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Chair,
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House of Commons
London
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Dear Chair

PUBLIC ADMINISTRATION AND CONSTITUTIONAL AFFAIRS SELECT COMMITTEE - COVID 19 DATA TRANSPARENCY AND ACCOUNTABILITY INQUIRY

Thank you for inviting me to provide evidence at the Public Administration and Constitutional Affairs Committee on "Data Transparency and Accountability: Covid 19" on 4 February 2021. I am writing in response to your letter of 5 February requesting further information on points raised at the evidence session and on issues which the Committee did not have time to raise during the session.

I am responding to the questions 2, 4 and 5 in your letter. The Paymaster General will write to you separately in response to questions 1 and 3.

2. Can you write to us about vaccine data that you are sharing with local officials (including public health directors)? Specifically:

A. To what level of local granularity is the data that is being shared with local officials? Is the data being shared at lower local authority level?

We are committed to ensuring that local authorities and Directors of Public Health have the data they need to understand uptake of vaccines in their local areas and to tailor efforts to reach those who have not yet taken up the offer of a vaccine appointment. COVID-19 vaccination data are being shared at both a Middle Layer Super Output Area (MSOA)[1] level and a lower tier local

[1] MSOA - a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales. The minimum population is c.5,000-15,000 population.

authority level with Directors of Public Health. The detail provided varies depending on the level and is included at Annex A.

B. *What demographic data on vaccine recipients are you sharing with local officials? For example, are they able to track vaccinations in their area by age and ethnicity?*

The demographic data on vaccine recipients being provided to local officials is set out at Annex A to this letter and includes age and ethnicity. This information is categorised by data being provided at the lower tier local authority level and at the MSOA level.

Public Health England (PHE) is currently facilitating the sharing of data with Directors of Public Health from NHS England and NHS Improvement (NHSEI/) Foundry (a secure data management platform) on the number of vaccinations given. These data are being made available via the PHE PowerBI dashboard (a secure Microsoft data visualisation platform) pending more robust automated feeds of National Immunisation Management System (NIMS) data from PHE at MSOA-level.

C. *Is the data you are sharing based on vaccines offered or vaccines given? What proportion of care home residents have received a vaccine in England? What data are you collecting on the numbers of people not taking up a vaccine offer, and what research have you done on why?*

Data is based on vaccines given. There is no data currently available on vaccines offered via a central system. However, data on vaccine offers is currently in development. NHSE/I are currently reporting on vaccine uptake as part of its oversight of the operational roll-out of the COVID-19 vaccines in England.

Data shows that from 8 December 2020 to 7 February 2021, a total of 248,115 care home residents in England were vaccinated with a first dose of vaccine out of a total of 265,295 eligible residents equating to 93.2% During the same period, 99.4% of eligible care homes were visited by vaccination teams. This data is now published on a weekly basis every Thursday[2].

The numbers of eligible residents are those identified by care homes for older people via the Capacity Tracker[3]. This excludes the following residents:

- residents who have tested positive for COVID-19 in the last 28 days and so, on clinical grounds, should not currently receive the vaccine;
- residents of care homes which are currently undergoing an outbreak and at the direction of the local public health teams cannot yet be visited;
- residents who have not received the vaccine for other valid medical reasons; and residents for whom there is no proper consent to receive the vaccination.

Data is collected on whether care homes have had a visit from NHS vaccination teams, the number of residents and of staff who have been vaccinated, and those who have not been vaccinated or whose vaccination status is unknown.

There are a number of relevant areas of research:

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[2] : https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

[3] The capacity tracker is a single data capture platform that provides information on care provider vacancies for health and social care teams.

- Attitudinal research is covered in the PHE COVID-19 Vaccine Surveillance strategy. This research is important for understanding views on vaccination and the barriers and drivers to uptake. This information can be used to adapt delivery models, patient information leaflets and wider communications about the vaccination programme. It is published online at:

  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951189/COVID-19_vaccine_surveillance_strategy.pdf

- PHE's currently commissions two annual attitudinal surveys exploring awareness of and confidence and trust in the national childhood and adolescent vaccination programmes. Expansion of this to cover confidence in the COVID-19 vaccination programme is planned.

- The National Institute for Health Research (NIHR) Health Protection Research Unit at the London School of Hygiene and Tropical Medicine has undertaken a survey of 18,000 people across the UK on their perceptions on both a novel COVID-19 vaccine and the seasonal influenza vaccine.

- PHE is also working closely with the NIHR Policy Research Unit at Newcastle University, who have undertaken an online behavioural insights survey. This includes those who are in high-risk groups and minority ethnic communities, who indicate they are unsure or do not want a COVID-19 vaccine, to try and improve the understanding of barriers to uptake in these communities.

Attitudes to vaccination will continue to be monitored through population surveys and qualitative interviews throughout and after the roll-out of the programme in order to adapt the communications and delivery strategy and maximise uptake in under vaccinated groups.

