After the pandemic: is the new public health system in England fit for purpose? The perspective of England's Directors of Public Health.

June 2023

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Acknowledgements: The design of the survey and the structured interviews with Directors of Public Health were informed by the members of the Advisory Board and Professor David Evans who also commented on drafts of the report for which we are extremely grateful.

We would also like to thank the Association of Directors of Public Health (ADPH) for their assistance in disseminating the survey - although there is no suggestion that the views expressed in this report represent those of the ADPH – and also those Directors who gave up their time and agreed to be interviewed. All errors and views expressed are the responsibility of the author.

The Joseph Rowntree Charitable Trust also provided funding for this study as part of their Power and Accountability programme.

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Executive summary

1. In August 2020, 6 months into the COVID 19 pandemic, the Secretary of State for Health and Social Care Matt Hancock made the surprise announcement that he was abolishing the national public health agency Public Health England which had operational responsibility for co-ordinating England's response to the ongoing public health emergency. This decision was not the result of a wider consultation with the sector on an overarching vision for the public health system, and unlike in previous changes to the UK's public health function it was not accompanied by the introduction of new legislation.

2. In place of Public Health England two new bodies were established which were given different roles: the UK Health Security Agency (UKHSA) - which was charged with focusing on health protection such as the threat from infectious diseases and other potential hazards - and the Office of Health Improvement and Disparities (OHID) which was tasked with improving population health. Although the UKHSA like Public Health England was given the status of an independent agency, OHID was incorporated into the Department of Health and Social Care and placed under the direct control of government ministers. Whilst both bodies were established to operate at a national level, they were both heavily reliant on local government and the NHS to undertake their work.

3. 2 years later, following the passing of the 2022 Health and Care Act the local structures of the NHS were radically transformed with the formal abolition of Clinical Commissioning Groups and the establishment of 44 Integrated Care Systems, underpinned by a loose governance structure, designed to pull together the delivery of health and social care into one system, with a more holistic focus on population health and tackling health inequalities.

4. Together these institutional changes have fundamentally changed how government organises itself to protect the population from health threats and has involved the thousands of employees re-applying for their jobs and being given new roles within new organisations. Over the past year, as the government wound down its response to the pandemic the UKHSA has also seen one of the largest reductions in size and scale of any public sector organisation – a 60% reduction in staff and a £12 billion (or 85%) reduction in funding.

5. This rapid and large scale transformation of the public health function in the middle of the pandemic has occurred with very little scrutiny by Parliament or the media of the impact on the UK's ability to manage the pandemic as well as its ability to prepare effectively for future pandemics and to promote and improve the population's health. A review of Hansard shows that since 2022 there have only been 15 separate occasions in the House of

Commons when the role of UKHSA has been raised and only 3 occasions when OHID has been mentioned.[1] Given the central role of the public health system over the past 3 years and the impact of the decisions take by public health professionals and government ministers on all areas of life this lack of scrutiny is itself an area of concern.

6. Based on a survey and interviews with the Directors of Public Health (DPHs) who have statutory responsibility for public health in local government we sought to understand their views on the following issues:

    - Are the objectives of the new system clear to those working in public health?
    - Is it clear to those working in the system who has responsibility for protecting the public's health at both a local and national level?
    - Can public health specialists working in the new organisations give advice and undertake their roles without undue political interference?
    - Is the new system more or less joined up than the one it replaced?
    - Does the new system make the UK better prepared to respond to a pandemic?

Key findings:

Our survey results identified the following concerns which Parliament and policy makers should take into account when considering the overall efficacy and accountability of the new system:

DPHs are much clearer about the aims and objectives of the UKHSA compared to OHID.

- In relation to OHID 42% of DPHs were either quite unclear or very unclear about its goals and objectives, however in relation to UKHSA 66% of DPHs were either very clear or quite clear about its goals and objectives.

There is a lack of clarity amongst DPHs about who takes decisions at national level.

- Prior to the abolition of PHE over 85% of DPHS were either very clear or quite clear about who took decisions at national level, however, since the creation of UKHSA and OHID now almost 50% of all DPHs were either not very clear or not at all clear about this issue.

A significant number of DPHs are not clear about the legal powers available to them to protect their local populations.

- 44% of DPHs stated that they were not very clear or not at all clear about the legal powers available to them to protect their populations during a public health emergency.

The recent changes to the public health system, including the creation of Integrated Care Systems has made the system less joined up at local level.

- Before the abolition of PHE and the introduction of Integrated Care Systems – 85% of the Directors who responded to the survey found that the system was either quite joined up or very joined up in their local area. After the recent reforms were introduced, 53% stated that the system was now not very joined up or very disjointed.

There was significant concern amongst DPHs about political interference in the work of the new bodies, particularly in OHID.

- 46% of Directors of Public Health said they considered that those working for the UK Health Security Agency had limited freedom to provide advice and data without political interference; with 14% saying that they had no freedom and 25% saying that they had some freedom.

- 33% of Directors thought that those working in OHID had no freedom to provide data and advice to the public without political interference, whilst 44% said that they thought they had limited freedom to do so.

Almost half of DPHs said that they thought the recent changes would make the UK worse prepared for a pandemic than under the previous system.

- Around 47% of those surveyed said that the recent changes would make the UK either much worse prepared or slightly worse prepared to respond to a future public health emergency or the ongoing pandemic.

Conclusions and recommendations:

7. Whilst we found nuances in our discussions with Directors of Public Health about how well Integrated Care Systems were functioning in different parts of the country and also disagreements about the merits of separating off the health protection function, from the health improvement function at a national level, there was a general consensus that in order to make the current system work more effectively there needed to be greater clarity of purpose and a much stronger independent voice for public health free from political interference.

8. Based on these discussions we have identified the following set of 5 recommendations to improve the functioning of the current system, which could be achieved without carrying out another set of widescale reforms which at this stage would likely have further damaging consequences for the system.

- **Set out the aims and objectives of the public health system and who is responsible for what.** Although attempts have been made by government to set out the role of UKHSA and its relationship with the role of the Chief Medical Officer, there is a strong need for policy makers to set out to those working in the system the overall aims and objectives of the public health system, who is responsible for what, who is accountable

to whom and who takes decisions in which instances. A lack of clarity in these areas impedes effective delivery and causes unnecessary confusion.

- **Clarify the role of public health within Integrated Care Systems.** Given the greater focus of the NHS on population health at local level it would greatly assist the day-to-day functioning of the public health system if national policy makers could set out who has responsibility for which public health competencies and who is best placed to achieve success within the current framework.
- **Enhance the independence and transparency of OHID.** Since the health improvement function was moved under the direct political control of Ministers as part of the Department of Health and Social care there is very little information on what OHID is delivering on a day-to-day basis, the resources available to it or its overall impact. To address this lack of accountability, the OHID leadership should be required to report directly to Parliament annually regarding its activities, budget, staffing and its measurable contribution to reducing health inequalities.
- **Ask the Law Commission to review the UK's Public Health Law.** In the light of the recent and hasty amendments to the public health laws during the pandemic and the concerns raised by Directors of Public Health about the lack of clarity about the powers available to them, it would be timely to ask the Law Commission – the independent body with a remit to improve public law - to be asked to carry out a review of the efficacy of the current public health laws. Given that the current public health laws do not take into account many of the changes to the UK system of government since Brexit and the devolution of powers to the 3 nations as well as to cities such as Greater Manchester and London the review should cover all of the UK.
- **Clarify the overall budget for England's public health function for the next 3 years.** It is concerning that budgets for the public health system had not been finalised until just prior to the start of the 2023-24 financial year. Government could provide greater certainty and stability to a public health system which has been majorly impacted both by the pandemic and large scale re-organisation by setting out the financial envelope for the new system for a 3 year period.

5 key principles for building an effective public health system:

9. In addition to providing potential solutions to the current system we engaged with Directors of Public Health during our interviews with them and in a later seminar about the types of principles that could be used order to make public health systems more effective and more accountable. We identified the following 5 principles which we hope will be useful to policy makers when reviewing the functioning of public health systems in general:

- **Administrative simplicity and legal clarity.** It should be possible to ask of each of the public health functions 'who is responsible for what and where do their legal powers come from?' and to receive a clear answer.

- **The link between health protection and health improvement should be built into design of the system.** The pandemic has confirmed that the social determinants of

health fundamentally determine outcomes and this learning should be built into the design of any public health system. Focusing excessively on health protection and health security in the design and resourcing of any system is likely to miss this crucial lesson from the pandemic.

