Shielding lessons learned review - March 2020 to June 2021

Background

Throughout the early waves of the coronavirus pandemic, individuals who were considered to be clinically extremely vulnerable[1] were advised to follow shielding measures by the Chief Medical Officer for Wales for two separate periods. This was due to a possible poor outcome if these individuals were to contract Covid-19. The first full shielding period ran from 23 March 2020 to 16 August 2020, and the second from 22 December 2020 to 31 March 2021. In between these periods and since 01 April 2021, the advice to follow these measures paused. Once we knew more about how the virus was transmitted, it was important to balance the risks and impact of complete isolation on mental health, so during the end of the first period and throughout the second shielding period, daily outdoor exercise was included in the advice.

Details of those who are considered clinically extremely vulnerable are held on the shielding patient list (SPL). This list was compiled from searches conducted by Digital Health and Care Wales (DHCW) (then the NHS Wales Informatics Service) of electronic patient records in primary and secondary care, community and hospital pharmacy records, identifying individuals with a list of conditions and medications as agreed by the four UK Chief Medical Officers.[2] GPs and secondary care clinicians have also been able to add patients to the list throughout. The SPL has been maintained throughout the pandemic, including periods where advice has paused, and has been used to maintain communications with this group and facilitate vaccine prioritisation.

In addition to provision of a notification in the form of a letter from the Chief Medical Officer for Wales advising people not to attend work or school outside the home and allowing people to access statutory sick pay, a number of support services were put in place to enable individuals to remain entirely at home. These services were largely intended to provide support for those who did not have existing sources of assistance (e.g., family and friends) available.

1) **Food boxes** – as there were challenges initially around the availability of some key food items, all those on the shielding patient list were able to ask for a free food box to be delivered. This support was in place until 16 August 2020 and was not reinstated for the second period of shielding advice.
2) **Pharmacy delivery** – In addition to existing local pharmacy delivery arrangements, two national schemes were put in place; The National Volunteer Prescription Delivery Scheme and the Royal Mail Track 24 Click and Drop Scheme. This support was in place until 16 August 2020 and was not reinstated for the second period of shielding advice.
3) **Local authority support** – while no particular form of support was indicated at a national level, each local authority utilised the shielding patient list to

[1]Guidance on protecting people defined on medical grounds as clinically extremely vulnerable from coronavirus (COVID-19) – previously known as 'shielding' [HTML] | GOV.WALES (available online)

[2] Further information on methodology available here: https://nwis.nhs.wales/coronavirus/coronavirus-content/coronavirus-documents/covid-19-high-risk-shielded-patient-list-identification-methodology/

identify, contact and support those in their local area as required. This approach differed depending on location both in terms of how need was established and how or by whom services were delivered. Although the format, type and frequency of contact may have changed throughout the period of the pandemic, those requiring support are still able to contact their local authority if they do not have other alternatives.

Major food retailers supported the clinically extremely vulnerable by putting in place priority access arrangements to online deliveries. This service remains in place in Wales at the time of writing.

To facilitate this support for individuals, the SPL was shared with major food retailers, local authorities and water companies.

Aims of this report

The introduction of advice to follow shielding measures for clinically extremely vulnerable members of the public and putting in place Government support to allow people to do so, was an unprecedented policy intervention. Systems and processes to introduce such a programme did not exist prior to 2020 and were established solely to support clinically extremely vulnerable individuals in response to the coronavirus pandemic.

Recognising the opportunity for innovative approaches to inform future ways of working, this short report aims to identify strengths and areas for improvement from the programme to learn from the experience of implementing 'shielding' policy.

Approach

This report has been drawn together by members of the current shielding team, based within the Health and Social Services Group, Welsh Government. As no current team members were involved in the activity to establish and deliver the shielding programme between March 2020 and May 2020, the list of participants to be invited to participate was agreed with the former Deputy Director for the shielding programme, Amelia John.

Internal colleagues were invited to access a survey or participate in a one-to-one interview. Colleagues external to Welsh Government were offered a one-to-one interview.

