

Agenda

Community Wellbeing Board: Supplemental Agenda

Thursday 4 February 2021

11.00 am

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Covid-19 Update

Purpose of report

For direction.

Summary

This paper updates the Board on the LGA's Covid-19 related work since its last meeting, including on the roll-out of the COVID-19 vaccines since December 2020. It also details ongoing issues including access to local vaccination data and provides an update on the work of the LGA Behavioural Insights Projects 2020/21.

Recommendation

Members are asked to:

- (a) Note the update on the LGA's Covid-19 related activity since the Board's last meeting including the related LGA Behavioural Insights Projects 2020/21.
- (b) Comment on the approaches outlined in the sections on self-isolation (paras 17-19) and vaccinations (paras 35-52).

Action

Officers to incorporate members' views into the LGA's work in this area.

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Covid-19 Update

Background

Issues

1. This paper updates the Community Wellbeing Board since its last meeting in December on the LGA's Covid-19 related work in relation to the priorities agreed by the Board in October.

Managing local outbreaks – the Contain Framework

2. The government announced the third national lockdown on 4 January 2021. This superseded the local tiers introduced as part of the Contain Framework. With the Prime Minister signalling that the government will set out the plan for taking the country out of lockdown in the week commencing 22 February, councils are now keen to understand how the transition from lockdown will take place. Reports in the media suggest the government is considering a transition made on a national rather than local basis due to the way the new variant of Covid-19 is behaving. We will be seeking clarification from government on what the role of local authorities will be in the transition arrangements and for sufficient warning of the implementation of the changes to allow councils to properly prepare and plan. As part of these discussions we will also be highlighting the capacity constraints in local government to undertake all the work government departments want councils to carry out.
3. One of the issues Whitehall departments have been interested over the autumn is assurance about what councils are doing. As a result the LGA has been involved in discussions with the Department of Health and Social Care (DHSC) and the Joint Biosecurity Centre to ensure there is a joined-up approach across government departments around assurance and the asks that are being made of local government.
4. This work has been complicated by the number of regional departmental teams working to support local outbreak management. These include Public Health England's (PHE) regional teams, and alongside them colleagues from the Contain Division, which leads on local outbreak management for Covid-19 within NHS Test and Trace, as well as staff from the Joint Biosecurity Centre (JBC). There are also a number of teams from the Ministry of Housing, Communities and Local Government (MHCLG).
5. The aim of the assurance process around local Covid-19 outbreak management is to identifying support needs, and the common and collective issues that is appropriate to escalate to help inform future policy and operational developments relating to local outbreak management and, importantly, identifying and sharing best practice. Having considered a number of options, it has been agreed that the regional teams along with the LGA's Principal Advisers and the Association of Directors of Adult Social Services and the Association of Directors of Public Health (ADPH) should form a group that meets regularly (at least fortnightly initially), but also with communication between meetings, to

pool insights and intelligence on local area Covid outbreak management; as such these meetings should build on what there already is in place rather than creating a new group. JBC will provide the secretariat support. In addition, it is proposed that at a national level a working group will meet on a monthly basis to take feedback on how the process is developing, and review as needed.

