Plan, Prioritise, Protect:
Redefining the Needs of Vulnerable Groups to Pandemics Through Covid-19

On behalf of the APPG on Vulnerable Groups to Pandemics, this report was researched, written & funded by the Secretariat:

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Foreword

It is increasingly apparent that the government needs to be better prepared for future pandemics. The impact of pandemics on the health of the most medically vulnerable society is severe. Furthermore, the Covid-19 pandemic is still a threat. Continued risk of transmission, disruption to the health system and elective care, and delayed policy action all cause conditions to worsen and are leading to deaths. Unless lessons are learnt from Covid-19, and plans are put in place, future health crises will discriminate against the medically vulnerable. Policy that lessens the impact of future pandemics is needed for protection and healthcare equality.

We have heard testimonies from patients who have been afflicted with worsening mental health, forced to return to unsafe workplaces, and unable to receive deliveries of food. Delays to elective care, and the current treatment backlogs across many disease areas, further adversely affect people’s existing medical conditions. This is unacceptable. Vulnerable patients should be cared for and supported during future pandemics to ensure they have an equal quality of life and are able to participate in society. We implore the government and the NHS to, in future, provide more financial and economic support, clearer communication, and continued healthcare services. We also call on the government to begin their statutory inquiry into the handling of the pandemic in order to expedite their policy creation for future health threats.

We are very grateful for all the evidence this inquiry received and would like to thank all the patients, charities, patient groups, clinicians, and politicians who engaged with the APPG and promoted this important issue. From their evidence we developed a set of recommendations which aim to inform and shape the policy response to future pandemics to ensure the most medically vulnerable are properly protected.

Lord Mendelsohn
Bob Blackman MP

Co-Chairs of the APPG on Vulnerable Groups to Pandemics

February 2022
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Introduction

Covid-19 has created extraordinary emotional and physical turmoil across the country and has challenged healthcare institutions across the UK. No one has been left untouched by the pandemic. The threat to the most medically vulnerable, however, has been even more severe. For these groups, the increased risk of death upon catching Covid-19 has meant they have spent the majority of 2020 – 2021 isolating in their homes, avoiding contact with loved ones and having routine healthcare consultations and elective surgery delayed. The immediate threat to health and the long-term societal impact of the pandemic has frustrated their lives and imposed a mental and physical burden.

We need to ensure the government’s plan to “build back better” is not just a slogan and that, in future pandemics, the medically vulnerable are properly protected. Their numbers are not small. The Office for National Statistics (ONS) estimates there are 3.7 million people classified as ‘Clinically Extremely Vulnerable’ (CEV) in England (around 7% of the total population). Caring for such a large and at-risk group, which encompasses all ages, backgrounds and ethnicities, should be a priority for policymakers in preparing for future pandemics.¹ They are also family, friends and neighbours. CEV groups include people with relatively common diseases such as those leading to immunosuppression (such as certain cancers) or solid organ transplants, severe respiratory conditions (for example, cystic fibrosis or severe COPD), and kidney disease.² Many times more were included in the ‘at risk’ grouping due to an underlying medical condition, for example diabetes or mild asthma.³ Although not designated ‘clinically extremely vulnerable’, these people still had an increased risk of severe illness if they caught Covid-19. As such, we include them in the catch-all terms ‘medically vulnerable’/‘vulnerable’ used in this report. These people should be protected with specific interventions, specifically attended to by the Pandemic Preparedness Partnership (the government body targeted with minimising the health impact of future global pandemics) and central to public inquiries regarding the handling of Covid-19 (as promised by Prime Minister Boris Johnson to the House of Commons in May 2021).

Initial meetings of the APPG raised the issues of the UK’s high Covid-19 mortality rate, failures in the protection of vulnerable people, and disruption to routine healthcare. As such, the members felt it was imperative that an inquiry be run to formally collect evidence on these issues. To formulate policy recommendations to protect the medically vulnerable in England, this inquiry has used vulnerable patients’, charities’, and other stakeholders’ testimonies about their experience of the pandemic. We asked: **What lessons can be taken from the government’s response to Covid-19 to inform long-term health policy on preparedness for future pandemics in the UK?** By placing the medically vulnerable at the heart of the APPG’s discussions on the harrowing effects of Covid-

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¹ The ‘CEV group’ includes those who were at the highest risk of Covid-19. Formally, The Department for Health and Social Care and Public Health England noted that they were the group who were advised to shield and follow specific guidance. People were identified as being CEV either due to an underlying condition or from an assessment from a medical professional that stated that they would be at higher risk of serious illness upon catching Covid-19. The specific guidance was published by the government. See the most recent advice, as an example: Department for Health and Social Care & UK Health Security Agency, ‘Guidance for people previously considered clinically extremely vulnerable from COVID-19’, GOV.UK (December 2021). Available online: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19.

² Many times...
19, we focussed the inquiry on the people affected by the pandemic, as opposed to any financial implications or the impact on NHS infrastructure.

The inquiry was open from January 2021 and submissions were encouraged throughout the year until October. We received emails from individuals, copies of reports published by patient organisations during the pandemic, and written statements from charities about their experiences. We also held oral evidence sessions and four events throughout the year with specific focuses - cancer and immunocompromised patients, respiratory patients, shielders, and the vaccination programme - attended by parliamentarians, clinicians, charities, patients, and members of the public. All of their contributions played a key role in our work to formulate evidence-based suggestions designed to elicit policy discussion and relevant policy change for future pandemics that will better protect and support the medically vulnerable.

The inquiry ultimately found that medically vulnerable people, including those classified as CEV, felt isolated, confused, and worried about their health and the impact of the pandemic. There were significant inequalities in care and support, meaning the worst off were left without adequate guidance or the requisite financial, food, or mental health support from local authorities, government departments, and health and care services. Our conclusion is that, in future, the government must provide more financial and economic support, clearer communication, a more flexible and comprehensive vaccine programme, and continued routine healthcare services in order to protect vulnerable groups in future health outbreaks. This conclusion not only applies to future pandemics, but also future strains on the health system which have a disproportionate impact on those with serious underlying health conditions.

We would like to thank all those who contributed to this inquiry. A list of participating individuals and organisations can be found in the acknowledgements.

“The participation in the APPG’s events has been tremendous and all the comments have been hugely informative. They have shone a light on areas of government laxity and will be invaluable for learning lessons from the pandemic.”

- APPG Secretariat

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2 A timeline of the advice/guidance/support published and available for vulnerable people is included in Annex A.
Recommendations

Guidance and information

1. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care:
   To more intensively and widely communicate facemask exemptions to the public and guidance about employment legislation to employers.

2. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care:
   To improve the timeliness, clarity, and medical accuracy of shielding guidance. This includes the publication of guidance alongside announcements and providing preparation time between legislation being published and it taking effect.

3. For the UK Health Security Agency, Office for Health Improvement and Disparities and Department of Health and Social Care:
   To ensure that guidance explicitly covers all forms of vulnerabilities, and their specific requirements, and all aspects of life where there are increased risks for medically vulnerable people. Topics should include what to do with children (whether also vulnerable or not), worker’s rights, and what support will be offered during the shielding period.

4. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care:
   To produce all guidance and updates about the healthcare system in hard copy and make these available to those shielding.

5. For NHS England:
   To provide more clarification about which NHS services remain accessible and possible to contact during a pandemic.

Government decision making

6. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care:
   To engage and receive input from patients, patient organisations, and charities in the development of policy related to a pandemic and to ensure that they are given up-to-date information throughout a pandemic.

7. For the UK Health Security Agency, Office for Health Improvement and Disparities, Joint Committee on Vaccination and Immunisation, Scientific Advisory Group for Emergencies, and Department of Health and Social Care:
   To publish more information publicly about scientific advancements and how data is being used in research (especially where this relates to CEV people). Also, to
commit funding for specific research into how the medical conditions that make people vulnerable are impacted by new viruses and affect the administering of vaccines.

8. For the UK Health Security Agency, Office for Health Improvement and Disparities, Joint Committee on Vaccination and Immunisation, Local Authorities, and Department of Health and Social Care: To ensure people have clarity regarding their vaccination priority groups and that the vaccine group designation matches the shielding guidance and a patient’s risk to the pandemic. Also, to carry out more scientific research into alternative vaccines and vaccines’ safety for vulnerable groups.

9. For NHS England: To compile and maintain accurate and up-to-date registers of CEV people that includes information about their current treatments, the severity of their condition, and their location. Also, to ensure that the ‘more effective data sharing’ and healthcare integration aims of the Health and Care Bill are explicitly related to vulnerable groups to pandemics.

Delivery of healthcare

10. For NHS England: To maintain clinics and resources for chronic conditions throughout the pandemic. To avoid clinics’ complete reallocation to pandemic patients and to ensure that there is no cross-infection between these patients and medically vulnerable patients. Also, to give patients choice about methods for contacting specialists and having follow-up appointments. Finally, to create a strategy to reschedule, for both during and after a pandemic, healthcare services that have been cancelled in order to deal with backlogs in care.

11. For the UK Health Security Agency, Office for Health Improvement and Disparities, Joint Committee on Vaccination and Immunisation, Local Authorities, and Department of Health and Social Care: To utilise local authority transport services to ensure that patients can be taken to vaccination centres. Also, to produce a strategy to ensure that vaccine supplies are distributed evenly and subsequent doses are offered at the same time across the country.

12. For the Office for Health Improvement and Disparities and Department of Health and Social Care: To increase awareness of the unique mental health strains for medically vulnerable people during a pandemic and provide tailored and accessible support services to alleviate the specific anxiousness and fears of those at high risk.

Isolation and shielding

13. For the Treasury and Local Authorities: To increase the amount and prolong the duration of financial and food support provided for vulnerable people to cover the whole duration of their isolation.

14. For the Treasury, UK Health Security Agency, Office for Health Improvement and Disparities, and Department for Work and Pensions: To lengthen any furlough scheme for vulnerable groups to cover the entire period they are at risk. Also, to increase the level of
employment protection for those who have been advised to shield and are unable to return to work so they are not at risk of redundancy or a reduction in pay.

15. For the Treasury, UK Health Security Agency, Office for Health Improvement and Disparities, and Department for Work and Pensions: To provide further support and guidance to employers to help ensure safety for those returning to the workplace. Also, to make the creation of adjustments to working conditions and hours, that are necessary to protect vulnerable people, a legal requirement for employers.

16. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care: To extend mandatory mask wearing periods during peaks in pandemic cases and to promote the importance of facemasks for protecting medically vulnerable groups.
I – Guidance and Information

Throughout the pandemic, the government used guidance to share information for and increase awareness of how to minimise the risk of catching and spreading Covid-19. They held press conferences to update the public about new regulations, changes in the level of restrictions, and new scientific evidence. The advice was, however, often identified as delayed, unclear, contradictory, or lacking in coverage. For vulnerable and CEV people, the consequences of this are severe. In order to minimise the risks to the medically vulnerable caused by a future a pandemic, and reduce the mental strain of trying to determine what is safe behaviour, it is crucial that these problems with the guidance and communication from the government are rectified.

“The expeditious production of coherent advice and guidance is necessary to ensure the physical and mental health of vulnerable people during a pandemic.”
- Lord Mendelsohn

Minimal social awareness of face mask guidance
The mandatory use of facemasks in enclosed public spaces enabled more social activity with a reduced risk of transmission. However, they further increased the difficulty of breathing for those with respiratory diseases and lung conditions. Many have reported to patient organisations such as Asthma UK that, although they are legally exempt from using facemasks, they feel prejudiced and targeted for not wearing them. Similarly, medically vulnerable groups have commented that their employers did not know, understand, or apply the government guidelines regarding facemasks when people returned to work after shielding. This left many, especially key workers in the health service, feeling forced back into an unsafe workplace.

Recommendation:

1. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care: To more intensively and widely communicate facemask exemptions to the public and guidance about employment legislation to employers.

There should be longer mandatory mask-wearing periods and better communication to the public of the facemask exemptions for vulnerable people. This could, for example, encompass more readily available badges/stickers that state the wearer is exempt from wearing a face covering. Furthermore, encouraging employees, trade unions, and employers to work more closely together to create safety guidance and legislation for returning to work and to disseminate information on vulnerable groups will remove the stigma of not wearing a facemask and avoid situations where vulnerable people are made to trade off safety for continuing normal life and continuing work.

Late and unclear shielding guidance
Much of the shielding guidance, in the form of announcements and personalised letters, was published too late. Charities reported that
this led to some patients electing to shield from February 2020, before the formal introduction of government guidance. There were also gaps of several weeks between the announcements of the classification of clinically vulnerable groups and shielding, and the written guidance being published and patients being personally sent documentation. Moreover, a long gap between an announcement and the publication of guidance pressured care providers and patients to act due to the belief that the announcement constituted immediate policy. They also noted they were often exposed to information through media outlets before formal confirmation from PHE or the Department of Health and Social Care. This led to some in the CEV community being unable to prove they should not be required to go to work in-person and, along with the delays, meant the ‘shielding period’ of 12 weeks varied across patient groups.

Guidance was also highly changeable - in one case, visiting guidance to care homes was subject to two updates in five days. There were also inaccuracies - a cancer patient received a letter wrongly stating she did not need to shield while undergoing chemotherapy.

Finally, guidance was published, albeit late, often shortly before legislation or advice came into effect. This left people without the adequate time to prepare mentally and practically, for example by finding childcare arrangements or buying food, either for a lockdown or removal of restrictions.³

Recommendation:

2. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care: To improve the timeliness, clarity, and medical accuracy of shielding guidance. This includes the publication of guidance alongside announcements and providing preparation time between legislation being published and it taking effect.

Clear and timely guidance, following the consultation of medical professionals, is vital for ensuring that people take the necessary action in good time to avoid catching the virus and compromising

34% of patients found government advice to be unclear and contradictory.

