts with who pay the real Living Wage from 22% in 2019 to 62% in 2022[33].

    - Warrington and Halton Hospitals NHS Foundation Trust have collaborated with local government in the region to develop health and wellbeing hubs in the local community. The Halton Health Hub opened in Runcorn Shopping Centre in 2022 and provides around 8,000 ophthalmology, audiology and dietetics outpatient appointments per year, reducing waits for these services. The development has had wider impact on regeneration of the local area, by increasing footfall to the shopping centre[34].

Secondary and tertiary prevention: improving access to healthcare services

15. NHS trusts can ensure that their services are accessible, in order to improve the experiences of individuals with illness or long-term conditions. Mental health trust leaders have shared the following actions trusts can take to improve access to services[35]:

    - Make access to prompt and personalised care easier, for example by giving people a choice of treatment location and timing
    - Offer easy and quick self-referral
    - Focus on delivering responsive services that work to prevent crisis
    - Enable free access to online resources, services and apps
    - Improve signposting and make information easy to find.

16. Offering preventative and early intervention to reduce unnecessary hospital admissions and to improve patient pathways is core to preventative action and there are numerous examples of good practice from trusts. For example:

[32] Being an anchor institution: Partnership approaches to improving population health, NHS Providers, February 2023
[33] Being an anchor institution: Partnership approaches to improving population health, NHS Providers, February 2023
[34] Being an anchor institution: Partnership approaches to improving population health, NHS Providers, February 2023
[35] Written submission to the Department of Health and Social Care's *Mental health and wellbeing plan* consultation, NHS Providers, July 2022

- Lincolnshire Community Health Services NHS Trust boosted community based support for managing respiratory conditions for children and young people – by providing a physio led rapid response call out for flare ups and providing support and training for parents and carers to prevent conditions reaching crisis level. The trust has estimated a total £600,000 worth of savings as hospital admissions were reduced by 80%[36].

- Bradford District Care NHS Foundation Trust established their 'First Response' service to provide mental health crisis support 24 hours a day, seven days a week. Since the service launched in 2015, there have been no out-of-area placements, meaning costs are reduced and patients have received care closer to home. As patients are receiving better signposting advice, they are less likely to require crisis care. There have been reductions in the number of people being detained under section 136 and reductions in the levels of demand on A&E services[37].

- Devon Partnership NHS Trust reviewed the rate of frequent attenders in their service, to create dedicated health and care plans for the most at risk patients. They host monthly multi-disciplinary meetings involving ambulance services, primary care, medical specialties and housing and social care, where appropriate. One of their patients reduced their attendances by 87% from 2017/18 to 2018/19[38].

17. Tackling the post- Covid-19 care backlogs is a priority for all NHS trusts. Some trusts have placed addressing health inequalities at the centre of inclusive recovery strategies. For example, University Hospitals of Coventry and Warwickshire NHS Trust have been commended for their data-led approach for prioritising waiting lists by clinical need and whether individuals have faced barriers accessing care[39]. Calderdale and Huddersfield NHS Foundation Trust eliminated the elective care backlog for people with a learning disability, by prioritising their needs during recovery[40].

18. Other innovative preventative measures trusts have developed include working with communities to improve rates of health literacy[41], virtual wards[42], poverty proofing healthcare services[43], social prescribing[44] and providing wraparound support for broader issues within health settings. Citizens Advice research found that 48% of people with debt problems reported improvements in their physical health after receiving debt advice, as it improved their wellbeing and levels of stress[45]. Separate research has indicated the value of employing housing support coordinators in hospitals to improve discharge processes[46].

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[36] Providers Deliver: New roles in prevention, NHS Providers, July 2020
[37] Bradford First Response, NHS England
[38] Providers Deliver: New roles in prevention, NHS Providers, July 2020
[39] Health inequalities tool, University Hospitals Coventry and Warwickshire NHS Trust, November 2022
[40] Eliminating the elective care backlog for people with a learning disability, Calderdale and Huddersfield NHS Foundation Trust
[41] Health literacy, South Tyneside and Sunderland NHS Foundation Trust, June 2023
[42] Providers Deliver: Patient flow, NHS Providers, May 2023
[43] Poverty Proofing health settings, North East and North Cumbria Child Health and Wellbeing Network, February 2021
[44] Social prescribing as a way of tackling health inequalities in all health settings, NHS England, March 2022
[45] Acting on the wider determinants of health will be key to reduced demand, NHS England, July 2023
[46] Exploring the impact of a housing support service on hospital discharge: A mixed-methods process evaluation in two UK hospital trusts, Health & Social Care in the Community, August 2023