- **The independence of the public health voice needs to be hard-wired into all institutions**. Public confidence is dependent on public health experts being able to offer advice to the public without undue political interference. Although major decisions will always be taken by elected politicians, if the public are to follow government advice and regulations, they must trust that decisions are being taken in the public interest and not for political reasons. As a result, the science and evidence which forms the basis of public health advice needs to be explained to the public by those with the relevant authority and expertise.

- **Avoid duplication and overlap between the health service and public health.** Although it is important that the NHS has a greater focus on the causes of disease and ill health within their local populations, in many instances it does not have the policy levers to achieve change in these areas as these mainly lie with local authorities. To avoid overlap and duplication, there should be a clear delineation between the delivery of health services and the role of public health within local authorities.

- **Support the hidden wiring.** No matter how well designed a system is on paper, personal relationships between professionals working across organisational boundaries will more often than not determine how well it functions, particularly in moments of crisis. Any consideration of how best to improve a public health system should focus on enhancing and supporting these relationships rather than disrupting them.

Introduction and background to public health administration in the UK

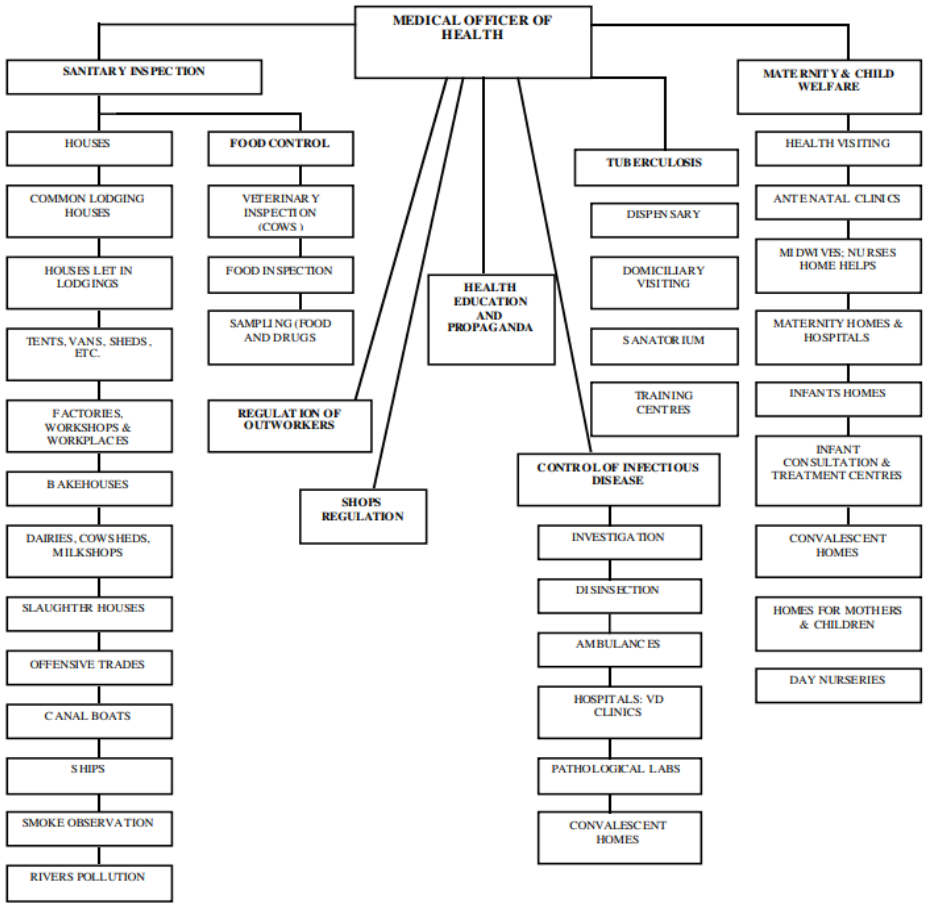
Protecting and improving the public's health is heavily dependent on how it is administered and organised.

10. The way in which government organises itself to protect the population from disease and other hazards and to promote the public's health is often a mystery to most policy makers and to many of those who work within the system.[2]

11. In the late 19th Century and early 20th Century, as public health became a central pre-occupation of the state, there was an administrative simplicity to the way in which things were organised, in the main because the UK state itself was much less complex, with fewer levels of government and none of the many hundreds of agencies now involved in delivering the state's functions. In the absence of a centralised co-ordinating body at national level, responsibility for most areas of 'health protection' and 'health improvement' lay with a Medical Officer for Health who was situated within local government.

12. As figure 1 shows, not only did Medical Officers for Health have oversight of functions such as sanitation, but they also had responsibility for the provision of healthcare services as well as other aspects such as housing (see figure 1).[3]

Figure 1. Diagrammatic representation of the activities of a public health department



Source: B.G. Bannington 'English Public Health Administration' 1929 p.1

13. Since then, as the state at national level has grown in complexity, the public health function has become increasingly intertwined with the national security agenda. Concerns about chemical and biological warfare in the lead up to the second world war led to the creation of the Public Health Laboratory Service and more recently the 9/11 terrorist attacks heightened concerns about anthrax releases and other bio-terror threats which led, in part, to the establishment of the Health Protection Agency in 2004.[4] It could be argued that the recent decision to name the UK's central public health body the 'UK Health Security Agency' is another example of how 21st century policy makers increasingly view public health through the lens of national security.

14. Public health as a function of government has also been dwarfed by the creation of the NHS which not only consumes the vast majority of the state's health budget, but also dominates the thinking of Ministers and the media, whilst the public are also inclined to think about government health policy as being about solely about the health service. This has meant that over the past 75 years policy makers have failed to consider how best to deliver public health when reforming the health service and have instead moved administrative responsibility for public health to accommodate the frequent restructures of the NHS. As a result, over the past century public health has shifted away from local

authorities to the NHS and back again, with some of its functions often sitting somewhere in-between.

15. As the UK has become more devolved over the past 20 years, with the governments in Scotland, Wales and Northern Ireland having now greater autonomy in public health policy, so the complexity of the arrangements has grown. And whilst, the constitutional settlement permitted Ministers in Wales and Scotland to take a very different approach to managing the recent pandemic to the politicians in Westminster, elected mayors in London and Greater Manchester have almost no formal powers in relation to protecting the health of their populations, creating uncertainty about who is responsible for what and why.[5]

16. Whilst there has been significant change to the overall administrative structures since the late 19th century and early 20th century, public health law in the UK is very much based on the laws and regulations of the Victorian era.[6] Where changes to the law have taken place, these have either been because of the UK's international treaty obligations (the implementation of the International Health Regulations, for example) or because of public health emergencies, such as the 2020 COVID pandemic which led to hasty, unplanned and unscrutinised revisions to public health law.

17. Nor have any of these laws been revised to consider the new roles and functions of different parts of the UK administrative system to ensure that there is clarity about where responsibility and accountability lie. At regular intervals throughout the recent history of public health, those reviewing the system have asked for an organogram setting out how it all fits together, but without success.[7]

18. Yet, despite the fact that policy makers and the media seemingly have little interest in this area, the experience of the last 3 years has shown that the way in which the public health system in England is organised is of huge significance. Not only are the UK public health agencies crucial for delivering an effective response to a national emergency, but those who work in them often wield significant power, for example by advising Ministers about whether to limit civil liberties to prevent the spread of infection through mandating vaccines in care homes, enacting lockdowns, closing schools or restricting access to care homes and hospitals.

19. And, as the public health agenda has become more closely intertwined with the health security agenda, with increasing reliance on private companies to deliver some core functions along with the harvesting by the state and private companies of vast amounts of personal data, the need for scrutiny of the system has never been greater.[8]

20. This need for accountability within the system also stems from the highly political nature of public health. Whilst many public health professionals recognise that protecting, promoting and improving public health can only be achieved by deploying strategies to work effectively with national and local politicians, when it comes to decision making there is frequently a tension between scientific evidence and the ideological approaches and political self-interest of those in power.

21. Politicians through the exercise of public health laws in a highly centralised state are able to impose sometimes politically motivated and occasionally arbitrary measures on the population without effective challenge or scrutiny. The ability of the public health profession to offer advice to the public and speak openly without fear of political interference is key for maintaining public trust and confidence in the overall system, whilst limiting political interference is central for preventing the arbitrary use of power by the state.

22. Finally, the overall objectives of the public health system should also be the subject of wider public debate. Despite the fact that the burden of death and disease caused by the COVID pandemic has largely been distributed according to socio-economic status, the approach to public health adopted by the current government appears to give priority to public health as a security issue (health protection) over and above reducing the societal inequalities which are known to be the main cause of ill health.[9] This bias is also likely to be reflected in how the public health system is configured and the extent to which public health resources are distributed in favour of things such as laboratories and diagnostics as opposed to investment in such things as good quality housing, tobacco control and clean air strategies.

