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UK COVID-19 INQUIRY

Module 4

VACCINES AND THERAPEUTICS

WITNESS STATEMENT OF JOANNA KILLIAN

ON BEHALF OF
THE LOCAL GOVERNMENT ASSOCIATION

Contents

I, **Joanna Killian**, will say as follows –

Introduction

1. I am the Chief Executive (CE) of the of the Local Government Association (LGA) of 18 Smith Square, London, SW1P 3HW. I am authorised by it to make this statement in response to the Rule 9 Request in Module 4 of the Covid-19 Inquiry (the Inquiry) concerning Vaccines and Therapeutics.

About the LGA

2. 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.

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

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

4. 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 (NALC), which is the membership body for Town and Parish councils, is a corporate member of the LGA.

5. A key function of the LGA has always been to act as a conduit between central and local government, providing and distilling information from councils into government and vice versa; this role assumed even greater importance during the Covid-19 pandemic.

My background

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

6. I have over 30 years of experience in the public sector, including 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.

The basis of my evidence

8. My time as CE of the LGA commenced on 18 March 2024 and therefore after the period of concern in Module 4.

9. As my career history shows 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 have had to rely on information provided to me by the LGA officers involved in its work over this period.

10. I am happy to do this since I know well that the LGA's officers are highly professional, and it is my belief that they have diligently and fairly reported to me the relevant information that I set out below. Accordingly, my statement should be read as representing the collective understanding and knowledge of the LGA in relation to the implementation and associated challenges of the vaccine rollout across the United Kingdom during the Covid-19 pandemic.

The LGA's role in Module 4

11. The LGA has applied and been granted Core Participant status in other Modules of the Inquiry. However, it did not do so in relation to this Module.

12. However, in January 2024 both it and Welsh LGA (WLGA) were informed that the Inquiry intended to issue a Rule 9 Request for information thought to be relevant, and this was followed up on 15 April 2024 by a formal request, pursuant to the Rule 9 of the Inquiry Rules 2006. In this statement I have sought to answer fully the

questions posed in that Request. The LGA is of course happy to respond to any follow-up requests to the extent that it would be able to do so.

Key points in this statement

13. At the outset. there are some points which the LGA would wish to emphasis about the role, it and local government played, in respect of the issues under discussion in this Module.

14. Thus, first the LGA recognises that the period covered by Module 4 was as challenging a period for good governance at all levels as any since 1945. During this crisis period decisions had to be made quickly and communicated well, it was also a period in which great demands were made on civil society at all levels. In this respect, it is important to record that 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, and that it did indeed step up with a determined aim to make a positive contribution.

15. More specifically, there are six key points that the LGA wishes to make in response to the Provisional Outline of Scope for Module 4:

- Throughout this period the LGA sought to be a strong, reliable and informed means of communication between central and local government.

- Central government engagement, communication and consultation with local government was often inconsistent, with councils and Local Resilience Forum partners feeling isolated from national decision-making and unable to effectively plan and strategize responses.

- Local government made a critical contribution to the vaccine rollout, particularly in encouraging uptake among groups less likely to get vaccinated.

- There were difficulties in vaccinating across the adult social care sector, and lack of parity between the NHS and social care.

- There were pre-existing disparities in the situation of the most vulnerable groups, and these were exacerbated by the pandemic; ensuring these groups are well informed about receiving vaccines and have full access to them is essential.

- There is a need to review the rules for data sharing in an equivalent crisis.

Outline of the statement

16. After this introductory section my witness statement is divided, into the following Parts representing the headings in the Rule 9 request –

Part A – Role of the LGA, engagement with others, and key decisions

Part B – Covid-19 vaccine delivery programme and roll-out procedures

Part C – Barriers to vaccine uptake

Part D – Public messaging

Part E – Vaccination rollout across social care

Part F – Lessons Learned

Part A – Role of the LGA, engagement with others, and key decisions

General outline of responsibility for vaccine delivery

17. Vaccination and immunisation programmes are a part of the Secretary of State's duty to provide a comprehensive National Health Service (NHS) under the National Health Service Act 2006. There are three distinct phases to such programme's advice concerning need, commissioning of provision of vaccination and local delivery of the programme. This must all be done while continuously keeping an eye to maintaining quality control and safety.

18. The Joint Committee on Vaccination and Immunisation (JCVI) advises the government on vaccine policy, including on what vaccines to commission and provide for the population.

19. Vaccines are subsequently commissioned by NHS England and delivered by a variety of providers such as GP surgeries and pharmacies. There is an existing NHS Public Health Functions Agreement between the Secretary of State and NHS England pursuant to section 7A of that Act, by which NHS England is responsible and accountable for the commissioning of national immunisations programmes.

20. The UK Health Security Agency (UKHSA) (formally Public Health England (PHE)) and local Directors of Public Health within local councils have key roles in respect of quality assurance and safety. Directors of Public Health are expected to provide appropriate challenge to arrangements and advocate for an emphasis on reducing health inequalities and improving access for disadvantaged groups in the work of commissioners, providers and other key stakeholders.

What happened in outline

21. During the pandemic, central government led the vaccination programme working through NHS England and the Department of Health and Social Care. The overall aim was to vaccinate the maximum number of people in a minimum period. This was planned to be achieved by the centre, in a command and control fashion, by organising the rapid deployment of the vaccination infrastructure, setting up clinical and reporting systems, and supply management. The NHS dominated this highly centralised strategy, with input by military planners, even though there would have to be significant local government involvement.

Local government's role during the pandemic

22. To understand fully the interaction between the vaccine programme and local government during the pandemic I must first say a little about the work that local government was doing at the time and how it interacted with general government more generally.

23. A key function of the LGA has always been to act as a conduit between central and local government, providing and distilling information from councils into government

and vice versa; this role assumed even greater importance during the pandemic.

24. Thus, throughout the period from January 2020 to the summer of 2022, councils were the first port of call for the most vulnerable people or those otherwise in need of support or assistance, simply because councils are uniquely placed at the heart of their communities and so were closely involved in public service delivery. In response, councils demonstrated flexibility, innovation, resilience, and responsiveness. Most of all, they demonstrated their ability to respond to emergencies irrespective of scale. Their knowledge of what operationally was achievable had much to offer to central government in terms of policy development.