Localisation of test and trace

6. Contact tracing remains a key pillar in the government's response to the pandemic. Over 300 Local Contact Tracing Partnerships have now been created across the country with the remaining 10 councils about to go live soon. The relationship with NHS Test and Trace has improved over the last few months but there is still a sense from frontline public health teams that they are still relatively remote. Councils report that when residents raise issues or queries with NHS Test and Trace there is quite a long chain of command for it to go all the way up and then for the answer to come all the way back down. It is perhaps not as responsive yet as the sector would like to see it. The government recently announced the roll out of a £100m programme to enable the piloting of work to enhance the trace to help build and execute trials related to further localisation of trace and isolation support services.
7. The government has prioritised essential workers for testing but also allowed councils to use the testing kits provided to address local priorities. There are emerging proposals for the enhancement of community testing, with government proposals for a mix of institution/business-led on-site Lateral Flow Device (LFD) testing for employees of larger organisations and locally-led community testing for self-employed people, small businesses and other at risk groups, alongside the general 'open' public offer. A mix of business-led and community testing for medium-sized organisations. There are also some discussions about the use of more 'home-testing' tests, which are currently available for primary school teachers, in a number of different settings.
8. Although government published evidence in December about the use of LFD testing, concerns have been expressed over the accuracy of the LFD tests compared with PCR tests, and the possibility of false-negative results. This raises issues for councils around the use of the tests in some settings and also in managing local communications. We are currently exploring the position for councils on the use of LFDs further.
9. The identification of new strains of Covid-19 in the UK (including those from Brazil, South Africa and Bristol/Liverpool) has led to the adoption of surge testing techniques. Currently the surge testing is being conducted in a number of postcode areas in England in relation to cases of the South African strain:
 - 9.1 East of England (EN10)
 - 9.2 London (W7, N17, CR4)
 - 9.3 North West (PR9)



9.4 South East (ME15, GU21)

9.5 West Midlands (WS2)

10. Councils in affected areas have established local communications to strongly encourage every person over 16 living in these locations to take a Covid test. Mobile testing units (MTUs) will be deployed offering PCR testing to people without symptoms who have to leave their home for work or essential reasons, and councils will be encouraging people to get tested in the area by providing additional home test kits. Councils will also be responding through their local test and trace teams.
11. Positive tests will be sequenced to identify any further spread of the South African variant, enabling a better understanding of the variant and identifying if there are any more cases of this particular strand of the virus in the area. There is currently no evidence to suggest this variant is more serious than others, or that the regulated vaccine would not provide a level of protection. With the identification of mutations of concern in Bristol and Liverpool it is likely that surge testing will be launched in these areas too.

Shielding

12. As with the second national lockdown, the government has issued guidance to clinically extremely vulnerable (CEV) individuals on how to protect themselves from Covid. While the new guidance has not reintroduce the full shielding programme seen in the spring of 2020, the CEV cohort has been advised not to go to work if they cannot work from home, or visit shops or pharmacies, and to contact their local council if they need basic support or assistance with accessing food. The CEV cohort is expected to follow this advice until 21 February when the advice on whether to shield will be reviewed.
13. Following the changes made to the shielding programme in the autumn support to CEV people is very much locally based, and centred on ensuring they can be as self-sufficient as possible when it comes to accessing food. Data collected through the National Shielding Service System suggests that only a small proportion of CEV people registering with it have requested support. MHCLG has stated that councils will be provided with funding to cover the costs of supporting CEV people based on the number of CEV people in their areas.
14. DHSC has identified more people who qualify for inclusion in the CEV groups due to a combination of factors such as age, sex, ethnicity and a range of underlying health conditions or treatments in addition to specific clinical conditions as currently. Once we have more information on these additions to the CEV cohort we will share it with the Board.

Enforcement

15. Councils' Covid-19 compliance and enforcement activity has continued to be a key area of focus for the Government and a core part of our Covid-19 support for councils. Since early December there have been frequent changes to the requirements applying to businesses, with premises moving from the second national lockdown to a tiered system of reopening, to a more stringent set of closures, and finally to the third national lockdown. Councils have had to quickly get to grips with and adapt their work to reflect the changing regulations. In December, for councils in tier 2 areas this included enforcing regulations in hospitality premises including the requirement to serve a substantial meal with alcohol and a ban on household mixing indoors, while compliance challenges in the context of lockdown include ongoing issues relating to the sale of non-essential items in mixed use premises. Feedback from councils suggest that overall, compliance levels amongst businesses are generally high, although concerns have been raised about the fact that businesses such as coffee shops, which opted to close in the first lockdown last March, are now remaining open, which is driving behaviours. Councils have also been asked by the Secretary of State to target their efforts on premises that are permitted to remain open, such as supermarkets, although in general councils were already targeting their activities to these businesses anyway.
16. The LGA has continued to work closely with member councils and the Government over this period. We held two compliance and enforcement webinars for over 600 delegates, and worked with MHCLG on a new good practice compliance and enforcement framework which is hosted on the LGA website. We are also contributing to a cross-Government regulatory services task and finish group which is looking at the pressures on regulatory services in the context of Covid-19 and EU exit.

