UNIVERSITY OF CAMBRIDGE

CSaP centre for science and policy

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ARC-CSaP-PHResH Prioritising Prevention Policy Workshop Report

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Prioritising Prevention at a Glance

Understand Prevention in Context

The COVID-19 pandemic has starkly demonstrated the weaknesses and fragility of our current health systems and widened pre-existing health inequalities.

To make progress with prevention work we need to focus on the wider factors that can drive poor health. Wider determinants are often linked to poverty, place and populations.

The Future of Prevention

The future work of prevention, including addressing inequalities, should act across our health systems and in partnership with communities, the voluntary and public sectors.

In a whole systems approach, how can prevention be embedded within communities? How do we achieve health across all policies?

The Role of Policy Makers

Aligning budgets from a wide array of sectors, such as education, would be one way to support prevention work for whole communities across life stages.

More broadly, participants advocated for increased dialogue across sectors and between academia, communities and policy makers.

Advocate for Prevention

How do we make the case for investing in, and advocating for, prevention now?

Participants highlighted that prevention plans need to be affordable, actionable and most likely need to have both short and long term benefits to secure successful investments.

Illustration credit: Jo Morton

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1.1 Scope and Summary

The COVID-19 pandemic and resulting global health challenges have starkly demonstrated the weaknesses and fragility of our current health systems. People with pre-existing non-communicable diseases, often modifiable through concerted prevention, are more likely to suffer adverse outcomes and increased mortality. If ever there was a time to reimagine, design research and catalyse action on prevention, it is now.

In November 2020, public health professionals, academics, and policy makers gathered to discuss the future of prevention at a workshop and webinar jointly hosted by the East of England Population Health Research Hub, the National Institute for Health Research Applied Research Collaboration (NIHR ARC) East of England, and the Centre for Science and Policy. These events were designed to inform the ARC East of England research strategy, to support the development of recovery plans, and to foster support for action on longer-term investment for prevention. This aligns with goals of the NIHR ARC East of England's work through their Prevention and Early Detection in Health and Social Care theme.

Throughout the discussions, participants explored what the future of prevention looks like, and how we can make the case for investing in and advocating for prevention. They also explored the influence that the COVID-19 pandemic has had on the prevention agenda. Moreover, they addressed how whole systems approaches, collaborations between the academic, public health and policy making spheres, the appropriate use of technologies, and strengthened relationships with local communities can play roles in strengthening and implementing the prevention agenda.

2.1 Understanding Prevention in Context: Exploring the Role of Health Inequalities and the Social Determinants of Health

In 1986, the First International Conference on Health Promotion launched the Ottawa Charter for Health Promotion, which committed to re-orienting health systems towards health promotion and disease prevention.[1] In more recent years, publications including Prevention is Better than Cure and Advancing Our Health: Prevention in the 2020s have highlighted the need for prevention to play a bigger role in the UK health system's long term vision.

In the broadest sense, prevention work in health systems focuses on addressing underlying risk factors including social determinants which can contribute to a country's disease burden, with the ultimate goal of reducing the burden of communicable and non-communicable diseases.[2] In practice, the idea of 'prevention' can be used by many groups to mean different things – ranging from aiming to prevent the progression of disease, to aiming to prevent diseases themselves, to prevent underlying determinants which increase a population's risk of developing a disease.

Prevention work encompasses a variety of work along the healthcare continuum, including patient care, service delivery, early detection, and taking steps to ensure that every contact with the health system is treated as an opportunity to engage with patients regarding factors that influence healthy and unhealthy behaviours. Common areas where prevention is important include lack of movement, poor diet, obesity, and smoking. While there is an

[1] https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference/emblem
[2] https://www.euro.who.int/en/health-topics/disease-prevention

emphasis on stopping health problems from arising in the first place, some also suggest that the prevention agenda additionally encompasses supporting people in managing specific or multiple health problems when they occur. This approach encompasses primary, secondary, and tertiary prevention interventions, and involves both preventing ill health and working to manage disease progression where ill health has already occurred.[3]

While there is a lot that the health system could theoretically prevent, some of the work involved in implementing a prevention agenda includes determining how to best use limited resources to improve population health, how to address issues of practical concern to populations, where in the system to implement interventions, how to best employ the results of research, and how to work with regional policy makers in implementing prevention goals. Much of the prevention work of public health professionals is tied up in determinants that are linked to poverty, place, and populations. Here, it should be noted that prevention work and addressing health inequalities are inexorably linked. There are also some who take the view that prevention and public health work are not necessarily interchangeable. While there are some problems within the prevention sphere which must be addressed at a population health level rather than an individual level due to their scale (i.e. obesity), individuals and systems both have roles to play in prevention more broadly.

