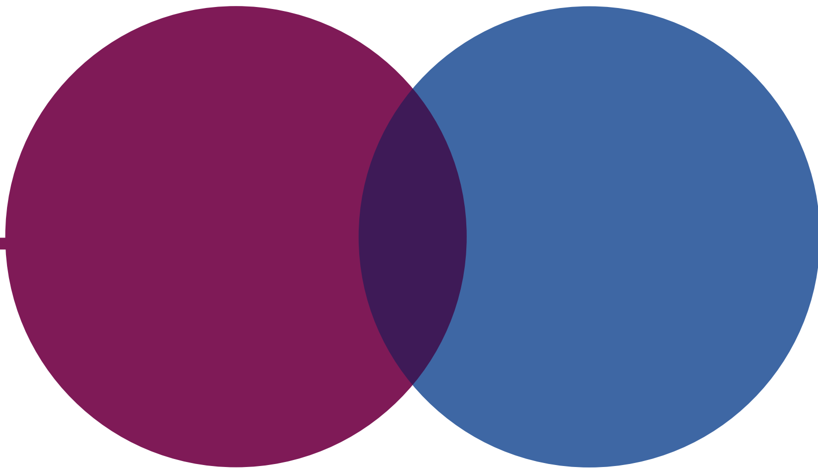

Protecting and supporting the clinically extremely vulnerable during lockdown

Ministry of Housing, Communities & Local Government,
Department of Health & Social Care

REPORT

by the Comptroller and Auditor General

SESSION 2019–2021
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Key facts

2.2m

number of people identified as clinically extremely vulnerable (CEV) by 7 May 2020

510,486

number of CEV people who asked for and received at least one food box

£308m

cost of shielding to 1 August 2020

1.3 million number of CEV people added to the shielded patient list (the List) and formally eligible for central support through the shielding programme by 12 April

900,000 additional people added to the List between 18 April and 7 May as GPs and clinicians completed the necessary clinical review. The List continues to be updated.

375,000 number of CEV people who could not be reached because of missing or inaccurate telephone numbers within NHS patient records

5 number of days between the start of shielding and deliveries of the first food boxes

4.7 million number of food boxes delivered between 27 March and 1 August 2020

94% of CEV people reported that overall, they were following shielding guidance mostly or completely (14 May)

Not known whether the shielding programme led to fewer deaths of those advised to shield than otherwise would have been the case when compared with an age-matched sample of the general population

Summary

1 On 22 March 2020, the Secretary of State for Housing, Communities and Local Government announced that those people in England who faced the highest risk of being hospitalised by COVID-19 should shield themselves and stay at home. This marked the start of shielding. Government guidance urged people considered clinically extremely vulnerable (CEV) to the virus to not leave their homes for 12 weeks and not go out for shopping, travel or leisure.

2 The objective of the shielding programme (the Programme) was to minimise mortality and severe illness among those who are CEV by providing them with public health guidance and support to stay at home and avoid all non-essential contact. Through the shielding programme, CEV people could get support accessing food, medicine and basic care.

3 At the start of shielding, on 22 March, government anticipated 1.5 million people to be classified as CEV, but by 7 May it had identified some 2.2 million CEV people as formally eligible for central support through the shielding programme. Government considered people with specific medical conditions as being most vulnerable to COVID-19 based on a clinical understanding of the virus at the time. These conditions initially included some respiratory illnesses and specific cancers.

4 The Ministry of Housing, Communities & Local Government (MHCLG) had overall responsibility for overseeing and delivering the Programme. The Department of Health & Social Care (DHSC) was responsible for determining who should shield, evaluating the health impact of shielding and determining and issuing clinical advice. NHS Digital was responsible for producing the list of people who were to be advised to shield and working with GP systems' suppliers on any required changes. The Department for Environment, Food & Rural Affairs (Defra) led on providing food to people shielding. NHS England & NHS Improvement (NHSE&I) ran the service to get medicines to people using local pharmacies and enhanced support to CEV people through the NHS Volunteer Responder service. The Government Digital Service (GDS) was responsible for creating and running the digital service, which consisted of a website, an automated telephone helpline and other services required to collect, store and share information on the support needs of CEV people. The Department for Work & Pensions (DWP) provided a national shielding contact centre.

5 Local authorities were responsible for contacting difficult to reach CEV people and distributed emergency food supplies (paid for by Defra) in the initial stages of shielding while national food distribution was being put in place. They were also responsible for providing basic care for those CEV people who requested this support, and arranging help and support for CEV people if a more tailored approach was needed, for example, if food boxes did not meet cultural or dietary requirements.

