

Covid-19 Update

Purpose of report

For discussion.

Summary

This paper updates the Board on the work against the COVID-19 priorities agreed at its meeting in October. It sets out some of the changes to national policy the LGA has been able to secure on behalf of the sector, as well as the immediate challenges local authorities face in the coming weeks in managing the pandemic. In addition it provides details of the package of support the LGA is providing to councils to manage local outbreaks.

Recommendations

Members are asked to:

- (a) Note the LGA's work against the COVID-19 priorities set by the Board in October.
- (b) Comment on the LGA's work programme going forward and in particular whether the LGA should be highlighting the financial impact of the need to test care home visitors on care providers (see paragraph 41).
- (c) Provide views on the LGA's support offer to councils and whether any additional strands should be offered to it.

Action

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

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Background

1. This paper outlines for the Board the LGA's work against the COVID-19 related priorities agreed at its meeting in October. As members will recall the Board agreed the following objectives at that meeting:
 - 1.1. Highlight the impact constraints in the testing system have on councils' ability to successfully manage local outbreaks, and continue to make the case for a local by default approach to test, trace and outbreak management.
 - 1.2. Lobby government to ensure that councils have the resources and information they need to trace those who might have been exposed to Covid-19 at a local level.
 - 1.3. Assist councils in supporting the clinically extremely vulnerable who need to be shielded from Covid-19.
 - 1.4. Lobby for councils to be given the powers and tools they need to ensure business and communities adhere to social distancing requirements.
 - 1.5. Work with government and councils to implement the system to financially support those on benefits and low incomes who need to self-isolate.
 - 1.6. Press for greater engagement of local authorities in the planning, development and then delivery of the Covid-19 vaccination campaign.
 - 1.7. Develop and deliver a sector-led improvement support offer to councils to share good practice and help councils respond to local outbreaks.
 - 1.8. Make the case for councils to receive the funding and other resources they need to manage local outbreaks, and to work with Whitehall departments to address the winter capacity issues councils and the social care system face.
2. As managing local outbreaks requires a range of measures to reduce the rate of transmission in the local community, members will recall that some of this work falls not only under the remit of the Community Wellbeing Board, but also those of the Resources and the Safer and Stronger Communities Board.

Managing local outbreaks - the Contain Framework

3. The division of responsibilities between local and national government in preventing, containing and managing local outbreaks is set out in the Contain Framework first published in July. Part of the purpose of the framework was to support local authorities by clarifying their responsibilities and the powers they had to take local action.
4. At the time of the Framework's first publication councils were divided into a number of categories based on the level of Government support: areas of concern, areas of enhanced support, and areas of intervention. As a result of experience in managing local outbreaks during August and September, these categories were replaced by three tiers in October.

5. Local authorities' experience of the tiered approach raised issues around the funding made available to councils in tiers 2 and 3, the differences in business closures between areas in the same tier, the lack of incentives for those on low incomes to self-isolate, the powers available to councils to enforce COVID secure measures to prevent the spread of the virus, and the lack of clarity about how areas moved back down the tiered system to tier 1 from tiers 2 and 3.
6. Lobbying from the LGA alongside direct feedback from the sector both ahead of publication of the Framework and then after its introduction resulted in its ongoing development. For example when the Framework was published in July it included additional enforcement powers to enable councils to close specific premises and public outdoor spaces as well as preventing specific events from taking place. However, councils found in practice that these powers could not be used in a swift and proportionate manner to address breaches of social distancing in a number of instances. The LGA therefore pressed Government to provide councils with better tools, and an announcement on them was due at the time the Government introduced the second national lockdown.
7. Following the introduction of the second national lockdown the LGA and councils have been pushing Government for clarity on what would happen when it ends on 2 December. At its meeting on 20 November the Local Outbreak Plan Advisory Board chaired by the LGA's Chairman, Cllr Jamieson, discussed the issues and policies needing to be resolved or in place ahead of national restrictions being lifted on 2 December. This discussion was informed by feedback from the Community Wellbeing Board's Lead Members on the key issues, and the proposals agreed by the Local Outbreak Plan Advisory Board reflected the views of the Board's Lead Members :
 - 7.1. A clear published framework setting out the rationale for different tiers: which criteria and considerations determine which tier a Local Authority is in and how do they move up and down a tier. We need a standard framework made public to allow local areas to plan and engage with the public to manage expectations and explain what could happen.
 - 7.2. Standard restrictions for each tier – to maximise their preventative impact. It is possible the national framework could give explicit permission to allow some variation in restrictions at local discretion without requiring individual negotiations with each area. For example, the national curfew on the hospitality sector should be moved to a later time, such as 11pm or midnight, with local discretion on bringing a curfew earlier to respond to rising infection rates in the area.
 - 7.3. Funding – for those continuing in Tier 3/2 additional funding above that already received. It is crucial to consider support for retail. Higher tiers cannot cope with just the payments made available so far and we need a clearer forward view for the rest of the pandemic with resources aligned to it.
 - 7.4. Geography for tiers – Public Health Authorities should remain the building block for restrictions, with broader regional approaches to be agreed locally (to reflect the fact

