Versus Arthritis' response to the Government consultation 'Transforming the public health system: reforming the public health system for the challenges of our times'.

April 2021

1. Versus Arthritis welcomes the opportunity to provide input into the Government's consultation 'Transforming the public health system: reforming the public health system for the challenges of our times'.[1]

2. Versus Arthritis is the charity formed by Arthritis Research UK and Arthritis Care joining together. We work alongside volunteers, healthcare professionals, researchers, and friends to do everything we can to push back against arthritis. Together, we develop breakthrough treatments, campaign for arthritis to be a priority and provide support. Our remit convers all musculoskeletal conditions which affect the joints, bones and muscles including osteoarthritis, rheumatoid arthritis, back pain, and osteoporosis.[2]

Securing our Health: The UK Health Security Agency

What do local public health partners most need from the UKHSA?

3. During COVID-19, local authorities were limited by a lack of granular data, which could have been used to determine the picture on the ground and better understand variations in health within the community. UKHSA should look to support the work of local public health teams through providing highly localised health data.

4. Health protection cannot be separated from health promotion and disease prevention. UKHSA needs to work closely with the Office for Health Promotion (OHP), Integrated Care Systems (ICSs) and local public health teams on the basis that the effectiveness of their programmes will have a direct impact on the success of health promotion and prevention initiatives. Likewise, the health improvement work of OHP, ICSs and public health teams, will influence the effectiveness of infection control and other health security measures. There must be joined up thinking and working between UKHSA and all agencies involved in health promotion and improvement, including NHS Digital.

How can the UKHSA support its partners to take the most effective action?

5. Health protection and prevention are inherently linked, as improvements in population health reduce the impact of communicable diseases like COVID-19. Establishing a robust public health system will be key to the success of UKHSA.

6. The functions of UKHSA and OHP, and DHSC activity more broadly, need to be closely connected. The bodies responsible for different aspects of the public health system should be in constant communication and be proactively looking for opportunities to collaborate on key deliverables.

7. The outputs and insights from data collection and analysis functions that are being transferred from Public Health England (PHE) into UKHSA and NHS Digital should be

made readily available to all other bodies involved in public health, including voluntary sector groups, to support their work.

8. Dividing PHE's knowledge and intelligence functions between UKHSA, OHP, and NHS Digital, as suggested in the current proposals creates the risk of over fragmentation, diluting the insights this data can provide. Part of UKHSA's work should be focused on collating and linking datasets from across these bodies, and with other sources like the ONS Health Index and NHS data, to maximise their usefulness. A version of PHE's Knowledge and Library Services should be maintained in the new system and be available to all partners working on public health programmes.
9. UKHSA should have a strong relationship with major research groups and continue PHE's collaborative working with appropriate partner organisations and the private sector to support the translation of research findings into practice. UKHSA should lead on facilitating access to all population level public health data from across the system for researchers and ensure that this process is as efficient and flexible as possible.

How do you think the health protection capabilities we need in the future should differ from the ones we have had to date?

10. The research and innovation priorities of the new public health system cannot be limited to pandemics or other acute health crises. More clarity is needed on which part of the system will be responsible for continuing the research functions currently being delivered by PHE which do not directly relate to health protection or biosecurity i.e.,
11. the broader, non-communicable diseases research functions.
12. If UKHSA is going to be solely responsible for providing scientific leadership within the new system, it needs to take a wider view of scientific research and its purpose, including the role it can play in improving prevention and health information programmes, in addition to health security. If UKHSA's remit in relation to research is going to be limited to health protection, the Government needs to identify which bodies will take over PHE's research priorities related to health promotion and prevention, including multimorbidity, chronic disease management, and health inequalities.
13. The agencies responsible for population health data collection and analysis must also be clarified, at the national, regional, and local level.
14. The priorities set out in PHE's 2015 Strategy for research, translation, and innovation should be maintained under the new system, along with clear guidance on which of the new agencies is responsible for delivering on these priorities, with a focus on improving our understanding of pressing health challenges like multimorbidity, which pose a threat to our nation's overall health and wellbeing.
15. Analysing the effects of long COVID and the other health impacts of the pandemic, which might not be currently known, needs to be a key part of UKHSA's remit. This insight will be valuable to our understanding of the state of the nation's health and help highlight areas of need in a way which can inform both future health protection and prevention work.

How can UKHSA excel at listening to, understanding, and influencing citizens?

16. In the new system, the Government needs to ensure that the patient voice is genuinely centered and integrated into every aspect of their mission. Medical research charities are

experienced at incorporating patient voice into all their activities through well-established links to the public, who view charities as trusted partners. Charities are well-placed to support the Government as facilitators of the implementation of public health protection and improvement policies.

17. UKHSA needs to establish a fully embedded routine and accessible process of engagement with the general public and patient organisations that represent individuals who are especially vulnerable during an acute health crisis. People with underlying health conditions like arthritis were significantly more likely to be affected by COVID-19; our survey research indicated that around 40% of people with a musculoskeletal condition had to shield at some point during the pandemic, and 45% reported experiencing increased levels of pain or mobility issues.[3] The experiences and needs of those who have disproportionately been affected should be prioritised in the work of UKHSA moving forward.