Barriers preventing progress within NHS trusts

19. In November 2021, we surveyed trust leaders within NHS Providers' membership on the impact of health inequalities[47]. We received 254 responses, representing 63% of the trust sector. While the respondents identified high levels of commitment to addressing health inequalities, they also shared a number of barriers preventing progress. The primary challenge facing trusts is responding to the wider system and operational pressures, which can distract from focusing efforts on upstream prevention and tackling health inequalities. At the current time, this includes managing workforce shortages and industrial action alongside recovering backlogs and waiting lists, although NHSE has signalled that trusts should consider how to ensure that backlog recovery plans seek to address inequalities[48]. Workforce shortages and capital constraints limit the NHS' ability to diagnose more people earlier and so the NHS Long Term Workforce Plan[49] must be fully funded on implementation.

20. Data on health outcomes must be widely shared and understood. Lack of data, incomplete data, lack of interoperability, and low levels of skills to interpret data are all barriers to understanding the health inequalities experienced in the local areas that trusts serve. Data can identify groups who are more likely to experience inequalities and where there are gaps in a service. Trends in data are also useful for tracking progress over time and setting targets for making progress on reducing health inequalities. These data can be reported to trust boards to enable monitoring and accountability. Yet respondents to our survey highlighted inaccurate data reporting among clinicians, with crucial gaps in ethnicity and deprivation coding. Trusts also recognised the need for dedicated data analysis teams, which requires additional resourcing.

21. We also recognise that data can only provide part of the overall picture and should be viewed alongside feedback from local communities on their experiences of healthcare services. There has been variability in the levels of trust engagement with local communities and VCSE partners to co-design and co-produce services, with more research needed to better understand the benefits of these approaches.

22. Our survey results also found that unclear accountability mechanisms for improving outcomes on health inequalities was a barrier to ensuring that it is consistently prioritised at board level[50]. Trusts are keen to work towards an operating model which enables them to prioritise addressing health inequalities and recognises making progress on health inequalities as a measure of good operational performance.

23. The Health and Care Act 2022 went some way in addressing this challenge by placing a responsibility on all NHS services to reduce health inequalities[51] and NHSE guidance is due to be published shortly that sets out the specific legal duties that trusts will be expected to report on nationally to outline their progress in meeting health inequalities targets. We have heard from some trusts that they have developed their own local-level metrics around health inequalities targets that are reporting to their board. However, through our engagement with trust leaders we heard that there remain several barriers around board reporting on health inequalities[52]. These include data quality and availability, lack of guidance around data dashboards and translating the data reporting into meaningful action to tackle health inequalities - and limited leadership headspace due to the operational pressures we set out above.

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[47] United against health inequalities: A commitment to lasting change, NHS Providers, April 2022
[48] Elective recovery planning: Supporting guidance, NHS England, April 2022
[49] NHS Long Term Workforce Plan, NHS England, June 2023
[50] United against health inequalities: A commitment to lasting change, NHS Providers, April 2022
[51] Health and Care Act 2022, UK Government, 2022
[52] Board reporting and assurance on health inequalities, NHS Providers, February 2023

24. Ultimately, we would like to see trusts supported to ensure that health equity is embedded as core business across the work of the board. We will not see gains in preventing ill health without ensuring work on health inequalities is nationally prioritised, appropriately funded and resourced, and considered a measure of good performance. The barriers outlined here can be reframed as enablers if they are effectively tackled.

Policy commitments to reducing health inequalities within the health sector

25. We welcome the policy shift towards addressing health inequalities in recent years. There have been important commitments within the NHS Long Term Plan to take stronger action on health inequalities, through targeted funding at more deprived areas and via interventions for specific groups (such as individuals with severe mental illness, carers and homeless populations)[53]. The Health and Care Act 2022 built upon this, which placed a duty on NHSE to reduce inequalities, with commitments for annual reporting against progress[54]. One of the four stated aims of ICSs is to "*tackle inequalities in outcomes, experience and access*", alongside other aims on population health and prevention[55].

