



The HPA's response to 'Healthy Lives, Healthy People', the Government's strategy for public health in England

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Purpose of the paper

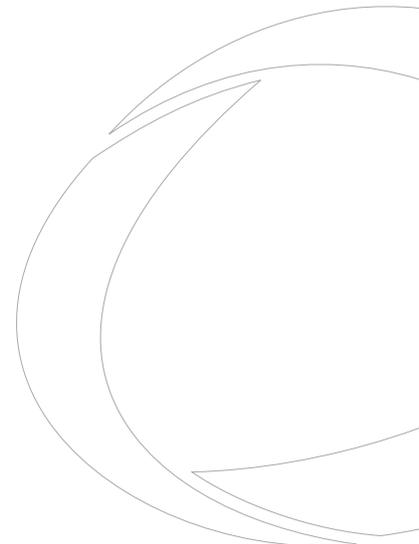
1. This paper is the Health Protection Agency's formal response to the White Paper *Healthy Lives, Healthy People*. It was prepared on behalf of the Board following extensive consultation within the HPA, with external stakeholders from local to national level and with members of the public drawn from the HPA's People's Panel.
2. The paper sets out the HPA's views on the proposals in the White Paper and identifies some key risks which the HPA believes need addressing in the implementation of the proposals.

Summary

3. The HPA supports the overall strategy for public health outlined in the White Paper. At local level the re-integration of public health with local government will support and encourage the work necessary to tackle the wider determinants of health thereby improving health and reducing health inequalities. At a national level the creation of Public Health England (PHE) will provide expert support for local public health action as well as providing a sound evidence base for national public health strategy and for developing an appropriate framework for delivering effective health improvement.
4. Incorporating the functions of the HPA into PHE will strengthen the new organisation and allow it to deliver, from the start, high-quality health protection services at local, national and international level.
5. The HPA welcomes the Government's commitment to public health, as demonstrated through the emphasis on improving surveillance and research to drive the evidence base for public health action, preserving scientific independence, and supporting ongoing workforce development. The retention of Health Protection Units as a key component of the public health system will enable the internationally-leading specialist expertise in PHE to be deployed locally in addressing challenging public health issues.
6. However, there are some critically important issues that need to be addressed to protect the public and avoid creating risks to the delivery of an effective public health service and safe emergency response system:
 - a. **Independence and identity:** Maintaining the confidence and trust of the public and professionals in PHE, and in the independence of its scientific and public health advice, will depend on PHE having its own strong separate identity as an expert body, and there being proper arrangements to safeguard the independence of its staff in providing expert scientific and public health advice at the local, national and international levels.
 - b. **External income:** The significant external income currently generated by the HPA (at almost £150m for 2010/11 this is approximately half of the HPA's total income) is essential to maintain the organisation's overall capability both to provide expert advice and to provide an effective specialist emergency response. This income, and the extra HPA staff (1250 people), expertise, and facilities it supports are an essential component of the HPA's (and therefore the national) response capability. The ability of the new system to deliver an effective response to significant incidents will depend on retaining this income. However, becoming part of a government Department of State will put some of these income streams at risk and robust solutions to address this challenge need to be identified.

- c. **Expertise and the fundamental importance of integrated research:** For PHE to establish itself as an expert organisation, research must be integrated into the organisation's activities and ethos alongside operational delivery. This requires suitable funding arrangements to be established within the Department of Health, and with other funding bodies. Equally, without a focus on research and strengthening the evidence base, PHE's ability to recruit, develop and retain the best scientists and experts will be compromised and its reputation and effectiveness diminished.
- d. **Transition and resilience of emergency response:** The creation of PHE is happening at a time of whole system reorganisation across the health sector and those organisations involved in emergency planning and resilience. Potentially, this could create considerable risks to the national capability to launch multi-agency responses to incidents and emergencies. These risks must be actively managed, with effective coordination across government to safeguard effective response and resilience (up to and beyond the Olympic Games in 2012).
- e. **Roles, responsibilities and accountabilities:** There needs to be absolute clarity about the responsibilities and accountabilities of the different organisations and individuals involved in the new system, particularly at the local level. The role of the Director of Public Health, both as an employee of the local authority and an appointee to PHE, needs particularly careful consideration and definition.
- f. **National Institute of Biological Standards and Control (NIBSC):** The strategic focus of PHE will be substantially different from that of the NIBSC and we believe it is appropriate to consider other possible models for discharging NIBSC's functions within the Department of Health.

