HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Covid-19: Supporting the vulnerable during lockdown, HC 938

Monday 22 February 2021

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Watch the meeting

Members present: Meg Hillier (Chair); Olivia Blake; Sir Geoffrey Clifton-Brown; Peter Grant; Mr Richard Holden; James Wild.

Gareth Davies, Comptroller and Auditor General, Ashley McDougall, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-98

Witnesses

I: Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; Jeremy Pocklington CB, Permanent Secretary, Ministry of Housing, Communities and Local Government; Dr Jenny Harries, Deputy Chief Medical Officer, DHSC; Lee McDonough, Director General, DHSC; David Kennedy, Director General, Food, Farming and Biosecurity, Department for Environment, Food and Rural Affairs; Ben Llewellyn, Director, Shielding Programme, MHCLG; and Mark Reynolds, Chief Technology Officer, NHS Digital.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General

Protecting and supporting the clinically extremely vulnerable during lockdown (HC 1131)

Examination of witnesses

Witnesses: Sir Chris Wormald, Jeremy Pocklington, Dr Jenny Harries, Lee McDonough, David Kennedy, Ben Llewellyn and Mark Reynolds.

Chair: Welcome to the Public Accounts Committee on Monday 22 February 2021. This is the latest of our sessions looking at how the Government has responded to the covid-19 pandemic. I will say, for anyone who follows our work, that if you follow the hashtag #CovidSpending, you will be able to see a thread going through some of the hearings that we are doing.

Today we are looking at how the Government has supported clinically extremely vulnerable people during lockdown. Those of you who can remember back to March 2020 will know that the Government initially contacted 2.2 million clinically extremely vulnerable people and told them they needed to stay at home for 12 weeks at that time, and later advised an additional 17 million vulnerable people to exercise caution, in order to protect themselves from the virus. The Government provided food packages for some of these people, and some of it was provided at local level. There was also support to collect medicine, and extra, additional care support where that was needed.

We are asking today how that went, what lessons there are to be learned and, given that we are still in lockdown, whether there is anything that needs to be happening now and what lessons in particular are learned on the perennial issue of what should be provided centrally and locally.

I am delighted to welcome a suite of witnesses today. We have Sir Chris Wormald, the permanent secretary at the Department of Health and Social Care; Jeremy Pocklington, the permanent secretary at the Ministry of Housing, Communities and Local Government; Dr Jenny Harries, the deputy chief medical officer, from the Department of Health and Social Care, and star of the news briefings; Ms Lee McDonough, the director general for the NHS policy and performance group at the Department of Health and Social Care; David Kennedy, the director general for food, farming and biosecurity at the Department for Environment, Food and Rural Affairs, which was responsible for the food parcels in that early phase; and Ben Llewellyn, who is the director of the shielding programme overall at the Ministry of Housing, Communities and Local Government and therefore was working closely with local authorities on how these people were best supported. A warm welcome to you all. I am going to throw first of all, before we go into the main session, to Richard Holden MP for a question about something that has been topical recently.

Q1 **Mr Holden:** This is to Dr Harries. There has been some concern and newspaper reports recently about people with severe learning difficulties—reports that "do not resuscitate" notices are being used widely in hospitals, which is leading to a higher mortality rate for those from this group who have got covid. Could you comment on this, please?

Dr Harries: Clearly, I am not overseeing the work directly in the NHS but, on a purely clinical process, I am very sure that is not an approach which clinicians would routinely be taking. I think there have been a number of notices out to the NHS during the pandemic, where clearly people are concerned about their welfare, to ensure that everybody has entirely appropriate clinical care. Obviously, as I say, I am not part of the NHS, and colleagues may want to respond. Ms McDonough may want to respond on that one as well.

Lee McDonough: I don't think I have anything to add to what Dr Harries has said, actually.

Q2 **Mr Holden:** Can I push you on this, Ms McDonough? The DHSC has said it is completely unacceptable for these notices to be issued. Given the real fear from people with severe learning difficulties themselves and also their families and carers, can you just reiterate today that it is definitely, absolutely your cast-iron policy that there should be no blanket "do not resuscitate" in these areas?

Lee McDonough: I can confirm that that is the policy, yes—no blanket approach.

Q3 **Mr Holden:** Okay. More broadly, there is another issue that flows from this, which is the vaccination programme and people with Down's syndrome and certain other learning difficulties needing to get vaccinated more quickly because they are at much greater risk. Can I press you, Dr Harries, on this a little bit? Why weren't some of these people in higher risk category groups, particularly the top four, when we knew the risk to these people?

Dr Harries: I am very happy to answer that. The recommendations for the order of vaccination came from the independent Joint Committee on Vaccination and Immunisation. Having said that, they have gleaned information from a number of different sources, including from the work that we have been doing in the clinically extremely vulnerable programme. The order of prioritisation, as I think many of you will know, is based at this stage of the pandemic on the risk of mortality—so those who are at increased risk of serious outcomes, particularly of death. Where that information has been made available, it has been reviewed in great detail. In fact, the clinically extremely vulnerable programme—the shielding programme—for which I provide clinical oversight, particularly added, for example, Down's syndrome adults as the information on increased risk, which you have described for that group, became available last autumn. So, as soon as there is good evidence, we absolutely act on that as quickly as possible.

Using that as an example, adults with Down's syndrome are within the clinically extremely vulnerable group 4 and should have been vaccinated already. JCVI has recommended that those with severe and profound disabilities should be included in group 6, and that will also include individuals with learning disabilities in residential care settings. We know that those contained settings themselves contribute to an increased risk.

Finally, many of you will be aware that the population risk assessment tool was launched last week. It uses the QCovid research, which again included learning disability to identify any people who had a learning disability and other conditions that moved them into that higher risk bracket. For other people with mild or moderate learning disabilities, there is not strong evidence yet. Although it is really important that this group had very strong advocacy, in part because of the potential increased difficulties of communication following guidance, the LeDeR report and the PHE report, which you might be aware of, have been considered by JCVI and also by the clinical shielding panel.

Q4 **Mr Holden:** One final question on this, Dr Harries. Obviously the residential care sector was particularly badly hit in the early stages, particularly for those in older age categories. Some of the most vulnerable in residential care settings had severe learning difficulties. In retrospect, do you think that vaccinations in those settings for some of these groups should have been given a higher priority?

Dr Harries: What we have there is a number of different angles on the evidence. One, as you say, is for those in older care settings. We know that the contained setting is a higher risk environment for many individuals, so we might, for example, compare with prison settings as well. These are high public health risk settings, and you have some of the frailest individuals in those that cater for older age, so that was why they were included as a priority. However, that does not necessarily apply to all settings. It is one of the component features. In fact, the QCovid research, which I referred to a moment ago, includes an element that looks at the risk associated with contained settings, so it is very much about individuals with their combination of risk factors in those settings. As I said, that is why learning-disabled individuals who are in residential care settings are prioritised in group 6.

Q5 **Mr Holden:** Sorry, Dr Harries, but you didn't quite answer my question. In retrospect, do you think that they should have been prioritised? Given the much more difficult nature of residential settings with the ease of spread there, and the much higher mortality rates for people with learning difficulties—obviously, if you are in a residential care setting, you are naturally more vulnerable, and probably have more severe needs—should that have been changed, and will it be something that we might reassess for potential future pandemics, learning from this?

Dr Harries: Clearly, the JCVI sets the prioritisation agenda. I was trying to explain that when you take into account those different components—the residential care setting and the individual risk—it does not always mean that individuals have a high risk of mortality. It is very much a

combination. That is why we have older, frailer individuals in residential care settings right in the top group, because we have evidence of high mortality. By the time we take out, for example, the adults with Down's syndrome, whom we absolutely recognise have increased risks, it very much comes down to a combination of pictures, and that is exactly what the Q risk model does.

In summary, to answer your question, it is not a blanket recommendation. We recognise the risks around care settings, but it very much depends on the other characteristics of the individuals who are within the care setting. Some of the problems with the LeDeR and PHE reports are that the individual characteristic risk variables are not untangled in those reports, and that is what we have tried to do by looking in very detailed ways at other evidence.

Sir Chris Wormald: I just want to add, on Mr Holden's question, that I do not think it is a question whether we would have done things differently in retrospect, because what has happened has been that our knowledge of the disease has advanced all the time and we have updated as we have gone along.

On the second half of the question: are we learning from it? Yes, all the time. We update what we know about the disease, and therefore how we prioritise people, as more knowledge becomes available about the effects of the disease. That has happened right from the beginning. We will continue to do that. As new clinical information comes to light, we will continue, and I am sure that JCVI will continue to update its guidance as a result.

Q6 **Chair:** Dr Harries, you talked a bit about the vaccines and how they are rolling out to different groups. However, locally and nationally, we have been struggling to get meaningful data on that. Can you shed any further light on when we will have a breakdown of what percentages of which groups have had the vaccine? Will that be broken down regionally and so on?

Dr Harries: Colleagues may wish to comment on this, because again it is something that I do not oversee directly. I absolutely recognise the importance of people's questions, particularly in relation to minority ethnic groups and the importance of very vulnerable populations, to which I am sure you are referring.

My understanding is that directors of public health have access to that data, and increasingly that is reported in the public domain. The issue is that we have to be very careful about stigmatisation of groups, so, as with individual clinical data, it is important that we do not stigmatise communities as well. There is quite a difficult balance to achieve on this.

A huge amount of work is ongoing to ensure that populations who have perhaps been less forthcoming in accepting vaccination are equipped with all the right information, including translating that into languages or sensitive ways to approach individuals. Directors of public health with their

local communities are the most relevant people to have that. They have a special link, if you like, to ensure that they have access to much more granular information.

Q7 **Chair:** In your view, is that something they should be willing to share with MPs or local authorities—though obviously they work in a local authority setting? Or should it not be published, or should they be willing to publish it locally?

Dr Harries: My natural starting point is for almost all scientific information to be published—we should be absolutely transparent. My only caveat, as I was trying to highlight, is that we need to be very careful because we want to encourage groups to take the vaccine. Some are, historically perhaps, a bit more reluctant on vaccination. If we push too hard and too publicly, they might not have the time to absorb the information that specialists are trying to get across, increasingly and very importantly, through their own local leaders. That is an important area of communication.

Q8 **Chair:** I see Sir Chris anticipating me coming to him on this. I have been asked by the Alevi Turkish faith group to do a plea for them—and there are other groups that wish to be highlighted. They actually want to know this information so that they can spread the word among their own community. Picking up on what Dr Harries has said, Sir Chris Wormald, as permanent secretary, do you think we should be getting this information in real time, and is there any reason why we are not getting that granular data?

Sir Chris Wormald: What I was going to add is that the reasons to be careful are exactly as Dr Harries set out. We are looking at this right now—at balancing the two factors that have been set out in this meeting: one is the benefits of transparency, as you have set out, Chair, and the second is some of the confidentiality questions that Dr Harries set out. As I say, we are looking at whether we can go further with granular publishing.

Q9 **Chair:** Sir Chris, just to be clear, what is the barrier to providing this information? Is it the squeamishness about telling a group of people that they are not taking up the vaccine at pace, or is it that you are worried that the roll-out is not uniform across the country?

Sir Chris Wormald: There are two. As we discussed with this Committee previously, we have to be very clear that everything we publish is accurate. As you know, we have been criticised, including by this Committee, in other contexts, about this. We have to be sure that whatever we publish meets the correct statistical standard. The second is the stigmatisation question that Dr Harries raised. We are looking at this right now and we will go as far as we can on granularity, but we see the same advantages as you, Chair.