- some larger areas want to move as one given high mobility between local authority areas).
- 7.5. Hybrid rollout of local tracing where areas want to do this, with faster data being essential for this to be effective.
 - 7.6. Enforcement regulations giving new powers to local government to close premises quickly to be implemented in advance of 2 December.
 - 7.7. An isolation system that works – positive incentives at a national level using behavioural science to maximise voluntary compliance, for example extending the discretionary as well as the fixed element of £500 self-isolation payment. New resources may be needed to assist more people in need who do not currently qualify for the payment.
 - 7.8. Clarity on the mass population screening programme (including deployment of lateral flow devices) – it is not possible to test 75 per cent of the total population without much greater capacity and stronger incentives, and even then such a high level of testing may not be practical; there is a need to clarify the purpose and role of mass population screening and instead utilise “targeted testing at scale,” enabling the deployment of targeted testing by Directors of Public Health depending on local need and priorities instead; need much greater capacity and to recognise pressure also on contact tracing arrangements and how it interacts. Also recognise that the people we most need to test are those least likely to come forward voluntarily.
 - 7.9. Strengthening of the narrative and incentives to encourage disadvantaged groups and communities to take up both vaccination and testing. Mistrust is a barrier. Could strengthen incentives by allowing 2 negative tests to unlock self isolation requirements (“smart release”). This would help the economy too.
8. The Government published the Winter Plan on 23 November. Based on an analysis of the effect of the three tiers in suppressing the virus the plan sets out a revised system of standardised tiers compared with those that were in place before 5 November, which addressed a number of the issues identified by the Board’s Lead Members and the Local Outbreak Plan Advisory Board.
 9. The list of which areas were in which tiers was published on 26 November, with the majority of England placed in tiers 2 and 3, and a small handful of councils in tier 1. The decision on which tier an area is placed in has been primarily based on five indicators: the case detection rate in all ages; the case detection rate in the over 60s; the rate at which cases are rising or falling; the positivity rate; and pressure on the NHS.
 10. There remain, however, a number of questions about the operation of the new tiers. The Winter Plan indicates that movement between the tiers will not depend just on the five indicators, but also on broader economic and practical considerations. As the Community Wellbeing Board Lead Members, the Local Outbreak Plan Advisory Board and council leaders have highlighted to Government local authorities are keen to understand exactly how and when they can transition from the higher tiers back to the lower ones when the Government reviews the allocations of areas to tiers every 14 days. Councils have

indicated there needs to be more detail available on how the review process works, there needs to be greater transparency about the data used to make decisions on which tier an area is allocated to and the weighting given to the five indicators, and whether the current geography of areas in the various tiers will be maintained when it comes to deciding if a place can step down from the current allocations to tiers. This will undoubtedly be an area where the LGA seeks more detail from the relevant Whitehall departments on behalf of our member authorities.

11. The Winter Plan also sets out proposals to offer councils in tier 3 areas a six-week surge in testing capacity, which can be used to test the general population as well as high-risk work places, hard to reach communities and schools. It is not however clear what is being offered to areas, and what government expectations are in taking up this additional testing capacity; is it optional or will all tier 3 areas be expected to undertake this surge in testing, and if an area does not take up the offer will that impact on the decision on what tier it is in? Again this is an area the LGA will be seeking clarification on.