Section 1: What changes to the public health system were introduced during the pandemic, why and what do we know about them?

The tri-partite structure of local government, national public health agencies and the NHS going into the pandemic.

23. Whilst mapping the entirety of the UK's public health system is an almost impossible task - due to the range of functions which lie across government - the main responsibilities in England are situated in a tri-partite structure involving central government departments and agencies operating at regional and national level, local government and the NHS. As noted in the introduction, where each function sits within this tri-partite system is frequently subject to change for a range of mainly political, sometimes operational reasons.

24. However, each part of the system is dependent on each other to function. The national public health agencies, provide support to local authorities – especially in the form of providing diagnostics and testing as well as providing them with the consultants in communicable disease control who manage local disease outbreaks – whilst the Directors of Public Health put in place the operational response to public health incidents and use their budget – which comes from the nationally ring-fenced public health grant - to focus on health improvement measures for their local population.

25. The NHS in turn provides the facilities and personnel to treat those affected by disease, as well as administering vaccinations and providing screening services. In addition to this, over the past 2 decades and prior to the creation of Integrated Care Systems, the NHS has also been charged with improving wider population health and focusing on reducing inequalities in access to healthcare services initially through Primary Care Trusts and more recently through Clinical Commissioning Groups.

The background to the current changes – the abolition of Public Health England

26. On 18 August 2021 some 6 months after the start of the pandemic the then Secretary of State Matt Hancock announced that Public Health England would be replaced by a new National Institute of Health Protection, which would have a dedicated focus on "investigation and prevention of infectious diseases and external health threats" with consideration being given to where the other functions of the national public health system – health improvement and prevention – should be established.[10]

27. This announcement signalled the end of the "holistic" approach to public health at national level which had emerged since the creation, first of the Health Protection Agency in 2004 and more latterly the establishment of Public Health England in 2013, whereby the two functions of public health – health protection and health improvement/promotion rested within one organisation.

28. Although the initial proposals for Public Health England – which replaced the Health Protection Agency - was that it would be part of the Department of Health it was eventually

established as non-Departmental Public Body with the intention of giving the organisation some independence from Ministers, although it was directly answerable to the Department and was separately answerable to Parliament.

29. Given that the Department of Health and Social Care set its objectives and mandate each year it still remained subject to political control but was a separate legal entity and had a measure of independence in terms of the work that it did and the advice that it offered both to Ministers and to the wider system.

30. Following a further set of policy revisions, the government announced that whilst the health protection function would be established as an Executive Agency – to be known as the UK Health Security Agency, the remainder of Public Health's England's main functions would be incorporated into the Department of Health and Social Care under the title of the Office for Health improvement and Disparities (OHID) with other functions such as screening and data collection being subsumed into the wider NHS.

31. There were significant objections to the incorporation of OHID into the DHSC raised by the public health community and medical professionals as well criticism of the fact that there had been no consultation on the government's plans – the creation of the UKHSA had been announced via a press release - and the absence of primary legislation to establish the new bodies – as had been the case under previous reforms. [11]

32. However, the Health Minister Lord Markham explained the government thinking as follows in December 2022:

"The option of creating an arm's-length body to sit alongside the UK Health Security Agency was considered, but it was felt that establishing those functions within government outweighed the strengths of an independent ALB."

"In forming OHID, we were clear about the distinct advantages of convening functions […] and the ability to access expert advice, analysis and evidence, alongside policy development and implementation. The decision to make OHID a core part of DHSC was taken because influence and proximity to decision-making matters." [12]

33. One of the other major changes to the public health system which occurred as a result of the pandemic was the creation of "Test and Trace" which became part of the DHSC in May 2020. This was an outsourced function of the pandemic response which, whilst working in collaboration with Public Health England, delivered most of its functions through a series of private contractors who were tasked with carrying out testing services for COVID 19, collecting data on the spread of the virus and to undertaking the contact tracing of infected individuals.

34. To a large degree "Test and Trace" sat outside the wider public health system and around half of its employees were management consultants.[13] It was established at speed because there was insufficient capacity within Public Health England to carry out the mass

population testing required by the pandemic, and unusually it began its life reporting directly to the Prime Minister rather than to the Secretary of State for Health and Social Care. [14] In March 2021 the government announced that Test and Trace would become part of the UKHSA.

Reforms to the NHS at local level – the creation of Integrated Care Systems and Integrated Care Boards

35. Separate to the decision to re-structure the public health system, the government in England had been planning major revisions to the administration of the NHS at local level for a number of years prior to the pandemic. Whereas responsibility for organising the delivery of NHS services since 2013 had been undertaken by GP-led Clinical Commissioning Groups, a decision was taken to abolish these bodies and replace them with new statutory bodies, known as Integrated Care Boards. This policy decision was the result of an acknowledgement that the commissioning of health care services in a competitive market had not delivered the expected benefits and had instead led to greater fragmentation across the NHS. It was recognised by policy makers that separating the NHS into separate "purchasers" (e.g commissioning bodies) and "providers" (e.g hospitals) was less effective in addressing the health needs of the population than through collaboration and integration.

36. This thinking led to the idea of developing Integrated Care Systems at local level, whereby those involved in both the commissioning and provision of services would work together and focus on delivering health care services from a wider population perspective. These changes were introduced gradually from 2017 onwards and were formalised under the Health and Care Act 2022.

37. From the perspective of public health, this change had two implications. First, it introduced new statutory bodies at local level for the delivery of health services – again in the middle of a pandemic - which would play a key role in both ensuring the delivery of some public health functions (such as vaccinations and screening) as well as having key responsibilities under emergency preparedness legislation. And second, Integrated Care Boards were also tasked with focusing on wider population health issues – the usual domain of local authority public health – which created uncertainty about the respective responsibilities of the NHS and local authorities. Whilst the intention behind this new system was to remove these boundaries, for those working in the public health system in local authorities engaging with these new administrative bodies added to the wider challenges of ensuring that the overall system was joined up at local level.

Why were these changes introduced?

38. Unlike the previous significant changes to the public health system in England – in particular the creation of the Health Protection Agency in 2004 – no White Paper or public consultation was published by government setting out a clear policy rationale for the reforms. This meant that there was a risk that there would be a lack of a shared

understanding amongst those working in the system as to the motivation behind these changes and what government hoped to achieve.

39. Work by Peter Littlejohns et al in 2023 suggest that there were two competing narratives behind the decision to abolish Public Health England. The first was that Public Health England had failed in its response to the pandemic, in particular, 'its inability to scale up its test and trace operation to the required level, an inability that revealed structural flaws in its organisation'. The second was a more sceptical interpretation which saw the decision primarily as a piece of blame-deflection behaviour on the part of policymakers. [15]

40. Our survey of DPHs also found that a number of those who commented on the changes were of the view that there was no policy rationale for them but, instead that the motivation was purely political in the context of the government's response to the pandemic. For example, one DPH commented that:

> *"I can only speculate that it was a political decision to disband an arm's length body right at the height of pandemic, where there was less government (and therefore political) control and more opportunity to provide an evidence based view, that wasn't biased by political rhetoric."*

41. However, others were clearer about the need to establish the UKHSA as a distinct operational body focused on health protection, with other aspects of public health policy moved to another part of government. As one DPH said:

"I think the primary focus was on providing a separate accountable and operational organisation responsible for responding to public health and health protection risks and situations. I believe ministers felt during the pandemic that PHE had too broad a remit and should be split into an operation, emergency and response function (UKHSA) with the 'longer burn' policy functions moving into OHID closer to DHSC."

The overall impact of re-organising at both scale and pace.

42. An Institute of Government report in 2010 identified that it takes 2 years for the re-structuring of a government department or a government agency to fully recover from the impact of the reforms.[16] It should be noted that this study did not consider the impact of re-designing the entire public health system in the middle of a pandemic and so it is not clear whether it will take longer than 2 years for those working in public health to return to their pre-pandemic functionality.

43. To get some understanding of the scale of the transformation within England's core public health functions it is useful to look at staffing changes.

