REFORMER THOUGHTS

The biggest health challenges of the 2020s

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Introduction

As we begin to recover from the greatest health crisis Britain has confronted in a century, we must not lose sight of the other pressures our health system faces. We must look to the future and ask – "what will be the defining health challenges of the next decade?". This *Reformer Thoughts* brings together health leaders to answer this question and consider how these challenges can be met head on.

Recent experience shows that responding to infectious diseases remains a core health challenge. David Heymann, Professor of Infectious Disease Epidemiology at the London School of Hygiene and Tropical Medicine, argues that we must "shift the mantra" on controlling infections by stopping diseases at their source – the interface at which animal diseases "make the jump" to humans.

While future pandemic threats will remain at the forefront of our minds, demographic change and the burden of lifestyle related illnesses will continue to drive demand for health services.

By 2040, one in four people in England will be 65 or older and the number living with dementia is expected to reach 1.6 million. MSD's Medical Director, Cham Herath, argues that investment in R&D is key to understanding the biological mechanisms behind ageing and developing innovative treatments for the diseases ageing causes.

The obesity epidemic also poses acute challenges – the adult obesity rate in England stands at 28 per cent, putting millions at increased risk of developing type-2 diabetes, cancer and heart disease. Obesity Health Alliance Lead, Caroline Cerny, argues that governments, health providers and communities will all have to play their part in addressing the structural factors that drive obesity.

Tackling smoking has long been a health priority and evidence-based regulation has been remarkably successful in combatting the damage it causes. However, Deborah Arnott, Chief Executive of ASH, argues that bold action is needed for Government to meet its ambition of pushing smoking rates in England below 5 per cent by 2030.

Alongside tackling the drivers of ill health, we must consider how our health system can be best organised to deliver citizen-centred care and tackle entrenched inequalities in provision.

Cross-sector collaboration and community understanding are vital to improving health outcomes for society's most vulnerable. John Dillon, Professor of Hepatology at the University of Dundee and Ann Eriksen, Executive Lead for Blood Borne Viruses at Tayside's Public Health Directorate show how close engagement with injecting drug users, a community with a long history of poor interactions with health services, helped Tayside overcome daunting odds to eliminate the Hepatitis C virus.

Better integration between health and other care services has been a long-standing policy ambition. Rob Webster, West Yorkshire and Harrogate Partnership's Chief Executive, reflects on what the partnership can teach other Integrated Care Systems about successful joint working. Building a shared vision and developing inclusive governance structures have been key to West Yorkshire's success in unleashing the potential of integrated care.

By understanding the drivers of ill health and how our health system can be equipped to cope with them, we can better position ourselves to meet the health challenges of the next decade.

Sebastian Rees
Researcher, *Reform*

"Alongside tackling the drivers of ill health, we must consider how our health system can be best organised to deliver citizen-centred care and tackle entrenched inequalities in provision."

Changing the mantra on infectious disease prevention

Recent infectious disease outbreaks – SARS in 2003, swine flu in 2009, and COVID-I9 - have all begun in a similar way – a series of risk factors aligned and allowed an infection in animals to jump to humans. However, the current mantra for controlling emerging infections is to rapidly detect them in humans, respond with public health measures that stop sickness and death, and attempt to prevent infection from spreading further. This model comes with huge costs: strict public health measures – though necessary – affect societal wellbeing, bring large-scale negative economic impacts, and struggle to quickly get on top of fast spreading infections.

As we begin to recover from the pandemic, this mantra must shift. We cannot wait for disease to emerge in humans before acting. We must address infections at their source – the interface at which diseases in animals "make the jump" to humans.

Acting early requires understanding the way risk factors line up to cause viruses to spread from animals to humans. Rift Valley Fever serves as a useful case study. It is a disease of cattle, camels, sheep and other ruminant animals, caused by a virus that is endemic in eastern Africa and spread to these animals by mosquitoes.

At times the virus spreads to humans, either through the bite of an infected mosquito or by contact with infected animal blood during slaughter for food or religious purposes, causing severe illness and in some cases death.

The virus tends to make the jump when a number of risk factors line up with one another. These include a failure to vaccinate animals, but also excess rainfall and flooding related to el niño events in the Indian Ocean. Flooding forces animals and humans to live closer together on dry land and deposits excess standing water, increasing the number of mosquito breeding sites.

