NHS Confederation

Lilly

When opportunity knocks: transforming weight management

A thematic analysis of the challenges facing weight management services

The document is an output of a collaborative working project with the NHS Confederation and Eli Lilly and Company (Lilly)

This report is based on interviews with leaders and practitioners across England and has been reviewed by the interviewees for accuracy.

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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.[i]

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Lilly is a medicine company turning science into therapies to make life better for people around the world. We have been pioneering life-changing discoveries for nearly 150 years, and today our medicines help tens of millions of people across the globe.
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For more information visit www.lilly.com/uk

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ii. UNICEF(2024). Lilly, UNICEF expand support to help millions of young people at risk of noncommunicable diseases.

iii. European Foundation for the Study of Diabetes. EFSD and Lilly European Diabetes Research Programme.

Contents

Key points

- The NHS Confederation and Lilly are working together under a Collaborative Working Agreement (CWA) to support teams seeking to develop and improve weight management services. This report, based on interviews with leaders and practitioners across England, explores the barriers to redesigning weight management services. It will be followed by further research and resources, providing practical insights into how to develop more effective weight management services.

- Obesity is one of the leading causes of severe health conditions in the UK, contributing to conditions including cardiovascular disease, diabetes and cancer.[1] Despite the impact on individuals, communities and the NHS, participants in our interviews believe weight management services (WMS) are not adequately designed or resourced to meet the needs of the public.

- Current models of care have been described as "paternalistic" and "transactional" by interview participants. As such, systems are seeking to redesign services into more holistic wraparound support, and to shift towards prevention.

- The 10 Year Health Plan and other recent developments present opportunities to redesign and expand services outside of hospital and into holistic closer-to-home interventions to better meet public need.[2]

- Our interviews surfaced five key barriers to improving services: limitations in service design and provision, stigma, coalition building, funding and building an evidence base.

- We found a lack of cohesiveness in how services are commissioned and delivered within integrated care systems (ICSs). Although the variety in service provision can be good, because systems are dealing with large populations made up of different cohorts with different needs, NHS professionals delivering services feel the variation fosters a fragmented pathway instead of a cohesive pathway that offers multiple options.

- Interviewees shared that their systems are dealing with long waiting lists and wait times for weight management services, with Tier 3 specialist multidisciplinary team (MDT) weight management services being identified as the pressure point in the pathway.

- There is a perception from professionals we interviewed for this work that obesity is not widely acknowledged as a long-term relapsing condition by the health sector. There is also a perception among these professionals that people living with obesity are 'ineffectual', and this is perpetuated by how they are represented in media and professional stigma.

- Interviewees described an environment in which there is a shared acknowledgement of the need to redesign services and pathways, but a challenge in developing 'groups of the willing' who can practically contribute and drive work forward.

- We found that many systems have formal and informal collaborations with communities and the third sector and have a strategic ambition of bringing them into planning and designing services.

- Most interviewees described a situation in which their systems operate on 12-month funding cycles which presents challenges for demonstrating a return on investment. Outside of the Digital Weight Management Service, weight management services are often not an explicit focus in the 10 Year Health Plan. This

is common across national guidance and metrics. As a result, integrated care boards (ICBs) often struggle to prioritise obesity over other elements of their portfolio that receive more explicit attention.

- Because weight management services are not explicitly included in integrated care systems' current strategies, there is no clear source of funding and budgets, so ICBs reported that they are often having to be creative in accessing funding via other portfolios.

- ICBs reported that they are having to take a pragmatic approach to identify how their limited resources can have the biggest impact on existing demand, projected demands, and the impact that future interventions (socioeconomic, pharmacological or technological) will have on service demand.

- We found that there are challenges in the ability to demonstrate the need for and impact of interventions, largely due to a combination of the points above, which then have a domino effect on how much funding can be secured for weight management services.

- We also found that there is a lack of data on demand, demographics and service expenditure, and the data that is available are often not collated in one space. This means there is difficulty in gaining a full understanding of the issue of obesity within systems and building an evidence base for interventions.

Introduction

Obesity is one of the leading causes of severe health conditions in the UK, contributing to conditions including cardiovascular disease, diabetes and cancer.[1] More than 1 million admissions to NHS hospitals in 2019/2020 included obesity as a factor,[3] and the overall cost of obesity to the NHS is £6.5 billion a year.[4] Despite the impact on individuals, communities and the NHS, participants in this joint NHS Confederation and Eli Lilly and Company (Lilly) project reported that weight management services are not adequately designed or resourced to meet the needs of the public.

