Designing effective central-local co-operation: lessons from Liverpool’s Covid-19 response

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ABSTRACT

We present empirical evidence from anonymized interviews with local leaders on governance challenges facing health and social care in England. Responding to the Covid-19 pandemic has allowed policy practitioners to see the sector’s problems with new clarity and illustrated potential solutions. We draw conclusions about central government policymaking, regional and local policymaking and some specifics of the pandemic response. Even during the Covid-19 pandemic, we found continuity with governance patterns identified in earlier scholarship. Command and control from the center, although understandably prominent as an emergency response, was not the whole story. Network governance was also visible, for instance in the ability of local organizations to shape the design of national policy on community testing. Central government was also persuaded, reluctantly, to share responsibility with subnational policy makers, for example in contact tracing and the use of individual-level health data, when local authorities demonstrated its usefulness and showed ability and responsibility in its management. The stresses of a crisis will always challenge mutual trust between local and central government, but lessons need to be learned. Central government could explain its actions more effectively, be more transparent about acknowledging uncertainty, and avoid promises which run ahead of the possibilities of delivery. We show how, during the Covid-19 pandemic, central government has neglected the potential contribution of local government even more than previously: we go beyond this to suggest practical steps which local government can take despite central resistance, drawing on sound science, insight into local conditions and community engagement.
1. Introduction

This article presents new empirical evidence on how public services actors at different scales of government work together in the health and social care sector. The challenges of responding to the Covid-19 pandemic have exposed existing problems more clearly, above all excessive centralization, but also suggested potential solutions. Our work adds to the existing literature by reporting the results of real-time interviews during the pandemic with people shaping policy, providing otherwise unavailable insights into how power is exercised. England has a particularly centralized governance structure: the power dynamics revealed here contrast with those in more federal or decentralized states. There is no constitutional bar to Parliament revising the status of local government, which has progressively lost legal and fiscal independence for over a century. Governments with Parliamentary majorities have found it advantageous, and easy, to draw power toward the center. England has elected local authorities at county, city and district levels, but only recently any structures at regional level: these, in some cases, have directly elected Mayors (Gaskell et al. 2020). Regions’ powers are limited. Health care is the responsibility of the National Health Service (NHS), accountable principally to central government.

The article’s geographical scope is the area served by the Liverpool City Region Combined Authority (see Figure 1). Liverpool is a city in the north of England, of 500,000 inhabitants, with social deprivation above the England average (Liverpool City Council 2021). The City Council has been controlled in recent years by the Labor Party, the main opposition party in England. Much of Liverpool’s experience of, and response to, Covid-19 has been similar to other British cities. One exceptional feature has been its selection by central government for a pilot of mass asymptomatic serial testing (MAST), discussed below: this pilot has attracted national and international interest (Washington Post 2020). The wider City Region, established with an elected mayor in 2014, has 1.5 million inhabitants.

Our University’s links with local government and health care suggested increasingly to us over the summer of 2020 that there was a governance angle to the problems of the UK’s Covid-19 response. At that stage, many leaders of the local Covid-19 response were concerned by what they saw as over-centralization. They spoke of central government’s impulse to set up new structures which were centrally led and did not make use of existing local expertise or engagement with communities. Liverpool’s successes and failures in navigating this central-local dynamic hold wider lessons.

We interviewed 12 participants between November 2020 and February 2021. Our interviewees were selected for their closeness to the interactions between central government and the Liverpool City Region, and were drawn, mainly at Director Level, from local government, health care and related sectors. Ten hours of interviews were recorded and transcribed. Oral history interviewing of those involved in policy offers insight into the operation of power and its structures which is not available from official documents (Berridge 2010).
Interviewees spoke on condition of anonymity, enabling them to speak more frankly. Given the political sensitivities of their work, they did not wish to be identifiable, for example by recording a job title. The anonymity of the interviewees is problematic, but there was no alternative: our complete anonymity approach was the only one under which the interviewees would permit their evidence to be used. We took an oral history approach to interviewing and analysis, as we have in previous research on the national dimension of the Covid-19 response and in other projects (Atkinson and Sheard 2018; Atkinson, Sheard, and Walley 2019; Atkinson et al. 2020).