Improving our Health

Within the structure outlined, how can we best safeguard the independence of scientific advice to Government?

18. The OHP's priorities should be informed by the data and be focused on the prevention and management of the most prevalent long-term health conditions in the country, including musculoskeletal conditions, as set out in the Global Burden of Disease Study.[4]
19. The CMO should provide detailed plans on how the work of OHP will help achieve the Government's existing health-related goals, including increasing healthy life expectancy by 5 years by 2035 and achieving the commitments set out in the Prevention Green Paper.[5]
20. UKHSA and OHP should have a close working relationship with UK Research and Innovation body (UKRI), and other research institutes which can provide independent specialist scientific advice to the CMO and other decision makers in Government. A list of the scientific and research bodies which Government engages with should be kept and regularly updated.
21. The OHP should actively engage with leading health research charities and coalitions like the Association of Medical Research Charities to secure independent feedback and scrutiny in their areas of expertise.
22. To protect the independence and transparency of the CMO's role, the advice provided to Ministers and supporting rationale should be published regularly and consideration given to establishing a mechanism for the independent scrutiny of advice.
23. The data and analytical functions, including health surveillance and the PHE Fingertips programme, which are transferred into DHSC under the current proposals, must be sustained with a minimum commitment to publish these datasets at the same frequency as PHE does currently. There is an opportunity to use this period of transition to expand data collection and publication, with the aim to provide as much accurate real-time public health information to the sector as possible. Widespread access to this level of insight will strengthen accountability and transparency, which is key to maintaining the integrity of the new system.

Where and how do you think system-wide workforce development can be best delivered?

24. In addition to housing subject-matter expertise on broader public health issues such as physical activity, OHP should have named individuals or teams to provide leadership in the specific disease areas which represent the leading causes of preventable morbidity and mortality in the UK, including musculoskeletal health.

25. Retaining condition-specific topic expertise on musculoskeletal health is vital due to the prevalence of musculoskeletal conditions, coupled with the impact these conditions have on every other aspect of an individual's wellbeing, including their mental health, employment, activity levels, social care needs, and ability to manage common comorbid conditions.

26. Much like the clinical leadership provided by National Clinical Directors within the NHS, an equivalent role is needed within OHP, for example a National Musculoskeletal Health Prevention Lead, to focus on building a public health approach to improving the nation's musculoskeletal health. Without this leadership, there is a risk that the core programmes developed by OHP, including on obesity, exercise, and the NHS Health Check, will not be appropriate for or address the needs of people with musculoskeletal conditions.

27. OHP needs to maintain the wide-ranging public health expertise that exists within PHE and invest further in this workforce to develop world-leading public health capabilities at a national level. This specialist workforce should be available to provide advice and quality assurance within DHSC and across the system.

28. Redeployment due to the COVID-19 pandemic has left PHE's prevention and improvement functions under-resourced. Investment in building and supporting the workforce in OHP should be equivalent to the resources being provided to UKHSA.

29. To embed the principles of prevention within the health system, information on protecting musculoskeletal health should be a core part of the Making Every Contact Count (MECC) programme, and all healthcare professionals should be encouraged to signpost people to useful resources about preventing and managing musculoskeletal pain.

How can we best strengthen joined-up working across government on the wider determinants of health?

30. The Cross Government Ministerial Board on Prevention should be used to coordinate how public health priorities are built into ongoing workstreams, with representation from DHSC, Department for Business, Energy & Industrial Strategy (BEIS), Department of Work and Pensions (DWP), Department for Digital, Culture, Media & Sport, Ministry of Housing, Communities & Local Government (MHCLG), Department for Transport, and HM Treasury.

31. OHP should provide the Board with insights and expertise on specific disease areas and highlight aspects of public health where a cross departmental approach is most needed.

32. All major policy and strategies with implications for the population's health, should be required to set out how they align with public health targets, for example in the form of a public health impact assessment. The Behavioural Insights team which currently sits in PHE should inform and support cross-departmental work on the underlying determinants of health and healthy behaviours.

33. The UK Research and Development Roadmap highlighted the role research plays in improving health outcomes. BEIS and OHP should work together to identify opportunities to fund innovative public health research and develop a robust evidence base on preventative health interventions.

34. Joint teams like the Work and Health Unit (WHU) within DWP could act as a model for how cross-departmental workstreams are coordinated. Any cross-governmental public health activity should seek input from third sector partners.

35. The Government should strengthen the current responsibilities of the Minister for Public Health, for example through expanding the position into a cross-departmental role with ministerial oversight across multiple departments including DHSC, MHCLG, and DWP, collaborating with the Cabinet Office where appropriate.

36. Versus Arthritis is a member of the Inequalities in Health Alliance (IHA). IHA are calling for the Government to develop a cross-departmental strategy to reduce health inequalities, which could be developed as part of the Prevention Board's remit.

How can we design or implement these reforms in a way that best ensures prevention continues to be prioritised over time?