While many specialist obesity management services (Tier 3 and 4) are largely hospital-based, the 10 Year Health Plan presents an opportunity to redesign and expand services outside of hospital and into holistic closer-to-home interventions – correcting the imbalance in supply and demand. At the same time, the recommendation from the National Institute for Health and Care Excellence (NICE) that some pharmacological weight loss treatments can be prescribed in primary care is a further driver for system improvement.[5]

The NHS Confederation and Lilly are working together to examine these opportunities in the context of wider pathway redesign. Since December 2024, we have been working with a cohort of NHS and wider system leaders to understand the barriers to redesigning weight management services to meet the demands of a population with increasingly complex needs.

This report explores the findings from phase one of our project, in which we interviewed representatives from 11 NHS and wider system organisations in England to better understand the barriers and enablers to delivering weight management. We sought a wide range of perspectives, including GPs, clinical leads, directors, public

health specialists, medical advisers, commissioning managers and senior project managers.

The interviews identified five barriers to improving weight management services, which are explored in detail in the chapters that follow:

- Limitations in service design and provision
- Stigma
- Coalition building
- Funding
- Building an evidence base.

One message was clear: adopting a whole-system view and making changes across systems rather than working in silos is key to driving progress in weight management services.

The insights are informing the second stage of the project, which will address specific challenges identified in phase one and will involve four workshops co-designed by the NHS Confederation, Lilly, a patient representative and an expert facilitator. The final phase will collate lessons learned into practical resources, drawing on good practice in local systems and distilling effective principles in weight management services.

This report will be of interest to NHS and wider system leaders seeking to better understand the barriers to delivering weight management services and attempting to redesign pathways. It explores the current state of weight management services – a critical first step in improving obesity pathways.

What challenges are system partners facing?

Limitations in service design and provision

The NHS is currently unable to supply sufficient resources to meet the levels of demand seen across all categories of NHS weight management services, according to interviewees. This is compounded by fragmented pathways and a lack of cohesiveness in service commissioning and delivery. The result is a rigid structure ill-suited to the needs of patients or the NHS.

In their attempts to overcome these challenges, interviewees highlighted how systems are split between the immediate pressures placed on existing services, and longer-term ambitions. In the long term, positive change comes from developing locally led weight management services that are founded in preventative, holistic, long-term and patient-centred strategic planning.

Obesity pathways in England consist of four tiers:

- Tier 1 and 2 services are typically provided by local authorities and "focus on providing information and guidance on nutrition, physical activity and lifestyle in a generic and high-level way."[6]
- Tier 3 covers specialist multidisciplinary team weight management services and is commissioned by either integrated care boards (ICBs) or local authorities, though the responsibility for who commissions Tier 3 services continues to be debated.
- Tier 4 covers bariatric surgery and is commissioned by NHS England.[7]

A number of interviewees reported variation in their services across different parts of their system (for instance, Tier 3 is available in some places and not others), and in some cases services (Tier 3) are not offered in any parts of the system. In addition, interviewees reported instances where ICBs have made the decision to pause Tier 3 services. These variations were reported to be due to the scale of demand and insufficient funding. Three systems out of the 11 described their current weight management provision as 'fractured', with one noting that different localities within their ICS will commission different services from the same service provider. Another gave the example that services within one tier are not uniform throughout their system (for example, some Tier 4 services offer bariatric surgery while some are medicine-based instead).

Although some variation in service provision can be expected, as systems will be dealing with different cohorts and the different needs of communities who face different challenges, professionals felt the variation fosters a fragmented and rigid pathway instead of a cohesive path that offers multiple options based on the needs of the patient.

For example, one interviewee described the need for patients to progress through each of the associated tiers, and their associated waiting lists, despite Tier 4 bariatric surgery being the most appropriate option for their needs. In some cases, this is exacerbating the inverse care law (see glossary), because services are not as accessible for populations who need them the most.

Additionally, there are currently different services provided for children and adults. Although public health preventative measures have a focus on children, one interviewee noted that targeted prevention for children is only referenced and not a core component of the Core20PLUS5 strategy,[8] and there are ongoing discussions on the approved medications for eligible children. Another interviewee noted that for children's initiatives to be effective and sustainable, families and schools must be engaged.