When these risk factors lined up in the late I990s, an outbreak of Rift Valley Fever occurred, causing over 450 reported human deaths.

In the UK, an infectious agent from cattle emerged in humans a decade earlier – mad cow disease (Bovine Spongiform Encephalopathy) – which causes a fatal human neurological disease called variant Creutzfeldt-Jakob Disease. The risk factors that aligned to allow the virus to spread from animals to humans, were an unstudied change in the processing of cattle carcases to bone meal, feeding of ruminant animals with bone meal from infected animals, and the slaughter of cattle that contaminated meat products with the infectious agent. Because the infection only passes between cattle and humans, not between humans, culling of cattle was required. In addition to the mortality it caused in humans from the beef products they used, the economic cost was severe.

A better understanding of these risk factors allows prevention to occur closer to the source. In the case of Rift Valley Fever, mitigating these risk factors would involve short term measures such as ensuring sufficient vaccination supplies to vaccinate ruminant animals, and their provision to farmers at a cost they could afford.

Professor David Heymann, Professor of Infectious Disease Epidemiology, London School of Hygiene and Medicine

"We cannot wait for disease to emerge in humans before acting. We must address infections at their source- the interface at which diseases in animals "make the jump" to humans."

In the longer term it would include measures such as completing the negotiations for the United Nations Climate Change Framework Convention to mitigate risk factors related to climate change and flooding. For BSE, prevention closer to the source would have included paying close attention to the rendering process of cattle carcasses, adhering to the policy of not feeding livestock feed made from other ruminant animals, and taking better precautionary measures at slaughter houses.

The UK Government has already put measures in place to monitor emerging infectious risks in other species. Since 2004, the Human Animals Infections and Risk Surveillance (HAIRS) group, containing representatives from Public Health England, the Department for Environment, Food and Rural Affairs, the Animal and Plant Health Agency and other expert bodies has met regularly to identify and discuss infections with potential for interspecies transfer.

Yet global problems require global solutions, and the UK must use its position as a health leader to make this kind of monitoring the norm around the world. The recently launched Pandemic Preparedness Partnership, a key initative of the UK's G7 presidency, could play a crucial role in helping secure international support for better tracking and responding to novel infectious diseases.

To avoid the the catastrophic toll of infectious dieases we must ensure that prevention at the human-animal interface becomes a priority for all governments and global health institutions. The mantra must continue to include rapid detection and response to tackle disease quickly when it emerges in humans. Yet, all countries must work towards preventing disease emergence closer to the source. The UK has the expertise and understanding to help them along the way.

Rising to the challenge of demographic ageing

As the UK looks to take on the next decade of health challenges, it will be essential that industry and the NHS are future-fit and able to come together to face the rising challenge of demographic ageing. At the start of the decade, Britain had the worst healthy life expectancy in Europe. Even prior to the pandemic, UK healthy life expectancy was falling behind most other European countries – and was one of only four countries whose healthy life expectancy declined between 2008 and 2016. As such, it will be critical that the 2020s deliver decisive progress in how we meet the challenges associated with our ageing population.

Government and its partners in the health sector must take steps to ensure that, alongside a focus on ageing healthily, the importance of ageing equitably is stressed. The pandemic has shone a light on inequalities and made clear that levelling up on health is the biggest enabler of healthy population ageing. The Government's focus on health inequalities is essential to ensuring that everyone has the opportunity to maintain good health into old age.

To enable healthy longevity, we must also shore up a thriving science base in which early and late stage R&D and inclusive innovation are supported. It is important that innovative approaches, treatments and services can reach the people that need them throughout the life course, and that we have suitable systems in place to allow for this.

Investment in R&D is key to unlocking the UK's scientific leadership potential in the field of healthy ageing. Central to this ambition will be innovative research and the development of new treatments to tackle neurodegenerative diseases, which continue to grow as a result of

population ageing. This is an area in which MSD is investing, building the Discovery Research Centre in London which will recruit a team of 150 scientists to collaborate with leading UK institution, improve our understanding of the underlying biological mechanisms of ageing, and help develop innovative treatments. The U.K. has many excellent dementia drug discovery initiatives and partnerships such as the Alzheimer's Research U.K. (ARUK) led Dementia Consortium, of which MSD is proud to be a member. Research is inherently collaborative and international and enabling these dynamics to thrive will secure the UK's innovation potential.

