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Lessons for public bodies from the pandemic response in health

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About this report

The Covid crisis threw public bodies to the forefront of the government's pandemic response. There were notable successes but politicians, civil servants and public body leaders have much to learn from their experience of working together under pressure. This report offers nine key lessons that will help the UK prepare for and then manage the next crisis, drawing particularly on the experience of three public bodies in health.

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Summary

When the pandemic struck, public bodies jumped. But did they jump high enough? Key decisions being taken at the centre of government led to confused accountability and contributed to a culture of blame. There were notable successes but politicians, civil servants and public body leaders have much to learn from their experience of working together under pressure.

Public bodies must earn ministers' confidence quickly at times of crisis and accept stretching demands on their capabilities and resources. Ministers and their advisers, in turn, must understand and trust what public bodies can do. This would make them less likely to opt for risky and expensive new infrastructure like NHS Test and Trace or to embark on distracting reorganisations like the abolition of Public Health England in the middle of a pandemic.

Mobilising the entire public sector effectively in the next crisis will require action now. Government needs better tools to plan for contingencies, align accountabilities, allocate resources and communicate with a single voice. But this does not mean crude central control. Success will rely on credible specialist organisations with the confidence and authority to lead in their spheres of expertise. When called to jump into action in the next crisis, public bodies must do more than ask how high.

Introduction

Coronavirus plunged the UK into crisis in March 2020, taking most of the population by surprise. Even the health service had just a short time to prepare after the first known global case in December 2019.[1] The government response was urgent and covered many areas, from school examinations to business finance and from care homes to prisons. This led to intense political and public focus on some parts of government that were not used to such attention, including public bodies.

Public bodies' performance has been a key determinant of how the UK has fared in responding to the pandemic. It has also been controversial: the now defunct Public Health England (PHE), for example, came under pressure early in the pandemic, particularly over its inability to increase testing capacity but also for system-wide shortages of personal protective equipment (PPE) that were not fully under its control. This report looks at how some key public bodies, including PHE, interacted with government departments and ministers during the pandemic and recommends how such relationships could work better in preparation for, and during, a future crisis. We focus on health as our case study, but draw lessons relevant to all public bodies.

There are good reasons for government activity to be carried out at arm's length in normal times. Some of these are widely accepted – the activity is highly technical, requires political impartiality or needs to be performed independently to establish facts.[2] Others are debated – work is better conducted according to private sector methods, better managed by those outside government or is a political hot potato better kept at a distance from ministers. In a crisis, ministers are held directly accountable for key outcomes and so understandably want greater day-to-day control over them, particularly where they may not trust the relevant delivery bodies. During the pandemic, decisions that would normally have been made by prominent public bodies were centralised, with ministers making more decisions personally.

Shortening the arm of control improved some outcomes. For instance, the Cabinet Office leading the 'ventilator challenge', working with the Medicines and Healthcare products Regulatory Agency (MHRA) as needed, led to a faster and better-informed response – albeit one that proved less necessary than first feared. Bodies that needed to deliver new tasks or work together in new ways required central guidance. But there were also examples of over-centralisation, such as in NHS Test and Trace, where the use of new infrastructure with more direct political involvement may have resulted in worse outcomes than could have been achieved by using existing infrastructure held by PHE and local authorities.

As well as learning the right lessons from the pandemic, it is just as important not to learn the wrong ones. This is a risk given the intense focus that some public bodies have received since March 2020. In the heat of a crisis and when facing political pressure, a minister may give undue weight to their perceptions of a public body's performance under stress. But an optimal institutional structure for crisis response is not necessarily

optimal for normal day-to-day operations. This report draws out emerging lessons for crisis preparedness and response, but we also argue that – in the first instance – public bodies should be optimised for normal times rather than for crises.

The report draws on insights from a range of areas engaged in the pandemic response, but focuses on the distinctive experience of public bodies in health, specifically PHE, the MHRA, and NHS England and Improvement (referred to herein as NHSE&I, as the two bodies operated de facto as one during the crisis). This is not a comprehensive list of the health bodies involved and entails a focus on England rather than the devolved administrations since most health policy is devolved (although some lessons may be transferable). But differences in the constitutions of these three bodies enable us to describe how organisations with a range of structures were able and expected to react. The Department of Health and Social Care (DHSC) also features prominently and we include recommendations for sponsor departments as well as for the Cabinet Office and ministers.

Table 1 **PHE, MHRA and NHSE&I at the start of the pandemic**

Body	Relevant responsibilities	Classification	Size (31 March 2020)
PHE*	Leading on public health aspects of the pandemic response	Executive agency	£4.2bn annual expenditure; 5,546 staff
MHRA	Issuing regulatory judgments on new vaccines and medical devices	Executive agency with regulatory responsibilities	£146m annual expenditure; 1,291 staff
NHSE&I	Delivering essential healthcare services	Executive non-departmental public body	£126bn annual expenditure; 8,120 staff

Source: Cabinet Office, Public Bodies 2020, Gov.uk, 15 July 2021, www.gov.uk/government/publications/public-bodies-2020. NHS England and NHS Improvement were included separately in this data, so we have used a sum of their staff numbers and budgets here. All staff figures are full-time equivalent (FTE). * = PHE was wound up on 1 October 2021.

Our recommendations concern the role of public bodies rather than health policy decisions specifically, focusing on where public bodies and those who work with them can learn more general lessons from what we have observed in health. Some recommendations describe action that should be taken – or avoided – during a crisis itself. The majority, however, describe actions that would leave government and its public bodies better prepared for a crisis, and which should be taken now.

Despite the government lifting all remaining restrictions, at the time of writing the pandemic is not over. A public inquiry will follow and some of the facts discussed here may need to be revised. But early reflection is necessary to inform decisions which are, in some cases, already being made.

Formal governance of public bodies

Public bodies have specific, often unique, governance arrangements, which put them at a greater or lesser distance from direct government control. These arrangements sometimes, although not always, have a legislative dimension. But there are common features: all public bodies are led by an accounting officer, who reports to a principal accounting officer in a sponsoring department. They have specific delegations to make decisions alongside a responsibility to act in the interests of the public sector as a whole.[3] Government has powers to override their independence, including through the ministerial direction process (which was used extensively during the pandemic) if required.[4]

Public bodies comprise all fully or partially government-funded bodies that deliver public services but are not ministerial departments, including publicly owned companies, parliamentary bodies and those reporting to devolved and local government. They are classified according to the Cabinet Office's taxonomy of public bodies.[5] Arm's length bodies (ALBs) are a subset of public bodies that includes non-ministerial departments, executive agencies and non-departmental public bodies (NDPBs) – and therefore all three of our case study organisations.[6]

NHS England is classified as an NDPB, which means it sits outside of DHSC, is not staffed by civil servants, and has more independence from government. Its chief executive is appointed by the NHS England board, although the appointment is ratified by the health and social care secretary. MHRA and PHE, on the other hand, are executive agencies and so legally part of the department, staffed by civil servants and under greater day-to-day ministerial control. The table in the Annex lays out the governance arrangements of our case study organisations in detail.

As previous Institute for Government research has shown, these Cabinet Office categories do not directly correspond with the functions public bodies perform.[7] For example, some regulators are non-ministerial departments (like Ofsted), some are executive agencies (MHRA) and some are NDPBs (the Pensions Regulator). Two bodies in the same Cabinet Office category might also have a different status in legislation. For instance, the government would need to put a statutory instrument before parliament to abolish the MHRA, but it did not need any legislation to abolish PHE, despite both being executive agencies. Many public bodies have little standing in legislation at all, relying on framework agreements that set out bespoke governance and accountability mechanisms for each organisation.

Public bodies have been a feature of British government since at least the 16th century, with some even pre-dating ministerial departments. They now deliver a vast range of government services and regulatory functions. Anxieties around their scope, number and relationship to government have existed for over a century, and recent

governments have sought to reduce the number of bodies, circumscribe their functions and increase their efficiency. A decade ago, their numbers were significantly reduced by the coalition government in what was known as the "bonfire of the quangos".[8]

The Institute first looked in depth at public bodies in two reports around this time: *Read Before Burning* (2010) and *It Takes Two* (2012).[9] These reports highlighted the sheer complexity of public bodies in the UK as well as opacity in their relationship with government. Unclear roles and responsibilities, often inconsistent across different bodies and departments, were too often accompanied by a low level of understanding among participants of how the arrangements that were in place should work. In the 'sponsorship' teams in government departments that oversee public bodies this was worsened, for example, by high staff turnover, lack of induction for key staff and the perceived low status of sponsorship roles.

