Royal Society for Public Health

Response to *Transforming the public health system: reforming the public health system for the challenges of our times*

The Royal Society for Public Health (RSPH) is an independent public health charity, granted a Royal Charter to protect and promote the public's health and wellbeing. We are the world's longest-established public health body and have members drawn from the public health community both in the UK and internationally.

As a stakeholder organisation operating within public health, and with our members forming part of the wider public health workforce, we are pleased to have the opportunity to feedback on the proposed reforms to the public health system. We have been involved with the Population Health Advisory Group and discussions about system reform since summer 2020 – this submission is based on RSPH's view that has evolved throughout our engagement on this matter over the past nine months.

Securing our health: The UK Health Security Agency

Question 1: What do local public health partners most need from the UKHSA?

Local public health partners most need from the UKSHA:

1. Deep understanding of the local context: we would expect to see, for example, investment in formal inks to local structures and good representation of those with local public health experience in all tiers of UKHSA.

2. Data and intelligence shared as close to real time as possible with local environmental health and public health teams. This data should be available at the level of granularity that the local teams require and be specified jointly by local teams UKHSA analysts. We would also wish to see this data shared with the CMO and made public at a level that protects anonymity.

3. Surge or response capacity – a trained and maintained reserve health protection workforce that can be deployed locally and builds on local assets, systems and expertise. The infection prevention and control capability which has been built up over the pandemic should be maintained and strengthened.

4. Support for a workforce of sufficient capacity and capability – both supporting the number of trained and in-training public health specialists and analysts and supporting integrated training across the country. This includes maintaining professional development that allows movement between local areas and across the four nations of the UK

5. Evidence-reviews and policy guidance to support local public health teams in identifying, preventing, and responding to health protection issues and health security incidents.

6. UKHSA should also engage with local public health teams in the development of pandemic preparedness plans, and ensure there are clear lines of communication about plans of action and responsibilities in the event of a health security incident.

Question 2: How can the UKHSA support its partners to take the most effective action?

To ensure the OHP works effectively with the UKHSA, there should be a Memorandum of Understanding and Service Level Agreement which details how they will work together. Besides the Secretary of State, the UKHSA should be accountable to a cross-government public health committee.

Ensuring an advisory system group (similar to PHSG) as well as a standing advisory workforce group are prioritised within UKHSA's governance will help ensure effective partnership working.

There must also be clear working arrangements between regional branches of UKHSA and OHP with RDsPH playing a key oversight role. The role of RDsPH in relation to UKHSA needs to be strongly articulated in implementation plans for the new system. There must be greater clarity on responsibilities and reporting arrangements for screening and immunisation and dental public health.

Data, intelligence, and evidence needs to be connected across the whole system at national, regional, and local levels. UKHSA must support and enable access to robust and complete data and intelligence across organisational boundaries. The UKHSA should also be informed by wider data including health improvement and wider determinants data.

To enable this, there must be greater clarity across the system of how data and intelligence is used and by whom. UKHSA should further adopt a co-design approach where appropriate, to ensure that the users of the data are involved in the decisions about the data system and the data requirements and are able to provide continuous feedback. UKHSA should also provide leadership in building heath protection knowledge and competence within the local public health system.

We would like greater clarity on how the UKHSA will relate to the public health agencies in the devolved nations. Close collaboration with these agencies, and the all-Ireland public health agency is crucial, and connections with those organisations should be built into UKHSA's governance arrangements.

Question 3: How do you think the health protection capabilities we need in the future should differ from the ones we have had to date?

A thorough review of what has, and has not, worked well through the Covid-19 pandemic is urgently needed. The findings should inform UKHSA's planning in this area.

The lessons of that review must then be applied to the context of the new public health system. This means taking account of the interface between England's public health system and those in the devolved nations, and post-Brexit arrangements. The lessons must also be applied across all levels – local, regional and national – in the increasingly complex public health system in England.

One clear lesson from the current pandemic is that accountability for predicting, detecting and preparing for future health security challenges must be clear and unambiguous.

Question 4: How can UKHSA excel at listening to, understanding and influencing citizens?

Community engagement is most effectively done at a local level, and on a continual basis – by the time a crisis hits, it is often too late to try to build trust. Local public health teams are therefore in the best position to do this. Therefore, we believe the UKHSA would best be able to listen to, understand and influence citizens by resourcing local public health teams to do community engagement work around issues of health protection on an ongoing basis, with reports on emerging issues and best practice being fed back to the central agency and then disseminated nationwide, where appropriate.

As there is a strong relationship between health protection and health inequalities, mitigating these inequalities should be central to the UKHSA's remit. In particular, UKHSA should have strategic responsibility for monitoring inequalities in screening and immunisation, and developing policies to address these, based on community engagement done at a local level.

We also recommend UKHSA funds academic research into what initiatives are most effective at addressing inequalities around health protection, and that universities are encouraged to work with local public health teams in developing and piloting these projects.

