Witness Name: Professor Carolyn Wilkins OBE
Statement No.: 01
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Dated: 05/06/2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF PROFESSOR CAROLYN WILKINS OBE

I, Professor Carolyn Wilkins, will say as follows: -

INTRODUCTION

1. I make this witness statement to the UK COVID-19 Inquiry ("the Inquiry") in response to a Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 27 January 2025. Pursuant to the Rule 9 Request, in this witness statement, I have been asked to address various matters relating to the work of NHS Test and Trace ("NHSTT") during the COVID-19 pandemic, and my involvement as the Divisional Director of Contain ("CDD"). I will address several matters that took place between 01 January 2020 and 28 June 2022 ("the relevant time/period").

2. I make this statement on the basis of my own personal knowledge, as refreshed by documents which have been made available to me following searches undertaken by colleagues at the UK Health Security Agency ("UKHSA").

BACKGROUND

3. I am currently a Professor of Practice at the University of Birmingham, Birmingham Leadership Institute and, through my previous experience, I have a deep knowledge of local government, health and care and the wider public sector landscape.

4. I have held a number of senior executive roles at local, city region and national levels. My local government career commenced in October 1989 and included roles at Bolton Metropolitan Borough Council ("MBC"), Trafford MBC, Salford City Council, Bury MBC and Chief Executive of Rossendale Borough Council.

5. From 2014 to 2021, I was the Chief Executive of Oldham Council, and the Chief Accountable Officer at the NHS Oldham Clinical Commissioning Group from 2018 to 2021. I continued these roles during my tenure as CDD at NHSTT.

6. Throughout this period, I also undertook a number of Chief Executive lead portfolio roles in the Greater Manchester ("GM") Combined Authority, including as lead Chief Executive for Population Health. This involved working closely with the 10 Directors of Public Health in GM. I had a key role in the COVID-19 strategic command arrangements in GM, and led the GM COVID-19 Chief Officers Group during 2020.

7. My qualifications are as follows:

- Doctorate in Business Administration, Sheffield Business School (2013).
- MA in Literature, Open University (2007).
- Masters of Public Administration, Warwick Business School (2004).
- Postgraduate Diploma in Management Studies, Manchester Metropolitan University (1997).
- BSc (Hons) in Psychology, University of Leeds (1989).

SECTION A: ROLE FUNCTION AND RESPONSIBILITIES

Appointment to the Role of Contain Divisional Director

8. I was appointed as CDD on 27 July 2020, see my appointment announcement at **[Exhibit: CW1/01 INQ000608004]**. This role had been established prior to my appointment and was previously held by the Chief Executive of Leeds City Council, Tom Riordan, for a period of three months.

9. I was previously offered the role of CDD earlier in July 2020, which I initially declined as I was leading the Strategic Coordinating Group ("SCG") for Oldham,

and I was a member of the SCG for GM as part of the local emergency response to COVID-19. I discussed the potential secondment with the Council Leader and the Deputy Leader of Oldham MBC, and the Chair of Oldham NHS. We needed to ensure sufficient local resilience in our local and subregional response arrangements given the leadership/operational capacity consequences of my secondment.

10. At this stage in the COVID-19 pandemic response, there were challenges between the local government and the central government communication, engagement and coordination. For example, from my perspective as Chief Executive of Oldham Council in the early stages of the pandemic, communication between central government and local authorities was difficult. Communication felt very NHS-dominated, and continued to feel siloed and uncoordinated, with messages and guidance targeted through specific services/profession routes such as directly to schools or adult social care providers rather than to local authorities as a whole. Guidance changed extremely rapidly at points, which meant multiple local briefings with staff and stakeholders such as social workers and care homes. This had capacity and coordination implications with local teams having to connect to multiple government departments and work to understand the cumulative impact of different strands of guidance, requirements and funding on their places, organisations and communities.

11. Equally, there was a lack of understanding of the role and responsibilities of local government, particular in relation to public health. This meant that Directors of Public Health ("DPHs") were not always sighted on policy decisions or guidance, and necessary investment was not made in local response infrastructure.

