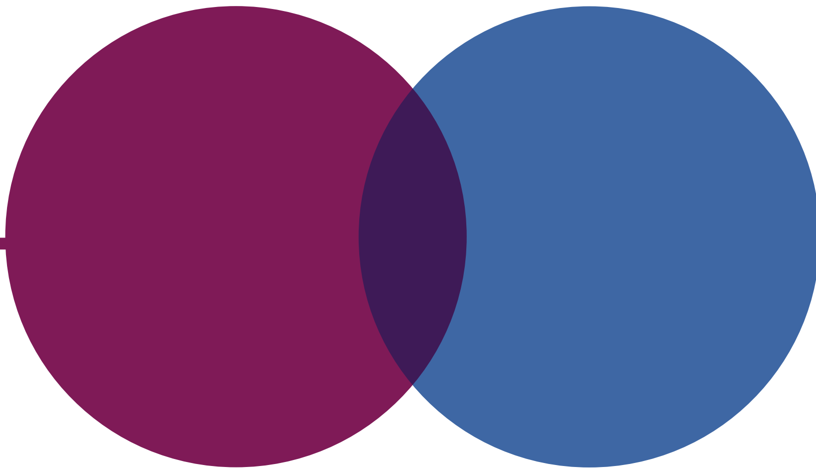


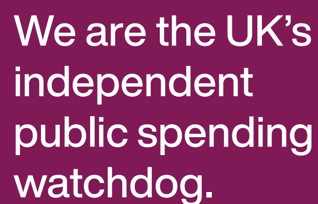
Protecting and supporting the clinically extremely vulnerable during lockdown

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

REPORT

by the Comptroller and Auditor General

SESSION 2019–2021
10 FEBRUARY 2021
HC 1131



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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

Ordered by the House of Commons
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Gareth Davies
Comptroller and Auditor General
National Audit Office

4 February 2021

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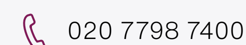
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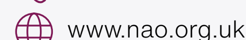
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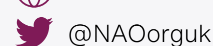
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Key facts

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.**

Part One

The shielding programme

1.1 This part of the report sets out the origin, goals and organisation of the shielding programme (the Programme).

The origin of the Programme

1.2 On 16 March, in response to increased cases of COVID-19, the Prime Minister set out a need to ensure that those with the most serious health conditions were largely shielded from social contact. On 22 March, the Secretary of State for Housing, Communities and Local Government urged people in England who faced the highest risk of being hospitalised by the virus to shield themselves and stay at home from that date.

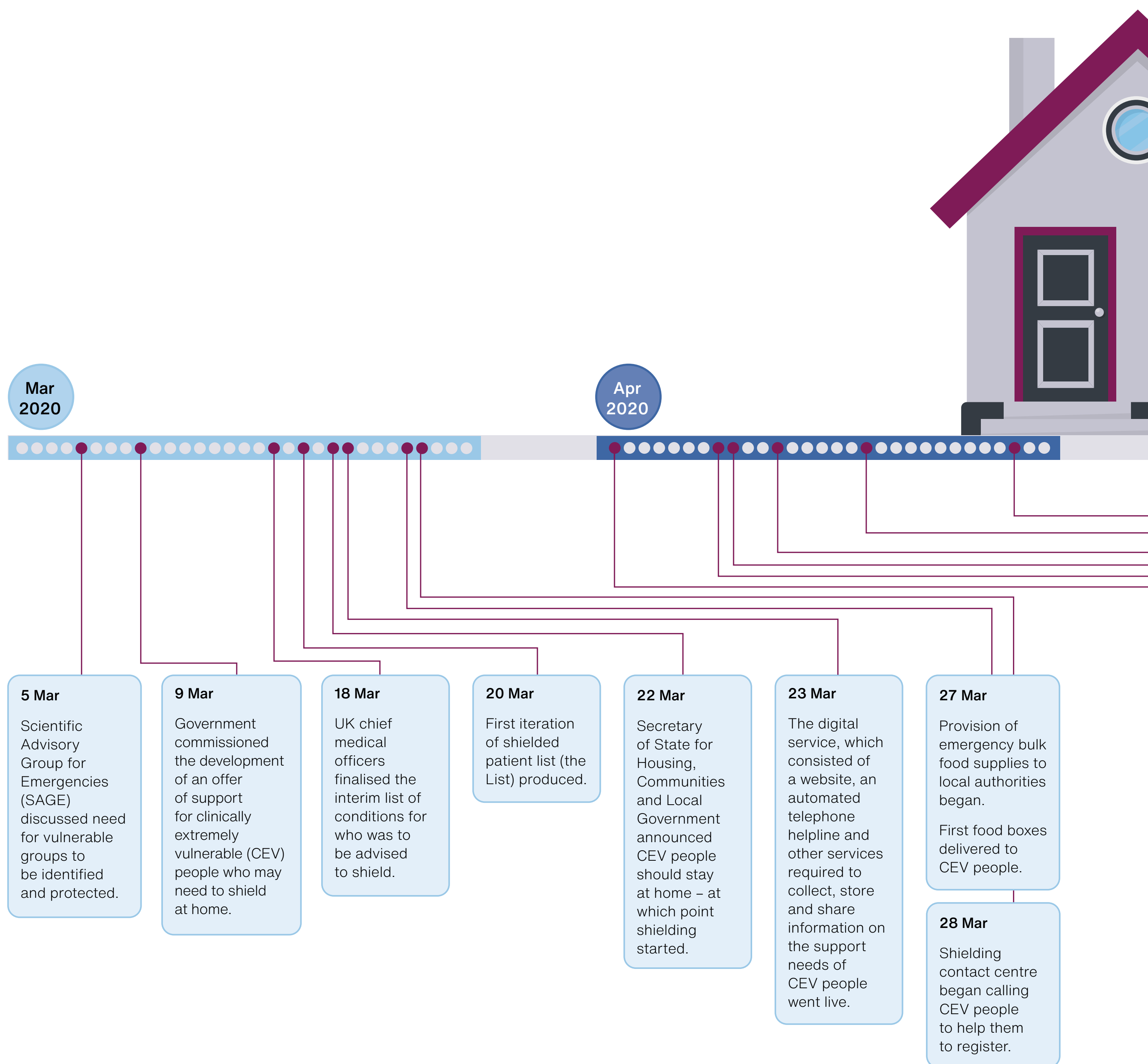
1.3 The 22 March announcement gave more detailed guidance and information for shielding, including the conditions which made people clinically extremely vulnerable (CEV) and the support they would receive. The announcement advised CEV people to not leave their homes for 12 weeks from 22 March and not go out for shopping, travel or leisure. Initially government anticipated 1.5 million people to be classified as CEV, and it ultimately identified more than 2.2 million CEV people. 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. **Figure 1** on pages 16 and 17 sets out key dates in the Programme.

1.4 There was no pre-existing mechanism or organisation for identifying and supporting a significant population advised to shield. In 2016, the Department of Health & Social Care (DHSC) commissioned Public Health England to run Exercise Cygnus, which was designed to assess the UK's preparedness and response to 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.

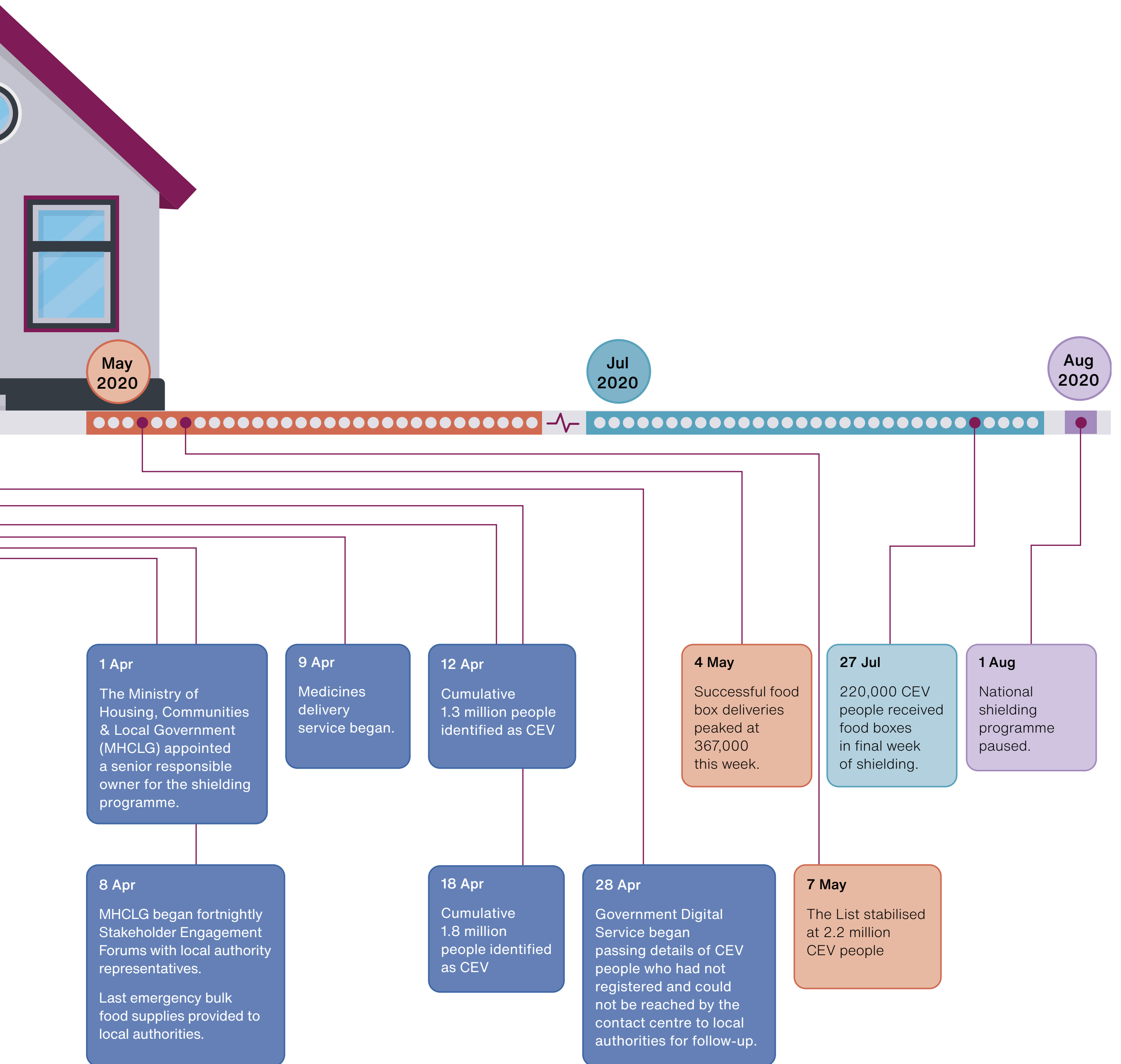
Figure 1

Key events in the shielding programme from 5 March 2020

The national shielding programme started on 22 March 2020 and was paused on 1 August 2020



Source: National Audit Office analysis of documents from the Ministry of Housing, Communities & Local Government, Department of Health & Social Care, Department for Environment, Food & Rural Affairs, NHS Digital, NHS England & NHS Improvement, Government Digital Service, and Department for Work & Pensions


May 2020
Jul 2020
Aug 2020
1 Apr
The Ministry of Housing, Communities & Local Government (MHCLG) appointed a senior responsible owner for the shielding programme.
9 Apr
Medicines delivery service began.
12 Apr
Cumulative 1.3 million people identified as CEV
4 May
Successful food box deliveries peaked at 367,000 this week.
27 Jul
220,000 CEV people received food boxes in final week of shielding.
1 Aug
National shielding programme paused.
8 Apr
MHCLG began fortnightly Stakeholder Engagement Forums with local authority representatives.
Last emergency bulk food supplies provided to local authorities.
18 Apr
Cumulative 1.8 million people identified as CEV
28 Apr
Government Digital Service began passing details of CEV people who had not registered and could not be reached by the contact centre to local authorities for follow-up.
7 May
The List stabilised at 2.2 million CEV people

1.5 Faced with an immediate need to ensure reliable access to food, medicines and care for an anticipated 1.5 million people, in March, ministers quickly commissioned shielding as a centrally directed programme with an offer of local support to all people considered CEV. Government chose a centrally directed system of support for CEV people led by the Ministry of Housing, Communities & Local Government (MHCLG). Government chose a centrally directed rather than local approach for speed and confidence in delivery. It did so because of concerns about capacity in local food supplies and supermarket shortages 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.

Objective of the Programme

1.6 The objective of 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 Programme, CEV people could get support accessing food, medicine and basic care.

