First Witness Statement of Mark Lloyd

Chief Executive of the Local Government Association

12th December 2022

IN THE MATTER OF MODULE 1 OF

THE UK COVID-19 PUBLIC INQUIRY

REFERENCE FOR REQUEST - M01/LGA/01

--

WITNESS STATEMENT OF
MARK LLOYD
ON BEHALF OF
THE LOCAL GOVERNMENT ASSOCIATION

--

CONTENTS

I, **Mark Lloyd**, say as follows –

Part 1 - Introduction

Preliminaries

1. I am the Chief Executive (CE) of the Local Government Association (LGA) of 18 Smith Square, London, SW1P 3HW. I was appointed to this role in November 2015 after having previously worked in local government, latterly as a Chief Executive of Cambridgeshire County Council and before that Durham County Council. I am authorised by the LGA to make this statement on its behalf.

2. On the 11th October 2022, the Lead Solicitor for Module 1 of the UK Covid-19 Inquiry (the Inquiry), wrote on behalf of Baroness Heather Hallett, the Inquiry Chair, to say that she wished to have an understanding of the role played by the LGA and local government in England, during the period covered by Module 1 – 11 June 2009 - 21 January 2020: Request for Evidence under Rule 9 of the Inquiry Rules 2006 Reference for Request - M01/LGA/01.

3. That letter contained two Annexes, A and B. This statement refers to the facts and matters concerning the LGA as raised in Annex A. My second witness statement will address the product of a survey of the LGA's local authority members carried out pursuant to the request for information about the work undertaken by the memberships of the LGA as set out in Annex B.

The Local Government Association

4. The LGA was set up in 1997 as an unincorporated Association. In 2018, the LGA moved to a new structure as an unlimited company. Once all member councils had joined the new company, the former unincorporated Association was dissolved. Membership is voluntary and councils make their own decisions on whether to join.

5. The full membership of the LGA in England and Wales now comprises –

   - All but two of the 333 principal councils in England (i.e., all but London Borough of Bromley and Leicestershire County Council),
     and
   - All the 22 principal Welsh councils through a corporate membership scheme with the Welsh LGA (WLGA), an independent organisation with its own business plan, priorities and governance structure.

6. The LGA also has Fire and Rescue Authorities, and Fire, Police and Crime Commissioners, and National Parks Authorities, as associate members. Further the National Association of Local Councils (NALC), which is the membership body for Town and Parish councils, is a corporate member of the LGA.

7. In contrast to WLGA, neither the Convention of Scottish Local Authorities (COSLA) nor the Northern Ireland Local Government Association (NILGA) are members of the LGA. They are independent membership bodies representing the interest of local government in Northern Ireland and Scotland, respectively.

8. Sometimes the LGA will undertake joint work with the WLGA, COSLA and NILGA, particularly looking at issues such as the overall financial needs of local government and workforce planning. There is no joint formal work programme on emergency planning between the LGA and WLGA, COSLA and NILGA.

9. The LGA is funded through a combination of membership subscriptions, central government grants and contracts and commercial income including from a programme of conferences and events.

10. It is a politically-led but cross-party organisation, with the overall purpose to promote, improve and support local government. It provides a strong, credible voice for local government with national government.

11. Its Board of Directors is elected annually by the General Assembly, comprising representatives of all authorities in full membership of the LGA, and meets every six weeks.

12. The LGA's activities relating to council service areas and their statutory duties and related policy issues, such as public health or emergency planning, can be broadly stated as follows -

- Providing the views of our members to government on national policies, guidance, legislation or regulations.

- Acting as an interface between central and local government sharing information where this is necessary (for example, in relation to a specific issue or challenge).

- Developing guidance and other support materials (e.g., training programmes) for our members, including sharing good practice.

- Issuing media and other communications to provide information about the work of our members and to defend the reputation of local government.

The basis of my statement

13. While I have broad oversight of the LGA's work I cannot have first-hand knowledge of everything that it does. Accordingly, in making this statement I have had to rely on information provided to me by officers of the LGA who have special knowledge of the policy issues to which Module 1 relates. These officers have much more detailed knowledge of the work in specialist areas during the period with which Module 1 is concerned. They will in some cases have relied on information which has been shared with them in the past as will be evident below.

14. It is my belief that they have diligently and fairly reported to me the relevant information that I set out below. My statement should therefore be read as representing a statement concerning the collective understanding and knowledge of the LGA in relation to the period 2009 to the beginning of 2020 to which Module 1 refers.

The professionalism of local government

15. There is one point I wish to make at the outset. Although I shall have to express a number of criticisms in particular that plans in place did not adequately foresee a pandemic like Covid-19, it is also a fact that local authorities did quickly respond to the pandemic. I believe that this is a testament to the expertise, capability and professionalism that they, their staff and officers, and their partner organisations, were able to bring to bear in this time of national crisis.

Part 2 - General outline of LGA work in relation to emergency planning during the Module 1 period

16. These activities have included informing government of the issues and concerns facing member authorities during an emergency and providing information about members' activities.

17. The LGA has circulated requests for assistance and facilitated mutual aid between councils, including providing resources to individual councils responding to emergencies. It has undertaken national media work relating to incidents and emergencies and provided communications support to individual councils and local government collectively. On occasion, in relation to some incidents, it has represented local government at meetings of COBR (Cabinet Office Meeting Room).

18. Over time the resource available to undertake this work has reduced. In 2009, the LGA had 478 staff but by early 2020 this had reduced by about 27% to 348. A consequence of this staff reduction has been that, whereas in 2009 the LGA had a dedicated policy officer working predominantly on emergency planning issues, by 2020 this was no longer so. In 2009, the LGA's emergency planning lead had more capacity to work proactively on general emergency planning issues and engage with council emergency planners through an emergency planning advisory group. This included work on specific risks, such as surveying councils' readiness following swine flu, and working with government on exercises.

19. Following restructuring in 2010-11, emergency planning was one of a number of competing priorities for the LGA, so work on this reduced. This was not just because of changes to staffing structures but also reflected there being less national policy work to feed into. This contributed to the EP Advisory network the Emergency Planning

Advisory Network being disbanded in 2014. A further restructure in 2015 also reduced capacity in the policy team leading work on general emergency planning issues. Nevertheless, this did not mean that no work was done by the LGA on emergency planning thereafter.

20. In 2016, the LGA published a councillor's guide to civil emergencies, and hosted two workshops to publicise the document. The handling of the emergency response by the Royal Borough of Kensington and Chelsea following the Grenfell Tower fire in June 2017 was criticised. This led the LGA to reprioritise emergency planning work, though some constraints on the available amount of officers' time remained.

21. LGA officers liaised with the Cabinet Office's Civil Contingencies Unit to consider what options there may for implementing assurance mechanisms for local resilience, as well as for providing surge capacity for local areas during a response period. These ideas were not subsequently pursued and the LGA understood that this was due to a lack of Government funding to support them. Though it is believed that one outcome of this work was the development of the Government's Resilience Standards (ML/1 - INQ000080818), setting out possible activity on different resilience themes. These standards then formed part of the guidance available to Local Resilience Forums (LRFS).

22. In 2018, the LGA updated the councillor guide to reflect the learning from the multiple tragedies to which councils had responded in 2017 and developed two guidance documents to share the learning from these specific incidents. The LGA developed a councillor training course on emergency planning, which was run four times over 2018-2019.

23. From Autumn 2017 until the end of 2019, LGA officers met regularly with the Resilience and Emergencies Division (RED) team in the Government department now known as the Department for Levelling Up, Housing and Communities (DLUHC). They worked on several specific issues including developing an agreed approach as to how the LGA would seek mutual aid from its members when local approaches had not secured the support that was needed.

24. Over this period, the LGA's emergency planning policy lead had some engagement with the Government on specific risks, in particular on "no deal" EU exit planning in the run up to an exit agreement being signed at the end of 2019. The LGA was often, although not consistently, invited to attend LRF events. The LGA also worked from time to time with the Cabinet Office's Civil Contingencies Secretariat (CCS) during this period.

25. The LGA was very much aware that their specific areas of local government policy which had to be considered alongside more general emergency planning work, such as issues concerned with flooding and pandemic flu. At the level of central government there is different ownership of such specific contingencies and the LGA recognised that there was thus a risk that emergency planning could become fractured, whereas there was a clear need to ensure at the local level that councils' preparations were fully joined – up.

Part 3 - The Civil Contingencies Framework

Introduction

26. In this section I shall explain the LGA's understanding of the key civil contingencies legislative and policy framework and summarise the role of local authorities in that framework. My focus in this Part is on the basic civil continency framework, whereas in the next Part of my statement I shall discuss health protections and health and social care issues.

27. In my view it is important to distinguish between the role of Local Resilience Forums under the basic civil contingencies' legislation and the separate (though as I shall explain connected) role of those who are engaged in health protection whether or not an emergency has arisen that engages with civil contingencies legislation.

28. The point can be put in this way. There is a health protection side to major incidents such as pandemics which engages with all aspects of emergency planning such as business continuity, emergency planning and service co-ordination side. However, it is also important to recognise that many cases and clusters of communicable disease

are handled within routine health protection business without the need to formally involve the relevant local Forum.

29. These Forums were utilised during Covid-19 in part because of the size and scale of the disruption and issues brought by the virus. but they are just one part of the system that is relevant to a pandemic response. This contrasts with what can happen in other emergencies, where blue light services take control handing over to the council when an incident moves into the recovery phase.

30. A further point is that during the COVID – 19 emergency, in some places it was the council (often through the Director of Public Health) that was chaired strategic coordinating groups, convened tactical cells, and led on both the response and the subsequent recovery. The LGA therefore considers that health protection structures as discussed in Part 4 are of equal relevance both to civil contingencies structures and in the preparatory phase.

31. With that introduction and qualification, I shall now consider the basic civil contingencies framework, as noted the next section will pick up on the specificities of health protection, health-based emergencies and the issues of health and social care which can arise.

The CC Legislation

32. The key legislation concerned with civil emergency response that refers specifically to "civil contingencies" is contained in the Civil Contingencies Act 2004 (CCA 2004) and the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (the 2005 Regulations) made under CCA 2004. I shall refer to these two provisions collectively as "the CC legislation".

33. The CC legislation provides the legal framework within which key civil society undertakings are required to prepare for, and respond to, civil emergencies. These are defined by section 1 CCA 2004 as –

"…an event or situation which threatens serious damage to human welfare or the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK."

Category 1 Responders (C1Rs)

34. The CCA legislation divides these undertakings into Category 1 Responders (C1Rs) and Category 2 Responders (C2Rs). All the principal local authorities[1] in England are defined as C1Rs by schedule 1 to the CCA 2004,[2] having the responsibilities set out in Part 1 of the Act as supplemented by subordinate legislation.

35. C1Rs are seen by the CC legislation as being at the heart of the response to most emergencies. As C1Rs, local authorities are required to -
    - assess the risk of emergencies occurring and use this assessment to inform contingency planning,
    - put in place emergency plans,
    - put in place business continuity management arrangements,
    - put communications arrangements in place to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,
    - share information with other local responders to enhance coordination,
    - cooperate with other local responders to enhance coordination and efficiency, and
    - provide advice and assistance to businesses and voluntary organisations about business continuity management (this responsibility applies to local authority category one responders only).

---

[1] These are county councils, district councils, London borough councils, the City of London, the Council of the Isles of Scilly, and the Greater London Authority: see schedule 1 to CCA 2004.

[2] Other C1Rs are Police forces, including the British Transport Police, Fire Services, Ambulance Services, HM Coastguard (MCA), NHS bodies, Port health authorities, The Environment Agency, and the UK Health Security Agency.

The location of operational local authority functions relating to emergencies

36. Beyond the above, the CC Legislation does not prescribe specifically what are the appropriate local structures for ensuring that the organisation is complying with its requirements. For local authorities that is a matter within their discretion and as a result, the operational function of emergency planning may be located in more than one part of a council, including corporate and resources directorates and in public health functions.

37. The way this operates may look different in two-tier areas, and in some places upper tier authorities will provide emergency planning capability on behalf of district councils, with district teams having a smaller emergency planning capability, if at all. In some areas councils have come together to establish a combined emergency planning team, for example Greater Manchester's Local Authority Civil Contingencies and Resilience Unit.

38. Where a council's emergency planning function is located will impact which senior manager, portfolio holder or committee has oversight of the issue. As with their other responsibilities, oversight of councils' local resilience work ultimately rests with councils managerial and political leadership structure, which politically may be through a leader and cabinet model, a committee structure or a directly elected Mayor.

39. Emergency planning and business continuity will often be overseen by an audit committee (or equivalent named committee) as part of a wider overview of corporate risks, and that council scrutiny functions may also exercise regular or *ad hoc* engagement oversight of emergency planning work and within many councils, planning for risks relating to climate change work is undertaken outside emergency planning teams.

40. The LGA does not have a systematic or comprehensive overview as to how councils oversee emergency planning locally at the political level. As there are no specific mechanisms within the CC Legislation for democratic oversight and accountability, there is no specific guidance on what councils should do to ensure there is clear

oversight of their resilience work and as far as I am aware this has not been audited nationally.

Local Resilience Forums (LRFs)

41. The CCA Regulations do require all C1Rs to co-operate with other C1Rs in the respective Local Resilience Forum (LRF) for their area.[3] The responsibilities of councils, as C1Rs (and more broadly as members of LRFs) are set out further in extensive government guidance –

    - *The role of Local Resilience Forums: A reference document* (published by the Cabinet Office's Civil Contingencies Secretariat (CCS), v.2 July 2013) (ML/2 - INQ000080824)
    - *Emergency preparedness* (CCS, originally published 2006, chapters updated differentially since then) (ML/3 - INQ000080784 to INQ000080798), and
    - *Emergency response and recovery* (CCS, 2013 version) (ML/4 - INQ000080805).

42. Notwithstanding the extensive guidance to support it, the CCA 2004 does not set out a specific way of doing things and there is scope for considerable flexibility in how local authorities and other C1Rs deliver their relatively limited number of legal requirements. For each of the legal responsibilities – and in relation to subsequent sections of this response – it is for each C1R and local area to determine how they will interpret and apply the requirements and guidance.