There has since been some progress on public body standardisation and reform, including a high-level Cabinet Office code of good practice. As a result of Brexit, some have seen significant increases in their responsibilities (for example, the Competition and Markets Authority, CMA, which is now responsible for regulating the UK's internal market and subsidies control regime). But at the outset of the pandemic the configuration of public bodies remained a product of the coalition-era reforms, containing fewer organisations than in previous decades, with a tendency towards relatively closer government control.

The recent reduction in public body numbers has not, however, been reflected in a similar reduction in budgets or headcount.[10] This means that on average those public bodies that remain have become larger and have accrued a wider range of responsibilities (as is clear with Ofcom, or again the CMA). The health system in some ways represents an extreme example of this tendency: NHS England is the UK's largest public body by expenditure by far. But health is also a special case because in direct contrast to the "bonfire of the quangos" it remains a product of the 2012 Health and Social Care Act, which attempted to transfer some accountability for running the NHS away from the health secretary.

The relationship between health bodies at the beginning of 2020 was complex. PHE was responsible for quality-assuring NHS services like immunisation and screening programmes, while NHSE&I provided the data PHE needed to perform its population-level public health analysis.[11] The delegation of responsibility to a collection of powerful bodies established by the 2012 Act came at the cost of clear accountability for the functioning of the system overall, though the public and parliament – as well as subsequent secretaries of state themselves – still saw the health and social care secretary as the crucial steward of the system.[12]

Strengths and weaknesses revealed by the pandemic response

The UK entered the pandemic, then, with a configuration of public bodies that was a product of recent reforms. The "bonfire of the quangos" had left it with fewer ALBs than at any time in recent history. The public expected central government and politicians to remain accountable for major issues arising in the delivery of government priorities by public bodies, and ministers generally accepted and reinforced that view. In this light, and as the pandemic went on to reveal, ministers were not always even aware of the governance surrounding public bodies or the reasons for it, seeing themselves as ultimately responsible and in ultimate control. Under pressure, they tended to decide what they wanted to happen and simply ask the civil service to make it so.

This state of affairs facilitated centralised ministerial decision making during the pandemic, for good and ill. The prime minister, chancellor and minister for the Cabinet Office – alongside the health and social care secretary – swiftly took control of the coronavirus response. There were more decisions to be made everywhere, not just at the centre, but it was clear that key decisions on social distancing, lockdowns, reopening, financial support and other major issues were being taken around the cabinet table or by the prime minister himself, and that the public expected this to be the case.

Ministers were willing and able to act contrary to public bodies' advice when they thought this necessary. One interviewee cited the government's initial decisions not to follow PHE advice regarding Christmas lockdown rules in 2020 and the return to schools in January 2021 as particularly clear instances – albeit not ones in which ministers were proven right. Nonetheless there were still times when ministers felt they had insufficient control over public bodies, which led them to propose centralising reforms such as new powers of direction over NHSE&I.[13] But reforms designed in the heat of a crisis may look misguided afterwards, as the Institute has argued they are in this case.[14]

Delivery departments and public bodies had to work out how best to fulfil their roles in the context of this centralising impetus. Variations in the governance of different public bodies on paper had a less obvious effect on outcomes under crisis conditions than they do in normal times: the fact that NHS England is an NDPB and MHRA and PHE are executive agencies within DHSC did not in itself directly shape the major decisions during the pandemic. Indirectly, however, these distinctions may have affected how the bodies came to be perceived by ministers which, as we will see, was of heightened importance given the intensity of ministerial oversight in the early stages.

Many of the government's achievements were delivered by public bodies. The NHS was able to keep treating patients with Covid and co-ordinate the vaccine roll-out. The MHRA was quick but rigorous in assessing vaccines, helping to build public trust in them. The UK also acted quickly to develop genomic sequencing capability,[15] enabling PHE to make a leading contribution to global efforts to fight the virus.[16] These achievements are all the more notable in the context of funding constraints that had affected the wider capacity of the health system prior to the pandemic. NHSE&I, though somewhat protected in comparison to other areas of the public sector, received lower funding increases than managers believed were needed to

cope with rising demand and technological progress. PHE's core administrative and programme funding fell by 38% in real terms between 2013/14 and 2019/20 – something interviewees felt had significantly reduced its capacity to respond to crisis demands.[17]

Despite the successes, there have been clear shortcomings to the pandemic response that have been acknowledged by those in government. The then Cabinet Office minister Michael Gove, in a speech launching the *Declaration on Government Reform* in June 2021, listed the following problems that the pandemic had laid bare: "PPE procurement, test availability, the clarity of data required for decision making, the structure of Public Health England, the Cabinet Office's own co-ordinating functions."[18] He described these issues as revealing "how confused lines of accountability and the wrong incentives impede effective delivery, especially when policies cross over from being the responsibility of an individual department to other parts of the public sector".

It is striking how much of this diagnosis is structural, relating to public bodies and their co-ordination with government. This report explores these issues further and proposes solutions. In particular we look at:

1. How the heightened role of the centre of government in decision making left the formal governance of public bodies through delivery departments struggling to catch up, resulting in ambiguity around responsibilities.
2. The defensiveness and caution driven by a blame culture during the crisis, which was aggravated by briefing against PHE and could have been mitigated by better ministerial awareness of public bodies, their governance and their capabilities.
3. Limitations to government-wide contingency planning, and the relative lack of ministerial engagement in that, which left gaps in pandemic preparedness.
4. The pressure on sponsorship teams co-ordinating between public bodies and the rest of government, particularly given tension between formal governance and the locus of decision making in practice.
5. Difficulties in recruiting staff at short notice, and in retaining and moving existing staff to where they were needed across institutional boundaries, evidenced by the high number of contractors at NHS Test and Trace but also by some missed opportunities elsewhere.
6. How public bodies' credibility with ministers depended on having built stakeholder confidence and independence before the pandemic.
7. The degree to which successful government responses to the pandemic depended on using existing infrastructure rather than building new capability from scratch, as with the vaccination effort compared to NHS Test and Trace.
8. The disruption inevitably caused by structural reforms, such as the abolition of PHE, running concurrently to the crisis response effort.
9. The delicate balance that needed to be struck in ensuring consistent communications across the whole of government in a crisis, while enabling public bodies to continue to react quickly and decisively in their specialist fields.

Lessons to be applied in preparation for future crises

Many lessons from the pandemic response can be learnt in advance of another crisis, and this section sets out those that can be acted on now.

1. Clarify accountability promptly and publicly

A crisis can put normal channels of accountability under pressure. New activities may be required to respond to the crisis, including activities that cut across pre-existing institutional boundaries or sit outside them. Some existing activities may also become more critical. More intensive central government oversight is therefore likely, as we saw during the pandemic. But normal governance arrangements usually only recognise the relationship between a public body and its sponsor department (DHSC in the case of health bodies), rather than any direct relationship with the Cabinet Office or No.10. The prime minister formally has no direct power over most public bodies – or indeed most policy, operational and spending decisions – and must instead work through departmental secretaries of state. In a crisis situation, this indirect form of governance between the centre and public bodies can become frustratingly cumbersome for all involved.

Public bodies have important but largely unwritten relationships with the centre of government in normal times, as well as during crises. For example, public body staff we spoke to were acutely aware that the Treasury, rather than their sponsor departments, was the ultimate arbiter of major funding decisions. As a result, many carefully cultivate direct relationships with the Treasury. NHSE&I also has a relationship with No.10: this is not mentioned in NHS England's framework agreement, which sets out its relationship with DHSC, but is inevitable given that NHS England represented over 13% of total government spending in 2020/21.[19] However, we heard that these direct relationships sometimes made life difficult for the DHSC staff responsible for oversight of NHSE&I, who felt bypassed.

