behalf of the Secretary of State – but also comprised an additional 'standalone' responsibility for the exercise of local authority functions that relate to public health emergency planning and response.[237] What sounded complicated on paper proved complicated in practice. The blurred statutory overlap between local authority, Secretary of State, and Civil Contingencies Act duties could create significant operational confusion over prime protection responsibility during emergencies (see below).

102. At the national level, a new mammoth public health organisation in the form of Public Health England (PHE) replaced HPA. PHE would combine previously distinct health protection and promotion functions and merge over 5,000 staff from 120 organisations.[238] The new organisation would initially have four directorates: Health Protection, Health and Wellbeing, Knowledge, and Nursing, with cross-cutting responsibility for strategy operations. To ensure geographic spread, PHE had four regional centres (North of England, Midlands & East of England, South of England, and London) while 15 local PHE centres acted as the 'front door of PHE' and partnered with local government, CCGs, the local NHS, and the voluntary sector. However, in reality, most of the agency's resources remained concentrated in the South of England with significant bases in Colindale, Chilton, Porton Down, as well as the planned new campus in Harlow.[239]

103. Responsibilities for communicable disease control were primarily spread across PHE's Health Protection and Operations directorates. The remit of the Health Protection directorate included responsibility for field epidemiology, infectious disease surveillance and control, and emergency response. Regional units within the Operations directorate were charged with preparing for and responding to

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[237] Lancaster et al., 'The development of the system for communicable disease control'; on the broader political context of the reforms see also: Gorsky et al., 'Public health and English local government', 546-551; Middleton, J. and G. Williams, 'England', in Rechel, B. et al. (eds.), *Organization and Financing of Public Health Services in Europe Country Reports* (Copenhagen: WHO Europe, 2018), 5–22.

[238] *Public Health England*, 'Additional Follow-up Written Evidence (PHE0022),' in House of Commons Health Committee, *Public Health* England, Eighth Report (London: House of Commons, 2013), Annex D.

[239] Public Health England, 'Written Evidence (PHE0002)', House of Commons Health Committee, *Public Health England*, Eighth Report (London: House of Commons Health Select Committee, 2013), Annex C; IANPHI, *Public Health England. Evaluation and Recommendations* (Atlanta: Public Health Institutes of the World/ IANPHI, 2017), 6 and 8; Kirchhelle, 'Giants on Clay Feet', 738.

major incidents and liaising with local health protection.[240] PHE also took over HPA's slimmed down public health laboratory network: Colindale continued to host most specialist reference laboratories, regional public health laboratories remained based in large NHS hospitals, and PHE also maintained a food, water, and environment laboratory in York.[241] Overall, PHE would continue to act as a centre of epidemic intelligence, provide specialist reference, global health, and cost-effectiveness services across the UK, and use its health protection teams to support local Health and Wellbeing Boards (HWBs) and DPHs.[242]

104. Although it absorbed many pre-existing structures, PHE also differed from its predecessors in key ways. In addition to its combination of health protection and promotion functions, PHE broke with the post-1950s English tradition of statutory non-departmental public health bodies that were set up by Parliament by being integrated as an executive body within the Department of Health. This not only resulted in far greater political control over PHE activities by ministers, but also meant that all employees were civil servants and subject to the Official Secrets Act – a cause of concern amongst public health workers (see below).

105. Another difference between PHE and its predecessor bodies lay in the career background of its chief executive. According to a 2013 *Lancet* feature, Duncan Selbie had extensive managerial experience across numerous NHS services, appreciated the value of academic research, but had no medical qualification and little public health experience – Selbie himself joked that his public health experiences could fit "on a postage stamp".[243] Selbie's career background was reflected in the health challenges he prioritised during the *Lancet* interview: "reducing preventable deaths from non-communicable diseases and increasing healthy life expectancy by tackling poor mental health, substance misuse, and

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[240] *Public Health England Annual Report and Accounts 2013/14* (26.06.2014), 53; *Public Health England Annual Report and Accounts 2019/20* (26.11.2020), 55; Public Health England, 'Additional Follow up Written Evidence (PHE0022)', in House of Commons Health Committee, *Public Health England*, Eighth Report (London: House of Commons, 2013), Annex C; Public Health England, *PHE Microbiology Services Colindale. Bacteriology Reference Department User Manual* (London: PHE, 2014); PHE Organogram (MHRA, Annex E).
[241] *Public Health England Annual Report and Accounts* 2019/20 (26.11.2020), 17-18.
[242] IANPHI, *Public Health England,* 5-10.
[243] Das, Pamela, 'Duncan Selbie: the new face of public health in England', *The Lancet* 381/9873 (2013), 1175.

reduction of the public health grant from over £3.5 billion in 2015–16 to just over £3 billion in 2020–21 (- 14 percent).[249] Other estimates by the Institute for Public Policy Research spoke of an even more dramatic reduction of £850 million in net expenditure between 2014/2015 and 2019/2020 with the poorest areas in England experiencing disproportionately high cuts of almost 15 percent.[250] Resulting pressures on local public health were exacerbated by an overall 49 percent real term cut in central government funding for local authorities between 2010/11 and 2016/17 and a resulting practice of 'top slicing' whereby authorities reallocated ring-fenced public health budgets to other services broadly impacting health and wellbeing such as trading standards or parks and green spaces.[251] In 2010, *Healthy Lives, Healthy People* had promised to give "local government the freedom, responsibility and funding to innovate and develop their own ways of improving public health in their area." [252] Freedom and responsibility had been granted – but funding was often lacking.

109. Described financial problems were accompanied by pressures on the public health workforce. Similar to previous decades (see above), councils established sharing agreements for public health teams. Alongside reduced salaries for some newly appointed specialists, and a wider fall in the number of public health directors, consultants, and specialists, these agreements led to increasingly thin-stretched local public health services. By 2017, the scaling back of public health staffing, retirements, and recruitment problems had left 17 percent of DPH posts vacant.[253] Although DPH vacancies were subsequently reduced, rising pressures also accelerated a shift of workforce composition. Until 2003, the UK's public health speciality had been a branch of medicine but had been formally widened to include

[249] Local Government Association, *Health and Local Public Health Cuts, House of Commons Briefing 14 May 2019* (London, 2019), 2.
[250] Thomas, Chris, *Hitting the Poorest Worst? How Public Health Cuts Have Been Experienced in England's Most Deprived Communities* (London: Institute for Public Policy Research (IPRR), 2019), https://www.ippr.org/blog/public-health-cuts#anounce-of-prevention-is-worth-a-pound-of-cure [accessed: 30.05.2023].
[251] Buck, David, *The English local government public health reforms. An independent assessment* (The King's Fund, January 2020), 6; Iacobucci, Gareth, 'Raiding the public health budget', *BMJ* 348 (2014), g2274.
[252] Department of Health, *Healthy Lives, Healthy People,* 2.
[253] Middleton, J. and G. Williams, 'England', 16; Peckham et al., 'Views of public health leaders in English local authorities', 850-881.