SHAPE the Future – Resilience, recovery and renewal

Call for evidence

Please complete this form and return by email to covidandsociety@thebritishacademy.ac.uk by Friday 29 August 2025

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Background

The British Academy is launching a new phase of our *SHAPE the Future* programme, which seeks to bring together insights and evidence from the Academy's last four years of work and from the wider SHAPE (Social Sciences, Humanities and the Arts for People and the Economy) community, to examine the progress made against the long-term societal impacts identified in the Academy's 2021 *Covid Decade* reports and offer lessons learned from the Covid-19 pandemic. In doing so, we hope to mark the middle of the 2020s - the 'Covid decade' – with reflections on the country's policy response to the challenges of recovery and renewal following the Covid-19 pandemic.

Aims of the call

In this next phase of work, we are seeking engagement with a wide range of individuals and organisations with expertise on the core public policy areas of focus identified in *Covid Decade* as being key for successful social and economic recovery:

- **Health and wellbeing**
- **Digital society**
- **Social and cultural infrastructure**
- **Education and employment**

In each of these policy areas, we wish to analyse them with these five cross-cutting themes in mind:

- **Governance -** How Covid-19, and the government response to it, has affected relationships between national and local actors, accountability for decisions, and freedom of the individual.
- **Trust -** How Covid-19, and the government response to it, has affected society's trust in information, data, the media, political institutions, and the role of science and experts.
- **Cohesion -** The effect of Covid-19, and the government response to it, on relationships within and between communities of people and ideas.
- **Inequalities -** The role of Covid-19, and the government response to it, in highlighting, ameliorating, causing or exacerbating inequalities.
- **Sustainability -** How Covid-19, and the government response to it, has affected the way we think about, and the importance we attribute to, issues of sustainability and how we balance present needs against preparing for the future.

Responding to the call

Responses to the call for evidence should consider the main policy challenges within these policy areas but should also consider the effects as related to one or more of the cross-cutting themes. For example, your evidence could look at how Covid-19 has changed inequalities in mental health provision, how Covid-19 has had an impact on trust and cohesion in a particular local area, or how Covid-19 has raised questions about sustainability and our relationship with nature.

To help with our analysis, we ask that you aim to provide your evidence as a response to the following questions (if you provided evidence to the first phase of the SHAPE the Future/COVID Decade work, please consider these with respect to the main challenges and opportunities in the policy areas that you identified in your evidence submission):

- What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged?
- What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?
- How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?
- Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?

Respondents should aim to draw on evidence from either existing research or from their professional experience in the areas under investigation. This might include, for example: survey data, interviews and focus groups, reflections from practitioners, case studies, historical examples, or insights from experiential or quasi-experimental studies. Please provide references and links to relevant sources wherever possible.

Publication of evidence

The evidence collected in this call will be analysed alongside evidence from the British Academy's policy programmes and funded research since the publication of the original COVID Decade reports, as well information gathered through a reference group of external stakeholders, and continued engagement with the British Academy Fellowship and research award holders. A final report is expected to be published in early 2026 based on the analysis of evidence from these sources

The British Academy policy team plans to publish a list of the responses that we receive in response to this call as part of an evidence hub on the British Academy website, as we have done for earlier phases of the SHAPE the Future/COVID Decade programme. We ask for your contact details so that we can engage with you on this consultation if needed, but we will keep any contact details provided confidential.

Your response

Full name	Alice Bradbury
Job title	Professor of Sociology of Education
Organisation / University / Research institute	Co-Director, Helen Hamlyn Centre for Pedagogy 0-11 Years (HHCP) Department of Education, Practice and Society UCL Institute of Education University College London

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Cohesion • Inequalities
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Please see our blog here and linked research on the government's response to Covid in terms of education, and the failure to listen to research gathered at the time. Teachers knew what children needed to recover from the pandemic – but their insights were ignored
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	

Question	Response
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	

Your response

Full name	Anna Powell[1], Osman Sankoh, Laura Salisbury, Sharifah Sekalala, Patricia Kingori, Halina Suwalowska, Cara Wilkins, Ruth Ogden
Job title	[1]Research Fellow
Organisation / University / Research institute	[1]Liverpool John Moores University

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• **Health and wellbeing** • Digital society • **Social and cultural infrastructure** • **Education and employment**
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• **Governance** • **Trust** • **Cohesion** • **Inequalities** • **Sustainability**
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	We have identified the following factors as critical to understanding the progress and challenges from COVID-19. **1. Conceptualisations of time in crisis** Since COVID-19 there is greater recognition of the need for global partnerships (and public-private research collaboration) which bring together knowledge and can respond rapidly to emergent threats. However, current conceptualisations of crisis management remain linear, with the core objective of getting to "the end" of the crisis. By conceptualising crisis as either active, or ended, narratives and policy fail to acknowledge the drawn out and prolonged nature of the crisis – after its official end. In reality, endings of crises are rarely absolute as illustrated by Ebola. On 14th January 2016, amid much media fanfare, the end of the Ebola emergency in West Africa was declared (World Health Organisation, 2016). After two years and over 11,000 deaths, the Ebola outbreak had finally ended. A day later, however, an update was issued - a new case was reported in Sierra Leone (SL) and

Question	Response
	others quickly followed (World Health Organisation, 2016). In Liberia, the end of Ebola was initially declared in May 2015 (World Health Organisation, 2015). Next came a cycle of official 'endings-and-detections' in July and November 2015, and March-April 2016 (CDC (Centers for Disease Control and Prevention, 2016). These 'endings' continued until 9th June, 2016 – six months after Ebola's official ending in West Africa (World Health Organisation, 2017). However, in early 2021, during the COVID-19 pandemic, the Guinea Republic experienced another Ebola outbreak (Aborode et al., 2021); despite the official declaration of the end of Ebola. The protracted end of Ebola is reminiscent of the detection and spread of new COVID-19 variants. Ultimately, the terminology is misleading, as that a disease has 'ended' often only means widespread acceptance that it has moved into an endemic state (Greene & Vargha, 2020). Premature ending announcements such as these can undermine trust in government and erode social cohesion. Whilst governments are often motivated to capitalise on the kudos of ending – because it implies that their actions have somehow bought about a positive outcome for all, the timing of these endings often fails to align with public perceptions and expectations. Professors Ogden and Kingori (2022) collected data the day after the UK government officially ended COVID-19, finding that of over 1,300 people, 57% disagreed that lifting restrictions signalled the end of the pandemic, and less than 25% felt that doing so was morally right. Critically, only 10% of respondents reported that the government (as opposed to medics) should decide when the pandemic is over. This work highlights the need for improved public communication of the rationale behind decision making at a local and national level. Indeed, Professors Greene and Vargha (2020) argue that crises are not merely biological, but also social, with each element having its own impact on daily life and mortality rates, and not necessarily subsiding on the same timeline. Linear representations of crisis exacerbate existing inequalities. Declaring the ending of a crisis leads to a drop in resources, despite ongoing needs in affected communities, as happened in 2016 with Ebola (Salisbury et al., 2025) and COVID-19 for individuals with long-covid, and those whose education and employment were disrupted. Critically official endings can obscure important counter-narratives and undermine social, environmental, political, and epistemic justice, as those 'left behind' are excluded from

Question	Response
	discussions of whether the end has been achieved, is achievable, or how it might be brought about (Knight, 2016). Additionally, overlooking what comes after 'the end' compromises the management of ongoing and future crises in ways that are in sync with those most affected. Lived experiences of continuities, endurance, and survival that occur after the end are frequently overlooked, despite signalling where global health might mitigate ongoing inequities and injustices. Understanding what happens after the end of crisis is critical to reducing inequality. When global outbreaks of disease are declared 'over', what, when and for whom is an end 'the end' and what happens after? How do declarations of ends shape personal experiences of crises ongoing access to care, health and obligations? Our groups are currently exploring these critical questions in the Wellcome Trust Discovery Award (After the End). Our case study of the ending of the Zika outbreak in Brazil in 2016 offers important lessons for post crisis management in the UK. Through "ending" the Zika crisis and failing to acknowledge the ongoing needs of marginalised groups, particularly mothers of children with zika-syndrome, existing inequalities and vulnerabilities were exacerbated. Preventing the perpetuation of structural barriers to equality, autonomy and prosperity in post-crisis times requires careful work to understand the needs to the most affected (Diniz et al., 2025). **2. Vaccine development success, hampered by inequal distribution and increased vaccine hesitancy** COVID-19 demonstrated the potential for powerful global collaboration through rapid development and distribution of vaccines. As King (2024) states, this was made possible by several interrelated factors: the availability of pre-existing research and adaptable platform technologies such as mRNA and viral vectors; early State investment that allowed manufacturing and clinical trials to proceed in parallel; and the presence of flexible, scalable manufacturing infrastructure supported by contract manufacturing organisations. Regulatory bodies also played a crucial role by adopting flexible approaches, including emergency use authorisations, rolling submissions, and rapid reviews. Furthermore, coordinated global efforts, led by organisations such as the World Health Organisation (WHO), the Coalition for Epidemic Preparedness Innovations (CEPI), and the COVID-19

Question	Response
	Vaccines Global Access (COVAX), enabled knowledge sharing and technical support, while public-private partnerships provided essential funding and resources. Together, these efforts enabled fast and widespread vaccine deployment. These elements highlight the importance of sustained investment and collaboration in pandemic preparedness, and that it is possible for these to occur. However, despite these advances, vaccine barriers have been exacerbated by COVID-19. Indeed, even during the pandemic, vaccines were not distributed equally – such as the 'vaccine apartheid' observed in late 2022, by which many countries in the Global North had vaccinated over 80% of their populations, while countries in the Global South were struggling to reach even 25%. Professor Sekalala (2025) argues that this was the inevitable result of "entrenched colonial power asymmetries". These include intellectual property laws and donor-driven initiatives, which keep the Global South in a "state of dependency", and discriminatory border policies that stigmatise Global South nations. Such structures systematically limit the autonomy and capacity of these countries to produce and distribute vaccines independently. Furthermore, attempts to solve these structural issues through an urgent 'Pandemic Treaty' to address this inequity, focused on speed instead of the underlying equity issues, risks sidelining low- and middle-income countries from meaningful participation, as they typically operate with smaller delegations and fewer technical resources. The new pandemic treaty has now moved the most contentious issues on access and benefit sharing to a further agreement. However, without deliberate attention to time equity (the fair allocation of time and resources needed for such decision-making), the treaty and its attempts to fix structural issues around vaccines may replicate the same exclusionary dynamics that undermined global solidarity during COVID-19 (Sekalala et al., 2024). In addition to these global and systemic barriers, individual and population level barriers have also been aggravated by the handling of COVID-19. Vaccine hesitance (the delay or refusal of a vaccine, despite its availability), has increased since the pandemic, across multiple vaccines (Widyaningsih & Hakim, 2024). Hesitance is typically higher in ethnically minoritised communities, which leads to health inequalities in disease outcomes such as influenza (Powell, Jones, et al., 2025). Preliminary analysis of interviews and focus groups (conducted January-May 2024) with 55 members of the public, 14 community engagement workers, 20 primary healthcare staff, and 10 policy professionals, suggests that barriers

Question	Response
	to influenza vaccination increasingly reflect COVID-19 legacy effects. These include vaccine fatigue, misconception and confusion around the difference between COVID-19 and other winter illnesses, and diminished trust in healthcare systems and authorities – stemming from perceptions around how the pandemic was managed, including 'Partygate' (Powell, Van Hout, et al., 2025). This erosion of trust will likely have been further intensified by the US Health Secretary Robert F Kennedy Jr's recent announcement that he intends to cancel $500 million in funding for mRNA vaccine development. Kennedy claimed, without scientific consensus, that "these vaccines fail to protect effectively against upper respiratory infections like covid and flu" (Tanne, 2025). This contradicts peer-reviewed evidence showing mRNA vaccines reduced severe COVID-19 outcomes by ~90% in clinical trials (Baden et al., 2021; Polack et al., 2020) and real-world effectiveness studies demonstrating 70-90% protection against hospitalisation (Vasileiou et al., 2021). These assertions disregard the pivotal role mRNA technologies played in the COVID-19 response, and the importance of their rapidity and scalability in future pandemics. Such rhetoric not only undermines the global scientific community's ability to respond swiftly to future pandemics, but also risks further deepening public mistrust of that same community. Vaccines should not be considered a panacea, Vaccine development and distribution are typically time-consuming processes, yet the speed with which COVID-19 vaccines were deployed was a testament to prior time and resource allocation. If such preparation is undermined by funding cuts, the ability of any government to respond swiftly in future emergencies is severely compromised. Strategic prior investment of time and resources is essential to ensuring a timely and effective response when a crisis occurs. Equally important is allocation of resources and research into understanding and addressing vaccine hesitance, which plays a critical role in supporting distribution, and therefore in strengthening overall crisis response. **3. Societal progression hampered by institutional regression – a desire to return to the past** While vaccine development showcased global coordination capabilities, workplace policy responses revealed a different temporal dynamic – one where institutional memory seemed to favour regression over consolidation of beneficial changes. For

Question	Response
	example, the COVID-19 pandemic accelerated the adoption of remote and flexible work models (Vohra et al., 2024). Due to the necessity of adapting to such arrangements during the pandemic, it acted as a catalyst for the Employment Relations (Flexible Working) Act 2023, brought in to reflect the changing expectations of the UK's workforce, and to streamline the process for employees to request flexible working. Data from the UK shows that over 25% of all workers indicate that their home is their main place of work (Chung & Yuan, 2025). Around 40% of people work from home at least once a week, and 25% do so three or more days a week. Such arrangements associate differentially with various benefits, the patterns of which are gendered. As a UK-based example, women experience greater wellbeing when working from home, while men thrive more on flexitime, though both genders benefit somewhat from either (Agnoletto, 2024). Improvements are likely driven by better balancing of work with caregiving and household responsibilities, which are experienced differently across genders and high- and low-income levels. Women across both income groups benefit from flexible working, likely due to bearing the burden of these responsibilities regardless of income; while men in lower income households (perhaps less likely to delegate these tasks) benefit more than those in higher income households (Agnoletto, 2024). The continuation of these work models since COVID-19 may therefore reduce inequality via lessened work-family interference for women, and for men from lower income households. Additional to the personal work-life benefits, flexible arrangements also increase productivity and job satisfaction, though can lead to adverse personal outcomes when people experience higher employer expectations, such as work exhaustion (Vohra et al., 2024). However, despite evidence that such work models are beneficial, and indications that they are becoming the norm, some institutions (particularly large private sector employers) have stated they wish to reverse these working conditions by increasing mandated office days (CIPD, 2025). Employees are resistant to this, with women and young children describing themselves as less likely to comply with return to office mandates (Chung & Yuan, 2025). This increases the risk that women and parents who remain remote working may face stigma, bias, and career penalties. Regarding conceptualisations of time, this seemingly demonstrates a desire by institutions to regress back to pre-pandemic practice, rather than to support the continued embedding of these beneficial work practices into post-pandemic life. This institutional

Question	Response
	regression can also be observed on a wider level, for example in the U.S. withdrawing from the WHO, and in the decline of international cooperation on public health surveillance. This is evidenced by the weakening of key institutions such as the U.S. Centers for Disease Control and Prevention, which has faced funding cuts, political interference, and reduced global engagement. It appears that there is a lack of clarity and vision around the nature of a post-pandemic world (aka the future), versus the pre-pandemic past, and around how targeted support can be a step towards to embracing those positive outcomes of the pandemic, and in reducing inequalities. Furthermore, it could be argued that if institutions are determined to look to the past, they should instead consider reparations in the form of transformative structural changes to address global health inequities, an enduring injustice rooted in colonial legacies (Sekalala, 2025). **4. Simultaneous addressing and embedding of health inequalities** A key benefit is the acknowledgement of one of the challenges: that COVID-19 exacerbated health inequalities. This prompted local councils to consider novel methods of engaging marginalised communities, for whom more conventional methods may be less effective. A successful example of this includes the community champions model implemented by Liverpool City Council in 2021, partly inspired by the Kenya Community Health Strategy (Liverpool School of Tropical Medicine, 2024), which involved using trusted community messengers to deliver targeted intervention within community settings (Ministry of Health, 2006). Another instance is the Cheshire & Merseyside Living Well Bus, a mobile drop-in service launched in 2022, which aimed to take COVID-19 vaccinations to the communities (NHS Cheshire & Merseyside, 2023). Both these strategies continue to be used and have been expanded to promote and provide other preventative healthcare priorities (such as breast cancer and cervical screening, and other vaccinations) for marginalised groups. However, while there have been strides related to such approaches, COVID-19 still exacerbated existing issues (alongside the vaccine-related problems already described), both directly and indirectly. Indeed, service provision by the already stressed NHS now faces even larger delays and backlogs resulting from the pandemic; waiting times for both treatment and emergency continue to be far higher than those pre-COVID, cancer targets are

Question	Response
	still not being met, and GPs are struggling to make referrals due to capacity issues in secondary care (British Medical Association, 2025). Furthermore, as an example of an often-overlooked adverse healthcare impact of the pandemic om marginalised groups, one could consider alcohol-related harm. During COVID-19, alcohol use behaviours intensified, with heavier drinkers increasing their use (Boniface et al., 2022). This, in combination with the reduced availability of support, resulted in an increase in alcohol-related deaths and unplanned admissions, moreso in deprived populations (Quelch et al., 2023). The increased use among heavier drinkers is anticipated to last beyond the pandemic, potentially for up to five years, with an estimated NHS burden of £1.1 billion over the next 20 years (Angus et al., 2022). Additionally, that alcohol-related emergencies rose, indicates that the increase in drinking was to a harmful level. As a result of these combined factors, it is expected that services will experience a "monsoon" of individuals with alcohol-related brain damage (ARBD, an umbrella term for cognitive impairment and behavioural changes following chronic harmful alcohol use) (Quelch et al., 2023), a potentially reversible condition (Powell et al., 2024), but for which there currently no consensus guidelines for its assessment, diagnosis, or management. Following the pandemic, there are likely increased rates of those living with newly developed ARBD, plus worsened outcomes in those who already had pre-existing ARBD (due to lack of available support during the pandemic). This is a group whose needs are often unmet, who have grown in number due to the pandemic, and who are expected to overwhelm services within the next few years. Like a ripple that continues to spread, this is a further example of how long-term consequences challenge the idea that crises can be neatly managed from beginning to end.
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	Broadly speaking, the pandemic demonstrated that the UK population is not well-prepared for significant societal change that happens very rapidly. Anyone can remember the empty supermarket shelves in March 2020, fuelled by panic buying as people worried that they did not have the necessary resources to cope if they were unable to purchase items later. Some of this stockpiling was misguided, with less necessary items amassed (toilet paper being a notable example), as uncertain citizens struggled to assess what was needed. This bulk-buying impacted more vulnerable groups unable to participate due to lower monetary resources, mobility, or social support – with increased

Question	Response
	demand demonstrated at food banks, who in-turn faced supply issues (Power et al., 2023). Indeed, there is currently a lack of well-promoted public health guidance in the UK on how families and individuals can prepare for specific forms of threat, or for situations which would require them to be able to survive without access to their usual resources. While this COVID-19 stockpiling was not unique to the UK, citizens in our European counterparts are more likely aware of specific advice regarding the resources they should aim to prepare to enable them to survive and manage during crises. It is anticipated that after an adverse event, emergency services may not be able to reach everyone within the first 72 hours, and therefore, among other key actions in their 2025 Preparedness Union Strategy, the European Commission prioritises developing guidance to enable people to be "self-sufficient" during that critical 72-hour window. This is typically achieved through an "emergency kit" of water, food, important documents, cash and other items. Within the EU, certain countries, such as Sweden and Finland, have strong longstanding public campaigns encouraging citizens to prepare in this manner. Outside the EU, Japan, Canada, the USA, Australia, and New Zealand are also notable in this regard. In the UK, emergency preparedness is primarily guided by the Civil Contingencies Act (2004), which mandates planning for a wide range of threats, via several agencies, including the UK Health Security Agency. Individual preparedness is promoted to the public through the Prepare campaign (an informational website: https://prepare.campaign.gov.uk/) launched in May 2024 by Deputy Prime Minister Oliver Dowden, described as a response to the poor preparedness highlighted during COVID-19. The website offers advice on creating household emergency plans (including a printable template), first aid resources, alerts and warnings for risks (e.g., flooding, fires, extreme weather), information on preparing the home (e.g., insurance, fire safety checks, knowledge of gas/electricity/water controls), and guidance for vulnerable groups. Individuals are also advised to keep an emergency kit or "grab bag" for an emergency that lasts "a few days" (no specific timeframe is given), with recommendation on what items to include. Prior to this, emergency bags were first promoted to the UK public by a booklet sent to citizens in 2004, and then by local authorities through multi-agency Local Resilience Forums (LRFs), who shared guidance via websites and social media posts, though the messaging and frequency of this varied (Pickering et al., 2018).

Question	Response
	LRFs still give information tailored to local risks and support, and can be accessed through the Prepare website. Despite this recent Prepare campaign, a Cabinet Office (2025) national survey of 10,536 adults found that only 13% of respondents felt that their household was largely or totally prepared for an emergency/disaster (32% felt moderately prepared, while 51% felt slightly or not at all prepared). Similarly, in the event of a scenario that prevented access to usual resources (a power cut that also impacted gas and water supply), only 39% of people thought they could meet their basic household needs for 2-3 days. While 47% did report having some essential items stored in one place (e.g., a radio or important phone numbers), 19% had not undertaken any preparations listed. Importantly, 75% said they had not seen or heard advice in the last 12 months about how to prepare for emergencies or disasters in the UK, and 82% had not visited the Prepare website – indicating that whilst guidance is available, it has not yet been effectively promoted to communities. Pickering et al. (2018) highlight that the UK has previously lacked consistent public messaging on this, and suggest that tailored messaging should be utilised to promote emergency bags. Indeed, that the current level of unpreparedness should be observed even after such a significant global emergency as the COVID-19 pandemic, is concerning. It further demonstrates that the current approach towards crises as 'beginning', 'middle', and 'end' is not suitable, as it does not encapsulate the permanent nature of the impacts of such situations. It should therefore be a priority for the UK government to promote a clear set of public health guidance to enable the public to prepare the items necessary to support them during the recommended 72-hour window. After which, relief efforts such as emergency services, non-governmental organisations, government aid, or mutual support groups, are more likely to be mobilised and able to reach affected citizens. This government-led preparation would significantly support the population's ability to respond to such events, and would therefore best-place them to start adjusting to the realities of their "new normal" (or "recovering" if thinking in linear terms), once relief efforts are in place and the initial crisis has ended. Finland's success with public preparedness messaging stems from integration into national service requirements and school curricula. UK adaptation could leverage existing PSHE (Personal, Social, Health and Economic) education frameworks, requiring minimal legislative change but coordinated implementation across education authorities. We recommend the Cabinet Office allocate

Question	Response
	£2.5 million annually for a coordinated preparedness campaign, delivered through local authorities and featuring: (a) standardised emergency kit guidance aligned with EU recommendations, (b) annual household preparedness assessments via council tax communications, (c) community resilience training programs targeting vulnerable populations, with implementation beginning April 2026.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	Effective policymaking in this context should be that which displays adaptability, equity, and foresight. Frustratingly, UK institutions showed both resilience and regression during the pandemic, revealing structural limitations in how time, change, and recovery are conceptualised. As argued above, policymaking often follows a linear temporal model of 'beginning, middle, and end', which fails to account for the enduring nature of societal disruptions. The assumption of both government and other institutions (e.g., employers) of a "return to normal" ignores the permanence of societal shifts because of such massive incidences, and undermines progress made. To be effective, structures should strive to embrace continuity and permanence, not just crisis-response cycles. This means recognising that the effects of major societal threats, such as pandemics, do not dissipate with the immediate danger, but instead reshape the social fabric in lasting ways. This conceptual limitation was evident in the UK's phased pandemic strategy: "contain, delay, research, mitigate"(Department of Health and Social Care, 2020), which, as Professors Baraitser and Salisbury (2020) argue, framed time as something to be managed rather than experienced, closing down opportunities for reflection and care. Their work on "Waiting Times" highlights how delay, often seen as bureaucratic failure, can instead be reimagined as a space for ethical attention, especially in healthcare, where waiting is a core experience. Yet UK governance largely failed to embrace this temporality, opting instead for urgency-driven interventions that neglected long-term consequences. Similarly, containment was reduced to epidemiological control, overlooking its potential as a form of psychological holding, while mitigation failed to address the layered suffering: physical, emotional, and social, experienced by those most affected. A tendency toward premature closure was further exemplified by the government's "Living with COVID-19" strategy (Cabinet Office, 2022), which formally ended most legal restrictions and shifted responsibility from public institutions to individuals. By withdrawing free mass testing, routine contact

Question	Response
	tracing, and the requirement to self-isolate, the policy signaled an "end" to the UK experience of the pandemic, despite ongoing transmission, unequal vulnerability, and indications that this was not supported by the Scientific Advisory Group for Emergencies (Vaughan, 2022). In doing so, the UK government reinforced the linear temporal model and sidelined those for whom the crisis remains active. As described regarding inequal vaccine distribution, vaccine hesitance, ARBD, NHS backlogs, and individual preparedness, let alone those who are immunocompromised or are experiencing long-COVID, time is not, as often considered, a "great healer." For those already marginalised, time embeds disadvantages. Existing inequalities become entrenched when governance structures rely on the assumption that a crisis can end cleanly, and that time past this point is restorative. Mechanisms and policies must appreciate that their role is to mitigate the impact of time on recovery, not to facilitate it passively. Until this is acknowledged, our framework for responding to and managing crisis will never meet the needs of the most vulnerable. Effective policymaking must therefore be cyclical, inclusive, and attuned to the long tail of societal trauma. Until institutions embrace the permanence of disruption, recovery will remain a privilege, not a policy. However, while our critique of premature endings focuses on their harmful effects, we recognise that governments face legitimate pressures to signal control and restore public confidence. Alternative framings could achieve these goals without abandoning ongoing support needs. For instance, shifting from 'ending the emergency' to 'transitioning to sustainable management' maintains institutional credibility while acknowledging continued challenges.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	As described, approaching pandemics through the lens of linear time, with the assumption of absolute endings, fails to deliver the sustained resources and support required for recovery, which exacerbates inequalities. International examples offer alternative approaches that challenge this logic and foreground equity, continuity, and community engagement. For instance, the experiences described in West Africa regarding Ebola illustrate the cascading nature of endings, where the social, psychological, and economic consequences persist long after the epidemiological threat subsides. Professor Diniz et al. (2025) in their guidance on research preparation for the Oropouche virus in

Question	Response
	Brazil, advocate that effective responses must be shaped through dialogue with those most impacted. Given that health crises such as Zika and COVID-19 disproportionately impacted pregnant women in Brazil, they advise that future preparedness must centre women and families in research, collaborate with trusted women-led associations, equip community health workers, and prioritise clear communication and emotional support. It is urgent that we realise these lessons to be learned from the global south and avoid perpetuating colonial approaches to understanding holders of knowledge. Such approaches resonate with the UK's need to move beyond linear, top-down models. One instructive example is the work led by Professor Chan, which has contributed to the development of public health interventions in disaster-prone regions across various countries. This approach is grounded in long-term relationships with communities, often built through years of fieldwork and collaboration with local leaders, health workers, and educators. These partnerships ensure that interventions reflect the specific risks, resources, and cultural practices of each community. By distributing emergency kits, promoting disease prevention, and delivering tailored health education, this work reflects an 'all-of-society' approach to risk reduction (Pickering et al., 2018) rooted in trust and local knowledge. Importantly, it exemplifies a wider ethos of transnational solidarity and mutual aid that is increasingly vital in global health responses. Finally, the UK should consider improving preparedness in securing critical supplies, especially in light of the severe shortages experienced during the COVID-19 pandemic. Like Canada and the U.S., the UK faced severe shortfalls in essential items, particularly personal protective equipment (PPE) (Zbyszewska & Sekalala, 2023). These shortages were largely due to an over-reliance on global supply chains and private companies (who attempt to keep costs low by only ordering supplies when needed), and poor stockpiles of supplies due to underfunding and fragmented supply chains. The UK should look to other countries such as Norway, who make use of exceptions within international trade rules to build ongoing stockpiles, and therefore are better prepared for future crises. Additionally, stockpiling strategies should be guided by a feminist ethics of care, emphasising the importance of everyday items like PPE and the needs of frontline workers (including those in the social care sector), rather than focusing on high-end equipment (e.g., medicines and medical equipment). This approach prioritises care not only during emergencies but also in

Question	Response
	daily healthcare settings, helping to build more sustainable and equitable supply systems that truly support those who provide and receive care (Zbyszewska & Sekalala, 2023). These models align with the broader argument that effective policymaking must be cyclical, inclusive, and attuned to lived experience. The UK would benefit from such approaches, not only to prepare for future emergencies, but to reimagine recovery as an ongoing, relational process rather than a return to a pre-crisis norm. Crucially, understanding lived experiences of time and temporality of the endings of crises, and the moral and ethical responsibilities of global institutions in the aftermaths of such crises, is key to progressing in this space. Success under a non-linear framework could be measured by: (1) maintained funding for post-crisis populations at 80% of peak levels for 24 months, (2) inclusion of affected community representatives in 'ending' decision processes, (3) establishment of monitoring systems tracking long-term impacts for 5+ years post-declaration.