(Lupus UK)

The quality of guidance was also problematic. Many people commented that the communications from the government were unclear and did not help them understand their level of risk. Asthma UK stated that shielding criteria lacked definition, or had contradictory definitions, about respiratory conditions. A Pseudomyxoma Survivor representative reported that there was significant variation among the shielding letters for their patient group despite very little variation in the specific condition. This created added stresses for vulnerable people as they tried to determine what was safe behaviour.

There was a 250% increase in calls to the Blood Cancer UK support line due to governments’ advisory, rather than prescriptive, guidance, which left patients with no confidence in their decisions.

(Blood Cancer UK)

³ See Annex A for evidence of guidance being published a day before legally enforced lockdowns.
their ongoing treatments. While appreciating the importance of immediate legislative action to protect the wider population, the provision of preparation time needs to be considered, where possible, to allow medically vulnerable people to react to advice and guidance given their greater need to arrange for care and to strictly follow guidance. This will also require it to be published much earlier than in the Covid-19 pandemic so it can still take effect to be pre-emptive of any problems.

In a Kidney Care UK patient survey:
- 13% of respondents didn’t know they were advised to shield.
- 18% of respondents had verbal confirmation but received nothing in writing and weren’t able to access government support such as food boxes or employment support.

(Kidney Care UK)


Lack of holistic guidance
There are a vast range of conditions and diseases that make people vulnerable to pandemics. As such, local and national advice and strategies for dealing with pandemics need to encompass the full breadth of these. Asthma UK noted that lung conditions, despite affecting one in five people in the UK, were not deemed a political priority. Care England similarly reported that they felt that those with learning difficulties had been overlooked when vulnerable groups were defined. Guidance should include more than an instruction to shield. Many patients believed that they could not be furloughed and instead must rely on statutory sick pay. The clarification that CEV people were eligible for furlough came 11 days after the initial shielding advice.

Furthermore, many areas of life had increased risks for vulnerable people. The APPG received statements from shielders who felt that there was minimal advice given to them about how to manage the risk of infection with their children at school. In fact, a representative from PHE reported at an event that 15% of people in the CEV group live with children under 16 which significantly impacted their ability to shield. It was noted that the guidance did not address whether medically vulnerable people should send their children to nurseries. Similarly, questions were raised in the APPG’s events about whether the children of immunosuppressed people would be receiving the vaccine before being sent back to school. Social care leaders also reported that care homes elevated the risk of health complications, increased recovery times for residents, and produced higher rates of mortality.

Recommendation:

3. For the UK Health Security Agency, Office for Health Improvement and Disparities and Department of Health and Social Care: To ensure that guidance explicitly covers all forms of vulnerabilities, and their specific requirements, and all aspects of life where there are increased risks for medically vulnerable people. Topics should include what to do with children (whether also vulnerable or not), worker’s rights, and what support will be offered during the shielding period.
As well as reflecting the well-known factors that increase mortality and severe complications (age, obesity, dementia, etc.), we recommend that pandemic guidance and strategies reflect clinical advice about the full range of conditions that make patients medically vulnerable. Information about the support offered when shielding, and guidelines on the recommended behaviour for members of vulnerable peoples’ households, are crucial to reducing the anxiety caused by a pandemic. People also need to be informed about the level of risk involved in regular activities and necessary excursions, like shopping or sending children to school, and they need to be assured that they will be provided with the services and vaccines to continue these and maintain a healthy life. Furthermore, once the shielding requirement was lifted, many did not know the level of risk they faced. Guidance that includes information relating to after a period of shielding will ensure that CEV people do not feel forgotten and do not expose themselves to unnecessary risks.

Difficulties accessing online guidance
Much of the detailed guidance and scientific evidence produced during the pandemic was only available online. Similarly, government advice was often first publicised or updated on social media platforms. This created major inequalities as some vulnerable people, especially the elderly or those with learning difficulties, were unable to access this information.

Recommendation:

4. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care: To produce all guidance and updates about the healthcare system in hard copy and make these available to those shielding.

We recommend publishing guidance in hard copy and circulating it using patient organisations or primary care providers. This will avoid

Natalie Goodchild
Natalie spoke at the APPG’s respiratory event. Here is what she said about her experience of the pandemic with Cystic Fibrosis:

- “Shielding majorly affected my ability to exercise. Regular outdoor activity is central to day-to-day management of my Cystic Fibrosis. There needs to be awareness that self-isolation can lead to a deterioration in certain respiratory conditions.”
- “Previously I have been admitted to hospital only twice. However, during the pandemic, I had to undergo 10 weeks of IV antibiotics because of an infection that was missed. There needs to be better monitoring of CEV patients during pandemics so these developments are not missed.”
- “However, there were some positive developments in the pandemic. I had access to helpful virtual clinics and new drugs that reduced my coughing and inflammation. It was also good to see the normalisation of mask-wearing and regular sanitation. I also developed a better self-awareness of my symptomology.”
leaving people without up-to-date advice about how to live safely and it will prevent the issue of digital exclusion.

**Lack of clarity around what health services were accessible**
A National Voices inquiry found that vulnerable people were confused about which core NHS services were open during lockdown. Despite instruction from the government to continue to use the NHS, people had been sent messages by their primary care providers stating that they were prioritising urgent cases only, suggesting patients should only call their GP. One message said: “if possible, please delay contacting us about your problem for 2 weeks”. This meant many felt unable to request the non-urgent, but necessary, advice and care they needed. Furthermore, the absence or delay of primary care services, such as diagnostics or rehabilitation, can cause deteriorations in the conditions that make people vulnerable to a pandemic.

**Recommendation:**

5. **For NHS England:** To provide more clarification about which NHS services remain accessible and possible to contact during a pandemic.

It is necessary to decide, at the central government and NHS level, which NHS services are core and then making it known that they remain open during a pandemic. This may necessitate the creation of temporary sites designated for Covid-19 patients to enable vulnerable people to attend their GP surgeries with less risk of virus transmission. This will remove this risk of vulnerable people not seeking necessary healthcare.
Between January 2020 and February 2021, 47% of all contacts to the Cystic Fibrosis Trust were directly related to Covid-19.

(CF Trust)
II - Government Decision Making

Many vulnerable people reported feeling uneasy when having to follow guidance that they felt did not accurately reflect the nature of their condition or had minimal scientific backing. Trust in and adherence to the published advice is necessary to ensure people are acting safely and not taking unnecessary risks. Medically vulnerable patients and their charities/organisations had many suggestions and opinions about the government’s handling of the pandemic. Attending to these would, potentially, solve many of the issues noted in this report. Patients and patient organisations are knowledgeable about the specific conditions that make people vulnerable. They represent a significantly untapped resource that can inform and improve policy, advice and direction.

