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Cheshire and Merseyside

Joint Forward Plan

2023-28

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3 Our approach to Population Health

We know that wider social determinants of health contribute to people experiencing poorer outcomes. Common risk factors, such as smoking, alcohol consumption, obesity or lack of exercise can cause multiple long-term conditions or diseases.

We are committed to improve the health of our population through our Population Health programme – focusing on early intervention, tackling inequalities, addressing wider determinants and promoting good health.

Our system is diverse, containing both urban and rural communities including areas of high deprivation and ethnically diverse communities. Consequently, we need to adapt our approaches to respond to local need, and a huge range of activities is already happening at both a Cheshire and Merseyside and individual Place level.

Our established system wide Population Health Board oversees our Population Health programme of work. The aims are to improve health outcomes and reduce health inequalities by embedding sustainable system-wide shift towards focusing on prevention and health equity. Our newly appointed Director of Population Health plays a key leadership role in this work.

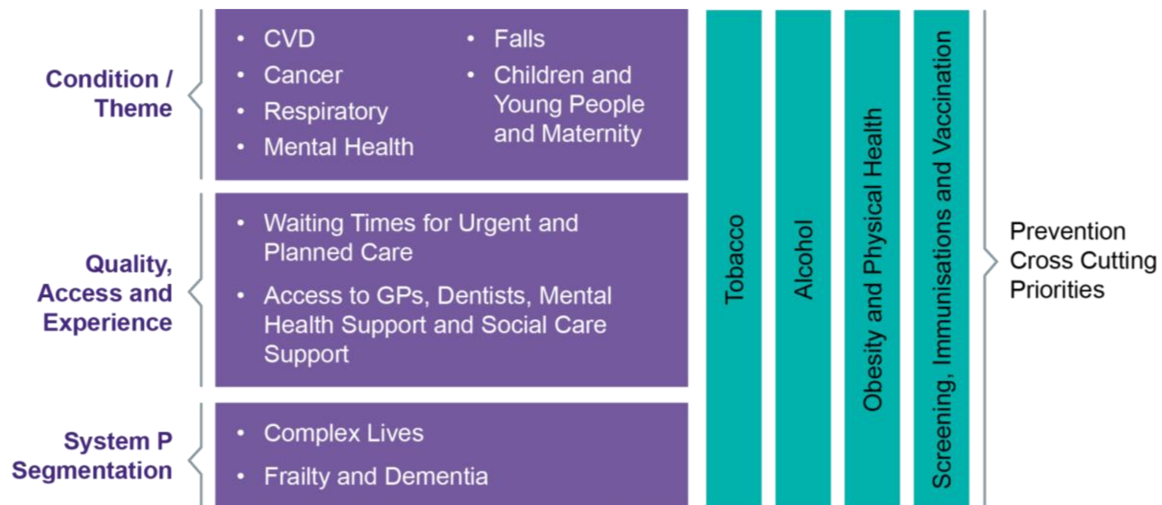
In line with the Hewitt Review recommendations, as an ICB we intend to increase year on year the proportion of our budget being spent on prevention. Multiple agencies invest in the prevention agenda, and we will work with partners to map existing investment to allow a holistic assessment of how we can best invest resources in future (see section 7).

The Population Health Programme Board and Programme Management Office supports the delivery of the Population Health programme through:

- Programme delivery, oversight and assurance roles.
- Communications, connectivity, and collaborations across ICS partners.
- Partnership working, influencing, advising and advocacy roles.
- Holding system programmes to account, constructively challenging.
- Workforce development and wellbeing, and supporting workplaces.
- Data analysis, monitoring and prioritisation for population health.

Figure 2 provides a summary of the areas which our analysis tells us that our population experience worse outcomes when compared to the “England average”, and where our people have told us their experience of accessing care does not meet their expectations. We know that it is often the wider social determinants of health which are the cause of these poorer outcomes and this is why we are committed to addressing these wider determinants and to promote good health.