Colleagues were asked the following questions:

1) What went well?
2) What was challenging, or could have been improved?
3) What improvements were made?
4) What further changes would be useful for the future?

Summary of Responses

The responses to these questions have been collated, analysed and grouped into common themes below.

(i) Collaboration

Many respondents identified collaboration between colleagues, Ministers, local authorities and internal and external stakeholders as very positive, with particular emphasis on strength in working together to achieve a common goal. Due to the unprecedented and emergency nature of the work, many colleagues reported working outside the scope of their usual roles, navigating through areas of uncertainty, but felt they were able to maintain focus and deliver key services at pace.

Collaboration was stronger in some areas than others. Relationships between WLGA/WCVA and Welsh Government had an existing foundation of partnership and, though there were challenges to overcome, the establishment of daily contact calls, which reduced in frequency over time, facilitated immediate discussion and collective approach to working through issues. This group also facilitated the sharing of information and a collective sense of responsibility and accountability.

Relationships were less well established with DHCW and recognising this, a co-ordination role was established by the NHS Delivery Unit - acting as an intermediary between DHCW and Welsh Government colleagues. This lack of an established relationship prior to the pandemic, limited resources in both DHCW and Welsh Government health policy and the limited understanding within Welsh Government of the mechanisms/ways of working within DHCW meant that when an element of delivery went wrong, there was less support in place for colleagues working as part of a shared endeavour. Shared ownership of issues was highlighted as a challenge. Regular cross organisation team meetings were put in place after May 2020 when the health policy function became more established.

The importance of maintaining good relationships and networks across a wide scope of organisations was identified as key to enabling rapid establishment and delivery of services in emergency situations.

(ii) Resourcing

In almost all teams that we spoke with/responded to the survey, resourcing was a key challenge at the start of the pandemic, due to very short timeframes required for emergency response and insufficient numbers of staff to be diverted to the task. This led to staff working long hours, including evenings and weekends, on a regular basis over a number of weeks and concern was expressed that this way of working felt unsustainable. Respondents reported sometimes feeling a lack of direction but felt that the flexibility demonstrated by those involved was crucial for delivering at the pace required by the circumstances.

In May, shielding policy moved to within Health and Social Services Group. This coincided with priority resourcing being placed on a more established footing across Welsh Government, thus despite continuing with long working hours, for the first time the main policy function was properly resourced. However, for teams in other

organisations the resourcing position became more challenging as people were asked to take on more of their previous work or were diverted to other pandemic priorities.

(iii) Data Sharing

Implementing data sharing arrangements was a significant challenge due to the complex data pathway (involving various contact points for data to pass through) and legislative context involved.

Establishing the approach to data flows for the SPL was a key early success. Use of emergency Covid-19 legislation made it possible to share data with a range of bodies and companies critical to supporting vulnerable people (local authorities, food box suppliers, pharmacies, supermarkets, utility companies) in a rapid timescale.

There were existing data agreements and processes in place which helped facilitate the sharing data. However, some local authorities who had not previously used the selected system (Objective Connect) reported some frustration at having another system requiring different passwords and new processes. There was also a lack of alignment for data sharing formats and processes across the wider Covid response, increasing workload for colleagues in DHCW, due to varying format requirements between different teams working on aspects of Covid response.

Identifying the correct lawful basis was a key barrier requiring substantial resource and expertise to resolve. The differing approaches between Wales and England were also challenging to work through at times. To make this easier for the future, officials should work with UK government to consider legislative arrangements that could enable greater flexibility of response, such as pursuing an 'emergency response' objective for the data sharing powers in the Digital Economy Act.

Colleagues also faced technical challenges relating to the coding of health record data. This impacted capability to answer queries about specific conditions. Changes made to improve documentation of codes made by Knowledge and Analytical Services (KAS) aided the process for maintaining the SPL and increased resilience and ability to rectify any procedural errors that arose.

(iv) Communications

The main method of communicating with individuals on the SPL was through sending letters containing advice from the Chief Medical Officer directly to individual addresses, while also, for later versions, publishing the content of the letter online. During periods where shielding advice was in place, letters fulfilled a legal requirement that a notification was issued, for the purposes of eligibility to statutory sick pay. Letters also ensured that digitally excluded individuals were able to access advice easily.