Demand outstripping supply

Every system we spoke to identified demand for their weight management services outstripping their ability to supply care to those who need or are eligible for it. Eight of the 11 systems described the pressure point as being at Tier 3 services, with one system reporting waits of up to two years for patients to be seen, and another raising 1,200 people on their waiting list for Tier 2 and Tier 3 services across just two geographic areas within their system. One interviewee stated this is largely due to recruitment freezes across providers as a result of funding limitations (which will be discussed in the chapter on funding).

How systems are redesigning services

Interviewees described an explicit consideration within ICBs about how they balance the 'here and now' need to respond to the demands placed on Tier 3 and 4 services. In the long term, ICSs have the ambitions of developing preventative services, such as trauma-informed approaches and biopsychosocial models, which are reflective of an individual's unique circumstances and the environment in which they live. However these ambitions are often curtailed by high demand on existing services, which consumes available resources.

Improving existing interventions (navigation and digital)

Due to variation and fragmentation of services, the weight management pathway is described by interviewees as inconsistent and complex, even within systems. This complexity can make it difficult for professionals, as well as patients, to know where they can access services. One interviewee raised that this complexity means that professionals would benefit from education and awareness about the available support and services they can offer to patients. The interviewee went on to describe how patients

would also benefit from navigation support through the tiered pathways and other available support.

Interviewees also reported little practical support for the use of national digital weight management services. One interviewee noted that despite its availability, general practitioners still prefer to refer to local services over digital services, though it is important to note that there are varying perceptions among systems on how robust existing local services are for managing obesity.

Shifting to holistic and wraparound support

Current models of care were described as "very paternalistic and medical", with one interviewee describing Tier 4 services in particular as transactional, with no focus on circular care/holistic care. Although there was acknowledgement that new medicines have the potential to transform how obesity is viewed and managed, interviewees highlighted that there is still a need to reframe how to tackle obesity through long-term holistic health and care improvement, which is not dependent on the rollout of certain medications. Systems are seeking to shift interventions towards holistic and wraparound support where behavioural, lifestyle and mental health are integrated into the service alongside medical support, rather than delivered as an 'add-on'. One interviewee also described the need for ongoing support similar to how relapse is treated in alcohol and drug addiction.

Additionally, it was highlighted that vulnerable and deprived communities may require tailored, personalised and culturally appropriate support. Primary care networks already use Additional Roles Reimbursement Scheme (ARRS) roles to deliver this type of support on the wider determinants of health and there is a similar opportunity for weight management services to provide the same. The updated NICE guidelines[9] and upcoming commissioning framework (currently in development)[10] were noted by interviewees as responsible for this shift, as they have an increased focus on patient-centred pathways.

Designing preventative measures

Interviewees felt that planning guidance priorities are largely reactive and focus on the 'here and now' demand on services, despite the acknowledgement in the 10 Year Health Plan that ending obesity will require actions to address obesogenic environments. One interviewee suggested the use of existing community assets, and another described the idea of a 'Tier 0', which considers a risk-based approach with people who are not currently living with obesity as a meaningful type of early intervention or living well.

Several interviewees also reported how obesity and weight management were being looked at through the lens of long-term condition management and being considered as a co-morbidity alongside other chronic conditions such as diabetes, rather than a separate pathway.

Stigma

Stigma was highlighted as a key challenge in every interview and identified as a consistent exacerbating factor in all other challenges and themes discussed in this report, from limitations in funding, to leaders' ability to redesign services and amend provision.

Interviewees reported that stigma exists in professional, personal and community contexts. Interviewees explained stigma as negative attitudes towards individuals based on their health conditions, leading to discrimination or inequitable access to care and health services. There was a commonly held view that obesity is not widely recognised or treated as a long-term relapsing condition by the health service, exacerbated by societal perceptions and media portrayals of people living with obesity.

Professional stigma

There was a perception among interviewees that obesity is not widely acknowledged as a long-term relapsing condition (LTRC) across various parts of the health service, from senior leadership through to individual clinicians. There is a lack of appreciation for the impact that poorly developed weight management services are impacting on other parts of the system as a result of obesity's contribution to other LTRCs. One interviewee felt that because society mostly does not view obesity as a clinical condition, it is not treated as such, allowing stigma to prevail.