12. Following conversations with my colleagues, I agreed to have further discussions about the role and ways we could address these challenges. I had a call with Tom Riordan and Dr Clare Gardiner, Director General of the Joint Biosecurity Centre ("JBC"), to this effect, which was followed by an informal interview with Baroness Harding, the Executive Chair of NHSTT.

13. I subsequently agreed to take up the role of CDD for a period of three months only. However, I ended up being in this role for a total period of ten months, from July 2020 to May 2021, because the role was required beyond this initial period.

Responsibilities as Contain Divisional Director

14. There was no formal job description or job specification for my role of CDD.

15. As CDD, my role was to be the link between local governments and central government. My responsibilities included the following:
    a. To support the implementation, review and updating of the Contain Framework, published in July 2020, see **[Exhibit: CW1/02 INQ000223952]**.
    b. Liaising with local government across England, working closely with the Local Government Association ("LGA"), Association of Directors of Adult Social Services ("ADASS") and Association of Directors of Public Health ("ADPH").
    c. To liaise across national government, for example, with the Cabinet Office ("CO") COVID-19 Taskforce; the Ministry of Housing, Communities and Local Government ("MHCLG") Regional Chief Executives Group; Public Health England ("PHE"); and the JBC.
    d. To work with the Regional Partnership teams ("RPTs"). These were the JBC and PHE regional leads together with the Contain leads (primarily former local authority Chief Executives who undertook regular communication and engagement with local authorities in their regional areas). This was a key element of developing communication and engagement infrastructure with local government.
    e. Chairing daily NHSTT Containment and Service Delivery Review Group (otherwise known as "Bronze") calls, where the latest COVID-19 dashboards were discussed. There was wide attendance from PHE, other government departments, and RPTs.
    f. Attendance at other cross-government calls, such as the national "Silver" meetings, the NHSTT Executive meetings, and, occasionally, COVID-O meetings.

16. Liaison and engagement primarily took place with the Chief Executive and statutory officer roles of the DPH and ADASS, as well as council leaders. I acted as a conduit between local authorities and the aforementioned individuals. I occasionally attended briefings with members of Parliament, in support of Baroness Harding.

17. As part of my role as CDD, I did not take any decisions relating to Contain or Test, Trace and Isolate policy, outside of being part of the NHSTT Executive team.

18. The role remained broadly consistent throughout my tenure, but focus on areas varied as the pandemic progressed. This ranged from the development and roll out of community testing, to the review and update of local outbreak management plans.

SECTION B: DECISION MAKING FOR TEST, TRACE AND ISOLATE

Role played in Developing key test, trace and isolate policies

19. As set out above, I did not take any decisions relating to Contain or Test, Trace and Isolate policy, but my role was to relay important local government insights into central government for consideration in such decision-making.

20. In my role as CDD, I created feedback loops for policy design through my engagement with the LGA, and other local stakeholders. This enabled local leaders to report data and other insights they captured for ultimate consideration during national decision-making. For example, I received strong feedback from local areas that one of the blocks to people self-isolating was the absence of financial support (e.g., for individuals in roles with no occupational or statutory sick pay). In multiple discussions with different stakeholders, such as the LGA Regional Leaders Board; through RPTs; Chief Executives of councils; and DPHs, the issue was raised. I fed this into discussions with the NHSTT Executive meetings and the CO COVID-19 Taskforce to explore possible solutions. A pilot approach was ultimately agreed; I worked with stakeholders to identify the terms of and areas for the pilot, with support from RPTs. On 22 August 2020, NHSTT set out a submission to the Secretary of State for Health and Social Care for the proposed terms of the

pilot for financial support for people on low income for self-isolation. **[Exhibit: CW1/03 INQ000203685]**. The objective of the pilot was to incentivise people on lower incomes to self-isolate after testing positive for COVID-19.

21. Such pilots took place in Oldham, Pendle and Blackburn with Darwen, with an initial payment of £13 per day, this equated to £130 for an individual who tested positive and was required to self-isolate for 10 days. These locations were chosen as there were high rates of COVID-19 in these areas. Discussions were had with various local authorities ahead of the pilots to ascertain which authorities were interested in taking part in the pilots.