44. The UKHSA reported in January 2023 that it had reduced the size of the workforce by 60% overall from the peak of the pandemic. Within that reduction the agency achieved a reduction from 11,100 full time equivalent positions to 6,700. The Agency reported that out of those which remained a growing proportion were permanent civil servants –

increasing from 31% in March 2022 to 54%, with considerably fewer agency and consultancy staff being employed. [17]

45. In November 2021, Health Minister Lord Kamall told Parliament that the total staff compliment for OHID when it was first established was 1,230, with three quarters of these (930) transferring from PHE and the remainder being civil servants previously working on Public Health in the Department of Health and Social Care.[18]

46. Because 'Test and Trace' deemed under the government's "Living with COVID Strategy" to be no longer needed in its current and its functions wound down and its contracts with suppliers and staff ended.[19] According to the CEO of the UKHSA the winding up of Test and Trace required a reduction in spending by the UKHSA of £12 billion from April 2022 onwards, which was an 85% reduction in the UKHSA's original budget. This was an unprecedented challenge for any public body, and it led to the UKHSA experiencing difficulties in being able to account fully for its expenditure, resulting in a formal censure from the National Audit Office in January 2023. [20]

47. The destabilisation to the public health system caused by the widespread re-structure was no doubt compounded by the fact that as of March 2023 – at the end of the 2022-23 financial year – the UKHSA board reported that it had still received no indication of what its budget for the forthcoming year was likely to be.[21] From a transparency perspective, Parliament itself was not made aware of the UKHSA's budget for the previous two years.[22] A similar lack of transparency applies to the OHID budget – a review of the DHSC accounts and the parliamentary records gives no indication of the budget allocated to OHID for the past two financial years.

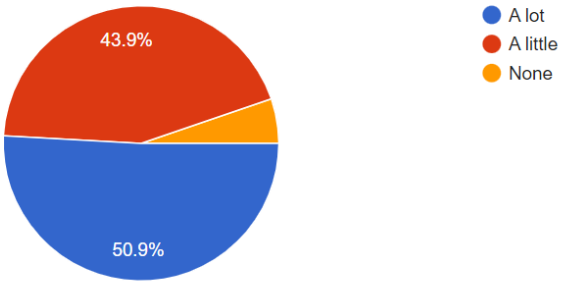
48. Our survey of Directors of Public Health found that in many cases the re-organisation had impacted their work, even though they were not directly employed by Public Health England or its replacement bodies. Thus, over half of the DPHs found that the reforms had caused a lot of disruption to the delivery of public health services in the preceding 2 years.

49. The general lack of parliamentary scrutiny and accountability of both the new parts of the new system remains a concern particularly because of the critical role they play in preparing for any future pandemic and the fact that parliament and the media failed to interrogate the efficacy, budget and organisational capacity of Public Health England in the run up to the COVID 19.

Question 2c) How much disruption, if any, have the recent changes to the public health system caused to the delivery of public health services over the past 2 years?

Copy

57 responses



Section 2: The views of Directors of Public Health on the new system following the abolition of Public Health England

50. In order to understand how the new changes to the system were working in practice we undertook a survey and interviews of Directors of Public Health - the most senior healthcare professionals with responsibility for public health within local authorities in England.

51. Based on the findings from previous studies into the organisation of public health in the UK, the recent research which had been carried out into the perceived motivations for the introduction of the new systems and the concerns which had been expressed to us by Directors of Public Health, we wanted to understand more about their views on the following areas:

    - Are the objectives of the new system clear to those working in public health?
    - Is it clear to those working in the system who had responsibility for protecting the public's health at both a local and national level?
    - Can public health specialists working in the new organisations give advice and undertake their roles without undue political interference?
    - Is the new system more or less joined up than the one it replaced?
    - Does the new system make the UK better prepared to respond to a pandemic?

52. The survey was sent to 121 Directors of Public Health in England between October and January 2023 and we received 57 responses to all the questions set out below. We also undertook 11 semi-structured interviews with DPHs between December 2022 and January 2023 and presented the findings of the survey to 15 DPHs as well as public health academics in March 2023.

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Section 2 a: Clarity about the aims and objectives of the UKHSA and OHID amongst Directors of Public Health: who takes decisions at national and local level?

53. Like any part of government, if the public health system is to be effective, there needs to be a clear understanding of the aims and objectives of the main organisations amongst those at local level. Whilst it is without doubt that the newness of both OHID and the UKHSA are likely to mean the new identities of the organisation will take time to emerge, a negative consequence of major structural re-organisation is a short-term loss of clarity about what different parts of the system are there to do, which can cause duplication and confusion which in turn impacts on operational delivery.

54. According to our survey there is a lot more work to be done to ensure that the roles of the two new organisations are clarified and understood. In relation to OHID 42% of DPHs were either quite unclear or very unclear about its goals and objectives.

55. Directors were clearer about the purpose of UKHSA, with 66% stating that they were either very clear or quite clear or very clear about its goals and objectives – which perhaps reflects the fact that this organisation has been given a tighter focus than OHID in relation to infectious diseases, emergency preparedness and wider health threats in the light of the pandemic response.

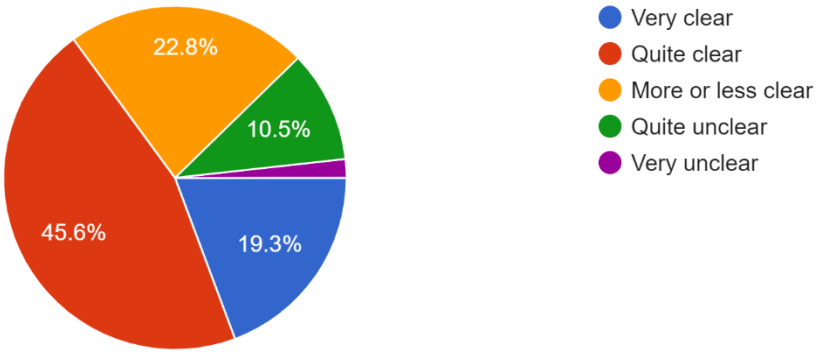
56. This is reflected in one of the comments by a DPH who stated in response to a question about the motivations behind introducing the re-organisation that:

"I think the primary focus was on providing a separate accountable and operational organisation responsible for responding to public health and health protection risks and situations. I believe ministers felt during the pandemic that PHE had too broad a remit and should be split into an operation, emergency and response function (UKHSA) with the 'longer burn' policy functions moving into OHID closer to DHSC."

57. Another DPH commented *"UKHSA has a remit letter OHID doesn't"* explaining that the government itself has taken greater steps to clarify UKHSA's goals than OHIDs through issuing it with a clear remit.

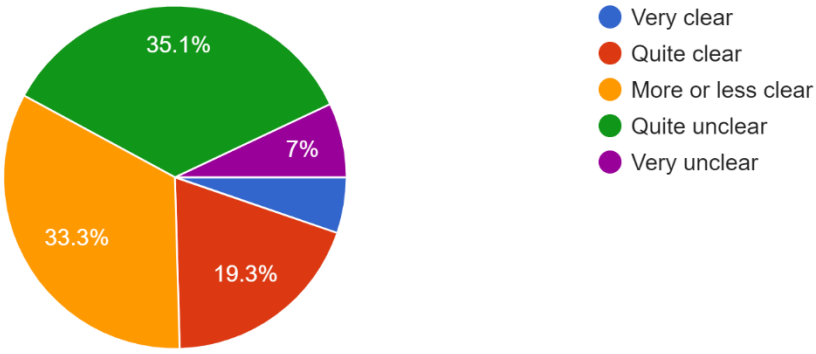
Question 1a: Are you clear about the goals and objectives of the UKHSA?

57 responses



Question 1b Are you clear about the goals and objectives of the OHID?

57 responses



58. Another important feature of an effective public health system, particularly during an emergency, is the idea of a 'clear line of sight' from those sitting at the top of the national structure to those working on the ground to deliver interventions. Whilst we heard criticisms from DPHs about the "command and control" nature of certain aspects of the UK's response to the pandemic – in particular those in central government having little understanding of the solutions needed in particular localities – it is also the case that confusion about who takes decisions at the top impedes the effectiveness of the overall system.

59. The key players who sit at the top of the national structure include the Secretary of State for Health and Social Care, the Chief Medical Officer, the CEO of the UK Health Security Agency who is formerly the Deputy Chief Medical Officer and the lead of OHID who is also the Deputy CMO. Whilst the CMO sits within the DHSC and advises the Secretary of State and is the ultimate arbiter for advice on scientific and medical matters and he must also be

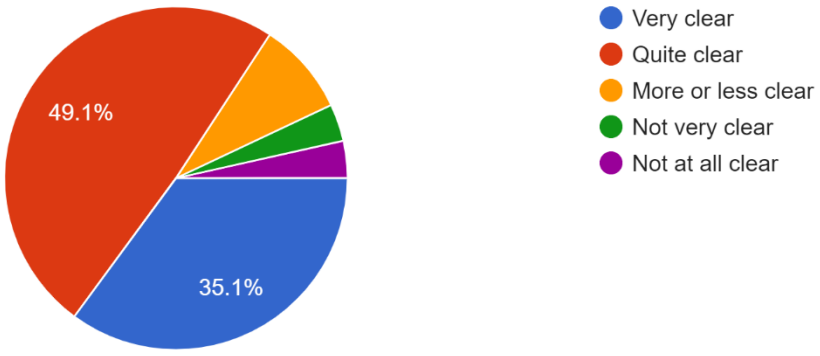
formally consulted on wider health protection strategy.[23] The CMO is also the professional lead for the UKHSA's most senior medical professionals, whilst the Deputy CMO – the co-lead within OHID -is the professional lead for the directors of public health in local government.

