Local authorities were vital for the successful deployment of COVID-19 Test, Trace and Isolate policies

Recent research has focused on the public health challenges posed by the COVID-19 pandemic, through interviews with public health experts in England predominantly from local authorities. ***Anne West*** *outlines what we've learnt about the challenges faced by local authorities regarding testing, tracing and isolating strategies and raises a number of issues for the future.*

In April 2020, the UK had one of the worst cumulative COVID-19 mortality rates in the world. The government used a "command-and-control" approach during the pandemic. Local government was largely neglected by central government at the beginning of the pandemic. This is surprising as historically epidemics were controlled by public health doctors and their staff at the local level, using the tools of testing, tracing contacts, and isolating.

Elected mayors in English regions and local government leaders complained about the government's decision-making process. However, it was not until June 2020, that regional teams, which involved local government officials, were set up by the government to help with the management of outbreaks.

Testing

Care homes

A major issue at the beginning of the pandemic was the discharge of patients from hospitals to care homes. Government guidance did not require negative COVID-19 tests prior to discharge. However, one local authority decided to implement testing prior to discharge in March 2020. This was a "challenging decision" taken in advance of the national policy and facilitated by "a really strong partnership with our acute hospital trust".

Scale testing and hard-to-reach groups

Interviewees noted that the “biggest challenge was the lack of scale testing availability”, with the major issue nationally being the lack of an appropriate testing infrastructure. Initially regional drive-through sites were set up, but these often required transport to access them, which posed difficulties in areas where many people did not drive. The national public health agency, at the time Public Health England (PHE), subsequently defined a walk-in model and local testing sites were developed.

A challenge with the testing infrastructure was registering tests and results online for people who were digitally excluded: “Central government is very good assuming everybody’s got access to a smartphone… Quite a few elderly people weren’t confident [and] lots of people around here don’t have the Internet or smartphones, so they were unable to register test results.”.

There were also hard-to-reach groups. Local authorities used different approaches to encourage testing amongst these groups. In some local areas, mobile testing vans were used to reach communities who would not come to a testing site. Councils also employed workers who could speak relevant languages to facilitate testing.

> When there was an outbreak which required a swift response, local decision-making came to the fore.

One local authority set up a large community championship network. “We got volunteers working with us from the different communities. The Director of Public Health would brief them on a weekly or fortnightly basis, on what was happening”. Another local authority, set up “trusted networks and established sounding boards” for different groups: Bangladeshi, Pakistani, Black African, people with disabilities.

When there was an outbreak which required a swift response, local decision-making came to the fore. In one local authority there was an outbreak in a prison. The local authority decided to carry out testing from a public health point of view. However, they had to fund the testing: “We made the right public health decision… but there was a no clarity on the funding stream, there was no formal policy.”

Lateral flow tests

Central government invested in technology, including lateral flow antigen testing devices (LFT), which enabled self-swab taking. By the end of 2020, there was widespread, accessible, lateral flow testing for the general public where people came to collect tests or could order them online.

LFTs played an important role in enabling schools in reopen in January 2021. Schools were required to carry out testing prior to opening, which "put immense pressure on the school system… Schools were getting guidance but in [this LA] we did make the decision in December 2020 [that we would] provide testing on behalf of schools. That was against national policy".

Contact tracing

Local authorities had very limited involvement with contact tracing at the beginning of the outbreak. Responsibility quickly shifted to the central level where it sat with PHE. Subsequently, the government decided to procure a national contact tracing service; this was centralised outside PHE and ran as a separate system, part of NHS Test and Trace (NHST&T).

NHST&T did not work with local authorities at the outset. It took local authorities "many months of quite fierce lobbying to get any meaningful contact and especially resourcing to supplement the NHST&T effort" even though Directors of Public Health knew that they "would be able to get better, quicker reach". By August 2020, the DHSC announced a change in focus for the test and trace programme: local and national teams would "work as one".

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

> "The central tracing element didn't really work… [NHST&T] were using remote teams who didn't understand the community… ringing from [a UK wide national number] that people [won't answer]."

When there were massive surges, the national tracing service was not able to reach

people. One local authority had “2,000 cases come through one day”. “The big fault in the national system was when it couldn’t cope, everything came to the local [level]. But there was no extra money, no extra resources”.

“Local knowledge” and “local understanding” were important. One interviewee described the case of a man in his late 80s with COVID who the national system had not managed to reach for three days. The local authority successfully tracked him and was able to sort out food and his medication from the doctor.

In some areas, local authorities eventually took on all the contact tracing: “We had our own number for our local team, with nurses in the team. When people picked up the phone we said, ‘we’re public health nurses from [the city]’ and that made all the difference… We always started the conversation with, ‘How are you feeling’… which… was not even part of the [national] script”.

Isolation and support

Local authorities were sent information regarding individuals who were isolating or shielding and needed support. Councils provided a range of practical support including food, medication collection and dog walking. Community organisations “provided food for people, dropping things off at people’s doors, and the council provided nappies and things for babies… we managed to support people to get medication because you can’t order paracetamol.”

Initially, there was no financial support for those who were not able to work from home, but later local authorities “did get money from government to give payments if people had to isolate”. Some local councils also put in additional support for self-isolation for people who could not work from home.

Government messages lost in translation

Communications from central government were vitally important but could pose problems at a local level: “Often you would hear stuff on Twitter, or on the news before you’d got the press release from the government about it… I don’t think it was colleagues in [the public health agency] it was… the politicians. It felt like they were making stuff up… on the hoof.”

“Boris Johnson [the Prime Minister] would stand on a podium at 5 o’clock at night announcing something that we had to implement the next day… We didn’t have enough time to be able to implement things as we’d want to.”

More generally, there was a concern regarding the messaging from government which was found to be confusing and frequently changing. Local authorities had to set up their own communications in different languages and more accessible formats, since “the national comms were not fit for purpose for our local communities.”

The language that was used in central government communications also caused confusion: “The interpretation of ‘household’ culturally for many people was family, but family lived across more than one household. Because of the way they interpreted the message they thought it was fine to get five households together, because they were all the same family.”

Going forward

Interviewees reported positive relations between central government and the key central agencies PHE and its successor UK Health Security Agency. They welcomed the introduction of a regional structure.

However, resourcing was a key issue. “[For] local authorities to have an active role they need to be resourced; without adequate resourcing they play the game of risk / muddling through”.

Trust was vitally important: central government needs to trust local government to make decisions given the expertise at a local level. “The word ‘trust’ is a key one throughout everything”.

This post draws from the author’s research paper: West, A. (2023) COVID-19 Testing, Tracing and Isolating Strategies in the UK (England). London: LSE.

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