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Your response

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Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Digital society • Social and cultural infrastructure • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Trust • Cohesion • Inequalities
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Some of the progress made in relation to making work accessible for disabled people, via remote/flexible working have been rescinded since the pandemic. Whilst simultaneously proposing to cut benefits to disabled people and those suffering with ill health. **Source:** The following contribution is adapted from a Blog entitled 'Learning from older and disabled people's experiences during the pandemic: envisaging a better future of care', written in 2025. A special issue in *Frontiers in Sociology* which I edited with Dr Maria Berghs De Montford University, showcased papers by **McFarland et al.** in Canada who found that pandemic time enhanced access for people growing older with or into disability via online technologies. Whereas the shifting from 'pandemic time' to 'normal' in-person interactions, excluded those who continued to remain at risk to COVID and because in-person spaces are designed for 'normal' bodies. **McFarland et al.'s** work highlighted the need for technological advancement to be designed with not just for older and disabled groups. Digitalisation can both include and exclude older people,

Question	Response
	and this was also found by **Konig and Seifert in their work** reporting older people's internet usage in Switzerland and reiterated a need to focus on including and making accessible technology for older people. In another paper showcased in the special issue, **Alnamnakani's in-depth account** of one disabled, older Muslim woman's experiences of multiple forms of discrimination during the pandemic in the UK, powerfully illustrates the indirect impact that the COVID-restrictions had on experiences of disablism in that time and space. Zora suffered gender-based abuse on public transport. However, she refused to be labelled as a victim, instead called herself 'brave' for acting against her abuser by reporting it and thus addressing the collective safety of women in society.
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	The lessons the government need to learn in response to and to avoid the further entrenchment of ageism, disablism and ableism in society are as follows: (**Source:** The following contribution is adapted from a Blog entitled 'Learning from older and disabled people's experiences during the pandemic: envisaging a better future of care', written in 2025.) **The need for an anti-ableist and anti-ageist ethics of care** **In my paper** the ethics of rationing treatment using utilitarian triage tools is discussed. Particularly in the first wave, age was used as a proxy measure for health, instead of making personalised decisions based on need. **Maria Berghs et al.** also discussed how people with sickle cell disease in the UK were in fear of being 'triaged' and there not being anyone to advocate for them if admitted to hospital. Ableism alongside racism contributed to their condition being placed lower down the hierarchy of illnesses which are taken seriously in the provision of care services. There is no convincing evidence that the government is aware of the impact that the failure of British Governments to protect particular aged, disabled populations from COVID-19 in subsequent policy proposals. For instance, the lack of ongoing protections for these vulnerable groups since 'Living with the virus' in 2021 and returning to 'normal' working/societal practices (including pressure being put on employees to return to fully in person working and lack of mask wearing in high-risk medical/transport settings) has received limited attention. The

Question	Response
	mental and physical health impacts on groups with intersecting inequalities, based on age, disability, class, gender, and ethnicity, has not been considered or subsequently ameliorated in policy. In fact, since Labour came into power in July 2024, they have announced a number of ageist and disablist policy changes, which include, restricting the Winter Fuel Payment to groups of older people (subsequently rescinded following public pressure), and publishing a green paper which plans to restrict the eligibility for Personal Independence Payments (PIP) and freezing the health elements of Universal Credit. Most notable in these policy developments, is the lack of meaningful consultation with older and disabled groups on these proposals and the missing or underestimated negative effects on these groups assessed via full equality impact assessments.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	**Source:** The following is adapted from a policy brief which highlighting key messages and recommendations from internationally impactful monograph (Simmonds, B. (2021) *Ageing and the Crisis in Health and Social Care: Global and National Perspectives*, Bristol Policy Press). The COVID-19 pandemic hit after a decade of austerity, when health and social care services in the UK were not able to provide good quality care or dignity to older people. Health and social care were already in crisis and susceptible to underperforming when any pressures were exerted on the system — for instance, a pandemic. The decades of neoliberalisation and privatisation of health and social care have exacerbated the class and aged based inequalities, which the welfare state was originally constructed to eradicate. These inequalities were laid bare by the high number of deaths, particularly of older people. Mazzucato (2021) argues to fix 'wicked' problems, such as health and social care, governments must be reimagined and reconfigured to achieve their mission. *Ageing and the Crisis in Health and Social Care* argues that we should begin with the restructuring of welfare states around the principle of universal care for all, whilst resisting and reversing the unjust neoliberal marketisation of care systems. Care systems need to be opened up to new collective ways of thinking, which move away from outdated notions of care as 'women's work' to broader conceptualisations of providing care within interdependent communities. There needs to be legal protection of older people's right to health care, and ageism must be challenged in society

Question	Response
	more broadly. Governments urgently need to learn from their past mistakes to prevent more older people dying needlessly. **Do older lives matter?** During the COVID-19 pandemic, neoliberal rhetoric has been successful in perpetuating intergenerational ageism (Walker, 2012), by arguing that older lives are perceived as worth less than younger lives. Age discriminatory practices were seen clearly operating through a number of 'exceptional practices' during the first wave, including unsafe hospital discharges, blanket 'Do Not Resuscitate Orders' and a denial of medical treatment or transfer to hospital (Calvert and Arbuthnott, 2021). Further, intergenerational ageism has also helped to justify the multiple delayed and rescinded public health measures, such as lockdowns, face masks, social distancing and test-track and isolation measures. However, ageist practices which have neglected older people in the health and wider social system have a long history. Successive governments since the 1980s have hollowed out health and social care services, which have left the system extremely precarious. **Failure of residential adult social care organisations** The 'Caring for people' White Paper (DH, 1989) insisted that 85% of local authority budgets had to be spent in non-public sectors (Glasby, 2017). Previously, 80% of budgets were spent on public sector residential homes (Barron and West, 2017). This reversal of funding sources marketised and commodified social care, while leaving the responsibility for purchasing, providing, and regulating care to the public sector (Barron and West, 2017). A few companies capitalised and bought up large sections of the care home market (Scourfield, 2011). By 2015–16, five large, commercialised organisations were running chains accounting for 35% of the beds for adults in residential care (Harrington et al, 2017). These big chain organisations are based on similar financial models as those developed in the private equity sector, where shareholders invest funds in high-risk, high-return, financial projects (like startup companies) or bail out failing organisations (Harrington et al, 2017), inappropriate for low risk sectors like adult social care (Horton, 2019). These conglomerates are making up to 19% profits (Harrington et al, 2017) which should be invested into public services, not into shareholders' pockets. Further, the structures of these organisations are so complex that the accountability for the flow of public funds is difficult.

Question	Response
	Improving integration or increasing privatisation? The UK government has acknowledged that care for older people is inadequate and not fit for purpose (DHSC in Health Policy Insight, 2021). Although integrated care systems (ICSs) look promising, several criticisms have been levelled at them, including a lack of transparency, unrealistic financial savings and hospital admission targets, and a lack of involvement with the community (Charles, 2020). Further, the overall control of the NHS (including ICSs and NHS England) passing to the Secretary of State for Health and Social Care, who would have the potential to intervene in the delivery of local health services, is concerning (McKenna, 2021), particularly considering the management of NHS Track and Trace is outsourced to private companies. Furthermore, the draft act does not address the deep-rooted inequalities within the system, particularly the urgent need to reform social care or chronic workforce shortages (McKenna, 2021). **How can they be improved?** **Innovative, alternative health and social care models** Over the years, many alternative innovative health and social care solutions have been trialled in the UK but not adopted fully. The four examples discussed in the book are: • Homeshare scheme • Therapeutic nursing homes • Age-friendly cities • Relational/ asset- based approaches. What these examples of innovation have in common is: 1. A focus on the quality of relationships between people, whether they are related or not. Outcomes-based approaches are far superior, as they focus on what care means subjectively to particular individuals. Care could be listening to someone talk about their day or a simple hug; care is socially and culturally constructed, and that is what process- based models do not capture. 2. Relationships engendered by holistic models, which do not reduce older people to their physical or biological functions, are needed. Instead, the whole person is considered, including their psychological and social wellbeing (Burns et al, 2016).

Question	Response
	3. Reciprocal relationships. The older person is not reduced to a passive entity 'to' whom something is done. Instead, they are treated as someone 'with' whom something is done (Barnes et al, 2018). There is an exchange of activity, interaction, knowledge, experience or feeling that demonstrates the agency of both parties (Sevenhuijsen, 1998). Moving on from the tragedy of COVID-19, there is a unique opportunity for transformation and change. The pandemic has highlighted our interdependence and collective responsibility, like never before 'COVID- 19 and lockdown have taken us to a moment of viscerally experiencing our interdependence: in shared risk, shared care, shared experience' (Melville and Wilkinson, 2020: 40).
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	**Source:** The following is adapted from a policy brief highlighting key messages and recommendations from internationally impactful monograph (Simmonds, B. (2021) *Ageing and the Crisis in Health and Social Care: Global and National Perspectives*, Bristol Policy Press). The 'lessons learned to date' report (House of Commons, 2021) was highly critical of the government's management of the COVID-19 pandemic, citing that the UK government could have learnt from other countries to better protect the lives of their citizens. This echoed my book's analysis: Germany's health and social care system fared much better, with its locally organised and devolved federal system. The UK government could have learnt from Germany in its handling of the first wave of the COVID-19 pandemic, particularly in relation to the legal protection of older people's right to health care and the implementation of track and trace to control the spread of the virus. Source: Simmonds, B. (2021), *Ageing and the crisis in health and social care: Global and national perspectives,* Bristol, Policy Press p102-103). "The German health system was founded on corporatist traditions, establishing an insurance system (Moran, 1999). Since the 1950s there has been a shift from health services being free at the point of contact, to patients contributing to the costs of health care consumption (Moran, 1999). Following mass unemployment after reunification, markets and state regulation were introduced — both key characteristics of neoliberal politics (Moran, 1999), as is customer choice, competitive tendering and pressure to derive

Question	Response
	profits from 'efficiency savings' (Moran, 1999). From 1994, all older people (and the rest of the population) were insured for health and social care costs (Busse and Riesberg, 2004). However, the health insurance reforms of the 1990s did lead to the marketisation of the residential and home-based care sector, however, the dominance of charities providing residential care has largely continued (Bahl, 2003; Grohs et al, 2015). Due to the decentralised political and financial structure, the provision of end of life care has received criticism for being patchy or non-existent (Buser et al, 2008). As has involving older patients in end of life care discussions in hospitals (Jox et al 2010). Nevertheless, by law, older people have the right to choose whether care be provided by family, domiciliary, residential or ambulatory carers (Bahl, 2003). When it came to respond to Covid-19, Germany's federal state system, with local health authority autonomy, swiftly implemented 'test and tracing' systems, unlike the UK, which contracted out testing to an accounting firm (Reintjes, 2020; Mazzucato, 2021). Germany went into lockdown on 16 March 2020 and visiting bans to residential care homes were strictly enforced (Carroll et al, 2020). A two-week quarantine procedure was also strictly enforced for residents being discharged from hospital back into their residential home. As a result of these measures, only 0.4% of older people in residential homes in Germany died from Covid-19 by 23 June 2020. In comparison, after the first wave of Covid-19, the UK rate was 13 times higher, at 5.2% (Comas-Herrera et al, 2020). It is prohibited to discriminate against people based on age in Germany, and this legal framework may lie behind the rigour with which residential homes and people in receipt of domiciliary care were protected (Comas-Herrera et al, 2020). Therefore, although Germany also provides care to its older residents privately, it outlawed age discrimination legislatively and its local health authorities were able to respond quickly to protect older people during the first wave of the Covid-19 pandemic. As the second wave of Covid-19 infections began to rise in the Autumn of 2020, Germany's government introduced 'lockdown light' in November, but restrictions were quickly tightened (Sinclair, 2021). Shops and schools were closed over December 2020 and into January 2021, with the numbers of people able to meet indoors limited to five (France, 2020). The national lockdown was extended until mid-February 2021, with new instructions to require higher grade face masks on public transport and in shops, and employers instructed to allow people to work from home (Sinclair, 2021). Although Germany had challenges with its

Question	Response
	vaccination programme (administrative and cultural), with only 13.8% of the population having received a first dose by the 8th of April, a change in strategy from mass vaccination centres to family doctor surgeries has increased the vaccination rate (Metro US, 2021). Notwithstanding the initial problematic vaccination strategy, Germany's death rate for Covid-19 on the 8th of April, was still significantly better than the UK, at 39th in the world, with 935 people dying per million of population (de Best, 2021). There are lessons that the UK government could have learnt from Germany in its handling of the first wave of the Covid-19 pandemic, particularly in relation to the legal protection of older peoples' right to health care and the implementation of track-and-trace to control the spread of the virus (Mazzucato, 2021). Yet, as described, the UK failed at implementing these measures and has been slower to enact national lockdowns and requirements to wear face masks. However, the UK government, also has another challenge to its precarious health and social care system: the aftermath of Brexit."

Your response

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Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Digital society • Social and cultural infrastructure • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Trust • Inequalities • Sustainability
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	This submission relates to the UK government's response to the mental health crisis in the UK and the parallel digitalization and platformization of the therapy sector. The research and writing that this report relates to is UberTherapy: The new business of mental health published by BUP in October 2025. The key argument is that the emerging financialised model of digital therapy that dominates the therapy sector, including the growing workplace wellbeing, Employee Assistance Programmes and private medical insurance creates services that aim to create attrition for those in greatest need, that deepens pre-existing health inequalities and undermines the safety of mental health services by driving therapists and counsellors into a precarious employment (Cotton, 2018) market driven by platformization.
Question 2: What lessons are there from the pandemic for government's preparation	There is an inherent weakness in the UK Gov response to the mental health crisis in that it assumes an evidence base for NHS services (IAPT, now NHS Talking Therapies) that is highly contested and based on a financial logic for solving a policy problem rather than a clinical one. The original objective of IAPT to increase access

Question	Response
for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	to therapies was ambitious but in reality with the degradation of the service and its link to It has led to the emergence of a highly diluted model of CBT that has let to an 'uberization' of NHS services, and its current digitalization and use of AI technologies to provide MH services (Cotton, 2025). The NAO carried out an inquiry into the gaming of IAPT data in 2018 but the report was never published. Additionally the wages and working conditions of clinicians working within this system continue to fall with a prevalence of low wages, unwaged work and increasing levels of 'wage theft' associated with platformization and the gig economy (Worker Info Exchange, 2024).
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	There has been consistent lack of governance and oversight in relation to both welfare and mental health services, linked through government policy, with the involvement of private insurance and digital providers at senior level in the formation of government health and DWP policy (Pring, 2024). There should be an inquiry into the 'gaming' of the evidence base for short term CBT interventions in the NHS and digital providers such as Palantir and the extraction of NHS data for profit, carried out by the families and survivors of the service and published for public debate. One of the consequences of this model of 'attrition by design' (Cotton, 2025) is the The regulatory solution to this problem is likely not to come from policy actors or the NHS, rather in the emergence of consumer action, advertising standards and the emergence of a field of responsible business and a digital therapy kite mark (www.thedigitaltherapyproject.org).

Question	Response
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	Yes, as a warning the US experience has to be understood in relation to what will happen to medical care in the UK as a result of the growth of private medical insurance, platformization and digitalization of Business to Business (B2B), Business to Consumer (B2C) and direct to consumer business models that include both AI technologies, digital therapy and pharmaceutical prescriptions (Michaels et al, 2023). In the UK context this is a highly unregulated movement from public service to a sector of ecommerce where individuals will self-refer themselves into commercial services. The dominance of a large digital providers who are both predatory and litigious in nature has led to a rise in legal cases being taken on both sides of the therapeutic relationship, including the suing of mental health practitioners and bodies who challenge the legitimacy of digital therapy services such as text based support. To allow the continued uberization of mental health services in the UK will remove any hope of governance and oversight as to the nature and safety of mental health services in the UK.

Your response

Full name	Francesca Humi; Dr Ella Parry-Davies
Job title	Freelance worker for the Covid-19 Inquiry; Lecturer
Organisation / University / Research institute	Kanlungan Filipino Consortium; King's College London

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• **Health and wellbeing** • **Education and employment**
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• **Governance** • **Trust** • **Inequalities**
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Kanlungan Filipino Consortium is a London-based registered charity working to empower Filipino, East and Southeast Asian migrants, advocating for their rights and welfare since 1994. Kanlungan is a Core Participant in the national COVID Inquiry. From the outbreak of COVID-19 in the UK in 2020, Kanlungan has been coordinating frontline mutual aid, research and policy-focussed advocacy for Filipino migrants in the UK. The UK-based Filipino community is remarkable both for the severe impacts that it felt during and after the pandemic (in particular due to the large proportion working in the health, social care and domestic work sectors), and also for the density of community support and mobilisation that arose in response to those impacts. • In Spring 2020, almost 1 in 4 deaths of NHS workers were Filipino, despite making up only 3.8% of NHS staff.[i] • In a survey of Filipino migrants with insecure/undocumented status, 56% had lost all of their

Question	Response
	work and income by June 2020 and were facing destitution.[ii] • From 2020 to 2022, Kanlungan supported over 2,000 people through advice, referrals, and mutual aid support. Since the pandemic, we have noted a generalised and multifaceted failure on the part of policy-makers to take note of lessons learned regarding protections for marginalised (and in particular migrant) communities in the UK; and in contradistinction, a sustained rise in social justice networks and solidarity efforts between communities. This combination has acted to unmask the operations of a state that seems invested in scapegoating and vilifying migrant and racialised people, even in the midst of, and following, a national health crisis in which no one is safe until we are all safe. Specifically: • The Labour government has maintained policies proven to worsen health outcomes, including the No Recourse to Public Funds (NRPF) condition; legislation enacted under the Hostile Environment agenda such as 'right to rent' and 'right to work' stipulations that push irregular migrants into exploitation and housing precarity; and inadequate Statutory Sick Pay, which is not accessible to undocumented workers and also does not sufficiently support work to go on sick leave. • A White Paper entitled 'Restoring Control of the Immigration System' (forthwith White Paper on immigration) lays out a suite of efforts to penalise people seeking asylum and migrant workers, especially those who are considered "low-skilled" yet perform essential functions in society, such as care workers. • The Border Security, Asylum and Immigration Bill (forthwith Borders Bill) is set to intensify a vicious cycle of fear and isolation for migrants by creating new criminal offences and enhancing surveillance, data-sharing and immigration enforcement powers. This cycle worsens labour exploitation, housing precarity and barriers to healthcare access for migrants. Meanwhile, however, grassroots movements and charities have extended solidarity and pointed out the inextricability of struggles over migrant rights, disability justice, anti-racism, housing, working conditions and LGBTQ+ rights. Coalitions have sought to challenge

Question	Response
	and dismantle inequitable mechanisms of governance, and also to meet community needs where governance falls short. For example: • The Status Now Network (SNN), co-founded by Kanlungan. SNN is a coalition campaign for the regularisation of all undocumented migrants in the UK, as a way to guarantee access to free healthcare • The Disability and Migration Network, a network of disabled and/or migrant activists, academics, and organisations coming together to establish links between the struggles for migrant and disability justice
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	**Lessons** A key lesson from the pandemic is that immigration policy crucially shapes access to and delivery of healthcare amidst major societal threats. This is because: • Visa terms dictate working conditions for migrant health, social care and domestic workers, including their rates of pay, contracts of employment, access to sick pay, and their ability to switch jobs or challenge exploitation when their employer acts as an immigration sponsor. Weaker protections for migrant workers facilitate unsafe working conditions, such as lack of sick leave, lack of PPE, and 'no work, no pay' conditions that leave both workers and patients vulnerable. • Immigration policy can create barriers to the public accessing healthcare, for example through an expensive NHS International Health Surcharge, or through the threat of data sharing between the NHS and the Home Office, and immigration checks in NHS hospitals and trusts. These deter migrants and racially profiled groups from accessing healthcare, including emergency treatment and vaccination. • Immigration policy restricts access to public funds, including disability support and emergency refuge for survivors of domestic violence, through the No Recourse to Public Funds condition. Improving healthcare access and delivery must therefore include scrapping NRPF, ending short-term visas that tie workers to employers, and broadly dismantling the Hostile Environment legislation and policy introduced since 2012.

Question	Response
	Calls for change During the pandemic, migrants rights organisations contacted NHS England, local government, and national government to make these concerns heard. Kanlungan engaged with the Mayor of London, London Assembly, and NHS Trusts in London. In January 2021, Kanlungan, in collaboration with Sarah Owen MP, academics, and other community organisations, submitted evidence to the government on their call for evidence on racial disparities.[iii] Kanlungan is now a Core Participant for modules 3, 4, 6, and 10 the Covid-19 Inquiry as part of a group of migrants' rights organisations representing the experiences and demands of migrants during the pandemic, the Frontline Migrant Health Workers Group. Prior to and throughout the pandemic, the government was warned of the impact of immigration policy and the social exclusion of migrants on healthcare access and provision but chose to ignore the evidence and medical advice. For example, in their submission to a call for evidence by the Independent Chief Inspector of Borders and Immigration in 2018, Doctors of the World emphasised fear of data-sharing between the NHS and immigration enforcement as a deterrent to seeking necessary healthcare.[iv] In a rapid needs assessment in May 2020, they further emphasised digital and language exclusion affecting migrant and other excluded groups.[v] A Joint Council for the Welfare of Immigrants (JCWI) report on national recovery from the pandemic in 2021 advised the government to repeal the offence of illegal working and scrap the NRPF condition.[vi] Yet whilst giving evidence during Module 4, which was on vaccines and therapeutics, former Equalities Minister and leader of the Conservative Party, Kemi Badenoch spoke of prioritising border enforcement over public health, saying: "We cannot adjust our health system, in my view, to undermine borders and border security."[vii] **Government responses** Although we are awaiting recommendations from the Inquiry Chair, the current government's approach to migrant workers is not indicative of any commitment to learning lessons from the pandemic and strengthening migrant workers rights. The White Paper on immigration, the Borders Bill, and the Labour government's approach to immigration more generally suggests

Question	Response
	that current and proposed policy is actively eroding migrants' safety and wellbeing in the UK, with implications for all of us. This is evidenced in: • The elimination of the Adult Social Care visa, increasing the risk of irregular migration and irregular employment to fill a known workforce shortage • The restriction of rights to family and spouse sponsorship, and suspension of refugee family reunification applications, undermining migrant rights to family life in the UK • Increasing the income threshold for family and spouse sponsorship • Increased surveillance and criminalisation of irregular immigration, facilitating precarity, exploitation and isolation • Undermining and scapegoating migrants and refugees in public discourse, leading to discrimination and hate crime To avoid catastrophic health outcomes in a future scenario comparable to the COVID-19 pandemic, the government must scrap these policies and implement better protections for migrants in the UK.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	The effectiveness of policy-making institutions and governance in the UK is weakened by a lack of accountability to those most impacted. Experts-by-experience are rarely listened to, which can lead to ill-advised and ineffective policy. A lack of accountability erodes public trust in institutions. There is little accountability of policy makers to people impacted by policies. The Home Office is the institution with the most impact on migrants' lives, but is are not accountable to migrants. Consultations with migrant communities and organisations frequently amount to tokenistic activities, or are part of a political play to achieve the policy change desired. For example in February 2022, while the Nationality and Borders Bill (now Act) was being debated in the House of Lords, Kanlungan participated in a consultation with the Home Office about reforming the Overseas Domestic Worker visa, alongside other organisations supporting and campaigning for migrant domestic workers' rights. The following day, when the Government spokesperson in the House of Lords was asked about making amendments in the Bill to protect migrant domestic workers, especially those who have been

Question	Response
	trafficked or subject to modern-day slavery, he cited our meeting as evidence of consultation and that no further consideration needed to be made. We did not receive any further communication following our meeting with the Home Office. Improvements to effective governance at the intersection of immigration and public health policy would include: • Meaningful and timely dialogue with migrant rights organisations • Accountability via trusted and efficient mechanisms • Establishing trust through reversing existing policies proven to worsen health outcomes
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	A number of countries internationally used regularisation measures to protect public health during the pandemic. For example: • Portugal temporarily regularised the status of all migrants in March 2020[viii] • Italy regularised migrants in specific employment sectors in May 2020[ix] • Colombia regularised more than 1.7 million Venezuelan migrants in February 2021, an initiative lauded by the UN Secretary-General.[x] • Thailand granted two-year work permits to undocumented migrants from Cambodia, Laos and Myanmar in December 2020 to curb the spread of COVID-19.[xi] • Ireland's regularisation scheme of 2022 cited the importance of ensuring migrants' access to healthcare.[xii] In the UK, the Status Now for All coalition campaigned for the regularisation of all migrants, with an Early Day Motion #658 'Leave to Remain Status', which was tabled on 24 June 2020 by Claudia Webbe MP. Despite a concerted upsurge during and after the pandemic in migrant rights organising, recommendations from the sector have yet to be implemented in policy and legislation. As international examples demonstrate, regularisation – when accompanied by equity and anti-discrimination – creates safer conditions for all by ensuring migrants' equal rights and protections, in particular in relation to healthcare access, safe working conditions, and adequate housing.