D. How long is the lag between a vaccine being administered and data being available to local officials?

At present there are three main vaccine point of care (PoC) systems: the National Immunisation Vaccination System (NIVS) App; the NIMS App; and, Pinnacle.

The NIVS and NIMS Apps are used in the NHS's hospital hub model while Pinnacle is used in primary care settings and the majority of vaccination centres. These PoC systems validate a person's identity through NHS records prior to checking vaccination status using records in NIMS (e.g. if they have already had a COVID-19 vaccine.

To record vaccinations in England, the NHS NIMS system is being used as the national register for COVID-19 vaccinations. The PoC systems outlined above connect to and feed the NIMS database. This also allows GP systems to be updated to identify that a patient has been vaccinated through other points of care. The NIMS database feeds through on a daily basis to PHE and NHSE/I, and is picked up in Foundry, for reporting analysis. The data is 'near real time', as would be expected with data on such a fast turnaround the initial reporting will tend to undercount the most recent days to a small degree. The undercount is 'made good' in the next few days following the initial count.

The daily published data is on an 'as reported by' basis. For example, on a given day the publication includes total number of vaccinations administered and reported by close of play the previous day. There will be some instances where vaccines administered will not have been reported in time so that the latest figures will represent a small undercount for the latest days.

However, there is also a monthly publication, which shows data on two different bases: on an 'as reported' basis and on an 'date of jab' basis. These two series alongside each other allow users to understand the difference between the volume of jabs initially reported for a given day and the total number finally reported for that day.

Regarding vaccinations in care settings, data is updated daily by care homes and immediately available via live online systems to local authorities.

E. Can you outline all the data on vaccines that is available to Ministers, Whitehall Officials, and/or Government scientists or advisors, which is not currently being available to local directors of public health? Can you explain why this is not being shared?

As mentioned above, PHE has secure information governance permissions and data sharing agreements to allow sharing of record level data and coverage at MSOA-level with Directors of Public Health via the PHE PowerBI dashboard in line with data requests from local Directors of Public Health.

PHE provides NHSE/I with weekly aligned figures of the numbers of people vaccinated derived from NIMS that is then published in the public domain by NHSE/I. It has also established a record level data feed from NIMS to Joint Biosecurity Centre (JBC) that is used by JBC for further analysis and communication.

NHSEI's weekly statistics for England contain coverage percentages for the 70-74, 75-79 and 80+ age groups. NHSEI have used ONS mid-year population estimates as the basis for both unpublished and published vaccine uptake denominators so far.

Ministers currently having sight of management information for operational purposes, ahead of data being fully quality assured and verified for publication, to ensure that publication is in line with the Code of Practice for official statistics.

All data relating to vaccine deployment in care homes that is available to ministers and officials in Whitehall is available via the Adult Social Care COVID19 Dashboard to Directors of Social Services in local authorities.

4. Can you outline actions the Government is taking to get ahead of misinformation, particularly misinformation about the vaccine?

The Government takes the issue of misinformation and disinformation very seriously. Misleading information about COVID-19, whether intended or not, could have serious health consequences and we are collaborating closely across Government to address this.

A. UK Government work with social media companies

We welcome the positive steps taken by social media platforms to curtail the spread of harmful and misleading narratives relating to COVID-19.

Recent changes have focused on limiting the spread of anti-vaccination content, including:

- Facebook banning adverts that discourage vaccination uptake and launching a public information campaign to support immunisation efforts.
- YouTube introducing information panels on its videos that contain links to accurate information about COVID-19 and banning content that contradicts expert consensus from health authorities, in relation to a COVID-19 vaccine.
- Twitter introducing new labels and warning messages to provide additional context and information to counter Tweets containing disputed or misleading information relating to COVID-19.

The Secretary of State for Health and Social Care and the Secretary of State for Digital, Culture Media and Sport held a joint roundtable in November 2020 to secure commitment from the social media platforms to continue to work with public health bodies. Building on this roundtable, the Government established the new cross-sector Counter Disinformation Policy Forum, bringing together industry, civil society and academia to improve responses to misinformation and disinformation and prepare for future threats.

The cross-Whitehall Counter Disinformation Unit (CDU), set up in March 2020 and led by the Department for Digital, Culture, Media and Sport, looks for trends on social media platforms so that misleading content can be countered rapidly. Action can take a number of forms, from labelling, to down-ranking, to removal where there is significant risk of harm, in line with the terms and conditions of different social media platforms. Through the CDU, the Government can act wherever false and harmful content appears to gain traction, by either flagging the content to platforms or through direct rebuttal.