Figure 5: Population Health needs and cross cutting prevention themes in Cheshire and Merseyside



Whilst much of this document describes our work related to individual conditions, many people have multiple conditions and our plans must support the needs of a person holistically. Through our CIPHA (Combined Intelligence for Population Health Action) and System P programmes we have used intelligence to support the identification of segments of our population in order to offer support and turn "Intelligence into Action".

3.1 Population Health programme

To help realise our ambition to improve the health of our population, the ICB has recently appointed a Cheshire and Merseyside Director of Population Health who will come into post in the summer of 2023. The Director of Population Health will oversee the existing workstreams and strengthen system-wide action on prevention, inequalities and strategic intelligence for population health.

Population health programme priorities are as follows:

1. Build system-wide population health capability and capacity
2. Improve our strategic business intelligence capabilities
3. Address the social determinants of health
4. Promote **community centred approaches** to improving Population Health
5. Deliver the **Core20PLUS5 priorities** across the system
6. Focus on prevention at scale and Making Every Contact Count (MECC)
7. Roll out and implement the **NHS Prevention Pledge**
8. Strengthen screening, vaccination and immunisation uptake
9. **Co-ordinate work across the ICS** through appropriate governance, assurance and oversight arrangements.

Key population health programmes which support the delivery of these priorities are described below.

3.2 Strategic Business Intelligence

Strategic business intelligence is vital to underpin, inform and drive a coordinated and sustainable population health management approach across ICS programmes. It enables us to identify areas for targeted interventions and to monitor progress.

We will develop the capacity and functionality of the ICS population health strategic intelligence function. As outlined in our Digital and Data Strategy, we will build on our CIPHA and System P Programmes to enhance our strategic intelligence functionality.

Our Population Health Board will oversee the development or our strategic functions, including the CIPHA and System P Programmes, to ensure work is aligned across ICS Business Intelligence and Public health teams.

Our initial Population Health priorities will be informed by the Cheshire and Merseyside HCP Strategy (currently in interim draft form) once this has been finalised. Over time population health needs and priorities will change, and the Population Health Programme will take a data-driven and intelligence-led approach to identify and prioritise emerging priorities.

3.3 All Together Fairer: Addressing the social determinants of health and inequalities

The primary objective of the draft interim Health Care Partnership Strategy is to reduce health inequalities. Through our established **All Together Fairer** programme we aim to improve population health and reduce population level inequalities in health, by focussing on the social determinants of health across Cheshire and Merseyside and supporting action at Place level.

A shift towards focusing on the social determinants of health will help to increase life expectancy (LE) in the most disadvantaged populations in the long term and help to narrow the inequalities in health in the Cheshire and Merseyside populations. Data shows that at present, the highest LE ‘gap’ in Cheshire and Merseyside is 14.3 years for men and 15.8 for women (All Together Fairer, 2022).

The All Together Fairer programme supports the eight Marmot principles (below)

Marmot principles

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

Seven objectives have been agreed as system level areas for action.

1. Increase, and make equitable, funding for social determinants of health and prevention.
2. Strengthen partnership for health equity.
3. Create stronger leadership and workforce for health equity.
4. Co-create interventions and actions with communities.
5. Strengthen the role of business and the economic sector in reducing health inequalities.
6. Extend social value and anchor organisations across the NHS, public service and local authorities.
7. Develop social determinants of health in all policies and implement Marmot Beacon Indicators.

Below is an outline of some of the key elements of our All Together Fairer work.