Greater Localisation of Testing and Tracing

12. As members will be aware there has been a significant increase in testing capacity since the start of the pandemic. This has been accompanied by the development of a range of new testing technologies that allow for much faster turnaround times for results.
13. Ahead of publication of the Winter Plan the LGA made the case for greater localisation of testing and tracing system. In our view this would have a number of benefits. NHS Test and Trace has been struggling to reach the number of cases and contacts needed to slow the spread of COVID-19, and to do so in a timely way. There are over 163 local contact tracing partnerships, and these arrangements have had greater success than the national system. Alongside local contact tracing arrangements, making greater testing capacity available to councils would help to address the spread of the virus in areas of high deprivation, crowded and multi-generational households, concentrations of vulnerable communities and younger age groups. The LGA stressed that any localisation should be done on a voluntary basis, should accommodate different speeds in localisation and has to be accompanied by the necessary resources (both financial and in the form of programme managers from the Ministry of Defence for example).
14. The government responded earlier this month to calls by the LGA and directors of public health for greater local testing capacity by making available lateral flow tests to directors of public health. Initially 10,000 tests were made available to those areas that wanted it, and with the subsequent ability to order tests for up to 10 per cent of the local population. So far over 90 councils are receiving these tests, though some have reported delays in delivery or only partial receipt of what they ordered.
15. Making these tests available to councils is part of a wider Government intention, set out in the Winter Plan, to expand testing beyond areas with outbreaks, and protecting those

most at risk, to try and identify those without symptoms who could be unknowingly infecting others. By finding cases quicker the ambition is for the country to become more effective at breaking the chain of transmission while the vaccination programme is rolled out.

16. The pilot of mass population screening arrangements in Liverpool demonstrated how difficult it is to test a significant proportion of the total population. The Community Wellbeing Lead Members, the Local Outbreak Plan Advisory Board and council leaders and chief executives have highlighted that the only way to increase the proportion of the population being tested is through both greater test capacity, but also stronger incentives to encourage more people to come forward for tests, given that many people we most need to test are least likely to come forward. The LGA has therefore suggested that greater consideration is given to whether mass population screening is the most effective use of the increased testing capacity available, and consideration instead is given to targeted testing at scale led by local Directors of Public Health as a better means of breaking the chain of transmission in the population.
17. In order to support testing at scale, greater clarity is needed in the LGA's view from government on the detail of how it will work, including what funding will be available, where councils will get the additional capacity and capability to conduct the tests, how the data from local testing is integrated into the national system, and how people can be incentivised to be tested. We will continue to seek answers to these points going forward.

Shielding

18. The original programme for shielding individuals clinically extremely vulnerable (CEV) to COVID-19 came to an end at the start of August. Building on work from March developing the programme and sharing practice, LGA and a group of councils have been working with MHCLG to design a system of support for CEV people in the event they were advised they needed to isolate themselves again. Councils and the LGA have successfully pushed for a system that means CEV individuals can be as self-sufficient as possible when it comes to accessing food, for a local approach to be taken rather than a national one, for effective data flow to and from councils and for councils to receive funding for their support locally.
19. With the introduction of the second lockdown, the Government issued new guidance to CEV individuals. While the new guidance has not reintroduce the full shielding programme, 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. County and unitary councils have received funding equivalent to £14.60 per head of CEV population in their area for the 28-day period up to 2 December to support this activity.

20. Between the announcement of the second national lockdown and its coming into effect, the LGA and group of councils working with MHCLG on shielding CEV individuals raised a number of queries about the detail of the arrangements not immediately covered in the guidance and effective communications to the CEV group. More detail was sought from Government on what the parents of CEV children advised not to attend school should do if they were unable to work from home, and the cost to the public sector of supporting CEV employees unable to work from home, given the furlough scheme is not always available to them.
21. Feedback from councils suggests that only a small proportion of CEV people registering on the National Shielding Service System are requesting support. Of these, more people are requesting assistance in other ways than access to food. Councils have been collating outcomes based data on a voluntary basis and this will provide an evidence base for the crucial role councils in supporting this group and the costs of doing so. Once the second national lockdown ends the guidance to CEV individuals not to go to work or school will end, and specific advice will be reintroduced on what they should do to protect themselves at each tier. Councils will be expected to support CEV individuals in tier 3 areas as part of ongoing work communicating to and supporting vulnerable people in their communities, working with local partners, and discussions continue with MHCLG on support to CEV individuals going forward.