25. Yet in the early days of the pandemic, meaningful engagement between the Government and the LGA and local councils on the local impacts of key decisions was more limited than the LGA believes was merited.

26. Engagement was often informal or *ad hoc*, or reliant on existing structures such as the 9 Regional Chief Executives (R9) MHCLG (formerly called MHCLG and DLUHC) meetings originally established to input to the European Union (EU) exit work. Although engagement through these channels increased, this was usually to discuss decisions that had already been taken.

27. Remote command and control from Whitehall had limited efficacy because it lacked the knowledge that local councils have about their areas. Rather, such crises require 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.

28. Overall - as has been said in earlier Modules - while recognising that some key decisions had to be made at pace, as the situation was escalating rapidly, it is the LGA's view that there was a lack of proper engagement with local government on the important decisions taken at the outset of the pandemic. The lack of local government input led to centralised, rather than localised, systems being developed, with poorer outcomes resulting from the lack of local input and subsequent delivery.

29. On the other hand, 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. Councils are able to develop trusted relationships with their communities which are crucial for reassuring people in relation to vaccines. The local government workforce played a significant role in the pandemic. It was something that was almost forgotten how many people were ready and willing to support in local government. Many aspects of the response that were dictated from central government demonstrated the problems in trying to design, control and manage from the centre, activities that required local responses to widely differing community-based challenges.

Central and local dialogue on vaccination during the pandemic

30. Turning more specifically to the dialogue in relation to vaccination, the LGA considers that in the very early days meaningful engagement between the Government and the LGA and local councils on the local impacts of key decisions was more limited than it believes was merited.

31. Many aspects of the pandemic response — from shielding, to test and trace, and vaccination — demonstrated the problems in trying to design, control and manage from the centre, activities which must be delivered locally to community-based challenges. Regrettably, at the start, local government stakeholders did not feel their existing experience of logistics and knowledge about their communities had been taken fully into account at an early enough stage in key decision making and implementation of the vaccine rollout programme by NHSE and DHSC. In the LGA's view this highly centralised strategy and lack of consultation and engagement with local actors in the design of the initial vaccine delivery strategy, led to difficulties with logistics, communications and efficiencies that could have been avoided.

32. The LGA emphasises that throughout the pandemic it raised issues consistently with officials, including through informal routes, about the steps government was taking, from an operational perspective, relating to the timeliness of decision making and communication to councils, funding and workforce issues.

33. Though local government had an absolutely critical role in helping the country get through the pandemic it was rarely a partner in co-designing the response with central government. Moreover, particularly at the beginning, the disconnect between national policy formation and its local implementation, meant that councils

spent much effort trying to stitch together different elements of the pandemic response on issues such as vaccinations, shielding and test and trace.

34. Once it was clear that effective vaccines would be available, NHS England, whose ultimate responsibility the roll-out has been, was clear that local authorities had a crucial part to play. Over time, there was a broad transition to more localised (or at least locally influenced) approaches. Repeatedly, councils found that they were able to work far more effectively once central government began to engage with them either directly or through the LGA. Councils were able to develop better targeted and effective solutions because they knew how things would work in their widely differing communities.

35. Initially during the pandemic, NHS England's engagement with the LGA on the Covid19 vaccine rollout was minimal. That changed in November 2020 with the appointment of Dr Emily Lawson, head of the NHS COVID vaccination programme.

36. On her first day in the job, Emily Lawson set up a call with the LGA and one of the earliest NHS circulars on the deployment strategy was addressed not just to the NHS but to council leaders, setting out 'what the NHS and Government will provide nationally, and what we expect the NHS working with local government and other partners locally to deliver'.

37. Eleanor Kelly, the Chief Executive of Southwark Council, was seconded in January 2021 into the senior vaccine team at NHS England as a key liaison with councils and mayors.

Key decisions, actions, and documents

38. The table below sets out a chronology of key dates concerning the work of the LGA in respect of the issues set out in the Provisional Outline of Scope for Module 4. The LGA does not have any of the minutes and agenda papers for the meetings listed below. They should be available via NHSE and DHSC (Exhibits JK/01 - INQ000503934; JK/01a - INQ00503937; JK/01b - INQ000503935; JK/01c - INQ000503940; JK/01d - INQ000503941; JK/01e - INQ000503942; JK/01f - INQ000503933; JK/01g - INQ000503932; JK/01h - INQ000503931; JK/01i - INQ000503930; JK/01j - INQ000503928; JK/01k - INQ000503927; JK/01l - INQ000503925; JK/01m - INQ000115214; JK/01n - INQ000503921; JK/01o -

INQ000503907; JK/01p - INQ000503908; JK/01q - INQ000503917; JK/01r - INQ000503910; **JK/20 - INQ000257242;** Vaccine boosters Taskforce meeting, dated 06/01/2022 (produced within the eighth witness statement of Sir Christopher Stephen Wormald at INQ000000000) - INQ000257242; JK/01s - INQ000503904; JK/01t - INQ000503906; JK/01u - INQ000503900; JK/01v - INQ000503899).

20/05/2020 -17/09/2020	Covid-19 Vaccination Programme Board
25/01/2021 - 28/06/2021	Vaccines Planning Meeting Department of Health and Social Care
06/01/2022 - 22/02/2022	Vaccine Boosters Taskforce Department of Health and Social Care
March 2020 - onwards	Weekly national Covid-19 Social Care Provider meetings convened by the LGA
17/12/2020 – 15/04/2021	Vaccine Deployment Communications Group
October 2021 - onwards	Regular meetings with Skills for Care (convenor), ACAS & DHSC to discuss mandatory vaccination and support for Registered Managers having to implement the policy; shared updates from Skills for Care & ACAS around councils
01/07/2021 – 18/07/2021	Vaccination as a Condition of Deployment (VCOD) stakeholder working group - DHSC convened.