Protective factors and risk factors for ill health interplay across the lifespan, and impact both physical and mental health and wellbeing. As people live longer in poor health, there is also increasingly a need to address and improve healthy life expectancy. Consequently, prevention work is important throughout the life course. Moreover, investing in prevention across the life course offers both health and economic returns. Here, a 2018 paper on prevention from the Department of Health and Social Care which explored upstream initiatives addressing wider determinants of health across the life course has found that you can expect "£14 of social benefit for every £1 spent across a broad range of areas."[4]

In 2019, the publication of the NHS Long Term plan included a call for more NHS action on prevention, alongside a call to reduce health inequalities. Participants in this workshop noted that preventing ill health is not presently the number one priority of the health system – and some posed the question as to whether it perhaps should be.

2.2 Prevention and the COVID-19 Pandemic

What has the impact of COVID-19 been on the current and future prevention agendas, including with respect to addressing pre-existing non-communicable diseases and inequalities?

Prevention is at the heart of public health, and workshop participants stressed that prevention has never been more important than it is now during the pandemic. The relationship between excess weight and increased risk of hospitalisation from COVID-19 has highlighted the vital need for prevention work to support healthier populations. Meanwhile, the impact of the pandemic upon minority populations and lower socio-economic groups has demonstrated present system-wide failings in addressing health inequalities. Moreover, the pandemic has impacted our behaviours around factors including food purchasing and physical activity which are likely to have longer-term consequences for population health.

[3] https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf

Long-term effects are likely to be further amplified among some children who have missed school during the pandemic, and those in our society who have faced precarity, uncertainty and poverty during this period. This increased need for prevention work has come alongside major disruption to the prevention efforts normally undertaken by local authorities and individuals alike, with this disruption a result of competing systems pressures brought about by the pandemic.

Workshop participants echoed the Lancet view[5] that we are not simply facing a pandemic, but that rather we are facing a syndemic – in which underlying sources of inequality within our societies have allowed non-communicable diseases and the social determinants of ill health to thrive, with the COVID-19 pandemic acting as a compounding and amplifying factor. Here, workshop participants emphasised that the long-term effects of the pandemic will still be with us in the years to come, and that the underlying determinants which affected who was most vulnerable to the pandemic will outlast the pandemic itself. Consequently, it was suggested that recovery from the pandemic must involve delivering on preventative programs and making long-term commitments to addressing underlying determinants of health – including addressing inequalities.

The COVID-19 pandemic has created new prevention opportunities, and new challenges. We have seen the rise in pre-existing inequalities, the emergence of new inequalities, and the rise of increased pressure on allied health professionals because of the need for rehabilitation care for many who have survived COVID-19. However, participants noted that the pandemic has also created new opportunities for contact with patients through virtual appointments and has shown that if there is a will to address longstanding inequality issues such as rough sleeping, ways forward can be found.

3.1 The Future of Prevention

What does the future of prevention look like? What are the key challenges, priorities, and opportunities?

Throughout the webinar and workshop, key challenges to implementing prevention mechanisms were identified by participants. Lack of political will, funding shortages, insufficient evidence, the complexity involved in implementing prevention tools effectively, barriers to collaboration, insufficient capacity, lack of hope, and insufficient attention to certain minority groups in current survey research were among the challenges raised throughout the afternoon's events.

As we go forward in implementing prevention agendas following the pandemic, workshop participants highlighted the need for us to do more to learn about the conditions that cause ill health outcomes, to work more with local communities and local authorities to understand drivers of poor outcomes, to focus on getting innovations which are supported by high quality, robust evidence into action, and to find ways to demonstrate value for money in implementing prevention programming. Workshop participants also suggested that the future of prevention must involve looking for double wins for public health and disease prevention; increased support for proactive professionals; an increased emphasis on multi-disciplinary research; an increased focus on equity; and further research into the practical delivery of scalable, accessible preventative measures which maximise public engagement and uptake. Throughout this discussion, participants repeatedly noted the need to improve collaboration between organisations – including in the areas of data and

[5] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32000-6/fulltext

infrastructure – if these efforts are to successfully utilise existing assets to contribute to the implementation of improved prevention measures.