[i] 'Witness Statement of the Frontline Migrant Health Workers Group', COVID Inquiry Module 3, 2024. p.12
[ii] Parry-Davies, Ella. *A Chance to Feel Safe*,Kanlungan, 2020. p.10.
[iii] 'Response to the Call for Evidence on Ethnic Disparities and Inequality in the UK', January 2021 https://static1.squarespace.com/static/5f369d95ba72601ce27f00bf/t/600a9f5a61523742064e243a/1611308902466/Response+to+the+Call+for+Evidence+on+Ethnic+Disparities+and+Inequality+in+the+UK-21Jan2021.pdf
[iv] Doctors of the World, *Response to the Independent Chief Inspector of Borders and Immigration's call for evidence: Home Office partnership working with other government departments*, May 2018.
[v] Doctors of the World, *A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic*, May 2020.
[vi] Joint Council for the Welfare of Immigration, *Work It Out: Respecting and protecting migrant workers as we recover from the pandemic*.
[vii] Cited in Public Interest Law Centre, 'A Legacy of Mistrust', 27 February 2025. https://www.pilc.org.uk/blog/a-legacy-of-mistrust/
[viii] Chantal Da Silva, 'Portugal's COVID-19 Strategy to Treat Immigrants Like Citizens is Working', 18 June 2020, https://www.newsweek.com/portugal-protecting-public-health-amid-coronavirus-pandemic-means-protecting-migrant-health-too-1506817
[ix] Perna, R., & Puig Batalla, M. (2023). Immigrant regularisation politics during COVID-19: advocacy coalitions and governments' incentives in Italy and Spain. *South European Society and Politics*, *28*(4), 415–438. https://doi.org/10.1080/13608746.2024.2354007
[x] 'UN chief welcomes Colombia's 'act of solidarity' with 1.7 million Venezuelans', 9 February 2021. https://news.un.org/en/story/2021/02/1084202
[xi] Nanchanok Wongsamuth, 'Thailand offers work permits to undocumented migrants to curb COVID-19', 29 December 2020. https://www.reuters.com/article/us-thailand-workers-migrants-idUSKBN293193/
[xii] Dept. of Justice, Home Affairs and Migration press release, 'Minister McEntee announces new landmark scheme to regularise long-term undocumented migrants,' 3 December 2021. https://www.gov.ie/en/department-of-justice-home-affairs-and-migration/press-releases/minister-mcentee-announces-new-landmark-scheme-to-regularise-long-term-undocumented-migrants/

Your response

Full name	Professor Hannah Farrimond
Job title	Associate Prof in Medical Sociology
Organisation / University / Research institute	University of Exeter

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Trust • Inequalities
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	I am an academic who has **expertise in stigma theory, particularly stigma change over time.** I define stigma as a form of social devaluation, a loss of social status, usually with a moral dimension. Individuals that are stigmatized internalise this and feel devalued; they may also experience exclusion, isolation and discrimination as a result. Stigma also causes people to hide their status; particularly important in a viral pandemic when you need to know if people have the virus or not; hiding it through fear of stigma leads to greater transmission and spread. I have published two papers which analysed Covid stigma and Long Covid stigma. Taken together they demonstrate a) that Covid stigma emerged very quickly within Covid, clustered around already marginalised or disadvantaged groups (e.g. widespread anti-Asian stigma; people with obesity or pre-existing conditions) but has largely died out; b) Long Covid stigma (social devaluation due to having Long Covid) is extremely prevalent and ongoing, leading to many people with Long Covid not seeking continuing health-care, as well as becoming isolated and excluded, causing poorer wellbeing. Long Covid stigma has knock-one effects in employment through lack of disclosure, increased disability and

	lack of support in the workplace; c) stigma can be driven by symbolic and unconscious drivers, in the case of Long Covid stigma, most people want to forget the pandemic and this creates a problem for people and health-care systems that need to remember and care for those who live with the health consequences of Covid. The main challenge is **to ensure that health-care in the UK does not perpetuate the stigmatization or exclusion of people with Long Covid or other disabilities/energy-limiting conditions** by either dismissing or not responding to their disabilities or health-care conditions (including mental health) and to lead by example in this regard. **Relevant papers:** Farrimond, H. and Michael, M. (2025)' How stigma emerges and mutates: The case of Long Covid stigma', in Recalibrating stigma: Sociological perspectives in health and illness, Eds O. Williams, A. Chandler, T. Spratt and G. Thomas, Policy Press (Open Access). file:///C:/Users/hrf202/Downloads/978-1-5292-3583-8-ch008.pdf Farrimond, H. (2023) Stigma mutation: Tracking lineage, variation and strength in Covid-19 stigma. Sociological Research Online 28 (1): 171-188. (Open Access) https://journals.sagepub.com/doi/10.1177/13607804211031580
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	• The government should not exacerbate stigma in cases of pandemics (e.g. Boris Johnson writing 'Bollocks' on the first report on Long Covid in 2021 is an example of how stigma and disbelief can be perpetuated at the top of government; individualist public health campaigns which target, say, obese individuals whilst not tackling the structural and industry-based causes of obesity would be another example and have no effect on anyone's obesity or risk of Covid levels either). • All public health interventions should undergo a 'stigma audit' to consider whether they are making things worse and not better in terms of stigmatizing practices- if you create fear, suspicion or scare people then they hide their behaviour; this causes transmissible disease to spread further and does not reduce risk. Public health

	interventions may inadvertently increase disease stigma because policy-makers don't think through the 'unintended consequences' of their campaigns; thinking through these 'unintended consequences' is key to understanding if you are really going to make a positive impact on public health and prevent pandemics widening inequalities. • No, there is no evidence the government is aware of the above, although they do listen to the World Health Organization in terms of naming pandemics without stigmatizing them, this is good practice. Using the term 'M-Pox' instead of 'Monkey Pox' is a good example of this)
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	1. Involving sociologists or critical social psychologists as well as traditional health behaviour psychologists would help governments understand how communication messages about risk and what to do in the face of infectious/transmissible diseases can be more effective and stop the stigma and secrecy that hinders containment. Stopping stigma also contributes to tackling social and health inequalities as stigma always hits those who are already disadvantaged the hardest, which in turn means their risk is higher.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	The World Health Organization, the BMJ, the Lancet etc. all published on the topic of stigma and how it can impede infectious diseases/transmissible epidemic outbreak containment, and the government should be familiar with these guidelines and use communication messages that are in line with them: e.g. https://www.who.int/publications/m/item/a-guide-to-preventing-and-addressing-social-stigma-associated-with-covid-19

Your response

Full name	Helen Lomax
Job title	Professor of Childhood and Children's Participation
Organisation / University / Research institute	Sheffield Hallam University

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• **Health and wellbeing** • **Digital society** • **Social and cultural infrastructure** • **Education** and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• **Governance** • **Trust** • Cohesion • **Inequalities** • Sustainability
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	*When you look on the news, its mainly, erm, scientists' ideas, or big people ideas and I would want that to be a tiny bit more of what the children want to be, want it to see. Like one percent or something …(Peter, Back Chat Lomax and Smith)* 'The Covid-19 pandemic has cast a long shadow over the life chances of a

	generation of children' (Save the Children) This response draws on empirical work conducted during and immediately after the pandemic to consider the challenges that emerged for children's **health, wellbeing, education** and **inclusion** in decision-making (**governance**) (Lomax and Smith, 2022, Lomax et. al., 2022; Lomax and Smith, 2024; Lomax et al. 2025; Tunstall et al, 2024). This evidence, generated with young people. illustrates how children were exposed to greater risk as a result of policy decisions in which they were not consulted and their rights to family life, to information, to share their views, participate in education, play, meet others and access culture were overlooked (articles 9,12,13,15,17, 28, 29 and 31, UNCRC,1989). It considers the impacts of the pandemic and post pandemic socio-economic and policy landscape, and **widening socio-economic inequalities**, to suggest that the health and wellbeing and inclusion of the most vulnerable children needs to be addressed as a matter of priority if children are to flourish and not be further disadvantaged in the case of major societal threats. The evidence for this submission is drawn from recent research projects that explore the health and wellbeing and education of children including those with SEND, minoritized, digitally excluded and socio-economically disadvantaged children (Lomax and Smith, 2021; 2022, 2024, 2025 and

	Tunstall, Bucelli, Grugulis, Henderson, Lane, Lomax et al, 2025): 1/ Back Chat: Participatory research with children during global crises (Lomax and Smith 2020-21) *"I was scared about Corona getting worse … I was worried how it would end because my mum and dad were worried about their jobs … mostly my dad because my mum is an NHS worker .. But, erm, she were **worried** about that .. …and so my family were all **worrying** and I were **worrying** about them, because I don't like to see my family all **worrying**"* (Frankie, aged 10, (Lomax and Smith, 2020-2021). This British Academy funded participatory research heard directly from children (aged 9-12) about the impacts of the Covid-19 pandemic and its continuing effects on their everyday lives, relationships and learning. Bespoke collaborative socially distanced digitally-mediated arts-based methods enabled the direct participation of children identified as disadvantaged (BAME, care experienced, digitally and/or socio-economically excluded children). Findings are available in an animated film, 'Our Voices' and a Zine, 'Back Chat' capturing key messages about what supports children to maintain their relationships, education and wellbeing and what they need to recover now and in the

	future. To hear from children about their experiences *Watch the Our Voices animation* and read the Zine here. 2/ Children's Lives in Changing Places (Lomax, H.; Smith, K.; Alfaro Simmonds, M.; Bond-Taylor, S.; Humphry, D. and Turner, W. 2022-25) *"We don't get a say, we wanted to have a youth council, but (it) never happened" (Declan, aged 13 years).* Funded by the Nuffield Foundation, Children's lives in changing places (CHiLL) was a participatory research project with young people aged 10-15 that sought to understand the lives of children growing up in socio-economically disadvantaged neighbourhoods, what challenges and what support them to flourish, and they can be involved in positive social change. Project findings indicate widening, including gendered and geographical inequalities in children's lives including access to safe places to meet and connect with others that impact their health, wellbeing and opportunities (findings available here) 3/ Insecure lives and the policy disconnect (Tunstall, B; Bucelli, I; Grugulis, I; Henderson, S; Lane, L; Lomax, H; Mangan, A; McKnight, A; Payne, J; Pearse, S; Sorvala, L and Webb, J, 2024-25) *"I have to explain to (my children) what it means to **pay rent** and what it means to pay.*

	*They are **only 9 and 10.** What it means to pay (for) these things and what it means when mummy says we can't have this, **even if it's fruit.** You know fruit is expensive. Things like this. So that was **really stressful,** and I think that it makes you **more sick**"* (Clara-Louise, Tunstall, Bucelli, Grugulis, Henderson, Lane, Lomax et al (2025) This ESRC funded research analysed UK survey data, *Understanding Society,* and conducted in-depth interviews with 36 participants experiencing multiple insecurities (defined as insecurity in more than one dimension of life, such as money, work, housing, food, health or care) to explore what risks and combinations of risks people are facing and how these affect wellbeing, employment and impacts on children. Findings are available here ***Insecure lives: The growth and impact of multiple insecurities*** Collectively these projects illustrate the impact of the pandemic, the global economic downturn and UK policy responses on vulnerable children and their families. This includes rising inequalities and increasing financial, housing and health insecurity, impacting wellbeing and opportunities. Alongside this, children and families described how they feel overlooked by decision-makers, with implications for social cohesion and trust in government. Children told us about

	how their lives had been affected by the pandemic (Our Voices animation), the challenges that remained for them and what that what they need to recover. Illustrated in their Zine this includes the following opportunities that they considered would support their recovery in accordance with their rights (UNCR, 1989): 1/ 'Going Out' (Article 31 right to relax, play, access arts and culture; Article 15 right to meet with other children, join groups and organisations) - Represents children's experiences, and the importance for them, of having the resources and opportunities to meet with other children, to contribute to clubs and organisations, to spend time outdoors, including in quality green space and take part in activities in order to feel well. - Many of the children were still not able to resume these activities due to financial hardship, being now too old (therefore missing significant transitions) or because clubs had closed permanently due to the pandemic. 2/ 'Our Relationships' (Article 9, keeping families together) - Depicts the need for opportunities for children to connect with their families and friends (some of whom they had not been able to spend time with during the pandemic) as well as the need for time with pets and time to care for the wildlife that had been so important for many of them at the height of the pandemic. 3/ 'Our Learning' (Article 28: access to education; Article 29: aims of education)

	- Represents the right to education so that children can develop and learn. Children were (mostly) pleased to be in school and to have opportunities to learn. However, while they were anxious to recover their learning there was a strong sense from children that this should be balanced with time to connect with others at school and in their wider communities. 4/ 'Our Voices' (Article 12, respect for children's views; Article 13, Sharing thoughts freely; Article 17, Access to information) - Reflects the important role that children played in the pandemic and represents children's views that they are knowledgeable and want to communicate their ideas to other children and adults. They also want access to reliable and accurate information so that they can make informed decisions about their lives. 5/ 'What needs to happen', (Articles 12,13 and 17) - Offers children's perspectives on the wider global crisis and the need for everyone to learn from the pandemic, to be better prepared for another global crisis and for adults to support children's involvement in decisions about their lives and the lives of their communities. - Identified key messages about what children felt needed to happen as a result of their lives in the pandemic, it offers unique solutions from the perspectives of children for parents, teachers, policymakers and other children - a mandate in the form of "10 key messages about what needs to happen now".

	However, since the pandemic, the global economic downturn, cost-of-living crisis and policy responses have eroded public services (Fahy et. al., 2023; Webb et. al., 2022), consolidating the UK's position as home to some of the worst regional inequalities in the developed world (Etherington et. al., 2022; The Health Foundation, 2024). Regressive cuts to local authority budgets have reduced access to parks, playgrounds and green space for children living in the most deprived local authorities in England (Pickett et. al., 2021), young people's health and wellbeing has worsened (Pickett et al, 2021) and school attendance has declined. Our mixed methods research (Tunstall, Bucelli, Grugulis, Henderson, Lane, Lomax et al, 2025) indicates rising levels of multiple insecurity (insecurity on more than one important domain of life), reflecting the complex impacts of austerity, the pandemic and the cost-of-living crisis which followed. Protective policies to address the pandemic and the energy price inflation from 2022 reduced the shock, but as these policies were withdrawn, high rates of inflation in consumer and housing prices and soaring energy prices led to a sharp increase in multiple insecurity. Insecurities and multiple insecurities were not equally distributed. The combination of financial, health and housing insecurities was concentrated in working age adults, women and minoritised ethnic groups. 12% of all UK households with dependent children were experiencing

	financial, housing and health insecurity in 2022/23 rising to 26% of lone parent (and 8% of couple) households, meaning that almost ONE million households with children are experiencing a triple combination of financial, health and housing insecurity (Tunstall, Bucelli, Grugulis, Henderson, Lane, Lomax et al, 2025). As the earlier quotation from Clara-Louise suggests, this impacts directly on children's health and wellbeing. Multiply insecure children lack safe, warm secure housing, have poorer diets and limited access to safe outdoor and green spaces in which to play and meet others and to flourish. There is a strong relationship between levels of multiple insecurity and poor wellbeing, with parents in multiply insecure households experiencing higher levels of stress and strain (Tunstall, Bucelli, Grugulis, Henderson, Lane, Lomax et al, 2025). Children in insecure households are also exposed to worry and stress (Lomax and Pearse, in progress; Cheetham et al, 2024) while research by Pickett et al, (2021) indicates that children living in adverse circumstances, household poverty or high levels of family stress, have poorer mental health outcomes than their peers. Our research alongside the other cited sources suggests worsening health and wellbeing for the most disadvantaged children. Children's health and wellbeing is affected by poverty and multiple insecurity and its effects including poor housing, spatial and environmental inequality, reduced access to education, digital inequality stress and poor mental health. These already disadvantaged children are highly vulnerable to the effects of future societal challenges. The wellbeing and resilience of the

	most vulnerable children needs to be addressed as a matter of priority if children are to flourish and not be further disadvantaged in the case of major societal threats.
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	*"I just want them (the decision makers) to know that children are alive, that we exist. They know we are here, but they don't think about us" (Nicole, aged 11, Children's Lives in Changing Places, Lomax et al. 2025).* Children need to be at the forefront of decision-making in accordance with their rights and to ensure their best interests (Save the Children; UNICEF). However, evidence from children and children's organisations suggest that the government was not well prepared in terms of prioritising children's health, wellbeing and inclusion (Lomax and Smith, 2022; Spray and Hunleth, 2020; Morgan Jones, 2020). While it is encouraging to see that children's testimony is included in the national Covid Inquiry (Children and Young People, Module 8) in accordance with their rights (UNCRC,1989), evidence suggests that young people remain marginalised in national and local and national decision making: 'Children and young people .... have faced unique challenges, but their voice in policymaking (is) severely limited.' Morgan Jones et. al. (2020: 172) This is despite, as the above quotations from young people who took part in our research suggests, a great appetite from young people to be included in policy-making and recommendations from Save the Children and UNICEF about

	the benefits of inclusive governance in which children's rights and voices are front and centre. Our empirical research with young people living in economically under-resourced neighbourhood in England show how they remain excluded from decision-making (Lomax et al, 2025) and how national and local government lack the resources and infrastructures to support this (see also Save the Children)
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	We see (in the time of Covid) a large-scale *invisibilising* of children. We see children's *dis-appearance* … in how *they are ignored or minimized or leaders forget that children exist* (Spray and Hunleth, 2020: 42) *'Well like … the first time that Boris Johnson said it I was I was like WHAT! I was like does that mean I can't go to school 'cos I quite enjoy school so::: … It was confusing too lockdown 'cos I was like well, what can we do and what can't we do?'* (Gemma, 'Our Voices', Lomax and Smith) As outlined in sections 1 and 2, lack of investment in services for children, widening regional inequalities and lack of appropriate infrastructure to support children's inclusion has heightened the vulnerability of the most disadvantaged children and young people and the strength of institutions to support children. Children were left out of decision making at the time and were excluded from expressing their views (Lomax and Smith, 2022). It is to be hoped that the UK's institutions learn from the

	lessons of the national Covid Inquiry (Children and Young People, Module 8)
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	UNICEF have set out guidance for how children can be involved in planning for future emergencies, based on a children's rights approach. This document includes examples of where this has been done effectively, including in the City of Liverpool (see UNIICEF UK Child Friendly Cities and Communities Programme. **References and links** Cheetham, M., El-Zerbi, C., Bidmead, E., Morris, S., & Dodd, T. (2024). *'You can see when your parents are struggling'*: a qualitative study of children and young people's views of Universal Credit. *Journal of Social Policy*, 1-21. Advance online publication. https://doi.org/10.1017/S0047279424000333 Etherington, D., Jones, M., & Telford, L. (2022). Challenges to Levelling Up: Post-COVID precarity in "left behind" stoke-on-trent. *Frontiers in Political Science*, 4: 1–13. https://doi.org/10.3389/fpos.2022.1033525 Fahy, K., Alexiou, A., Mason, K., Bennett, D., Egan, M., Taylor-Robinson, D. and Barr, B., (2023) Inequalities in local government spending on cultural, environmental and planning services: a time-trend analysis in England, Scotland, and Wales. *BMC Public Health*, *23*(1), p.408.

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Your response

Full name	James Stanyer
Job title	Professor Communication and Media Analysis
Organisation / University / Research institute	Centre for Research in Communication and Culture, Loughborough University

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• **Health and wellbeing** • **Digital society** • ~~Social and cultural infrastructure~~ • ~~Education and employment~~
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• **Governance** • **Trust** • **Cohesion** • ~~Inequalities~~ • ~~Sustainability~~
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Our responses to the questions draw on a number of funded research projects undertaken by CRCC members, these include, but not limited to: PANCOPOP; THREATPIE and EVERYDAY MISINFORMATION. *The UK government continues to develop* more specialized institutional capacity for addressing mis and disinformation threats since the Covid-19 pandemic but challenges still remain and new ones have emerged. Research by the CRCC members found: 1. Social media platforms need stronger misinformation flagging systems. Public Report (O3C 4) - Beyond Quick Fixes | Online Civic Culture Centre | Loughborough University 2. Covid Vaccines and personal messaging apps revealed a number of specific challenges. People struggle to challenge vaccine misinformation in personal messages, especially

	from close contacts. Covid Vaccines and Online Personal Messaging 3. Collective group interventions may be more effective than individuals challenging misinformation alone Covid Vaccines and Online Personal Messaging 4. Person-focused approaches work better than content-focused methods for reducing vaccine misinformation spread in private messagingCovid Vaccines and Online Personal Messaging 5. Source credibility can boost the spread of accurate news but can also be used deceptively to propagate falsehoods.lboro-o3c-emp-apsa-2024-philadelphia-deceptive-source-misattribution.pdf 6. In relation to the challenges from external states. Since Russia's invasion of Ukraine state-backed disinformation presents an ongoing challenge particularly for individuals who have a conspiratorial mindset. Research found they are more likely to believe Ukraine war-related disinformation.
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	Research by CRCC members on the PANCOPOP project identified the following Recommendations for government officials: 1. Maintain the autonomy and transparency of specialized agencies headed by health professionals and the integrity of the scientific process of gathering and analysing information and formulating recommendations. 2. Anticipate political contestation over public health threats and preventative measures and revise existing guidance and training tools for public health emergencies, incorporating advice and scenarios that envisage lack of support from political elites. 3. When developing preventative measures and treatments, avoid purely top-down styles of communication and develop mechanisms for dialogue with a range of actors, seeking to find multipartisan solutions that will have a better chance of being more widely accepted. 4. Nurture cooperative relationships with media organizations, ensure that questions received from journalists are never left unanswered, and facilitate journalists' access to experts with suitable expertise.

	5. Develop and implement an integrated strategy for combatting health misinformation both online and offline, coordinating counter-misinformation efforts at national, regional and local levels, and engaging multiple stakeholders from media organisations, regulators and digital platforms to influencers and local communities, paying special attention to vulnerable groups.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	*N/A*
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	Research by CRCC members on the PANCOPOP project makes the following Recommendations: 1. • In Brazil, qualified health professionals became widely available to the media, granting interviews and responding to specific queries in a timely manner. 2. • Several public health officials in Brazil and the US provided ad-hoc training in public health and health communication to journalists, recognizing that many of them were assigned to cover public health issues at short notice and without prior training. 3. • To counter politicization, local and regional public health authorities in the US took special care to engage with communities of different political, ideological and religious affiliations, attended both Republican and Democratic events, as well as a range of churches, mosques, synagogues and temples. 4. • To connect with local communities and tackle distrust, regional public health authorities in the US introduced special mobile units called 'care-a-vans', which were designed to provide information on protective measures and distribute protective equipment at a local level. 5. • Public health communicators in the US found effective new channels of reaching communities, engaging with non-traditional trusted messengers, from hairdressers and

	barbers to school principals and local DJs, and involving them in their communication strategies. 6. • Rather than reaching out to different communities directly, regional health departments in the US provided micro-grants for local organisations to help disseminate information about preventative measures and vaccines, allowing them to use strategies they felt were most effective. 7. • To tackle distrust of COVID-19 vaccines, especially following Trump's pressures for fast approval, the US Food and Drug Administration increased the transparency of its decision-making by making relevant committee meetings public and providing open webcasts about its Emergency Use Authorization mechanism. 8. • In Brazil, state health secretaries adopted several strategies for providing fact-checked information to local media and digital platforms and the Federal Health Institute Fiocruz developed a partnership with fact-checking agencies to challenge misinformative content and provide fact-checked alternatives.

Your response

Full name	John MacArtney
Job title	Associate Professor
Organisation / University / Research institute	Warwick Medical School, University of Warwick

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• **Health and wellbeing** • Digital society • Social and cultural infrastructure • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• **Governance** • **Trust** • Cohesion • **Inequalities** • Sustainability
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	My research during the UK's public health emergency period (from March 2020 to July 2021) and since has been focused on the effects upon people who are dying and who use (specialist) palliative care services, such as hospices (in- or out- patient, day and wellbeing, and/or community). (I provide a full list of outputs at the end of this document.) People with terminal illnesses will, or should, receive some form of palliative care in the last weeks, months or even years of their lives (WHO, 2018). Definitions of palliative care identify three ideals that together inform what makes it distinctive approach (WHO, 2018). Palliative care should be: timely (right type of palliative care, by the right specialities, provided in the right place); holistic (addressing physical, emotional, social and spiritual issues); and, promote quality-of-life left (in contrast to life-prolonging or curative measures). In achieving these goals palliative care holds itself to "gold" standards (Shaw *et al.*, 2010), asserting it has "one chance to get it right" (LACDP, 2014). Palliative care has taken the maxim

	from Cecily Saunders' – the founder of modern hospice movement – "You matter because you are you. And you matter until the end of your life" (Cicely Saunders International, 2021) to assert the irreducible value of the dying person and of palliative care as a "human right" (Brennan, 2007). I led a UKRI (ESRC) Agile Research and Innovation Response to Covid-19 grant to explore the impact of the pandemic on hospices, which collected 70 interviews with patients, carers, staff and senior managers between 2021-2022. This study found that all three of palliative care's values were threatened not only by covid-19 disease, but by the way mitigations were conceived of and put in place in palliative contexts. This was so much so that the covid-19 emergency public health period posed an "existential crisis" for palliative care (MacArtney *et al.*, 2024), even when much of palliative care was seen to be at the forefront of the pandemic response. This was because what counted as palliative care in the emergency period were reactive responses (contra "timely"), was mostly focused on physical care (contra "holistic), and was about protecting life (contra "quality of life" left). Palliative care also provides an interesting and important case study for how Covid-19 is understood beyond the emergency period because of the focus upon *quality of life*. Indeed, it provides a novel framing of the move to "living with covid", which was described as the "removing domestic restrictions while encouraging safer behaviours through public health advice, *in common with longstanding ways of managing most other respiratory illnesses*" (italics added; HM Government, 2022). This is an approach that has been described as **ableist,** assuming that a person will recover from (multiple) infections (Gurdasani *et al.*, 2022), while also supposing people are in the socio-economically **privileged** position of having the means to take time off work or other responsibilities to recover (Marmot *et al.*, 2021). What we have shown is "living with covid" – and other airborne viruses – is especially problematic for those with life-limiting conditions, for whom a viral infection presents considerably more jeopardy for both their quality and amount of life left. The NHS Green Book for Covid-19 identifies the conditions that put people at a higher risk of Covid-19, the majority of which can be described as life-limiting or terminal illnesses (UKHSA, 2025). Although people on that list are prioritised for vaccination, vaccines are not always attuned to the variants in circulation and recipients many have conditions that mean the vaccine is less

	effective (UKHSA, 2025). Even for those who are expected to survive infection, contracting Covid-19 can mean dealing with a complicating illness – with higher risks of long-Covid or contracting other infections (Cai *et al.*, 2025) – for weeks or months, affecting their already compromised quality-of-life left. Significantly, virologists have warned that if a more evasive and deadly mutation of any virus is to come about, then one place it could develop is within those with weakened immune systems (Corey *et al.*, 2021). However, across the NHS and allied healthcare services, despite existing guidance (e.g. NHS England, 2025), few mitigations or considerations for the ongoing needs of those with life-limiting illnesses are implemented. Part of the sociological ending of the pandemic (Adler-Bolton, 2024) has been to reduce monitoring of infections, but where data is collected it suggests that nosocomial infections (an infection acquired in a healthcare facility) could account for 30-40% of Covid-19 infections (data from Canada, CNISP, 2025). Moreover, people with life-limiting conditions in a hospice are six-times more likely to experience a Covid-19 infection than any other communicable disease (Marie Curie, 2024; NB no data was collected for other airborne viruses). As part of our ESRC study we produced multiple outputs for policy, clinical practice and the public including five reports and three short films. The final film heard from people with life-limiting illnesses speaking about their experiences of hospice care as the emergency public health period came to an end (MacArtney, 2022). Participants described their worries about the loss of protections that "freedom day" (21 July 2021) brought. Our analysis of the interviews identified the sociological ambivalence within the (re)normalisation narrative that was at the centre of attempts to "live with covid" at the end of life. Here we described the tension between attempts to normalise pandemic mitigations as part of everyday life, and the socio-political drive to return to pre-pandemic ways of living and dying (MacArtney *et al.*, 2024; Sundaramoorthy, MacArtney and Eccles, 2025). In the months after the ending of the emergency period we conducted a follow-up study that recruited staff at three hospices. We identified the difficult and unresolved issues they faced when "living with covid", while seeking to promote quality-of-life left (Evans and MacArtney, 2024). Staff explained that they knew what to do to mitigate the risks, but we found that norms of living with covid had become infused with other palliative care discourses. The effects of which included reinforcing pre-pandemic

	naturalisation of certain types of dying (e.g. dying with an airborne virus); raising new human rights issues around the privileging of the able body to recover from infections; and, the presentation of novel clinical difficulties as staff sought to understand what promoting quality-of-life left meant, if they were not proactively mitigating asymptomatic transmission. We have found that the master sociological ambivalence of the pandemic's legacy is that living-with Covid-19 and other airborne transmissible viruses means understanding them as both problems to "move-on" from, while also being something that will repeatedly interject and affect life and society (Evans and MacArtney 2024; MacArtney et al., 2024). Because of this the discourses and practices seeking to bring the end of the pandemic and processes by which people come to "live with" viruses will need constant sociological (re)production (Adler-Bolton, 2022). This means that people with life-limiting illnesses and those that care for them must continually negotiate new landscapes of viral-vulnerability. Currently the forms of care available to those who are dying limited by healthcare policies, political discourses, and social imaginaries formed in – and constrained by – the emergency public health period. This has several implications. First, as the dominant framing, discussions of 'living with' become reduced to a perpetual **renegotiation of past experiences** and decisions, rather than building on the wealth of new knowledge about airborne viruses. Second, attempts to address those ongoing concerns are then constrained by a knowledge base that was predominated by the States's **numerical focus on deaths**, to the detriment of concerns for the quality-of-life (left) that "living with…" policies also effect. Third, the emergency period's politics of **exception** approaches interventions in dichotomous and transactional win-lose, all-or-nothing, terms at the expense of understanding the relational and inter-dependent implications of "living with…". Fourth, the lessons, when they are learnt (Pagel, 2024), are **more concerned with preparation for the next emergency** e.g. Birdflu, Monkey Pox (Mpox), at the expense of addressing the *ongoing* implications of living with Covid-19, the effects of the emergency period, and how other airborne viruses might now be addressed.

Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	The move to "living with…" sought to (re)balance airborne viral mitigations with the effects upon quality of life. It is premised on ideas of social and physiological privilege, the individualising of responsibility, normalising of infection, and the need to forget the collective lessons previously learnt (Adler-Bolton, 2022). As a consequence, "living with…" is a novel form of public health that makes some people more vulnerable to infection. Disability activists and researchers have provided a much-needed voice and insight into how a new "viral underclass" (Thrasher, 2022) has been imposed, but that has also become a space in which some have (had to) form new identities and collectivise as part of an "undercommons" (Harney and Moten, 2013). As I note above, those who are dying are some of the most vulnerable to viral infection affecting both the amount of life left, and the quality of that life. It is important to understand that people with life-limiting conditions are "made vulnerable" (Ford (Ford *et al.*, 2023: 8) to other viruses through "ecologies of ableism" (Taylor, 2024) within which experiences, practices and discourses of living with airborne viruses circulate. This includes an "enforced normalcy" (Davis, 1995) of "living with…" approaches in palliative care settings, which starts with a compromised biomedicalised body – where "normal" is to be well – when identifying what quality-of-life left is (ableism). But it also includes socio-political norms that devalue the dying person's rights (disablism), which have become infused within palliative health and social care discourses and practices (Gunaratnam, 2001; Gunaratnam, 2009; Gurdasani and Ziauddeen, 2022; MacArtney *et al.*, 2024).
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	My work so far has looked at the effects of the emergency public health period upon hospice staff and has considered their capacity to address the ongoing issues covid poses and has implications for how they might face any future (airborne virological) threat. I summarised my reflections for a blog on BMJ Supportive and Palliative Care (MacArtney, 2024): Some relevant extracts: "Hospice staff are still struggling with the emotional implications of working through the emergency period and foreground ways of getting back to pre-2020 "normal", but also recognise there is a 'new normal' that includes COVID affecting patients' amount and quality of life left, which can get pushed to the background.

	This tension reflects the wider "living with COVID" approach in healthcare, which assumes people have time and capacity to recover from infections. The uncertainty staff expressed suggests that hospice palliative care needs to engage in more explicit reflection on what ways of mitigating COVID-19 best fulfil a core value of promoting quality of life left." "[There is] a social paradox that healthcare faces when trying to address COVID. Ideas of how to mitigate COVID are associated with staff experiences of the emergency period that so many found distressing and want to avoid returning to. But many healthcare staff also recognise the added risks patients face if they do contract COVID. However, the emotional difficulties some had with talking about COVID along with the systematic push across healthcare and society to put COVID in the background has made it very difficult to address the "new normal" in which COVID circulates." "Providing hospice palliative care in-line with a "living with" approach is therefore not unproblematic for a service that seeks to promote quality of life left; that argues a dying person's life is of equal value to a healthy one; that needs to provide care wherever and whenever it might find people in need of palliative support; that puts so much time, research and effort into increasing equity of access." "What path hospice palliative care takes next is unclear. But it seems to me that the first step is to recognise that there are palliative care professionals who are struggling, professionally and personally, with a "living with (getting) COVID" approach that can be seen to fall short of the values and practices of hospice palliative care. It might then be possible to explore better ways to promote quality of life left while seeking to live with not getting COVID." You might also find comments in my responses to Q1 and Q4 helpful.
Question 4: Are there any international examples of policy interventions to address the	I developed my concern about the legacy of the emergency public health period upon people with life-limiting conditions in a co-authored paper with an Australian colleague conceptualising the potential issues that "pandemic delay" may have on those

impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	diagnosed with terminal illnesses during this time (Kirby and MacArtney, 2023). Drawing on our expertise in the fields of sociology of "early" cancer diagnosis (e.g. MacArtney *et al.*, 2017a; MacArtney *et al.*, 2020) and transitions to palliative care (e.g. MacArtney *et al.*, 2017b; MacArtney *et al.*, 2015; Kirby *et al.*, 2018) we identified multiple ways that the pandemic emergency response and ongoing circulation of covid might affect those who are dying. We have argued that as there have been **narrative and normative shifts in healthcare use** related to the pandemic we might expect to see disruptions to traditional narratives around illness, dying, and bereavement. We expect that this might be particularly prevalent for those who understood waiting (delays) for diagnosis and treatment as practically necessary or part of a "greater good", which has the potential to reshape how people understand and experience end-of-life care. We also reflected upon the **cultural and social norms around the interpretation and attribution of symptoms**. Here, delay in help-seeking may have been affected by the disruptions caused by a novel virus, with multiple symptoms and effects, leading to confusion about what was an "appropriate" symptom to seek help for. For palliative care the delays in diagnosis could mean an increase in late-stage or terminal diagnoses, which are often more complex and could mean that palliative care services would have to **quickly adapt the structure of palliative services**. This would be because it was expected there would be an increase the need for emergency or rapid palliative care beyond that which existing in-patient units (e.g. hospices) could provide contributing to pressures to expand complexity of provision in community-based services, like hospice-at-home, as well as further collaborating with primary palliative care services (e.g. general practitioners and district nurses). We also highlighted how the pandemic intersected with existing inequities in healthcare and how delays might **disproportionately affect marginalised groups** (e.g., ethnic minorities, low socio-economic status, non-cancer diagnoses), potentially widening disparities. We developed our arguments and insights into a successful award of an Australian Research Council (ARC) Discovery Grant that we are co-investigators on (2024-2027). We have just completed recruitment of our first cohort (clinicians) and are working through

	our analysis. We will start recruiting patients and carers in the coming weeks. Please check the study website for updates and do feel free to contact me if you would like information on initial findings.

Impact of Covid-19 pandemic on hospices (ICoH) study outputs (UKRI ESRC).

Led by Associate Professor John MacArtney, University of Warwick.

A requirement of the ESRC funding was to disseminate findings quickly and widely. To achieve this we used an innovative multi-pronged strategy that eschewed traditional peer-review routes to dissemination including pre-print, open peer-review, articles published during the study period and two **peer-reviewed papers**; four **cohort reports** with implications for clinical practice and one **policy report** published in collaboration with Marie Curie; several **blogs** and **editorials**; and, multiple forms of **visual media**, including artworks and short films.

Peer-reviewed publications

Sundaramoorthy, T,H., Eccles, A., and **MacArtney, J.I.** (2025) Experiences of hospice staff beyond the frontlines during Covid-19: a qualitative secondary analysis study, *Palliative & Supportive Care*, https://doi.org/10.1177/26323524251327804

This paper was a follow-up study and was not part of the main ESRC study:
Evans, R. and **MacArtney, J.I.** (2024) "'Backlash!'? A qualitative exploration of hospice palliative care staff's ongoing experiences of 'living with covid', *Palliative Care and Social Practice*, 18. doi:10.1177/26323524241283064

MacArtney, J.I., Eccles, E., Fleming, J., Grimley, C., Dale, J., Almack, K., Mayland, C., Mitchel, S., Driscoll, R., Hammond, R., Tatnell, L., Roberts, L. (2024) Pandemic narratives in stories about hospice palliative care: The impact of Covid-19 upon ideals of timely, holistic care and quality of life. SSM - Qualitative Research in Health, (5). https://doi.org/10.1016/j.ssmqr.2024.100447

van Langen-Datta, S., Wesson, H., Flemming, J., Eccles, A., Grimley, C., Dale, J., Almack, K., Mayland, C.R., Mitchell, S., Driscoll, R., Tatnell, L., Roberts, L., **MacArtney, J.I.** (2023) The impact of Covid-19 pandemic on hospices: A systematic integrated review and synthesis of recommendations for policy and practice [version 2; peer review: 2 approved]. *Health Open Research* 2023, 4:23 (https://doi.org/10.12688/amrcopenres.13105.2)

Mayland, C. R., Mitchell, S., Flemming, K., Tatnell, L., Roberts, L., & **MacArtney, J. I**. (2022). Addressing inequitable access to hospice care. *BMJ Supportive & Palliative Care*. doi:10.1136/bmjspcare-2022-003590

MacArtney, J.I., Fleming, J., Eccles, E., Grimley, C., Dale, J., Almack, K., Mayland, C., Mitchel, S., Driscoll, R., Hammond, R., Tatnell, L., Roberts, L. (2021) What do we know about the impact of the Covid-19 pandemic on hospices? A collaborative multi-stakeholder review and knowledge synthesis. [version 1; peer review: 3 approved]. *AMRC Open Research*, 3:23, https://doi.org/10.12688/amrcopenres.13023.1

Reports

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Your response

Full name	Katie Chadd
Job title	Lecturer
Organisation / University / Research institute	University of Essex

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Inequalities • Sustainability
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	My research is based on the speech and language therapy (SLT) workforce. Overall, it indicates that there has been poor progress since the COVID-19 pandemic, and the NHS SLT workforce continues to struggle especially with high attrition rates, despite more SLTs qualifying to join the profession (HCPC, 2025). The Royal College of Speech and Language Therapists (RCSLT) continue to highlight significant vacancy rates across the UK (Royal College of Speech and Language Therapists, 2023a). Ultimately, the impact is felt most by those with speech, language, communication and swallowing needs, across the lifespan. There were well-known challenges about the SLT workforce prior to the pandemic: the RCSLT have long engaged in lobbying for this recognition. Though published in 2023, the NHS long term workforce plan did identify the SLT profession as one in shortage, but with a projected increase in demand, where it was already outstripping supply (NHS England, 2023). Through national surveys of the profession and examinations of routinely-collected clinical data, my research further evidences indicates that prior to COVID-19, there were major workforce

	challenges, but during and after the pandemic these were hugely exacerbated (Chadd, Moyse and Enderby, 2021; Chadd *et al.*, 2024). These exacerbations were influenced by burnout and fatigue, but also the lack of recognition of the value of the profession in both COVID-19 management (Chadd *et al.*, 2024) but also in the new condition Long Covid, where SLTs' expertise was undermined (Chadd *et al.*, 2022). More recently, my research on the SLT workforce in the East of England (via surveys and interviews) has shown that challenges still remain even in 2024 regarding retention of staff (Chadd, 2025). A major determinant of retention in the SLT workforce was found to be job satisfaction, which is related to workload, but also the autonomy provided to the workforce to do things in the ways they think they ought to be done, including models of care and evidence-based management of caseloads. A recent report from the RCSLT noted that administrative workload and pay were other major factors influencing SLTs' intention-to-leave (Royal College of Speech and Language Therapists, 2025) Since the pandemic, waiting lists in SLT have been chronically overwhelming and models of care have shifted considerably to target this, often leading to care that SLTs deem inappropriate or insufficient (such as discharging less severe patients) (Royal College of Speech and Language Therapists, 2025). This inability of SLTs to do the job they are trained in, restricted by the *health system* is directly associated with willingness to stay in jobs, but also desire to remain in the profession altogether (Chadd, 2025). References Chadd, K. et al. (2022) 'An evaluation of speech and language therapy services for people with long COVID in the UK: a call for integrated care', Journal of Integrated Care, 31(4), pp. 375–388. Available at: https://doi.org/10.1108/jica-07-2022-0038. Chadd, K. et al. (2024) 'Impact of the initial COVID-19 response in the UK on speech and language therapy services: a nationwide survey of practice', Journal of Health Organization and Management, 38(2), pp. 264–285. Available at: https://doi.org/10.1108/jhom-11-2022-0337. Chadd, K. (2025) A regional perspective on retention in speech and language therapy. Monograph. University of Essex. Available at:

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Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	The lesson is to attend to on-the-ground experiences, professional bodies and the public. For a system, like the NHS, to recover from major threats like the pandemic, it is imperative for its daily functioning - with its workforce at the heart - to be adequate in order for any buffer to be in place to support resilience. This was simply not in place in 2019. As noted, my research supports that the NHS SLT workforce was a*lready struggling* way before the pandemic. The continual cuts to NHS funding and their subsequent impact of models of care have direct consequences on the workforces' utilisation of skills and autonomy; without which they seek to leave. Many currently-employed SLTs have an intention-to-leave the NHS workforce specifically (Chadd, 2025). We have since developed a set of recommendations for improving retention in the SLT workforce, which are targeted at various levels (Chadd, 2025) however, fundamentally, greater investment in the workforce would surmount many of these: to fund more posts, reduce individuals' workloads, to empower SLTs to do the work justice and enable

	more meaningful models of care that are evidence-based and ultimately deliver better outcomes for the nation. Written parliamentary questions have been submitted to the House of Lords Integration of Primary and Community Care Select Committee Inquiry (Royal College of Speech and Language Therapists, 2023b) based on our research. The new NHS ten year health plan serves as the most critical policy intervention (National Health Service, 2025). While it focuses on increased staff training, development and wellbeing support for its allied health workforce, it also ambitiously commits to greater neighbourhood health services which SLTs will be critical component of (National Health Service, 2025). There is concern that this will not be viable without significant investment therefore in the workforce (which, is already struggling). **References** Chadd, K. (2025) A regional perspective on retention in speech and language therapy. Monograph. University of Essex. Available at: https://doi.org/10.5526/err-00041449 (Accessed: 2 September 2025). National Health Service (2025) 10 Year Health Plan for England. Available at: https://www.longtermplan.nhs.uk/ (Accessed: 25 July 2025). Royal College of Speech and Language Therapists (2023b) 'Written evidence from the Royal College of Speech and Language Therapists (PCC0052) HOUSE OF LORDS INTEGRATION OF PRIMARY AND COMMUNITY CARE SELECT COMMITTEE INQURY'. UK Parliament Select Committee Publications. Available at: https://committees.parliament.uk/writtenevidence/120972/pdf/ (Accessed: 29 August 2025).
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major	Evaluation of the strength of institutions' effective policy-making and its enactment in relation to health care workforce ought to workforce and service-user centred, listening to the voices of those on the ground. Often, services are commissioned, and evaluated, in response to policy, and by metrics such as throughput and contact where it

societal threats and how they can be improved?	would more meaningfully be based on therapy or treatment outcomes, as well as workforce voice. Privileging health and social care professionals' voices in evaluation is central, who can provide an emic perspective of the enactment of policies and models of care to scrutinise their effect. My research using participatory action research with early years' workforce has highlighted the potential of these approaches to evaluate complex health care delivery systems (Chadd, Malik and Kapilashrami, 2025). Streamlined and systematic routinely-collected data about service users outcomes and impact of services can also be leveraged to offer systematic evaluations of models of care and ways of working that best support service users, also illustrated by my research (Chadd *et al.*, 2025). This approach also inherently enables longitudinal comparisons to made over time to effectively examine responses to major threats - as illustrated in my research looking at referrals into SLT before the onset of COVID-19 and after (Chadd, Moyse and Enderby, 2021). In particular, as outlined in my research participatory action research and evaluation utilising routinely-collected patient data can support evaluation of the effectiveness of policy-making on those most marginalised by society, identifying and addressing health inequalities. **References** Chadd, K. et al. (2025) 'Operationalising routinely collected patient data in research to further the pursuit of social justice and health equity: a team-based scoping review', BMC Medical Research Methodology, 25(1), p. 14. Available at: https://doi.org/10.1186/s12874-025-02466-9. Chadd, K., Malik, M. and Kapilashrami, A. (2025) 'Operationalising participatory action research to evaluate early years' population health services', BMC Public Health, 25(1), p. 947. Available at: https://doi.org/10.1186/s12889-025-22183-8. Chadd, K., Moyse, K. and Enderby, P. (2021) 'Impact of COVID-19 on the Speech and Language Therapy Profession and Their Patients', Frontiers in Neurology, 12.

Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	There are none that I am aware of in relation to this issue specifically.

Your response

Full name	Keri Ka-Yee WONG
Job title	Associate Professor of Developmental Psychology; Co-Director Centre for Education and Criminal Justice; ESRC Policy Fellow
Organisation / University / Research institute	University College London, Institute of Education

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Social and cultural infrastructure • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Trust • Cohesion • Inequalities
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	**Progress** • Since the Covid-19 pandemic, research progress has been made in 'health', 'access and support for positive health', 'mental wellbeing' and more 'inclusion of lived experience voices. • Covid-19 brought communities of experts and stakeholders from a variety of disciplines and sectors together as there was a common goal of sharing experiences, expertise, and ideas – some of this interdisciplinary working has remained [1]. • Whilst Covid experiences were often negative, there were some positive aspects as well and the majority of the population returned to pre-pandemic levels of mental health [2] and for some, the fear of contracting Covid-19 still weighed heavily on their motivation to change their sedentary lifestyles post-Covid [3].

	• There is more discussions around the role of the environment on one's health – mental, physical, social, and brain health [4]. **Remaining challenges** • Life for Individuals living with existing health inequalities continue to be challenging, if not more challenging. Their livelihoods are now compounded by the rise in living costs, incidences of bereavement, long-Covid, and in some cases continued domestic violence/trauma. This is especially true for marginalised minority ethnic groups of young people speak of continued challenge in all aspects of life, development, and the lack of support from authorities and government [5, 6]. Few community-based interventions exist, and investment is prioritised. • The training of trainee teachers and doctoral students, including early career academics (ECRs) have been negatively impacted during Covid-19 [7, 8]. Many may not have had the same training and employment opportunities as a result. • There is a lack of trust in institutions/government's pandemic response [9]. The paranoia/mistrust experienced due to Covid-19 has also been shown to relate to sustained poor mental health over short and longer periods of time of up to 2 years, and these relationships are maintained by feelings of 'loneliness' and disconnection with others [10]. • More children and young people are 'not-in-education, employment, and training' (NEET) – almost 1 million 16–25-year-olds – and some are also implicated with the criminal justice. This could be due to the cutting of resources and support at the community level, closing down of key physical 'safe spaces' (e.g., youth clubs and community centres, and the lack of trusted adults in the community whom they can go to. Ongoing research in this area is vital and would meet Labour's Safer Streets Mission on Youth Futures Hubs [11]. • The Covid-19 pandemic has further squeezed the charity and voluntary sector on its resources. Local authority cuts and inabilities to provide *timely* mental health support is critical. Youth workers are not just providing 'employability skills and opportunities' for young people but asked to provide trauma-informed therapy when untrained, young youth workers are also in desperate need for therapy and support themselves. • This additional burden on an already under-staff, under-resourced sector and staff has contributed to a shrinking

youth work sector and an unsustainable workforce. This is also the only lifeline for many local communities. This is sector serves families, migrants, and the most vulnerable young people from the most disadvantaged backgrounds by providing the 'connection and trust' they need to feel 'safe' and integrate into our society [of relevance to Labour's Safer Streets Mission].

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Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	My opinions below draw on my experience as a mental health psychologist/criminologist, academic, and insights into government as an ESRC Policy Fellow: • The global evidence on the impact of school closures and full lockdown is clear: **school closures have been especially negative.** The lasting negative consequences for children and young people's development are still being seen today, and every effort should have been invested into 'safe learning' i.e., school ventilations. The consequences of this is still being felt and examined by researchers (e.g., UCL Covid Social Mobility Cohort study – COSMO, Children of the 2020s Study). • A lot of the research point to the increased levels of loneliness being experiences by the population – and thankfully, by the second lockdown, the UK government had introduced 'social bubble' and leaving the house once a day for exercise which helped ease the psychological anxiety for many individuals. These were good policies. • However, other 'eat out to help out' policies were less good and led to potential spike in the spread of Covid. These 'quick' policies ill-informed by public health guidance at the time should never happen again. • Independent SAGE – The independent SAGE expert group was a very good thing that should definitely be in place even prior to the pandemic. This group offered objective evidence informed updates to the population when a similar expert group is not available in many other countries at the time, hence garnering international viewership. • Currently the UK government has 'Chief Scientific Officers' and advisory groups in each department. However, membership to these advisory groups should be more transparent. There should be clear channels through which academics across different sectors could contribute to government policy making. Furthermore, current memberships are primarily open to full professors, I would argue that the involvement of ECRs are vital in ensuring

	the latest methods/evidence is being transferred into government and for ECR scientists to recognise that our duty as scientists should involve 'science to policy' translation of knowledge. • **Reinvestment in community spaces and community leaders is vital to rebuilding and recovery**. Rather than local authority funding cuts, investment should be put into local community leaders who know best what their community needs. The government knows very little about what's happening on the ground, hence should draw on the expertise of local communities, lived experience research, and invest in money in this type of research.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	• **Access to timely evidence.** Pandemic preparedness and responses to future threats could and should be improved. A key issue I've found is that government civil servants simply do not have full access to academic evidence in a timely manner that academics do. This is evident in the mismatch between the pandemic response and evidence. I think funders, like the BA, have a role to play in brokering better access to evidence, experts, and knowledge for government and academics. This means open access for all government civil servants, so access to knowledge is the default position and not a luxury (as it is currently dependent on funding!). **I find it absurd that both academia and government are funded by taxpayers' monies yet access to our research outputs to make country-wide decisions is not a priority.** • **Seamless academic-government relationship**. My policy fellowship experience has further strengthened my belief that better government-academic relationship is essential for us to build a resilient government, one that is pandemic-ready and able to design 'prevention policies'. For starters, government civil servants ought to have direct channels and access and a culture that encourages colleagues to reach out to academics. Similarly, academics at all levels – especially early career academics – should have exposure to policymaker conversations, civil servants, and government priorities as part of their training. The level of exposure to policymakers/decision-makers should not come down to whether the academic is well-connected but should be based on the merit of the evidence and the need for it in policy. Better relationship,

	communication, and regular interaction between academics-government also means that both sides are more likely to align their goals and share knowledge/expertise as and when, which would strengthen our government operations.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	Not that I can think of.

Your response

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Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Digital society • Social and cultural infrastructure • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Trust • Cohesion • Inequalities • Sustainability
Question 1: What progress has been made since the	As a matter of introduction, the points raised below and in the next four sections drawn upon the following three projects that I've been leading:

Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	**2024-25 Emergency Food Planning, Food and Health Justice and Resilient Communities and Places - ESRC IAA 2023-28 UCL Impact Acceleration Account** The aim of this impact-accelerator project is to run a series of workshops to share knowledge and insights and through co-design, to develop recommendations for food emergency planning, food and health justice and resilient communities and places in England as to inform strategies and policies at local and national levels. **2023-2024 Adaptable Cities, Pandemic Mitigation and Crisis Preparedness (British Academy)** Cities and specifically large and very dense metropolitan areas have been severally impacted by COVID-19 particularly people's health and wellbeing as well as local economies. There is an urgent need to gather insights, assess and reflect on how cities have and can be adapted, promptly and proactively, as to immediately mitigate the impact of any future pandemics while ensuring their urban, social and economic resilience and continuity as rich transactional spaces hosting all types of human, economic, financial and information flows. While we situate this research area across the G7, we specifically focus on three continents _North America, Europe and Asia _ and zoom on four cities: New York City, London, Paris and Tokyo. The project ultimate goal is to co-design with a panel of built environment experts, a set of multi-scalar and evidence-based lessons as to promote proactive adaptability. **2022-2024 PANEX-YOUTH - Adaptations of young people in monetary-poor households for surviving and recovering from COVID-19 and associated lockdowns (ESRC - ES/X000761/1 /NRF/FAPESP _ TAP Programme)** This project is part of the Trans-Atlantic Platform (T-AP) Recovery, Renewal and Resilience in a Post-Pandemic World (RRR) Call and aims to understand and assess the impact of COVID-19 and associated policies on food, education, play/leisure of young people living in deprived settings and in conditions of poverty in the UK, Brazil and South Africa. To do so, we adopt a nexus approach, focusing on food, education, and play/leisure embedded within a wider understanding of the living settings (local places) and home/personal contexts (household composition and home/personal life). This project seeks to use an action research methodology to co-create this knowledge about such adaptations and generate wider recommendations, with young people, and the communities in which they live, and non-government bodies and non-profit organizations that focus on this age group. Progress and challenges are intrinsically connected and these are related to numerous issues linked to Health and wellbeing; Digital society; Social and cultural infrastructure and Education and employment. • Poverty is a holistic and intersectional driver for multiple socio-economic and health vulnerabilities (including food poverty). Poverty and inequalities have been increasing since the pandemic. This is widely acknowledged politically however no workable solutions seem to emerge. https://doi.org/10.1111/chso.12924

	• Overall, the UK is characterized by increased health inequalities with significant impact on the health care system (including access to health and mental health crisis). Mental health is acknowledged as a rising global health challenge since the pandemic (for all but more importantly for young people) and is connected to social isolation – see https://panexyouth.com/wp-content/uploads/2024/10/learning-from-children-and-young-peoples-experiences-of-covid-19-panex-youth.pdf; https://doi.org/10.25910/3eb2-6h89 ; https://panexyouth.com/wp-content/uploads/2023/12/panex_englandreport_final.pdf • Intersectional burdens and layers of vulnerabilities are mostly tackled within siloed approaches (i.e. a governance issue); these lack coordinated responses adapted to people and places' needs. The pandemic allowed to do things differently from a governance and an everyday deliver of key services and needs. These were responses which were much closer to people's experiences and linked to the inability of accessing whatever government service it might be. Data and stories are available here; these should be used further to move beyond emergency and tackle poverty holistically and aren't currently. • Re inequalities and poverty, supporting mechanisms are available however they are often not known and not located in the same place (at neighborhood level). Those in situation of extreme poverty aren't seeking support (i.e. the state isn't coming to you). In situation of extreme poverty, precarity and emergency, food is the primary anchor to reach those in needs as crucial to everyday survival. However, food is a non-statutory obligation for local councils (which is a major issue noting that many local councils issues a Section 114 notice declaring themselves effectively bankrupt). • There is a crisis in volunteering and in funding associated with a very bureaucratic and compliant-focused process of securing financial support for small organisations and charities. • There is an urgency to identify alternative solution to provide integrated health and social care at the neighbourhood level (with food as an entrance to reach those in poverty). There is a need to think about the development of so-called "community hubs" – in which care and support is at the core of activities as to deliver health, food and social justice. https://doi.org/10.1111/chso.12924 • Marginalised young people from around the world used social media obsessions to help provide care, and map communities of people in need, during the pandemic. Our Annals of the Association of American Geographers worked with 180 marginalised young people aged 10-24 from Brazil, South Africa, and the United Kingdom to understand their everyday lives during the Pandemic. Many of the young people who took part in the research project shared how activities including the use of social media became a source for positive aspects of their identity; for finding practical support and developing such as learning new skills; as a coping mechanism against the challenges of isolation

and existential anxiety; and for socialising with peers especially when lockdown rules were being enforced. https://doi.org/10.1080/24694452.2025.2523523

- Education: significant improvements have been made towards digital learning however absenteeism remains a key challenge (connected to mental health) – see points above School absence and refusal have increased since COVID-19. Where appropriate, schools should introduce and/or signpost to students measures that enable school engagement during and after a period of lockdown (or similar), whilst also addressing the root causes for disengagement.
- There is a lack of trust towards the government in supporting those in needs (during/post pandemic) _ typically children and Yong people who were ignored during the pandemic. This is also linked, amongst other factors, to not enough flexibility and too much red-tape (specifically bureaucracy, compliance, etc.) for organisations at the forefront of supporting those in needs.