**Lack of consultation with patients and patient groups to inform policy**

Charities noted that guidance was often first announced via the press, rather than being communicated directly to them or health professionals, and commented that their patients’ views were not considered throughout the pandemic. This lack of communication and engagement meant that patient charities/groups were left with very short timescales to react to the changing advice, offer feedback, and publish information. Given the reliance of patients on these organisations (for example, calls to the Asthma UK helpline increasing by 500 percent over the pandemic) these timescales left many vulnerable people without adequate support.

Charities also emphasised their ability to communicate public health messages to patients. Care England, for example, manages approximately 4,000 care providers and both publicly and privately owned associations. This gives them, and similar organisations, a uniquely opportune position to both pass on information to their patients and convey their patients’ experience-based views back to policy makers.

“**Patient groups demonstrated clear communicative value through the pandemic.**”

- Professor Alison Birtle (Cancer and immunodeficiency event)

**Recommendation:**

6. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care: To engage and receive input from patients, patient organisations, and charities in the development of policy related to a pandemic and to ensure that they are given up-to-date information throughout a pandemic.
To ensure that the government is sufficiently informing medically vulnerable people and using the most fruitful sources of information for policymaking, we recommend that the government communicates advice and guidance directly to patient organisations. They should also give these organisations a greater role in disseminating information and influencing policy.

Of those receiving regular surveillance to monitor cancer at the Rosemere Cancer Centre (Lancashire), 35% used charity websites/helplines.

- Professor Alison Birtle (Cancer and immunodeficiency event)

Opaque formulation of advice and inadequate speed of research
The APPG inquiry received evidence that suggested that people were unclear about the work of the Scientific Advisory Group for Emergencies (SAGE) and about how scientific research informed the creation of Joint Committee on Vaccination and Immunisation (JCVI) guidance. It was alleged that policy seemed to be driven by political salience more than scientific research. Care England noted that in February 2021 the learning-disabled sister of BBC DJ Jo Whiley was admitted to hospital with Covid-19. This generated a large public backlash over the neglect of people with learning disabilities in the priority groups for the vaccine. Several days later, it was announced that all people on the learning disabilities register in England were to be invited for a vaccine. Vulnerable people were left feeling as though decisions were politically reactive rather than made using scientific reasoning.

In the APPG event on vaccination (December 2020), the JCVI noted that the government’s advice was based on the UK’s “world-leading” epidemiology and that data from previous influenza and pneumonia programmes was used to highlight the disease groups that were most vulnerable. Publicly, then, it was stated that policy was made on the back of scientific advice. However, the evidence received by the inquiry suggests that decision makers need to consider how to make this process, and the evidence used, more accessible to the general public, particularly vulnerable groups, so they can have more trust in the guidance.

Furthermore, important and beneficial research took a long time to be completed and published. It was only in mid-2021 when the UK Coronavirus Cancer Monitoring Project (UKCCMP), a clinician-led research programme to protect people with cancer from Covid-19 that ran ahead of any government programme, found that patients with blood cancers are more likely to get Covid-19 (with leukaemia patients three times more susceptible than the overall cancer population). They also discovered that anti-cancer treatments had no effect on Covid-19 mortality rates and intensive therapy unit admissions were low in cancer patients with Covid-19. If discovered earlier, this finding could have been used to make guidance more informative and tailored to certain groups who were medically vulnerable.

Recommendation:

7. For the UK Health Security Agency, Office for Health Improvement and Disparities, Joint Committee on Vaccination and Immunisation, Scientific Advisory Group for Emergencies, and Department of Health and Social Care: To publish more information publicly about scientific advancements and how data is being used in research (especially where this relates to CEV people). Also, to commit funding for specific research into how the medical
conditions that make people vulnerable are impacted by new viruses and affect the administering of vaccines.

Research like this is invaluable for informing medical professionals about medically vulnerable peoples’ level of risk and what treatments can be continued. Greater transparency and regular updates about how scientific research is used to produce guidance will reduce people’s uneasiness toward government policy and satisfy their right to understand how public bodies function. Part of this could be a publicly accessible repository for clinical studies on vulnerability to pandemics and vaccine response.

Also, by conducting studies earlier in pandemics, more clinical evidence can be made available to formulate guidance. The increased understanding should mean that underlying health conditions will pose less of a threat to individuals’ health and they can be better managed. It is therefore also recommended that the government support and fund initiatives like the UKCCMP earlier in future pandemics.

58% of blood cancer patients develop an antibody response after two doses of the Covid-19 vaccine (compared to 97% of healthy adults). Among Chronic Lymphocytic Leukaemia (CLL) patients this immune response was 40% less than healthy adults.

(Blood Cancer UK)

Lack of understanding about the protection offered by the vaccine and agreement with the vaccine prioritisation

Asthma UK reported that the evidence base used for vaccine prioritisation for asthma patients was unclear and did not align with the flu vaccine prioritisation. People were surprised when younger people with moderate asthma were omitted from the priority groups, and many were left anxious and angry when they were not invited.

The criteria used to determine those in ‘group six’ was also described as very specific, meaning that many with respiratory conditions were not prioritised for a vaccine on minor technicalities.4 Crohn’s and Colitis UK also noted that the vaccine programme, unlike the shielding guidance, did not reflect the changeable nature of vulnerable people’s conditions. Ideally it would have incorporated a dynamic where people could move between vaccine priority groups.

Many vulnerable people’s vaccine hesitancy was often the result of limited information available about vaccine efficacy. Written submissions to the inquiry reported that people struggled to cope with the uncertainty about the protection offered by the vaccine and

4 Vaccine priority group specification provided in Annex B.
how long shielding would last. There was also confusion among patients and primary/secondary care workers about whether the third vaccine (announced in September 2021) would be provided, or be safe, for immunosuppressed patients. Options for providing this information, available to the government, were not explored fully. A representative from the National Pharmacy Association identified their organisation’s ability to encourage the uptake of the vaccine and provide public health information about safety and efficacy.

**Recommendation:**

8. **For the UK Health Security Agency, Office for Health Improvement and Disparities, Joint Committee on Vaccination and Immunisation, Local Authorities, and Department of Health and Social Care:** To ensure people have clarity regarding their vaccination priority groups and that the vaccine group designation matches the shielding guidance and a patient’s risk to the pandemic. Also, to carry out more scientific research into alternative vaccines and vaccines’ safety for vulnerable groups.

To ensure people feel confident that they will be offered a vaccine when it is needed, and that it will be safe, information needs to be made clearer and consistent with individuals’ level of risk and the current shielding guidance. Increased analysis of national data sets, testing results, and treatment outcomes should be used to understand the risk in medically vulnerable groups and formulate the vaccine plan.

We also recommend that, to practically promote vaccine uptake in high-risk groups, primary and community care institutions, especially pharmacies, are better utilised.

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**“Not having any data telling us how well it [vaccination] works with people on immunosuppressants worries me.”**

- comment to a Kidney Care UK patient survey.