43. LRFs are thus the multi-agency partnerships responsible for identifying and planning for local civil resilience risks and their work extends beyond C1Rs talking among themselves. In their respective LRFs, local authorities work closely with other C1Rs

[3] The description I give of the way LRFs function is based on a combination of the texts of the CC Legislation, publicly available information about LRFs, and the information that relevant emergency planning officers among the LGA's members have in the past shared with the LGA. It is by no means suggested that my statement gives a fully comprehensive picture of the different ways that they work in practice across England; if more detailed or comprehensive comparative information about this is required the LGA would have to conduct a further survey similar to that undertaken for Annex B.

(such as the police and fire and rescue services) but also with C2Rs,[4] as well as with local partners such as the voluntary and community sector (VCS) and business groups.

LRF functions

44. The CCS guidance *The role of Local Resilience Forums: A reference document* states that the functions of the LRF are to –

- Compile an agreed risk profile for the area, through a Community Risk Register,
- Undertake a systematic, planned and co-ordinated approach to encourage C1Rs, according to their functions, to address all aspects of policy in relation to -
    - risk;
    - planning for emergencies;
    - planning for business continuity management;
    - publishing information about risk assessments and plans;
    - arrangements to warn and inform the public; and
    - other aspects of civil protection duty, including the promotion of business continuity management by local authorities;

  and

- Support the preparation, by all or some of its members, of multi-agency plans and other documents, including protocols and agreements and the co-ordination of multi-agency exercises and other training events.

LRF Meetings

45. *The role of LRFs, a reference document* guidance document does highlight how the CC Legislation requires that LRFs meet at least once every six months. I understand that in practice, many strategic LRF groups will meet more formally regularly, and often

[4] These are set out in Part 3 of Schedule 1 to the CCA 2004. They include Network Rail, London Underground, Transport for London, Highways England, Airport operators, Harbour authorities, and the Health and Safety Executive. It should be noted also that Civil Contingencies Act Post-Implementation Review 2022 made recommendations for further undertakings to be new category 2 responders.

quarterly. There may be other occasions where LRFs come together, but not for a formal LRF meeting.

46. Underpinning the strategic LRF group, there will be a number of operational/tactical working groups looking at different issues or workstreams; for example, risk assessment, or communications. While some of these may be more likely to be constituted in anticipation of, or following, an emergency (for example as a communications group), others will meet outside of a response phase, with the regularity of meetings determined locally. This will often be three or four times a year.

The management of LRFs

47. The LGA does not have detailed information on how individual LRFs are constituted in practice, and there may be variations between them, however, its general understanding is that LRFs will broadly comprise:

- A strategic level meeting of senior officers from partner agencies within the LRF which typically meets 3-4 times a year, usually known as the LRF executive.
- Tactical/operational working groups (or cells) which will focus on specific issues (such as risk assessment) or workstreams. Some of these may be standing groups, while others may be ah-hoc or convened as part of a response. These may cover workstreams such as communications, multi-agency information sharing, or be specific to the nature of the response.
- An LRF secretariat providing the administrative function of the LRF, including professional emergency planning and resilience capability as well as LRF capacity.

48. Councils will often host the LRF secretariat, although this may also be managed through the police or fire service. Although historically no funding was provided to support LRF secretariats and functions, during the period of EU exit planning and the Covid response and subsequently, the Government has begun to provide resources to support the work of LRFs.

49. In some areas, as in London, groups of councils coordinate their input into the LRF, including being represented by an agreed representative at specific meetings. It is unlikely to be feasible always for all councils to participate in each LRF working group, with these roles sometimes shared across councils. However, other areas have reported an open invitation for all LRF members to be actively involved in the LRF's full range of meetings.

50. Senior council officers may chair the local LRF, although the LGA believes that this role is more often fulfilled by a local police or fire senior officers. The LGA's understanding is that in the vast majority of cases, LRF engagement takes place at the officer, rather than elected member level. [5] This is not an entirely consistent picture - for instance, in London Deputy Mayor Baroness Twycross is the LRF chair. The CCA 2004 neither mandates nor excludes political involvement, accountability and engagement., but the LGA is aware that there is a strong perception of local elected councillors is that they are not adequately reflected within LRF structures.

Category 2 Responders (C2Rs)

51. It should be noted that almost all the most relevant C2Rs are private businesses such as
    - Utility providers
        - Electricity distributors and transmitters
        - Gas distributors
        - Water and sewerage undertakers
        - Telephone service providers
    - Train operating companies
    - Airport operators

52. The LGA does not have direct evidence of how these private sector firms operate within local risk management and emergency planning structures, including with councils and

[5] This is because there has to be a Chief Officers' Group see reg 4(7) of the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005

LRFs. However, it suspects that this is a variable relationship. The recent Civil Contingencies Act Post-Implementation Review 2022 implied this saying -

> *"To varying degrees, consistency of Category 2 responder engagement has been raised as an area of concern from call for evidence respondents."*

LRFs and the voluntary sector

53. LRFs will usually discharge the duty to have regard to the voluntary sector on behalf of C1Rs but may do so in different ways. Some LRFs may have a VCS representative on the LRF executive and effectively treat the VCS as a partner in the same way as other C1Rs and C2Rs, while others may have a dedicated VCS cell or working group. In 2019, the British Red Cross highlighted concerns about VCS engagement in LRFs (see People Power, 2019) (ML/5 - INQ000080819), although anecdotal feedback suggests that collaboration has strengthened significantly since then, not least due to joint work during Covid.

54. The VCS will often be involved in local testing and exercising, as well as running their own exercises. Councils may also specifically commission the VCS etc....In a response, tactical coordinating groups would have close engagement with the VCS to help harness and channel VCS contributions.

55. As members of LRFs, councils will be part of this liaison, but will also be closely plugged into the local VCS through their wider work.

The Governmental view of LRFs

56. It seems to the LGA that the Government views LRFs as the main interface with local agencies on resilience matters, and increasingly the 'go to' body for difficult local issues even where they may not meet the legal definition of a civil emergency, although as noted below, local officers perceive some challenges with this.

57. Before 2020, in the period covered by this statement, the DLUHC Resilience and Emergencies Division's Strategic Resilience Advisers (known as Government Liaison Officers during a response period) acted as relationship managers for individual LRFs.[6]

58. While recognising the challenging brief of large areas of responsibility and multiple LRF meetings, council officers perceived a reduction in the effectiveness of the relationship manager approach following the abolition of the Government Offices Resilience Manager role, although they feel that the strategic resilience adviser posts have been strengthened since Covid.

Geographical issues concerning LRFs

59. LRFs are based on police force areas, and therefore can include very different numbers and types of local authorities, according to the specific geographical location. In particular it should be noted that LRF organisational geography does not always coincide with that for health bodies within the NHS or that the UK Health Security Agency (UKHSA) (formerly Public Health England (PHE)). This can mean that staff are stretched thinly as advisors.

60. Many police force areas, and therefore LRFs, are aligned to a county council footprint (for example, Lancashire, Lincolnshire, Hertfordshire and Essex) and will therefore comprise a single upper tier county council and multiple lower tier district councils and sometimes (though not always) one or more unitary authority. By contrast, in more urban areas, the LRF footprint typically comprises varying numbers of single tier unitary councils (for example, South Yorkshire, West Midlands and Greater Manchester).

61. Other LRF footprints can be a more complex mix of councils. For example, Thames Valley LRF comprises the county and district councils in Oxfordshire, as well as the six unitary councils in Berkshire, Buckinghamshire and Milton Keynes, while Avon and Somerset LRF includes the unitary councils of Bath and North East Somerset, Bristol

[6] This approach was developed after the abolition of the former Government Offices for the regions; formerly, Resilience Managers within the Government Offices had provided a route into government departments.

City and South Gloucestershire as well as (ahead of local government reorganisation in 2023) the districts and county councils in Somerset.

62. London, whose LRF covers the Metropolitan and City of London police force areas, has a specific and different resilience structure. While the London Resilience Forum is the equivalent to other LRFs, comprising London C1Rs, London is also required to maintain a network of Borough Resilience Forums,[7] effectively similar multi-agency groups which focus on emergency planning issues at the level of the 32 London Boroughs.

63. London Boroughs are still full members of the London Resilience Forum, and a Local Authorities Panel (chaired by a London council Chief Executive) coordinates London's local government input into the London Resilience Forum. It also oversees the work programme led by the London Resilience Group in relation to its support for local authorities and the London Gold arrangements (through which the nominated London LA Gold Chief Executive can discharge emergency response functions on behalf of the councils affected by an incident, when particular triggers are met). The London Resilience Group is a central team, funded by London Fire, London local authorities and the Greater London Authority.

Issues with the management of LRFs

64. This lack of direct involvement of those democratically elected is a significant issue. In the LGA's response to the Government's 2021 National Resilience Strategy call for evidence and CCA2004 Post Implementation Review (ML/6 - INQ000080817), the LGA stated that –

> *'we would like to see the role of local elected representatives formally recognised within civil continencies structures. Councillors have vital roles to play in providing civic, community and political leadership throughout the emergency planning cycle and this should be reflected within legislation.'*

[7] See regulation 4(7) of the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, SI 2005 No. 2042.

65. While its members respect the point of view that professional officers should lead operational responses to emergencies, the LGA believes it would be appropriate, particularly for longer emergencies such as Covid, for there to be a minimum expectation of oversight and assurance by political leaders in politically led organisations. The LGA also noted in its response that –

> *'in recognising the principle of local political engagement within the Act, however, there will need to be flexibility about how this is structured locally given diverse LRF footprints and differing local and mayoral/combined authority arrangements.'*

66. There are ten Combined Authorities in England (covering Cambridgeshire and Peterborough, Greater Manchester, Liverpool City Region, North East, North of Tyne, South Yorkshire, Tees Valley, West Midlands, West of England, West Yorkshire).
While their constituent councils are C1Rs, as far as the LGA is aware the Combined Authorities are not themselves made subject to the Civil Contingencies Act. The LGA is aware that in some areas regional arrangements have been created to bring partners together or lead on resilience issues. For example, Greater Manchester have a lead Chief Executive and Council leader for resilience from within the ten GM authorities; while London has the arrangements outlined above. However, the LGA does not have a map, or oversight, of how councils and LRFs arrange this for each LRF area. Nor does the LGA have detailed information about how individual combined authorities engaged in emergency preparedness work alongside their constituent councils prior to Covid, or since. However, in Appendix A I have provided a short overview based on our broad understanding, which again is derived from high level discussions with council officers, feedback from some combined authorities and the LGA's general awareness of this area.

LRFs' role in strategic, tactical and operational co-ordination

67. The CCA 2004 defines a LRF as a planning body; when it comes to the response to an emergency situation, different agencies will join to work together as best suits the

needed response. So multi-agency structures at strategic, tactical and operational level will bring partners together through a strategic coordination group (SCG), tactical coordination group (TCG) and operational level working groups, to ensure coordination, although each individual agency within the LRF retains command authority for their own resources and personnel.

68. The type and range of emergency that call for a response will vary significantly, and this influences the senior officer responsible for chairing the SCG. While the blue light services would be expected to lead responses to incidents such as a terror attack or fire, for other responses (as in the case of Covid-19) it may be more appropriate for a local authority officer to chair the SCG. For these reasons, the chair of the LRF does not always chair the SCG. In protracted emergencies, the chair of the SCG may also rotate between officers.

69. While the blue light services are often seen as leading emergency response work (notwithstanding the point above about different types of emergencies), councils are generally expected to lead the process of recovery following an emergency.

Further issues concerning the LRF system

70. The LGA considers that there are several other issues in the current LRF system beyond those mentioned above which warrant further review. The work on the new National Resilience Strategy provides an opportunity to look further at these.

71. One issue concerns the question whether there should be detailed provision for the financing and governance of LRFs.

72. The LGA would also wish to point out that there is no designated representative body for LRFs collectively. This is not a gap which the LGA would wholly fulfil since not all C1Rs are LGA members. There is no other body which has been established to carry out a collective representational role equivalent to that of the LGA for local authorities.

73. I should add that the LGA understands that collectively, RED and the Cabinet Office's Civil Contingencies Secretariat (CCS) have arranged opportunities for LRF chairs to come together during LRF chairs conferences once or twice a year. The LGA is not

aware of LRF practitioner groups being routinely constituted at the national level. Since Covid, RED arranges regular virtual LRF chairs webinars.

74. There is concern at the local emergency planning level that LRFs are increasingly seen as the only interface between central and local government on certain issues, and at the lack of engagement with senior officers in individual agencies on resilience issues compared to engagement with LRF chairs.

75. Many perceive an increasing tendency for central government to use LRFs as an easy route for engaging with local agencies, alongside a recent trend to use LRFs as the vehicle for responding to a wide range of issues that fall outside the definition of an emergency under the Civil Contingencies Act; a trend that started towards the end of the period covered by this request but has continued since 2020 too.

76. The reliance on LRFs for planning on a wide range of issues linked to no deal EU exit planning is one example of this, as was the recent request for LRFs to provide data reports from councils only in relation to Operation London Bridge and the national mourning period following the death of HM Queen Elizabeth II. There is a concern among local council resilience officers that the focus on LRFs ignores the role and capability of component parts of the LRF that are ultimately legally accountable for most aspects of preparedness and response.

77. Conversely, concern has also been raised at the extent to which other government departments, with policy responsibility for certain national risks will through resilience structures as well as their usual local routes. For example communication from the DHSC to non-health bodies, such as to LRFs, was highlighted as being poor.

78. The LGA also draws attention to its submissions to the Government's 2020 Integrated Review of Security, Defence, Development and Foreign Policy, and the subsequent National Resilience Strategy Call for Evidence/Post Implementation Review of the Civil Contingencies Act.

79. These made the following points about the operation of the CC Legislation -

- *The Act is primarily focused on emergency preparedness and response, but says little about building resilience more generally. We support the broad view*

set out in both consultation documents that there would be benefits to thinking about how legislation and relevant frameworks promote general resilience as well as preparedness.

