

William Wragg MP
Chair, Public Administration and Constitutional Affairs Committee
House of Commons
London
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9th November 2020

Dear William,

Data transparency and accountability: Covid-19 inquiry

I hope this finds you well. Thank you for your kind invitation to provide evidence to your inquiry on 'Data transparency and accountability: Covid-19'. I hope that the evidence I provided will be of use to your Committee and I thought it might be helpful if I provided further thoughts from the local government perspective.

Better data practice

As I mentioned, councils have worked closely with government throughout the pandemic to protect our local communities and save lives. They have shown great leadership and delivered for their communities in very challenging circumstances. Data sharing between public services has been essential to support the most vulnerable in our communities and central and local government have shared several different types of data during the pandemic, including shielding data, test and trace data, adult social care data and death management forecasts.

Unfortunately, the data flows from national to local government (including from the NHS to councils) have not always worked well. Conversations between Whitehall and councils about these flows have too often focused on processes rather than outcomes, as well as what restrictions need to be placed on sharing data, rather than thinking about how we can better use data collectively while meeting data protection requirements. Additionally, the NHS did not share discharge data in the pandemic, and still does not routinely, which has made it difficult for councils to plan services.

Moreover, basic good practice for data has not always been followed. With shielding data, for example, there have been instances of inconsistent, poor quality and duplicated data along with other issues of delays in providing updates. For example, some councils reported issues with accessing data due to being sent incorrect passwords, and other councils reported that Government data did not necessarily match the data coming from GPs and clinical commissioning groups and vice versa. One council calculated that 14 per cent of the data it received from the shielded list was incorrect. Councils have spent a lot of time cleansing data and trying to identify means of contacting individuals which could have been avoided. I know of one case where a shielding person's details were sent to a council with no address other than a postcode, and the council had to knock on their resident's doors to find this person.

In the future, Government should ensure that good data practice is followed when communicating with councils. Specifically, data should be up to date and available at local authority or smaller area level; case-level data should have unique identifiers, such as the unique property reference numbers; the format of datasets should not keep changing and, where it is necessary, any changes should be flagged to councils; and finally, the users of the data, such as councils, should be involved in decisions about the data system and the data requirements.

A better strategic vision of data and the importance of co-production

There have been multiple government requests for data from councils. Whilst we understand some feedback to central government is necessary, many have not been proportionate or coordinated, with the Infection Control Fund being one good example. It has sometimes felt there was little real consideration of burden, and new collections missed the usual challenge process of the New Burdens Unit or the Single Data List.

In part, we feel that these problems were caused by a lack of a single strategic view of data. Multiple departments or bodies passed on multiple data sets or made multiple requests for data, rather than considering the whole data ecosystem and making a strategic decision about what is needed. An overarching data lead, who took into account all the work being undertaken by councils and listened to their requirements, would have made the use and sharing of data much more effective.

It is notable that improvements have been made to the data flows where government has co-designed the approach with local government, ensuring that councils' requirements, as the key users of the data, are incorporated into the design and that it is proportionate and fit for purpose. This approach should be used across all the data systems. It was successful, for example, for the revised shielded persons data system, contingency planning for adult social care providers and on action to address infections in specific care homes.

We also expect that government may be interested in introducing a permanent co-ordinated approach for capturing and using data about adult social care providers. As the key users of that data, it will be essential for local authorities to co-design any new approach. This will ensure any collection gathers the intelligence needed by councils to assess the adult social care market, not just the data of interest to national government, and will look at care in a range of settings, including care homes and home and community care settings. It will also be important to keep the governance of social care data within the sector, rather than it being seen as a subset of the NHS.

Early communication

Early communication with councils is vital. National and local government communicators have worked more closely during this crisis. Information, new government initiatives, and national communications campaigns have been shared through mechanisms such as weekly virtual meetings held by the Cabinet Office and DHSC communications teams. This has been considered useful by those councils that have participated. Additionally, MHCLG have worked hard to improve co-ordination of communications across Whitehall departments to councils, which has been helpful.

However, there has been considerable frustration at the tendency for announcements which have implications for local government to be briefed to the press before any consultation with councils. This has included some government initiatives, such as COVID marshals, and the moving of local

areas into tighter restrictions. There have also been missed opportunities for local government to help amplify national initiatives – for example, councils did not receive collaterals in advance of the launch of the NHS app to help them promote its use. Where new regulations or restrictions are implemented, councils need sufficient lead time to prepare for these to allow them to be adequately resourced and undertake the necessary engagement with businesses and residents.

Councils should be trusted as key data partners

The LGA has been consistently making the case for councils to have necessary powers, resources and authority to lead the COVID-19 response locally and tackle outbreaks swiftly and effectively. Experience of the test and trace system to date has shown the advantages local authorities have over national systems in being able to identify those who have been exposed to COVID-19 and working with their communities to slow and stop community transmission.

Initially, the sharing of testing data with councils was poor, despite their crucial role in containing and managing outbreaks locally. Throughout May and June councils were having to argue for and justify why they should receive granular data. When data did start to flow, access was hampered by multiple data sharing agreements and restricted access protocols, and the tools and format the data were provided in were not always conducive to council's needs.

Whilst increasing amounts of data are now being provided to councils, which is very welcome, there are still concerns around the timeliness, quality and format of that data. These concerns are: that the delay in test and trace data hampers authorities' efforts to support communities locally; key pieces of data, such as missing or incomplete workplace, alternative addresses and lack of unique identifiers, continue to be an issue; councils spend huge amounts of time trying to access data: this is time that could be better spent if data were consolidated and provided as data feeds; and that the lack of equity in access to data means that authorities are given different data (in terms of granularity and the amount of analysis) depending on which tier they are in, yet all authorities would benefit from the full detail in order to contain and manage outbreaks effectively.

The other limitation of the data is it is only provided for the geographic boundary of the authority. Therefore, cases that cross boundaries, such as close contacts that reside in a neighbouring authority, will not be included in the data. Opening the dataset up to neighbouring authorities would help in tracking the spread of infections.

I hope the information outlined above is useful. Thank you again for your kind invitation to speak at the inquiry. If we can help with anything else, please do not hesitate to get in touch with my colleague jade.hall@local.gov.uk.

Yours sincerely,



Cllr Ian Hudspeth
Chair, LGA Community Wellbeing Board