Module 2 of the COVID-19 Inquiry

Second Witness Statement of Mark Lloyd, CBE

Chief Executive of the Local Government Association

17 March 2023

IN THE MATTER OF MODULE 2 OF
THE UK COVID-19 PUBLIC INQUIRY ("the Inquiry")
REQUEST FOR EVIDENCE PURSUANT TO RULE 9 OF THE
INQUIRY RULES 2006
REFERENCE FOR REQUEST - M2/R9/LGA/01

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

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I, **Mark Lloyd**, say as follows –

Introduction

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 in relation to Module 2 of the Covid-19 Inquiry (the Inquiry).

2. I have already provided two witness statements in relation to Module 1 of the Inquiry, but this is my second statement in relation to Module 2 in which I understand that the Inquiry will consider and make recommendations about the UK's core political and administrative decision-making between early January 2020 and February 2022.

3. My first witness statement in relation to this Module, which made the key point at paragraph 33 that the LGA considers that -

> *"The rules for data sharing in an equivalent crisis require review."*

4. I shall provide further information relating to the concerns of the LGA on this point. This my second witness statement should thus be read as supplementing my first witness statement in this Module. My evidence goes to the management of data as between local and central government at the early stages of the pandemic, particularly in 2020.

The role of local authorities

5. As noted in my first witness statement, throughout the period from January 2020 to the summer of 2022, local authorities were the first port of call for the most vulnerable people or those otherwise in need of support or assurance. This meant that following lockdown, in March 2020, it became particularly important for councils to have access to data particularly in relation to three topics, on:

1) those who were shielding (clinically extremely vulnerable data);

2) those who had tested positive/were quarantining (COVID-19 cases data); and
3) those who were vaccinated (vaccination data),

both in order to support people (to identify those who might need help whilst shielding or quarantining with access to food, medicines or who might have caring responsibilities they cannot undertake; or who have other needs); but also to undertake their statutory duties within the health system (such as controlling outbreaks, providing assurance of immunisation programmes and also addressing health inequalities by improving access for under-served groups).

6. Whilst I do not suggest that no data was shared between central and local government to support councils' responses, there are some key points that the LGA wishes to make concerning the way data-sharing with local authorities in response to the COVID-19 pandemic, was carried out and the problems that occurred. I believe that what I shall say below illustrates the issues which arose during the Module 1 period and therefore enables lessons to be learnt for any future similar pandemic crisis. In fact, I consider that this evidence will have relevance beyond just pandemics, but to the general approach to the relationship between local and central government during a civil contingency in which issues of social welfare and social care might arise.

Clinically Extremely Vulnerable people (CEV) data

7. During the Module 2 period there were ongoing issues with the data provided to local councils, to enable them to be aware of the CEV cohort in their areas. Without this information it was extremely difficult for them to be able to provide the necessary support to CEVs pursuant to their obligations under the Care Act 2014 or more generally. In the following paragraphs under this heading I shall outline the nature of these issues.

8. A first issue was that CEV data was not always provided in a timely way, with councils reporting delays, in particular, in receiving the original list of shielding people. On 25 March, even though people had already been sent letters requesting they shield, councils were raising concerns that they had not yet received details of who in their area was shielding.

9. Later, during April 2020, there were also delays. Councils were repeatedly asking for the outbound call data, or at least clarity on when they would get it and likely volumes, in

shielding stakeholder engagement forum meetings with the Ministry for Housing, Communities and Local Government (MHCLG). And there were problems caused by the single, late, large package of additional CEV data, which was given to councils without warning, at the end of April. This added significantly to the scale of the data cleansing and preparation that had to be undertaken by councils before they could use it.

10. Another issue was that the data provided by central government on CEV persons sometimes changed format between versions sent to authorities, resulting in a significant amount of already over-stretched local resource having to be devoted to manual cleansing of the data before it could be used by councils.