Source: Kidney Care UK, ‘Lifting lockdown’

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**Mis-categorisation of conditions for those in CEV groups**

Several patient groups, clinicians, and charities identified that NHS databases of CEV patients, in particular, were incomplete, noting discrepancies between primary and secondary care and a lack of address information. This is extremely serious as those designated as CEV are the most at risk of serious illness upon catching Covid-19. In addition, Care England reported that their patients felt that NHS commissioning bodies and secondary care clinicians did not recognise the importance of social care in enabling vulnerable people to manage the pandemic. This led to the mis-categorisation of conditions and failures to accurately assess peoples’ vulnerability. As a result, many of the medically vulnerable were not initially told to isolate or not invited for their annual flu vaccine, increasing their chances of catching Covid-19 or falling ill. Incomplete patient lists also created inequalities in care as those patients that contacted their GPs and hospitals were registered and attended to, while others missed communication and support.

**Recommendation:**

9. **For NHS England:** To compile and maintain accurate and up-to-date registers of CEV people that includes information about their current treatments, the severity of their condition, and their location. Also, to ensure that the ‘more effective data sharing’ and healthcare
integration aims of the Health and Care Bill are explicitly related to vulnerable groups to pandemics.

To avoid these errors and gaps in the provision of care, it is essential that lists of vulnerable patients are continuously completed and updated. The adoption of more modern technology for data collection aligns with the commitment to a wider digital transformation outlined in the NHS’ 2022/23 ‘priorities and operational planning guidance’.

There should be clear guidelines around the information required and how often they should be updated so as to include all medically vulnerable people and be integrated, allowing for input from primary, secondary, and social care services.

With the ongoing passage of the Health and Care Bill through Parliament, we recommend that the focus on data sharing and integration is related specifically to the experience of vulnerable groups to pandemics. This could mean creating a single, centralised, patient database and better facilitating the sharing of information across the healthcare sector.

Example strategy

Public Health Scotland’s (PHS) digital strategy (launched on 1 June 2021) is a potential solution. It aims to use digital technology to benefit community health and wellbeing, collect more accurate and wide-ranging data, and improve patient engagement. The strategy was designed to improve collaboration and the evaluation of the healthcare system. It also has a welcome focus on Covid-19. We recommend a strategy with these focuses and aims, and ask the Secretary of State for Health and Social Care Sajid Javid to build on his speech, delivered on 21 September 2021, that recognised the importance of a ‘digital transformation’ and of healthcare systems embracing data-driven technologies.
“I was told I was at the highest risk from Covid-19 and told to shield...when the vaccine came out, I was only in priority group 4...many older people were ahead of me in the queue despite the fact that my calculated Covid-19 age was +85...I felt completely abandoned and devalued.”

- Written submission from a patient
III - Delivery of Healthcare

Covid-19 raised awareness of the nature of serious illnesses and the limited capacity of healthcare systems globally. Vulnerable people, however, required healthcare services more as a result of the pandemic. A lack of exercise and fresh air, worsening mental health, and risk of infection all increased the need for those with serious chronic conditions to have access to their healthcare professionals. Because of the increased need for protection, vulnerable groups also required urgent receipt of the vaccines that were developed as the pandemic progressed. In order to protect the medically vulnerable during the pandemic, healthcare and vaccines need to be accessible and timely for all.

Cancelled/postponed elective surgery and secondary care

The APPG inquiry received the largest proportion of submissions on the maintenance of routine consultations and clinics. It was universally agreed that these should be continued throughout a pandemic and that appointments should not be limited only to those in urgent need of medical help. However, some patients struggled to contact their doctors, nurses, or specialists. There were reports of oxygen for cancer patients being limited because of its use in Covid-specific wards. A consultant oncologist commented that cancer centres prioritised treatment differently due to varying professional ability and availability of staff. These inequalities in care have severe consequences. Specifically, Cystic Fibrosis Trust noted that many cystic fibrosis wards were reallocated to treat Covid-19 patients, creating risks of cross-infection and reducing the amount of equipment for cystic fibrosis patients.

The main strategy used to ensure the continuation of healthcare services was utilising remote consultations and home care. One clinician even described an “obsession with telehealth”. Many patients and medical professionals saw this as a positive development. Phone consultations helped people discuss a range of multi-morbidities at once and allowed patients to be assessed and triaged before risking an in-person visit to a GP surgery or hospital. Diabetes UK reported lots of benefit in the ability to “link up remote consultations” with “greater access to wearable diabetes technologies such as insulin pumps and glucose monitors”. They saw a number of improvements in patients’ self-management and awareness of their symptomology.

However, others found they felt uncomfortable discussing their condition remotely. Over-the-phone appointments also meant clinicians were blind to symptom progression and, as Age UK found, sometimes led to “poor care, misdiagnosis, and prescriptions for the wrong treatment.” The increased reliance on technology also widened ‘digital divides’ and meant that those without phones or computers (mainly the elderly) could not have access to advice and check-ups. This only worsened feelings of isolation.

Despite the implementation of remote consultations and home care, a lot of treatment was prevented from taking place at all due to the increased risk of transmission of Covid-19 in hospitals. Almost every patient group that submitted evidence to the inquiry or spoke at an event alluded to both urgent care and elective surgery being cancelled. An Asthma UK/British Lung Foundation survey found that a third of people had their care delayed (at best). The cancellation of spirometry and urine analysis led to a large backlog of patients
waiting for a diagnosis of a respiratory condition or kidney disease respectively.

Often, the delays to treatment meant conditions worsened. In the respiratory disease-focussed event, it was noted that a lack of scheduled pulmonary rehabilitation led to deconditioning in lung disease patients and increased their breathlessness. Age UK found that many elderly people gave up on trying to access necessary treatment, which meant that their “health and conditions deteriorated further, sometimes irreversibly”.

**Recommendation:**

**10. For NHS England:** To maintain clinics and resources for chronic conditions throughout the pandemic. To avoid clinics’ complete reallocation to pandemic patients and to ensure that there is no cross-infection between these patients and medically vulnerable patients. Also, to give patients choice about methods for contacting specialists and having follow-up appointments. Finally, to create a strategy to reschedule, for both during and after a pandemic, healthcare services that have been cancelled in order to deal with backlogs in care.

The health of vulnerable groups needs to remain a priority during future public health threats. The NHS needs to ensure that minimum services are continued, and patients can be admitted, safely and quickly, into care. This involves not withdrawing necessary services from departments that treat vulnerable people and avoiding condition-specific wards being used predominantly for admissions that result from the pandemic or public health threat. The NHS should also continue with remote consultations and home care, utilising the resources provided by wearable technology and telehealth. However, they must allow patients more autonomy in deciding how they wish to interact with their healthcare professionals.

There needs to be more shared decision-making between patient and clinician to determine the best way to access treatment, hold follow-up consultations, and improve self-management given the specific condition. Creativity in the methods of delivering care should also be encouraged. This could involve placing healthcare staff in community NHS infrastructure. Patients could contact these experts when necessary while remaining ultimately responsible for their own personal health monitoring.

