that policy decisions can be made, and also to develop a tool that clinicians can use to discuss individual risk. NM noted that they receive regular enquiries from patient groups around why specific conditions do not fall under the shielding group. The model is likely to be heavily age modulated, and may result in some people being taken out of shielding. It was noted there might be issues related to the granularity of data in the model.

1.4 The Subgroup commented on the need to involve patient groups at an early stage to test the presentation and communication of the data. The Chair asked if NR could support this work. NR replied that they were happy to be involved with testing of the final product via patient groups, but public facing communications around the protocol would be better done by someone else. The Chair suggested DHSC should take on this task.

Action: DHSC to start draf ting lay explanations of the work/proposals for the tool, which could be tested with the working group, and then with patient groups.

2.0 Development of the model

2.1 The group discussed the type of risk that the stratification should be based on. The group agreed it was key to get people into risk bands/strata – and not to apply numerical and individual risk scores. The group agreed to use relative risks (relative to another person's risk), rather than absolute risks.

2.2 The group agreed on the need to be clear that this risk stratification shouldn't be used to inform clinical decision making – such as decisions over who would or not get treatment, or qualify for ICU.

2.3 The group discussed possible outcome measures. Most members agreed that risk of death if positive for COVID-19 should be the primary outcome measures, noting that a definition of a COVID-19 positive death was required.

Action: All to contribute towards developing a precise definition of COVID-19 mortality - ideally to match the figures which the govt has been publishing.

2.4 The group discussed other possible outcomes, and whether a composite measure could be used. The group noted that including composite outcomes such as death and admission to hospital would provide greater clinical gr anularity, however composite outcomes would be harder to interpret. The group agreed that the public are likely to be more interested in the risk of death than other outcome measures.

2.5 The group agreed to use the following outcomes:

i. Primary outcome: COVID-19 positive death

ii. Secondary outcome: Hospital admission

2.6 The group discussed the study population and whether children should be included. NM noted the paediatric view that the shielding list for children is too large – and that the risk to children of being kept off school outweighs the risk of a child in a cli nically vulnerable group.

2.7 EW suggested it would be necessary to look at a separate risk model for children with difference outcomes, as their inclusion would skew the results. The group agreed that children should be excluded from the main analysis, and that a separate work stream should be established