Roles and responsibilities

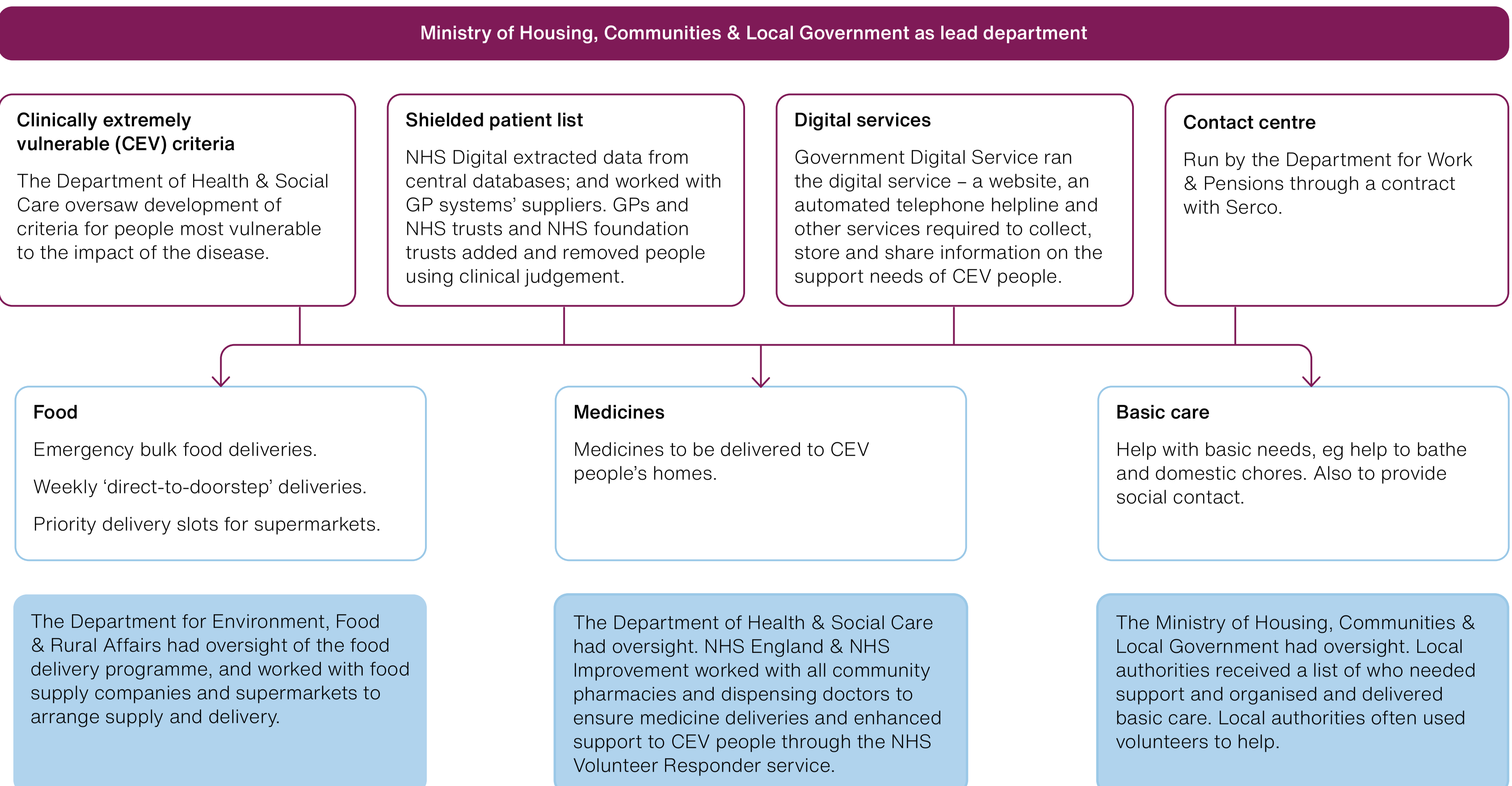
1.7 MHCLG had overall delivery responsibility for the Programme and DHSC was responsible for determining who should shield, evaluating the health impact of shielding and determining and issuing clinical advice (**Figure 2**). NHS Digital was responsible for producing the list of people who were to be 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 as it had relationships with the food industry. NHS England & NHS Improvement (NHSE&I) ran the medicines delivery service to get medicines to people through 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) ran a contact centre to call CEV people.

1.8 Cabinet Office suggested to MHCLG that it appoint an external senior responsible owner (SRO) for the Programme. Approval for this short-term appointment was given by the Civil Service Commission. A steering group to decide the Programme's strategy was in place by 7 April (**Figure 3** on page 20). Stakeholders across the Programme have noted that early working was energetic but not well joined-up, however, this improved markedly once the SRO took up post given his work.

Figure 2

Roles and responsibilities in the shielding programme (the Programme) from 22 March to 1 August 2020

Several government departments were involved in the Programme

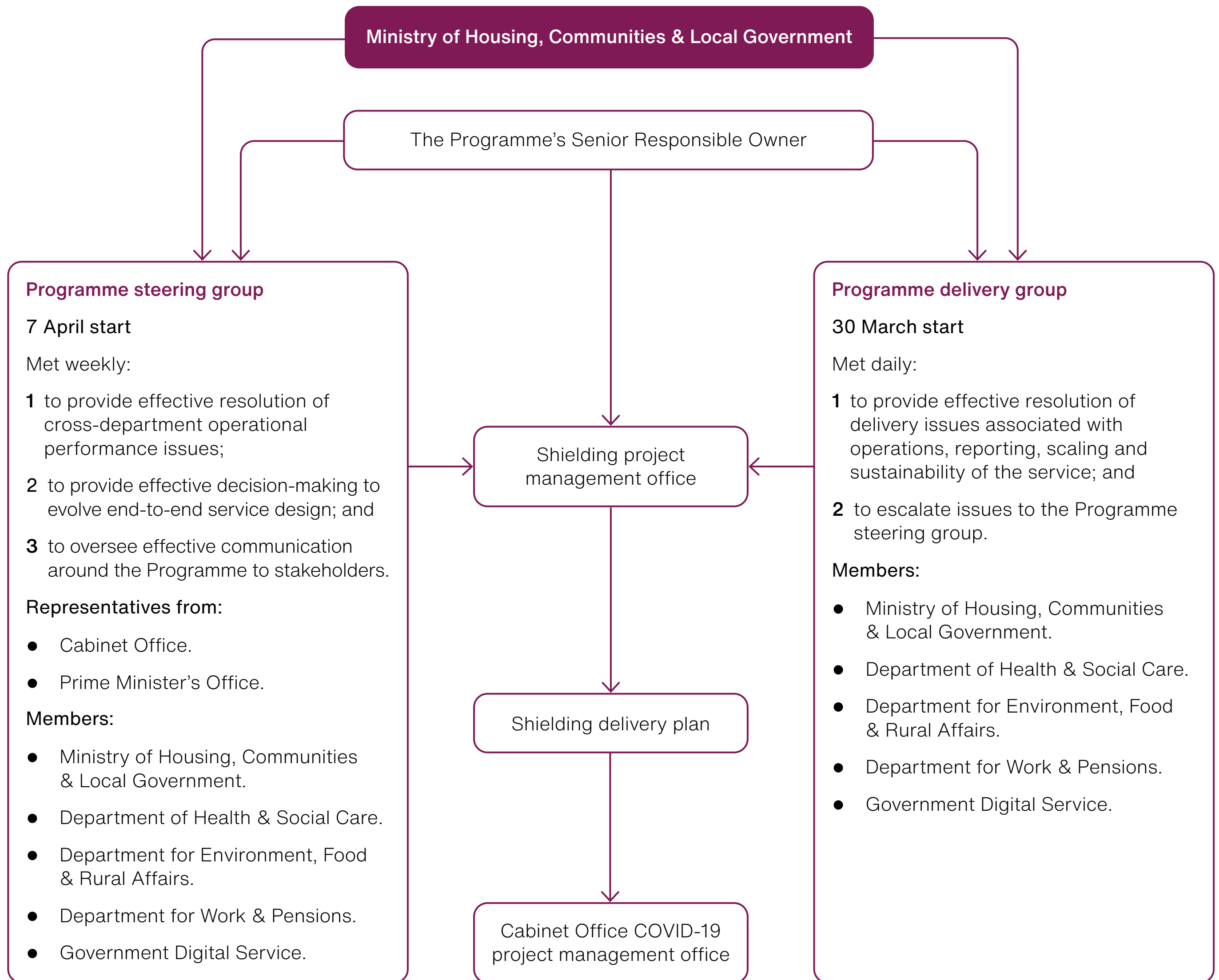


Source: National Audit Office analysis of documents from the Ministry of Housing, Communities & Local Government, Department of Health & Social Care, Department for Environment Food & Rural Affairs, NHS Digital, NHS England & NHS Improvement, Government Digital Service, and Department for Work & Pensions

Figure 3

Governance and reporting in the shielding programme (the Programme) from 22 March to 1 August 2020

Key departments for the Programme were all involved in the governance arrangements



Source: National Audit Office analysis of Ministry of Housing, Communities & Local Government documentation

1.9 Before becoming the Programme's SRO in April 2020, the individual concerned had accepted a position in KPMG, starting later in the year. Prior to his appointment as SRO, KPMG had been awarded a contract with MHCLG worth an estimated £1.5 million (actual spend was £0.7 million) to work on the Programme, leading to a concern, from the proposed SRO, as to how to avoid potential conflicts of interest. Before taking up post, and following his disclosure of his future post with KPMG, MHCLG and the incoming SRO therefore agreed to his request that, for any commercial arrangements in respect of shielding where the SRO might be needed to set the specification, they would not be involved in any selection or appointment process or commercial arrangements.

1.10 Local authorities were responsible for contacting difficult to reach CEV people and distributing emergency food supplies (paid 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 for 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. Local authorities estimate that they spent £54.4 million on supporting CEV people from 1 April to 1 August. Government provided authorities with £3.7 billion in non-ringfenced emergency COVID-19 funding between March and July 2020. This included £500 million on 2 July. MHCLG also expected local resilience forums to have a strategic coordination function in terms of keeping an overall view of demand and direction of supply of support. In reality, local resilience forums played a minor role focused on reporting progress to MHCLG.

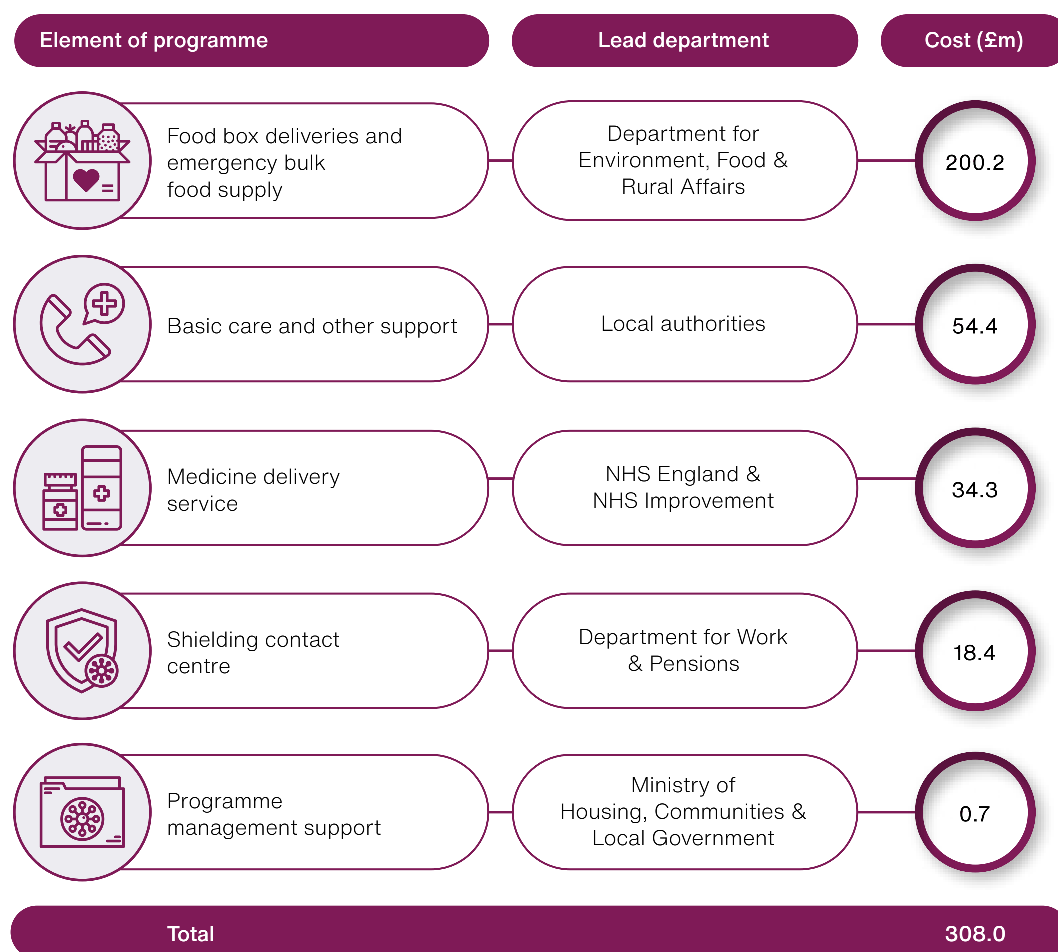
Expenditure

1.11 Total expenditure on the programme up to 1 August was £308 million (**Figure 4** overleaf). The food delivery service was the highest area of expenditure at £200.2 million. Expenditure on the medicines delivery service was £34.3 million 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 variation of the numbers of CEV people created a disproportionate burden on some local authorities to support CEV people as funding allocated to local authorities did not take into account the numbers of CEV people in that area. However, funding levels for the second lockdown in November 2020 were based on local CEV numbers.