7. The HPA believes that a number of the risks associated with these issues could be more effectively managed if PHE were established, in the manner of CDC Atlanta, with the features of an Executive Agency within the Department of Health. This would be in line with recommendations made by the Public Administration Select Committee in their January 2011 report *Smaller Government: Shrinking the Quango State*.



Background

8. The Coalition Government published its strategy and long-term vision for public health in England in the White Paper *Healthy Lives, Healthy People* on 30 November 2010 and invited comments.
9. The paper built on the principles set out in the earlier White Paper on the future of the NHS, *Equity and excellence: Liberating the NHS*.
10. Following publication of *Healthy Lives, Healthy People*, the HPA commenced an internal consultation with its 4,000 staff as well as a dialogue with principal external stakeholders to identify the key issues for health protection arising from the White Paper. HPA Board members led 19 consultation events for staff across the organisation in addition to local consultation events. Individual staff members also contributed via an online survey. The HPA's People's Panel, made up of members of the public, also contributed.
11. The responses and feedback from these discussions were compiled, analysed and reviewed for the HPA's Executive Group and Board to distil the significant themes and questions.
12. The HPA's intention in this process was to identify the opportunities to strengthen the proposals for health protection presented in the White Paper, to recognise any risks to the continued delivery of the functions currently carried out by the HPA, and to look for ways to ensure these risks can be effectively managed. This will enable the success that the HPA has demonstrated in protecting people's health from 2003, to be continued into the new organisation beyond 2012.
13. Inevitably, this paper focuses on those things where the HPA believes there needs to be more work, more clarity or perhaps a different approach; but these should be seen in the context of the HPA's overall support for the vision set out in the White Paper.

Key issues

Maintaining the public's confidence and trust in the independence of PHE's scientific and public health advice locally, nationally and internationally

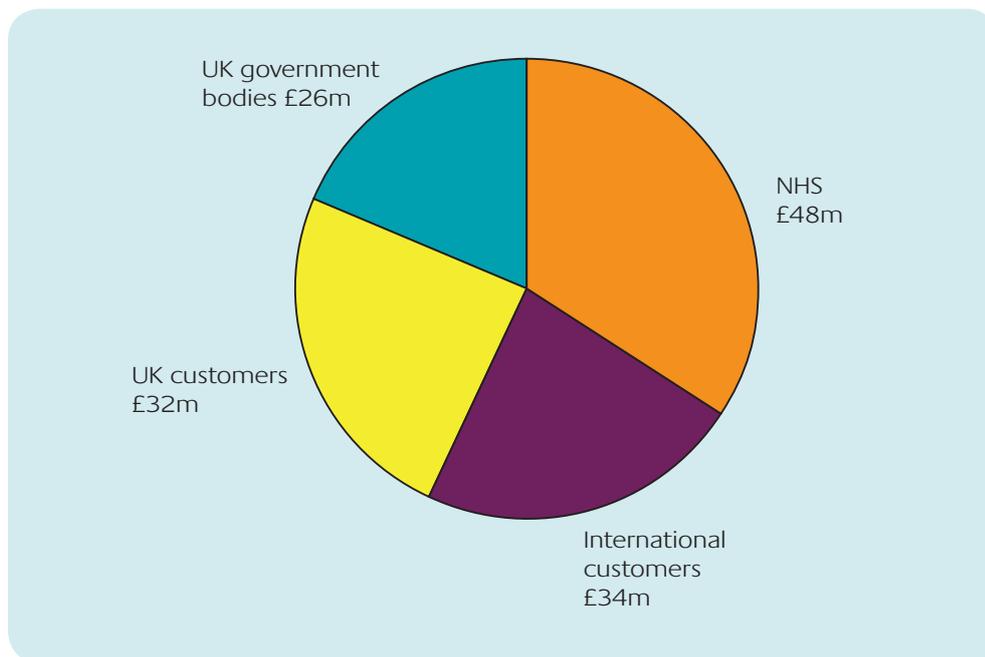
14. Independence of advice, both actual and perceived, is critical to maintaining public trust in scientific and public health advice. As part of a central government department, as proposed by the White Paper, PHE may not be, or may not be perceived by the public, by professional groups or by key stakeholders to be, completely independent and might be thought to be subject to political pressures. This could affect the public and professional confidence in the scientific and public health advice given nationally and locally by PHE staff and the international reputation of PHE's evidence and advice.
15. At a local level, there is also a risk that the relationship between Directors of Public Health and elected local authority members might be perceived as compromising their independence. This was recognised historically, when public health was previously a part of local government, and was thought to be a significant enough risk that medical officers of health in local authorities were given protected status to ensure they could advise independently.
16. Measures suggested that might mitigate these risks include openness and transparency in PHE's systems and processes for developing scientific advice and clear adherence to good scientific practice and to the available evidence. Transparency in publishing evidence and reports and in the appointment of experts will also be important. There might be merit in using existing professional bodies and their codes of conduct to build a framework for assuring independence of advice. These might be more helpful, or easier to demonstrate, at the national level than at the local level where issues can develop more quickly.
17. A key element of actual and perceived independence will be the creation of a strong separate identity for PHE, supported by effective means for branding and delivering its advice to professionals and the public, such as its own website. Health professionals, stakeholders and the public value the independence of the HPA. The HPA's website has proved a critical tool in the timely provision of the expert, independent, evidence-based advice, guidance and information so valued by these groups.
18. We believe that establishing PHE to incorporate the features of an Executive Agency would support the establishment of a strong separate identity for PHE, helping it to maintain public confidence and trust in the independence of its expert advice and providing an appropriately clear separation from the policy-making functions within the Department of Health.
19. **Risk of not addressing this issue:** If there is reduced public trust and confidence in the independence of public health advice, that advice will be less effective. Where the scientific advice forms the basis for policy-making, the policies may be subject to more challenge. In the context of a major