Q10 **Chair:** But, Sir Chris, we have been vaccinating happily and successfully since December, and very rapidly and at a huge pace, as we have acknowledged as a Committee. We have been world beating at getting

the vaccines, and the roll-out has been going very well, but isn't there a danger that a Government Minister will name a headline figure beneath which there are problems? I still don't understand what the problem is with providing more granular data. You may decide not to go absolutely granular for the protection of certain vulnerable groups, but I can think of very few where it would be a big problem. You say that you are only just starting to look at this now. We have been doing it for some time. It puzzles me.

Sir Chris Wormald: We basically agree with you, but we want to proceed properly and carefully in this area, for reasons that I have set out.

Q11 **Chair:** But, Sir Chris, in meetings with Ministers, MPs have been asking for this data repeatedly—and it is not just MPs, I am sure, but this is certainly the case in the meetings we have been privy to—since January, week after week, and you are just looking at it now. That is what I am puzzled about—why isn't there a more definitive answer and why aren't you providing the more detailed information? We are hearing an announcement every day about the number of people who have had a vaccine, so breaking it down by age or group in a broad sense would be pretty easy, I would think. Certainly, granularity by very specific ethnic background might be harder, but surely doing so by age and cohort and area would be easy to do.

Sir Chris Wormald: Perhaps I should write to you setting out the full position, but it is not as straightforward as you might imagine. For example, our headline population index that the ONS produces is not broken down at very local level. We actually use two different data sets depending on whether we are using national numbers or local numbers, and which is the best population index. It is unfortunately more complicated than—

Chair: Fine, okay. What I would suggest—

Sir Chris Wormald: As I say, we have been criticised previously for using numbers which people felt were not statistically valid, and I am afraid you can't have it both ways. But I will write setting out the position. On the general principle, we agree with you: the greater the transparency, the better, for reasons that Dr Harries set out. I will write setting out the full position.

Chair: We appreciate that the statistics need to be accurate, but there is also a great cry out there for more information. That information would help all of us on this call, help the public understand when their turn is coming, and help make sure that we are all playing our part and waiting our turn before we get our vaccines. *[Interruption.]* Yes, because I am certainly not old enough yet to have been in the first cohort. It is the one time in life when it would have been great to be 20 years older—or 30 years older, even; I am just shaving 10 years off my life there—but hey.

Thank you very much indeed for that. We will now go into the main session, looking at the support for the most clinically vulnerable people. I will ask Olivia Blake to kick off.

Q12 **Olivia Blake:** My first questions are to Dr Harries. What is the latest guidance to those who are shielding?

Dr Harries: For those who are shielding, last week we extended the guidance to 31 March. Obviously, we are in a national lockdown at the moment. That is quite a precautionary piece of advice, and letters go out to every single person on the shielded patient list, so they receive an individual letter. That is because, as well as giving them all the information and signposting they need for support, it also provides them with their access to financial support, should they need it, to maintain shielding.

I should highlight of course that that often gets confused, so this is a good opportunity for me to say that this is for personal protection, and individuals can choose. It is not in any way a legal requirement to shield; it is for individuals to take up that support offer if they wish to, and we advise them to. The reason we are being a little precautionary at the moment is that, as many of you will be aware, it is a difficult changeover time. We have, as has been noted, a very successful vaccination programme in action, but we have new variants that we are starting to monitor, and we will be starting to change some of the lockdown measures. That whole combination means that many of the shielding population will feel much more comfortable having that date ahead and having some assurance in the interval.

Q13 **Olivia Blake:** On the new tool that is being used—the Q risk model—and the 1.7 million extra that came through in the media last week, are you confident that that number is accurate?

Dr Harries: The work that has been done to use QCovid, which is what you are referring to, stems from work very early on around recognising that our binary clinical approach, if you like, did not necessarily pick up all the potential risk factors, as I described earlier for learning disability. We have cast the net quite wide so that the number represents just about the right number of people who we will be contacting. Some of those letters will have gone last week, some of them are going this week, to the older population, because they will already have received their vaccination, and as we are in lockdown, they are protected.

What we will find, because of that highly precautionary approach, is that over time, some of those numbers will reduce. In fact, our communication says very clearly, "We may have overestimated your risk". That is intentional to make sure that we capture anybody who we think is genuinely at increased risk, but also to signal—hopefully in a sensitive way of communicating—to those who may perhaps be a little alarmed by receiving a letter. This very novel way of reaching out to people in all sorts of different ways has not been tried, as far as we know, by any other Government. I do expect those numbers to decrease slightly as we go forward, and as always, any patient can discuss with their clinician and come off the shielded patient list if they do not wish to stay on.

Q14 **Olivia Blake:** Going back to the tool, why has it taken such a long time to roll it out? I read that it reported back in October. Do you think that if

you had rolled the tool out a bit earlier it would have had an impact on hospitalisation?

Dr Harries: I cannot answer the second point. We may come back to these sorts of things about understanding. What we have tried to do is something entirely novel. Perhaps I could just draw a parallel, if you like, with vaccine development. This is something that has never been attempted before. As far as I am aware, it could not be in most health systems because it depends on having the national health system. It is highly complex to deliver, because of the working across different systems—myself, clinical, NHS Digital, and out to communities. The most important thing is that this particular approach has an academic element, which is the part you referred to, a clinical element and a technical element. All those need to be assured as we go forward.

In fact, in 10 months, we have done completely novel research—or rather, it was led by Oxford University. That has been peer reviewed, as you referred to, and published in the *BMJ.* It has then been evaluated: it was evaluated first against a population of 8 million, and it was then externally evaluated with the ONS. It was shown to have extremely high concordance levels—so, a very high statistical, Harrell's C output. We have then done a clinical evaluation. It is now an MHRA-registered tool, so that has to go through that whole process in the same way that a vaccine does. Finally, NHS Digital then have to put it through their own technical governance and assurance processes, so I would slightly push back and say that if we have done all of that in 10 months, that is pretty good going.

Q15 **Olivia Blake:** Given how streamlined the vaccine programme was, do you think that this could have been done faster, or do you think you worked as quickly as you possibly could on this?

Dr Harries: If anything, I would say the vaccine programme started with a slightly—you know, we know how to deliver vaccine programmes. There are systems set up. That is not to diminish any of the novel science and the distribution implementation through the NHS, but this is entirely new, so I would like to think people should be actually applauding the work that we have done, and it is very, very cross-system. QCovid involves academic, technical, clinical and colleagues from communities and local government who may well come in shortly, so I think it would have been very difficult to deliver it in any closer a timeframe.

Q16 **Olivia Blake:** Given that 1.7 million extra have been added, do you think that the advice to those who were probably seen as medium risk before but may find themselves at high risk now was adequate, and do you think there needs to be stronger messaging to that group until the roll-out of the vaccine is finished?

Dr Harries: Obviously, as the permanent secretary has said, we are learning as we go along, and we did not have any information on this particular virus when we started off. In fact, if we look back at children, for example, which is a slightly different group, we overestimated the risk, which I think people would welcome in many ways. We tried to protect the

children, and then took them off as we recognised that the risk to children has decreased. What I think we now have with QCovid now is a mechanism of identifying individuals who have combined risk factors, including personal characteristics, which will pull them to the top of the list of those people who have underlying health risks. I think it is helpful to clinicians to be able to do that, and it is the right thing for patients as well.

Q17 **Olivia Blake:** Do you think that the focus on clinically vulnerable factors in the beginning of this programme led to the exclusion of these issues of ethnicity, multiple morbidities, and socioeconomic factors that are now pulled in? Do you think that if Public Health England were running this, they would have picked up on those, given that a public health response would take those factors into account?

Dr Harries: Perhaps to start backwards, I was a previous Public Health England employee and have recently been a director of public health, so my natural thinking pattern, if you like, is "What would this feel like if I were in a community as a DPH?" I think the answer is no, and the reason for that is we have to learn from the evidence that we have as we go along, which is exactly what has happened.

The original guidance was for the clinically vulnerable. We knew age was the predominant risk factor, and that is still true. We provided advice for the clinically vulnerable and those with underlying health conditions—quite general advice—but this particular programme, which we now call the shielding programme, is actually for the very high-level clinically identified individuals. This is quite specialist, and to pick up on your latter point, what we have been able to do as we have learned more about the disease is understand how we can pull some of these additional risk factors into that.

On your point about ethnicity, for example, we considered that at length at the start of the programme. However, what we now know from the work of the SAGE ethnicity sub-group, and from watching the virus move across the country and the different communities it affects, is that the predominant issues are around socio-demographic features, which is characteristic of infectious disease. They tend to go to more underprivileged societies, and that will be because of more people in housing. We know all the issues that affect respiratory virus transmission, but what QCovid does is start to add a particular dimension: it adds both the postcode and an ethnicity rating to try and pull that more into line, to fit with supporting individuals who may be more adversely affected.

Q18 **Olivia Blake:** Do you ever consider healthy life expectancy as a factor that could play into making these lists?

Dr Harries: In what dimension?

Olivia Blake: Looking at areas in the country that perhaps have a worse healthy life expectancy, and seeing whether there should be a regional approach to some of this.

Dr Harries: I know JCVI have looked at that in terms of vaccination. When we looked at these clinical conditions for both the clinically vulnerable and the extremely vulnerable, in some ways, sadly, that is accounted for by the underlying health conditions. If you have an area of deprivation, you expect to find, sadly, different people with lower life expectancies, and they are in that position because they have multiple underlying health conditions. Both the CV guidance and the CEV guidance picks that up. I think the QCovid picks it up in a much more nuanced way and allows us to reach out to individuals who are most affected.

Q19 **Olivia Blake:** Given the higher mortality rate, particularly in ethnic minority groups, do you now think that this was the correct approach?

Dr Harries: Obviously, if you have a condition such as homozygous sickle cell disease, that will be picked up in the specialist category that we have listed within the clinically extremely vulnerable group. There will be a few more examples of that as well. But it is really important to reiterate that ethnicity itself is not necessarily a marker of disease. It is a very small component of it, so it is really important that we understand how those communities are affected. As I say, that is how the QCovid tool helps us to account for that. I am sure that, in time, we will be starting to unpick that. We have already, with things such as evidence around risks of infection in multi-generational households.

Q20 **Olivia Blake:** This question is to Sir Chris Wormald; it is about planning ahead of the pandemic. Were shielding or at-risk groups part of emergency planning for the pandemic? Had some of the key issues that came out in the early stage of the pandemic been planned for, and did you have any plan in place that was ready to roll out if we entered a pandemic?

Sir Chris Wormald: Not in the way that we ran the programme, no. As Dr Harries said, we believe what we have done is entirely unique in the world. It certainly has not been done in the UK before. We are not aware of anywhere that has done a similar programme internationally. We did of course have some things to start with. The original list of the most vulnerable drew very heavily on the flu list and the flu vaccination list, which has many of the same categories, but what we have done, as Dr Harries has described, is tailored to the particular disease that we have. But as I say, I am not aware that anywhere has done a programme on this or planned for it.

Q21 **Olivia Blake:** Why did it take up until 12 April for there to be access to GP data?

Mark Reynolds: I will take that question. The conditions that were used to identify people from the shielding list were identified by the chief medical officer on 18 March. We had those conditions. It was not possible to generate the shielded patient list; we needed that to be had. When we first developed the list, we used the data that was held by NHS Digital. NHS Digital is a safe data haven. It does not hold all the patients' records, but it has access to some of the data that it collects.

