Dr Jonathan Marron
Director General, Prevention, Community and Social Care
Department of Health & Social Care

FACULTY OF PUBLIC HEALTH

BY EMAIL

21 December 2020

Dear Dr Marron

Re: The future of Public Health and the generation of evidence for England and the UK

We are writing in our capacities of President of the Faculty of Public Health and as the Chair of its Academic and Research Committee[1] to provide our collective view on how public health infrastructure in the UK could be strengthened in view of the current focus on public health and the re-organisation of Public Health England (PHE).

The new public health structures will need not only to integrate current public health functions far better than at present, but also to minimise the impact of future pandemics and incorporate the ability to generate all the types of evidence needed in real time. Clearly the current focus is on the need to minimise suffering and dying from the effects of this and any future pandemic pathogen. This cannot be done without also considering health inequalities and social determinants that were already known to have major impact on healthy life expectancy in specific population groups, almost certainly already worse and likely to worsen further because of the pandemic.

New structures must be learning environments where it is the norm to test and evaluate, with capacity to conduct robust evidence generation, and freedom from 'fear of failure' or the expectation to conform to politically driven narratives. Only through such learning can we truly mitigate the wider impacts on health and social care after a pandemic and for the population in 'usual' times.

This cannot be done if the new structures are silo-ed. If health protection is to be disaggregated from other PHE functions, and we do not agree this is an evidence-based decision, it must be done with structural and clear mechanisms for combined working such as joint posts. The current pandemic has demonstrated how closely the public health functions are intertwined. For example: COVID-19 is more dangerous to those with cardiovascular disease risk-factors and the COVID-19 response has presented an opportunity to re-address non-communicable disease risk-factors such as smoking cessation and weight loss. Environmental and occupational factors such as poor housing and overcrowding are part of a wider complex of socioeconomic disadvantage affecting multiple aspects of health. Any discussion with public health service colleagues on the frontline response, whether from PHE or local authorities reveals just how public health practitioners themselves function across boundaries with skill sets that cover all aspects of public health practice: health improvement, health and social care public health.

The pandemic has revealed just how important it is for any public health structures to have embedded evidence capacity generation across these domains, enabled by existing partnerships with academics and researchers in university and other relevant structures. This provides the evidence for how to

[1] The Academic & Research Committee is the voice of the academic public health community. It is our role to support a strong academic workforce to produce high quality evidence that can be used to inform policy and widen our understanding of public health issues and interventions.

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create a robust, forward looking, capacity to address key questions to support critical decision making that is truly independent and fit for the challenges we face and will face. Rapid mobilisation of evidence across and between academic and service interfaces will be crucial, both at national and across local health and social care system levels. This agility would be best supported by structures and funding to enable public health practitioners to undertake flexible service and academic roles, embedded into both settings with secure capacity building pipelines and appropriate long-term career posts. Public Health research and service capacity both cannot be achieved without stability and long-term approaches, including leadership roles.

Research questions tackled in the new structures cannot, and will not be, confined to those typically considered under the umbrella of "health protection" as this will be dangerously narrow to address the challenges society faces (well-articulated by the Sustainability Development Goals). We have previously published the committee's view that urgent research is needed alongside that examining the pathogen itself, to understand (1) the non-virus impacts of preparing health and social care systems to cope with COVID-19 and (2) the health effects mediated by the educational, economic and social injuries sustained during the pandemic (Oyebode, Ramsay and Brayne, 2020 https://jech.bmj.com/content/early/2020/10/06/jech-2020-214997).

It is vital to recognise and retain those areas that work well in current practice. One of these is the ability for PHE staff to apply for research funding with applications being considered on merit, as is the case for staff of Higher Education Institutions. These should be complemented with other capacity, including a carefully considered research budget to address needs responsively with appropriate checks and balances. A carefully constructed flexibility, with ability to work across sectors, disciplines and levels of service is vital if we are to retain and strengthen our position as one of the world leaders in public health research.

As noted above it is important to emphasise that it is critical that the new structures are integrated within and across local public health teams, the NHS and academia with appropriate links to other sectors. This includes, but is by no means restricted to, data sharing between the new structures, local government, the health and social care sectors and academia to enable both rapid response to emerging challenges and longer-term in-depth research on social impacts.

We would like to highlight one such example is a dataset key to the UK government's violence prevention strategy (Information Sharing to Tackle Violence (ISTV, ISN 1594), which is part of the Emergency Care Data Set (ECDS). In this respect, the COVID-19 pandemic has brought opportunities through redeployment of academics into practice positions. This could inspire future arrangements that are more effective and efficient- permanent joint roles would be a positive step.

We hope you are able to consider our views during further discussion about new public health structures. We would welcome further opportunities to contribute to national discussions on decisions that will affect all our futures.

Yours sincerely,

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