Enforcement

22. The LGA's recent work has focused on influencing the development, interpretation and enforcement of regulations being used for COVID-19 compliance and enforcement; highlighting to Government the challenges councils are experiencing on the ground, and supporting councils in their work on this.
23. From the outset of businesses reopening in summer, we have been working with councils and the Government to strengthen the tools councils have to help ensure local businesses and premises are COVID secure. Inevitably, given the speed with which policy approaches and legislation have had to be developed, there have been some issues with the regulations councils have been working to enforce and we have been encouraging Government to share draft policy and regulations with the LGA and councils so we can identify issues before regulations are made.
24. The initial approach coming out of the first lockdown was that key requirements (for example, around collecting contact details of customers) were set out in guidance, rather than legislation, with the focus on using the Health and Safety At Work Act 1974 (HSWA) to require businesses to operate in a COVID secure way.
25. The LGA and councils highlighted challenges around using HSWA to take action linked to COVID-19, with the Health and Safety Executive expressing the view that prohibition notices could not be used, and improvement notices with a long lead in period unsuitable when quick changes are required to prevent the risk of the virus spreading in premises.

We also emphasised the need for key requirements to be set out in legislation, rather than non-binding guidance.

26. As an alternative to HSWA, some councils have also used powers available to them under the Licensing Act and Anti-Social Behaviour legislation.
27. The Government, led by the Ministry of Housing, Communities and Local Government (MHCLG), has gone to significant efforts to engage with councils on compliance and enforcement issues and has responded positively to the suggestions from councils. As Board members will be aware, a series of regulations were introduced over the summer putting into law the requirements on businesses to take steps to make their businesses and premises COVID-secure, with particular obligations on hospitality premises. Councils were given COVID-specific powers to close businesses through the use of directions issued under the 'no 3 regulations', which give councils powers to close businesses and stop events from happening where there is a serious and imminent threat to public health, following consultation with the director of public health and notification to the Secretary of State.
28. More recently the Government has accepted the need, as put forward by the LGA, the Local Outbreak Plan Advisory Board and the sector, for councils to have further powers to issue improvement notices requiring businesses to take rapid steps to implement COVID-secure measures and, where these are not immediately complied with, issue closure notices more quickly than through the no 3 direction powers. These are powers that councils' environmental health and trading standards officers are experienced in using, and which can provide a more powerful incentive for business to comply with than the fixed penalty notices currently available under the COVID-secure regulations.
29. The Secretary of State for Housing, Communities and Local Government recently wrote to council leaders and chief executives to confirm that new regulations giving councils the powers to issue improvement notices and closure orders in relation to COVID-secure regulations are expected to be introduced on 2 December, a commitment repeated in the Winter Plan.
30. One area where the LGA played a role in influencing policy was in relation to the high-profile announcement of the COVID marshals scheme. The final outcome, with flexibility for councils to spend the funding in a way that best suited their areas – for example through backfilling enforcement roles, supporting overtime, recruiting marshals or stewards – was very similar to a proposal the LGA had previously made to MHCLG for additional enforcement funding.
31. During the second national lockdown councils' the focus has returned to business closures, and we have been engaging with the Office for Product Safety and Standards (which provides guidance and templates to councils on the regulations) on a number of

queries relating to the interpretation of the regulations, such as the meaning of a significant amount of essential retail.

32. We have also supported the development of the approach to supporting local residents to self-isolate, with councils responsible for investigating any complaints about employers refusing to allow workers to self-isolate and triaging any cases where individuals may need support (or equally may need to be referred to the police if they are willfully refusing to self-isolate despite being advised to be NHS Test and Trace).

Self-isolation

33. An issue local authorities highlighted during the summer was the lack of incentives for people on low incomes who had tested positive for COVID-19 to self-isolate. Along with councils the LGA pressed for a scheme to be introduced and on 19 September the Government announced the introduction of a £500 payment to people on in-work benefits who are told to self-isolate by NHS Track and Trace to be administered by councils.
34. Following the announcement the LGA worked closely with the Department of Health and Social Care (DHSC), the Department of Work and Pensions (DWP), the Ministry of Housing, Communities and Local Government (MHCLG) and a group of councils to put the arrangements in place to enable payments to be made from 12 October. As well as making payments to those who meet the eligibility criteria councils are allowed to make discretionary payments in exceptional circumstances to someone who meets the main qualifying criteria and could suffer financial hardship as a result of not being able to work.
35. Under the scheme, which will last until 31 January 2021, councils have received:
- 35.1. £25 million to cover the costs of payments to applicants. This was distributed according to MHCLG's COVID-19 relative needs formula (RNF), with councils receiving a minimum payment of £21,000;
 - 35.2. £15 million for discretionary payments, again distributed according to the RNF; and
 - 35.3. £10 million for administration costs, based on the estimated costs of setting up and running the scheme.
36. As the national response has evolved since the introduction of the scheme the LGA has sought clarity from government on a number of different questions on behalf of councils. We have for example raised the interaction between this scheme and furloughed employees, as well as the implications of mass testing on the number of applications, and issues with the compatibility of the system and the NHS COVID-19 app.
37. While overall demand across the country has been lower than initially predicted, there has been significant regional variations in take-up, and the Department of Health and

