Wednesday, 18 February 2026

(10.00 am)

LADY HALLETT: Good morning, Ms Rahman.

MS RAHMAN: Morning. My Lady, may I call the first witness, Professor David Osborn.

PROFESSOR DAVID OSBORN (sworn)

Questions from COUNSEL TO THE INQUIRY

MS RAHMAN: Good morning, Professor.

A. Morning.

Q. Please could you give your full name, please?

A. Yeah, my name is Professor David Osborn.

LADY HALLETT: Thank you for coming along to help us, Professor Osborn.

A. Thank you.

MS RAHMAN: Professor, if I could just ask you to keep your voice up, we've got a stenographer writing down everything you and I are going to say and that will help.

A. Sure.

Q. Professor, you should have in front of you a copy of a report with the reference INQ000588211. Can you confirm that is an expert report that you've provided for the purposes of the Inquiry?

A. I can confirm that.

Q. And can you confirm that any facts stated within the

report are true to the best of your knowledge and belief?

A. I can.

Q. And can you also confirm that any opinions that you've stated in the report represent your true and professional opinion?

A. I can.

Q. Thank you.

Now, Professor, I know you've got a copy of your report. As I ask you questions, I'll give you the paragraph numbers just in case you need to refresh your memory at any point. It's a very detailed report. I'll also be putting up on the screen in front of you just a few slides from time to time, and I'll let you know when that's happening.

So, Professor, turning first to your professional background which you deal with at paragraph 2 of your report, you're a clinical professor of psychiatric epidemiology at University College London?

A. Correct.

Q. What does psychiatric epidemiology entail?

A. So psychiatric epidemiology is particularly involved in looking at patterns of mental health problems. Relating to this report, particularly we're interested in patterns of severe mental illness and will often use

large data, particularly NHS data, to look at things like inequalities but also look at treatment outcomes for people with severe mental illness over time.

Q. Thank you. And you're also an honorary consultant psychiatrist at the North London NHS Foundation Trust?

A. I am.

Q. And your clinical work, as I understand it, Professor, covers general adult psychiatry and acute crisis teams for people with severe mental illnesses?

A. That's correct, and I worked in those crisis teams during the pandemic.

Q. Thank you. You've also led and published wide-ranging research on physical health problems in people with severe mental health for more than 20 years as I understand it?

A. Correct.

Q. And finally, you've contributed to the international and national clinical guidelines on the management of these patients?

A. That's right.

Q. Thank you, Professor.

Professor, at page 4 of your report, just briefly touching on your detailed instructions for the report, you say that you were instructed by the Inquiry to provide a report on the impact of the Covid-19 pandemic

on mental health services for people with severe mental illness.

A. Correct.

Q. And you explain that you've reviewed regional, national, and international literature for the purposes of your report?

A. That is right.

Q. And I think you may have contributed to some of that research, partly, or your team would have responded to some of those studies.

A. Indeed.

Q. Thank you.

And just finally, you've acknowledged at the same page the contribution of Jennifer Dykxhoorn whose research focuses on severe mental illness in socially excluded and historically marginalised populations?

A. Yes.

Q. Thank you.

Professor, moving on to the substance of your report, at paragraph 2 it's right to say that there are a number of different approaches to defining severe mental illness?

A. It is.

Q. Now, we'll be hearing from another witness, my Lady, Professor Das-Munshi. More in that later. But for the

purposes of your evidence, at paragraph 2 of your report you've given some examples of the sorts of conditions that are included and you mention schizophrenia-spectrum disorders, other psychotic disorders, bipolar disorders, eating disorders, personality disorders and severe depression?

A. That's correct.

Q. And, Professor, is it right that people with these sorts of conditions tend to have a high need for mental health services?

A. It is true. They're often in contact with particularly secondary care mental health services but also use primary care services a lot.

Q. So GPs and hospitals --

A. Exactly.

Q. -- would be providing quite a lot of care to people with these conditions?

A. Exactly.

Q. And why is that? It may be obvious but why do they have such a high need for these services?

A. Well, particularly because of the mental health symptoms that they experience, they can include things like hearing voices or perhaps having abnormal beliefs, for instance being paranoid. Others have quite severe presentations with either low mood, or at times with

elated mood. So a range of presentations that affect areas of their daily life, and they require specialised treatments for those.

Q. Thank you. So it would be expected then, that any disruption to services such as may have happened during the pandemic, or their access to the services, that would have a significant impact on people like that; would that be fair to say?

A. That would be fair to say.

Q. Now, before we discuss your findings about that impact, I just want to ask you a little bit about the nature and the quality of the research that you reviewed.

You flagged at paragraph 8 of your report various limitations. For instance, it's right to say there was far less evidence about mental health services in the later waves of the pandemic; is that correct?

A. It is correct. We found far more evidence in the early stages of the pandemic published rather than as things moved on through the months and years.

Q. Thank you. And also you say there was some evidence about some specific conditions, so, for instance, severe obsessive compulsive disorder, so there were a few things that you didn't find that came up so much in these studies?

A. That's correct. We tended to find that it was -- the

research was about groups of people with severe mental illness rather than specific diagnoses, although we did look for that evidence.

Q. So that's just one example of a data gap, which is a concept the Inquiry has heard quite a lot about.

A. Precisely.

Q. Whilst we're on that point, I don't need to take you to it, but right at the end of your report, at section 6, just to touch on this: you say that whilst you found a large body of evidence, little was available using representative populations, and much was published on single sites or convenient samples.

Could you just explain what you mean by that.

A. I can. There were some strong pieces of evidence, that were from, for instance, particular NHS provider trusts, so mental health service providers, but of course they were one provider, and so it would be difficult to always say that those results could be generalised all across the country. However, there were other pieces of evidence that had far more providers, and indeed some studies with national evidence, so they speak to each other to build a bigger picture.

Q. Thank you.

Finally, just in terms of limitations, you also say that there were fewer studies from Wales,

Northern Ireland and Scotland, though I think you have referred to some research from those areas in your report?

A. That's correct.

Q. And again, Professor, despite the caveats, it's right to say you have reached some findings and conclusions on the basis of the evidence that you've reviewed?

A. Absolutely.

Q. Thank you.

Well, I'll just take you through, now, the main findings that you've made.

The first section of your report is changes in demand for existing mental health services. So, Professor, you've explained to us that, in normal times, these sorts of patients would have a high demand or need for mental health care services, but in this section of your report, you explain there was a dramatic reduction in people presenting to mental health services during the pandemic?

A. That's right.

Q. And just to illustrate, if I could ask for figure 1a to come up on the screen.

It says there "Psychiatric presentations". So this is a study that you've reviewed. Could you just explain to us -- there are two charts here, one says

"Psychiatric presentations", in a moment we'll come to one that's "A&E presentations" -- what's the difference between a psychiatric presentation and an A&E presentation?

A. So we've got people who have been referred for an emergency psychiatric assessment in one and we've also got people who have attended an accident and emergency department with a psychiatric emergency.

So we see a similar pattern in both of those types of presentation, which is that, as we went into the very first wave of the pandemic, there's this huge decrease in 2020, which is the orangey-yellow line, where we see a big, big decrease in people presenting, and the top line just shows -- the year before the pandemic -- shows that normally there wouldn't be much variation. So it was very striking.

Q. And we also see that in November, don't we?

A. We see that -- (overspeaking) --

Q. In the second lockdown.

A. Exactly. A huge decrease again.

Q. Thank you. And then, if we can go to the second slide, figure 1B, we see the same sort of pattern, do we? March into April and then November. And that's people coming to A&E and seeking help for these conditions?

A. For these conditions, exactly. A decrease at both time

points.

Q. Now, in your report you have talked about the sharp reductions that we see on that graph aligning with lockdown periods and public health messaging encouraging people to avoid hospitals and observe travel restrictions. Can you expand a bit more, if you're able to, on the impact of public messaging on people with severe mental illnesses?

A. I think as you describe, people were perhaps less willing to go to emergency departments and also fearful of travel and obviously not wanting to breach the rules, and that perhaps explains why people were less likely to go to the emergency department, as well as hearing how overrun the emergency departments were with the -- with dealing with the presentations from the Covid pandemic.

Q. This is -- as I understand it, these two graphs and this study that we've looked at, it's from three acute mental health liaison teams and two acute mental health centres in England.

A. It is.

Q. I mean, does it fit with your own experience, looking at these sorts of reductions, very sharp reductions?

A. It does, it does. And in the later evidence it also fits with the fact that some of these presentations would then generate people needing to go into hospital

and in the later evidence we see a big decrease also in the number of people who were admitted to psychiatric hospitals in the early stages of the pandemic.

Q. Thank you. I want to move on to a different topic or a different feature that you've flagged in your report at paragraph 15.

You say, essentially, that those who did present had more severe symptoms compared to what you'd see before the pandemic. We're going to hear more from Professor Das-Munshi about specific impact on symptoms, but are you saying, in simple terms, people were leaving it later to seek help during the pandemic? Is that what you're describing there?

A. It is what we're describing there. I think we saw that people had left it longer to seek help for their symptoms, and we also saw that people were more likely -- there were more people with severe presentations who were being seen in what we'd call the caseload or the case mix of people presenting.

Q. And that, as you say, aligns with public health messaging at the time, sort of, on the theme of: don't burden the NHS unless you can absolutely, sort of, avoid it?

A. Exactly.

Q. Okay, thank you.

Can I move on to another topic now, Professor, that is in your report, again from paragraph 15, you're talking about involuntary admissions.

Now, in simple terms, is it right to say that an involuntary admission is one where the person concerned is detained on a compulsory basis for treatment under legislative powers?

A. That is correct. And the use of the Mental Health Act so the people who are admitted are not consenting to the admission.

Q. So sometimes you call it a detention; is that correct?

A. Yes.

Q. And you say that involuntary admissions or detentions increased according to both an English and a Scottish study that you've referred to; is that correct?

A. That's correct, yes. We saw increases in the proportion of people who were under this legislation and admitted.

Q. And do you consider that the increase in the admissions was in part also a feature of what you have described earlier as people presenting later, essentially in crisis?

A. I think that's absolutely one of the likely explanations for that, possibly that also people did not want to go into hospital voluntarily because perhaps of fears of infection and what the situation would be like on the

mental health wards.
Q. Now, at paragraph 16 of your report you also refer to an additional study that Professor Das-Munshi has mentioned, I think it's the Hildersley study -- I'll ask her about it later. But to pick up the point with you, the study refers to higher rates of involuntary admissions in Black Caribbean and Black African groups, and am I right to say that the Scottish paper that you referred to had similar findings?
A. That's correct.
Q. And that's during the first lockdown?
A. Exactly.
Q. You explain that higher rates of these involuntary admissions for some ethnic minorities were already a concern before the pandemic?
A. That's right. There's a strong body of evidence that shows that there are increased Mental Health Act detentions among some particular ethnic groups and particularly black and Asian ethnic groups.
Q. But the way you put it is that this ethnic inequality in involuntary admissions was exacerbated by the pandemic.
A. It was.
Q. Do you say that because, as we've seen, the study is showing higher numbers of people being detained with higher rates from these ethnic groups?

A. There were a greater proportion of detentions amongst people from black ethnic groups, if I am understanding you correctly.
Q. So, in summary, there is evidence of higher rates of some ethnic minorities being involuntary detained --
A. Exactly.
Q. -- according to those studies?

Just a couple more points on this area, would it be fair to say that when people were detained during the pandemic, it would be more difficult to actually provide them with the treatment for which they had been detained?
A. I think there's strong evidence that people are concerned that treatment on particularly inpatient units was very challenging to provide. To elaborate, particularly because there was lots of -- of course, lots of emphasis on infection control on the wards, and that made it more difficult for people to feel they could offer therapeutic interventions to people, often people needing to socially distance, so not being able to have social contact, and to have therapeutic contact that would be part of normal inpatient care.
Q. So you have a situation where people are being detained under these powers, but in fact the treatment that's justified that is very challenging to provide during the

pandemic?
A. It was certainly more challenging with all the restrictions to control infections.
Q. And they're also being exposed to the sort of specific infection risks that you've described, and we'll come back to?
A. Sure.
Q. Thank you.

Just to then tie up on this area, we've just described -- you've just described to us the increased involuntary admissions, but you also say at paragraph 15 that there was a corresponding decrease in voluntary admissions?
A. Yes.
Q. We've already touched on people not wanting to come in so much, but you also say that mental health professionals may have been more cautious about admitting people even if they did attend. Why would that be?
A. Yes, I think there's certainly factors to do with the individual service user, but also, in the health service, there was -- you know, people were concerned not to expose people to a risk of infection by them being in hospital. There were also concerns about capacity, as people weren't sure what was going to

evolve in that very early wave of the pandemic.
Q. Thank you.

Just final point on this section. You say at paragraph 16 that when people did present, there's some evidence that slightly fewer of them were being discharged without any follow-up being necessary. So follow-up could mean community referrals or other form of support; is that right? Not just being admitted?
A. Exactly, exactly. So with less community follow-up.
LADY HALLETT: Sorry to interrupt.

Going back to your point about capacity, Professor Osborn, I've heard a lot of evidence about the redeployment of particularly medical staff. Did the mental health services suffer redeployment?
A. There were some concerns about redeployment. I think there was also huge concern about absence of staff because of people having to isolate and to shield, and especially in those early days where we didn't have testing available. So there were large decreases in staff numbers.
LADY HALLETT: Sorry to interrupt.
MS RAHMAN: No, not at all.

On the issue of at least some care being required when they did present, is that also consistent with what you've said about people presenting a bit later with

more severe symptoms? So less people being told, in fact, "You don't need any further treatment at all"?
A. Sorry, could you repeat the question, please. I'm not sure I fully understood.
Q. I think that what you described is that you've got fewer people in the pandemic being discharged with no further treatment being required, and I just wondered if that's consistent with the fact that people are presenting with more severe symptoms, so some sort of treatment is required?
A. Yeah, I'm not sure I follow that, sorry.
Q. I'm sorry. It's not an important point. What is the significance, at paragraph 16, of the evidence that slightly fewer were being discharged without any follow-up? Or it's simply something that you've observed that's -- (overspeaking) --
A. Well, it's something that we've observed. I mean, obviously there were -- as the rest of the report shows, there was a lot less -- there was a lot less availability of community treatment for people with severe mental illnesses during lockdown, with a big move towards telemedicine and non-face-to-face contact.
Q. Thank you, Professor.
Professor, your report then turns to a number of different mental health care settings. I won't go

through all of them in detail. They're set out at paragraphs 19 to 38. But as a broad proposition, would it be fair to say there's a pattern of reduced presentations to inpatient wards, GPs, and community mental health services in the first wave of the pandemic?
A. I think that's correct. There's a striking decrease in presentations across different services that are described.
Q. And you also identify research which found fewer referrals to secondary services for adult mental health including older adults?
A. Exactly.
Q. Now, you've explored all of those settings in depth in your report. I just want to pick up on some specific points that you raise.
At paragraph 20 of your report, you talk about rapid discharges and you refer to a particular paper from one trust that looked at these rapid discharges. And as I understand it, Professor, it was looking specifically at whether or not those patients suffered any acute relapses or negative outcomes like self-harm or being readmitted in crisis; is that correct?
A. Correct, yes.
Q. And I think it's right to say that those negative

outcomes in this study weren't observed?
A. They weren't observed, no.
Q. But you point out that this is a single-site study and you also consider that it is possible that the adverse outcomes weren't picked up because of pressure on community services; is that correct?
A. That's completely correct, exactly. It may be that the same factors which were preventing people from seeking help in the first place also when people were discharged, perhaps they were less likely to seek help and so we didn't see the outcomes that you mention occurring. But I agree with your observation that it is one mental health provider, albeit a large one.
Q. Thank you. You have mentioned community health services. In the literature that you looked at, did you find or see any specific evidence about how effectively community mental health services were able to operate?
A. I think there were real concerns that community mental health services were challenged particularly with complying with all of the restrictions, and although they tried to carry on, there was a rapid, rapid shift from seeing people face-to-face, which would be normal in mental health care, to using video or telephone consultations, instead.
Q. Thank you, Professor.

I'm going to move on now to quite an important point you make in your report a couple of times, starting at paragraph 22. And this is this concept of rebound, inpatient admissions rebounding after lockdown and slightly fewer discharges, as well. Does that mean that more people are going to be on inpatient wards, essentially?
A. I think that's right. As the restrictions were lifted, we saw that more people were then referred and admitted onto wards, and people were perhaps -- I'm not sure, but healthcare professionals on the wards were perhaps not pushing to discharge people as quickly.
Q. And you've referred in your report quite a few times to an unmet need and a treatment gap for the periods when people were not presenting. Is it right to say that you consider, then, that during this period when people weren't attending, they were clearly still suffering from the mental illnesses and they needed the care and the treatment gap describes the fact they didn't receive that care?
A. I think you describe it correctly. People had ongoing mental health problems and there's lots of other evidence showing that they had ongoing symptoms and Professor Das-Munshi will talk about that, but they weren't receiving the care in the community during those

periods.
Q. And you would say that the rebound in admission supports there having been that gap?
A. Yes, absolutely.
Q. Yes, and you cite in your report, paragraphs 29 and 38, a Care Quality Commission report and also evidence of high levels of calls to the NHS England mental health hotline; is it right, Professor that that also supports that there was a high level of need despite the drop in presentations?
A. Yes, I think that's exactly what it describes, that people, I mean, these are long-term conditions often for people and so the need hadn't gone away but we have evidence that when these opportunities to seek help were provided, people used them.
Q. Thank you. Another way you've explored that in your report is by looking at some research on presentation to GPs. That's from paragraph 26. And you refer to a study that showed a large reduction in mental health diagnoses, and prescription of psychotropic medication and self-harm episodes.
I think, just before, I'm just going to take you a figure on that, you do point out that severe illnesses weren't specifically covered in that paper.
A. That's correct.