11. In a meeting on 15 July 2020 of the local authorities which formed part of the 'Shielding Data Accounts-based System Working Group', it was noted that one of the key improvements which were needed to data included –

> *'Avoiding changes to the data format and codes once launched. Any changes should follow due process and give local authorities two weeks to prepare for them.'*

12. Poor addressing information on some CEV data made contacting people to support them very difficult. For instance, one authority calculated that 14 per cent of the data it received from the shielded list was incorrect. Another example is a case in which a shielding person's details were sent to a council with no address other than a postcode, and the council had to knock on their residents' doors to find this person.

13. There was no unique property reference number (UPRN), or other unique personal identifier, on the multiple CEV data sources. Had there been, this would have considerably helped authorities to combine the different data and identify duplicates; it would also have dealt with the poor addressing quality. The LGA first raised the issue with government in mid-April 2020, and regularly thereafter. Despite a mandate from the Open Standards Board, via Government Digital Service (GDS), for central government to use UPRNs in all new systems with addressing, this remained an issue throughout the pandemic (with test and trace data also missing UPRNs at the outset). The scale of the problem is illustrated by the fact that one council reported a duplicate individual appearing some 30 times in their data. And, in May 2020, a council reflected to GeoPlace that –

"Having UPRNs on the data coming in would have eliminated the hundreds of hours our team has spent matching 28,000 records (so far). It would have accelerated the process of using address data in an accurate and meaningful way. And, if the UPRN had been included, we could have picked up any anomalies at an earlier stage rather than trying to resolve them later."

14. In June 2020, the head of the shielding service, Chris Townsend, attended shielding stakeholder engagement forum meeting, and acknowledged how difficult the data issues had been, and how government had not always appreciated what that looked like at the local level.

15. In October 2020, it was reported during a webinar that North Yorkshire County Council shared with iStandUK that –

"the differing formats, standards and categories of personal information held with…partners and the lack of key unique personal identifiers (meant that) the data matching process could not be fully automated and manual resources and a second pair of eyes were required to check the accuracy and completeness of comparable information."

16. There was a further and additional data burden, when authorities were trying to support people, of being requested to report to central government via a range of different collections. Councillor Ian Hudspeth noted to the Public Administration and Constitutional Affairs Select Committee on Data and Transparency that, while we understand some feedback to central government is necessary, many requests had not been proportionate or coordinated, with the Infection Control Fund being one good example. It sometimes felt there was little real consideration of burden.

COVID-19 Cases/Test and Trace data

17. There were significant issues with COVID-19 cases/test and trace data. In the following paragraphs I have set out some notable examples of this.

18. First, at the outset, central government thought there was neither a legal basis nor a need to notify local authority Directors of Public Health (DPH) of individual cases of infection within their areas. This was both wrong in law and a very significant administrative mistake.

The LGA believes that there was a general reluctance to routinely share data with local councils, and notes that valuable time and effort was expended by local Directors of Public Health in trying to access data that would enable them to respond better, and which should have been shared with them as a matter of course.

19. I and others have noted that local authorities' DPH have long and regular experience of testing and tracing when there are local contagious disease outbreaks. That experience was there to be used again but required data. Yet there seems to have been a serious misunderstanding of the role that local authorities had and could play. For instance, one official of Public Health England said to the LGA:

> *"The example I use is my husband, who tested positive. Why does the LA or the DPH need to know? Why would you need to know the mobile phone number of his contacts?"*

20. In early April, data on cases within care homes was available nationally but not shared locally, which hampered the effort to tackle outbreaks. Vic Rayner, executive director of the National Care Forum, which represents more than 120 not-for-profit care organisations, said

> *"The consequences of not having that data are huge. It has affected our ability to plan, prioritise, identify early outbreaks and bring in the right level of medical and health expertise."*

21. DPH noted that data and intelligence sharing from Public Health England (PHE) to local authorities worked better when existing systems and processes were used, but where new arrangements had been established (for example, with testing and contact tracing) data flows were more problematic. Because they had limited and unreliable access to data, DPH often relied on relationships with local organisations like care homes and businesses, as well as PHE and local NHS colleagues to get hold of information. In the case of care home testing, some DPH established lines of communication with the care homes to obtain results direct from them, rather than receiving them from PHE. This was both resource intensive and time-consuming – and sometimes introduced error – but it gave councils at least some of the information they needed.