Ambiguities in accountability at the onset of a crisis may be inevitable. Some DHSC officials suggested the division of responsibilities was generally clear, but others who had worked elsewhere in the department and its public bodies felt differently. A senior member of staff from a health body told us that at the onset of the pandemic "there was initially some parallel processing going on within government, and a lack of clarity about which government group was responsible for what". Sir Jeremy Farrar, director of the Wellcome Trust and a former participant in the Scientific Advisory Group for Emergencies (SAGE), also told the Commons Health and Social Care Select Committee in July 2020 that:

> **"The fragmentation across government has been a challenge. Having separate agencies – Public Health England, the NHS, the Department of Health and Social Care and other elements – means that it has been difficult to cobble together a coalition that can work together when they have been used to working somewhat separately."**[20]

The diffusion of some areas of responsibility in the health system led to some key tasks, such as pandemic planning and maintenance of the stockpile of PPE, falling between the cracks and failing to be properly handled by any single body.[21] New bodies being set up during the crisis, like the Joint Biosecurity Centre, the Vaccine Taskforce and NHS Test and Trace, further complicated matters.

When a crisis occurs some ambiguity of this kind is to be expected initially, but it must be addressed. Pandemic experience is mixed in this regard. As late as June 2021 one interviewee described a Covid-related cross-agency decision making structure that was still in need of work:

> **"There is going to be stuff that we have to spin on a sixpence because the data changed, or because a new political crisis lands, or because we need to get two and a half thousand people into Wembley Stadium without having an appropriate isolation period. That is kind of acknowledged. But I think people are absolutely crying out for a process."**

It falls to the sponsoring department – and in the case of cross-departmental responsibilities, the Cabinet Office – to proactively identify ambiguities in responsibility when they arise during a crisis and clarify them. Departments rightly retain principal accounting officer responsibilities for their public bodies. But in many cases it would be helpful for departments to build emergency clauses into the framework agreements of public bodies to clarify how their relationship with the centre should function in a crisis. This could be done iteratively as framework agreements come up for periodic review. For new bodies, it should be considered at the outset.

If the public, parliament and the media, as well as those within government, understand where the buck stops, it is easier for everyone to learn lessons from a crisis and for leaders to be held accountable. There is already good transparency surrounding responsibilities in health, insofar as these responsibilities are in fact known. PHE receives a remit letter and NHS England an annual mandate from ministers, which are published annually and lay out ministerial priorities and the overall aims of the body for the year ahead. Similarly, ministerial directions (used to permit public bodies to override value for money concerns, among other things) are published in the form of letters from the secretary of state to the relevant permanent secretaries and chief executives of bodies like NHS England, which was given permission to breach departmental expenditure limits in March 2020, for example.[22] An expectation that accountability for any new responsibilities that arise in a crisis should be publicly and promptly disclosed could help to catalyse the necessary clarification at an early stage.

Recommendation 1: Clarify accountability promptly and publicly
It is particularly important during a crisis to be clear who in government is responsible for what. But crises can often create ambiguities. For example, leaders of public bodies are normally accountable to their 'sponsor' department. But, in a crisis, accounting officers often find themselves reporting directly to the centre of government where high-profile decisions and announcements are made. Confusion over responsibilities can make government policy harder to translate into delivery when this matters most, and gaps in accountability can make it harder to learn from mistakes.

The Cabinet Office should work with public bodies and their sponsor departments in normal times to define how the bodies would work to a No.10, Treasury or Cabinet Office agenda if a crisis occurred. This might include, for example, specifying how a body could be instructed or contracted directly by the centre so that lines of accountability accurately reflect where decisions are being made.

When a crisis occurs, ministers should then clarify who is accountable for any new tasks the public sector is undertaking, for example by writing to the relevant select committee(s).

2. Avoid a blame culture

The apportionment of blame began early in the pandemic. PHE, in particular, bore the brunt. Negative briefings suggesting it was to blame for the failings of the government's initial response[23] were quickly followed by the announcement of its abolition, which many staff first found out about in a newspaper article following a leak to the press.[24] One interviewee articulated the experience of several who found that this encouraged "a culture of fear" in the sector, with individuals and organisations less willing to act boldly or deviate from the consensus for fear of being blamed when things went wrong. The Boardman review into Covid procurement also noted that some officials were discouraged from working on Covid by "a reluctance of some civil servants to risk their reputations in handling an emergency where their actions will be subjected to intensive scrutiny at the time, as well as with hindsight".[25]

To encourage the best possible crisis response, ministers, advisers and leaders of public bodies should avoid a blame culture. One interviewee commented:

> "You'd have needed to sit people down round a big table and bang their heads together, and say: 'I don't care. You guys are going to be all right, unless you do something stupid, because we all fail if one of us fails.' I can't imagine [former health and social care secretary Matt Hancock] doing that, particularly when they decided to get rid of PHE mid-crisis. Everybody else would have been thinking: 'Oh, I'd better watch my back then.'"

This is not to say that blame should never be apportioned, but the heat of a crisis is not the time. The leaders government relies on at times of pressure need to know that they will be held accountable, but also that this will not occur prematurely or unreasonably.

To avoid some of the most public casting of blame, there needs to be clarity about what is and is not the responsibility of ministers. This is particularly true in the health system. Alistair Burt, a former health minister, has said that from a ministerial perspective: "Anything that goes wrong anywhere in the Health Service is your fault. Whereas anything that is done well in the Health Service is down to our marvellous NHS staff who do wonderful things despite the government."[26] The diffuse nature of the health system, with decision making spread out across multiple national and local bodies, makes this unfair: ministers cannot be held responsible for everything that happens. But aside from clinical decisions that can remain ring-fenced, the limits to ministerial responsibility become even harder to draw in a crisis.

For example, as health and social care secretary Matt Hancock was heavily engaged in the operational side of NHS Test and Trace in spring 2020, having set a target of delivering 100,000 Covid tests a day by the end of April. The Commons Health and Social Care Committee concluded that this particular target was an "appropriate" intervention "to galvanise the rapid change the system needed",[27] although the prime minister's chief adviser, Dominic Cummings, alleged that Hancock prioritised meeting his target publicly over building a more long-term system.[28] It is at least clear that the high profile of the target received extensive political attention and therefore incentivised staff to game the numbers.[29]

A lack of clarity over whether ministers or civil servants were responsible for decisions was not limited to DHSC. When controversy over exam results in summer 2020 led both the chair of Ofqual, Roger Taylor, and the Department for Education's permanent secretary, Jonathan Slater, to resign but the education secretary, Gavin Williamson, stayed in post, the Institute argued that this reflected a propensity to blame civil servants for political failures, and that Williamson should have gone too.[30] We did not identify such a propensity as clearly in health when researching this report, despite the tendency to blame PHE for failings early in the pandemic.

To help solve these problems of confused accountability, ministers and their advisers must ensure they understand the nature of the bodies they manage, and their responsibilities regarding these bodies, as clearly as possible. This is not always the case, as illustrated for example by Cummings reportedly planning for emergency legislation to take control of PHE before realising it was under ministerial control already.[31] Civil servants should inform ministers on such matters when they first take up their roles and on an ongoing basis, and ministers should respond positively and be open to learning about the institutional landscape.

Recommendation 2: Avoid a blame culture
Ministers need to understand and trust the public bodies that sit within their portfolios if they are to avoid misdirecting blame in a crisis. The pandemic demonstrated that ministers and their advisers are sometimes unaware of which public bodies sit within their portfolio, and their powers over them. They may not realise the importance of this information and civil service briefings are not always successful in ensuring they absorb it.

Ministers' private offices should work with departmental sponsorship teams to ensure ministers learn enough about the public bodies they sponsor, including about their governance and expertise. Ministers should meet leaders of public bodies regularly to build the trusting relationships that are needed when a crisis occurs. Public body leaders should act with confidence that blame for crisis outcomes will not be apportioned prematurely or unreasonably.