The requirement to issue a physical letter presented challenges – the contact information held about individuals through GP systems was sometimes incorrect and in the original issue of letters a significant number were misdirected due to the manual process required for list management. The production of letters took time both in terms of drafting and appropriate clearances and subsequently in printing,

sorting and distribution. From the announcement of a letter to doorstep took a minimum of two weeks which was not ideal considering the immediacy of the message some of the letters needed to convey. As time went on, processes across organisations were agreed e.g., monthly demographic refresh of the SPL to streamline the process. This included utilising a commercial print solution for communications to the full SPL.

Publication of letters was prioritised in English and Welsh only initially and this resulted in some poor feedback around accessibility of messaging. Accessible versions were then made available online and provided on request for each letter issue. To provide as much assistance as possible and in response to feedback from the disability forum, all letters were then produced with an easy read section at the start and end of each letter offering sources of support.

Other sources of communication with the public included strong media coverage and interest. This helped to ensure a large degree of public awareness of the support available for people on the SPL. However, while the policy intent was to align on shielding policy across all four UK nations, cases where approach diverged led to confusion between national and devolved administration messaging. For example, In Wales, shielding was not introduced in the two-week firebreak period at the end of October 2020. However, England introduced a letter for people to not attend work or school during their lockdown during November/early December.

From June 2020 onwards, stakeholder forums consisting of representatives from third sector groups, local authorities and community voluntary councils were held virtually on an ad hoc basis when there were new updates to advice and to inform guidance development. These provided a space for Welsh Government to share and receive information. This two-way relationship supported policy officials to be able to respond to the needs of the shielding community, while clarifying any areas of ambiguity or consolidating understanding.

Additional challenges for communicating a clear narrative included confusion around whether shielding measures were advice or legal measures, as well as the role of GP surgeries in providing advice (while GP surgeries were provided with guidance and a template of the letter to issue if required, patients were often redirected to contact Welsh Government instead). Instigating a central contact mailbox helped to alleviate some of this difficulty, as policy officials were able to respond directly to individuals with concerns.

(v) Service Provision

The speed at which services such as pharmacy and food boxes were established stood out as a positive achievement. The pharmacy service[3], which recruited volunteers to help deliver medications to shielding individuals, was set up over a five-week time period (an exceptionally rapid timescale compared to pre-pandemic procurement exercises). It included a clear audit governance trail despite the large number of contracts required. Consideration was also given to future planning, with potential for extension embedded into contracts from the outset.

[3] New volunteer prescription delivery scheme to support those shielding or self-isolating | GOV.WALES

Food box services were also introduced in a short timescale, with national contractual and delivery arrangements set up within two weeks, despite the complexity of the process. These could be requested from local authorities and were delivered weekly to people's doors, with a typical box containing 'a range of items, such as UHT long life milk, tinned produce, pasta, toilet roll, breakfast cereal, fruit and vegetables and bread.'[4].

However, substantial challenges were associated with this service. Partners such as local authorities and strategic co-ordination groups (SCG) critiqued the quality of food provided, while some local authorities requested to receive funding directly rather than through the nation-wide scheme. Cross-border communication difficulties were encountered with food boxes provided from England. Catering for dietary requirements was not possible under the initial scheme, which impacted people with religious and disability-related (or other dietary preference) requirements, although some LAs introduced the ability to adapt food boxes later in the pandemic.

The food boxes had been a national contract. There was lack of control with accuracy of where, when and what was delivered due to the scale of the contract. As the weeks went by, and to ensure effective delivery of the food boxes, both Ceredigion and Carmarthenshire piloted their own food box scheme to ensure quality food was delivered at the right time and to the right place. Supermarkets developed their own food box scheme (at a cost) which made it easier for others who were not on the SPL to have access to essential food, without the issues of working through an online order.