Figure 4

Costs of shielding programme (the Programme) to 1 August 2020

The costs of the Programme totalled £308 million



Element of programme	Lead department	Cost (£m)
Food box deliveries and emergency bulk food supply	Department for Environment, Food & Rural Affairs	200.2
Basic care and other support	Local authorities	54.4
Medicine delivery service	NHS England & NHS Improvement	34.3
Shielding contact centre	Department for Work & Pensions	18.4
Programme management support	Ministry of Housing, Communities & Local Government	0.7
Total		308.0

Notes

1 Costs are exclusive of VAT where known.

2 We have excluded the costs of the NHS Volunteer Responders as it is not possible to disaggregate the costs relating to clinically extremely vulnerable (CEV) people.

3 The medicines delivery service is led by NHS England & NHS Improvement but funded by the Department of Health & Social Care.

4 Costs for the shielding contact centre include programme management payments to KPMG and £17.5 million cost of the Serco contract.

Source: National Audit Office analysis of documents from the Ministry of Housing, Communities & Local Government, Department for Environment, Food & Rural Affairs, NHS England & NHS Improvement, and Department for Work & Pensions

Part Two

Identifying clinically extremely vulnerable people

2.1 In this part of the report, we examine how effectively government identified and communicated with clinically extremely vulnerable (CEV) people.

Developing the criteria for who is most vulnerable

2.2 On 5 March and 10 March 2020, the Scientific Advisory Group for Emergencies (SAGE) discussed the need for vulnerable groups to be identified and protected in response to COVID-19. Following SAGE discussions, government decided to develop a policy to socially distance the vulnerable and elderly. The main objective of distancing vulnerable people was to prevent loss of life.

2.3 The four national UK chief medical officers, advised by clinical leaders, within two weeks, agreed the clinical criteria for who was to be advised to shield, based on the limited clinical evidence on the virus available at the time. The criteria for shielding were exclusively clinical to identify people at the highest risk of mortality and severe illness from COVID-19. On 18 March, the chief medical officers finalised the interim list of conditions (Appendix Three). The chief medical officers continued to consider and include new medical conditions as required. New medical conditions were also added when shielding was reintroduced in November 2020. Protected characteristics were considered at the start, and throughout the shielding programme (the Programme) and were dealt with as the the chief medical officers considered to be clinically appropriate:

- to develop the criteria of who was CEV, the UK chief medical officers drew up a list of medical conditions which they considered could make people more at risk from severe illness of mortality from COVID-19, based on the clinical evidence at the time;
- age was not an individual criterion for inclusion in the CEV group, but all people aged 70 and over were advised to take extra precautions as part of the group considered clinically vulnerable;[1] and
- potential risks associated with ethnicity were considered in detail but the clinical criteria used to determine if someone was CEV already covered those clinical conditions more prevalent across ethnic minority groups. At this time, ethnicity risks could not be differentiated from other non-clinical factors such as occupation.

1 People considered 'clinically vulnerable' were those at moderate risk from COVID-19 and includes people over the age of 70 or people who are very obese.

Developing the shielded patient list

2.4 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. The Department for Health & Social Care (DHSC) tasked NHS Digital to use existing patient data to identify people who were CEV. It shared the list of criteria with NHS Digital on 18 March. NHS Digital applied the list of criteria to medical codes, to identify patients from several existing datasets: hospital data; GP patient data; prescribed medicines data; and maternity data (**Figure 5**). From this, NHS Digital compiled the shielded patient list (the List).

2.5 NHS Digital developed the List in several iterations, as more data became available. The first iteration, based on hospital, maternity and prescribed medicines data, was ready on 20 March and included some 870,000 people. The second iteration, using GP patient data added 420,000 people, and was not released until 12 April owing to the time needed to extract these data as NHS Digital did not have ready access to this dataset. Some 1.3 million CEV people were on the List by 12 April. These people were sent letters advising them to shield and of their eligibility for support, for which they needed to register. The time taken to identify all CEV people from when the criteria for CEV people were agreed on 18 March was largely down to the challenge of extracting usable data from different NHS and GP IT systems.

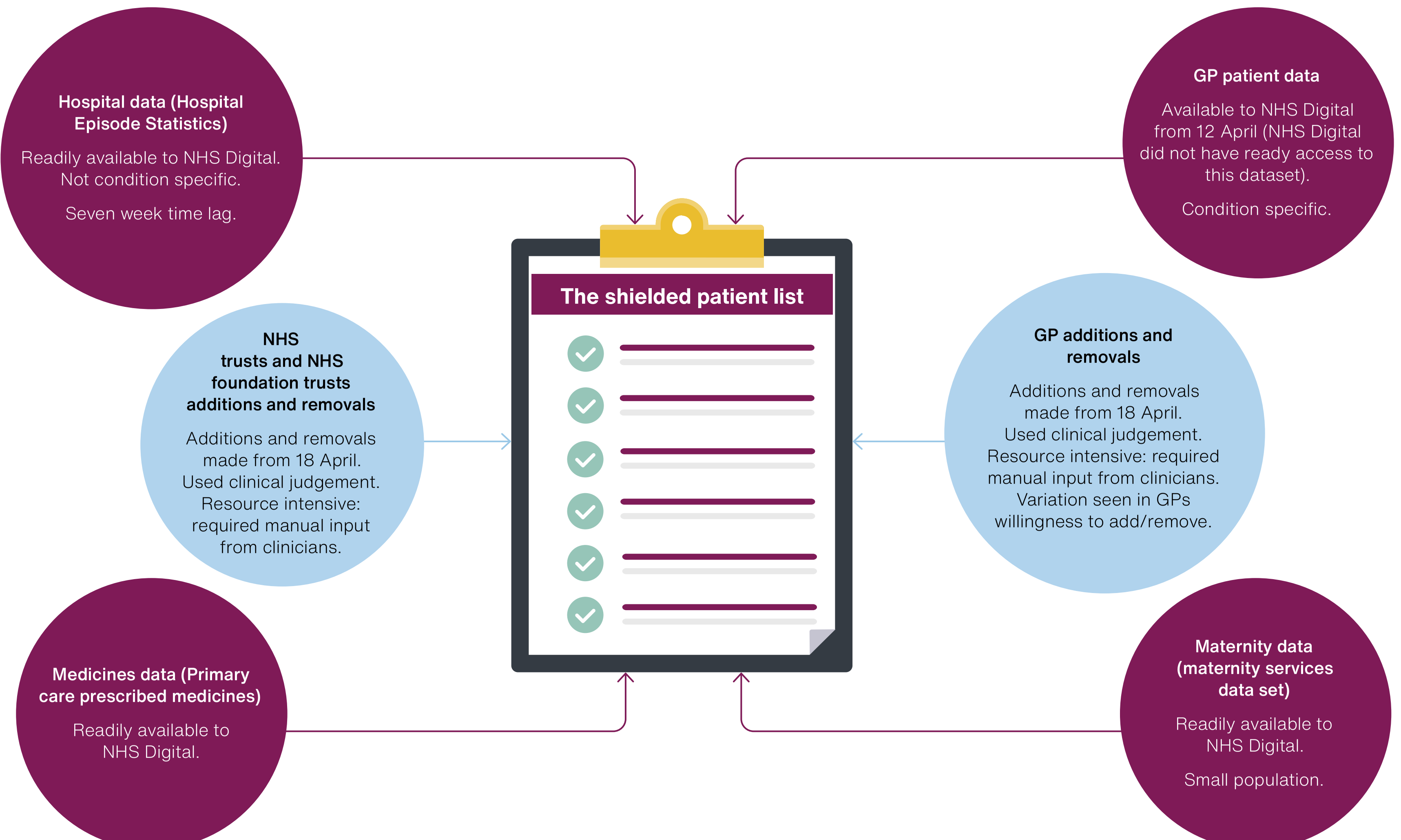
2.6 As part of the agreed clinical decision making process set out by the UK chief medical officers, on 9 April NHS England & NHS Improvement (NHSE&I) asked GPs and NHS trusts and NHS foundation trusts (trusts) to review the List and add or remove people based on their clinical judgement, local patient 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. As a result, the List continued to increase and the Programme started to add a further 900,000 people to the List between 18 April and 7 May making them formally eligible for the central support offered through the Programme. There were 1.8 million people on the List by 18 April and the List stabilised at 2.2 million CEV people by 7 May (**Figure 6** on page 26). Some of this increase of 900,000 people will also have been due to new diagnoses and other conditions being added to the criteria, for example, dialysis.

2.7 People would not have been formally eligible for the central support of food boxes and medicines provided by the Programme until they were on the List but would have been able to ask their local authority for help. They would have been eligible for statutory sick pay given the changes made to the regulations in March to ensure people advised to shield could claim statutory sick pay if they were not able to work from home and were otherwise eligible. People identified by trusts and GPs should have been advised to shield by their GP or trusts as soon as they were considered CEV.

Figure 5

Data used to create the shielded patient list (the List) from 18 March 2020

NHS Digital created the List from various data sources



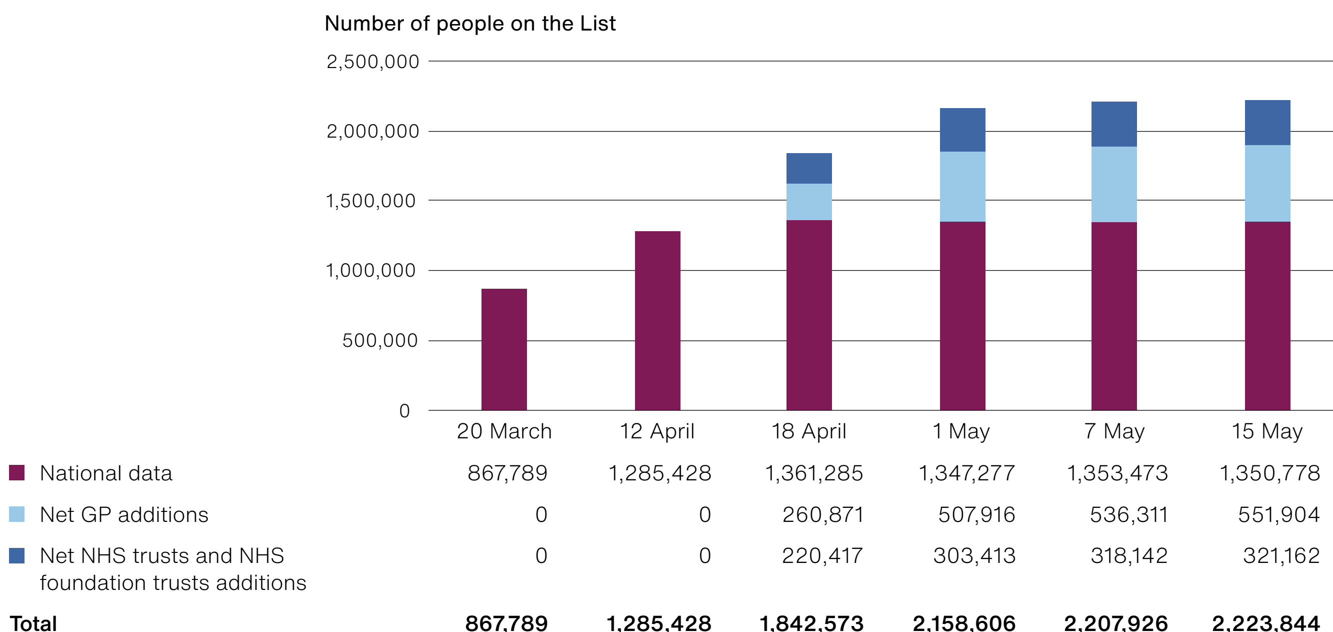
- People added through the national process by NHS Digital
- People added locally

Source: National Audit Office analysis of NHS Digital documentation

Figure 6

Identification of people on the shielded patient list (the List) from 20 March 2020

The List took several weeks to develop and stabilised by 7 May



	20 March	12 April	18 April	1 May	7 May	15 May
National data	867,789	1,285,428	1,361,285	1,347,277	1,353,473	1,350,778
Net GP additions	0	0	260,871	507,916	536,311	551,904
Net NHS trusts and NHS foundation trusts additions	0	0	220,417	303,413	318,142	321,162
Total	**867,789**	**1,285,428**	**1,842,573**	**2,158,606**	**2,207,926**	**2,223,844**

Notes

1 National data include: Hospital Episode Statistics data, GP patient data, Primary Care Prescribed Medicines data, and Maternity Services data set. This also includes deceased patients who were removed from the List.