- *While the Act itself sets out a relatively narrow role for local resilience forums – in summary, to facilitate multi-agency risk assessment and planning for incidents that fall within a tightly defined definition of emergency – in recent years the Government has made demands of LRFs that go far beyond this statutory role, for example by supporting EU Exit planning, or providing logistical support in the Covid-19 response (such as the distribution of PPE). As a general principle, legislation and practice should broadly reflect each other, so there is a need to review both the CCA and the role of LRFs and ensure these are aligned, and that there is clarity about the role of LRFs.*

- *The CCA does not acknowledge the role of elected councillors (or other locally elected officials) in leading and governing their organisations, or set out a role for them in providing democratic oversight and accountability. This democratic deficit should be addressed.*

- *There have been repeated issues with central Government's willingness to share critical planning information with local responders, both in a timely way or at all, which undermines the ability of C1R to plan properly and erodes central-local partnership working.*

Part 4 - The health and social care functions in civil contingencies

Introduction – the key players

80. One complicated area for emergency planning concerns how to address the special issues that appear in emergencies which are so intimately connected with health issues as in a pandemic. Health protection *per se* is not a function of LRFs but lies within the domains of local authority Directors of Public Health (DsPH), Environmental Health, Trading Standards and what is now called the UK Health Security Agency (UKHSA) and was formerly called Public Health England (PHE). In the next

paragraphs I give an overview of these different domains. So, there will always be questions about their inter-relationship with the work of LRFs. Of course, there can be and often will be health and social care issues that arise following or in an emergency that is not at the start a health emergency. In this Part I shall address some of the issues that can arise starting with identifying the roles and responsibilities of the various undertakings that can be involved.

The NHS role

81. There is a duty under the NHS Act 2006 to protect the population which rests with the Secretary of State, and this is discharged, now, through UKHSA, and formally, by the PHE, which will provide the specialist health protection expertise to support local agencies in developing their plans to respond to public health emergencies and incidents. NHS England has a duty to cooperate with local authorities on health and wellbeing under the NHS Act 2006, including cooperation on health protection.

Local authorities

82. Local authorities have a key role in investigating and managing outbreaks of communicable disease. Unitary and lower tier local authorities have health protection functions and statutory powers under the Public Health (Control of Disease) Act 1984, as amended by the Health and Social Care Act 2008, and regulations made under it as well as other legislation, such as the Health and Safety at Work Act etc 1974 and the Food Safety Act 1990 and associated regulations, which enables them to make the necessary interventions to protect health.

83. However, the way much of these responsibilities as they affect local authorities are discharged is based on the provisions of the Health and Social Care Act 2012 (HECSA 2012) which I describe more fully below.

84. In summary, as of January 2020, and before the Coronavirus Act 2020, the legal context for managing outbreaks of communicable disease which presented a risk to the health of the public requiring urgent investigation and management sat in four main places -

- Public Health England under the Health and Social Care Act 2012,
- Directors of Public Health under the Health and Social Care Act 2012,
- Chief Environmental Health Officers appointed pursuant to the Public Health (Control of Disease) Act 1984,
- NHS Clinical Commissioning Groups which had a duty to collaborate with Directors of Public Health and Public Health England to take local action (e.g., testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012.

85. Additionally, the Civil Contingencies Act 2004 gave further responsibilities as already outlined.

86. The effect of this was that local authorities and Public Health England (PHE) jointly held the primary responsibility for the delivery and management of public health actions to be taken in relation to outbreaks of communicable disease through Local Health Resilience Partnerships (LHRPs) and local memoranda of understanding. These arrangements are clarified in the Communicable Disease Outbreak Management Operational Guidance (ML/7- INQ000080783). These arrangements had been previously clarified in the 2013 guidance Health Protection in Local Government.

87. Local authorities had (and continue to have) a critical role at the local level in ensuring that all the relevant organisations locally are putting plans in place to protect the population against the range of threats and hazards. Local authorities have a key lever to improve the quality of health protection plans through the effective escalation of issues. This includes raising issues locally, with the partner concerned, or with the health and wellbeing board (see para 105), or directly with commissioners if there are concerns about commissioning of prevention services.

Directors of Public Health (DPH)

88. Within the local authority, it is the DPH that had and retains the primary responsibility for the health of their communities. This includes being assured that the arrangements to protect the health of the communities that they serve are robust and are implemented. The primary foundation for developing and deploying local outbreak management plans is thus the public health expertise of the local DPH. In general, the

statutory responsibilities of the DPH are outlined in the HSCA 2012, the NHS Act 2006 and regulations issued under these.

89. As most health protection incidents are contained locally, the director of public health, with UKHSA (formally PHE), lead the initial response to public health incidents at the local level, in close collaboration with the NHS lead.

90. The DPH role is to provide strategic challenge to health protection plans/arrangements produced by partner organisations. They can scrutinise and as necessary challenge performance and if necessary, escalate any concerns to the local health resilience partnership (LHRP).

91. Section 30 of the Health and Social Care Act 2012 requires county and unitary local authorities to appoint a DPH, acting jointly with the Secretary of State (in practice this joint appointment function is exercised by Public Health England). It gives that individual responsibility for the Local Authority's public health functions.

92. The DPH should receive information on all local health protection incidents and outbreaks and take any necessary action, working in concert with UKHSA and the NHS. This may include, for example, chairing an outbreak control committee, or chairing a look back exercise in response to a sudden untoward incident. The Director of Public Health will contribute to the work of the LHRP, possibly as lead DPH for the area and provide the public health input into the local authority emergency plans.

93. In 2018, the Association of Directors of Public Health (ADPH) published Major Incidents Checklist for Directors of Public Health (ML/8 - INQ000080816), which considered the role of DsPH in relations to events such as flooding, terrorist attacks of disease outbreaks. Four broad areas were described:

- **The DPH as public health specialist -** DsPH have specialist technical knowledge of the identification and management of threats to public health, the determinants of physical and mental health, use of data, and an understanding of the services that contribute to health and wellbeing. In this capacity the DPH is a source of

expert advice and may, for example, be asked to support or chair a Scientific and Technical Cell (STAC). In this capacity the DPH will also be an informed link to other national or regional expert health bodies like UKHSA or the Environment Agency, or indeed other DsPH with relevant experience.

- **The DPH as a controller of local resources** - DsPH may have direct managerial or even indirect commissioning control of staff and resources that can be called upon in crises. These will vary considerably in nature and scale between localities but might include emergency planning officers, environmental health or health protection officers, information analysts, health visitors, health promotors, public health commissioners, community development workers and administrative staff, any of whom might be called on to play a variety of roles to fit local needs. It is also possible that a DPH may be able to call on similar types of support from nearby public health teams.

- **The DPH as a senior manager and leader in councils** - DsPH may be on the corporate on-call rota. They may represent their local authorities on Strategic Coordinating Committees and be prominent in coordinating the overall council response. Even in this general director role they may well have more relevant training, if not experience, than many colleagues, reflecting their Emergency Preparedness, Resilience and Response (EPRR) responsibilities.

- **The DPH as a local system leader** - This is perhaps the most interesting and valuable role, and one that is increasingly common, but by its very nature it is less well-defined. DsPH are senior leaders or Chief Officers within their local authority, but they also have a professional independence linked to the health and wellbeing of the population they represent, which gives them a high level of natural authority wherever that wellbeing is under significant threat. DsPH will often have among the most extensive local networks of any senior officer, interfacing in their normal work with such a diverse array of public services, community groups, strategic networks and private organisations. They particularly bridge the realms of local government and the NHS, and understand the complexities and languages of both. Overall, DsPH have a wide-ranging role that could encompass assessing needs, monitoring that any response is working for all affected communities and demanding and

facilitating effective joint working when necessary. This role will vary greatly and require a good balance of confidence and judgement.

Public Health England/UK Health Security Agency

94. The PHE (now UKHSA) was mandated to fulfil the Secretary of State's duty to protect the public's health from infectious diseases, working with the NHS, local government and other partners. This included providing surveillance; specialist services, such as diagnostic and reference microbiology; investigation and management of outbreaks of infectious diseases; ensuring effective emergency preparedness, resilience and response for health emergencies.

95. At a local level PHE's health protection teams and field services worked in partnership with DsPH, playing strategic and operational leadership roles both in the development and implementation of outbreak control plans and in the identification and management of outbreaks.

96. Thus, PHE provided an integrated approach to protecting public health through the provision of support and advice to NHS England, local authorities, emergency services, government agencies and devolved administrations. Specialist advice areas related to outbreaks and incidents include infectious diseases, outbreak surveillance and management, chemical, biological and radiation hazards.

97. The PHE responded to incidents and outbreaks through Health Protection Teams (HPTs), which sat within PHE Centres. Local HPTs would investigate and manage outbreaks of communicable disease, provide surveillance of communicable diseases and infections and support LAs (including port health authorities) in their responsibilities under the Public Health (Control of Disease) Act 1984 and associated regulations, as well as new duties set out in the HSCA 2012.

98. With that general outline, in the next section I shall describe the main changes made by the HSCA 2012 as they affected local authorities.

The making of the Health and Social Care Act 2012 (HSCA 2012)

99. The HSCA 2012 represented a major restructuring, not just of health services, but also of councils' responsibilities for health improvement and the coordination of health and social care. The Act was the largest piece of health legislation since the creation of the NHS. It was subject to 50 days of debate in Committee and on the floor of both Houses. Over 2,000 amendments were agreed.

100. The Association of Directors of Public Health (ADPH) and the LGA played an active role in responding to government consultations on the proposed provisions of the Act, which received Royal Assent in March 2012, and was heavily involved in making representations to Members of the Houses of Commons and Lords during the passage of the legislation. The sector was successful in securing a number of amendments to the legislation on issues of particular concern to local government.

The main effects of the HSCA 2012

101. The HSCA 2012 marked a split in public health leadership and core functions between local authorities, PHE, NHS England (NHSE) and Clinical Commissioning Groups (CCGs). It should be noted that the Act's reforms applied only to England and not Wales or the other devolved nations.

102. A fundamental change was that much of the responsibility for public health was transferred from the NHS to local authorities. Local authorities came under a statutory duty to improve the health of their populations. From the HSCA 2012's commencement on the 1 April 2013 they assumed responsibility[8] for a large range of public health services including, for example, services to tackle drug or alcohol misuse. These services may be provided by commissioning services, for example through contracts with NHS, voluntary sector, or private providers.

[8] The Secretary of State retains ultimate responsibility for public health and has powers to take steps to improve the health of the people of England, as well as responsibility for health protection.

103. Central to this was section 30 of the HSCA 2012 which required – as noted - each upper-tier local authority, acting jointly with the Secretary of State, to appoint a DPH whose role is integral to the new duties for health improvement and health protection. Further the Act required these DPHs to publish annual reports on the health of their local population and that local authorities publish that report. The reports are intended to help such DPHs to account for their activity and to chart progress over time.

104. The HSCA 2012 also established the Local Health Resilience Partnerships (LHRPs) which I have already mentioned to ensure that 'nothing falls through the cracks' in the public health system. NHS England and relevant DPHs were made co-chairs of these partnerships. The LHRPs are responsible for identifying risks and developing plans relating to health and emergency preparedness, resilience and response and linking in to the LRF and wider emergency response.

105. The HSCA 2012 also established Health and Wellbeing Boards as statutory committees of all upper-tier local authorities to act as a forum for key leaders from the local health and care system to work jointly to –

- improve the health and wellbeing of the people in their area; reduce health inequalities; and,
- promote the integration of services.

The act also places duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

106. The Department of Health and Social Care prescribed six mandated services that all unitary and County Councils have to provide. They are sexual health services (sexually transmitted infections testing and treatment and contraception); the NHS Health Check programme; health protection; public health advice; the national child measurement programme; and public health services for 0–5-year-olds.

HSCA 2012: Guidance and Review

107. The Association of DPHs (ADPH) produced a series of 'What Good Looks Like' publications that set out the guiding principles of 'what good quality looks like' for population health programmes within the new local public health system (ML/9 - INQ000080826 to INQ000080836).

108. In 2019, the LGA commissioned an Independent report from the Kings Fund in order to understand the impact and implications of the 2013 public health reforms which transferred responsibility for the commissioning and provision of some services to local government from the NHS.

109. Since 2013 the government has looked twice at the decision to locate public health primarily in local authorities – once alongside the publication of The NHS Long Term Plan (NHS England and NHS Improvement 2019) and more recently following the abolition of Public Health England and the creation of the UK Health Security Agency and the Office for Health Improvement and Disparities (OHID) at the national level – and on both occasions it has decided to keep public health in local government.

110. The Health and Care Select Committee undertook their first review of the Health and Social Care Act 2012 back in 2016. The LGA provided written and oral evidence to the committee. In 2017, as requested by the House of Commons Health Select Committee, PHE led an audit of local health protection arrangements through a Local Health Protection Assurance Exercise.

111. This consisted of an online questionnaire to all 36 LHRPs. The responses provided an understanding of the extent to which compliance had been achieved for various standards and what further actions were needed to achieve compliance. The audit process helped to identify the key capabilities required of local health systems for effective health protection response.

112. While there have been real positives from the changes introduced in 2013, for example, integration of public health functions into wider local council services, including improved collaborative working with Planning, Housing, Social Services and Environmental Health departments in an attempt to bring about real change in terms of Health Protection. There has also been some fragmentation of health protection, intelligence architecture and commissioning functions, and also some duplication and

overlap, which council public health teams have argued limited their capacity to effect significant change.

113. The view among councils is that one effect of these changes is that public health is no longer regarded by some as integral to, or even part of, the NHS family. This has led to numerous difficulties including the sharing of and access to data on health protection incidents, engaging with other NHS services, and understanding each organisation's role and responsibility for the wide array of health protection issues within their boundary. It has also led to examples where either work has been duplicated or rather alarmingly where there are gaps in work required.

114. Nonetheless, despite concerns about the fragmentation of some services, most have judged the location of DPHs and their teams in local authorities in England as one of the successes of the reforms.

115. Many system partners have worked together to strengthen the governance, integration and coordination of Health Protection. The LGA was aware back in 2013 that clarification of roles was a problem. In 2013, the LGA worked with the DHSC and PHE to produce clear guidance (ML/10 - INQ000080811), since it felt local government needed guidance on who does what in the circumstances of any outbreak.

Delivering health and social care in a pandemic

116. So, it is clear that the responsibilities imposed by the HSCA 2012 on local authorities have had a considerable impact on emergency planning.

117. By section 194 the HSCA 2012 established "Health and wellbeing boards" (HWBs) as a formal local authority committee charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. These HWBs have a statutory duty, with clinical commissioning groups (CCGs), to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population. Obviously, the work and functions of HWBs will be relevant in the context of a health emergency such as Covid.

118. Some major incidents such as pandemics, require both a health protection and a business continuity, emergency planning and service co-ordination side. And in many cases and clusters of communicable disease are handled within routine health protection business without the need to formally involve the LRF.

