Witness Name: Joanna Killian

Statement No.: 3

Exhibits: 60

Dated: 29 April 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF JOANNA KILLIAN

ON BEHALF OF THE LOCAL GOVERNMENT ASSOCIATION

Table of Contents

I, Joanna Killian, will say as follows: -

INTRODUCTION

1. I am the Chief Executive of the Local Government Association ("**LGA**") of 18 Smith Square, London, SW1P 3HZ. I am authorised by the LGA to make this statement on its behalf in response to the Rule 9 Request for evidence dated 20 August 2024 issued under Rule 9 of the Inquiry Rules 2006 in relation to Module 7 concerning Test, Trace and Isolate ("**TTI**").

2. The LGA has previously made statements in Modules 1, 2, 4 and 5 of the Inquiry. I provided statements on behalf of the LGA in Modules 4 and 5. On 31 May 2024, the LGA was designated as a Core Participant for Module 7.

3. This statement responds to the Inquiry's request for evidence provided to the LGA on 20 August 2024 under Rule 9 of the Inquiry Rules 2006.

4. My statement is structured as follows:

    a. Part 1: Overview of the legislative framework relevant to TTI;

    b. Part 2: Local government infrastructure, capacity and expertise (including discussion of contact tracing, data sharing, self-isolation and support payments);

    c. Part 3: Local government's involvement in and contribution to TTI (including discussion of its engagement with national government, testing, compliance and enforcement, the Contain Outbreak Management Fund, local examples and an assessment of the robustness and efficacy of the Test and Trace Programme);

    d. Part 4: The LGA's involvement in and contribution to TTI (including discussion of the LGA's key figures involved in TTI, its involvement with working groups, engagement with national government and local authorities and its communications role);

    e. Part 5: Impact on deprived communities; and

    f. Part 6: Recommendations.

5. Appendix One includes a glossary of acronyms used.

(A) My background

6. I have over 30 years of experience in the public sector, with extensive experience of local government, including two periods as a chief executive, from 2006 to 2015, at Essex County Council, and between 2018 and the beginning of 2024, at Surrey County Council.

7. Between those periods, I was a Partner and Head of Local Government at KPMG leading its advisory practice across local government and the wider public sector. I have also held the position of Chair of the Association of County Chief Executives.

(B) The basis of my evidence

8. My time as Chief Executive of the LGA commenced on 18 March 2024 and therefore after the period of concern in Module 7.

9. I was not directly involved in the LGA's discussions with the Government during the relevant period for this Module and therefore do not have first-hand contemporaneous knowledge of work that was done by the LGA's officers. So, in making this statement I rely on information provided to me by the LGA officers involved in its work over this period.

10. My statement must therefore be read as representing the collective understanding and knowledge of the LGA in relation to the period January 2020 to February 2022. The LGA's officers are highly professional, and it is my belief that they have again diligently and fairly reported to me the relevant information that I set out below.

(C) About the LGA

11. The LGA is the collective voice of local government in England and supports the collective voice of local government in Wales to be equally heard.

12. 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.

13. The full membership of the LGA in England and Wales now comprises —

    a. All but two of the 333 principal councils in England (i.e., all but London Borough of Bromley and Leicestershire County Council); and

b. 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.[1]

14. The LGA also has 31 fire and rescue authorities; Police, Fire and Crime Commissioners from Cumbria, Essex, Northamptonshire, and Staffordshire; and national parks authorities, as associate members. The National Association of Local Councils, which is the membership body for town and parish councils, is a corporate member of the LGA.

15. 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.

16. 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.

17. 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.

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

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

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

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

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

19. A key function of the LGA has always been to act as a conduit between central and local

[1] In contrast to the WLGA, neither the Convention of Scottish Local Authorities nor the Northern Ireland Local Government Association are members of the LGA.

government, providing and distilling information from councils into government and vice versa. This role assumed even greater importance during the Covid-19 pandemic.

(D) Overview of the LGA's role in the pandemic

20. The LGA does fully recognise that the period covered by Module 7 was as challenging a period for good governance at all levels as any since 1945. The LGA recognises that it was a crisis period in which decisions had to be made quickly and communicated well, but it was also a period in which civil society at all levels, including local government, stepped up with a determined aim to make a positive contribution. The goodwill, experience and expertise of local government was there to be harnessed to the task of overcoming the Covid-19 virus from the very start.

21. Alongside its public facing work such as bulletins, Parliamentary briefings, and press releases, during the pandemic the LGA also communicated its members' and officers' views and insight to central government's political and administrative decision makers. Some of this occurred through formal scheduled meetings with agendas and minutes, but there were also many short notice informal meetings and discussions, at both the political and officer level, between organisations working at pace on a range of different issues (see, for example, **Exhibit JK3/01a -** INQ000575944, email chain dated 19 April 2020 between LGA, Public Health England ("**PHE**") and the Association of Directors of Public Health ("**ADPH**") re contact tracing; **Exhibit JK3/01b -** INQ000115017 email dated 22 April 2020 from PHE to ADPH, LGA and councils re pathway and delivery model and **Exhibit JK3/01c -** INQ000115018 the attached PowerPoint slides on "Testing and contact tracing"; **Exhibit JK3/01d -** INQ000575919 email dated 3 May 2020 from Tameside Council's Director of Public Health to ADPH and LGA attaching agenda for contract tracing programme board meeting (**Exhibit JK3/01e -** INQ000575910 and graphic of contact tracing model (**Exhibit JK3/01f -** INQ000575911).

22. During the pandemic, the LGA had to engage regularly with Government to share concerns about impacts on the ground, to communicate the challenges for councils, and so to help the Government ensure its policies and approaches were understandable, practical, and thus made sense to local government and its local partner organisations. Consistent concerns were raised by councils with the LGA from an operational perspective about the steps government took in terms of the timeliness of decision making and communication to councils, funding and workforce issues.

23. Engagement included discussions between the LGA and Government representatives,

and forums at meetings involving Government representatives, the LGA and council representatives, at both officer and political level. These included representatives from Department of Health and Social Care ("**DHSC**"), **PHE**, NHS England ("**NHS**") and the Ministry for Housing, Communities and Local Government ("**MHCLG**").

24. At no stage during this period did the LGA seek to influence the Government's science-led approach to making decisions about matters such as whether to impose lockdowns, use of vaccines, social distancing requirements, or other restrictions. The LGA always recognised that this would have been inappropriate since it did not have access to the scientific evidence and expertise which was informing the Government's decisions. Instead, the LGA's focus was on the implications that these decisions would have for communities and local councils, and on what policy decisions local government would need to make to work effectively at the local level.

25. Throughout the period from January 2020 to the summer of 2022, councils were the first port of call for the public, businesses and local agencies simply because they are uniquely placed at the heart of their communities and so closely involved in public service delivery. They were therefore at the very heart of this crisis, and in this role, councils demonstrated flexibility, innovation, resilience, and responsiveness. Most of all, they demonstrated their ability to respond to emergencies irrespective of scale.

26. Councils were able to devise solutions that were effective 'on the ground', precisely because they knew best how things could be made work in their communities. Many aspects of the response that were dictated from central government — from shielding, to test and trace, and volunteering schemes — demonstrated the problems in trying to design, control and manage from the centre, activities that required local responses to widely differing community-based challenges. The local voice, knowledge and links to reach and support people from diverse and disadvantaged backgrounds added huge value. Significant work was needed to understand the end-to-end journey of a person using the Test and Trace Service, the various behavioural responses and how barriers can be removed to make the process simple.

27. For example, one barrier to testing and self-isolation was being unable to take time away from work due to financial insecurity. This was of particular concern to those who are self-employed, on zero-hours contracts or in precarious employment. The number of generations in a household, number of occupants, ethnicity and deprivation status also impacted on the increased risk of Covid-19 transmission.

28. Remote command and control from the Westminster will never work by itself because it

will always lack the knowledge that local councils have about their areas. There ought to be a partnership from the outset between central and local government, in which each side is willing to appreciate the special knowledge and abilities of the other.

29. Local government's immediate response during the pandemic was decisive. Thus, within days and weeks, local authorities redesigned and reprioritised essential local services, suspending some services and introducing new operating models, working remotely and volunteering overnight, , to change the roles of thousands of workers temporarily to contribute to the emergency effort. Collaboration and mutual aid were key features of the public service response.

30. 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 councils and their directors of public health ("**DsPH**") could draw on when the pandemic hit. Councils mitigated this by using the relationships they had built across their councils to draw on staff from other departments to support the local response to Covid-19.

31. The UK entered the pandemic on the back foot – most notably underfunding of public health and wider cuts to public services. Councils' ability to respond to emergencies extends far beyond emergency planning structures, however, and key services had also seen funding reductions and challenges in the decade before Covid-19. There was a real-terms £700 million cut to public health funding in England between 2015 and 2020, with greater cuts in more deprived areas. Between 2010 and 2020, there was a reduction to core government funding to councils in England. Local government's planned core funding and overall spending power fell by 26%. Cuts of this level inevitably impacted councils' capacity to plan, prepare, resource and respond to an emergency, and their overall organisational resilience.

32. Throughout the pandemic there was a difference in culture between local partners and some parts of national Government. There was a tendency towards big announcements from central Government (such as on mass testing) which were made prior to conducting meaningful dialogue both as to the merits and practicalities of implementation, and as to how local government could contribute to outcomes that were desired. The lack of understanding about the skills, knowledge and experience that exist in local councils too often resulted in that input being overlooked or undervalued. Had there been better engagement, particularly in the first half of 2020, the LGA considers that there would have been a more effective response and better outcomes.

33. Councils must be able to influence decisions and codesign how the system will work at the national as well as local level. Ensuring local government is properly involved and consulted at an early stage is key to the success of local implementation on the ground. Clear communication and alignment with existing arrangements will be important for local areas to be able to use and build on what is already happening to avoid duplication by creating new structures.

34. The LGA does recognise that, over time, meaningful engagement did improve. Regular meetings took place at officer level with the nine regional representatives of local government ("**R9**"), convened via MHCLG. In early May 2020, ministers appointed Leeds City Council Chief Executive, Tom Riordan, to work on the NHS Test and Trace programme and to help to ensure the central teams worked closely with local councils. He was followed in this role by Dr Carolyn Wilkins, Chief Executive of Oldham Council. Both worked extremely closely with the LGA during their periods in the role.

35. Local government is committed to making decisions at the most local level, as close as possible to the communities that they affect. The LGA will continue to advocate for greater subsidiarity: what can be done locally should be done locally, what must be done nationally should be done nationally. This means a locally-led public health system where place is central to decision making as well as delivery; where elected members, officers and DsPH can use their system leadership role to bring partnerships together to improve and protect health using research, evidence, intelligence and a close knowledge of their populations. DsPH and local authoritiess already successfully collaborate to deliver on the most appropriate footprint.

36. The LGA's views on subsidiarity are demonstrated throughout my statement.

PART 1: OVERVIEW OF THE LEGISLATIVE FRAMEWORK RELEVANT TO TEST, TRACE AND ISOLATE

37. In Part 1 of my statement, I set out the legislative and governmental structural framework that informed the TTI response, development and implementation during the pandemic.