To drive forward healthy and equitable ageing, we must ensure that innovation reaches a broader spectrum of the ageing population. As we approach the 40th anniversary of the discovery of the first AIDS cases in the UK, we are reminded of the significant strides in scientific understanding, medical innovation and clinical management of HIV, that have allowed people to live with the condition into older age. HIV treatment is recognised as one of the great health success stories of recent times, but today people living

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"The pandemic has shone a light on inequalities and made clear that levelling up on health is the biggest enabler of healthy population ageing."

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References available upon request

with HIV continue to face health inequalities, social isolation, financial stress and stigma. These challenges worsen as they age. Ageing with HIV is associated with increased incidence and earlier onset of multimorbidity and frailty and Public Health England projects that the prevalence of high cholesterol, hypertension, diabetes and 'heart conditions' in the ageing HIV population will double in the UK in the forthcoming decade. It is important that we continue to collaborate to drive improvements that help people with HIV live and age well.

These include ongoing research to understand the changing nature of HIV, sustained access to clinical innovations, future-proofed and joined-up commissioning and funding, and new models of care that are designed to address the evolving needs of the individual.

Ensuring good health later in life will also require further research and innovation in vaccines and immunology. As COVID-19 has shown, vaccination is an indispensable public health tool that can be employed across the life course to protect people of all ages against vaccine-preventable diseases. Immunisation is a key component of any healthy ageing strategy – older adults suffer from vaccine-preventable diseases more frequently and with poorer outcomes. This is due to a number of factors such as underlying chronic medical conditions and age-related reduction in immunity.

Vaccine innovation must recognise the complex needs of older populations and ensure the right vaccines are matched to the right population to support individual protection. Vaccine R&D must meet the unique needs of varied populations, and innovations in the system must ensure that vaccines get to the people who need them most.

As a future-focused company, MSD's mission is to discover, develop and provide innovative medicines and vaccines that save and improve lives globally. Understanding and responding to population ageing is crucial to this mission and we are committed to helping develop a future-fit health system that can flex and adapt to the needs of an ever-ageing population and the new and unchartered health challenges which it brings.

Creating a smokefree nation

Smoking is the epidemic which hides in plain sight. It has crept up on us, taking decades to reap its annual toll of death and disease. But make no mistake, smoking is more deadly than COVID-19, killing up to two thirds of long-term smokers, who lose on average ten years of life. In 2020, around 80,000 people in the UK died from COVID-19. Smoking kills on that scale year in year out.

Beyond its obvious harms to physical health, smoking has much wider impacts. It affects users' mental health - many wrongly believe that smoking relieves stress, when in reality quitting is linked to long-term improvements in wellbeing at least as great as those derived from taking anti-depressants.

The economic costs of smoking are severe, driving over a million people – including over a quarter of a million children – into poverty and leaching money out of local communities, particularly those in which household income is lowest.

The harms of smoking are not distributed equally. Smoking rates remain highest among poorer people, in poorer communities. Half the difference in life expectancy between the richest and poorest is due to smoking. If the Government achieves its ambition to create a smokefree nation by 2030, it will have taken the most important possible step towards delivering on its manifesto commitments to increase healthy life expectancy by five years by 2035 while reducing inequalities and levelling up society.

Fortunately, the smoking epidemic is, slowly but surely, being brought under control. Since the turn of the century, governments have ratcheted up smoking regulation. Advertising and sponsorship promotion by tobacco companies has been banned, the product is in plain packs, taxation has reduced tobacco affordability, and smoking is prohibited in enclosed public places. Since 2007, we have led Europe in taking regulation even further. The results are clear to see: in 2007 our smoking rates were average for Europe, by 2020 they were less than half those of the 27 EU member states.

However, there are still nearly six million smokers in England – one in seven adults – and we are nowhere near achieving the Smokefree 2030 ambition. To do so smoking rates must fall by two thirds in a decade, and by three quarters for smokers in routine and manual occupations. At current rates of decline we will miss the target by seven years, and twice that for the poorest in society.

Government understands that meeting the smokefree target of rates below 5 per cent by 2030 is extremely challenging and has committed to publish a new Tobacco Control Plan, which ASH has long called for. To achieve its aims, the plan must be innovative and ambitious.