22. The feedback from these pilots was that the low-level the initial daily payment was set at was a barrier to uptake, and therefore did not improve compliance with self-isolation requirements as intended. It was subsequently recommended that a country-wide scheme be introduced at an increased level of funding.

23. As set out above, this work with local governments was fed back through my attendance at regular meetings, which I typically attended remotely. "Bronze" calls had a very wide attendance from across government. An example of the standing agenda and situational awareness/update documents considered at these meetings are exhibited here **[Exhibit: CW1/04 INQ000608007; CW1/05 INQ000120210; CW1/06 INQ000608006]**.

24. "Silver" meetings were primarily chaired by the Chief Medical Officer ("CMO"), and attended by the Chief Medical Advisor ("CSA"); Clare Gardiner (Director General, JBC); Baroness Harding (Executive Chair, NHSTT); Sarah-Jane Marsh (Director of Testing); DHSC's Permanent Secretary; the Director of Health Analysis (JBC); and Contain Regional Leads. These were often hybrid meetings with some people attending in person, and others joining remotely. RPTs were in regular dialogue with the local authorities in their areas, and were able to provide information to "Silver" meetings on local response, issues, and concerns, including views on the nature of COVID-19 restrictions. Updates were provided both via presentations and verbally; an example standing agenda is exhibited here **[Exhibit: CW1/07 INQ000608005]**. I regularly attended Silver meetings.

25. "Gold" meetings were chaired by the Secretary of State for Health and Social Care and broadly aimed to discuss and challenge operational containment activity and make policy decisions. The Gold meetings reviewed recommendations from the Bronze and Silver meetings. The Gold meetings were the final stage before issues were escalated to COVID-O. I regularly attended Gold meetings.

26. In August 2020, Clare Gardiner and I commissioned advice on the improvement of the process for the Bronze/Silver/Gold meetings ("B/S/G meetings"). The key note setting out the proposed improvements can be found here **[Exhibit: CW1/08 INQ000608003].** In summary, the improvements made included:

    a. establishing a single secretariat to coordinate the B/S/G meetings;
    b. improve consistency of the format for the B/S/G meetings, whilst maintaining some degree of flexibility. It was important that the meetings were scheduled to enable the flow of information and decision making, but also stayed responsive to the current conditions/situation;
    c. several preparation meetings were established to support the B/S/G meetings, such as the:
        i. daily Situational Awareness meeting
        ii. daily Joint Response and Planning meeting
        iii. daily Local/National Regulations meeting
        iv. a post-Silver/pre-Gold meeting;
    d. establishing greater engagement with relevant local authorities earlier in the weekly meeting schedule;
    e. establishing clearer objectives for decisions that needed to be made in Gold meetings.

27. In addition to the above, I often attended the LGA Leaders Board, which met regularly.

28. I felt that the feedback I supplied back into central government was listened to within NHSTT and actioned on areas within their remit. For example, concerns were raised by local authorities across England that delays in receiving testing data results were impacting their ability to conduct local contact tracing and containment measures. I raised this at NHSTT Executive meetings and significant

plans of work were put in place by Testing teams to increase the turn-around times to get data to local health protection teams within 24 to 48 hours. The Testing team leads are best placed to provide further detail on specific interventions taken here. Similarly, issues of data quality were fed back by local teams and work was put in place to address this.

29. I was involved in the design and roll-out of community testing through my attendance at the NHSTT Executive and my role as CDD. I enabled feedback loops between local and central government. Such feedback loops from local areas to Community Testing teams in NHSTT included RPTs, who were involved in a dialogue with their local areas on community testing roll-out.

Bids for Funding

30. In some areas, a lack of funding prevented local government from being able to put in place the relevant infrastructure to maximise testing. This was particularly the case in areas that had a high prevalence of COVID-19 for extended periods of time, and where there was limited investment in local outbreak management systems. There had also been significant reductions in core funding to local government in the years prior to the pandemic, which impacted capacity and resilience in key areas such as public and environmental health, as well as local surge capacity required in management of outbreaks.