2 Net NHS trusts and NHS foundation trusts additions is the total of people added and removed from the List by NHS trusts and NHS foundation trusts.

3 Net GP additions is the total of people added and removed from the List by GPs.

4 The List developed over several iterations, the dates above are for each iteration of the List from 20 March to 15 May.

Source: National Audit Office analysis of NHS Digital data

2.8 Because of the nature of the data, the process and the need to act quickly, (Figure 5), several problems arose:

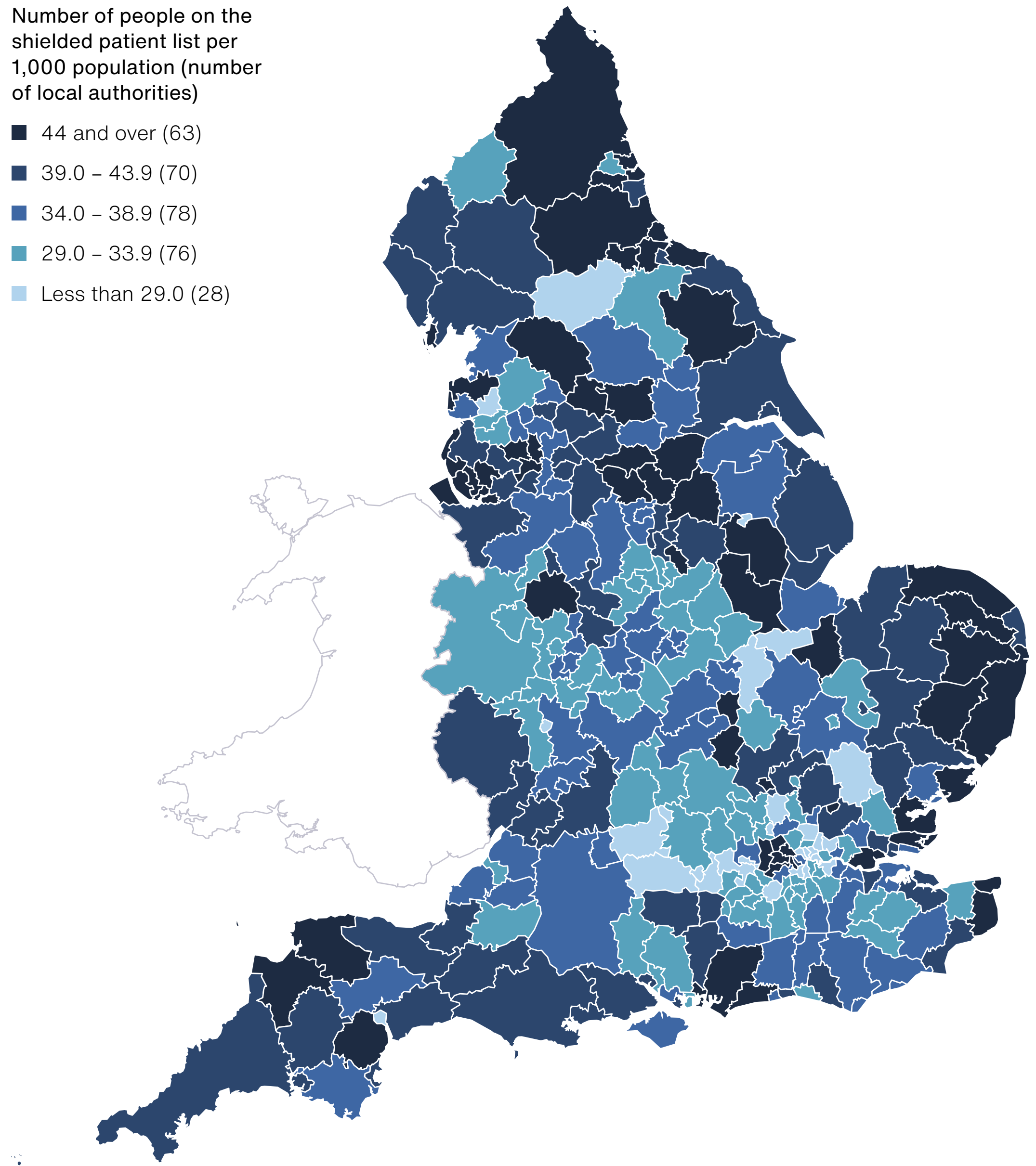
- The speed at which the List was developed (two days) meant NHS Digital relied on hospital, maternity and prescribed medicines data for the first iteration. Hospital data, while immediately available, were seven weeks out of date.
- Limitations with hospital data led to 30,000 people who had died before 20 March being sent a letter advising them to shield.
- Hospital data did not always specify sufficient detail of people's medical conditions, leading to 126,000 people being added to the List and unnecessarily advised to shield.
- A lack of joined-up data systems meant it took NHS Digital three weeks to undertake the technical task of accessing and extracting GP patient data, which were more specific about people's medical conditions.
- GPs reported that the need for them to review, add and remove people from the List created a burden on already stretched services.
- Variations in practice locally. For example, in line with guidance available at the time, the Clinical Commissioning Group in Liverpool added some 37,000 people to the List, increasing it to nearly 50,000 people – approximately 10% of the city's population, who became formally eligible for support under the Programme.
- Inaccurate or missing personal information in NHS patient records (such as telephone numbers) caused problems when trying to contact people on the List (see paragraph 3.24).

Variation

2.9 The proportion of people on the List varied locally (**Figure 7** overleaf), from 24 people per 1,000 in Oxford, to 95 people per 1,000 in Liverpool (as of 15 May 2020). Potential contributory factors include higher proportions of elderly people or people with underlying health conditions, health inequalities, or differences in the way local healthcare providers added to or removed people from the List. The extent to which the List grew varied at local level (**Figure 8** on page 29). For example, between 12 April and 15 May increases in the List at local level ranged from 15% in Carlisle to 352% in Hounslow. NHSE&I was not responsible for managing any local variations and did not challenge local clinical decisions.

Figure 7
Number of people on the shielded patient list (the List) in England, by local authority districts, per 1,000 population at 15 May 2020

Regional variation exists throughout England in the number of people on the List



Notes

1 NHS Digital combined some local authorities to create larger areas: Cornwall and Isles of Scilly were merged and so were Hackney and the City of London. This is reflected on the map.

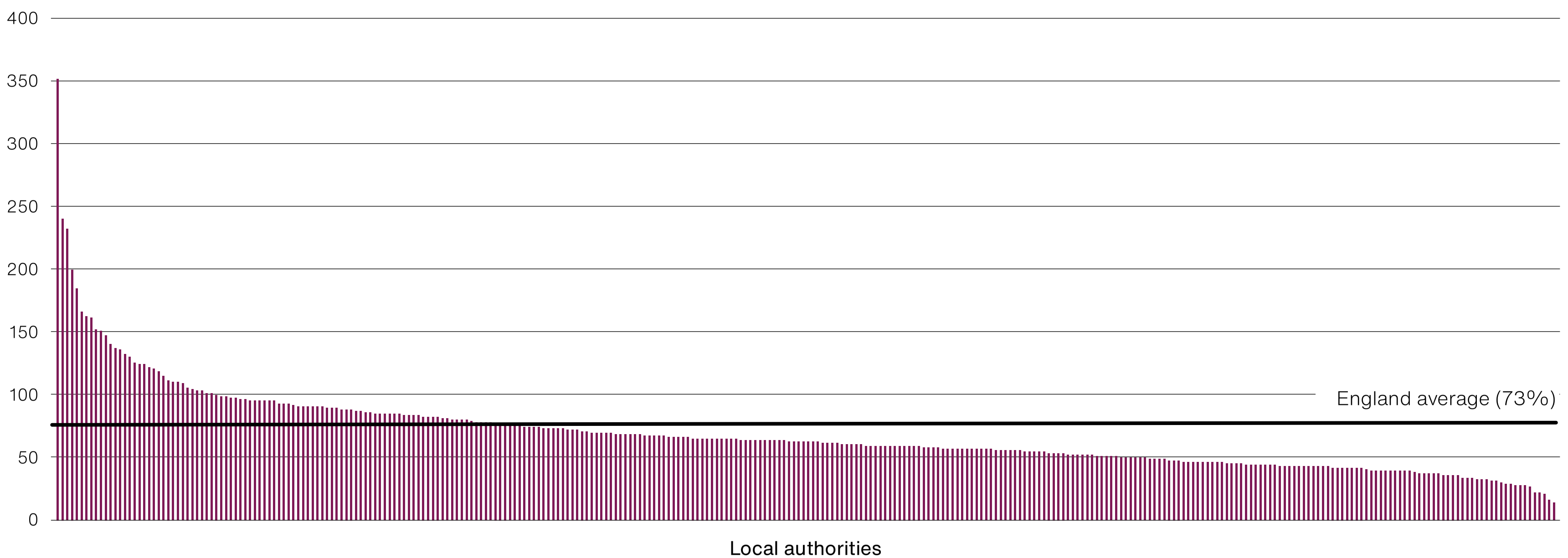
2 This map uses the old districts of Aylesbury Vale, Chiltern, South Bucks, and Wycombe for Buckinghamshire as this is what was used for Coronavirus Shielded Patient List Summary Totals, England as at 15 May 2020.

Source: National Audit Office analysis of NHS Digital data, Coronavirus Shielded Patient List Summary Totals, England – as at 15 May 2020 and Office for National Statistics, Mid-2019 estimate of the population for the UK, England (using April 2019 Local Authority District Codes)

Figure 8

Growth in the shielded patient list (the List) from 12 April to 15 May 2020

There were wide variations in the number of people added to the List when local GPs and NHS trusts and NHS foundation trusts made their clinical recommendations



Notes

1 GPs and NHS trusts and NHS foundation trusts added to and removed people from the List from 18 April. Smaller changes to the List were also made using national data by NHS Digital throughout 12 April to 15 May, and beyond this time period.

2 NHS Digital combined some local authorities to create larger areas: Cornwall and Isles of Scilly were merged and so were Hackney and the City of London. This is reflected in the graph, which shows 312 local authority areas in England. All local authorities in England are included in this graph.

Source: National Audit Office analysis of NHS Digital data

Communicating with CEV people

2.10 NHSE&I and DHSC were responsible for initially informing people that they were considered to be clinically extremely vulnerable to COVID-19. NHSE&I used Capita and the NHS Business Service Authority to send letters and text messages to people on the List. GPs were responsible for informing CEV people that they were added to or removed from the List. NHSE&I did not track this communication.

2.11 The iterative development of the List caused confusion as people struggled to understand why they received a letter advising them to shield, or why they were told they no longer needed to shield as late as June and July. Further confusion was caused by inconsistencies in the process by which NHSE&I and DHSC communicated with CEV people. For example, in May 235,000 people were added to the List and received a letter advising them to shield, but their GPs were not informed at the same time. While GPs received general guidance on shielding and were aware that people were being added to the List, they were not necessarily ready to advise these individual patients.

2.12 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. They noted issues with a lack of transparency on why some conditions were considered to make people CEV, which caused confusion and uncertainty. Charities also told us that national communications were not always consistent with guidance and had confused people, and left some people unsure as to whether they needed to shield.

2.13 Charities played an important role in advising concerned people. DHSC engaged with charities through various forums such as focus groups. However, charities reported difficulties in getting detailed evidence and information from government. Charities also noted inconsistencies with media reports, ministerial comments and official guidance. For example, in mid-March some media outlets reported, incorrectly, that people aged over 70 would be asked to shield. 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.

Part Three

Supporting clinically extremely vulnerable people

3.1 This part of the report assesses the effectiveness of the support provided: food, medicines and basic care.

Registering support needs

3.2 Government worked rapidly to create a range of ways that clinically extremely vulnerable (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 2020, the Government Digital Service (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 service was operational by 23 March. Government provided details of how to access the website and helpline in the letters it began sending out to CEV people from 23 March.

3.3 When the website was first operational, people who were not on the shielded patient list (the List) could 'self-declare' that they needed support and register on the website. Initially, wording on the website was not clear that only people who met the criteria as CEV were eligible for this form of support. The wording was updated within six days to clarify who was eligible but by this time, some 277,000 people had self-declared. Where possible, NHS Digital gave GPs the contact details of their patients who had self-declared before this clarification but were not on the List, for GPs to check if they needed to be added. The Ministry of Housing, Communities and Local Government (MHCLG) decided to honour their requests for support until it could be established whether or not they met the clinical criteria as CEV. It is likely that some people who self-declared at this time did not get their CEV status confirmed. A number of people continued to receive support even though not eligible, but the data do not capture how many. People who subsequently 'self-declared' as CEV on the website but were not on the List were advised to contact their GP or clinician who would consider if they were CEV.