Figure 1. Map of Liverpool City Region Combined Authority boundary and constituent local authorities.
2. Policy problem: governance at different scales

Our findings contribute to two debates. First, they provide material for looking at the epidemic response and learning lessons for future emergencies (Boin, Lodge, and Luesink 2020). The success or otherwise of co-operation between government organizations at different scales has emerged as one important issue, in the UK and elsewhere (Cairney 2021; Weible et al. 2020). There will be future epidemics, and lessons from Covid-19 need not only to be learned but applied (Haddon et al. 2020).

Cairney’s recent work on the UK’s Covid-19 response (Cairney 2021) usefully frames some issues about relationships between different scales of government. For him, actors in “multi-centric” policymaking should ideally recognize the limits of central government control. In practice however, Cairney finds that policymakers in the UK are “too driven by the idea of order: maintaining hierarchies, and producing top-down strategies and performance indicators to monitor and control the public sector.” Local problem-solving and learning would have produced better responses to Covid-19 but the UK government has centralized the (inevitable and necessary) process of trial and error in Covid-19 response, all the while trying to claim that central government has the solutions. Rubin and de Vries’ work on the Covid-19 response in Denmark underlines how different public authorities can have different ways of making sense of a crisis, leading to misunderstandings between them (Rubin and de Vries 2020).

A second, wider, debate for which our findings are relevant concerns governance and devolution. What has the highly unusual experience of pandemic response showed us about the continuing question of how well government actors at different scales work together? Our focus is on health and social care, fields often neglected in debates about devolution (Quilter-Pinner and Gorsky 2017). Studying an epidemic response is an opportunity to redress this imbalance.

Discussion of the national-level governance of English health and social care is well framed by Alvarez and Mays (2008), who address the debate over whether central government is adopting a “command and control” approach – top-down intervention – or gradually losing power through the rise of “network governance.” They use Rhodes and Dunleavy’s (Rhodes and Dunleavy 1995) concept of the “core executive” to argue that central government “command and control” measures are a reaction to the increasing complexity and difficulty of managing the policy process. The growing intervention of the media in health policy is a good example, which the core counters by trying to manage the flow of information from local health care organizations to media organizations.

It is surprising that more recent work has not drawn on this important article. One influential contribution which does is Ferlie (2017), who shows the continuing validity of Alvarez and Mays’ hypothesis since 2014, noting how, despite a rhetoric of market-led devolution, the center intervened heavy-handedly when financial deficits emerged in local NHS organizations (Alvarez and Mays 2014). The UK government response to Covid-19 has been the strongest ever peacetime manifestation of “command and control,” and hence the best illustration yet of this centralizing impulse, especially as a reaction to crisis.

During the early months of Covid-19, Government frustration that the health system was not more responsive to its instructions led to plans for centralizing reforms.
These are expressed in the 2021 Health and Care Bill, still under debate at the time of writing. They would give Ministers more control over the National Health Service Organization, NHS England (NHSE), which in turn will restrict local policy autonomy by diminishing NHSE’s capacity to filter and buffer central demands on the NHS (Guardian 2020). A sense of proportion is needed, though: Klein, the authoritative voice on the politics of the NHS, wisely stresses (Klein 2013) that changes in governance produce gradual, not radical, change in health and social care services. This should make us question how far-reaching any Covid-related changes to governance will be in the long term.

Besides the national dimension, subnational policymaking (however downtrodden in England) also matters. Arnold (2020) concentrates on the machinery for co-operation between different levels, and concludes that Covid-19 has laid bare longstanding failings. Controversies between Metro Mayors and the center about funding for Covid-19 response illustrate a need for mechanisms to manage relations between the center and local authorities, after a decade of “institutional churn.” Existing literature on central-local relations tends to emphasize how in the UK these may be shaped by national-level political strategies, as in Mackinnon’s work on the so-called Northern Powerhouse, the northern regions of England (Mackinnon 2021). This perspective emphasizes the tactical importance, in learning from the Covid-19 response, of framing proposals with an appeal to the center as well as to local authorities.

Other scholarly work provides further useful framings for the lessons Covid-19 response tells us about broader governance problems. Lorne et al. (2019) review the literature on regional co-ordination of health and care in England. They find that “regions” (with populations greater than three million) have progressively lost influence (in our own view, since the 1980s), sidelined in favor of centralized forms of performance and financial management. This was abundantly clear in the Covid-19 response when three separate national structures found it necessary to reinstall liaison machinery at a regional level, as we discuss here.

