

The Health Foundation's response to the Public Accounts Committee's inquiry on supporting the vulnerable during lockdown

February 2021

About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

About the Networked Data Lab

The Networked Data Lab is a collaborative network of analytical teams across the UK, using linked data sets to help tackle the most important health and care priorities, as identified by both those working in the health and care system and engagement with the public.

Linked data sets have shown themselves to be a crucial part of the COVID-19 response, allowing services to identify people most impacted by the pandemic and ensure they receive essential support and resources. The recent NAO report '[Protecting and supporting the clinically extremely vulnerable lockdown](#)' - highlights that a lack of linked data led to delays in identifying people as clinically extremely vulnerable (CEV) to serious illness from COVID-19.

The Networked Data Lab was established by the Health Foundation and we work with five partners across England, Wales and Scotland. A full list of the partners can be found on the [Health Foundation's website](#).

The Networked Data Lab is currently undertaking research to understand the experiences of those considered to be CEV, also known as the shielding population. The programme is ongoing and further findings can be shared with the Committee as they become available.

How effectively did government identify clinically extremely vulnerable people

CEV people were identified either through the national algorithm or through local health services. [An analysis by the Networked Data Lab](#) shows there is variation in the proportion

of people identified as CEV across these two different channels. While detail on method of addition to the shielded patient list was not available for all Networked Data Lab partners, there is substantial variation between the three sites with this data available – Grampian, Leeds and Wales. In Leeds, the majority (61%) of CEV people were identified by their local health system. This was even higher for those over the age of 80 (71%). In contrast, in Wales, 88% of people were identified by the centrally developed **Welsh** methodology, with little variation with respect to age.

There are likely to be multiple causes of this variation including:

- Different local approaches locally to adding people to the shielded patient list
- differences in the demand for additional support, and
- differences in coding practices within health records, leading to variation in who is captured via the centrally developed methodology.

By sharing the approaches, methods and code lists that have been used to build the shielded patient list locally, the Networked Data Lab has begun to understand the nature of these differences across areas and ensure that all individuals who are CEV have equitable access to the support they need to keep themselves safe during the pandemic.

From our analysis, we also demonstrated variations in the number of people identified as CEV by ethnicity, age, deprivation and regions.

The three Networked Data Lab partners in England were able to analyse ethnicity data, highlighting the significant variation. While broad categories do not accurately capture an individual's ethnicity, the data does indicate that North West London serves the most ethnically diverse population: of those with known ethnicity data available, 63% of the CEV population were from black, Asian and ethnic minority backgrounds. In Leeds this was 13% and in Liverpool and Wirral, 10%. This likely reflects the demographic diversity of these areas.

Although age is not part of the criteria in the guidance for CEV people, almost two-thirds of those who were asked to shield in England are aged 60 or older; while 7.3% of those asked to shield are younger than the age of 30. This age distribution reflects that the conditions that place people at the highest risk of serious illness from COVID-19, are more likely to present in older adults. There are small differences across gender, with 4.1% of women and 3.8% of men being asked to shield.

There are also substantial variations in the proportion of people asked to shield across income deprivation. Of people living in the fifth most deprived local authorities, 4.2% of people have been asked to shield. In contrast, only 3.5% of those living in the least deprived areas have been asked to shield. The **prevalence of long-term conditions**, in particular **respiratory conditions** that put people at higher risk of serious illness from COVID-19, **varies by socioeconomic deprivation**. This may explain the variation seen in shielding across deprivation levels.

While a total of 4% of people in England have been asked to shield, there are substantial variations in the proportion of people asked to shield across different local areas. In the

North West, 4.8% of people were asked to shield whereas in the West Midlands this was only 3.6% of people. Variations across local areas have important implications for how services are arranged and delivered to ensure that this group is still able to receive the health and social care they need, as well as being able to participate in society while still being protected.

How government protected and supported vulnerable people

By definition, the CEV population have conditions which require ongoing support and care from the health and social care system, and they are more likely to need to access to health and social care to ensure their health does not deteriorate.

Networked Data Lab analysis of the NHS Digital data about people in England asked to shield shows that as of October 2020, over a third (38%) have been asked to shield because of a respiratory condition, 17% because of a rare genetic, metabolic or autoimmune disease and 14% due to being treated for cancer.

The results of the **ONS Shielding Behavioural Survey** revealed that by the middle of July, approximately one in three people (31%) who were shielding in England experienced a reduced level of care for their existing health conditions. One in ten were not accessing any care at all.

People who were shielding had the option to register for support, for example to receive priority supermarket deliveries or other forms of local help. According to the same survey, 13% of people shielding registered to receive this type of support. Among this sub-group, 38% experienced reduced access to care. The levels of reduced care within this group are concerning, particularly as this is a group that has requested additional support and is known to local services.

The survey also reported that more than one in three people (37%) experienced a decline in their mental health and wellbeing since being advised to shield. This was echoed in a survey of older adults using the **English Longitudinal Study of Ageing (ELSA) COVID-19 Substudy**. This found that those asked to stay at home experienced higher levels of depression, anxiety, loneliness, and a reduced quality of life compared with the study population.

This analysis of the NHS Digital and ONS data on the CEV population reveals a concerning lack of access to health services to treat ongoing health conditions, and the impact of shielding on mental health. While shielding was intended to protect those most at risk of becoming seriously ill from COVID-19, it is important to recognise that there have been a number of unintended consequences which may be long lasting, including the potential long-term impacts of unmet health care needs. This analysis specifically focused on experiences of access to care and adds to what the NAO has examined.

Whether government has learnt and applied lessons from its shielding programmes

The analyses carried out by the Networked Data Lab are not intended to be an assessment of whether the shielding policy was effective. However, through the process and in collaboration with our partners as well as patients and the public, we have identified a number of outstanding questions which, if answered, will aid the understanding of how well the policy has worked and what can be learned.

1. What proportion of people have been added to the shielded patient list locally and why were they added?
2. How many people were added to the list for multiple health conditions?
3. What long-term conditions (other than the reason for shielding) does this group of CEV people have?
4. How have these people used health care services previously in the treatment of their long-term conditions?
5. How has their use of health care services, including inpatient, outpatient and A&E, changed over the course of the pandemic?
6. How many people who were asked to shield had a COVID-19 admission to hospital?
7. How did contact with council-led services affect the use of emergency services for those who were asked to shield?
8. What has been the impact of the pandemic on depression and anxiety in children and young people who were identified as CEV?
9. What are the mental health needs of those who have been asked to shield?

Conclusions

There are substantial differences between regions in how people have been added to the shielded patient list, as well as variation in the composition of the CEV population in terms of level of deprivation, rurality and ethnicity. A transparent approach, including better understanding and sharing of the context of these differences, can inform local responses and the services they deliver to support the needs of those who have now been asked to shield once more. This is particularly important as the shielded patient list is used to target COVID-19 vaccine prioritisation and provides furlough support where appropriate to CEV people.

The Networked Data Lab plans further analysis using linked secondary care data to develop a better picture of the health needs of these CEV individuals and develop highlight care which may have been missed during the initial shielding period between March and July 2020. This will provide valuable insight to assist with service planning in 2021 as infection rates and demand for hospital care increase. These data will also point to where health and care systems should plan for high levels of delayed need going forward for those who are currently at very high risk of serious illness with COVID-19.