38. In England, public health services are commissioned either through local government or through the NHS. The Secretary of State for Health and Care has the overarching duty to protect the health of the population, a duty which is discharged for them by the UK Health Security Agency ("**UKHSA**"). Between 2013 and 2021 it was the responsibility of PHE.

39. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, delegate to local authorities the critical role of providing information and advice to relevant organisations (including UKHSA) so as to ensure all parties discharge their roles effectively for the protection of the local population.

40. Over and above their existing responsibilities as Category 1 responders under the Civil Contingencies Act, under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations, upper tier and unitary local authorities are required to take certain steps to protect the health of their local population. In particular, they are required to provide information and advice with a view to promote the preparation of health protection arrangements by key health and care partners within the local area.

41. The duty to report notifiable diseases and contain them is outlined in the Public Health (Control of Disease) Act 1984 and the Health Protection (Notification) Regulations 2010 as amended by the Health and Social Care Act 2008.

42. The use of confidential patient information for the purposes of diagnosing, recognising trends, controlling and preventing, and monitoring and managing communicable diseases and other risks to public health, is known as a "section 251 approval" and includes, for example, using test results if you test positive to start the contact-tracing process. The part of the law that applies here is section 251 of the National Health Service Act 2006 and Regulation 3 of the associated Health Service (Control of Patient Information) Regulations 2002.

43. Other legislation of relevance, such as the Health and Safety at Work Act 1974 and the Food Safety Act 1990 and associated regulations, also enables local authorities to make the necessary interventions to protect health.

PART 2: LOCAL GOVERNMENT INFRASTRUCTURE, CAPACITY AND EXPERTISE

44. In Part 2 of my statement, I explain the existing infrastructure, capacity and expertise for TTI that existed within local government prior to the onset of the pandemic. To understand how this landscape developed during the course of the pandemic, it is necessary to understand how the national government did or did not utilise local government's existing infrastructure, capacity and expertise.

45. Therefore, Part 2 contains an account of local government capability, as well as

addressing some of the difficulties that local government faced during the pandemic. Local authorities and the LGA's involvement in implementing and developing TTI measures is expanded on further in Parts 3 and 4 (to the extent that it is not covered in Part 2).

46. I note that civil contingencies structures, including local resilience forums, did not play a role in the context of TTI. Further, the LGA was not involved in, and does not have knowledge of, the pre-existing infrastructure and capacity to support testing. Local government's involvement in testing post-outbreak of the pandemic is discussed in Part 3.

(A) The role of local government in contact tracing

47. Contact tracing is a recognised public health activity used to identify and break chains of transmission to help reduce the spread of infectious diseases. It has been used for many decades in the response to infectious disease outbreaks and epidemics, usually alongside other public health activities and control measures. Its purpose, to identify people with an infection or potentially infected and isolate them before they infect others, is widely accepted and works in many, but not all, infectious diseases to a greater or lesser degree.

48. Local UKHSA health protection teams and local authorities have long-standing relationships with their community and a history of handling infectious disease outbreaks via contact tracing (amongst other responses). Public health officers and environmental health officers in local authorities have extensive experience with contact tracing and a strong understanding of the need and best methods for contact tracing. For example, contact tracing is routinely carried out during local outbreaks of communicable disease such as norovirus, salmonella or legionnaires' disease. Contact tracing (via 'partner notification') is also a key method for controlling the spread of sexually transmitted diseases.

(B) The role of local government in data sharing

49. There were problems at least in the early stages. Local authorities' DsPH have long and regular experience of testing and tracing when there are local infectious disease outbreaks and they a critical role in responding to the pandemic. Their experience was there to be used again but required data to enable it. Their expertise in population health and knowledge of infectious disease control were vital in addressing its immediate impact of Covid-19 on the health of their local populations, as well as the ongoing economic

impacts. Their understanding of local places and resources, and their wider role in local government, puts them at the centre of local decision-making that affects public health.

50. DsPH hold a varied skillset that spans beyond their statutory responsibilities of health improvement and protection. In a time of crisis, they provided critical leadership to their local authority colleagues and to their local community in responding to the Covid-19 pandemic.

51. It is the role of DsPH to lead on major health issues that affect local populations, particularly in relation to tackling health disparities and protecting communities from diseases. They also have a role in tackling outbreaks, which can only be undertaken if they have detailed knowledge, in the form of location and demographic data, of those testing positive. Despite this, there was a reluctance from national Government to share detailed data with DsPH. At the beginning of the pandemic, national bodies (PHE and NHS Test and Trace) were slow to provide local authorities with vital data – this caused significant problems. During the containment phase, for example, DsPH were struggling to get information on the positive cases in their area. This often meant DsPH were learning about cases via the media and left on the backfoot when responding to requests for advice from settings such as schools.

52. The lack of any individual level data on Covid-19 cases being shared with DsPH at the outset made it impossible to support those affected and to control outbreaks. The LGA repeatedly requested this data at meetings and in emails, and published a media release on 10 May calling for it to be made available (**Exhibit JK3/01 – INQ000512488**, LGA media release dated 10 May 2020). Later on, the Kings Fund reported that many DsPH in England described difficulties in accessing the data they needed to trace contacts. At various times, the LGA was questioned by PHE about why DsPH would need individual-level data.[2] For example, on 11 June 2020 PHE emailed the LGA seeking clarification over DsPH requests, including why local authorities or DsPH would need to know information such as the mobile phone number of a positive case's contacts (**Exhibit JK3/01g – INQ000587143**.

53. For some time, the only data available was aggregated at a local authority level, which prevented DsPH from undertaking their role to prevent outbreaks. In addition, even within the aggregated data, key variables, such as ethnicity, age and sex were missing, as well

[2] That is, data about an individual person which allows DsPH to put in support for that person where necessary and to control outbreaks.

as information about workplace, which would have allowed DsPH to target their action much better. In part, this was caused by a lack of DsPH involvement in the design of data collection forms, so that some of the operational data needed by councils was simply not collected.

54. Data on cases within care homes was available nationally but not shared locally, which hampered the effort to tackle outbreaks. By not sharing individual-level data with DsPH, it was impossible for them to spot outbreaks in care homes early so they could work with them and support their response and recovery. Additionally, the lack of information about the workplace attached to test results prevented an understanding of how the social care providers' workforce overall was being affected in their area. As a result, some DsPH established their own lines of communication with care homes to obtain results direct from them (see paragraph 64).

55. Vic Rayner, Executive Director of the National Care Forum, which represents more than 120 not-for-profit care organisations, said in the BBC News article "Coronavirus: Data delay left care homes 'fighting losing battle'" dated 19 May 2020 (**Exhibit JK3/02 – INQ000512489**):

> *"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."*

56. Had NHS Digital/PHE shared individual-level or very small area data (a term for data which has been aggregated across a small area, such a part of a neighbourhood) with authorities from the outset, it would also have allowed a much more effective test and trace system. Although very small area data is not as helpful as individual-level data (which places a test result very precisely in a household so that DsPH can target activity), very small area data would at least have allowed DsPH to narrow their focus of activity more precisely than information at whole local authority level.

57. Local data and local activity at the outset would have been more efficient. As noted by the Kings Fund research, "Directors of public health and the Covid-19 pandemic: a year like no other" dated September 2021 (**Exhibit JK3/03 – INQ000204012**), a national call centre had no understanding of the needs of the people living in a local community, and no understanding of the language spoken, how best to engage them, or the support that was available to people to encourage them to quarantine.

58. Some very specific difficulties were caused by having a central call centre. The central

call system meant that people being contacted saw a non-local number on their phones when they were called and often ignored them. One authority reported during a meeting (not minuted) that they had reached 80% of the people on the 'uncontactable' list they were given once they had made one local phone call, because people were more comfortable answering a local phone number. Contact tracers were told to follow heavily scripted cues. There was no room for discretion. It led to the situation whereby call handlers had to try to make individual calls to every member of a household and go through the same forms. Some households found themselves receiving multiple calls.

59. Because of the UK Government's misunderstanding about the role local authorities could play, it also excluded them from the design of any data collection – which captured information needed to act on the test result, such as an individual's identity, location and key characteristics. As a result, the data collection forms for testing and tracing were poorly designed for operational use at a local level: 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. In addition, 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 (**Exhibit JK3/04 – INQ000547466**, email from LGA to DHSC and NHS requesting data dated 29 July 2020). Although there was an immediate response, which indicated that some of the issues were in hand, others were acknowledged as being more difficult to deal with (**Exhibit JK3/04 – INQ000547466**). Data colleagues in DHSC, NHS Digital and PHE always tried to help, but the lack of DsPH involvement in the design of forms and discussions at the outset, to ensure all the data needed was collected, often made it difficult and slow for them to meet councils' data needs retrospectively.

60. The impact of poor data collection design was considerable. For example, because detail about a person's workplace on the tracing form was collected as free text, it was very difficult to ascertain where a person who was infected was working (for example, a supermarket name without an address could be one of many branches, and not necessarily within the same local authority as the person resided). It was therefore very difficult to trace work colleagues and others who may have been in contact, to limit the spread, without the local authority needing to contact the individual again, so duplicating the original call and slowing activity. This delayed or prevented contact tracing taking place. To be effective, case investigation and contact tracing must be speedy and the information as complete as possible. The lack of information about ethnicity and occupation also had impact: it prevented DsPH from understanding quickly whether they

needed to target particular communities or types of workplaces.

61. There was also little use made of available address lookups in the data collection form, which would have helped with accuracy: in particular, unique property reference numbers ("**UPRN**") (unique identifiers for every addressable residential and commercial property in the United Kingdom) were not used – the mandate to use them came into force only a few months later, in July 2020. An address look-up would have allowed the user to type in the start of an address, like the street name or postcode, and have addresses suggested to them from which they could select their own. This avoids typing errors and, once the address has been selected, the UPRN attached to it is automatically captured. It would have helped not only with accuracy but would also have avoided the situation later where data released with postcode as the location identifier covered such a wide area that it was not easy to target activity. Using UPRNs would have allowed much more precision (for example, it identifies an individual apartment within a block, and the co-ordinates), as well as helping authorities to link the information with other data they held, for example, whether the resident was additionally vulnerable in some way.

62. Despite repeated requests to change the collection form to solve some of these problems, officials were not willing to change the form used to collect the data, even though it would have helped local response. Requests were made via the Good Practice Network – Data Integration Group, chaired by officials from DHSC and made up of a number of local authorities and the LGA. The group was used to feed in local authority data asks to the Government's Cross Data Alignment Group (see, for example, **Exhibit JK3/04a – INQ000575932**, **Exhibit JK3/04b - INQ000575933**, and **Exhibit JK3/04c – INQ000587146**. Some items were eventually added, but some were not. Because of the general reluctance by Government to routinely share individual test and trace data with local councils, valuable time and effort was expended by local DsPH 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.

63. From April 2020 to April 2022, the LGA facilitated a working group of DsPH, who met weekly with officials in a number of Government organisations (for example, PHE and NHS Digital) to make the case repeatedly for access to this data and spent some time doing this. The meetings were chaired by DHSC as a means of coordinating local authority asks and they were clear that, although local authorities were a priority group, the DHSC but could not mandate other departments to action the requests.