Hammond et al. (2017) critique NHSE’s creation of intermediate-level Sustainability and Transformation Plans (STPs), arguing this is not a technical exercise but an example of “post-politics—closing down the political dimensions of policy-making by associating ‘place’ with ‘local’ empowerment to undertake highly resource-constrained management of health systems, distancing responsibility from national political processes.” Taking a similar line and again exploring relational understandings of place, Bambra, Smith, and Pearce (2019) argue that it is essential to “scale up” our analysis of public health and health inequalities to bring the “vertical,” or national-local, axis into view, because the social determinants of health are determined in turn by political and economic structures and relations, among which national ones are influential. Many policy levers (such as fiscal ones) reside, in England, at national level. Both these groups of scholars helpfully develop Alvarez and Mays’ (Alvarez and Mays 2008) effort to nuance the idea that central government is simply imposing more and more control. They suggest that, in addition, it disguises this behavior by proclaiming that local authorities are the responsible ones. An informed reading of the Covid-19 response, in the UK and worldwide, would highlight which public health policies can be adopted effectively at local level and which require the support of central government.
International evidence so far suggests that the quality of co-operation between levels of government has more impact than the degree of centralization (OECD 2020). In that light, the most interesting questions are about how different scales of government can work together. But Gaskell et al. (2020) point to the weaknesses in this co-operation in British systems of governance which Covid-19 has revealed. They find that the UK’s response to Covid-19 has neglected the “knowledge and resourcefulness” held in local centers of governance “which, if leveraged, can enable responses that benefit local communities and highlight best practice or innovative measures.” Cairney (2021) doubts this will happen, taking a pessimistic view of central government’s willingness to delegate and let local authorities learn from experience. Our findings here provide some partial relief to this pessimism, identifying opportunities for local actors to carve out some degree of agency.

3. Discussion: the Liverpool city region and central government in the Covid-19 response

3.1. Co-operation in general

Several interviewees referred to the degree of trust that central government had in local government (perceived to be low), and vice versa. This reinforces Cairney and Wellstead’s (2020) finding that trust is an essential consideration in Covid-19 policy design. We find that trust between different scales of government is a particularly important element of the quality in these relationships which the OECD (2020) sees as critical to success. Our interviewees spoke of a poor relationship in the early months, which improved substantially through the summer and autumn of 2020 as local government worked on being seen as a trusted partner: the success of this was reflected in the selection of Liverpool for the MAST pilot, discussed below.

Local actors expressed understanding for central government’s “command and control” response, but regretted many of its consequences. As a hospital manager said,

> being given local discretion and autonomy about how you deliver [an] objective, is probably a better way of working, rather than thinking you can actually run the show from Whitehall [central government] (interviewee D)

Some went further: one observed a contradiction between the centralized NHS response and emergency planning legislation giving roles to Local Resilience Forums (interviewee G). There was a widespread view that those taking the early central decisions were ignorant of what local government did, notably in social care, and overconfident in their own capacity to reach the right decisions unaided. One example given was Merseyside Resilience Forum finding itself obliged to buy personal protective equipment (PPE) for social care use, as central plans had not included social care (interviewee I). Central government showed little understanding of the role of the Director of Public Health (DPH). Our interviewees said this apparent ignorance of local government extended even to the Ministry of Housing, Communities and Local Government (MHCLG). They felt it led to many missed opportunities to use local knowledge and capacity for engagement with communities, especially those which are hardest to reach. These findings underline Gaskell’s (2020) conclusions about the
center’s underestimation of local authorities’ knowledge and resourcefulness, a point to which we will return.

Some interviewees found the governance of the national response to Covid-19 unclear, making it harder to identify who the necessary central contacts were. It was noteworthy that three separate national structures, the Department of Health and Social Care, NHSE, and the Joint Biosecurity Center, each found it necessary to improvise new forms of regional liaison machinery, with conveners rapidly drafted in, frequent calls with already busy chief executives and DsPH, and a roving team of Cabinet Office officials visiting the regions. This sudden reversal of the center’s pre-Covid rejection of the use of such machinery is instructive. We can update Lorne’s (Lorne 2019) account of the decline of regions and suggest that the center sometimes still finds that it needs this machinery, even if the role it envisages for it remains limited.