6 National shielding advice was paused in England on 1 August, although it continued in some areas in local lockdown, on clinical advice from the chief medical officer. DHSC issued new guidance for CEV people on 5 November as the second lockdown started in England, and again for the third lockdown which started in January 2021. This guidance strongly advised CEV people to work at home and to stay at home as much as possible, except to go outdoors for exercise or to attend essential health appointments.

7 This report looks at how effectively government identified and met the needs of clinically extremely vulnerable people to 1 August 2020. This report only examines the support provided through the shielding programme and does not include wider support to CEV people, such as statutory sick pay. This report sets out:

- the inception of the shielding programme (Part One);
- identifying clinically extremely vulnerable people (Part Two);
- supporting clinically extremely vulnerable people (Part Three); and
- outcomes and lessons learned (Part Four).

We set out our audit approach and evidence base in Appendices One and Two, the clinical criteria of CEV people in Appendix Three and our assessment of the commercial arrangements in the Programme in Appendix Four.

8 The Programme was set up just before the UK went into the first lockdown in March in response to an urgent and unprecedented need to support vulnerable people so they could shield. This was at a time of dramatic disruption to private lives, public service providers, including the NHS, and food supplies. Ministers were clear that shielding was imperative to protecting the lives and wellbeing of CEV people who were yet to be identified. How well the Programme could protect people’s lives and wellbeing depends on both the support provided and other factors such as individuals’ actions. Our evaluation of the Programme considers the circumstances in which it was set-up and operated, including what this meant for setting clear objectives and roles and responsibilities, and how lessons were learned.

Key findings

The inception of the shielding programme

9 Government acted quickly in the absence of detailed contingency plans for identifying and supporting a large population advised to shield. In 2016, DHSC commissioned Public Health England to run Exercise Cygnus to assess the UK's preparedness for an influenza pandemic and identify lessons. However, the testing of plans and policies for the identification and shielding of clinically extremely vulnerable people were not objectives of Exercise Cygnus. As a consequence, in early March 2020, government urgently needed to develop from scratch a new means to identify vulnerable people and arrange to support their needs in light of its advice to not leave their homes (paragraph 1.4).

10 Government decided to use a centrally directed model of support for CEV people. Faced with an immediate need to ensure reliable access to food, medicines and care for an anticipated 1.5 million people, ministers quickly commissioned a centrally directed programme, led by MHCLG, to support vulnerable people. Government chose a centrally directed model with local support rather than a wholly local approach. It did so because of government concerns about shortages in local food supplies, supermarket capacity and after briefly consulting a small number of local authorities. Government did not attempt to systematically assess the capacity or willingness of local authorities to provide a more local model of support as a thorough assessment would have been difficult in the time available (paragraph 1.5).

Identifying vulnerable people and their needs

11 CEV people were identified based on clinical judgement of the risk of severe illness or mortality from COVID-19. On 18 March, the four national chief medical officers finalised the interim list of conditions for who was to be advised to shield based on the limited clinical evidence on the virus available at the time. Protected characteristics such as ethnicity, age and gender were considered at the start and throughout the Programme, and were dealt with as the chief medical officers considered to be clinically appropriate (paragraph 2.3).

12 At the start of the pandemic, there was no mechanism to allow a fast 'sweep' across all patients to identify, in real time, those who fell within a defined clinical category. NHS Digital used several datasets to compile the shielded patient list (the List): hospital data; GP patient data; prescribed medicines data; and maternity data. Because of the nature of the data, the process and the need to act quickly, several problems arose, including:

- the speed at which the List was developed (two days) meant NHS Digital relied on hospital, maternity and prescribed medicines data for the first iteration. Hospital data, while immediately available, were seven weeks out of date;
- hospital data did not always specify sufficient detail of people's medical condition, leading to 126,000 people being added to the List in error and unnecessarily advised to shield;
- personal information, known to be missing or inaccurate (such as telephone numbers), caused problems when trying to contact people on the List; and
- local authorities told us that they received different 'lists' of CEV people who could not be contacted centrally which needed reconciling (paragraphs 2.4, 2.8, 3.24 and figure 5).