22. There was a lack of any individual level data on COVID-19 cases being made available to DPH for some time, making it impossible to support those affected and to control outbreaks.

The LGA published a media release on 10 May calling for this data to be made available. The Kings Fund also reported in September 2021, that DPH in England described difficulties in accessing the data they needed to trace contacts.

23. When individual level data was finally made available, there were some issues with data quality. For instance Councillor Georgia Gould, Leader of Camden Borough Council and Chair of London Councils, said

> *"We were getting [test and trace] data with lots of gaps. Often key information is not filled in, and it is difficult to integrate it with our existing systems. That is a real challenge when we are trying to do our own tracing."*

24. A further problem was that access to data was initially restricted to the local authority's DPH, despite the fact they were not the data analysts. Councillor Ian Hudspeth has noted that individual-level positive cases data was made available to DPH in late June for outbreak management. But when data did start to flow, access was hampered by multiple data sharing agreements and restricted access protocols. Data disclosure rules meant COVID-19 cases data could not be shared with others in the council, even to offer support.

25. DPH noted the testing infrastructure which was created did not acknowledge or deliver the type of information needed locally. The early test and trace data had no unique identifier, ethnicity, postcode, occupation or information on work address or care home address, despite the fact this would be needed for outbreak control; and only positive results were being shared, not negative, making it impossible to tell the positivity rate. The LGA formally requested access to this data on councils' behalf on 29 July 2020.

26. Even by November 2020, when test and trace data had been available at individual level to councils for several months, Councillor Ian Hudspeth noted that key pieces of data, such as missing or incomplete workplace, alternative addresses and lack of unique identifiers, continued to be an issue.

27. Access to COVID-19 cases data, when it came, was fragmented across multiple platforms with different rules, logins, access rights etc. For instance, Duncan Selbie, Chief Executive of Public Health England at that time, wrote to authorities on 10 July 2020, to help DPH and their teams with a list of the data sources for test and trace that were currently available to both the local authorities and the public. There were 14 different sources at that point in time.

28. A focus on dashboards by central government, or perhaps an unwillingness to trust authorities to hold the data securely, meant that data shared with authorities often needed to be viewed through dashboards or portals. This limited how local authorities could use the data (as many of the dashboards would not allow downloading of the data), for example, they could not map it alongside other data to get a deeper understanding of COVID-19 cases in their area. The LGA formally requested access to downloadable data for authorities (rather than being limited to viewing it in a dashboard) on 29 July 2020.

Vaccination data

29. There was lack of access to any data on vaccination numbers and rates at the outset, despite the statutory role of DPH to assure vaccination programmes and their obvious role in encouraging people to be vaccinated and targeting groups of people with low rates of vaccination.

30. In the following paragraphs I have set out the issues with vaccination data during this early period in the pandemic.

31. On 12 January 2021, the LGA brought together a group of DPH to articulate better the vaccination data they needed, since the vaccination programme had started over a month earlier (on 8 December) and authorities still had no vaccinations data at all. This was despite their statutory role to assure immunisation programmes and provide appropriate challenge to arrangements and also to advocate for reducing health inequalities and improving access for under-served groups.

32. Access to individual-level data was never provided, despite the fact that authorities requested it, for example, to link to their 'Clinically Extremely Vulnerable' residents to gain understanding of whether they were being reached or whether support was needed.

33. The Kings Fund reported, in their report of September 2021, DPH's frustrations concerning the lack of data sharing locally by NHS England and nationally by the Department of Health and Social Care and not being able to have further influence on vaccine equity locally as a result.