'Move more, eat less' is still seen as the way of addressing obesity within some components of the NHS and the public, which fosters attitudes that it is 'not their problem to fix' unless it requires a medical solution, thus emphasising the "paternalistic" culture described in the service design chapter. These raise the following questions, which could be helpful for further discussion:

- How do health professionals treat patients who are overweight or living with obesity differently?
- Is there an unconscious bias impact on the way that NHS organisations decide whether to fund/not fund weight management services?

Three systems compared how obesity and weight management are treated to smoking or alcohol and drug addiction, where interviewees felt the latter has a 'no fault, no judgement' model, which is not felt as strongly in weight management services.

Furthermore, it was noted by one interviewee that health professionals often feel unsure how to best raise the subject with patients, given the sensitivities around language and appropriate communication.

Personal and community stigma

There was a view among interviewees that society can view those with obesity as 'ineffectual', and this can be perpetuated by how they are represented in media. This perception and representation are not helped by the professional stigma mentioned previously, as the two influence each other. One interviewee stressed that while the obesity systems map featured in the UK Government's Tackling Obesity Foresight report[11] demonstrates the interconnected role of hundreds of factors, in the subsequent two decades common understanding of and attitudes towards obesity have not moved on from individual control.

One ICB is working on ways to address this stigma through a trauma-informed approach. Another interviewee highlighted the importance of lived experience case studies and the importance of co-designing/developing and implementing interventions with communities.

Coalition building

To move from their existing provision of services to the services they hope to provide, interviewees identified a need to build coalitions with a wide range of stakeholders who are necessary for making this change possible. Key to this are senior leaders who control the levers of strategy and funding, but can also include non-health leaders in the wider public sector, and non-public sector organisations across the voluntary, community and social enterprise (VCSE) sector and the wider third sector.

The process of developing and maintaining these coalitions varied between organisations, with some finding it straightforward in achieving personal commitment, while others have found the process more fraught. However, despite the variation, it was broadly accepted that the challenge facing system leaders is not in winning hearts and minds, because there is now a clear sense of a shared appreciation within systems for the urgent need to

improve weight management services. Rather, it is the practical development of a 'group of the willing' who can contribute and drive a common vision for weight management services forward. This is due to individuals, groups and organisations feeling the pressure to focus on their siloed part of the system.

Systems are being creative in how they overcome this, with some using a population health approach or linking obesity with other strategically prioritised diseases, such as cardiovascular disease, as a means of driving the work forward, as well as looking into opportunities to collaborate with communities and the third sector.

Winning hearts and minds

While interviewees felt that stigma and bias are evident across professionals and the public, they also described a situation where there is a clear sense of a shared vision for the need to change the current weight management operating models in systems.

However, our interviews identified challenges that arise from varying perspectives about priorities for this change. This variation is based on how professionals and organisations will experience demands, budgets and governance, as well as the existence of varied and often fragmented pathways.

Ultimately, for system leaders this is associated with challenges in developing the group of willing organisations within their system needed to drive this work forward. One system described two years of work necessary to assemble the professionals needed to make change. This was only possible due to the momentum caused by the introduction of new pharmacological interventions.

Meanwhile, others described a situation where colleagues recognising the need to do something new is present from the outset, but their ability to implement system transformation is hindered by limitations on their funding and the complexity of

commissioning processes. However, the systems we interviewed are being creative in overcoming these challenges, with some using a population health management approach to risk stratification and population segmentation to improve population health outcomes and reduce health inequalities as key drivers of the work.

Interviewees described a necessity to understand the different working perspectives and contexts that colleagues will enter conversations from, due to their professional role, seniority and position in the system, and the importance of building relationships and trust across these different interfaces. Although there are echoes of the need for system working, overwhelming demand means each individual, each team and each organisation are often forced to focus their attention on their siloed part of the system to deliver against the reactive and overflowing demand, as mentioned in 'Limitations in service design and provision'.

Working beyond the NHS

Many systems interviewed have formal and informal collaborations with communities and the third sector, including interviewee steering groups, and have a strategic ambition to bring community representatives into the strategic planning and designing of weight management services. VCSE alliances reach higher risk or underserved cohorts, while local authorities create good health by cultivating healthy communities through tackling commercial determinants of health, such as advertising bans, fast food emergence restrictions and creating green spaces, similar to the use of existing community assets referenced in 'Limitations in service design and provision'.