Key References:

Kraftl, P.; Andres, L., (…) Zara, C. (2025) Cultures of COVID-19: Marginalised Young People's Experiences of a Global Pandemic in Brazil, South Africa and the UK, Annals of the Association of American Geographers, https://doi.org/10.1080/24694452.2025.2523523

Andres, L., Moawad, P., Kraftl, P., Stevens, S. D., Marais, L., Matamanda, A., Bizzotto, L., & Giatti, L. (2025). Children and young people's access to food, education, play and leisure in times of crisis: An international, integrative review of policy responses, impacts and adaptations during the COVID-19 pandemic. Children & Society, 39, 495–511. https://doi.org/10.1111/chso.12924

Bower, M., Smout, S., Johnson, S., Costello, A., Andres, L., Donohoe-Bales, A., Leach, M., Pellicano, E., Hiller, R.M., Fonagy, P., Ypsilanti, A., Kumar, S., Scott, L., Pearson, S., Hobson, H., Barclay, D., Harding, S., Teesson, L., Baggaley, J., Stears, M. and Teesson, M. (2024). Placing Social Connection at the Heart of Public Policy in the United Kingdom and Australia. London & Sydney: UCL Policy Lab & The Matilda Centre, University of Sydney. https://doi.org/10.25910/3eb2-6h89

Marais, L., Matamanda, A., Gbadegesin, F., John Ntema, Abongile Mgwele, Mischka Dunn, Verna Nel, Timothy M. Lehobo, Lauren Andres & Stuart Denoon-Stevens (2024)The COVID-19 restrictions, child services and the well-being of children in South Africa. ICEP 18, 12. https://doi.org/10.1186/s40723-024-00138-7

Andres, L., Moawad, P., Kraftl, P. (2023), The impact of COVID-19 on Education, Food and Play/Leisure and Related Adaptations of Children and Young People in England, London. https://panexyouth.com/wp-content/uploads/2023/12/panex_englandreport_final.pdf

Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	**Lessons from the Panex Youth project:** Reference: Peter Kraftl, Lauren Andres, Cristiana Zara, Victor Agbontean & Nishika Aggarwal (2025) **Learning from children and young people's experiences of COVID-19. Recommendations for policy-makers, practitioners and organisations working for, with or on behalf of children and young people** https://panexyouth.com/wp-content/uploads/2024/10/learning-from-children-and-young-peoples-experiences-of-covid-19-panex-youth.pdf Young people, and particularly vulnerable young people suffered dramatically during the pandemic and continue to do so. They were not seen as a priority during COVID-19 and continue to be neglected in some areas of policy and service provision, despite the significant proportion of their lives affected by this unprecedented health crisis. While a considerable amount of public funding was allocated to emergency funding during the pandemic, it was nevertheless insufficient and poorly targeted in some cases. Some (vulnerable) children and young people will struggle to catch up; this will have long-term consequences on their adult lives which cannot be ignored. Our findings support recommendations about how to help those young people as well as what could be done differently in the event of a future crisis like COVID-19. The daily survival of children and young people and their families was ensured due to the involvement and commitment of individuals, communities, faith groups, charities, schools and teachers who all stepped in in unprecedented ways as part of the pandemic solidarity effort. Hence, as well as making recommendations for policy-makers, our findings highlight their possible future role (and support needed) in responding to future crises like COVID-19 (Andres et al., 2023a&b1). Running through our findings – and our recommendations – is the vital consideration that young people's voices were often unheard during COVID-19. Hence, an overall recommendation underpinning all of our findings is that diverse young people – and particularly those who are most marginalised or vulnerable – were not heard enough and should have a voice in future policies, actions and decision-making processes. More specifically, our findings reveal the following: 1. School absence and refusal have increased since COVID-19. Where appropriate, schools should introduce and/or signpost to students measures that enable school engagement during and after a period of lockdown (or similar), whilst also addressing the root causes for disengagement. Cognisant of the multiple pressures on schools, schools may focus on some or all of the following: (a) making school environments less pressurised (thrown into sharp relief during time at home, when many students felt less pressurised); (b) measures to support young people with loss of confidence whilst away from school; (c) addressing sometimes patchy support in schools for student wellbeing and mental health; (d) finding (creative) ways to mitigate loss of contact with school during a crisis, which in turn can mean loss of the wider benefits of school.

	2. There is a need for further work around the 'soft skills' that some young people lost or did not develop during COVID-19, particularly as there is a shared feeling that we 'moved on' from the pandemic in a way that did not enable young people to come to terms with what had happened. Many professionals who work with young people have reported that there are cohorts who, for instance, lack the skills and ability to relate to others in appropriate ways. Schools and other learning institutions could, for example, work on relational pedagogic practices, using trauma- and compassion-informed approaches. 3. Whilst recognising they are vital, we must not over-emphasise the role that schools can play during or after a pandemic. They cannot provide and do not have the resources to provide a one- stop shop for all the issues young people face. They are not and should not be the only place that CYP gain support – families, friends, communities, and other organisations should also be key. There could be greater consideration of how in turn to support those organisations, and how there could be greater coordination, partnership and/or multi- agency working to ensure some young people, and some needs, do not slip between the cracks. 4. Linked to recommendation 3, there could be planning for greater resources and sharing of good practice for organisations outside of schools who provided support for home education during lockdowns. This would also need to acknowledge (as per recommendation 1) that after COVID-19, some young people did not return to school and remained home educated. Any work with such organisations should also ask young people how they would like to be supported outside of school. 5. There could be a concerted focus on support for young people's key transitions – for instance to secondary school, to College/University, and to work. Those transitions and support for them were compromised during COVID-19, with some young people getting 'lost in transition'. Guidance and support for young people could be two- fold: targeted at young people, now, who missed out during key transitional periods during the COVID-19 pandemic; better preparedness, plans and resources to provide guidance and support for young people going through transitions during future pandemics. 6. Address inequalities in children and young people's access to greenspace, and outdoor spaces, which in turn affect their opportunities for play, learning and socialisation. Children and young people are often excluded from outdoor, public and green spaces in their communities; this situation was exacerbated during lockdown restrictions, when playgrounds and other leisure spaces were closed and young people's time outside was limited. There should be greater efforts towards and investment in building on guidance to make public spaces more accessible to diverse children and young people, and placing greater emphasis on children and young people's access to such spaces during a lockdown scenario. 7. Support and advice around technology use (especially social media and gaming) could be more nuanced. Use of these technologies is a complex issue, especially when children and young people cannot access outside spaces. It should not be assumed that social media use or gaming

	are always negative behaviours, when they can facilitate learning new skills, socialization and allow downtime; but it should be recognized that use of digital technologies can also be dangerous, problematic and toxic. Supporting young people to find a balance – where that balance may be different during a pandemic – is key. 8. Linked to recommendation 7, recognise and support the ways in which digital media can enable young people's participation in high-level decision making and co-research (as with the PANEX- Youth project) alongside or even more than more traditional approaches to meeting/consultation cannot. There could be greater consideration of how to ensure scaling up of these approaches, inclusion in terms of the young people involved (equal access to these opportunities) and training for young people participating in such activities. 9. Ensuring better preparedness and equitable opportunities for digital access (to devices and/ or data) for different groups of children and young people, their families and those who work with them (both for education and other purposes). There is an opportunity here to engage with the work of UNESCO's Digital Readiness Index team, which assesses and provides recommendations for countries in the event of a pandemic or similar crisis. 10. Work with young people to battle misinformation around crises. Young people have the skills to act as a bridge (and/or to co-produce) accurate information, especially in short form on digital media, to counter misinformation in, for instance, the circulation of public health information during a pandemic. Remembering and learning from COVID-19 – and listening to children and young people 11. Learn from what worked in COVID-19. Some apparently haphazard or reactive approaches happened to work – whether in terms of flexibility in pedagogic approaches or ways of working through digital media, or how local organisations responded to meet local needs. At the national, regional and local scale there could be efforts to collate and share examples of what worked (our longer reports, referenced at the end of this document, are examples of such efforts). Similarly, more learning is still needed on what could still work in a post-COVID context, and what could work in terms of better and equitable preparedness for a future crisis. 12. Don't just move on: COVID-19 happened but young people have not had the opportunities to deal with its shorter- and longer-term impacts. COVID-19 was a major part of their lives (proportionately, compared with adults, and because of the impact of restrictions on them). It is crucial to keep talking about COVID-19 and address trauma. 13. Develop a systemic approach to policy for children and young people, particularly for times during and in the years after a crisis. In particular, working across health, education and employment can help deal with challenges in respect of young people's transitions. Such policies – as per wider policy-making for (and with) young people – need to be aligned, coherent and joined up, stopping young people from falling down the cracks. They also need to be properly resourced and involve children and young people in appropriate ways in their design.

	14. Those working with and advocating for young people could call out and put pressure on organisations who should be engaging young people in debate about and responses to crises, but don't. Examples of good practice in engaging children and young people – whether specifically during crises or more widely – could be collated and shared, with resource to support good forms of engagement. 15. Finally, recognize the importance of food in times of crisis and post-crisis. This includes access to food (specifically healthy, nutritious and culturally diverse food) in a context of increased food poverty for young people. It also involves acknowledging its role as a way to get together and cope but also as a mean to access vulnerable young people and their families and hence provide adequate support. **Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?** Many organisations with whom we have been working are lobbying the government and we are currently shaping some policy workshops with the Cabinet Office to reinforce some of those issues. Clearly, the expansion of free school meals to all children in England whose parents receive Universal Credit, regardless of income, starting in September 2026 is a result of this overall acknowledgment and mobilisations from many stakeholders across the UK. That said there are still much more progress to expect in this area and children/young people are not the core focus of government policies. **Lessons from the ADAPT4 Project:** Andres, L., Moawad ,P., Appendino, F., Sakai, A., Zepf, M., (2025), Adaptable Cities, Pandemic Mitigation and Crisis Preparedness – Final Report, UCL, London. https://discovery.ucl.ac.uk/id/eprint/10208869/ Drawing on lessons from emergency and unpredictable situations that required reactive and adaptable measures during the unprecedented COVID-19 pandemic, we present key recommendations for future major crisis preparedness. These are intended to support proactive adaptability through a more integrated and agile approach to temporary adaptations. While primarily tailored to pandemic events (and restrictions similar to those imposed during COVID-19), these recommendations should inform preparedness to other types of unprecedented and long-lasting crises. We do also recognise that any future pandemic may differ from COVID-19 and may impose different constraints. Expert health knowledge must therefore be translated into clear regulations and actions that local actors can implement effectively. These recommendations are intentionally presented in a generic format, reflecting how G7 countries (USA, Canada, France, Italy, United Kingdom, Germany, and Japan) adapted outdoor

spaces during the pandemic. We fully acknowledge that these will need to be tailored to specific national and local contexts, taking into account distinct planning, political, and governmental systems, as well as the importance of locally specific interventions.

1. The Importance of Experimentation

The COVID-19 pandemic presented an unprecedented opportunity for experimentation— an opportunity that must be recognised and embraced in the face of future crises. These experiments emerged through various mechanisms within the built environment. Some were initiated and implemented by small groups responding to immediate needs, often without expert guidance, while others were instigated by institutions and regulatory bodies (e.g., local authorities). Many of these responses proved to be effective, offering adaptive and creative solutions to seemingly impossible situations.

Permissible experimentation—within clearly defined boundaries—is essential for enabling creative thinkers to respond to crises. Not everyone approaches challenges with innovation; some contribute in other valuable ways. However, recognising the role of innovation in responding to unpredictable circumstances is vital if cities are to remain agile and responsive to the needs of those who live and work in them. As demonstrated during COVID-19, temporary experiments can help address both immediate challenges and longer-term impacts on mental health and wellbeing.

The pandemic accelerated both temporary and more permanent adaptations, and sparked the imagination of alternative urban futures—such as healthier, greener, and car-free cities. For built environment professionals, this was, and continues to be, a critical moment for knowledge and capacity building. Of course, these visions were shaped by the specific restrictions of the time, which may differ in future crises. Crucially, experiments must be clearly communicated as temporary, and should not be retained if they are no longer relevant or appropriate.

Moreover, experimentation should not be confined to times of crisis. Space, funding, processes, and frameworks that support diverse forms of experimentation—adaptable to different crises—must become integral to future planning. These mechanisms offer valuable guidance for navigating future emergencies.

Therefore, cities and governments must embed creative, temporary experimentation into their resilience and crisis preparedness strategies. This should include pathways to permanence for those experiments that prove effective. Such efforts must be collaborative and non-siloed, supporting local economies, encouraging community participation, and enhancing liveability and wellbeing—thereby demonstrating socio-economic, financial, and political value.

2. Experimentation as a Form of Fostering Inclusiveness

During the COVID-19 pandemic, all countries shifted to alternative forms of citizen engagement, often temporarily suspending traditional participatory processes. These changes had significant consequences, frequently resulting in tensions and public backlash in the years that followed. This highlights the importance of reactive and immediate experimentation.

	The narrative surrounding experimentation must not only acknowledge the essential value of participatory processes but also emphasise the need for alternative methods of participation and feedback collection during times of crisis. Temporary creative adaptations should be more widely recognised as a form of alternative engagement and empowerment —helping to overcome resistance to change and fostering dialogue around liveability and wellbeing. Experimentation enables engagement and empowerment by allowing for testing and iteration. Due to their localised nature, such initiatives often encourage broader participation, including from individuals and groups who may not typically engage in conventional participatory processes. Temporary uses, as a form of experimentation, are powerful tools for engagement. Unlike traditional consultations, which often last only a few days, temporary interventions can span several months or more, offering the opportunity to build meaningful relationships with local communities over time. These relationships can yield valuable insights that inform, develop, and potentially evolve into longer-term strategies. Moreover, experimental approaches often attract participation from more marginalised groups, supporting inclusivity where traditional methods may fall short. In this way, experimentation is not merely a means of fostering inclusiveness—it is inherently rooted in it. Inclusivity is both a foundation and a product of successful experimentation. In this context, temporary adaptations should be seen as part of a broader, long-term strategy for change. They need not to always be framed solely as precursors to permanent solutions, nor confined to emergency contexts. Instead, they can serve as ongoing mechanisms for meeting community needs and shaping more inclusive urban futures. 3. Flexible Resourcing for Area-Based Interventions and Bottom-Up Engagement Processes Emergency situations demand creative and flexible approaches to resourcing. While the allocation of funding for area-based adaptations is essential, it must be accompanied by a level of accountability that fosters trust and encourages contributions from all stakeholders. At the same time, accountability requirements should be relaxed—particularly for small- scale, trust-based funding allocations that support place-shaping initiatives grounded in collaboration between institutions, communities, and individuals. Although significant national and city-level funding is often directed towards large-scale schemes, smaller-scale funding for local interventions is equally vital. This includes establishing funding mechanisms that allow communities or small organisations to apply for and deliver local adaptations. In such contexts, funding and resources are everything. It is often overlooked that charities, small businesses, and social enterprises also have salaries to pay. While capital investment is typically prioritised, the value of people's time— especially in short-term, high-intensity projects—is frequently underestimated. Crisis response efforts often require a significant time commitment from skilled individuals, who can be difficult to recruit without appropriate compensation.

	It is also worth noting that third-sector, area-based organisations often deliver better value for money than public sector bodies. Therefore, providing adequate funding opportunities for local interventions is likely to result in more projects being delivered, more viable activities that meet community needs, and greater overall value. Funding opportunities empower communities and organisations (e.g., BIDs or third-sector groups) to determine their priorities, organise effectively, and implement schemes. This flexibility enables faster, more responsive action. In times of crisis, funding processes and approvals for area-based interventions must be fast-tracked and significantly simplified. Immediate funding is crucial—accountability can follow—so that authorities, communities, and small organisations can accelerate their adaptability efforts. This means reducing application and approval processes to the bare essentials. Returning to the importance of trust, devolving power to neighbourhoods enhances responsibility and ownership. However, this must be managed carefully. Bodies that cede power and resources must also take responsibility for monitoring outcomes and determining whether power should be reclaimed—temporarily or permanently. Any investment and transfer of responsibility should be subject to later evaluation, particularly in terms of benefits and value for money. 4. Soft Regulations, Deregulation, and Crisis-Specific Regulations Effective pandemic responses often depend on the relaxation of regulatory controls and processes to foster experimentation and adaptability. The hybrid adaptation of public spaces and buildings for temporary functions during crises has proven to be a valuable tool —alleviating pressure caused by restricted outdoor space usage and enabling the activation of underused or unused areas for social experimentation. Relaxing regulatory controls should translate into more decentralised urban governance and decision-making, supported by softer, time-limited regulations embedded within temporary frameworks. It is essential for local authorities to either maintain or develop a portfolio of such time-bound regulations—with clearly defined terms and revocation mechanisms. This enables swift responses to crisis-specific community needs without being hindered by standard decision-making timelines, levies, or prohibitive administrative costs. Crisis-specific regulations often involve reactivating pre-existing (but dormant) planning permissions or making minor amendments to them. For example, in England, the Town and Country Planning (General Permitted Development) Order 2015 was amended through the Coronavirus Regulations 2020 to allow temporary land use for up to 56 days (later extended). This facilitated outdoor markets, pop-up medical facilities, and drive-through testing centres. Local authorities were also permitted to operate markets without planning permission, supporting local food supply chains and economic resilience. Similarly, emergency permitted development rights were granted to local planning authorities (LPAs) and health bodies, enabling the rapid construction or repurposing of buildings without the need for full planning applications. In New York City, temporary concessions were extended

from 29 to 119 days during the pandemic, allowing for greater flexibility in the use of public spaces—including their temporary privatisation.

However, authorities should not have to reinvent the wheel with each new crisis. Maintaining a library or portfolio of adaptable regulatory solutions is a practical step forward. Moreover, it is worth critically examining why certain relaxed rules—if proven effective during a crisis—should not remain in place permanently. This reflection can inform more resilient, responsive, and inclusive regulatory frameworks for the future.

5 Flexible, Hybrid, and Un-siloed Adaptive Governance

Adaptive governance is essential during times of crisis, but it cannot be assumed— particularly in the face of entrenched institutional cultures, norms, and legacies. In situation of emergencies, centralised decision-making can often be too slow to respond effectively. Granting greater authority to local governments, enabling them to act flexibly in response to the specific needs of their communities, can therefore be highly effective.

However, the role of central government remains critical. By providing consistent guidelines and strategic direction, it ensures fairness, coherence, and national balance. If local authorities act entirely independently, disparities between regions may emerge, potentially leading to unintended and even harmful consequences. Thus, local flexibility and central oversight must be seen as complementary. Effective crisis response depends on coordination between the two, with shared responsibilities, shared risks, and mechanisms for maintaining accountability.

At the city level, governance should be made more flexible and simplified through a hybrid and porous distribution of power between regulatory bodies and non-regulatory actors (e.g., private organisations, community groups, and civil society). This approach supports democratic responsiveness and enables an interdisciplinary, cross-departmental, multi- agency, place-based response to crises.

The COVID-19 pandemic demonstrated that reducing bureaucracy and breaking down silos can lead to faster, more effective responses—an insight that holds true beyond crisis contexts. Scale is also important: integrating both the micro (neighbourhood, everyday life) and macro (city-wide) levels of governance is essential for delivering meaningful change.

Un-siloed strategic thinking is thus key to enabling rapid, reactive, and transformative adaptations. However, this must be underpinned by a robust feedback loop—one that allows all levels of governance, including city agencies, private organisations, and communities, to contribute meaningfully. Such inclusive and iterative governance structures are vital for building resilience and ensuring that adaptive responses are both effective and equitable.

6. Trust-Based Participatory Decision-Making

Crises highlight both the necessity and potential of trust among people and institutions. Building broad-based trust in new, temporary planning tools and actions is essential to their effectiveness. Successful adaptations depend on trust—trust in existing partners, and trust in new collaborators with whom relationships may not yet have been established. Trust is also

vital in recognising area-based, city-specific, and cultural differences, and in ensuring that local communities feel supported by governing bodies throughout a crisis.

Trust in planning processes and tools is fundamental, particularly in relation to inclusiveness, empowerment, and experimentation. Ensuring proper representation of all communities within governance structures helps build trust and facilitates more effective crisis management by enabling clearer, more direct communication channels. This is especially important given that public trust in the state has, in many contexts, been significantly eroded and is vulnerable to manipulation.

Trust is grounded in both competence and ethical values. It is shaped by skills, training, and organisational capacity. Despite the often unequal power dynamics in the built environment, trust remains a critical component of any partnership. It reflects mutual recognition of each party's strengths and limitations. Trust-based participatory decision- making can lead to more ambitious, socially driven, and context-specific experimental projects than hierarchical approaches typically allow.

Temporary projects led by third-sector organisations operating at the city level can play a key role in this process. These groups often act as connectors between government bodies and other stakeholders. In this context, scale and place matter—trust must be embedded in programmes through local, tangible actions.

However, the qualitative concept of trust must also be supported by quantitative evidence. Measurable outcomes—such as project milestones, employment rates, educational attainment, health improvements, and reductions in crime—can provide tangible proof of the effectiveness of trust-based approaches. Using quantitative data in this way enhances transparency and helps build confidence among stakeholders. In short, a balanced combination of qualitative insight and quantitative evaluation can lead to more effective, inclusive, and resilient decision-making.

7. Adaptability and Knowledge-Sharing

Successful adaptability and creative experimentation are grounded in lessons learned from previous adaptations. Knowledge is central to this process. Maintaining detailed records of the foundations and evolution of projects—including seasonality, and before-and-after impacts—is essential for learning and effective knowledge-sharing. However, retaining and transferring this knowledge remains a challenge at all levels.

Greater diligence, support, and funding must be dedicated to documenting and archiving the processes, tools, and methods used to deliver creative adaptations during unprecedented times. This includes capturing information on regulations, partnerships, collaborations, and project outcomes. Equally important is ensuring that this knowledge is made accessible through both formal and informal open-access platforms and networks. Doing so maximises opportunities for knowledge translation, peer learning, and the development of multi-scalar communities of practice.

A flexible, learning-oriented approach to governance and planning is a critical strategy for the recovery, growth, and long-term adaptability of cities and regions. By accumulating and sharing

knowledge within and across organisations and communities, cities can respond more swiftly and effectively to emerging challenges. As knowledge-sharing deepens, collaboration between experts and local communities can flourish, enabling more holistic and context-sensitive responses.

To ensure this approach is effective, knowledge-sharing must be both critical and cautious

—mindful of issues related to the quality and accessibility of information, as well as the potential politicisation of knowledge. Transparent, inclusive, and well-curated knowledge ecosystems are essential for building trust and resilience in the face of future crises.

8. The Role of Community Hubs

Cities and neighbourhoods are shaped around places where individuals and groups come together; these are often generically referred to as community hubs. Schools, community centres, religious institutions, and libraries frequently serve this role. To enable effective crisis responses and foster long-term resilience, it is vital to identify—and, where necessary, activate—these hubs as focal points for collective urban adaptation.

Community hubs function as essential social infrastructure, generating cohesion and trust

advance and during times of crisis, can help identify demographic gaps and areas of greatest need. In a context of limited resources, being intentional and strategic in project delivery is key to achieving maximum impact.

Beyond formal hubs, it is also important to recognise the value of more informal or micro- scale spaces, such as rooftops, open staircases, or vacant apartments and offices. These can serve as micro-hubs, in other words, spaces of adaptation, refuge, and safety during crises. They also hold potential for repurposing and should be considered as part of alternative planning strategies.

9. Better Use of Technology-Enabled Solutions to Support Adaptations

Urban adaptations during crises should be embedded within city-level strategies and aligned with a clear narrative and vision to secure public support and ensure timely delivery. Health-related crises, such as pandemics, bring specific requirements around prevention and wellbeing. A holistic approach to urban health must be technologically informed, with digital tools supporting experimentation, enhancing efficiency, and improving liveability. Crucially, these technologies must be accessible to all citizens.

The lack of human contact during the COVID-19 pandemic had profound psychological impacts. While technology-enabled solutions can support preparedness and immediate responses, new modelling and AI tools should also consider ways to mitigate the effects of isolation and disconnection. For example, AI and digital planning tools can help identify suitable locations for temporary urban interventions. These insights should be integrated into city resilience strategies and made accessible to local communities.