**A Blood Cancer UK survey found that 80% of respondents had not received appropriate information from their healthcare team on their ongoing health protection.**

(Blood Cancer UK)

**NHSE figures show that the waiting list for heart operations and procedures has grown to over 200,000 people for the first time since February 2020, before the pandemic began.**

(Asthma UK/BHF)

To ensure that surgeries and rehabilitation take place, and any complications to chronic diseases are limited, we recommend that clear recovery plans are formulated to alleviate the backlog of care caused by future pandemics. This could include defined surgical pathways (taking account of the increased risk of infection) and ‘green sites’ that are free of any virus for certain surgeries. Plans should also show awareness of the finding from a Covid-19 surge study that the chance of mortality for patients undergoing surgery
was increased if they had a perioperative Covid-19 infection. This may require the imposition of necessary delays to elective surgery for those who have tested positive for the virus in a pandemic.

Example strategy

It is notable that the government has already committed a lot of resources to resolving the backlog of care. In May 2021 the NHS funded ‘accelerator sites’ to return to pre-pandemic levels of testing and treatment. In September 2021, a total of £5.4 billion in funding for the NHS was announced to help with the Covid-19 response, new NHS clinical leads were introduced to help resolve issues in the NHS, and ‘surgical hubs’ were piloted to increase the number of elective surgeries.

These are encouraging steps, however the funding for surgical infrastructure in the NHS still needs to be increased if patients are to be treated quickly enough. The BMJ reported in September 2021 that, even if hospitals maintained activity 5 percent above pre-pandemic levels, it would take until 2033 to clear the backlog of patients across the cancer care pathway. We therefore also recommend that these programmes are started earlier in future pandemics to avoid the creation of such a large backlog.

Inequalities in vaccine access

Issues related to vaccine provision were raised to the APPG. Submissions commented that there were significant variations in timing between first and second doses of the vaccine despite the standard time frame outlined in official guidance. These variations were often reported to be the result of supply chain issues to and judgement of GPs and local healthcare services. People’s differing levels of immunisation had the effect of making guidance updates for entire patient groups inapplicable. It also created an inequality of care as, in areas with small amounts of the vaccine, vulnerable patients had to shield for longer. Independent Age also raised a concern that housebound or frail people often struggled to reach vaccination centres due to lack of transport.

**Recommendation:**
11. For the UK Health Security Agency, Office for Health Improvement and Disparities, Joint Committee on Vaccination and Immunisation, Local Authorities, and Department of Health and Social Care: To utilise local authority transport services to ensure that patients can be taken to vaccination centres. Also, to produce a strategy to ensure that vaccine supplies are distributed evenly and subsequent doses are offered at the same time across the country.

To avoid generating future inequalities of care, we recommend that vaccine distribution attends to the population across the country and the timing between doses is consistent. To resolve other reasons for vaccination to be delayed, we call on local authorities to arrange better transport for patients with limited mobility to attend vaccination centres. We also encourage further research into vaccine alternatives for future pandemics so that vulnerable groups can be attended to more rapidly and not face a lack of treatment as a result of their conditions.

Example strategy

The inquiry received evidence from medical professionals that CEV people may receive increased protection from the virus after a fourth of fifth vaccine booster. Others noted that plasma-derived therapies or monoclonal antibody treatment could act as alternatives to the vaccination programme for immunosuppressed patients. It is encouraging to note that the government instituted a booster programme in autumn 2021 and announced the first monoclonal antibody treatment in September 2021, having been approved by the MHRA.

“The vaccine is the route out of this crisis and the approval this morning of the Oxford/AstraZeneca vaccine is another world-first for Britain and it’s the single biggest stride that we’ve been able to take since this pandemic began.”

- Matt Hancock, then Secretary of State for Health and Social Care (December 2020)

Source: C. Anderson, ‘Matt Hancock sniggers as SNP calls for national lockdown We need to keep our freedoms!’, Express (December 2020). Available online: https://www.express.co.uk/news/politics/1378100/matt-hancock-snp-philippa-whitford-tier-4-extended-england-lockdown-latest-update-vn

Lack of provision for worsening mental health in vulnerable groups

Patient organisations reported that the pandemic led to worsening mental health for their patients. PHE also recorded a spike in self-reported mental health issues as a result of shielding. Many struggled with the uncertainty of their health and fear of catching the virus, especially given that a lot of guidance warned of death. Evidence submitted to the inquiry noted variation in treatment locations, reduced contact with clinicians, and delays to routine care all negatively affected people’s mental health. Others felt forgotten and alone during self-isolation. The Barts Shielders Group noted that CEV NHS staff who had to self-isolate felt stigmatised as lazy for their absence from work and personally guilty for not being able to alleviate the pressure on health services.

Recommendation:
Barts Shielders Group

- Barts Shielders emerged from an initial group of eight volunteers who used virtual resources to support shielding staff across Barts Health NHS Trust. Virtual meetings were voluntary but focussed on promoting feelings of psychological safety.
- They provided peer and organisational support for staff members by connecting them to their colleagues, HR, union reps, and occupational health services.
- One shielder described it as “providing a safe space to people who were upset, creating connection when it had broken down.”
- The group found that it promoted feelings of inclusion and empowerment, reduced adverse mental health outcomes for staff, created more ‘digital capability’ in the NHS, and increased individual and team capability and responsiveness.
- They addressed stigmas of laziness against shielding NHS staff, helped those feeling guilty for not being at work, and reduced the anxiety and loneliness that characterised many people’s experience of lockdown.

“I found that it was surprisingly supportive and gave me reassurances and answers. It empowered me to understand what kind of questions I could direct to my team to prepare … and that it was ok to not feel ok and it was ok to ask these questions… information was trickling down very, very precariously.”

- Barts Shielder

12. For the Office for Health Improvement and Disparities and Department of Health and Social Care: To increase awareness of the unique mental health strains for medically vulnerable people during a pandemic and provide tailored and accessible support services to alleviate the specific anxiousness and fears of those at high risk.

In a Kidney Care UK patient survey:

- 38% of respondents felt their overall health declined during the pandemic.
- 40% of respondents reported their concern over their emotional wellbeing.
- 33% of respondents reported feeling lonely or isolated.
- 68% of respondents said they would like peer or professional mental health support to help manage or reduce their worries.

(Kidney Care UK)

Source: Kidney Care UK, ‘Lifting lockdown’

To alleviate the mental burden on medically vulnerable people, we recommend that the government and primary health and care providers ensure that vulnerable people are able to access holistic mental health support services. Some people felt that, during the pandemic, these services should be more widely advertised, more accessible (on various media outlets and with capacity for all who
require them), and specific to pandemic-related worries. They should also include: the ability to address multiple mental health needs; the creation of peer support groups (such as the Barts Shielders Group); and the provision of non-clinical support/advice (e.g. regarding exercise). It was also commented that carers and healthcare staff often did not know how to support those with declining mental health. Therefore, we also suggest that this training is given to all healthcare staff.