Q. And also that there were quite significant differences in patterns across the nations?
A. There were some differences in patterns, yes, across the nations.
Q. But the overall picture as illustrated, for example, if we could get up on the screen, please, figure 5 from your report on page 12.
Essentially that is from primary care practices in Scotland, Northern Ireland and Wales, and the larger, thicker, yellow line in the background is what you'd expect, and the pink line shows what actually happened in the initial stages of the pandemic. So you see sharp declines, that -- the vertical line shows the date of the pandemic, sharp declines in prescriptions and presentations across the board; is that a fair summary?
A. I think that's correct. I think it's striking to see the decreases across all these different measures of people's mental health, including the bottom right figure, which is referrals for mental health to mental health services, which perhaps would include people with severe mental illness.
Q. Thank you.
And again, you explain that the prescribing levels then appear to rebound after the first wave of the pandemic. Again, that supports the existence of

a treatment gap?
A. Exactly.
Q. We've touched on the public messaging. Another thing that you talk about in your report, at paragraph 27, is that people may not have felt they were worthy of clinical attention during this critical time for the country, and we'll explore that and the term "self-stigma" with Professor Das-Munshi later, but is this is an example of that? Is that what you're referring to?
A. I think it is an example of that, where people sometimes talk about diagnostic overshadowing, where they feel that their mental health problem overshadows physical health problems, but also perhaps feel that it's not as worthy, particularly when all the headlines were around deaths around Covid.
Q. You've also mentioned in your report a fear of infection as another reason why people might not want to attend. Would that have particular relevance to people who were clinically vulnerable or clinically extremely vulnerable, in your view?
A. I mean, it's hugely relevant. People with severe mental illness, as you'll hear from Professor Das-Munshi, but that we have lots of evidence that they have lots of coexisting physical health problems, respiratory

problems, cardiovascular problems, so that people with those conditions would be particularly more at risk of having poorer outcomes with Covid.
Q. Thank you, Professor.
Professor, pausing now, just to consider what lessons can be learned from what you've described, do you think that the risk of a treatment gap for those with severe mental illnesses should be recognised in devising public health messaging in a future pandemic or civil emergency?
A. I think it's important that we recognise that people didn't receive the support and care that they required, and particularly when they're in vulnerable groups.
Q. And can you think of any practical steps that could address that risk, that public health messaging inadvertently discourages people from seeking the mental health care that they need?
A. I think that would be something around the messaging, that encourages people to make sure they do stay in contact with their mental health services.
I think, perhaps as an aside, but there's a -- there were similar concerns that people weren't seeking help for non -- for other physical conditions at the same time, that perhaps they weren't presenting for very serious physical conditions. So perhaps the lesson

learned is try to really encourage people to keep in contact with their -- the services that they require.

Q. Finally, on the impact of these delayed presentations, you say at paragraph 29 that early treatment is important in achieving the best outcome for those with severe mental illness, and delaying treatment can have long lasting impacts.

Could you expand a little on what sort of impacts you might see in this cohort, people with severe mental illnesses, if their treatment is delayed?

A. I think certainly we know when people first present with severe mental illness that if there are delays in their treatment that that has a negative impact in the longer term, in terms of their mental health and some of their social and other outcomes. So, it is a well-recognised fact that we need to have -- people need access to treatment very promptly to try to overcome, for example, symptoms of psychosis.

Q. Does it also follow there's an impact on health services, because more care would then need to be provided for those patients in the longer term?

A. Certainly in the longer term, that's correct, because if people aren't recovering as well then they're going to need longer term support.

Q. Thank you very much, Professor.

I think that's a good point at which to move on to the second part of your report. We've been dealing with the need for care and we're now looking at the changes to mental health services during the pandemic.

Again, I'll just ask you some of the main points that you draw out about this. At paragraph 40, you've noted some instances of specified mental health centres or hubs being opened to divert mental health patients away from hospitals.

Do you have any views on that as something to consider in any future pandemic or civil emergency? Does it seem like a good idea to you?

A. I think it was a very successful intervention, and particularly I have knowledge of one in north London that opened and was particularly successful in providing emergency psychiatric care to people, and took them away from the risk of going to the emergency department, but also meant they got specialist care more quickly.

Several of those -- to my knowledge, several of those centres have continued to exist, offering that kind of specialist care but it's certainly something that was felt to have worked in the -- during the pandemic to offer emergency psychiatric assessment and management.

Q. Thank you.

And second, of course, the major change that you describe in your report is the closure or conversion of some inpatient wards in order to provide Covid-19 care.

A. Yes.

Q. And clearly that had the immediate effect of reducing the availability of mental health beds and that would have had an impact on services and patients for, I take it, obvious reasons. However, you have also noted that some stable patients were moved to receive treatment at home to reduce infection risk.

A. Yes.

Q. Is that correct? And that, again, is because of the high risk of contracting Covid on the ward?

A. Absolutely. I think that -- I remember these were very challenging times for mental health inpatient services wanting to keep the service users safe, and opening specific wards where people who were infected could be cared for together, but of course certainly if in another ward there was somebody infected, then it was very challenging then to reorganise services to try and move people to one of the, I'll call it Covid-positive ward, if you like. So it was a challenge.

Q. So you might have seen a more stable person being moved home to reduce their risk of infection but would the other side of the coin be a risk that what was available

at home wouldn't be adequate for their mental health support?

A. I think there's certainly that risk with all of the evidence that we saw about lack of community follow-up for people. But that, I guess, was balanced against the risk of being infected while they're on an inpatient psychiatric unit.

Q. Thank you, Professor.

So I want to move now to infection control for those who remained in hospital, and you've described this at paragraphs 43 and 44, and you've said that infection control was particularly challenging for psychiatric patients. Could you expand on that a little, please?

A. I think there were a number of challenges. There were challenges particularly for people who have been admitted and perhaps are very distressed or agitated, for them to adhere to the rules, be they about hand washing, be they about masks, be they about social distancing, when they're in a state of mental distress. I think there were also challenges for the staff in being able to manage those things, as well. And particularly on the wards, the need to keep places clean and to deal with PPE when it was available, to deal with testing; all challenges that wouldn't be a normal part of psychiatric inpatient care.

Q. So, I mean, is it right to say that the sort of care you're needing to provide is often face-to-face group activities, sometimes -- it's something you're in close contact with the patients, and therefore any delays in getting PPE, those sorts of things that you've described in your report, they had a particular impact?

A. I think they would have a particular impact and we know that from evidence given by surveys of -- large surveys of mental health staff about their experiences of the pandemic, and they found this really impeded their ability to have therapeutic interactions with the people they were caring for.

Q. Thank you, Professor.

In terms of, again, of lessons learnt from that, are there any specific measures that you could think of that could alleviate some of these challenges that you've described about infection control for these sorts of patients?

A. I think -- I mean, the things that were challenges as we all went into the pandemic at the beginning, of things like availability of testing, availability of PPE training to use it -- it's not part of my usual clinical practice to wear masks and aprons and et cetera. So, the availability of those, the training, would be really important.

Q. Thank you, Professor.

Can I move now to another topic, which is remote services. Again, a very major change in service provision, a rapid replacement of face-to-face care with remote services.

You touch on particular challenges of delivering mental health care remotely at paragraph 43, and then you have -- and I don't need to take you to all of it, but just to highlight -- you revisited it at section 3.7 of your report as well.

Is it fair to say that your broad conclusion on this is that rapid transition to remote consultations was seen as a success, but it wasn't suitable for all?

A. I think you're correct. There's national evidence and local evidence, and evidence from staff that there was a massive shift to this type of work. However, it was new for many mental health workers, and it was felt to at least fill some of the treatment gap to be able to contact service users in the community.

However, there were major concerns about people, particularly vulnerable people, and the suitability of these types of consultations to deliver positive therapeutic intervention for people. So it works for some people but not for a large number of other people, for a variety of reasons which I'm happy to talk about

if you want me to.

Q. I think you've touched on unequal access to technology and adherence to medication. Are they some of the issues that arise?

A. Exactly, technology, the ability to use it. Confidentiality, finding a space to have those consultations, both for the service user themselves to have privacy, but also for the staff actually having space to deliver those confidential interventions.

Q. And just in terms of the impact on the patients themselves, Professor, we've sent you some extracts from the Every Story Matters report on mental health and wellbeing, and just to illustrate the potential impact, get your thoughts on it, if we could have a slide up with some extracts from accounts.

So this is from one or two people, the first says that they sought therapy privately but came up against a brick wall of therapists being unable to take them on as a new client. They describe there no one thinking it safe to see them in person, but it wasn't safe to see them online because of severe PTSD.

Does that illustrate some of the issues that you were facing?

A. Absolutely. All of these stories were really important to moving about both the treatment gap but also about

how these types of remote consultations actually were not found to be helpful for a large number of people.

Q. The second account there, they say they came close to ending their life. They were admitted to hospital following a suicide attempt and they felt that that could have been avoided if they'd just been able to sit down, talk to a skilled counsellor or therapist or in a group environment. Does that resonate with you?

A. Absolutely. I think, again, this is an example where people are not able -- were not able to access the care and support face-to-face in the community during the pandemic.

Q. Thank you, Professor.

Essentially, these accounts were illustrating some of the issues that arose with this rapid change to online service. Are there any sort of broad, I suppose, rules? Does your research suggest to you there are some circumstances in which remote therapy would always be inappropriate?

A. I mean, I think several of the reports highlight the fact that care needs to be personalised and agreed between the clinician and the person using the services and, for some people, it really doesn't work, and they could be for the reasons we outlined just before, be that access to technology, be that not being able to use

the technology, et cetera.
Q. So, in terms of any criteria, that you could consider to determine whether it would be appropriate, it sounds as if what you're saying is that it would be quite case dependent or patient dependent?
A. It would be case dependent but I think we've highlighted some of -- the types of people who have got particular financial challenges, housing challenges, challenges with technology, where it's really not going to be an appropriate form of support for them.
Q. Were there any alternatives or safeguards that occurred to you as you were experiencing these challenges that you thought: ah, if we needed to do this again, this might help with these challenges? Or was it all just too challenging to think of an easy fix, as it were?
A. I'm not sure about an easy fix, but I do think the -- considering, as you said, the care plan for the individual person, and sure, some people did report finding telemedicine very helpful. As an example, some people don't like it when mental health professionals come to their home. They feel that it's intrusive. Other people don't want to go to appointments. It costs them time, it costs them money, actually, for them to go. So there were some benefits for some people. But I think, rather than generalise about groups of people,

it's about having the personalised approach and seeing whether remote consultations will work for them personally, and for the type of treatment plan that they need.
Q. Thank you, Professor.

At this point, there are -- we are going to hear tomorrow from the mental health charity Mind about some of the initiatives, including digital peer networks.

And my Lady, I pause at this point to adduce a number of statements from charities across the UK that also contain information about both the positive and the negative impact of the move to online services, only one of which I'll ask you about, Professor, in a moment.

Those statements, my Lady, are from Scottish Action for Mental Health, INQ000657975; Inspire Wellbeing, INQ000588200; the Association of Mental Health Providers, INQ000659785; and finally, the Scottish Mental Health Partnership, INQ000660114.

For your part, Professor, as you've said, you have noted some innovations that were positive. There's one, again, it's a specific psychological intervention and you describe it at paragraph 55. Is there anything from that example, from the Manchester Crisis Resolution Team that gives us an insight into how these services can be made to work online?

A. I think this was an example of a crisis team offering a particular form of therapy that they delivered, and it's particularly interesting how people did move to bring innovations in, and it sounded successful, as did the other intervention in that paragraph, to try and engage people in physical health interventions when they had severe mental illness.

They're small studies, so I think they're hopeful, but they perhaps are things that us in the mental health research community need to think more about, about understanding their effectiveness and acceptability to people for any future lessons learned.
Q. Just finally, you confirm that according to the research that you've looked at, the rapid transition to digital services is not just something we saw in the UK, but that's an international development in this area?
A. Absolutely, yes, yes.
Q. It's perhaps worth pausing to say, as well, that at the end of your report you say that all of your findings at section 5 applied across the board. Does that mean, essentially, the trends you've explained about mental health services, they're consistent with the international picture?
A. They are consistent with the international literature particularly decreases in inpatient admissions and

closure of community services, or certainly decreases of community services. Perhaps we were better at maintaining services than some other countries in the international evidence.
Q. Thank you.

Professor, I'm going to take the next part of your report from paragraphs 58 to 59 quite quickly -- that's also section 3.6 of your report -- and what you're doing there we've already touched on, the impact on staffing in the workforce and my Lady's asked you a question about it. We've also heard about the impact of pandemic on UK healthcare systems in Module 3. But just in terms of mental health services, it's right that you identify factors like illness, care-giving responsibilities, and some mental health staff being required to redeploy?
A. Correct.
Q. And you describe the adverse impact on staff morale, stress, burnout, and exhaustion; is that correct?
A. Correct.
MS RAHMAN: And again, my Lady, to note that the Every Story Matters report has a section on the impact on the mental health workforce with accounts from staff.

I'm not going to take you to any more of those accounts, Professor, but you go on to say that that issue with staff severely impacted on the delivery of

mental health services to patients. You say that --
A. Yes.
Q. -- at paragraph 58. Perhaps the reason is obvious, but could you just explain why, why those things impacted particularly on patients?
A. I mean, particularly because some staff were shielding. Often, in the early stages of the pandemic where people were having to isolate when they had symptoms, we had huge reductions in staff numbers. So this whole range of factors meant there was decreased capacity to deliver care to people with severe mental illness.
Q. Thank you. Professor, the next section of your report, section 3.10, touches on specific disorders affected by those changes. I'm going to ask you about couple of them. The first is eating disorders.
A. Mm-hm.
Q. And it's right that there were already issues with long waiting times for treatment and beds?
A. Correct.
Q. But again, the research you've looked at suggested that that was exacerbated during the pandemic?
A. Exactly.
Q. And you've said also that the evidence suggests that some were being admitted to general hospitals rather than specialist units?

A. That's right, there's evidence for that.
Q. What would be the impact of that on a patient with an eating disorder?
A. I mean, particularly not receiving the specialist eating disorder care that would normally be provided to them. Not to say they wouldn't receive any appropriate treatment, but perhaps less contact with the staff who were specifically trained in dealing with eating disorder care.
Q. You did flag one what you've described as a "novel" treatment at paragraph 65 of your report, from the south west, and you say it's enhanced cognitive behavioural therapy, and I think you're saying that that study showed that that seemed to get a better outcome than traditional inpatient treatment. Are you able to say what it was about that approach that led to that?
A. No, I think -- I mean, I think it was -- again, it was a small study, but an interesting innovation that came about during the pandemic that was aimed to help to decrease the need for inpatient care, so -- and seemed to improve people's outcomes. So something -- perhaps a positive innovation during the pandemic.
Q. Thank you.
Moving on to psychosis, that's the other topic I'll ask you about. You address it at paragraphs 67, 68, and

you note some research suggesting there was an increase in first episodes of psychosis; is that correct?
A. That's correct. Yes. These are new presentations of people with a psychotic disorder.
Q. So I'm going to deal with this point in a little bit more detail. You note that before the pandemic, there was evidence that the rate of the presences was higher in black Caribbean and black African groups; is that correct?
A. That's correct, there's well-established evidence for that.
Q. So a gap between those groups and white individuals?
A. Correct.
Q. That was already a feature?
A. Yes, it was already a concern, yes.
Q. Now, looking at what happened during the pandemic, you've noted one study, and I'll take you to that in a moment, where, would it be right to say, the gap increased during the pandemic for black individuals?
A. Yeah, that's correct. It did increase. So there was a greater inequality, a larger number of people from black ethnic backgrounds who presented with psychosis.
Q. And also -- and again, we will look at this figure just in a moment -- quite a significant increase in Asian ethnic groups as well?

A. That's right, there was a --
Q. So let's just have a quick look at that chart.
It's figure 12 on page 27 of your report.
And I'll summarise and you can tell me if I get it right afterwards. It goes over six years, from 2018/19 onwards. The blue column indicates "White British", the orange column, "White Other", of the green column "Asian", and the pink column, "Black" individuals; is that correct?
A. That's correct.
Q. And within each column at the top is a vertical line with two ends, a bit like an extended capital I, and that's the confidence interval?
A. It is.
Q. So the true figure could be anywhere between the top and the bottom, but you have, for instance, a sort of 95% confidence that it's somewhere there?
A. Exactly. That's the area of certainty for the result.
Q. And you take the midpoint as the top of the column?
A. Yes.
Q. So would I be right to say that the chart shows the highest incident rate for black individuals was in the years 2020 to '21 and 2021 to '22?
A. Yes, that's exactly what it shows.
Q. So, around the time of the pandemic, essentially?

A. Yes.
Q. And there's a significant widening of a gap between the black individuals that were reviewed and the white individuals in the second year in particular?
A. Yes.
Q. And for Asians, again, it seems it's in the second year you've got a very significant widening of the gap between them and the white individuals?
A. Yes.
Q. Thank you, Professor.
Going back to your report at paragraph 68, pausing to think about the implications of that, you say that structural inequalities, including discrimination, substandard living, working conditions, that may be an explanation for what that study found.
A. Yes, I think there's a wide body of evidence looking at this increased rate of psychosis in people from black ethnic groups, and these are some of the factors that are known to contribute to psychosis which might be more common in people from black ethnic groups.
Q. We're going to ask Professor Das-Munshi about what she says about it, and we're also hearing from other experts on structural inequalities.
A. Exactly.
Q. Professors Bécares and Nazroo, who you refer to in your

report.
There's also a reference in one of the statements we sent to you, Dania Hanif of the Association of Mental Health Providers -- just to summarise, I don't need to take you to it. That also provides further evidence about higher rates of mental health detentions amongst black people, and it says that in 2020 to 2021, individuals living in the most deprived areas of the UK were twice as likely to be in contact with mental health services compared to those in the least deprived areas, and it describes factors like job insecurity, homelessness, discrimination, displacement, being linked to increased risk of mental health.
Are they the sorts of points that you're referring to when you talk about structural inequalities?
A. They're exactly the kind of points, yeah, and there's well-established research around those inequalities.
Q. Thank you, Professor.
Section 4 of your report. Again, I'm going to take this really quite shortly. You've already explained that massive transformation of services during the pandemic had an impact on patients, and we've also talked about the treatment gap. So you've got people presenting with more serious symptoms. So we see more people with severe mental illnesses seen after the

earlier waves of the pandemic.
In terms of continuity of care in this section of your report, we've already discussed issues such as remote services, PPE. Are there any other particular challenges you'd like to highlight, for instance, I think you've referenced segregated patients, guidance, difficulty with referrals.
A. I think the other thing that people particularly mention is continuity of care and it's something that comes up outside of the pandemic, but something that people feel is -- has been lacking in their mental health care. And I think we've touched on the -- on some of the tele-mental health not being felt to be useful or helpful for people, and people needing to seek help elsewhere other than mental health services was reported in some of the studies.
Q. You've dealt in a lot of detail in your report about the disruption of access to medications specifically. Is it right to say, in broad terms, the challenges were in terms of monitoring and lack of flexibility around essentially caring for people and prescribing their medications?
A. Yeah -- yes, and again, I think particularly at the beginning of the pandemic, people were having difficulty contacting services in order to discuss medication, be

that in the general practice or be that secondary care mental health services. And then the lack of flexibility or availability of clinicians to then consult with people to discuss medication management and monitoring.
Q. Thank you. And at the end of the section, paragraph 81, Professor, you touch on the fact -- again, it's something we'll ask Professor Das-Munshi about -- there's a higher rate of physical comorbidities amongst people with severe mental illnesses.
A. Exactly.
Q. A particular point, I just want to ask you about, which you make, you say that this meant that people with severe mental illnesses also have a higher rate of morbidities that make them clinically vulnerable?
A. Absolutely.
Q. And you raise in particular the fear of infection following shielding advice and I think you say, Professor, you think that might have played a particular part in people not presenting for the care they need, as well as cancelled appointments?
A. Absolutely. I mean, we've seen a whole range of excess physical health problems like respiratory -- long-term problems or diabetes that make people vulnerable and potentially therefore in this frightening time for all

of us, more reluctant to seek help.
Q. So you you've got people who have got a need not only for mental health care but a real need for physical health care and the fear of infection --
A. Yes.
Q. -- or following the advice is leading to, again, what you describe as a large hidden backlog of unmet need and long-term implications?
A. Yes.
Q. Thank you, Professor.
Just couple more questions about the clinically vulnerable and the clinically extremely vulnerable, then. Is there anything specific to them that you can share in terms of access or provision of mental health care, for instance, are you aware of any specific evidence that they were deterred from seeking care due to concerns about PPE, ventilation, other infection control measures? Was there anything about that or -- to your knowledge?
A. Not research evidence that I came across relating to that, but if you're asking about people being extremely vulnerable, many of the definitions of people being vulnerable, such as homelessness or house insecurity, domestic violence, some people who were really struggling with any type of functioning in terms of

their daily care, those type of factors are much more commonly seen in people with severe mental illness and so would make them much more vulnerable, if that answers your --
Q. And in terms of what might be done, I suppose, in any future pandemic, can you think of any specific lessons to be learnt about those who were at the highest clinical risk to reduce the impact on their mental health from the sorts of issues that you've described?
A. I think, if we had time again, we've learnt that people with extremely severe presentations, people who were much more vulnerable, that they need to be prioritised. So you might kind of think about it in terms of grouping people and making sure that those extremely vulnerable people were not left behind from receiving both mental health and physical health care and support for their social vulnerabilities.
Q. Thank you, Professor. Just a few points to close my questions. At the outset of your evidence, you spoke about certain data gaps, which you set out at section 6. You found research on service provision for those with eating disorders and psychosis during the pandemic, which we've talked about. However, there was an absence of evidence on severe obsessive compulsive disorders, severe anxiety, depression, or PTSD.