60. The role of the CMO, in particular, has always been uncertain due to the fact that it is situated within government but is neither an elected position nor occupied by a civil servant but is instead traditionally the head of the medical profession in England.[24] However, the experience of COVID 19, with the input from advisory groups such as the Scientific Advisory Group for Emergencies – which is chaired by the Government's Chief Scientific Advisor – followed by a rapid and significant transformation of the institutional architecture has led to confusion amongst DPHs about who within this cast of senior players ultimately calls the shots on any given issue.

61. This is shown in our survey responses which identified the fact that whilst under PHE over 85% of DPHS who responded were either very clear or quite clear about who took decisions at national level, since the creation of UKHSA and OHID now almost 50% of all DPHs were either not very clear or not at all clear. It is not certain whether this will change and if national decision making will become clearer to DPHs as the new institutions 'bed in' but the lack of clarity about who takes decisions within such a key part of government requires attention by policy makers.

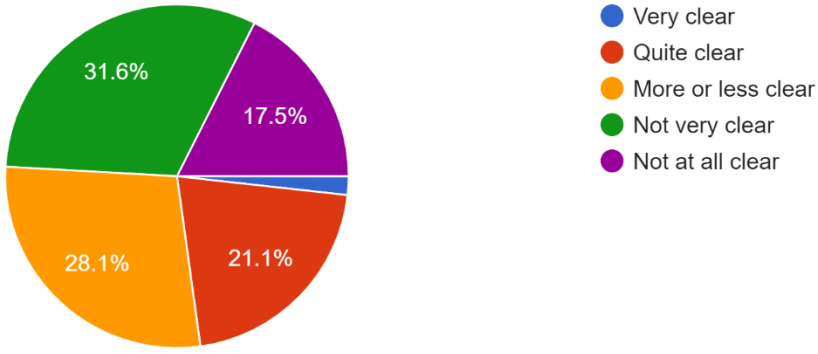
Question 3b) Under the previous organisation of the public health system (i.e. when Public Health England existed) were you clear about who took the decisions at national level ?

57 responses



Question 3 d) Under the new public health structures (i.e. since UKHSA and OHID were created) are you clear about who takes decisions at national level?

57 responses



Section 2 b: Are the current public health laws fit for purpose?

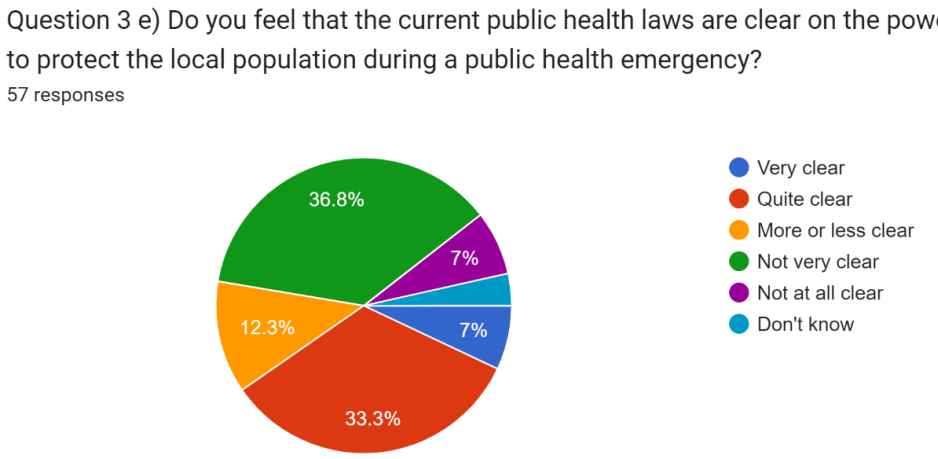
62. The UK's public health laws are vital in ensuring that those charged with protecting the public's health have the tools to be able to direct individuals, businesses and other public services – such as schools, hospitals and care homes - to comply with the requirements to prevent the spread of disease. They are also critical in setting out who has statutory responsibility across the various different layers of government for protecting and maintaining the health of the population. As the purpose of these laws is often to restrict both individual and population movement and behaviour they encroach significantly on the rights and freedoms of individuals and so need to be exercised in a clear and transparent manner, with effective oversight and scrutiny.

63. The current body of laws which lie at the heart of the UK public health system have emerged from the Victorian era and have often been amended as a result of changes to international treaties such as the International Health Regulations or because of Emergency Preparedness legislation for example the Civil Contingencies Act and more recently the COVID 19 Act regulations They currently cover areas of activity relating to food safety, infectious disease and environmental health. On a day to day basis, and outside of a public health emergency, it is Environmental Health Officers based in local authorities who most frequently use these powers.

64. Over the past 3 years, the exercise of public health laws by different levels of government have caused confusion about who has which powers to do what. For example, whilst the devolved administrations in Wales and Scotland used public health laws and other emergency powers to put in place different restrictions on their populations to those in England, including limiting who could enter their geographic territories, there was no such powers available to other regions of the UK.

65. Whilst the elected Mayors in Greater London and Greater Manchester had no powers under public health legislation to impose restrictions on their populations or to arrange testing or tracing within their regions, some Directors of Public Health initiated this amongst their own local communities. Private companies which were asked to undertake certain public health functions such as testing and tracing, were either unaware of or chose not to comply with existing public health legislation.

66. The responses to our survey showed that there was a significant proportion of Directors of Public Health who were concerned about whether the current legal framework was clear about the powers that they had to protect the local population, with 44% stating that they were not very clear or not at all clear about what these powers consisted of.



67. The comments provided by DPHS in our survey and during interviews revealed some of the reasons why some of them held this view. For example, during the pandemic there was confusion about how far the powers of the Secretary of State for Health and Social Care could reach and whether central government departments could require Directors of Public Health to comply with their requirements. One DPH commented in our survey that:

"Under our mandate from the Secretary of State for Health, it's clear that the local director of public health is responsible for making the key decisions affecting the local area all along, though some national and regional bodies seem to believe that they can tell us what to do."

"During COVID I had government departments telling how to do things, failing to realise that they are not my boss and that I am not going to do things which do not fit with the best interests of the citizens that I serve. And I have done things which are at odds with what I have been instructed to do by the DfE and DHSC because I didn't think that they were the right thing to do.

68. Some DPHs also commented on the fact that there is a mismatch between the current tiers of government and the public health legislation.

69. For example, one DPH commented that: *"DPHs remain responsible for local decision-making (on the whole) however I am unclear as to who/where decisions are being made nationally."* Whilst another stated that *"Working in a county the public health legislation is really written for district and unitary councils and neither OHID nor UKHSA appear to understand it anyway.*

70. As new organisations, including ICSs emerge from the changes post the abolition of PHE, some of our survey responses suggested that there is a potential for confusion about who is responsible for using public health powers in different circumstances. For example, one DPH commented that:

"As the recent diphtheria outbreak highlighted there is a lack of clarity at regional and national level with NHSE implementing outbreak control measures via EPPR [Emergency

Preparedness, Resilience and Response – the new powers granted to ICS via the Health and Care Act 2022] and not via UKHSA. This caused confusion at local level and missed key public health considerations."

71. One DPH suggested that a number of legal changes were brought in quickly as a result of the pandemic whilst another suggested that it was time for a review of the existing public health laws to make them fit for purpose:

"Much of the recent legislation made in covid was done quickly and didn't reflect the existing legislation, it was interesting when we had monkeypox. Although there are some rescinded it would be really helpful to have a review and clear update about all the current legislation."

"Although the law is clear, it isn't fit for purpose and could do with updating."

Section 2 c: Is the new system joined up?

"The question is – is it working is it functioning? And the quick answer is no, its cobbled together with blue tack and cellotape on the back of good will and relationships." (Director of Public Health – interviewed January 2023)

72. Since the fragmentation of the public health function across different tiers and agencies of government started to occur in the post war period, one of the major challenges faced by those working in the system has been to ensure that the creation of institutions with responsibility for different parts of the public's health does not impact on the protection and improvement of population health.