**Example strategy**

It was promising that, on 24 May, the government launched nine pilot programmes to help people in self isolation. They were funded by £12 million and were in partnership with local councils. Pilot initiatives provided accommodation for people in overcrowded households, mental health support, and language communications support for individuals where English is not their first language. While this was a welcome initiative, we recommend that similar programmes are instituted earlier and over a wider area so that more people can be helped while self-isolation/shielding is continuing.

80% of blood cancer patients reported that the pandemic had negatively impacted their mental wellbeing.

(Blood Cancer UK)

“We know the pandemic has had a huge impact on people’s mental health. I am committed to working closely across the NHS, Public Health England and charities as part of a combined effort, so no one has to cope with mental illness alone... Hearing first-hand the personal stories of those who had mental illness exacerbated by lockdown, or experienced difficulty in getting help, has made me more determined than ever to ensure we address the long-term consequences of the virus on our mental wellbeing.”

- Nadine Dorries, then Minister for Patient Safety, Suicide Prevention and Mental Health (July 2020)

“With the lifting of restrictions, it has felt like being diagnosed with cancer all over again…the current phase of the pandemic is presenting the greatest mental health impact across my whole cancer journey.”

- Nick York (CLL patient and Patient Advocacy Healthcare Liaison Officer at Leukaemia Care)
IV – Isolation & Shielding

The Covid-19 pandemic affected every aspect of daily life. Work, schools, and shops became sites of virus transmission and this, coupled with government advice, forced medically vulnerable people to remain in their homes for safety. The burden of this isolation, and the importance of local and national strategies to protect vulnerable people, was clear in the statements provided to this inquiry. As waves of the pandemic ended, and the risk of catching Covid-19 declined, restrictions were justly loosened. However, returning to work and re-entering social environments posed an issue for the medically vulnerable. Given that any risk of catching Covid-19 was most significant for those in CEV groups, the creation of safe workspaces and a general public understanding of those at risk was vital.

Poor availability of nutritional food from delivery services
For many medically vulnerable people, shielding meant they were unable to get shopping and earn as much as they needed to live. The pandemic also meant that food delivery slots were scarce and that they cost more. As a result, they required practical support. Public Health England (PHE) indicated to the APPG that they worked with local authorities to make arrangements for those in need and that 87% percent of people advised to shield received support. However, many still reported to the inquiry that they were confused about what support was available and what was needed to register for services such as food delivery. Others reported that the products provided were of poor nutritional value. One CF patient noted that sticking to their condition-specific diet and managing CF-related diabetes was challenging given the irregular and nutritionally inadequate food deliveries.

Recommendation:

13. For the Treasury and Local Authorities: To increase the amount and prolong the duration of financial and food support provided for vulnerable people to cover the whole duration of their isolation. To ensure that CEV people have enough money to live and can maintain a healthy diet in future threats to health, we recommend that the government and local authorities work together to increase and prolong financial and food support for those shielding, for the duration of their isolation. Furthermore, funding sources, such as a voluntary payment scheme for food boxes, should be explored. To alleviate any additional concerns, information on the eligibility criteria and provision should be published alongside the general guidance for vulnerable people and the deliveries should meet the necessary daily nutritional requirements for adults.

Since April 2020, The Cystic Fibrosis Trust has awarded over 500 emergency financial grants to individuals facing an imminent risk to health and for those requiring more expensive online shopping.

85% of adults with Cystic Fibrosis experience at least some concern because of the financial burden caused by the condition.
(Cystic Fibrosis Trust)

Insufficient financial support
Many commented that the financial assistance offered to vulnerable people during the pandemic was insufficient. It was also reported that many patients took over six weeks off work, on statutory sick pay, before shielding/furlough guidance – which gave them the
authority to remain at home – had been produced. This meant that the persistently vulnerable, whose shielding period had come to an end and who were not on furlough, had to either return to work or remain at home relying on statutory sick pay. This was often described as not enough to cover the cost of living during a pandemic.

Recommendation:

14. For the Treasury, UK Health Security Agency, Office for Health Improvement and Disparities, and Department for Work and Pensions: To lengthen any furlough scheme for vulnerable groups to cover the entire period they are at risk. Also, to increase the level of employment protection for those who have been advised to shield and are unable to return to work so they are not at risk of redundancy or a reduction in pay.

To provide enough support for vulnerable people during a pandemic, we recommend that furlough schemes for vulnerable groups be lengthened to cover the entire period they are at risk. We also suggest that employment protection be increased so that those who were advised to shield, and so may continue to feel unable to return to work after isolation, receive more of their salary for home working or any necessary days off due to health concerns.

Lack of support when returning to work and problems with safety in workplaces

On 1st August 2020 the shielding guidance was relaxed, meaning people in the clinically extremely vulnerable group were able to return to work. Even though some support was still available (such as food deliveries), the guidance encouraged people to return to work (as long as it was safe from Covid-19). This created many worries and problems. Submissions to the APPG stated that employers were given little guidance on the requirements for returning to work. Some excluded their vulnerable employees by not taking on the full Covid-19 safety advice. Government guidance also did not cover how to communicate concerns to employers and the rights that vulnerable people had in the workplace. Returning to these environments potentially endangered many people and, at least, increased their anxiousness. As noted above, the alternative to returning to work was often financial hardship.

Recommendation:

15. For the Treasury, UK Health Security Agency, Office for Health Improvement and Disparities, and Department for Work and Pensions: To provide further support and guidance to employers to help ensure safety for those returning to the workplace. Also, to make the creation of adjustments to working conditions and hours, that are necessary to protect vulnerable people, a legal requirement for employers.

“There is no social distancing in the office, but I have no choice if I want to keep my job.”
- comment to Kidney Care UK patient survey.

Source: Kidney Care UK, ‘Lifting lockdown’
To avoid people feeling forced back into unsafe workplaces we recommend that, in future, the government require that employers take the necessary reasonable steps to facilitate medically vulnerable people to work from home (for example by employers subsidising necessary equipment) and make it mandatory for employers to fully cater to vulnerable people who choose to return to work. We also recommend that guidance is published about the workplace, including how to conduct risk assessments and how to create a safe environment. This will reduce the risk of returning to work for the medically vulnerable.

**Recommendation:**

16. For the UK Health Security Agency, Office for Health Improvement and Disparities, and Department of Health and Social Care: To extend mandatory mask wearing periods during peaks in pandemic cases and to promote the importance of facemasks for protecting medically vulnerable groups.

In order to alleviate these anxieties, we suggest that mask wearing and social distancing be continued for longer in places that are unavoidable for vulnerable people. These include, but are not limited to: large shopping centres, public transport, doctors surgeries/hospitals, and care homes. To encourage people to wear masks and not put others at risk, we also suggest more messaging from the central government to the public about the prevalence of those with vulnerabilities in society and the severe consequences of them catching a virus or becoming ill.

Anxieties created upon relaxation of restrictions

The change from 'mandatory' to 'encouraged' mask-wearing in the spring of 2021 further reduced the freedoms of vulnerable people as the lack of mask-wearing in the general population meant many reduced their time outside and social contact. This was noted by two patients at the APPG’s cancer-focussed event in July 2021. Others had persistent concerns about the increased transmission of the virus during ‘unlocking’ phases of the pandemic due to the lack of social distancing practiced by low-risk groups.