What explains the absence of any research on those topics, in your view?
A. In my view, it was partly because a lot of the research was very broadly about mental health services across the piece rather than looking at specific diagnostic groups. Perhaps that -- it's also a factor that sometimes these diagnoses are not well recorded in some of the -- some of our healthcare records, but also, I think a lot of the research questions were around what happened to services rather than what happened to specific diagnostic groups, so the data just weren't collected.
Q. Thank you.
Turning, finally, to section 7 of your report, that sets out some very detailed lessons to be learnt from the pandemic, and you set those out under four main headings: preparedness, continuity of care during a public health crisis, recovery, and cross-cutting principles.
Professor, I've already suffered some specific points for learning, for instance in relation to infection control, online learning, the clinically vulnerable. Are there any other specific points that you'd wish to highlight in terms of the lessons learned?
A. I think the major concern was about parity of mental health services and protecting them, but also making

sure that they had the best chance of continuing to deliver appropriate care, and particularly access to the things that we've -- were discussed around PPE and testing. That feels particularly important.
MS RAHMAN: Well, we'll be hearing some more about that from Professor Das-Munshi.
Professor, that closes my questions but there are some other questions for you from others here.
LADY HALLETT: Thank you very much, Ms Rahman.
Ms Beattie is over that way, Professor.
Questions from MS BEATTIE
MS BEATTIE: Professor Osborn, good morning. I ask questions on behalf of national Disabled People's Organisations.
A. Good morning.
Q. In your report, you explain that the Coronavirus Act 2020 altered the safeguards in place for mental health detention, extended periods of -- permitted periods of detention and made it easier to apply for a compulsory treatment order. And you also tell us, and you've given evidence this morning, that the caseload mix in the first waves of the pandemic did change so that we saw more involuntary detention rather than voluntary inpatient crisis in community services.
Disabled People's Organisations are concerned that,

as a result, disabled people were detained where they might have remained in the community, detained for a longer period, and that this contributed to increased institutionalisation of disabled people. How did the changes to the statutory provisions and safeguards impact services and people with mental health illness who needed support?

A. Thank you. My evidence -- just to take the second point about people being detained for longer, we didn't find that in terms of the mental health admissions, but I can imagine that that would be a concern for some individuals, particularly if there was a lack of available community care for them. So I share that concern.

I think that the revisions around the Mental Health Act that were proposed that you reference, they weren't actually put into place. So there were some real concerns, I think across the whole mental health community, that there were suggestions that people could be detained perhaps with less -- with, for example, less protections around detention. They were proposed, but they're not enacted. So I think there's a section of the report that talks about that, about them not being in place.

MS BEATTIE: Just to clarify -- my Lady, I realise I have

limited time -- but it's right, isn't it, that they were brought in in Scotland and Northern Ireland? And I think your report addresses that in paragraphs 48 and 49. It's not a memory test, Professor Osborn, but is it right that we did see those measures in those jurisdictions and some changes in how compulsory treatment and detention was implemented there?

A. Yeah, I think our report highlights, though, the concerns about those and that they were withdrawn, and that that should be -- the recommendation was that they should not be included in future responses to the pandemic.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Beattie.

Ms Sergides.

Questions from MS SERGIDES

MS SERGIDES: There we go. Can you hear me?

A. I can.

Q. Good morning, Professor. You were asked questions earlier this morning about data gaps and you highlighted that one of the difficulties is that research about mental health services across the piece, if you like, rather than looking at specific diagnostic groups -- sorry, I should have introduced myself, I am Ms Sergides, I represent the Domestic Abuse Group.

Just turning to that point specifically, if I may, when considering access to mental health services, do you agree, therefore, that there is a critical need for gender-disaggregated data as well as it being broken down by both ethnicity and gender? So just focusing really on the data gaps.

A. Absolutely. And a real call for the availability of those data, both in terms of gender and ethnic group but also as having better data quality which is one of the real challenges, actually, in, particularly, secondary care mental health research, and including, I think, data also from the non-NHS, from the voluntary care sector, to be able to understand what works for people and what doesn't work.

Q. Thank you.

I'm going to turn to a slightly different topic. Again, in your evidence and I think in your report you discuss the benefits and disadvantages of remote consultations, I note in particular at paragraph 56 and 57 of your report, and the impact on health inequalities. And again, just now in evidence, you said that the types of factors much more commonly seen in people with SMIs are homelessness and domestic violence, people functioning in terms of daily care, but make sure that extremely vulnerable people don't get left behind,

that was one of the points you made.

The DA Group's experience is that some perpetrators of domestic abuse control their victim's access to technology, any technological communications. And so my question is, do you agree that being required to stay at home and subject to a perpetrator's controlling technological communications, makes it hard to contact existing mental health support or make new contact with that support?

A. I completely agree. It's a major concern, and one in the research, but also in my clinical experience, that making sure people are safe from the perpetrators is key, and many of these interventions are therefore not suitable to support people --

Q. And therefore --

A. -- or the victims.

Q. -- I'm grateful. Just turning to the point you make therefore in the report, do you agree therefore that this would have further exacerbated health inequality?

A. I do.

MS SERGIDES: I'm grateful.

LADY HALLETT: Thank you very much indeed.

Now, Mr Pezzani, he is over that way, Professor. Could you please make sure, you have quite a soft voice, that you keep speaking into the mic --

A. I will.
LADY HALLETT: -- and Mr Pezzani won't object if you have your back to him.
Questions from MR PEZZANI
MR PEZZANI: No, not at all.
Good morning, Professor, I ask questions on behalf of Mind, the mental health charity.
My questions are threefold but they all relate to the same section of your report, which you have already touched on in your evidence. It's paragraphs 18 to 22, where you describe distinct patterns in inpatient admissions and discharges through the waves of the pandemic and in particular in relation to the first wave.
You say that there were relatively fewer admissions in the first wave and an increase in rapid discharges. You mention at paragraph 21 the possibility that the reduction in admissions could be due to changes to clinical thresholds for admissions and discharge?
A. **(Witness nodded)**
Q. And you say that it is possible that a result of decreased availability of community services explained decreased detection of crisis from non-admission or rapid discharge.
So, for the first of my questions: were these

changes, in your view, driven by pandemic-related exigencies, or individual clinical need, or both?
A. I would say both of those. I think there was a need to protect patients from admission that might put them at risk of infection, but I think -- but there were also pressures on the service. So I think each of those factors that you mentioned combined together to affect both admissions and rapid discharges.
Q. Thank you, Professor.
My second question is, where community services were attenuated at the same time as there were changes to the rate and timing of admissions and discharges, so that suitable community aftercare might not have been available or as available as it had been before the pandemic **--**
A. **(Witness nodded)**
Q. -- can you assist on the consequences for people with severe mental illnesses of non-admission or rapid discharge into that relative absence of aftercare?
A. I don't have research evidence on that, but I think, of course, there's very strong evidence that people with severe mental illness do well from having interventions which involve continuity, seeing professionals, peer support, all of those things in the community. And the lack of those, we know, puts them more at risk of

a recurrence, a relapse of their severe mental illness symptoms.
Q. Thank you. And my third and last question, and you said in answer to my previous question, "We don't have research evidence on that", are you able to assist on whether, or to what extent we have reliable data on what happened in this period of time to people with severe mental illnesses who either were not admitted when clinically they might have been assessed to need admission, or who were discharged prematurely?
A. The only evidence was a small study we referenced earlier, which suggested that people who were discharged did not have very severe relapses, but that does -- that study did not have good evidence on the service user experience, it wasn't measuring service users' mental health, so I can't give you any stronger evidence. But clearly we heard from many staff, and also from service user interviews, that they felt that they were not supported during that time, and they reported concerns about their mental health during that period.
MR PEZZANI: I'm very grateful.
Thank you, Professor.
LADY HALLETT: Thank you very much, Mr Pezzani.
Professor, that concludes the questions we have for you. Thank you very much indeed both for all the effort

that went into your report -- and I think also your colleague assisted, could you thank her for me too, please -- and for coming along today to help us.
I suspect in your clinical work you don't have the easiest of jobs at the best of times, but it must have been particularly tough during the pandemic, so thank you for all that you did.
THE WITNESS: Thank you.
LADY HALLETT: Thank you very much. We shall return at 11.30, please.
(11.14 am)
(A short break)
(11.30 am)
LADY HALLETT: Ms Blackwell.
MS BLACKWELL: My Lady, may I call the next witnesses, please, Professor Clare Bambra and Professor Sir Michael Marmot.
PROFESSOR MICHAEL MARMOT (affirmed)
PROFESSOR CLARE BAMBRA (sworn)
Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 10
LADY HALLETT: Welcome back, Professors, good to have you back and thank you for your continuing help with the Inquiry.
PROFESSOR BAMBRA: Thank you, my Lady.
MS BLACKWELL: Thank you.

Professor Bambra, Professor Marmot, you should each have before you a copy to your report which bears the reference number INQ000588215. Can you each confirm, please, that that is the expert report, the joint report that you have prepared for Module 10 of the Inquiry.

PROFESSOR BAMBRA: It is, yes.

PROFESSOR MARMOT: It is.

Q. Thank you. And can you also confirm that the facts stated within the report are true to the best of your knowledge and belief?

PROFESSOR BAMBRA: Yes.

PROFESSOR MARMOT: They are.

Q. Thank you. And that any opinions that you have stated in the report represent your true and complete professional opinions?

PROFESSOR BAMBRA: Correct.

PROFESSOR MARMOT: Yes.

Q. Thank you. Very much. You last gave evidence back in June of 2023, and I just want to remind ourselves, please, of your professional qualifications.

I appreciate we've been through this before, but for those who were not present on the previous occasion: Professor Bambra, you are a professor of public health, population health -- at the Population Health Sciences Institute in the faculty of medical sciences at

Newcastle University; you are an elected fellow of the Academy of Medical Sciences; the Academy of Social Sciences; the Faculty of Public Health; and the German national academy of sciences; you are a senior investigator in the National Institute for Health and Care Research at the Academic College; and an academic co-director of Health Equity North, as well as a member of the World Health Organization's Scientific Advisory Group on health equity in Europe.

PROFESSOR BAMBRA: Yes.

Q. Thank you.

Professor Marmot, you are a professor of epidemiology and public health and director of The Institute of Health Equity at University College London; an elected fellow of the Faculty of Public Health, the Academy of Medical Sciences; an honorary fellow of the Royal Society of Public Health, and the British Academy; and a Foreign Associate Member of the Institute of Medicine. In 2000 you were awarded a knighthood, and in 2023 made a Companion of Honour for services to public health. You chaired the 2008 World Health Organization Commission on Social Determinants of Health; and led the seminal UK Government commissioned Marmot Review: Fair Society Healthy Lives in 2010; as well as the Health Equity in England: the Marmot Review 10 Years On in

2020, and Build Back Fairer: the Covid-19 Marmot Review, also in 2020.

And more recently, you have been a member of the Global Council on Inequality, AIDS and Pandemics, which is a council composed of global experts proposing evidence-based solutions for addressing inequalities linked to both AIDS and pandemics, looking at how inequalities affect the course of a pandemic and how pandemics exacerbate inequalities.

And we shall return to that piece of work at the end of our evidence, if we may.

In Module 1 you prepared a report in which you examined health inequalities and the social determinants of health in the lead-up to the Covid-19 pandemic, and you concluded that the UK entered the pandemic with its public services depleted, with health improvements stalled, health inequalities increased, and health among the poorest people in a state of decline.

In this follow-up work for Module 10, you have provided an overview of trends in socioeconomic inequalities in some of the key social determinants of health during the pandemic period, namely income, poverty, debt, and housing.

You then examine the socioeconomic inequalities in Covid-19 mortality, in life expectancy, and in healthy

life expectancy, and you go on to explore protections and mitigations that were put in place and how those affected society, and, finally, you make recommendations for improvements in the future.

One point to make before we go into the detail is that you have told us that it's often the case that data and studies are only available for certain areas of the UK, and so your assistance is really determined by the data that you are able to, and have been able to, obtain; is that right?

PROFESSOR BAMBRA: That's correct, and it varies for the different outcomes, and we've made it clear on each occasion whether there were studies available for each of the devolved nations, for example, and stated where we were unable to find any.

Q. Thank you. And we'll come on at the end of your evidence to discuss what improvements should be made in terms of data collection.

According to the World Health Organization, health inequalities are a result of disparities in the social determinants of health, the conditions in which we are born, grow, live, work and age. Is that right?

PROFESSOR MARMOT: That's correct.

PROFESSOR BAMBRA: Yeah.

PROFESSOR MARMOT: I actually wrote that, but yes.

Q. And in your 2010 review, Professor Marmot, did you outline six key social determinants of health in the UK?

PROFESSOR MARMOT: Absolutely. We drew both on the World Health Organization commission report that I chaired, and a panel of experts in the UK.

Q. Thank you. And those six key social determinants are: early child development; education and lifelong learning; employment and working conditions; income and cost of living; healthy and sustainable places in which to live and work; and prevention?

PROFESSOR MARMOT: Absolutely. May I say we've now added two?

Q. Yes.

PROFESSOR MARMOT: To tackle racism, discrimination and their outcomes; and pursue environmental sustainability and health equity together.

Q. Thank you.

Professor Bambra, you have described how the Covid-19 pandemic was a "syndemic". Can you plain to us what you mean by that term, please.

PROFESSOR BAMBRA: Yes, the syndemic is a way of referring to the fact that the virus interacted with the existing social inequalities in the social determinants of health that Sir Michael has just outlined.

Q. Thank you. And are you also of the view that it's

important to note that health inequalities are often experienced intersectionally?

PROFESSOR BAMBRA: Yes, in our evidence for Module 1, we described how people can have different positions of privilege and subordination in society. Would you like me to add to that?

Q. Yes, please.

PROFESSOR BAMBRA: Yes. So, for example, you can experience a class advantage or an educational advantage, by going to university, for example, and that leads to health advantages on average over your life course. On the other hand, you might experience disadvantage in terms of -- by being a member of an ethnic minority or by being a woman or from another socially -- social minority group, such as LGBTQ, for example.

Q. Right. So when we're considering health determinants, it's important to look at the full picture and to assess, on a case-by-case basis, what level of intersectionality there is?

PROFESSOR BAMBRA: Yes. In this report for today, we were asked particularly on socioeconomic inequality but also, where possible, where the data showed, for example, intersections with genders, so if there's variations between men and women, or other aspects such as homelessness, domestic abuse, and so on.

Q. Thank you very much.

So let's turn to look at your evidence on social and economic inequalities during the pandemic, and I'm going to come to you first, please, Professor Marmot.

At paragraph 7 in your report, you tell us that:

"Income inequality in the UK experienced a small reduction in 2020/2021, as the lowest income households experienced a small increase in income whilst those above them had a small decrease."

And you tell us that the most likely cause of that was the Universal Credit uplift. But then, after that small increase, things corrected themselves, and in fact you saw a trend the other way?

PROFESSOR MARMOT: You could use the word "correct themselves" if you think the magnitude of income inequality that we have is the right level. I don't. Then you could say they "corrected themselves". They reverted to previous patterns --

Q. Reverted, perhaps that's the better phrase. Yes.

2021 into 2022 and, going further forwards again, 2022 to 2023, is it right -- and this comes from page -- paragraph 84 of your report -- that UK households, except for the highest fifth, experienced a decrease in their real incomes before housing costs? And in relative terms, that was highest for the bottom fifth

households.

First of all, can you explain why housing costs after so important in terms of any measurement of increase or decrease of income?

PROFESSOR MARMOT: Yeah, particularly in England, from the home nations, and particularly in London, housing costs are a major contributor. If you measure poverty, for example, before housing costs and after housing costs, you get higher levels of poverty after housing costs, and it seems to me one should -- I prefer to look at the after housing costs measure, because that's real, that's what people have to pay. And that's much closer to the real standard of living, and you see, as I say, particularly in London and the south east, that poverty after housing costs is much higher than the before housing costs.

Q. Thank you.

You go on at paragraph 86 to talk about trends in the Gini coefficient. Can you explain to us, please, what that is?

PROFESSOR MARMOT: Yeah, I'll explain it and then say why there's a slight paradox. If you look at the incomes of every individual in the population, then if we all -- if 10% of the people had 10% of the income and 20% of people had 20%, and 30% had 30%, the Gini coefficient

would be zero, the departure from equality would be zero. But if Elon Musk had all the income in the world and the rest of us had nothing, then it would be 100%, it would be a total departure from that line of equality.

So it's a measure of the individual inequalities, departing from the line of equality, the lower the Gini, the more equal the income is distributed; the higher the Gini, the more unequal.

The slight paradox is that everything else in our report, we talk about quintiles or deciles, we talk about groups, not individuals. So it's a slight contradiction that we measure income inequality as individual differences, but we measure health inequalities as group inequalities.

Q. Right. Thank you for that explanation. And did you see, in relation to the Gini coefficient, a similar pattern over the UK, in terms of what was happening in England and the devolved nations?

PROFESSOR MARMOT: By and large. The differences don't merit too much concentration.

Q. Right. Thank you.

Turning to poverty, food insecurity and destitution. Relative household poverty rates measured both before and after housing costs, then. Again, slightly

decreased at the beginning of the pandemic, but then increased again as the pandemic developed?

PROFESSOR MARMOT: Exactly right, and we think the Universal Credit uplift played an important role. £20 a week, if you're below the relative poverty line, is really very important, and we think that was part of the decline. The poverty level -- we're not supposed to talk about children, families with children --

Q. Yes.

PROFESSOR MARMOT: -- the poverty level was around -- after housing costs was around 31%. 31% of families with children's were living in relative poverty in the UK. That is worth dwelling on. That went down a small degree in the first year of the pandemic, but when the uplift to Universal Credit was removed, the poverty level went up again.