Contact centre

3.4 Government also commissioned a contact centre through the Department for Work & Pensions (DWP) to call CEV people who had not yet registered through the website or the automated helpline as directed in the letters, to register them on their behalf (**Figure 9**). The contact centre also administered surveys and information campaigns on behalf of the shielding programme (the Programme). DWP appointed Serco to provide the contact centre under emergency procurement procedures. Running the contact centre cost a total of £18.4 million to 1 August 2020 (of which £17.5 million was paid to Serco).[2] Details of the contact centre contract are in Appendix Four.

3.5 The contact centre started making calls on 28 March. Higher than expected numbers of CEV people and lower than expected website and helpline registrations increased demand on the service. Around 1.8 million CEV people were referred to the contact centre because they had not registered using the website and automated helpline.

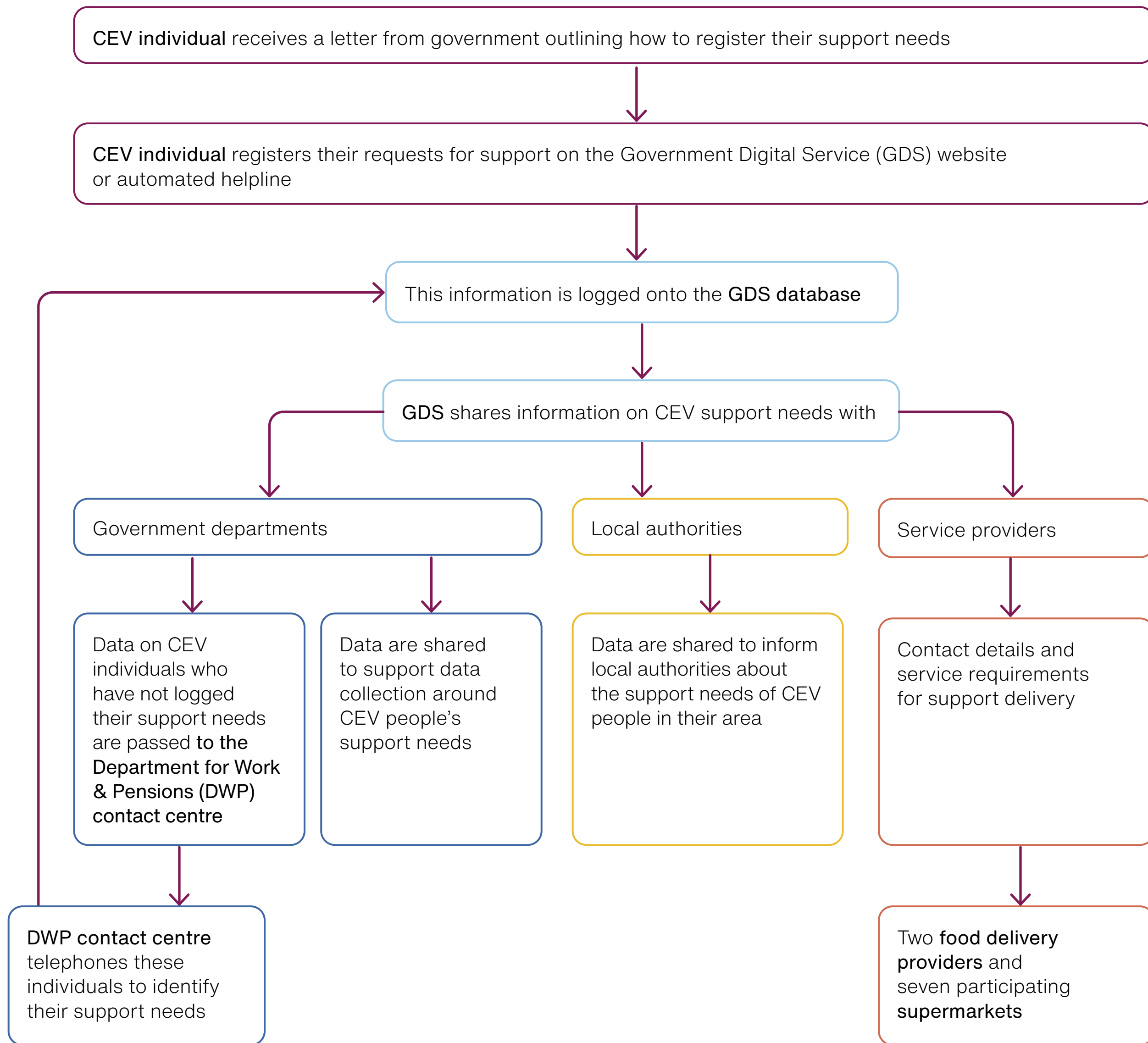
3.6 By 23 June the contact centre had attempted to contact 1.8 million CEV people compared with initial expectations of 750,000. It was unable to register 815,000 CEV people. Around 375,000 of these 815,000 people could not be reached because of missing or inaccurate telephone numbers within NHS patient records (**Figure 10** on page 34). 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. To ensure these 815,000 people did not slip through the net, from 28 April, GDS shared with local authorities the contact details of people that could not be reached, so local authorities could check if these people needed help (see paragraph 3.24).

2 The £18.4 million also includes programme management payments to KPMG.

Figure 9

Routes for registering clinically extremely vulnerable (CEV) people's needs during the shielding programme

There was a process to help ensure all CEV people were contacted and their needs registered



Note

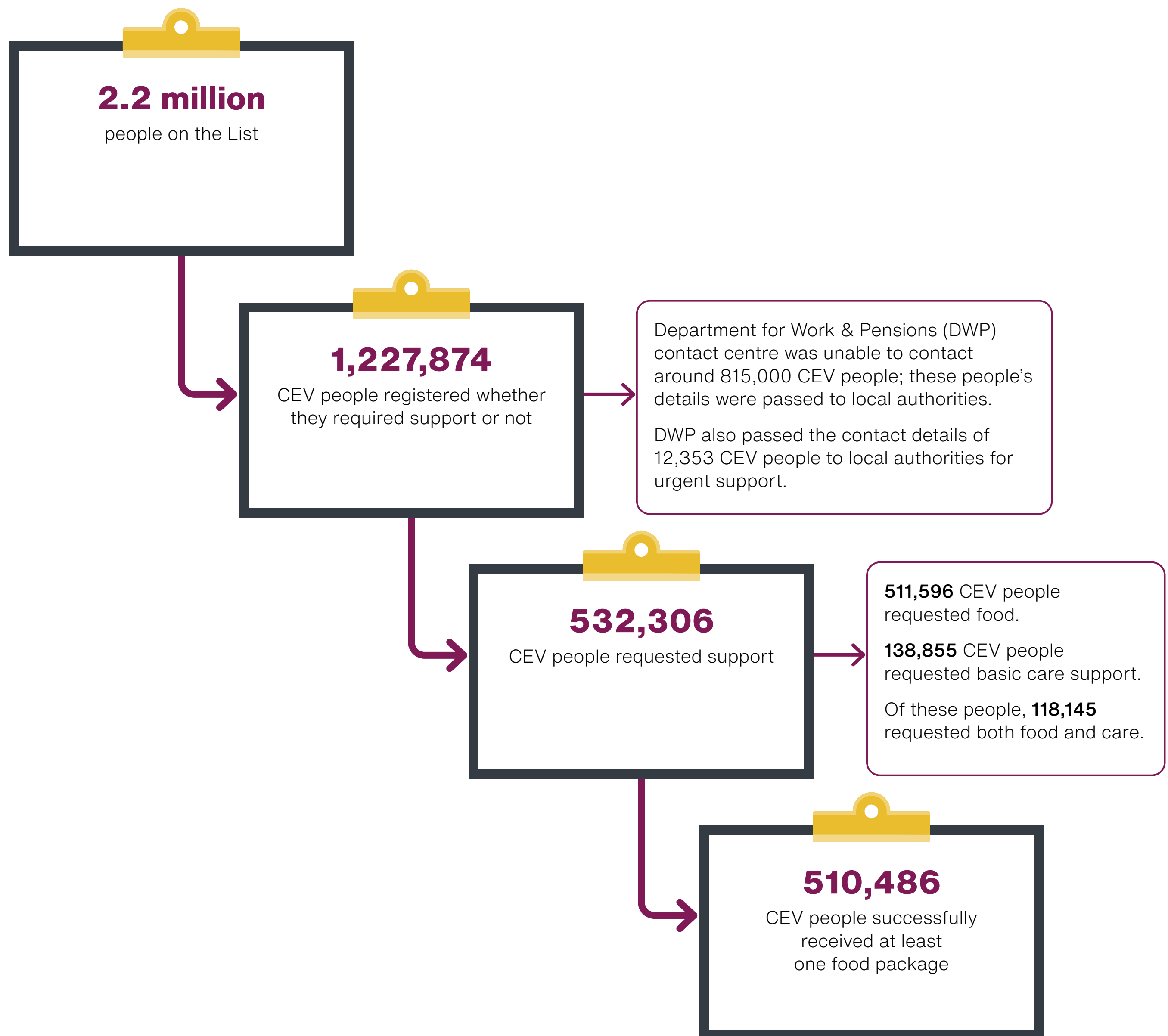
1 The food service suppliers are Brakes and Bidfood.

Source: National Audit Office analysis of documents from the Ministry of Housing, Communities & Local Government, Government Digital Service, and Department for Work & Pensions

Figure 10

Number of clinically extremely vulnerable (CEV) people requesting support from 23 March to 3 August 2020

There were some 2.2 million people on the shielded patient list (the List); of these, 510,486 CEV people successfully received at least one food box



Notes

1 The 1,227,874 CEV people registered whether they required support or not, excludes CEV people who had de registered before 3 August 2020.

2 The data in this figure exclude self-declared people who may have received support but did not get their CEV status confirmed (paragraph 3.3). It is unclear if the data from the contact centre include self-declared people.

3 The List stabilised at 7 May at 2,207,926 people; 2.658 million were identified in total, but some of these died or were subsequently removed from the List.

4 Government Digital Service collected data on registrations to 3 August 2020.

Source: National Audit Office analysis of Department for Work & Pensions and Government Digital Service data

Providing food support

Direct food support for CEV people

3.7 Government worked quickly to design a food support service and identify suppliers who could deliver it. The Department for Environment, Food & Rural Affairs (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. By 24 March, Defra was negotiating with Bidfood and Brakes for doorstep food box deliveries, preceded by emergency bulk food supplies for local authorities to distribute while food box deliveries were set up.

3.8 Defra negotiated contracts under emergency procurement procedures, and secured some reductions on initial prices. Defra signed provisional arrangements three days after starting negotiations, with the first deliveries starting on 27 March. Three further provisional arrangements were signed over the following weeks before Defra and the providers signed full contracts on 23 April. Over this period Defra used information from cost benchmarks and industry consultants to negotiate price reductions compared with the initial pricing quoted by the providers. In return, Defra gave providers increased notice for contract termination and took on more of the financial risk involved in providers maintaining sufficient stock levels to meet uncertain demand. The contracts included key performance indicators, but with no financial incentives attached. Details of the contracts are in Appendix Four.

Emergency bulk food supplies

3.9 Bulk supplies were not intended to mirror the content of the subsequent food box deliveries, instead they were to help local authorities meet basic needs, as a stop-gap, before food box deliveries were set up. Local authorities were told bulk supplies would be based on what was available to suppliers at that point. Between 27 March and 8 April, around 170 local authorities requested and received supplies costing £502,000 from Bidfood and Brakes, funded by Defra. Local authorities have criticised the quality of provision, in particular:

- 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.

Food box deliveries

3.10 Government designed a food box intended to provide sufficient nutrition for a CEV person for seven days. Defra consulted food charities and Public Health England nutritionists on content, developing a 'basket' of goods Bidfood and Brakes were expected to supply, along with approved substitutions should key items not be available. For cost and simplicity, government chose to provide a standard food box. Government required local authorities to provide support for people whose needs were not met by the standard box, for example, to meet religious, dietary or cultural requirements. Bidfood and Brakes were required to deliver food boxes to recipients' front doors.

3.11 Uptake of food box deliveries was not as widespread as expected. Defra forecast that demand for food support from the initially anticipated 1.5 million CEV people would equate to 440,000 food boxes a week. However, while the List grew to 2.2 million people, successful food box deliveries never exceeded a peak of 367,000 on the week commencing 4 May 2020. Between 27 March and 1 August, Brakes and Bidfood successfully delivered 4.7 million food boxes.[3] Nearly 172,000 boxes went undelivered, mostly because people rejected the delivery as no longer needed. Defra only paid the delivery charge for these undelivered boxes, not the cost of the food box itself. Defra paid Bidfood and Brakes £200.2 million for food boxes and emergency bulk supplies.