64. Meanwhile, particularly for care home data, some DsPH established their own lines of

communication with institutions to obtain results direct from them, rather than receiving them from PHE. This was both resource-intensive and time-consuming – and, because it was inevitably a more informal exercise, the numbers and characteristics of every individual would not necessarily be exact – but it gave local authorities at least some of the information they needed to understand and respond to the local situation.

65. When individual data was eventually shared, it was not always good quality, in large part due to the data collection not being operationally focussed. Even by December 2020, when test and trace data had been available at individual level to councils for several months (since July 2020), poor quality data, missing or incomplete data (such as workplace) and a lack of UPRNs, continued to be an issue (see, for example, Exhibit **JK3/04d – INQ000587149** the email chain between Nottingham City Council and Geoplace dated 7 December 2020, demonstrating the impact of poor quality data from central Government) .

66. In addition, there was a focus by central Government on making that data available through dashboards, perhaps caused by an unwillingness to trust authorities to hold the data securely, which meant that data shared with authorities often needed to be viewed through multiple dashboards or portals in order to get a comprehensive picture. I discuss this in more detail below at paragraph 69. This approach 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 regularly requested access to downloadable data for authorities (rather than being limited to viewing it in a dashboard) during meetings with officials and by email, for example, it was requested on 29 July 2020. The LGA received an immediate response to its request for downloadable data which indicated that, while some of the data requests were in hand, downloading of data was still an issue (**Exhibit JK3/04 – INQ000547466**, Email from LGA to DHSC and NHS requesting data dated 29 July 2020 referred to at paragraph 59, above). It was eventually made available some months later because of our requests.

67. When data did start to flow, approximately 10 weeks later, access was hampered by multiple data sharing agreements and restricted access protocols. Councils were required to nominate a named person to be given access, and then there was a period of delay while those nominated were given access.

68. There were problems caused by the fact that only a single person could be nominated, making it difficult to access data if someone was on leave or unwell; or where the DPH

was nominated and not one of their analysts. Initially, registration was prioritised for DsPH, chief executives and leaders as signatories of the data sharing agreement. However, access was really needed at the officer level. This was considered a secondary priority, taking a couple of weeks before officers were able to access the data as well.

69. In addition, the PHE's data disclosure rules, developed specifically for this exercise, meant Covid-19 cases data could not be shared with others in the council, even to offer support. This included county councils sharing information with district councils, even where they were part of delivering the response. I have exhibited the PHE disclosure and data sharing rules as **Exhibit JK3/05 –** INQ000575941 (see also, **Exhibit JK3/05a –** INQ000575940, PHE document dated 22 June 2020 "Data Sharing with Local Authority Public Health Teams"; and **Exhibit JK3/05b –** INQ000575939 email dated 30 June 2020 from DHSC to LGA regarding data sharing and disclosure rules).

70. 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 PHE at that time, wrote to authorities on 10 July 2020, to help DsPH 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. This letter from Duncan Selbie to Local Authority Chief Executives and DsPH is exhibited as **Exhibit JK3/06 – INQ000050496**. There were 14 different sources at that point in time.

71. In conclusion, local authorities and, specifically, their DsPH, had the capacity and expertise to assist with testing and tracing but were prevented from effectively doing so by a lack of access to data. The issues with access to data were three-fold:

    a. National Government at times had a lack of understanding of why DsPH and local authorities should have access to the data (i.e. a lack of understanding of the role and expertise of DsPH);

    b. the pre-existing and post-outbreak regulation of data and privacy protection prevented local authorities from accessing data or, where access was granted, limited the use that could be obtained from that data; and

    c. the data collected often was not fit for the purposes of TTI that DsPH and local authorities were expected to use it for.

(C) The role of local government in self-isolation and support payments

72. For those who tested positive for Covid-19, self-isolation was a legal requirement in the UK from September 2020 until February 2022, when it became a recommendation rather than a requirement.

73. Repeated iterations of the guidance and eligibility criteria were produced by DHSC, updated as changes were made to the scheme.

74. DHSC collected information on the main scheme but councils had some flexibility over eligibility for the discretionary scheme and this varied between councils, many of whom ratified eligibility through their own local decision-making processes. However, the criterion that this was for people who did not quite achieve eligibility for the main scheme was broadly adhered to.

75. The discretionary scheme was put in place to extend access to support to people who did not completely meet the eligibility criteria for the main scheme. Councils had to fit their criteria to the fixed funding that was available, which ministers refused to extend until January 2021. At this point the criteria were adapted again to accommodate changes including support for parents of children who had been sent home from school, among other emerging issues. These changes can be tracked through the changing guidance.

76. The LGA was involved in initial discussions with Government about the role of local authorities in supporting compliance with the self-isolation requirements. Although it was broadly accepted that it was the role of the police to enforce Covid-19 regulations as they applied to individuals, councils had an important role in encouraging compliance through the provision of support to those who might be struggling with the requirement.

77. The Government's self-isolating requirements in response to the pandemic had significant implications for those on low incomes. It was not immediately recognised within Government how unprepared many households would be to cope with even a modest reduction in household income, and how, for example, having children at home might immediately increase living costs.

78. Local authorities were sent information regarding individuals who were isolating or shielding and needed support. Local authorities provided a range of practical support including food, medication collection and dog walking. Community organisations provided food for people, dropping things off at people's doors, and local authorities

provided nappies and items for babies, and managed to support people to get medication.

79. Initially, there was no financial support for those who were not able to work from home, but later local authorities did receive funding from Government to give payments if people had to isolate. Some local authorities also put in additional support for self-isolation for people who could not work from home.

80. One key challenge that local authorities faced in ensuring self-isolation compliance was the financial consequence for people temporarily stopping work – either to self-isolate themselves, or to care for a child who was required to stay home from school.

81. In its continued engagement with Government and health partners, the LGA identified the need for a financial support package for isolation to both increase compliance (delivering a public health objective) and mitigate the loss of employment income. The Test and Trace Support Payment Scheme was designed collaboratively and at pace between DHSC and councils, with high levels of engagement and support from the LGA, Department for Work and Pensions ("**DWP**") and NHS Test and Trace.

82. Government did not position compliance as the main objective, it positioned mitigating financial hardship as the primary objective. This was reiterated repeatedly following concerns raised by some councils in relation to the sufficiency of the fixed pot of funding for the discretionary scheme. During the autumn of 2020, there were times when the LGA was at odds with some parts of Government about the purpose of test and trace support payments. This shifted in early 2021 when funding for the scheme was significantly extended.

83. Local authorities moved quickly and effectively – putting arrangements in place from scratch to administer and deliver the Test and Trace Support Payments. Revenues and benefits teams were, at this point, already under considerable pressure due to other emergency support that they were administering and the impacts on their service of overall increased demand for welfare support.

84. Challenges were present from the outset, due to the speed of implementation and the need to refine the scheme in real time. Ministerial concerns, and competing objectives across Government, meant that councils found themselves working with strict but shifting eligibility criteria, which made the scheme harder to administer and led to confusion and resentment as local people perceived a lack of consistency and fairness in who was able to access payments.

85. Despite consistently highlighting the need for flexibility, local authorities were initially given a small pot of funding to provide discretionary support (to support those who did not fully meet the strict criteria in the main scheme, which included passporting from specific welfare benefits), set against significant demand. Flexibility was primarily necessary because the criteria for the main scheme required receipt of benefits. This meant that many people at risk of financial hardship did not qualify.

86. Partners and advocacy organisations were also referring people who they felt needed help, even if they did not meet the criteria. As a consequence, local authorities were dealing with high volumes of unsuccessful applications, all of which nonetheless had to be processed and managed. The LGA considers that, at times, there was a lack of understanding of what the criteria was, because the criteria were revised. DHSC attempted to communicate changes to referral partners, but at certain points some councils were receiving high levels of referrals for ineligible claims.

87. They also faced significant challenges in ensuring that help was fair and consistent and reached those who needed it most, delivered its twin aims of reducing hardship and preventing the spread of the virus, and was not open to fraud or abuse. Policy was implemented on the hoof and ministers did not agree on approaches. Civil servants did their best to assess and respond to real-time challenges that were being raised by councils, but ministers and then-Her Majesty's Treasury ("**HMT**") could not agree on funding.

88. Overall, the LGA considers that, generally, those who needed support through the scheme did receive it. In some cases, councils used other sources of funding to sustain the discretionary scheme while Government resolved disagreements about funding. DHSC, LGA and councils worked hard to ensure consistency and adequacy in the main scheme.

89. The scheme depended on clear and effective referral pathways between NHS Test and Trace and local authorities. Partners worked quickly to put in place both robust data-sharing agreements and access to systems to enable this to happen, including ensuring that appropriately trained staff had access to Searchlight. Searchlight is DWP's customer information system. It was used to share benefits information with councils as this was a component of entitlement for the main scheme. In some places this created an unavoidable bottleneck that local authorities also had to navigate.

90. In the run up to Christmas 2020 it became increasingly apparent to Government, from evidence shared via the LGA and local authorities, that the restraints on the discretionary

fund were – as predicted – preventing the fund from delivering on its key policy objectives. For example, see email dated 16 December 2020 and attachments shared internally within the LGA regarding council concerns over the self-isolation discretionary payment funding, included as **Exhibit JK3/06a – INQ000587097**

91. Eventually the Government responded by increasing the funding and allowing greater discretion. The Government's determination letter, dated 8 January 2021, for this funding is exhibited as **Exhibit JK3/06b – INQ000587096**. This was, however, after the main peak had passed.

92. The last-minute announcement meant that local authorities then had to rapidly redesign their schemes. From criticising local authorities for overspending in the run up to Christmas, Government then quickly switched to criticising local authorities for underspending, including pressuring the sector to minimise fraud checks and expedite payments more quickly, something that local authorities were neither able nor willing to do. These criticisms occurred in forums such as meetings with HMT and in meetings with lead officials on TTI. The LGA also highlighted the constraints on capacity within revenues and benefits teams, which had been struggling with recruitment and retention for many years due to uncertainty caused by the drawn-out implementation of Universal Credit and persistent shortfalls in subsidies for administration and costs.

93. To process a claim (and minimise fraud) effectively the person processing it needs to know who is eligible and be able to check that they are who they say they are, and they are in the circumstances they say they are. This is more difficult if the criteria are constantly changing. For the discretionary scheme some councils required that decisions about funding support should go to the council's cabinet (or similar formal decision-making), which meant that there was a bureaucratic process that needed to be followed.

94. Despite these challenges, local authorities administered the scheme very effectively, within the constraints they were facing, and civil servants in DHSC worked closely, collaboratively and at pace with the LGA and officers to resolve challenges as they arose and mediate communications across a wide range of stakeholders.

95. Councils were required to give effect to many of the Government's schemes with very minimal notice and rapid timescales for implementation. In all cases they entailed extensive and intensive collaboration between local authorities, LGA and Government officials, which often had to happen at pace after a public announcement had been made. They were also often subject to considerable shifts in policy. DWP Local Authority

Partnership, Engagement and Delivery colleagues in particular worked closely with the LGA and local authorities' revenues and benefits teams to support departments with less experience of working with local government, but regrettably they were also not always brought in at the earliest opportunity.

