NIHR | Applied Research Collaboration South London

Lessons from the demise of Public Health England: where next for UK public health?

September 2022

This report is based on a six-month research project that reviewed the policies and actions behind the establishment and closure of Public Health England (PHE). Its aim is to provide learning for PHE's successor organisations – the UK Health Security Agency (UKHSA) and Office for Health Improvement and Disparities (OHID) – but its conclusions are much broader, focusing on how public health policy should be enacted in a post-pandemic United Kingdom.

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Executive summary

In August 2020, in the midst of the Covid-19 pandemic, it was announced in *The Sunday Telegraph* that Public Health England (PHE) would be closed. This was the first that staff had heard about the closure of their organisation. In a subsequent speech, Matt Hancock (then Secretary of State for Health and Social Care) said that he was in favour of creating a model that would emulate the Robert Koch Institute in Germany. At the time, the UK and rest of the world were still dealing with an unprecedented pandemic. It was puzzling, therefore, that the national organisation in England responsible for public health should be suddenly terminated with no consultation or discussion. Having been established in 2013, PHE was only seven years old. This study seeks to understand why this dramatic and unexpected event happened in order to identify possible lessons for future public health policy and, in particular, for PHE's successor bodies, UK Health Security Agency (UKHSA) and Office for Health Improvement and Disparities (OHID). If addressed, we hope our findings and insights will enable the new bodies to respond more effectively to the current challenges as well as future ones.

The study was conducted over six months between October 2021 and March 2022 and comprised three stages:

i) a rapid narrative review of the literature;

ii) interviews with senior public health officials, academics, and commentators; and
iii) a stakeholder workshop where preliminary findings from the first two stages were presented to invited participants as a sense-check and to identify any gaps or misconceptions in the findings.

The rapid literature review and interviews were subjected to thematic analysis and Kingdon's Multiple Streams Framework was adopted, comprising three streams: a problem stream, a policy stream and a political stream. There was a broad consensus between the three sources of information on what the main underlying issues were. However, whether PHE was destined to fail by virtue of how it was established and funded or because of its much-criticised pandemic response, or perhaps as a result of a mix of the two, remains unclear.

There were five broad underlying issues identified in the research which contributed to the demise of PHE:

- first, severe cuts in public health spending both nationally and locally since 2010 meant that PHE was functioning with reduced capacity across the system by the time the pandemic arrived in England

- second, PHE did not have the capacity to undertake a testing regime of the size and complexity required by the pandemic, the lack of which was the basis of the main criticism of the organisation at the time

- third, the governance of PHE as an executive agency within the Department of Health and Social Care (DHSC) meant that that it was not possible to be truly independent

- fourth, while decisions made by PHE at the start of the pandemic were later considered mistakes (and indeed considered outside the law by a judicial review), at the time there was little information about the nature and possible effects of the SARS-CoV-2 virus and the limited capacity meant that tough prioritisation decisions had to be made

- fifth, the sudden closure of PHE without any form of consultation was widely reported to be due to blame-avoidance behaviour on the part of key actors, principally Dominic Cummings (as former Chief Advisor to the Prime Minister Boris Johnson) and Matt Hancock (as former Secretary of State for Health and Social Care). It was also considered to be based on current political policy favouring the use of the private sector and contracting out functions like test and trace.

The lessons identified from the research, combined with the speed with which UKHSA and OHID were established, suggest that the new bodies may suffer the same fate as PHE unless the lessons are heeded and acted upon.

Background, research aims and methods

Background to project

As part of a portfolio of health policy projects, researchers within the public health and multimorbidity theme at the National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) South London undertook a research project related to the formation and closure of Public Health England (PHE). It investigated why the executive agency (legally part of the DHSC) established in 2013 to "support local innovation, help provide disease control and protection and spread information on the latest innovations from around the world" was suddenly and unexpectedly closed during the Covid-19 pandemic in August 2020. The project was designed to be an exploratory study that aimed to understand the mission of PHE (including its structures and processes) and explore the influences and causes that led to its closure. The study was carried out by a multidisciplinary team of researchers working in health services research, public health, political science, public policy and sociology. The research findings produced several lessons for the two new organisations established to replace PHE, the UKHSA and OHID. The findings will be submitted to the UK Covid-19 Inquiry in to the Government's handling of the pandemic when it makes its call for evidence (Cabinet Office, 2022).