Q. And similarly, in terms of food poverty, and you deal with this at paragraph 11 of your report, official statistics indicated that the proportion of people living in food-insecure households in the UK initially decreased from 8% to 6% in 2020-2021, but then slightly increased to 7% in 2021-2022, and then jumped to 11%, that's 7.2 million, in 2022-2023. Does that show the same trend that you are describing?

PROFESSOR MARMOT: Very much so. And we quote the Trussell

Trust that has a higher level, and I think that's because they measured food insecurity in a slightly more expansive way, being hungry, not being able to satisfy your hunger because of cost, eating smaller proportions -- smaller portions. Skipping meals. And when you measure it in that slightly more expansive way, 11 million people, said the Trussell Trust, in food insecurity.

Q. As of 2022-2023?

PROFESSOR MARMOT: Yes.

Q. Yes, thank you.

PROFESSOR BAMBRA: Could I just add, as well, that the increase, the jump up into 2022/2023 might also reflect other things happening in that period, for example that's the beginning of the inflation on food influenced by the war on Ukraine and also after the pandemic there's an increase in economic inactivity, so the jump happens, but it's not necessarily entirely pandemic attributable.

Q. Yes, thank you very much.

PROFESSOR MARMOT: May I add something from our global report --

Q. Yes, please.

PROFESSOR MARMOT: -- on Inequality, AIDS and Pandemics. We have a graph in the evidence we compiled for that

report. In the first year of the pandemic, the wealth of the world's billionaires increased by $5 trillion. At the same time, if you look at the trend of people in the world with food insecurity, it was going up. And at the same time as the wealth of the billionaires increased by $5 trillion, there were 2.5 billion people in food insecurity. Divide one by the other, you get $2,000 per person. If that $5 trillion increase in wealth had been applied to doing something about food insecurity, you could have spent $2,000 per food-insecure person in the world.

So what we're seeing in the UK, in microcosm, we're seeing globally in a much bigger way.

Q. Yes, thank you.

Professor Bambra, I'd like to come to you to ask you about savings, debt and financial difficulties during the pandemic, please.

At paragraph 12 of the report you tell us that survey data found that increases in debt and rent arrears, erosion of savings, and severe financial difficulties were most likely to be experienced by those in the most deprived fifth of neighbourhoods across all four UK nations; is that right?

PROFESSOR BAMBRA: Yes, that's correct, and we've taken that from the various sources that we were able to find for

the different countries. It's difficult to fully explain why, other than obviously people wouldn't have had as much savings, for example, to draw on, but also there's some evidence that suggests that it might be to do with the five-week wait that's part of the Universal Credit system.

Q. Yes.

PROFESSOR BAMBRA: So people would have to drain what small savings they had. Or there's evidence, for example, from Ulster University's report saying that people were having to go to, you know, loans -- debt collector people, to support them through that period, which happens in, you know, what we might call normal times, but also was particularly exacerbated in that period because, obviously, of the employment changes.

Q. Yes, it's perhaps worth noting that although the Universal Credit uplift helped many, as you've just said, Professor Bambra, it took a while to take effect.

PROFESSOR BAMBRA: Yes.

Q. And so for that period of time people were still struggling.

PROFESSOR BAMBRA: Yes, and not everyone was entitled to the Universal Credit.

Q. Yes, of course.

PROFESSOR BAMBRA: Including, for example, people on legacy

benefits but also other groups who wouldn't be entitled to state support regardless.

Q. Yes. Certain migrants and groups like that?

PROFESSOR BAMBRA: Potentially.

Q. Yes.

You also note, in terms of financial difficulties, there were regional inequalities evident particularly in England. For example, respondents to the survey in Yorkshire and the Humber, and the east of England and the West Midlands were more likely to have experienced a negative financial outcome at the beginning of the pandemic, April to May 2020, than those in the rest of the UK.

PROFESSOR BAMBRA: Yes, we draw on data there from a study by Cross and colleagues where they analysed the Understanding Society study, which is a large UK-wide survey of around 40,000 people, and we present further data showing the extent of this in table 1.

Q. Thank you. I'm going to come to table 1 now in fact, please.

Can we display INQ000588215 -- thank you very much, you're ahead of me. Page 23 of your report.

Can you tell us, please, Professor Bambra, what we can see in this table?

PROFESSOR BAMBRA: Yes, so this is data showing different

measures of financial problems, what they call negative financial outcomes during that very early period of the first wave and obviously during the first lockdown. And you can see that for each of those outcomes, the column there for the most deprived, number 1, of the quintiles, is red, indicating that they were worse than the other 80% of the population, that things were worse for them. You can also see that there were problems across all, but particularly so for people in the most deprived neighbourhoods.

Q. Yes, we see the highest figures in that first column, yes. Thank you very much.

PROFESSOR BAMBRA: Yes.

Q. And in general terms, did you see a similar type of pattern across the devolved nations as well?

PROFESSOR BAMBRA: With the data that was available, yes, and of course this does relate -- this survey is available for the United Kingdom.

Q. Thank you. Yes, finally in that section -- we can take that down now, please.

Professor Bambra, housing and homelessness. Inequalities in housing costs increased in 2020-2021, official data showing that the proportion of household income spent on rent increased during that period in both private and in relation to social tenants, and you

tell us that that was possibly due to higher rents, lower incomes, or a combination of both?

PROFESSOR BAMBRA: Mm-hm.

Q. There was a small reduction in the overall risk of homelessness in England, Scotland and Northern Ireland, and you tell us at paragraph 14 that that was likely a result of the Everyone In policy.

PROFESSOR BAMBRA: (No audible answer)

Q. But that there was an increase in the need in Wales and amongst the most vulnerable groups in England; is that right?

PROFESSOR BAMBRA: That's correct, we found interactions, for example, with unemployment risk and for people experiencing domestic abuse.

Q. Thank you.

You tell us at paragraph 120 that over the same period, so the beginning of the pandemic, close to 40,000 households in England were assessed by councils as being owed a "main homelessness duty", which was a slight decrease compared with the previous year.

What does that mean, please?

PROFESSOR BAMBRA: Yes, it's a way of assessing whether people are considered to be in need of support for their housing. Yeah.

Q. Right. But then, later on, you say at paragraph 120.1:

"... over 15,000 households with children were homeless or threatened with homelessness due to domestic abuse ..."

And that figure was up by 14% from pre-pandemic levels?

PROFESSOR BAMBRA: Yes. I mean, there is other evidence, from charitable groups, for example, that domestic abuse was a particular problem during the pandemic.

Q. And are you able to comment on whether or not there is an interaction between homelessness and domestic abuse generally and during the pandemic?

PROFESSOR BAMBRA: Generally, yes. And the data here you've just mentioned would suggest that there's an interaction during the pandemic as well.

Q. Thank you. The Inquiry has received a witness statement from Tim Gutteridge, who is the chief executive of Shelter, the charity for homelessness, and he tell us that in terms of overcrowding, which was clearly a problem during the pandemic because of the close proximity in which people were living --

PROFESSOR BAMBRA: Mm-hm.

Q. -- that appeared to be more prevalent in the rented sector than for owner-occupiers. He says that during the period 2021 to 2022, 170,000 households were overcrowded, those households being owner-occupiers,

compared with 325,000 such homes of private renters -- sorry, of private renters, yes.

Do those figures accord with your understanding of the problems that were persisting during the pandemic?

PROFESSOR BAMBRA: Yes. In terms of the evidence that we looked at, for example, with the inequalities there, for example, in rent, then there's a difference between renters and people who own their own homes. And that might be obviously to do with people's income and family size and so on, but also to do with some of the aspects, for example, that mortgage companies put in place to support, you know, their customers, in effect.

Q. Yes.

PROFESSOR MARMOT: Could I add?

Q. Yes, please.

PROFESSOR MARMOT: It's worth distinguishing between the social rental sector and the private rental sector. In general, the quality of housing is higher in the social rental sector than in the private rental sector.

Q. Yes, thank you.

I'm going to turn now to part 2 of your report: "Health Inequalities During the Covid 19 Pandemic". And, Professor Marmot, I'll turn to you, please, if I may, to provide an explanation of the limitations in interpreting data.

At paragraph 149 you say:

"It should be noted that due to different deprivation indices and other reporting practices ... across the four nations, the data presented in this section [of your report] should be interpreted with some caution."

Is that right?

PROFESSOR MARMOT: That's correct.

I should add that the quality of data in the UK is astonishingly high. I mean, we were blessed through the pandemic with very good data, in general. So any limitations here need to be put in the context that the data we had in the UK were much better than in most other countries.

Q. That's good to hear.

You tell us --

LADY HALLETT: It's the first time since I've started this Inquiry that I've had a compliment about the quality of the data we've had in this country.

PROFESSOR MARMOT: Well, you know, I've done a lot of work in other countries and we're just blessed with good-quality data.

MS BLACKWELL: At paragraph 150 you explain that:

"Area-level deprivation is a way of measuring how well-off or disadvantaged a local area is in terms of

factors such as income, jobs, health, education, crime, access to services, and the local environment."

How, then, do you use the area-level deprivation measurement in terms of mortality? How do those two interact?

PROFESSOR MARMOT: So, let me make couple of comments about it. Firstly, it seems odd to have an index that's got health in the index, when you're looking at the relation between, then, this index and health outcomes. That sounds like confusion. It is. But if you take health out of the deprivation index, it doesn't make any difference to the relation between deprivation and health outcomes. So it sounds like a tautology but it is not, because, as I say, if you remove health out of the deprivation index, the remaining six indicators correlate very highly with health outcomes.

The second is, we use deprivation of the area because it's there. We can measure it. So for convenience.

Q. Yes.

PROFESSOR MARMOT: We use it in two ways: one, as a proxy for individual circumstances, and it's a proxy. So not everybody who lives in a deprived area is deprived. Not everybody who is poor lives in a deprived area.

Q. Yes.

PROFESSOR MARMOT: They could live in a relatively affluent area, local housing, whatever. So it's not perfect. We use it as a proxy. It works pretty well. But it can also be used to tell us something about the area, when that's the right measure. You don't want to measure individual education if you're trying to understand area effects. You want to measure deprivation of the area.

So with those caveats it works remarkably well. It's a pretty good proxy for individual socioeconomic position, because if you do measure education, income, occupation of individuals, you get pretty well the same relationship you get with the deprivation of area of residence.

Q. Thank you. Well, we're going to take a look at the various areas of the UK, and first of all, please, could we have on screen INQ000588215, page 32, and it's your figure 2. And this is in England, so the Covid-19 mortality rates, by deprivation quintile where 1 is the most deprived and 5 is the least deprived.

So what do we see here, Professor Marmot?

PROFESSOR MARMOT: Well, we said right at the beginning of the pandemic before we got the data, when people were saying that Covid will be no respecter of social position, prince and pauper alike could get Covid, and we said, yeah, maybe, but the experience of other

pandemics is that it will expose the underlying inequalities in society, and amplify them.

Q. Yes.

PROFESSOR MARMOT: And I quoted Camus, La Peste, that's what he said, he said it better than I did, but that's essentially what he said. And you look at this figure, that's what we predicted. There was a social gradient in mortality and we'll come on to that in a moment, and -- before we even knew there was such a thing as Covid, and then Covid comes along, that doesn't look like it's affecting prince and pauper alike. It's a social gradient. The greater the deprivation, the higher the Covid mortality.

And it's really striking. Then the question is, why does it get less over time? And we'll come on to that, but we think, you know, society put in place control measures, and lockdown, and mask wearing, and then finally the vaccine.

Q. Yes.

PROFESSOR MARMOT: And so the control measures made a difference to the inequalities.

Q. And digging in a little deeper, there were regional inequalities within England, weren't there? You tell us at paragraph 16.1 that the cumulative death rates were highest in the north west of England, in London, in the

West Midlands, and the north east.

PROFESSOR MARMOT: So, London was an interesting exception to the kind of prediction that I made, and it's good to get things wrong, because then you learn something. And I think the reason London was relatively high is because everybody is moving about, coming from abroad, there's a lot of mixing. It's very crowded, as I say, people coming in, bringing viruses in. Initially, people were bringing virus back from skiing holidays and the like, which only the more affluent do. And we saw the same in the United States when New York initially was very high for Covid.

Q. Yes.

PROFESSOR MARMOT: Apart from that London exception, the high rates in the north east and the north west were exactly what we predicted, because that's what we saw pre-Covid.

Q. Yes. And what you tell us about that is that the most deprived local authorities in the north of England, in the north east, the north west, and Yorkshire and the Humber, had 14.5% higher Covid-19 death rates than equally deprived areas in the rest of England?

PROFESSOR MARMOT: That's right, and again, that's a continuation of the pattern that we'd seen pre-Covid. In my 2020 report, Health Equity in England: the Marmot

Review 10 years on, we pointed to the fact that for a given level of deprivation as measured by the National Index of Multiple Deprivation, the consequences for health, both life expectancy, and healthy life expectancy, were bigger in the north east and north west, Yorkshire and Humber, than they were in London and the south east.

So when we saw that with Covid, we said yes, that's what we saw pre-Covid.

Q. Predictable. Yes.

PROFESSOR BAMBRA: It's got a term to describe it as the amplification of the effects of deprivation that we can see in the north and also you can see it in Scotland, as well, in terms of health outcomes and also here with Covid as well.

Q. Thank you. And we're going to turn and look in a moment at another table which I think demonstrates that.

But before we do, let's just look at the other areas of the UK, please, in terms of Covid-19 mortality. And at figure 3, please, at page 33 of the same report, you can see at the bottom of the page, that's regions of England.

Figure 4, please, which is at page 34. Thank you very much.

That's Wales. Does that, in general terms, show the

same pattern?
PROFESSOR MARMOT: It does. And just to make the point again, that it's not poor people versus the rest. It's a social gradient.
Q. Yes.
PROFESSOR MARMOT: People in quintile second from the top, number 4, have a higher mortality than those at the top. It's not much bigger in number 3, but number 2 and then number 1. So it's a social gradient. And again, as in England, it got flatter over time.
Q. Yes.
And then Scotland, please, which is figure 5.
The same pattern again?
PROFESSOR MARMOT: Yeah, and you can see the gradient very clearly, and it flattens over time.
Q. Yes.
And then finally, figure 6 at page 36.
Now, this is a different graph. Is that because the data that you received in terms of Northern Ireland was different data?
PROFESSOR MARMOT: Yes. Yeah.
Q. But we see that the mortality rate for the first quintile is the highest?
PROFESSOR MARMOT: And again, it's the highest. In fact, the gradient is not quite as clear as with the other

nations, but it -- pretty much the three in the middle are intermediate between the poorest and the richest.
PROFESSOR BAMBRA: And the data was only available for one year for Northern Ireland.
Q. Yes, thank you very much.
Thank you, we can take that down.
Now, Professor Bambra, I want to return, please, to intersectionality and the syndemic which you have described to us, and ask you about the five key pathways through which inequalities occurred. Can you explain us to what they are, please.
PROFESSOR BAMBRA: Yeah.
When looking at inequalities in Covid-19 deaths and hospitalisations, and you can look at five different things. One is the higher risk of exposure, for example, for people who were key workers still going out to work, and these tended to be people from lower-skilled or lower-income groups, and people from ethnic minorities, you know, interacting with that.
Then you have the transmission, which we've touched upon, with the evidence, for example, about overcrowding, but also that deprivation -- more likely to concentrate in urban areas, including, for example, London, that Michael has just talked about.
Then there's the vulnerability once someone has an

infection, then people from lower-economic backgrounds are more likely to have pre-existing comorbidities and clinical vulnerabilities, which means obviously that the disease can have a worse outcome.
There's also evidence to suggest that people in more difficult circumstances are also more susceptible to the adverse impacts of viruses, evidence from flu, for example, showing it's -- that their immune systems are eroded, through living in poverty.
And then, finally, which we will touch upon later in this section, is around inequalities in terms of treatment, particularly in terms of uptake of the vaccine, for example.
Q. Yes, thank you.
Could we have on screen, please, figure 8 from the report, which is at page 39.
I'm going to return to you, please, Professor Marmot to ask you about all-cause mortality by area-level deprivation. What do we see in this chart, please?
PROFESSOR MARMOT: What we see is pretty much what we predicted at the beginning: that the pandemic would amplify the inequalities. So if you look at 2019, the blue or whatever you call that colour -- dark blue -- at the bottom, and then the next year, the first year of the pandemic, in England, in Wales, in Scotland,

particularly, you can't quite see it in Northern Ireland, but in the other three you see a very clear increase in the absolute inequality. So this is a way -- later we'll get on to the gradient, but this is a way of measuring inequality as a difference between the least deprived and the most deprived quintiles, 20 per cent. And you can see the big increase.
What you can also see is that the absolute inequalities are bigger in Scotland than they are in England. And it's what Clare said a moment ago, that what I described -- Clare used the term the "amplification", what I described, that the consequences of deprivation for your health are worse in the north east and north west of England, and they're worse in Scotland. I think it's the same kind of phenomenon that we're seeing here.
So we see the big increase particularly in the first year of the pandemic. And this is all cause mortality. This is not Covid. Covid's important but this is all causes.
Q. Yes.
PROFESSOR MARMOT: And we see it happened in all four nations, and bigger in Scotland.
Q. Thank you. Yes.
Can we take that down, please.

Moving on and away from mortality to talk about inequalities in life expectancy and healthy life expectancy, please.

Could we please display figure 9, at page 43 of the report.

Noting that this relates to life expectancy only, not healthy life expectancy.

So could we -- thank you very much.

We can see that this is entitled:

"Absolute gaps in life expectancy for males and females ..."

Separated out, males are blue, females are orange.

"... pre-pandemic between the most and least deprived local authorities ..."

So we're dealing here with before -- the period of time before the pandemic hit.

PROFESSOR MARMOT: Yes, and it shows an interesting phenomenon that we don't -- or certainly I don't completely understand, that inequalities, in general, there are some significant exceptions, but in general, the social inequalities in health are bigger in men than in women. And I say, I don't completely understand it. And the exceptions are really interesting and important. We'll come on to healthy life expectancy in a moment but also, in my 2020 report pre-pandemic, what we saw was

that if anything, the impact of austerity on health was bigger on women than on men, and so I say the exceptions are interesting.

Q. Yes.

PROFESSOR MARMOT: And it was pointed out to me -- I didn't say it, but it was pointed out to me -- that the impact of austerity on women's circumstances was bigger than it was on men. The austerity hit women worse than it hit men. And we saw it in the mortality statistics, the life expectancy statistics.

So I say this general pattern we see for reasons that I don't completely understand, and the exceptions are interesting.

Q. So just so that we understand, life expectancy at birth is a statistical measure of the estimate of the average remaining years?

PROFESSOR MARMOT: It's an artefact, it's a convenient artefact. It -- forgive me for this. It's saying if you had a theoretical population of people, and to take today's age-specific mortality rates, the rates that apply today, and assume that as that group of people moved through life, today's age-specific mortality rates would apply to that. And then you sum all that up and you say that's the expectation of life. It is not a prediction of what would happen in the future.

Q. No.

PROFESSOR MARMOT: And so children born today may have much longer life expectancy than these figures were to suggest. If something dreadful happens, it might be shorter life expectancy. But it's a statistical summary of -- and it's a very useful summary, so having said it's an artefact but we use it all the time.