Part B – Covid-19 vaccine delivery programme and roll-out procedures

Data collection

39. At the outset of the pandemic, there was lack of access to any data on vaccination numbers and rates. The sector was seeking data at a small enough geography to allow them to fulfil their role in the delivery of the Vaccination Programme: DsPH have a statutory responsibility for health protection, to assure immunisation programmes and to address health inequalities. For screening and immunisation programmes, they are expected to provide appropriate challenge to arrangements and also to advocate for reducing health inequalities and improving access for under-served groups (see DHSC/PHE's guidance to DsPH) **(Exhibit JK/21 - INQ000023105).** Guidance from Prepared by the Public Health Systems and Strategy Unit within the Department of Health and Social Care, Public Health England, the Local Government Association, the Association of Directors of Public Health and the Faculty of Public Health, titled Directors of Public Health in Local Government Roles, Responsibilities and Context dated January 2020 -INQ000023105).

40. The local vaccination data being sought allowed councils to understand which neighbourhoods within their area might have low take-up of vaccinations. DsPH

also sought data at individual person level, which would have allowed them to see the characteristics and/or location of each person vaccinated. This supported their role in direct outbreak management: local authorities have a key role to ensure safety in care settings, both their own and also those of external care providers, therefore understanding the vaccination status of residents and staff was important.

41. There was no data available at all until more than a month after the first vaccination, so councils had no sight at all of the situation in their areas. When data was first made available, it was published at small area level, but as numbers rather than rates, which made it difficult to detect hesitancy or low vaccination rates, as it was unclear what proportion of the population with different characteristics had received vaccinations.

42. Data on disability was never available which, given the known vulnerabilities of people with some disabilities to Covid-19, made it difficult for councils to understand whether the programme was reaching those who needed it most. This was because the data was not collected at the point of vaccination. Similarly, at the point of vaccination no information was taken to allow identification of care staff. This placed an additional burden on care providers (and councils), who were asked to monitor and report the vaccination status of their staff (and which was a requirement under the Infection Control Fund). Again, had local government been involved in the design of data collection at the point of vaccination, this key information would have been picked up. Without it, local authorities' role in direct outbreak management was compromised, as they could not ensure safety in care settings locally by understanding the vaccination status of the staff in each care home.

43. The lack of individual-level data for councils over the period of the Vaccination Programme made it difficult for councils to fully undertake their statutory role. Individual level information would have allowed early identification of care homes with low vaccination rates (as, for example, the data provided about vaccination in even a small area may well have included a number of care homes within the same geography; whilst the exact location of an individual would have allowed identification of a specific care home). Similarly, in urban settings, it is not uncommon for areas of deprivation and wealth to be close together and appear within the same geographical boundary. Precise, individual level data about vaccinations would allow a council to understand exactly which areas had lower

rates, so they could ensure equality of access and appropriate local prioritisation.

44. Local government called for more transparency from central government over local vaccination data. There was a great deal of frustration that data could not initially be shared with DsPH for what were said to be "commercially sensitive" reasons. Without this data, Directors of Public Health had minimal sense of the supply chain picture in terms of planning and quantities for future delivery, and no local uptake data, meaning no clear picture of vaccination by specific groups.

45. In an article in the Local Government Chronicle dated 8 January 2021, Directors of Public Health reported they had been told data cannot be shared with them for "commercially sensitive" reasons – the same reason given to them earlier on in the pandemic when they were unable to access local contact tracing data. In an open letter dated 6 January 2021 to the Health and Care Secretary Matt Hancock, Birmingham City Council Leader, Councillor Ian Ward called for exact data on constituency vaccination numbers to be shared with local officials. (Exhibit JK/02 - **INQ000507716).**

46. The LGA provided NHS Digital, NHS England and Public Health England with a full explanation of why local authorities needed this data for their statutory role, both in January and February 2021 (Exhibit JK/03 - INQ000503951). Although eventually over time, many elements of our request for data describing small areas was met, the individual-level information was never made available, but the level of detail available to local councils was not always sufficient to help DsPH tackle vaccine hesitancy, vaccine refusal and 'no shows', as well as emerging inequalities.

47. The first vaccination took place on 8 December 2020. By 12 January 2021, the LGA brought together a group of DsPH to articulate better the vaccination data they needed, since a month had passed and authorities still had no vaccinations data at all. The first action was to provide NHS Digital, NHS England and Public Health England with a list of data asks (via their Vaccination Programme). Asks were divided into three categories: core (minimum requirement) enhanced (where DsPH would welcome more information) and ideal (individual level data, identified separately not to hold up core data).

48. The situation improved, as data was made available over the months that followed. The LGA conducted a regular stocktake of progress against these asks:

- 5 February 2021 (Exhibit JK/04 - INQ000503950) by which time 12 of 23 core asks had been provided; and one out of 10 enhanced asks.
- 12 February 2021 (Exhibit JK/05 - INQ000503948) – by which time no additional core or enhanced asks had been provided, although the Vaccination Programme had identified those for which data was simply not available. One of the ideal asks (daily updates) had been provided.
- 26 February 2021 (Exhibit JK/06 - INQ000503947) – no further core, enhanced or ideal asks had been provided, but an additional request we had made for public data saw progress.
- 5 March 2021 (Exhibit JK/07 - INQ000503946) – an additional core ask was delivered.
- 12 March 2021 (Exhibit JK/08 - INQ000503949) – two further core asks were delivered.

49. The analysts in the Vaccination Programme did work hard to provide the requested data and did make good progress over the months. However, some data was not possible to provide, simply because it was not collected. Involvement of local government in the design of the data collection at the outset, to ensure it met the needs for their own statutory role, would have resulted in data that was more useful for an effective response.

50. Nonetheless access to individual-level data was never provided, even though authorities requested it, for example, to link to their Clinically Extremely Vulnerable residents to gain understanding of whether they were being reached or whether support was needed.

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

52. Sir David Norgrove, Chair of the UK Statistics Authority, commented that the disparate bodies involved in the provision of health are, in terms of statistical output, too often inchoate. For example, both the NHS and [formerly] Public Health England produced statistics on vaccinations that were published separately. (Exhibit JK/09 - INQ000226520)

53. Councils noted the vaccination data infrastructure which was created, did not acknowledge or deliver the type of information needed locally. There was a missed opportunity to identify people being vaccinated who were care staff at the point of their vaccination. This placed an additional burden on care providers (and councils), as they were asked to monitor and report the vaccination status of their staff (which was a requirement under the Infection Control Fund). The LGA and care providers requested this addition to the system at several meetings with government officials but, despite repeated promises by NHS England that point of care data collection would happen, it never materialised. The attached PowerPoint (slide 3.) (Exhibit JK/10 - INQ000503952) **shared** with DHSC also shows we sought a single point of data collection at the point of NHS vaccination.