73. As noted in the introduction, over the past 70 years there has been greater involvement of national agencies in the delivery and co-ordination of some aspects the public health function (such as the Health Protection Agency, Public Health England and the UKHSA) which need to interact effectively with the local NHS and local government. However, the administrative structure for delivering the public health function at both national and local level has been revised by policy makers in order to accommodate changes to the institutional architecture of the NHS – which continues to dominate ministerial thinking - rather than to specifically enhance how public health services are delivered.

74. Those working at local level have therefore often been faced with the dual challenge of ensuring that the work of local authorities fits together with public health agencies operating at a regional and national level, whilst also building relationships with the NHS structures which have been in almost constant state of flux for the past 25 years. However, as the experience of the pandemic and other recent public health emergencies have shown, a poorly joined up system – at both national and local level - is both inefficient and ineffective in protecting the population's health.

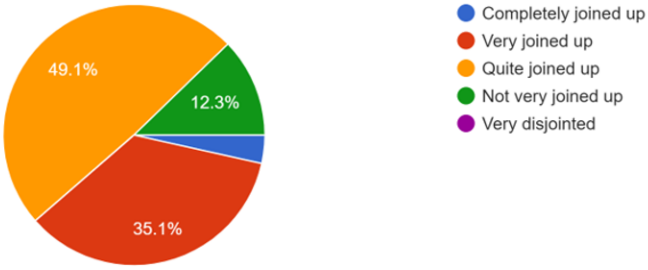
75. The recent set of reforms occurred in the middle of a pandemic and without any prior consultation with those working in public health and they have also involved revisions to the national public health agencies as well as to the NHS at the same time. This has compounded the de-stabilisation which has occurred and has meant that previous relationships between those working in the different agencies have been disrupted.

76. Our survey reveals that the combination of a large scale re-organisation without any clear focus on maintaining a joined-up system has led to significant concerns amongst Directors of Public Health about how well the system functions at local level.

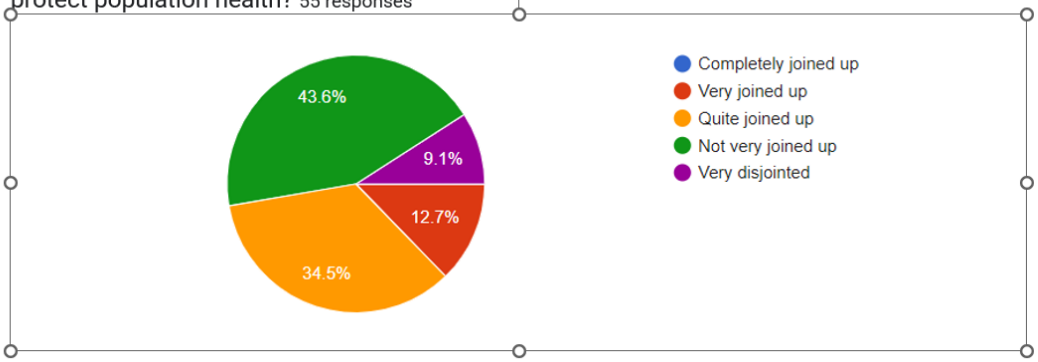
77. Thus, under the previous structures – i.e., before the abolition of PHE and the introduction of ICSs – 85% of the Directors who responded to the survey found that the system was either quite joined up or very joined up in their local area. However, after the recent

reforms were introduced, 53% stated that the system was now not very joined up or very disjointed.

Question 4a) Under the **previous** public health structures - i.e. **before** the creation of UKHSA and Integrated Care Systems - how well did the system work in a joined up way in your local area to improve and protect population health ? 57 responses



Question 4b) Under the **new** public health structures – i.e. **since the creation of UKHSA and Integrated Care Systems** - how well does the system work in a joined-up way in your local area to improve and protect population health? 55 responses



78. Some of these results can be attributed to the disruption in networks caused by the reform process itself. As one DPH commented, the reforms had led to *"[…] a loss of clarity on named points of contact within organisations for pieces of work. Loss of representation from these organisations on key meetings. The loss of key relationships is an enormous challenge within complicated systems."*

79. Other DPHs viewed the nature of the changes – particularly separating the public health function into health protection and health improvement - as creating a large fracture in a previously cohesive system.

"PHE was held up as an exemplar globally and no-one globally can understand why this separation happened – everywhere else everyone is trying to put health protection and health improvement back together."

80. One of the areas of disagreement that we encountered between DPHs was the extent to which the new Integrated Care Systems had improved the delivery of public health services. One of the main goals for introducing Integrated Care Systems was to facilitate a more holistic approach to population health, including requiring the NHS to focus on the wider system rather than just provider organisations such as hospitals and primary care. They were also intended to facilitate joint working between the different parts of the health and care system operating at local level.

81. For some DPHs, the creation of these new bodies had led to significant improvements and permitted a much more joined up system at local level.

"NCL ICS is quite well organised in relation to population health."

"at a place level i think we are doing ok. however new structures take time to bed in, and we are still in the formative stage at the moment."

There are more conversations happening in a joined up way, but the test will be whether these can be turned into actions and commitments.

And my boss is also the lead for the ICB and she she's also the DAS for the local authority and I think honestly, […], I can't speak highly enough. They've been brilliant. I mean, I think some of the days DPH got a bit annoyed because the NHS has stepped into the wider determinants space. But the thing is, people complain about the fact that no-one is interested in the wider determinants but when they are we moan about that too.

82. Others held a fairly strong view that the creation of ICS had merely added complexity to the system, particularly as there was now a lack of clarity about who was ultimately responsible for population health, the ICS or the local authority through the DPH.

"Population health/population health management in the ICS is just public health being reinvented in the NHS, in the NHS's image, without the involvement of public health itself. Fairly typical of the NHS not to believe something exists unless they do it themselves. It's a massive waste of resource/duplication of effort."

"The health protection functions of UKHSA at a local level match closely enough to those of PHE and many of the personnel are the same so a level of continuity has been maintained. This is not the case with the ICS where NHS roles and responsibilities as well as funding is being re-negotiated. There is a risk that Integrated Care Board begin to duplicate local authority public health functions while neglecting their roles for community infection control and prevention, for example."

"The creation of ICSs has been more challenging to a joined up public health system than the creation of UKHSA, in my experience."

"It wasn't great before, but it has gotten worse. The ICSs with their obsession with governance and control have worsened this considerably but the PH system fragmentation has been a major challenge. Instead of having one group of people round the table at

region we now have several. We have determined we will continue local partnership and health protection boards and take charge wherever possible because the new situation wastes time."

"The other factor in the mix (probably the biggest factor) - has been the establishment of ICS. For us - the took a step back in terms of NHS/ LA relations - because we lost 'coterminousity' and much joint work was lost as new people and systems came on board."

83. One of the key findings to emerge both from the survey and the interviews was the fact that the public health profession plays a key role both at local and national level in 'stitching the system' together to ensure that it works effectively, despite the repeated disruption caused by re-organisations. This is achieved by recognising the importance of building key relationships across the different agencies and tiers of government in order to be an effective practitioner.

"We are seeing some slow improvements, but we have had to rebuild joint working arrangements following the reorganisation and there is still work to do to get us back to where we were pre 2021."

"In the North East we have worked hard to establish joined up ways of working. This has facilitated the continued delivery of joint working and close working relationships. This has happened DESPITE the reorganisation rather than because of it."

"There are significant attempts to ensure work is joined up regionally through ADPH, UKHSA, OHID and the Deanery. This is despite national fragmentation and is based on good communication and relationships."

84. One DPH we interviewed spoke of the need for policy makers to take a step back and to consider how all the various new bits of the institutional jigsaw fitted together:

"OK so we have got two organisations now and we have got an ICS and we have got local government. Unless we have someone articulate what each of the roles of each of the bits of the system are and what kind of capacity and skills you need in there, we are just going to end up with a lot of duplication."

Section 2 d: What is the impact of political interference on the new system?

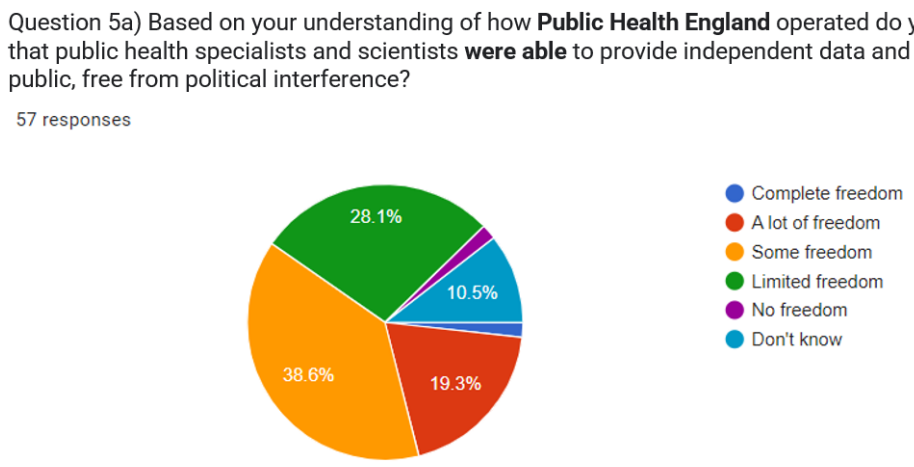
"Public Health England felt more like Public Health, whereas UKHSA and OHID feels like government."