Research project aims

The aims of the study were twofold:

1. To understand the policies and reasons behind the establishment of PHE in 2013 and the circumstances of its sudden closure in 2021.

2. To identify lessons to support the two new institutions established to take over from PHE, the UKHSA and OHID.

Methods

The study included three components:

(i) A rapid narrative review of the literature on PHE

(ii) Interviews with public health experts

(iii) A workshop with key players to present and consider the emerging research findings

Rapid narrative literature review

A rapid narrative literature review approach was chosen rather than a systematic review because of the nature of the information the project was seeking to collect and explore. Normal search processes for published literature (eg Medline) were unlikely to be sufficient, especially given the recent and rapid sequence of events surrounding PHE during the pandemic (although these databases were searched). Instead, a range of sources were utilised based on a cascade approach linked to key articles concerning the closure of PHE and those identified by the collaborators. These sources comprised:

- Government website of policy papers and press releases (42 relevant documents retrieved)

- Parliamentary Select Committee inquiry reports (35 relevant documents retrieved)
- King's Fund publications (12 relevant documents)
- The Health Foundation (4 relevant documents)
- NHS England (8 relevant documents)
- British Medical Journal (6 relevant documents)
- The Lancet (1 relevant document)
- PHE blog (8 relevant documents)
- Published medical and healthcare articles, including Royal College reports (65 relevant documents).

One author (TK, a postdoctoral researcher within the NIHR ARC South London) read all the papers and undertook an inductive thematic analysis (Hayfield, 2021) – coding and theme development was directed by the content of the data.

These themes were discussed with two other authors (PL, DH).

The data were also analysed according to Kingdon's Multiple Streams Framework comprising three streams: problems, policies, and politics (Kingdon, 1997).

Figure 1. **Kingdon's Multiple Streams Framework: problems, policies, politics**

Stream	Definition
Problem	comprises evidence that establishes the existence of an issue that merits attention
Policy	process whereby stakeholders in policy communities involved in the issue discuss ideas, proposals and solutions
Politics	considers the political aspects that may shape agendas, including the influencing role of stakeholders

Kingdon's Multiple Streams Framework analysis

Within political science and policy studies there is a widely used account of how policy change comes onto the policy agenda. According to Kingdon's Multiple Streams Framework , there are three streams of policymaking: problems, policies and politics (Figure 1). Problems can be thought of as the substantive focus of policy, for example, how to improve the health status of the population or how to finance healthcare activity. Policies are the measures, usually in the form of spending or regulation, that governments might adopt in order to respond to those problems, for example, the banning of smoking in indoor public places or the use of prescription charges for raising revenue. Politics refers to the constellation of actors and forces that shape and take the policy decisions, ranging from public mood, the work of lobbyists, politicians and policy makers through to a change in government.

Kingdon suggests that it is usually problems and politics that lead to policy change coming onto the agenda, but it is when the streams converge that we should

expect a change of basic policy. In other words, problems may persist, even though politics change, if there is no available policy option that policymakers can agree on or adopt. The model does not apply to everyday policies that are developed incrementally, but to more fundamental changes, like the phasing out of a nuclear power programme, the deregulation of airlines or the introduction of new policy instruments, like waterway charges or economic instruments for pollution control. The general picture is one of relative policy stability until there is some emerging problem that, combined with the policy and politics streams, brings about relatively sudden change as a 'window of opportunity' opens up and a "product champion" emerges.

At first sight, the demise of PHE seems to conform well to this model. A pandemic on the scale of Covid-19 is the problem of all problems, providing a challenge to governments around the world and requiring unprecedented innovations in policy.

Interviews

The interviews (13 in total) were conducted virtually by two researchers (TK and AK for all, except one when PL replaced AK). All interviewees signed consent forms. If they preferred, their contribution could remain anonymous. But even if their contribution was acknowledged, no views would be directly attributed to them. The results would not include quotations in order to preserve anonymity.