UKSHA should also strengthen its links with voluntary and community sector organisations, recognising them as a vital part of the public health system. This will give communities more ownership of health protection through asset-based approaches and co-production.

Improving our Health

Question 1: Within the structure outlined, how can we best safeguard the independence of scientific advice to Government?

The "strengthened role" for the CMO is essential to safeguard the independence of scientific advice to government and to ensuring the effectiveness of the public health system across government and at national, regional and local level.

The governance arrangements behind the Office for Health Promotion must ensure its independence and transparency, and explicitly protect the CMO's and OHP's ability to take public positions that challenge ministers if political responses do not reflect the best evidence. To achieve this, the mechanisms for publishing independent evidence reviews, consultation responses, and reports need to be strengthened within the OHP. They should, for instance, safeguard against the publication of independent reviews being unnecessarily stalled.

We also recommend establishing an advisory board for the OHP and the UKHSA, and expert independent standing committees (akin to the National Screening Committee and Joint Committee on Vaccination and Immunisation) as these are crucial to ensuring the independence of expert advice. Opportunities to set up new scientific advisory groups should also be explored (for example on health inequalities, and non-communicable disease prevention).

The role of Government in addressing the "power imbalance" with some industries requires a clear framework for protecting health policy from commercial interests which should build on the existing PHE guidance.

Question 2: Where and how do you think system-wide workforce development can be best delivered?

As many PHE employees perform roles across health improvement and health protection, there is a real concern that, by moving to specialise on either area, there will be a substantial loss of capacity. To address this, a new national public health workforce strategy must be developed, which is data-led, encompasses both the OHP and the UKHSA, and allows for staff to move easily between the two organisations.

The DHSC should clarify the roles of the organisations involved in workforce development. We recommend Health Education England be allowed to focus on addressing the severe shortages in the clinical workforce rather than being assigned responsibility for public health workforce development.

The Chief Medical Officer should be supported by a Chief Nursing Officer, a Chief Midwifery Officer and Chief Environmental Health Officer to provide professional leadership for each of these workforces. There may be other roles that should be represented by a Chief Officer, such as Allied Health Professionals. These leaders should sit on a standing workforce committee along with representatives from membership bodies, like the RSPH, the FPH, and the ADPH, and the UK Public Health Register.

The current alignment between the four nations must be retained: staff should be able to move around the system and across the UK as part of their career development and rapidly be deployed in times of exceptional need. To enable this, there must be clear entry points to a career in public health at all levels, common career pathways, and training programmes.

The workforce strategy should also be built around an understanding of the public health workforce that is not limited to traditional roles but includes all roles across government and the NHS that have the potential to improve the public's health. The NHS, amongst others, should invest in the development of public health skills.

Question 3: How can we best strengthen joined-up working across government on the wider determinants of health?

A Health in All Policies approach and budget is needed to ensure cross-government working to tackle the wider determinants of health. This would require every Department to assess the impact of their policies on health, to make commitments to reduce any negative impacts by a set amount, and to actively review ways in which they could introduce measures which would positively influence health. The national Health Index could facilitate this approach, as it creates a measure which can sit next to GDP. Ultimately, the Government should commit to a Levelling Up Health agenda, given the inextricable relationship of health and the economy. Every Department needs to take responsibility for their impact on population health; the Treasury should look to introduce fiscal measures which can promote healthy behaviour. We should look to Wales' Future Generations Act and New Zealand's Health and Wellbeing Budget for inspiration for how to legislate for cross-departmental ways of working.

The cross-government cabinet committee on public health should be reintroduced, or could form part of the new ministerial board on prevention. The Chief Medical Officer should be given resource specifically to deliver on reducing health inequalities, and ensuring this is factored into policies across Government through a health inequalities strategy. Ministers should be held accountable to this strategy, and external stakeholders including public health bodies and charities should advise on policy and implementation.

As the Office for Health Promotion exists for England only, the Government should set out a clear memorandum of Understanding with Public Health Wales, Public Health Scotland, and the Public Health Agency in Northern Ireland to ensure that intelligence and best practice is shared effectively across the agencies.

Public health expertise should be available across government. Secondment to other Departments should be encouraged, with a permanent health advisor position held in each Department.

Question 4: How can we design or implement these reforms in a way that best ensures prevention continues to be prioritised over time?

The best way to ensure prevention is prioritised over time is through addressing the social determinants that influence health; prioritising prevention through the health service; increased and sustained funding for public health; and effective regulation to tackle the key drivers of ill health.

The Prevention Green Paper should be progressed by introducing a white paper on the model of Wales' Wellbeing of Future Generations Act. This would require public bodies to consider the long-term impact of their decisions; put on them a legal duty to act sustainably and improve wellbeing; and would introduce a Commissioner for Future Generations who would fund research and make recommendations to improve the sustainability and positive impact of public bodies. The National

Audit Office could review the health impact of each Department and identify ways in which performance could be improved.