3. Collaborate on contingency planning and risk analysis

With hindsight, it is of course regrettable that the UK had not prepared for a novel pandemic in the way that, for instance, South Korea – with its experience of SARS – had. This was despite global indications that the risk was real[32] and a UK government 2016 pandemic planning exercise having recommended a review of the South Korean experience.[33] Instead, the UK's initial response was based on a plan designed for pandemic influenza, rated as the biggest risk to the UK before the pandemic, which as well as being inadequate for the more transmissible Covid-19 coronavirus also dated from 2011 – before the creation of PHE or NHSE&I.[34]

At the public body level, PHE had created more detailed response plans building on the pandemic influenza response strategy before March 2020.[35] It was accustomed to managing local outbreaks alongside local authorities and the NHS,[36] although shared procedures for managing sustained outbreaks on a national level were less developed. PHE published an infectious diseases strategy in September 2019, but the actions it contains were not fully implemented before the pandemic struck.[37] In addition to this, NHS England's 2015 Emergency Preparedness, Resilience and Response Framework contained detailed guidance on who is responsible for what within the NHS and public health system, and the NHS had well understood command and control structures on the ground that operated well during the pandemic.[38] But this document was authored by NHS England alone and did not include anyone from DHSC in its stated "target audience"[39] so it may not have helped to clarify plans at the national level – in central government – where they appear to have been less clear.

There is potential to improve risk management and contingency planning across government – not just in health. The National Audit Office, for example, recently published the results of a cross-government study of pandemic business continuity arrangements, commissioned by the Civil Contingencies Committee in February and March 2020, which found that most plans (82%) were unable to meet the

demands of any actual incident.[40] The Public Accounts Committee noted in September 2021 that "the Cabinet Office does not require departments to provide it with information on the risks in their ALBs, and standardised data on the risks across ALBs still does not exist".[41] The House of Lords Select Committee on Risk Assessment and Risk Planning has also criticised government's overly "centralised and opaque" approach to risk management.[42]

The Cabinet Office and Treasury have since set out their plans to conduct a series of "reviews to examine the effectiveness of the management of areas of significant risk" in ALBs, and to promote good practice on the sharing of risks between departments and their ALBs.[43] But this alone is not enough. Public bodies themselves should conduct more work on shared contingency planning in combination with other parts of government, in recognition that most crises cut across institutional boundaries. As the Institute has previously recommended, transparency around planning exercises and the actions arising from them would also help to reinforce preparedness.[44]

The risks relevant to public bodies can be complex and difficult to compare. Sponsoring departments therefore have an important role in synthesising and evaluating the risks associated with their bodies. Co-ordination should not rely on direct interaction between the Cabinet Office and all public bodies, although the former has an important role to play in establishing who bears lead responsibility for whole-system risks.[45]

Some issues that would otherwise fall through the cracks could be identified and addressed by bringing people together from different bodies. For instance, as well as the crisis planning exercises proposed above, leaders of major public bodies might meet with their secretaries of state as a group every two months to agree key priorities and build senior relationships. The Institute has previously recommended that ministers should be involved in a crisis planning exercise in the first six months of their role[46] and these should include leaders of major public bodies too. Given the multi-purpose nature of at least some contingency plans (as some bodies discovered when they were able to repurpose Brexit-related contingency planning during the pandemic) there remains value in public bodies doing their own contingency planning alongside any central process.

Recommendation 3: Collaborate on contingency planning and risk analysis
Public bodies are often closely involved in departmental contingency planning and crisis preparation but the risks they face are not incorporated systematically into central government risk assessments. This means cross-cutting risks may be underappreciated and contingency planning may be siloed.

The risks facing public bodies should be incorporated into central government assessments of risk. Where the risks are distinctive, public bodies should be directly engaged in central contingency planning and crisis preparation to ensure that responsibilities for mitigation do not fall through the gaps between public bodies and departments.

4. Sponsorship teams should play a brokering role in a crisis

Departmental sponsorship teams are key to public bodies' interaction with government. High-performing sponsors can enable departments to work with public bodies effectively, facilitating the exchange of information to ensure activities are aligned. In a crisis, the role requires skilful pragmatism as normal governance expectations need to be adapted to what is possible. Yet previous Institute research has shown a lack of relevant skills in sponsorship teams,[47] while one interviewee described the role as "necessary but extremely dull". If sponsors are viewed in this way and are, for instance, bypassed in interactions between ministers and public bodies they may be unable to give politically sensitive and up-to-date advice, while formally retaining the responsibility for doing so. The same interviewee recalled one sponsorship team providing procedurally correct advice that "as a result of being divorced from the broader policy context... was completely politically and policy tone-deaf".

Sponsor departments must accept that public bodies will talk directly to the centre in times of crisis and should facilitate that dialogue. The MHRA's work with the Cabinet Office on the ventilator challenge is one example, and the direct communication between No.10 and NHSE&I during the crisis is another. Sponsor departments will need to remain sighted on these interactions and public bodies should not withhold information from their sponsor departments or play central and sponsor departments off against each other. Departments cannot perform their principal accounting officer functions effectively if this happens. But departments in turn should think twice before seeking to control interactions or insert themselves as intermediary gatekeepers between the centre and a public body, especially at pressured moments. For example, when deciding to quickly accelerate booster vaccinations in December 2021 at the explicit expense of other medical appointments, No.10 would have needed to speak directly with NHSE&I as well as with DHSC.[48]

In the case of the ventilator challenge, initial plans were formulated within DHSC. MHRA colleagues realised that they had the expertise to help refine the ventilator specification in a way that would improve the quality of ventilators procured, and so inserted themselves into the process early, working directly with the Cabinet Office. They did so despite not ordinarily being responsible for writing product specifications – and it is to DHSC's credit that they accepted this input.[49] The MHRA's involvement also resulted in an expedited regulatory approval process that could have taken many months being concluded in the space of a few weeks. One interviewee reflected that in many successful government responses "someone has needed to step up to the plate and say 'right, okay, here's how this is going to work'". Ensuring that those who might be able to do so are involved in discussions early is essential. It was right that DHSC did not seek to lead all of these discussions or act as an ongoing intermediary between the MHRA and the Cabinet Office, as this would have slowed down decision making. It was more helpful for DHSC to embrace its role as a convening power, enable connections between the right people in the public body and the centre and ensure both understood what the other was doing and was capable of.

Those we spoke to in sponsorship roles emphasised how they had worked to build collaborative relationships with public body leaders during the pandemic, clarifying where responsibility lay for new issues and seeking to scrutinise rather than to intervene in operational decisions. This approach to sponsorship does, however, depend on the willingness of the secretary of state to accept it. One interviewee described how Jeremy Hunt, when he had recently become health secretary, was briefed by civil servants on the independence of the health bodies in these terms: "We have a new devolved system, and these are the boundaries, and there are some very good reasons for it." In response Hunt "basically said: 'No, I'm not going to do that... I'm the secretary of state.'"

There have been attempts both in departments and centrally to make sponsorship teams more effective, with some success. One interviewee described how DHSC had put in place a central team in the department, close to ministers, to co-ordinate sponsorship teams and ensure they were able to contribute effectively to ministerial interactions. Such departmental 'centres of expertise' on sponsorship were praised in a recent Public Accounts Committee report, which suggested the Cabinet Office should encourage departments to roll them out more widely.[50] We also heard that DHSC had set up a health policy graduate scheme that included rotations in public bodies as well as within the department itself, creating a cohort of civil servants who properly understood both sides of the relationship between sponsor and body.

The Cabinet Office's *Declaration on Government Reform*, published in June 2021, laid out its intention to "commence a review programme for Arm's Length Bodies and increase the effectiveness of their departmental sponsorship, underpinned by clear performance metrics and rigorous new governance and sponsorship standards".[51] The Cabinet Office has made efforts to improve sponsorship teams in the past, following criticism from the Institute and from the National Audit Office (NAO).[52] But in a recent survey, most departments told the NAO that they would welcome more support from the Cabinet Office to share best practice on sponsorship.[53] After the distractions of Brexit and the pandemic, the Cabinet Office is right to bring renewed focus to improving the skills of sponsorship teams.[54]

Public bodies can be a valuable source of expertise to support government's wider decision making in a crisis, and guidance for sponsorship teams should include how they can convene expertise most effectively at such times, bringing public bodies, ministers and officials across government together as decisions are made. The government's more general pandemic experience of convening experts is informative in this regard. Most external experts and ministers would agree with Chris Whitty, co-chair of SAGE meetings during the pandemic, that "the old saw that advisers advise and ministers decide remains".[55] This is an important distinction between the accountability of experts and policy makers, but government learned early in the pandemic that the relationship between the two requires intensive work, particularly where the evidence and its potential interpretation and implications are evolving.[56]

Sponsorship teams can valuably link expertise in public bodies with policy conversations happening in the department. Doing so may result in more voices at the table, but it should be a core skill of policy makers to triage insights effectively having heard them. The costs of excluding relevant expertise – as with NHS Test and Trace – can be large and evident only with hindsight. Experts should be encouraged not only to provide facts but to help interpret them, albeit that ultimate responsibility for the interpretation rests with policy makers.