Within two days, we were able to create the first list using hospital data, which had roughly about 900,000 patients on it. In order to expand that, we then needed data from GP IT systems—we did not hold that nationally. We worked with GP IT system providers to design, build and gather that data, and then run it through and identify from the user data that was given the specific patients with those conditions. That took us three weeks. From nothing at all, to having a list of 1.3 million patients, took us three weeks. If you put that in the context of the time it has taken to generate QCovid, you can see that was done incredibly fast.

Once that data was available, we made it available to GPs and hospital doctors, so they could review it. That was the right thing to do, because having generated a list of 1.3 million patients, we did not want the GPs and hospital doctors to have to start from scratch; the whole point was to save them time at the point where they were incredibly busy.

Then, a few weeks later, we gathered that review. I think that one of the important things for this Committee to understand is that that was a clinical review and therefore it required the clinicians to consider who should not have been on the list but had been included by us as a precaution, and who was missing but needed to be added in. So, on 18 April we had our 1.8 million, which was the majority of the list at that point.

Q22 **Olivia Blake:** Can I just ask a bit more about joining up data? This is obviously an issue for the NHS more generally, but in this instance why was it difficult to join up the data between hospitals' and GPs' systems? And what could be done to resolve that going forward?

Mark Reynolds: I would not characterise it as difficult. I think taking three weeks to get the data from GP systems is incredibly rapid; normally, this would be something you would plan over four to six months. In part, we were able to do it that fast because of the investment in IT that had been made.

What I think the shield patient list was able to do was to make sure that we could bring together the different aspects of patient care, both in primary care—under a GP—and in hospitals. The power was being able to bring those two things together and have the complete picture, especially with patients who, by definition, have conditions that bridge across primary and hospital care.

Q23 **Olivia Blake:** Do you have a view on that, Sir Chris?

Sir Chris Wormald: No—I do not have very much to add to what Mark has said. We have some advantages over the rest of the world here; we are the biggest health jurisdiction and able to bring an awful lot of data to bear. And as you know, we have some disadvantages around how some of our IT systems work, which this Committee has looked at before.

The only other thing that I would add is a very important thing about this whole programme and partly about why some of these things take a little time. It is because we have gone for neither an entirely algorithmic-

created system or an entirely human judgment system. What we have tried to do throughout is to do as much as we can entirely data-driven, for speed and to keep the workload on clinicians down, but then to have an element of individual clinical judgment, particularly by GPs, about the final list. That is because we are very conscious of the data being at either end of the spectrum, although most of what we have done has contained those two elements, which adds a little time, but we feel that it gives us a better result.

Q24 **Olivia Blake:** Do you mind me just following up and asking if you feel that you have learned anything fresh about any strength or weaknesses in the NHS data that you have?

Sir Chris Wormald: We have confirmed what we knew already, which were the two things that I said: the enormous power we have from having an NHS and its data bubble; and some of the challenges, particularly of legacy IT systems. Those, of course, are the big things, but we and you knew those things already.

I might ask Mark whether he has some other specifics.

Mark Reynolds: I think they are really good points. There is definitely stuff that we have learned, which will roll forward into further initiatives.

If I had one big ask, it would be around investing in additional digitisation of hospital records. We could see that the fact that general practice has completed its digitisation journey allowed it to be a much richer source of information than hospitals.

Q25 **Mr Holden:** Dr Harries, one of the things we are looking at is the massive changes between what happened in April and what happened in May. The range of increase during that time was huge. Some areas had 15% of people added to lists, which is sort of understandable—my area was at the lower end—but we saw 350% of people added to some of the lists in other areas. How can that anomaly be accounted for from your end?

Dr Harries: I don't think it is an anomaly. I go back to what Mark Reynolds just said. There were some specified processes through this, and as the permanent secretary said, it was very much to ensure that people were added on in as systematic a way as possible, but with that clinical oversight. As a clinician, I really support that. We often think of the CEV group as a group, but they are not. They are made up of hugely different varying conditions, and varying numbers. You can have minority diseases with a handful of people. It is also a living list and it continues to grow. We add people and take them off as different conditions or treatments go.

It has been fairly static from the 2.2 million, going forward, and there were some incremental adjustments as we went on. Those are principally, as Mark explained, the first hospital element, a second specialist clinical element, and then the need for different clinicians to add on their groups. Some of them did that in different ways, and they will have adjusted how they did that at a local level.

In a few cases, we have looked at the representation across different regions to try to understand whether that reflects a genuine underlying illness—a variation between one layer and another—or a different practice between clinicians and, if you like, thresholds for them adding individual patients. Where we have seen particularly marked differences, we have worked with NHSE clinical directors back through the NHS to challenge some of them. In general, we have taken a precautionary approach to make sure as many people as we think should be protected are.

Q26 **Mr Holden:** Okay, so you are working backwards from the clinicians. Given your concern about the idea that people might be getting added in different ways in different areas, how extensive do you think that is? We have seen increases of between 15%, which is sort of understandable, to three and a half times as many after you have already done your six-week baseline assessment, which Mr Reynolds has been talking about. How do you end up with these astronomical increases in numbers? Do you think there is a large divergence on an area-by-area basis in who is in these groups?

Dr Harries: There is a timing issue, and there is a population coverage issue. On the timing issue, between the early dates and when clinicians started adding, there would not only be GP reviews. Running alongside that in hospitals there are, for example, patients on biologics, who need to be looked at by very different specialist groups. We work with each individual specialist clinical group to try to agree guidelines to ensure consistency of patient additions across the country. You will see quite reasonably that you get large changes at the start of this programme, where guidelines are agreed to get consistency and patients are added. Once the guideline is agreed, you will see numbers added.

There will be some variation, which we allow. As I said, we did some work on that. Mark may wish to come in, because we have an oversight group and we report back and discuss some of these clinical variations. If we see a particular signal, NHS Digital helpfully goes back and investigates, and we pick up with clinicians in NHS England.

Q27 **Mr Holden:** Mr Reynolds, do you want to come in on this? How are we seeing variations of essentially 15% to 350%? How is that possible on an area-by-area basis?

Mark Reynolds: We think the most important thing that we did is publish the data publicly so that any local authority or CCG can see the patients allocated in an area and have a breakdown by clinical commissioning group and so forth. From the data, we can see that for the patients who have been added nationally—this is the set of rules that identifies them using codes on their GP or hospital records—there is actually very little variation, and it is pretty much what we would expect on an area-by-area basis. It is just prevalence of the condition.

Q28 **Mr Holden:** So basically, the national data is pretty clear that if you have a condition, you will be on the list wherever you are, essentially?

Mark Reynolds: Essentially, yes. Where there are areas that are higher or lower, we provide that information firstly to NHS England, but in some areas we follow that up and speak to them. To take one area, they talked about how they established a clinical reference panel and they had worked through the rules for their local GPs' flagged patients. They had gone through that process, which seemed entirely appropriate, based on their local population. We took comfort from the fact that this isn't an arbitrary decision as a result of a computer; this is a set of clinical decisions that are asked of the patients.

Q29 **Mr Holden:** Except, Dr Harries, that as we can see from this, and as Mr Reynolds has just said, there is national level where everybody was getting it, but some areas end up with massive increases—multiples in the numbers of people getting recommendations—and other areas have very small increases. Do you agree that we created a total postcode lottery of support, depending on what your local CCG was suggesting?

Dr Harries: I just want to clarify the question; I think the question is, do we think we have covered the right clinical people, if you like? Have we systematically identified people in all these areas?

Q30 **Mr Holden:** We know that occurred at a national level, because it was across the board, yet there were vast differences in the number of people in individual local areas. We can understand a 15% uptick in people needing to be asked, but three and half times as many as nationally were being suggested in other areas. Therefore, do we not know that some people in some areas, with certain conditions, would have got extra support, and different people in other areas, with exactly the same conditions, would not have got that support?

Dr Harries: I think that, as Mark has explained, we did everything possible to ensure that we had a consistent application. In fact, from the work that he has just described, I don't think we have identified any systematic differences across the patch. We do see variation, but where we have looked at whether the guidance has been appropriately applied, we have no evidence to the contrary. At the end of the day, we have to rely on local clinicians to make the decisions about who to add. We can only control so much at the national level.

As I say, I want to flag that the GPs, for example, worked right over the Easter period to ensure that individuals were appropriately added, at great speed, to the list. We have to acknowledge their input to this.

Q31 **Mr Holden:** But do you understand the issue here, Dr Harries? You provided a national consistency, and then you went out to CCGs. Some of those CCGs increased the numbers by 15%; some of them increased them by 350%. Are you saying that in some areas your national system was so out of whack that almost four times as many people needed the support, which your national system didn't put in place? Or, are you saying that your national system was pretty good, but it wasn't perfect, and you needed a bit of extra support from local CCGs? Which is it?

Dr Harries: I don't think I am saying either of those. I think I am saying that our national system was as good as it could be. I think it was pretty good. It started from a hospital base and it involved specialist categories. Then it went out to general practice and local commissioners to add individuals on. As I said, they have worked really hard to ensure consistency, wherever they can.

Right from the start, we worked with the Royal College of General Practitioners, for example, not just through the NHS. They have had training modules to try and ensure that there was a consistent approach and understanding to the individuals who were added. We have worked with stakeholder groups and advocacy groups for different diseases. It is very complex. We would expect variation, to a degree, from one area to another, because of underlying conditions.

Q32 **Mr Holden:** I understand that, but you wouldn't expect four times as many in one area as in another, when you have already accounted for those national issues across the board, would you Mr Reynolds?

Mark Reynolds: The national rules don't cover all the conditions that can be pushed to be added. There are the ones that are defined by the chief medical officer and there was a set recommended by a number of royal colleges. They will be added on top and will have their own regional variations.

Q33 **Mr Holden:** So the chief medical officer and the royal colleges set the national conditions. You then put out to local areas what they could do and said, "Who do you want to add?" Some areas came back with 15% more, some with 350% more. Do you accept that in different areas people with exactly the same conditions would either have been placed into these support groups—the shielding groups—or not placed in them, depending on the local variation, Dr Harries?

Dr Harries: I cannot answer for an individual clinician, especially at a local level. I really need to reinforce that we are dealing with the very top level of the population here. Not everybody has these conditions. It is a very small percentage of the whole population, and therefore a clinician has flexibility to identify those and any other particular elements. We clearly cannot control that at a national level.

Q34 **Mr Holden:** Dr Harries, we understand flexibility, but there is flexibility and then there are people with the same conditions getting support in one area and not another. There was a 15% uplift in the number of people in one area and a three-and-a-half-times uplift in another area. Do you understand that people out there in the country will be concerned that, if they have a condition, they will get support in one area and not in another?

Dr Harries: I also just want to distinguish between the support that came with the inclusion in the SPL. There is a difference between the uptake of support, which will include vast variation, and the individuals who were added on a clinical basis, where there is less differential. Those are two different phenomena.

Q35 **Mr Holden:** Yes, but the variation is in those added to lists by GPs. You are telling me that there is more variation in other areas, and that is absolutely fine, but on those added to lists by GPs, the different is between a 15% increase and a 350% increase. That surely means that people with the same conditions have received different support in different areas.

Dr Harries: People with the same conditions, at the same level, and with the same other clinical circumstances—not only the disease—should have been included in the same way. We cannot, clearly, go down to every GP and check every single patient who has been added. That would not be appropriate, particularly not in a pandemic. However, what we have done is to work with the—

Chair: I do not think Mr Holden was suggesting that.

Q36 **Mr Holden:** I was not suggesting that. Do you accept that the discrepancy between a 15% increase and a 350% increase—23 times higher—should raise some red flags for yourselves?