Q. But healthy life expectancy is something different, that's the average number of years that a person can expect to live in good health, not impeded by disabling illnesses or injuries or poor health; is that right?

PROFESSOR MARMOT: That's correct, and were those data readily available all the time, we would use them all the time, because in a way, it's a more meaningful measure. People want not just to live a long time, they want to be healthy for a long time, and living a long time with ill health is less desirable than living a long time in good health. So that healthy life expectancy is a meaningful measure, and -- you're probably going to ask me this in a moment -- the inequalities in healthy life expectancy are much bigger than the inequalities in life expectancy. And what that means is, if you're living in a more deprived area, not only can you expect fewer years of life, you will live more of those fewer years with ill health.

Q. Yes.

PROFESSOR MARMOT: So that's a dreadful inequality. Not only do you have a shorter life, you have more of that life spent in ill health.

Q. Well, let's have a look, please, at the healthy life expectancy figure which is figure 10 in the report at page 43.

So this is the absolute gaps in healthy life expectancy, again for males and females, pre-pandemic, between the most and least deprived local authorities. So what do we see here?

PROFESSOR MARMOT: So we see that they're bigger. If you remember the previous figure, it was around nine years for life expectancy. Now we're talking around 18 to 20 years for healthy life expectancy. So the gaps are bigger, and when I said that in general, men are affected by social inequalities more than women, but the exceptions are really interesting. Here's an exception. What we've seen consistently is women have more ill health. They live more years, on average, but they have more ill health. And again, we saw pre-pandemic, which we think was a consequence of austerity, that women's healthy life expectancy particularly did not improve, because of the increase in ill health.

And here, we can see, for England and Wales and

Northern Ireland, not for Scotland, that healthy life expectancy gaps are bigger for women than for men.

Q. And throughout the pandemic, were these patterns replicated in terms of life expectancy and healthy life expectancy?

PROFESSOR MARMOT: By and large, yes.

Q. Thank you.

Professor Bambra, I'd like to ask you, please, about Long Covid by area-level deprivation, and you deal with that at two areas of the report. I want to ask you about the definition of Long Covid, which the Inquiry is familiar with. It's defined by the National Institute for Health and Care Excellence, NICE, as signs and symptoms that continue or develop after acute Covid-19; is that right?

PROFESSOR BAMBRA: That's correct.

Q. And what did you find in terms of the available data on Long Covid? What did the data tell you about patterns across area-level deprivation?

PROFESSOR BAMBRA: Thanks for raising this point, Kate, because I think it's very important that we remember that people are still suffering from Long Covid at the moment, and what we found in the analysis that we present in the report is that basically in deprived areas, the prevalence of Long Covid is around twice as

high as in the least deprived areas, and we've got that from two different survey sources that reinforce each other. That's for England. And we also found data that showed a similar pattern for Scotland, and to a slightly more nuanced extent, in Wales.

Q. Thank you.

Can we put up figure 14, please, from the page 49 of the report, and we can see that this is per English region as of March 2023, and does that support the evidence that you've just given, Professor?

PROFESSOR BAMBRA: Yes, so that just shows that the north east and the north west and the West Midlands have, as of 2023, have the highest prevalence of Long Covid, and that potentially also reflects the patterning of deprivation, as well.

Q. Thank you.

Professor Marmot, as a connected issue, I just want to ask you about employment, and the data that you have looked at in terms of what level of danger key workers were placing themselves in, in terms of perhaps being more exposed to the virus than others.

Is it important to look at the type of employment that somebody was engaged in, as well as the area that they were working in, in terms of geographical area?

PROFESSOR MARMOT: Indeed. As you said earlier, my third

recommendation in the 2010 report was employment and working conditions. Employment and working conditions are fundamentally important for health. Unemployment is very bad for health. Work is much better than unemployment but the quality of work really matters, and we know, particularly psychosocial working conditions, shift work, long hours, job insecurity, high demand, low control, effort-reward imbalance, poor organisational justice, all increase physical and mental health, and all of that would operate during the pandemic.

Then, in addition to all of that, you've got people working in frontline occupations. Forgive my coloured language, but the heroes who are coming to collect your garbage, who were serving as cashiers in the supermarkets, these were the heroes in the pandemic, putting themselves at risk by helping society to once.

So in addition to all the other things that we know about that would be operating during the pandemic, there's then exposure to the virus because of the nature of work, and the inequalities are key, because people who could work from home and do their work without interruption were not exposed in frontline ways like that. So that was on top of all the other things connected with work. That was an extra risk.

Q. Yes, thank you.

PROFESSOR BAMBRA: Could I also add that people in those lower-paid roles, as well, were also less able to access sick pay which we did discuss in our first Module 1 evidence which would have meant they were potentially working with symptoms of Covid and also, you know, potentially spreading it, because they weren't able to afford to take time off.

Q. Yeah. And being placed in that level of deprivation was not in any way going to encourage people to disclose their Covid symptoms.

PROFESSOR MARMOT: Well, you'll remember, during the pandemic, when there were these ill-fated tiers of risk, and in Manchester and the north west there was the concern that if people weren't compensated, if they were told, "If you've got -- if you've tested positive, stay home. We won't give you any money, but stay home", that was a pretty strong disincentive to get tested.

Q. Yes, thank you.

Professor Bambra, you deal within the report, at paragraph 215, with inequalities in health-related outcomes.

PROFESSOR BAMBRA: Mm-hm.

Q. And you list several of those: alcohol consumption, smoking, physical activity, obesity, and loneliness.

Just touching upon one of those, please, you talk

about the "alcohol harm paradox". What do you mean by that phase, please?

PROFESSOR BAMBRA: So that means that even if you have the same rates of drinking amongst more educated groups versus lower educated groups, there's more harm for people who are at the lower income, lower educated end.

Q. Why is that?

PROFESSOR BAMBRA: It's, I think -- I'm not sure we have the answer, which is why it's called a paradox, but the speculation would be around how the drink is consumed. So, for example, higher prevalence of binge drinking. But it also would probably, in my opinion, interact with the other social determinants that Michael has outlined, and draws into that idea of one of the pathways around susceptibility and the -- in effect, the physiology of the body as well.

Q. Thank you.

Well, going back to the pathways, could I ask you to tell us about unequal treatment, because that is something which you've already mentioned. I think it was the fifth of the five pathways. What does your research tell us about that?

PROFESSOR BAMBRA: So, are you wanting me to discuss the vaccination programme? I'm sorry, I'm not sure where you want me to go with that.

Q. I'm wanting to move on to protections and mitigations --

PROFESSOR BAMBRA: Okay, that's fine.

Q. -- so let's deal with vaccinations as the first one, please.

PROFESSOR BAMBRA: Okay. So I know that my Lady has had a lot around the vaccinations, but there's been later studies showing the impacts on inequalities in Covid mortality, and there's a strong association over time that the rollout of the vaccine was effective in reducing the social gradient, as we saw earlier with the graphs and Michael's commentary. However, it didn't eliminate the Covid mortality gap.

Modelling suggests that was because of the unequal uptake. And you can see with the first, second and third dose, increasingly people from more deprived areas have a lower take-up of the vaccine. And that's something I think is a very important point for us to make, is that the vaccinations were working, in terms of reducing mortality, but that we need to do more to ensure that everyone takes up that offer, including, at the moment, people in more clinically vulnerable groups who are still entitled, for example.

PROFESSOR MARMOT: And can I just add the global perspective?

Q. Yes, please.

PROFESSOR MARMOT: There were huge inequalities globally in access to the vaccine. Low and middle-income countries had less access than high-income countries.

Q. Yes, thank you.

We've already touched on housing policies, the Everyone In policy, and how that assisted, but the Inquiry has received evidence that, of course, when that scheme stopped, when it finished, did things go back to how they were before, or was there any retention of benefit to the homeless?

PROFESSOR BAMBRA: So I think what you find is that you then get, for example, evictions went down in that sort of early pandemic period, where there were pauses due to legislation, but then they go back up again, and in fact increase, and perhaps compensate for the suspension.

And we can also see this -- with other aspects, for example with the £20 uplift in Universal Credit, when it's taken away, then the increase in poverty that you get in the later period, that Sir Michael outlined earlier, is likely associated with that reversal of policy as well.

Q. Thank you.

And we've also touched upon Universal Credit, and you've already told us, Professor Bambra, that one important consideration is, of course, that not

everybody would have been entitled to that mitigation, and so the benefit that that had of course only attracts to those who were entitled to claim it?

PROFESSOR BAMBRA: Yes, it would only attract to those who were entitled to it, and in the report we talk about some of the groups that were less likely to have that, and that did include, for example, people who had been on legacy benefits for a long time, such as certain groups of disabled people.

Q. Yes, thank you.

Professor Marmot, we've already discussed or touched upon lockdowns and how that helped to reduce the gap in Covid-19 death rates.

PROFESSOR MARMOT: (Witness nodded)

Q. Is there anything else that you would like to say about the difference in the timing of the lockdowns, or shielding, or social distancing and how any of those mitigations assisted?

PROFESSOR MARMOT: Well, in general, I would hope that one of the things that would come out of the Inquiry is we get a judicious view of the balance with these protective measures. I think all of us at the time were concerned to get the balance right, on the one hand. On the other hand, if you close schools, children will suffer. If you stop workplaces, people will suffer. On

the other hand, you let the virus run rampant, and you get high mortality. So I hope we'll get some reflection of that.

But what it does show -- I mean, my fundamental view that I've tried to express is that there are deep-seated social and economic inequalities in society that lead to inequalities in health. What these data show is specific interventions -- vaccination, protective measures -- can reduce those inequalities. Wow, that's pretty good. That's a good lesson to learn.

Q. Yes.

PROFESSOR MARMOT: And the fact is, these protective measures, applied equitably, can reduce inequalities. Very important. So we, do you know, in learning this very important lesson, we need to get this balance right.

Q. Well, that brings us very neatly on to lessons learned, which you deal with beginning at paragraph 328 of your report, the first of which is: to reduce health inequalities in pandemics, we need to reduce health inequalities outside of the pandemic period, and before the next pandemic or civil emergency occurs.

The phrase that you use, and I know that you used this last time, Professor Marmot, when you were here, is to "fix the roof whilst the sun is shining".

You've touched upon government actions to mitigate and how those assisted, but I'd like to ask you about pandemic planning and implementation, which you say should integrate a health equity lens across all aspects of the process. What do you mean by that?

PROFESSOR MARMOT: Well, what we said in Module 1, and it was amply, amply supported by the council that I co-chaired on Inequality, AIDS and Pandemics globally, the council, that to prepare for pandemics, you need to have less social and economic inequalities in society, because they lead to social and economic inequalities in health, and that was a key driver of the problems that we had, which is why, in the early phases, mortality was so high.

So -- and we said this in our global report: we even got the G20, in a ministerial statement, to say: to prepare for the next pandemic, countries have to invest in improving the social determinants of health.

So a key message is that we should not limp into the next pandemic with the same levels of social and economic inequalities that we limped into this pandemic.

Q. And what about those who suffer from particular, either disabilities or clinical vulnerability, do those sections of society of need to be protected?

PROFESSOR MARMOT: Well, let's look at disability first.

What we've shown when we've looked at it in all our reports, is that people with disability are more likely to have adverse exposures to the social determinants of health, whether it's from early childhood, education, employment conditions, income, housing, all of our social determinants of health apply even more so to people with disabilities. So they're more exposed.

They may also, to come back to what Clare laid out in her five pathways, our five pathways, what Clare laid out, they may also, either because of the ill health that caused the disability, or because of ill health that's a consequence of the disability, and social determinant, be more vulnerable.

Q. Yes.

PROFESSOR MARMOT: And I would then apply that to other subgroups in society, and we were asked not to look at other forms of inequalities but they applied to other subgroups in society.

Q. Yes, that was because I know that my Lady is going to be receiving expert evidence from others who have looked specifically at those areas.

But does that come back to intersectionality, that all of these aspects of difficulties and those that -- those in society who are the most vulnerable need to be looked at together to determine what level of

protections and what type of protections need to be added?

PROFESSOR BAMBRA: I think it comes back to the fact that inequalities weren't thought about in the preparedness and the planning in the early -- in SAGE. I noticed in Neil Ferguson's evidence, for example, that's in position for today, that he said that they didn't think about deprivation and the dynamics that might have on the transmission of the disease in that quite significant modelling that they were doing.

So that's what we mean when we're talking about the health equity lens, is to actually consider that people are different, and that that might have impacts on their experience of a civil emergency like a pandemic.

Q. Thank you.

PROFESSOR MARMOT: Because there's a -- I don't want to get philosophical in giving evidence, but there are a couple of different reasons for classifying people in the way we do.

Q. Yes.

PROFESSOR MARMOT: One is, if that's a target of intervention, so if people are rough sleepers, you classify them as rough sleepers because rough sleeping is not good for your health. And that's the target of intervention. If people are below the poverty line, and

we describe them in that way because it's not good before their health, and if we could get them above the poverty line, their health would improve. So that's one reason.

The other is, it's a guide to the conditions that we think of what's determining their health. You could say, "Well, somebody's got to be in relative poverty, what's wrong with that?" Well, to the extent that it's a guide to poorer education, to poorer working conditions, and all the other determinants, it's a way of looking at what's needed. So the intervention could be on the descriptor, low-income.

Q. Yes.

PROFESSOR MARMOT: Belonging to a particular subgroup, disabled, minority ethnic, or whatever that could -- but you can't change minority ethnic. What you can change are the conditions that attach to that descriptor, and that's what's important.

So we're trying to do both of those things.

Q. Thank you.

And just to come back to your international work, and the work on the council that you've mentioned, looking at AIDS and pandemics, is what you have found, looking at the United Kingdom, similar? Are the patterns the same, by and large, to what you have found

on that international council, looking at countries such as Sweden and Brazil and I know elsewhere as well?

PROFESSOR MARMOT: The graphs that you put up on the screen, we could have put up an almost identical graph from Sweden or from Brazil that would look the same. So where we had data -- and, my Lady, my earlier comment about the quality about data is we don't have such good data from most other countries, but where we had those data, we saw the social gradient in all the things that we've been discussing here: the inequalities that led to worse pandemics, and the impact of the pandemic on inequalities.

So everything we've concluded here is consistent with what we found in our global council. Not only because I was co-chairing it!

PROFESSOR BAMBRA: Could I just add a little bit on the data side of things? Because one of our recommendations is to still further improve the data.

Q. Yes.

PROFESSOR BAMBRA: Because I accept what Sir Michael's saying in relation -- you know, from a global perspective, but that doesn't mean we shouldn't try to do even better. And I just wanted to particularly highlight that obviously in today's report it's quite difficult to find information on, you know,

intersections between area deprivation and other factors. We have very good area-level data but, as Michael explained earlier, that's not the same as individual-level data, and it's therefore very hard to look into what happens to other groups and -- during an emergency like a pandemic.

MS BLACKWELL: Thank you.

Professor Bambra, Professor Sir Michael Marmot, thank you very much. I think there are two questions coming from other core participants.

LADY HALLETT: There are.

Ms Davies, who is over that way.

Questions from MS DAVIES KC

MS DAVIES: My Lady, thank you very much.

My Lady, before I ask the question for which I've had permission, we have just emailed STI and CTI in terms of some questions that we were told CTI might ask about migrants, those subject to domestic abuse, and the healthcare charging regime. I wonder -- they weren't asked. I understand that these things happen. Would you give me permission to ask one more question in relation to that area?

I've reduced the three questions we suggested to one.

LADY HALLETT: Very well, Ms Davies.

MS DAVIES: I'm grateful.

If I may start, Professors, with my first question, for which I was given permission -- and I'm sorry, I should have said, my name is Liz Davies and I represent the Domestic Abuse Group, which is a group of three organisations concerned with violence against women and girls.

You set out in your report the various intersectional nature of health inequalities, socioeconomic status we spent a lot of time on today, and also ethnicity and groups experiencing multiple disadvantage.

You said so at the beginning of your evidence, and it's referred to at paragraph 147, but can I just confirm that domestic abuse should also be recognised as a contributing driver of health inequalities?

PROFESSOR BAMBRA: Yes, I would agree that it's an important health matter for the women that are affected by that, and would potentially intersect with other inequalities as well.

Sir Michael and I were discussing this in the evidence room beforehand and, Michael, you had some data that you could share on that.

PROFESSOR MARMOT: Yeah, in general, like most other important health outcomes, what we see is that the

greater the deprivation, the more frequent is domestic violence. And probably other forms of domestic abuse as well.

Q. Thank you.

And my second questions, for which my Lady has just been kind enough to give me permission, relates to those subject to domestic abuse who are migrants and may be considering seeking health care, of course you're aware -- and I'm sorry, this is not dealt with in your report, but we did put it in earlier, that there is a healthcare charging regime for migrants, it's a condition attached to visas, whereby migrants pay a certain amount in order to apply for the visa, and then there are types of migrants who may be undocumented who have not paid that and would be charged for certain secondary care -- there was an exclusion for Covid-19, but other forms of secondary health care.

Can I ask, the experience of the Domestic Abuse Group is that those who were subject to domestic abuse, predominantly women, who are also migrants, are deterred from seeking health care, both primary and secondary, as a result of that charging regime. Would you be able to comment on that? Can you agree with that?

PROFESSOR MARMOT: We were asked specifically not to deal with migrants and ethnic differences, so we didn't look

at it.

MS DAVIES: Thank you very much, I'm grateful.

I'm grateful, my Lady.

LADY HALLETT: Thank you, Ms Davies.

Ms Peacock, who is right down the end there.

MS PEACOCK: Thank you, my Lady.

Professor Bambra and Professor Marmot have already addressed my question in response to Ms Blackwell. I won't ask them to repeat their very clear evidence, I'm grateful.

LADY HALLETT: Thank you very much, Ms Peacock.

That completes our questions for you, Professor Marmot and Professor Bambra. We began the Inquiry hearings, it seems like a lifetime ago, a couple of years ago and I think we probably, I suspect we shamelessly used your work throughout the Inquiry because we have had this focus on inequality, so it's particularly apt that having begun the Inquiry hearing from the two of you in that first week, this is our last module and you're giving evidence again. So thank you so much for all the work that you've done helping the Inquiry, for coming back again, and as I say, for work that even if we didn't call you as a witness, we probably made reference to your work in other modules.

So I'm really grateful to you, and thank you for the

work you do to highlight and therefore fight inequalities.

PROFESSOR BAMBRA: Thank you very much.

PROFESSOR MARMOT: Thank you.

LADY HALLETT: Thank you. Is that a moment to pause for lunch?

MS BLACKWELL: It is, and we're a little early --

LADY HALLETT: Don't worry.

MS BLACKWELL: -- but I won't apologise for that.

LADY HALLETT: I don't suppose people will object. I shall be back at 1.45.

MS BLACKWELL: Thank you.

(12.45 pm)

(The Short Adjournment)

(1.45 pm)

LADY HALLETT: Ms Blackwell.

MS BLACKWELL: My Lady, may I call the next witnesses, please, Professor Clare Herrick and Professor Azeem Majeed.

PROFESSOR CLARE HERRICK (affirmed)

PROFESSOR AZEEM MAJEED (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 10

LADY HALLETT: Thank you for coming along to help us.