- Fair Employment Charter:
- Supporting adoption of the Liverpool City Region Fair Employment Charter by NHS and partner organisations to support fair employment policies, payment of the Real Living Wage and enhance workforce health and wellbeing. Ongoing.
- Supporting health sector and public health input to the consultation on the Fair Employment Charter in Cheshire and Warrington by July 2023.
- **Prevention Pledge**: Continuing to extend the NHS Prevention Pledge to all Cheshire and Merseyside NHS Trusts and drive upstream, ill-health prevention at scale for all NHS staff, patients, and visitors (see section below for further details on plans).
- **Anchor and Social Value Organisations**: Reviewing progress and further developing NHS, public and private sector businesses as Anchor and Social Value organisations by adopting a 15 percent social value weighting in all NHS procurement and increasing training and employment opportunities for local people by April 2024.

- **Beacon Indicators**: Reviewing the progress with new data recording, collection systems and monitoring of Marmot Beacon Indicators and ensuring the data is accessible and updated to identify areas for immediate attention and demonstrate progress on the social determinants of health by November 2023.
- **Social Determinants Development Programme:** Delivering training on social determinants of health to ICS system leaders. Building system capability and leadership to transform how organisations function to address social determinants of health to reduce inequality and improve health. To be in place from July 2023.
- **Network**: Establishing an *"All Together Fairer network"* to share good practice in Cheshire and Merseyside, link to national initiatives and inspire action to tackle inequalities. Delivering an All Together Fairer 'one year on' event in May 2023 highlighting the progress and success of the first year after the strategy has been launched, and further strengthen the years ahead.
- Engaging with and supporting the **Deep End primary care initiative**. March 2023 through to March 2024.
- **The Children and Young People Beyond** programme is overseeing the policy areas and All Together Fairer recommendations relating to CYP. Also working with Barnardo's and Institute of Health Equity on a Health Equity framework within a three-year plan. Ongoing.
- Developing an **evaluation framework** that will map the current work and developments to the outcomes indicator set. September 2023.
- Aligning the All Together Fairer programme with the **Core20PLUS5**

By April 2024 we will have undertaken a review and refresh of the **governance arrangements** for the All Together Fairer programme to ensure continued effectiveness.

We will measure the success of the All Together Fairer programme in the 2023-28 period against the 22 beacon indicators in the Marmot indicator set. Key measurements are difference between life expectancy and healthy life expectancy for both males and females, and how these differences compare between the populations that are the most and least deprived in Cheshire and Merseyside.

These measures are reliable indicators of long-term trends in the social determinants of health. As such, they are responsive to changes in policy and practice but on a longer time period than most planning cycles. Ultimately closing the gap in inequalities between communities, as measured by these indicators, is our goal and we aim to see progress towards the goal over 2023-28.

In pursuit of this goal, and in line with the strategic objectives, the All Together Fairer programme will measure impact and improvement in the following populations and outcomes.

All Together Fairer: outcomes summary	
Children and Young People	• Increased percentage of children achieving a good level of development at 2-2.5 years. • Increased percentage of children achieving a good level of development at the end of Early Years Foundation Stage. • Reduction in hospital admissions as a result of self-harm (15-19 years). • Increase in pupils who go on to achieve a level 2 qualification at age 19. • Reduction in proportion of children in workless households
Adults of working age	• Reduction in percentage unemployed (aged 16-64 years). • Reduction in percentage of employees earning below real living wage. • Reduction in proportion of employed in permanent and non-permanent employment
Adults	• Reduction in percentage of individuals in absolute poverty, after housing costs. • Reduction in the percentage of adults reporting loneliness. • Increase in activity levels. • Increase in number of people cycling or walking for travel (3 to 5 times per week).
Other indicators outside of Beacon indicator set	• Increase in weighting of funding for work in social determinants of health. • Visibly strengthened partnership work on health equity. • A visible and strengthened role of business and the economic sector in reducing health inequalities.

3.4 Core20PLUS5: System-wide action on healthcare inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies focus clinical areas (5 for adults and 5 for children and young people) requiring accelerated improvement.

'Core20' refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

'PLUS' population groups are locally-chosen population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the

Core20 alone and would benefit from a tailored healthcare approach, e.g. inclusion health groups.