The Government should commit to a long-term, multi-year investment in ill-health prevention, and reverse the years of cuts to the public health grant for local authorities so that local public health teams have the resources they need to support the health and wellbeing of their communities.

The publication of the immunisation strategy is long overdue. We urge that it is updated in light of lessons learned and best practice identified through the roll-out of the Covid-19 vaccines. The Government should detail how it will improve access to all vaccinations, reduce inequalities in uptake, and improve understanding of, and confidence in, vaccinations.

We need metrics determined in advance which will indicate whether these reforms have succeeded in improving the population's health or had any negative consequences, such as on health inequalities. Evaluation should be made public so that the Government is accountable. We need further clarity on accountability for the success of prevention and for the whole system including between Government, Secretary of State, DHSC and CMO/OHP.

Strengthening our local response

Question 1: 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?

Both the UKHSA and the Office for Health Promotion should have regional teams which are involved in delivering the strategies set at the national level and feeding intelligence from the local level into those central bodies. They should both work closely together, and with Local Authority public health teams and Directors of Public Health.

Directors of Public Health need to be properly funded and resourced, with access to all local data. They should be involved in planning and licensing decisions. Moreover, the independent voice of Directors of Public Health should be protected, with local government and the NHS expected to respond to their Annual Report.

Local Health and Wellbeing Boards could be involved with Integrated Care System prevention strategies. Joint commissioning of Section 7A (public health functions) should take place between the NHS and Local Authorities to provide more co-ordination.

This would allow Local Authorities and Directors of Public Health to have greater clarity on their role in screening and immunisation. There is scope for improvement in outcomes through greater DPH involvement, given their extensive understanding of their local community, and potential barriers to maximising uptake.

Health visitors were moved into Local Authorities, but given the cuts to the public health grant, the workforce has been heavily cut and workloads have substantially increased. The public health nursing workforce needs to be restored to its proper level as health visitors and school nurses play a crucial role in addressing health inequalities. The Local Authority remit can only be increased if the funding goes with it.

Question 2: How do we ensure that future arrangements encourage effective collaboration between national, regional and local actors across the system?

We recommend both the UKHSA and the Office for Health Promotion work in collaboration at a national and regional level.

The Office for Health Promotion's regional teams should sit under the Chief Medical Officer rather than in the NHS, to reduce the risk of their being medicalised (although this still exists under a CMO role). We need clarity on what a region is including the footprint it covers, and how they will relate to the NHS and public health teams in local authorities, given the multiplicity of overlapping bodies. Co-terminousity should be sought – systems are very doomed to hard work or failure without it.

There should be a clear link between the local and the national – feeding intelligence to the centre and driving action and implementing strategies at the local level. Intelligence flowing across organisational boundaries should provide geographical granularity in a timely manner to support action at regional and local levels. This should include wider demographic and health data to allow for action on inequalities and the wider determinants of health. Regional teams would be best positioned as the local to national link.

There should be greater clarity on the regional teams' role than there is currently, and an accountability process through the regional role in particular – a balance of support, benchmarking, peer-review, and assurance. There needs to be clear accountability (who, where and what) for

population health outcomes across all levels of the system and transparency of funding to support delivery of these outcomes.

Finally, we need a clear requirement on primary care to address health inequalities and participate in prevention strategies.

Question 3: What additional arrangements might be needed to ensure that regionally focussed public health teams best meet the needs of local government and local NHS partners?

A review should be undertaken of the metrics that determine how local and regional funding is allocated to take deprivation into account across systems of wider determinants of health and inequalities, including but not limited to social housing, infrastructure projects, public health, and local services. The formula for the allocation of the new Levelling Up fund should be reviewed to ensure that the funding is allocated to Local Authorities most in need.

Elected regional mayors should be given a clear mandate for health improvement to boost regional political leadership of population health: currently only Greater Manchester has this.

Regional teams should be guided by evidence and best practice, encouraging input from a range of audiences such as businesses, academia, and the charity sector. Mechanisms should be put in place to encourage regular evidence sharing between these bodies to guide priorities, particularly in relation to reducing health inequalities.

The regional public health team is the only place that is able to integrate the skills and practices of the three domains of public health, together with data intelligence and workforce development. Regions need to have the scope and independence to develop regional approaches built on local insights while also being accountable to the national vision.

Key to the successful functioning of regional activity is adequate Knowledge and Information teams. The way in which these will operate needs to be clearly set out showing how they will support the functions of the regional team and provide the insights and data needed locally, nationally and regionally.

Regions should continue to play a key role in training and appointing future system leaders and public health specialists, scientists and practitioners, as well as providing professional leadership – there may be a need for a mentoring programme for new consultants as the future leaders of public health.