Self-isolation

17. MHCLG are looking at councils' role in contacting and providing non-financial support for those required to self-isolate (SI). Subject to views from Ministers, they are developing a draft framework which would require councils to increase their contact with people receiving positive tests in order to assess individual non-financial support needs. This will be funded through the current funding stream for the CEV group, with a start and finish date yet to be confirmed. We welcome the opportunity to engage with government on this issue but would support a local approach based on councils' understanding of their local communities, as evidenced by the success of local testing and tracing (T&T), as we are aware many councils are already delivering this sort of contact and support. We have however in discussions with MHCLG stressed the need for key principles to underpin any future framework:
1. **Whole system approach:** an integrated, whole system response applying to anyone who is required to self-isolate needs to underpin any future framework. This needs to include clarity on both financial and non-financial support for people who test positive and for their close contacts, as both groups will be required to self-isolate. This also needs to link with the national and local approach to testing and

tracing. There needs to be a clearer recognition that the actual and perceived availability of financial support remains a key driver of behaviour.

2. **Recognising current capacity:** given the ongoing priorities of vaccination roll out and testing, local capacity is stretched. There needs to be a clear assessment of how councils could take on a substantially greater role and how they should be prioritising these workstreams while maintaining core services. There also needs to be an assessment of whether the CEV funding model is applicable. As well as clear confirmation of potential start dates with a reasonable lead in time, a clear outline of what councils' role may be in the medium to long term around supporting self-isolation is also needed to inform local planning.
 3. **Effective targeting:** linked to the above, any contact and support provided by councils should be on a reactive basis, with people ideally directed to seek support via websites etc rather than by phone, given the potential time and capacity cost of the currently proposed proactive model. This would also use the learning from the support provided to the CEV group and existing T&T follow up activity, which suggests that national contact centres may incorrectly flag local support needs. Whilst the framework does refer to councils making decisions on appropriate support, there needs to be clearer recognition that different people will have different barriers to self-isolation, with defining the 'vulnerable' as a group to focus activity on remaining problematic
 4. **Communications and data:** any framework needs to be supported by strong national communications around expectations for self-isolation. This should promote self-sufficiency, with councils the last resort support for those without any other routes, and could encourage those who can afford it to prepare for self-isolation, such as ensuring food supplies and other critical goods. Councils' role needs to be seen as nudging, triaging and signposting to existing support offers and local partners; not enforcing. Effective data flow is also fundamental, with councils reporting issues with the national T&T data, and any monitoring requirements from government need to be proportionate.
18. The LGA remains keen to ensure any future work is informed by current council practice and to share any learning, with any examples from Board members of work in their councils on supporting self-isolation very welcome.
19. We are also continuing to press for closer joint working between MHCLG and DHSC on the integration of financial and non-financial support for people who have been asked to self-isolate. The Resources Board is leading discussions on Test and Trace Support Payments scheme (TTSP), including the sufficiency of funding and the importance of consistent and effective communications on policy intent and eligibility. The current scheme has been extended to 31 March 2021 with a further £20.4 million funding to the end of January. The LGA has emphasised the need for councils to have sufficient time and resources to implement any further changes, and for Government communications to be clear and consistent to minimise the operational and reputational risks for councils.