Relationship between LHRPs and LRFs during the emergency

119. The Inquiry should be aware that though LRFs were utilised during Covid-19 (in part because of the size and scale of the disruption and issues brought by the virus, and also because they are the forum that the Government increasingly defaulted to in an emergency), yet they are just one part of the system that is relevant to a pandemic response and in many areas it was councils (often through the DPH) who were chairing strategic coordinating groups, convening tactical cells and leading the response, as well as subsequently the recovery.

120. This is in contrast with what can happen in other kinds of emergencies where the blue light services lead initially, and councils follow once the incident moves into the recovery phase. Therefore, health protection structures are of equal relevance to civil contingencies structures in considering preparedness.

121. There is often a health protection side to major incidents like pandemics as well as a business continuity, emergency planning and service co-ordination side, as a result of the size and scale and multi-dimensional nature of challenge. In a pandemic or in a major contaminated water issue, for instance, public health issues and LRF functions may overlap to a considerable extent, but they are still distinct. And it is important to note also that health protection incidents do not always need LRF co-ordination.

122. Alongside LRFs, the LHRPs bring together local health organisations, regional representatives of the UKHSA (and previously PHE) and others agreed locally. These partnerships were established by the HSCA 2012 to deliver national EPRR strategy in the context of local health risks. They bring together the health sector organisations involved in emergency preparedness and response at the LRF level.

123. The LHRP is a forum for co-ordination, joint working, planning and response by all relevant health bodies. The LHRP was a formalisation of arrangements that already existed in many local health economies to co-ordinate health sector input to the LRFs and emergency response.

124. In June 2020, the LGA, ADPH, FPH, PHE, Solace and the UK Chief Environmental Health Officers Group published Public Health Leadership, Multi-Agency Capability: Guiding Principles for Effective Management of COVID-19 at a Local Level (ML/11 - INQ000080810). It considered local roles and responsibilities in relation to health protection.

125. The Strategic Co-ordinating Group (SCG) of the Local Resilience Forum has responsibility to agree and co-ordinate strategic actions by C1Rs and C2Rs for the purposes of the CC Legislation in managing demand on systems, infrastructures and services and protecting human life and welfare. The SCG has crucial capabilities in aligning and deploying the capabilities of a range of agencies at local level in supporting the prevention and control of transmission of COVID-19.

126. As noted previously, the geography of an LRF may mean that it will cover multiple local authority areas and at a local level, the relationship between each local authority and the SCG needs to be agreed and understood by stakeholders. In this respect, the SCG will add value to co-ordination and oversight across larger geographical footprints, for example for facilitating mutual aid. Local areas are best left to determine how these arrangements will work.

127. The LRF and the public health parts of a local system require each other to deliver a Local Outbreak Plan. An SCG may take scientific and technical advice in furthering their role, but it is clear that the DPH's role, and role of the public health family of agencies in outbreak management on an LRF or SCG in a major disease outbreak is not solely advisory, it is also executive in furtherance of their role and as leader and holder of the Local Outbreak Plan for COVID-19.The system will work best when every part of it acknowledges distinct, overlapping and mutually dependent responsibilities.

128. It is worth reflecting that feedback from some local resilience specialists suggests that the specific structures for health resilience can create barriers and undermine a joined-up approach to planning and responding to health emergencies. Although in some areas, this was not felt to cause any issues, in others, it meant that the health response could be separate to wider resilience when health should be a full partner in the LRF landscape. The challenge of separate structures can also be compounded by geography, with health geography less likely to align with LRF structures. This is not something the LGA has taken a position on, but is clearly a concern among at least some local emergency planners.

129. I appreciate that this is a complicated picture. The diagram below from 2013 may help as it gives a general overview of the relationships between LHRPs and LRFs.

130. Overall, however I understand that the Department of Health and Social Care did not expect local authorities to produce a single all-encompassing "health protection plan" for an area, but rather to ensure that partners have effective plans in place. This includes commissioning plans aimed at prevention of infectious diseases, as well as joint approaches for responding to incidents and outbreaks agreed locally with partners.

131. The primary objective in outbreak management is to protect public health by identifying the source and implementing control measures to prevent further spread or recurrence of the infection. The investigation and management of outbreaks and implementation of necessary control measures obviously requires multidisciplinary

expertise and collaboration. As I have described the roles of local authorities and the PHE in the public health system are complementary. In practice these organisations work closely as part of a single public health system to deliver effective protection for the population from health threats.

132. It is recognised that many cases and clusters of communicable disease are handled within routine HPT business without the need to formally convene an Outbreak Control Team. The DPH had and retains primary responsibility for the health of their communities. This includes being assured that the arrangements to protect the health of the communities that they serve are robust and are implemented. The primary foundation of developing and deploying local outbreak management plans is the public health expertise of the local Director of Public Health.

The HSCA 2012 and emergency preparedness, resilience and response (EPRR)

133. The local authority, and the DPH acting on its behalf, have a pivotal place in protecting the health of its population. Under the HSCA 2012 the DPH has the overarching duty to ensure the local health protection system works effectively. However also under section 18 of the HSCA 2012, the Secretary of State can use regulations to delegate his health protection duties to local authorities or to require local authorities to undertake their health improvement duties in particular ways.

134. It is well recognised that the Secretary of State is ultimately accountable for emergency response, supported by the Chief Medical Officer (CMO) and the Department of Health and Social care and with a direct line of sight to the front line through the NHSE and UKHSA/PHE.

135. UKHSA/PHE is/was responsible for providing public health EPRR leadership and scientific and technical advice at all levels, co-ordinating its activities closely with the NHS and DsPH. It is responsible for the delivery of specialist public health services to national and local government, the NHS and the public, working in partnership to protect the public against infectious diseases and minimise the health impact from hazards. UKHSA/PHE is/was also responsible for assuring itself that its systems are fit for purpose to respond to incidents and emergencies.

136. The local authority role in health protection planning is not a managerial, but a local public health leadership function. It rests on the personal capability and skills of the local authority DPH and his or her team to identify any issues and advise appropriately. Where the DPH identifies issues, it is their role to highlight them, and escalate issues as necessary, providing advice, challenge and advocacy to protect the local population, working with UKHSA/PHE which will provide specialist health protection services.

Part 5 - Local authority planning for a pandemic

137. I shall now turn to looking at some of the aspects of local authority planning for a pandemic such as COVID – 19.

Risk assessments by local authorities

138. Chapter 4 of Emergency Preparedness (Local responder risk assessment duty) (most recently updated in 2012) provides detailed guidance for councils and other C1R organisations on how they should fulfil their statutory duty to undertake a risk assessment to assess the risk of an emergency within or affective their areas. Risk assessments should consider non-malicious hazards as well as malicious threats and be undertaken 'from time to time.'

139. This Guidance summarises the purpose of the duty as being to:

- ensure that Category 1 responders have an accurate and shared understanding of the risks that they face so that planning has a sound foundation and is proportionate to the risks;
- provide a rational basis for the prioritisation of objectives and work programmes and the allocation of resources;
- enable Category 1 responders to assess the adequacy of their plans and capabilities, highlight existing measures that are appropriate, and allow gaps to be identified;

- facilitate joined-up local planning, based on consistent planning assumptions;
- enable Category 1 responders to provide an accessible overview of the emergency planning and business continuity planning context for the public and officials and
- inform and reflect national risk assessments that support emergency planning and capability development at those levels

140. The LGA understands that this guidance has been supplemented in the past with Local Risk Management guidance shared on Resilience Direct and the methodology that is produced with the National Security Risk Assessment (NSRA).

141. The Inquiry should note here that not all the relevant guidance is in one place, thereby creating a significant risk that different guidance documents will diverge from one another over time.

142. It is for each council, and the wider LRF membership, to interpret this Government guidance and to ensure there are local arrangements to fulfil the duty to risk assess. The LGA does not have detailed information on the steps taken in individual areas to fulfil this duty, although its understanding is that this process is heavily influenced by the NSRA and that LRFs and local agencies plan for the risks set out in the various iterations of the Cabinet Office's National Risk Register since first released in August 2008. The LGA is also aware that many emergency planning leads in councils believe that there is significant scope to strengthen the national approach to risk assessment.

143. It is understood that LRFs will typically have a risk assessment working group through which agencies participate in the process of multi-agency risk assessment. The process is usually led by emergency planners, but officers with other specialists will be involved. The process is heavily influenced by the NSRA, although locality considerations (such as deprivation, equalities issues) are also taken into account. The process involves identifying gaps in capability and what plans need to be developed to respond to individual risks.

Other undertakings relevant to risk management and emergency planning

144. Other private sector businesses will be relevant to local risk management and emergency planning due to specific risks linked to their activities, for example businesses which are subject to the Control of Major Hazards Regulations (COMAH).

145. Under COMAH, there are legal duties requiring businesses to provide information to local authorities to enable them to prepare, review and test external emergency plans for dealing with the off-site consequences of major accidents at specified COMAH sites, while C1Rs are under a requirement to cooperate in tests of the external emergency plan. Where councils undertake work to prepare, review and test external emergency plans on behalf of businesses under COMAH, they are able to charge for this work.

146. Councils may also work on related issues with a much wider range of local businesses as part of their duty to provide support to businesses and voluntary sector organisations on business continuity.

147. The Government's Emergency Response and Recovery also sets out a wider range of public sector teams which may also have a role in local resilience activity, including public health, coroners, the Animal and Plant Health Agency and the Armed Forces.

Issues with the risk assessment process

148. Emergency planners in councils and LRFs have highlighted to the LGA a number of issues with risk assessment processes, suggesting that flaws in approach, mean that risk assessments do not significantly assist an area's ability to respond to an issue.

149. It has been noted that the secrecy and length of the NSRA makes it challenging to draw down from. More fundamentally, there are concerns that local risk assessment takes place in isolation from national risk assessment and planning, leading to a lack

of clarity about the national capability that would be available to support local areas in relation to nationwide risks that will affect all areas equally.

150. It has been suggested that a more joined up national and local process considering shared risks and capability would be an improvement. It has also been suggested that rather than treating all types of risks in the same way in the risk assessment process, efforts would be better focused on a closer assessment of more localised risks, with a more generic approach to national risks that are not locality specific.

151. It has also been suggested that risk assessment processes could be strengthened through bringing together evidence from previous incidents and responses to help understand what has been required and what has worked. It was also felt that there is scope to work across LRFs, rather than simply within them, on how risks would impact similar areas in diverse LRFs, understanding common consequences and undertaking capability analysis; but that as a general principle, structures are not geared towards cross-LRF information sharing and learning.

Emergency planning

152. Chapter 5 of Emergency Preparedness summarises the requirements for local authorities on emergency planning as follows:

- Maintaining plans for:
  - preventing emergencies
  - reducing, controlling or mitigating the effects of emergencies in both the response and recovery phases
  - taking other action in the event of emergencies.
- Ensuring plans contain procedures for determining whether an emergency has occurred; provision for training key staff and provision for exercising the plan to ensure it is effective. Plans should be reviewed periodically and kept up to date.
- Having regard to risk assessments when deciding which plans are required and developing/reviewing them.

153. The overall objective of the plans is to ensure that, if an emergency occurs or is likely to occur, councils can deliver their functions so far as necessary for the purpose of preventing the emergency, reducing, controlling or mitigating its effects or taking other action in connection with it.

154. The LGA's broad understanding is that emergency plans will be influenced by what is in the community risk register and therefore what councils need to plan for, however it seems that there is some variance in how councils develop such emergency plans.

155. While the development of emergency plans will usually be led by specialist emergency planning officers, developing them should be a collaborative process with relevant services and other council officers, to ensure that the document is understood and owned across the organisation. The emergency plan should be closely linked to the council's business continuity plan; in some areas the major incident and business continuity plan may be a single document, in others they will be separate documents but should still have a close read across.

156. Once they have been developed, emergency plans tend to be updated rather than fully redrafted from scratch. Of course, testing and exercising plans requires capacity, capability (people) and time.

157. Most LRFs will have a three to five year programmed approach to training and exercising at the LRF level. Ideally, LRF exercise programmes will be arranged in a way that enables individual partner organisations to test their own plans, which sit underneath the LRF's. Outside of LRF exercises, it can be challenging for agencies working with multiple councils to participate in multiple individual council exercises.

158. There are legal requirements for organisations to maintain plans for specific risks (for example, under COMAH (Control of Major Accidents Hazards) regulations); typically, when these plans are tested, councils/LRFs will use the opportunity to test out other aspects of their plans, for example a COMAH exercise may involve testing out plans for rest centres.

159. Local exercising is also informed by national exercises. Ideally, local areas will have sufficient notice of plans for national exercises, enabling them to write plans and test them in advance of a wider national exercise; in practice, national exercises are often arranged at shorter notice, and may be directed by different government departments as well as the lead departments for civil contingencies, which can disrupt local exercise plans (ML/12 - INQ000080804).

160. There is an expectation that in formulating emergency plans, LRFs and individual agencies including local authorities will take into account the needs of vulnerable people. Vulnerability is not framed in government guidance in terms of protected characteristics, nor is it clearly, or narrowly, defined, but instead includes broad references to children and young people; faith, religious, cultural and minority ethnic communities; and elderly people and people with disabilities. Previous research from the British Red Cross (People Power in Emergences, British Red Cross, November 2019) (ML/5 - INQ000080819) published shortly before Covid indicates different practices on whether vulnerability is defined in local plans, and on whether this is seen as a responsibility of the LRF or of councils. However, the LGA understands that there is very limited direction and no specific requirement from Government as to the issues for which councils and LRFs should test and exercise, even where these could be identified as national level rather than local issues.

161. The LGA understands that, broadly, plans work on the basis that everybody is vulnerable, and there have been some efforts to focus on specific groups in line with the guide, such as those who may be experiencing domestic abuse and the implications of this for evacuation plans and rest centres. There can be challenges in accessing relevant information and implementing practical steps in response, but the LGA understands this is an issue that local areas are increasingly focused on.

162. Feedback from member councils indicates that most emergency plans would not have systematically taken protected characteristics under the Equality Act 2010 into account prior to the pandemic, but instead, in line with government guidance, focused on a broad definition of vulnerability. They would be expected to take into account the Public Sector Equality Duty generally of course.