54. 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 was not simply about sharing data, but about doing so quickly and with quality 'granular (individual-level) data.

Community Leadership Role

55. It should be obvious that the community leadership role of local government and the importance of local health protection, emergency planning and social care systems, as well as the pivotal role local councils have played throughout the course of the pandemic cannot be taken for granted. Building trust is important to improving vaccine uptake. National systems are not good at addressing inequalities (just because of their nature as national systems) and an approach of 'come and get it, if you want it' to vaccination is not going to work. You need to go and reach communities directly.

56. Once engaged, local authorities took many different steps - from the small to the more apparently large - to enable effective vaccination. For instance, they suspended yellow lines and parking bays outside vaccination centres; they found vaccination sites, supported mobile vans, and led big drives to build trust in the vaccine and spread the word. They helped set up vaccination centres in sports centres, places of worship and theatre buildings, and used their local networks to ensure accurate information reaches all members of our communities.

57. Local authorities – both elected members and officers – along with partners in the emergency services and voluntary, community and faith sectors stood shoulder to shoulder with the NHS to support this national effort. This allowed greater reach into communities; supported confidence in the vaccine; and most importantly ensured help was there for those in the priority vaccine groups to access the vaccine quickly and safely.

58. The location of mass vaccination sites was mostly decided centrally, and local councils had limited input. There were practical reasons for the choice of locations, including space availability, requirement for social distancing and transport links. However, the lack of local consultation was criticised by some councils. Some of the mass vaccine centres were expecting a massive amount of throughput, which did not materialise in the event.

59. Underlying factors of poor utilisation included being located too far from local populations; difficulty of access for those without a car; concern by those shielding about using public transport; lack of familiarity and reluctance to leave local communities; and in some case multiple mass sites being situated within a few hundred meters of each other.

60. Some of this could have been avoided. Local authorities are particularly good at knowing places, people, and wards, including the potential locations that will have high footfall, or how to reach groups with low uptake. Communication with them would have enabled conversations such as 'you should open up something here', or 'if you want to get to such and such a group, use a mobile van and place it in this car park'.

61. Over time, and particularly throughout Spring/Summer 2021, when confronted with the need to achieve high uptake in under-served minority ethnic groups, there was a gradual re-grouping of local systems and an allowance for greater flexibility in the delivery of the programme.

62. Once local authorities began to be engaged, councils were able to play a key role in coordinating the rollout on the ground, by using their knowledge and connections with their communities to help get the word out about the vaccine, and by using trusted local leaders to answer residents' questions and dispel any myths.

63. Many councils developed their outreach work from an early point in the pandemic. So when it came to the vaccine, they were able to get all kinds of community leaders together, from people running playgroups and community centres to faith leaders. They were then able to develop communications such as 'this is what we know about the vaccine, this is how it has been developed, and why it has been done so quickly'. In this way they could do some early myth-busting while encouraging such leaders to use their networks to get the vaccine message out there and build trust.

64. Interventions to make the vaccine more accessible included flexible booking approaches, appointments and walk-ins, and innovative transport and outreach models to reach vulnerable groups. Pop-up clinics, whose locations were informed by data on community uptake, were a key method for delivering the vaccine to those who could not access the vaccine in other settings. High-profile surge vaccination events proved popular with younger cohorts and raised the profile of the vaccine programme but had been much less effective at reaching specific populations with low uptake, requiring parallel dedicated activity for those groups to prevent exacerbating health inequalities.

Vaccine case studies

65. Throughout the pandemic, the LGA sought to capture examples of the vaccine roll-out. (Exhibit JK/11 - INQ000485179)

Examples include the following -

St Albans City and District Council

The council offered the NHS a building, Batchwood Hall, that it had recently leased to a nightclub as a site for vaccinations in the district. Working with local GP surgeries, the council cleared the site ready for use in just a weekend. This included performing deep cleans, installing internet connections and clearing cloak rooms/bar areas.

Kent Fire and Rescue Service (KFRS)

Throughout the vaccine rollout, officers from KFRS helped to collect thousands of vaccines from hospitals across Kent and Medway and deliver them to vaccination centres. Without this support, centres would have struggled to have access to the vaccines they need to run clinics as the programme massively intensified at speed during the vaccine rollout.

Kirklees Council

The council redeployed staff to help work in vaccination centres as well as to provide transport to residents unable to get to their vaccination appointment. Staff from outdoor centres helped give lifts to vulnerable patients to attend their appointments, as well as using council vehicles to rescue vaccine shipments stuck in snow and adverse weather.

Folkestone & Hythe District Council

The council offered the use of Folca – the former Debenhams site in Folkestone – to be used as a vaccination centre. With support from the local NHS, the site opened seven days a week and provided thousands of vaccinations a week. The authority's Civic Centre was also being used as a drive-through vaccination centre.

Cambridgeshire and Peterborough City Council

The councils worked together with their partners to tackle vaccine hesitancy within local communities. They worked with 30 community champions, the interfaith network and the voluntary sector to ensure important messages about the vaccination process reaches a range of different communities, often making use of WhatsApp and Facebook groups. Their Adult Social care teams worked closely with the Cambridgeshire and Peterborough Clinical Commissioning Group to ensure social care staff on the frontline have access to vaccinations.

Wyre Council

The council offered up two local venues, the Thornton Little Theatre and the Poulton Civic Centre for use as vaccination centres. The local theatre had been unable to open for much of the pandemic and the council found a new use for the venue to help vaccinate thousands of local residents.

Southend on Sea Borough Council

The council offered up two local venues, the Thornton Little Theatre and the Poulton Civic Centre for use as vaccination centres. The local theatre had been unable to open for much of the pandemic and the council found a new use for the venue to help vaccinate thousands of local residents.

