From the Permanent Secretary
Sir Chris Wormald

Department of Health & Social Care

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Rt Hon Meg Hillier MP
Chair of Public Accounts Committee
House of Commons
London
SW1A 0AA

Sent via email to: pubaccom@parliament.uk

10 March 2021

Dear Chair

PAC - COVID-19: Supporting the vulnerable during lockdown

Following the Public Accounts Committee Hearing on 22nd February 2021 regarding COVID-19 shielding, we committed to write to you on a couple of points raised during the hearing.

- **In response to questions from the Chair, Sir Chris Wormald agreed to write to the Committee with more detail concerning the publication of vaccine statistics both demographically and regionally. As per Q 6-11.**
- **In response to questions from Richard Holden the Chair and Sir Geoffrey Clifton-Brown, Sir Chris Wormald and Mark Reynolds agreed to provide the Committee with more information regarding the variation between local areas in the numbers of people GPs have added to the shielding list. As per Q38-48.**

Vaccine Management Information

The vaccination programme has been fast moving, and the published data that is available has been improving week on week as we build our confidence in the data quality.

We now have a range of data that provides figures for people vaccinated across a series of sub-sets, which is broken down into regional and constituency level (see Annex 1). This data is updated weekly and is updated on the following link:

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

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We do not publish target numbers by ethnicity as we do not yet have sufficient data to allow us to compare vaccination numbers. Setting arbitrary targets in these circumstances could potentially be misleading and go against our commitment to provide clear and accurate information to the public.

The vaccine deployment programme is continually improving tracking and monitoring of uptake by priority cohorts and BAME groups to further our understanding. We are working jointly with NHS Digital, primary care systems and secondary care data to establish cohorts by Sustainability and Transformation Partnerships and Local Authority.

A key priority is improving the quality and availability of ethnicity data – we are:

- Improving data collection at point of care by including worker type and ethnic category from next week;
- Improving the coverage of ethnicity population data by cross-matching with NHS Digital data for records submitted prior to introduction of point of care collection; and
- Developing a dashboard for the programme that can be used to better understand the location and cohorts where vaccination uptake is low and target resources and deploy appropriate actions to improve uptake.

Annex 2 includes the vaccine uptake statistics you requested for the shielding population. This is provided by NHS Digital in a private dashboard to CCGs, Directors of Public Health and other system leaders. It is updated weekly.

Variation between Local Areas

Additions process

The NHS Shielded Patient List was developed based on clinical guidance from the CMO for England and other senior clinicians, the Royal Colleges and local clinical judgement.

As a first step, patients were identified nationally based on their GP or hospital record if they had one or more clinical conditions as defined by UK CMOs. A list of these conditions is included in Annex 3.

Subsequently, patients were added locally by GPs and hospital Trusts. This allowed clinical discretion from the doctors that best understood their patients and their level of vulnerability to the disease.

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Action taken by NHSD and NHSE/I to address potential local variation

As per the guidance from the Chief Medical Officer, local clinicians have discretion on who to add to the Shielded Patient List. NHS England & Improvement (NHSE/I) and NHS Digital (NHSD) took steps to ensure that this process was consistent across England, whilst also ensuring clinicians retained discretion to make their own professional clinical judgements.

Guidance was issued by NHSE/I to GPs and hospital Trusts. This guidance, including letters to all GP practices on 21st March, 3rd April and 9th April and wider communications in late March and April, made very clear that whilst GPs could use their professional judgement to make additions, in doing so they should only follow the CMOs clinical guidance on additions. Webinars were also held with GP colleagues.

Alongside this, during the peak identification period by clinicians in March - April 2020, the NHSE/I high risk cell responded to almost 1,300 queries from clinicians to provide support on ensuring the CMO's guidance had been understood and appropriate operational steps had been followed to identify high risk individuals and add them to the Shielded Patient List.