Recommendation 4: Sponsorship teams should play a brokering role in a crisis
In a crisis, sponsorship teams need to ensure that public bodies and government departments communicate effectively, taking into account the increased involvement of the centre of government in decision making. They need to make structures of accountability, even if imperfect for the crisis, work as well as possible – and to recognise when delivery against a body's normal objectives may need to be temporarily deprioritised.

The Cabinet Office should develop guidance on how, during a crisis, sponsorship teams can convene expertise and broker agreement between public bodies and government departments most effectively and proportionately. This should include guidance on how sponsorship teams should and should not get involved in decision making in a crisis, depending on how accountability is distributed across government (see Recommendation 1).

5. Share resources – particularly staff – flexibly

Lord Stevens, the former NHS England chief executive, has said one of the biggest lessons from the pandemic was to "try to build more resilience into public services rather than running everything to the optimum just-in-time efficiency"[57] – a lesson also emphasised by the Commons Health and Social Care Select Committee's report into the pandemic response.[58] PPE shortages early in the crisis, for example, occurred partly because stockpiles had been run down due to budgetary pressures, while the lack of slack in the system required staff to come out of retirement[59] and made the Nightingale hospitals seem a necessary precaution.

In priority areas within the civil service, including the SAGE secretariat in the Government Office for Science, we heard that drawing in additional staff from other areas was fairly straightforward and was done quickly during the pandemic. But some public bodies found this difficult because, with government departments holding on to staff due to being under pressure themselves, their other options were limited. For public bodies whose staff are not on civil service terms even transfers within the public sector need bespoke negotiation. External hires – which take longer anyway – can also be delayed by vetting requirements.

The Cabinet Office is producing a 'playbook' on how to manage secondments out of the civil service, but this guidance does not yet distinguish between secondments to public bodies and those to the private sector. Transfers within the public sector should be easier than externally (for instance, there should be fewer conflict of interest issues) and could help public bodies on the front line of a future crisis. The Cabinet Office should therefore consider a streamlined process for secondments to, as well as from, public bodies in crisis situations. It could also develop a means of keeping track of the skills and experience of staff across the public sector so that secondees with relevant skills can be found more quickly when needed. Departments should consider the needs of their public bodies, as well as their internal needs, when prioritising the use of transferable staff.

These measures would help make transfers easier, but would not in themselves resolve a shortage of staff with the necessary skills. Consultants were widely used during the pandemic, but they are expensive and some interviewees complained of difficulties working with them because they did not understand how civil service processes worked. While the use of consultants in new organisations like NHS Test and Trace is understandable, this is necessarily a short-term solution and can lead to high turnover and a lack of institutional memory in these organisations as staff move on quickly. One interviewee recalled, for example, that "the rate of staff turnover in Test and Trace was quite astonishing", causing extensive disruption as new staff had to keep learning on the job.

The new Government Consulting Hub (GCH), set up to help government make best use of internal and external consultants, should help. To some extent it can itself be a source of crisis surge capacity, although it should only be staffed to a level that can be effectively deployed on project work in non-crisis periods. Beyond this, the Cabinet Office is also considering proposals for a Civilian Reserve scheme to help redeploy current and former civil servants with crisis experience, including those who have retired, to crisis response teams.[60] This proposal could further help to lower the pressure on these teams and reduce the government's reliance on consultants or the armed forces. Once well established it will be important to ensure that both the Civilian Reserve and the GCH can be deployed in public bodies, as well as in departments, when necessary.

These initiatives address the need for staff with consulting or crisis management skills. More general resource and specialist delivery skills are also important in crisis situations. Government already has some solutions. HMRC's Surge and Rapid Response Team (SRRT) provides a pool of operational support staff with transferable skills, for example, which can be deployed to departments or public bodies.[61] It would also be possible to maintain expert networks of practitioners in key delivery areas who could be pulled away from their ordinary line responsibilities when needed to respond to emergencies. Countries such as France and Australia deployed emergency response teams to provide extra staff to care homes during the pandemic, for example.[62] Such a model would come at a cost and so would need to be considered on a case-by-case basis, but it could reduce the UK's need to redeploy military personnel as it did during the roll-out of Nightingale hospitals, for example – although the work of these personnel was praised by interviewees.

Recommendation 5: Share resources – particularly staff – flexibly
Staff with the expertise required in a particular crisis are not always available. Where such staff do exist, institutional boundaries between public bodies and government departments can hamper their timely redeployment.

The Cabinet Office should create straightforward protocols for secondments between the civil service and public bodies to make transfers of staff as easy as possible, and produce guidelines for fast-track secondments in a crisis. Departments should consider their public bodies' urgent resource needs alongside their own. New transferable resources such as the GCH and Civilian Reserve should be made available to public bodies as well as to government departments when needed (as the SRRT already is).

6. Foster expert bodies' independent voices

Public bodies that give expert advice sometimes need to be able to challenge government policy. The MHRA and PHE offer contrasting examples of how this occurred during the pandemic.

The MHRA has generally been trusted by the public on controversial issues such as worries over blood clots in patients who have received the AstraZeneca vaccine.[63] Credit is partly due to UK politicians, who were much less prone to publicly pronouncing on vaccine efficacy than in other countries, leaving space for the MHRA's advice.[64] But the MHRA was also seen as independent of government and willing to opine in line with its view of the evidence. It has not always opined in the government's favour: it prompted the government to rethink its approach to mass testing in schools, for example, by emphasising the risk of false confidence being provided by unreliable negative tests.[65]

The MHRA's public voice has been expressed corporately, rather than by dissenting individual experts within it. Individual, rather than corporate, dissent from government policy among public body executives is rare, with exceptions tending to be from firmly established organisations (such as the Bank of England). Where such individual voice is sanctioned it should be clearly distinguished from the public body's corporate view.

Although we heard of some tensions behind the scenes the MHRA has not been directly overruled by ministers even when opining against their plans. This is partly due to its established position as a regulator, which gives it a clearly defined opportunity to contribute an expert opinion. But the MHRA has a relatively weak standing in statute compared to other regulators. Legislation requires its regulatory activities to be performed, but does not specify which body should perform them and the MHRA itself is not mentioned in primary legislation. The health and social care secretary could ask a different body to perform its duties and could overrule its decisions.

PHE, by contrast, has been repeatedly criticised for its lack of an independent voice, despite being described as "one of the world's foremost public health institutes" in a review it commissioned in 2017.[66] The British Medical Association's evidence to the Health Select Committee in 2014 said that its members working for PHE "report that the requirement to adhere to civil service rules and regulations is having an impact on their ability to do their work. Particular concerns have been raised about... the ability to publicly discuss or criticise public health policies."[67] The select committee agreed with this assessment, telling ministers: "PHE can only succeed if it is clear beyond doubt that its public statements and policy positions are not influenced by Government policy or political considerations."[68] PHE's constitution as an executive agency comprised of civil servants employed within a department, rather than as an NDPB or non-ministerial department, seems to have weakened its culture of independence.

PHE's framework agreement entitles it to "publish and speak on those issues which relate to the nation's health and wellbeing in order to set out the professional, scientific and objective judgement of the evidence base".[69] But this clause was often interpreted narrowly as limiting PHE to publication of evidence rather than public guidance or interpretation of that evidence. It is not necessarily true that PHE therefore failed to offer firm advice in private to government, although some have speculated that it did.[70] But policy makers' and other key stakeholders' trust in PHE may have been lower than in other public bodies because it had not been seen to exercise judgment independently of politicians. Politicians may also have been less afraid to ignore PHE's advice as its leadership was less likely to disagree with them publicly.