37. The public health system needs an increased, sustainable, and defined budget for prevention, health promotion and improvement activity at all levels. The real-term funding cut to the Public Health Grant needs to be reversed, and additional long-term funding should be made available in areas of greater deprivation and be targeted in ways that aim to address health inequalities.

38. The OHP within DHSC should have a defined and ringfenced budget to invest in prevention and health promotion workstreams, to ensure both existing and new long-term projects receive the resources and prioritisation required to be successful. This includes ongoing PHE musculoskeletal health programmes like the Musculoskeletal Health 5-year prevention strategic framework.

39. Furthermore, the UKHSA budget should be used to support local authority partners leading on health promotion and prevention work crucial to the delivery of health security.

40. Any assessment of the programmes delivered by the OHP and regional public health activities should consider the long-term and indirect benefits of prevention and early intervention. For example, encouraging physical activity in younger people can reduce fracture risk in later life through improved bone strength, as well as providing more immediate improvements in adolescent health. Taking a more holistic, long-term view of how these interventions can deliver health improvements demonstrates the true value of prevention work. A similar approach should be taken at a local level, and local public health teams should have access to insights data which helps build the long-term business case for investing in prevention and public health interventions in their local communities.

41. For sustained prioritisation at a local level, it is vital that Directors of Public Health have strong links into their ICSs and that a population health approach is integrated into every aspect of the wider health and social care system.

Strengthening our local response

How can we strengthen the local authority and Director of Public Health role in addressing the full range of issues that affect the health of local populations?

42. Local authorities and Directors of Public Health (DoPH) should be represented on their local ICS NHS Board, in addition to representatives from the voluntary sector; together they should play a leading role in shaping the agenda of ICS Health Partnerships.

43. Population level outcomes relating to the prevention of common long-term health problems like musculoskeletal conditions should be used as key measures of success for ICSs. Tools like the Musculoskeletal Conditions Profile of the PHE Fingertips platform should be used to build understanding of local levels of need.

44. DoPH and their teams should have access to detailed, local level data about the major causes of ill health and wider health determinants to support resource allocation for prevention and health improvement activities. The existing PHE Fingertips database is a valuable resource in this regard and should be maintained and expanded to include other long-term health conditions such as chronic pain.

45. Plans set out by ICS NHS Boards should provide specific detail on how they will deliver on the prevention and public health priorities identified by their Health and Care Partnerships and outline the role of the local NHS system in this work. Prevention plans should be mandated with clear criteria for how local stakeholders, including the voluntary sector, will be included in their development and should act as a vehicle for local accountability.

46. Seeking support and input from Directors of Public Health and public health experts more broadly, should be prioritised as part of the new duty to collaborate in proposed NHS legislation.[6]

47. Coming out of the pandemic, local government's core public health grant is still almost a quarter per capita lower in real terms than in mid-2015/16.[7] Strengthening the role of local authorities will require this spending deficit to be addressed as a priority.

How do we ensure that future arrangements encourage effective collaboration between national, regional, and local actors across the system?

48. The OHP needs to establish a consistent and thorough process for engaging and collaborating with the voluntary sector (including health charities), public health groups, and patient organisations, to shape its activity. DHSC should also publish comprehensive guidance on how the regional and local tiers of the public health system can work with patient groups and people with lived experience to address local public health priorities. At all levels of the system, public health programmes and services should aim to be coproduced with the people who will use them whenever possible.

49. It is vital that there is seamless working and institutional integration between health intelligence functions at all levels of the system, and that there is a strong mechanism which enables the sharing of real-world insights and best practice examples between corresponding public health teams in different regions.

50. The voluntary sector is well positioned to help bridge the gap that often exists between national initiatives and strategies, and the work being done locally. Third sector organisations should be engaged by the system to help translate and tailor prevention

initiatives to the needs of the local communities they serve at every appropriate opportunity.

What additional arrangements might be needed to ensure that regionally focused public health teams best meet the needs of local government and local NHS partners?

51. Regionally focused public health teams need to be adequately resourced to support Regional Directors of Public Health in their system convenor role. They need to be able to have insight and access to the work carried out by UKHSA, NHS, OHP and local authorities, in order to be effective in their role linking the system together.

52. Regional teams need time and capacity to build relationships with local partners and develop a progressive culture based on collaboration. Consideration should be given to how staff, many of whom have been working above capacity since the beginning of the pandemic, can best build constructive partnerships and what resources they need to do this.

53. While a strong set of national objectives and metrics are needed for accountability, regionally focused teams need to be given the scope and independence to develop regional approaches built on local insights and place.

54. As with the programmes and workstreams developed at a national and local level, regional activity should be informed by, and engage with, stakeholders from the public health sector, the voluntary sector, and members of the public. A co-production approach to health and wellbeing should be at the core of all public health workstreams.

55. Regional activity should be supported by well-resourced knowledge and information teams, and regional teams should lead on collating and sharing data and insights with local public health officials that is specific and relevant to their place-based work on the ground.

For further information on this submission, please contact: Madeleine Webb, Policy Officer, m.evanswebb@versusarthritis.org

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