The NHS did have lines of upward as well as downward communication. The Chief Medical Officer had weekly calls with DsPH, and he was cited as an advocate of co-decision between government and local authorities on such matters as the allocation of authorities to different tiers of local restrictions (interviewee L). These improvised arrangements in response to an urgent problem suggest that Arnold (2020) is right to see a need for better mechanisms of central-local co-operation.

3.2. Appropriateness of central decisions to local circumstances

Did national decisions work for the Liverpool region? One area where respondents felt they did not was in awareness of the impact of social deprivation. They reported little grasp at the center of how deprivation would affect individuals’ ability to comply with shielding, one describing dealings with the center about this as “a shambles” (interviewee G). One public health officer suggested that, in Whitehall, health inequalities were always viewed as a black and minority ethnic (BAME) issue: central officials found poverty much harder than race to build into their thinking (interviewee L).

Another area of comment was the way that central decisions, although driven by data, sometimes relied on data exclusively and not on “the story behind them” (interviewee D). Some interviewees spoke of a lack of dialogue about interpretation of the data, and made the point, also heard from elsewhere in England, that the release of the first lockdown in June made sense for the timing of changing infection rates in the southeast, but came too early in (for example) Liverpool. In the early months of the epidemic, interviewees found the center much more prescriptive than later. Some felt that their own early responses to the epidemic succeeded despite central interventions rather than because of them, for example when they drew on local clinical expertise in place of central PPE advice (interviewee D).

3.3. Openness of center to local input on policy choices

Our interviewees felt that national decisions were better when Whitehall listened to local voices, and reported some success in bringing this about as the epidemic progressed. Interviewees’ account of the first wave of infection was mainly critical of central government: some (e.g. interviewee C) spoke of last-minute decisions made
without apparent reference to local bodies. We heard too of local public health leaders’
eagerness to influence national policies, and frustration when they were unable to, for
example over school closures, or income support payments to those required to
self-isolate.

Several interviewees spoke of Liverpool—or its region—working to gain a more
influential voice at the center, and having some success. For a city with a history of
problematic political relationships to central government, this was seen as a break-
through. Part of the reason for it seems to be a matter of timing. We heard that in the
first wave of infections, transmission peaked first in London, and London had to devise
the response strategies, whereas in the second (autumn 2020) wave, the highest infec-
tion rates came to cities like Liverpool first and it was their responses which influenced
the learning of other places.

However, the main source for Liverpool’s sense of a growing influence over policy
seems to have been the successful management of a local outbreak in August 2020 in
the deprived Princes Park area of the city. Success in dealing with this outbreak
resulted from familiar public health approaches: rapid engagement, deployment on the
streets knocking on doors (reaching those with no digital access), and the willingness
of community members to join the response. For example interviewee L recalled “the
image of an ice cream van driving down Princes Park, handing out leaflets encouraging
people to be tested.” The successful management of this local outbreak led to the Prime
Minister’s office taking a particular interest, with an exercise to identify lessons learned
and a visit from Whitehall officials (interviewees A, B and L).

In October 2020 local authorities were assigned to one of three tiers of lockdown
restrictions. Liverpool’s discussions with the center about this concentrated on the
need for rapid action, such as strengthened contact-tracing, rather than (like the Mayor
of nearby Manchester) a straightforward struggle for the maximum funding for
response measures: this approach seems to have added to Liverpool’s influence:

it wasn’t an issue of whether we were going to go into tier three [the strictest level of
local lockdown] or not, it was that we need to go into tier three, and we need to do it
in a way that is going to get the best for our population. (interviewee L)

Improving relations with the center were most clearly shown by the government
decision shortly afterwards to locate the MAST pilot in Liverpool, discussed later in
this article.

3.4. Quality of communications from center

Were national decisions, once made, communicated well? Everyone we spoke to was
critical, generally regarding communication as one of the weakest features of central
government’s performance. One criticism, directed at NHSE, was that their need to
influence a national news agenda made them take a very controlling approach to what
the local NHS could say to the media, a clear confirmation of Alvarez and Mays’
(Alvarez and Mays 2008) expectations of “core executive” behavior. Interviewees
described communication as reactive, failing to convey a long-term or medium-term
vision (interviewee C).
Initiatives were announced as realities before they were fully under way. Examples given included PPE supplies, vaccination plans and funding for infection prevention and control (interviewee F). A particular concern was the center’s message that using lateral flow testing (LFT) would allow relatives to visit care home residents, which was seen as an example of the Prime Minister oversimplifying and overselling (interviewee K). This presented local services with serious problems in managing public expectations which they felt had been unjustifiably built up. Central communications lacked the credibility essential to managing an epidemic. In one telling football metaphor, we were told that the government “lost the dressing room” early in the epidemic, in the controversy about the Prime Minister’s Chief Adviser Dominic Cummings’ alleged noncompliance with lockdown rules (interviewee L).