MS BLACKWELL: Professor Herrick, you should have in front of you a copy of your witness statement which for our

reference is INQ000661715. Can you confirm, please, that is your witness statement that you've provided for the purposes of the Inquiry.

PROFESSOR HERRICK: It is.

Q. Thank you. And that the facts stated in it are true to the best of your knowledge and belief?

PROFESSOR HERRICK: They are.

Q. Thank you very much.

Professor Majeed, you should also have in front of you your witness statement with our reference INQ000659865. Can you confirm that that is the witness statement you've provided for the purposes of the Inquiry?

PROFESSOR MAJEED: Yes, I confirm that.

Q. Thank you. And that the facts stated within it are true to the best of your knowledge and belief?

PROFESSOR MAJEED: Yes, I confirm that as well.

Q. Thank you very much.

By way of introduction, then, Professor Herrick, you are Professor of Geography and Global Health at King's College, where you have worked as an academic since 2007. Your research concerns the politics of health and health care, it spans historical and contemporary issues across different countries.

You have researched and written several publications

about the UK response to the Covid-19 pandemic, the one that is most applicable to our module is the 2023 paper entitled "'We thank you for your sacrifice': Clinical vulnerability, shielding, and biosociality in the UK Covid-19 response".

Thank you.

PROFESSOR HERRICK: (No audible answer)

Q. And although you confirm within your witness statement that you haven't, since you have completed that paper, conducted any further research, are you happy to confirm that your views are as stated in that paper?

PROFESSOR HERRICK: Yes.

Q. Thank you.

Professor Majeed, you are Professor of Primary Care and Public Health at Imperial College London where you also serve as head of the Department of Primary Care and Public Health. For 30 years you have combined clinical work as a general practitioner with research and teaching.

You are a National Institute for Health and Care Research senior investigator, and you're a director of the NIHR Applied Research Collaboration Northwest London, a fellow of the Academy of Medical Sciences, a fellow of the Royal College of Physicians, the Royal College of General Practitioners and the Faculty of

Public Health.

Is that right?

PROFESSOR MAJEED: Yes.

Q. Thank you.

I'd like to begin, please, by coming to you, Professor Majeed, and asking you about the definitions of clinical vulnerability and clinically extreme vulnerability, or clinically extremely vulnerable. What is your understanding of the definitions that will fall into each of those categories and the differences between them, please?

PROFESSOR MAJEED: So these are two groups which do overlap somewhat, the boundaries are not entirely clear where one ends and the other one starts. So the first group, clinically vulnerable, they're people with long-term medical problems like heart diseases, diabetes, asthma, which place them at higher risk of complications from infections such as Covid-19.

Q. I'm sorry to interrupt you. Could I ask you to slow down a little bit, please.

PROFESSOR MAJEED: Sorry.

Q. No, don't worry. The stenographer needs to pick up what you have to say.

PROFESSOR MAJEED: So as I was saying, the two groups do overlap somewhat so the boundary is not entirely clear

where one ends and one starts. The first group, clinically vulnerable, are people with long-term medical problems like heart disease, diabetes, asthma that place them at risk of adverse health outcomes from infections such as Covid-19.

The second group, the clinically extremely vulnerable, is a smaller group but with more serious medical problems, for example people who have undergone organ transplants or with immune deficiency and so they're at the highest risk of adverse events from any kind of infection.

Q. Thank you.

During the pandemic, the UK Government identified these groups based, I think, on guidance from bodies such as the National Health Service and Public Health England and later on also the UK Health Security Agency. And people who fell within those groups were advised to shield from March 2020; is that right?

PROFESSOR MAJEED: Yes, people in the second group, the clinically extremely vulnerable, were advised to screen, to shield. The first group were advised to take just additional precautions but not to shield, so the bigger group, which was the clinically vulnerable, were not advised to shield, but were advised to take additional precautions to reduce their risk of infection.

Q. All right. Well, we'll come to the definition of shielding, as well, in a moment.

But Professor Herrick, can I ask you about the changes that took place between these categorisations over time. Were they solid, in terms of people who would fit into each category or was there a certain fluidity about them?

PROFESSOR HERRICK: There was certainly a certain fluidity for both the categories, so the people that were included in the categories changed over time, the delineation of the categories changed over time, and people were added to categories, most notably in February 2021 when the new risk prediction algorithm was brought in that added, I think, over a million people.

And people were also taken away just very suddenly by text message, just one day to the next, a text message to say that they were no longer categorised as clinically vulnerable based on the course of Covid at that time.

Q. Yes. So is it right that because of all those changes and the unpredictability of them, people were finding the position confused and confusing?

PROFESSOR HERRICK: Yeah, absolutely. Especially when people felt that they should be included by virtue of their own understanding of their personal health

conditions and yet were not included, which meant people coming back to GPs, to then ask to be included in a list.

Q. Thank you.

LADY HALLETT: Sorry to interrupt. Can I ask you, I may be asking you to play devil's advocate here, Professor, but if you change a category depending on the course of Covid at the time, surely your categorisation will remain the same, whatever Covid was up to, or do you mean the knowledge of how Covid was transmitted or --

PROFESSOR HERRICK: The two categories had the same name, clinically vulnerable and clinically extremely vulnerable. The people that were contained within them, and the conditions that delineated who would be in it changed over time. So people's understanding of what they were at that time may not have caught up with what the category itself was composed of, if that makes sense. If someone tells you --

LADY HALLETT: Sorry, what I'm asking about is the change, and how, depending on the course of Covid, you say, people thought it was a good idea to change their category.

So, in other words, if I was clinically vulnerable in September 2020, why am I not still clinically vulnerable in February 2021? Or --

PROFESSOR HERRICK: Well, that's a good question, I think. Why were you not suddenly -- (overspeaking) --

LADY HALLETT: -- devil's advocate.

PROFESSOR HERRICK: Yes, I mean, that's a very good question: why were you suddenly not clinically vulnerable? And certainly those changes in categories did not chime with people's own understandings of their own vulnerability. So, to be told that you're vulnerable, and then suddenly, "Oh, you're not vulnerable any more", for people individually that must have been exceptionally confusing and made very little sense.

MS BLACKWELL: Thank you.

Going back to the beginning of the pandemic, you tell us at paragraph 2.4 that in the Prime Minister's national address on 16 March 2020, that was the first moment that the population was instructed to shield those that had -- and I'm using his words -- the most serious health conditions. But it wasn't for a couple of days until the interim list of clinical conditions was finalised to denote the membership of the clinically extremely vulnerable category.

PROFESSOR HERRICK: Mm.

Q. And that definition at that time was to remain in place until summer of 2020. Age was not included as

a criterion, was it, in the CEV category?

PROFESSOR HERRICK: No, it wasn't expressly included as a category, but, to my understanding, two-thirds of people included in that category were over 65.

Q. Right. And those aged 70 and over were advised to take extra precautions?

PROFESSOR HERRICK: As part of the clinically vulnerable category, yes.

Q. Okay. So, in theory, that list would have aligned with NHS records; is that right?

PROFESSOR HERRICK: As far as I'm aware.

Q. Yes. And we know from evidence that we're going to receive in the Inquiry tomorrow from Professors Watson and Shakespeare, that people were informed by letter, from their GP or other health provider, whether they were included on the list?

(No audible answer)

And they confirm also, as I'm sure they will tell my Lady tomorrow, that those groups were amended and changed over the course of time, which chimes with what you just told us, Professor Herrick.

But by May 2020, an estimated 2.2 million people were classified as clinically vulnerable, which you say at paragraph 2.6 was far in excess of the 1.5 million initially estimated to fall within the category.

PROFESSOR HERRICK: Mm.

Q. Was the categorisation common across all four nations of the United Kingdom? Was there any variants within it, do you know?

PROFESSOR HERRICK: That's a good question. The paper that I wrote was based on England. As far as I'm aware, the categorisation remained the same but the data that was used to identify people was different, given the different data systems that are used. So there would be perhaps different rates of missing people out or including people that shouldn't have been there, so the error rate might well have been higher.

Q. Yes, I understand.

I'm going to take you now to your paper, if I may, because as well as whether or not there was a commonality in description -- across the four nations, I want to ask you about what was happening out elsewhere in the world, really just to identify and highlight the importance of a definition and what people were being asked to do.

So, please could we have on screen INQ000655834.

Can you confirm, please, Professor, that this is the article to which I've referred?

PROFESSOR HERRICK: Yeah.

Q. Thank you very much.

So, please can we go to page 2, and to highlight the part of the paragraph that starts with "This paper". Thank you.

You explain here how:

"This paper explores how the UK's ever-changing clarifications of vulnerability have created a confusing and 'transient' category -- 'not in the sense of afflicting a single person for a while and then going away, but in the sense of existing only at a certain time and place' ..."

Let's go then, please, to page 5, and to highlight the passage that begins "On March 12". Thank you very much. There we are in the middle of the page.

And I'm just going to read these through before coming to any questions, thank you very much.

So, dealing with the history of matters:

"On March 12, Johnson gave a speech in which he spoke directly to older people;

"This disease is particularly dangerous for you ... even though for the vast majority this will be a mild to moderate illness, I know that many people will be very worried. We should all be thinking about our elderly relatives, the more vulnerable members of their family, our neighbours, and everything we can do to protect them over the next few months ..."

Then, three days later:

"On March 15, the government expanded its public education campaign beyond hand washing, to avoiding older and 'more vulnerable' people if exhibiting symptoms. On March 16, now with 1,543 official cases, the government held the first of its daily coronavirus briefings during which the Prime Minister, Chief Medical Advisor and Chief Scientific Advisor announced new social distancing measures, the suspension of mass gatherings, asked symptomatic households to isolate for 14 days, the public to cease all unnecessary contact with others and halt all non-essential travel. Johnson's speech at the press briefing that same day warned that,

"By this coming weekend it will be necessary to ... ensure that those with the most serious health conditions are largely *shielded* from social contact for around 12 weeks ... this is going to be very disruptive for people who have such conditions, and difficult for them ... I know that many people -- including millions of fit and active people over 70 -- may feel ... there is something excessive about these measures."

Now, I want to just concentrate on the word "shielded", because in the following paragraph we see this:

"The linguistic fusion of 'vulnerability' with 'shielding' -- a term not previously used in the lexicon of public health responses to infectious disease -- quickly become one of the defining narrative strategies of the UK government's approach to risk reduction. The implications of this [are then] further explored ..."

So the word "shielding", and "shielded", that phrase hadn't been used before. That was something new in the pandemic.

PROFESSOR HERRICK: Mm-hm.

Q. And did that in himself cause confusion as to what that might mean?

PROFESSOR HERRICK: Yeah, I mean, absolutely. If you introduce a new word to the public, that means that they have to adhere to really stringent sets of behavioural guidelines, it's going to cause confusion and worry and concern. But I do think that "shielding" took hold among the public more quickly than "vulnerability", because "vulnerability" was more confusing. "Shielding" -- there was a lot of work that went on for the messaging around "shielding" -- (overspeaking) --

Q. Yes.

PROFESSOR HERRICK: -- insights team, you know, government -- NHSX, especially around text messaging, to convey what shielding was and what it was meant.

Q. Yes.

PROFESSOR HERRICK: And because it's linked to a set of actions, and needs to be done, it was much easier for people to understand what it meant, whereas to be vulnerable is very confusing to people, about what they should then do.

Q. Yes, so there was something directive but something that was easily understandable, around the word "shield" and the term "shielding"?

PROFESSOR HERRICK: Yes, because I think it connoted a series of actions that needed to be taken by both the person shielding and also people that needed to shield them. That was very clearly communicated.

Q. Thank you.

Let's turn to page 14 of your article, please, and have a look at the meaning of the word in terms of what it conveyed. You say here:

"Given the overtures of protection, duty and weakness bound into the word 'shield', it serves to convey a sense of vulnerability far better than 'isolation'. However, beyond this, its use -- as both a technical term and moralised political trope -- is deeply significant, particularly in its creation of a new category (and thus subjectivity) of 'shielders'".

And at the bottom of this paragraph you say:

"As a letter to the British Medical Journal notes, 'the UK shielding policy is unique internationally' ... even if it was arguably far from unique in its effectiveness."

What did you mean by its "uniqueness"?

PROFESSOR HERRICK: No other country used the word. I mean, when I was writing this, I searched desperately for some other example there this word might have been used and it wasn't used in any other country or -- I mean, it's not used in any other context when it comes to public health.

Q. Right, thank you. I just, finally on this point, want to look at an expansion of that in the following paragraph, where you say:

"In the US, for example, CDC" -- what does CDC --

PROFESSOR HERRICK: Centers for Disease Control.

Q. Thank you.

"... guidance recognises 'people at increased risk' of severe illness and those who need 'extra precautions'. Australian guidance singles out those 'at higher risk of severe disease'. The [World Health Organization] identifies those over 60 and those with underlying medical conditions as being 'at higher risk of getting severe Covid-19 disease'. By contrast, it defines 'vulnerable population groups' as those who are

socially vulnerable by virtue of being homeless, migrants, refugees, disabled, living in remote locations, or closed facilities, or being in poverty. The French response categorises 'personnes fragiles' as 'those at risk of severe Covid-19 illness'. Similarly the Swiss classify those at 'higher risk' as 'personnes vulnérables'. Finally, the European Centre for Disease Prevention and Control, makes a distinction between those people 'at higher risk of severe disease' (high risk groups who are 'medically vulnerable'), which is counterposed against those populations who are 'socially vulnerable' to 'the consequences of the public health measures that have been imposed to control the spread of the virus' and which may exacerbate their already challenging life situations."

So, across the world, lots of variation.

PROFESSOR HERRICK: Yeah, absolutely, which I think just points to the complexity of dealing with the situation at that time, and thinking about how do you link actions to categories of people in ways that are meaningful, and in ways that people can adhere to?

Q. And I suppose a demonstration of the complication that can arise by different phrases being used in different parts of the world?

PROFESSOR HERRICK: Yeah, you know, there's a lot of

complexity in just the difference between "risk" and "vulnerability", how you define vulnerability, how you define risk, is it medical or is it social? And all of those things come together to mean different words are used in different contexts and also different medical traditions may favour different words in certain contexts. But that said, still I think the UK was unique in using a word that is not used otherwise in public health, whereas in other countries it was very much within the lexicon of public health, so an already familiar language was used.

Q. Is there any prospect of there being a common phraseology used across the world, do you think?

PROFESSOR HERRICK: I mean, public health is very particular to each country, so probably not, although I think the examples that I list there are probably more similar than the UK.

Q. Yes, thank you.

Professor Majeed, I'd like to come to you now, please, to discuss data collection, which you deal with in your report. Tell us, please, about overlaps in data collection and the challenge of separating data in order for it to be used to its optimum potential.

PROFESSOR MAJEED: The NHS has good medical records in electronic format but they've been quite fragmented in

different systems, so hospitals, GPs, et cetera have their own systems. So when the pandemic occurred, there was a need to integrate those records into a unified whole and that was done fairly quickly, and so we were able to link records from GPs with hospitals and elsewhere to provide data to monitor the impact of the pandemic to identify people who were clinically vulnerable, and to look at health outcomes as well. So that was an essential task.

You could argue it could have been done before the pandemic and should have been in place before, but it wasn't in place, but to give credit to the NHS, it was done very quickly and was a very useful resource once that work was done.

Q. Thank you.

I'm going to use a phrase now, "The national data platform". Is there a suggestion that the creation of such a platform would bring together general practice records, hospital data, social care data, in a unified privacy-protected place so that -- keeping all of that data in one place, and allowing it to be accessed by those who need to, it would improve the quality of the data and would simplify the collection of it?

PROFESSOR MAJEED: It would definitely simplify the process because the ability to link data from different systems,

that work would have been done through this new system, so it would definitely simplify the process of data analysis and data interpretation.

Q. Do you consider that the lack of routine disaggregation by clinical vulnerability status in health data has limited the ability to understand outcomes and inequalities?

PROFESSOR MAJEED: So we know with medical records, there are errors in all medical records, you get what we call a false positives where a diagnosis is present, where actually the patient hasn't got that diagnosis, and false negatives where a patient has a diagnosis but no one's recorded it on their record. So there are clearly errors and by having data aggregated you can look at it in more detail, you know, by hospital or by general practice, data quality and feedback information to try to improve data quality because data quality is, you know, the key factor which makes these data useful. With poor quality data, and a lot of errors and omissions, the data will miss certain people or put them in a category incorrectly so data (unclear) quality is a key requisite for any system for addressing health crises like a pandemic.

Q. What evidence or data do you consider would best capture the impacts felt by clinically vulnerable individuals or

their families in this regard?

PROFESSOR MAJEED: So (unclear) records systems have their own strengths, the most comprehensive is the GP record because that has the most information on it but it is lacking information on drugs, for example, prescribed by specialists or by rare diagnoses, so you need to combine both to get the maximum value, but in general (unclear) record (unclear) by the GP has the most data but will miss certain attributes like specialist drugs which are not prescribed by GPs.

Q. Moving on slightly to talk about the nature and quality of research and evidence, including potential shortcomings, you tell us in your statement about the INFORM study that took place during the Omicron era. Tell us what that entailed and what the results showed, please.

PROFESSOR MAJEED: So the INFORM study used data from the system you just described, the national data repository, (unclear) data on about a quarter of the population of England and looked at outcomes in people who were classed as clinically extremely vulnerable compared to the general population --

Q. Could I ask you to slow down again, please.

PROFESSOR MAJEED: Okay.

What it showed was that people who were clinically

extremely vulnerable had a much higher risk of adverse events like hospital admission or death of people in the general population and that risk, increased risk persisted despite vaccination, so although vaccination did suppress risk in all groups, groups who were clinically vulnerable still had a higher risk of adverse health outcomes like admission to hospital or death. So vaccination does help, but by itself it's not enough to suppress the risk down to the level of the baseline population.

Q. You tell us that ethnic minority data was poor.

PROFESSOR MAJEED: So there was often a lack of data on ethnicity in medical records. The NHS tried for a long time to improve that data quality, and I think it has improved since the pandemic, because the pandemic exposed the need for such data so we have seen improvements but at the start there were certainly deficits in data and many people did not have their ethnic group recorded in their NHS medical record.

Q. But at a high level, the INFORM study found that immunocompromised people were up to 13 times more likely to experience serious outcomes such as hospitalisation, intensive care unit admission, or death, even after vaccination.

PROFESSOR MAJEED: That's correct, yeah, depending on your

clinical category. So the risk was highest for those that had had organ transplants, for example.

Q. Yes, thank you.

Turning to the second area, please, that I'd like to ask you about, the impact of the pandemic on clinically vulnerable and clinically extremely vulnerable groups. Professor Majeed, Do you agree that the pandemic and its control measures didn't affect all groups equally and that for clinically vulnerable and clinically extremely vulnerable people they often exacerbated existing health risks and conditions resulting in a distinct health inequality?

PROFESSOR MAJEED: Yes, that is definitely the case. Particularly when there was intersections of, say, poverty and clinical factors, there was definitely an excess impact on some groups compared to others.