Governance for the **‘5’ (clinical focus areas)** sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims. Within Cheshire and Merseyside ICS, delivery and progress against Core20PLUS5 is a cross-cutting, system-wide responsibility, and delivery against priority clinical area objectives sits with respective ICS programmes and workstreams.

The Population Health Programme will provide strategic intelligence and system leadership to strengthen ICS level oversight and monitoring of progress against Core20PLUS5 through relevant programmes and provide an infrastructure through which ICB assurance for key Core20PLUS5 indicators can be delivered, and risks and issues can be identified.

Core20PLUS5 clinical priority outcomes for adults and children and young people are as follows:

Core20PLUS5 (Adults): outcomes summary	
1. Maternity	Continuity of care for women from minority ethnic communities and deprived groups
2. Severe Mental Illness (SMI)	Annual health checks for 60% of those living with SMI
3. Chronic Respiratory Disease	A focus on chronic obstructive pulmonary disease and increased uptake of COVID, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions.
4. Early Cancer Diagnosis	75% of cases diagnosed at stage 1 or 2 by 2028.
5. CVD prevention	Hypertension case finding and optimisation, and optimal lipid management
Smoking Cessation (cross-cutting)	Reduced overall smoking prevalence, with additional focus on priority groups and inpatient settings for Severe Mental Illness and maternity care.

Core20PLUS5 (Children and Young People): outcomes summary*	
1. Asthma	Reduced overreliance on reliever inhalers, fewer asthma attacks.
2. Diabetes	Improved access to gold standard care in deprived areas and ethnic minority communities, and more CYP with Type 2 diabetes receiving annual health checks.
3. Epilepsy	Increased access to epilepsy specialist nurses and ensure access in the 1st year of care for those with LD or autism.
4. Oral Health	Backlog tackled for tooth extractions in hospitals in under 10s.
5. Mental health	Improved access, and equity of access, to CYP Mental Health services (0-17).

*Section 4 describes our wider priorities in relation to improving outcomes for CYP

3.5 System-wide action on Prevention and Making Every Contact Count

We are committed to working collaboratively as a system. As part of this commitment, we are embedding the philosophy of Making Every Contact Count (MECC). This is an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors. This can support people in making positive changes to their physical and mental health and wellbeing.

A wide range of sectors, organisations and programmes have roles and responsibilities to support a shift towards prevention and to deliver MECC. Fantastic work is already underway, but there is scope to strengthen how we communicate, connect and collaborate so we can scale up and embed prevention delivery into 'business as usual' and make a bigger impact on outcomes.

Through system leadership approaches, the Population Health Programme will support cross-programme partnership working and system-wide programmes to embed action on prevention and Making Every Contact Count (MECC) and promote a focus on evidence-based high impact interventions and accelerate progress.

We see MECC and our focus on prevention as vital in addressing a range of risk factors which lead to poor health outcomes.

Headlines in prevention: outcomes summary	
Smoking	• Reduced smoking prevalence • Improved delivery of the Treating Tobacco Dependency Programme
Alcohol	• Reduced hospital admissions for alcohol-related conditions • Delivery of the national Alcohol Programme and Alcohol Care Teams
Healthy Weight	• Reduced percentage osf adults classified as overweight or obese • Strengthened uptake of the Digital Weight Management Programme
Physical Activity	• Increased percentage of physically active people • Reduced associated inequalities
Health Checks	• Increased uptake and quality of preventative health checks, e.g., NHS Health Checks, Diabetes Prevention Programme, annual reviews for patients with Severe Mental Illness (SMI) with a particular focus on increasing uptake in priority and underserved (including PLUS) groups
Mental wellbeing	• Mental wellbeing supported by strategic links with the Mental Health Board and Provider Collaborative Adoption of the Mental Health Concordat and by wider actions on healthy behaviours and social determinants.

MECC	• Widespread adoption and promotion of Making Every Contact Count principles and resources.