3.12 User satisfaction with food box deliveries was positive. Food boxes went to 510,486 CEV people between March and 1 August. Across Defra's user surveys (which ran from mid-May), satisfaction with the quality and balance of the box content varied between 83% and 79%. People reported fresh produce was usable for three days at least 83% of the time. However, charities and local authorities were critical of aspects of the service, reporting:

- poor quality of fresh produce in the box, often affected by hot weather;
- culturally inappropriate pork products (although Defra never intended food boxes to be culturally appropriate);
- high reliance on tomato-based content, inappropriate for kidney patients;
- limited variety and range of meals;
- lack of non-food essentials; and
- lack of feedback mechanisms to food box providers, meaning local authorities were fielding complaints relating to a service over which they had no control.

3 This includes 466,000 deliveries to self-declared people whose CEV status had not been confirmed.

3.13 Many CEV people who had tried to deregister from food box deliveries continued to receive unwanted boxes. Defra reported the problem to GDS in late April. Due to competing demands, the Programme prioritised other requirements and GDS did not address the issue until mid-May. Defra, GDS and the providers initially implemented a manual solution to remove deregistered people from future deliveries and then introduced an 'opt out' function although problems persisted until the end of July. Defra estimated that 90,000 food boxes were delivered to people who had tried and failed to deregister, at an avoidable cost of £4.1 million.[4]

Supermarket priority deliveries

3.14 Defra also engaged with the supermarket sector to increase the number of priority supermarket deliveries to CEV people. Where CEV people indicated on registering that they did not have a way of getting essential supplies delivered, their details were passed to the seven participating supermarkets in line with data sharing agreements. Where CEV people had online accounts with one or more supermarkets, their data were matched and they were provided with priority access to delivery slots. As the availability of supermarket delivery slots increased, from mid-May, government began encouraging people to move off the food box deliveries, with limited success. In the week commencing 27 July, there were 220,000 successful food box deliveries.

Medicines delivery service

3.15 On 9 March, government tasked DHSC to develop a service to ensure that CEV people could access their medicines while shielding. This was to help those who had no support from friends, family or volunteers. DHSC worked with NHS England & NHS Improvement (NHSE&I) to design a suitable service with pharmacy providers. This process took four weeks; as a result, the medicines delivery service was not commissioned to start until 9 April.

3.16 Under the service, pharmacies and dispensing doctors were responsible, and paid, for ensuring that CEV people got medicines.[5] The preference was for CEV people to ask family and friends or NHS Volunteer Responders to deliver their medicines, with pharmacies and dispensing doctors making deliveries when volunteers were not available. NHSE&I informed CEV people of the service using the letters that advised them to shield and the support available to them (see paragraph 2.10).

4 Defra considered that in addition to these 90,000 food boxes, there were approximately a further 60,000 food boxes unavoidably delivered to people who had tried to deregister, for example, as they tried to deregister too close to the delivery date.

5 The legal framework for the service was provided by the National Health Service (Amendments Relating to the Provision of Primary Care Services During a pandemic etc.) Regulations 2020 which came into effect on 27 March 2020.

3.17 As of the end of July, the total number of deliveries was 2,436,289. Not all CEV people used the medicines delivery service. Some would have asked family and friends or NHS Volunteer Responders to deliver their medicines, although some CEV people reported leaving home to collect their own medicines (Figure 13). However, in Office for National Statistics (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 shield at home.[6] 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.

3.18 Expenditure was £34.3 million at the end of July. NHSE&I had a system to assure payment claims from pharmacies and dispensing doctors; however, we have not validated or audited this process. 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. Because monitoring was based on monthly payment data, NHSE&I did not start getting information about how many deliveries CEV people got through the medicines delivery service until 10 May. NHSE&I considers that positive feedback as well as no complaints indicates that the medicines delivery service was working well.

Basic care support

3.19 Government identified that shielding could create challenges for CEV people who relied on informal support from friends and family which became unavailable due to lockdown restrictions and shielding guidance, and some would need additional support to help them follow shielding guidance. In those cases, CEV people could register basic care needs through the website, automated helpline or contact centre registration process; 139,000 CEV people registered for care support through national systems over the course of the Programme. Government asked local authorities to provide basic care. GDS provided data to local authorities on people who requested support as well as people who the contact centre had not been able to contact. The term 'basic care' caused some confusion as many local authorities are required to provide social care which has a statutory definition, whereas 'basic care' was open to interpretation. Local authorities had discretion over the delivery of basic care.

6 Surveys ran between 14 May and 16 July. The survey was co-produced by DHSC, DWP, GDS and the Office for National Statistics. There were five surveys conducted in total, we have chosen to use data from one survey conducted between 14 and 19 May. The survey for 14 to 19 May was based on a sample of 4,224 CEV people, although response rates to individual questions varied. ONS weighted the survey to be reflective of the whole CEV population: www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/coronavirusandshieldingofclinicallyextremelyvulnerablepeopleinengland

3.20 Local authorities could use NHS Volunteer Responders to help meet people's basic needs, although uptake varied across local authorities. Local authorities also used local voluntary groups (including charities, faith groups and so on) to help meet the basic needs of CEV people, and other vulnerable people. Examples include:

- in Devon, councils worked with local football teams and sports coaches who helped with food and medicines delivery; and
- Brent Council provided financial support to eight voluntary organisations it worked with to help with supporting vulnerable people, including CEV people.

3.21 MHCLG was not able to track local delivery of basic care support to CEV people. MHCLG attempted to collect data from local authorities on basic care provision but was unable to identify a workable solution that was 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.

Local and central engagement

3.22 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. The small number of local authorities we have spoken to have criticised government's engagement with them in the first few weeks of the Programme, with some noting that engagement improved over summer.

3.23 MHCLG recognised that it needed to improve engagement with local authorities and 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. The first meeting was held on 8 April. On 18 May, MHCLG began to email local authorities weekly with updates to the Programme. It also provided dedicated contact points with each local authority. At the end of June, MHCLG set up two 'task and finish' groups with local authorities and government to support future shielding.

Data

3.24 In addition to the clinical shortcomings of the data used to create the List (paragraph 2.8), other shortcomings with data have affected the efficiency and effectiveness of several aspects of the Programme:

- **Missing or inaccurate telephone numbers** in the data used to create the List caused problems when trying to contact CEV people. The contact centre was unable to call around 375,000 CEV people as telephone numbers provided in NHS patient records were missing or inaccurate. Local authorities also struggled with inaccurate contact data for CEV people which created additional work for them in cleansing these data and potentially delayed getting support to CEV people.
- **No system for feedback** – the system did not allow local authorities to return corrected data back to NHS Digital or GDS, so inaccuracies continued.
- **Multiple lists** – local authorities also told us that they received different 'lists' of CEV people which needed reconciling. Local authorities received the shielded patient list, people who had registered online, and food deliveries made. Local authorities did not receive data on CEV people who the contact centre could not contact until 28 April. This meant that local authorities struggled to check if all CEV people's needs were being met.

Sharing data on support needs

3.25 Government faced a complex challenge sharing registration data with those who needed it. GDS was responsible for the service that registered and stored CEV peoples' support needs, initially using data from the List. At peak, around 60 staff were involved in delivering the service. These data needed to be shared securely with other government departments, local authorities and food providers.

3.26 The highly sensitive personal data involved, required GDS to agree data sharing agreements across different bodies so it could meet the needs of CEV people. Government's need for swift and secure sharing of data required GDS to make compromises in the design of data storage and sharing approaches. Government needed to share data as soon as it was able, to quickly meet the needs of CEV people. GDS accepted that the quality of the data could be compromised, meaning that organisations receiving the data would have to cleanse some of these data. Legal restrictions meant GDS had to prioritise security of the dataset over usability. GDS sought to minimise the risk of data loss through restricting users' ability to access, review and update their information. As a result, CEV people could not have potentially vulnerable password access to the dataset to update their own details. If people needed to update their support needs, the design of the system meant that they had to reregister from scratch. Charities reported many CEV people struggled with this reregistration. It also resulted in duplicate records and further quality issues.

Part Four

Outcomes and lessons learned

4.1 This section of the report looks at outcomes for clinically extremely vulnerable (CEV) people and whether the Ministry of Housing, Communities & Local Government (MHCLG) and other departments have learned and applied lessons to the second lockdown.

Outcomes

4.2 The key aim of the shielding programme (the Programme) was to reduce mortality and severe illness from COVID-19 in CEV people by providing them with public health guidance and support to stay at home and avoid all non-essential contact. Offering this support was a prudent response to asking CEV people to shield.

4.3 Disentangling the impact of shielding from other factors, such as the lockdown and individual behaviours, is extremely difficult. Other interventions, such as the national lockdown, took effect at the same time, and there was no control group of similarly at-risk individuals who were not asked to shield. The Department of Health & Social Care (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. While DHSC and MHCLG can say how many people received elements of support, such as food boxes, they cannot determine whether providing that support ultimately reduced mortality and severe illness in CEV people.

4.4 The Office for National Statistics' (ONS) shielding behavioural survey ran from 14 May to 16 July and examined the behaviours of people shielding.[7] The ONS survey suggested that some CEV people experienced worsening mental and physical health since being advised to shield. In the survey, CEV people reported:

- 20% were no longer accessing certain types of care (for example tests, scans); and
- 36% reported worsening mental health and well-being.[8]

4.5 The ONS survey asked CEV people, whether they had registered for support or not, if they found the support provided by the Programme had helped them shield at home. 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. Overall, CEV people - whether they had or had not registered for support - reported that prescription delivery services, or having someone else to collect medicine and food deliveries or food boxes were the most useful elements. Of those who had not left their home since either being advised to shield or in the past seven days:[9]

- 49% reported that food deliveries or food boxes helped;
- 48% reported that prescription delivery services helped; and
- 9% reported that personal care at home helped.

4.6 DHSC and NHS Digital monitored overall mortality, mortality involving COVID-19 and emergency admissions for the majority of people who were on the shielded patient list (the List).[10] Some 7,130 CEV people died with COVID-19 on their death certificate, compared with 42,670 from non-COVID-19 causes between 23 March and 31 August 2020. NHS Digital data on healthcare outcomes for CEV people,[11] compared with an age-matched sample of the general population between 23 March and 31 August 2020, showed that:

7 Between 14 May and 16 July, the survey was conducted five times, approximately every two to three weeks. We have chosen to use data from one survey conducted from 14 to 19 May to avoid reporting behaviour that occurred after shielding guidance changed. The original guidance advised people to stay at home at all times. This changed on 1 June to advise CEV people that they could leave home once a day into open space, as long as they could keep two metres from others not shielding alongside them. The guidance was updated on 6 July to advise CEV people that they could leave their homes and be in open spaces with others. The survey for 14 to 19 May was based on a sample of 4,224 CEV people, although response rates to individual questions varied. ONS weighted the survey to be reflective of the whole CEV population: www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/coronavirusandshieldingofclinicallyextremelyvulnerablepeopleinengland

8 ONS report on Coronavirus and anxiety (June 2020) found 37% of respondents were reporting high levels of anxiety in the general population between 30 April and 10 May 2020.

9 The data relates to all CEV people surveyed, whether they had registered for support or not.

10 DHSC and NHS Digital only monitored outcomes for some 1.6 million people who were on the List as of 18 April. It is unclear why they did not monitor outcomes for people added to the List after this date.

11 All references to the general population refer to the age-matched sample of the general population used by NHS Digital.

- the overall mortality rate for CEV people remained higher than that of the general population and was nearly three times higher (39.5 per 100,000) at its peak on 2 April than the first wave peak for the general population (14.3 per 100,000) on 12 April;[12]
- the mortality rate where COVID-19 was mentioned on the death certificate was more than twice as high for CEV people at 13.6 per 100,000 at its first wave peak on 9 April,[13] compared with 5.3 per 100,000 people in the general population on the same date (**Figure 11** overleaf); and
- emergency admission rates before and during COVID-19 were higher for CEV people than the general population. While emergency admissions decreased for everyone in March, they decreased more for CEV people (46% decrease) compared with the general population (33% decrease) by mid-April and, unlike for the general population, have not subsequently recovered (**Figure 12** on page 45).

4.7 CEV people live in a number of settings including care homes. Care homes were not given detailed guidance on how to help their residents to shield. Instead, DHSC intended that their care would be covered by the general COVID-19 guidance provided to care homes. Analysis shows that approximately 45,000 of the 2.2 million CEV people were care home residents. Of those, some 3,889 (8.6% of CEV people in care homes) died and had COVID-19 recorded on their death certificate as at 7 December. We do not have comparable data for non-CEV people in care homes.