26. Alongside this, NHSE have developed the Core20PLUS5 framework for reducing health inequalities for adults[56] and children and young people[57]. The model allows local areas to identify population groups most at risk of experiencing inequalities, by deprivation and other characteristics. It focuses attention on five key clinical areas for improvement. For the adult version these are: maternity, severe mental illness, chronic respiratory disease, cancer, and hypertension. For children and young people these are: asthma, diabetes, epilepsy, oral health and mental health.

27. NHSE's 2023/24 operational planning guidance sets out the following objectives for NHS services to deliver on prevention and health inequalities[58]:

    - Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
    - Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
    - Continue to address health inequalities and deliver on the Core20PLUS5 approach.

    Earlier this year, the Department of Health and Social Care (DHSC) announced plans to publish a Major Conditions Strategy, with the case for change published in August 2023 and we understand that the final strategy is due for publication in early 2024[5960]. The strategy prioritises cancers, cardiovascular disease, musculoskeletal disorders, mental ill health, dementia, and chronic respiratory disease.

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[53] NHS Long Term Plan – Stronger action on health inequalities, NHS England, January 2019
[54] Health and Care Act 2022, UK Government, 2022
[55] Integrated care systems explained: making sense of systems, places and neighbourhoods, The King's Fund, August 2022
[56] Core20PLUS5, NHS England
[57] Core20PLUS5 for children and young people, NHS England
[58] 2023/24 priorities and operational planning guidance, NHS England, January 2023
[59] Major conditions strategy: case for change and our strategic framework, Department of Health and Social Care, August 2023
[60] Major conditions strategy: call for evidence, Department of Health and Social Care, May 2023

28. Despite these policy commitments, we expect progress towards meeting the government's target of narrowing the gap in life expectancy by 2030[61] to be limited. The Public Accounts Committee has critiqued the government for a lack of focus on prevention[62]. Many of the commitments within the government's Green Paper on Prevention remain pertinent and could be implemented[63]. Cross-government coordinated action is needed to tackle the root causes of health inequalities and make real progress.

Conclusion: what trusts need to make progress on prevention

29. We welcome the Health and Social Care Select Committee's exploration into prevention through this dedicated Inquiry and support the focus within that on reducing health inequalities and improving outcomes for major conditions. In our written evidence we have highlighted the key role NHS trusts play in prevention and tackling health inequalities and urge the Committee to reflect on their contribution within the work of the Inquiry. There are examples of good practice across the sector which demonstrate the progress that can be made and steps that could be taken nationally to identify, evaluate and scale these interventions.

30. There are key enablers for developing anchor institutions to support prevention and population health initiatives – these include visible leadership, making it business as usual, building relationships with system partners and empowering staff to innovate[64]. To scale existing effective prevention programmes, increased funding and time are needed to spread and embed innovations, alongside support from leadership, management and sharing knowledge among networks. Yet we have also identified barriers around operational and workforce pressures, data and accountability that need to be addressed in order to effect change – all of which will require appropriate resourcing.

31. Addressing health inequalities is central to a thriving economy. Research has demonstrated that there is a substantial return on investment when investing in healthcare services – every £1 spent on primary or community care could potentially increase economic output by £14, with a similar increase of £11 in acute settings[65].

32. In addition, there must be increased support for public services, including public health and social care, given the crucial role these services play in providing wider care and support and helping to prevent ill health and avoid deterioration. There are also interdependencies and connections between health services and other frontline services that play a key role in prevention, such as education, criminal justice and welfare services.

33. Nationally, we are calling for greater government attention on prevention and the wider determinants of health. Responsibility for action on prevention and health inequalities sits across multiple governmental departments and should not be tackled by the Department for Health and Social Care, the Office for Health Improvement and Disparities, and NHS England in isolation. Poverty drives health inequalities - economic inequalities and the wider determinants of health must be tackled in order to see improvements in health and wellbeing, requiring action across governmental departments and sectors.

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[61] Levelling Up the United Kingdom, Department for Levelling Up, Housing and Communities, February 2022
[62] Introducing Integrated Care Systems, Public Accounts Committee, January 2023
[63] Advancing our health: Prevention in the 2020s, Department of Health and Social Care, July 2019
[64] Being an anchor institution: Partnership approaches to improving population health, NHS Providers, February 2023
[65] Creating better health value: Understanding the economic impact of NHS spending by care setting, NHS Confederation, August 2023

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