Local decision making was also supported by a variety of guidance for specific specialities. Guidance for local additions was provided by the:

- Royal College of General Practitioners (https://elearning.rcgp.org.uk/course/view.php?id=377)
- British Society of Gastroenterology (https://www.bsg.org.uk/covid-19-advice/bsg-rcpadvice-for-ibd-liver-clinicians-on-identifying-immunosuppressed-patients-for-shielding-highly-vulnerable-categories/)
- The renal association (https://renal.org/)
- British Society for Rheumatology (https://www.rheumatology.org.uk/NewsPolicy/Details/Action-needed-coronavirus-identifying-high-risk-patients)
- British Association of Dermatologists (https://www.bad.org.uk/healthcare-professionals/covid-19)
- British Thoracic Society (https://brit-thoracic.org.uk/about-us/covid-19-identifying-patients-for-shielding/)

NHS Digital also published data at local authority and CCG level to ensure transparency and identify potential variation. These dashboards are published on the NHS Digital website. (https://digital.nhs.uk/data-and-information/publications/statistical/mi-english-coronavirus-covid-19-shielded-patient-list-summary-totals)

On 12th April, NHS Digital noted that additions by general practice showed wider than expected variation in comparison to practice size. It was identified that in some cases GPs were adding patients in bulk using computer searches rather than assessing individual patients. NHS England & Improvement then communicated to practices that there should be no automated processes used to complement or supplement individual clinical identification other than that used by NHS Digital.

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NHS Digital provided support to CCGs and Trusts to ensure patients were being appropriately identified, including Liverpool CCG, Manchester University NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust.

Joint NHS England & Improvement and NHS Digital action in the North West

NHS Digital and NHS England & Improvement were aware that Liverpool CCG had the highest number of local additions – significantly higher than many other areas. Approximately 11,000 Liverpool patients were centrally identified as meeting the criteria for shielding and approximately 37,000 were identified locally.

Liverpool CCG had rapidly established a local clinical group to identify appropriate codes to identify patients that met the criteria. These were then used to search patient records and lists were then reviewed by GP practices.

Although this approach did lead to a larger number of additions than in other parts of the country, local clinical leaders confirmed to NHS Digital and NHS England & Improvement that they were confident that the process was robust and appropriate and did not need to be re-reviewed. NHS Digital and NHS England & Improvement considered that ultimately additions were a decision for local clinicians as set out in the CMO criteria and guidance.

Analysis of local variation

In the PAC hearing on 22nd February, the Committee quoted percentage increases in the total shielding in an area (i.e., national + local) vs the initial national additions.

We have reviewed this approach and do not believe it is statistically correct. There is no underlying reason to correlate national and local additions, because they were used to identify separate conditions. For example, the incidences of haematological cancer (identified nationally) do not have a clinical relationship with incidences of chronic liver disease who are on immunosuppressants (added locally).