In addition to a strategic oversight and system connectivity role in prevention, the Population Health Programme is progressing work relating to smoking, alcohol, physical activity and the NHS Prevention Pledge. More information about these four workstreams are set out below.

3.6 Reducing smoking prevalence

Smoking is one of the leading risk factors driving the UK's high burden of preventable ill health and premature mortality (e.g., from cardiovascular disease, chronic respiratory disease, and many cancers), negatively impacting Life Expectancy and Healthy Life Expectancy and contributing to widening health inequalities. In 2019, the government set an objective for England to be smokefree by 2030, meaning only 5% of the population would smoke by then. Despite falls in smoking rates nationally, the Khan Review[1] (August 2022) estimates that without further action, England will miss this target by at least 7 years, and the poorest areas will not meet it until 2044.

Smoking cessation is a cross-cutting Core20PLUS5 priority, and data points to smoking cessation as an emerging priority for Cheshire and Merseyside. The Cheshire and Merseyside Health and Care Partnership is committed to reducing smoking prevalence in C&M from 12.5% to 5% by 2030 through a combination of existing Place-based community smoking cessation activities and implementation of the NHS tobacco dependency treatment pathways in maternity, mental health and acute inpatient services during 2023/24 and 2024/25.

We will continue to work collaboratively as system partners on this important issue, drawing on learning from our nine places to maximise our impact on reducing smoking prevalence and associated ill health and inequalities.

3.7 Reducing Harm from Alcohol

In Cheshire and Merseyside over a quarter (26.5%) of the adult population consume alcohol at levels above the UK Chief Medical Officers guidelines, increasing their risk of alcohol-related ill health. Alcohol misuse across Cheshire and Merseyside costs around £994 million each year across the NHS, social services, crime and licencing and the workplace.

We will deliver preventative and treatment interventions that reduce alcohol harms (workstreams 1-5) and drug dependency (workstream 6), through proactive co-production with the system. Across all workstreams, the programme aims to address inequalities in access to treatment and health outcomes within those at risk of harm from drinking.

Objectives for this work are outlined below:

1. **Integration of Alcohol Care**: Support for Alcohol Care Teams, including delivery of Phase 4 Competencies Framework Programme for Alcohol Care Teams (PROACT), and expanding this support to the wider system (e.g., Primary Care and Allied Health Professionals). New pathway development in terms of social prescribing, mental health and physical activity (to better address wider determinants of health) with outcomes monitored through integration of alcohol metrics into the CIPHA Population Health Dashboard. Links will be made with key Cheshire and Merseyside programmes, so that there is coverage across the key areas of Starting Well, Living Well and Ageing Well.
2. **Digital prevention**: Continual Quality Improvement (CQI) with provider and campaign development for digital delivery of Identification and Brief Advice (IBA) across all of Cheshire and Merseyside.
3. **Early detection and outreach**: Expand early detection of Alcohol Related Liver Disease (ARLD) projects across multiple settings and building the evidence base. Provide specialist support to the Cheshire and Merseyside Pathology Network with the intelligent Liver Function Test (iLFT) programme.
4. **Complex Lives and Homeless**: Delivery of Blue Light Projects in Liverpool and Cheshire West and Chester (targeting dependent drinkers, with complex needs, who are resistant to change).
5. **Advocacy:** Co-ordinated advocacy on alcohol harm through the North West Directors of Public Health (NWDsPH) and wider. (Office for Health Improvement and Disparities (OHID), NHS England/Improvement North West, Northern Coalition, Alcohol Health Alliance [AHA]).
6. **Inpatient Detoxification Placements (IPD)**: Support the Cheshire and Merseyside Commissioning consortium to manage and administer the OHID IPD grant income.

The work is recognised regionally and nationally, as including examples of best practice, and which we have been invited to share. The Cheshire and Merseyside approach has been adopted by the North-West Directors of Public Health Collaboration as a basis for joint working across our region.