incident the advice may not be immediately accepted by the media and public resulting in more challenge and lower compliance and hence an increased public health threat. In the absence of a clear authoritative source of trusted and respected advice nationally and locally, the public might give undue weight to less robust health advice, such as was seen with MMR vaccine.

Maintaining the HPA's current income generation in the new environment

20. The HPA has been very successful in growing external income in recent years, to the point where it represents approximately half of our total income. It has risen every year since 2003 and in 2010/11 is forecast to reach almost £150m. Figure 1 shows a breakdown of the source of external income in 2009/10.

21. **Figure 1**



22. Becoming part of a government department could reduce the current resources of the HPA because of the constraints this would place on the ability to generate income from sources other than government grant-in-aid. The risks to this income arise from:

- a. The inability of PHE to get funding from key bodies (such as the European Commission or some high profile research bodies) that are not permitted to fund or trade with central government departments.

- b. The inability of PHE to charge other government departments for support currently resourced through contracts (e.g. specialist support to the Department for Energy and Climate Change).
 - c. Issues of actual, or perceived, conflict of interest created by a department receiving money for work done, for example, for pharmaceutical companies, leading to a reluctance to continue to seek such work.
 - d. The loss of a competitive business culture, including appropriate support services such as Finance, Legal, Communications, and HR, which form an essential part of any commercial offering. Income generation demands a very different approach than that necessary for core government activities, due to the presence of competition and the associated need to be flexible and accept greater risks. In addition, the potential loss of experienced business and commercially focused staff who may choose to leave an unsupportive organisation, would further undermine its competitiveness.
 - e. The loss of income is not just a monetary issue; the loss of capacity, resilience and UK reputation for excellence in public health science that will follow the loss of income, will be very significant.
23. Measures suggested that might mitigate these risks and support commercial and research activities include: the establishment of a trading company (or companies); the development of a charitable trust; and the establishment of PHE with the features of an Executive Agency. A strong separate identity for the new public health service and a degree of separation from central government will be essential if current income generation is to be safeguarded.
24. **Risk of not addressing this issue:** Public Health England will lose resources in the form of externally-funded staff and facilities, resulting both in reduced public health capability and in increased costs to government. Public Health England's position as an internationally-leading science body will be damaged and the UK capacity for emergency response will be reduced.