As an executive agency, it would have been difficult for PHE to defend itself publicly when it felt scapegoated for early pandemic failures. An interviewee described PHE "feeling it had its fingers burned over the summer [of 2020] – more than burned; feeling as though its whole house had been burned down". The interviewee thought that "in the first six months of the pandemic PHE wasn't necessarily respected appropriately but equally didn't do itself any favours [by not speaking up]." We heard that while advice to DHSC ministers may have reflected PHE's views, these were not always then reflected in No.10 policy. More vocal leadership from PHE might have changed that.

The independence of expert bodies is a means of building challenge into decision making and preventing groupthink across government (a concern the Health and Social Care Select Committee has raised[71]). Public bodies will always need to pick their battles, recognising that they sit within a wider system and only asserting their independence where there is good reason. But doing so when required, and with careful management of political sensibilities, can increase stakeholders' confidence in a body and increase the impact of its advice. This requires an enduring culture of independence to be built, where bodies are prepared and able to give advice to ministers that they might not like, and where the key elements of these disagreements are, when necessary, made public. Achieving such a culture will rely on the strong leadership of public bodies themselves to a large extent, but ministers and departmental sponsors should give leaders the latitude they need.

Recommendation 6: Foster expert bodies' independent voices
Public bodies that have established credibility in 'peace time' will have more clout with ministers in a crisis. An overly deferential executive agency, which does not speak its mind in public, may not be listened to behind closed doors either.

Leaders of public bodies should speak independently in public on behalf of their organisations on matters of fact and expert interpretation, even where this may be inconvenient to ministers, to ensure decisions are made and challenged in line with the available evidence. Ministers and departmental sponsors should recognise the need for this and give the necessary latitude to public body leaders.

Lessons to be applied during the next crisis

A crisis response needs to work with the tools available when the crisis occurs. In addition to the preparations we have recommended in advance of future crises, the following lessons can be applied in real time during a future crisis response.

7. Use existing infrastructure wherever possible

The pandemic response tended to be more effective where it used existing systems, databases and bodies, and to struggle where it had to create new ones. This is true of the vaccine roll-out, which largely used NHS systems and expertise – including the 'primary care networks' of local GP practices created in 2019[72] – to deliver jabs. It also applies to the economic support packages, for instance, which used HMRC's data and delivery expertise to distribute money quickly. Conversely, a new centralised contact tracing system at NHS Test and Trace proved too slow to set up with unclear reporting and governance structures, high staff turnover and an over-reliance on contractors.

As the Boardman review into government procurement in the pandemic concluded: "It is easier to scale an existing operation, or to use existing structures, than it is to create something new from first principles."[73] There are exceptions: NHSE&I oversaw the building of the successful Covid data store from scratch in March 2020.[74] But in general this is an established observation and even the UK's 2013 guidance for local planners on preparing for pandemic influenza suggested that any response be "based on existing systems and processes wherever possible".[75]

The government's success or otherwise in several areas has been correlated, for instance, with the availability of high-quality databases that could be integrated with each other[76] – to the extent that developing data capabilities in a way that can be readily shared across government could itself be a worthwhile and more generic crisis preparation strategy for the future. But the importance of such databases might only show up in the operational phases of a crisis response project – that is, after the project has been designed. It is to the government's credit that decisions about financial support delivered through HMRC, for instance, do appear to have considered such operational data issues in the design phase.

Government needs to understand what resources it has in order to repurpose those resources in a crisis. We heard that ministers and advisers were sometimes unaware of the expertise of public bodies at their disposal (as has also been noted by the Public Accounts Committee[77]). For example, the UK public health system did have strong capability in contact tracing and even in testing, but it was located primarily in local public health teams, with PHE playing a monitoring and co-ordinating role. These capabilities were not recognised by ministers, who chose a more centralised approach.[78] One former senior civil servant we spoke to described a "continuing unwillingness, almost a resistance, to respecting local capability and what local government and local services can achieve. Fundamentally, the mindset that 'the centre knows best' is still too prevalent in Whitehall."

There were good examples of public bodies being convened to share expertise during the pandemic; for example, when the Covid-19 Genomics UK Consortium brought together the public health agencies and health services of all four nations to deliver UK-wide genomic sequencing.[79] But it is perhaps significant that this co-ordination was not led from the centre. The onus cannot be solely on central teams to research capability across the system when under pressure for solutions: it is also important that public bodies speak up when they can help. This is more likely to happen when relationships between key people have been actively nurtured in normal times such that trust and lines of communication are well established. As David Flory, former deputy chief executive of the NHS, has said: "The models are always dictated by the personalities, the relationships, the behaviours, and the trust between individuals or lack of it."[80] Although not always popular among those involved, former health secretary Jeremy Hunt's practice of convening health leaders for weekly meetings may have helped catalyse better communication in a crisis.

While central decision makers may be unaware of what existing infrastructure is available, they may be faster than public bodies to realise the need to take greater risks to try to deliver what is needed under crisis conditions. One interviewee who knew the PHE well told us it could have done more to "stick its head above the parapet" early in the pandemic. Public bodies must be willing to be stretched beyond what they would normally consider deliverable in a crisis context. Ideally, pre-existing contingency planning should facilitate evaluation of the risks involved (see Recommendation 3).

One example of rapid role expansion is Covid SAGE's provision of wide-ranging science advice. In previous crises the SAGE mechanism was used to provide specialist, early advice on specific issues but during the pandemic it became, in Professor Chris Whitty's words, "the final common pathway for major bits of scientific advice across government", reporting through multiple channels. This was a "much wider" role than in previous crises, when science advice was usually delegated to departments at an earlier stage.[81] SAGE participants and the SAGE secretariat coped well with blurred lines of accountability and the pressure on them, particularly considering that this role was maintained over a prolonged period.

Of course, it is not always possible to use existing infrastructure. But even then, building new capability or organisational structures within existing bodies tends to be far easier than setting up new bodies from scratch, which should be a last resort. In preparation for such eventualities, the Cabinet Office should consider how far it can follow the recommendation of the Boardman review and create off-the-shelf governance models that can be used to set up new teams and bodies in a future crisis.[82] These would need to take the form of templates and guidance rather than being entirely prescriptive, given the inherent uncertainty around what would actually be needed. But they could help to reduce confusion and to allay propriety concerns over issues like appointments, where there was some public criticism of figures with links to the Conservative Party being appointed as leaders of temporary Covid response bodies.[83] They could also cover common issues faced when embarking on new activities quickly, such as effective negotiation of contract terms.

Recommendation 7: Use existing infrastructure wherever possible
Existing infrastructure – people, institutions, IT and other resources – can always be deployed more rapidly than new infrastructure. The more aware decision makers are of what is available and how to stretch its capacity, the faster and more effectively a response can be mobilised in a crisis.

Establishing a new public body is an unwelcome distraction in a crisis and should be avoided. But where existing infrastructure is entirely unsuitable new organisational structures may be required at short notice to perform new functions.

Public bodies, civil servants and ministers should aim to deploy existing infrastructure in a crisis, before reaching for new tools. This will ensure that all the expertise and skills in different parts of the public sector are fully utilised and that the crisis response relies minimally on government's ability to build capacity from scratch.

However, the Cabinet Office should also create a range of off-the-shelf governance templates to be used if new organisational structures do have to be set up during a crisis. This should help to streamline delivery where there is no alternative course of action and avoid accusations of impropriety afterwards.

8. Avoid permanent structural reform until a crisis is over

Some change in how public bodies work may be necessary for them to respond to a crisis effectively but, unless completely unavoidable, even *decisions* on permanent structural reforms should be postponed until after the crisis. This would avoid demoralising or destabilising critical institutions and ensure that the full benefit of hindsight is achieved.