Dr Harries: Where there have been any concerns that we have apparent, if you like, over-inclusion in one or over-exclusion in another, as Mr Reynolds said, we have gone back to look at what is happening in those areas, working with the Royal College of GPs, clinical specialists and NHS England colleagues. That is the appropriate route. We do not have a direct line out to each CCG. We work with primary care colleagues in NHS England, and they have gone back in some cases, as Mr Reynolds said, and looked at those details. We actually have not uncovered any particular issue. If we had, obviously we would have acted on that.

Q37 **Mr Holden:** So you are telling me, absolutely seriously, that some areas are getting 23 times as much uplift as other areas—15% versus 350%—and that you see absolutely no issue in the system?

Dr Harries: I do not think uplift is quite the word I would apply to clinical population. It is about whether the right people have been identified. Some areas will have—

Q38 **Mr Holden:** It is about the right people being identified. In some areas, you are seeing three and a half times as many people as on the national list; in others you are seeing 15% more. I do not understand how you cannot see that there is a discrepancy here, and one that will naturally lead to some people in this country with exactly the same conditions getting support in some areas and not in others.

Dr Harries: I know the permanent secretary wants to come in. What I am saying is that, where we have seen evidence of a discrepancy, particularly if it looks unexpected—in terms of, for example, the socio-demographic elements of that population—we have gone back to look at the data, as Mr Reynolds has said, and we have then taken any queries back to NHS England for them to inquire of the CCGs. We have not uncovered any systemic errors.

Q39 **Mr Holden:** So basically you have checked these and there are no issues.

Sorry, Sir Chris, did you want to come in on this one?

Sir Chris Wormald: Yes. I think your numbers come from figure 8 on page 29 of the NAO Report. If you actually look at the distribution there, you have one outlier, at 350%. Most of the rest are what you would normally see as the normal distribution. I can fully see that there may be a question about that one outlier—

Q40 **Chair:** Sir Chris, can I chip in there? We have been furnished with the detailed information for our own areas as members of this Committee, which is a random sample of 650 constituencies that just happened to be those of the members of this Committee. The range is pretty wide just among the 16 members of this Committee. I think I should just lay that out. Yes, we recognise that one outlier, but there is still a big difference.

Sir Chris Wormald: If you would like to send us that information, we will look into it, but I would prefer to rely on what the NAO has written in its Report.

Chair: Mr Holden, do you want to explain to the permanent secretary where we got that information from?

Q41 **Mr Holden:** Sir Chris, that is from the NAO Report.

Sir Chris Wormald: I am looking at the table, which has one outlier—

Q42 **Mr Holden:** Sir Chris, I am aware of the table that you are looking at. We are looking at the same table. The figures for each of our constituencies are in that table as well. Even within that, there is a very wide distribution. The England average is 73%. That is a pretty significant increase, but the variation around that is absolutely huge. We are now hearing that NHS England has checked, and there are no concerns around this distribution. Sir Chris, are you seriously telling me that there are people in this country with the same conditions in different areas who did not get different levels of support?

Sir Chris Wormald: No, what I am saying is that I am quite happy to go away and look at the outliers that you are raising. I think that is a perfectly reasonable concern. That table, for me, does not show wide distribution. Other than the outliers, it shows a normal distribution. As we have said, when we have looked into these things we have found explanations. I perfectly understand why you are challenging that, and we will go back and check again. If the Committee would like to provide us with the information that you have collected, we would be quite happy to look at that too.

Q43 **Mr Holden:** Sir Chris, one of the issues here is that there is already a national level of control, which you would expect a normal distribution on. You would expect a normal distribution on a national level. In some areas there are more people who are clinically vulnerable than in other areas. We understand that. What we do not understand is how you have massive variations when you already have that national information and people are being added at a local level. That is the concern that we have.

Sir Chris Wormald: I perfectly understand your concern. As I say, I am quite happy to go away and come back to you on the outliers. It comes back to the issue, which the Chair raised right at the beginning of this session, and which we understand and appreciate is a question of judgment, of what we do by large national systems and where we allow local discretion. As you know, you can make an argument for both those things, but we have sought to strike a balance. As I say, we are quite happy to go and look at the outliers that you have raised, and any other information that the Committee wishes to give us from its own investigations about what it sees as anomalies. What I am saying is that the vast majority of the chart that you are referring to does look like a normal distribution.

Q44 **Mr Holden:** Sir Chris, just before I hand over to Sir Geoffrey, we have just been told by Dr Harries that you have already looked at the outliers, and there was no issue there. I think it would definitely be advisable to have a bit of a dig into this detail, because there are huge variations. What we are concerned about is that in some areas our constituents will be getting different treatment, despite our national health service. That is what we are really concerned about.

Sir Chris Wormald: I fully appreciate your concern, and I appreciate that you are not convinced by what we have said. Again, we will come back to you with the detail. What I am saying is that we are trying to strike a balance between what we do as a giant national system and—

Chair: Sir Chris, you are rather missing the point, but I am going to go to Sir Geoffrey now, and then we will come back to Mr Holden.

Q45 **Sir Geoffrey Clifton-Brown:** Can I try Mark Reynolds? I do not want to prolong this, because we have had a lot of questioning about it, but the two sets of data that we have been given on an individual constituency basis both come from your own figures: the NHS Digital data, coronavirus shielded patient list.

The first list is the shielded patient list per 100,000 of the population on 27 January. I represent two authorities: the Cotswolds and Stroud. The per 100,000 list at that point was about 40% for each. Yet if you come to this graph, which those individual lines are made up on, of my two authorities, one—the Cotswolds—increased by 64%, and the other increased by 95%.

That does imply that there was something wrong with the data that you had way back in January. You have caught it up now. Nobody is disputing that. But—this was the import of Mr Holden's question—what was it in the data that you held that needed to be corrected, right up to the six weeks from April through to 15 May?

Mark Reynolds: Sorry, but I will have to ask a couple of questions. You spoke about January. Do you mean January this year?

Sir Geoffrey Clifton-Brown: January this year.

Mark Reynolds: What change is that again? Obviously, it took us a few weeks to get the list stable, and the percentage increase from the first step probably is not that useful a comparator, as opposed to, say, the percentages in your population right now.

Q46 **Sir Geoffrey Clifton-Brown:** The percentage is a useful comparator, because it tells you that all of those people were not on your original list. The question that immediately arises from that is, why were they not on the original list? I am not apportioning blame. We are trying to learn, to see if there was a problem and to find out how you fixed it.

Mark Reynolds: Understood. For the six condition groups that the chief medical officer put forward—for example, severe respiratory illness—what NHS Digital did was take that list and work through all the different clinical conditions that underpinned that and the codes that are assigned in computers to it. For example, in medical records there is no such thing as severe asthma, but there is a range of conditions with asthma and the medications that you are on. The skill at the national level is to ensure that we bring together the right clinical conditions with the right medications to add people to the list. What we saw from the data is that we were successful in around half of cases in doing that.

The work of the clinicians is to ensure that, although we are using the data from their records, that is sufficient. That will be different in each patient's case. They might be on a non-standard medication, or their asthma might be characterised in a slightly different way. Hence there is a need to review the uptake. I appreciate that you are saying that there is an ability to use the stuff that was identified essentially as a baseline and calculate a percentage, but I think that there is a bit of danger in that. I think it is important to look at whether this ended up stably. For example, you may have a GP who uses a slightly different approach to clinical coding, because there is a different way of describing the disease, which is medically relevant but makes it hard for that to be picked up in computer terms. That is why we need both the national computer to do the work and the local commissioners to add to it.

Q47 **Sir Geoffrey Clifton-Brown:** I understand that explanation, Mr Reynolds, absolutely, and I understand why it was a good thing to let the GPs have a look at this list to ensure it was correct. What I do not understand, going back to Mr Holden's point, is this huge variation. I think there is something bigger underlining the problem than just the GPs adjusting the categories of clinical conditions in this extremely vulnerable group.

Mark Reynolds: I think I will have to go back to what Sir Chris said. We will take it away and look at it. When we have done individual checks, it has not revealed a systematic problem, but in each area that we have spoken to, they have been quite comfortable about the levels that they have seen. By giving the data, every area has had the opportunity to see this. We provide clinical commissioning groups with a de-identified version of the shielded patient list for their areas. They are able to see, without

identifying the patients, the type of patients who are added and the conditions, and everyone gets access to the information.

I also run an email help desk, which was initially set up for clinicians, but is also contacted by patients, as well. Where patients have not been able to get access to the list, we have been able to direct them back to their GP, who has the opportunity to assess them and put them on. We have not seen a large number of patients who feel that they have a specific condition that has not been able to get on the list. I have not seen that pressure that you have spoken about.

Q48 **Sir Geoffrey Clifton-Brown:** You are the chief technology officer. What I would really like an assurance on is that this whole exercise did not suddenly reveal that quite a lot of GPs out there have patients for whom they have incomplete IT records, because you would surely know that by now.

Mark Reynolds: I haven't seen that at all.

Sir Geoffrey Clifton-Brown: We look forward to having your written explanation for these variances. That would be very helpful.

Chair: Thank you very much. Let's go back to Mr Richard Holden.

Q49 **Mr Holden:** Mr Reynolds, you gave us a little example of how something could be on a local list but not on a national list, so it is going to be picked up locally. Why is it that there aren't certain national codes for patients across the board that are used by all GPs?

Mark Reynolds: There are. Every GP uses a set of codes called SNOMED CT, and it is as rich as the medical language. Our clinical experts—doctors who are high-quality medics but who are also skilled in this area—identified how to construct rules in the IT systems to identify the patients. Once we got past the initial set, they were peer reviewed and remarkably consistent, and we continue to rely on them. But it is very much a language that is used, so there will always be exceptions. I am not proposing that those exceptions account for the entirety of the variation; it is just one such example of how there is a need for local clinical input.

Q50 **Mr Holden:** We accept that the variations probably did not account for that, especially because it was peer reviewed at a national level, so what does account for the almost 100% increase in the number of people on the shielded patient list between 12 April and 15 May?

Mark Reynolds: I have to go back to my previous answer: when we spoke to some of the areas, they had constructed, very sensibly, a local approach to adding people to the list, which built on the clinical guidance. As we have discussed, we need to come back with more detail for you.

Q51 **Mr Holden:** Given that there was such local variation, would you have done it a different way around now? Would you have just gone out to the GPs and said, "Send us a big list. Let's not wait six weeks trying to create a national system that is peer reviewed and everything else. If you are going to add 350% in one area, and 15% in another area, why not just

send us the list in the first place?"? You might have been able to get to these shielded people two months before.

Mark Reynolds: It's a fair challenge. Did we ask GPs to create the list using data and their computers? That is essentially what we did. That would have made no difference at all. If we had asked GPs to do this through clinical review, each one of the patients who were identified nationally would have had to be identified through a clinical review—

Q52 **Mr Holden:** You did that anyway, Mr Reynolds. There was a clinical review anyway, essentially. This is why you have had all these extra patients added.

Mark Reynolds: That is true, but we have reduced the size of that review. By doing this locally only, it would have made the task even bigger.

Q53 **Mr Holden:** Right, okay. Given that in some areas you were adding 350%—the average was 70 with 3% added—it seems to me that we might have missed precious weeks of helping to identify these people at the start of this crisis, if we had just gone totally with the GPs in the first place. To date, there has been no issue with what those GPs have come back with, according to NHS England. Do you accept that, at the local level, we will probably see quite a significant amount of variation, and that people with the same conditions will get different outcomes depending on whether they are on the list or not?

Mark Reynolds: On the first part—whether we can see regional variations—absolutely. That is what the data says. I have no evidence of whether that has impacted on patients with similar conditions or not.