Co-production with system partners, patients and communities is a key principle of the programme and as such the first year of the strategy will involve both workstream delivery (as detailed below) and a Cheshire and Merseyside Alcohol Summit to determine the priorities and workplan from 2024-25 onwards. The scope, resource and hence pace of delivery being determined as resources are confirmed. Our work includes support from Police, Probation and Housing Association partners.

As part of measuring the impact of our work our CIPHA programme will initially use hospital-based metrics to assess the impact of the programme on attendances and admissions. Further metrics will then be agreed to cover the impact on primary care, community and ambulance activity. The programme will also contribute to a range of wider alcohol related health and wellbeing outcomes.

Reducing Harm from Alcohol: outcomes summary	
Reducing Harm from alcohol	Reduced hospital admissions for alcohol-related conditions (and delivery of the national Alcohol Programme and Alcohol Care Teams)
Delivery of improved outcomes in relation to alcohol related disease	Reducing harm from alcohol will positively impact on a range of indicators in relation to health and well-being; including access to mental health services, liver disease and employment metrics.

3.8 All Together Active

Currently, far too few people in Cheshire and Merseyside meet the NHS physical activity guidelines. Half a million adults in the subregion are inactive (Sport England Active Lives (2022)) with many facing barriers to physical activity because of issues around gender, race, disability, poverty, sexuality, religion and parental status. Yet physical inactivity costs the NHS around £1bn per year across the UK (NICE) and is a major contributor to both illness and reduced life expectancy.

Driven by place-based priorities, the All Together Active strategy involves us working together to improve physical activity levels across Cheshire and Merseyside. The All Together Active strategy roadmap details how subregional and Place- based partners will collaborate to achieve the ambitions of the strategy. Key priorities for All Together Active over the first year of the 2022-26 strategy period are:

- **System leadership and engagement:** All 9 Places and over 300 organisations (representing the mapped physical activity system) to be engaged in the All Together Active strategy by October 2023
- **Place-based Implementation Plans:** All 9 Places to have an implementation plan in place by October 2023, that is regularly reviewed and monitored with outcomes (for example physical activity levels, walking/cycling for travel levels (both are All Together Fairer indicators) feeding through to a subregional level dashboard
- **Resource Hub development:** Achieving over 500 views of the Resource Hub from health and social care professionals and other system partners across Cheshire and Merseyside by October 2023, with continual development and improvement based on partner feedback
- **Explore scalability of at least 2 pilots and identify other workstreams to collaborate with:** Measured through programmes (e.g. Alcohol Care Team) being piloted and then up-scaled into other areas of Cheshire and Merseyside, considering how many patients are being benefitted (and including subsequent outcomes for patients and professionals), and additional investment brought into the region as a result of expanding pilots into new Places by October 2023
- Supporting all 18 NHS Provider Trusts to embed physical activity elements within their NHS Prevention Pledge commitments by October 2023: Measured by number of Trusts working with, and number of Trusts that complete actions related to increasing physical

activity initiatives for staff and patients for example increase in staff using active travel, more clinical pathways embedding physical activity.

These activities will help to set the foundations for implementation at scale up to 2028 through the All Together Active strategy.

All Together Active: outcomes summary	
All Together Active	• Empowerment of 150,000 inactive people to become more active by 2026, focusing on those facing the greatest health inequalities • A whole-system approach towards physical activity • Our 9 Places supported to further develop opportunities to use physical activity as a way of improving population health • Embedding of movement, physical activity and sport within the Cheshire and Merseyside health and social care system

These system objectives will be continually monitored and evaluated using a framework that is currently being co-produced by system partners, and will be fed through to the ICS, ICB and Marmot (All Together Fairer) dashboards.

Alongside this headline goal will be other outcomes and benefits that the programme will achieve by 2028, with measures and indicators to be developed and co-produced by system partners as part of an Evaluation Framework for All Together Active.