Following CEV guidance

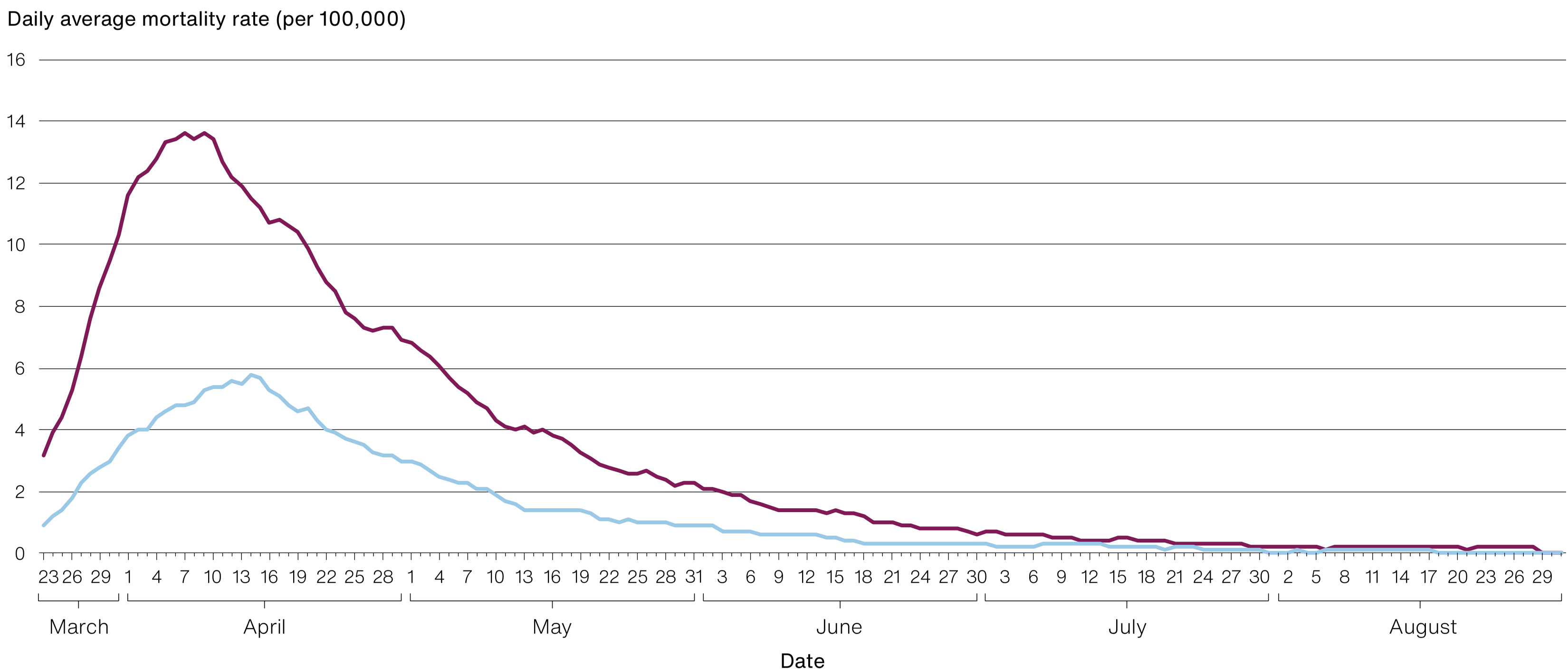
4.8 The ONS shielding behavioural survey between 14 and 19 May, found that 94% of CEV people reported that, overall, they had either completely or mostly followed government shielding guidance. However, behaviour reported elsewhere in the survey suggests fewer people followed the guidance completely. For example, of the 49% of CEV people who reported that they had left their home or garden since the start of shielding, 85% of these had done so in the previous seven days. The most common reason CEV people had left home in the previous seven days was for exercise, followed by shopping for essentials and GP or hospital appointments (**Figure 13** on page 46). This behaviour is not wholly compatible with the guidance which advised people to not leave their homes except if they needed to see their GP in person or attend planned hospital appointments.

12 NHS Digital measured mortality rates using a seven-day rolling average.
13 Mortality also peaked to this level on 7 April.

Figure 11

COVID-19-related mortality rates for clinically extremely vulnerable (CEV) people and an age-matched general population sample, March to August 2020

The COVID-19 mortality rate for CEV people peaked on 9 April and started reducing earlier than that of the general population, which peaked on 14 April. It is not possible to reliably estimate what the mortality rates would have been if shielding had not been implemented



Notes

1 COVID-19 mortality rates are defined as those where COVID-19 was mentioned anywhere on the death certificate.

2 NHS Digital tracked health outcomes for people who were on the shielded patient list at 18 April; this includes approximately 1.6 million of the 2.2 million CEV people identified.

3 For the age-matched general population sample, NHS Digital selected a random sample of the general population, which comprised one million people.

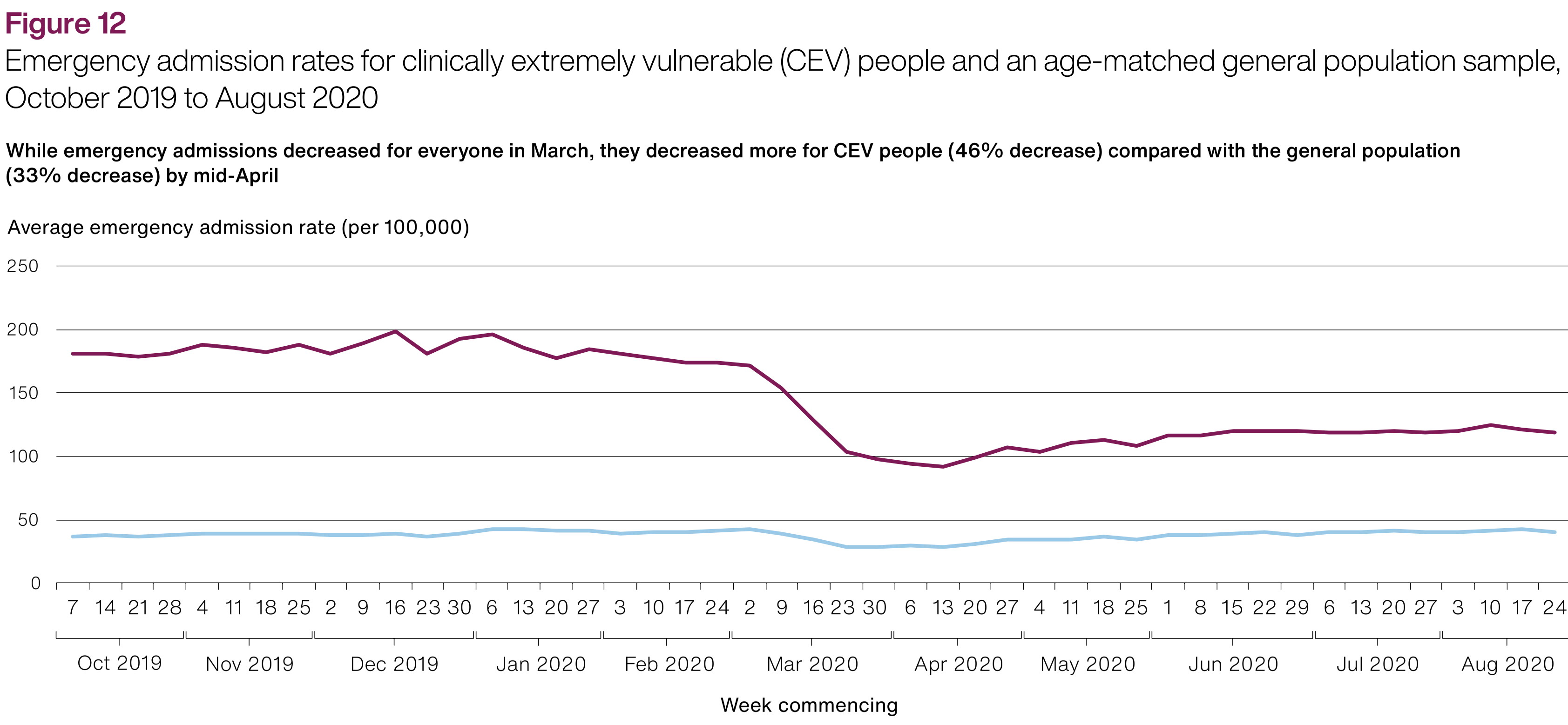
4 The COVID-19 mortality rate for CEV people peaked on 7 and 9 April.

Source: National Audit Office analysis of NHS Digital data

Figure 12

Emergency admission rates for clinically extremely vulnerable (CEV) people and an age-matched general population sample, October 2019 to August 2020

While emergency admissions decreased for everyone in March, they decreased more for CEV people (46% decrease) compared with the general population (33% decrease) by mid-April



Notes

1 NHS Digital tracked health outcomes for people who were on the shielded patient list at 18 April; this includes approximately 1.6 million of the 2.2 million CEV people identified.

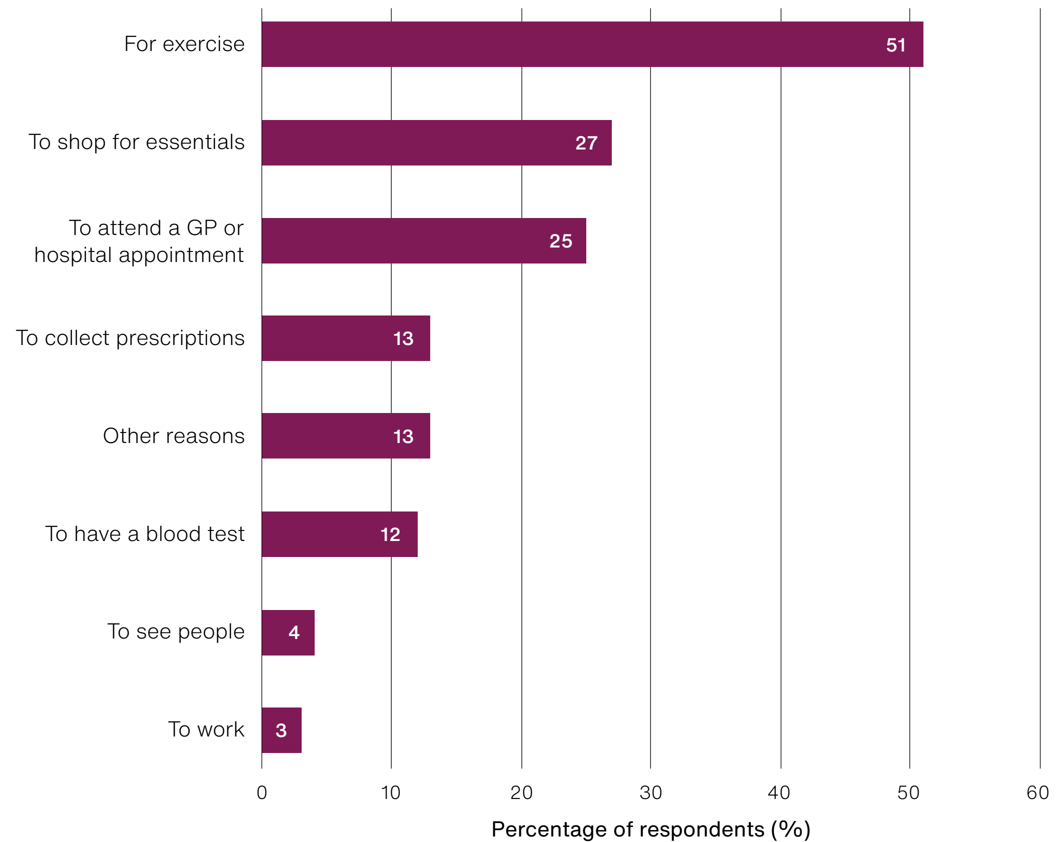
2 For the age-matched general population sample, NHS Digital selected a random sample of the general population, which comprised one million people.

Source: National Audit Office analysis of NHS Digital data

Figure 13

Reasons why clinically extremely vulnerable (CEV) people reported leaving their home or garden, 14 to 19 May 2020

Between 14 and 19 May, of the CEV people who said that they had left their homes and gardens in the past seven days, 51% reported it was for exercise and 27% reported it was to shop for essentials



Notes

1 From 14 May to 16 July the survey was conducted five times, approximately every two to three weeks. We have chosen to use data from one survey conducted between 14 May and 19 May to avoid reporting behaviour that occurred after shielding guidance changed.

2 The base population for the percentages is those who left their home or garden since receiving shielding guidance – 49% of people who responded.