The council, along with a number of other local authorities across the country, relaxed parking enforcement or offered free parking in local car parks near to large vaccination centres, as well as provide volunteer marshals to help direct residents.

Birmingham City Council

The council recruited 677 Covid community champions and 19 organisations to work throughout the city to help dispel myths around the vaccination process and to drive take up of the vaccine. These champions were specifically working through personal and professional networks to disseminate information into local communities. The community champions were supported through weekly briefings and training sessions led by the council's public health team.

Essex Fire and Rescue Service

Responding to the national appeal for volunteers, staff at the fire service underwent 50 hours of training to become fully qualified vaccinators and worked at vaccination centres across Essex. Staff from the fire service helped set up the centres and helped run them.

Prioritisation and eligibility

66. 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 vaccine prioritisation or delivery. 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 decisions local government would need to make to work

effectively at the local level.

67. There were some tensions in cohort prioritisation but also a recognition that rules were bound by the JCVI guidelines. In some deprived areas, respondents argued that age could be a blunt criterion where younger people tended to be in poorer health.

68. Individual councils did raise concerns about vaccine prioritisation. What may appear nationally to be a sensible decision can have quite different results in some areas compared to others. An example of this was the initial rollout of the vaccination programme. The JCVI prioritised older age groups on the basis that if they were infected, they were at the highest risk of infection. Broadly, councils with the LGA welcomed the prioritisation given to social care staff and to unpaid carers, despite some of the resulting delivery difficulties.

69. The priority at the start of the pandemic in social care was older age adults in nursing and/or residential care settings regulated by CQC, with priority for first vaccination given to care workers in these settings. This meant however that those working in domiciliary care, extra care, and settings for younger adults or those with a learning disability, were afforded lower priority for PPE, testing and vaccination, even though home care workers in particular would be arguably more at risk as they were seeing multiple clients in multiple settings/households. Skills for Care data confirms there are more people working in frontline domiciliary care at 625,000 compared to 460,000 in nursing/residential care. It's hard to understand why this group were not afforded priority 1 status for vaccination. In a future pandemic situation, we would expect that this would need to change.

70. The vaccine programme did not consider the individual's risk of getting infected in the first place. Councils report that in their areas some people would have been at higher risk of infection as a result of structural reasons – such as houses of multiple occupancy, numbers of large families, type of housing stock and fewer people able to work from home. They had higher risks of transmission but were provided with less vaccine protection.

71. Classification using narrow population groups was found to be unhelpful, as well as, for example the homeless being considered in the prioritisation ahead of asylum seekers who had similar health needs.

Part C – Barriers to vaccine uptake

72. On 28 January 2021 the LGA produced a briefing on guidance and recommendations (Exhibit JK/12 - INQ000485180) for local authorities on increasing uptake for Covid19 vaccinations with key guiding principles being to *'engage to understand, engage to empower and engage to evaluate'*.

    Role of volunteers

73. Over the period of the pandemic, hundreds of thousands of residents signed up to be Community Champions and Vaccine Champions. Collaborating with local councils, NHS and voluntary and community sector organisations, they developed networks to share vital information about Covid19 with their communities and support the rollout of the vaccine programme.

74. Community Champions programmes took many forms, and not only had a significant impact on the response to the pandemic, but also helped transform the way that councils, the NHS and others engage with and listen to communities. This connection extended to improved lines of communication between health systems leaders and local partners, influencing emerging policy and practice. Much learning emerged too from the collective experience on the ground, which enabled areas to collaborate around specific communities and community challenges.

75. The Champions programmes showed how important – and possible – it is for councils, the NHS and others to engage directly, openly and regularly with communities. Examples include:

    Leeds Covid Champions

    The programme was designed to build trust and relationships through co-production and co-delivery, not only with the council, Public Health, Leeds CCG, and trusted local organisations; but through the creation of meaningful opportunities for local people and groups to act as Covid-19 community champions.

Lewisham Covid Champions

The council had a network of 170 Covid community champions, including faith leaders and community and voluntary sector representatives, who have been working closely with the council over recent months on everything from promoting good social distancing restrictions to the importance of testing, tracing and isolating.

Sandwell Council: Creating an army of vaccine advocates

Sandwell developed a network of community leaders to promote vaccination; follow-up calls are also being made to those who refuse a jab.

76. UK 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. There is consistent qualitative evidence on positive outcomes through community champions and some positive impacts reported for target communities.

77. Getting to those who normally have little or no contact with the health service, and who lacked trust, may in fact be the biggest lesson from the vaccination rollout, and the biggest opportunity it has created.

78. The lesson from this, is that it is not enough for the NHS just to offer a universal service. It has to offer equal access, taking it to places that allow that to happen. Delivering equal services will not deliver equal outcomes, because what works for one section of their population is unlikely to work for another with very different needs, cultures, structures and circumstances.

Vaccine hesitancy

79. Vaccine hesitancy was present in all parts of the community, including among the white population, for a range of reasons. And there was, of course, the work of the anti-vaccine movement on social media and elsewhere.

80. Even before the pandemic, public health organisations had been facing the challenges associated with anti-vaccination beliefs. The World Health Organisation

(WHO) in 2019 listed 'vaccine hesitancy' as one of the top 10 major global threats.

81. In 1998, one of the most common vaccine safety concerns emerged from a speculated link between the MMR (Measles, mumps, rubella) vaccine and autism spectrum disorders due to a misrepresentation of clinical and biological data in a paper.

82. Public acceptance and uptake of vaccinations has fallen over recent years, both in childhood and adult vaccination programmes with significant implications for public health. Data suggests that many of the groups in society who have already been disproportionately affected by Covid-19 are those who are least likely to say they will be vaccinated. The risk therefore was that the vaccine roll-out could further exacerbate these inequalities.

83. The reasons for vaccine hesitancy and resistance are multifactorial and complex, and include concerns around side effects and vaccine safety, as well as a lack of trust in vaccine efficacy. As this was a new virus, people were hesitant about being part of the first cohort vaccinated.

84. PHE set out a framework which considered the impact and implications for health inequalities in the prioritisation of Covid19 vaccines. In addition to considering health inequalities in prioritisation of the vaccine, actions to address health inequalities should also be employed during the implementation phase.