31. There were numerous discussions about the funding and capacity requirements for local authorities to enable them to support national restrictions, compliance and the ongoing development and implementation of local contain outbreak management plans.

32. Prior to my tenure, £300 million had already been identified for supporting local authority funding, alongside a £100 million Test and Trace Support Grant. Allocations were first made in relation to the local authorities' position on the watchlist/areas of intervention. The Policy, Trace and Customer teams within

NHSTT were involved in supporting pilot work[1]. Sign-off depended on the scale of the funding. For example, in May 2021, 9 trailblazing pilots were announced to test ways of helping compliance with self-isolation, which required £12 million in funding.

33. Local authorities' watchlist/areas of intervention were based on data compiled by JBC, PHE and CMO on local authority areas. The watchlist identified areas of concern, areas for enhanced support, or areas for intervention. There were regular meetings (such as the B/S/G meetings) which looked at the data and considered which areas should be on the watch list. I attended these meetings.

34. More generally, as CDD, I had delegated authority from DHSC for Contain to agree amounts of funding up to the delegation limit of up to £405 million for the entire 2020/2021 financial year **[Exhibit: CW1/09 INQ000608008]**.

35. Discussions with HM Treasury ("HMT"), CO and MHCLG resulted in the extension of the initial Test and Trace Support Grant funding to the introduction of the Contain Outbreak Management Fund ("COMF"). The COMF formula was approved by HMT, and cleared by the Secretary of State for Health, as per the following submission **[Exhibit: CW1/10 INQ000608009]**.

36. The COMF was established to provide funding to local authorities in England to help reduce the spread of coronavirus and support local health. The COMF Panel was established to consider grant applications. The checklist for such grant applications can be seen at **[Exhibit: CW1/11 INQ000608000]**. A review of the COMF was conducted on 29 January 2021, which concluded that the funding provided under the COMF was considered essential by local authorities to enable them to mobilise their local COVID-19 responses, and to support the national response **[Exhibit: CW1/12 INQ000608001]**.

[1] The Policy team supported the programme board and design authority of NHSTT by developing and enacting policies that ensured clear strategy and supported the government's wider COVID-19 response in line with best scientific, medical and ethnical advice. The Contact Tracing team enacted an end to end tracing operation strategy and managed a large scale outsourcing of contact centres. The Customer team supported a customer services operation.

Contain Framework and Testing

37. I was also involved in the review and update of the Contain Framework **[Exhibit: CW1/02 INQ000223952]**. This needed to be updated throughout the pandemic to reflect changing conditions and the response, including differing approaches to variants. Under this Framework, each public health authority was required to produce a local outbreak management plan which set out the local response to COVID-19 pandemic.

38. Through the communication and engagement channels outlined throughout this statement, we briefed local government on updates, including the requirement to review and update local outbreak management plans in line with the revised Framework. An example of this engagement can be seen at **[Exhibit: CW1/13 INQ000608002]**.

39. The risk with a standardised approach to testing is that it is not accessible by all individuals or groups. Insight and intelligence into local populations available to local authorities was important in work on targeted engagement aimed at maximising take up. Such insight and intelligence came from a broad range of sources including:
    a. understanding the make-up of local communities (such as specific age groups, vulnerable populations or culturally specific communities with different language requirements);
    b. understanding the nature of local employment infrastructure and relationships with local employers;
    c. identifying economically at risk-groups and identifying trusted messengers within those communities, such as community and faith-based organisations, that could support culturally competent messaging and mobilisation of support;
    d. knowledge of particular areas of deprivation with specific housing challenges such as overcrowding;
    e. understanding of areas of digital exclusion and where primary media sources are non-UK based;
    f. prioritising households already known to services such as adult social care and children's services;

g. engaging young people directly through local institutions and services;
h. utilising trusted networks and local influences, including elected members.

40. Such insight to local communities and populations is often not held at central government level. Furthermore, in considering the various local outbreak management plans, it was evident that there were different public health capacities in different localities, due to differing public health team structures and capacity throughout the different local authorities. For example, this could be seen where public health posts were shared between councils, placing limitations on their ability to respond to the pandemic. Mutual aid was provided across councils but this became more challenging as more areas experienced increasing numbers of COVID-19 cases.