First and foremost, additional funding is needed. The per capita Public Health Grant has been cut by almost a quarter since its peak in 2014-15, and funding for smoking prevention has been particularly

Professor Deborah Arnott
Chief Executive,
Action on Smoking and
Health (ASH)

"The economic impacts of smoking are severe, driving over a million people, including over a quarter of a million children, into poverty and leaching money out of local communities, particularly those in which household income is lowest."

hard hit. In the 2019 Prevention Green Paper, government committed to consider a 'polluter pays' approach to funding tobacco control. This happens in the USA, where the industry pays for its regulation, without having any say in how the money is spent.

Government must follow through on this commitment. Tobacco manufacturers are far more profitable than any other consumer staple businesses, they can and should be made to pay to end the epidemic they caused.

Once funding is secured, funding for highly cost-effective, multi-media behaviour change campaigns must be re-instated. They are very effective and economical, but funding has crashed by more than 90 per cent from £23.38 million in 2008-9 to less than £2 million in 2019-20.

To tackle the stubbornly persistent inequalities in smoking, targeted support must be provided for disadvantaged smokers, including the 49 per cent of smokers in routine and manual occupations, the third of smokers who live in social housing, and the third of smokers with poor mental health.

We also need to further denormalise smoking by ratcheting up regulation. Why not put health warnings on cigarettes and rolling papers? These are cancer sticks so why not tell it like it is and put the warning on the cigarette itself? Government mandated pack inserts, already shown to be effective in Canada, provide advice on the inside of packs to match the health warnings on the outside.

Although cigarettes are now hidden from sight in shops, tobacco manufacturers still pay for large gantries highlighting 'Tobacco on sale here' just behind the sales counter, making it appear that smoking is still the norm in our society.

When the age of sale was increased from 16 to 18 in 2007 smoking prevalence reduced in 16 and 17 years olds by 30 per cent. Evidence from the US, where the age of sale has increased to 21, shows similar reductions in smoking among 18 to 20 year olds as a result. The impact of enacting this change in the UK would be immediate: over 100,000 fewer smokers aged 18 to 20 in year one, and 18,000 fewer every year thereafter.

When I started working for ASH in 2003 it was unimaginable that the end of the epidemic would be in sight while I was still there. Now we have government and public appetite to end it within the decade. This is achievable but only if the Government delivers the 'bold actions' it committed to in the Green Paper in the forthcoming Tobacco Control Plan.

Tackling obesity in Britain

As anniversaries go, this is perhaps not one for celebrating. 2021 marks thirty years since the Government first set targets to reduce obesity, after recognising the impact rising levels were having on population health. In 1991, a target was set to reduce obesity prevalence to 7 percent, to reflect 1980 levels.

Three decades later and obesity rates in adults have increased to 28 per cent. With around two thirds of English adults having a weight that is classed as overweight or obese, excess weight is very much the norm in our society.

So why is this cause for concern? While at an individual level, having obesity doesn't automatically mean poor health, at a population level it is clear that excess weight brings with it an increased risk of many diseases. These include type-2 diabetes, cancer, heart disease, liver disease and associated mental health conditions. But it's not just long-term conditions, having a very high BMI has also been shown to increase the risk of complications and death from COVID-19.

The impacts of obesity go far beyond the health sphere. Living with obesity can influence a person's life chances, ability to work and attainment. At a societal level, medical costs combined with productivity losses mean the wider cost of obesity to the UK is around 3 per cent of its GDP (£60 billion in 2018). There is also a stark inequality in obesity prevalence, with those from the most deprived backgrounds more likely to live with obesity, largely due to the wider drivers of inequality that influence poor health.

But despite excess weight being so widespread, significant stigma is still associated with obesity. Much of the stigma is rooted in a lack of understanding of the complex causes of obesity. The landmark 2009 Foresights report mapped over 100 factors that influence energy balance, including a person's genetic make-up.

Yet much of the public and political discourse focuses on individual behaviour. A lack of knowledge or willpower are commonly cited as causes of obesity, erroneously framing living with obesity as a choice that can be fixed by campaigns telling people to make better 'choices.'

The UK population has not suffered a collective failure of self-control in the last 50 years. What has been transformed is the environment in which we live with changes in how we work and travel and a seismic shift in the food system.