85. A major test of the abilities of public health teams and particularly the Director of Public Health to engage meaningfully with local people was the roll-out of the national Covid-19 vaccination programme from early December 2020. It began to emerge that take-up of the vaccine was not universal and that several community groups were hesitant about being vaccinated or finding it difficult to access a vaccine.

86. Councils had to work urgently in partnership with local people, community champions and different community group leaders (as well as formal organisations such as the NHS) to listen to concerns and help build trust in organisations seen as 'authorities' and promote culturally sensitive messages about the safety and efficacy of the vaccine.

87. Councils applied behavioural science to help navigate the challenges of vaccine hesitancy. The LGA provided frameworks and insight to help councils understand how and why residents are behaving as they are. It also provided principles and insights which could inform campaigns and develop solutions which could help people overcome barriers to vaccine take up.

88. This resource was developed for councils to provide a behavioural science 'toolkit' to tackle challenges related to Covid-19 vaccination. It was developed by The Behaviouralist (Exhibit JK/13 - INQ000503959) and drew on work being delivered by local authorities.

89. Local authority public health departments also conducted extensive population polls and focus group discussions, to explore reasons for non-vaccination and develop engagement strategies with under-vaccinated groups.

90. Directors of Public Health sought to engage the 'hearts and minds' of the public, and bring communities along with their strategy, making the case for the proposed action, rather than imposing a 'top down' approach on what they should or should not do, and being honest with the public. Directors of Public Health told us the trust they had developed with their local populations and with community groups and with health partners aided communicating public health messages and 'myth-busting'.

91. Examples of this work include -

Sandwell Council built an army of disinformation counter advocates - countering vaccine hesitancy.

Wigan Council undertook a trial run of Covid clinics that were acceptable to different communities.

Hertfordshire Council systematically identified every rough sleeper and every homeless person and set up special clinics.

Watford borough council organised transport for people who could not drive or could not get to a vaccine clinic and councils undertook significant work with communities around hesitancy such as working with BAME doctors working with

BAME social care staff on vaccine hesitancy.

Part D – Public messaging

Context

92. 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.

LGA's main communications activities

93. The LGA's Communications Directorate's main activities in relation to Covid-19, linked to that of the wider organisation, were –

- Producing daily bulletins to member authorities summarising the LGA's work with central government in relation to Covid19, as well as the dissemination of relevant information and updates;

- Liaison with communications leads in central government departments (including MHCLG, Cabinet Office, DfT, 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 chief executive bulletin was also included in it;

- Raising with relevant communications leads in government departments the issues raised by council communications teams;

- Covid19 webinars for councils and councillors;

- Creation of a coronavirus web hub, which included service information, FAQs, guidance, and support for people in their roles (councillors and officers);

- Briefings for parliamentarians and stakeholders covering parliamentary debates (including on Covid19 related legislation and regulations) as well as select committee submissions;

  and

- National media and social media activity to amplify central government public health messages and to communicate LGA lobbying.

94. Throughout the pandemic, the LGA liaised with government departments, NHS England and PHE to help disseminate government-produced communications materials to council communications teams. These were disseminated through the Commsnet bulletin. The government was keen for councils to amplify national public health messages at the local level.

Engagement with governmental communications

95. 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.

96. Communications materials developed by the Government were shared through 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 — particularly during periods where restrictions were in place.

97. Councils 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 councils could use their local knowledge to engage with parts of the community which were less responsive to central government campaigns. The LGA assisted councils 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.

98. The LGA also established a Covid19 communications hub **(Exhibit JK/18 - INQ000103870)** from LGA, titled COVID-19 communications, dated 26/01/2023. Produced within the Local Government Association witness statement of Mark Lloyd at INQ000215538 - INQ000103870) on its website which aimed to support councils 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.

99. 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 the LGA Covid19 communications webinars and MHCLG used examples of council good practice from the LGA website in its own communications, including bulletins and press releases.

100. The LGA's Communications Directorate directly engaged with central government departments on vaccine deployment communications. This involved weekly meetings coordinated by NHS England to discuss communications around the vaccine roll-out.

101. The first meeting took place on 17 December 2020 and continued until 15 April 2021. The purpose of the meetings was for central government departments, NHS England, and local government to share information regarding the rollout of the vaccine. This included updates on vaccine communications activity from central government, the LGA and ADPH raising any issues/concerns from councils and collaboration in areas such as webinars for local government communicators. This was not a decision-making forum.

102. The LGA's communications channels (website, bulletins, social media) were also used to amplify messages about the vaccine rollout and to share relevant materials

with councils.

103. The Cabinet Office ran weekly online briefing meetings for heads of communications in councils, which the LGA attended.

Assessment of effectiveness

104. In terms of the effectiveness of public health messaging, the LGA commissioned research regarding the effectiveness of communications and engagement during the vaccine rollout. This involved interviews with heads/directors of communications in local government and was funded through what was then known as the LGA's Care and Health Improvement Programme **(Exhibit JK/19 - INQ000103871)** Presentation titled, Local authority communications and engagement to support the vaccine programme, LGA, dated 10/08/2022. Produced within the Local Government Association witness statement of Mark Lloyd at INQ000215538 - INQ000103871).

105. The final area where the LGA engaged with DLUHC in relation to local compliance and enforcement work was on the development of vaccine certification and passes. Again, this is an issue where the LGA did not take a view on the merits of introducing vaccine certificates but worked with local councils to highlight compliance and enforcement issues for government to consider, if a decision was taken to implement them. In contrast to previous Covid work, there was a long lead in time for discussions on this issue ahead of a decision being taken, and even a public consultation, although the final design of the scheme did not take on board a great deal of the feedback from local council enforcement officers.

Part E – Vaccination rollout across social care

Outline

106. Councils played an important role identifying eligible frontline care staff to be offered a vaccination. There was a need in the early days of the vaccine rollout for central government to clarify the role of local government, alongside identifying adequate funding and resources, to support vaccination of the clinically extremely vulnerable and unpaid carers.

107. The LGA and its member councils were actively and heavily engaged in supporting

vaccination uptake by frontline social care workers, unpaid carers and personal assistants both within their own services and alongside their commissioned care providers.

