Clearance checklist

*Inclusion of this checklist is **mandatory**. Please complete the whole list and private office will remove before putting submission in the box. A submission without it will be sent back.*

***Note**: Contact names provided must have seen and approved the submission.*

Finance	Does this involve any spending or affect existing budgets?	☒ If yes, named official [redacted] ☐ No
Legal	Does this include legal risk, a court case or decisions that can be challenged in court?	☐ If yes, named official ☐ No
Communications	Could this generate media coverage, or a response from the health sector?	☒ If yes, named official [redacted] ☐ No
Analysis and fact-checking	Does this include complex data, statistics or analysis?	☒ If yes, named official [redacted] ☐ No
Devolved Administrations and the Union	Does this promote union wide policies, or will it affect Wales, Scotland or Northern Ireland?	☐ If yes, named official ☐ No
Legislation	Does this include options that may require or impact primary or secondary legislation/regulations? If yes, please discuss with the DHSC Legislation Team.	☐ If yes, named official ☐ No
Parliamentary Handling	Does this require engagement with parliamentarians or a statement in Parliament? If so, please discuss with the Parliamentary Affairs Team, and Intelligence, Insight and Engagement Team.	☐ If yes, named official ☐ No
Fraud	Have you considered fraud risks?	☐ If yes, named official ☐ No
Commercial	Does this include commercial or contractual implications?	☐ If yes, named official ☐ No
Technology, digital & data	Does this rely on or have crossover with a tech/digital/data solution?	☐ If yes, named NHSX official ☐ No
Health Data/Personal data use	Does this involve the use of sensitive health/care data? Discuss with the SIRO team. Could this require the processing of Personal Data (Data Protection Act 2018)? Discuss with the Data Protection Officer team.	☐ If yes, named SIRO/DPO official ☐ No
Strategy and Implementation Unit	Does this relate to cross-cutting or longer-term implications for wider DHSC strategy? Does this relate to one of the Secretary of State priorities or a manifesto commitment?	☐ If yes, named official ☐ No
Duties, Tests and Appraisals	Do the following tests apply and have they been considered; • Secretary of State Statutory Duties including on health inequalities • Public Sector Equality Duty • Family Test • Other (please specify)	☐ If yes, which test? ☐ No

To: **PS(P)**
SofS

From: [redacted]

Clearance: **Fiona Walshe, Director for Mental Health and Disabilities, Shielding and Volunteering Policy**

Date: **23/07/2021**

Copy: [redacted]
[redacted]
Private Office Submissions Copy List

FUTURE OF SHIELDING POLICY AND CLINICALLY EXTREMELY VULNERABLE COHORT

Issue	Since shielding advice for the clinically extremely vulnerable (CEV) was paused on 1 April, and in light of the easing of restrictions on 19 July and emerging evidence on vaccine efficacy, this submission considers the future of shielding policy [redacted]
Date a response is needed by **Reason**	29 July [redacted]
Recommendation	• That you agree to formally end the shielding programme and move away from a model of centralised shielding/precautionary advice for the CEV cohort as a whole, back to the pre-pandemic model whereby those susceptible to infectious disease receive risk advice from their NHS clinician. • [redacted] • [redacted]

Discussion

Background

1. [redacted]

[redacted]

2. [redacted]
   a. [redacted]
   b. [redacted]
   c. [redacted]

3. [redacted]

4. [redacted]

5. [redacted]

6. [redacted]

Current situation

7. All 3.8 million CEV people were included in JCVI's initial priority groups for vaccination in early 2021. Currently, 88% have had both doses and 91% have

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/coronavirusandshieldingofclinicallyextremelyvulnerablepeopleinengland. Wave 3 – Table 1.9; Waves 4-6 – Table 1.7

had one. A recent study by Public Health England[2], suggests that for the CEV group as a whole, there is little reduction in vaccine effectiveness compared to those not in high-risk groups. As a result, senior clinicians, including the Deputy Chief Medical Officer for Health Protection and the Chief Executive of UKHSA, have advised that it is highly unlikely that we would need to advise the full 3.8 million CEV cohort to shield again.

~~8.~~ [redacted]

~~9.~~ [redacted]

~~10.~~ [redacted]

~~11.~~ As we move beyond Step 4 of the roadmap, the clinical steer from Dr Jenny Harries, Professor Jonathan Van Tam and others is that it is appropriate to return to the pre-pandemic approach of local advice and recommend that CEV individuals, particularly those who may have had a poorer response to the vaccine, receive Covid-19 risk advice from their NHS clinician. This approach will best allow for nuances in vaccine effectiveness, including the permanency of any immunosuppression, and individual risk to be properly addressed and will ensure individuals get the most appropriate, tailored advice. [redacted]

12. That means that the ongoing response for this group would not focus on Government issued shielding advice, but instead focus on individual clinical advice. This will then be supplemented by ongoing access to vaccine boosters, antibody testing and treatments, driven by decisions from Government and the Joint Committee on Vaccination and Immunisation (JCVI). The Antivirals

[2] RCGP VE riskgroups paper (khub.net)

Taskforce is working to identify effective treatments for patients who have been exposed to the virus to stop the infection spreading and speed up recovery time. Those who are immunocompromised are a priority cohort for research into these therapeutic and prophylaxis treatments such as monoclonal antibody therapies, novel antivirals, and repurposed compounds.

13. All of this means that shielding as an intervention is very unlikely to be required, either for the full SPL, or any less well protected subset. [redacted]

14. [redacted]

~~Communication~~

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

[redacted]

19. [redacted]

20. [redacted]

[redacted]

21. [redacted]

22. [redacted]

23. [redacted]

[redacted]

24. [redacted]

25. [redacted]

26. [redacted]

27. D[redacted]

[redacted]

Conclusion

~~28.~~ In summary, given that shielding has been paused since 1 April and it is unlikely to be reintroduced, we recommend shifting away from centralised shielding/precautionary advice back to the pre-pandemic model whereby those susceptible to infectious disease receive risk advice from their specialist. [redacted]

[redacted]