The majority of us live in an environment where high calorie, nutrient poor food is readily available and cheap. Our high streets are dominated with fast-food outlets, supermarkets stuffed with deals on sugary foods and everywhere we turn we see adverts telling us we deserve the chocolate, we've earned the pizza, our teenagers will magically become communicative over a burger. And this is all available with minimal effort, simply tap an app and a delivery will appear on your doorstep.

Caroline Cerny
Alliance Lead,
Obesity Health Alliance

"It is now vital that the Government does not waver in its commitment to addressing the drivers of obesity and ill health and avoids allowing itself to be steered off course by the industry giants that profit from the unhealthy status quo."

We have a paradoxical system that encourages and facilitates people eating more, while simultaneously blaming them.

Governments must play a key role in addressing the structural factors that drive obesity. Just as government intervenes to ensure that the water we drink is clean, the cars we travel in are safe and that we can work and socialise in smoke free spaces, it also has a role to play to ensure our food system does not make us ill.

After the success of the soft drinks industry levy in reducing sugar in soft drinks by nearly 29 per cent, the Government has committed to regulatory approaches restricting how unhealthy food and drink can be marketed in shops, on TV and online, along with additional investment in weight management and support services. improved diet.

These policies are supported by health charities and medical organisations and largely welcomed by the public, who want to live in an environment that facilitates health. It is now vital that the Government does not waver in its commitment to addressing the drivers of obesity and ill health and avoids allowing itself to be steered off course by the industry giants that profit from the unhealthy status quo.

These new approaches all represent small steps, but together they signal an acceptance that while obesity is not a choice we make, it is not inevitable. After 30 years of ineffective approaches, false starts and u-turns, we are finally starting to head down the right track. It's now time to accelerate towards a goal of improved health for everyone.

Lessons from Hepatitis C elimination in Tayside: Building community health in Britain

Eliminating a virus is a rare and difficult challenge. Tayside in Scotland has achieved WHO elimination targets for the Hepatitis C virus (HCV) 10 years ahead of the global target, becoming one of the first regions in the world to do so. Tayside's experience offers evidence that a clear, collective vision and collaborative effort can overcome daunting odds.

HCV is a blood-borne virus that can seriously damage the liver with fatal consequences if left untreated. It is spread mainly through blood from an infected person and in developed countries the main route of transmission is recreational injection drug use.

HCV is often referred to as the "silent epidemic". By December 2006, an estimated 50,000 people in Scotland and 71 million globally had been infected with HCV. But many who are infected are unaware they have contracted the virus, and often show no symptoms over long periods. The outcome of HCV varies considerably between individuals – while the infection clears spontaneously in approximately 25 per cent of individuals, the remaining 75 per cent become chronically infected, leading to the development of serious liver diseases, including cirrhosis and hepatocellular cancer over a period of 10 to 40 years.

While there is no vaccination for HCV, the discovery and introduction of directly acting anti-viral treatments (DAA) in 2015 has created a revolutionary new era in treatment. DAAs have demonstrated their safety profile, have short treatment durations and are curative in over 97 per cent of people. Their advent raises the possibility of using treatment as prevention, turning the epidemic off at its source by treating individuals who still actively use drugs and are the main source of new infections.

However, although treatment is highly effective, the people most at risk of contracting HCV and suffering its consequences are among the most marginalised and stigmatised in our society, and often find navigating complex healthcare systems challenging. This raises significant challenges when we consider the "how" of eliminating HCV.

In the mid-2000s, conventional wisdom still held that it was not possible to engage people who use drugs in treatment and models of care remained confined to medical specialists operating from hospitals. Challenging this received wisdom has required sustained advocacy with key decision makers.

Our advocacy efforts have focused on establishing the wider societal benefits of changing our approach to HCV treatment. This has involved using case studies to demonstrate the impact of treatment and elimination for individual lives. Together with aligning the case for change with wider policy imperatives, these case studies have been key to releasing significant investment.

Professor John Dillon,
Professor of Hepatology and
Gastroenterology
University of Dundee

Ann Eriksen
Executive Lead and
Commissioner – Sexual Health
and BBV, NHS Tayside
Directorate of Public Health

Ways of working and the views of policy makers have begun to shift, but commitment from frontline staff and health services management to find ways to solve the problem remains essential to providing effective treatment for HCV. It also requires tailoring our response to meet the needs and preferences of the population groups most affected.

The first stage in providing appropriate HCV care is the acknowledgement that the people the service is trying to reach can be fearful of new environments and often have extensive experience of being stigmatised in health care interactions.