13 By 12 April, three weeks after shielding was announced, some 1.3 million people were identified as clinically extremely vulnerable, advised to shield and formally eligible for central support through the Programme. Using hospital, maternity and prescribed medicines data, by 20 March NHS Digital initially identified some 870,000 people who met the clinical criteria as CEV. After shielding was announced on 22 March, these people were sent letters advising them to shield and of their eligibility for central support through the Programme, for which they needed to register. NHS Digital subsequently identified a further 420,000 people formally eligible for central support by 12 April using GP patient data. The time taken to identify and communicate with these 1.3 million people by 12 April was largely down to the challenge of extracting usable data from different NHS and GP IT systems (paragraph 2.5 and Figures 1 and 6).

14 A further 900,000 people were added to the List between 18 April and 7 May. The List continued to increase as GPs and clinicians in NHS trusts and NHS foundation trusts (trusts) completed the necessary clinical review of their patient lists. As part of the clinical decision making process set out by UK chief medical officers, they added or removed people based on their clinical judgement, local patient records, and as individuals' medical conditions changed. Once changes had been made to IT systems to make the data available to GPs and trusts to review, they responded quickly, leading to further additions to the List from 18 April. The List stabilised at 2.2 million CEV people by 7 May by which time there were approximately 900,000 more people on the List than before GPs and trusts began their clinical review. People would not have been formally eligible for the central support of food boxes and medicines delivery offered through the shielding programme until they were on the List, but would have been able to ask their local authority for help. From March they would have been eligible to claim statutory sick pay if they were not able to work from home. People identified by trusts and GPs should have been advised to shield by their GP or trust as soon as they were considered CEV. The extent to which the List grew varied locally, with increases in the List ranging from 15% to 352% by local authority, between 12 April and 15 May (paragraphs 2.6, 2.7, 2.9 and Figures 6 and 8).

15 Government's communications with CEV people were not always clear. Government had to communicate clearly, but quickly, with some 2.2 million people. Charities we spoke to criticised government's communication with CEV people. On 28 May, nearly 50 charities wrote an open letter to the minister for the Cabinet Office asking for clear communications with charities, health and care professionals, and local authorities to ensure consistency of advice given to those who were vulnerable (paragraphs 2.12 to 2.13).

Supporting CEV people

16 Government worked rapidly to create a range of ways that CEV people could register for the support they may need while shielding. Government wanted all CEV people to register whether they needed help or not. On 20 March, GDS was tasked to develop a digital service, which consisted of a website, an automated telephone helpline and other services required to collect, store and share information on the support needs of CEV people. This digital service was operational from 23 March. Government also commissioned a contact centre through DWP to call CEV people who had not yet registered through the website or the automated helpline. The contact centre started making calls on 28 March (paragraphs 3.2, 3.4 and 3.5, and Figure 9).

17 The contact centre was unable to register 815,000 CEV people. GDS gave the contact centre the details of 1.8 million CEV people who had not registered through the website or automated helpline. However, the contact centre could not register nearly half of these CEV people. Of these, around 375,000 CEV people could not be reached because of missing or inaccurate telephone numbers within NHS patient records. While it was known to all parties that a proportion of telephone numbers in NHS records were missing or inaccurate, the Programme agreed to use telephone numbers from NHS records as a starting point to follow-up hard-copy letters. A further 440,000 declined to register for support when contacted; for example, they hung up or believed it was a nuisance call. From 28 April, GDS started passing details of the CEV people that could not be reached to local authorities to follow up (paragraphs 3.5 and 3.6, and Figure 10).

18 Defra quickly designed a food support service and identified suppliers who could deliver it. Defra consulted widely with industry from mid-March and considered a range of options, including supermarkets with delivery services and food wholesalers with distribution networks. Defra told us that industry engagement revealed that supermarkets were not able to meet anticipated demand in the time required, and Defra's assessment was that only two wholesalers – Bidfood and Brakes – had the capability to source, pack and deliver the food supplies required (paragraph 3.7).

19 Defra used emergency procurement procedures and secured some reductions on initial prices. Defra used cost benchmarks and industry consultants to negotiate price reductions compared with the initial pricing quoted by providers. In return, Defra gave providers an increased notice period for contract termination, and took on more of the financial risk of maintaining enough stock levels to meet uncertain demand. The contracts included key performance indicators, but with no financial incentives attached. Defra spent £200.2 million on the food support service contracts up to 1 August. The service successfully delivered 4.7 million food boxes (paragraphs 3.8 and 3.11).