Social Care (DHSC) has been working with councils to understand what is driving these differences. In some instances councils have either exhausted the discretionary funding made available to them or are close to doing so, and the LGA and the Local Outbreak Plan Advisory Board have been raising this issue with Government. DHSC continues to maintain that the discretionary funding is a fixed envelope to last councils until the end of the scheme.

38. We have pressed Government to review this decision if the emerging evidence requires it, and to ensure that the approach that is taken to discretionary payments is consistent with the overarching policy objectives of protecting low-income working households from hardship, and reducing the risk of COVID-19 transmission. However, the Winter Plan indicates Government intends to introduce frequent testing as an alternative to self-isolating, with those who have come into contact with a COVID-19 positive person only having to self-isolate if they test positive themselves. We will explore with Whitehall departments what this new initiative means for self-isolation payments.

Infection Prevention in Care Homes

39. Although not a specific priority agreed at the last Board meeting there has been a growing strand of work related to infection prevention in care homes. As we have approached winter and the normal pressures have increased on the NHS, the health service has been keen to ensure there were processes in place to enable the discharge of COVID positive patients back into care without that resulting in the spread of the virus in care homes. The designated premises scheme is designed to achieve this.
40. The LGA has been working with DHSC, the Care Quality Commission (CQC) and care providers on the development of the scheme. Funding for the scheme has been diverted from reablement support, and although this makes £588 million available to be routed through clinical commissioning groups it may not fully fund the costs of the scheme, leaving providers or councils to find the extra money. This gap in the funding may prove a disincentive to participation in it. During the discussions around the scheme we have made this point, sought clarification on the details of the scheme, and highlighted the need for councils to have the flexibility to adapt to the needs of their residents, including ensuring an individual's wishes on discharge are enabled and that the scheme builds on local arrangements. The LGA continues to be involved in the discussions about the roll out of the scheme.
41. The main focus for preventing the spread of COVID-19 in care settings has been through regular testing for staff and residents. The expansion in asymptomatic testing set out in the Winter Plan includes an increase in the frequency of testing in care homes and high risk extra care and support living settings, with both staff and residents being tested up to twice a week using supplementary lateral flow tests. Up to two visitors per resident in care homes will also be able to be tested twice a week using lateral flow tests. These tests are currently being piloted in Cornwall, Devon and Hampshire (including the Isle of Wight). However this commitment in the Winter Plan is already putting considerable

pressure on care home providers, and it is not clear if they will be funded for carrying out the tests as the Infection Control Fund has been identified as a way of meeting these costs, even though the Fund is now over committed. Members views are sought on whether the LGA should highlight the financial impact of the testing provisions on the care provider market.

42. After lobbying by the LGA and the sector, testing has also been extended on a weekly basis to domiciliary care workers, employed by CQC registered providers and looking after people in their own homes. All registered homecare agencies have been contacted so they know how to apply for the test kits and they will be responsible for ordering and distributing tests to their homecare workers for them to conduct at home on a weekly basis. We continue to press Government for the roll-out of these tests to live-in carers as soon as possible.
43. A further issue in preventing the spread of COVID-19 in care homes has been provisions to enable staff to self-isolate when they have symptoms and enabling staff to work in only one care home. The Infection Control Fund set up in May and extended in September to March 2021 was designed to give providers the support they needed to put in place measures that reduced these two sources of infection in care homes. The LGA has provided councils with template letters to use to encourage care providers to take up the support available through the fund. Government is still considering if additional measures are needed to reduce outbreaks as a result of staff becoming COVID positive, and the LGA continues to engage with DHSC on this matter. We have responded to the Government's consultation on the use of regulations to limit movement of staff but are not convinced that this is the most effective way to achieve this objective as there will not be capacity in the system to enforce these regulations