163. In considering the particular needs of, for example, different faith groups, or those disabilities, plans will have focused on groups with protected characteristics, as well as those without them. Covid has provided clear learning about the need to think about equalities issues through the lens of protected characteristics in developing and implementing emergency plans, and the LGA is aware that some agencies including local authorities are now revisiting their plans to include equalities impacts assessments.

164. The LGA notes that the government produced guidance in 2008 (which predates the Equality Act 2010) on Identifying people who are vulnerable in a crisis (ML/13 - INQ000080825). [9]The more recent guidance document Human Aspects in Emergency Management (ML/14 - INQ000080812) provides guidance on considering the human aspects of emergency preparedness and response. It includes a short section on vulnerability and the need to engage with different communities but is otherwise a more general document and set of case studies with limited practical guidance on how vulnerability should be managed in this context.

Business continuity management

165. Chapter six of Emergency Preparedness relates to Business Continuity Management and summarises councils' business continuity responsibilities as being to maintain plans to ensure that they can continue to exercise all their functions in the event of an emergency so far as is reasonably practicable.

166. Such plans must have regard to assessments of internal and external risks; there must be clear procedures for invoking a business continuity plan; arrangements for exercising them and training those involved in them, and they must be kept up to date.

167. Business continuity management follows well established processes and is a constant process, although not an easy one. Typically, council emergency planning

[9] At that time, there were equality duties in Great Britain relating to race, sex and disability equality but not in relation to other protected characteristics.

teams will support service teams with this process. Service teams have responsibility for undertaking business impact analysis to help understand the impact of different risks on their service areas. Applying individual risks to service areas helps them to understand the potential effect on issues such as staffing, which helps to identify minimum staffing requirements for each service, while also considering the potential impact of loss of building access, ICT etc.

168. Councils are also under a duty to provide advice and assistance to businesses and voluntary organisations about business continuity management. Many councils have published business continuity planning guidance, templates and toolkits on their websites; for example, Liverpool City Council, London Borough of Newham and Surrey County Council. Councils reported some challenges with promoting business continuity work and encouraging businesses to plan when it is not always possible to tell them what their plans should address because planning assumptions are being classified as Official Sensitive material.

Issues with continuity management

169. As councils use national risks to inform business continuity planning, it is likely that many councils had considered Panflu as part of their business continuity work, and how they could operate services with different proportions of staff off sick.

170. The UK Influenza Pandemic Preparedness Strategy 2011 identified the potential benefit of early school closures, depending on the public health risk assessment, to reduce the initial spread of infection. However, the LGA understands that not all business continuity planning had factored in the possibility of school closures.

171. A further and more fundamental issue concerns the absence of planning for breaking virus transmission. The concept of a lockdown to stop the exponential growth in infection was not included within national plans for Panflu ahead of the Covid -19 pandemic.

172. As a result, the LGA understands that national and local lock-downs were not factored into local business continuity planning or wider planning, both internally within

councils and in terms of the advice that councils gave to local businesses and the voluntary sector.

173. It is noteworthy that in one response to the LGA's survey of councils pursuant to Annex B, one council reported that in exercises, delegates at the sessions had raised lockdowns but been told this would not happen in the UK. Councils thus report that they have been largely unsighted on what the business continuity impacts of lockdown would be, and therefore having to adapt plans as policies were announced.

Public awareness and communication, and arrangements to warn, inform and advise the public

174. Chapter 7 of Emergency Preparedness addresses the issue of Communicating with the Public.

175. As C1Rs, councils are subject to distinct duties concerning

- public awareness, ahead of an emergency, so that the public are made aware of the risks of emergencies and how to deal with them if they occur, and
- warning and informing the public in the event an emergency is likely to occur or has occurred.

176. As I have noted C1Rs are also subject to a duty to arrange for the publication of all or part of risk assessments and plans they have made, where publication is necessary or desirable to prevent, reduce, control, mitigate or take other action in connection with an emergency.

Issues concerning the approach to public awareness

177. Councils and their C1R partners in the local LRF fulfil the general duty of public awareness in different ways. Some areas (such as Hertfordshire County Council and Hampshire County Council) have made information available via a single agency website, typically the agency that is hosting the LRF, for example the county council.

178. In other areas, there is a specific LRF website (for example, Thames Valley LRF) or other separately branded website (for example, Dorset Prepared).

179. Greater Manchester combines both approaches, with information about resilience on the website of the host authority, Greater Manchester Combined Authority, as well as a separate Greater Manchester Prepared website. The extensiveness of information shared through these websites varies, and the LGA understands this to be influenced at least in part by the budget available to the LRF for this work.

180. These sites will typically include the local community risk register (which differ considerably in how they are presented); information about how to prepare, and sources of information; and information about the LRF. On the community risk register, the LGA has heard feedback that it can be challenging to effectively highlight risks if planning assumptions are categorised as Official Sensitive and unable to be widely shared.

181. Beyond the information that is made available through different websites on an ongoing basis, the LGA understands there to be limited campaign work to increase public awareness, although some councils have stated that they have used the duty on councils to provide advice and assistance to businesses and voluntary organisations about business continuity management as a way to promote resilience and highlight the work of LRFs.

182. Many LRFs are involved in the Thirty days/Thirty ways campaign, which takes place each September and highlights how resilience can be boosted in thirty different ways throughout the month. However, more proactive communications at the local level tend to be linked to specific incidents and are therefore more 'warning and informing' in their nature. Among local resilience professionals, it is felt that there does not seem to be an appetite for general public information campaigns on resilience, and that we lack a national strategy for public awareness.

183. The LGA considers that there is therefore scope for this issue to be revisited as part of wider work on community resilience. In the LGA's response to the national resilience strategy call for evidence, it highlighted the convening role that national government can play on this issue, stating that –

- *COVID provides a relevant and timely platform for more open communications with businesses, organisations and individuals about the other risks society faces and how people can prepare for and try to mitigate them. While councils and local partners will be looking at these issues locally, for example through their work with flood groups, the pandemic provides an opportunity for national communications on building resilience.*

- *As general principles, the Government should work collaboratively with local partners to communicate messages around risk and risk appetite. Where the Government is taking the lead on communications, these should be shared with local partners – ideally in advance – who can play a supporting role in amplifying messages through their local communications. In other instances, it will be appropriate for local partners to take the lead on these communications, but there is a clear role for the Government to share best practice approaches to communicating risk and risk appetite.*

Warning and informing

184. Most LRFs operate a communications cell, bringing together communications representatives from different agencies, to discharge the warn and inform duty. This tactical group will lead the approach on providing information to local residents; however, this is typically done to warn and inform residents an emergency has occurred or is likely to, rather than proactive educating local residents.

185. Some LRFs may have their own social media channels to communicate messages to the public, while others rely on communications/messaging being promoted through individual agencies. As previously noted, while there is extensive guidance available on how a C1R can deliver its responsibilities, there is no prescription on how it should do so, and therefore considerable flexibility about how the obligations in the CC Legislation can be interpreted.

Cooperation and information sharing

186. Chapter 3 of Emergency Preparedness (ML/3 - INQ000080784 to INQ000080809) discusses the Formal Information Sharing between C1Rs and C2Rs and more widely, as they work to perform their duties under the CC Legislation. The guidance notes that although there are formal legal requirements for information sharing, most information sharing will be undertaken voluntarily as part of the broader co-operation between partners.

187. Information sharing encompasses routine liaison and updating between organisations, and formal or informal contacts, and includes the exchange of knowledge, understanding, advice and data. The Resilience Direct platform is sometimes used as a shared repository for information sharing, and a platform for secure exchange of data, but is not universally used by all local partners.

188. Local areas have sought to enable data sharing through developing information sharing policies and protocols covering category one and two responders and encouraging strategic support for information sharing.

Issues with information sharing

189. Some councils have reported to the LGA that there can be different appetites for sharing data among different LRF partners – locally and centrally.

190. This was demonstrated outside the Module 1 period during Covid-19 where there were particular challenges in accessing health data. This was in part due to the complex issue of the ownership of health data. Councils have told the LGA that Directors of Public Health have faced challenges in getting access to the right data to support their work.

191. Similarly, the LGA is aware of issues with the willingness of central government to share information with local partners, and in its response to the Civil Contingencies Act Post-Implementation Review 2022, the LGA set out its view that the duty to share information should extend to central Government as well as local partners.

192. I should also add that in April 2020 the government had to issue instructions allowing information sharing and sharing of confidential patient information amongst health organisations and other bodies engaged in disease surveillance for the purposes of research, protecting public health, providing healthcare services to the public and monitoring and managing the COVID-19 outbreak and incidents of exposure.

193. A connected point is that the LGA has received feedback from its members highlighting the reluctance from some Caldecott Guardians[10] to sign protocol agreements with local authorities, which enable lists of vulnerable people to be created and highlighting the differing views between DHSC policy and that of the Information Commissioner.

194. The LGA would like to see recognition enshrined in legislation and practice that councils and LRFs are trusted local partners when it comes to planning for and responding to incidents. During recent incidents, such as EU exit planning and Covid, local planning and operational responses have been hindered by the failure to share critical information or future plans in a timely way, as well as by the failure to bring local partners into co-design key mechanisms at an early stage. A legal duty to share relevant information with local partners should be considered.

Subsidiarity: the principle and its application

195. Emergency Preparedness and Emergency Response and Recovery notes the principle of subsidiarity as follows -

> '*Decisions should be taken at the lowest appropriate level, with co-ordination at the highest necessary level. Local agencies are the building blocks of the response to and recovery from an emergency of any scale.*'

[10] Senior persons responsible for protecting the confidentiality of people's health and care information and making sure it is used properly: see https://www.gov.uk/government/groups/uk-caldicott-guardian-council)

196. The LGA considers the clear intent of this principle is that emergency planning and response should be locally led as far as circumstances allow. Yet, obviously the application of this principle must differ according to the different types of emergencies. The risk of flooding, for example, will be specific to local flood risks and geography, while the adverse impacts of space weather on technology, or flu, are generic national risks with no obvious local dimension; meaning that planning for these will be quite different and may appropriately sit at different levels. Similarly, decisions about the response to a locally contained emergency will necessarily be more local than those in the response to a nation-wide incident.

197. Recognising the differences between such risks and what is needed to respond to them, and thus the different interdependencies between local and national in preparedness and response, is critical when considering subsidiarity. These factors mean it is essential that there is a clear and accepted understanding as to how the principle of subsidiarity should operates in practice.

198. The principle of subsidiarity suffers in practice from the problem that there is no single person or agency at the local level that is responsible or accountable for resilience matters (in contrast to central government structures such as COBR). LRFs do not fulfil this role see they are a multi-agency forum in which individual agencies retain powers to take their own decisions and direct their own resources.

199. That said, the LGA's view is that in a number of areas, the principle is not currently being applied effectively. Subsidiarity implies that local agencies are trusted, equal partners in emergency preparedness and response which, in appropriate circumstances, are empowered to lead local resilience work. However, there are a number of examples of practice suggesting otherwise.

200. As noted, a persistent issue, which has undermined trust and therefore the principle of subsidiarity, has been the extent of central Government's willingness to share information with local partners. There have been repeated challenges with central Government sharing intelligence and information about national risks (for examples, planning assumptions reasonable worst-case scenarios) on a limited basis

or not at all, thereby undermining the ability of local areas to undertake timely and informed local planning.

201. This has been seen in relation to EU exit planning, Covid-19 and more recently power disruption, when it has been commonplace for central Government to share watermarked copies of information on a confidential basis to just one or two named individuals within LRFs, hindering the ability to share critical information more widely across local agencies.

202. While these are all national level risks, local areas need detailed information to enable them to plan for them effectively. Moreover, local areas can bring valuable 'on the ground' expertise to help design responses and approaches to challenges that are national risks and issues. The most effective approaches to national challenges will blend national and local capability and expertise.

203. For example, on risk assessment, I have outlined above how there is scope to develop a more effective process that combines national and local planning. Current risk assessment processes see the national risk assessment process followed and duplicated by a local process that is largely separate; a more effective process better aligned with the principle of subsidiarity would see a joined-up framework for national risk management with capability, actions and responsibility at the national and local level clearly assigned.

Issues with the relationship between National Risk Assessment and Risk Register and local risk assessment and emergency planning

204. I have already discussed the National Security Risk Assessment and National Risk Register and their general relationship to local risk assessment and emergency planning. However, many local authority resilience leads have reflected to the LGA that there is considerable scope to take a more effective approach to this.

205. The issue is that current risk assessment processes involve broadly separate assessments taking place firstly at the national and subsequently at the local level, informed by the national work. This leads to duplication, with local risk assessment

processes replicating the risks identified nationally but without clarity on the national capability available to respond to these.

206. A more coordinated risk management and emergency planning process would involve joint national and local work to identify shared national risks, the national/local capability to respond to them and actions/responsibilities at each level; allowing for a greater focus in local risk assessment processes of specific local risks and responses.

Part 6 - National Planning Exercises

Introduction

207. An influenza pandemic was identified in the past decade as the highest priority risk on the national risk register, taking both likelihood and impact into account to the United Kingdom. Local authorities, with partners had been preparing for a possible flu pandemic for a number of years. Response plans were in place not only to deal with the impact of a flu pandemic across the country but also to describe how the council will work in collaboration with key agencies. Significant amount of work has been undertaken across local government to review and develop health protection arrangements. This has included development of plans, training, memorandum of understandings (MoUs), exercising and learning from incidents. In this section I shall outline what is known to the LGA.

Exercise Winter Willow

208. In the February of 2007, the UK government undertook Exercise Winter Willow, a major nationwide Panflu exercise. The largest emergency exercise since the cold war involving over 5,000 people to test whether it could cope in the event of a flu epidemic in Britain. The exercise was designed to ensure that the authorities could cope with up to 30% of the population being infected and a possible 750,000 deaths. Exercise Winter Willow covered the period from the first case inside the UK through the development of the epidemic.

209. The Exercise was delivered in two stages. Stage 1 comprised a national-level tabletop exercise with meetings of the ministerial Civil Contingencies Committee (CCC) and the official-level committee CCC(O), which simulated the first UK case of a pandemic. The decisions made by the CCC in the first phase were used to develop the scenario for the second stage of the exercise where Ministers were given the opportunity to explore the consequences of their initial decisions. The LGA attended meetings of the CCC

Exercise Winter Willow (stage 2)

210. Winter Willow (stage 2) was designed to allow Regional Civil Contingencies Committees (RCCCs) and Strategic Co-ordination Groups (SCGs) to understand better the challenges that they would face as the UK epidemic took hold and specially to provide structured information and feedback to the central Civil Contingencies Committee (CCC) and to cascade decisions and information from the CCC back to regional and local response organisations.