	Future pandemics may present different challenges—such as the need to manage shared indoor spaces or reconfigure water and waste systems. Technology must be mobilised to address a range of health scenarios, drawing on expert insights to plan for alternative urban futures. Developing and collecting relevant data to support such scenario planning must be a priority for cities' preparedness strategies. 10. Preparedness as an Ongoing Inspiration for Building More Resilient Cities Cities will continue to face a wide range of challenges and crises. Preparedness must therefore be a continuous priority; it should be an inspiration for building more resilient urban systems through innovative, adaptable responses that can be scaled up or down as needed. This requires preparedness to be embedded in policy and regulation before crises occur, including the development of soft regulations and flexible governance frameworks. Programme management is critical. Cities need robust infrastructures, governance systems, tools, and trained personnel to enable prompt and coordinated responses. Inter-agency protocols, informed by lessons from COVID-19, should be established and maintained. Preparedness also involves ongoing reflection and dialogue about past crises, rather than simply moving on. Urban systems must be continuously adapted in response to evolving risks. Flexibility within bureaucratic processes is essential to turn adversity into opportunity. Long-term interventions take time, which is not always available in emergencies. Preparedness strategies must therefore include mechanisms to fast-track or shortcut processes when necessary benefiting both authorities and the communities they serve, particularly vulnerable groups. Finally, preparedness means recognising that meanwhile and temporary uses are as integral to the urban fabric as permanent ones. These uses bring activity, interest, and diversity to cities keeping them vibrant and resilient in all circumstances. **Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?** There is very little awareness at national level versus strong awareness at local level, reflecting the nature of the planning system in the UK. This isn't a priority it seems overall even if strongly connected to other major agenda (i.e. climate change adaptations).
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in	Our research hasn't specifically looked at evaluating the strength of the UK's institutions and governance structures in providing effective policymaking. Overall though and based on Panex-Youth and Adapt4 results, UK institutions are badly prepared. This is due to three main factors. First, a centralised system of decision-making with a lack of localised understanding of the diversity of places. Second, a very bureaucratic and compliance-based system of policy making based on heavy regulations impacting innovative and prompt responses. Third, as I argue in my book (Andres, 2025), the rush to return to normal and to face new challenges and disruptions has led to the failure to reflect on what worked and what didn't work in efforts to adapt cities and allow communities to cope. Any lessons from the pandemic should be shaped with a

providing effective policymaking in responding to major societal threats and how they can be improved?	proactive understanding of adaptability, not solely to tackle preparedness and resilience but also social justice and equity. Evidence that this is happening is limited. What we argue in our ADAPT4 project is that ensuring that cities are better prepared for future pandemics, and crisis thus rests upon pro-active (rather than reactive) adaptability. These rely on a range of factors. Pandemic preparedness relies on the ability to ease regulations and acknowledge the importance of 'temporary' and 'tactical' techniques as a form of urban and place making (incl. materiality, zoning, governance, implementation etc.). It also rests upon the ability to mobilise and release dedicated funding, to distribute it through various channels (including communities) in an equal (through public engagement) but also flexible way. Adaptability and crisis preparedness is intertwined with political support and leadership (including long-term visions). Adaptable governance is here key and based on efficient and reactive distribution of powers and competencies. Crucially, a move away from siloed approaches is needed based on adopting integrated responses to urban adaptations, specifically those targeting outdoor spaces. Knowledge sharing is also key as well as a priority to reiterate the role of streets for non-mobility uses in cities, as a way to address socio-economic inequalities. Continuing engaging with communities in times of crisis as well as accounting for local specificities (incl. cultural diversities) is fundamental as well as better understanding how to approach constraints (legal, spatial regulations, related for example to health and safety and mobility) as to properly experiment & adapt. Reference: Andres L., (2025) Adaptable Cities and Temporary Urbanisms. Columbia University Press Andres, L., Moawad ,P., Appendino, F., Sakai, A., Zepf, M., (2025), Adaptable Cities, Pandemic Mitigation and Crisis Preparedness – Final Report, UCL, London. https://discovery.ucl.ac.uk/id/eprint/10208869/
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies	The Panex-Youth provided an international evaluation of the children and young people's access to food, education, play and leisure in times of crisis and associated policy responses, impacts and adaptations during the COVID-19 pandemic https://doi.org/10.1111/chso.12924 In this paper (combined with related report https://panexyouth.com/wp-content/uploads/2023/06/panex_youthreport_long_final.pdf) we highlight the range of policy interventions that were mobilised during the pandemic in a range of countries. Overall, we demonstrate that the scale of the problem was and remains a key concern. On one hand, most national policy responses led to, and compounded, a challenging situation with immediate needs of children to adequate education, food, play and leisure (and more besides) not being addressed. In turn, this situation led to longer term repercussions, all within contexts of the ongoing marginalisation of children and especially vulnerable children, in most countries around the world (Lundy, 2023; UNICEF, 2022). This reinforced and shed light on the role of localised adaptation as well as existing adaptive capacities that have been shaping children's resilience; these however may not always be sufficient or sustainable in the longer term in

that the UK could learn from?	dealing with the scale of the problem faced by children and young people—whether during COVID-19 or other crises and disasters. To work about children's learning, resilience, agency and activism during (broadly defined) 'environmental' disasters (Williams and McEwen, 2021; Börner et al., 2021), we would add a need for detailed research into their learning, resilience, agency and activism during health-related crises, such as a global pandemic. Globally, and despite distinct socio-economic and political characteristics, the impact of the pandemic on children and young people was amplified due to path-dependent and intersectional burdens that were already affecting youths' lives before the pandemic (such as political austerity measures and pre-existing inequalities). COVID-19 revealed the dramatic extent of those inequalities, typically concerning accessing affordable and nutritious food and in-person education, in terms of the domestic sphere, where over-crowded and conflicting home environments, limited or no access to outdoor spaces and distance to green spaces and play facilities impacted particularly on the lives of monetary-poor children and young people. All those factors led to an acceleration of challenges which hampered children and young people's access to basic needs, and especially education, food, play and leisure. Policy failures and an inability to respond to the scale of the problem—particularly the challenges of lockdowns for children and young people's access to key resources, services and networks, led to the need for localised adaptations. We also looked across the food/education/play/leisure domains and across international contexts, to assess which areas of these complementary needs and rights were (not) prioritised and where there were overlaps between these domains. From our analyses, responses towards the provision for education were clearly at the forefront of governmental policy, internationally, with direct implications for access to food. The most significant policy and localised adaptations were clearly in alternative educational provision—albeit via a range of technologies that could not be (fully) accessed by all children. Nevertheless, many were insufficient and partially failed despite significant resources being distributed in quantitative terms. Play and leisure on the other hand were deprioritised in comparison with the other two sectors, even though they are crucial to child development. We highlighted differences as well as striking similarities in the impacts of COVID-19 upon the needs and rights of more vulnerable children, young people and their families, across international contexts. The pandemic further reinforced households' vulnerabilities due to lost incomes for parents and carers. Poverty hindered children and young people's abilities to cope and survive and the voices of the most marginalised young people were hidden through the intersectional burdens and 'multiple intensities' of the pandemic (Eaves & Al-Hindi, 2020; Ho & Maddrell, 2021; Maddrell et al., 2023 p: 385). Here the unilateral lack of recognition of the importance of playing, having leisure and socially interacting is worth reiterating as a fundamental failure in governments' pandemic responses towards children and young people (Russell & Stenning, 2021). Pandemic responses and restrictions translated into school disruptions, interrupted food chains, and significantly diminished opportunities for play and leisure outside the home. As such, while policies with regard to access to food, education, play and leisure differed from one country to another, with key differences between low-, middle- and high- income countries, responses and adaptations actually followed similar trends. This is

true even in countries like Brazil, which were characterised by COVID-19 political denial, and where regional states stepped in to counter national discourses and policies. Children and young people's resilience was deeply challenged with significant long-term impact on their lives (Kelly et al., 2023).

Having their basic needs put on stand-by was not a decision without consequences and we call here not only for further, in-depth, especially qualitative and comparative research on vulnerable children and young people's experiences of COVID-19, but also for a re-interrogation of how children and young people's voices, needs and rights should be at the forefront of key international discussions (typically WHO) in times of emergency. There is also a need for more longitudinal and again internationally comparative research that tracks the impacts and outcomes for children and young people who lived through COVID-19. Ideally, that research should be interdisciplinary and able to trace not only the impacts on their rights to education, food, play and leisure, but impacts on (and adaptations for) health, well-being, employment, socialisation and political participation.

Fourthly, we demonstrated that, especially in the Majority Global North, national, regional and local responses around education were financially substantial; however, in most contexts they were ill-targeted, insufficient in scale, scope and/or focus in providing for the most vulnerable children and young people. Hence, we have highlighted how transformative support was achieved thanks to local and communal responses led by schools, teachers, volunteers and I/NGOs who stepped in to support children, their knowledge, well-being and even their families. Children and young people's coping, survival and resilience were ensured thanks to the support of community groups, charities, individuals (including teachers) who stepped in during an unprecedented time of crisis. The adaptive practices of these groups were at the core of how children and young people's basic rights were considered and in many cases met, during COVID-19. These directly connect to adaptative capacities widely discussed in the resilience literature, particularly in everyday resilience debates (Chinis et al., 2024; O'Loughlin et al., 2023). Such reflections feed into ongoing discussions about how to re-frame resilience in the context of unprecedented crisis and with the view of leaving no-one behind or at least giving a stronger emphasis to intersectional socio-economic vulnerabilities. In addition, it is important to stress the need for innovations that oppose monocultural tendencies in governmental rationalities, allowing for openings and dialogues, as in the case of young people's own knowledge and actions, which can contribute to more inclusive policies and are therefore better suited to strengthening resilience during crises (Bronk & Jacoby, 2016).

Finally, we highlighted specific places where children and young people's needs could be better addressed through existing examples of good practice, which were amplified during COVID-19. In many countries, these places were schools or community facilities which acted as life and care ‘hubs’ within communities, and as sites of support for children and young people's everyday life and well-being, played a crucial role during the pandemic globally. Their role went far beyond education and learning, to include food provision, play activities and mental health support. Indeed, while vulnerable children and young people's access to food was already channelled through schools before the pandemic, their role in tackling food poverty and accessibility became even more apparent and critical during COVID-19. Hence, while mindful of

	the implications for schools without the necessary resourcing, we call both for further, critical research about how schools and community centres can operate as 'hubs' (during, outside, and in anticipation of times of crisis and disaster) and for greater attention in national and international policy-making and advocacy for children's needs and rights to such hubs. Adaptations and community support observed in Brazilian favellas (see https://www.livrosabertos.abcd.usp.br/portaldelivrosUSP/catalog/book/1644&ved=2ahUKEwibg-r-p5SPAxWdZEEAHaIjNAgQFnoECBcQAQ&usg=AOvVaw1-VulQqbD7YbK3A_BaxvWV) are definitely exemplar and lessons should be learnt from it in the UK. I would suggest you also look at the reports produced by colleagues at IDT: https://www.ids.ac.uk/projects/building-back-better-from-belowb4-harnessing-innovations-in-community-response-and-intersectoral-collaboration-for-health-and-food-justice-beyond-the-covid-19-pandemic/ The ADAPT4 project looked at France (Paris), the USA (NYC) and Japan (Tokyo). While there aren't many lessons to drawn from the French case, a lot can be learnt from the NYC example. NYC has been at the forefront of pandemic experimentations. Differently to Paris or London, and in addition to being bigger in scale, NYC displays more distinct street and outdoor space patterns (typically the width of curbs and sidewalks), in addition to a very dense urban fabric (specifically in Manhattan). The city is exemplar in how it embraced a context of unprecedented emergency to develop significant reactive and pro-active initiatives constructed upon very fast and tactical responses. In addition to the spread of pop-up biking lanes, the city was characterized by two influential programmes: Open Restaurants and Open Streets. Both, while being shaped thanks to an exceptional systemic approach to crisis management, at municipal level, also relied on very strong partnership and involvement of local communities and sponsorship (City Bike). NYC innovative approach was anchored in the legacy of street fight strategies led by the transport commissioner Janette Sadik Khan and her team, under the Bloomberg's administration; these led to the flagship pedestrianization of Time Squares and instigated a culture of alternative street usage which served as the core base for pandemic adaptations. Despite the initial hesitations at the beginning of the pandemic from the then Mayor Di Blasio who then fully supported the ideas, the city saw during the pandemic a rapid development of Open Street and Open Restaurant initiatives allowing the temporary closures of streets and the reuse of parking spaces for outdoor dining; the latest included the construction of temporary roofed structures. The rapidity through which both programmes spread rested upon strong deregulation (including health and safety), easiness in accessing and applying for funding (for groups and organisations) and very soft control and policing (linked to the then ongoing Black Life Matters movement). In 2021, both programmes were made permanent. Differently to Paris and London, pandemic adaptations were therefore more founded upon experimentations (heavily relying on organisations, local businesses and communities to run the schemes) and were not strongly linked to other strategies and political agenda. This had an impact on the legacy of the programmes. To the issues of community fatigue and unequal spatial distribution across NYC, the city faced significant challenges, facing lawsuits and issues as to reintroduce control and regulations. While Open-Restaurant and Open-

Streets are still running, open-dining is now seasonal (with significant financial impact on local businesses) and open streets' numbers have reduced due to difficulties in securing funding to support the management and organization of Open Street events. It is important to note though that both schemes act as stand-alone initiatives not enough included into wide spatial planning thinking impact crisis preparedness and resilience thinking.

Interestingly while Tokyo was characterized by a limited number of adaptations during the pandemic, there are some interesting lessons for the UK. Tokyo (as Japan per se) has long been accustomed to risk, with the pandemic just being another risk. As such the city didn't implement any lockdown as citizens albeit to social distancing restrictions very smoothly. Second, Japan is characterised by a very strong political stability meaning that the government is respected and trusted by the citizens. The society is founded upon individual and collective responsibilities and respect of rules; this means that self-regulatory process of behaving appropriately and socially distancing, occurred automatically during the pandemic. Third, and in connection to the first two points, little efforts overall are made towards community engagement, and this characterizes how urban change occurs in the city. Overall, as a result, Tokyo was characterized by a limited number of adaptations during the pandemic, and these were highly localized. These included temporary closures of streets in commercial areas and business districts led by private/public sector organisations and not involving input from communities. Informed by tactical urbanism principles, but very much planned and top-down per se, several open street initiatives were developed. These were launched for recovery purposes rather than to offer more liveable urban environments in time of crisis for residents. Similarly, open dining schemes were implemented in some areas to support local restaurants. Again, these were not led by individuals but proposed by a collective, in other words an organization, like a shopping mall management company, with the goal of securing funding. Aside from an absence of (community) incentives to foster adaptations, the very strong government system characterizing the city of Tokyo also explains the small number of pandemic adaptations characterizing the city. Indeed, very strong legal regulations and barriers were in place restraining flexibility and adaptability. Tokyo therefore displays a unique approach to crisis management based on a different perception of risk, obedience and resilience. Interestingly though while limited thinking occurred during the pandemic, adaptability is emerging currently as an area of interest for city makers with the view of having Tokyo even better prepared in the future.

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Your response

Full name	Charles Hulme*+ & Maggie Snowling*
Job title	Emeritus Professors*
Organisation / University / Research institute	*University of Oxford + Oxford Brookes University

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Inequalities •
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Since 2020 we have been commissioned by the DFE to roll-out a language intervention - potentially to 11,000 English schools to reduce the inequalities in language observed among children entering school. https://www.teachneli.org/ To enable this, Charles Hulme founded an Oxford spin out https://oxedandassessment.com/ which currently delivers screening and when appropriate oral language interventions in reception classes and preschool settings.
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	The government are aware of the language gaps observed at school entry particularly among disadvantaged groups. This is why both administrations have continued to fund roll-out of the NELI program which has been shown to be especially effective for children on FSM . Moreover, its effects have been shown to be sustained after 2 years on language and on reading. NELI is normally delivered by teaching assistants in mainstream schools. An obstacle is the availability of resources for delivering

	the programme in some schools. Ideally this would need to be addressed to circumvent societal inequalities which begin early and continue through the school years.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	The DFE appear to look to the Education Endowment Foundation for advice on evidence-based programmes for schools. There is no comparable organisation in the other 3 nations of the UK which appears to be a shortcoming. There continues to be a lengthy time between scientific discoveries and implementation; perhaps more direct liaison between academics at the forefront of the science of language and reading, perhaps involving international leaders, could lead to a more timely response.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	

Your response

Full name	Michael Billig
Job title	Emeritus Professor of Social Sciences
Organisation / University / Research institute	Department of Media and Communication Loughborough University

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Digital society • Social and cultural infrastructure
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Trust • Cohesion
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Covid-19 threw into focus a large number of important issues, including the use of public statistics in medical crises. Throughout the pandemic crisis, governments and health organizations issued public statistics about the number of casualties, tests conducted, the rate at which the disease was spreading, etc. With so many statistics being published around the world, it is important for populations to be in a position that they can check whether they can trust the statistics that their governments quote. Research, which I conducted with Dr Cristina Marinho of the Department Psychology at Edinburgh University, examined how the UK government misused statistics to claim success in controlling the spread of the pandemic. We published articles in specialist journals showing the political manipulation of health data in the UK. Many of our findings were published in our recent book *Politicians Manipulating Statistics* (Cambridge University Press, 2025: https://www.cambridge.org/core/books/politicians-manipulating-statistics/692B3508A19D816C7BB6D1BF6464110B).

	The aim behind this research was two-fold: to expose the ways that governments manipulate public statistics; and to show how such manipulations can be best opposed, especially in any future pandemic. We focus on the role of independent, national statistical authorities, particularly those in the UK and France. Such independent organisations are vital for preserving the independence of governmental statistics, especially in times of health crises. There are worrying signs that, regarding the manipulation of health statistics, not all the lessons have been learnt.
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	A future pandemic is likely to resemble the Covid-19 crisis in that it will principally be governments who will be tempted to manipulate public health statistics, in order to claim political success in controlling the epidemic and to hide political failures. To make it difficult for governments to manipulate statistics, it is necessary to reinforce the importance and status of national, independent statistical authorities, such as the United Kingdom Statistical Authority (UKSA) or the French Authority for Public Statistics (ASP). These authorities are legally established national bodies whose task is to maintain the standards of their nation's public statistics. To fulfil their function, these statistical authorities not only need to maintain their independence but need to be seen to be independent, trustworthy institutions. Thus, if the government mis-uses social statistics, these are the bodies to pronounce independently on whether there is mis-use and, indeed, whether the statistics are trustworthy or not. There are signs that the statistical authorities realize that their own independence requires constant self-monitoring. ASP is arranging a major symposium for 2026 to discuss how statistical authorities like itself can best maintain independence, particularly in the face of pressure from governments. ASP is inviting statistical experts, including international academics, as well as users and producers of public statistics, to discuss the problems of independence. The President of ASP has contacted me to say that it is important that the ideas of *Politicians manipulating statistics* are presented at this symposium. The UK and French statistical authorities have opposed the manipulation of statistics, by using more than statistical expertise: they have used careful strategies to oppose statistical manipulation and to maintain their public profile of independence.

	One of our more surprising findings was that the statistical authorities in both the UK and France combat the manipulation of statistics by avoiding using the word 'manipulation'. Both organizations are aware that the major threat to statistical independence comes from politicians, and both tend not to state this too openly. The strategy is to appear publicly to be concentrating on the trustworthiness of the statistical data, and not on the motives of politicians commissioning manipulated data or (mis)quoting data that is potentially trustworthy.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	The evidence suggests that UKSA and official statistics are trusted in the UK, while the trustworthiness of politicians continues to decline. UKSA, like other regulatory bodies, is seen generally to protect national statistics, acting as a 'national watchdog'. Our analysis of press reports of clashes between UKSA and politicians supports this interpretation. However, national respect cannot be taken for granted. There are good signs that the UK statistical bodies are monitoring their own performances closely. For instance, this year the Devereux Inquiry has examined how the quality of UK public statistics can be improved and recommended some organizational changes to the Office for National Statistics. Professor Denise Lievesley was appointed to conduct a review of the UK Statistics Authority, and her committee made recommendations regarding the management structure of UKSA in order to protect and strengthen its independence. Such organizational and procedural changes offer no guarantee that in a future health crisis governmental politicians will act better than they did during the Covid-19 crisis. Regarding statistical data, there is nothing legally to prevent ministers exploiting the inevitable gap between numbers and words by misdescribing what the numbers mean. During Covid-19 crisis, this gap was exploited by the Minister of Health. The result was that more than a million more tests for Covid were claimed to have been conducted than were actually conducted. Also the Prime Minister misdescribed data to suggest erroneously that crime and unemployment fell during the Covid-19 crisis. As we argued in *Politicians Manipulating Statistics*, the claims about Covid testing were so intricate that the political mis-

	description and statistical manipulation could not have been accidental.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	Regarding the manipulation of Covid-19 testing figures, it is not clear how the Minister of Health might have put pressure on the statisticians in his department to produce a methodology for counting the tests which would inflate the recorded numbers. There is a constant danger that ministers might pressurize small groups of statisticians based in their ministries to produce politically advantageous figures. To minimize the chances of this happening, an example might be adapted from the operating procedures of the French ASP. The ASP has a duty to inspect regularly the groups of statisticians based in governmental ministries to ensure that the statisticians produce independent statistics. ASP pays particular attention to small and weak groups who might be vulnerable to ministerial pressures. If ASP suspects that statistical groups might not be operating independently, it can recommend that such groups should be merged with larger, stronger groups in neighbouring ministries or that they should be disbanded altogether. UKSA takes a more passive role, and does not actively inspect ministerial-based statistical groups. However, in the light of the performance of the British Ministry of Health during the pandemic crisis, there might be value in exploring whether the French procedure might benefit the independence of British ministerial statistics. President Trump provides what can be called an anti-example for British statistics. Trump has a history of dismissing statistics that he does not like, claiming without proof that the numbers have been produced simply to undermine him personally. During Covid-19, he applied this reaction to politically inconvenient Covid-related statistics and also to the recommendations of his chief medical advisor. The recent sacking of head of Bureau for Labour Statistics (BLS) fits this pattern, as did his treatment of BLS unemployment statistics during his first presidency. The United States does not have a respected national 'statistical watchdog' on a par with UKSA. The result is that there is little to restrain Trump and other politicians in mis-treating statistics. The question is whether the UK might be moving in the same direction. The rise of the Reform Party testifies to the public loss of faith in

	mainstream politics and politicians. In an age of post-truth, where growing numbers of the public distrust mainstream politicians and official organization, the national respect for national statistics may be endangered. Vigilance will be required to ensure that any future pandemic does not give rise to the sort of conspiracy theories and wishful thinking that finds solace in manipulated numbers and in rejecting trustworthy numbers.

Your response

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Organisation / University / Research institute	London Metropolitan University

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Social and cultural infrastructure
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Trust • Cohesion • Inequalities • Sustainability
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	I do not have any information on this
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have	I have written a chapter ' Following the Science: The UK Government's Response to "Herd Immunity" during Early Covid-19', in D.Crowther and S.Seifi (eds.), *The Complexities of Sustainability,* New Jersey, World Scientific, 2023. It should address questions 2, 3 and 4 in more detail than I can cover here. I have uploaded the final version of my draft chapter, should this be of interest.

seen policy interventions, what effects have these had?	
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	

Your response

Full name	Dr Rachael Barrow
Job title	Senior Teaching Associate
Organisation / University / Research institute	Lancaster University

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Social and cultural infrastructure • Education and employment • Digital Society
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Trust • Cohesion • Inequalities
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	My response pertains to the ongoing increase in home education, as an alternative educational provision to mainstream schooling, which despite existing prior to the Covid-19 pandemic has since been exacerbated due to the changes to how education was delivered during it (BBC England, 2024). As many will recall, significant challenges had arisen for primary and secondary educational institutions during the Covid-19 pandemic because of the forced closure of schools for the good of public health. This meant that pupils had to participate in some variation of home education often taking place via Teams or Zoom and supplemented by printed out content. One implication of this was how it exacerbated inequalities in the sense that not all families had the capabilities and financial means to accommodate the requirements of educating their children in this way. Often home education is a choice made by parents for philosophical, religious, pedagogical or lifestyle reasons, but the pandemic meant parents had no choice in home educating at least for the duration of the lockdowns. During this period, many parents also did not

	necessarily have the time to take on more of a role in their children's education due to their own working schedules, which had also encountered implications because of the disruption caused by the pandemic. Despite these drawbacks (and several others not addressed in this response) from educating children at home during the pandemic, had been several benefits associated with the practice also, which significantly included improvements to children's mental health (Twenge et al, 2020), alongside, quicker academic gains than those experienced in school (Twenge et al, 2020), and tailor-made curriculums with more flexible time scheduling (Twenge et al, 2020). In fact, the mental health element has surpassed most of these reasons and seen endurance since the pandemic ended, as a main motivator for families choosing to home educate in the past couple of years (BBC, 2024). This is because an existing challenge prior to the pandemic was the increasing number of parents with children who had special educational needs or disabilities feeling overwhelmed and disappointed in the school system for perceived failure of their child's needs and education (Maxwell et al, 2018). There has been a sense by some that the 'school system is broken' (BBC England, 2024). The pandemic, therefore, provided a way for many families who fit these criteria to experience what education outside of mainstream schooling could do for their child. Subsequently, many did not return to mainstream schooling after the lockdowns lifted because of these previously outlined benefits experienced for their child. The local community of Blackpool being a notable example of this from having experienced an above the national trend rise in the figures of those voluntarily choosing to be home educated in the locality (Parkinson, 2024; Hunt, 2025). Concerns have been raised as to how this rise in home education in the local area of Blackpool has particularly come from those children who could be identified as not in employment, education or training (NEET), which can further exacerbate their categorization due to their little to no involvement with educational or employment institutions (Parkinson, 2024). This is a concern that I would argue could be reflective of other local communities across the nation who have also seen a rise. It is important for policymakers and academics alike to consider how children who are forced into home education from vulnerable communities is not the same as children who or whose parents actively choose to home educate them for reasons beyond school failure.