Q54 **Mr Holden:** Okay, let's leave that there. Sir Chris, what do you do to overcome this huge problem of missing and inaccurate NHS record data? That is where a lot of this comes down from, doesn't it?

Sir Chris Wormald: I will refer some of that question back to Mr Reynolds. The approach in this case, as Dr Harries described earlier, was a precautionary one, which is why we used the double mechanism of identifying people—both the national and the local. If the data were perfect, it would clearly be considerably easier, and as you know—

Q55 **Mr Holden:** If it was precautionary, why not just go to the GPs in the first place?

Sir Chris Wormald: As Mr Reynolds has explained, we felt that this was the quickest way of doing it—if you identified those people that you could nationally and you went and asked GPs to add to that list, rather than having to review every single case. It is clearly quicker to do the people that you can do centrally, nationally, rather than having individual GPs do every single one. Certainly our assessment was that this was the quickest way of getting to the final list.

In terms of your wider question, which, again, I will ask Mark to come in on, we have an extensive programme about how we improve both the

underlying data of the NHS, which solves all our problems, as you have correctly identified, and, crucially, as you touched on in your earlier questions, the ease with which those different data sources can be put together so that you can do the cross-correlations. Those are both clear areas where we always want to improve, but we have a set of programmes to do just that, which Mark might want to elaborate on.

Mark Reynolds: What we can see from the shielded patient list is that relying on the clinical codes in the GP records has put increased focus on them, so the quality of the coding that GPs are doing has increased, because they know that it has an impact. What we haven't seen is that the patients who were added at the request of the GPs subsequently come through the national rules, so they have been added for a different reason, not for the specific ones we are running nationally. In general, GPs are incentivised, through various different schemes, to maintain high-quality coding, and I think this is a demonstration of why it's important that they do so.

Q56 **Mr Holden:** Ms McDonough, let's drill down into the numbers here a bit. There were 1.8 million people who were attempted to be contacted. We were unable to register over 800,000 of them. Of those, missing or inaccurate telephone numbers were the reason for about half. How is it the case that we are looking at massive amounts, proportions, of incomplete patient records, particularly for vulnerable people, many of whom will have regular contact with GPs? How is it that we are in this situation where we have just got huge quantities of incomplete data for some of the most vulnerable people in the country?

Lee McDonough: I will just say, on the missing telephone numbers, that is not our first port of call. Our default way of contacting patients and the clinically extremely vulnerable, when the letters went out, was through a physical letter, because that is where we know the highest-quality records are. A surprisingly large number of people change their phone numbers quite often, so it's always difficult to make sure that they are up to date, and that's why we don't use them as the first port of call. We use a multifaceted approach to communicating with people: a physical letter first, followed by email, followed by a telephone call—and we also rely on the GPs to make sure that the necessary contact is made.

Q57 **Mr Holden:** My understanding is that 30,000 people who got a letter had died up to 14 years before; that's about 2.5% of those people.

Lee McDonough: Mark needs to answer—if you could, Mark—about the data handling on that.

Mark Reynolds: When we first created the list, NHS Digital made a mistake and incorrectly included patients who had previously passed away, historically. As soon as this was found, we took corrective action: we wrote to the patients and apologised, and there is a formal apology on our website.

Q58 **Mr Holden:** That seems like a pretty good way of doing things.

One thing that I think a lot of us are interested in is this. Have you managed to learn lessons from the other nations of the UK and how they have been doing this service during the last few months, and what conversations have you had had with them?

Lee McDonough: We have regular contact through our working group and we speak to them regularly about ways of handling data and communication. Each country has a devolved approach and can make its own decisions about how to do so. The UK CMOs work together regularly, co-ordinating on the clinical advice. Dr Harries may want to say something on that. We are regularly in touch, on a weekly basis, with our colleagues in the devolved Administrations about all aspects of the shielding programme, including the development of the QCovid tool.

Q59 **Mr Holden:** Dr Harries, do you want to comment on that?

Dr Harries: Yes, it has been very collaborative work right from the start. The original list of clinical conditions was a UK CMOs' list. In fact, I chair a senior clinical advisers' UK shielding panel every week where we discuss and look at the evidence, and make recommendations to the four UK CMOs. So, strong consistency.

Q60 **Mr Holden:** Mr Reynolds, did you find issues like they had in Wales, with a population a 20th the size of England's? They sent 13,000 letters, according to the *Health Service Journal*, to people who had moved. Did we do something similar on that level as well?

Mark Reynolds: It would be unfair to comment on the Welsh issue. We work very closely with home countries colleagues as well—

Mr Holden: My point is not about Wales but about whether we did something similar to what they did.

Mark Reynolds: We have not done anything similar, where we have written to incorrect addresses—if that is what happened there. We are reliant on the information that is provided by patients to general practice—that is where we get our address data from—and we have only written to the addresses that are held through that route.

Lee McDonough: May I just add that the latest letters that have just been issued, to advise people about the extension of shielding? Basically, we asked them to ensure that their GP records were up to date. We know that the number of patients who are adding current email addresses is increasing. As I said, we have a multi-pronged approach to communication—a physical letter, and we email where we have those data—to make sure that we can access these people quickly. We will continue to update the records as our patients keep improving their record keeping with their doctor.

Q61 **Mr Holden:** Great. I am sure that is exactly what we would like to see across the board.

Sir Chris, on the 1.8 million contacts and being unable to register 815,000 of them, with a further 440,000 people on top of that, we are

now down to under 1 million people who you should have contacted. You missed out 815,000 unable to register, and now we have another 440,000, almost half of whom declined to register for support and had to be followed up with a phone call. Did the entire attempt to get people registered end up a bit of a shambles?

Sir Chris Wormald: No, I don't agree with that at all. It is entirely up to individuals whether they register for support. That is the offer that we made. If people did not want it, they were fully entitled not to register for it—that is their personal choice. Our records are only as good as what patients provide to us, which is why we took the multi-channel approach that Ms McDonough has described. As she said, a lot of people change their phone numbers; fewer people change their addresses, and so on. We have to use the tools we have to hand. I do not agree with your question at all.

Q62 **Mr Holden:** You don't. Okay, we have 1.8 million reduced to just under 1 million from the addresses and inaccurate contact information. Then we are going down a further 440,000 who declined to register when contacted, because most hung up or believed it was a nuisance call. Basically, to ensure that those 815,000 people out of 1.8 million did not slip through the net, all that information had to be passed on to local authorities to do it. It was not the fact, Sir Chris, that they did not want support; it is that the system to get the support to them was not adequate.

Lee McDonough: May I just say, 2.2 million people got letters and all of them were aware of the support available? We contacted them, as I said, with a multi-channel approach, but as Sir Chris said, it is up to the individual whether they choose to access the support or not. We were clearly signposting where they could go to access that support.

Q63 **Mr Holden:** But the communications people received by phone were not because a large number of them did not want the support, as Sir Chris indicated; it was a much greater issue than that. Those people—probably very vulnerable people, in a lot of cases—really need the support, and it is just not getting through to them, which is why it had to be passed on to local authorities. That is the big question, then: you have vulnerable people who need support, who then go and get it later. Sir Chris, why—

Sir Chris Wormald: Just to be clear, I was answering your specific question on people who decline support, which you raised. There were of course other reasons. I will ask Ms McDonough to comment on the further details.

Lee McDonough: Colleagues from MHCLG might also want to come in. As I said, the letters were very clear. The phone calls were a follow-up to add another mechanism to try to contact people.

Q64 **Mr Holden:** We understand that—I am coming to the end of my questions on this. Some people may well have refused support, as Sir Chris said, but a lot of them did get support in the end, but only when it was passed on to local authorities. Why did it take a month to pass on, from the

Department of Health to MHCLG, the details of vulnerable people who were told not to leave their houses and could not really access support?

Lee McDonough: As I said, we wrote out. We have been engaged with MHCLG colleagues throughout the start of this programme, and we took a multi-channel approach, including ultimately asking local authorities to support contacting to make sure that people had received the information that they needed to access support. I do not know whether Mr Pocklington would like to come in on that.

Q65 **Mr Holden:** You are quite right to refer me to Mr Pocklington rather than to you on this because he had the information, but it had not got out to the local authorities.

Jeremy Pocklington: I do not accept that the approach you are suggesting is accurate, actually. We established at considerable pace a communication strategy that took all reasonable steps to identify the clinically extremely vulnerable people. That was a multi-channel approach, as Ms McDonough has outlined, starting with the letter. We established an automated inbound call centre, and established at considerable pace an outbound call centre that was making hundreds of thousands of calls a day to contact those people.

Not all the clinically extremely vulnerable wanted to register. That was because they did not need the support; they already had support—

Mr Holden: All of them?

Jeremy Pocklington: Not all. Many of them would have had support—

Mr Holden: The majority of them?

Chair: Please finish, Mr Pocklington.

Jeremy Pocklington: We also provided their contact details to local authorities. That was part of the strategy to make sure that we captured everyone we possibly could. We have already highlighted that in some cases, unfortunately, the data was not up to date. We wanted to capture as many people as we possibly could, at pace, taking all reasonable steps that we could.

Local authorities also played a valuable part in that strategy. They obviously have a good understanding of their local communities. There are examples of councils making visits, knocking on doors, to ensure that as many as possible of the clinically extremely vulnerable were registered and captured in this programme, and given the support they needed. But of course, just because someone is clinically extremely vulnerable, it does not mean that they need additional food.

Q66 **Mr Holden:** Nobody is arguing that they do, or that they would accept it. How many of those people whom you contacted via local councils then took up the offer of support that they had not had previously?

Jeremy Pocklington: Mr Llewellyn is better placed to answer that question, I think.

Ben Llewellyn: What we did not collect from local authorities, Mr Holden, is data on all those whom they contacted and on those individuals who subsequently went back through our registration site to register for the service. We relied on local authorities to undertake that contact process themselves.

Q67 **Mr Holden:** Obviously, you only passed so many names to local authorities because other people had been contacted at an earlier stage. How many extras did the local authorities manage to find?

Ben Llewellyn: What's true to say, Mr Holden, is that there is more to—

Mr Holden: If you don't know, Mr Llewellyn, it's okay—just say.

Ben Llewellyn: Such a number does not exist.

Q68 **Mr Holden:** Obviously, a number does exist, but if it has not been collated, it does not exist. There will be people who were contacted by the local authority, who had previously not accepted the support for a variety of reasons. Maybe they thought it was a nuisance call. Maybe they needed one-on-one contact, which is the entire point I have been driving at: the most vulnerable people do need somebody on their doorstep to get that support.

Mr Pocklington, to go back to my previous question, why did it take a month before passing the details of people you were unable to contact on to the local authorities?

Ben Llewellyn: I wonder if I could have a go at that one. I think you were referring there, Mr Holden, to data on uncontactables that was sent to local authorities. You are right to suggest that that was sent about a month after the start of the programme. What local authorities did receive before that date was both the list of the entire SPL and the list of all the individuals that had positively registered on the website. So what local authorities de facto knew was who had registered and who had not. It was definitely the case that local authorities did not wait for us to undertake our own procedures before they started their own contact. Indeed, our advice to local authorities—I know that they did this because of the conversations I had with them. They themselves immediately, in parallel, were contacting individuals to make them aware of the programme and the support they could receive, which is why it is difficult to disentangle precisely how many people registered via contact with local authorities and via our own contact.

Q69 **Mr Holden:** It's a good thing they did, too. Given that over 800,000 of the 1.8 million were unable to register, and a further 440,000 people declined to receive your calls, it's a good thing they did act really swiftly rather than waiting for all of that to pass through. I genuinely cannot believe that you have not worked out how many people—it was only after local authorities got in touch that it actually came through. Clearly, they are some of the most vulnerable and most in need in this entire system.