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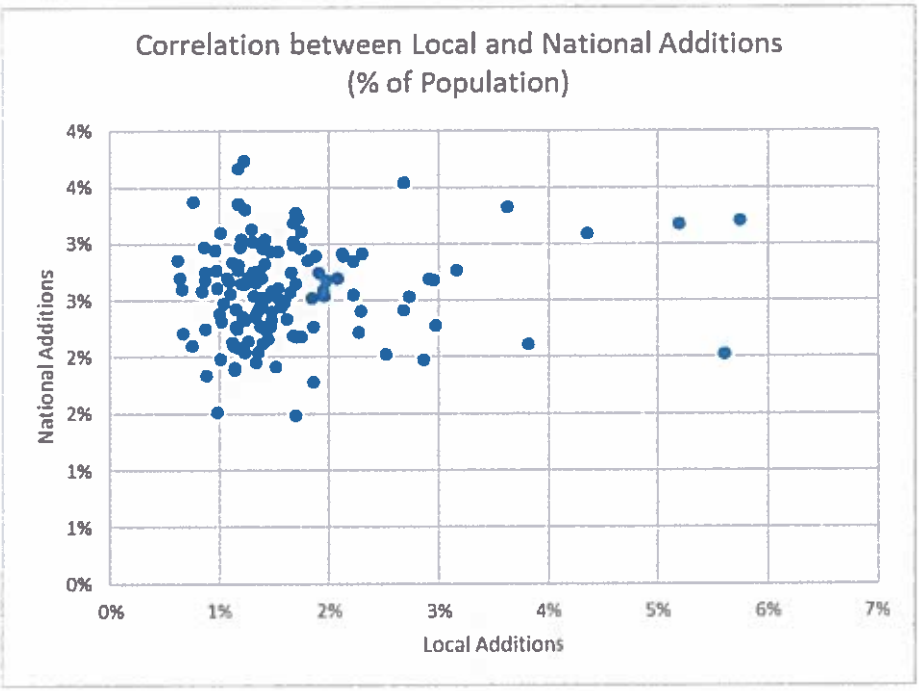
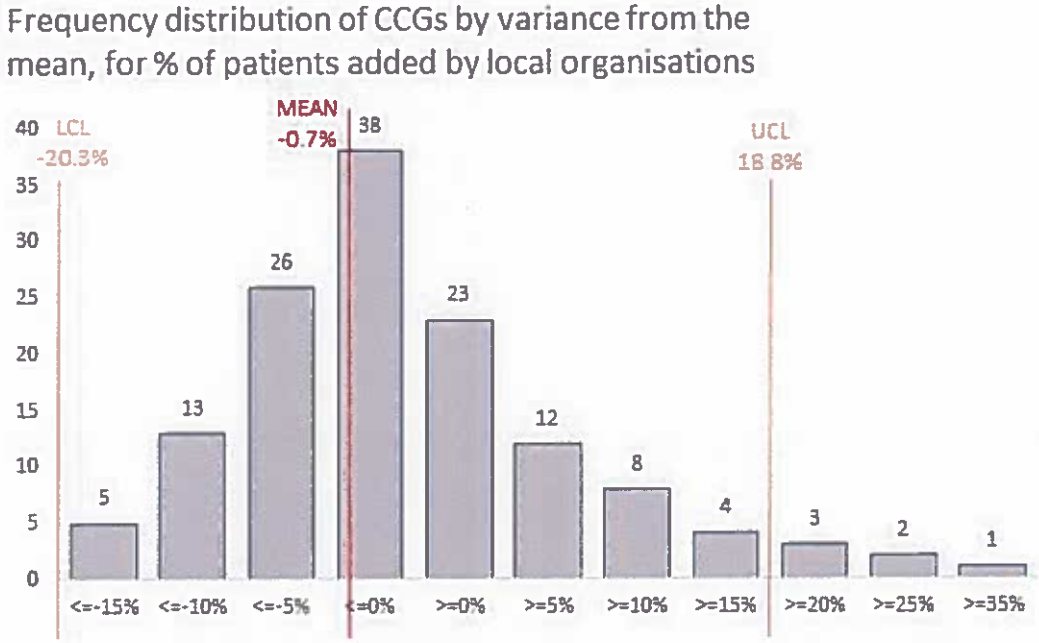
The lack of correlation is shown in the chart below using data from SPL43. If there was a correlation between nationally identified conditions and locally identified conditions, we would expect to see this as a more defined relationship.



Further analysis shows that variation in local additions largely fall within the range we would expect, with only a few CCGs outside of the expected distribution.



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NHS Digital has analysed the variation in local additions (i.e., those made by GPs and hospital Trusts) as of SPL43 (11th February 2021) that shows only a small number of outliers based upon a normal distribution. The analysis shows that six clinical commissioning groups out of 136 made additions more than 20% different from the 'mean' local additions as a proportion of the NHS Shielded Patient List. NHS Digital will repeat the analysis once the Q-COVID patients have been added and then work with CCGs to ensure consistency of approach.

Conclusion

As we have already noted to the NAO, local variation in the number of people identified and added to the SPL can be explained by demographic variations in the English population and the inevitable difference in decision-making arising from local clinical judgement.

As a first step, NHSD used a national ruleset to identify and add to the SPL people whose medical records suggest they meet the CMO's clinical criteria. This approach ensures a national baseline that means no-one is missed where they meet the minimum baseline definition of the CMO's criteria.

We then asked local clinicians to identify people, based on their better understanding and knowledge of local populations, an approach endorsed by the UK Chief Medical Officer to identify high risk individuals. As with other clinical guidance, the guidance published for clinicians on this was intended to be interpreted by clinicians with their patients based upon a more comprehensive understanding of their personal situation and medical history.

The programme has provided guidance, data and support to local NHS organisations to allow them to administer the programme according to their local health needs. This is a reasonable approach to ensuring consistency in local decision making.

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As indicated in the data, we believe this led to an acceptable regional variation in the NHS Shielded Patient List, both in terms of the incidence of disease identified by the national service and the range of additions made by GP practices and hospital Trusts. This is shown by the few CCGs outside the normal expected range. NHSE/I and NHSD provided support to local health systems to aid their decision making, including a specific follow up with Liverpool CCG which found the approach they had adopted was reasonable. This all took place at a time where there were competing demands on clinical time and so we are grateful to NHS colleagues for their work in creating and maintaining the list.