Modelling and Data

41. I was not directly involved in data modelling. The role of Contain was to gather insight and intelligence on development and implementation of local outbreak management plans, decide allocation of COMF, provide feedback on Test and Trace infrastructure, develop relationships between national, regional and local levels, and to share examples of good practice.

Challenges

42. The greatest challenge I faced in relation to Test, Trace and Isolate was the speed at which things were evolving and the dynamic and complex nature of the situation. Whilst all local authorities/local resilience forums ("LRFs") had pandemic influenza plans in place, and there was a level of understanding that an outbreak could happen, in reality there were significant challenges in implementing responses to COVID-19.

43. One of the principal objectives in the national response was to protect the NHS, but there was a short period of time where the implications and consequences for social care were more severe, particularly, during the absence of community testing and lack of available PPE.

44. Due to the dynamic nature of the COVID-19 pandemic, communication between central and local government was a prominent challenge. For example, DPHs flagged that restricted access to nationally collected data, particularly information about locations of people testing positive at post-code level, meant that local public health teams did not have the full information they needed to inform modelling and according actions to manage local outbreaks.

45. There were also some initial difficulties in sharing shielding lists of clinically vulnerable individuals between NHS England and local councils, and a lack of clarity regarding the expectations and requirements from such councils. MHCLG guidance published on 14 April 2020 to councils, LRFs and other delivery partners helped to set this out, see **[Exhibit CW/14: INQ000608010]**. As well as creating challenges for councils in providing and coordinating direct and community support for people who were shielding, councils' workforce and response capacity were affected by the numbers of staff required to shield.

46. The communication issue also extended to food distribution, with efforts for a national distribution system being unsuccessful. The idea had been that those on a national clinically vulnerable list would have been able to get food parcels delivered, or alternatively to set up food hubs with local distributions taking place. Delays in data sharing meant some delays in local support being able to be provided to people who were shielding due to higher vulnerability levels.

47. The Contain Division had a key role in collecting information from local areas on challenges being experienced with Test and Trace policy and infrastructure. As set out at paragraph 28, local authorities raised concerns about the timeliness of receiving testing data and the impact that delays and incomplete data were having on their ability to manage local outbreaks and model progress of the virus. I raised this at NHSTT Executive Team meetings and the data turn-around time was improved accordingly.

48. The scale of the COVID-19 pandemic placed significant pressure on regional and local public health capacity. There didn't appear to be an understanding in central government about the national position on health protection capacity in place at

regional and local level, and the impact that local funding cuts had had on that capacity in different places.

49. This issue also extended to the capacity of environmental health teams and community infrastructure. Many of the challenges faced by local governments in their ability to implement Test and Trace policies related to lack of funding, as already detailed in paragraph 10. Local government funding has been severely reduced across public services in recent years which has resulted in a reduction in local outbreak management capacity for many councils. This has equally resulted in the reduction in funding for local community infrastructure such as youth centres, libraries, children centres and community facilities. Local authorities, and functions within them, worked hard to collaborate and provide mutual aid where possible but local capacity constrains meant that often resources were already stretched to meet local need, therefore limiting their ability to provide wider support. This is compounded by limited cross-government understanding of the roles, responsibilities, powers and duties of local authorities and local resilience forums.

50. There were also challenges connected to data and information flows and around the clarity of roles and responsibilities in outbreak management. Such issues included local public health teams not being provided with patient identifiable information on COVID-19 cases which had implications for effective management and prevention of local outbreaks. There were also issues with the timeliness of data referred to in paragraph 28.

51. I worked with teams such as the Test and Trace Policy Team and the CO COVID-19 Team to address some of these challenges by allocating funding, requesting additional funding where required, creating feedback loops with local authorities and exploring what surge infrastructure was required to be put in place. Whilst some funding was made available through the COMF to try and address some of the capacity gaps, one-off or short term funding could not address the need for the qualified and profession capacity required within local authorities.