96. There was very little notice of the expectation that local authorities would administer payments such as the Test and Trace support payments, and from the outset there was a lack of clarity about whether the intent was primarily socioeconomic (to offset hardship caused through the inability to work), primarily health protection (through incentivising self-isolation) or both. The local government sector's informed recommendations on this issue were sometimes not taken into account, for example Government initially resisted feedback from local public health experts on the need to incentivise young, single people (who saw themselves as being at minimal personal risk) to self-isolate even if they were not at risk of extreme financial hardship.

PART 3: LOCAL GOVERNMENT'S INVOLVEMENT IN AND CONTRIBUTION TO TTI

97. In Part 3 of my statement, I expand on local government's involvement in the development and implementation of TTI. Part 2 focused on the existing and developing infrastructure, capacity and expertise in local government, while Part 3 focuses on the local government's role in TTI more broadly.

98. Local government played a critical role in the pandemic response. By working with the Government and partners in the NHS, with other public bodies and the third and independent sectors, it made a major contribution to finding a path through this unprecedented, and rapidly changing, national emergency.

(A) Timeline of engagement with TTI

99. In May 2020, councils were given responsibility for the testing of residents and staff in care homes. The letter from Minister of State for Care to council leaders and others dated 14 May 2020 is exhibited as **Exhibit JK3/07 – INQ000512495**. This continued to develop, with local public health teams becoming more involved in testing in the community, contact-tracing and managing outbreaks. Following the identification of new Covid-19 variants, public health teams worked in partnership with other local authority teams and NHS Test and Trace to carry out 'surge testing' in local areas to identify infection among people without symptoms.

100. The significant shift came as the national scheme continued to fall short of reaching the

80% of contacts of people who test positive that experts believed was needed for controls to be effective. The national scheme had faced criticism from MPs and public health experts for relying too much on inexperienced contact tracers and not enough on public health teams with local expertise. By June 2020, some councils in England had set up their own contact tracing services, citing failures of the national scheme.

101. In June 2020, local authorities in England developed Covid-19 outbreak control plans to help manage ongoing outbreaks, supported by an additional £300 million of funding. The DHSC press release dated 11 June 2020 is exhibited as **Exhibit JK3/08 – INQ000512496**.

102. On 25 June 2020, the LGA raised concerns that, according to official data, the Test and Trace Service had not been able to reach a third of people who tested positive for Covid-19, whose contact details were unavailable or incorrect or where there had been no response to text, email and call reminders. The LGA's media release dated 25 June 2020 is exhibited as **Exhibit JK3/09 – INQ000223952**.

103. In practice, if the national tracing service was not able to reach people, it passed information to local authorities. Local authorities were able to cross reference to those contacts to see whether they had tested positive. Local data, such as council tax databases, were used to increase the contact rate.

104. Local knowledge and local understanding were important. For example, the centralised NHS Test and Trace were using remote teams who did not understand the community, ringing from a UK wide national number that people would not answer. Local contact tracing allowed for tracing to be combined with signposting towards local advice and support for those being asked to isolate, increasing the likelihood people will comply.

105. It took local authorities many months of strong lobbying to get any meaningful contact and especially resourcing to supplement the NHS Test and Trace effort even though local authorities and their DsPH knew that they would be able to get better, quicker reach. DsPH argued that this was because of their extensive experience and knowledge of contact tracing, their local communities and the wider health and care system. Environmental health, trading standards, public health including sexual health services and infection control nurses are just some of the services which have unparalleled skills, knowledge and experience on the ground of contact tracing.

106. The initial performance of the national contact tracing service was "mixed" with the then Prime Minister himself acknowledging he had hoped it would be better. However, by

September 2020, over 100 councils had started to work in partnership with NHS Test and Trace to enhance the system by providing local contact tracing partnerships which combined national scale and data with local knowledge. Local authorities received more engagement and support as NHS Test and Trace and PHE extended their partnership with local public health efforts, with the aim of reach more people testing positive for coronavirus and their contacts.

107. As part of the partnerships, NHS Test and Trace would provide local authorities with a dedicated team of contact tracers for local areas, while local and national teams would work interconnectedly to ensure as many people as possible are reached by contact tracing efforts. If the dedicated national team could not make contact with a resident within a set period of time, the local public health officials could use the data provided by NHS Test and Trace to follow up. The approach had shown success in the pilot areas of Blackburn with Darwen, Luton and Leicester.

108. This integrated national and local system combined specialist local knowledge with the additional resources and data required from NHS Test and Trace. All data gathered was fed into the same system utilised by both the national and local teams, ensuring a complete overview of how the service is working and the spread of the virus.

109. On 17 July, the Government published guidance, "COVID-19 contain framework: a guide for local decision makers", UK Health Security Agency guidance "COVID-19 contain framework: a guide for local decision-makers" (the version of this guidance dated 21 October 2021 is exhibited as **Exhibit JK3/10 – INQ000512498**).[3] This clarified the responsibilities of local government to control local outbreaks in partnership with local PHE health protection teams. It also specified powers for local authorities to close specific premises and public events if necessary and introduced test and trace support and assurance teams (the DHSC statutory guidance "Local authority powers to impose restrictions: Health Protection (Coronavirus, Restrictions) (England) (No 3) Regulations 2020" dated 28 September 2021 is exhibited as **Exhibit JK3/11 – INQ000512499**).[4]

110. Following this increase in local responsibility and in response to rising case numbers, some local authorities, such as Sandwell and Blackburn with Darwen, developed local contact tracing processes for non-complex cases – reaching up to 90% of individuals

[3] The LGA was unable to locate the original guidance as published on 17 July 2020. The version exhibited was the final version updated on 21 October 2021, subsequently withdrawn on 7 April 2022.
[4] The LGA was unable to locate the original statutory guidance as published in 2020. The version exhibited was the final version updated on 28 September 2021, subsequently withdrawn on 28 February 2022.

that the national system was unable to contact. I elaborate on some of these local examples in Part 3(E) of my statement, below.

111. The role of local public health teams was further emphasised in the NHS Test and Trace business plan published on 30 July 2020 that set out a range of objectives. These included increasing awareness of NHS Test and Trace, expanding testing capacity, and shortening the time between taking a test and receiving results. The DHSC policy paper dated 30 July 2020 is exhibited as **Exhibit JK3/12 - INQ000512500**. See also **Exhibit JK3/11 - INQ000512499** referred to in paragraph 109, above.[5]

112. In August, NHS Test and Trace reduced the number of national-level contact tracers and designated a proportion of its specialist tracing staff to work exclusively to facilitate those local authorities that had their own scheme. According to the National Audit Officer's December 2020 interim report, "The government's approach to test and trace in England", by the end of October, 40% (60) of local authorities had a scheme in place, with a further 46% (69) planning to set one up (**Exhibit JK3/12a - INQ000573986**. The data came from UKHSA's "Weekly statistics for NHS Test and Trace (England)" (**Exhibit JK3/12b - INQ000575950**).

113. By March 2021, 149 of 151 upper tier local authorities had a local scheme. Initially, only complex cases that the national service could not reach were passed over to local authorities, but more routine cases were also passed to them. NHS Test and Trace would provide training, resources and funding to support local authorities. From March 2021, it also piloted the Local Zero scheme whereby local authorities undertake all contact tracing in their area.

114. In light of local contact tracing successes, the Government said on 10 August that NHS Test and Trace would reallocate 6,000 of its contact tracers to provide greater support to local authorities developing their own contact tracing systems for hard-to-reach non-complex cases. There is a widespread view in local government and public health that if local contact tracing had been resourced from the outset to take on an enhanced role, this would have resulted in a more effective and efficient system.

115. At the end of August 2020, NHS Test and Trace acknowledged that there needed to be better co-ordination of its tracing strategy and the growing range of national and local

---

[5] The LGA was unable to locate the original statutory guidance as published in 2020. The version exhibited was the final version updated on 28 September 2021, subsequently withdrawn on 28 February 2022.

approaches (see DHSC press release dated 10 August 2020 "NHS Test and Trace service to strengthen regional contact tracing" exhibited as **Exhibit JK3/12c - INQ000510820**

116. By the end of November 2020, over 200 local contact tracing partnerships had been set up across England to work with NHS Test and Trace, with another 100 in the process of being implemented (see the LGA media release dated 26 November 2020, exhibited as **Exhibit JK3/13 – INQ000512501**).

(B) Testing

117. Despite being crucial in tackling Covid-19, testing posed challenges for local government. Central Government did not effectively engage in shaping the national testing strategy yet expected public health teams in councils to manage local implementation. This led to frustrations, such as inadequate testing of patients before discharging from hospitals to care homes and slow test result turnaround. However, in May 2020 as testing developed, public health teams were making progress in embedding testing locally, including piloting mass and lateral flow testing in specific communities and educational settings.

118. Following the identification of Covid-19 variants, public health teams began to work in partnership with other local authority teams and NHS Test and Trace to carry out 'surge testing' in local areas to identify infection among people without symptoms. In the first half of 2020, public health teams in local government expressed their frustrations about the national testing strategy, including a lack of processing capacity leading to slow turnaround on results, also the challenges in meeting targets for testing. That said, as the year developed, public health teams were pushing through with embedding testing locally and ensuring it was a core part of the efforts to manage Covid-19. For example, one area was part of the pilot for mass testing. Another area piloted lateral flow testing in educational settings and targeted lateral flow testing in communities where there was a higher proportion of minority ethnic residents and/or people working in frontline roles who were more susceptible to becoming infected and severely unwell.

119. Challenges were particularly evident in initiatives such as setting up the lighthouse laboratories to boost capacity for processing Covid-19 tests. Challenges arose when test data was not always shared with local public health teams to enable quick contact tracing. Lighthouse laboratories were designed to be able to centralise data on the frontline, however councils reported that they were being denied postcode-level and

specific patient data for positive tests.

120. As new testing methods became available, clear communication and well-planned local implementation were essential. Early testing efforts faced challenges such as a lack of infrastructure, transportation barriers to regional drive-through sites, and difficulties for those without digital access. Testing sites were positioned in locations where people had to find transportation to the sites. Limitations existed with drive-thru sites for those who do not own a vehicle, or those who had to drive long distances or endure long wait times.

121. In areas with poor health system infrastructure, lack of access could exacerbate inequities in testing. Local authorities used mobile testing vans and multilingual workers to reach hard-to-access groups. Addressing these challenges was crucial for maximizing the impact and effectiveness of testing.

122. Many local authorities set up large 'community champion' networks, with volunteers working with the council from the different communities. Other local authorities set up trusted networks and established sounding boards for different groups, including Bangladeshi, Pakistani, Black African and people with disabilities. Evidence on community champions in health improvement shows that champions can strengthen social connections in disadvantaged communities and be a link between those communities and services. The PHE paper, published in August 2021, "A rapid scoping review of community champion approaches for the pandemic response and recovery" is exhibited as **Exhibit JK3/13a – INQ000587110**.

123. The Independent Scientific Pandemic Insights Group on Behaviours for the Scientific Advisory Group for Emergencies ("SAGE"), examined the evidence for community champion roles in supporting the pandemic response, particularly to improve engagement with the NHS Test and Trace service (see paper dated 23 October 2020, **Exhibit JK3/13b – INQ000587159**).