3.5. Devolution of decisions to local levels

The discussion this far has been about national decisions and their communication. We also asked whether more decisions should have been taken locally. One local government interviewee (interviewee K) noted the centralizing tendency represented by cuts in the public health grant to local government over several years, resulting in fewer local public health staff. What surprised this interviewee was that this grant was not increased in 2020 in response to the pandemic.

Most of the comments we recorded under this heading concerned the test and trace service, initially set up as a new national entity using private contractors. This approach was criticized by nearly all our interviewees. They stressed the greater effectiveness of using staff with more understanding of local geographies and social conditions, and simply the way that members of the public were more willing to answer a call from a local number and more forthcoming on the telephone with staff sharing a local accent.

NHS Test and Trace has developed considerably from its initial form. Many local authorities have set up their own tracing services, with varying degrees of co-operation with the national operation. Our interviewees often recognized the need for both national and local elements, but were disappointed that the center had not drawn on the important existing public health experience in contact tracing when designing and staffing the system. However, interviewee H, while sharing the disappointment at the centralization of the early model, sounded a note of caution about whether all local authorities and DsPH could in fact have discharged all the local responsibilities they were requesting.

Since summer 2020, NHS Test and Trace has worked at building a more effective relationship with local public health services. This has not been a smooth process, and interviewee E commented that the center tried to hold onto control until it became too hot to handle, then devolved responsibility rapidly. This has echoes of Hammond’s (2017) account of a center creating fairly illusory “local empowerment” so as to distance itself from responsibility for processes actually driven largely by national decisions. Other comments we heard about test and trace were more positive, for example that, while more devolution (e.g. a regional hub, and district “spokes”) would have been better, the service was nonetheless improving.
Some of our interviewees felt that relationships with individual civil servants at the center were good, and problems only arose when an issue had political as well as operational implications. One general conclusion drawn by interviewee B was that central government does know that it cannot succeed without local government, but remains bad at involving local partners in co-decision. This source remarked on how government keeps being surprised by local government independent-mindedness, for example in raising the issue of funding when told to do something. It appears that, during the pandemic as previously, central government tends to see local government as its local arm of service delivery, not as a publicly accountable institution in its own right. This leads to a reluctance to involve local authorities in decisions.

3.6. Willingness of center to share data with local organizations

The sharing of individual-level health data in real time has been an issue between central and local government around the country. Our interviewees felt that initially, the central attitude had been arrogant and ignorant, with an assumption that local analysis was either superfluous or would be of low quality (interviewee K). Central information governance officials did not recognize a need for public health officers to have the real-time access to individual data which the latter wanted for local contact-tracing, and to plan for surges in demand for health and social care services.

The Cheshire and Mersey Health and Care Partnership, which serves the Liverpool City Region and the adjoining county of Cheshire, was the body responsible for securing and analyzing health data for the Covid-19 response, and hence for resolving these problems. In May 2020, health leaders in this space set up a combined NHS, local authority and public health data/intelligence system, CIPHA, the Combined Intelligence for Population Health Action initiative. Over the summer of 2020, detailed work between local and central officials resolved many of the conflicts about data flows. We were told that central government was now persuaded of the merits of a “National Grid” model of health data management rather than an entirely centralized one (interviewee J). Local actors reported that timely data was now arriving where it was needed.

3.7. Case study: the MAST pilot

Liverpool’s experiences during its participation in the MAST pilot for central government provide some of the best examples of its relationship with the center. This section presents a case study which draws out their significance. The selection of Liverpool for the MAST pilot illustrated how the city had become a trusted partner for central government by October 2020. The pilot’s origins lie in a government concept of mass testing. The Department of Health and Social Care (DHSC) approached Liverpool City leaders on 31 October, proposing that 75% of the asymptomatic population over the age of 16 be tested in two weeks (Department of Health and Social Care [DHSC] 2021). After the pilot had started, the city renegotiated this goal to a more targeted serial testing approach, whose goal was to control outbreaks and determine when and how release from control measures would be possible, facilitating social and economic recovery. The new approach was described as SMART (systematic, meaningful,
asymptomatic, repeated testing). In a reflection of central government’s earlier reluctance to share timely information with local government, one of our interviewees reports that the Prime Minister’s office initially planned to announce Liverpool’s selection before speaking to local leaders (interviewee B).