(vi) Organisational Infrastructure

As with other elements of coronavirus response, organisational frameworks for response were not sufficiently in place pre-pandemic, and therefore were constructed at the same time as delivering the response itself. For shielding this was further exacerbated by the intervention itself being completely unique, with no obvious lead policy owner. This is an unfamiliar way of working within civil service structures, where large projects or programmes often feature planning phases prior to any delivery being conducted. As a result, various infrastructural challenges were encountered. These included:

- Lack of clarity around governance structures and which key areas needed to be involved within Welsh Government at the start of the pandemic.
- Lack of clarity around governance structures from external stakeholders
- Change in Minister for approval. Though the clinical aspects of the advice to shield have been led by the Chief Medical Officer of Wales, there has been a change of Minister where initially the policy fell under the portfolio of the Minister for Local Government and Housing but by June, the policy then moved under the Minister for Health and Social Services,
- The relationship with other partners.

[4] First food boxes delivered to the homes of people shielding from coronavirus | GOV.WALES

    - Communication and engagement with UK Government was a significant challenge initially, though this was always strong clinically and improved vastly on policy after the early stages.
    - The Emergency Co-ordination Centre (Wales) (ECCW) and Customer Help were not directly involved with shielding conversations so were unable to provide efficient and correct responses to the public. To prevent this, updates were provided to ECCW and Customer Help to ensure correct information was provided.
    - Clinical involvement was crucial for informing the approach appropriately but took a number of weeks to secure as the policy was not sufficiently linked in with health. This was partially resource related and partially due to poor feedback loops.
- Lack of capability to 'fast track' bureaucratic processes, or lack of pre-existing emergency routes to achieve everyday processes.
    - Processes to sign off funding felt challenging and quite bureaucratic, through Ministers and Star Chamber.
    - Usual processes for quality assurance were not suitable for the speed of delivery required at the start of the pandemic, and alternative quality assurance processes were not available.
- Government business processes were not adequately prepared for, or sufficiently resourced, to meet the volume of calls, emails and letters received containing enquiries from the public.

Some of these challenges were overcome by identifying a shielding team within Health and Social Services Group in the Welsh Government and setting up a central shielding mailbox. The team worked closely with government business team colleagues to overcome the backlog of public and ministerial enquiries. They also engaged and worked closely with stakeholders, such as Learning Disability Wales, to improve the accessibility of information provision, such as through adapting standard publication formats to include 'Easy Read' translation.

Recommendations

If shielding needs to be implemented again in the future the following actions need to be maintained and/or implemented to ensure an efficient and streamlined approach which is communicated well with internal and external stakeholders.

Actions for shielding team:

- Produce a high-level stakeholder organogram
- Ensure a clear point of contact is available for recipients of shielding advice. This could take the form of a contact centre. GPs should also be aware of this contact point, as well as specific guidance for them in how to support patients advised to shield.

Actions for wider Welsh Government:

- Incentivise flexible resourcing opportunities so that people can adapt to crisis when needed. Recognise longer term impacts of crisis ways of working and prioritise securing sufficient staffing resource for support.
- Identify and communicate clear governance and reporting structures and decision-making processes at the outset and maintain these.
    - This should extend to the four-nation level, including with clinical governance structures.
- Prioritise strong working relationships with stakeholders
    - Include local authorities and community voluntary councils in forums from the start
    - Establish good working relationships with counterparts in other UK nations
- Prioritise use of accessible formats, including providing easy read alternatives as standard and translation to other languages as appropriate (including BSL).
    - Ensure appropriate expertise is in place to advise on complexities of translating medical language.
    - Utilise 'call-off contracts' for translation
- Work with UK Government to pursue an 'emergency response' objective for the Data Sharing powers in the Digital Economy Act to aid in the response to future emergencies
- Consult the Information Commissioner's Office, if necessary, as a reassuring advisory source.

Actions for future similar pandemic response teams:

- Have desk instructions in place to ensure consistency. This could include useful lessons learned – e.g., that when sending queries, grouping them can be helpful - checking a list of 20 may only take slightly longer than checking one, but save a lot of time overall.
- Align policy approaches across UK nations to support consistency of messaging.
- Critically review stakeholder engagement and governance structures periodically to identify any areas of omission (important to ensure representation from health and local authorities).