85. Any public health system is necessarily politicised by virtue of being an arm of government. Decisions about which aspects of public health should be prioritised, how much resource overall should be granted to improving or protecting the public's health or which course of action to take in an emergency are all taken by elected politicians.

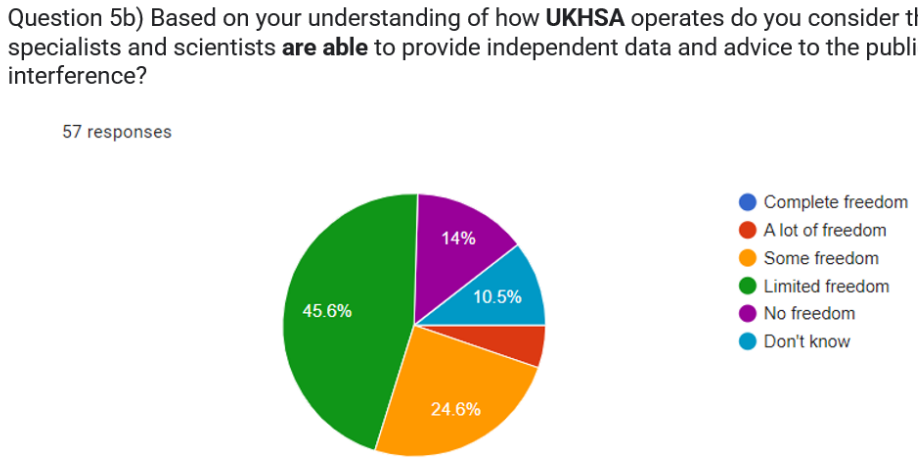
86. As a result, there can be no fully independent public health system, and the extent of independence from politicians is always matter of degree. Given what is at stake when making public health policy, it would be highly problematic if this was to lie solely in the hands of experts and scientists and not be subject to democratic control and oversight. This is true for those working at national level as well as those working within local government, where Directors of Public Health have responsibilities in relation to the public's health but are also answerable to elected council leaders.

87. At the same time, public health is a scientific, evidence-based discipline which is delivered by highly trained experts, who provide data and advice to both politicians and also to the public and the media. Given the declining levels of trust in elected officials, for any public health campaign to be effective the "independent" voice of public health specialists needs to be heard and the public needs to be confident that they are being given advice which is based on the best available scientific evidence. They also need to know that the data is accurate and has not been altered to meet political goals.

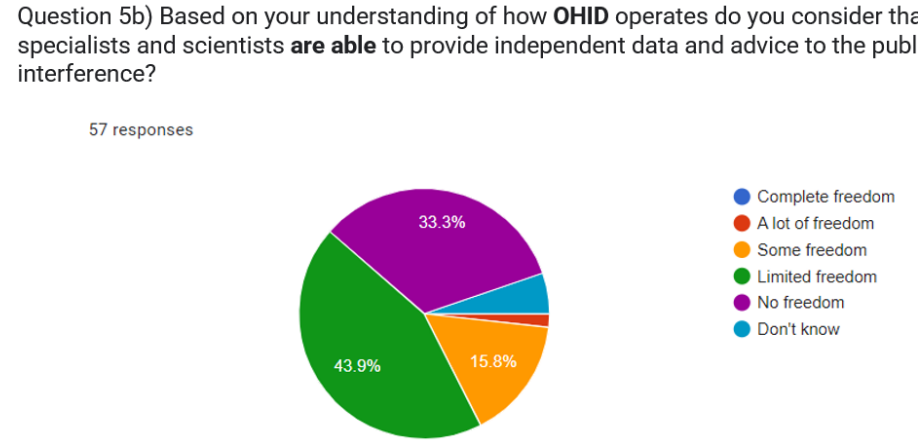
88. In our survey we asked the extent to which DPHs perceived that political interference in the newly created public health agencies had changed since the abolition of Public Health England. 38% of DPHs considered that those working for Public Health England had some freedom to provide independent data and advice to the public, free from political interference, with 28% considering that they had limited freedom.



89. 46% of Directors of Public Health said they considered that those working for the UK Health Security Agency had limited freedom to provide advice and data without political interference with 14% saying that they had no freedom and 25% saying that they had some freedom.



90. Directors of Public Health viewed those working for OHID as considerably more politically constrained than those working at its predecessor body PHE and also at UKHSA. A third of Directors thought that those working in OHID had no freedom to provide data and advice to the public without political interference, whilst 44% said that they thought they had limited freedom to do so.



91. We explored the nature of political interference in the new system during our interviews with DPHs and sought examples of when they had experienced this and why it mattered from the perspective both of their day jobs but also the wider functioning of the public health system.

92. During our interviews we heard examples from DPHs about how during the pandemic, the political self-interest of elected officials overrode the advice of public health specialists and potentially restricted the civil liberties of certain parts of the population illegitimately. Some though that this experience may have set a new precedent in terms of the relationship

between Ministers and public health specialists. In relation to a decision about lockdown restrictions within a particular region we were told that:

"So, during the pandemic, for example, colleagues from what was PHE and became UKHSA were going into meetings with the SoS for Health and saying for example, there is no point in breaking up [x district] into wards; part of the district was put into restrictions and part of it wasn't, which is an absolute nonsense when you look at people's movements and behaviours.

So all they were saying is that there was no point in doing any of them. If you are going to put [x borough] into restrictions, put it all in because at least that's manageable.

But interestingly, they turned around and said we are not going to do that, and the politicians put all of the Labour controlled wards (by hook or by accident, I don't know) under restrictions and kept the Conservative areas out.

There might have been a logical reason to that, and I suppose you could have argued from a deprivation perspective that made some sense but that kind of direct overruling of PHE advice at that point I think have made colleagues a lot more aware of the ability of politicians to kybosh what is essentially a good evidence base."

93. An example of the nature of political interference under the new system given by the DPHs we interviewed was the need for those within the new agencies to gain sign off of advice and communication before publishing it and informing DPHs. This was seen to be a consequence of greater Ministerial oversight of the activities of public health officials and was deemed to be detrimental to the public's health and the functioning of the system.

"OHID is clearly now a department of the department of health and social care– there is no flexibility in the conversation: "well we know that this is what the public health evidence says" everything goes back to well this is what the Minister wants, this is the department line."

UKHSA is slightly different. UKHSA has not yet managed to communicate between national and local, whereby we found out about health protection information by the BBC. What we think is happening is that UKHSA is not able to brief us because they haven't got clearance from Ministers.

For example at the moment I have asked for a briefing from UKHSA on Chinese variant (of COVID) and what is the strategy for Chinese New Year –[…]– there is no strategy there is no clear line on the variant. People will give this to me verbally but not write it down."

"The slow pace of information and support which comes from those organisations I think is tied to some of their political challenges."

94. There was also a view that the decision to move those aspects of public health which were not about communicable diseases into OHID and hence into a part of the Department of Health and Social Care had meant that certain areas of work undertaken by PHE – such as

on obesity and tobacco control – would not now be published. This was due to ministers taking a more challenging attitude towards these aspects of public health.

"I have yet to see OHID produce anything since they have been created and that is one of the concerns. I have seen several big projects from PHE slide backwards – so for example, physical activity programmes – OHID have effectively walked away and gone Sport England, your job – so that the physical activity initiative is completely non-existent within OHID. The work on work and health, health related worklessness again, virtually non-existent now; the work on inclusion health there is no clear narrative.

"At [unidentified Population Health Board] *there was a reference to some work that the OHID learning knowledge team had done in the North West on households at risk of fuel poverty, and the comment was made, that this is waiting for ministerial sign off before we can share it with you. Quite why that would require a ministerial sign off before it could be shared with us seems bizarre."*

95. In addition, one DPH considered that the new structures also reflected a more political attitude to public health and a push from Ministers to focus on certain types of intervention.

"I think that what we've seen is, particularly with the most recent ministers, is that they are far, far more anti kind of public health generally. So then, say for example, now there's this huge emphasis on secondary prevention.

