healthcare public health (ensuring that health services are the most effective, most efficient and equally accessible). These three core strands of public health are underpinned by public health intelligence (surveillance, monitoring and assessment), academic public health (promoting evidence, knowledge and research) and workforce development.

Our views on the UK's readiness for the COVID-19 pandemic

9. Throughout the planning and response to the pandemic there was a lack of executive awareness across responder organisations around the level of societal risk from pandemic events. This may have been due in part to the limited opportunity for multiagency response exercises outside of the workforce who directly work in health protection, public health and emergency planning. This is further exacerbated by a legislative framework for health protection (including port and border health) which is complex, archaic and not fit for purpose to address current and future hazards and threats. National pandemic planning was focused almost solely on a novel influenza virus and there was little consideration for other potential organisms and required capabilities.

10. The way health protection was delivered in local areas in England changed significantly following the enactment of the Health and Social Care Act 2012, with the transfer of public health from the NHS into local government and the creation of Public Health England (PHE). Health protection functions in local government public health teams moved largely to an assurance role without specific funding or assurance within the ring-fenced grant as a mandated service. There was also a lack of clarity and specificity on the statutory role of the director of public health for health protection in the 2012 reforms as they pertained to England.

11. Health protection teams, which moved from the Health Protection Agency (HPA) to PHE (in England), saw successive reductions in funding and capacity over the pre-pandemic years and a lack of investment in regional emergency preparedness, response and resilience (EPRR) teams. A direct result of these changes was a reduction in the amount of professional exposure that the public health specialist generalist workforce had to health protection duties and continuing professional development outside of PHE. There was also a reduction in the exposure that NHS staff in general had to important public health issues associated with health protection,

especially in community settings. This is likely to have contributed to a poor understanding of the role of the wider public health agenda around pandemic preparedness, and more specifically the role of local authority public health teams and wider system partners in pandemic preparedness and response. Community infection prevention and control (IPC) is a key element of pandemic planning and local health protection more generally, but guidance is unclear on commissioning responsibilities, funding streams, and standards for high-performing local integrated services. It is largely understood that provision for community IPC was a significant casualty of the 2012 reforms and the Faculty considers the creation of Integrated Care Systems, with local authority Directors of Public Health and UKHSA as key partners, an opportunity to rectify the current problems. The use of Contain Outbreak Management Funding (COMF) during the pandemic to temporarily increase IPC capability in many systems provides proof of concept of what can be achieved through concerted effort and funding enhancements.

12. Additionally, in England the nine Government Offices of the Regions had a statutory duty under the Civil Contingencies Act 2004 to run regional resilience forums chaired a by a regional director of resilience. Their purpose was to plan and support local resilience forums in their region for emergencies, coordinate all regional-based services (blue light services, armed services, utilities, business, the voluntary and community sector, with public health services and the NHS) and liaise with Whitehall. This was key to successfully managing swine flu in 2009 as well as other emergencies such as exceptional weather events, terrorism and strikes etc. Their abolition in 2010 led to the loss of this important part of the national resilience infra-structure for planning and response to the pandemic.

13. The net result of these changes was a lack of capacity for pandemic preparedness and response at regional and local levels within and across public health organisations working to improve and protect the health of the population.

14. At the time of the pandemic, the national guidance was widely acknowledged as being outdated and did not relate to contemporary structures, roles and responsibilities. For example, the Civil Contingency Act 2004 predates the Health and Social Care Act 2012 and the amends made since do not capture the full scope of emergency preparedness, response and resilience. The national strategy and guidance did not

cover the range of public health interventions that were utilised during the pandemic response – particularly absent were references to non-pharmaceutical interventions (NPIs) such as social distancing measures, population level test-and-trace programmes, the use of face-coverings in public, school closures or wider societal lockdowns. A draft Pandemic Flu Bill had been drafted centrally and without stakeholder engagement and co-design; this resulted in a legislative approach and planning assumptions which were not well understood across public health and wider system partners and could not be tested in advance.

15. Generalist specialists in public health, particularly those working in health protection at regional and local levels, have been under-represented in the development of national pandemic policy, strategy and guidance and there is opportunity for this to be addressed in the future through the UKHSA-hosted Centre for Pandemic Preparedness. There was a significant missed opportunity for broader engagement in planning across local resilience forums and local health resilience partnerships which require closer working and mainstreaming of planning, training and exercising of pandemic response arrangements.

Inequalities and pandemic planning

16. For the most part, local multi-agency planning (including pandemic planning) will have included provisions for the identification of vulnerable groups and those who may be disproportionately impacted by an incident or major emergency. This is collated and used to maintain the provision of services during a period of disruption. Although the UK National Pandemic Flu Strategy was supported by an ethical framework, this considered equality, fairness and equity, but not specifically health and social inequalities and disparities in impact.

17. Due to the nature and scale of the COVID-19 pandemic and the centralised coordination of the response, interventions were largely universal and there is a lack of evidence that health inequalities in impact and outcome were key considerations. An Equality Impact Assessment was published in 2011 as part of the UK Pandemic Preparedness Strategy. However, as population level non-pharmaceutical interventions (NPIs) employed for COVID-19 were not included in the scope of pandemic influenza plans, socioeconomic determinants and risks were considered in relation to the planned interventions only (e.g., National Pandemic Flu Service). This