Key to Tayside's success in eliminating HCV has been a recognition that individual therapeutic relationships based on mutual respect are key to engaging and maintaining people in care. Positive experiences of diagnosis, treatment and care are important for building trust in the affected community. Word of mouth and peer support from people with

shared experience is the most effective recruiter – combatting persistent myths linked to historical treatment regimens and giving people confidence and motivation to overcome perceived barriers to care.

As knowledge developed, it became clear that because DAAs were very safe and effective, the number of pre-treatment or on-treatment checks could be dramatically reduced. These changes meant that delivering testing and treatment could be rationalised, allowing services to be delivered by a more diverse workforce.

Nursing staff and care workers are able to test and treat, de-medicalising the service and enabling truly community based care – 80 per cent of all testing in Tayside is performed in the community by non-clinical staff working in non-governmental or third sector agencies. These changes allowed services to be made widely available in facilities that were local and familiar.

They are often co-located at sites of drug services or needle exchanges, allowing health workers to liaise with organisations who have existing relationships with people in need of treatment.

Building knowledge of the communities most at risk from HCV, facilitating their access to diagnosis and treatment and the need to underpin new initiatives with data and evaluation has reinforced the need for a multi-partner network to coordinate Tayside's response.

To solve this complex challenge, productive collaboration between academic researchers, NHS clinicians, and public health teams has been essential in attracting significant investment, enabling continuous improvement and evaluating success. This whole system approach to the design and delivery of an intensive treatment programme has been crucial to the effective eradication of HCV from Tayside.

"Key to Tayside's success in eliminating HCV has been a recognition that individual therapeutic relationships based on mutual respect are key to engaging and maintaining people in care."

Leading the way in integrating health and social care

For many years, integrating health and social care has been a cental tenet of reform. From NHS England's Five Year Forward View (2014), to the Long Term Plan (2019), significant attention has been paid to joining up care for the benefit of patients and communities. The White Paper, released in February 2021 marked a deepening in government's commitment to this agenda, whilst building on the NHS' recommendations for legislative change.

Legislation is one crucial element in delivering integration. However, looking at the history of NHS reform reveals that other, tougher obstacles must be overcome for us to succeed.

In the 1990s it was felt that welding together different organisations would make integration a reality. These changes never put the person or community at the heart of the model and often placed organisational form over service delivery. Because of this, they failed to build a sense of shared purpose or consider the values, culture and the motivators for bringing organisations together in service of people.

Long-standing cultural and institutional differences between health and local government can, on the surface, make integration challenging. The NHS is a 'free at the point of use' monopsony, whilst social care is largely means tested, often paid for directly by the recipient, and operating as a regulated market of public and private providers. This builds in complexity from the start and neccessitates partners working effectively across institutional boundaries.

True integration requires a long term sustainable solution for social care, an asset based approach to working with people and a continuous focus on our staff and carers. Making good on the White Paper's ambitions will require bold ambition for positive integration in practice and the removal of obstacles that remain to achieving it. More advanced care systems can play a crucial role in sharing their experience with those at an earlier stage of their integration journey.

In West Yorkshire and Harrogate, the vision described in the White Paper aligns closely with how we are currently working – partners in the NHS, local government and in the voluntary, community and social enterprise sector (VCSE) working closely together to improve health and tackle inequalities, facilitated by mature provider collaborations and transparent and inclusive leadership arrangements. Good governance and good relationships frame everything we do. The former should be helped by legal changes.

Our Partnership brings together NHS, commissioners, providers, local authorities, hospices, the voluntary community social enterprise sector (VCSE) and Healthwatch, at a local place and system level. All, including local political leaders and chairs of health and wellbeing boards, are influential members of our Partnership Board setting strategy and overseeing delivery. Their collective strength provides greater opportunities

Rob Webster
Chief Executive, West Yorkshire & Harrogate Partnership and Chief Executive Officer South West Yorkshire Partnership NHS Trust

"Our experience shows that collaborative working at all levels helps improve the experience of patients, build healthy communities and ultimately save lives."

to deliver on our ambitions, reducing future demand for healthcare by working to ensure that people are given the best start in life, with every chance to remain healthy and age well. Financial management is a collective endeavour and risk is shared for the benefit of citizens.