Infection Prevention in Care Settings

20. In September the government announced it would be supporting councils and care providers to maintain staffing levels over the winter period. On 16 January the government announced a further £120 million was being made available to support the care system to manage workforce pressures through the Workforce Capacity Fund. The Fund is a ringfenced adult social care grant for measures that provide additional staffing for adult social care providers, including those with whom the local authority does not have a contract, and maintain continuity of care. The letter asked councils to use this funding to target providers with the most urgent staffing shortages. The LGA worked with DHSC to provide guidance to sit alongside the fund, which includes examples of strategies used by some local authorities and providers to supplement and strengthen adult social care workforce capacity.
21. Along with the move to extend the provision of free personal protective equipment (PPE) to the adult social care sector, councils and Local Resilience Forums (LRFs) are now able to access free PPE for unpaid carers who support people they do not live with. Given the vital role unpaid carers have played in supporting vulnerable people during the pandemic, some councils and LRFs have already been providing unpaid carers with PPE. DHSC has written to council PPE leads and LRFs, asking them to supply this group with free PPE via the council/LRF distribution routes that are already in operation. DHSC is also providing councils and LRFs the flexibility to apply the eligibility criteria to best suit local needs.

Vaccinations

22. The World Health Organisation (WHO) report that there are currently more than 50 Covid-19 vaccine candidates in trials. At the time of writing three vaccines in the UK have been authorised for supply; the Pfizer BioNTech vaccine, the AstraZeneca vaccine and the Moderna vaccine, and the government has ordered doses of a number of other vaccines that have yet to be authorised for use.
23. The Joint Committee on Vaccinations and Immunisations (JCVI) published advice including a list of the groups/cohorts that should be prioritised for vaccination. The full list is below;
- (a) residents in a care home for older adults and their carers;
 - (b) all those 80 years of age and over and frontline health and social care workers;
 - (c) all those 75 years of age and over;
 - (d) all those 70 years of age and over and clinically extremely vulnerable individuals;
 - (e) all those 65 years of age and over;
 - (f) all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality;
 - (g) all those 60 years of age and over;
 - (h) all those 55 years of age and over; and

- (i) all those 50 years of age and over.
24. It is estimated that taken together, these groups represent around 99 per cent of preventable mortality from Covid-19. The vaccination programme is the biggest single logistics exercise in the history of the NHS with the aim to vaccinate 41.6 million people in England including 2.2 million CEV individuals.
25. On 4 January 2021 the Prime Minister gave a commitment to offer the first vaccine dose to all those in the top four priority cohorts by 15 February. With these groups accounting for 88 per cent of Covid-19 fatalities, the move will prevent thousands of deaths once their immunity develops in 14 days. This requires about 13 million people to be vaccinated.
26. On 11 January the government published the UK COVID-19 Vaccines Delivery Plan. The plan set out how the government aimed to reach its target of vaccinating the top four priority cohorts. The plan set out:
- (a) That at least two million vaccinations per week would occur with over 2,700 vaccine sites across the UK.
 - (b) How the over 200,000 offers of non-clinical support from the public and leading UK businesses to help with the logistics of the programme would be used.
 - (c) That by the end of January everyone in England would be within 10 miles of a vaccination site, or for a small number of very rural areas, the vaccine will be brought to them by mobile teams.
 - (d) That all residents and staff in over 10,000 care homes across the country would be offered the vaccine by the end of January.
 - (e) That government aimed to rapidly expand the programme to include;
 - 26.e.1. 206 active hospital sites;
 - 26.e.2. 50 vaccination centres; and
 - 26.e.3. around 1,200 local vaccination sites - including primary care networks, community pharmacy sites and mobile teams.
27. Due to limitations on the amount of vaccine available, the sharp rise of cases of Covid-19, and the need to increase the number of people being vaccinated, the government decided the public would be given both parts of either vaccine 12 weeks parts, as opposed to the original 21 days between the Pfizer vaccine jabs. The logic behind this decision was to spread the resource as widely as possible to achieve the most benefit; we support the Chief Medical Officers decision. In our view having more people vaccinated, thereby giving them up to 89 per cent protection from day 14 after receiving

the first dose, is favourable so long as the evidence is that this does not undermine the vaccines effectiveness.