20 Local authorities have criticised the quality of early emergency bulk food supplies. While the doorstep food box deliveries to CEV people were being ramped up, Defra provided local authorities with bulk emergency food supplies for local distribution, as a stop-gap, where local authorities saw need. Between 27 March and 8 April, 170 local authorities requested and received supplies costing £502,000 from Bidfood and Brakes, funded by Defra. Most local authorities we spoke with were highly critical of the quality of emergency provision. In particular, they were unhappy with food of poor nutritional value, seemingly random selections of provisions and catering-sized food and drink containers, which were impractical for individuals and difficult to repackage into food box portions (paragraph 3.9).

21 Most CEV people were satisfied with the food boxes they received. Food box deliveries started five days after the start of shielding and went to 510,486 CEV people between March and 1 August. From mid-May onwards, Defra ran several user satisfaction surveys on the food boxes delivered to CEV people's doors. These surveys found people's satisfaction with the quality and balance of the box content varied between 79% and 83%. The Office for National Statistics' (ONS) shielding behavioural survey (between 14 and 19 May) asked CEV people about the support available to help them shield at home. Of those who had not left their home since either being advised to shield or in the past seven days, 49% reported that food deliveries or food boxes helped. However, in contrast, charities and local authorities were critical of aspects of food boxes, the quality of fresh products and culturally inappropriate items. MHCLG and DHSC did not use centralised food box deliveries in the second lockdown, with local authorities responsible for helping CEV people access food (paragraphs 3.12, 4.5 and Figure 14).

22 Despite indications that the medicines delivery service worked well, NHSE&I had limited assurance that CEV people got their medicines as and when needed. DHSC commissioned NHSE&I to set up the medicines delivery service with pharmacies and dispensing doctors to help those who had no support from friends, family or volunteers. The contract with dispensing doctors and pharmacists had few service specifications and performance monitoring arrangements, limiting NHSE&I's assurance over whether CEV people got their medicines as and when needed. NHSE&I considered that the service specification and item of service payment gave it adequate assurance. NHSE&I recorded numbers of deliveries claimed for by pharmacies and dispensing doctors, not numbers of requests fulfilled by the service. In the ONS shielding behavioural survey, between 14 and 19 May, 48% of CEV people who had not left their home since either being advised to shield or in the past seven days, reported that prescription delivery services helped them to shield. Age UK and Carers UK told us, based on feedback on all services in the Programme, the medicines delivery service worked well compared with other support (paragraphs 3.15 to 3.18).

23 MHCLG could not track the delivery of basic care to CEV people as it wanted so took assurance in other ways. MHCLG attempted to collect data from local authorities on basic care provision for CEV people but was unable to identify a workable solution acceptable to local authorities by the end of July when the programme ended. Local authorities reported that bringing together data on basic support provided by a mix of local authority and voluntary groups was too burdensome. In the absence of these data, MHCLG accepted that it had some assurance that local authorities were meeting basic needs given that local authorities had provided similar support for a number of years. Its engagement with local authorities also gave it some assurance that they were meeting basic needs (paragraph 3.21).

24 MHCLG's engagement with local authorities was initially poor but did improve. The five local authorities we spoke to, and representative groups such as the Local Government Association, noted that the government's engagement with local authorities was initially poor. Some local authorities queried why government had chosen a centrally directed rather than a local system of support, particularly for food, and some felt that they would have provided better quality support than that provided by the Programme. From March, MHCLG discussed shielding with a small number of local authorities, and its regional forum of nine local authority chief executives, and provided guidance and direction to local authorities and their representatives, including the Local Government Association. However, MHCLG's initial engagement was more directive rather than consultative. MHCLG recognised that it needed to improve engagement with local authorities and the Programme moved to a more collaborative approach. Early in April, it set up the fortnightly stakeholder engagement forum, on which nine local authority chief executives were represented. On 18 May, MHCLG began to email local authorities weekly with updates to the Programme (paragraphs 3.22 and 3.23).

Outcomes

25 Most CEV people followed guidance on shielding. The Programme aimed to reduce mortality and severe illness from COVID-19 by providing CEV people with public health guidance and support (access to food, medicine and basic care) to stay at home and avoid all non-essential contact. Offering this support was a prudent response to asking CEV people to shield. The ONS shielding behavioural survey found 94% of CEV people reported that, overall, they had either completely or mostly followed government shielding guidance. In the ONS survey (in relation to CEV people who had not left their home since either being advised to shield or in the past seven days), 82% of those who had registered as needing support, reported that the food boxes and food deliveries helped them to shield at home (paragraphs 4.2, 4.4, 4.5 and 4.8).