The pandemic and associated economic shock have also disrupted and challenged other broader systems, including housing, transportation, how we plan our cities, and our response to climate change and air pollution. As we rebuild these systems, there are opportunities for prevention and public health to be incorporated in the rebuilding process. The future success of prevention work will rely on acting across our health systems and in partnership with the voluntary sector, communities, and the private sector. These collaborations must also involve evaluation, monitoring, and efforts to ensure that programs contribute to health equity. Fully addressing prevention needs will consequently require good data collection concerning vulnerable groups, and the use of health inequality impact assessments.

Throughout the workshop and accompanying webinar, participants highlighted a range of potential future priority areas for prevention and health promotion work. Suggested areas of intervention included mental health and loneliness; physical inactivity and obesity; sexual and reproductive health; links between health, poverty, and underlying inequalities; substance use including alcohol and smoking; links between climate change, sustainability and health; vaccination; nutrition and food systems interventions; and community-based work.

4.1 A Whole Systems Approach to Prevention

How can prevention be better embedded within systems?

Some workshop participants argued that we need deeper discourse about prevention, which extends beyond a thin discourse focused on behavioural medicine, clinical population health management mindsets, and the life course. It was argued that prevention work needs to make local communities resilient, and that we need to apply a health in all policies, health in all societies, health in all government approach if we are to be successful in implementing a comprehensive prevention agenda. Here, it was suggested that the INHERIT model[6], which links health, equity, and sustainability agendas, may be part of the way forward. Others also cited the need to better understand the linkages between place and health and raised the Marmot review and social prescribing tools as examples of how prevention measures can extend beyond the traditional health system.

4.2 Addressing Inequalities

Workshop participants acknowledged that UK policymakers have not yet succeeded in shifting the needle on health inequalities. While much of the public conversation around health promotion focuses on changing lifestyles, this conversation does not pay enough attention to the determinants of health which go beyond individual choice. Here, participants repeatedly raised the example of how BAME populations have been disproportionately impacted by the pandemic, not for biological reasons, but because there were multiple sets of determinants ranging from economic factors to racism which impacted how vulnerable these populations were to the pandemic. A whole systems

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6068874/#:~:text=INHERIT%20is%20a%20research%20project,of%20living%2C%20moving%20and%20consuming.

approach to addressing disease prevention and health promotion needs to pay particular attention to places where there is inequality or deprivation, to learn from the lived experiences of people regarding the economics of prevention and early detection, to do more to identify and address the care needs of those who already have underlying or multiple conditions or face an elevated risk, and to creative supportive environments and strengthened communities. One component of addressing these challenges is to introduce ways of co-production prevention initiatives with these communities rather than simply reproducing a narrative of problems. Another component of the solution may involve expanding the use of health inequality impact assessments at all levels of government.

4.3 A Role for Policy Makers

In reflecting upon the steps the policy making community could take to embed prevention within systems, it was suggested that aligning budgets from a wide array sectors such as education would be one way to support prevention work for whole communities across life stages. Here, the idea is that if you align budgets, the alignment of strategies will follow.

Others emphasised the role that policy makers in local governments have to play in successfully embedding prevention into systems and in engaging with local stakeholders to understand broader determinants of wellbeing within local communities. For example, London City Hall has strategies on culture, food, transport, housing, and health inequalities, all of which act at a population level and could have prevention embedded into their aims and work. At a population level, workshop participants expressed an interest in embedding prevention work into tackling issues including access to green space, housing investments, the design of housing estates, improving the availability of fresh food while tackling food deserts, improving uptake of public transportation, and improving air quality.

4.4 Linking Academia, Communities, and Policy Makers

Meanwhile, multiple workshop participants emphasised the need to improve upon the links between academia and other systems in order to ensure that prevention research is conducted at scale, in ways that are useful and likely to make a difference. It was suggested that population level research which recognises the complexity of real life, and which is developed through co-creation between universities and local populations or local stakeholders such as Directors of Public Health is one path to success. Some participants also highlighted the value of researching and evaluating initiatives that are already underway, rather than inventing new interventions from scratch. More broadly, participants advocated for increased dialogue between academia and policymakers who would challenge each other in the development and implementation of useful research, and for a more varied set of methodologies to be used in conducting prevention research and evaluating interventions.