Testing commenced on November 6 as a second national lockdown began. With the assistance of 2000 Army personnel, 48 new test sites were established in the city, using a stock of Innova lateral flow devices that had been bought by national government. Results were reported to individuals in 30–60 min with the required actions they should take, and also reported from NHS Test and Trace to CIPHA. During the pilot period to December 23 2020, 25% of city residents took up LFTs and 36% took up LFT or polymerase chain reaction (PCR) tests, identifying 897 individuals as positive via LFT and 2902 via PCR.

An interim evaluation report was published on December 23, 2020 (University of Liverpool 2020). Its main conclusions were that while testing most of a UK city’s population on a “mass” voluntary basis was not feasible, “large-scale, intelligence-led, targeted, and locally driven community testing, in concert with other control measures and vaccination, can support Covid-19 resilience and recovery.” Local knowledge and targeted communications, including tackling misinformation, were essential. Awareness of the pilot was high and attitudes toward it were generally positive. Collective identity and social responsibility were key motivators of testing uptake.

In the discussions of the pilot, interviewees with both Liverpool and central perspectives commented that the center “got more than it bargained for,” finding its Liverpool counterparts a determined and effective group with clear ideas about how the pilot should run – notably that testing should be targeted rather than aspire to reach the whole population (interviewees B and L). The decision on the choice of test sites was also handed over to local control after the initial selection failed to incorporate critical local knowledge. The MAST pilot was also, among other things, a chance for those in the city to contribute to the national debate, for example over what was required for safe visiting of care home residents. Interviewee G reported feeling more able than before to influence events at a national level.

While Liverpool participants cautioned against uncritical rollout of LFT, its rapid extension was one of central government’s aims. The center wished, for example, to use a “rapid community testing surge” in local authority areas of concern (HM Government 2020). In our interviews, staff in Liverpool felt that when they discovered “an inconvenient truth” about the sensitivity of the Innova test, central government stopped trusting their judgment. The clearest example of this concerned using LFT to enable visits to care home residents. Liverpool piloted this in 13 care homes as part of the MAST pilot: a national pilot also took place in late 2020. Liverpool staff concluded that a cautious approach to using LFT to enable care home visiting should be investigated first, with two tests within 24 h before a visit. This was not accepted by government or indeed by other authorities in the city region (interviewee F).

While Liverpool leaders were, on balance, positive about the impact of the MAST pilot on their relations with central government, others reminded us that taking part in a pilot made Liverpool a special case. One of the other Metropolitan District Councils in the City Region pointed out (interviewee I) that the provision of 2000 Army
personnel was not available to other authorities, and that resentments could arise for Liverpool’s special position.

Summing up, Liverpool leaders who were close to it saw the MAST pilot as an example of City people’s commitment to developing new ways of working. This included significant involvement from Higher Education Institutions. Interviewees felt the MAST pilot was a success, and hoped that it could be a model for future civic action. Far from simply providing people to deliver a national initiative, “mass testing,” they emphasized the City’s role in using local knowledge and public engagement to shape a testing strategy tuned to local needs and goals.

4. New directions and recommendations for improvement

The shortcomings of the Covid-19 response demonstrate the need for a radical rethink of relations between different scales of government in England. That could involve delegating decision-making, giving more local policymakers more of the resources, control, and freedom to learn from experience (Gaskell et al. 2020). As Sam Freedman, a Conservative former Special Adviser to government Ministers, has written:

Over five decades British governments of all stripes have chosen to hollow out local government and centralise numerous aspects of delivery …

A genuine attempt at reforming the “wiring” of the British state would require taking the kind of systems-approach that [Dominic] Cummings waxes lyrical about and applying it to the entire system of policy design and delivery; looking at the relationships between central and local government as well as the proliferation of non-elected regional bodies and the private sector. This is, of course, conceptually, and practically, much harder than pretending you can solve the problem by [simple measures within central government]. (Freedman 2020)

Cairney points out that the UK Government is unlikely to take such advice, because “Westminster systems encourage stories of accountability based on central government control” (Cairney 2021). In the absence of such central commitment to devolution, some progress is still possible. A number of things worked well in Liverpool, demonstrating the usefulness of local government, and can be built on here and elsewhere. After a shaky start when the center did not trust local actors, the sharing of data became a valuable resource for managing and targeting local epidemic response. The region’s CIPHA initiative carried conviction at the center because it demonstrated responsibility (e.g. over confidentiality), ability, and usefulness. When local agencies had successes (the management of the Princes Park outbreak is the best example), they made sure that the center knew: the center at this stage showed a willingness to learn lessons and identify best practice.