28. Significant progress has been made in vaccinating the top four priority cohorts by mid-February. At the time of writing around 10 million people have received their first dose of a vaccine. All residents and staff at every eligible care home with older residents in England has been offered a Covid-19 vaccine. This in the LGA's view is a reflection of the ongoing close partnership between care home managers, councils and the NHS. However a small number of care homes have had their visits deferred for safety reasons resulting from local outbreaks. DHSC has been clear that these homes will be visited and residents and staff vaccinated as soon as NHS staff are allowed to do so. The Department has advised any care home in England with older residents and staff who have not yet been visited to contact it. Within the wider priority groups almost nine in 10 of all those aged over 80 had been vaccinated, and over half of those in their 70s have also received their vaccines.
29. Although the national vaccination programme is on schedule in relation to protecting the top four priority cohorts, vaccinating the other cohorts before the end of spring remains a significant challenge. We have been working with NHSE and DHSC to ensure the logistical expertise and community reach of councils is acknowledged and fully utilised.
30. The role of councils in supporting the NHS has been acknowledged by government, and earlier this week the Secretaries of State for Health and Social Care and Housing, Communities and Local Government jointly wrote to councils setting out how they can support the national vaccination programme in the immediate future and over the longer term.
31. A list of possible roles for councils to play (though the government are keen to stress this should not constrain the contributions of councils) include assisting the NHS in removing barriers to vaccination through lack of easy access to a vaccination centre, developing local communications plans to foster take up of the vaccine, assisting in the running of vaccination centres, and ensuring eligible health and social care workers are vaccinated. The letter also acknowledged the additional costs for councils in supporting this work and indicated councils should be seeking to recover those costs through their relevant clinical commissioning groups.
32. As the vaccination programme has been rolled out in the UK, additional data has become available on the safety and effectiveness of Covid-19 vaccines. Most recently a study by Oxford University has revealed that a single dose of the Oxford AstraZeneca vaccine can reduce Covid-19 transmission by 67 per cent, the first study to reveal a Covid-19 vaccine can also impact onwards transmission. Additional data of this sort will provide the basis for consideration of vaccination in groups that are at lower risk of mortality from Covid-19 as the programme develops. The next phase in the vaccination programme is currently under discussion but is aimed at the further reduction in



hospitalisation, and targeted vaccination of those at high risk of exposure and/or those delivering key public services.

33. We are pleased that new Covid vaccination advice from the JCVI published recommends that carers who are in receipt of Carer's Allowance or are the main carer of an elderly or disabled person whose welfare may be at risk if the carer contracted Covid should be included in priority group 6 alongside people with underlying conditions.
34. The LGA has been supporting the sector in the roll-out of the vaccine programme. We held a webinar on 21 December about the vaccination programme, which was chaired by the Community Wellbeing Boards' Vice Chair, Cllr Paulette Hamilton. Speakers were joined by Professor Jonathan Van-Tam MBE, Deputy Chief Medical Officer for England of DHSC.

Challenges related to the vaccination programme

35. Ensuring the uptake of the Covid-19 vaccine is high enough to achieve herd immunity, will be of the utmost importance. Herd immunity refers to the concept that 'a population can be protected from a certain virus if a threshold of vaccination is reached' (WHO). Some reports have shown that a vaccine refusal rate greater than 10 per cent could significantly impede attainment. In April 2020 a survey conducted by the Royal Society for Public Health (RSPH) reported that 81 per cent of participants from the general public were willing to have a Covid-19 vaccination.
36. We need further details from government on how best to address the issues of vaccine hesitancy as this is likely to be a key challenge throughout 2021. Councils alongside national government will need to counter the myths and false information being circulated through social media, including claiming the vaccine can impact fertility. Some information has been religiously targeted including claiming these vaccines contain animal products or alcohol. Public Health England has issued information stating that both the Pfizer vaccine and the AstraZeneca vaccine do not contain animal products. We would emphasise the need for government to communicate with faith leaders on these issues too.
37. The government has produced a video answering questions on vaccine hesitancy. The video is linked [here](#). However, we understand more work is being undertaken on this topic and will continue to press for this to be made available to councils as soon as possible.
38. DHSC believes it is unlikely that the vaccines currently used will be unable to protect against the new strains of the virus. In the webinar on 21 December, Professor Van Tam explained to those present that current vaccines could be tailored more quickly to respond to a new strain if required. In his view a new formulating the Pfizer vaccine for a new strain would be achievable by Autumn 2021.