34. Access to aggregated vaccination data, when it came, was fragmented across multiple platforms with different rules, logins, access rights etc. Because of the multitude of platforms and access rights, the LGA developed a guide for DPH and their teams to identify them all in one place and describe the data they held. There were eight data sources.

35. Sir David Norgrove, Chair of the UK Statistics Authority, commented that the disparate bodies involved in the provision of health are, in terms of statistical output, too often inchoate. For example, both the NHS and [formerly] Public Health England produce statistics on vaccinations that are published separately.

36. As with COVID-19 Cases/Test and Trace data, councils noted the vaccination data infrastructure which was created did not acknowledge or deliver the type of information needed locally. There was a missed opportunity to identify people being vaccinated who were care staff at the point of their vaccination. This placed an additional burden on care providers (and councils), as they were asked to monitor and report the vaccination status of their staff (which was a requirement under the Infection Control Fund). The LGA and care providers requested this addition to the system at several meetings with government officials but, despite repeated promises by NHS England that point of care data collection would happen, it never materialised.

Concluding points

37. Local authorities feel it is highly likely that initial delays in providing them with granular data meant that the pandemic response was not as effective as it might have been. The issue is not simply about sharing data, but about doing so quickly and with quality data.

38. Our recommendations for the future are therefore as follows -

1) The Department of Health and Social Care should undertake a review of the wider health system in England, including public health and adult social care. Many of the delays in sharing data stemmed from a lack of understanding about the role of the DPH, and the wider role of the local authority in supporting vulnerable people. This role needs to be fully recognised and valued as an integral component of the integrated care systems and the national response to a health crisis. The output of this review should be shared widely across the whole of government, to

influence crisis planning in all departments, and ensure they factor in the role of councils when it comes to data sharing in any future emergency.

2) The Department of Health and Social Care, with support from the UK Health Security Agency (UKHSA), should undertake an urgent review of health data systems in England. The review should include consideration of the role of the Department of Health and Social Care in bringing together health data which is needed in a crisis from across the different health bodies; and identify the data that, in any future pandemic, will be needed by local authorities such as:

    - Individual-level data on vulnerable individuals who may need support,
    - Individual-level data for cases and test and trace, and
    - Data to monitor who is and is not vaccinated, so that councils can use this with their plans to support communities where vaccine uptake is low.

3) Other necessary improvements to data systems recommended by the LGA are:
    - All individual-level health data should include a UPRN as part of the core addressing information, to aid with data cleaning, accurate location and insight. While there is now a mandate that all new systems include a UPRN with address information, we should be adding it to existing systems, particularly health systems, as that is so important.
    - Vaccination data systems in future should be developed to interface with GP records. This will ensure that regardless of the setting in which a person is vaccinated, their vaccination status will be accurately reflected on their GP record.
    - In the meantime, local authorities should urgently be provided with a regular feed of the rolling immunisation data for each council area to ensure efficiency, equity and effectiveness of the programme for local residents. This data is not currently accessible to them, even now.

4) The need for data sharing agreements often delayed delivery of individual-level data to local authorities during the pandemic, so Government should be better prepared for data sharing with local authorities during future emergencies. This could be through a new objective in the Digital Economy Act 2017 to enable data sharing in accordance with emergency preparedness, or through a pre-agreed data sharing framework like the Wales Accord on Sharing Personal Information (WASPI) in Wales.

39. The LGA invites the Inquiry to consider these points and to adopt them in its conclusions and recommendations. It is quite clear that, as central government bodies within the UK gather more and more data about UK residents, it will be greatly facilitated by a specific data sharing plan for any future pandemic or similar emergency. Indeed, a clear data sharing plan for any civil contingency should be an absolute requirement. Central government's role is to set the course through such emergencies, but local government has significant responsibilities for service delivery. Good data sharing during such times is essential.

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 **… 26 May 2023 ...**