To create an initial list of key people to interview, the literature review analysis was consulted. The list included those who were mentioned often or were prominent commentators on public health policy, and members of relevant government departments and PHE as well as local government. In addition, further suggestions were provided by the project team. At the end of each interview, interviewees were asked who else we should invite for interview in order not to miss anyone with particular knowledge of events. This was cross referenced with the master list of interviewees.

The themes identified from the rapid literature review were used to inform the interview questions in a semi-structured format. This meant that all interviewees were asked the same standard questions, including: 'What is your background in relation to PHE?', 'What do you think about the suddenness of the closure?', 'What could have been done differently by PHE?', 'Was PHE prepared for the effects that the pandemic would have?'. Interviewees were encouraged to refer to any other issues they thought relevant or which had been missed by the set questions.

The interviews were recorded and transcribed. A thematic analytic framework was used (Hayfield and Terry, 2021) and coded according to Kingdon's Multiple Streams Framework: 'problems, policies, politics' (Kingdon, 1997). One researcher (TK) created the themes, and these were validated by two others (CC and AK) from May to July by systematically going through the codes that were created and triaging them to create larger themes.

Results

The results are presented in three parts: from the rapid literature review, from the interviews, and from the workshop.

Results from literature review:
Many of the articles about the closure of PHE were critical of the timing and how it was implemented. While most of the articles took a positive stance on how PHE was actually functioning, there was still criticism of the relationship between PHE and departments of public health located in local government, particularly concerning the sharing of information. The main criticism came from the joint Health and Social Care and Science and Technology select committees' inquiry into PHE's testing policy and its apparent lack of evaluating testing and tracing in other countries. There was also a court case that considered whether PHE guidance around testing patients before discharge from hospital to care homes was legal.

Reported below are the themes collated into Kingdon's three streams.

Problem stream
The unprecedented nature of the pandemic and a perceived lack of an evidence-base for initial management strategies for Covid-19 meant early decision making was difficult.

Due, in part, to the various lapses in preparedness, in addition to widening health inequalities since 2010 affecting health status and life expectancy, Covid-19 hit the poorest communities in the UK hardest.

Policy stream
Central versus local responsibilities - PHE was established as a central resource for public health at the same time as local authorities were also given lead responsibility for public health, transferred from the NHS, where it had been located since 1974.

Clarity of responsibilities between the national and local levels and respective funding issues were never fully resolved pre-pandemic - PHE had to deal with seven years of continued cuts to funding (e.g. a 16% funding cut to PHE, and a 22% cut to the wider local public health system since 2015) (Perry, 2020).

While PHE was an executive agency reporting to DHSC and accountable to the Secretary of State for Health and Social Care, there was confusion over the relationship, which was already being discussed in the wider public health sector in terms of the unequal responsibility on the part of these bodies for responding to the pandemic.

The lack of clarity about responsibility for the widely publicised lack of testing and tracing, and in preparations for the procurement of essential equipment, including personal protective equipment (PPE), and materials needed for testing for Covid-19 and to tackle the disease on the frontline.

Politics stream

Key questions were: Why was a decision to close the national lead public health organisation taken during the pandemic, and who took that decision? Given the evidence concerning the limits and costs of major structural change, why didn't politicians consider reorganising PHE, given that the majority of staff from PHE have been transferred to UKHSA and OHID (although not its leadership)?

When PHE was established, the then Secretary of State for Health, Andrew Lansley, considered that the promotion of a healthy lifestyle was better achieved at a local level with the emphasis being at a national level for infection control. It was intended that PHE would develop a close relationship with local government and its public health work - this was, in part, the intention of the Public Health Outcomes Framework. Obviously, given local government's autonomy, PHE could not oversee or direct its work, but equally it didn't achieve as much as it might have done to develop a supportive relationship, putting pressure on local government by, for example, comparing the performance and achievements of local authorities and indicating where local authorities were doing things from which others might want to learn. These weaknesses in the relationship proved unhelpful in responding effectively to the pandemic, where careful and close coordination between central and local organisations was essential.

A non-influenza pandemic (involving asymptomatic spread) was never really envisaged by the government or their advisors – commentators, including Dominic Cummings and the House of Commons report, considered 'many institutions failed' in this respect.