39. Covid-19 has exposed long-standing health inequalities in different parts of the country while also proving the value of local knowledge and leaders. Going forwards ensuring there is no unequal access to the vaccine is key. Monitoring and evaluation of the programme should therefore include indicators for tracking uptake and acceptability in key underserved groups and across protected characteristics.
40. Government commissioned [an independent report that was published on 30 December](#) to consider the impact on and implications for health inequalities in the prioritisation of Covid-19 vaccines in the context of initial supply constraints, and we know from publicly available data that in the period between 8 December and 24 January at least 10 per cent of the white British population of England were likely to have received their first dose of a Covid-19 vaccine, compared with around 6 per cent of the Asian population and 4 per cent of the black population.
41. We need to ensure that the appropriate equalities impact assessments are undertaken so underserved populations are not missed, and the LGA will continue to emphasise this with government. Government needs to ensure inequalities are not exacerbated and that data is captured on the characteristics of those coming forward to be vaccinated.
42. As part of any approach to ensuring there is a fair and equitable roll out of the vaccine, the gap in local accountability needs to be addressed. We have to consider what the appropriate governance would be for this going forwards. A Local Vaccination Overview Committee involving key local leaders such as the council chief executive, director of public health, director of adult social care, chair of the Health and Wellbeing Board as well as clinical representation would be a route to improve local oversight and accountability around fair and equitable roll out of the vaccine.
43. Once the four top priority groups in the JCVI list has been vaccinated and we progress into phase two, we may wish to consider the value of local flexibility in those new priority groups. Phase two is currently described as being aimed at the further reduction in hospitalisation and targeted vaccination of those at high risk of exposure and/or those delivering key public services.
44. Absolute priority must of course be given to prioritising high risk groups. However, some frontline workers and communities may need the vaccine sooner than others. This could include a range of professions such as cemetery and mortuary staff, foster carers, those looking after vulnerable children and children with additional needs and those working in community outreach. Those groups most in need will likely vary according to each local area.
45. If there was to be some degree of local flexibility in determining priority groups in phase two, having access to demographic data of those already vaccinated would be invaluable in determining the groups most in need in a local area. For example a much larger

proportion of frontline workers or communities may have been vaccinated for being in other priority groups during phase one.

46. Data sharing with local government has again been a real challenge. There is a significant groundswell calling for more transparency over local vaccination data and there was a great deal of frustration that data could not initially be shared with Directors of Public Health for “commercially sensitive” reasons. Without this data Directors of Public Health were left no sense of what the supply chain looks like in terms of future delivery amounts and no local uptake data, so nothing by specific groups. A daily feed of the rolling immunisation data for each Local Authority area would ensure efficiency, equity and effectiveness of the programme to local residents.
47. The vaccine programme committed to establishing a working group focusing on addressing these data issues and took the LGA up on their offer to participate in this group. Following significant input from the LGA, we are pleased the following developments have quickly improved the amount of data available to Directors of Public Health;
 - (a) From 14 January NHS has provided publicly available data including all Covid-19 vaccinations administered in the reporting period, which can be viewed by age band, dose and by NHS region. This can be found linked [here](#). Data is still needed at a more granular level.
 - (b) We are pleased that since 15 January Directors of Public Health have been given access to vaccine data by local authority. This data includes the daily and cumulative total vaccinations by first and second dose and by the higher risk cohorts for each local authority area. This data is not currently accessible in the public domain.
48. Accessing vaccination data on the roll out in care homes and ethnicity data continues to be a challenge. NHS Wales for example provides ethnicity data in their daily and weekly statistics, and we would like the same in England.
49. We will continue to work closely with the vaccination programme in ensuring Directors of Public Health have access to the data they require and we will push for greater transparency of this data as it is developed.
50. While progress has been made in vaccinating care home staff, this is only part of the overall social care workforce, and DHSC has now written to councils and care providers to set out the plans for vaccinating social care workers based in the community. In order to keep track of progress in vaccinating the wider social care workforce, councils have also been asked to report on vaccinations so an accurate picture of social care staff vaccine uptake across the country can be maintained.