You'll have seen it with the childhood obesity stuff. And you know, these are evidence based policies that have been built by coalitions over many years that are just being kind of knocked into the long grass."

*The information that we've had from, you know, quite senior people is that don't even, don't even attempt primary prevention [*strategies focused on tackling the root cause of ill health*], just focus on secondary prevention [*strategies focused on early diagnosis and prompt treatment*]"*

96. A DPH that we spoke to said that a consequence of moving the national health improvement function into OHID was that this area was now staffed with civil servants rather than public health professionals. We were told that a large number of consultant level public health specialists had either left or been "restructured" out of the new system, leaving those in place much more amenable to government control.

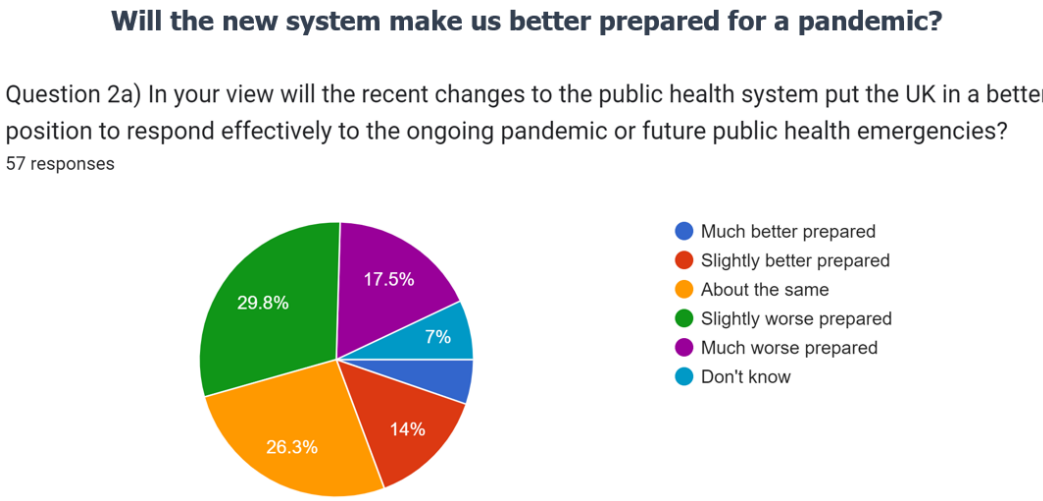
"When I speak to colleagues in OHID they describe themselves as civil servants now – perhaps some colleagues are thinking I don't know what it means to be part of OHID and what it means in terms of my value base and my independence."

"I view OHID now in the same way as I view the Department, their job is now in effect, to support/enforce Ministerial priority. Their job is not to help Directors of Public Health solve wicked challenges which lie outside of Ministerial priorities."

"I think some of this is because they have stripped out a lot of the consultant tier - a lot of the specialists were structured out of the organisation, so what you have got now is an organisation which is predominantly civil servants by career rather than public health specialists."

Section 2 e: Will the new system make us better prepared for a pandemic?

97. If the stated purpose of the reforms was to enable the UK to respond more effectively to a future pandemic, then the Directors of Public Health who responded to our survey were not convinced that this objective was likely to be achieved. Around 47% of those surveyed said that the recent changes would make the UK either much worse prepared or slightly worse prepared to respond to a future public health emergency or the ongoing pandemic.



98. The explanations provided by DPHs for this finding can be broken down into a number of areas.

99. First, a significant number of DPHs raised concerns that by breaking the public health function into discrete parts and placing them in separate organisations this was likely to create fragmentation which would impact on planning. For example, one DPH commented:

"[The] system is more disjointed. As well as a disconnect between national and local there is now more of a gulf between the different organisations nationally and regionally which means planning is not joined up."

100. Another stated that: *"The COVID pandemic showed the need for a whole system approach. The changes have created separation at a national level and between local and regional.",* whilst another commented on the impact that this would have on accountability *"two organisations with lots of grey areas between them means that the potential for duplication and/or lack of clear lines of accountability."*

101. For some this disconnection was problematic because it failed to recognise that responding to a public health emergency such as a pandemic required a holistic response, considering not just the scientific aspects of monitoring, testing and diagnosing a disease

but also dealing with the social and environmental factors which caused the disease to spread. For example, one DPH commented that:

"Separating health improvement and inequalities work from health protection was a backward step. The two have many co-dependencies. For example, infectious diseases like TB, as well as vaccination uptake, are more challenging in deprived areas. Splitting their oversight up into two organisations with different budgets. structure etc inevitably hinders collaboration, effective prioritisation and an appropriately joined-up approach."

102. For other DPHs the separation of the public health function was problematic from an emergency preparedness perspective because it created two smaller organisations out of one large one, leaving less opportunity to create "surge capacity". Under PHE public health specialists who were not working on health protection moved to support the pandemic response once an emergency was declared. One DPH commented the following:

"In the case major incidents such as pandemics, surge capacity will still be required e.g. from local authorities and public health staff working in OHID. In the case of the latter workforce, having them in a separate organisation to UKHSA may actually make it more difficult to quickly mobilise surge capacity if required."

103. Another commented that: "*Those staff who are now employed by OHID will be in a worse position to support a response to a health protection threat."*

104. It should be stressed that there was not general agreement on the impact of separating the health protection from the health improvement function, either in our interviews with DPHs or through our survey. Contrary to the view that separating the two functions into separate organisations caused fragmentation and a possible loss of potential surge capacity, some DPHs suggested that providing UKHSA with a dedicated focus on disease threats both domestically and internationally enhanced the UK's ability to respond more effectively to a public health emergency.

105. For example, one DPH commented that:

"*Pandemic response needs a multiagency approach. Pan flu response responsibility used to sit with DHSC (and DH before that) and now it is being led by UKHSA on behalf of DHSC. Response and emergency preparedness may improve as there is now a dedicated expert agency responsible. PHE's specific role for pan flu response, for example, was unclear."*

106. Another DPH supported this view stating that:

"*There is potential for a more integrated resilience and health protection response, with UKHSA having that dual responsibility,* whilst another stated that: "*I think the command structure through UKHSA may make for a clearer route for operational responses. However, the health protection staff on the ground are largely the same people carrying out the same functions."*

107. A number of DPHs expressed the view that the reforms themselves would make no difference to the UK's success in managing future pandemics as any improvement in future responses would be due to the learning from handling COVID 19.

108. For example, one DPH said:

"The restructuring didn't seem necessary since we already had a functioning [..] health protection system. The pandemic itself has improved our ability to respond, not the restructuring" whilst others said that *""I think the improvements will be as a result of learning as opposed to new structures."*

109. And, irrespective of the nature of the reforms, the issues regarding future pandemic preparedness were seen by some DPHs to be less about the performance of the public health agencies and more about the capacity within central government.

110. As one DPH put it:

"The shortcomings in preparing for the Covid-19 pandemic had less to do with public health organisation than lack of understanding and priority given by government."

Whilst another supported this assertion by stating that: *"What was missing [from the COVID 19 response] was any coherent cross government response (nobody cared about it until it was too late)."*

Conclusion:

111. Radical re-organisation of the public health system in England is nothing new, and contending with regular changes to the administrative infrastructure is accepted as part of the job for many of those working within the system. However, re-organisations have the capacity to destabilise government functions, particularly those which have been operating under high levels of stress for a sustained period of time, as has occurred since the start of the latest pandemic. This may mean that the impact of the latest re-organisation may have longer lasting consequences for public health than those which have occurred in more benign circumstances.

112. Although it is too early to say whether the creation of new institutions, in particular Integrated Care Boards, will lead to improvements in population health, the findings from our research with Directors of Public Health shows there is a significant amount for policy makers to do in order to set out the basics of who does what, what the aims and objectives of the new system are and who makes decisions at national level.

113. Whilst this lack of clarity and administrative coherence has been endemic within the history of public health in England, the experience of operating within such a system during a pandemic has shown the extent to which such incoherence has the potential to hamper the response to a public health emergency. It will be important for the COVID 19 Inquiry to reflect on whether the new arrangements improve administrative coherence, and if not at what possible cost.

114. Finally, the current government's views about the role played by the state in improving the public's health has clearly influenced the shape and design of the new system, with a much greater emphasis being placed on public health as a national security issue and much less focus on intervening in the economy or people's lives to tackle the social determinants of health. This shift has also been reflected in the reduced status of the work previously undertaken by Public Health England on issues like obesity as well as the failure to produce a White Paper on health inequalities. Whether the current structure would suit a government with a more interventionist approach to improving population health remains to be seen.

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