Yours sincerely,

Chris Wormald

SIR CHRIS WORMALD
PERMANENT SECRETARY

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Annex 1 – Vaccination Management Information

On 25 February 2021, weekly published stats from NHS England & Improvement started displaying numbers at Local Authority and Constituency level, as well as including Social Care Staff numbers.

Currently, the NHS weekly publication provides a breakdown of vaccinations:

- By Region and Age
- By Integrated Care System (ICS)/Sustainability and Transformation Partnership (STP) and Age
- By Clinical Commissioning Group (CCG) and Age
- By Ethnicity
- By Ethnicity and Region
- By Ethnicity and Integrated Care System (ICS)/Sustainability and Transformation Partnership (STP)
- By Constituency
- By Lower Tier Local Authority
- By Middle Layer Super Output Area (MSOA) of residence and Age
- Residents in Older Adult Care Homes
- Social Care Staff
- Trust Healthcare Workers by NHS Region
- Clinically Extremely Vulnerable (CEV) Cohort by NHS Region

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Annex 2 – Vaccination Management Information – Shielding Cohort

The information below has been provided by NHS Digital using the following data sources.

- Shielded Patient List – 18th February 2021
- Vaccination data – 21st February 2021

This snapshot is taken before the addition of patients through the Q-COVID population risk assessment.

Total Vaccinations

NHS Digital

SPL split by number of vaccinations - BETA Version

If you need help using this dashboard, or have any feedback, please email Covtandashboard.accessrequest@nhs.net

SPL Data extracted on:	18/02/2021
Vaccination Data extracted on:	21/02/2021
Data published on:	25/02/2021
Next publication:	04/03/2021

England Totals

FIRST Dose to Shielded Patients:	SECOND Dose to Shielded Patients:
2,134,021	71,627
(70.3% of SPL)	(2.36% of SPL)

First Dose Vaccination by Age Group

% Shielded Patients Vaccinated Table (First dose)

Click '+' to view further Ethnic Categories (when split by: Ethnic Category is selected)

		% Patients Vaccinated
16-29	England	44.47% (75,734/170,311)
30-39	England	38.54% (126,362/327,844)
40-49	England	48.71% (207,241/425,422)
50-59	England	63.88% (360,604/564,509)
60-69	England	80.27% (456,136/568,279)
70-79	England	92.67% (521,603/562,833)
80-89	England	93.53% (319,465/341,574)
90+	England	91.81% (66,876/72,844)

0.00% 20.00% 40.00% 60.00% 80.00%

% Patients Vaccinated

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First Dose Vaccination by Ethnic Category

% Shielded Patients Vaccinated Table (First dose)

Click '+' to view further Ethnic Categories
(when split by: Ethnic Category is selected)

		% Patients Vaccinated
		20.00% 40.00% 60.00% 80.00%
Asian or Asian British	England	42.91% (145,980/340,235)
Black, African, Caribbean..	England	36.28% (69,000/190,175)
Mixed or Mulitple ethnic g..	England	45.52% (21,005/46,140)
Not Stated or Unknown	England	57.89% (125,595/216,960)
Other ethnic group	England	43.19% (28,435/65,830)
White	England	80.21% (1,744,005/2,174,270)
		20.00% 40.00% 60.00% 80.00%
		% Patients Vaccinated

First Dose Vaccination by Gender

% Shielded Patients Vaccinated Table (First dose)

Click '+' to view further Ethnic Categories
(when split by: Ethnic Category is selected)

		% Patients Vaccinated
		0.00% 20.00% 40.00% 60.00% 80.00%
Female	England	68.17% (1,138,664/1,670,223)
Male	England	73.01% (995,327/1,363,276)
		0.00% 20.00% 40.00% 60.00% 80.00%
		% Patients Vaccinated