	Overall, the Covid-19 pandemic gave spotlight to the ongoing need to reform schools on the one hand due to an increase lack of cohesion and trust, while also considering what can be learned from the variety of alternative educational practices that exist outside of the mainstream system on the other hand, to ensure that education is more inclusive and flexible for all children in the UK and not just select groups who fit the societal norms around education. All sources drawn on throughout this response: • Concern at rising numbers of children home-schooled in Blackpool | The Lead • Home education for children with additional learning needs – a better choice or the only option?: Educational Review: Vol 72, No 4 • The parents who insist home-education is the answer for their children - BBC News • The Children's Wellbeing and Schools Bill: what parents need to know – The Education Hub • Concerns raised over number of children homeschooled in Blackpool • Twenge, J.M., Coyne, S.M., Carroll, J.S. and Wilcox, B.W. (2020). Teens in Quarantine: Mental Health, Screen Time, and Family Connection. [pdf] Institute for Family Studies. Available at: < final-teenquarantine2020.pdf (ifstudies.org)> [Accessed 11 September 2025]
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	A key lesson from the pandemic for educational recovery is to consider the variety of ways in which children did successfully learn during the pandemic and can learn in the future despite no immediate societal threat, to reform schools and the wider educational system to ensure innovation for a sustainable future. This might differ from the societal norm that society are used to but with the evident ongoing rise of digital society, alongside the rise in children who have special educational needs and disabilities, and children from a variety of cultures, there does need to be a greater consideration of innovative pedagogical and curriculum advancements to children's education within UK society. For any future societal threats or emergencies such as another pandemic or some other world event, it is of my opinion that educational innovation through how the provision and curriculum is delivered is a crucial way for institutions and government to prepare. This

	would also help to mitigate some of the challenges that needed to be responded to from the previous threat within this sector. There is evidence of government being aware of the increase in home education through their proposed Children's Wellbeing and Schools Bill as well as a need to reform schools. The bill aims to introduce measures to support children and families, from school reform and home education to safeguarding (Department for Education, 2024). There has been acknowledgement through this of children who are considered NEET and how these children need to be safeguarded by local and national institutions to avoid them slipping through the system. The suggestion has been to develop a home education register to account for all those children who are engaged in the practice. This, however, has created division within the long-standing home education community because they feel that they are having their privacy and trust eroded by government institutions and actors because of a select minority group of children who are forced into the practice as opposed to making the active choice to practice home education. It is important for policymakers to consider that home education motivators, reasons, and practices are not one fits all but rather encompass significant variety.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	Current institutional and governance structures do not currently provide for effective policymaking when it comes to major societal threats on education and employment for vulnerable communities. For example, UK employment and professional body institutions such as the Job Centre, ACAS, CIPD, and many trade unions currently do not have policies or structures in place to support parents who provide education at home for their children, while also working full or part-time. It is also the case for young people who have been home educated and transitioning to employment for the first time. HR policies specifically do not address alternatively educated people, as a vulnerable or minority group, despite the growth the phenomenon is seeing. This can lead to this group of people experiencing discrimination and further marginalization by employers and employees such as during recruitment and selection processes, grievance and dismissal practices, and work and employment relations. They have little to no protection. This has become more significant since the pandemic because every child in the UK now possesses an experience of being home educated (Barrow, 2024). This means employers should take seriously the need to consider this in their policies, as this current generation entering the workforce will

	come to the labour market with knowledge and skills gained from not just mainstream schooling but from home education also. This was also a recommendation out of Barrow's (2024) study on home educated adults experiences of employment because even older members of the population, who have previously been home educated, have experienced issues in employment because of their educational backgrounds that required support and protection from institutional policies that did not exist. For example, some of the participants felt that flexible working and wellbeing policies that lend themselves to working outdoors and flexibility in working hours could have been beneficial for their mental and physical health in the workplace, alongside, greater acknowledgment of their unique experiences and differing qualifications during recruitment and selection processes. I have provided some examples of this below: Tom was a participant who experienced the Job Centre structures when he was out of work. *"The Job Centre made me take a maths course because I didn't have my maths GCSE and it was an absolute joke. My maths IQ was much higher than the others and even the teacher. The others would even ask me to check their work because they recognised this but all the Job Centre cared about was that I had a piece of paper to certify my maths ability. I ended up going into gardening which didn't even require a maths GCSE. Education needs to adapt to the needs and aspirations of children because just taking this example of GCSEs, not every child needs them for their aspirations and failing at them or not being able to take them can seriously harm a child's mental and physical wellbeing." (Tom)* *(taken from a conference presentation by Barrow (2019))* Arthur was a participant who experienced discrimination by a potential employer during the selection process because the interviewer did not have a favourable opinion of home education. *"During the interviews, my home education came up a lot in that I remember when I went to meet the person who was positioned to kind of focus on the educational aspects of training, they were very negative about home education. They told me they didn't think I would be able to train to be a vicar because they just thought I wasn't suitable for it at all based on my home educated background and to kind of overcome that, the solution was for me*

	to go and take a 10-week course independently to prove my worth." *(taken from Barrow (2024)'s published thesis)* Sophie was a participant who expressed strongly her distaste for the lack of understanding in workplace policies for employees physical and mental needs when it comes to their productivity. *"I particularly dislike control around not just being able to leave at any point of the day to go and take a walk outside to get some fresh air. Like I always did that when I was homeschooled, it was fine. No one told me otherwise, but the supervisors in work are going to be like, sorry, but you need to stay sat at your desk, and things like that really set me of internally. It's like managers don't trust people, it's like if I'm a higher performer then just leave me alone."* *(taken from Barrow's (2024) published thesis)* Improvements to institutional structures to provide for more effective policymaking in this area could entail labour market intervention programmes to assist young EHE people transition into employment or further education, given their alternative educational backgrounds might mean alternative qualifications and experiences to negotiate with employers with. A further improvement could be for government to consider what knowledge, skills, and pedagogical practices could be learned from the home education community. This is an area that is often missing from existing literature and current research studies but is something that previously home educated people and academics researching in this area alike have considered to be a crucial oversight. This is because many home educators utilise an array of pedagogical approaches inside the classroom and outside that could be extrapolated for use in mainstream schooling. Such considerations could also be beneficial for future societal threats by considering the role of an increase in innovative home-based, local community-based, and digital-based pedagogical practices that break from the norm, and through which, mainstream education can also become more inclusive of different groups of children (for example, to accommodate more inclusively children with special educational needs and disabilities). This might also

	reduce school absence and children leaving the system and falling into the NEET categorisation.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	

Your response

Full name	Prof. Rebecca Pearson, Dr. Nicky Wright, Dr. Alex Kwong
Job title	Professor of Developmental Psychology and Epidemiology
Organisation / University / Research institute	Manchester Metropolitan University /Child and Adolescent Mental Health Group / Institute of Children's Futures/ University of Bristol

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Inequalities • Sustainability
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Several longitudinal studies have tracked mental health and wellbeing in parents, children and young people from before, during and now after the pandemic. We summarise the evidence for continued concerns for mental health and wellbeing in young people across the UK. ***When? Role of Development periods*** We focus on evidence of the impact on the development of children and adolescents (between 1 and 18), who represent the age group affected that are most vulnerable to mental health disorder onset in the next 5 years. They are also approaching key academic milestones (GCSE and A-Levels) while moving into employment. Thus, their needs are of urgent attention to current policy to secure the health, productivity and wellbeing of our future society. However, trends over time in children and young people's mental health are complicated by developmental changes; with known

	periods of change in emotional development (i.e., sharp peaks in behavioural problems in early childhood and in depression and anxiety in mid-adolescence). We summarise data from two UK studies which use specific methods to account for developmental changes to demonstrate that emotional and behavioural problems have risen more than would be expected. **Study 1 (Southwest England ages 1-13)** Using data from the 3rd generation of Avon Longitudinal Study of Parents and Children (ALSPAC-G2), including children at multiple ages between 1-13 years in Southwest England, we estimated matched pre and post pandemic trajectories of children's emotional and behavioural difficulties. Pre-pandemic trajectories were characterised by difficulties peaking around age 2 but then declining throughout the rest of childhood. However, the trajectories for children growing up within the pandemic highlighted *a 'slowing down'* of this post 'terrible twos' decline. This slower emotional development, translated to children growing up in the pandemic having a 9.5-point higher (95% CI: 4.5 to 14.5), difficulty score at age 8 than would have been expected based on pre-pandemic estimates. Paul et al. 2020 Trajectories of Child Emotional and Behavioural Difficulties Before and During the COVID-19 Pandemic in a Longitudinal UK Cohort by Elise Paul, Daphne Kounali, Alex SF Kwong, Daniel Smith, Ilaria Costantini, Deborah A. Lawlor, Kapil Sayal, Helen Bould, Nicholas J. Timpson, Kate Northstone, Melanie Lewcock, Kate Tilling, Rebecca M. Pearson :: SSRN (under response to review in JCPP advances) **North-West England (ages 11 to 14)** Using the Wirral Child Health & Development Study (WCHADS) study with overlapping ages from 11-14 to estimate both age-related and pandemic-related change, we show that the pandemic led to increases in boys depression (this increased by 31% from pre-to post pandemic) and in girls and boys behavioural problems (this increased from pre to post, 40% and 41%, and increased further one year later, by a further 33% and 18%). Girls' depression increased steeply with age over this period; with no evidence the pandemic added to this. ***Current picture:*** The ongoing trajectory of these observed changes in mental health difficulties during the pandemic in recent times as these children

	enter late adolescence are not yet clear. However, recent unpublished data accessed for this submission (Wright), report that 29% of the WCHADS population (14% of boys and **40%** of girls) show clinically relevant levels of depressed mood (based on validated thresholds) at age 15.5 years (collected in 2024-25, n=600). We compared this using the same measure (and cut point) in as close an age as was available (14-year-olds) in a national sample of 11,176 children in Millenium cohort in 2015 (pre-pandemic). Here, only 18% of adolescents, 10% of boys and 26% of girls, showed this level of depressed mood. Suggesting mental health problems appear to have remained elevated in WCHADS 5 years on from the pandemic compared to estimates in similar ages of adolescents. Furthermore, national NHS digital data continues to report higher than ever levels of mental health difficulties in this age range. NHS England 2023 data shows that one in five children and young people aged eight to 25 had a probable mental health disorder, with higher rates among ethnically diverse and low-income families. ***Who? Children and young people at greatest risk and resilience factors.*** Policy changes also need to consider a changing population need, different risk factors and different presentations. Our studies show that rises are seen not just in the 'usual suspects' but those not previously 'at risk'. With over 1 in 5 young people suffering this has become a public health problem that can no longer be considered by specialist services alone nor are these appropriate for initial presentations of milder symptoms of depression and anxiety. Community, family and relational support often within the voluntary sector may be better placed to meet this need if properly supported. Indeed, referrals for child and adolescent services have risen drastically as have waiting lists. For example, in the north-west of England referrals for child anxiety were 11-times higher in 2023/24 compared to 2019/20, with the longest recorded wait time from referral to appointment being 57 weeks, see Our Research Into Children's Mental Health Referrals Using WCHADS data collected three months pre-pandemic and three months post-onset of the pandemic (child age 11-12 years).

	We showed depression, Post Traumatic Stress Disorder (PTSD) and behavioural problems increased in boys and girls. But interestingly, there was a greater increase in behavioural problems in young people who had not previously had behavioural problems. Increases in both mothers and child's depression during the pandemic was also influenced by deprivation, but like childhood behaviour problems this was "closing the gap", with greater increase in non-deprived mothers. Wright N, Hill J, Sharp H, Pickles A. Interplay between long-term vulnerability and new risk: Young adolescent and maternal mental health immediately before and during the COVID-19 pandemic. JCPP advances. 2021 Apr;1(1):e12008. Interplay between long-term vulnerability and new risk: Young adolescent and maternal mental health immediately before and during the COVID-19 pandemic - Wright - 2021 - JCPP Advances - Wiley Online Library. A paper published on a cohort of children in Norway explored the impact of variation in use of restrictions in mental distress for children between 16–17-year-olds. With higher levels of mental distress coinciding with more strict and changeable measures such as lockdowns and school closures. In this cohort study of 7787 participants, stricter public health measures and quarantine were associated with adolescent mental distress. Those with lower genetic liability to depression (a marker for previous risk) showed particularly elevated mental distress by more frequent quarantines. The regional variation in public health measures, such as length of lockdowns and need to isolate in different areas, allowed this study to show the role of strict lock downs in a way not possible in the UK data above. Consistent with Wright et al, this study also shows those not previously 'at risk' showed rises in mental distress during pandemics. Citation: Pettersen, J.H., Hannigan, L.J., Gustavson, K., Lund, I.O., Pearson, R.M., Jensen, P., Nesvåg, R., Brandlistuen, R.E. and Ask, H., 2024. COVID-19 pandemic quarantines and mental health among adolescents in Norway. *JAMA Network Open*, *7*(7), pp.e2422189-e2422189. COVID-19 Pandemic Quarantines and Mental Health Among Adolescents in Norway - PubMed Finally, in the ALSPAC-G2 study using data from 411 children between the ages 1 and 13, we showed a promising source of resilience. Keeping a routine was associated with emotional and

	behavioural difficulty scores 5.0 points lower (95% CI -10.0 to -0.1), p = 0.045 than not keeping a routine. Parents who reported keeping a routine had anxiety scores 4.3 points lower (95% CI -7.5 to -1.1), p = 0.009 than those who did not. Children of keyworkers tended to have lower emotional and behavioural difficulty scores [-3.1 (95%CI -6.26 to 0.08), p = 0.056] than children of non-keyworkers. Maintaining a routine may be beneficial for both child emotional wellbeing and parental anxiety, although it is also possible that lower parental anxiety levels made maintaining a routine easier. Being the child of a keyworker parent during lockdown may have been protective for child emotional wellbeing. Citation: Lees V, Hay R, Bould H, Kwong ASF, Major-Smith D, Kounali D, Pearson RM. The impact of routines on emotional and behavioural difficulties in children and on parental anxiety during COVID-19. Front Child Adolesc Psychiatry. 2023 Dec 13;2:1114850. doi: 10.3389/frcha.2023.1114850. PMID: 39839582; PMCID: PMC11747911. Frontiers | The impact of routines on emotional and behavioural difficulties in children and on parental anxiety during COVID-19

Question 2:
 	
What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats?
 	
Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?
	• Stricter and more frequent public health measures contributed to the impact on mental distress in young people. Consideration of the impact on longer term mental health alongside balancing any acute risk from future pandemics is important when future policy might again have to decide if strict lockdowns are needed.
	• Those who were not previously 'at risk' showed rises in pandemic, meaning new approaches to identification and targeting support might be needed without assuming pre-pandemic strategies will work. Approaches of more flexible adaptation of existing evidence-based interventions at a local level may be more effective.
	• Family level routine may be protective and keeping families in routines of school and work is important.
	• The 10-year health plan moves towards community and prevention, regional response and community hubs.
	  ○ Establishment of *Neighbourhood Health Services*, shifting resources from hospitals into community-based care.
	• Family support and interventions are at the core.
	  ○ Expansion of mental health support teams in schools, Young Futures Hubs, and Family hubs

Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	Outside of expertise
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	The recent Norway Mental Health plan also emphasizes a shift to prevention and family support. Meld. St. 23 (2022–2023) Report to the Storting (white paper) Youth clubs as health-promoting arenas are suggested which may provide a template for current suggestions in policy of Family Hubs and Neighborhood Health.

Your response

Full name	Saffron Karlsen (please find full contributor details below*)
Job title	Professor of Sociology
Organisation / University / Research institute	University of Bristol

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Trust • Cohesion • Inequalities • Sustainability
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	The Covid-19 pandemic brought much needed political attention to the structural nature of health inequalities, including those related to ethnicity, in part enabled by the work of the British Academy in collaboration with the Royal Society. While there has been some reversion to the dominance of more behavioural/biological explanations for health inequalities since that time, this period still provides a valuable foundation for continuing work in this area. More specifically, the pandemic exacerbated on-going issues with vaccine hesitancy and inequalities in vaccine uptake, while introducing new challenges related to vaccines missed during the lockdown periods, such as for human papilloma virus. The guidance below provides insights for policymakers regarding effective approaches to addressing persistent health inequalities post-pandemic, as well as specific details of opportunities to improve vaccine uptake.

Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	The 2021 British Academy review concluded that addressing the long-term societal impacts of Covid will require us to recognise and respond to the ways in which pre-existing social and structural marginalisation both increased risk of infection, hospitalisation and death and undermined people's capacity to contribute to the "community-led responses that draw upon local knowledge and resources, and build capacity and channels of interconnectedness between government, community organisations and the public" which are so crucial for effective crisis responses. Yet evidence suggests that, typically, the national government policy developed to respond to the Covid-19 pandemic, and health inequalities more generally, not only ignores but can work to misrepresent the experiences of local communities and marginalised groups, experiences which directly undermine public trust in policymakers as well as effective pandemic responses. By contrast, the pandemic response of local government in Bristol placed the expertise of members of local marginalised ethnic groups at the centre of a network of representatives from local government, health and public services, the voluntary, community, faith, and social enterprise (VCFSE) sector and other local stakeholders. Known as the Bristol Race Equality Covid-19 Steering Group (RECG), This approach, described in more detail below, enabled an evidence-based, empowering, collaborative and effective pandemic response, and as such provides a valuable example of practical approaches which might more successfully respond to the concerns raised in the 2021 British Academy report. Initiatives emerging from this group directly contributed to both improved public understanding of the pandemic and improved vaccine uptake amongst marginalised ethnic groups, leading to lower ethnic inequalities in vaccine uptake compared with elsewhere in the UK. Unfortunately, significant progress in response to certain challenges was undermined by barriers generated by national policy, for example in relation to the implications of NHS charging for recent migrants on pandemic responses, including access to Covid-19 treatment and vaccinations. However, our research also shows that the Bristol approach has been instrumental in improving trust amongst local stakeholders and a sense of empowerment and efficacy among group members and the communities they represent, which provided welcome relief to the wider pandemic chaos. Since the pandemic, this collaboration has been formally established as the Race and Health Equity Group (RHEG), and

	remains a critical mechanism for the consideration of persistent ethnic health inequalities in the city. It maintains a democratic approach whereby members - drawing on their engagement with other stakeholders – determine the group's priorities, with the support of senior political leaders from Bristol City Council. As such, the focus of the group continues to directly respond to local public, as well as emerging academic and political, concerns regarding persistent ethnic inequalities in a range of physical and mental health issues. Engagement with these issues continues to be evidence based and reflective of the structural nature of health inequalities and how these manifest at the local as well as the national level. This approach also ensures the availability of the "strong web of communities and community engagement at local levels" should it be required as part of an effective response to future crises. Bristol's 'unique and brave' whole-city approach towards racial equity led to it being a shortlisted semi-finalist for the prestigious European Capital of Innovation Awards 2024.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	A significant criticism of national government responses to ethnic inequalities in health, in relation to the pandemic and more generally, relates to their ineffective and sometimes problematic use of empirical evidence, driven in part by the exclusion of those with lived experience from policy-making circles. In Bristol, by contrast, the response to ethnic inequalities in the pandemic experience was explicitly underpinned by comprehensive empirical evidence. The RECG was founded in response to a rapid evidence review commissioned by the Council from Bristol University, which drew attention to the need for a collaborative response which prioritised the needs of communities. The routine scrutiny of emerging national evidence and its application to local settings then became a key role of the group, evidence which was supplemented with local data provided by academic and non-academic groups, including VCFSE organisations. These data were then shared across the city. The effectiveness of this scrutiny and the initiatives developed in response was ensured by a group governance structure which supported a cohesive and collaborative multi-sector pandemic response, which placed the experiences of those in marginalised communities at its centre. This work to establish an effective evidence base from which to identify and respond to ethnic inequalities in health continues to be a critical role of the RHEG, informing their own activities and those of others. This focus on the perspectives of minoritised ethnic groups, including through the specific expertise of VCFSE

	sector representatives, has also been instrumental for ensuring that the initiatives emerging in response to the inequalities identified are appropriate, meaningful and useful to those marginalised communities most disadvantaged by them. Our evaluation identified several other factors which have been key to ensuring this effective action. Perhaps most significantly, the work of building trusted relationships and evidence-based policy was not left until the pandemic began. Bristol has a history of multi-sectoral engagement, evidenced by their OneCity approach, which enables the empowerment of marginalised groups in relation to policy-making. This drives and is driven by a long-standing commitment to responding to the structural drivers of ethnic inequalities in health and other social inequalities amongst policy-makers and others in the city, which was easily translated into a commitment from the Mayor's Office to respond to these pandemic challenges effectively, once this evidence (again) emerged. This tradition of open dialogue and commitment to meaningful action meant that the open invitation to collaborate sent to all stakeholders by policymakers following the release of the University of Bristol report was quickly met with an enthusiasm for proactive and creative action from across the city. Importantly, this approach also ensured that those involved maintained a sense of efficacy and ownership over what emerged. There were also practical/bureaucratic changes brought by the pandemic which contributed to this success. The relaxation of bureaucratic rules around local government policy-making supported the engagement of a wider group of stakeholders. It also supported the development of more creative responses to the issues identified, which could be introduced in a more timely manner. The switch to online meetings also permitted the involvement of larger numbers of delegates – with monthly meetings typically attracting more than fifty people – as well as an improved sense of open dialogue and inclusivity within the group. This is one of a number of opportunities identified through the RECG experience which have been incorporated into the new RHEG structure. The RHEG also retains this open membership, which ensures the contribution of the group remains relevant and responsive to on-going and emerging challenges in the city. It also continues to invite contributions from non-members, where this is required. Its non-hierarchical structure enables valued dialogue between

	systems leads and community members, approaches which align with the group's wider efforts to value non-traditional means of engagement and evidence gathering and its founding principles of co-production. The group's rotating priorities are determined using a submission process which allows for mixed method submissions, from any interested parties on any health equity related issue, on which members then vote. Meeting agendas are structured to provide space for constructive conversation, ensuring all perspectives can be heard. The group also retains an open standing agenda item, which encourages attendees to provide updates on any related topic from their respective organisations, further supporting these egalitarian and empowering facilitation approaches. The RECG/RHEG also engages people from across the city directly through their contribution to Bristol's 'Race and the City' programme, an annual series of race-focused events designed to enable whole-city positive conversation and action. To date, the groups have played a lead role in delivering three 'A Spotlight on Race and Health' events through this programme, attracting 750 delegates. These events enable all members of Bristol's communities to actively share their health-related concerns and challenges, while reflecting on how to effectively collaborate to address these. More generally, these on-going conversations proactively support the maintenance of mechanisms for building Bristol's resilience and forward thinking responses to current and future challenges. The RHEG also continues to work closely with Bristol City Council. The Council's Public Health and Equality & Inclusion teams attend each RHEG meeting, subsequently escalating matters to senior leadership where appropriate. The group's priorities and outputs are routinely shared both within the Council and across the city's strategic governance structures. In particular, the group contributes a long-standing agenda item to the meeting of Bristol's Race Equality Strategic Leaders' Group, to both provide information and seek support, ensuring a close relationship between the groups. ***Vaccine hesitancy*** A key contribution of the RECG was its response to concerns regarding vaccine hesitancy and ethnic inequalities in Covid-19 vaccine uptake in the city. Members co-developed and then

	practically enabled a range of initiatives, designed both to reduce concern about the vaccine and ensure practical barriers to vaccination uptake among marginalized communities were addressed. Over 500 people from across the city attended an online webinar in January 2021, which brought together the public and experts to discuss the vaccine. Most attendees reported that, following the event, they felt they had sufficient information about the vaccine, with their perceptions of its safety improved. The Council's evaluation also identified a significant increase in the proportion of people stating that they would now receive the vaccine, and that they would get it more quickly, as a consequence of attending the webinar. Numerous practical barriers to vaccine uptake were also acknowledged by the group. Following a successful test-case to improve uptake of the flu vaccination, it was decided that temporary 'pop-up' vaccination clinics, provided in spaces frequented by people in those communities traditionally underserved by existing approaches, could reduce pressure on existing services, while enabling the public to receive vaccines in familiar locations in direct communication with people they trusted. The additional funding and flexibility enabled by the pandemic combined with the enthusiasm, expertise and networks offered by the partnership of statutory services and VCFSE organisations in the RECG culminated in a series of award-winning vaccination centres – held in local community centres, faith spaces, parks and on the streets – which made a significant contribution to reducing race disparities in the Covid-19 vaccine uptake in the city. Clinics were generally oversubscribed, largely as a consequence of work done by RECG members to build trust through direct community engagement to address concerns and misinformation about both Covid-19 and the vaccine. As the clinics provided vaccines without appointment they could respond quickly, while also providing access to undocumented individuals. By the time of our evaluation, it was estimated that the clinics had provided 20,000 vaccines, the vast majority of which were to people who would not have otherwise received it. As the Covid-19 vaccine rollout continued, health providers took the opportunities offered by the clinics to provide other vaccinations to these under-served groups. This approach was then embedded into the approaches of other organisations involved in providing vaccinations in the city.

	Vaccine hesitancy continues to be an important priority for the RHEG, seen in their 2024 focus on increasing immunisations for Measles, Mumps and Rubella (MMR) and Human Papillomavirus (HPV). As before, their approaches have prioritised dialogue with communities and myth-busting activities, through public events designed and delivered in collaboration with VCFSE sector organisations, local health providers and Bristol City Council's Public Health Team. Such activities have enabled important shared learning and an increase in vaccine uptake as well as the development of several valuable practical resources to support further improvements. At present, the percentage increase in vaccine uptake for the 12-25 age group is the best of any Integrated Care Board in England, and fourth in the country for vaccines provided to those aged 12 months. Central to this success has, again, been the ways in which the RHEG has enabled effective engagement with the underlying causes of vaccine hesitancy and low vaccine uptake, and the opportunities this understanding offers to develop appropriate social and cultural narratives and intelligence to support this programme of work. These approaches have also attempted to respond to the significant challenges to RECG engagement of VCFSE organisations created by their insecure funding. For example, the 2024 work to improve immunisation rates for MMR and HPV was supported by community grants provided to VCFSE organisations using inequalities funding from NHS England. However, these funding models remain short-term and focused on specific programmes of work and cannot address the ways in which the funding models for VCFSE organisations undermine a continued, meaningful contribution to these broader initiatives. Identifying opportunities to financially invest in these relationships is key to their long-term sustainability and success.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	N/A **Full list of contributors:** • Prof Saffron Karlsen, Professor of Sociology, University of Bristol • Aaliyah Miller, Equity and Inclusion Team, Bristol City Council

	• Andrew Mallin, Deputy Head of Equality & Inclusion, Bristol City Council • Dr Joanne Brooks, FRCPCH Consultant Community Paediatrician, Sirona Care and Health, Co-Chair of Bristol Health and Race Equity Group • Huda Hajinur, Director, Caafi Health, Co-Chair of Bristol Health and Race Equity Group

Your response

Full name	Sam Whimster
Job title	Emeritus Professor
Organisation / University / Research institute	Global Policy Institute Editor, Max Weber Studies

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Digital society • Social and cultural infrastructure • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance Yes • Trust Yes • Cohesion Yes • Inequalities • Sustainability

Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Restoring and increasing sociability is central to any progress. Societal integration and solidarity at the moment must be reckoned as weak and insufficient to weather another Covid-19 type crisis.
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have	Government and administration are so centralised and secretive that it is difficult to know of the government's awareness or the civil service's capabilities. The abolition of National Health England is potentially a step backwards *if* it does not strengthen medical services and prevention at the local level.

seen policy interventions, what effects have these had?	
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	Policy has become politicised and is no longer seen as a neutral force for good. This trend is on full display in the USA, and the UK has little defence against hostile and malicious social media. The 'policy expert' is only effective for a population that believes in science, rationality, and policy outcomes. That social action framework does not apply to a growing minority of the population who live phenomenologically in a different world. The LSE philosopher McKenzie Atkinson has tried to explain the boundary between the acceptance of the truth of everyday real objects and beliefs held in the equivalent 'real' of social media (Quoted in Mathuru). Critical studies of expert knowledge suggest the importance of situational knowledge and pragmatic outcomes (Turner). The local level is crucial where most people absorb their 'real' knowledge: specifically at GP surgeries, hospital A&E, and school gates.
Question 4: Are there any international examples of policy interventions to address the	Singapore and Taiwan and the SARs outbreak and subsequent Covid-19 experience. South Korea which prizes its civil society and openness. Sweden's experience should be studied at the sociological level. Maintaining sociability is a sine qua non for a society and in the longer perspective Sweden might have come out of the pandemic better than severe lockdown societies. This is especially apparent in keeping the schools open, subject to doable precautions.

impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	Keeping sociability going in everyday interactions is crucial. In Durkheimian terms the poles of anomie and egoism are, at this moment in British society, dysfunctionally strong. The anthropological update on Durkheim is Mary Douglas's work. Microsociology suggests minimal interventions consonant with the facts of virus transmission has to be closely studied. Once it was established early in 2020 that Covid-19 was airborne transmission, the prophylactic was 2 metre social distancing. Randall Collins, a premier sociologist, has turned away from grand theory to microsociology. He analyses minutely where people are in specific cases, e.g. the January 6 attack on the US Capitol. Outcomes depend on contingency and chance. This can be applied to social distancing, which is strongly determined by social interaction rituals. For example, in Igbo society social distance is a marker of status difference, Japanese face-to-face encounters are formal and distanced, and as Norbert Elias showed courtly deference and distance was replaced by the merchant handshake. The UK has many cultural communities governed by very different conventions on social distance. For a policy expert social distancing is a self-evident imperative, but in small scale social interaction it is the stuff of life. The enforcement of stay at home regulations in the UK for funerals contravened a universal ritual of coming together at a basic -'liminal' - life event. Governments have to find ways of working around these rituals, and failure to do so accounts for the fury that was directed at the Johnson government - with a permanent loss of political legitimacy. One obvious inequality in infection and mortality rates was that construction workers, transport workers, supermarket cashiers, and hospital staff were placed at risk. These infection sites are, in urban sociology, referred to a dead spaces (first applied to supermarket queues). Doormen were especially at risk with couriers and visitors consistently breaking the 2 metre rule, as established in ccv footage. In conclusion, policy expertise is still required but it has to adapt to a rapidly changing sociological and knowledge environment. References: Collins, Randall, Social distancing as a critical test of the micro-sociology of solidarity. *American Journal of Cultural Sociology*, 2020, 8: 477-497. https://doi.org/10.1057/s41290-020-00120-z Mary Douglas, *Risk and Blame, Essay in Cultural Theory*, London, 1994. Noguchi, Mashiro: Noguchi: Cluster Based Approach and Self-Restraint. Japans' Response to Covid-19, *In the Realm of Corona Normativities*, ed. Gephart, W., Frankfurt 2020.

	Hardeep Mathuru, 'The Cost of Lies: Why we identify with deadly misinformation', *Byline Times*, August 2025. Stephen Turner, 'Double Heuristics and Collective Knowledge: The Case of Expertise' ehttps://www.academia.edu/143644799/Double_Heuristics_and_Collective_Knowledge_the_Case_of_Expertise Sam Whimster, 'Discovering Society in a Time of Plague', *In the Realm of Corona Normativities*, ed. Werner Gephart, Frankfurt, 2020. Sam Whimster, 'Social Distancing and the Social Contract. Dual Normativities', *In the Realm of Normativities II*, ed. W. Gephart and J. Leko, Frankfurt, 2022.