PHE's lack of independence, combined with having no politician at ministerial level acting as its 'friend' or mouthpiece meant that it was unable to defend itself when criticised (the Secretary of State for Health and Social Care had overall responsibility but was a self-confessed critic of the organisation; the CEO of PHE was a former civil servant and NHS manager and clearly felt for whatever reason unable to fight PHE's corner publicly).

Findings from interviews:

We interviewed a range of public health experts. We have published here only the names of those who have permitted us to do so. A total of 13 interviews were completed:

- David Heymann, former chair of PHE (until May 2017)
- Jim McManus, Director of Public Health for Hertfordshire
- Greg Fell, Director of Public Health for Sheffield, and Vice President of the Association of Directors of Public Health
- Brian Ferguson, Chief Economist of PHE (between 2012-2021)
- David Buck, worked at the Department of Health as deputy director for health inequalities and as an advisor to PHE, currently in the policy team at The King's Fund
- Sian Griffiths, Emeritus Professor of Public Health, CUHK, Associate Board Member, PHE (2014-2021), Past President, UK Faculty of Public Health, Board Member, Public Health Wales

- anonymous – senior public health person in national public health institution
- anonymous – senior public health person in national public health institution
- anonymous – senior public health person in PHE
- anonymous – senior public health person in PHE
- anonymous – senior public health person in NHS England
- anonymous – senior public health person in PHE
- anonymous – senior public health person in NHS England

Senior politicians were invited for interview, as were representatives from UKHSA and OHID, but did not respond to requests.

Four main themes were identified from the interviews:

- The **governance** of PHE meant that by virtue of its close relationship with government it was difficult to give independent advice in respect of the pandemic.

- The closure of PHE was allegedly due to **blame-avoidance behaviour** by key actors, primarily Dominic Cummings and Matt Hancock, concerning actions that were not totally attributable to PHE, such as the failure of track and trace, and the lack of materials to test in the community in the beginning of the pandemic, which meant only those already in urgent care were being tested due to the shortage of tests.

- **Cuts** in healthcare and public health spending since 2010 meant that PHE was functioning at a reduced capacity by the time the pandemic arrived in England and the rest of the UK.

- Decisions made by PHE at the beginning of the pandemic were later considered to be mistakes. However, there was **little information about the nature and possible effects and extent of the SARS-CoV-2 virus** at that time. For example, the decision to test in hospitals and not in care homes, where elderly people were left most vulnerable, is now considered to have been a serious mistake, but at the time there was also a capacity issue and hence a need to prioritise limited testing availability and to protect the NHS from being overwhelmed. Ultimately, the decisions were political choices made by ministers, albeit with little attempt made to communicate honestly with the public on the difficult choices to be made.

Summary of workshop discussion

In order to sense-check our findings from the literature review and interviews, a multi-stakeholder workshop was held online at the end of March 2022. There were 16 attendees, including public health experts and officials, as well as the research group. The list of attendees was collated by inviting the research and steering group members; all the interviewees plus additional public health experts who had not already been interviewed. The research findings and proposed lessons for the new organisations were presented by the Project Leader Peter Littlejohns and the meeting was Chaired by Professor Sir Graham Thornicroft. The workshop was framed around two questions: 'Why was PHE closed?' and 'What are the lessons for the two new bodies which have replaced it?'

Attendees:

- David Heymann, former chair of PHE until May 2017
- Greg Fell, Director of Public Health for Sheffield and Vice President of the Association of Directors of Public Health
- Brian Ferguson, Chief Economist of PHE between 2012-2021
- Sian Griffiths, Emeritus Professor of Public Health, CUHK, Associate Board Member, PHE (2014-2021), Past President, UK Faculty of Public Health, Board Member, Public Health Wales
- anonymous – senior public health person in NHS England
- anonymous – senior public health person in PHE
- anonymous – senior public health person in PHE
- anonymous – senior public health person in national public health institution
- anonymous – senior public health person in NHS England
- anonymous – senior public health person in PHE
- anonymous – senior public health person in PHE
- anonymous – senior public health person in NHS England

A recurring discussion point was that PHE was never set up or funded to be able to carry out mass testing and tracing. It was considered both an unfair and unrealistic expectation of the government to think that PHE could be solely tasked with such a large undertaking. PHE was a £300m organisation that did not have the capacity or funds that were ultimately needed to deal with SARS-CoV-2. The immediate successor to PHE was Test and Trace with a budget of £37bn over 2 years. PHE did what it could do within the limited funding it had available.