One interviewee had the perception that the onus for obesity and the shifts systems are trying to make to weight management services currently sits mostly with public health. This means a lack of strategic commissioning is happening at system level and

organisations are instead having to explore how they can link what is happening in each of their respective spaces. Another highlighted that NHS and local authorities need to partner to achieve neighbourhood health, but there is a perceived disconnect between the two.

Methodologies

Interviews identified governance structures that bring people and groups together, including policy sprints, circles and soup analysis, Ripple Effect Mapping, and creating communities of practice (See glossary). One system is also conducting a service mapping exercise to define a standard level of service across their local authorities.

Funding

Weight management services are facing the same funding challenges that many other parts of the health system are, including, but not limited to, the constraints of 12-month funding cycles. However, funding challenges within WMS are further compounded by perceptions of the existence of unconscious bias – stemming from stigma – towards the value of investing in obesity services. They are further hampered by unclear funding sources, because the treatment and prevention of obesity is often not strategically prioritised. As such, system leaders have to use funding from a range of portfolios rather than a dedicated fund to undertake WMS transformation and redesign projects.

Financial limitations

While the extent of financial constraints is well documented, some interviewees highlighted the specifics and extent of these financial constraints. One system's spending on weight management services equates to just 0.08 per cent of the ICB's total spending. Although the interviewee did report that this is likely to be an overestimate of system spending, as not all of this funding comes via the ICB; some is the result of national funding for digital weight management services and Tier 2 services commissioned by local authorities. This figure is therefore likely to be diluted further.

Additionally, this does not include funding for medications as part of the Tier 3 service provision. The consequent lack of medicine in Tier 3 contributes to access challenges, which has a knock-on effect for access to Tier 4 services, as patients are required to complete Tier 3 first. Another interviewee recounted that Tier 2 funding was reduced nationally which, alongside ICBs' financial challenges, led to service reductions.

Funding cycles

Interviewees reported that 12-month funding cycles present challenges for demonstrating a return on investment on long-term health and lifestyle improvement against metrics and integrating obesity into strategies and financial plans. Interviewees also noted that existing metrics do not have an exclusive focus on weight management and obesity and thus are often reflective of other individual diseases. This does not foster efficiency within the health system because obesity is linked to multiple other diseases, such as diabetes and cardiovascular disease.[12]

Impact of unconscious bias

One interviewee raised the financial limitations linked to stigma and queried the national perception of the value of investing in obesity and weight management compared to other diseases such as cancer, when obesity is known as a factor for increasing risk for such diseases.[13]

Funding source

The source of funding and budgets, as well as how to access them, remain unclear to the system leaders we interviewed. One interviewee described how their ICS uses 'portfolios' to direct their work but reported that there is not a specific home within any of these for obesity/weight management. They reported that obesity is not included in the ICS's long-term condition portfolio strategy but may be included in the improving population health portfolio at some point in the future.

This means that funding for service transformation has to be accessed across the seven portfolios on a case-by-case basis, by demonstrating a link to a portfolio. For example, there are a high number of obesity related A&E admissions, so funding has been found from the urgent and emergency portfolio. This lack of 'home' creates uncertainty for the team about the scale and longevity of the work they can deliver, in their view, undermining the ability to make a positive contribution to the delivery of weight management services and the ensuing health impacts of excess weight and obesity.

The UK Government's Foresight on obesity, which was used to develop a unique obesity systems map providing "insight into the complexity of and interrelationships between the determinents of obesity" was referenced on numerous occasions throughout our interviews.[11] For ICB leaders with limited resources (money, people, time and political capital), addressing each of these influences

is not possible. Instead, leaders are having to take a pragmatic approach to identify how their limited resources can have the biggest impact on the demands facing services now, the projected demands for the future, and the impact that future interventions (socioeconomic, pharmacological or technological) will have on service demand.

Evidence base

It is difficult to demonstrate the impact of interventions, largely due to a combination of the themes previously discussed, which has a domino effect on how much funding can be secured for weight management services in the future. There is a lack of data on demand, demographics and service expenditure, and the data that is available are not collated in one space. This means there is difficulty in creating a full understanding of the issue of obesity within systems, as well as limited opportunities for peer learning and sharing effective practice.

Demonstrating the need for and impact of interventions

The combination of single-year funding cycle constraints, stigma and data limitations are holding systems back from moving from a transactional service provision to a transformational service provision. For example, one system uses a process of appreciative inquiry (see appendix 2), through their health determinant research collaboration (HDRCs) with the National Institute for Health Research (NIHR), which makes use of storytelling to demonstrate impact. This method reportedly works well at the system level, but quantitative data needs to report to a national level.