51. Work is also in progress to develop a Standard Operating Procedure (SOP) for the vaccination of unpaid carers. As has been indicated earlier in the report JCVI priority group 6 includes unpaid carers - although many will receive early vaccination due to their own age, or clinical need as defined in JCVI groups 1-5. DHSC is working with the vaccination programme and key stakeholders, including ADASS, the LGA and carers organisations with the aim of this SOP being launched shortly. Like other SOPs, this will include clarity on definitions, eligibility, and the process for unpaid carers to access vaccination as a guide to support local implementation, and will also set out the role of local authorities.
52. If this involves councils playing a role in identifying unpaid carers for vaccination this could be a considerable ask of the sector. There are no robust figures on the number of unpaid carers, but this could potentially be as many as 1.5 million people. Among the other work councils are undertaking in response to Covid, this could require significant resource from councils, and if this work is to be undertaken by councils it is not clear whether there will be additional financial funding made available to support it.

Behavioural science interventions and the LGA Behavioural Insights Projects 2020/21

53. Behavioural science interventions could be invaluable in informing how best to approach resident vaccine hesitancy and increase vaccination rates, with a particular focus upon communications. Understanding the socio-behavioural factors that influence vaccine hesitancy can properly inform the next steps that need to be taken in addressing the take up of Covid-19 vaccines. Behavioural science approaches should be embraced to help motivate those not inclined to have the vaccine and support myth busting. We will continue to emphasise its value to public health.
54. On this topic, the LGA has been building an evidence base of what Behavioural Insights projects work that councils can apply to their own services locally. This work so far has produced;
- (a) [A list of current council behaviour change projects addressing COVID-19 related behaviours.](#)
 - (b) [A podcast series detailing practical examples on using behavioural insights in a range of Council Services.](#)
 - (c) [The LGA and the Behavioural Insights Team have also developed a set of practical recommendations to assist local authorities with increasing their revenue collection.](#)
 - (d) [A publication detailing a summary of the top ten lessons that we have learnt throughout the LGA's behavioural insights programme.](#)
55. North Yorkshire County Council and the LGA conducted a Behavioural Insights project together. The first aim of this was to support council officers to adjust from working from

home during Covid-19. This includes assistance with home-schooling for parents who have these new responsibilities. The second aim of the project was to mobilise citizens living in North Yorkshire to support and volunteer in their local community during the pandemic. Links to relevant documents are below;

- (a) [Nudges](#)
- (b) [Examples of nudges](#)
- (c) [Behavioural science](#)

56. On the 23 February 2021 between 10:00 and 11:30, the Local Government Association will be hosting a [Behavioural Insights and COVID-19 webinar](#) about how we can use behavioural change techniques in our council services to work with communities and change their behaviour when responding to both the Covid-19 and climate change emergencies. More details about the event can be found by following the [link](#).

57. At this webinar a think piece will be launched, produced to support councils to use behavioural insights techniques to encourage the take up of the Covid-19 vaccine. This will include a collation of useful resources, interviews with those using behavioural insights to encourage take up of the vaccine and top tips and guidance.

Implications for Wales

58. Health is a devolved responsibility to the Welsh government so the work outlined in this report is only relevant to English councils.

Financial Implications

59. In order to support the LGA's work around testing, tracing and outbreak management a new cross organisational team has been established, which has been funded to date from existing LGA resources, although we have also sought to secure funding from DHSC in addition. As the areas of work outlined in this report are likely to continue into the 2021/22 financial year, consideration will have to be given to the future funding of the team.

Next steps

60. Members of the Board are asked to:

- (a) Note the update on the LGA's Covid-19 related activity since the Board's last meeting including the related LGA Behavioural Insights Projects 2020/21.
- (b) Comment on the approaches outlined in the sections on self-isolation (paras 17-19) and vaccinations (paras 35-52).