The issue of whether or not there was confusion over PHE's structure and function came up repeatedly in discussion. Most participants felt there was confusion, with only one participant disagreeing. The argument advanced by this person was that the objectives were clear for PHE in that it was responsible for both health improvement and health protection, and whether they were successful in their prosecution was the main question to be addressed.

Any confusion surrounding PHE's role was exacerbated by the pandemic, which no one was prepared for. The risk from any pandemic of this size and nature was at the top of the National Risk Register but was focused on an influenza type pandemic. The lessons identified from what happened in East Asia and the SARS epidemic were largely ignored by the UK although could and perhaps should have been learnt from. But to be able to do so requires having in place reserves in capacity that can be quickly triggered. But the ability to act quickly was absent at the start of the pandemic.

There was a consensus around the issues that the two new organisations needed to address and these are presented below.

Challenges identified for the new bodies from the literature review and interviews

The challenges identified by the research team as emerging from the rapid literature review and interviews, and subsequently confirmed at the workshop, are identified below:

1. There needs to be a clearer remit relating to the creation of OHID and UKHSA that would allow for a stronger foundation and a timely coordinated response to crises that avoids fragmentation. This would mean that even with devolved healthcare, with clear remits, a collaborative preventative healthcare model could help aid in further health emergencies.

2. The issue of resourcing in preparation for the changing Covid landscape needs to be addressed. Clarity is required on how everything will function, who is responsible for what, and at what cost. This includes the separation of responsibility for communicable diseases (CDs) and non-communicable diseases (NCDs) under the two new bodies. This separation risks diluting public health skills and expertise by spreading them across different agencies, which could lead to further lack of co-ordination and confusion around remits. This is especially the case when both OHID and the UKHSA have responsibilities over infectious diseases, but will function as separate agencies.

3. Separating CDs and NCDs is a serious mistake since. As the pandemic has shown, there are close links between them when it comes to those people and communities which suffered most in terms of illness and death. A syndemic understanding of diseases and their underlying social factors is pivotal in future disease prevention.

4. There was an element of hope expressed by interviewees that OHID being located within Whitehall as part of the DHSC may be better placed to influence, and have closer collaboration with, ministers. But such optimism was accompanied by the caveat that there is a risk of OHID disappearing into Whitehall and becoming invisible, since it lacks even the limited degree of independence PHE had. To succeed, OHID needs to be both visible and to have allies inside government, such as the CMO for England. How OHID staff will work with public health staff in DHSC also needs addressing, as well as how it will work with local government and its public health teams.

5. If lesson four is addressed, and OHID is seen to be visible, there is the further issue that its working style will be important, especially regarding how it operates across government and builds relationships with other departments and sectors. This will be challenging in a government which is topic and department focused, rather than concerned with cross-government issues.

6. There needs to be a minimum national standard in England in terms of the resources allocated to local authorities and how they can best cater for, and meet the needs of, their communities. This includes recording disease prevention and outbreaks to enable the UKHSA to then monitor and manage lesson three. The last report on the national standard for health was in 2014 by the Regulation and Quality Improvement Authority. This will need to be updated in light of the pandemic, requiring a collaborative effort across public health.

7. Strong leadership is required at the top of both new bodies (the UKHSA and OHID) so that they can represent and safeguard their respective interests in appropriate and optimal ways.

8. Finally, there must be close collaboration between UKHSA and OHID, as well as ministers, if the possible fragmentation noted in lessons four and five is to be avoided.

Discussion

There was broad agreement in the literature consulted and interviews conducted that public health capacity in England had been severely reduced in the years of austerity leading up to the pandemic. It is not surprising that closure of PHE during the pandemic should trigger both criticism of the government and general support for the organisation. However, there were criticisms of PHE's testing policy and the lack of ambition in seeking to ramp up capacity. Whether announcing the closure of PHE and spending £37bn in two years to set up Test and Trace – a new and mainly privately outsourced organisation, which was subsequently merged with the bio-security centre to create the UK Health Security Agency – was a better option, is still under scrutiny. While the literature review was able to assess all the relevant information on the performance of PHE, the information collected in the interviews may have been more biased. The majority of those that accepted the invitation to be interviewed had been closely linked with PHE and may have been more favourable in their interpretation of how PHE had responded to the challenges posed by the pandemic.