211. The Exercise was an opportunity to test out the UK National Framework for Responding to an Influenza Pandemic and helped to inform further local authority/LRF work on its development and revision. This exercise identified a number of lessons, some of which remained issues during the H1N1 'swine flu' 2009 pandemic response, including the management of 'excess deaths',[11] crisis management and coordination; public advice and communication; and business continuity.

H1N1 'Swine flu' 2009

---

[11] 'Excess deaths' is a phrase that will seem insensitive to those who lost loved ones during the pandemic. It is however an established phrase used within civil contingencies framework for analytical and planning purposes. It reflects the difference between the observed numbers of deaths in specific time periods and the expected numbers of deaths for that period. All deaths require management processes; in normal times these will be planned for, but in the context of a civil contingency it is often necessary to plan for and address a greater need.

212. The H1N1 'Swine flu' 2009 influenza pandemic involved council departments in many different aspects of the crisis. Maintaining frontline services on which many vulnerable people rely, such as residential and nursing homes, remained a top priority, and councils were able to put in place robust business continuity plans to maintain essential services.

213. The pre-pandemic planning, set out in the national framework ensured that many decisions had already been made in principle prior to the pandemic and that key personnel had already had the opportunity to work together. Key issues, approaches and decisions were outlined in the National Framework to ensure that the UK was able to make decisions rapidly when required.

214. The LGA attended meetings of the Civil Contingencies Committee (CCC) along with relevant UK government departments, the devolved administrations, the Health Protection Agency (HPA), the Government Office for Science, and the Association of Chief Police Officers.

215. Drawing on resources from across the organisation, the LGA implemented a set of regular briefings and tailored guidance for councils. Key outputs included: A special LGA swine flu briefing event in Birmingham in July 2009 aimed at sharing lessons learnt from the first wave. A special swine flu guide for elected members. A *Local Authority Swine Flu Survey*, survey sent to all emergency planning officers across England and Wales. The final report was published in December 2009 (ML/15 - INQ000080822).

216. Several local authorities at the time fed back some concerns which affected their ability to implement or change swine flu business continuity management including a reluctance from the health sector to involve councils in the local response or did so quite late in the response. Poor coordination of information from central government departments to local authorities and greater clarity over the funding allocated to local authorities to meet their costs. The LGA provided summary reports (ML/16 - INQ000080815) on the findings from 2009 and lessons learned.

The Hine Review

217. Following the Swine flu outbreak of 2009, the then Government set up an independent review of the UK's response to the 2009 influenza pandemic, which reported in July 2010. The review was led by Dame Deirdre Hine The 2009 Influenza Pandemic (ML/17 - INQ000080823). The LGA gave evidence to the review.

The HSCA guidance 2013

218. In 2013, the Department of Health and Social care, PHE and the Local Government Association published guidance to define the new health protection arrangements for local authorities. *'Protecting the health of the local population: the new health protection duty of local authorities'* (ML/10 - INQ000080811), focussed on the changes resulting from the implementation of the HSCA 2012 and described how the new system would continue to protect the public's health.

219. In 2019, the Association of Directors of Public Health (ADPH) and PHE supplemented this guidance with the *'What Good Looks Like for High Quality Health Protection Systems*' (ML/18 - INQ000080831).

Ebola exercises 2014 - 15

220. Outbreak scenarios under new arrangements proved useful rehearsals at a time when there were new potential international threats from, e.g., the Ebola outbreak in West Africa, and from the risk of another flu pandemic. The majority of the LRFs and LHRPs in the country held exercises during 2014–15 to test the readiness of the Ebola plans in case Ebola cases were diagnosed in the UK.

221. A number of places undertook whole system LRF work on the High Consequence Infectious Disease (HCID) pathway, from arrival of a suspected Ebola case at the port of entry, transfer to specialist Infectious Diseases Unit to public warning and informing. Councils reported that Ebola planning proved a good example of a whole system local health protection pathway which could be applied across a range

of HCIDs and outbreak management in general. Reassuringly, the response to Ebola at both a national and a local level was seen to have worked well.

The Greater Manchester review 2015

222. In 2015, Greater Manchester undertook what is believed to be one of the largest Sector Led Improvement (GM SLI) review of disease outbreak management arrangements in the UK to capture and build on, not only the lessons identified from Ebola but also from more local outbreaks.

223. The review findings were shared with PHE and across the GM LRF, however as there is no formal mechanism for sharing this sort of review, it is not clear how learning from the SLI review was picked up by the Cabinet Office/RED and shared with other LRFs. As noted below, there is a view among local planners that more could be done to share the learning from this type of exercising, as well as from responses.

Strategic Defence and Security Review 2015

224. The 2015 Strategic Defence and Security Review gave prominence to the role of LRFs, highlighting that the response to, and recovery from, an emergency is carried out "first and foremost at the local level". It committed to better coordination between the local and national levels of response and greater support for organisations involved in response planning "to share and apply learning from exercises and real-life events".

Exercise Cygnus 2016

225. Exercise Cygnus was a cross-government exercise to test the UK's response to a serious influenza pandemic. The LGA attended meetings of the EPRR Partnership Group on 25 July 2013 to discuss the timetable for the planned rollout of Exercise Cygnus

226. The main component of Exercise Cygnus was a cross-government command-post exercise to be held during the week beginning 13 October 2014. This part of the

exercise was to simulate a point in the pandemic when it is clear that all sectors are going to come under pressure from sickness and increased deaths.

227. LGA attended meetings with officials in advance of the Exercise and LGA officers kept member authorities informed of developments. In October 2014, Exercise Cygnus was due to take place then subsequently postponed as Ebola Planning had become a priority for DHSC, PHE and Cabinet Office. The recontinuation of planning for Exercise Cygnus began in December 2015.

228. Exercise Cygnus took place over three days between 18-20 October 2016. 8 LRFs took part in the exercise (London, Kent, Hertfordshire, Leicestershire, Northamptonshire, South Yorkshire, Essex, Merseyside). It is possible that some other local authorities may have had some informal engagement with this exercise but the LGA is not aware of this.

229. Exercise Cygnus ended up being a smaller exercise compared to its predecessor, whereas Winter Willow (2009) marshalled more than 5,000 people, including government ministers, civil servants, emergency planners, NHS staff, and emergency services personnel to test how the UK would hold up under the strain of a pandemic.

230. The LGA were not involved in the actual command post Exercise, and it was not invited to attend Civil Contingencies Committee (CCC). The LGA has attended meetings of the Civil Contingencies Committee on an ad-hoc basis. We believe that there needs to be a presumption that the LGA should be invited to attend COBR to represent the views and interests of councils and their communities during times of national emergency.

231. A report on Exercise Cygnus was not published by the government until October 2020. The report found uneven levels of resilience and limited capacity in some areas to surge resources into excess death management, and health and social care. The report called for more national-level operational guidance to 'scale up' the local response. It remains unclear why the government adopted the policy of keeping

Cygnus secret. Lessons from Winter Willow had been published without incident, shared with key stakeholders and remains freely available online.

232. Council resilience leads and public health directors fed back to the LGA that there is scope to ensure the learning from exercises is more systematically shared. Although it was noted that there have been some improvements in this, with the Emergency Planning College having launched a quarterly lessons digest for the Emergency Planning Society, officers reported that there is a general issue with receipt, sharing and assessment of tier one exercise learning (including Cygnus) and a need to share more granular detail and information than is available in public reports. I should add here that In the LGA's survey of councils for the Inquiry, a number raised 'excess deaths'. Likewise feedback to the LGA independently of the Inquiry reflects that there were issues with this aspect of planning. The LGA heard some reports that in general there had been more of a focus on mass fatalities planning linked to specific incidents rather than a broader focus on excess deaths over a prolonged period. During the pandemic there was a fundamental challenge at the local level because councils held the responsibility for this even though most did not own mortuaries, with provision often contracted from the NHS. It is unclear whether all the partners that needed to be around the table were discussing death management processes in an 'excess death' scenario prior to 2020.

Exercise Alice 2016

233. In the Autumn of 2022, the LGA became aware that a further relevant exercise was carried out in February 2016 by PHE. PHE published a report of the exercise under the title "Exercise Alice, Middle East Respiratory Syndrome Coronavirus (MERS-CoV) 15 February 2016" (ML/19 - INQ000080821). I am informed by LGA Officers that it was not informed of this Exercise at the time that it was carried out. It would also seem that although local authorities had significant public health, and health and social care responsibilities by that time, neither PHE nor the then Chief Medical Officer thought to engage with local authorities or the LGA in respect of the exercise.

234. The LGA finds this surprising and indeed regrettable. The report of the exercise demonstrates an awareness that a Coronavirus may well require quarantine steps to be taken to stop its spread. It may not have been fully apparent just how far such steps

might have had to go but it is surprising that this exercise has been kept away from the LGA and relatively secret for so long.

Part 7 - Civil Contingencies Secretariat (CCS) and Resilience and Emergencies Directorate (RED): relationship to local responders

Introduction

235. The LGA's understanding is that CCS has overall policy responsibility within government for civil contingencies/resilience work, while the RED team in what is now the Department of Levelling Up, Housing and Communities (DLUHC) primarily leads engagement with local responders through LRF structures and could be seen as more operationally focused given its responsibility for LRF relationship management and operating an emergency control centre.

236. In response to the Integrated Review in 2020, the LGA questioned whether it is helpful for there to be a split in resilience work between CCS and RED and suggested that this should be considered as part of the Civil Contingencies Act Post-Implementation Review 2022.

237. Other government departments will hold the policy leads for specific risks/resilience issues, for example the Department for Health and Social Care on a pandemic or Department for Business, Energy, Innovation and Skills on fuel and power.

RED

238. The LGA understands that the RED team's structures include regional leads for different regions to develop relationships with LRFs, but these are not at the level of senior civil servant roles. Outside of a response period, these roles are known as strategic resilience advisers; during a response period, they are known as Government Liaison Officers (GLOs).

239. These officers will typically attend LRF meetings (or SCG meetings in a response) in their areas and effectively act as a relationship manager on behalf of central government. During the period of the Covid response, RED scaled up its staffing significantly, although concerns were raised by LFR members (including council officers) at the time about the seniority and experience of some of the GLOs.

CCS and RED joint working

240. CCS and RED also periodically host national meetings/events to focus on specific risks or issues. Our understanding is that the majority of external CCS-RED meetings in the immediate run up to 2020 had been focused on EU exit planning and the risks of a no deal scenario.

The "Resilience Direct" platform

241. Resilience Direct (RD) is a web-based platform for sharing information on resilience matters. Although some individual LGA officers have been allocated log ins enabling them to access parts of the platform they have granted access to, it is not a system that the LGA uses widely or that we are organisationally familiar with.

Issues with the RD Platform

242. The LGA understands many LRFs have created local RD sites which they use to provide access to shared documentation including risk registers, planning assumptions and plans. RD does have the functionality to provide locked down platform to share sensitive information, however as noted above, not all local partners are regular users of Resilience Direct.

243. The government sometimes uses RD to make information available to LRFs and individual agencies, including some sensitive information which not all RD users are authorised to access, but the LGA understands there is no single, consistent systems that is used by any and all lead government departments. Also, unhelpfully,

there is no single repository of relevant guidance and information on emergency preparedness and response, which is instead available on different parts of the gov.uk website.

244. Although there is a facility for LRFs to report information to Government via Resilience Direct, prior to the COVID Pandemic the government had begun using the DELTA system as its primary route to collect information from LRFs, rather than Resilience Direct. This is the online system used by DLUHC more generally to facilitate the collection of statistical data and was not previously a standard LRF platform.

245. The LGA is not aware whether resilience and emergency planning activity by councils is routinely reported on to RED or DLUHC. It seems that there is no agreed data collection as part of the single data list (indicators on which councils are required to report); however, there may be ad-hoc data collection from LRFs. It is possible that Strategic Resilience Advisers may share information/internal assessments on LRF activity. During an emergency response, LRFs are typically asked to provide information on local activity.

246. More recently (in relation to Operation London Bridge), DLUHC/RED has used LRFs as the vehicle for collecting information from local authorities about local activity during the national period of mourning for HM Queen Elizabeth II, despite this is not being an issue that would fall within the remit of CCA2004 or LRFs'.

Part 8 - LGA's Perspective on Preparedness for Covid-19

247. In Annex A the LGA is asked for its views on the civil contingency arrangements as they applied, in the context of the Covid-19 pandemic, within the proposed date range. The LGA is not in a position to offer detailed insight into the exact arrangements in place during the specified date range and as at January 2020. In the following paragraphs I shall make some comments on this topic, but these must also be read in the light of what I have already set out. It may be that the Inquiry will get a better insight into this from the responses to the Survey carried out as a result of Annex B.

Government's state of readiness

248. The LGA is not in a position to assess or comment on the Government's overall state of readiness during the overall period or as at 21 January 2020 to any great extent. Certainly it would seem that planning had focused too closely on influenza rather than diseases like SARS and MERS.

249. Local emergency planners have observed that much of the guidance on pandemic flu was relatively old by the time of 2020. In the years immediately preceding 2020, central government resilience capacity was visibly targeted at EU exit planning as a national priority, but it is not clear whether this impacted the ability to plan for a wider range of pandemic scenarios than the existing plans for influenza.

Dissemination of information and guidance on COVID-19

250. The LGA does not assess the Government information and guidance on emergency preparedness as being well structured or shared. There is a significant body of guidance available, but there is no single repository where it can be accessed, either on the gov.uk website or within Resilience Direct.

251. Several of the documents cited in this statement are extremely lengthy, and local resilience leads have reported that it is too long, overlapping and difficult to find. By 2020 it was also several years old with much of it not updated since 2012/2013 and, in some cases, actually out of date (for example in its references to Government Offices).

252. The LGA is not aware as to how the Government would have disseminated specific guidance across all responders; and as noted above, in relation to some issues (such as no deal EU exit planning) the Government had shifted from disseminating information to all responders to sending critical information to very limited numbers of named LRF representatives.