SECTION C: PUBLIC COMMUNICATION

52. As CDD, I shaped how the Test, Trace and Isolate guidance was communicated to the public through engagement with local government associations, councils and regional groups. In doing so, I identified good practices on communication and engagement, as well as developing local communication plans as part of the local contain outbreak management plans. In addition to the core messages set by central government, councils developed their own communication campaigns and approaches, tailoring these to connect to different population groups in their boroughs.

53. In my view, it was important to ensure the public health messaging was tailored to the local demographics and insights of a local area to ensure all communications were as effective as possible. Similarly, contain outbreak management pilots and funding support were focused on putting in place the infrastructure for effective and responsive communication and engagement. This is discussed further at paragraph 61.

54. Effective communication came with challenges due to the dynamic nature of the pandemic; the rapid changes in messaging for settings such as care homes, and different areas being subject to different restrictions at different times.

55. In my view, messages had to be tailored to the community they were being delivered to, but this was just as important as the complexity of the message that was being delivered. Unfortunately, the feedback I was receiving from local communities was that the messaging was confusing and this, in turn, was impacting compliance.

56. There were two main issues: how effective the communication mechanisms were, and the nature of the message being communicated. In the early stages, the three point message of "stay home, protect the NHS, and save lives" was clear and communicated effectively. Specifically, once different messages applied to different (and neighbouring) areas regarding the nature of restrictions under the COVID-19 tiering system, and the quick-changing nature of such messaging, it became increasingly difficult for effective communication to take place. The

messaging was complex, covering a wide range of issues such as funerals; weddings; travel; overnight accommodation; household mixing indoors, in gardens and in public spaces; and leisure facilities etc.,. People do not naturally live in line with local authority boundaries, meaning their workplace, school and home may be in differently "tiered" areas: this added particular challenge and complexity in communication.

57. When addressing the considerations given to the clarity and consistency in the messaging on Test, Trace and Isolate, the feedback from localities was that insufficient consideration was given to the complexity of the messaging on guidance and testing. I cannot recollect specific examples of such feedback at this time.

SECTION D: ADHERENCE

58. I have attempted to recollect whether any data was available to me regarding adherence to Test, Trace and Isolate rules and guidance, however, I do not recall what specific compliance data was collected nationally on adherence to such rules and guidance.

59. Through my role as CDD, I engaged with localities and through their feedback I was able to identify the challenges they were facing with ensuring adherence. The following barriers were identified by communities and local areas:

    a. Access to testing;
        i. in response to this, community testing was developed and local area pilots such as mobile testing sites were put in place to increase the uptake.
    b. Financial barriers to self-isolation;
        i. in response to this, pilot self-isolation payments and the introduction of Test and Trace Support Payments were put in place to mitigate any financial barriers.
    c. Communication and Engagement;

i. in response to this, targeted engagement was put in place for low compliance areas and businesses were given 'COVID-19 Safe Awards' for taking proactive preventative action;

ii. local areas developed their own communication strategies as part of their Contain Outbreak Management approaches. RPTs and the LGA worked to share good practice across these areas, and the COMF was used to support this work.

d. Compliance and Enforcement;

i. the COMF for councils was put in place, and was used to support a wide range of preventative and outbreak management approaches including compliance work by including environmental health, as well as targeted working with areas and settings of concern, such as hospitality and leisure settings; universities; factories and food processing plants.

60. The role of the Contain Framework was to help clarify roles and responsibilities at local, regional and national levels, and to work with other parts of the COVID-19 infrastructure (such as Test and Trace support payments and the COMF) to mitigate the issues raised.

Pilots

61. An overview of the programme of 16 pilot projections to support self-isolation during the COVID-19 pandemic can be seen at **[Exhibit: CW1/15 INQ000496204** A range of pilots supported by the contain outbreak management plans addressed areas such as Contact Tracing, Enforcement, Communication and Engagement; and multi-agencies working within vulnerable/high-risk settings and communities.