B. *Can you outline actions the Government is taking to get ahead of misinformation, particularly misinformation about the vaccine?*

The Cabinet Office has acted quickly to stop scams and frauds related to vaccine appointments working with departments and the NHS to produce proactive social media content. When false narratives are identified, the CO coordinates with departments across Whitehall to deploy the appropriate response. For example, it has clarified that the public will never be asked to pay for vaccines.

The Government recently published its response to the Online Harms White Paper consultation, which sets out new expectations on companies to keep their users safe online. The Bill will be published later this year. Additionally, the NHS has joined up with law enforcement services, including the National Crime Agency and the City of London Police, to publish joint messaging on scams looking to exploit the vaccine campaign.

Robust research and evaluation have informed the development and delivery of cross-Government communications programmes. This includes testing communication materials before they go live, amending messages and channels in line with public response whilst activity is live and using the results from each programme to inform future planning. In this way, the Government can ensure that all its communication activity is as effective and efficient as possible.

The Department of Health and Social Care, NHSE/I and PHE are providing information and advice at every possible opportunity for all those eligible for vaccination and anyone who has questions about COVID-19 vaccines. This includes the SHARE checklist which aims to increase audience resilience by educating and empowering those who see, inadvertently share and are affected by false and misleading information. The checklist provides the public with five easy steps to identify false content, encouraging users to stop and think before they share content online[4]. Additionally, we have partnered with the University of Cambridge to create a game called “Go Viral!” to build the public’s resilience to false information, mitigating the risk of undermining the uptake of COVID-19 vaccines, treatments and diagnostics.

The Department of Health and Social Care, the Ministry of Housing, Communities and Local Government and the NHS also hold regular meetings with local authorities, faith leaders and black

[4] https://sharechecklist.gov.uk/

and minority ethnic (BAME) representative organisations to provide advice and information about COVID-19 vaccines and how they will be made available. Our communications include targeted information and advice via TV, radio and social media. This has been translated into 13 languages.

Recent polling from the Office for National Statistics on "coronavirus and the social impacts on Great Britain" (4 February 2021) suggest that 91% adults reported they would be very likely or fairly like to have the COVID-19 vaccine.

5. **The Royal Statistical Society recommended "a formal government review, analogous to the Bean review of economic statistics, is conducted into England's health data to ensure that a well-functioning system is established at the earliest opportunity." We would be grateful for your view on this.**

We agree that cross-organisational working and data sharing is more important than ever given the nature and impact of the Covid-19 pandemic.

As a result the Government's actions and those taken by our partners, various channels of data access and sharing have been strengthened or established during the pandemic, and both internal and public-facing central dashboards have been set up to show joined-up, UK wide data on a number of COVID-related metrics, ensuring analysts from within and outside government have access to the same key metrics. We are building on this to ensure that health and social care organisations routinely share data, when they can do so, for the benefit of the wider health and social care system.

NHSX is working on a Data Strategy for Health and Social Care which will set out how we can build on the lessons of COVID-19 and set out measures, including legislation, to allow for timely access to data for legitimate purposes and with appropriate protections beyond the pandemic response; and have established a new Data Alliance Partnership (DAP), which aims to make data accessible for legitimate purposes and within existing legislation.

In addition, we are considering changes to primary legislation which are intended to complement other measures to address cultural, behavioural and secondary legislative barriers to the effective, secure and appropriate processing of data. Dr Ben Goldacre has also been asked by the Secretary of State for Health and Social Care to examine how access to data can be better facilitated for researchers, analysts and innovators.

We will consider the merits of conducting a review similar to the Bean review once the Data Strategy and the work of the Data Alliance Partnership has had time to embed, the legislative changes have been made and we have the outcome of the review from Dr Ben Goldacre due late Spring 2021.

I hope that the Committee will find the additional information I have provided in this response helpful.

Helen Whately MP
Minister of State for Care

ANNEX A

DEMOGRAPHIC DATA ON VACCINE RECIPIENTS SHARED WITH LOCAL OFFICIALS

Data shared at lower tier local authority level:

- By detailed minority ethnic groups (17 categories below) and by gender:
- Total dose 1 latest day and cumulative vaccination events
- Total dose 2 latest day and cumulative
- 70-74 cohort by dose, cumulative
- 75-79 cohort by dose, cumulative
- 80+ cohort by dose, cumulative
- Care home cohort by dose, cumulative

At MSOA level (c.5,000-15,000 population):

- The same data fields as above but split by higher level ethnic group (6 categories) below.

Six higher-level groups (in bold) and 17 detailed ethnic groups:

- **Asian**
  - Bangladeshi
  - Indian
  - Pakistani
  - Any other Asian Background
- **Black**
  - African
  - Caribbean
  - Any other Black background
- **Mixed**
  - White and Asian
  - White and Black African
  - White and Black Caribbean
  - Any other mixed background
- **Other Ethnic groups**
  - Chinese
  - Any other Ethnic group
- **White**
  - British
  - Irish
  - Any other White background
- **Not known**