4.5 Learning from the International Community

Other countries beyond the UK are also interested in preventative measures to improve population health, and there are opportunities for the UK to learn from work which is ongoing elsewhere. Participants cited the following as potential sources of relevant knowledge:

- UN Research Roadmap for the Covid-19 Recovery,
- The European Union's CHRODIS PLUS Joint Action work on chronic diseases,

- The European Union's Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases,
- WHO work on disease prevention and health promotion,
- Joint country profiles from collaborations between the OECD and the European Observatory on Health Systems and Policies.

4.6 A Role for Technology?

Workshop participants were divided as to whether technologies could play a greater role in embedding prevention in systems and our communities, with one participant asking whether technology is the answer, or a red herring. Here, it was noted that politicians like simple solutions to complex problems – which may make affordable technological solutions attractive – but that technological solutions may not be appropriate or beneficial. For example, while technology from integrated health measures on smart phones to Fitbits and pedometers are being used by the general public, the evidence base has suggested they do not make people walk further, that some fitness apps are of low quality, and that reliance on these forms of technological solutions may drive inequalities.

However, discussions about implementing the use of technology in health systems covers a broad array of areas beyond smart wearables, and there are likely to be both pros and cons of digital changes more broadly. For example, the rapid shift in the ability to have remote consultations with GPs – with 99% of GPs offering this service during the pandemic[7] – has increased the accessibility of GPs for some, while at the same time highlighting the number of residences in the UK which do not have the access to mobile phones or reliable internet with which to access online consultations.

Ultimately, one participant suggested that rather than having tech companies search for problems to solve, the best way to incorporate technology more comprehensively into our systems is through collaboration. This could involve delivering disease prevention initiatives or supporting other components of the health system through co-production with health technology users such as hospitals.

5.1 Advocating for Prevention

How do we make the case for investing in, and advocating for, prevention now?

In advocating for the implementation of prevention measures and programming, workshop participants emphasised that there is a need to be realistic about the constraints of public purses, and that investments which generate both short-term and long-term benefits are much more likely to be attractive to public officials, who have to demonstrate concrete value for money to constituents on very short time horizons. It was also noted that there is a need to frame initiatives in ways which will appeal to multiple audiences, with short, mid, and long-term benefits appealing to political, policy, and commissioning cycles, respectively. Here, it was noted by some that the UK does not have a healthcare policy environment which allows for long-term planning without cyclical political interruptions – meaning that advocacy work is likely to be more successful if it incorporates these cycles into their planning, proposals, and intervention timelines. Others highlighted the potential for new approaches to financing prevention initiatives to help fill this gap.

[7] https://www.england.nhs.uk/2020/05/millions-of-patients-benefiting-from-remote-consultations-as-family-doctors-respond-to-covid-19/

Workshop participants from the policy community also stressed that current approaches to implementing and evaluating prevention programming rely on a narrow a range of methodologies and are often presented by academics who focus on articulating the uncertainties in our understanding rather than what we know about the success of prevention programs. Here, it was suggested that there may be value in rolling out a prevention intervention in different ways in different communities, to determine what lies at the heart of the successful intervention while also turning a rigid intervention into a flexible toolkit which can meet the needs and resource limitations of multiple places. Workshop participants emphasised that interventions which are likely to appeal to the policymaking community would need to be affordable, straightforward, and actionable. It was also noted that policymakers do have an appetite for a black box approach to causality – what matters most is whether an intervention works in a demonstrable, concrete, way in a timely fashion, and whether it can be implemented by the people who are already available within the system.

Finally, workshop participants highlighted the value of a strong communications toolkit as part of the advocacy work for advancing the prevention agenda. It was noted that those working in public health need to do more to be in the room earlier in policymaking processes, and to ensure that health messages do not become fragmented as new actors from the business sector who claim they work for health prevention appear on the scene. Narrative building and successful storytelling – presenting both quantitative data on efficiency gains and qualitative first-hand stories which drive home how prevention can make a change in people's lives – can be powerful tools for this advocacy work.