Chair: I am going to bring in Dr Harries on this point, and then I will move to Olivia Blake MP.

Dr Harries: I just wanted to add that it is really important that we start off with individuals with clinical conditions, which is why they are on the list. Running alongside all of this were some very good local relationships, with every single GP contacting each clinically extremely vulnerable individual and working locally through directors of public health and through their local authorities, so it is not a reasonable representation to assume that a simple contact number necessarily missed these individuals. In fact, I think—I don't have the detail with me—the support from general practice was excellent and well recognised by these individuals. In addition, NHSE took out, with an expert advisory group, some particular modes of working with these clinically extremely vulnerable individuals to make sure that they were supported clinically, but also linked in to local services.

Chair: We are going to move on to some of those local services issues with Olivia Blake MP. Over to you, Ms Blake.

Q70 **Olivia Blake:** The first question is to Dr Harries. What advice would you give to shielding parents if schools go back on 8 March, as has just been announced?

Dr Harries: Just to clarify, do you mean a parent who is clinically extremely vulnerable or a parent of a child who is clinically extremely vulnerable?

Olivia Blake: I'd go with both.

Dr Harries: I don't like to say "label", but the category of clinical extreme vulnerability refers to the individual themselves, whether it be a child or an adult. If it is an adult, the child should go back to school. We do not distinguish. If you are in a household, we do not advise the rest of the household to stay in as well. There is a balance. A lot of this discussion, as we have heard already, is about balance, because there are risks to individuals staying out of society as much as there are around their staying away from society. So the short answer is: if you are the child, you go to school if you are not clinically extremely vulnerable.

The only exception in the advice is if you have very small children who cannot understand at all, or perhaps the child has challenging behaviours or whatever vulnerability they themselves might have, where it is impossible to maintain that distance, but there are very few cases where that might apply. As I mentioned earlier, very few children should remain on the clinically extremely vulnerable list. Through sequential letters and through national clinical directors working with the Royal College of Paediatrics and Child Health, we have tried to reinforce that, but we have never allowed a child to be taken off the list without having a clinical review.

Q71 **Olivia Blake:** I know this is an issue that we picked up in an earlier session, but I just wondered if there has been any more progress in

under-16 vaccination—of CEV, obviously.

Dr Harries: Vaccinating children?

Olivia Blake: Yes, under-16s.

Dr Harries: At the moment, there is no vaccine that has a current licence in the UK for vaccination of children. There are exceptional circumstances where a clinician could decide to use that without the appropriate authorisations, if you like, but it would be really exceptional. This advice is guidance from the Royal College of Paediatrics and Child Health. It would not normally be a GP decision, and it would be within a hospital environment. It really is very, very few individuals. As you may have seen in the media over the past couple of days, there are trials. We do not yet have safety data; we have no reason to assume the vaccines will not be safe, but that data is not there at the moment. I am sure that will change as time goes forward.

Q72 **Olivia Blake:** Mr Pocklington, I was interested in what you said to my colleague just now. Can I ask whether local authorities had any powers to suggest additional vulnerable people? I am particularly concerned about those who are not registered with GPs, or have not really been dealt with by health services before, but may have some additional needs.

Jeremy Pocklington: The decision on whether or not someone was added to the shielded patient list is ultimately a clinical decision, so that was arranged through the NHS and through GPs, as we have discussed at considerable length during the hearing. However, obviously, local authorities have their understanding of local communities: they understand vulnerable people in their area and often help additional people register with GPs. We talked about that in our last hearing—for example, rough sleeping as an example of how local authorities and the NHS work well together at a local level—but ultimately it was for GPs to make decisions about who to add to this programme. However, this is a programme that is particularly about the extremely vulnerable; local authorities can provide other support to those who need it as well.

Q73 **Olivia Blake:** Can I ask why the Government initially decided that, essentially, a directed delivery model for support would be the best model?

Jeremy Pocklington: Of course. Our judgment was that a centralised offer for the food boxes was more likely to guarantee delivery of food boxes in every part of England in the context of the start of the pandemic, at a time when there was real concern about food shortages in supermarkets. We did engage with a number of local authorities and other local partners in making that decision, and that was the decision that we took. I think the wholesalers were available as well, which was also a relevant factor, so this was a relatively straightforward and quick option to ensure those who needed access to a basic supply of food could receive it.

Finally, I would add that it is important to remember that this was a hybrid model. Councils still had an important role: as we have discussed, we

asked councils to help contact the clinically extremely vulnerable where other channels had not worked. We also asked them to provide basic care as part of the shielding programme and, in relation to food, to provide supplementary food for those with specific dietary requirements.

Q74 **Olivia Blake:** I guess it is easy to forget that supermarkets were limiting items at that stage. Can I ask what assessment the Department had of local authorities' capacity to identify, contact and support vulnerable people? Perhaps Mr Llewellyn and Mr Kennedy also want to comment on that.

Jeremy Pocklington: A reflection from me. The first thing to stress is that we were operating at quite a high degree of pace back at the start of the pandemic last year. As the Report notes, we discussed the right way to approach the challenge that we had with a number of local authorities. We could not carry out a full assessment of capacity in the way that perhaps we would have done if this was a business-as-usual programme. We had to make a judgment based on the evidence that we had at the time, but what has been important for the programme—Mr Llewellyn and Mr Kennedy may want to talk about this—is that we have continued to build and adapt our assessment and our understanding of capacity as the programme has gone one. I will hand over to Mr Llewellyn.

Ben Llewellyn: We built, within my directorate, a regional-facing team, so we had ongoing relationships with each and every local authority. We would talk with each authority every few weeks at least, and we would have group sessions with authorities, all of which were an opportunity to really understand how delivery was going down on the ground, and any capacity issues that local authorities faced. I am pleased to say that our engagement with authorities and their engagement with us showed that there was significant capacity as we went along.

Olivia Blake: Mr Kennedy?

David Kennedy: Good afternoon. We focused on standing up a national offer, which had wide coverage at pace. We started off asking whether the supermarkets could provide that offer, and it became very clear that they didn't have the capacity to do that, at least in the first instance. Hence, we looked at their supply chain and we ended up with the wholesalers Brakes and Bidfood.

We worked closely with local authorities in asking, "Shall we evolve our offer? In the second phase, for example, should we look at local contracting?" There was the non-shielded vulnerable offer as well, where we went through local authorities, which referred their vulnerable people to the supermarkets. There was very close working with the local authorities. The only practical thing at the start of this whole thing was to work with the wholesalers at the national level, and then we developed a supermarket option that has superseded the food parcels. We have half a million people prioritised by the supermarkets, who continue to be prioritised by the supermarkets over the last months and for the foreseeable future.

Q75 **Olivia Blake:** Can I ask you all whether you are confident that you have a full picture now of the capacity to deliver? Have you identified any areas of risk in that?

Jeremy Pocklington: Perhaps I should start with that. Our model has evolved as the pandemic has progressed, and that was noted in the Report. As we have got more confidence in the supply chain and in local authority capacity, we have moved to a locally led model. We began work on that model relatively early—in April—and we moved to it over the summer. We have also engaged in regular dialogue with councils, and we now have good information about what their activity is on the ground, in terms of the delivery of the programme.

One fact that I would observe is that, as the pandemic has progressed, fewer of the clinically extremely vulnerable have needed support through this programme. That is perhaps because they have been able to put their own arrangements in place. Thanks to the excellent work in DEFRA, more and more vulnerable people have access to supermarket slots, so they can arrange for deliveries at a time and in a way that suits them. As the pandemic has progressed, we have been confident that a locally led model, reinforced with a new registration system that we have built over the summer, has proven an effective way of delivering this programme.

Q76 **Olivia Blake:** Have you conducted any—let me think of a way of phrasing this—user experience to see whether any of that drop-off is because it simply wasn't meeting need?

Jeremy Pocklington: I will bring in Mr Llewellyn here.

Ben Llewellyn: Yes, we have focus groups that we run with CEV individuals via local authorities. We also ask them about surveys that they have conducted locally, and they will obviously have insight about their local communities. During wave 1—and soon to start again—there was an ONS survey to understand how the support people are provided supports them to shield. Certainly, during the first phase it was felt that the support was a great help to them around shielding. For example, a survey the ONS ran in June-July time showed that 91% of people felt they had the support they needed to shield. We continue to collect data, obviously, and adapt the offer accordingly depending on what we are told.

David Kennedy: Can I just add something about capacity as well? We stood up the national offer in the way that we did, and the food boxes, because it was really uncertain what the supermarkets would be able to do. It was uncertain, as you have said, because we had a food supply risk nationally. Also, the uncertainty related to the capacity for online orders and deliveries. We were not sure, actually, how many people were going to be able to order online, either, so it was a practicality point. What we have learned is that pretty much everybody who signed up for support and got food parcels was matched by a supermarket, was prioritised by them, and has been served by them since then, so about 450,000-plus continue to be prioritised by the supermarkets. That is working really well, so the need for the food parcels, which was there at the beginning, fell away.

On food parcels and the survey evidence, our own survey said 80%-plus of people who received food parcels said they were very happy with them, and 80% said that the support in terms of food parcels helped them to stay in isolation.

Q77 **Olivia Blake:** How quick was it to get mobilised, and were there any issues when you were initially setting it up from scratch?

David Kennedy: It was very quick. There were several weeks to go from nothing to having an offer which we could announce. I think the first parcels were delivered within five days of the shielding announcement, so it was incredibly quick. I don't think the quality suffered as a result of that, so we were able to get boxes to people that were well designed in terms of nutrition, for example. We were able to get them there quickly and, as I say, the satisfaction with those boxes was relatively high. I think you can probably find a few examples where people said they didn't really want a box and asked why they had got it, but I think the vast majority of people were satisfied on that very fast timeframe. So, it was several weeks.

Jeremy Pocklington: I do not have much to add. I would agree: this programme was established at considerable pace in the early days and weeks of the pandemic. It took five days from its announcement to the first food deliveries happening. We built the registration system, which we have discussed, in four days. Councils rapidly stood up their support, and the Department of Health and Social Care, the NHS, led on the medicine delivery system that ran alongside this programme. I would note that we have adapted and learned as we have gone along. We had a very conscious strategy to establish a minimum viable product, so although it is a nutritious food box, we were very conscious that it was a basic supply of food. We established a basic service and have then adapted and learned as we have gone along, as the programme has developed.

Q78 **Olivia Blake:** I think people were quite surprised that DEFRA was asked to lead part of this response. Do you feel that that was an appropriate decision, and what was the main challenge for DEFRA in providing this national food support service?

Jeremy Pocklington: May I start and then bring in Mr Kennedy on this? I think this was actually a very good example of joint working across Government Departments and strong working with local government, notwithstanding the challenges of the first few days and weeks. We had very effective governance that drew on the expertise that existed in Government. We didn't have time to build new expertise in individual Departments, so the Government Digital Service supported us establishing the digital registration system; DEFRA supported on food with their experience and their relationship with the supermarkets; and the Department for Work and Pensions obviously use call centres as part of their ongoing work, so we drew on their expertise. This was a very effective example of joint working across Government. Mr Kennedy may want to talk about DEFRA's role in relation to food supplies.

David Kennedy: Just very quickly, DEFRA is responsible for food supply to the country. This was part of our food programme, so food supply overall included food supply for vulnerable people but went well beyond that. It was our job to maintain security of supply. We have the expertise; we have the relationships with the food industry. I think we were the natural partner for this programme, and it was very much in the spirit of partnership, working with MHCLG and DHSC in particular.