3.9 NHS Prevention Pledge

The NHS Prevention Pledge is a framework underpinned by 14 'core commitments' that NHS provider trusts work towards as a means of formally adopting the 'Pledge', thus strengthening NHS Trust leadership for action on prevention, social value and inequalities. The framework includes commitments to embed MECC, incentivisation for provision of brief advice techniques, maximising the social value of Trusts in their journey towards 'Anchor Institutions', and developing health promoting environments that can create the conditions for healthier patients, workforces and wider communities.

The programme is supported by a Community of Practice including all 18 provider Trusts that meets quarterly, and Place-based meetings bringing together Trusts and partners at local level. Specific actions and Key Performance Indicators (KPIs) aligned to each of the 14 commitments need to feature within a provider Trust's action plans in moving to formal adoption the Pledge.

The NHS Prevention Pledge programme works in collaboration with a range of ICS prevention and inequalities programmes including All Together Fairer, All Together Active, workforce development programme, Treating Tobacco Dependency, Cheshire and Merseyside Social Value Award and Anchor Institution Charter and the Mental health and suicide prevention concordat.

We are also exploring how we interpret the Pledge in a primary care setting, which may provide further opportunities for partners to take early action to support health and wellbeing across a broader range of health and care settings. A working group of Primary Care Networks and partners at Place will support scoping and piloting of an NHS Prevention Pledge for use in primary care settings. It is anticipated that a pilot will include a minimum of four Primary Care Networks within the sub region, two in Merseyside and two within Cheshire. We may also consider piloting with pharmacies and dental surgeries.

NHS Prevention Pledge: outcomes summary	
NHS Prevention Pledge	• All 18 NHS Trusts supported to adopt and implement the core Pledge commitments through a community of practice • Supports delivery of the NHS People Plan by supporting staff health and wellbeing within provider trusts and supports staff retention. • Action on Social Value and sustainability • Phase 1 and 2 Trusts supported to apply for Anchor Institution status by April 2024, and Phase 3 Trusts by March 2025 • Supports action at Place to address the social determinants of health in partnership with the All Together Fairer programme • Supports financial efficiencies and savings in NHS Trusts • Reduced burden on primary care, A&E, social care and fewer re-admissions • NHS Prevention Pledge for primary care scoped and piloted with at least 4 PCNs with a view to expanding in 2025/26

We will undertake an evaluation of NHS Prevention Pledge to assess impact on population health and wider outcomes.

3.10 Screening, Vaccination and Immunisation

Screening, vaccination and immunisation arrangements (under Section 7a) currently sit with NHS England (i.e. not currently delegated to ICSs). The Population Health programme will work with NHS England (NHSE) / UK Healthy Security Agency (UKHSA) and local commissioners to establish clear responsibilities, accountabilities and oversight in order to strengthen screening, vaccination and immunisation uptake and to reduce associated inequalities. Acting together, we will reduce the burden to lives and livelihoods associated with vaccine preventable disease.

This workstream will include:

- Strengthened **networked arrangements** between Local Authorities, the NHS, UKHSA and the Integrated Care Board (ICB) to ensure shared understanding and agreement of roles and responsibilities, shared good practice and lessons learned. This will include actions aimed at avoiding widening vaccine inequalities across our Places and among different communities, including where helpful measures to overcome vaccine hesitancy.
- A shared understanding of common Section 7a service **risks** and development of **mitigation** plans.
- Promotion of common Section 7a service actions to address ICS inequalities, and **Sector Led improvement** plans developed to address gaps.
- Sharing and promotion of guidelines, evidence, and new national literature
- Section 7a **data, intelligence, surveillance, and analytics** to enable effective and informed screening, vaccination and immunisation advice and action.

[1] https://www.gov.uk/government/publications/the-khan-review-making-smoking-obsolete/making-smoking-obsolete-summary