26 DHSC is unable to say whether shielding led to fewer deaths and less serious illness in CEV people than would otherwise have been the case, although it is likely to have helped. DHSC is confident that shielding has helped to protect CEV people. However, it told us that, because of methodological challenges, it has not been possible to reliably estimate what the mortality rates would have been if shielding had not been implemented. The mortality rate where COVID-19 was mentioned on the death certificate, remained higher for CEV people than that of the age-matched general population sample throughout the Programme. It was more than twice as high for CEV people at 13.6 per 100,000 people at its first wave peak on 9 April, compared with 5.3 per 100,000 people in the age-matched general population sample (paragraphs 4.3 and 4.6, and Figures 11 and 12).

Expenditure

27 Total expenditure on the programme up to 1 August was £308 million. Two-thirds of expenditure (£200.2 million) related to food box deliveries, with £34.3 million spent on the medicines delivery service and £18.4 million on the shielding contact centre. MHCLG paid £0.7 million to KPMG for programme management work. Local authorities estimate that they have spent £54.4 million on basic care and other support to CEV people. Regional variations in the numbers on the List created a disproportionate burden on some local authorities as funding allocations did not consider the numbers of people on the List, although funding levels for the second lockdown in November 2020 were based on local CEV numbers (paragraph 1.11 and Figure 4).

Shielding during the second lockdown

28 The departments involved in the Programme have applied lessons learned to the second lockdown (5 November to 2 December 2020). In mid-April, DHSC and MHCLG started to consider future options for shielding once the initial 12 weeks ended at the end of June. In August, following the pausing of shielding and increased confidence in the local availability of food, the government conducted an early lessons learned review of the Programme. This review followed engagement with local authorities, and concluded that the speed and context in which the Programme was developed meant that it was largely offered universally – resulting in poor targeting and inefficient use of funds. It noted that, should shielding be needed again, adopting a local support model could improve flexibility and potentially be more cost-effective. It is clear that departments have applied many of these lessons to the second iteration of shielding in November 2020. For example, they have introduced a new National Shielding Service System which allows CEV people to register their needs more easily and has been well received by those local authorities we spoke to (paragraphs 4.10 and 4.11, and Figure 14).

Conclusion on value for money

29 The shielding programme was a swift government-wide response to protect clinically extremely vulnerable people against COVID-19, pulled together at pace in the absence of detailed contingency plans. Government recognised the need to provide food, medicines and basic care to those CEV people shielding to help meet its objective of reducing the number of people suffering from severe illness and dying from COVID-19. There was impressive initial support offered to many people, with food provided to just over 500,000 people. Although the need to support was urgent, it took time for people to be identified as CEV, and therefore access formal support. This followed challenges extracting data from different IT systems and the understandable need for GPs and trusts to review the List of vulnerable people from their clinical perspective.

30 DHSC is confident that shielding has helped to protect CEV people and it is clear that many CEV people benefited from the support the Programme provided. However, given the challenges in assessing the impact of shielding on CEV people's health, government cannot say whether the £300 million spent on this programme has helped meet its central objective to reduce the level of serious illness and deaths from COVID-19 across CEV people. Departments have learned lessons from the first iteration of shielding from March to August 2020 and applied many of these to shielding during the second lockdown in November 2020.

Recommendations

31 To improve support to CEV people when advised to shield in the future, we recommend that:

a DHSC should ensure that **healthcare data systems allow easy, but secure, access to healthcare data**;

b NHSE&I and NHS Digital should set out how they will **improve the accuracy of patient telephone numbers** to improve the speed of communication with patients;

c DHSC should set out **the core data requirements it is likely to need in a future pandemic** or civil emergency and how it can access these data in a timely manner;

d DHSC should establish a **robust plan on how to communicate clearly, quickly and consistently with CEV people** to ensure that people are clear if they need to shield, why they need to shield, how to shield and the support available to them;

e By April 2021, MHCLG should **review the effectiveness of the new National Shielding Service System**, introduced for the second lockdown, to ensure that it provides intended benefits;

f MHCLG should set out how it can **establish the capacity and capability of local authorities to support shielding-type exercises** in a timely way in the event of future pandemics or civil emergencies and how it can engage more effectively with local authorities; and

g For future pandemic planning, government should consider how it **will approach balancing the relative merits of central, universal offers of support against targeted local support.**