Q79 **Olivia Blake:** Mr Kennedy, there were a couple of reports from local authorities on the quality of the bulk food supplies. What might you do differently if this was to happen again?

David Kennedy: Ideally, we would not have done the bulk supplies; these were a stopgap while we were waiting to get to everybody who had signed up for support. I think, first of all, it was a small proportion of local authorities who said they weren't happy. There were a couple of examples where they got stuff that they said they hadn't asked for. Ideally, that would be avoided. As I say, I think it works well as a stopgap. The really important thing was to get the actual food parcels to individual people, not via local authorities. We had a chance to consider and say, "Should we continue delivering to local authorities the bulk?" We didn't think that was a good option going forward. It was an urgent, one-off thing that we didn't repeat.

Q80 **Olivia Blake:** Mr Pocklington, what lessons have you learned about these situations? Would it have been better just to get the food to the locality and then get the locality to kind of manage this issue, or do you think that it was absolutely necessary to have this national programme, given the situation we were in?

Jeremy Pocklington: This is another example of the question that we began the hearing with: ultimately, what is the right balance between when central Government should lead an intervention itself and when local government should take responsibility and be invited and funded to lead the work themselves?

Obviously, in terms of central Government, there is an advantage of the resources of central Government—the scale that sometimes we can bring to it. We placed the priority that we took on ensuring that all parts of the country had similar outcomes and that all the clinically extremely vulnerable who needed it could receive the food boxes, whereas local government, of course, know their local communities and can perhaps tailor services accordingly.

I think we took exactly the right decision at the start of the pandemic. We know—because we spoke to local authorities in the months that followed and many of them told us—that they would not have been able to provide the food delivery service in those early months. We have confidence that we took the right decision, but it was also right that as early as April and May we began discussions about how the model should evolve.

We learned a lot from the period over the summer, when you may recall that a small number of areas—I think they were Leicester, Leicestershire,

Blackburn with Darwen, and Luton—continued to have a higher level of measures. We learned a lot from working with those councils over the summer, through the engagement that Mr Llewellyn has set out. We then used that period to co-create with local government—with a group of chief executives and others—a shielding framework that we could put in place in the autumn. We rebuilt a digital system with the Government Digital Service over the summer as well.

Q81 **Olivia Blake:** Moving to medicines, clearly this is a key issue for clinically extremely vulnerable people. Why was there such a delay—of a month—to get the delivery service for medicines up and running?

Lee McDonough: Actually, I think it was stood up pretty quickly, given that it was stood up from scratch. It needed to be designed, it needed to have agreement with the provider side, and we needed new regulations to be laid. Obviously, handling medicines is quite a significant issue and you would want to make sure that all the safeguards are in place to make sure that that was handled effectively. It all happened within a month and the satisfaction levels that we have from both patients and charities have been really high. We have over 11,000 community pharmacies signed up to help deliver the service, and we are really grateful to them for everything that they have done. Overall, I would say that this is a really successful part of the essential support for people that is in place.

Q82 **Olivia Blake:** Was that the main challenge—the fact that they were handling some difficult medications and that the provider side was perhaps having difficulties?

Lee McDonough: We needed to do the design of the programme and issue standard operating procedures, and we needed to have an agreement with the community pharmacy side to effectively understand how they were going to deliver all of this. It was also a conscious approach to think about utilising friends, family and volunteers as the primary way to get the service in place. Obviously, that was not dependent on the pharmacy side being stood up—it was happening ahead of that. We know that about 40% of those on the clinically extremely vulnerable list were using the pharmacy delivery service at any one time, which means that quite a lot of them were using friends, family and volunteers to ensure that they got their medicines. It was a combined approach, and obviously it is much better in some ways, if you have friends, family or somebody who can support you, to use that service. The pharmacy was there as a backstop, to ensure people got what they needed.

Q83 **Olivia Blake:** Clearly, there were a lot of people who were socially isolated and digitally isolated, so I can understand why you would need the backstop. I want to ask a couple of questions about finances and money. I know the Report did not touch on that, but it is a really important question and I want to get the views of your different Departments. How much of an effect do you think this has had on success and the protection of the most clinically vulnerable people?

Lee McDonough: Do you mean in terms of the medicines?

Olivia Blake: No, just generally. If each Department could answer, that would be really helpful.

Jeremy Pocklington: Shall I start? There is a helpful table in the Report that sets out how much each Department and how much local government spent on the programme, at least in the early months, so I won't repeat that. The approach that we took was that MHCLG had overall responsibility for the service delivery side of this programme, but costs were funded by the individual Departments in question and signed off by the relevant accounting officer. For local government, we know that in wave 1 the costs that they had reported to us through the monthly reporting, which we have discussed at previous hearings, was a little over £54 million. That was funded as part of the un-ringfenced funding. It was a small proportion of the un-ring-fenced funding, which, again, we have discussed—the £4.6 billion that has now been allocated to local government for the 2020-21 year.

For wave 2, it is worth noting that the model has evolved as we have adapted, and there is no perfect answer for how to fund local government. We decided on balance to move to a world where we are funding local government per clinically extremely vulnerable person that they have living in their area. That is funded at the rate of £14.60 per CEV. The vast majority do not need support, so that money is then concentrated at those who do need support from their local authority. That is the answer for MHCLG.

Olivia Blake: Would anyone else like to comment?

David Kennedy: Shall I give a DEFRA answer? I think the best way to achieve the objective was to get food to people who were in isolation and who did not have any other way of getting food. That was the best way to do it—I am confident in that. Are we confident in the price we paid for each of the boxes of food? That started at £60. We did a lot of work with Brakes and Bidfood, the wholesalers providing the boxes, to establish that that was the right price. We were able to get that down from £60 to £40. You might ask why we didn't get £40 as the initial price. That was because it had set-up costs built in and a wider range of foods, and because there was a risk premium built in, given that there was a lot of uncertainty over the scale of the programme for the wholesaler. So, £60 would pay for the first 100,000 parcels. For the rest of that, which is 4.7 million, we paid £40, so I am confident on the price.

I think it was really important that we had an exit option as well, so that we did not continue paying for this indefinitely. That is why we developed the supermarket prioritisation. That works really well and does not cost the Government anything, and that is the basis of the approach going forward. Anybody who comes through the new list of shield and vulnerable will be prioritised straightaway by the supermarkets. If they say that they want support with food today, the data will go to supermarkets tomorrow and they will get an email from the supermarket tomorrow saying, "We will prioritise you. Click on this link and you can get food." In that respect, food parcels were the right way to go. We got a very competitive price,

but it was right to evolve it to a supermarket offer that is buttressed by local authority support as well.

Lee McDonough: On the medicines delivery service, as I said, we really emphasised and promoted the use of volunteers, family and friends, which helped to keep the price down. We consider the total spend of £34.3 million to ensure that 2.2 million clinically vulnerable people were able to get their medicines to be really good value for money.

Q84 **Olivia Blake:** Mr Pocklington, I am curious whether you as a Department have done an assessment of housing and of clinically extremely vulnerable people who are struggling with arears in council housing or in the private rented sector, or of people in private ownership who are presenting with associated difficulties, in order to get a view of the financial impact.

Jeremy Pocklington: As we have discussed at previous hearings, we have done a lot of work to support the vulnerable with housing needs over the course of the pandemic. The extreme end of that touches on what we touched on at the last hearing in relation to rough sleeping and those at risk of rough sleeping. For those in the private rented sector, we have provided security and confidence, first through the ban on evictions and then preventive action that we have taken to stop enforcement proceedings, to make sure that the vulnerable are protected throughout the pandemic.

We don't have the specific access to the data to understand everything about the lives of the individuals who have been identified as CEVs, and that is for good reason. It is only really to ensure that data was provided to those whom it was absolutely essential to provide it to, so that the councils had it. They have also been able to provide support and ensure that the needs of those individuals have been met.

Q85 **Olivia Blake:** Finally, on the quality of the supply chain, foods and delivery slots, how much thought did you give to individual needs, such as dietary needs and preparation? One person told me that they did not own a can opener because they do not in general cook, due to their health conditions, and they eat a lot of preprepared meals. They could not open most of the food that they were given because most of it was canned food. They were not able to lift pans to cook a lot of the food, either, even though they live independently. Was any thought given to providing a hot food offer for those who are very much the most vulnerable and unable to make their own food, given what they were given, as opposed to what they would make usually?

Jeremy Pocklington: I think that is a question for Mr Llewellyn and Mr Kennedy.

David Kennedy: Why don't I start? For the national offer, we had to have something that would be practical for half a million people very quickly. We designed a box with a focus on good nutrition—a balance of, for example, carbohydrates, protein and vitamins. We worked with Public Health England and other nutrition experts on that, so we think we had a

good box in that respect. It was simple foods that we thought everybody could use. We did question if we could vary according to dietary need, but that was not practical to do. Instead, we focused on making sure that there was very good labelling so people were clear what was in the box, and they could choose from the box according to their need.

In addition, there was always going to be a limit to how much range we could put in a box, to meet specific needs. That is why the supermarket prioritisation was so important. We wanted another channel where people could be prioritised and could order what they wanted from the supermarkets. What happened was that we met the basic need for most people. Very quickly, they were prioritised by the supermarkets and they began to rely over time on the supermarkets, to the point that the food parcels were no longer needed.

Ben Llewellyn: Just to add briefly that local authorities were asked to fund these, to provide support for people with very particular dietary needs, regardless of what they were, including in the cases that you described, which both complements the supermarket offer that Mr Kennedy talked about and the food box. I would hope that in all cases, a solution can be found for every individual need.

Q86 **Olivia Blake:** Mr Pocklington, do have any insight into work around the new situations? Were people just wasting the food they were provided?

Jeremy Pocklington: I am afraid I do not have anything to add.

Chair: Don't be afraid. That is fine. If you have a team that can answer, that is good.

Just a couple of quick follow ups from me, one around the basic care that was provided to people shielding, which was a new thing for local government. I will go to you, Mr Llewellyn, on this, because it is not social care; it is an odd hybrid. Have you learnt lessons about that? What are you doing about the money—maybe Mr Pocklington can answer that—to make sure that local authorities are properly funded to support that? Whatever the Prime Minister said just now, which has been heavily trailed, we are going to be in this situation for some time to come.

Ben Llewellyn: It was a new sort of service, although I would say that it builds on the strengths of local authorities and the things they have provided more generally to their vulnerable populations in the past. They tend to be provided by the VCS sector. It was quite a broad offer in terms of the statutory care that individuals would receive, and we made that very clear. It could be anything from support with personal care or cleaning your house, walking the dog or gardening. Lots of local authorities sought to provide a pretty holistic offer.

In terms of learning, I think that equally applies to local authorities. The key to learning is actually about working with authorities, so they can learn from each other about what good quality care looks like. There has been an increasing focus on mental health and supporting individuals' mental health. Early on, we updated our guidance to include a check-in

and chat service, which could help to tackle self-isolation. Some authorities are doing great work to build on that, for example around bringing people together in group sessions or for cream teas on Sundays. Younger sessions are for people's physical health, as well as their mental health. It is a broad service.

In terms of funding, local authorities are funding this support. In our regular returns that we get from authorities, we are confident that they are being adequately funded to provide the care that they are providing to individuals.

Q87 **Chair:** In the long term, Mr Pocklington—you are not the Treasury—what is your bid on making sure that local authorities continue to be funded to give this vital support to this group of people?

Jeremy Pocklington: The model that we have established is that local authorities will be funded by £14.60 per clinically extremely vulnerable person for each four-week period that the programme continues.