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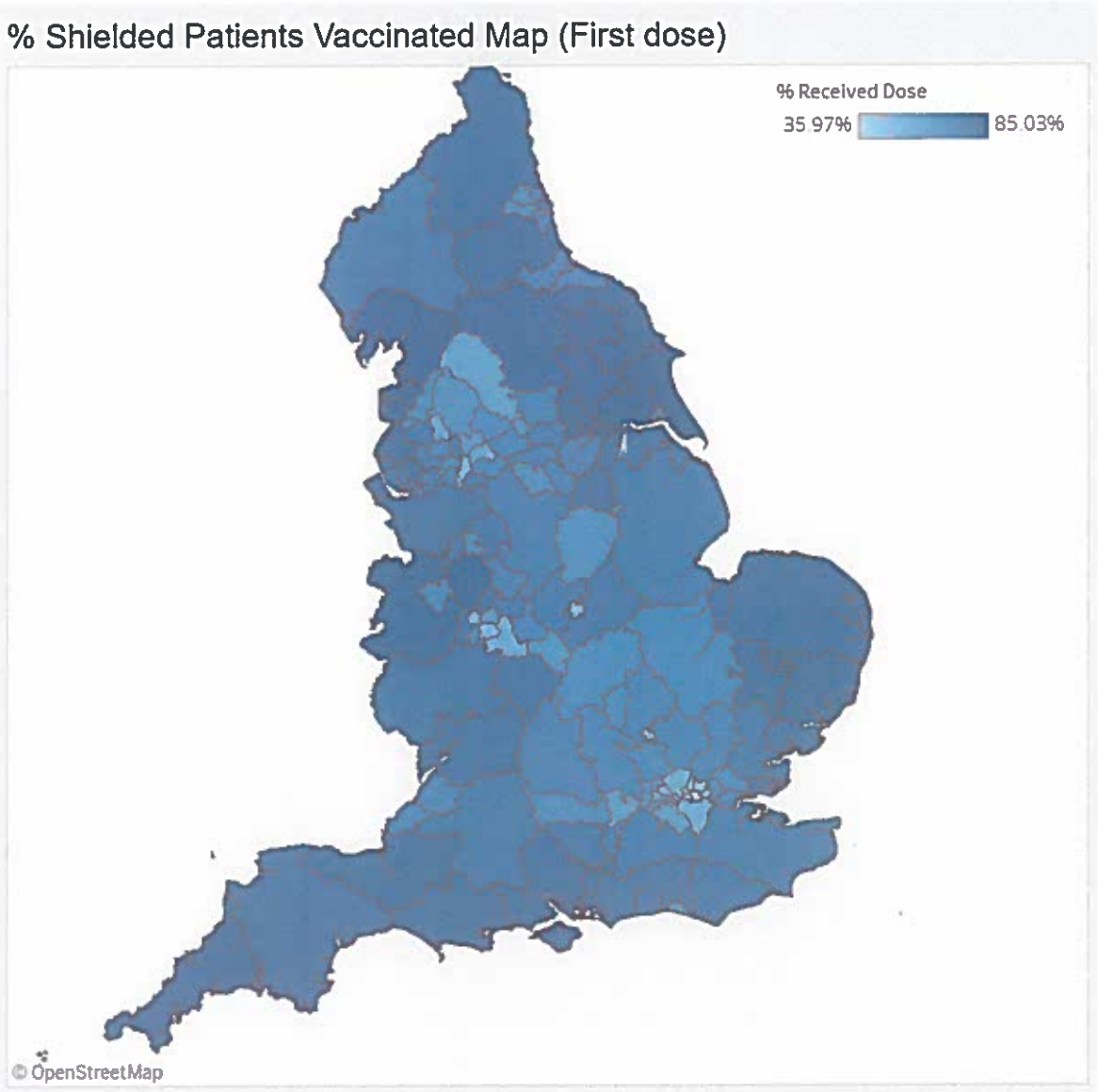
First Dose Vaccination by Clinical Commissioning Group



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Annex 3 – List of conditions identified nationally that qualified a patient as clinically extremely vulnerable

- solid organ transplant recipients
- people with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD)
- people with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as Severe combined immunodeficiency (SCID), homozygous sickle cell)
- people on immunosuppression therapies sufficient to significantly increase risk of infection
- people who have problems with their spleen, for example have had a splenectomy
- adults with Down's syndrome
- adults on dialysis with kidney impairment (Stage 5 Chronic Kidney Disease)
- women who are pregnant with significant heart disease, congenital or acquired
- people with cancer who are undergoing active chemotherapy
- people with lung cancer who are undergoing radical radiotherapy
- people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
- people having immunotherapy or other continuing antibody treatments for cancer
- people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
- people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs