Public health medicine committee  
ARM report 2021

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**PHMC**

**Summary**

The 2020-21 medico-political year has been dominated by two things. The complex and wide-ranging effects of the COVID-19 pandemic and the re-organisation of Public Health structures in England. So it has hardly been a typical year but despite the challenges, there has been much to celebrate, including the opportunity for Public Health doctors to make an invaluable contribution to the work of the BMA.

The pandemic has created many challenges to date and there remain crucial questions and unresolved issues. In particular: the premature lifting of precautions such as mandatory wearing of masks in crowded public spaces and no requirement for testing of those who are vaccinated following exposure to individuals who test positive; future emergence of variants and questions around vaccination policy, for example whether vaccination should be mandatory for frontline health and social care workers, whether children should be vaccinated, booster vaccinations; and what role the UK can and should play in ensuring adults across the world have the same opportunity to receive vaccination against COVID-19.

Looking more widely, there is an urgent need to reduce health inequalities by effectively addressing the underlying determinants of health and to ensure health services are prioritised and organised to address the needs of the populations they serve. The presence of public health professionals and their ability to speak out and publish independently and the willingness of government to be led by this advice, will be key to navigating a path which most benefits the health of the population. We look forward to continuing to collaborate with members of the PHMC and colleagues across all branches of practice, as well as patient representatives, on issues related to the pandemic and health protection and as importantly, in health improvement and healthcare public health, which also have significant and far-reaching impact on the profession and for the public we all serve.

**Pandemic**

In October 2020, when the PHMC formed for the new session, the Committee had already been rising to the unprecedented challenges of the pandemic for ten months. The Public Health Consultants and trainees we represent had been instrumental in countering the first wave in all the UK nations, crown dependencies and across the world. Unfortunately, the UK went into the pandemic with inadequate preparation, greatly reduced Public Health budgets centrally and locally and health inequalities which had widened significantly over the preceding ten years. National policy errors were made from the outset, of which arguably the most serious was failing to include in advisory groups, sufficient Public Health professionals with experience of managing epidemics on the ground and not taking the advice given by those who were there, even at most senior level, or not acting on this in a timely manner. Repeatedly locking down too late and releasing lockdown too early, with inadequate public-facing communications at every stage. Decisions on the procurement of PPE and on the organisation and leadership of testing and contact tracing were seemingly made for the financial benefit of friends of ministers, rather than in the best interests of the population. Investment was made in outsourcing, rather than to support established local Public Health teams to provide test and trace. There has been a lack of transparency around decision-making, a lack of proper accountability and insufficient learning from mistakes. All of this has had devastating consequences for the public health workforce, our medical colleagues and the public, especially those most disadvantaged by geography and deprivation.

Throughout this time, the PHMC, particularly the Executive of the committee, often working long hours alongside us, has made a major contribution within the BMA, in an effort to support our clinical colleagues to stay safe in their frontline roles, to inform evidence-based BMA policy and to communicate with BMA members and the public, through press releases and media appearances. It is impossible to fully detail the breadth and volume of this work but by way of a few examples: we have helped interpret the science of the pandemic through the COVID expert advisory group and the Covid listserver; contributed to the weekly and sometimes twice-weekly, pan-BMA chief officer, national leads and Branch of Practice Chairs’ “8.30 Covid “meetings; answered queries and participated in discussions amongst UK Council members, Consultants, GPs and Ethics’ committees. Areas of work have included: imposition of restrictions; lockdown and lifting lockdown; PPE type and quality; testing in various settings; contact tracing; vaccinations; tourism; schools; the impact of the pandemic on BAME groups and the deployment of recently retired doctors. The majority of the resulting policy documents, briefings and comments, have been used to directly influence decision-makers in government and healthcare and for communications and interviews with the media, across the UK and worldwide.

**Public health workforce survey**

We have carried out a wide-ranging survey of the Public Health workforce, to better understand the impact of the pandemic and resulting changes to working patterns, on our own membership. Concerningly, this survey found very high levels of physical and mental ill health, moral distress and burnout, resulting from longer hours with unpaid over-time, inadequate leave and a lack of consultation and perceived appreciation. There is an alarmingly high proportion of members with a stated intention to permanently reduce their working hours, leave their current post or the profession. Drawing on all this information, we are compiling a Public Health “Manifesto” with clear recommendations for change and we are already working to engage and influence on the key issues for our members, as a committee, through the BMA as a whole and in partnership with others, such as the Faculty of Public Health and the BDA, for example via the Public Health Medicine Consultative Committee.

**Public health restructuring**

Announcements last autumn that PHE would be abolished were received with dismay across the profession; the consensus seemingly that imposing a reorganisation affecting all areas of Public Health delivery in England during a pandemic response, was at best inadvisable and at worst, reckless. The PHMC has engaged alongside the Local Negotiating Committee (LNC) of PHE, the FPH and other bodies, to work together to provide support for members facing huge uncertainties about their future employment and to try to influence decision-making about the nature of the new structures and their relationship with each other and with the NHS and other agencies. Within the BMA, matters of organisational design and policy lie with the PHMC, while collective and individual consultation, contracts and pay, are the remit of the LNC. Many of the key issues are similar to those which arose at the time of previous reorganisations and the PHMC has existing policy in some areas which still have relevance now. Key among these are the non-negotiable demand that the Public Health system should be integrated, not fragmented, with reach, capability and adequate funding and specialist staffing at local, regional, national and international levels and with key partners and agencies, including the NHS and the new Integrated Care Structures. Public Health specialists and trainees should be offered NHS or NHS-equivalent terms and conditions and pay, to facilitate movement around the “system” and should be free to advise, speak and publish on matters of professional concern at any time, without seeking their employer’s consent. For this last reason, it is especially concerning to note the recent proliferation of non-disclosure agreements across the Local Authority Public Health system.