Your response

Full name	Sarah Curtis
Job title	Professor Emerita
Organisation / University / Research institute	Durham University

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Digital society • Social and cultural infrastructure • Education and employment (?may relate to informing and training those involved in pandemic preparation and response) In this submission I have listed selected examples of sources of evidence relating to the themes indicated. This is not a complete literature review. I have indicated in **bold text** the key points which I think are demonstrated by the examples from research literature that I have cited. Where I have directly cited the authors of the work referred to, the text is in *italics*.
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Trust • Cohesion • Inequalities • Sustainability In this submission I have listed selected examples of sources of evidence relating to the themes indicated. This is not a complete literature review. I have indicated in **bold text** the key points which I think are demonstrated by the examples from research literature that I have cited. Where I have directly cited the authors of the work referred to, the text is in *italics*.
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Remaining challenges: **Future preparedness strategies should consider whether there are more lessons to be learned from the COVID-19 experience and previous pandemics, which might inform strategies to cope with future pandemic scenarios. One example of the kind of information that is likely to be useful is to note how the geographical spread of COVID-19 and earlier pandemics is known to have developed over time. This could potentially, inform strategies for targeting public communication, vaccination and lockdown procedures by region and sub-regional locality making the use of limited governmental resources more effective in controlling infection rates.** **It is not clear that policy relating to the COVID-19 pandemic was well informed by a large body of pre-existing research associated with other pandemics that have affected the UK (including Scotland) in the past. Examples of relevant publications are as follows (including research published by Peter Haggett (sadly, a recently deceased FBA):**

	Smallman-Raynor, M. & Cliff, A., 2021, Eight Centuries of Epidemic and Pandemic Control, Chapter 7,p61-69 in Andrews, G.J, Crooks, V.A, Pearce, J.R., Messina, J.P. (Eds), *COVID-19 and Similar Futures Pandemic Geographies,* Springer https://link.springer.com/book/10.1007/978-3-030-70179-6.) A.D. Cliff & P. Haggett, (1989) Spatial aspects of epidemic control, Progress in Human Geography, Vol13, issue 3, https://journals.sagepub.com/doi/abs/10.1177/030913258901300301 AD Cliff and P. Haggett Statistical modelling of measles and influenza outbreaks (1993) Statistical Methods in Medical Research Volume 2, Issue 1 https://doi.org/10.1177/096228029300200104
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	**The impacts of social isolation due to lock down during the COVID-19 pandemic need to be considered, as they had significant impacts on wellbeing and mental health.** Strategies to help reduce these impacts should be part of preparedness planning, and the needs of different groups should be considered (for example, different social, ethnic and demographic groups will vary in their needs). This is exemplified in papers included in a special issue of the journal Wellbeing, Space and Society, summarized by the Editors in this overview: Curtis, S., Riva, M. (Guest Editors) (2023) Introductory Article to a Special Issue on 'Home spaces and wellbeing'. Wellbeing, Space and Society. https://doi.org/10.1016/j.wss.2023.100140 The following 2 papers relate to **experience in the UK of the importance of home spaces for social interaction and wellbeing during the COVID Pandemic** (see also articles from this special issue referenced below in response to Question 4 in this document): Harding, S., Smith, L.M., 2022. Freedom through constraint: Young women's embodiment, space and wellbeing during lockdown. Wellbeing Space Soc. 3, 100101. doi:10.1016/j.wss.2022.100101 Houweling, R., Power, A., Smith, D., 2022. Parent health and well being at home before and during COVID-19. Wellbeing Space Soc. 3, 100082. https://doi:10.1016/j.wss.2022.100082 **Various aspects of the social, demographic and physical environment are now known to have been associated with the local variations in the risk of COVID infection.** **Examples of research using geographical analysis of area level factors which are associated with varying health effects of COVID-19 at local level are addressed in sources referenced below:** Feng, Z. (2023) Spatiotemporal pattern of COVID-19 mortality and its relationship with socioeconomic and environmental factors in England, *Spatial and Spatio-temporal Epidemiology,* 45. Wang, R., Clemens, T., Douglas, M., Keller, M. & van der Horst, D. (2023), Spatiotemporal Modeling of the Association between Neighborhood Factors and COVID-19 Incidence Rates in Scotland, *Professional Geographer*. 75, 5, p. 803-815

	See also reference to work on local access to green space, and exposure to sunlight, noted in response to Question 4 below.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	More attention might be paid to **strategies for risk communication**. See for example: Shortt, N. (2021) Knowledge Translation and COVID-19, Chapter 57 in Andrews, G.J, Crooks, V.A, Pearce, J.R., Messina, J.P. (Eds),2021, *COVID-19 and Similar Futures Pandemic Geographies,* Springer https://link.springer.com/book/10.1007/978-3-030-70179-6. Shortt states (p433) that: *To gain a better shared understanding between researchers and policymakers regarding both the research and policy process, we need to improve our knowledge of each other's working environments.* **Shortt raises questions about how the interpretation of knowledge from research is applied in practice by politicians and practitioners and advocates an 'enlightenment' perspective**, suggesting (p434) that: *Taking an enlightenment approach means that our research, particularly that of inequalities, is important at all times and exerts influence over time, not just at critical moments'.* **Risk communications strategies can also draw on lessons learned in the past during other pandemics.** See for example: Bennet, P., Calman, K., Curtis, S., Fischbacher-Smith, D. (editors) (2010) *Risk Communication and Public Health*, Second Edition, Oxford University Press, Oxford, which includes the following chapter: Petts, J., Draper, H., Ives, J., Damery, S. 2010, Risk Communication and Pandemic Influenza, Chapter 10, p 147-162, in The authors draw attention (p148) to **World Health Organization 'outbreak communication guidelines'** (latest version, WHO 2008) and on (p155-159) they summarize '**lessons for public risk communication'**, including that, when confronted by a pandemic risk that has not been experienced before, ' *people are likely to draw on ideas about communicable disease that are already familiar to them'* and that ' *their understanding will draw not only on official medical and scientific information but also upon personal experience, familial and social traditions, socio-economic factors, and cultural beliefs' (* reference is made to Helman, C.G. (2007) Culture Health and Illness, Hodder and Arnold, London). Petts et al. also suggest (p158) that '***people will be inclined to take protective measures and life-style changes if advised to by a trusted source, in a manner they understand, and which speaks to their current understanding rather than the understanding experts would like them to have'****….'whether understanding has a material impact on subsequent behaviour to reduce risk to self or others is determined by a number of context-specific factors.* Petts et al suggest that *'Giving a clear and consistent message is difficult when the facts….are uncertain. Uncertainty often breeds fear and may lead to 'worst case' or overly precautionary measures…User-centered risk communication ..will be essential….This is particularly important, as information transmission via multiple pathways has the potential to lead to public confusion…..it seemed essential to at*

	*least start to prepare the public for the likelihood of a pandemic….**Planning should ensure advanced identification of potentially effective and empathetic communicator**s…..the best means of protecting the majority is by mutual cooperation rather than the anarchy of self interest…* Petts et al. also refer to: Blake, J. (1999) Understanding responses to risk: some basic findings, In Bennett, P., and Calman, K. (eds) Risk Communication and Public Health, Oxford University Press, New York.)
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	**A useful collection of commentaries which describe various aspects of relevant international experience in different parts of the world is this**: Andrews, G.J, Crooks, V.A, Pearce, J.R., Messina, J.P. (Eds),2021, COVID-19 and Similar Futures Pandemic Geographies, Springer https://link.springer.com/book/10.1007/978-3-030-70179-6. Some relevant chapters in this text are cited elsewhere in this response. Other examples of publications referring to research, from different parts of the world, which can inform policy interventions in the UK are summarized below. **International evidence underlines the importance of home spaces during pandemic conditions, which should be considered in planning policies and interventions during pandemics. Home environments are always important determinants of health and wellbeing.** For example, the following 2 papers in the journal Wellbeing Space and Society relate to the importance of home spaces during the COVID Pandemic in settings outside the UK (see also other articles from the same special issue, referenced above in response to Question 2 in this document,): **These papers also underline the impact of pandemic conditions on young people in different settings**: The following references are examples of the impact of COVID on young people in different parts of the world: Agyekum, B., 2022. Adult student perspectives toward housing during COVID-19. Wellbeing Space and Society 3, 100086. doi:10.1016/j. wss.2022.100086. This shows how in Ghana **young people's education was impacted by conditions during the pandemic**. Coppella, L.I., Flicker, S., Goldstein, A., 2023. "Make sure I hear snoring": Adolescent girls, trans, and non-binary youth using sound for sexual wellbeing boundary-making at home during COVID-19. Wellbeing Space and Society, 4, 100117. doi:10.1016/j.wss.2022.100117. This provides an example of how adolescent girls in Canada experienced **the impacts of the COVID-19 pandemic on young people's sexual wellbeing**. **Nearby access from home to greenspace is another factor which is shown, in international research, to be relevant to the experience of Pandemic conditions.** In the special issue of Wellbeing, Society and Space referred to above, access to green space during the pandemic is emphasized in the following paper which reports on data from the UK, Ireland and Spain relating to **the significance of access from one's home to nearby natural spaces and how these moderated the wellbeing of the participants while they were 'locked' into their home and the**

	spaces nearby, restricting their normal everyday flows over wider daily action spaces: Foley, R., Garrido-Cumbrera, M., Guzman, V., Braçe, O., Hewlett, D., 2022. Home and nearby nature: Uncovering relational flows between domestic and natural spaces in three countries during COVID-19. Wellbeing Space and Society. 3, 100093. https://doi:10.1016/j.wss.2022.1000 93 Similar points are made in this book chapter by the same lead authors: Foley, R. & Garrido-Cumbrera, M., 2021, Why Green and Blue Spaces Matter More Than Ever, Chapter 37, p 281-289 in in Andrews, G.J, Crooks, V.A, Pearce, J.R., Messina, J.P. (Eds), COVID-19 and Similar Futures Pandemic Geographies, Springer https://link.springer.com/book/10.1007/978-3-030-70179-6. Also **higher exposure to Ultraviolet Radiation in the outdoor environment may be related to lower risk of COVID-19 mortality**, as discussed in this paper, which draws on international research: Cherrie, M., Clemens, T., Colandrea, C., Feng, Z., Webb, D. J., Weller, R. B. & Dibben, C. (2021) Ultraviolet A Radiation and COVID-19 Deaths in the USA with replication studies in England and Italy, British Journal of Dermatology, vol. 185, issue 2. **The international literature on planning and resilience relating to disasters more generally may need to be considered in the context of pandemic events.** For example, this literature draws attention to the problem of **lack of consultation with local communities and individuals impacted by disasters.** For example, a **discussion of how SHAPE disciplines can inform disaster preparedness** is provided in the following paper in the Journal of the British Academy, which was based on a series of BA workshops: Curtis, S., Leach, M., Ardern, K., Beckerman, Hunter, P.R., Ruszczyk, H., Pelling, M. (2024) Health and wellbeing in the face of crises associated with climate or conflict: how can knowledge from the humanities and social sciences help us respond to disasters? Journal of the British Academy, 12,1/2, article a13, https://journal.thebritishacademy.ac.uk/articles/12/1and2/a13 The authors draw on several examples from the UK, and also from the international literature, which were raised in a series of workshops organized by the BA.. They state that: *The **significant roles of governmental agencies and non-governmental organisations, and the importance of international cooperation were acknowledged**. The discussion also emphasised **the need to acknowledge the importance of using effective means to engage with stakeholders in communities at the local scale, whose lived experience and knowledge, often embedded in cultures and traditions, can usefully inform 'joined-up' policy and practice**. A case was also made for **more inclusive strategies**: for example, acknowledging the vital roles of women during and after disasters.* Similar conclusions are drawn from research in Nepal, reported in this paper: Ruszczyk, Hanna, A (2019) Ambivalence towards discourse of disaster resilience, Disasters, 43,4 p.818-839 The author states (p818) that: *This paper investigates empirically how the international aid community (IAC)—donors and practitioners—considers and implements disaster resilience in a specific country setting, Nepal, and throughout the rest of the world. A key finding is that there is ambivalence about a concept that has become a discourse. … The mythical resilient urban community is fashioned in the IAC's imaginary; **understanding how people create communities and what type***

	of linkages with government urban residents desire to develop their resilience strategies is missing, though, from the discussion. … an explicit focus on individuals and their communities is lost in the process.'

Your response

Full name	Dr Sazana Jayadeva
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Organisation / University / Research institute	University of Surrey

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Digital society • Social and cultural infrastructure
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Trust • Inequalities
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Long COVID (also referred to as 'post-acute sequelae of COVID-19') is a multisystemic condition following infection with SARS-CoV-2 (Peluso and Deeks, 2024). Although Long COVID is now widely recognised, and a growing body of research has documented hundreds of biomedical findings about the condition (Al-Aly et al., 2024; Altmann et al., 2023), **the medical support available to people with Long COVID remains highly inadequate in the UK and elsewhere.** A number of studies have shown that people with Long COVID still report discrimination, dismissal, ignorance of the science, lack of validation, and stigma when they seek medical care (e.g. Jayadeva and Lupton 2025a; Clutterbuck et al., 2024). Together with Deborah Lupton (UNSW Sydney, Australia), I conducted research on people with Long COVID who use self-tracking technologies in relation to their Long COVID symptoms (Jayadeva and Lupton 2025a; Jayadeva and Lupton 2025b). In 2023, we conducted 30 semi-structured interviews with people with Long COVID, who were living in the UK (10), USA (14), Australia (2), Germany (2), Denmark (1), and Canada (1). Roughly

	equal numbers of participants had developed Long COVID in 2022 (15 participants) and 2020 (12 participants), while the remaining three had begun experiencing symptoms in 2021. While those who had developed Long COVID in 2021 and 2022 had been able to obtain a diagnosis of Long COVID more easily than those who became ill in the first wave of the pandemic, all had struggled – and were still struggling at the time of the interviews – with obtaining medical support. Importantly, receiving a diagnosis of Long COVID was not necessarily a path to accessing medical care or having their symptoms taken seriously by the medical professionals from whom they sought help. Participants described how medical practitioners had been largely dismissive of their accounts of their illness and, in some cases, had been quick to psychologise their symptoms. In many cases, medical practitioners, even those in Long COVID clinics, were poorly informed about symptoms and syndromes commonly associated with Long COVID (e.g. Postural Orthostatic Tachycardia Syndrome). Very few participants had been able to access tests and investigations that might have helped identify problems causing their symptoms and open symptom management pathways. Suffering from debilitating symptoms and unable to access adequate medical support, participants had turned to self-tracking technologies and online patient communities to learn more about Long COVID, make sense of their symptoms, and – as one participant put it – essentially become their own doctors. Long COVID patient groups provided participants with information about the condition, as well as guidance about how to use self-tracking technologies to monitor and understand their symptoms and health states. Through a combination of self-tracking and guidance from members of their Long COVID patient group/s, many participants had been able to identify patterns and correlations between their symptoms, activity and exertion levels, diet, and key metrics (e.g. heart rate, heart rate variability, oxygen saturation, sleep data). In several cases, identifying such patterns, correlations and trends had enabled them to discover thus far undiagnosed problems or syndromes that were responsible for some of their symptoms. Participants described their self-tracking data as offering much needed validation by reflecting, backing up, or providing an explanation of their subjective experiences of their illness. In addition, such data served as a valuable – albeit not completely successful – tool of medical advocacy. The apparently more

	'objective' forms of information generated with wearable devices and apps were used by our participants to prove the validity of bodily experiences, when qualitative accounts of symptoms and experiences were treated dismissively. Some participants felt that it was because of their self-tracking data that they had been able to get referrals to tests or specialists, and subsequently obtain formal diagnoses and access treatment to manage their symptoms. However not all participants had had positive experiences with sharing their self-tracked data with their doctors; some reported that their doctors had been uninterested in such data, while others worried that sharing self-tracking data with a doctor might inadvertently lead to the doctor feeling as if their expertise was being challenged. Even in cases where participants had not shared their self-tracking data or had their self-tracking data taken seriously by a doctor, many believed that as a result of paying close attention to their bodies and documenting their symptoms and key metrics over time, they had become confident in their knowledge of what they were experiencing, which made them more likely to stand up for themselves in medical contexts and less susceptible to medical gaslighting. Although our research shows the agentic ways in which people with Long COVID are navigating their illness, it is highly problematic that very ill people are still being forced to make sense of their symptoms themselves and advocate to get medical tests and treatments. Not all patients have the resources and capacities to usefully engage with self-tracking technologies and advocate for themselves.
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	An important lesson from the COVID-19 pandemic is that post-viral illnesses – which have long been under-researched, wrongly psychologised, and treated dismissively (Hunt et al 2022) – pose substantial risks to national health and productivity. About 2 million people in the UK (3.3 per cent of the population) suffer from Long COVID (ONS 2024). Research has demonstrated how, apart from the substantial impact on quality of life of patients (Walker et al 2023, ONS 2024), Long COVID is exacerbating health inequalities (Scott et al 2024) and adversely impacting the UK's economy (Cambridge Econometrics 2024). While the number of people affected by Long COVID has brought much needed attention to post-viral illnesses more broadly, these

	conditions continue to be under-researched, and healthcare systems remain underequipped to appropriately and adequately support patients. Research into understanding and treating post-viral illnesses is thus urgently needed in terms of preparing for future viral pandemics – and, as importantly, for dealing with the significant and continued impacts of the COVID pandemic. Concerningly, it appears that political will to support research into and treatment of Long COVID is waning (Altmann 2023). Existing government funding ring-fenced for Long COVID research is drying up and no new dedicated funding has been made available since 2021. Rather than efforts to improve Long COVID services in the country, NHS Long COVID clinics are being defunded and shut down (Gregory-Kumar and Fenwick 2025).
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	There have been significant flaws in the government's response to Long COVID, including an apparent lack of anticipation, appreciation, or – at the very least – preparedness for the post-viral illness that a viral pandemic would produce. In the first months of the pandemic, it was patient advocates, often including medical practitioners and researchers who themselves were affected by Long COVID, who played a major role in bringing the problem of Long COVID to the attention of health agencies and the government in the UK and other countries (Callard and Perego 2021). Despite the number of people suffering from Long COVID (ONS 2024), the level of symptom burden (Walker et al 2023), and the lack of medical support available to patients (Jayadeva and Lupton 2025a), there appears to be no long-term strategy developed by the government for understanding and treating Long COVID, through biomedical research and educating and training healthcare professionals.

Your response

Full name	Sviatlana Kroitar
Job title	Honoured Visiting Research Fellow
Organisation / University / Research institute	University of Leicester, School of Business

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Digital society • Social and cultural infrastructure • **Education and employment**
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• **Governance** • Trust • Cohesion • **Inequalities** • **Sustainability**
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	My research, which focuses on the impact of the pandemic on young people's careers in the UK, reveals a complex picture. While there has been progress in adapting services – for example, the rapid transition to online learning and digital career support – many challenges have not been solved but have simply evolved. My systematic review, as well as a related publication (see for example: The pandemic is still disrupting young people's careers), indicates that rather than creating new problems, the pandemic amplified existing inequalities. This has left a lasting "pandemic scar," with challenges that continue to persist or have emerged, including a deepened digital divide, a skills gap from disrupted learning, and enduring mental health issues due to economic uncertainty.

Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	The most critical lesson for government, based on my research into the impact of the pandemic on young people's careers, is the need for a holistic, long-term policy approach. The initial government response, while necessary, was largely a short-term, economic intervention focused on maintaining employment through schemes like furlough. While effective in the moment, these policies did not address the deeper, interconnected issues affecting young people's lives—namely the relationship between employment, education, and mental health. The evidence suggests the government has been aware of these long-term issues. However, the subsequent policy interventions have had mixed success. Many policies aimed at youth employment, for example, were not sufficiently targeted to address the specific vulnerabilities of marginalised groups. This has meant that while the interventions prevented a complete economic collapse, they have struggled to reverse the long-term trends of precarious employment and skill mismatches among young people.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	My research on young people's careers during the pandemic suggests that the UK's institutions demonstrated impressive agility, particularly in the rapid deployment of digital services. However, this period also exposed a key weakness: a tendency towards siloed policymaking. Different government departments addressed separate issues—employment, education, health—without a cohesive framework that recognised how these areas intersect in a young person's life. To improve, policymaking must become more integrated and anticipatory. This could be achieved by fostering greater collaboration between government departments to create a truly joined-up strategy. Furthermore, policy should be designed with an explicit focus on inclusivity, using data and evidence to target interventions towards the most vulnerable groups. By embracing a more evidence-based and holistic approach, the UK can build more resilient governance structures.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare	Absolutely. While my research is centered on the UK, the challenges for young people were global, and other countries have adopted strategies that offer valuable lessons. The UK could learn from international examples where countries with more robust social safety nets and stronger universal services were better able

for future emergencies that the UK could learn from?	to shield young people from the worst of the economic shock. Additionally, some nations developed long-term, cross-sectoral recovery plans that integrated support for mental health and well-being directly into their employment and educational strategies. This contrasts with the UK's more segmented approach and highlights the importance of recognising mental health as a fundamental component of economic recovery.

Your response

Full name	Viraj R Nair
Job title	Lecturer in FinTech and Doctoral Researcher
Organisation / University / Research institute	University of East London

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Social and cultural infrastructure • Education and employment
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Inequalities • Sustainability
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	Since the Covid-19 pandemic, UK higher education institutions have rapidly adapted to deliver education and research through digital channels. While this shift has allowed continuity, it has also exposed structural inequities between institutions in their ability to support innovation and commercialisation. My research uses data from the 2025 HESA Spin-outs Register to examine the recovery and innovation output of UK universities post-pandemic. The data reveals that Pre-1992 universities have largely sustained or even expanded their innovation capabilities, generating significantly more spin-outs than Post-1992 universities. This divergence reflects underlying inequalities in research funding, commercialisation infrastructure, and policy support. Quantitative analysis conducted using SPSS, including independent samples t-tests and regression modelling, confirms that institutional type is a statistically significant predictor of spin-out volume ($p < 0.001$), accounting for approximately 28% of the variance. This finding highlights systemic differences and reinforces

	the urgency for targeted post-COVID policy interventions to bridge innovation disparities. Despite greater visibility of these disparities post-Covid, policy and funding frameworks have not adequately adapted to support Post-1992 institutions, many of which serve local and disadvantaged communities. These challenges remain a key concern for an equitable recovery.
Question 2: What lessons are there from the pandemic for government's preparation for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	A key lesson is the need to broaden the understanding of innovation beyond traditional elite institutions. The pandemic highlighted the importance of diverse institutional contributions to regional resilience, digital transformation, and local economic renewal. There is limited evidence that government policy has effectively responded to this lesson. Funding for innovation remains concentrated in Russell Group universities, with Post-1992 institutions continuing to face barriers in accessing spin-out capital, research commercialisation grants, and public-private partnerships. The quantitative modelling further supports the need for inclusive funding strategies. By recognising the predictive role of institutional type in innovation outcomes, policies must actively support those institutions historically underrepresented in the innovation economy.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	UK higher education institutions have demonstrated resilience, but governance structures remain overly centralised. University-level autonomy has not translated into equitable funding or innovation opportunities for all types of institutions. Governance mechanisms should strengthen regional decision-making, provide dedicated innovation support for Post-1992 institutions, and incentivise cross-sector collaborations. Enhancing transparency and equity in innovation funding allocation will also improve institutional trust and performance.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	Countries like Germany and Canada have implemented decentralised funding models that allow regional universities to access innovation grants and spin-out support directly. These models have improved regional development and institutional inclusivity.

	Germany's High-Tech Strategy and Canada's Innovation Superclusters initiative both provide examples of targeted investments in non-elite universities, resulting in stronger post-pandemic recovery across diverse regions. The UK could adopt similar models to ensure innovation-led growth is distributed and resilient.

Your response

Full name	Dr Emmanuel Arakpogun
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Organisation / University / Research institute	University of Stirling Business School.

Question	Response
Does your evidence have relevant insights for one or more of these public policy areas? Select all that apply.	• Health and wellbeing • Digital Society • Social and cultural infrastructure
Does your evidence touch on one or more of these cross-cutting themes? Select all that apply.	• Governance • Trust • Cohesion • Inequalities
Question 1: What progress has been made since the Covid-19 pandemic? What challenges remain or have since emerged? (Links are permitted)	The initial use of digital tools such as contact-tracing apps and vaccine passports during COVID-19 highlighted significant flaws in governance, as these technologies were treated as standalone solutions rather than part of a broader system. By 2025, there has been a clear shift in approach, with the UK government now focusing on community-based care through the rollout of Neighbourhood Health Services. This initiative aims to bring healthcare closer to people's homes, particularly in areas with high levels of need, and to ease pressure on hospitals. It also ensures that individuals not reached by digital solutions still have access to care. While the initiative is commendable, close attention must be paid to its implementation to address early challenges and support its long-term success. Furthermore, as the government turns to artificial intelligence to improve healthcare, including a recent partnership with OpenAI, it is important to adopt technology from a hybrid perspective. Clear safeguards must be put in place to ensure the ethical use of patient data and uphold public trust.
Question 2: What lessons are there from the pandemic for government's preparation	One of the key lessons from the COVID-19 pandemic is the lack of understanding around the phenomenon of fake news and how it can combine with technology to create a serious threat to public health. While COVID-19 was damaging in itself, the accompanying

for, response to, and recovery from major societal threats? Is there evidence that government is aware of these and, where we have seen policy interventions, what effects have these had?	infodemic was equally harmful, spreading misinformation and undermining trust. This highlights the urgent need for the government to establish a dedicated body to address fake news, with a strong online presence to actively engage in the digital public sphere, counter misinformation, and lead on timely, accurate communication during future health emergencies. This need is even greater now, as advances in AI have made it possible to generate deepfakes and false content at the click of a button. Had AI been as mainstream during the height of the pandemic as it is now, the consequences could have been even more devastating. Infodemics, AI, and fake news are now inseparable from public health strategy and must be treated as critical areas requiring focused attention and action.
Question 3: How would you evaluate the strength of the UK's institutions and governance structures in providing effective policymaking in responding to major societal threats and how they can be improved?	The UK's institutions and governance structures have shown resilience in responding to major societal threats, such as COVID-19, but their effectiveness has been uneven. Strengths include a strong public health system and the ability to mobilise resources quickly. However, weaknesses have emerged in areas like digital governance, misinformation management, and the integration of technology into policy. To improve, the UK should invest in digital literacy, establish dedicated units for tackling misinformation, strengthen data ethics frameworks, and promote more agile, transparent policymaking that includes community engagement and cross-sector collaboration.
Question 4: Are there any international examples of policy interventions to address the impact of the pandemic and/or prepare for future emergencies that the UK could learn from?	Several international examples offer valuable lessons for the UK in improving its pandemic response and preparing for future emergencies. Taiwan demonstrated the effectiveness of an integrated digital approach, combining real-time contact tracing, health data integration, and transparent communication. This strategy balanced technological efficiency with strong privacy safeguards, which helped maintain public trust and compliance. As such, our paper calls for a blended epidemiological approach to future pandemics and the need for the government to design and deploy eHealth apps in line with existing societal limitations. Speaking of societal/community limitations, Rwanda provides a compelling example of how community health networks can be leveraged during crises. Its widespread use of trained community health workers helped reach rural populations, disseminate accurate information, and ensure access to essential services. This highlights the importance of investing in community-level healthcare systems as a foundation for resilience. Together, these examples suggest that the UK could benefit from greater integration of digital tools, stronger local-national coordination, enhanced public communication, and a stronger focus on community-based healthcare as part of a comprehensive strategy for future emergency preparedness.