Preserving research integration and funding – strengthening the evidence base and maintaining capability

25. The use of both internal (Department of Health/National Institute for Health Research) and external funds for research work in PHE is at risk in the proposed model and could fundamentally threaten the continuation of the current 'expert organisation' model in PHE. For example, critical capabilities such as the ability to work with the world's most dangerous pathogens at the highest level of containment would be at risk. Such a loss of research capability would lead to a substantial reduction in the expertise within PHE in the short-term, and an inability to attract the best scientists in the

- future. Without this, PHE would not be a credible and authoritative source of expertise on the science underpinning public health.
26. The loss of income and the associated loss of the staff and facilities supported by that income would be very significant. In 2010/11 an extra 1250 staff were employed directly as a result of the external income and these are an integral part of the HPA's overall public health response capacity. This could in theory be compensated for by a corresponding increase in core government grant-in-aid funding. However, even if that were to be made available, the loss of in-house research would fundamentally damage PHE's position as an expert organisation because high-quality scientists would not wish to work for an organisation in which they would be unable to undertake research. The synergy between translational research and the provision of expert advice and operational delivery that exists in the agency is one of the key drivers for its ability to recruit and retain the best scientists. Without its research activity, PHE would also have a diminished position in scientific networks, with the consequent loss of the valuable benefits and influence that these bring. The inability to participate in collaboratively-funded research, both in the UK and internationally, would severely limit the development of PHE's knowledge base, its access to wider expertise, and seriously undermine the UK's international standing and reputation.
 27. Mechanisms to ensure research funds can still be directly accessed by PHE and used for in-house research are essential. Even if the Department of Health can resolve the issue in relation to internal funding (as the Home Office has done for its research activities and other government departments have done via their Executive Agencies), the threat to external funding will remain significant.
 28. For both UK and external funding bodies (such as the European Commission) perceived distance from central government is important. Their Executive Agency status enables other similar organisations (such as the Veterinary Laboratories Agency) to undertake research within a government department.
 29. **Risk of not addressing this issue:** PHE will not retain an expert science capability and its ability to develop the scientific evidence base to underpin public health practice and to offer expert advice and support (including for emergency response) will be substantially undermined. In addition, the UK's reputation in the field of public health science will be diminished.

Maintaining and strengthening emergency preparedness, response and resilience

30. Alongside the changes proposed to public health, there are major changes happening, or proposed, to many key partner organisations in emergency preparedness and response, including the NHS, local authorities, and resilience forums. These create considerable uncertainty, and therefore risks,

in maintaining relationships and effective joint working and in understanding how the whole system will respond in a major incident.

31. These issues are in addition to the reduction in response capacity due to loss of income referred to above.
32. As part of transition planning, a joint workshop has been held with the Department of Health, the NHS and HPA to work through these issues, and this has established two workstreams to develop proposals for how the system could work in future and through the transition period.
33. It is essential that this work is given the highest priority so that new arrangements can be developed with the level of detail necessary to facilitate effective joint working, and the safety and resilience of the new systems can be assured. In the interim, the risk is real.
34. Resilience will also be affected by the way in which PHE is structured. Experience in managing complex public health incidents suggests that some sub-national coordination, communication, command and control is vital to success and we would recommend that a sub-national tier is included as part of the structure of PHE. This will form a critical component of a resilient emergency response capability, acting as a node for communications, leadership and coordination. The lessons from pandemic flu also suggest that there should be co-terminosity between the sub-national tier in PHE and that for partner organisations.
35. The HPA is currently a Category 1 responder under the Civil Contingencies Act and this has benefits for emergency planning and response by specifying a duty of cooperation with and from partner responder organisations. The HPA recommends that PHE should be classified as a Category 1 Responder.
36. **Risk of not addressing this issue:** Major high profile incidents requiring multi-agency coordination will not be effectively managed. Preparation for, and response to, incidents arising in association with the Olympic and Paralympic Games will be compromised.

Defining local roles, responsibilities and accountabilities, and developing relationships between PHE and Directors of Public Health in local authorities

37. A key element of the new public health service will be the transfer of some responsibilities and resources to the local authority which will appoint a Director of Public Health to ensure delivery of agreed public health outcomes. The Director of Public Health will depend on PHE, mainly through Health Protection Units, to provide the right support (expert advice and resources) to enable them to fulfil their role. Equally, NHS resources essential to effective outbreak management are currently accessed through the Primary Care Trust. It is not yet clear how these resources will be accessed in the future and, as mentioned in HPA's response to *Equity and excellence*:

Liberating the NHS, this is a considerable risk to the collective ability to manage outbreaks and incidents effectively.