62. These pilots were located in Newham; Yorkshire and Humber; Lancashire, Blackburn & Darwen, Blackpool; Greater Manchester; Cheshire and Merseyside; Royal Borough of Kingston; Hackney; Peterborough, Fenland and South Holland and Somerset. The areas chosen were based on enduring transmission of COVID-19 and where there were variants of concern outbreaks. Pilots were focused on different aspects of outbreak management. For example, pilots in Blackburn with Darwen, Luton and Leicester focused on integrated localised approaches to testing

indicated the need for flexibility in the implementation of Test, Trace and Isolate guidance, supported by national policy and infrastructure such as the provision of the testing infrastructure, support for local capacity and resources for self-isolation payments. This led to the eventual roll-out of such integrated localised approaches to all public health authority areas. A press release announcing this approach can be seen at **[Exhibit CW1/16: INQ000607999]**.

SECTION E: INEQUALITIES

63. From the beginning of the COVID-19 pandemic, it was clear that there were different impacts for different geographical areas, communities and individuals. There was a significant correlation between high levels of cases of COVID-19 and indices of multiple deprivation and protected characteristics such as ethnicity, age and disability. Furthermore, the nature of the local economy and employment rates was also connected to the increase in vulnerability due to likely exposures, ability to self-isolate and follow guidance, access to healthcare and other public sector infrastructure, as well as the overall resilience of the local community.

64. The initial focus nationally was on those individuals who were clinically vulnerable, rather than on communities, settings or locations. Following the initial response, the national data evolved to include age and ethnicity. There were a range of actions taken both locally and nationally to mitigate inequalities, such as self-isolation payments, community and home testing, and mobile testing units. However, the reality and scale of structural inequalities, and other factors such as quality of housing; the nature of employment undertaken (such as zero hour contracts or key worker roles); and pre-existing health conditions all impacted on the effectiveness of such strategies.

65. When considering how this can be mitigated for future pandemics, in my view, the quality and granularity of the data, the range of equity dimensions and congruence with mapping to local authority footprints will all be important to ensure the rapid insight into local communities and appropriate targeted responses.

SECTION F: LESSONS LEARNED

66. In the early stages of the Test, Trace and Isolate system there was a very limited focus on engagement with local authorities despite their statutory roles and responsibilities for public health, social care, civil contingencies, compliance and enforcement as well as community insight and relationships. In addition, communication was limited and targeted communication with special areas such as care homes and schools, rather than the local authority, made efforts for coordinated responses extremely difficult and confusing. Furthermore, the lack of outbreak information due to testing being limited to clinic settings, made local responses even more challenging.

67. NHSTT, when it was put in place, did recognise the importance of working effectively with regional and local partners and invested in supporting the Contain Framework and infrastructure. In my view, it would have been more impactful and beneficial if this relationship and ways of working had been in place from the beginning of the pandemic.

68. When considering what, if any, changes should be made to the relevant systems and processes in the future, I am of the view that connectivity between the systems and processes at national, regional and local level should be in place with a clear understanding of the relevant roles, responsibilities, relationships and accountabilities at all levels. This includes consideration of co-ordination of communication and engagement channels with local government by different government departments.

Legacy of the COVID-19 pandemic on Infrastructure

69. From my time as CDD, I witnessed the relationships and understanding of the relevant roles and responsibilities between regional and local outbreak management teams improve. It would be important to understand to what extent these improvements were based on individual relationships, knowledge and understanding, and to what extent these are now incorporated into ways of working and whether they remain in place to be called upon, should another pandemic

arise.

70. Moreover, the resilience of local communities to a future pandemic will be impacted by significant vulnerabilities to public infrastructure and reduction in capacity due to funding cuts. Understanding the differential resilience of places and communities and the differential demographics impact will be crucial. This will require an improvement to the gathering of data. In particular, it is essential that central government understands what health protection capacity and resources we have in the country currently, to enable effective and informed balancing of risk. This applies not only to the state of play of public health infrastructure locally, but also environmental health teams within local government given their broader public health responsibilities.

71. Similarly, the importance of communication and feedback between central and local government was established throughout the pandemic. It is essential that central government understands the statutory roles, responsibilities, structure, and powers of local government. Not only this, but the autonomy and agency of local government – it is not singularly a delivery mechanism of statutory frameworks, but also an important basis of local leadership and insights. It is essential that it is understood to be utilised effectively in a pandemic again.

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: 05/06/2025