The experience of running the MAST pilot in Liverpool demonstrated that local agencies with a confidence in their own abilities and their own understanding of local circumstances were able to shape a national initiative to better meet local needs. Local actors did not duck controversial issues such as the sensitivity of the Innova LFT or the implications of reopening residential care home visiting. They succeeded nonetheless in retaining the confidence of their national counterparts that their arguments were based on evidence and on public health needs.
At regional level, interviewees were equivocal about the performance of regional policymaking machinery. Preexisting problems about the geographies of organizational co-operation surfaced. Doubts were expressed about whether either the Liverpool City Region or the NHS’ new Cheshire-Mersey Integrated Care System (successor to the STP described above) were the right scale of geopolitical units to succeed. Several referred to political difficulties between the smaller local authorities and Liverpool city, above all a wish not to lose a local identity within the City Region.

There were other difficulties, especially of communications. Some of the points complained of, such as changes in central policy at short notice, are largely explained by the circumstances of the pandemic, with great uncertainty and the need for rapid learning (Weible et al. 2020). Other issues could be handled better: the center could build greater credibility with its audiences, including local agencies, by explaining its actions more effectively, being transparent about uncertainty, and by avoiding promises which run ahead of the possibilities of delivery. (This became a severe problem in relation to, for example, care home visiting.)

Another area for improvement was the center’s understanding of local service delivery issues. Examples we heard included a lack of comprehension about how social deprivation affected service use, and a general lack of knowledge about what DsPH and their staff would be able to contribute. This may reflect a hollowing-out of central government leaving it with fewer resources to devote to retaining these kinds of knowledge. The pandemic may, we hope, lead to a re-setting of the balance of priorities between efficiency and resilience, in which this kind of capability could be increased. To give a small example, the need for central departments to improvise forms of regional liaison during the pandemic, now crystalizing into “Covid-19 Regional Partnership Teams” (DHSC 2021), suggests that it would be wise to consider the reintroduction of permanent machinery of this kind.

What does the Covid-19 response tell us about earlier models of health policy governance? In Alvarez and Mays’ terms, the pendulum swung back toward command and control, but local examples of network governance survived and delivered well, for example local authorities’ “test and trace” operations, the NHS’ regional Covid-19 response cells, and the co-ordination of health data. One risk now is that as the center brings forward its latest governance reforms in the Health and Care Bill, it will reveal a stronger appetite for command and control which, on the evidence here, is not justified. Our interpretation of the Covid-19 response in the Liverpool region is that, in general, things subject to command and control worked the least well, those under network governance the best. And as Klein (2013) has reminded us, radical policies to shake up the governance of health and social care often have modest results.

5. Conclusion

The challenges of responding to Covid-19 have cruelly exposed the harmful effects of the excessive centralization of governance in the UK, above all in health and social care. The experience of the last two years confirms many of the earlier analyses of scholars: among others, of Alvarez and Mays, and Ferlie, that much of this centralization is a defensive response to complexity (no peacetime challenge has been more
complex than Covid-19); of Mackinnon, that central-local relations are at the mercy of central power plays, and of Gaskell, that the center lacks trust in local actors. This is a challenging picture for those who hope for better-governed health and social care systems, and the evidence we present here suggests the price to be paid for failing to make progress, but we also uncovered some signs of what is possible.

A problem-solving approach combining the rigorous use of data and science with political pragmatism has allowed Liverpool to build a better relationship with central government in the last two years. The history of public health provides much evidence of the effectiveness of this approach to health challenges. DHSC recently declared that the new UK Health Security Agency, which took over Public Health England’s health protection functions in October 2021, “is committed to empowering local leaders, ensuring they have the appropriate tools and resources, and working in partnership to co-design the ongoing response to COVID-19 and other threats” (DHSC 2021). If UKHSA does do this, it will be a welcome departure.

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