38. Clarity of roles for all organisations with a significant contribution to make to public health (e.g. PHE, local authorities, Directors of Public Health, NHS Commissioning Board, Health and Wellbeing Boards, GP consortia, etc) is an essential pre-requisite for the system to work. This is borne out by HPA's early experiences where a lack of clarity between HPA's role and that of the NHS sometimes caused difficulties in guaranteeing an appropriate service. Developing effective working relationships supported by appropriate management arrangements, including clear accountability, quality assurance and governance, will be essential.
39. The HPA has started to work with the Association of Directors of Public Health to explore how this can be managed. This has underlined the need to get absolute clarity about roles, responsibilities and accountabilities agreed and mandated throughout the new system, and to develop explicit agreements between PHE and its partners about mutual expectations.
40. **Risk of not addressing this issue:** Lack of clarity about roles, responsibilities and accountabilities locally will seriously compromise preparation for, and management of, public health events. Inability to access and mobilise NHS resources in an outbreak or incident will result in ineffective public health delivery.

Public health information and intelligence

41. The HPA recognises that bringing together in PHE the information and intelligence functions of the HPA, Cancer Registries, and Public Health Observatories presents an opportunity to achieve significant improvements in the availability of surveillance data to provide evidence to drive public health action both locally and nationally provided that the relevant skills and expertise are retained during the transition to PHE. The HPA is working closely with colleagues across the public health arena to develop detailed proposals for how this can be achieved.
42. **Risk of not addressing this issue:** PHE will not fully realise all the potential synergies and benefits of integration, and opportunities to improve the public health evidence base will be lost.

Public Health England and the Devolved Administrations

43. It is important that current arrangements for health protection across the four UK countries are maintained. The HPA currently has certain statutory responsibilities across the UK and it provides a range of expert advice and services to all the Devolved Administrations in partnership with their local agencies and on which the Devolved Administrations rely. The independence

of PHE's advice will be important in sustaining the confidence of the Devolved Administrations in that advice.

44. The relationship between PHE and the Devolved Administrations is also critical in ensuring a coordinated and resilient response to major public health incidents that cross borders.
45. The HPA therefore welcomes the agreement between the English Department of Health and the Devolved Administrations to continue the existing relationship with respect to specialist health protection advice and services. The HPA believes it will be important to continue to maintain the current presence in Cardiff and Glasgow to signal that we will continue to work in close partnership with the Devolved Administrations and their local agencies.
46. **Risk of not addressing this issue:** Current effective public health cooperation across the UK will be diminished and public health action across borders will be less effective and efficient. Current funding for some health protection services across UK will be destabilised.

Public Health England and international public health

47. The HPA currently plays a significant role in international public health and is seen as a key expert body in providing authoritative, evidence-based advice. The agency also hosts a number of WHO Collaborating Centres across a range of public health topics.
48. International engagement provides access to professional networks which are the most effective sources of intelligence on developments and incidents across the world, and so helps this country's public health preparation. It also gives UK staff opportunities to work with internationally-leading experts, often in challenging circumstances, and so improves their expertise.
49. Research work at this level brings us scientific credibility on the international stage and has helped to strengthen the UK's international reputation in the field of public health.
50. This international contribution also supports the UK's Global Health Strategy by supporting and developing public health in less well resourced countries. Improving public health effectiveness in other countries reduces the risk to the UK from public health events outside the UK.
51. The HPA recommends that PHE continues to develop an effective international dimension to its work which includes both policy support and a focus for the technical delivery of expert health protection services internationally.
52. **Risk of not addressing this issue:** The UK's reputation for international science will be diminished; the UK capacity for health protection will be compromised and the UK public health contribution to international development and global health security will be reduced.