253. The LGA can offer one example of how this might have been an issue. Thus a reference to possible school closures was included in the 2011 document UK Influenza

Pandemic Preparedness Strategy (ML/20 - INQ000080803), however by 2020, this document was nearly nine years old. Unless those concerned in 2020 had excellent recollection and had been involved at the time of publication they would not have known about this advice and guidance since there was no obvious signposting as to where to find it.

Local risk assessments, emergency plans and forecasts, and the possibility of a pandemic like Covid-19

254. The LGA did not, and does not now, have oversight of local risk assessments, emergency plans or forecasts, so it is unable to definitely answer this question. However, from discussions with local council and LRF resilience leads, the LGA is not aware that any local areas had plans for a pandemic of the nature of Covid-19.

255. Despite over 10 years of influenza pandemic planning, when COVID-19 hit the UK in January 2020, the evidence would suggest that neither the Government, Public Health England, nor local government was ready or prepared to deal with COVID-19.

256. Planning had focused closely on influenza rather than diseases like SARS and MERS that had in recent years appeared in Asian countries. Previous exercises to test the national response capability, namely Exercises Cygnus and Winter Willow, did not adequately address a disease with the characteristics of COVID-19. As noted above the Exercise Alice was kept largely secret.

257. Additionally, as noted, the plans did not account for some of the major non-pharmaceutical interventions that shaped the emergency response, principally lockdown, PPE distribution and shielding of the clinically extremely vulnerable. Councils have told us that in exercising and testing plans, when raising the question of lockdown, they were told by PHE/UKHSA and southeast NHS England and Improvement representatives that there would be no lockdowns in the UK.

258. From an emergency planning perspective, this meant that many existing plans were effectively ripped up at the outset of the response because they did not reflect

the situation that occurred. However, the LGA would note that the expertise and capability at local level meant that, despite not working to established and tested plans, councils and their partners responded well to the huge challenges of Covid-19.

Communication between local responders and government

259. The LGA is unable to comment further on the communication taking place between LRFs and central government, (including CCS and RED and the Department for Health and Social Care), in the context of resilience and preparedness for the Covid-19 pandemic, as at 21 January 2020. While it has been party to some communication between central government and LRFs (including for much of this period, about meetings on EU exit), it is not clear that it received all or routine communications to LRFs.

260. Obviously, communications to councils and their key respective partners developed rapidly from that date.

The general state of readiness of local authorities for a COVID-19 type pandemic

261. Not having oversight of councils' emergency plans the LGA cannot provide a definitive view as to the state of readiness. However much more information is now available about this is the response to the Annex B survey. That said the view of the LGA is that there was limited readiness for a pandemic of the kind actually experienced since this was not included within the national risk register to which local areas work.

262. However, while there may not have been readiness for the specific emergency that occurred, councils did demonstrate a laudable ability to pivot from existing plans so as quickly to develop and implement new plans and to provide an extremely effective, and vital, response to Covid-19.

263. The LGA cannot comment from its own knowledge as to how any difference in readiness varied between localities. The best evidence on this will emerge from the result of the Annex B Survey. As a general comment, local areas which had previous

experience of responding to emergencies – such as flooding events, or other incidents – would have had more experience to draw on, and it may therefore have been the case that they had more developed relationships between responders, or with specific groups such as the VCS. However, there is no evidence of which the LGA is aware of that any local area, or groups of authorities, had greater or less readiness than others.

264. The Annex B Survey will give some idea of the factors which were significant in impacting on readiness. In practice the LGA considers that a huge number of factors had the potential to impact either positively or negatively on councils' state of readiness for the Covid-19 pandemic.

265. These include -

- The extent to which risk assessments did, or did not, accurately reflect the type of pandemic experienced during Covid-19, and similarly the extent to which emergency plans reflected this.
- The clarity, effectiveness and coordination of health resilience structures at the local level.
- Prioritisation of planning for an influenza pandemic relative to other resilience priorities.
- Local emergency planning and public health capability.
- Local emergency planning and public health capacity.

Brexit's impact on local authorities' preparedness

266. The LGA is well aware that in the run up to the UK's exit from the EU, a significant amount of national and local resilience capability was targeted on planning for the possible disruption arising from a no deal exit scenario. From its engagement in this process, it is aware of meetings and discussions taking place between Government, LRFs and councils to consider this issue, at a time when other risks were not being discussed to the same extent, if at all.

267. The LGA is clear that EU exit planning was seen as a higher national resilience priority than other issues such as Panflu in the period up to an exit agreement being

reached at the end of 2019. As a result, national - and local - resilience capacity and capability was directed towards EU exit, and not Panflu.

268. The LGA has heard that one council officer reports having contacted government about another area of risk to be told 'if it's not Brexit, it's not happening,' and some councils have highlighted to it how prolonged incidents/LRF activity on issues such as EU exit planning impact the ability for routine activity such as reviewing plans, testing and training, sometimes leading to some of this work being deferred.

269. It is perhaps a paradox that it has also been said that the intensive multi-agency work across LRFs to prepare for a no deal exit did however help to prepare these agencies for the necessary cross-agency work during the response to Covid.

Part 9 - Resource and readiness issues

Funding overview

270. LGA analysis of data published by the DLUHC shows that councils in England have had their core funding from central government reduced by £15bn from 2010-11 to 2019-20 in cash terms.[12] This is a real terms reduction of 57%.[13]

271. While there has been a strong consensus on public health being in the right place in local government, there has been a significant amount of concern about whether it has had the right level of resources, both through the ring-fenced public health grant and through the wider funding of local government.

---

[12] The precise figure is £14.7bn but is reported in LGA publications as £15bn. This calculation measures the real terms percentage changes to councils' revenue/core spending power less council tax. The calculation excludes the public health grant, as it is associated with new responsibilities for councils, and the Better Care Fund. Discontinuities in the data due to reporting or definitional changes are addressed through the use of chain-linking process. We measure the change for English upper tier authorities and for shire district councils. All other authority types covered by spending power are excluded (fire authorities, the GLA, Combined Authorities).

[13] We apply CPI inflation to get to a real terms figure.

272. In 2015/16, as part of the government's response to financial pressures. Funding made available through the public health grant fell right up to the Covid-19 pandemic. The King's Fund and the Health Foundation (ML/21 - INQ000080813) calculated that, given population increase and inflation, the like-for-like purchasing power of the public health grant fell by almost a quarter per head of population between 2015/16 and 2020/21 and that an extra £1 billion a year would be required to fill the gap.

273. The government's response to the 2008 financial crisis was to cut funding across the public sector. Local government has taken a funding hit seeing significant reductions across the many areas that public health teams went to local government to influence. Upper tier' local authorities have had local public health responsibilities in England since 2013/14. These authorities receive an annual ringfenced grant from the Department for Health and Social Care. Authorities are also able to supplement funding from the grant with other local resources such as council tax income should they choose.

274. The level of grant funding provided to upper tier authorities and the accompanying level of spend is shown in Table 1. Note that local authorities were given new public health responsibilities for 0-5-year-olds in October 2015 for which they were given additional funding. As a result of this change in responsibilities public health funding and spending is only comparable from 2016/17 onwards.

Table 1: Public health grant allocations and net current expenditure in public health between 2016-17 and 2019-20 (£bn – cash terms)

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Public Health Grant	£2.7bn	£2.8bn	£3.5bn	£3.4bn	£3.3bn	£3.2bn	£3.1bn
Net Expenditure	£2.5bn	£2.7bn	£3.2bn	£3.5bn	£3.4bn	£3.3bn	£3.2bn

(Source: LGA analysis of DHSC annual public health grant allocations and DLUHC revenue outturn data on public health expenditure (RO3) Note: Due to a change in responsibilities for councils in 2015-16, data is only comparable from 2016-17.)

Between 2016-17 and 2019-20, public health grant allocations reduced by 7.5 per cent, from £3.4bn to £3.1bn (cash terms). This was accompanied by a 7.3 per cent reduction in net current expenditure in public health, from £3.5bn to £3.2bn. Note that these are cash terms figures. If inflation is taken into account there will have been a real terms reduction in both grant funding for, and spending on, public health by upper tier authorities.

275. The LGA local government finance team are unaware of any specific data on pandemic preparedness and have not examined whether changes in patterns of public health funding have affected pandemic preparedness.

276. The impact of a reducing budget has resulted in a reduction in the number of public health posts in local government. In some cases, those operating at senior specialist or director of public health level were also required to cover broader portfolios, cover larger geographies and/or collaborate with neighbouring public health teams to ensure access to the full range of public health skills in an area.

277. The LGA, like many other organisations, have been calling for a funded workforce plan for health and care that tackles both the short-term staff shortages we already see, as well as the ones that are predicted for the future. The need for such a plan is just as great for the public health workforce to confront the existing shortages and then deliver on the challenges ahead. Public Health England got part of the way in its 'Fit for the Future' but this fell short of quantifying the sheer lack of capacity and setting out a strategy to fill it.

Readiness

278. Funding cuts have been referenced elsewhere. One key lesson from this pandemic is that maintaining a well-resourced public health system, including health protection and Public Health analysis functions, is not a “nice-to-have” but a “must-have”.

279. Since 2013, when public health in England transferred into local authorities, there have been several high-profile major incidents of diverse types. These include the fire in Grenfell Tower, several large floods, terror attacks in Manchester and London and the tram crash in Croydon. There have also been significant disease outbreaks and incidents that may not have attained a high national profile but have had major local impact. Public Health teams have been prominent in many of these incidents just as they were when situated in the NHS, for example, during the 2009 Swine Flu pandemic.

280. However, in the post-2013 system the role of the DPH in such incidents is perhaps less clearly defined than it was previously. Where incidents are public health related it should be clear to partners that the DPH is central to the response. For other incidents the links might be less obvious to colleagues in both local authorities and other organisations, and the leadership or expertise of a DPH could be missed, impacting on the local response.

281. While formal emergency planning structures were well established before the Covid-19 pandemic and went into action promptly, the broader circumstances of funding reductions over the past decade impacted the resources that directors of public health (DsPH) could draw on when the pandemic hit.

Funding for emergency planning

282. The LGA is not aware of any specific government funding to support local emergency preparedness in the period in question. The LGA believes that there may previously have been ringfenced funding for emergency planning, but that this had been removed by the time the CCA 2004 came into effect. Instead spending will have had to have been funded from un-ringfenced government grants and local resources such as council tax.

283. Councils record their annual spend on the provision of integrated emergency planning as part of their annual finance returns to DLUHC. This includes civil

emergency and disaster planning and support, maintenance of emergency networks, and conducting of exercises.

Table 2: Net current expenditure on emergency planning by councils between 2009-10 and 2019-20 (£m – cash terms).

2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
£55.5	£54.0	£44.9	£45.0	£46.9	£42.5	£39.0	£39.1	£36.3	£34.8	£47.7

(Source: LGA analysis of DLUHC revenue outturn data (RO6))

284. Table 2 shows that between 2009-10 and 2019-20, councils' net current expenditure for emergency planning reduced by 14 per cent, from £55.5m to £47.7m in cash terms.[14] However, these figures reflect a significant spending increase in 2019-20. While we have no direct evidence of this, this uptick may represent additional spending undertaken in the early phases of the pandemic from January to March 2020.

285. Before this uptick, prior to 2019-20, overall local authority spending on emergency planning had fallen by almost 38% between 2009-10 and 2018-19, from £55.5m to £34.8m. Anecdotal feedback suggests that emergency planning staffing in councils may have roughly halved over this period. Although the LGA has not investigated whether this is the case, its assumption is that this is directly linked to the reduction in government funding to councils over this period referenced above.

286. In March 2021 the National Audit Office published a report on local government finance in the pandemic. In this it concluded that

> *"funding reductions and growing demand means that authorities' finances were potentially more vulnerable to the impact of the pandemic than they would have been otherwise" (para 1.4).*

[14] This includes upper tier authorities and shire district councils.

287. A subsequent (January 2022) report from the Public Accounts Committee on Local Government Finance System: Overview and Challenges stated -

> *"After steep funding reductions between 2010–11 and 2019–20, local government went into the pandemic with planned core funding down by 26% in real terms. Even factoring in other income sources, local government income was £8.4 billion less than in 2010–11 in real terms at the start of the pandemic" (para 1).*

288. Councils hold reserves; this places them in a different position to much of the public sector and is due to their different constitution and their sources of funding. A significant proportion of these reserves are ringfenced for specific purposes (for example, schools balances). The majority of the remainder are earmarked for known risks such as insurance or for planning for the future (for example sums set aside for major schemes, such as capital developments or asset purchases). These earmarked reserves regularly go up and down between years as projects are undertaken over a number of years.

289. The remainder, which are only a small proportion of the total, are general reserves which are held to meet unexpected challenges such as being able to cover immediate costs of storm or flood damage, as well as other risks and pressures. When the pandemic struck in March 2020, councils were able to react to the immediate financial problems caused by the pandemic by temporarily calling on their general reserves. This was before it was clear that central government funding would subsequently be made available.

290. Holding reserves enables councils to react to local incidents nimbly and effectively, but it would be unrealistic to expect councils to hold sufficient reserves to fund the costs of a local response to a national emergency of this scale, and would lock up a large amount of public resources.

291. The NAO report (linked above) states that £9.7 billion of council funding for the pandemic had been announced by the Government by December 2020; this is

equivalent to nearly a quarter of councils' net revenue expenditure (£42.4 billion) in the preceding financial year (2019/20); by contrast, councils' general reserves at the end of March 2020 were £3.5 billion and these were held to cover all unquantified risks and pressures.

Part 10 - Future Pandemic Planning

292. The LGA has recently undertaken an internally focused piece of work looking at how the organisation responds to emergencies, based on our work supporting councils in relation to the Grenfell Fire, Covid-19, Afghan and Ukraine refugee crises and many other issues councils or the LGA have had to respond to over more than a decade. The focus of this work was not local government more widely, but the LGA specifically and how it works to support councils, including how the organisation is able to pivot its activity and the challenges for staff / risk of burnout from successive emergencies.

293. In anticipation of the Covid Inquiry, the LGA has not undertaken an externally focused review of how councils responded to Covid, and do not collate information about reviews or other lessons learned approaches undertaken by individual councils.

Initiatives etc. by local government relating to changes to delivery

294. Annex A asks for a chronological list of any initiatives or actions involving, overseen or responded to by the LGA and/or other local government organisations concerning the making of changes to any of the entities, structures and processes relating to any of the issues in the Provisional Outline of Scope for Module 1 since March 2020.