In a Kidney Care UK patient survey:

- **54%** of those respondents who were in employment felt concerned about returning to their workplace, but felt they had no other choice.
- **10%** stated they would not return to work, even if that meant losing their job.

(Kidney Care UK)

Source: Kidney Care UK, ‘Lifting lockdown’
There needs to be improvement in “educating non-vulnerable people on the importance of safeguarding vulnerable people.”

“I need the government to shed more light on CEV people, address the topic of CEV people, and answer CEV questions during TV announcements. It never seems to be addressed.”

- comments to a Kidney Care UK patient survey.

Source: Kidney Care UK, ‘Lifting lockdown’
Acknowledgements

We were extremely grateful that so many people attended the APPG’s events and recognised the importance of the inquiry. Here we acknowledge all those who submitted evidence, spoke at our events, and brought this important issue to the APPG’s attention:

**Patient groups and patients**
Action for Pulmonary Fibrosis
Age UK
ALK Positive UK
Anthony Nolan
Asthma UK/British Lung Foundation
Barts Shielders
Blood Cancer UK
British Red Cross
Cancer52
Care England
Crohn’s and Colitis UK
Cystic Fibrosis Trust
Diabetes UK
Fight Bladder Cancer
Healthcare CNWL
Immunodeficiency UK
Independent Age
Kidney Care UK
Kidney Research UK
Leukemia Care
London Older People’s Strategy Group
Lupus UK
Macmillan UK
Methodists Housing Association
Motor Neurone Disease Association
MS Society
Muscular Dystrophy UK
National Rheumatoid Arthritis Society
National Voices
Parkinsons UK
Positive Ageing in London
Pseudomyxoma Survivor
Sickle Cell Society
The Arthritis and Musculoskeletal Alliance
The Brain Tumor Charity
UK Plasma Action
Vasculitis UK
Versus Arthritis
Wise AGE

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Susan Watson
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Government/clinician organisations
PHE
JCVI
NHS Digital
National Pharmacy Association
NHS providers
UK Coronavirus Cancer Monitoring Project
NHS
British Medical Associations GP Committee
Primary Care Respiratory Society
Respiratory Medicine, Leeds
Lancashire Teaching Hospitals
Central and North West London NHS FT

Individuals who contributed to APPG events
Helen Rowntree

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Hal Cohen
Nick York
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Roger Greer
Richard Vautrey
Lord Lansley
Professor Robert Read
Andrew Blackie
Neil Bhayani
Virendra Sharma MP
Professor Isabel Oliver
Angela Brook
Lydia Makaroff
Joe Brunwin
Jim Shannon MP
Jennifer Mitchell
Sarah Woolnough
Daniel Peckham
Natalie Goodchild
Carol Stoneham
Annex

A: timeline of relevant advice/guidance/legislation

First Covid-19 guidance: 3 March 2020
Guidance for residential care, supported living and home care guidance: 13 March 2020
Guidance on social distancing for vulnerable people: 16 March 2020
Coronavirus Job Retention Scheme (CJRS) announced (up to 30 June): 20 March 2020
Guidance on shielding for ‘extremely vulnerable’ people: 21 March 2020
1st national lockdown measures legally enforced: 26 March 2020
Secretary of State for Health and Social Care Matt Hancock announces badge for care home workers: 15 April 2020
Communication to adult social care sector of PPE guidance and supply routes: 16 April 2020
CJRS goes live: 20 April 2020
Conditional lifting of lockdown (allows return to work): 10 May 2020
Announcement that CJRS extended until 31 October (only for employees currently furloughed): 12 May 2020
Changes to legislation on group size and overnight stays, schools reopen, non-essential shops reopen: 1, 15 June 2020
Announcement of plans to ease guidance for those shielding – 22 June 2020
Relaxation of social distancing: 23 June 2020
Lockdown ends, local lockdowns instituted: 4 July 2020
Guidance for extremely vulnerable people updated to include information related to the pausing of shielding: 31 July 2020
Shielding advice removed, replaced with ‘strict social distancing’: 1 August 2020
Reduction in generosity of CJRS: August – October 2020
New guidance for young people who are clinically extremely vulnerable and have been shielding: 18 August 2020
Return to home working and further restrictions: 22 September 2020
Announcement that CJRS extended until 2 December: 31 October 2020
Updated guidance for extremely vulnerable people on new national restrictions: 4 November 2020
2nd national lockdown legally enforced: 5 November 2020
Announcement that CJRS extended until Spring 2021: 5 November 2020
2nd lockdown ends, beginning of ‘tier 4’ restrictions: 2, 21 December 2020
JCVI first publish recommendations for vaccine priority groups: 3 December 2020
First vaccine received: 8 December 2020
3rd national lockdown: 6 January 2021
Vaccines offered to clinically extremely vulnerable (priority groups 3 and 4): **18 January 2021**

Vaccines offered to those in ‘at risk’ groups (priority group 6): **15 February 2021**

Updated definition of clinically extremely vulnerable groups: **16 February 2021**

Gradual relaxation of group size, distancing, shop closure requirements following ‘roadmap’ for lifting lockdown: **March – July 2021**

Shielding guidance paused: **1 April 2021**

Guidance updated for clinically extremely vulnerable people to, as a minimum, follow the same guidance as the general population: **12 July 2021**

Reduction in generosity of CJRS: **July 2021- September 2021**

Vaccine booster does administered to vulnerable people: **September 2021**

Note to confirm the end of the shielding programme, and to advise that guidance will be updated shortly: **14 September 2021**

Shielding programme paused: **15 September 2021**

Guidance updated to reflect the end of the shielding programme: **20 September 2021**

CJRS ends: **30 September 2021**

‘Plan B’ measures introduced, including compulsory facemask wearing: **8 December 2021**

**B: Vaccine priority group specification**

<table>
<thead>
<tr>
<th>Group</th>
<th>Risk group</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Residents in a care home for older adults and staff working in care homes for older adults</td>
</tr>
<tr>
<td>2</td>
<td>All those 80 years of age and over and frontline health and social care workers</td>
</tr>
<tr>
<td>3</td>
<td>All those 75 years of age and over</td>
</tr>
<tr>
<td>4</td>
<td>All those 70 years of age and over and clinically extremely vulnerable individuals (not including pregnant women and those under 16 years of age)</td>
</tr>
<tr>
<td>5</td>
<td>All those 65 years of age and over</td>
</tr>
<tr>
<td>6</td>
<td>Adults aged 16 to 65 years in an at-risk group</td>
</tr>
<tr>
<td>7</td>
<td>All those 60 years of age and over</td>
</tr>
<tr>
<td>8</td>
<td>All those 55 years of age and over</td>
</tr>
<tr>
<td>9</td>
<td>All those 50 years of age and over</td>
</tr>
<tr>
<td>10</td>
<td>Rest of the population</td>
</tr>
</tbody>
</table>