Q88 **Chair:** Just to be clear, that figure that you cited earlier in answer to Ms Blake is the amount for every type of support, not just for the basic care?

Jeremy Pocklington: Yes. Crucially, only a small fraction of those who are clinically extremely vulnerable are actually needing care from local authorities. That is why the individual figure sounds small, but I think this programme is well funded for the support it needs and I am comfortable with that, given the importance of the vulnerability of this group. It is £14.60 per CEV individual, per four-week period, as long as the programme continues.

Q89 **Chair:** Have you seen any regional variation in the level of support that has been needed? That is obviously a flat-rate figure, but is there any regional variation that we should be aware of?

Jeremy Pocklington: It is a flat-rate figure. We have seen a lot of different approaches that local authorities have taken for this aspect, which is the basic care—the additional care on top of the formal care that local authorities will be providing through the social care system. I want to draw that important distinction.

Chair: We appreciate that. This is the dog-walking, and so on.

Jeremy Pocklington: The approach that we have taken is to bring authorities together so they can share their experience about what they are doing. This is not an area where we asked authorities to impose a model in every part of the country. There were some things that were more national. Check-in and chat was an example of something that we encouraged all local authorities to do.

Q90 **Chair:** In terms of the money, certain areas such as London—my constituency, for example—have higher wage costs for council staff, so the cost of any intervention is going to be higher than in areas with lower wage costs. Given this flat rate, you did not factor in regional variations?

Jeremy Pocklington: Not for the funding for this programme, but I am confident that, even in London, that funding is adequate. You will recall that our general un-ring-fenced funding—the covid-related needs formula, which we discussed on previous occasions—included a factor for deprivation that would also support places like parts of London. It also includes a factor for relative wages and prices, so there is a wage factor and a price factor included in that formula.

Q91 **Chair:** Mr Llewellyn, as director general for this area of dealing with this programme, which was new when you started it, what are the key lessons that you have learned, particularly about the question I posed at the beginning about what is working better now that it has gone to a local support model? We have touched on some of this, and Mr Kennedy has talked about supermarkets, but do you think it has improved its performance? Is the value for money of support better now that it has gone more local?

Ben Llewellyn: Just to clarify, I am only a director.

Chair: Sorry, I have just promoted you. Your boss next to you on the screen can take the hint.

Ben Llewellyn: How has the model changed? As was said, it was very much a hybrid model in any case, so care and an element of the support was provided by local authorities throughout. The move to a model that was based on food access, rather than just food provision, has basically increased the VFM of the scheme. Indeed, the NAO Report points to a report that we wrote advocating that change for that reason. That was possible because of the changing context over the summer, in terms of more freely available delivery slots, for example, and as Sir Chris said, food in supermarkets. As well as that offer, local authorities have the ability to target the offer to the local population so that the food that they offer can better represent those who live locally, so all in all I think it is better.

The other point that I was going to raise is that I think local authorities are very conscious of not wanting to create a dependency culture any more than they need to because of the ongoing pressures. The ability to have a conversation with individuals about food and whether they have friends and family who can help, and how they can rely on volunteers more than direct food provision, for example, helps the local authority and perhaps helps the individual over the longer term to maintain their independence.

Q92 **Chair:** I want to go to Sir Chris Wormald on the next point about the evaluation that you have done, and maybe Dr Harries on the national shielding support service's effectiveness. It is very difficult without a control group to assess how it has saved lives, given that we are all in lockdown anyway. Has there been any evaluation done? Clearly, in any future pandemic planning—for colleagues of mine who are young enough to be here at that point—these are the important questions to be thinking about, even if we have not got full answers to them. This is to Sir Chris, and then Dr Harries if you have anything.

Sir Chris Wormald: I will mainly ask Dr Harries to answer that question. You are absolutely right, Chair, that it is not possible to do a sort of clinical-standard evaluation because there is no control group, and there shouldn't be a control group.

Q93 **Chair:** I think it would be immoral, in medical terms—unethical.

Sir Chris Wormald: Yes, exactly. That is not the same as saying that there isn't evidence. There is obviously very good evidence in principle for this sort of programme, which we know from general covid infection rates, but there have also been some specific things we have looked at. Maybe Dr Harries could come in.

Dr Harries: Thank you, yes. You are exactly correct. Ideally as a scientist I would want to do a randomised control trial—clearly unethical; it would never get ethics approval. But we do know from first principles it was a very simple idea. You take people out of the path of the pandemic, when there is more likely to be virus around. I would just like to reinforce, when it was designed it was actually to take people out of the peak of the modelled tip of the peak—if you like—for 12 weeks. So that is important, because we recognised that keeping people, or advising them to stay, inside and away from society does have risks and benefits. So in terms of evaluation I think we know on those principles we would have moved people out.

We know around 94% of people mostly followed the advice, so we think they would have come out. We know we supported them to do that, so I think we can reasonably assume that we have reduced infection rates in those individuals, but it is very difficult to say. There are a multitude of different clinical conditions. Some people have to come out. For example, dialysis patients are at very high risk and have to go to hospital appointments, so that the only way to evaluate them would be to do it in individual clinical groups.

We have done some work, so NHS Digital colleagues tried very hard to do some work and it went out to peer review to see if we could get somebody else to try and see how we could do it. We haven't been able to. Nobody has come up with a way of evaluating fully. We are trying to look at some individual patient groups, where we can control, if you like, for some of the picture—but very difficult to do.

Q94 **Chair:** Okay, but I think it is very important that it is still attempted, in order to plan for a future. I have two more questions, really. One is about the communication, with individuals but particularly around some of the professional groups. The Royal College of Midwives have sent some evidence in, which you may have seen, saying that they were not consulted in advance about the decision to place pregnant women on the vulnerable list. They were not consulted: nor was the Royal College of Obstetricians and Gynaecologists. While they were given advance warning that those women would be on the list, they were not advised.

I know you were working at pace but we have heard—this is one bit of evidence, but it is a bit of a trend—that some people felt a bit behind,

when they felt they could have been helping their patients or, if they were a charity, the group that they supported, better with more information. I suppose it is probably Lee McDonough who might be the person to pick this up first. What thinking were you giving to the communications at the time that you were setting this up, from the Department?

Lee McDonough: Obviously the communications are really important, and Jenny might want to come in on the pregnant women angle, which is the clinical piece, but without doubt we can learn lessons from the various data about how to engage and communicate. We did make real efforts early on to make sure we reached out certainly to charities and other representative groups, and we had a weekly call, actually, with charities and patient groups from March, which a DCMO ran. Then following further feedback from charities we set up in May a shielding working group with various groups.

Q95 **Chair:** Can I say to you, Ms McDonough, there is a world of difference between a Zoom call, which we are all rather weary of—we have a lot, as MPs: a briefing, sometimes at short notice, with a Minister, that is only an hour, and you cannot all get a question in. Is that what you were relying on as your consultation with these organisations, which actually could have really eased the load for the Department, the NHS and local authorities and eased the worry of many of the people who were involved, had they been involved better at an earlier stage?

Lee McDonough: I think there has been ongoing engagement, and again, Dr Harries might want to come in, in terms of the colleges and other clinical groups. My focus was really on engagement with charities, where we did reach out and have, still, ongoing discussions so that they could help to shape the communications and also be part of the communication solution, which is where we wanted to get to, so that they were able to reach out to patients within their particular constituencies and feed back their concerns. Jenny, do you want to come in on the relationship with the colleges?

Dr Harries: Thank you, yes. If I just take the example of the Royal College of Obstetricians and Gynaecologists, I think it is fair to say you highlighted that at the start of this it is very difficult to consult, actually, when neither group has the information. That advice for pregnant women was a UK CMO decision based on a precautionary approach. In fact—I am sure people here would understand—it is very difficult to get information about vertical transmission for a foetus or things like breastfeeding and the viral transmission risk. At that stage we had nothing robust coming in from early experience in China or other countries, so I think it was entirely appropriate that there was a rapid discussion.

Having said that, we have done huge amounts of work with the Royal College of Obstetricians and Gynaecologists, with the president. I personally have chaired, for example, two roundtables on occupational health. That is particularly relevant to pregnant women, and we have multi-branded and almost every professional organisation's advice—RCOG,

the Royal College of Midwives—has gone up on the Department of Health's website. As Ms McDonough has said, I contribute regularly to stakeholder meetings with different advocacy groups. Where there are particular clinical conditions, we meet with them directly or they put forward queries and concerns about their group. We have had that with motor neurone disease, with Asthma UK and Diabetes UK. Those are considerations for the panel.

We have had ongoing communications all the way through—regular meetings with the Royal College of General Practitioners, the Royal College of Physicians, and with our clinical colleagues in NHS England, for example. I think probably the start of it was a little bit rapid for precautionary reasons, but I like to think that that has improved a lot as we have gone on. My diary is full of huge numbers of relevant meetings with colleges and stakeholder groups. Through various media channels as well we have tried to communicate—

Q96 **Chair:** One of the key things is that the decisions made by you and your colleagues, Dr Harries, on a medical basis, precautionary or otherwise, have a huge impact on someone's ability to earn money. Pregnant women are a good example—or a bad example, if you like. Furlough drops your salary, and that drops your maternity pay and so on, so there are a lot of layers to this. Was that in your mind when you were making these decisions? Were you liaising with other bits of Government?

Dr Harries: Absolutely. In fact, the issue about pregnancy was one of the issues—if I am honest—with some of the NHS advice: this is very much individual choice. People have different risk perceptions. Somebody, for example, at the end of life will have a different approach to how they manage this advice than perhaps somebody who is younger. People have different risk appetites. On the example of pregnant women, that was the driving point for chairing two professional and external roundtables on occupational health.

Q97 **Chair:** My final question is to Mr Reynolds. In an exchange earlier, largely with Richard Holden MP, we probed the data issues and the role that NHS Digital had in identifying these patients early on. In your view, what would be the best thing that could change? If we were faced with this situation again, or if, as we potentially face variants, we need to deal with changing clinical needs in relation to any future variation of the virus or public health lockdown, what would be on your wish list from GPs, from the centre of NHS Digital or other parts of Government that would practically and technically help get that early list better in the first place?

Mark Reynolds: There are two things that I would speak to. The first one is being able to get access to data in the GP record faster. We did that very rapidly, but improvements there would help.

Q98 **Chair:** Would that be a technical solution?

Mark Reynolds: I am always going to advocate technical solutions. Yes, it would be a technical solution. The other bit is that, quite rightly, we need to take the GP profession with us through any use of their data. It is

ultimately the patient's data and we need to make sure that the general practice who collects it is comfortable with its use. The second area would be to continue the digitisation of the hospital sector. With these patients especially, a large part of their care is delivered out of hospitals, and with higher quality digital data we would be more accurate in identifying them.

Chair: It is interesting that you say that. I had a recent experience in the last couple of years where I was a mystery shopper for a long period of time in one of our large NHS trusts, which prided itself on its paper records, so I think there is some way to go there, as this Committee has long looked at. I will leave that there for now. We can have a whole further debate on digitisation in the NHS and digital record keeping.

I thank our witnesses very much indeed. Can you please take the Committee's thanks back to your Departments for the work that your staff did during covid? Also please take a shout-out as well to our frontline NHS staff and frontline workers in local government who did enormous work to deliver—plugging gaps, delivering the basics and so on. There has been a herculean effort.

We have a role and a responsibility to probe and challenge the efficiency and effectiveness of what you have done, as well as how you have spent taxpayers' money. That does not mean we are not grateful for what has happened, but we want to see it improved, and we will pick apart any holes in it. That is our constitutional and important role, and we do that on behalf of the taxpayer. Thank you very much.