295. In this section I shall summarise the information that the LGA is able to offer on this issue.

296. I can say generally that the LGA has played a key role in communicating key national messages to local authorities during emergencies, including Foot and Mouth

Disease outbreaks and other subsequent animal disease outbreaks, storms, floods, the 2009 swine flu pandemic and the severe weather.

297. The LGA is able to assemble and disseminate essential information and guidance to local authorities via its website and via our contacts with senior officers and councillors in all local authorities in England and Wales. During the swine flu pandemic the LGA reprioritised its work to support councils on the response, drawing on resources from across the LGA and implementing a set of regular briefings and tailored guidance for councils.

298. In September 2020, the LGA responded to the Government's integrated review of security, defence, development and foreign policy: Integrated review of security, defence, development and foreign policy: LGA response | Local Government Association (ML/22 - INQ000080814)

299. In September 2021, the LGA responded to the call for evidence on the Government's National Resilience Strategy, which incorporated a post implementation review of Civil Contingencies Act 2004: National resilience strategy call for evidence Local Government Association response - September 2021 (ML/6 - INQ000080817).

300. In December 2021, the LGA hosted two workshops, one with LGA officers and one with local councillors, with members of the team undertaking the National Preparedness Commission's independent inquiry into the Civil Contingencies Act, to provide input to the review.

301. Apart from this I must add that the LGA does not collate submissions made by individual councils to these or other reviews, so are not aware of whether member organisations have undertaken activity in this area.

Lessons already learned

302. Annex A also asks for details of the method, conclusions and recommendations of those reviews, lessons learned exercises, reports, initiatives or activities outlined

above. I have already indicated some of the important points concerning this in the references I have made to LGA submissions to the Civil Contingencies Act Post-Implementation Review 2022.

303. More generally I can say that as with any other LGA submission, these were informed by discussions with council officers and councillors (we held two councillor workshops in relation to the national resilience strategy call for evidence and independent review of the CCA 2004) and approved through the LGA's political structures.

304. As to the extent of response to any conclusions, and implementation of any such recommendations, I can say that the LGA has seen the recommendations of the independent review of the Civil Contingencies Act, and the post-implementation review of the same Act, but is currently awaiting publication of the National Resilience Strategy before providing further advice to our members on these issues.

305. In anticipation of consideration within the National Resilience Strategy of how to ensure greater democratic accountability in relation to emergency preparedness and resilience work, the LGA has recently commissioned a series of case studies of effective democratic engagement in local resilience work. The LGA anticipates that these will be available by early 2023.

Further reflections

306. Annex A also asks for reflections on the UK's preparedness and resilience to the Covid-19 pandemic, nationally and locally, and what changes, if any, should be made to relevant systems and processes in the future relating to any of the issues raised in the Provisional Outline of Scope for Module 1.

307. LRFs and public health teams locally have been preparing for an influenza pandemic for some years. These preparations were tested by the H1N1 'Swine flu' (2009) influenza pandemic. However, despite over 10 years of influenza pandemic planning, when COVID-19 hit the UK in January 2020, the evidence would suggest

that neither the Government, Public Health England, nor local government was ready or prepared to deal with COVID-19.

308. Planning focused too closely on influenza rather than diseases like SARS and MERS that had in recent years appeared in Asian countries. Previous exercises to test the national response capability, Exercises Cygnus and Winter Willow, did not address a disease with the characteristics of COVID-19. Nor it would seem did Alice have such a virulent virus in view. Nevertheless, some useful lessons were learned through the various exercises and applied in the handling of the pandemic.

309. The inquiry provides an opportunity to reflect on the lessons learned during this pandemic and explore how we can strengthen the public health system as a whole – local, regional and national levels must work coherently and should not be considered separately.

310. Councils have articulated the need for clearer, more coherent national guidance. The system within which the health protection function is delivered is complex. In some areas there is still uncertainty over roles and responsibilities, lack of clarity over funding arrangements and poor coordination between local and national levels of response. Having clearer lines of accountability for working across health protection practice - particularly in relation to emergency planning and response - with strong leadership roles for Local Health Resilience Partnership and DsPH.

311. Local councils encountered various challenges going into the pandemic. Key examples include workforce shortages within public health teams; and central government not engaging properly with councils regarding major elements of the overall response to Covid-19, most notably the national coronavirus testing strategy and the roll-out of NHS Test and Trace.

312. A further concern raised with us is the shrinking capacity in local government to provide additional, timely support during outbreaks. While formal emergency planning structures were well established before the Covid-19 pandemic and went into action promptly, the broader circumstances of funding reductions over the past decade impacted the resources that directors of public health (DsPH) could draw on when the

pandemic hit. DsPH mitigated this by using the relationships they had built across their local councils to draw on staff from other departments to support the local response to Covid-19.

313. Decision making in public health, from routine responses to acute public health threats and long-term planning of interventions to improve the public's health, is increasingly reliant on the efficient use of data.

314. Increased data harmonisation, timely access across organisations, a code of conduct for data producers and data users and an acceptance that LAs are safe havens for personally identifiable data. We need a collaborative culture of openness, transparency and shared objectives at a system level, for the protection of the public's health. As well as ensuring effective sharing and linking of data, to inform health protection action.

315. To ensure we can respond to current and future pandemics a full preparedness and surveillance system both nationally and internationally is required to ensure preparation for more emerging and novel infections. For future outbreaks, a national, regional and local partnership of all key sectors, playing to their strengths and operating as a virtual team of teams, is needed.

316. Any consideration of the Public Health system's response and readiness for future pandemics needs to be scoped and conducted as a whole system with both national and local partners as is the need for the routine sharing of best practice approaches, curation of information, and learning from colleagues in other organisations. There needs to be strong system-level governance arrangements, particularly in relation to emerging systems such as the Test and Trace Service.

317. UKHSA needs to be able to think, mobilise and act nationally (labs, research, highly technical skills, systems capability) to respond as a global player to major threats to health. This needs to be aligned to 'boots on the ground delivery' so when there is a major health protection threat it is able to tap into the local delivery capability in councils' functions in relation to public health, environmental health, emergency planning, communication and engagement, contact centres etc. In addition, there is a need to strengthen links between formal health protection services and public and

voluntary sector organisations working with high risk or vulnerable groups, e.g., homelessness services and drug and alcohol services.

318. To further enable local government to meet their duties a full review of public health law including ongoing powers for local councils and their directors of public health is needed to ensure councils have the right powers to exercise in an emergency.

Future plans for resourcing and prioritising the UK's pandemic readiness at a local government level.

319. Annex A also asks about future plans. However, it must be borne in mind that the LGA is a membership and representative body for English local authorities and does not have powers or control over how councils use their resources or choose to prioritise their work.

320. The LGA provides advice and support to councils on a range of different issues. This may be in the form of information and analysis, guidance documents, sharing good practice, online and in person training courses and peer reviews. In some cases, we directly provide or commission corporate improvement capacity or specific expertise to councils where this is required.

321. The issues on which it provides support and advice are identified in different ways including through our membership highlighting an issue that is high priority and may require support; through the LGA identifying a new or emerging issue on which councils would benefit from advice and support, or where the Government identifies that it would like the LGA to focus on a specific issue. The Government may request the LGA to undertake work on specific areas as part of the LGA's sector led support activity, which is funded by a grant from DLUHC to the LGA; or through other grant-funded activities commissioned by other government departments such as DHSC.

322. The COVID-19 pandemic and emergency response is an example of an issue that was identified as a high priority by the LGA, our members and the Government. For a considerable period following the start of the pandemic in the UK in early 2020,

the LGA's policy and improvement support was tailored almost exclusively to supporting councils and working with the Government on Covid issues.

323. Prior to Covid, in the two years immediately preceding the start of the pandemic, the LGA had developed guidance documents and a member training programme on resilience to help improve awareness and understanding of this area of work. Although there was some interest and involvement in this work by RED, there was no direction by DLUHC generally for the LGA to undertake more resilience focused work as part of our support offer.

324. As a matter of course, the LGA will work with its membership to consider and respond to the findings of the Covid Inquiry as and when these are available; as we will for the Manchester Arena Inquiry and Grenfell Tower Inquiry. Sitting alongside this, we expect to work with councils to consider the outcome of the National Resilience Strategy and whether there are changes or other activities that the LGA should support councils and their resilience partners in implementing.

325. There remains an option for the Government to consider specifically requesting or commissioning the LGA to undertake more extensive resilience work as part of the existing sector led support offer, or through a separate, dedicated programme of activity (for example a peer review programme or pilot programme). The LGA has previously indicated to the Government that it may be able to host a funded programme of LRF focused peer reviews as part of our broader support offer.

I, Mark Lloyd, declare that the contents of this my statement are true and accurate to the best of my knowledge and belief,

Signed:

Personal Data

Dated:

19 April 2023

Appendix A – Combined Authorities:

Formal role in civil contingencies

1. Combined authorities are not C1Rs under the Civil Contingencies Act, and therefore do not have a formal role in preparing for (or responding to) emergencies. Combined authorities do not have the operational levers, or deliver the operational services, that have historically led to an agency being designated a C1R. Instead, their remits typically focus on policy and strategy work in such as skills, economic growth and transport. Greater Manchester also has additional powers in health and the Deputy Mayor is also the Police, Fire and Crime Commissioner; the Mayor of West Yorkshire is also Police and Crime Commissioner.

2. Until recently, no devolution deal had referenced civil resilience matters, but the recently released Greater Manchester Combined Authority trailblazer deeper devolution deal (ML/23 - INQ000148452) commits to further work on this area (see paragraph 12).

3. However, with combined authority mayors seen as highly visible leaders of local places where they are in place, it is understandable that there should be some form of role for them, and the combined authorities supporting them, in dealing with emergencies. It seems likely that this role is still evolving as combined authority structures mature, and it is possible that the role of some combined authorities may now be different to pre-Covid (again, as outlined in paragraph 12 this may continue to develop further).

Involvement in preparedness work

4. Feedback to the LGA suggests that the extent to which combined authorities were involved in emergency preparedness work pre-Covid varied from place to place. In some areas, the combined authority was an active member of the relevant LRF; in other areas, the combined authority was a member but with very limited involvement and no engagement in preparedness activities, while in others, the combined authority was not a member of the LRF and was not involved in emergency preparedness work at all. The LGA's overall general understanding is that most combined authorities had more limited engagement in emergency preparedness work than were closely involved.

5. A factor influencing this may be the extent to which a combined authority's footprint aligns with the LRF footprint. While in some areas (typically metropolitan areas), the combined authority and LRF boundaries are the same, or largely the same, in other areas they are not, and may be substantially different, for example only covering half of an LRF area (for example, the West of England Combined Authority covers the Bristol, South Gloucestershire and Bath and North East Somerset council areas, while the Avon and Somerset LRF covers these councils and two additional authorities in North Somerset and Somerset).

6. Feedback to the LGA indicates that some combined authorities have regular engagement with their LRF on preparedness, response and recovery issues relating to their key areas of responsibility, typically transport (as local transport authorities) and the economy. This engagement included participating or leading relevant LRF sub-groups. This reflected wider feedback (including from areas where the combined authority is not part of the LRF) that combined authority engagement in civil contingencies work relates to transport and the economy, and particularly economic recovery work. Anecdotally, we heard that combined authorities were more involved in EU Exit preparedness work given the potential economic implications of this, in contrast to there being little or no engagement on pandemic planning issues.

7. The LGA has also heard instances of combined authority structures involving senior council officers and leaders being used for informal discussions and consultation during the response to Covid, to share best practice, share information, agree and escalate matters, although no formal decision making took place in these forums.

8. More specifically the LGA would wish to highlight the position of Greater Manchester Combined Authority (GMCA), as for several years it has been linked into resilience structures in a way that is unique among combined authorities. There are a number of contributory reasons why this is the case including:

    - First, there has been a firm foundation for joint working on the combined authority footprint. The establishment of the Association of Greater Manchester Authorities in 1986 led to joint work between the ten GM councils a range of different issues, including the creation of a shared Civil Contingencies service in 2010 (the Greater Manchester Resilience Unit). Additionally, the combined authority and LRF boundaries are aligned;

- Secondly, the Manchester Arena attack occurred early in the tenure of the Mayor, prompting early consideration of his role and that of the combined authority in resilience matters. Guidance on the role of the Mayor in civil emergencies was subsequently developed, drawing on the experience of similar structures in London;

  and

- Thirdly, Greater Manchester joined the 100 Resilience Cities Network in 2017, leading to the creation of a Chief Resilience Officer post hosted by GMCA with a remit for place-based resilience. While this role is broader than emergency preparedness, GMCA's ten year resilience strategy recognises the importance of emergency preparedness, among other things. The CRO post oversees the Greater Manchester Resilience Unit.

9. GMCA continues to host the Chief Resilience Officer post, which currently remains the only post funded by GMCA to work on resilience. However, the full GM Resilience Unit will shortly move so that it is also hosted by the GMCA alongside the CRO (although the Unit will continue to be funded by the constituent authorities, who will retain their statutory responsibilities). GMCA also employs a number of staff working in support of GMLRF, funded through grants given to the LRF (and others) following the end of the pandemic.

Combined authorities involvement in the Covid-19 response

10. As noted above, the LGA understands combined authorities to have been more consistently involved in the emergency response to Covid than they were involved in preparedness activities ahead of it, with a focus on coordinating or supporting work on transport, the economy and business communications, as areas of work closely aligned with most combined authorities' key responsibilities.

Future role of combined authorities

11. Further the Government has indicated its view that combined authorities should in future have a role in resilience. The Levelling Up White Paper (ML/24 - INQ000148453) section on keeping the public safe and healthy noted that Government -

'…will ensure that all combined authorities have a clear role for them in local resilience, as part of the work on resilience that was committed to in the Integrated Review.'

12. Subsequently, the UK Government Resilience Framework, published in December 2022 (ML/25 - INQ000148454), set out an ambition for the 'integration of resilience into levelling up and growth mission/wider local policy and place making' with options such as resilience being included as key aspects of devolution deals and considering making the case for Combined Authorities and Mayoral Combined Authorities to become C1Rs under the Civil Contingencies Act. The Greater Manchester Combined Authority Trailblazer deeper devolution deal is the first example of this (ML/23 INQ000148452).