There have already been changes to how health functions are delivered at arm's length since the onset of the pandemic. DHSC's Health and Care Bill, introduced to parliament in July 2021, announced the upcoming formal merger of NHS England and NHS Improvement.[84] Although NHSE&I was widely perceived to have had a 'better crisis' than much of government, the bill also announced greater powers for ministers to intervene in operational decisions like reorganisations.[85] The abolition of PHE was announced in August 2020[86] and it ceased to exist in October 2021.[87] PHE's pandemic preparedness and infectious disease management functions merged with the Joint Biosecurity Centre and NHS Test and Trace to form the new UK Health Security Agency (UKHSA), while the new Office for Health Improvement and Disparities was set up to deliver public health campaigns and tackle obesity, smoking and other social determinants of health within DHSC.[88] The timing of the changes, in the middle of the pandemic response, has been widely – and rightly – criticised.[89]

Health bodies were also affected by the announcement of significant reforms to streamline and centralise the Government Communication Service – including in public bodies – in early July 2020.[90] The proposals appeared in the press before they had been communicated in private to those affected, which damaged morale and led staff to worry unnecessarily about their job security, especially as the initially leaked reforms were more radical than those eventually pursued. Those we spoke to felt that the worthwhile elements of the reform, which have survived,[91] could have been furthered with significantly less disruption at this already pressured time.

Not all of the changes in health were a direct result of the pandemic, and their relative merits will become clear over time. The merger of NHS Improvement and NHS England had been planned for a while. *The Times* reported in February 2020 that Dominic Cummings was already looking at proposals to move NHS England under more ministerial control, reducing its operational autonomy.[92] But some reforms proposed during the pandemic seem to reflect a perception that ministers lacked sufficient control over health bodies during the crisis.[93]

The reforms following the abolition of PHE are the latest in a series of changes to the structure of public health agencies over recent decades. They risk focusing too much attention on crisis-related issues like health protection and pandemic planning, and deprioritising longer-term activities to combat smoking, obesity and other public health problems.[94] The reforms may also reduce the already limited ability of PHE to give a judgment independent of government on public health issues: the new Office for Health Improvement and Disparities is just a unit in DHSC with no independent standing or framework document supporting this role.

The abolition of PHE has already had negative consequences, with one interviewee we spoke to in June 2021 worrying that it was "taking up time of people who would otherwise be working on pandemic preparedness and response". They also noted that previous reorganisations had been "hugely destructive, and a lot of good people leave". The sudden announcement while the pandemic was ongoing was certainly demoralising to PHE's leadership and staff.[95] Plans to replace it also benefited from less detailed advance planning than previous reorganisations, risking avoidable mistakes in the design of the new arrangements.

In the case of NHSE&I, a clarification of ministerial powers is unavoidable as the new Health and Care Bill confirms the merger of NHS Improvement and NHS England in legislation.[96] Ministers previously had different powers over each of these bodies, and these need to be consistent across the new body and sufficient to hold what will be the highest-spending public body in the UK to account. But the proposed legislation goes beyond merely consolidating ministerial powers, giving ministers more powers of direction over NHS England's activities.

In the long term, ministers could regret taking more direct interest.[97] For example, there is currently a clear and public process in place regarding operational reorganisations within the health service. Proposals are referred to the Independent Reconfiguration Panel (IRP), which publishes its recommendations before ministers

make final decisions based on its analysis. Previous ministers have largely abided by the IRP's recommendations, which have in practice taken reconfiguration decisions out of their hands. But proposed legislation would confer broader "intervention powers in relation to the reconfiguration of NHS Services" on ministers and would require health authorities to notify them of any reconfiguration decision, however minor.[98] Ministers would then be likely to come under greater pressure from MPs and members of the public to intervene regarding the closure of specific facilities in local hospitals, for instance.[99]

Some pandemic-related initiatives more directly under ministerial control, like NHS Test and Trace or the procurement of PPE,[100] were less effective than those overseen by public bodies. This may partly reflect the greater novelty of the initiatives over which there was ministerial control: it is more difficult to create a large-scale testing programme from scratch than to speed up the regulatory approval of vaccines. But ministers should not see responsiveness and independence as necessarily opposed, particularly given that the latter can have demonstrable value under crisis conditions.

Recommendation 8: Avoid structural reform until a crisis is over
In the heat of a crisis and when facing political pressure, a minister may give undue weight to perceptions of a public body's performance under stress. While some internal reorganisation may be necessary to deliver against new objectives, trying to permanently reconfigure a public body while it is responding to a crisis will inevitably distract it from fulfilling its remit. Furthermore, the best institutional structure for crisis response may not be the same as for normal day-to-day operations.

Unless completely unavoidable, permanent structural reconfigurations of public bodies should be postponed until after a crisis.

9. Communicate early with a single voice

The pandemic has clearly presented major communications challenges for government. Many of these have related to the underlying policy being communicated in the media. No communications strategy – however seamlessly negotiated across government and its public bodies – could have glossed over the chaos surrounding the late U-turn on Christmas 2020 social distancing rules. By stark contrast, the subsequent publication of a six-month roadmap out of lockdown in the first half of 2021 showed how forward communication of options and contingencies can help individuals and businesses to plan with some confidence. There are also lessons to learn about the interaction between ministerial and government communications: ministers have sometimes simply got the rules wrong on media rounds,[101] but divergent public interpretations of lockdown guidance by ministers have caused confusion too.[102]

How did public bodies, in particular, fare in terms of communications? Lee Cain, No.10's director of communications until December 2020, articulates one view of how communications staff in public bodies performed:

> **"These staff, in particular, are often overgraded and over-paid as a way of compensating them for being further from power – the currency of Whitehall. All too often during the pandemic government communication plans were knocked off course by briefings from within ALBs that had not been shared with central government. This made the handling of events look chaotic, eroding public trust in the government's handling of the pandemic. This could have been solved by having a closer relationship and a clearer command and control structure between government and ALBs, with clearer understanding of clearance processes."**[103]

These words illustrate how public bodies can look from the centre of government, although they should be read in the context of Cain's wider argument that the individual government communications professionals closest to an issue should be empowered to engage the media directly (albeit within a more centralised reporting structure).[104]

Unsurprisingly, we gained a different perspective from public bodies themselves. We heard positive experiences of working with departments on proactive campaigns, where there was sufficient time and policy clarity to develop these. But politicians' desires to communicate certain messages personally caused problems of co-ordination (Hancock's daily testing target is one example – see Recommendation 2). There was also frustration with announcements being made or leaked without the knowledge of the public bodies affected (PHE's abolition was an instance of this, as was the proposed reform to the Government Communication Service itself, discussed in the previous section). In the area of reactive communications, public body staff we spoke to felt that they could – and had to – respond faster than government departments, where convoluted approval processes meant departments could miss stories altogether.

A public body's chief executive is also likely to feel that their operational independence – and potentially their ability to discharge their duties as accounting officer – depends on controlling their own communications team. Specialist audiences, while less significant to the centre, may matter greatly to the relevant public bodies and they will want to be able to prioritise them.[105] We heard from interviewees that this remained the case throughout the pandemic as stakeholders expected more direct communication from public bodies than usual. Public bodies may have other communication responsibilities too, such as a duty to consult on service changes, which are not amenable to central control. Discretion over how a body communicates day-to-day is also an important tool for fostering its independent expert voice as set out in Recommendation 6.

Public bodies noticed a lot of central focus on news media engagement during the pandemic, but less on internal health service communications or proactive communication through other channels. Public bodies' communications teams felt they would have benefited from greater clarity as to how far central press offices

were content for them to work independently in these areas. It would also have been better if government had been able to develop stronger proactive communications campaigns that departments and public bodies could all get behind and deliver (had the underlying policies been sufficiently developed to facilitate such campaigns).[106]

Finally, as in other areas, public bodies experienced central control over communications creeping beyond what they considered strictly necessary for the pandemic response. For example, they reported ongoing reputation management issues that were previously left to public bodies themselves receiving greater central focus than before – even after day-to-day ministerial interest from the centre had waned. It will be important to ensure a full return to business as usual takes place, except insofar as deliberate decisions are made to implement reforms.

Recommendation 9: Communicate early with a single voice

In a crisis, clear and consistent public messaging is vital – especially when the public must act in a particular way for the crisis to be navigated. Public bodies must support this effort, taking their lead from the centre. But public bodies are often better placed than central communications teams to communicate swiftly and accurately with specialist audiences, and should be supported in doing this. The centre of government should make all major announcements collaboratively with the relevant public bodies.