Over the last five years, partnership working has accelerated with each tangible improvement or challenge we have collectively overcome. This has not been straightforward or easy. It requires constant work and attention. Effective collaborative working has been strengthened by a shared commitment to putting local people rather than organisations – or our egos - first.

Many examples in our system bear this out, including our work on stroke, cardiovascular disease, learning disability and leadership, and our intention to tackle health inequalities head on. COVID-19, with its disproportionate impact on particular groups, including minority ethnic communities and colleagues, added urgency to this

work. Our commission on this topic focuses on real action, from housing and jobs to improved planning, representative leadership and improvements in mental health services.

This solid foundation has been crucial in our handling of the pandemic. Issues like maintaining PPE supply, coordinating testing, helping over 100,000 people shielding, and successfully rolling out the vaccine programme have been led by individuals working for the collective. We have avoided disaster by working to ensure that the resources necessary to work in local streets, neighbourhoods and places are in place.

Investment has been directed towards issues like loneliness and carer support, as well as cancer and urgent care. On top of local place funding, a slug of our transformation money – £2.5 million – has been given to the VCSE sector for its essential work.

The VCSE are equal partners in our work – supporting for example men's mental health as part of our

suicide prevention strategy and the Grief and Loss Support Service.

Partnership working across West Yorkshire and Harrogate is underscored by an entrenched ethical framework, focused on valuing respect, fairness, reciprocity, and collaboration. Shared values helped individual clinical decision makers and multidisciplinary teams maintain confidence and integrity during COVID-19 and will be crucial to accelerating system working as we recover from the pandemic.

We are a mature integrated care system that has navigated its way through the past five years and a catastrophic pandemic. Integrating care is a difficult logistical and cultural challenge. Our experience shows that collaborative working at all levels helps improve the experience of patients, build healthy communities and ultimately save lives. With permissive legislation and social care reform, perhaps we can finally deliver that central tenet of reform – truly integrated care.

Conclusion

Meeting the health challenges of the next decade will require a concerted effort to tackle the drivers of ill health and ensure that health improvements are shared by all communities. Top-down changes to make health a priority across government will need to be complemented by local level innovations targeted at delivering truly citizen centred care.

Some of our most pressing health challenges are global in nature and addressing them will require close engagement with our international partners. As Professor David Heymann argues, the UK can and should use its G7 Presidency to secure international support for better responding to infections wherever they emerge in the world, helping us avoid the catastrophic toll of infectious diseases of which we now far more aware.

International scientific collaboration and investment will be key to meeting another of our most complex health challenges – the impacts of demographic ageing. Cham Herath notes that R&D investment in immunology, neuroscience and clinical innovation will all be central to keeping an ageing population healthy.

However, high-tech, globe spanning policy initiatives will not drive sustained health improvements on their own. Building a healthy population will require examining the determinants of wellbeing at a much more local and personal level. As our contributors point out, social deprivation and inequality remain key drivers of ill health and addressing them will be vital for ensuring that health improvements are shared by all communities.

In this vein, Deborah Arnott argues that reducing smoking rates will necessitate providing targeted support to help disadvantaged smokers quit, including the third who live in social housing and the third who live with poor mental health. In the case of obesity, Caroline Cerny notes that unhealthy weight is closely associated with deprivation and argues that addressing social inequality will be central to tackling this acute health challenge.

Health providers will play an essential role in driving improvements in wellbeing in their local communities. Yet to do so effectively will require active engagement with partners that fall outside the traditional boundaries of health care provision. As John Dillon and Ann Eriksen argue, engaging Tayside's drug injecting community with vital Hepatitis treatment programmes has necessitated collaboration between health teams and community organisations to deliver care that is more sensitive to the needs of vulnerable service users.

Rob Webster's piece shows how successful community engagement and joint working can occur on a larger scale. By fostering close relationships between NHS organisations, local authorities and the third sector, the West Yorkshire and Harrogate Partnership has delivered its ambition of putting the interests of local people first. Collaborative working at all levels has improved the experience of patients, built healthy communities and ultimately saved lives.

As we recover from the COVID-19 pandemic we must not be content to settle for restoring "business as usual" to our health system. We must embrace clinical innovation, new ways of working and the principle of collaboration to make health improvement a shared priority. Only by turning bold thinking into action will we equip ourselves to meet the next decade's most pressing health challenges.

Sebastian Rees
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