Source: National Audit Office analysis of Office for National Statistics Shielding Behavioural Survey data

Ending support

4.9 Some 220,000 people were still receiving food boxes in the final week of the Programme at the end of July 2020. CEV people were still eligible for priority supermarket slots if they had registered before 18 July. The Department for Environment, Food & Rural Affairs' (Defra's) original contract with Bidfood and Brakes ran to 3 July, and on 4 June Defra signed an extension to continue provision to 3 September. Within three weeks of agreeing the extension, Defra had to serve a termination notice giving rise to contractual termination costs of £3.8 million, although Defra negotiated this down from a potential £6.9 million. NHS England & NHS Improvement (NHSE&I) continued to commission the medicines delivery service as needed to support local lockdowns. Following the pausing of shielding nationally, CEV people in local outbreak areas were advised to continue shielding and were able to have their medicines delivered to them and access support from local authorities. Local authorities were no longer expected to meet CEV people's basic care needs and were encouraged to make use of local community groups and the NHS Volunteer Responders, who continued to provide help.

Lessons learned and the second lockdown

4.10 It is evident that the departments involved in the Programme actively considered lessons learned which they applied to shielding during the second lockdown from 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. Following engagement with local authorities, the review 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. MHCLG has also conducted a formal lessons learned exercise, which focused on the support element, not the identification of, or communication with CEV people. The departments involved in the Programme have all contributed. This exercise was finalised in December, four months after shielding was paused and after the second lockdown.

4.11 It is clear that the departments have still applied many of these lessons to this second iteration of shielding. For example, MHCLG introduced a new national shielding service system, which allows CEV people to register their needs more easily. This has been well received by the local authorities with whom we spoke (**Figure 14** on pages 48 and 49).

Figure 14
Lessons learned and applied in second lockdown, November 2020

The departments have considered and applied many lessons to the second lockdown

Features	Phase one of shielding (22 March – 1 August 2020)	Developments and lessons learned	Lockdown two (5 November – 2 December 2020)
Identifying clinically extremely vulnerable (CEV) people and creating the shielded patient list (the List)	The criteria were based on clinical understanding and agreed by the chief medical officers (Appendix Three).	The Department of Health & Social Care (DHSC) is working to apply the predictive risk model to enable a more sophisticated approach to clinical risk in conversations with GPs and clinicians. The model incorporates known relevant risk factors such as age, sex, body mass index (BMI) and ethnicity alongside long-term health conditions and specific treatments. Timings for the model are uncertain.	The conditions identified originally remain unchanged with two additions: • chronic kidney disease (stage 5) and those undergoing dialysis; and • adults with Down's Syndrome.
Model for support	Centralised and universal offer to all who met CEV criteria.	The government's early lessons learned review 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.	Support offered to all CEV people as set out below.
Registering for help and reporting requests to local authorities	The Government Digital Service (GDS) set up 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. GDS shared information from the website with the contact centre and local authorities.	Missing or inaccurate telephone numbers in NHS patient records caused problems when trying to contact CEV people. Local authorities unable to feedback data inaccuracies and allows users to see changes immediately. GDS has developed an accounts-based system for people to request help: people can login, review and update personal details and support preferences.	A new web-based national support system (national shielding service system) was set up for CEV people to register for help which used the accounts-based system. Local authorities could use this national support system to help CEV people access a supermarket priority slot or support with shopping or access to basic care.
Food provision	Doorstep food box delivery service provided to CEV people, at their request.	That local support along with greater use of supermarket deliveries would be more efficient.	No offer of centrally commissioned food boxes. Local authorities supported CEV people with access to food. Government provided £32 million non-ringfenced funding to unitary and county councils in England to support CEV people (£14.60 per head as one off payment) between 5 November and 2 December, including for food support and basic care.

Figure 14 *continued*

Lessons learned and applied in second lockdown, November 2020

Features	Phase one of shielding (22 March – 1 August 2020)	Developments and lessons learned	Lockdown two (5 November – 2 December 2020)
Basic care	Government asked local authorities to offer to provide basic care for CEV people.	The term 'basic care' caused some confusion as many local authorities are required to provide social care, which has a statutory definition.	Guidance to local authorities changed. Amended terminology to 'basic support' to make this clearer.
Medicines	CEV people could get help through the medicines delivery service, and register for help from NHS Volunteer Responders.	No specific learning point.	No change. CEV people could still get help through the medicines delivery service, and register for help from NHS Volunteer Responders.
Sharing data across central and local government	Systems not capable of 'speaking' to each other across hospital, primary care, specialist and adult social care services.	Possible solutions discussed across DHSC, other key departments, and wider local authority stakeholders.	Systems still not capable of 'speaking' to each other although the new national shielding service system aimed to improve government's ability to view and analyse data on CEV people and their needs.

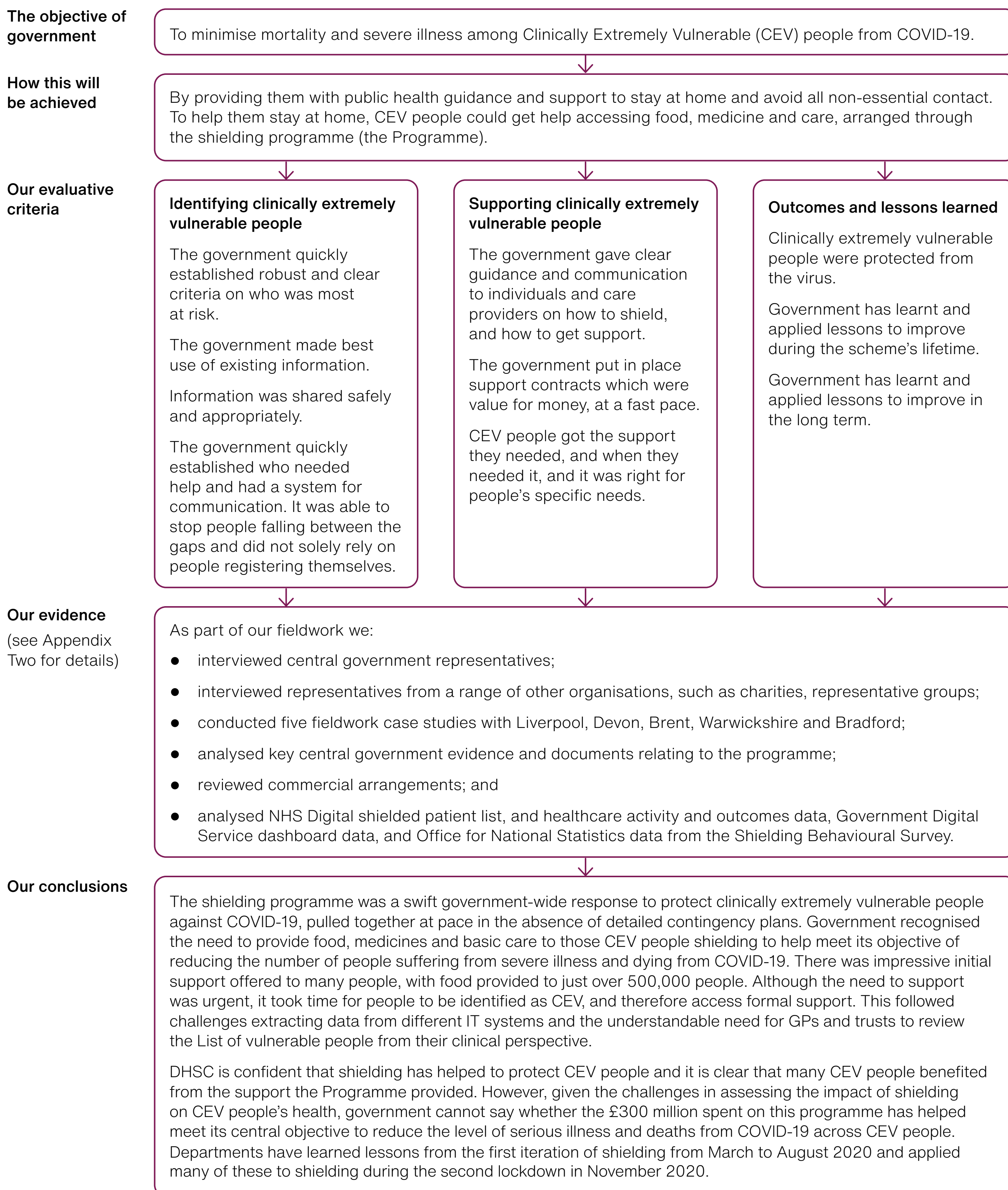
Source: National Audit Office analysis of documents from the Ministry of Housing, Communities & Local Government, Department of Health & Social Care, NHS England & NHS Improvement, and Government Digital Service

Appendix One

Our audit approach

1 See **Figure 15**.

Figure 15
Our audit approach



Appendix Two

Our evidence base

1 We assessed the effectiveness of the shielding programme (the Programme). We analysed how effectively the Department of Health & Social Care (DHSC) and NHS Digital identified people who were most clinically vulnerable to the virus and how effectively they supported these people in terms of providing food, medicine and basic support under the Programme.

2 We analysed NHS Digital shielded patient list (the List) data and healthcare activity and outcomes data, Government Digital Service dashboard data, and Office for National Statistics data from the shielding behavioural survey.

3 We interviewed central government representatives from the Ministry of Housing, Communities & Local Government (MHCLG), DHSC, NHS England & NHS Improvement (NHSE&I), the Department for Environment, Food & Rural Affairs (Defra), the Department for Work & Pensions (DWP), NHS Digital and the Government Digital Service (GDS).

4 We interviewed representatives from a range of other organisations. These included representative groups including the Local Government Association and the Association of Directors of Public Health. We also spoke to and/or considered evidence from charities who represent people who were among those advised to shield. They include National Voices, Carers UK, Age UK, the Neurological Alliance, Kidney Care UK, Versus Arthritis, The Patients Association, Scope, the Asthma UK and British Lung Foundation Partnership.

5 We reviewed documents relating to the development of the List, governance and reporting arrangements, communication between DHSC, NHSE&I and clinically extremely vulnerable (CEV) people. We also reviewed documents outlining engagement with local authorities.

6 We reviewed commercial arrangements relating to the DWP contact centre and Defra contracts with Bidfood and Brakes.

7 We conducted five case study interviews with local authorities in October and November with Liverpool, Devon, Brent, Warwickshire and Bradford. We also spoke with members of the Stakeholder Engagement Forum.

Appendix Three

Definition of clinically extremely vulnerable groups (March 2020)

1 Solid organ transplant recipients.

2 People with specific cancers:

- People with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer.
- People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment.
- People having immunotherapy or other continuing antibody treatments for cancer.
- People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or pharmacological inhibitors of the enzyme poly ADP ribose polymerase (PARP).
- People who have had bone marrow or stem cell transplants in the last six months, or who are still taking immunosuppression drugs.

3 People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease (COPD).

4 People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as severe combined immunodeficiency disease (SCID), homozygous sickle cell).

5 People on immunosuppression therapies sufficient to significantly increase risk of infection.

6 People who are pregnant with significant heart disease, congenital or acquired.

Appendix Four

Commercial arrangements

1 See **Figure 16**.

Figure 16

Commercial arrangements on key shielding contracts from 20 March 2020

The Department for Environment, Food & Rural Affairs awarded a contract for doorstep delivery of food boxes. The Department for Work & Pensions awarded a contract for an outbound contact centre

Awarding body	Department for Environment, Food and Rural Affairs (Defra)	Department for Work & Pensions (DWP)
Suppliers	Brakes and Bidfood	Serco
Contract for	Doorstep delivery of food boxes	Outbound contact centre
Contract spend	£200.2 million	£17.5 million
Procurement route	Urgent Regulation 32(2)(c) direct award	Urgent Regulation 32(2)(c) direct award from call centre framework contract
Conflicts of interest	Considered. None reported. Not noted in regulatory procurement report	Considered. None reported. Noted in regulatory procurement report.
Market engagement	Thirty-four providers approached in market engagement exercise (19 March) exploring range of delivery models	Eight providers on contact centre framework, all of whom approached
Provider selection	Only two providers Defra reported were willing to negotiate on service	Only framework provider DWP reported had capacity to meet requirement
Service dates	27 March to 3 July with three-month extension option	20 March to 11 June with six-month extension option
Contract signature	23 April, with weekly letters of intent from 27 March	5 April
Contract transparency	Contract award details published: EU – 6 May UK Contracts Finder – 6 May	Contract award details published: EU – Not applicable UK Contracts Finder – 30 April
Payment mechanism	Flat content/packing fee per box Delivery cost per box varies according to weekly delivery volumes	Hourly rates for available call centre agent hours. Management fee varies according to number of agents deployed. Fixed set-up costs
Termination clauses	Termination for convenience – 45 days' notice	Termination for convenience – three months' notice
Contract extensions	Extension 3 July to 3 September	Extension at reduced capacity 12 June to 23 July Extension for stand-by services 24 July to 19 September
Contract end	Termination notice served 22 June to end contract 6 August; £3.8 million exit costs	19 September

Note

1 The £17.5 million cost of the contact centre relates to Serco contract only. Elsewhere in the report we use £18.4 million as cost of whole contact centre service, which also includes programme management payments to KPMG.

Source: National Audit Office analysis of Department for Environment, Food & Rural Affairs and Department for Work & Pensions information

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