Following discussion afterwards within the research team, an argument was put forward by AW that there were two ways of viewing the circumstances around the demise of PHE. The first interpretation is the one favoured by the public health professionals interviewed for the project; the second one emerged from the rapid literature review, particularly from the House of Commons joint Health and Social Care and Science and Technology select committees' report, and the Gardner & Harris judgement. Figure 2 presents the two scenarios.

Figure 2: **Two contrasting interpretations for why PHE was abruptly closed**

Interpretation 1:

There were no sound reasons for the demise of PHE; it was a simple piece of blame-avoidance behaviour on the part of Cummings and Hancock.

The key propositions in this interpretation include:

1. Covid was an unprecedented pandemic on a scale and of a character that was a serious challenge to every public health agency in the world. PHE found it particularly difficult in respect of test and trace for a number of reasons: it was never designed to have the operational capacity to undertake large scale test and trace.

Interpretation 2:

Although PHE functioned well in many respects, it made some serious errors in respect of planning for a novel pathogen and in elements of its initial response to Covid. Against this background, a new body, Test and Trace, had to be created urgently, with which PHE was subsequently merged.

The key propositions in this interpretation include:

1. There is no perfect way of organising public health functions. Any way involves the need for separate organisations to coordinate with one another. PHE should have given more effort to liaising with local authorities in charge of public health locally.

As PHE was separated from local government, it made it more difficult to establish the necessary collaborative working relationships that would prove necessary to develop an efficient test and trace programme. There had been repeated squeezes on public finance as a result of the Coalition government's austerity policy, which had deprived PHE of resources from its inception. The pandemic came with some novel features, most notably asymptomatic transmission, that would make test and trace crucial.

2. The DHSC never gave public health adequate priority and was concentrating, as ever, on the challenges facing the NHS and health care and treatment.

3. The science and modelling capacity of PHE were internationally admired, which is evidence of its strength as an organisation.

4. Against this background, when Covid hit, the staff at PHE worked very hard and did a good job in many respects.

5. When the new Test and Trace system was set up it was given a huge budget that could have gone to PHE, an already established organisation that would have avoided the start-up problems of Test and Trace (PHE had an annual budget of £300m for all its functions while Test and Trace had a budget of £37bn over two years).

6. Much of the hostility to PHE was ideological, coming from the libertarian wing of the Conservative Party, bolstered by its pro-privatisation views. This was exemplified by Dido Harding, who lacked public health expertise, being put in charge of Test and Trace.

2. PHE lacked staff in the test and trace area from its inception in 2013, but there is no evidence that it gave priority to recruiting more or making contingency plans to recruit more.

3. Budgets were tight over the decade, but as is often said, the art of good management is managing with the resources you have.

4. The lack of testing capacity was a result of PHE's bias to science, rather than operational effectiveness. One manifestation of this was its insistence on very high lab standards in testing in the early stages of Covid.

5. PHE was caught in the groupthink that led key policy makers to conclude that the next pandemic would be like flu, and so not asymptomatically transmissible.

6. PHE never really learnt from the East Asian experience, particularly the syndemic nature of the interaction between a coronavirus and pre-existing medical conditions, and the test and trace programme in South Korea, which led WHO to insist that 'test, test, test' was a central part of pandemic strategy.

7. Given the above, there were no sound reasons for abolishing PHE. Instead, it should have been bolstered by the funds given to Test and Trace.

8. Since there were no sound reasons for the abolition of PHE, it follows by elimination that its demise can be explained by reference to motives of blame-avoidance, which were particularly pressing at a time when the government was being criticised for its initially slow response.

7. Against the background of these problems, it would have been unwise simply to have thrown money at PHE. It was better to give it to a separate organisation, headed by someone who lacked the caution of the traditional civil service, with which it could subsequently be merged.

8. No doubt, in conclusion, the closure could have been handled better. It was unfortunate that the staff were given no warning and the decision came as a bolt from the blue. But all organisational change is messy to some degree and results in a fallout of some kind.