Vaccinations

44. Vaccines that provide durable and effective immunity to COVID-19 will substantially reduce the mortality rate of the virus and should also assist in limiting its transmission. The use of effective vaccines therefore offers the opportunity to manage the pandemic while also lifting the restrictions that will be in place under the different tiers. An increasing number of vaccines are becoming available and the Government has secured access to up to 350 million doses of seven different vaccines between now and the end of 2021.
45. Once the vaccines have been approved, a vaccination programme will begin for those most at risk, as currently recommended by the independent Joint Committee on Vaccination and Immunisation (JCVI). The JCVI published a list in September of the groups that should be prioritised for vaccination, as and when vaccines are made available. On this provisional list, prioritisation would begin with older adults resident in a care home and care home workers, followed by all those 80 years of age and over and health and social care workers. In our view priority also needs to be given to the millions of unpaid carers as well.

46. Delivery of a vaccination programme will be a significant logistical challenge for the health service. Council chief executives were copied in on a letter sent to NHS trusts and foundation trusts on 20 November, which provides further details on the roll out of mass vaccinations. In the letter the NHS sets out what the NHS and Government will provide nationally, and what Government wants the NHS to work with local government and other partners to deliver locally. The LGA is currently engaged in discussions with DHSC about the role of councils in supporting the NHS, which we anticipate continuing as the vaccination programme is developed.

Sector-led improvement

47. Given the complex issues councils are grappling with the LGA has developed a support offer to councils. This includes:

47.1. Sharing good practice through:

47.1.1. Webinars. The LGA has run 48 webinars since the first national lockdown, including four related to the contain framework, six specifically related to test, trace and outbreak management, one on compliance and enforcement (and two more are planned this year), and two on shielding. Each webinar saw attendance in the hundreds with the most popular a webinar titled 'COVID-19 and ethnicity' with 758 attendees. We have produced a set of Frequently Asked Questions after each webinar. The future programme of webinars covers mass testing technologies, prevention and intervention and there is also a monthly programme of chief executive webinars with Carolyn Wilkins (with the most recent held on 20 November on the current national restrictions).

47.1.2. Case studies. We have produced case studies covering testing, contact tracing, outbreak management, enforcement, compliance, vulnerable people, governance, schools, care homes, high risk locations, communications, adult social care, emergency food provision, health and wellbeing, personal protective equipment, social distancing, and workforce capacity. Further ones are planned on health inequalities, data, home testing, supporting compliance and social distancing, and supporting mental health during lockdown. We have also published a series of interviews with Directors of Public Health, with 24 available already and more planned.

47.1.3. An online Knowledge Hub – this currently has over 550 members, contains over 100 documents and links to other Knowledge Hub groups including those on environmental health, licensing and trading standards and the LGA/ADASS group. We are planning (subject to funding discussions with DHSC) to develop this into a web resource deploying an approach we delivered in 2019 known as the Transformation and Innovation Exchange (TIE) Hub. This online resource will provide support local authorities by providing: a self-assessment/self-selection capability to guide council users to the best practice/resources/information/discussion forum most relevant to them in

relation to their readiness to manage local testing, contact tracing, and local outbreaks; an interactive map that enables easy access to information about what councils are doing to enable them to access shared learning opportunities; a content hub where examples of good practice, guidance materials, briefing notes and other supporting resources are catalogued; and a simple search facility and menu options

47.2. Support to local authorities through:

47.2.1. Action learning sets. We have already facilitated two groups of chief executives to discuss experiences with intervention, and we are planning similar sets for council leaders.

47.2.2. A Top tips documents. We have published one for chief executives, which is a collaborative piece with SOLACE and highlights the experiences of chief executives in areas that faced increasing infection rates between the lifting of the national lockdown measures imposed in March and the most recent national restrictions. We are also developing a version for council leaders.

47.2.3. Media training workshops for Directors of Public Health.

Implications for Wales

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

Financial Implications

49. 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

50. Members of the Board are asked to:

50.1. Note the LGA's work against the COVID-19 priorities set by the Board in October.

50.2. Comment on the LGA's work programme going forward and in particular whether the LGA should be highlighting the financial impact of the need to test care home visitors on care providers (see paragraph 41).

50.3. Provide views on the LGA's support offer to councils and whether any additional strands should be offered to it.