Another system is modelling the impact of doing nothing to address weight management services and collaborating with a university to develop resources to reduce stigma.

Data limitations

Demand, demography (age, deprivation, ethnicity) and service expenditure data are limited and often split across numerous providers. This makes it difficult to garner a full understanding of the issue of obesity within their system because they only have weights and measures for around a third of their registered adult population. One system said it is not possible to assemble a complete system picture as providers could not share data. Another raised that it is impossible to gather data on those who are not registered in the health service and may be at more risk of disease or ill health. Systems are attempting to use available data through carrying out health equity audits and use Healthwatch and VCSE alliances to provide patient representation.

Inaccurate reporting

It was also reported that there can be a disincentive to accurately report waiting list data, especially when systems are maintaining long waiting lists, as this attracts criticism from other parts of the service.

Conclusion

Weight management services are, like the rest of the health and care sector, facing immense pressure and challenges around access and demand. For weight management services in particular this is exacerbated by public and professional stigma that makes it harder to build an evidence base, in turn limiting the funding, service design and provision needed to drive improvement. These challenges compound each other and are further exacerbated by the current uncertainty created by wider NHS challenges following the planned abolition of NHS England and consequential ICB restructuring and personnel cuts.[14]

At the same time, the 10 Year Health Plan makes it clear that 'ending the obesity epidemic'[15] is a key priority for the government and NHS and will use new models of service provision alongside changes in the food environment and advances in genomic and pharmacology.

Improvement in service design requires whole-systems change and whole-systems working to shift towards preventative measures and holistic wraparound support. While there are enablers and creative solutions for progressing these shifts in the long term, systems are struggling to balance this with the need to alleviate the 'here and now' demands faced by existing services.

Insights identified in this report have been used by the NHS Confederation, Lilly, a patient advocacy organisation and an expert facilitator to co-design four improvement workshops for participants in the project. These workshops will address the specific challenges identified here and provide a space for sharing insights and peer learning. This project will culminate in a final report and a suite of resources to support teams seeking to develop weight management services which can more effectively meet the needs of the populations they serve, and the service itself.

Appendix 1: Areas of focus

We asked interviewees specifically what they would like to see the most or get out of the four workshops, and heard the following:

- Challenges around data sharing
- Data analysis, including what data should be analysed and what questions should be asked to get the most out of data
- Health economic analysis to inform commissioning
- Predictive analytics to inform commissioning
- What is the interrogation of population health datasets which have pointed in the direction of targeting populations?
- How do you embed data support to meet the intersection of obesity and health inequalities?
- Budgeting and commissioning
- Sandpit – sharing of ideas and intellectual input
- Feasibility studies and evaluation
- NICE guidance in layman terms, so it can be easily translated into business cases
- How do we operationalise the NICE guidance at scale?
- What do ideal weight management services look like?
- How do we ensure we are not just implementing another medical service, and considering the wider determinants of health?
- How does the health system take on a more active advocacy role in healthy lifestyles i.e., before a person presents to the health service with obesity?
- What could a Tier 0 look like i.e., before people need intervention?
- What role do medicines play in ideal weight management services?

- How do we fund and drive different behaviours in society?
- How do we operationally shift the focus to prevention? There is a shared vision for more prevention, however this is not happening in practice.
- Systems thinking and change
- Tools to help healthcare professions talk to patients to break down stigma

Appendix 2: Glossary

Appreciative inquiry – Strengths-based approach to organisational change.

Biopsychosocial model – A comprehensive framework that integrates biological, psychological and social factors to understand health and fitness.

Circles and soup analysis – Exercise used to identify the parts of a team's work they can control directly, the factors they can influence, and those which are outside of their control. Once identified, the team can make better decisions about how to prioritise their work.

Communities of practice – Groups of people who share a common interest or profession and engage in collective learning to improve their skills and knowledge in a particular area of work.

Inverse care law – The principle that those who need healthcare the most are often the least likely to receive it. For more information, read the Health Foundation's Tackling the inverse care law.

Policy sprints – A policy-making format where teams undertake rapid analyses to address important policy questions, create products, and engage with stakeholders to enable collaboration.

Ripple Effect Mapping – An evaluation method that visually captures the intended and unintended impacts of a project.

Trauma-informed approach/practice – An approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development.

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