Participants

- **Dr Jag Ahluwalia**, Chief Clinical Officer, Eastern AHSN
- **Professor Carol Brayne**, Professor of Public Health Medicine, Department of Public Health and Primary Care, University of Cambridge; Population Evidence and Data Science theme lead for the NIHR Applied Research Collaboration (ARC) East of England (EoE)
- **Dr Jo Broadbent**, Deputy Director, Public Health England East of England
- **Candice Bryan**, Health and Sports Strategy Manager, Stevenage Borough Council
- **Nicola Buckley**, Associate Director, Centre for Science and Policy, University of Cambridge
- **Hannah Graff**, Public Health Policy Advisor and Researcher, HealthLumen
- **Caitlin Grant**, Public Health Policy Coordinator in a joint role between the Cambridge Institute of Public Health and Public Health England
- **Dr Julian Huppert**, Director, Intellectual Forum, Jesus College, University of Cambridge
- **Deborah Jenkins**, Public Health Specialty Registrar, The Health Foundation
- **Professor Peter Jones**, Professor of Psychiatry & Deputy Head, School of Clinical Medicine, University of Cambridge; Director of the NIHR ARC EoE
- **Professor Mike Kelly**, Senior Visiting Fellow, Department of Public Health and Primary Care, University of Cambridge
- **Halima Khan**, Executive Director, Communities and Skills, Greater London Authority
- **Craig Lister**, Health and Wellbeing Programme Lead, Public Health England
- **Dr Angelique Mavrodaris**, Consultant, Public Health Medicine, Public Health England and deputy theme lead (Prevention and Early Detection) for the NIHR ARC EoE
- **Professor Jim McManus**, Director of Public Health, Hertfordshire County Council
- **Kate McNeil**, Communications Coordinator, Centre for Science and Policy, University of Cambridge
- **Lauren Milden**, Policy Adviser, Centre for Science and Policy, University of Cambridge
- **Clive Needle**, Policy Adviser, Euro Health Net
- **Dr Emma Pencheon**, Policy Advisor at Department of Health and Social Care
- **Frances Pugh**, Policy Advisor at NHSX
- **Naomi Radcliffe**, Deputy Director of Technology Policy at NHSX
- **Elaine Rashbrook**, National Lead for Lifecourse, Adults and Older Adults, Public Health England
- **Jessica Stokes**, Deputy Director for Health and Wellbeing, Public Health England, East of England
- **Dr Claire Thompson**, Senior Research Fellow in the NIHR ARC EoE Prevention and Early Detection in Health and Social Care theme, based at the University of Hertfordshire
- **Dr Adam Wagner**, Senior Research Fellow in the NIHR ARC EoE Health Economics and Prioritisation theme, based within the Health Economics Group at the University of East Anglia
- **Professor Jennifer Whitty**, Professor of Health Economics at the University of East Anglia and lead for NIHR ARC EoE Health Economics and Prioritisation theme
- **Rebecca Willans**, Specialty Public Health Registrar at UK Faculty of Public Health
- **Hannah Williams**, Events Coordinator, Centre for Science and Policy, University of Cambridge
- **Professor Wendy Wills**, Director, Centre for Research in Public Health and Community Care (CRIPACC), University of Hertfordshire; NIHR ARC EoE theme lead, Prevention and Early Detection in Health and Social Care
- **Dr Ed Wilson**, Senior Lecturer in Health Economics, University of East Anglia

About the Organisations

NIHR Applied Research Collaborations

NIHR Applied Research Collaborations (ARCs) support applied health and care research that responds to, and meets, the needs of local populations and local health and care systems.

These 15 local partnerships between NHS providers, universities, charities, local authorities, Academic Health Science Networks and other organisations also undertake implementation research to increase the rate at which research findings are implemented into practice. The ARC aim to improve outcomes for patients and the public; improve the quality, delivery and efficiency of health and care services; and increase the sustainability of the health and care system both locally and nationally.

The ARCs undertake research on a number of areas of need highlighted by the NIHR Futures of Health report, including: the challenges of an ageing society; multimorbidity; and the increasing demands placed on our health and care system.

The £135 million five-year funding also aims to deliver national-level impact through significant collaboration between the ARCs, with individual ARCs providing national leadership within their fields of expertise.

The NIHR ARC East of England is a five-year collaboration between Cambridgeshire and Peterborough NHS Foundation Trust, and the Universities of Cambridge, East Anglia, Hertfordshire and Essex along with other NHS Trusts, Local Authorities, Regional Sustainability and Transformation Partnerships (STPs), patient-led organisations, charities, and industry partners across the region.

To learn more about ARC East of England, please visit: https://arc-eoe.nihr.ac.uk/

East of England Population Health Research Hub

The East of England Population Health Research Hub is a collaborative network which aims to inform, co-design, understand and apply responsive public health research and evaluation to address population health challenges and inequalities.