Q. Yes, the Inquiry has heard this morning from Professors Marmot and Bambra that really one needs to look at the intersectionality between different areas of people's lives, and that the picture is particularly complicated, or can be particularly complicated, where there are lots of overlap of vulnerabilities and disabilities and issues such as socioeconomic deprivation, that sort of thing.

It's not necessarily a clear picture, is it?

PROFESSOR MAJEED: No, it's not, no, and it does depend on how these factors come together.

Q. You tell us at paragraph 13 of your statement that several factors mitigated or worsened impacts from infection and that vaccination was a key mitigator of adverse outcomes.

PROFESSOR MAJEED: That's correct, yes. The vaccination did reduce adverse outcomes for all population groups if they were fully vaccinated.

Q. Thank you. Although you go on at paragraph 19 to tell us that, later in the pandemic, clinically extremely vulnerable patients sometimes reported difficulties in obtaining antiviral drugs after testing positive for Covid-19.

PROFESSOR MAJEED: Yes, that is the case, because there were variations across the country in access, what you might call a postcode lottery. So, in some areas it worked better than other areas, and I think we can learn lessons from those areas where the system performed better than others.

Q. Yes, thank you. And you go on to say that:

"Previously, people would have been contacted by their local COVID-19 Medicines Delivery Unit ... once they logged a positive Covid-19 test."

But then the system changed, and:

"In the new system, the onus was now on patients to contact their local health services when they had a positive test."

And that caused confusion?

PROFESSOR MAJEED: That's correct, so the system changed and clearly people who were less well educated or with poor English will struggle with that new system.

Q. Thank you.

Professor Herrick, I'd like to ask you about a change in direction or guidance that was given by the government from a rule-based system to something called personal responsibility. And how that affected those who were both clinically vulnerable and clinically extremely vulnerable.

PROFESSOR HERRICK: So when lockdowns were lifted -- well, you know, I think some of the tensions here is that public health guidance is generally based on personal responsibility --

Q. Yes?

PROFESSOR HERRICK: -- because the -- UK, the predominant diseases are chronic, most of the public health advice is about behavioural risk and self-responsibility and modifying behavioural risk. Obviously when you have a novel infectious disease, the way that risk is managed is completely different, and largely unfamiliar to

people in the UK.

But when restrictions were lifted, suddenly that idea of protecting others shifted, and it became an advice to people who had previously been shielding -- and at this point, when those restrictions were lifted, still a huge proportion of people who were initially being advised to shield were continuing to do so --

Q. Yes.

PROFESSOR HERRICK: -- to kind of reintegrate themselves into society, to -- you know, if they could go back to work they should go back to work, or if their workplace was Covid safe they should go back to work. And obviously for people that have been isolated at home, this is a moment, of deep confusion about what is actually safe. And I think the moment of those restrictions lifting also chimed with the sort of moment of a fraying of trust in the government response. And so I think that made things much, much less clear for people.

So, rules are easy to follow, but suddenly when there are no rules it's very hard to make personal risk calculations.

Q. In your view, were there inequalities created by this change of system?

PROFESSOR HERRICK: I think certainly yes in some respects,

but possibly no greater than existed before, in the sense that if you were able to work from home before, you know, you could continue your daily life without fear, without risk. For people that couldn't work at home, you know, then you start to get into this set of impossible risk calculations. And especially if your workplace couldn't be made Covid safe, as it was called at the time, what do you do? Do you put yourself at risk, having previously been unable to leave your house, or do you decide that actually the risk isn't worth it? And some of the data bears out that people made that active decision to say: actually, you know, I'm going to have to leave my job because it's not safe.

Q. What in your view -- what changes are needed, or can be considered so that high-risk groups are not left to manage their harm individually?

PROFESSOR HERRICK: I think it would be a very difficult one to say. You know, Covid was exceptional. It won't be the last time that there is an emerging -- novel emerging infectious disease, but it's very hard to generalise from something so specific.

If there is another pandemic, the clinically vulnerable groups may be completely different. It may be children. Who knows? So it would be impossible to generalise about what could be done differently in this

sense. It was what it was, based on, you know, who was categorised as risky and vulnerable at the time.

Q. Thank you.

I'd like to now move to talk about the impact of shielding.

Could we display, please, INQ000661715 -- which is your witness statement, Professor Herrick -- and go to page 4 and display paragraph 3.2. Thank you.

By February 2021, you tell us, 3.7 million would be classified as clinically extremely vulnerable, which was a gross increase on the 2.2 million classified as such in 2020, which was the previous figure that we discussed.

PROFESSOR HERRICK: Mm.

Q. "This increase was fuelled by the inclusion of some disabilities (eg Down's syndrome) as a marker of CEV ... and the introduction of a new risk prediction algorithm ... in February 2021 ... This tool identified an additional 1.7 [million] people as [clinically extremely vulnerable] as it included deprivation scores, age, ethnicity and domicile type as indicators of risk ... This shift also then included women with a history of gestational diabetes, but not those with current diabetes."

So I want to just pause for a moment and ask about

the characterisation of Down's syndrome as a basis for clinically extremely vulnerable designation. Is that -- was that included, do you think, because there was an increased risk caused by an array of health issues such as immunological issues, congenital heart and respiratory conditions, and increased rates of obesity and diabetes?

PROFESSOR HERRICK: Yeah, that would be my understanding.

Q. Thank you.

"Linguistic slippage" is another phrase which is used.

"... linguistic slippage ..."

At paragraph 2.10. We don't need to display this, but:

"... between 'guidance' and 'advice' and the confusion between CEV and CV led many people [you say] to shield unnecessarily."

So can you explain, please, what you mean by "linguistic slippage between 'guidance' and 'advice'".

PROFESSOR HERRICK: I mean, "guidance" and "advice" have different meanings, but were used interchangeably, often in the same sentence, advising people. This guidance is advisory but we strongly suggest that you follow this advice. I mean, how anyone is supposed to decipher this and decide what they should do -- especially against

a background, you know, at the time, 2020, 2021, it was all about the rules. This is the Covid rule. You know, 2 metres away from someone, don't do this, don't do that.

So you've got a background of the rules against a sort of patchwork of lockdowns, and then people being guided and advised, who knows -- who knows what they should be doing?

I think the simplest messaging really was: if you're shielding, you must stay at home for 12 weeks.

That's something that somebody can understand.

Q. Something solid.

PROFESSOR HERRICK: Solid. Very hard to do, but very solid. And I think that was the point of it.

But the rest, especially in the letters that were sent to people, very hard to know. You know, am I going to be arrested if I step outside my home? What if I open my window? Can I go into my garden?

And these are all legitimate questions that people had at the time, that seem bonkers, really, but, you know, when you are being advised and guided, how do you know what you should be doing, and where the risks lie in a disease that no one knows anything about?

Q. The Inquiry has already begun to hear evidence of the effect of shielding and isolation on people's mental

health and how severe that became for some. So, in your view, it was important to have as clear a message as possible so that those who really did need to shield understood that that was the advice or guidance, whereas those who really didn't need to shield may have been confused or shielding unnecessarily?

PROFESSOR HERRICK: Yeah. And I think that messaging was very effective. If you look at the rates of people that were shielding, it's extraordinarily high. I mean, the British love a rule, so I think that it was very effective, but a lot of work went into that messaging, in terms of behavioural psychology and how do we get people to adhere to this. And a lot of it was about messaging of altruism, support, "You can do this", and encouraging others to support others.

So there was a lot of psychology that went into the adherence to that.

Q. And finally on this topic, you describe at paragraph 3.5 the neologism of "shielding" entering the mainstream language. You also go on to say that the notion of the clinically vulnerable and clinically extremely vulnerable needing to "be shielded" (which is the passive rather than the active form of the verb) from risk, is in stark contrast to the general tenor of public health messaging that focuses on individual

agency, control and responsibility. And that:

"This induced novel forms of health behaviours and beliefs, which, in turn, often set up new types of inter-generational conflict and solidarity."

What do you mean by that?

PROFESSOR HERRICK: I mean, I think it was socially a very interesting moment, that if you have delineated all people over 70 as clinically vulnerable, you have associated "vulnerability" with the need to shield. Even if technically those who aren't clinically vulnerable don't need to shield, and you've cast "shielding" in the language of protecting others, there's therefore the assumption that anyone over 70 must be protected by everybody else, and this is our societal duty. Which is quite a few way of looking at things. And that therefore sets up the assumption amongst people in particular categories that there is a duty of care. Which -- you know, I'm not casting judgment about whether this is right or wrong, but socially that's an interesting thing.

So there is an intergenerational difference, I think, in how people viewed what society should do for them, which is very much at odds with the general way that public health goes about things, which is: okay, well, stop drinking so much, please don't smoke, don't

do this, don't do that, but it's your choice.

So I think that is a very novel moment, and also a difficult one to exit.

Q. Yes. What further research do you think might be required to develop and implement appropriate public health strategies which protect risk groups going forwards?

PROFESSOR HERRICK: I mean, risk groups aren't static, so this was -- these were risk groups for this particular moment in time. Those risk groups have changed over that time, and they won't be the same risk groups going forward. So I think that we can think about language and messaging and categorisation and the use of data and the efficiency of that, but again, I don't think you can take general lessons from something that is exceptional.

But what you perhaps could look at is the impact of how people view themselves, and their own vulnerability, and what long-term consequences has that had for people in terms of how they engage with the world, their workplace, all these things. Has it had an impact on how people see themselves and their own health behaviours going forward?

Q. And I suppose, as well as thinking about the protection of certain sectors of society in the next public health emergency, there's also the other side of the coin which

needs to be considered, which is the potential adverse consequences of telling somebody to do something or advising somebody to do something. And by that I mean, you know, the mental health impact of shielding and isolation?

PROFESSOR HERRICK: Yeah, absolutely, but like all risks, you know, it's a cost-benefit analysis. You have to weigh things up. There will be very much adverse effects but are they counterposed against, you know, the decreased risk of severe illness or perhaps death if you contracted Covid? Again, in a novel situation, it's very hard to know what the right thing to do is. You just do the best you have, given the information available.

Q. Yes.

PROFESSOR HERRICK: But yeah, I think going forward, there will always be certain groups who will be much more vulnerable, where care has to be taken appropriately, in terms of safeguarding those groups.

Q. Thank you.

I'd like us to look now at some of the experiences that the Inquiry has heard about during our Every Story Matters campaign, and let's put up, please -- I'm just going to give the INQ reference for the record -- 000659895. Thank you. And can we go to page 33,

please. Thank you.

So we can see here that this is the experiences of those who shielded, or who are clinically vulnerable.

"People who were advised to shield or who did so to protect clinically vulnerable family members, told us how difficult this period was. Shielding often brought deep feelings of isolation, loneliness and anxiety, made harder by the constant worry about catching Covid-19 and the potential impact it could have on loved ones. The experiences of clinically vulnerable people during the pandemic are covered in further detail in Modules 3, 4, and 8, [and their] Every Story Matters records."

One Every Story Matters contributor from England said:

"I have no spleen due to cancer, so I am clinically extremely vulnerable and we were told to shield. This was isolating and difficult and harder for the fact that the rest of my family didn't have to shield and always risked bringing the virus home to me. Mental health has been an issue since, and I'm still worried about travelling, being in buildings near other people, and I feel far more nervous and anxious than before the pandemic."

Another contributor told us:

"I was in the extremely vulnerable category, so

shielded for the first few months of the pandemic. It was a very scary and isolating time -- and it affected my relationships with family and friends, some of whom couldn't understand why I was being so cautious. I'm still suffering from a mental health perspective due to the stress and isolation.

"People who had been shielding spoke about the distress and anxiety they felt when restrictions were lifted. Many described how unsettling it was to mix with others again and how strong their fears remained about catching the virus. Some in clinically vulnerable households told us they stopped working or limited contact with loved ones to protect family members' health. The ongoing isolation and fear took a heavy emotional toll, leaving lasting effects on their mental wellbeing."

"Further into the pandemic, when shielding was lifted, I was told return to work", says an Every Story Matters contributor from Scotland.

"I was so scared of going back to an indoor space with lots of people, I realised I just had to face the world again, but the anxiety level was extreme. My work went through the motions to show support, but it was clearly causing problems. I was struggling emotionally, and physically, and so left in May 2021 and I have never

worked since."

Thank you, we can take that down now.

But it wasn't just the shielding and the isolation and the undoubted mental health effects that that had; there were also poorer health outcomes for those who were clinically vulnerable and clinically extremely vulnerable, and sadly, also a heightened risk of death; is that right, Professor Majeed?

PROFESSOR MAJEED: That's correct, yes, so there remained a higher risk of death throughout the pandemic, even post-vaccination.

Q. Thank you.

Professors Shakespeare and Watson, from whom we will hear tomorrow, tell us in their report that people who self-identified on the 2011 census as requiring a little or a lot of support, represented 60% of all Covid-related deaths in England between 24 January and 20 November 2020. And they talk about the risk of death for more disabled men being 3.1 times greater as compared to non-disabled men.

We've also looked at a briefing by the Health Foundation, which is entitled "Assessing the impact of Covid-19 on the clinically extremely vulnerable population", which tells us that NHS Digital data shows that a total of 50,635 clinically extremely vulnerable

people died in England between March and August of 2020.

Does the higher mortality level of rates amongst the clinically extremely vulnerable population reflect the nature of their health conditions, or the pandemic and the effects of the pandemic, or a combination of both? And is it possible to distinguish between the two?

PROFESSOR MAJEED: It's a combination of all those factors, so the pandemic, their age, their medical problems, their disabilities, their socioeconomic status, all of those will interact to increase their risk.

Q. And so one of the most important protective factors, particularly for these groups of people, was vaccination.

You deal with this at paragraph 13 in your statement, Dr Majeed. By how much did the vaccination of these groups of people mitigate the risk of death?

PROFESSOR MAJEED: So for people who were fully vaccinated with three doses, perhaps 90%, so it was quite a large reduction in their risk of death, but that did vary by clinical group. Some groups showed little benefit from vaccination but generally it was up to 90% reduction in death rates if you were fully vaccinated.

Q. Thank you.

Turning to look at unequal impacts and intersectionality, we've touched upon this already. Did

you find, though, Dr Majeed, that disparities were stark?

PROFESSOR MAJEED: We did, particularly in the first year of the pandemic before vaccination was present. So death rates were much higher in the clinically vulnerable and extremely vulnerable, in ethnic minorities, in those with disabilities, in poorer groups, so certainly in the first year there were stark disparities, though it did somewhat attenuate over time as vaccination became available, and everyone essentially became infected with Covid at some point in their lives, but in the first wave there were certainly stark disparities in outcomes between different population groups.

Q. We've also touched upon mental health but I want to ask some more questions about mental health and wellbeing across the whole of the pandemic. We know that clinically vulnerable families who are a Core Participant in this module, ran a survey in the summer of 2025. In fact, let's have a look at the survey findings that appear in the statement of Lara Wong from Clinically Vulnerable Families, at INQ000657970.

We can see that this is her witness statement, and if we go to paragraph 23, which I think is at page 11 -- thank you.

This is a survey in relation to which they received

125 responses from people in clinically vulnerable households across the United Kingdom, capturing experiences over multiple stages of the pandemic.

And we can see that the responses:

"... showed that impacts were multi-layered, often combining social, emotional, and practical challenges. Participants described both the direct strain of living with increased health risks and the secondary effects of prolonged exclusion from safe public spaces, healthcare, and social contact."

And the key themes that emerged from the data included the following:

"Social isolation was reported as a major factor for most respondents, associated with shielding, ongoing risk from airborne infections, and the withdrawal of mitigations (for example, masking in public and healthcare settings), leaving many finding it harder to return to their former lives."

Second:

"A large proportion described their concerns linked to increased infection risks, particularly in healthcare environments, workplaces, and high population density public spaces without ventilation or masking."

Third:

"Many experienced depression and a sense of

hopelessness when mitigations were lifted without protections for high risk individuals."

Fourth:

"Grief and trauma were compounded by circumstances such as being unable to visit dying relatives, restricted funerals or lack of post-bereavement support due to shielding".

And five:

"Reports of loneliness were particularly acute in households not only where the [clinically vulnerable and clinically extremely vulnerable] individual lived alone, but also where they were the only vulnerable member, creating divisions within families about acceptable risk and behaviours."

So the whole gamut of mental health effects upon those who were following the rules and who were trying to protect themselves often, as we've seen with that final point, in families where they might have been the only vulnerable member.

Do you say, Professor Majeed, that those difficulties affecting the mental health of clinically vulnerable and clinically extremely vulnerable individuals alleviated as the pandemic began to pass, or do you think that there is an argument for saying that for those people, as life was getting back to normal for

the general population, really they were still stuck in a life of taking these additional precautions for a lot longer and perhaps until today?

PROFESSOR MAJEED: Yeah, I think the latter. I think once measures were relaxed, this group still felt very vulnerable, and had high levels of anxiety, depression and still felt concerned about their risk of infection and risk to their health if they did get infected. So those feelings did persist once measures were relaxed in 2022.

Q. And is it your view that for some of the people who fall within those categories, though that mental health difficulty or the changes to their lives which started during the course of the pandemic are continuing to persist today?

PROFESSOR MAJEED: Yes, even now there are people who struggled to cope with the changes that have occurred since the pandemic started and struggle with getting back to normal, normal routines, as was seen in your examples.

Q. Thank you.

Finally, I'd like to ask you about lessons learned and what can be considered by way of improvement for the future. We've touched upon data collection. And one of the other issues which you raise, Professor Majeed, in

your statement, is "an increase of trust between communities and public health authorities."

PROFESSOR MAJEED: Yes, so we did see, in the pandemic, interventions were taken up not in the same way by different groups, and some groups had a lack of trust in authority. So for example, some ethnic minority groups didn't have confidence in the government or local authorities, and that then did lead to a lower uptake of key interventions like vaccination or shielding, for example. So trust is very important, and trust takes a long time to build up, it can't be done in a pandemic, you need to start, you know, essentially now, and keep working on it constantly.

Q. Yes, and something which will chime very much with the evidence that the Inquiry heard this morning from Professors Marmot and Bambra, is a targeting and proactive strategy around the reduction of inequalities?

PROFESSOR MAJEED: Yes, so the health service can do so much, but much of health status is determined by non-health factors like housing, employment, income, and so on, which are not under the control of the NHS.

Q. And finally, from your suggested lessons learned, Professor Majeed, you say that there should be an increased level of support to the workforce.

PROFESSOR MAJEED: Yes, so we mentioned people that are

vulnerable in this session, but the health workers also felt very stressed as well at the time, they were obviously seeing patients with Covid and some had their own medical problems and so we obviously need to protect the workforce as well to ensure its resilience and can manage any future health crisis that might occur in the UK.

Q. Thank you.

And Professor Herrick, to identify a couple of the lessons learned from your statement, you say that there should be greater public understanding of the terms and the issues which a pandemic can throw up on to people who are clinically vulnerable and extremely vulnerable?

PROFESSOR HERRICK: Yeah, I mean I think our understanding of public health terms is probably much better than it was in 2019, I think we're all very familiar with key terms and epidemiology by now, but yeah, going forward, I think a simplification of language, not creating multiple categories to describe similar things, and shifting them around would be helpful to people.