124. As national testing infrastructure was developed, it was initially difficult for some people to reach a testing centre because it was either too far away or individuals did not own a car. To help with this, postal tests were introduced, and there were plans to expand testing so that by October 2020 most people in urban settings would be within a 30-minute walk of a test site. However, testing problems escalated in September with limited laboratory processing capacity meaning many individuals had been either unable to get a test or asked to travel hundreds of miles to access one. In addition, home test kits and drive-through booking slots were prioritised for those living in regions with high or rising case rates.

125. Initially, local public health teams were not provided with the patient identifiable information on Covid-19 cases that they needed to manage and prevent local outbreaks effectively, preventing them undertaking contact tracing themselves.

126. The data council public health teams were receiving from community drive-through testing centres and home testing kits (from "pillar 2" of the Government's testing scheme) were anonymised, and postcode and occupational data was often missing or of low quality. As a result, local teams could not use the data to examine possible connections between cases, such as a common workplace, or whether one of the cases could be a "super-spreader."

127. 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.

128. As previously stated, the LGA believes that there was a general reluctance to routinely share data with local councils. For more detailed discussion on data, see above at paragraphs 49 to 71.

129. The testing infrastructure which was created did not acknowledge or deliver the type of information needed locally.

(C) Compliance and enforcement

130. Local authorities' compliance and enforcement role during the pandemic primarily focused on how the multiple different regulations in place at different points were implemented by premises; as noted above, police forces took the primary role in enforcing the regulations that applied to individuals.

131. In relation to test and trace, this involved ensuring that for example hospitality premises had mechanisms in place to support contact tracing in the event of a subsequent positive test by someone who had visited the premises; for example, requiring visitors to 'check in' to venues. There were also discussions with Government on how councils could monitor whether local employers may have been knowingly permitting or encouraging employees to work when they should have been self-isolating.

132. The LGA set out in its Module 2 statement a number of the challenges that arose in relation to compliance and enforcement activity during the period when Covid-19 regulations were in force: these are summarised below.

133. Although there was regular engagement with local authorities on their compliance and enforcement work from July 2020, there was a lack of engagement with the LGA and local authorities on the development of legislation and controls, leading to avoidable challenges with the suite of new regulations that were introduced during Autumn 2020.

134. It is important to stress that the lack of engagement here related not to the question whether to introduce specific controls, for example, requiring customers to register QR codes when they visited a hospitality premises, but the workability of the controls enacted to achieve these policies. Lack of, or limited engagement in the development of the controls and associated regulations impacted the practicability of council officers enforcing rules, such as the need for hospitality businesses to collect customer data for contact tracing purposes. Examples of issues with the contact tracing regulations are set out in the following documents as exhibits:

    a. Email chain dated 1 October 2020 between LGA and councils feeding back on issues with DHSC test and trace regulations (**Exhibit JK3/13c – INQ000587110**);

    b. Email dated 1 October 2020 from East Sussex to LGA feeding back on issues with DHSC test and trace regulations (**Exhibit JK3/13d – INQ000587117**);

    c. Email dated 1 October 2020 from LGA to DHSC feeding back on issues with DHSC test and trace regulations (**Exhibit JK3/13e – INQ000587167**; and

    d. Informal notes taken by the LGA on 3 September 2020 at a meeting bringing together council enforcement, environmental health and trading standards leads for feedback on issues, which would then be relayed back to Government in meetings (not often in writing) (**Exhibit JK3/13f – INQ000587134**. In this instance, a representative of MHCLG was present.

135. One example was the introduction of new regulations that in two-tier areas could only be enforced legally by county councils, rather than district councils, though it would be the district council's officers who undertook other compliance work with relevant businesses and were already heavily involved in local compliance work.

136. The Health Protection (Coronavirus, Collection of Contact Details etc and Related Requirements) Regulations 2020 as initially introduced in September 2020 included a definition of councils that did not include district councils. District environmental health officers were heavily involved in contract tracing and wider Covid-19 compliance work.

Without legal authority to enforce regulations, officers could not undertake this work or take action against businesses that were not compliant. While there was an option to put in place delegated authorities between counties and districts, this created additional burdens.

137. For example, on 18 September 2020, the LGA contact DHSC alerting the Department to the assumed drafting error which excluded district councils in county areas, requesting that the wording should be amended to include district councils in two-tier areas (**Exhibit JK3/13g –** **INQ000587138**). The LGA received feedback on this issue from Wyre Forest District Council on 19 September 2020 (**Exhibit JK3/13h –** **INQ000587116**, requesting that the LGA lobby hard for the regulations to be amended.

138. It is worth noting that the two-tier issue had been explicitly highlighted with MHCLG in the very short window councils had to provide input as Government was developing regulations (which did not include sight of the full draft regulations) (see **Exhibit JK3/13i – INQ000587156** email chain between local authorities and Government dated 16 September 2020 re feedback on policy and regulation proposals).

139. The LGA continued to liaise with Government to try to get an appropriate amendment to the regulations, and to explain why the original definition excluding district councils was an issue (see, for example, **Exhibit JK3/13j –** **INQ000587115**, email chain between LGA and Government dated 23 September 2020 regarding the definition of local authorities in the regulations). In corresponding with DHSC officials and lawyers after the regulations had been published, LGA officers were conscious that these were officials whose job titles suggested their normal areas of work did not involve councils, or council regulatory / enforcement work, and there seemed to be a general lack of familiarity with how these areas operate.

140. Another issue which concerned the LGA and councils was not having sight of draft regulations before they were laid and typically made, as regulations often came into force almost instantaneously. Local authorities had virtually no time to understand and prepare for new regulations before businesses and the public became aware of them and began seeking guidance and an interpretation of them. This made local authorities' compliance and public information work much harder, and this was compounded by frequent discrepancies between what was in the regulations and what was in the accompanying Government guidance, creating expectations about local authorities being able to stop certain activities that were not, in fact, prohibited under the legislation. This applied to the contact tracing aspects of TTI, specifically in relation to businesses. For examples,

see:

a. LGA letter on 8 July 2020 to UKHospitality and British Beer & Pub Association regarding challenges with approach to guidance and the underpinning legislation (**Exhibit JK3/13k –** INQ000587106;

b. Association of London Environmental Health Managers statement regarding insufficient legal powers to enforce guidance for non-compliant businesses (**Exhibit JK3/13l –** INQ000587109; and

c. LGA's compilation of LGA and council feedback, dated 25 September 2020, on "What councils need to support enforcement" (**Exhibit JK3/13m –** INQ000587166

141. The period from September 2020 to January 2021 was characterised by frequently changing regulations, as new controls and the tier system were introduced, creating challenges for council regulators in repeatedly digesting and enforcing new sets of controls.

142. In general, the we believe that the LGA and local authorities could have helped to reduce some of the implementation and enforcement challenges had we had the opportunity to comment on draft legislation and highlight some of the potential pitfalls of unclear terms and likely loopholes. Council frontline officers have considerable expertise in enforcement issues but for a long time, the opportunity to draw on this expertise, however briefly, was missed.

143. Finally, capacity was a key issue at the local level, with multiple demands – including regulatory work with premises and contact tracing – placed on local environmental health teams in particular. Environmental health teams were recognised as a critical part of the local Covid-19 response, but with staff numbers having reduced significantly due to reductions in local government funding, they were stretched very thinly. Environmental health teams were involved in contact tracing (for example, trying to follow up people that the national system could not reach) and enforcement of Covid-19 business controls in particular, on top of their existing core activity. Some areas of core work were exacerbated by Covid-19, for example councils experienced an increase in statutory nuisance work. At the same time, demands on some teams were increasing in relation to Brexit changes.

144. Many council teams experienced capacity issues as demands linked to Covid-19 were

layered on top of existing activity. Trading standards teams, which were also involved in supporting Covid-19 enforcement activity, are one example. See also **Exhibit JK3/13m – INQ000587166** referred to at paragraph 140. The LGA's informal meeting notes also demonstrate these recurring issues (see, for example, **Exhibit JK3/13f – INQ000587134**, from 3 September 2020; **Exhibit JK3/13n – INQ000587135**, 17 September 2020; and **Exhibit JK3/13o – INQ000587135**, 23 September 2020).

(D) Contain Outbreak Management Fund

145. The Contain Outbreak Management Fund was a financial support initiative provided by the Government to local authorities in England to help reduce the spread of Covid-19. Local authorities had the discretion to use the funds based on their local outbreak management plans.

146. The Contain Outbreak Management Fund was crucial for councils in supporting test, trace, and contain activities during the Covid-19 pandemic. They utilised the funds to expand public health teams, provide non-financial support to those required to self-isolate, hire agency staff for local testing, build local test-and-trace capacity, conduct targeted testing in high-risk areas or groups, communications and raise awareness and promote public health messages and invest in the local voluntary and community sector through easily accessible grants and locality networks.

147. Councils made the most of this short-term or emergency funding while it was available, and they said it was unusually easy to get funding for Covid-19-related activities. There was flexibility for DsPH to use this resource as they saw fit to build capacity and fund targeted outreach work.

(E) Local examples

148. Throughout the pandemic, the LGA sought to capture examples of the role of local authorities in supporting contact tracing and testing. For 18 months, the LGA interviewed public health teams and captured dozens of examples (see exhibited LGA publications, **Exhibit JK3/13p – INQ000575943** "Public health on the frontline: responding to COVID-19"; **Exhibit JK3/13q – INQ000575913,** "Covid-19: Testing case studies"; **Exhibit JK3/13r – INQ000575912,** "COVID-19: local contact tracing case studies".) I set out some of these examples in more detail below.

Calderdale Council

149. Faced with high rates of infection in the summer, Calderdale Council developed a local contact tracing service in partnership with and as part of NHS Test and Trace, which went live in the middle of August 2020.

150. It operated seven days a week – although the hours of operation were shorter at the weekend. Depending on the information the team received, residents would receive a text message and/or an email ahead of the call to let them know the local contact tracing service would be ringing them and a local 01422 number is available for residents to call back on if they miss the call.

151. Twenty contact tracers were recruited – drawn from both the council's own staff and people from the local community. The service consistently reached between 80 and 90% of the cases that are passed on by the national team.

Blackburn with Darwen Council

152. Blackburn with Darwen Council was among the first in England to launch its own local enhanced contact tracing service, sending tracers door to door after 48 hours if they are unable to contact people by phone.

Hertfordshire County Council

153. Hertfordshire Council started planning its local contact tracing service during the summer of 2020. The public health team consulted with Sandwell MBC, which was one of the first areas to launch such a service in July. Watford and Three Rivers borough councils teamed up to launch the first service. This went live in mid-September with the two councils having a core team of contact tracers supported by door-to-door tracing provided by environmental health officers. The other eight districts followed suit in early October, but with a central core team of tracers provided by the county and the individual districts doing their own door-to-door tracing. Calls that are made display a local number. The call centre service operated seven days a week.

Birmingham City Council

154. Birmingham had its own Test and Trace team, which had a variety of roles from data analysis and complex contact tracing to communications and community engagement. It was staffed by a combination of public health practitioners and environmental health officers working alongside staff drawn from other areas of the council, as well as external

recruits, and supported by the customer contact centre.