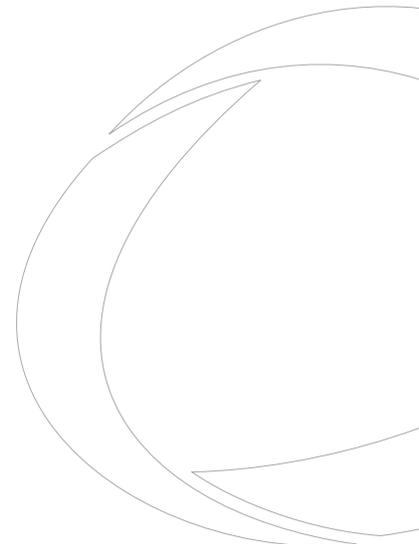
Preserving an integrated approach to health protection

53. The HPA has developed an integrated approach to health protection. World-leading expertise from national centres is available to support the thousands of front-line public health responses the HPA leads each year, and front-line experience informs and helps to prioritise the work of the national centres. Expertise in topic areas is 'joined-up' across the organisation (and with external bodies) in formal 'programmes' of work, driving whole system improvements. Using this approach has led to significant improvement in these topic areas, and the HPA is keen to ensure that this approach continues to realise benefits in the new public health system. The priority health protection topics targeted by the HPA are:
1. Healthcare-associated infections
 2. Respiratory infections
 3. Bloodborne infections
 4. Gastrointestinal infections
 5. Sexually transmitted infections
 6. Vaccine-preventable infections
 7. Environmental hazards
 8. Biological standards and control
 9. New vaccines and novel interventions
 10. Climate change
54. The HPA looks forward to working with the Department of Health and partners to ensure that the significant progress already made in these integrated topic areas is able to continue and improve and deliver further benefits in the new public health system.
55. **Risk of not addressing this issue:** Action for key public health topics will be less well coordinated, will not be as well evidenced and will consequently be less effective than currently.

The strategic fit of the National Institute for Biological Standards and Control and Public Health England

56. In addition to looking at the implications of the White Paper proposals across the whole HPA, consideration has been given to the implications for the component parts of the agency to consider whether the arguments apply equally across all these components.
57. With one possible exception, the HPA's view is that the integrity of the public health work of PHE requires all the functions and components of the HPA to transfer to PHE.
58. The possible exception, which requires further consideration, is the National Institute of Biological Standards and Control (NIBSC).

59. All the concerns about independence, income generation, research capacity and conflicts of interest apply to NIBSC as they do to the agency as a whole.
60. While these could be mitigated by establishing PHE with the features of an Executive Agency, in the case of NIBSC there is an additional concern that does not apply to other parts of the agency: the strategic fit of NIBSC within the broader remit that PHE will hold compared to the HPA.
61. The remit of NIBSC is to assure the quality of biological medicines, such as vaccines, blood products and protein-based therapeutics through developing measurement tools to underpin accurate dosing and consistent production (standardisation). It also carries out independent regulatory testing of products to support market release (control). Given that biopharmaceutical manufacturing and regulation is now largely conducted outside the UK, these activities are essentially international.
62. When it was proposed in 2004 that NIBSC join the HPA, a review was carried out to explore the 'strategic fit' between the institute and the HPA. The conclusion was that although there were differences between the two bodies' roles and ways of working, there was sufficient synergy between them as expert science organisations to believe that the amalgamation would be of mutual benefit.
63. Since the merger in 2009, the two parts of the HPA have striven to ensure that the synergy works and that the benefits have been delivered. The synergy is principally around the scientific and operational aspects of work. It has been important to maintain a separate NIBSC brand, particularly to support NIBSC's international standards work where it has a world-leading position.
64. However, with the incorporation of the HPA functions into a new public health organisation with a much wider public health remit but with a local and national rather than an international focus, it is less clear that the strategic fit remains convincing. In particular, the work of NIBSC does not have any direct benefits at local level, and its staff are not routinely involved in supporting local public health activity. These are the areas which will (rightly) be the main focus of attention in PHE. Consequently the work of NIBSC may not receive the support it needs to flourish.
65. There is also a specific concern about the need to maintain the actual and perceived independence of its regulatory (batch release) and advisory role. This is particularly sensitive in the area of vaccines, where the Department of Health has responsibility for procurement and implementation.
66. The HPA believes that the position of NIBSC within the Department of Health merits more consideration before a final decision is made on future structures.
67. **Risk of not addressing this issue:** The key national and international role of NIBSC becomes diluted within the wider remit of PHE and its scientific strength and international reputation are compromised. The UK's capability for supporting the development of biological medicines and responding to problems is reduced at a time when the opportunities and risks associated with these medicines are growing sharply.