In practice, these interpretations are not mutually exclusive and the real story of what happened to PHE probably lies somewhere between the two. What is irrefutable, however, is that two new bodies have been established in haste, and that they will have the responsibility for responding to future public health emergencies as well as improving the public's health in general. While of course Covid is yet to disappear and the threat of new variants is an ever-present possibility, with the ongoing impact of NCDs, such as obesity, remaining a major challenge, it is important not to ignore or overlook the strong links between the two. Those communities hardest hit by Covid were those most deprived and already suffering from poor health and widening inequalities. Getting a grip on future pandemics is not merely a challenge for infectious disease controls, but also for reducing inequalities and tackling the social determinants of health.

Our research highlights the importance of the governance of public health organisations, their relationship to government at all levels (i.e. central and local, and the devolved administrations), and to other national bodies responsible for public health. There is little evidence that these issues of governance have been fully taken into account in the setting up of the new public health bodies, the UKHSA and OHID. Both organisations are trying to establish themselves at a time of considerable political upheaval in the UK and uncertainty in the coming years. The UK Covid-19 Inquiry has the opportunity to examine the new bodies and assess how they should evolve to improve and protect the public's health.

Next steps

The lessons emerging from our project have been disseminated in several blogs and a Viewpoint paper in the Lancet Public Health (published 1 September 2022). These are listed below.

A publication is in preparation that will explore in further detail the public health governance issues.

A copy of our final research report will be submitted to the UK Covid-19 Inquiry when it issues its call for evidence.

Outputs from the project

Papers:

Reforming the public health system in England
Hunter DJ, Littlejohns P Weale A
Public Health Lancet. 1st September 2022, Vol 7 issue9 e797-e800

Two areas of concern are highlighted in this *Lancet Public Health* Viewpoint: the respective remits of the new bodies established to replace Public Health England, and their governance arrangements. Both issues demand urgent attention if the new structures are to succeed and avoid a similar fate to that which befell PHE. But underlying these concerns is a much larger challenge arising from the UK's broken political system. Overhauling this is a prerequisite for successfully improving the public's health.
https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(22)00199-2/fulltext

Blogs:

Designing public health governance: its challenges, consequences and key lessons for the Covid-19 Public Inquiry **(June 2022)**
In this blog public health researchers Jacqueline Johnson, Peter Littlejohns and Albert Weale explore how public health governance in the UK is designed and the implications for the Covid-19 Public Inquiry and how to ensure effective working between government, local authorities, and the voluntary and community sector in managing public health in the future.
https://arc-sl.nihr.ac.uk/news-insights/blog-and-commentary/designing-public-health-governance-its-challenges-consequences

"Bonfire of the Quangos" – let's make a pyre of this perennial ritual **(May 2022)**
In this blog, Toslima Khatun, Prof Peter Littlejohns and Prof David J Hunter argue that public health policy in the UK urgently needs a more strategic approach. The authors draw on early results from their research into the closure of Public Health England, to make practical recommendations with implications for the two new organisations now responsible for leading public health in the UK.
https://arc-sl.nihr.ac.uk/news-insights/blog-and-commentary/bonfire-quangos-lets-make-pyre-perennial-ritual

Evidence – was it really used in the Covid-19 pandemic? A key issue for the Covid-19 inquiry to address **(April 2022)**
In this blog, Prof Michael Kelly, Prof Peter Littlejohns and Dr Sarah Markham, argue that existing knowledge on health inequalities and social differences in the UK was overlooked in the development of policy during the pandemic, and that the Covid-19 inquiry should aim to learn from these mistakes.
https://arc-sl.nihr.ac.uk/news-insights/blog-and-commentary/evidence-was-it-really-used-covid-19-pandemic-key-issue-covid-19

***Gone and even forgotten... what did Public Health England do (or not do) to deserve this?* (March 2022)**

It has been 18 months since Peter blogged about the demise of Public Health England (PHE) and we are at last seeing signs that the end of the pandemic may be near. The promised independent inquiry into the Government's response to Covid-19 has been announced and will be led by Baroness Hallett.
https://arc-sl.nihr.ac.uk/news-insights/blog-and-commentary/gone-and-even-forgotten-what-did-public-health-england-do-or-not

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