Peterborough Council

155. Peterborough Council launched an enhanced contact tracing service on 12 August 2020. Environmental health officers and redeployed regulatory officers underwent special training to ensure the service was staffed seven days a week. Peterborough managed to contact between 80% and 90% of the cases that the national tracers were not able to.

Covid-19 app – Isle of Wight Council

156. The Covid-19 app pilot on the Isle of Wight was an early adopter phase of the NHS Covid-19 app, aimed at testing the functionality and effectiveness of the app before a wider rollout. The pilot, which took place in May 2020, involved residents of the Isle of Wight using the app to help with contact tracing efforts. The app used Bluetooth technology to detect when users were in close proximity to each other and notified them if they had been near someone who tested positive for Covid-19.

157. The NHS Covid-19 app was launched across England and Wales on 24 September 2020. The app was designed to help control the spread of Covid-19 by using Bluetooth technology to log the amount of time users spent near each other and the distance between them. If a user tested positive for Covid-19, the app would alert those who had been in close contact with them, even if they did not know each other. The LGA responded to the launch of the app with a media release dated 11 September 2020 (**Exhibit JK3/14 – INQ000120511**).

Operation Moonshot – Liverpool City Council

158. In September 2020, the prime minister announced plans for a new testing system under "Operation Moonshot" that could test millions of people a day and turn around results in as little as 20 minutes.

159. Mass asymptomatic testing for Covid-19 was piloted for the first time in the City of Liverpool on 2 November 2020. The pilot was a collaboration between the NHS Test and Trace, Liverpool City Council , NHS Liverpool Clinical Commissioning Group, the Army (8 Engineer Brigade), Cheshire & Merseyside Health and Care Partnership, and Liverpool Charity and Voluntary Services. The aim of this study was to identify barriers and facilitators to engaging in mass asymptomatic testing and to generate recommendations for improving uptake of mass asymptomatic testing in future.

(F) Local government engagement with the voluntary and community sector

160. In March 2020, the LGA's Covid-19 work took account of a wide range of vulnerable groups, and the impact of the pandemic and associated non-pharmaceutical interventions, on them. The LGA's broad aims were to ensure that, working with partners in the voluntary sector, councils were enabled to support people who needed it, and to keep councils up to date on the latest government advice and other resources to help people in vulnerable circumstances.

161. At the onset of Covid-19, councils and the voluntary and community sector ("**VCS**") alike provided rapid crisis support to communities. This period brought both parties into a different, less transactional relationship. They had to work in close partnership to meet a shared challenge. As the country faced lockdown and social distancing to curb the spread of the disease, many residents were left isolated and at risk. It soon became clear that in many places the VCS was able to respond fastest to this crisis. The community infrastructure built up over time meant the VCS knew who needed help, what help they needed, and how to get it to them quickly.

162. Councils worked with the voluntary sector to run community hubs to ensure individuals who are self-isolating were able to access food and medicine.

163. The pandemic also created new vulnerabilities, for the cohort of people considered clinically extremely vulnerable to Covid-19 and asked by the Government to shield. Councils had an important role in supporting this shielded group, and it was an area in which the LGA undertook a significant amount of work, not least because the centrally designed and managed system created numerous challenges for councils to deal with.

(G) Robustness and efficacy of the UK Government's National Test and Trace Programme

164. There was a regrettable delay in central Government's engagement with local government. While local government moved very quickly to make the changes needed to protect the population and services as far as possible, by contrast, there was an initial failure by central government to engage with local government on key issues and decisions, and so to benefit from councils understanding of their communities.

165. This delay affected the design of schemes of very great importance to the community at large, for example, contract tracing, as well as to aspects of the legislation that was introduced and supporting guidance. I shall explain below how there were failures when

devising policies, to consult and engage with local government, and so take advantage of councils' closeness to their communities.

166. Consistent concerns were raised with LGA from an operational perspective about the steps government took in terms of engaging with local government. Local government was rarely a partner in co-designing the response to the pandemic, despite the extent to which it was critical in managing this. Moreover, particularly at the beginning, the disconnect between national policy formation and its local implementation, meant that local authorities spent much effort trying to stitch together different elements of the pandemic response on issues such as personal protective equipment, volunteering, and test and trace.

167. Contact tracing, where individuals who have been in close contact with an infected person are identified and advised to isolate, is a crucial public health measure for controlling the spread of infectious diseases. The success of contact tracing will depend on a truly integrated approach between national and local government and partners. No single organisation or agency, whether national or local, should have designed and overseen this operation alone. Contact tracing was not unique to the Covid-19 pandemic. It has been used extensively in previous emerging infectious disease outbreaks.

168. SAGE recommended that at least 80% of close contacts of positive cases must be reached for the system to be effective. SAGE also expressed the importance of contacts of individuals who had Covid-19 isolating within 48 hours. Minutes from "Thirty-second SAGE meeting on Covid-19" dated 1 May 2020 are exhibited as **Exhibit JK3/15 – INQ000512503**.

169. Since Covid-19 could be spread before symptoms occurred or when no symptoms were present, case investigation and contact tracing had to be speedy and the information as complete as possible. The ability to subsequently encourage and support cases and contacts to self-isolate is also vital. Broad community engagement is therefore needed to develop greater awareness, trust and acceptance of these measures locally. Financial and practical support for self-isolation is likewise fundamental for many.

170. Local authorities are a key element of this. DsPH and environmental health officers – and their teams – have extensive experience and knowledge of contact tracing and case finding, their local communities and the wider health and social care system. They have a critical contribution to ensuring contact tracing works on the ground. Local authorities were disappointed at the limited extent the Government involved local government in the development of all aspects of the Test, Track and Trace programme.

171. Local government had the local voice, knowledge and links to reach and support people from diverse and disadvantaged backgrounds. There needed to be far better reflection and discussion on what functions were best performed at what level; local, regional or national, and by who..

172. The approach in England contrasted with that in Wales, where national and local government collaborated and co-designed the contact tracing system from the start, whereas the LGA, and local government in England as a whole, were neither engaged nor involved in national plans for contact tracing until June 2020. As a result, some very precious time was lost. In Wales, the population-wide contact tracing service used existing public sector structures and had a focus on joint local–regional–national working across the Welsh Government, Public Health Wales, all seven health boards, 22 local authorities, and NHS Wales Informatics Service.

173. Further afield, in Germany, disease notifications from clinicians and laboratories primarily went to local authorities, where most of the practical work in infection control took place. Federal and state governments provided additional investment to strengthen local public health authorities. Civil servants were redeployed to public health from elsewhere and extra staff employed to support local contact tracing. Germany built on existing infrastructure and experience from the outset, unlike England, where the government preferred a centralised system run by outsourced companies.

174. The structure of the NHS Test and Trace Service in England was opaque, and it was unclear where responsibility lay for different functions. As a result, it was challenging to direct requests or concerns to the right part of the system, or engage constructively in finding solutions, and responses were often slow.

175. Call handlers providing contact tracing for non-complex cases were recruited by Serco. Through the first two months of NHS Test and Trace, it became apparent that call handlers were struggling to reach a significant proportion of cases and their contacts. Data at the time found that around 20% of cases passed to NHS Test and Trace had been uncontactable and, of the non-complex cases contacted by call handlers, only around 60% of their contacts had been reached and advised to isolate (see **Exhibit JK3/12b – INQ000575950**. For these non-complex cases, each contact needed to be identified and reached by a contact tracer.

176. It became apparent very early on that the system designed by Serco only dealt with people as individuals, divorced from connections to others – rather, given how infections link people to each other and to certain settings or events, the system did not recognise

people as part of a household, or part of an outbreak or cluster of Covid-19 cases.

177. Local government stakeholders expressed concern that they had not been sufficiently engaged on the design and implementation of test and trace services. The Government did not document the basis for the delivery model it chose for the national test and trace programme. Ministers did not speak to the LGA or ADPH to explore alternatives to a centrally commissioned contact tracing system. From August 2020 onwards, engagement improved as test and trace switched to a local model (see, for example, **Exhibit JK3/15a – INQ000575930**, Email chain dated 15 May 2020 from PHE to LGA, ADPH and MHCLG re test and trace Q&A for local government officers; and **Exhibit JK3/15b – INQ000575909,** the attachment with draft FAQs for local authorities on the national test and tract programme).

178. Central bodies and their contractors had not engaged sufficiently with local government and public health experts on key decisions about the design of test and trace services or the practicalities of implementing these services. At no time did representatives from the outsourcing companies, Sital or Serco, seek the LGA's advice and at no time did Sital or Serco attend any of the joint meetings held between ADPH, Chartered Institute of Environmental health ("**CIEH**") Faculty of Public Health, Society of Local Authority Chief Executives ("**SOLACE**") and PHE.

179. At no point have we seen the rationale for commissioning a national contact tracing system over a locally delivered programme.

180. As the pandemic developed, NHS Test and Trace sought local engagement and feedback in a number of ways, including senior-level secondments from local authorities, advisory groups such as its local authority design group, and activities such as the pilots for mass testing and door-to-door testing.

181. Over time, engagement did improve. Regular meetings, convened by MHCLG, took place at officer level for instance, with representative council chief executives (sometimes referred to as the R9 group) who were brought in to play a leading role on contract tracing and to ensure government central teams worked closely with councils.

182. It was pleasing to see in August 2020 the national system being redesigned to include local contact tracing, initially in areas with high prevalence, with resources from the national system transferred to local authorities which were tasked with contacting people testing positive who could not be reached within 24 hours, and people in complex settings such as care homes (see **Exhibit JK3/12c - INQ000510820** referred to at paragraph

115).

183. The combined effort meant that by December 2020, national test and trace reached 86%of people testing positive (see **Exhibit JK3/12b -** INQ000575950). Furthermore, local contact tracing allows for tracing to be combined with signposting towards local advice and support for those being asked to isolate, increasing the likelihood people will comply.

184. Local knowledge and local understanding were important, as discussed above at paragraphs 102 to 104. Councils used their local knowledge to successfully trace many hard-to-engage cases. By cross-checking contact data with their own records, such as council tax records, they were able to identify better contact details in some cases.

185. By using local telephone numbers and local staff, councils reported that significant numbers of people were willing to engage where previously they did not appear to want to. Even where this did not happen, the local services were having some success using their staff to knock on doors and deliver letters urging them to get in touch.

186. The strength in councils delivering these services does not solely lie in their ability to reach people. They were also able to help them isolate through support networks, many of which were established in the first wave to support vulnerable groups. Whether it is arranging food or medicine deliveries or simply finding someone to walk the dog, councils made it easier for people to stay at home and reduce transmission of the virus. As the crisis began, councils quickly identified those in most need. Every council set up a range of communications channels, locally tailored in a way not possible at a national level. Befriending schemes and mental health support were offered to tackle loneliness and isolation, whilst many councils provided additional financial support to those they assessed as being in greatest need.

PART 4: THE LGA'S INVOLVEMENT IN TTI IMPLEMENTATION AND DEVELOPMENT

187. In Part 4 of my statement, I expand on LGA's specific involvement with TTI implementation and development to the extent that this has not already been covered in Parts 2 and 3.

188. I note that, while the LGA is in partnership with the Association of Directors of Adult Social Services ("**ADASS**") as Partners in Care and Health, the LGA did not work with ADASS in the context of TTI.