108. Each council had a designated vaccination lead; the LGA hosted the list of designated leads and kept it updated. At a local level councils developed their own comprehensive vaccine uptake action plans.

109. DsPH were an essential conduit for advice, information and education for local services seeking to maximise vaccination uptake and tackling vaccine hesitancy, but civil servants were often slow to recognise and value this local knowledge and expertise about the local population, relying instead on centralised, top-down approach.

110. Once a decision had been taken to prioritise frontline social care workers, the issue was how to identify them for communication. Civil servants within DHSC and NHSE did not initially always understand that councils do not hold information about every frontline social care worker in their patch, and that the vast majority were employed in the private/not for profit sector, some of whom would have no relationship with the council; they also did not understand the difference between care workers operating in Care Quality Commission (CQC) regulated settings, and unregulated settings or that councils could not collect or report vaccination uptake data on staff not employed by them. Once this had been pointed this out, officials did work with the LGA and others to find work around solutions.

111. Emails between the LGA and DHSC (Exhibit JK/14 - INQ000503958) reinforces why it was/is important to collect data about all care workers regardless of sector or role at the point of vaccination as there is no central registry of all those working in the care sector (regulated and unregulated). There were low levels of confidence in the data being reported on capacity tracker for those working in unregulated settings. Also worth being mindful that it's the setting, which is regulated, not the care worker. The care workforce is unregulated. In the end NHS and DHSC accepted our pragmatic suggestion that, in the absence of having a registered workforce and in the absence of any data being collected at the point of vaccination, vaccination points would simply have to accept at face value any declaration from someone claiming to be a front-line social care worker.

112. During the roll out of the vaccine, at strategic level, the LGA were full partners in the design, development and operationalisation of the Standard Operating Procedure (SOP) for frontline care worker vaccination (priority group 2) - this was an excellent example of co-production and civil servants made an effort to listen to the advice and experience of the sector. The LGA also contributed to the SOP for unpaid carer vaccination (priority group 6).

113. The LGA published an extensive list of resources for councils and partners to tackle vaccine hesitancy taking a behavioural insights approach as well as case studies a three-stage guide to encourage vaccine uptake a report on countering vaccine misinformation, a review of research on vaccine uptake, encouraging uptake among younger people.

114. The LGA ran a series of webinars, disseminated all communications it received from DHSC and NHS England which encouraged uptake and tackled vaccine hesitancy in social care through multiple channels including e-bulletins to Chief Executives in member councils, e-bulletins to Directors of Adult Social Care, e-bulletins to vaccination and operation leads in adult social care in councils, webinars, and through our LGA networks of Principal Advisers, Care and Health Improvement and Advisers, and our ADASS networks in the English regions. The LGA also worked with provider representative organisations such as the Care Provider Alliance, using the forum which the LGA convened in March 2020, to promote mutual communication and understanding between providers and central government/the NHS.

115. The process used to improve uptake and to measure the degree of success achieved was via the Capacity Tracker (CT) - a spreadsheet set up originally to monitor bed capacity in care homes (hence the name) and was hastily repurposed as a tool for monitoring a range of Covid-related issues in care settings, including reporting vaccination take up by frontline social care workers.

116. Levels of confidence in the Capacity Tracker in terms of the reliability and validity of the data remained low. Problems included not being able to see aggregated vaccination uptake data at local level, even though this would give a local snapshot

or support benchmarking; it was a significant extra reporting burden on care providers already stretched to the limit which was completely unfunded; providers often found discrepancies in the reported data; it was frequently out of date; and crucially, it was impossible to disaggregate the numbers unvaccinated by choice, and those claiming an exemption from vaccination.

117. The LGA and ADASS, as well as care providers, repeatedly asked Government, civil servants and NHS England for a central mechanism to collect information about vaccination status and who was a care worker at the point of vaccination delivery, i.e. by the NHS when people turned up to get their injection. The sector received "Confirmation that plans are in place to develop a national vaccination register to collect information on vaccination status, this will be linked to the GP record." (Exhibit JK/15 - INQ000503970)(Exhibit JK/15a - INQ000503971) Scotland for example holds a central register of all care workers so tracking vaccination was much easier. Use of NHS numbers to link to care worker status was also suggested. None of the promised central processes materialised. In Emails between the LGA and DHSC we raised our concerns (Exhibit JK/14 - INQ000503958)This is one of the great failures of frontline care worker vaccination and VCOD: that a central system was never set up and should a pandemic or similar reoccur, we will have nothing better in place than individual settings reporting individual vaccinations.

118. There were also discussions about how to verify at the point of delivery, whether those attending were indeed social care workers. In the absence of any central registration process, some workarounds were suggested, all of which had problems. In the end, it was decided, correctly in the LGA's view, that on a balance of risk it was best to accept that those attending were indeed social care workers without demanding proof. This does flag up the ongoing need to address the issue of registration of this workforce.

Vaccination as a condition of deployment (VCOD)

119. There was little support for 'Vaccination as a condition of deployment' (VCOD) from the care sector, with a consistent message from stakeholders that encouragement and support were better than threats of being sacked ("no jab, no job") in increasing take up.

120. Care providers developed strategies likely to support uptake, including information campaigns and facilitating communication between staff and managers to openly discuss concerns regarding possible vaccination side effects.

121. Overall, a majority of respondents (57%) to the government's consultation (Exhibit JK/16 - INQ000468754) did not support the proposals, but government pressed on. On the 21 March 2021, the LGA published our public response to the first VCOD consultation (Exhibit JK/17 - INQ000485183).

122. The LGA cautioned that the approach proposed could entrench vaccine hesitancy (subsequent evidence suggests that this indeed happened) and exacerbate health inequalities (also evidence this happened). It urged government to concentrate on maximising voluntary take-up and tackling vaccine hesitancy.

123. National data told us that the target of 80 per cent take-up had already been reached, but with significantly lower take-up in some places; the LGA therefore suggested a targeted approach to voluntary take up with outliers could be more appropriate than making this mandatory across the board.