Communications teams across government and public bodies should agree proactive communication strategies in advance on key policies. Reactive communication on technical matters should remain the responsibility of those closest to the substance.

The Cabinet Office should develop a framework clarifying the division of roles and responsibilities across communications teams in departments and public bodies for use during the next crisis. This should be consistent with fostering expert bodies' independent voices as far as possible (see Recommendation 6) and should extend beyond press office functions to include strategic, internal and social media communications.

Conclusion: the new normal

Two years on from the start of the pandemic and with the UK beginning to return to some form of normality, the hope is that the government and its public bodies can return to a steady state. But learning the right lessons from the pandemic is important, both in terms of how any future crisis should be approached and of what should be done differently to prepare in normal times.

Coronavirus has had a profound impact on public bodies. Many have got used to operating differently – staff working from home, departmental oversight changing and in some cases plans emerging for structural reform. The pandemic has left major delivery challenges in its wake, with those responsible for public services often having major backlogs to clear.

The political context around public bodies is changing too. Many bodies suffered significant financial shocks due to Covid and therefore became more reliant on discretionary central government funding. Alongside this the extra debt taken on by government during the crisis means the Treasury will seek opportunities to cut spending in the next few years, including in public bodies. Political interest in public appointments[107] and in the actions of some cultural bodies is growing.[108] Government is exploring different governance models for key services such as broadcasting (with Channel 4 set to be privatised) and rail (with the new Great British Railways centralising many functions).[109] And the government's new public bodies reform programme, prompted by the *Declaration on Government Reform* in 2021, has already set out plans for new guidance on reviewing public bodies and improving departmental sponsorship.[110]

The transition to this 'new normal' will not be easy, but government should not approach the future in endless crisis mode. There is now more interest in public bodies and their governance than at any point since the coalition's "bonfire of the quangos" began over a decade ago. This creates promising opportunities for reform, but the good reasons for establishing public bodies at arm's length from government remain. A crude centralisation of day-to-day decision making and control would be a poor outcome from the pandemic experience, and would run counter to the ongoing need for meaningful delegation in an increasingly complex economy and society.

Annex: Governance of case study bodies

Increasing independence →	PHE	MHRA	NHS England*
ALB type	Executive agency	Executive agency	Executive NDPB
Accounting officer arrangements			
Accounting officer	PHE chief executive	MHRA chief executive	NHS England chief executive
Principal accounting officer	DHSC permanent secretary	DHSC permanent secretary	DHSC permanent secretary
Any specific AO issues		The MHRA chief executive is also accountable to the Treasury for its trading fund	
Appointments			
Who appoints the chief executive?	DHSC permanent secretary	DHSC permanent secretary	NHS England chair and non-executive directors (NEDs), with the consent of the health and social care secretary
Who appoints the chair and non-executives?	Health and social care secretary (unregulated)	Health and social care secretary (unregulated)	Health and social care secretary (regulated by the Commissioner for Public Appointments)

* We describe NHS England's governance here, as it is a larger body than NHS Improvement and former NHSE&I chief executive Lord Stevens was NHS England chief executive before taking on the combined role. NHS Improvement has similar governance arrangements to NHS England – it is also an executive NDPB enshrined in primary legislation, has the same principal accounting officer, and is also subject to annual mandate letters from the secretary of state. Source: DHSC and NHS Improvement, 'Framework Agreement between DHSC and NHS Improvement', Gov.uk, 8 October 2018, retrieved 3 February 2022, www.gov.uk/government/publications/framework-agreement-between-dhsc-and-nhs-improvement

Increasing independence →	PHE	MHRA	NHS England*
Objectives			
Who is responsible for setting objectives?	The health and social care secretary is responsible for "setting objectives for PHE through the annual remit letter"	The health and social care secretary is responsible for "agreeing the Agency's strategic objectives" with the chief executive	The health and social care secretary must publish an annual mandate which "sets out the objectives which NHS England must seek to achieve"
How are objectives set out?	A minister (usually the parliamentary under-secretary) sends an annual remit letter[111]	The chief executive produces a long-term plan, including priorities, every five years, which is submitted to parliament and approved by the health and social care secretary[112]	The health and social care secretary lays the mandate before parliament ahead of each financial year. NHS England then produces a business plan including targets on what will be delivered
Powers of intervention			
Can ministers intervene in the work of the ALB?	"If the Secretary of State considers that PHE is significantly failing or has failed to discharge any of its functions he is able to intervene and require PHE to take certain steps"	"If the Secretary of State considers that the Agency is underperforming or significantly failing in the exercise of its functions, he/she is able to intervene and require the Agency to take certain steps"	"If the Secretary of State considers that NHS England is significantly failing in its duties and functions he is able to intervene and issue directions to NHS England. This also applies where he or she considers NHS England has failed to act in the interests of the health service. In the first instance, the Secretary of State could direct NHS England about how it carried out its functions"

Increasing independence →			
	PHE	MHRA	NHS England*
Can core departmental civil servants intervene in the work of the ALB?	The DHSC permanent secretary is allowed to "address significant problems in PHE, making such interventions as are judged necessary"	The DHSC permanent secretary is allowed to "address significant problems in the agency, making such interventions as are judged necessary"	No specific powers specified
Are interventions made public?	The health and social care secretary must publish reasons for intervention	Not mentioned	The health and social care secretary must publish reasons for intervention
What formal right of public reply does the ALB have?	None	None	None
Statutory footing			
Is the body named in statute?	No	Yes, but only in a statutory instrument which establishes the trading fund that finances the MHRA	Yes (as the NHS Commissioning Board)
Are its duties mentioned in statute?	Yes, as responsibilities of the health and social care secretary	Yes, as responsibilities of the health and social care secretary	Yes

Increasing independence			
	PHE	MHRA	NHS England*
Would change require primary or secondary legislation?	Neither	Secondary, to remove reference to trading fund	Primary or secondary, depending on the change
What is the statute text?	The duties performed by PHE on behalf of the health and social care secretary are set out in the National Health Service Act 2006,[113] especially sections 2A and 2B, and in the Civil Contingencies Act 2004 (which mentions Public Health Scotland by name).[114] But PHE is not mentioned by name in legislation	The trading fund is established by the Medicines and Healthcare products Regulatory Agency Trading Fund Order 2003,[115] under the Government Trading Funds Act 1973. The body's duties (officially those of the secretary of state) are set out in the Human Medicines Regulations 2012[116]	The NHS Act 2006 (which was amended by the Health and Social Care Act 2012) establishes the body's existence, gives it statutory duties to commission services, and requires the secretary of state to provide an annual mandate.[117] It is also given duties in Schedule 1 of the Civil Contingencies Act 2004[118]
Crisis override			
Are there any other provisions to override governance?	All NDPBs and executive agencies can be the subject of ministerial directions, which are formal instructions from ministers to proceed with a course of action despite an objection from a permanent secretary. The government has issued two directions to DHSC or its public bodies since 1990:[119] one in March 2020 permitting it to break departmental spending limits;[120] and another in January 2022 overriding value for money concerns over the purchase of private bed capacity to address shortages in hospitals during the Omicron wave.[121]		

Source: Unless otherwise stated, PHE, MHRA and NHS England framework agreements: Department of Health and Social Care and Public Health England, *Framework Agreement between the Department of Health and Social Care and Public Health England*, Gov.uk, February 2018, assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/677457/Framework_agreement_between_DHSC_and_PHE_2018.pdf; Department of Health and Social Care and NHS England, *Framework Agreement between Department of Health and NHS England*, Gov.uk, February 2014, retrieved 4 March 2022, www.gov.uk/government/publications/framework-agreement-between-dh-and-nhs-england; Department of Health and Social Care and the Medicines and Healthcare products Regulatory Agency, *Framework Agreement between the Department of Health and the Medicines and Healthcare products Regulatory Agency*, Gov.uk, March 2016, retrieved 4 March 2022, www.gov.uk/government/publications/dh-and-mhra-framework-agreement

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