189. Similarly, the LGA did not work with its sister organisations (Convention of Scottish Local Authorities, Northern Ireland Local Government Association and the Welsh Local Government Association) in respect of TTI.

190. The key figures at the LGA involved with TTI were:

    a. Mark Lloyd (at the time, Chief Executive) gave strategic direction on behalf of the organisation, working with central Government on behalf of local government to influence the national agenda;

    b. Sally Burlington (at the time, Head of Policy – People) provided an advocacy and leadership role for councils through proactive and coherent policy development in relation to policies relating to children and adults;

    c. Mark Norris (Principle Adviser) ensured that our policy teams were providing councils and officials with excellent advice and advocacy;

    d. Paul Ogden (Senior Adviser) was the public health policy lead and key link to PHE, Chief Medical Officer and ADPH;

    e. Rose Doran (Senior Adviser) was the welfare policy lead and key link to DWP;

    f. Ellie Greenwood (Senior Adviser) was the enforcement policy lead and key link to local resilience forums, Cabinet Office, MHCLG Emergency Planning Team;

    g. Juliet Whitworth (Head of Research and Information) was the data lead and key link to NHS Digital/England, PHE and DHSC data teams; and

    h. Jonathan Evans (Programme Manager Data Development).

191. As is evident from the rest of my statement, the LGA's involvement in TTI was not to directly develop nor implement national Government initiatives. The LGA's role with respect to TTI, as with the pandemic in general, was to support local government and act as a conduit between local and national Government. The key figures listed above played strategic roles as well as assisting to respond to TTI policy issues affecting local government.

(A) LGA's involvement in working groups

192. Government departments established numerous working groups and other arrangements to which they invited local government representatives and the LGA, and the LGA worked hard to coordinate input from the sector to ensure consistent messages were fed into those discussions as far as possible. The list of regular engagement mechanisms in relation to the themes covered in Module 7, developed as the pandemic progressed includes:

Date	**Meeting Title**	**Convening Organisation**
19/03/2020 - 29/05/2020	Task and Finish Group — Adult Workforce and Social Care Covid-19	DHSC
24/03/2020 - 24/02/2022	Regional Leads Call	MHCLG
22/04/2020 - 07/05/2020	Local Government and Tracing Strategy	PHE
29/04/2020 - 20/05/2021	National Covid-19 Social Care Provider Issues Group	LGA
12/05/2020 - 03/09/2020	Local Government Contact Tracing and Outbreak Management Design Working Group	LGA
22/05/2020 - 01/02/2022	Local Outbreak Plan Advisory Board	LGA
08/04/2020 - 26/01/2021	Shielding Stakeholder Group	MHCLG
09/06/2020 - 21/07/2020	Local Outbreak Plans — Good Practice Areas	DHSC
19/06/2020 - 26/08/2020	Social Care Sector Covid-19 D Taskforce	DHSC
27/08/2020 - 01/02/2022	Local Government/Local Authority Government Compliance Working Group	MHCLG
21/09/2020 — 04/12/2020	Test and Trace Support Payment Implementation Working Group	DHSC
17/11/2020 — 28/04/2021	Chief Executives Sounding Board	Solace

	(Test & Trace)	
08/01/2021 — 04/02/2022	Policy & Ops Co-design Group	DHSC
13/01/2021 — 24/02/2021	Self-Isolation Task and Finish Group	MHCLG

193. The Regional Leads Calls were convened by MHCLG and attended by the local authority regional representatives (the R9 group). The group cascaded views up and feedback down. The LGA only assisted with the Regional Leads Calls in a facilitatory role.

194. The R9 group met with officials of MCHLG (and later the Department for Levelling Up, Housing and Communities). From February 2020, the weekly meetings included Covid-19 as an agenda item. Meetings and emails between the group increased from the second half of March 2020 and were then ongoing during the height of the pandemic.

195. The Local Outbreak Plan Advisory Board was established and convened by the LGA in late May 2020 with the aim of improving consultation and communication. In time, government departments established numerous working groups and arrangements to which they invited local government representatives or individuals. The Board was able to draw on expertise from across local government and would provide advice on how best to support the delivery of effective local outbreak control plans, as part of the national approach; comment on information and advice to local areas and partnerships to ensure it can be understood and acted on by local government and its partners; advocate for agreed approaches with local government networks to promote effective local action as part of an agreed national strategy.

196. The Local Government Contact Tracing and Outbreak Management Design Working Group was established by PHE and convened by the LGA. The group was established to ensure that national contact tracing arrangements build on local government and wider local capability to support the national effort to manage the Covid-19 outbreak as effectively as possible; that local arrangements were able to deliver effective local plans, supporting coherent local arrangements for testing, contact tracing and tracking to manage local outbreaks, and providing local support for people who need it.

(B) Timeline of engagement with TTI

197. In this section of my statement, I summarise the LGA's engagement with the Government in the early months of 2020 in relation to Testing and Contact Tracing.

198. In early 2020, the public health teams within local authorities were heavily involved in infection control and managing outbreaks of Covid-19. Nationally, the LGA's engagement at both the political and officer level was also beginning, both through scheduled meetings and more informally.

199. In early February 2020, the LGA was approached by PHE, looking to strengthen contact tracing capacity within local health protection teams based in PHE centres. PHE were seeking volunteers (such as school nurses, smoking support staff, infection control nurses, health champions) who would be able to talk to members of the public about health issues, and clinicians managing confirmed cases and contacts — for example, members of public health teams. The LGA along with PHE and ADPH co-signed a letter to DsPH seeking their help in identifying volunteers, dated 28 January 2020 (**Exhibit JK3/16 - INQ000512504**; see also the email correspondence, dated 28 January 2020, related to this letter at **Exhibit JK3/17 - INQ000512505** and **Exhibit JK3/18 - INQ000512507**).

200. The test and trace infrastructure in England by early March 2020 was soon overwhelmed by the sheer number of cases and their contacts. Laboratories in PHE were not designed for mass testing and the difficulties of rapidly increasing test availability shaped the government's decision to stop testing potential community cases in early March.

201. On 12 March 2020, as the number of cases in the community rose, testing and contact tracing of members of the public in England ended (the 'contain' phase). Instead, a case in the community was defined based on an individual's symptoms and their likely exposure to someone with the virus, rather than on a positive test result (the 'delay' phase). The country's limited testing capacity was reserved for patients admitted to hospital, and active contact tracing was confined to high-risk settings with vulnerable individuals, such as care homes and hospitals.

202. The LGA were not advised of the Government's decision to all but abandon contact tracing. We understand this was not consistent with WHO guidelines, which urge a test-and-trace approach. At a WHO media briefing on Covid-19 in March, director general Tedros Adhanom Ghebreyesus said: "Tracing every contact must be the backbone of the response in every country." We know now that failure to have enough testing capacity in the early weeks of the pandemic was reflected in the decision to halt test and trace in the community.

203. At the Government's daily press briefing on 23 April, the Secretary of State for Health and Social Care previewed the contact tracing elements of the proposed test, track and

trace system for Covid-19 in England. The Health and Social Care Secretary's statement dated 23 April 2020 is exhibited as **Exhibit JK3/19 – INQ000512705**. Further details were cascaded to local directors of public health the following day. The letter from PHE to DsPH dated 24 April 2020 is exhibited as **Exhibit JK3/20 – INQ000512509**. The plan combined the PHE web-based contact tracing tool, known as the contact tracing and advisory service , with both telephone-based contact tracing and a smartphone app.

204. On the 24 April 2020, the LGA responded to the Government's coronavirus contact tracing strategy. The LGA's media release dated 24 April 2020 is exhibited as **Exhibit JK3/21 – INQ000103810**.

205. The system was piloted from 5 May 2020 on the Isle of Wight and NHS Test and Trace was launched on 28 May 2020, The Prime Minister at the time Boris Johnson pledged to deliver a 'world-beating system'.

206. On 10 May 2020 the LGA publicly raised concerns that crucial testing data must be shared with councils to make use of their local knowledge and expertise and ensure vital national efforts to track and trace coronavirus succeed. See LGA media release dated 10 May 2020 and exhibited as **Exhibit JK3/01** – **INQ000512488**, as referred to above.

207. In early May 2020, ministers appointed the then Leeds City Council Chief Executive Tom Riordan to work on the NHS Test and Trace programme and to help to ensure the central teams worked closely with local councils. In August 2020, he was followed in this role by Dr Carolyn Wilkins, Chief Executive of Oldham Council, as national tracing lead. Both worked extremely closely with the LGA during their periods in the role. See the LGA media release dated 18 May 2020 exhibited as **Exhibit JK3/22 – INQ000512510**.

208. At the political level, the Local Outbreak Plan Advisory Board established in late May 2020, improved this consultation and communication. In time, Government departments established numerous working groups and arrangements to which they invited local government representatives or individuals.

209. As discussed at paragraph 101, local authorities in England developed Covid-19 outbreak control plans to help manage ongoing outbreaks. However, local directors of public health were initially unable to implement much of their plans because they were unable to access the necessary case-level data from commercial laboratories due to concerns surrounding data governance.

210. Proactive data sharing around contact tracing, outbreak management, and ongoing

surveillance should have been a priority from day one for both the National Testing Strategy and the NHS Test and Trace Service.

211. Data is the starting point for public health activity. Our decisions are determined by the degree of timely, reliable data available. The information system is a core part of any public health activity – including our response to an epidemic. The purpose is to transform data into information and then into intelligence which can lead to our evidence-based decisions for action.

212. DsPH need data for surveillance, i.e. assessing and monitoring changes in the level of infection in an area; and we need data to then actively prevent or manage any clusters or outbreaks that may occur. It is vital that DsPH have access to timely and robust data, including data related to testing, the number of cases, data on contact tracing undertaken (linked to the cases), and local clusters or outbreaks in places such as schools, hospitals and care homes, hospital use and deaths. The integration of both national and local data and intelligence is essential for scenario planning, rapidly responding to outbreaks and informing and supporting more effective targeting of interventions to prevent and manage outbreaks.

213. National bodies had been slow to provide local authorities with data – this had caused significant problems. During the containment phase, for example, DsPH were struggling to get information on the positive cases in their area. This often meant DsPH were learning about cases via the media and left on the backfoot when responding to requests for advice from settings such as care homes and schools.

214. With limited and unreliable access to data, DsPH have often had to rely 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, DsPH have had to establish lines of communications with the care homes to obtain results from them, rather than receiving them directly from PHE. This had been both resource intensive and time consuming – and can introduce error.

215. DsPH were proceeding by guesswork and were prevented from accessing postcode or individual level data – for example, they did not have the postcodes of residents who tested positive for Covid-19 (or any form of the denominator). This systematically delayed effective local responses. Without Personally Identifiable Data, public health teams were unable to fully understand the nature of infection and spread within their local area, or to undertake the 'detective work' that is required to understand what is happening and how it can be addressed effectively.

216. Furthermore, the information received was often incomplete, especially in relation to ethnicity and occupation. It also did not capture workplace postcode, which is essential in identifying potential outbreaks where the individual who has tested positive works in a different area to the one in which they live.

217. Conversations between local authorities and national partners (such as the NHS, UKHSA (formerly PHE) and the Office for Health Improvement and Disparities) about these flows had too often focused on processes rather than outcomes, as well as what restrictions need to be placed on data sharing, rather than thinking how public health teams in local government can better use data collectively while meeting data protection requirements.