The operating model for public health

68. The White Paper clearly spells out the rationale for including the new public health service as an integral part of the Department of Health with clear oversight by, and accountability through, the Secretary of State for Health.
69. The HPA would not wish to challenge this rationale but the questions and issues identified here mean that there is a need to reconcile the tensions between this accountability and the difficulties that flow from PHE being a part of a government department. There may be benefits in running aspects of PHE at one step removed from central government.
70. The logic presented in the Public Administration Select Committee's 5th report, *Smaller Government: Shrinking the Quango State* (January 2011), sets out a potential way of alleviating those tensions.
71. The report concludes that bringing former non-departmental public bodies into a government department does not necessarily achieve the objective of improving accountability from the public's perspective. It recommends that the government consider converting into Executive Agencies those organisations whose functions it intends to retain and move into government departments.
72. The HPA believes that establishing PHE with the features of an Executive Agency would help alleviate many of the issues identified above. It would provide a strong separate identity for PHE and allow it to build the trust of the community in the way that the HPA has done over the last eight years. It would provide a visible degree of separation from the policy-making functions within the department while at the same time, as part of the Department of Health, provide the Secretary of State for Health with the direct line of sight he requires. Such a model would be a good vehicle to enable a culture in PHE that would facilitate excellence in operational activities and retention and growth of current income streams while not compromising the culture necessary in the Department of Health to support the Secretary of State for Health and ministers.
73. Over its lifetime, the HPA has worked hard to develop an organisational culture and service ethos appropriate to a body with a prime role as an operational public health organisation. This requires a focus across the organisation on immediate effective delivery 24 hours a day throughout the year with appropriate supporting infrastructure and services. This will be equally important in PHE.
74. The terms and conditions of employment of its workforce also need to be appropriate to ensure the future sustainability of the organisation. The HPA welcomes the support in the White Paper for workforce development and the recognition of the need for closer working with the NHS on this issue. This is significant because PHE will require access to many of the same skills as the NHS, so ease of movement between PHE and the NHS will be very important.

75. The right framework to develop an effective culture for PHE must include:
- a. The right terms and conditions of service to recruit and retain the best scientists and public health experts from the natural labour pools including the NHS, and facilitate attractive career paths and exchange of staff.
 - b. A learning and developing environment that will maintain and continuously improve the quality and skills base of the public health workforce and encourage, train and develop the next generation of public health experts.
 - c. Recognition of the synergy between research and operational delivery that ensures that we have the best scientists and the best evidence base to support the public health effort.
76. Establishing PHE with the features of an Executive Agency would facilitate the development of the right culture for PHE within the Department of Health.
77. As stated previously, the HPA also believes that emergency planning and resilience would benefit from continuing as a Category 1 Responder under the Civil Contingencies Act, with the obligations and benefits and the inherent cooperation with other Category 1 Responders that flow from the Act.

Conclusions

78. The HPA supports the Government's overall strategy for public health outlined in the White Paper, welcoming its commitment to public health. Nonetheless, clarity is required in critically important areas such as:
- How the independence of expert staff will be safeguarded.
 - How external income streams can be maintained and further developed.
 - How research and strengthening the evidence base can remain an integral part of the organisation alongside operational delivery.
 - How the transition across the organisations involved in emergency resilience will be managed.
 - The roles, responsibilities and accountabilities of different organisations in the public health arena.
 - How the National Institute of Biological Standards and Control's functions will transfer into the Department of Health.
79. Action in these areas is required to mitigate risks to the public and ensure the delivery of an effective public health service and safe emergency response system.
80. The HPA believes that a number of these risks and issues could be more effectively managed if PHE were created with the features of an Executive Agency in the Department of Health, in line with the logic in recommendations made by the Public Administration Select Committee in their recent report.
81. The HPA will continue to work proactively with the Department of Health and partner organisations to help clarify these issues, mitigate risks, develop solutions, and build a strong, new, expert, independent and effective public health service for England.