The Hub aims to provide:

A NETWORK: by bringing practitioners and researchers together for meaningful engagement and understanding of regional priorities and research approaches
A KNOWLEDGE HUB: to map and provide a greater connection between public health assets and challenges within the region
COMMUNICATION: through channels and forums to effectively share regional research, to facilitate collaboration, and to translate research into local contexts
CAPACITY BUILDING: by building bi-directional knowledge, integration and capacity of research and practice across the region, and to provide workshops to build evaluation skills within the region and demonstrate impact of local public health approaches
RESEARCH STRATEGY: to develop a regional strategic framework to inform public health research within the East of England, and identify opportunities to support co-designed research partnerships which responds to current and emerging public health issues.

For more details please visit: https://adph.org.uk/networks/eastofengland/eoephresh/

The Centre for Science and Policy

The Centre for Science and Policy is a knowledge exchange centre based at the University of Cambridge. CSaP's mission is to help improve the quality of public policy making through the more effective use of evidence and expertise. CSaP starts with the questions from policy professionals and fosters networks between policy and science based on mutual understanding, respect, and trust. The experience and diversity of CSaP's unique network provides fresh perspectives and critical challenges to conventional thinking and helps research from all disciplines contribute more effectively to society.

CSaP's brokerage work includes a flagship Policy Fellowships Programme, a flexible professional development programme which starts with five days spent at the University of Cambridge, meeting with relevant researchers from a wide range of disciplines. Over two years, CSaP Policy Fellows continue to benefit from support and involvement with the network's activities. CSaP also provides professional development training for policy professionals and early career researchers, the facilitation of curated knowledge exchange Policy Workshops for researchers and practitioners and participation in several research programmes. The Centre helps facilitate a Policy Forum on climate change with Cambridge Zero, and runs outreach work which seeks to bring the latest information about science policy to members of the general public.

You can learn more by visiting their website at http://www.csap.cam.ac.uk.

Appendix A: ARC-CSaP-PHResH Prioritising Prevention Webinar Mentimeter Results

1.What do you think are the top public health prevention priorities that should be addressed (using keywords)?

2. What do you think are the barriers that currently hinder action on these priorities?

- Lack of evidence base for innovative prevention solutions.
- Resources, personalised advice based on education level, lack of empathy.
- Political will, global pandemic, the complexity of these challenges.
- For sexual orientation/gender identity the lack of notice of these issues by Marmot, NIHR, current government, tantamount to institutional homophobia. For example, none of the big covid-19 surveys measured sexual orientation, despite an ONS validated Q.
- Lack of hope for the future and poor self-worth, especially for those in the lowest socio-demographic groups and (topically) areas of highest job loss due to COVID. Areas where there is high prevalence of food outlets providing poor food choices.
- Current focus on health protection (COVID 19).
- Lack of national strategy.
- Funding and resource issues.
- Lack of join up across systems.
- Collaboration across sectors health social care industry revenue from taxation.
- Budgets.
- Capacity.
- Limited funding.
- Funding. Understanding across non-health sectors of their role and impact (still!)
- Ideology, politics, and investment.
- Collaboration, duplication of effort, resource, grass roots understanding partnered with research skills.
- Lack of collaboration between LA, CCGs, and NHS E&I.
- The vast majority of equality agendas are very damaging. Redistribution of wealth is complex and subjective concept. Providing opportunities alone is not the key as it depends on how people value the opportunity.
- Covid-19.

3. How do you think we can better utilise our existing assets and infrastructures to address these barriers or support these priorities?

- Start taking notice of sexual orientation/gender identity issues/ health inequalities and find out why they are being systematically ignored up to now and address that.
- Prioritise PH funding to top priorities focus on accessible preventative measures that maximise citizen engagement.
- Focus on collaborative community-based programmes, via social prescribing/place for example, that seek to improve personal resilience. Stop constantly creating new products and use successful assets such as MECC in an aligned manner.
- Research into practice and roll out at scale and pace.
- Make most of new structures to emphasise benefits, including ROI for prevention.
- Multi-disciplinary teams bringing wide expertise to tackle problems at a local level.
- Looking for and prioritizing win-wins across public health/prevention silos.
- Focus on key priorities and try and work regionally.
- Collaborate on local pilots of digital prevention to develop an evidence base and identify whether targeted prevention works.
- Evaluate duplication of remit and focus more on practical/delivery aspect, support for proactive professionals even if not part of the 'usual suspects'.
- Joining them all up?
- Integrate all infrastructure investments around place and population.
- Improved joint working between organisations.
- There is a need for a national digital mapping infrastructure that can provide up to date data on existing assets in place-based communities.