218. When data did start to flow, access was hampered by multiple data sharing agreements and restricted access protocols; and the tools and format the data were provided in were not always conducive to authority's needs. It was not until early August that patient identifiable data started flowing through. This allowed public health teams to better understand who was getting infected and where, and whether there were links between cases.

219. There was a significant contrast between the beginning and end of the pandemic with regard to data sharing. The importance of local public health team data access was recognised and data and intelligence became a lot more readily available.

220. From June 2020, the LGA also joined the Local Government Contact Tracing and Outbreak Management Design Working Group alongside ADPH, SOLACE, the Faculty of Public Health, the Association of Chief Environmental Health Officers, and the CIEH and PHE. This group was established by PHE when it was recognised that local government public health leads, and local government more generally, was missing from discussions.

221. At the political level, the Local Outbreak Plan Advisory Board, was established in May 2020. Government departments established numerous working groups and other arrangements to which they invited local government representatives and the LGA, and the LGA worked hard to coordinate input from the sector to ensure consistent messages were fed into those discussions as far as possible.

(C) Communications

222. The public are not the LGA's primary audience for the majority of the LGA's communications. While the LGA does use national, trade and social media to outline some of the LGA's key messaging, its primary audience tends to be its members and key stakeholders such as government, Parliamentarians, and partner organisations.

223. Although the LGA did engage in some work to amplify public health messaging through the LGA's national media and social media activity, the LGA's core communications activity during Covid-19 was not based on promoting messages to the public. Instead, the LGA's Communications Directorate's main activities in relation to Covid-19, linked to that of the wider organisation, were:

    a. Producing daily bulletins to member authorities summarising the LGA's work with central Government in relation to Covid-19, as well as the dissemination of relevant information and updates.

    b. Liaising with communications leads in central Government departments (including MHCLG, Cabinet Office, Department for Transport, DHSC) to disseminate relevant information to council communications teams through the Commsnet bulletin - this is a subscriber bulletin emailed to all council communications teams in England (there are currently around 4,000 recipients) which the LGA uses to share updates from the LGA, alongside information and good practice and assets from other stakeholders such as central Government, it is usually sent weekly but went out more frequently during the pandemic as the LGA hief executive bulletin was also included in it.

    c. Raising with relevant communications leads in Government departments the issues raised by council communications teams;

    d. Hosting Covid-19 webinars for council officers and councillors.

    e. Creating a Covid-19 web hub, which included service information, FAQs, guidance, and support for people in their roles (councillors and officers); and

    f. Drafting briefings for parliamentarians and stakeholders covering parliamentary debates (including on Covid-19 related legislation and regulations) as well as select committee submissions.

224. Providing good, clear communication was an important part of local government's role

during the pandemic. In the early days of the outbreak, local directors of public health, leaders and chief executives spent a lot of time engaging with the media on television and radio. Effective communication and the provision of information was crucial. All councils amplified central government public health messages throughout the pandemic, although individual councils were responsible for their own communications, and this was not coordinated by the LGA.

225. As noted, communications materials developed by the Government were shared in LGA bulletins to allow councils to use them through their own channels. The Cabinet Office held a weekly briefing for council communications leads to ensure council communicators had access to the latest coronavirus campaign materials, and to ensure there was a consistency to public health messaging across central and local government.

226. However, councils also ran tailored local campaigns to ensure messages resonated with their communities — whilst ensuring that overall messaging was consistent with the national approach. This was particularly powerful during the vaccine rollout, when local authorities could use their local knowledge to engage with parts of the community which were less responsive to central government campaigns. The LGA assisted local authorities through webinars where different authorities shared examples from campaigns, and through the LGA's website where the LGA hosted hundreds of examples of good local practice.

227. The LGA also established a Covid-19 communications web hub on its website which aimed to support local authorities to plan for and think strategically about communications and engagement during the pandemic. It provided practical guidance and advice, building on the lessons learned since March 2020.

228. The LGA met with communications colleagues in central government throughout the pandemic to share information and the LGA's approaches. Key Government departments presented at all of the LGA Covid-19 communications webinars and MHCLG used examples of council good practice from the LGA website in its own communications, including bulletins and press releases.

229. Councils ensured that the information they were promoting was available in other languages and formats, as is standard for local public health and health promotion work. Some parts of a local community will only engage with information in their own languages.

PART 5: IMPACT ON DEPRIVED COMMUNITIES

230. The disproportionate effects of Covid-19 on deprived population groups are well documented. Not only were case and fatality rates for Covid-19 higher than among people living in less deprived areas, but policies also that were aimed at preventing spread, such as social restrictions and lockdown, had a greater effect on vulnerable populations.

231. The areas of England with high case rates were the same places that experienced higher case rates, hospitalisations and deaths in the first six months and were subject to the most prolonged and restrictive local lockdowns.

232. These are also places that are more deprived, where people are less likely to be able to work from home, and where people are more likely to live in more crowded, multiple occupancy households. The percentage of positive cases and their contacts who had been successfully contacted was lower in the most deprived areas than in the least deprived. Understanding these differences is crucial to ensure that the inequalities that were exposed by Covid-19 are not repeated.

233. There is also recognition amongst local government of the disparities experienced by particular groups including traveller communities, people with black and ethnic minority heritage, people living with disabilities and rural communities.

234. Inequalities emerged through the 'syndemic' nature of Covid-19, in that it interacts with and exacerbates existing social inequalities in chronic disease and the social determinants of health. Factors highlighted include existing chronic disease, ethnicity, housing, work conditions and access to healthcare, which together produce unequal experiences of the pandemic between communities.

235. Local government recognised these factors relating to individual risk, and suggested that structural issues linked to age, gender, ethnicity, occupation and geography have exacerbated impacts of Covid-19 on certain communities.

236. In the early months of the pandemic, it was heavily urbanised areas such as London and the North East that saw high levels of Covid-19 mortality. As time went on, rates in areas of deprivation such as Leicester and Blackburn with Darwen remained high. Urban areas including London with greater density of population were hit hard, reflecting the deprivation that comes with crowded housing and homes of multiple occupancy. The more deprived a local authority, the higher the Covid-19 mortality rate had been.

237. Overcrowded living conditions and poor-quality housing are an obvious consequence of low income and deprivation, adding to the higher risks of infection and mortality from Covid-19.

238. Health inequalities such as deprivation, low income and poor housing have always meant poorer health, reduced quality of life and early death for many people. The Covid-19 pandemic has starkly exposed how these existing inequalities – and the interconnections between them such as race, gender or geography, are associated with an increased risk of becoming ill with a disease such as Covid-19.

239. The Contain Outbreak Management Fund was designed to help local authorities tackle enduring transmission, by supporting 'testing, non-financial support for self-isolation, support to particular groups, communications and engagement, compliance and enforcement'. This fund ended in March 2022.

240. DsPH emphasised the need for local approaches, stating that local insight was needed in order to develop culturally appropriate action to support residents from groups who had been disproportionately affected by the pandemic. The need for local approaches to engage communities in managing transmission.

PART 6: RECOMMENDATIONS

241. The LGA invites the Inquiry to consider the following points and to adopt them in its conclusions and recommendations.

242. There can be no success in addressing an equivalent civil emergency if local government, being most closely connected to local communities, is not fully engaged from the outset, as a committed and critically important partner.

243. Any future approach to testing must be developed with local authorities and local health protection teams, ensuring they are able to meet local needs and address inequalities. This means co-designing policies for testing, contact tracing and self-isolation with the communities and places most affected, with a genuine 'local by default' approach where local leaders have the resources and flexibility they need to deliver local solutions.

244. The response to Covid-19 has too often been 'national be default' with systems and process designed from Whitehall and limited engagement, and understanding, of the value and role of local councils and DsPH.

245. Any future approach must be developed with local authorities and local health protection

teams, ensuring they are able to meet local needs and address inequalities. This means co-designing policies for testing, contact tracing and self-isolation with the communities and places most affected, where local leaders have the resources and flexibility they need to deliver local solutions.

246. There needs to be far better reflection and discussion on what functions are best performed at which level; local, regional or national, and by who.

247. Contract tracing systems must be fully integrated with local public health teams, local communities, NHS and primary care systems. Local public health teams, including community nurses and environmental health practitioners, have long experience of contact tracing and this expertise must be maximised. A strong place-based approach is essential for the long-term control and suppression of infectious diseases. Local government provides the leadership, expertise, partnership-working, and access to local resources that are fundamental to strong place-based coordination of health protection.

248. There must be a transparent and clear systems map available in the public domain that shows how different agencies and organisations work together and how information flows between them. There is an increasing expectation of health protection work from local public health, which should be both more specifically detailed and appropriately funded.

249. It is crucial that local public health teams have strong links to UKHSA. Strong local connections should be built into UKHSA's governance arrangements including public health professionals with local authority and DsPH experience at the highest levels within its staffing.

250. There should be local authority presence (i.e. through ADPH, LGA and CIEH) on UKHSA's Non-Executive and advisory boards, as well as systemic links to existing local structures (i.e. health and wellbeing boards, local health resilience partnerships, and local resilience forums).

251. Flexibility of local decision making is what drives an efficient public health system. Assurance should be based on trust not centralising control. This does not mean everything is devolved; some things are better done regionally, some done nationally and some shared. It should mean whole system working – including local government, public health authorities, other public sector, third sector and businesses, who all have a part to play.

252. Quality standards for contract tracing systems must be explicit and reported on. This must include as a minimum, the proportion of cases contacted, the average time taken to contact cases, the average number of contacts identified and the proportion of contacts successfully traced. Information should be provided on the number and proportion of cases linked to institutions such as healthcare providers, care homes, schools, places of worship or other workplaces. Regular monitoring of the quality of advice given should be undertaken.

253. Despite being a legal requirement for most of the pandemic, adherence to self-isolation was low. Understanding why this is the case must inform future policy to promote positive public health behaviours.

254. The MHCLG and DHSC should consult on how to improve working around data between central and local government in England. This should include the creation of a data brokering function to facilitate two-way data sharing between national and local government. The Government should complement this by reviewing the role of the UK Statistics Authority to support timely data and data sharing across all tiers of government in the UK.

255. 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.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 29 April 2025

APPENDIX ONE – GLOSSARY

Acronym	Meaning
ADASS	Association of Directors of Adult Social Services
ADPH	Association of Directors of Public Health
CIEH	Chartered Institute of Environmental Health
DHSC	Department of Health and Social Care
DsPH	Directors of Public Health
DWP	Department of Work and Pension
HMT	Her Majesty's Treasury (as it then was)
LGA	Local Government Association
MHCLG	Ministry of Housing, Communities and Local Government
NHS	National Health Service
PHE	Public Health England
R9	Nine regional representatives of local government
Rule 9	Rule 9 of the Inquiry Rules 2006
SAGE	The Scientific Advisory Group for Emergencies
SOLACE	Society of Local Authority Chief Executives
TTI	Test, Trace and Isolate
UKHSA	UK Health Security Agency
UPRN	Unique Property Reference Number
VCS	Voluntary and Community Sector
WLGA	Welsh Local Government Association