124. The LGA warned about the sense of grievance, unfairness and injustice which could result from this policy being applied only to those working in older age care homes, and not the NHS, saying –

"*Care workers across all settings understandably feel undervalued, underpaid and marginalised compared to their NHS counterparts, and may feel particularly aggrieved that the outstanding commitment and care they have shown in performing their caring duties, often sacrificing time with their own families in the process, is to be rewarded with a mandatory vaccination requirement which will not apply to those in similar frontline care roles in the NHS or in other parts of the care sector.*"

125. The LGA cautioned about the impacts this policy could have on recruitment and retention –

"*This proposal, as it stands, does not offer a convincing clinical and scientific*

argument for limiting this intervention to a single segment of the health and care workforce, or set out how the risks in terms of impacts on morale, motivation, recruitment and retention will be mitigated e.g. through increased pay or improved terms and conditions."

126. The LGA highlighted the additional unfunded extra burden for employers including.

"the feasibility for many care providers of redeploying unvaccinated staff; the time, cost and resources involved in making changes to existing contracts and terms and conditions; the cost of defending potential legal challenges; and the administrative burden on providers of verifying vaccination or exemption from vaccination".

127. The LGA asked for a list of things in its response, but these never materialised:

- A fuller understanding of why a minority of older adult care home workers were still choosing not to be vaccinated and what progress has been made in achieving vaccination targets voluntarily since the consultation was launched.

- The Government's estimate of the anticipated impacts of the proposal on existing recruitment and retention, and projected numbers of leavers from the sector following implementation of the policy, as well as the assumptions underpinning the estimate.

- Factual and demonstrable evidence that this policy would have a net benefit, and that the benefits of implementing this policy would not outweigh the negative consequences for the sector, and quality and sustainability of care overall.

- What additional and more focussed work the Government intended to undertake to increase voluntary vaccine take-up.

- How the Government would engage with all relevant stakeholders, including: councils, care providers, care workers, unions, organisations representing people who draw on social care and support, and individuals in receipt of care and support, and their families, friends and advocates.

128. Despite being pressed by the LGA, Care England and National Care Forum - the Equality Impact Assessment was only published two days before legislation was enacted. The Impact Assessment acknowledged that -

"higher proportion of staff from ethnic minority groups could therefore face action from their employers or lose their jobs for refusing to take the vaccine"

thereby tacitly recognising that some groups of workers could be disproportionately affected by this policy.

129. The LGA convened weekly national Covid-19 Social Care Provider meetings convened by the LGA with DHSC and others by invitation for specific items; VCOD was a standing agenda item and issues, concerns and challenges of implementing the policy were regularly flagged with DHSC civil servants joining the meetings.

Part F – Lessons for the future

130. Vaccination has been central to the UK government pandemic response and has operated in a complex and fast-paced environment and under important logistical and organisational constraints. The vaccine programme took a highly centralised approach, which had some benefits such as consistency and clarity, and it achieved its overall vaccination targets of providing 2 doses of the vaccine to 85% of the population by July 2021.

131. Without proper planning, universal action to improve health can widen health inequalities, as vulnerable groups are less likely to engage with health services. Poor access to services is a result of multiple barriers, related both to the individual and to the services. For example, people may have difficulty understanding and navigating the system or have had past experiences of being turned away from services or being badly treated.

132. However, the programme was less able to address inequalities in uptake in some communities and ethnic minority groups. Trade-offs between a top-down and bottom up-approaches had to be made, and gradually those two approaches became more complementary.

133. With the benefit of hindsight, the LGA could have been more insistent – publicly and privately – through politicians and officers about the key role of local government in vaccine delivery.

134. Although plans existed, the role of local government as a whole in health protection may not have been fully understood – by central and local government - before the pandemic started. In this capacity local government could have pushed government to strengthen plans for pandemics, including clarity on working with local government proactively and help identify gaps and areas for improvement.

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

Central Government

1) It is necessary for effective action that central and local government have a shared understanding of the issues and that there is a joint approach and shared ownership of decisions.

2) Vaccination delivery models need to be adapted to underserved and hesitant groups, working in collaboration with local system partners while giving more flexibility to local systems to adapt plans.

3) Clear articulation of roles and responsibilities (with reference to statutory responsibilities of key professionals and agencies, including local government, LRFs and the Director of Public Health).

4) Commitment to equitable access and take up of vaccination, followed up with appropriate monitoring and action.

5) Communications plan rooted in simple, evidence-based messages and utilising trusted community voices that can be tailored locally.

6) Recognition that a 'combination strategy' of other public health measures may be necessary in addition to the vaccination to control transmission – hygiene, limiting social contact, extra protection for vulnerable groups.

7) One important learning point for the future is about how social care workers can be verified and identified. The various proposals around workforce including registration would help address this.

8) The need for data sharing agreements often delayed delivery of individual-level vaccine data to local authorities during the pandemic.

Local Government

1) People often like to hear from people like them or directly from health professionals, rather than corporate information from the NHS or local authority. Agencies need to engage at a community level with people who understand the services. Feedback at local level can help to ensure information is delivered in different ways and by different people and groups who people trust.

2) Evidence shows people in underserved populations often have other health needs as well, so consideration should be given to linking vaccination to other programmes that could be beneficial as well.

3) More consideration should be given to how local efforts can target vulnerable groups less likely to be vaccinated by offering more opportunistic and flexible approaches to vaccination (e.g. providing a roving vaccine model in areas of higher deprivation).

4) Consideration should be given to support for other care settings outside of the elderly population that were the prime focus during the pandemic (e.g. people in learning disability settings and those providing domiciliary care).

5) In using volunteers, it is important for statutory organisations to be alert to the best approaches to nurturing voluntary capacity and realistic about the demands made especially when it is required to be sustained over an extended period.

6) The choice of who promotes public health messaging is crucial, with the

expert scientists, rather than politicians, used to address vaccine questions and concerns. The involvement of faith leaders can be helpful, as decisions on whether to have vaccines are also determined by beliefs about religious acceptability; and use of Community Champions as trusted voices capable of promoting initiatives in a way that is responsive to specific local challenges.

7) With the advent of Integrated Care Systems there is an opportunity to address vaccination coverage rates from a system-wide perspective.

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: 14 October 2024