Q. And you also promote a further exploration and understanding of longer-term effects.

PROFESSOR HERRICK: Yeah, I mean, I think that the examples that you put up, your lived experience examples, show that there's a very long tail to this in terms of

people's, yeah, place in the world, and their very, very different experiences of what happened in 2020, 2021 and 2022, and understanding the consequences of that set against the need to protect, so was shielding worth it? Was it worth it in terms of the consequences that many people now feel? Yes, maybe it was, in terms of the lives saved. It's hard to quantify what would have happened otherwise. But there has certainly been a long tail, in terms of, yeah, you know, people's wellbeing, I think, from this, and the way that it was managed.

MS BLACKWELL: Thank you very much.

Professor Majeed, Professor Herrick, thank you for your time.

There will be some additional questions, my Lady, I hope you have the list and you can see that.

LADY HALLETT: I do, thank you.

And we start with Mr Weatherby who is just there.

Questions from MR WEATHERBY KC

MR WEATHERBY: Thank you very much.

Very briefly from me. I ask questions on behalf of the Covid Bereaved Families for Justice UK group.

Professor Majeed, you were briefly asked some questions about the unified privacy-protected national data platform. And this is a concept that, in your report, you argue for with respect to the need for

integrated real-time data linking primary care, hospitals, and public health. Can you just help us on what progress, if any, has been made towards that end since the pandemic?

PROFESSOR MAJEED: So progress, you know, has carried on, albeit not as fast as you might have hoped, there are legal rules around data linkage which were relaxed in the pandemic which, you know, are now back in force, so those have to be addressed by the government.

So yes, so I would say that we need to address those legal issues, get public consent and trust because the public need to be fully on board with the process because it's their data, ultimately. But that resource is essential because it allows us to identify at-risk groups and monitor outcomes and plan interventions going forward for this or any future health issue that may occur.

Q. Okay. Can I take it from the fact that there's still questions over the legality of the data issues that in fact it is not in place yet?

PROFESSOR MAJEED: Yes, so in the pandemic, as I mentioned, the rules were relaxed somewhat, but those rules have come back now, but the NHS is working towards trusted environments where data is anonymised and can be used for -- (overspeaking) --

Q. So would it be of assistance if the Inquiry were to recommend that that is looked at carefully and expedited?

PROFESSOR MAJEED: Yes, I would fully agree with that, we need to look at that very carefully so legal issues are not a problem for any future health crisis that may occur.

Q. Yes, thank you very much.

Professor Herrick, you may have dealt with this already but just for completeness really, in terms of shielding, are you aware of any post-pandemic research on its use as a public health concept or disease mitigation strategy other than the work yourself that you've referred to? Is there anything else that we can point to?

PROFESSOR HERRICK: Not that I have found, in terms of, you know, preparing for today to see what else had been written, and I couldn't find very much --

Q. Again, is there a need for that, in terms of it being a new concept, a neologism as you term it?

PROFESSOR HERRICK: Yes, I think -- yes, although it doesn't exist any more, in a way. So the difficulty is going back and tracing what it was. That's the methodological problem with understanding what shielding was, where it came from, who came up with the term, why they did.

So I think it would be more interesting to understand the consequences of that experience on people, so how -- you know, in terms of mental health outcomes, physical health outcomes. That would be very important and interesting research to do.

MR WEATHERBY: Yes, thank you very much.

LADY HALLETT: Thank you Mr Weatherby.

Mr Wagner, who is down opposite you.

Questions from MR WAGNER KC

MR WAGNER: Good afternoon, Professors. My name is Adam Wagner and I act for the Clinically Vulnerable Families.

First of all, a question for Professor Herrick. You say at paragraph 3.5 of your statement that -- I'll just let you get to that -- that public support for shielding "arguably weakened" from June 2020 onwards.

Is that proposition based on any particular studies or evidence?

PROFESSOR HERRICK: Sorry, paragraph?

Q. 3.5.

PROFESSOR HERRICK: 3.5. Sorry, can you repeat the question.

Q. So, about halfway down that paragraph you say, from after June 2020:

"... the public sense of moral obligation and duty

to protect the vulnerable arguably weakened."

That's the full statement.

Is that based on evidence or is that something that you are sort of taking from general knowledge?

PROFESSOR HERRICK: I mean, I think that's the general backdrop of what was going on at that time, in the sense that in June, as far as I recall, digging back into my memory, things were starting to open up again. That was the end of the lockdown.

Q. Right. But it's not based on a study or --

PROFESSOR HERRICK: No, it's not necessarily based on a study but it would have been based, when I wrote the paper, on media analysis of what was being reported at that time in terms of what was going on, what was being said, what were politicians saying. You know, it was a time of a lot of press conferences.

Q. I just want to ask next, Professor Majeed, please, about data collection. And you say at paragraph 9 of your statement:

"However, in areas like data collection, overlaps between these two groups [that's clinically vulnerable and clinically extremely vulnerable] made separation challenging, as NHS electronic health records did not always flag Clinically Vulnerable and CEV [clinically extremely vulnerable] status consistently."

Have you got that there? I'm not reading from something you can't see?

(No audible answer)

Do you agree, in that respect, that a clear nationally consistent way to define and record clinical vulnerability, using, for example, datasets like flu vaccine eligibility, would allow protections and communications to be activated quickly and consistently in a future emergency?

PROFESSOR MAJEED: I think it would be helpful. So in a -- in the pandemic we saw that these groups were advised at several points during the pandemic, so in general, as the data got better, they were expounded somewhat. As you got more data. I think it would be -- you know, ideally you would have these groups categorised in advance of any future health crisis, with the caveat that, for each different crisis, they may differ. So for the measles currently, it's children mainly at risk, not older people. So it would vary, for example, on the actual health crisis. But in general it would be helpful to have the groups defined in advance so that on day one you can press a button and go with any intervention you want to run for those groups.

MR WAGNER: And I see Professor Herrick nodding there in agreement. And, Chair, may I just ask a follow-up

question to something that Professor Herrick said about that earlier?

LADY HALLETT: You may.

MR WAGNER: Professor Herrick, you said, entirely fairly, that clinically vulnerable groups in the next pandemic may not be for the same, as it could be, you know, something that affects children or whatever it would be, and you went on to say that it's not necessarily possible to draw general lessons from the very specific situation of Covid-19, and the pandemic that arose from that.

May I just explore that with you quickly? Might it be possible to draw some general lessons in relation to groups, for example, immunocompromised people who generally will be clinically vulnerable to lots of different pathogens and probably to whatever pandemic comes next? Might it be possible to draw some -- with the caveat that there will be differences around the edges -- that there might be groups that are generally clinically vulnerable in the sense that we now understand it to mean, not just to Covid but to other pathogens? And you might draw a lesson, for example, relating to the workplace, where you'd have better air quality as a requirement, some things like that, that don't -- can apply to peacetime and not just pandemic

time, if I put it like that?
PROFESSOR HERRICK: Yeah, I mean, there are certainly groups that are clinically vulnerable regardless of what is going on, that -- you know, cancer treatment, immunocompromised, suppressed, organ transplant. Those people are always vulnerable, wherever they are and whatever conditions are being faced, and always have to be very careful.

To link that then to the workplace is a question of employment law that I'm not qualified, perhaps, to comment on. Obviously we would all like to have clean air, we should all have access to clean air, so, yes, I would in theory agree with that. In practice, whether or not that can be delivered within every environment is a different question.

Q. Yes, it would require a variety of expertise in addition to your own?
PROFESSOR HERRICK: Yeah, exactly.
Q. Just staying with you, Professor Herrick, you refer in your statement, at paragraph 2.5, to the categorisation of CEV (clinically extremely vulnerable) people who would be on the shielding list at the time in 2020, when the list began, and this system whereby GPs could categorise somebody if they asked them to, if they, for example, had been missed off -- as many people were --

the algorithm that used medical records.

Would you agree that the -- what -- the actual way the system worked was not that someone self-declared, it was that they would go to the GP and ask to be declared as clinically extremely vulnerable and then have access to the protections if the GP agreed?
PROFESSOR HERRICK: Yes. I mean, depends how you're defining "self-declared". I mean, self-declared declared themselves to the GP --
Q. Yeah.
PROFESSOR HERRICK: -- yes. But there were also people that decided to shield even if they weren't actually on that list. So there were plenty of people that decided to shield because of their own personal risk calculation. But yeah, people were omitted from a letter. There were later communications and broad understandings of what it was, how vulnerability was defined at that point, and then people would say -- understand -- "I think I would fall in that category, and therefore what do I need to do to have the letter?" Which became the passport to the things that you needed to support yourself while shielding.
Q. Yes. And that's the difference, is that you could self-declare if you weren't on the list, but you couldn't -- you didn't have the passports --

PROFESSOR HERRICK: Yeah.
Q. -- to the benefits that would allow you to do it until it was confirmed by the GP?
PROFESSOR HERRICK: Yeah.
MR WAGNER: Thank you.
LADY HALLETT: Thank you, Mr Wagner.

That completes the questions we have for you Professors, thank you both very much indeed for your witness statements. So don't worry if there's something you wanted to say but you didn't quite -- if it's in your witness statement, I take the written material into account as well. So thank you very much for what you've said in your witness statements and for coming along today to help. I'm really grateful to you.

We'll now take a break I think before the next witness and I shall return at 3.10.
MS BLACKWELL: Thank you, my Lady.
(2.55 pm)

(A short break)

(3.10 pm)
LADY HALLETT: Ms Rahman.
MS RAHMAN: My Lady, may I call the next witness, Professor Jayati Das-Munshi.

PROFESSOR JAYATI DAS-MUNSHI (affirmed)

LADY HALLETT: Professor, I hope you were warned you're the

last witness of the day so I hope you haven't been kept waiting.
THE WITNESS: Yes.

Questions from COUNSEL TO THE INQUIRY

MS RAHMAN: Professor, can you give the Inquiry your full name, please.
A. It's Jayati Das-Munshi.
Q. Thank you. And, Professor, you should have in front of you a copy of a report with the reference INQ000588210. Can you confirm that that is an expert report you have provided for the purposes of the Inquiry?
A. Yes.
Q. And can you confirm that any facts stated in the report are true to the best of your knowledge and belief?
A. Yes, I can.
Q. And can you also confirm that any opinions you have stated in the report represent your true and complete professional opinions?
A. Yes.
Q. Thank you.

Professor, I'm going to go through report largely in the order in which you present your conclusions. There is also going to be a few slides that will go up on the screen in front of you -- I'll give the paragraph numbers -- sometimes touching on things that come up

later or earlier.

If you need a moment to refresh your memory, please take the time to time you need. Thank you.

Turning to page 4, first, of your report, and your professional background. In summary, you are a professor of social and psychiatric epidemiology at King's College, London?

A. Yes.

Q. And you're also an honorary consultant psychiatrist with the South London and Maudsley Trust and the St Christopher's Hospice, UK?

A. Yes.

Q. And your clinical work covers psychiatry of general adult and older adult populations in a liaison psychiatric setting?

A. Yes.

Q. And finally, you have also researched and published extensively on health inequalities impacting people with severe mental health problems?

A. Yes.

Q. Thank you.

Now, Professor, at paragraph 1 of your report you touch on the instructions you received from the Inquiry to provide a report on the impact of the Covid-19 pandemic on people living with severe mental conditions?

A. Yes.

Q. And in your report you cover two elements of that impact. Is it right to say, first, it's the impact on physical health and mortality?

A. Yes.

Q. And second, the impact on the mental health symptoms experienced by those with the conditions?

A. Yes.

Q. And I understand that you've drawn on your own research as well as those of others, including some international research?

A. Yes.

Q. And you also acknowledge the contribution of Dr Dario Moreno-Agostino?

A. Yes.

Q. And it's correct that he conducted research on the population mental health trends and trajectories over time, including during the Covid-19 pandemic.

A. Yes.

Q. Thank you.

Moving to the substance of your report, I want to touch first on how you have defined severe mental illness, and it will be helpful to have up on the screen what you have set out at paragraph 17.1 which starts on page 8 of the report. It's INQ000588210 and it's at

page 8, paragraph 17.1.

And you've set out there a number of illnesses and disorders:

"Schizophrenia-spectrum and delusional disorders;

"Mood (affective) disorders, including severe depression and bipolar affective disorder;

"Neuroses, including phobias, panic and obsessive compulsive disorder ...

"Behavioural disorders, including eating and stress disorders."

And finally:

"Personality disorders."

The last, I think is the only one where you've not given an example. Could you give an example of a personality disorder?

A. So personality disorders are essentially longstanding ingrained ways in which people relate to others, and that -- and personality disorders can have an adverse impact on people's relationships and their functioning, and there are many types of personality disorders such as borderline personality disorder, narcissistic personality disorder, and so on.

Q. Thank you, Professor.

Now, turning to paragraph 17.2 which is, again, the same INQ number, INQ000588210 at page 9, what you touch

on there is that some definitions of these conditions also consider a second element relating to the level of functional impairment, and you've said there that this aspect is somewhat fuzzy, and I understand that's because, as well as severe mental disorders, it seems that these criteria also include some common mental disorders such as depression and anxiety; is that correct?

A. Yes, that's correct.

Q. Later in your report, I don't need to take you to it just now, but it's at paragraph 21, you say that common mental disorders tend to exist along a continuum. Could you briefly describe what you mean by that?

A. So common mental disorders are distinguished from severe mental illnesses as being highly common, as the name suggests, in the population, and include conditions like depression and anxiety. So in the population people may have symptoms of depression and anxiety, which exist as a sort of continuum, as a spectrum, with people with more symptoms potentially having -- being more impacted in terms of their functioning, needing to seek care and so on.

So I suppose the point I was making is that depression can be more common and less severe, or can also be more severe and therefore included within the

purposes of this report.
Q. And some people can experience symptoms across a continuum, so some mild, some severe, so that it isn't necessarily the case you can say they have a disorder or not, it's not a tick-box exercise and you can have some common aspects and some more severe aspects?
A. Yes, exactly.
Q. Just again in terms of your approach to that, fuzziness, as I understand it, where there's a lack of evidence relating to severe illness you have included some studies that consider both severe and less severe conditions in your research?
A. Yeah, I think it's fair to say that the risk factors for mental disorders whether it's a sort of milder form of depression or a more severe depression, they're still going to be similar. So where there was an absence of evidence for severe mental illnesses, I may have looked to the evidence for common mental disorders.
Q. Thank you. And just coming back finally to personality disorders again, it's right to say that some definitions of severe mental illnesses don't include those conditions?
A. Yes.
Q. But again, you've included those for the purposes of your report because specifically that group is known to

experience markedly adverse impacts, including on physical health and mortality?
A. Yes.
Q. Thank you. Professor, I now just want to ask you a few questions about the quality of the evidence generally that you've considered and draw out a few points from paragraphs 23 to 26 of your report, which starts on page 10.

Now, you've said that ideally, you would have data collected on the same individuals over a period of time, which is known as longitudinal data. So would I be right to say it would be quite helpful to have information about the same individuals both before and after the pandemic?
A. Yes.
Q. But you've said that people with severe mental illnesses can be unrepresented in studies of that type?
A. Yes, that's true.
Q. Is one of the issues there that the effect of the illnesses themselves makes it quite difficult to recruit and retain individuals in the studies?
A. That can be a concern, but I think the other element is that the population-level cohorts, or longitudinal studies, might include people with severe mental illnesses but, because they're less common, they're not

represented in these data sources to a sufficient extent where it's possible to look at the sort of size and scale needed -- (overspeaking) --
Q. Draw solid conclusions from that sort of data?
A. Yes.
Q. Thank you. You also described cross-sectional data, and that captures data on a number of individuals at a single point, so what you've said is it's useful as a snapshot in time of what those people are experiencing at that point?
A. Yes.
Q. So, for our purposes, looking at a group of individuals with severe mental illnesses and considering the data at a certain point after the pandemic started?
A. Yes.
Q. Thank you. A couple more points on limitations, you've pointed out that the symptoms of severe mental illnesses are usually assessed through questionnaires, and is it right that the quality of those can vary?
A. Yes.
Q. And you also say, and we heard from Professor Osborn about this a little this morning, that some of the studies and research may not be generalisable beyond the participants who took part. What do you mean by that?
A. So what that means is that the study sample might be

from one region, for example, and it might be difficult to then generalise to other regions, so it becomes difficult to make inferences that might apply to other context.
Q. Thank you. We will return later to the issue of particular data gaps, but, as a general point, despite these limitations, Professor, it's right to say you have managed to reach some conclusions on the way people with severe mental illnesses were impacted by the pandemic?
A. Yes.
Q. We'll consider those findings now.

Professor, I want to turn to the first point in your report, the first section, that's on excess mortality. And that's addressed at section 3 of the report starting at page 12.

The first really important point that you make, at paragraph 29, is something I understand is extremely well known in your field, but may not be more widely known, and that is that people with severe mental illnesses are known to have a significantly reduced life expectancy, of up to 15 to 20 years compared to the general population; is that correct?
A. Yes, that's correct.
Q. And that is across the UK?
A. Yes.

Q. And also internationally?
A. Yes.
Q. Now, Professor, you've noted in your report an increased risk of suicide amongst these groups?
A. **(Witness nodded)**
Q. But it's right to say that that's not an explanation of the reduced life expectancy when you look at the causes of death?
A. **(Witness nodded)**
Q. Can you expand on that.
A. Yes, we've known, actually, for decades prior to the pandemic, this very large 15 to 20-year gap in life expectancy. Most causes of death are from common, preventable conditions, like cardiovascular disease, type 2 diabetes, and so on. So, although death by suicide is more common in this group, actually most causes of death are through common, preventable conditions.
Q. Thank you.

You've mentioned in your report, you deal with this in a lot of detail, a number of factors at play. I'm going to ask you a couple of questions about what I understand to be the main ones, and I've drawn conclusions about that from what you've highlighted in your executive summary at paragraph 4.

First, the direct effects of the condition itself, including an inability to self-manage physical health and health seek. Could you expand a little on what that last term means.
A. So health seek refers to the ability to seek care when somebody needs it. And as I've highlighted in the report, the symptoms of the condition might have an impact, but also stigma may also play a role in terms of people feeling that they are unable to health seek when they might need to.
Q. I'm going to come back to stigma in all its forms in a moment. Just before I do that, there's another factor that you've highlighted, again in your summary, and I summarise that as a higher risk of health-related behaviours. So could you summarise the sorts of behaviours we might be looking at here which might impact mortality.
A. So we know that certain health-related behaviours like tobacco use or alcohol and substance use disorders are more prevalent in people with severe mental health conditions.
Q. And finally, mental health stigma, I will deal with this in a little bit more detail. And you say -- this is picking up from around paragraph 32 of your report -- that this operates at three levels. The first is the

level of health systems, and you note longstanding concerns about funding for mental health services and a lack of parity of esteem. Could you explain a little bit more about that term?
A. So parity of esteem simply refers to the fact that -- well, we would want good parity of esteem for mental health, to be given the same status of physical health. And a lack of parity of esteem implies that mental health is given a lower status compared to physical health. And as I've detailed in the report, this then plays out at a health systems level, for example through lower funding for mental health services compared to physical health services, that then have an impact in terms of the quality of care that people with mental health problems might be able to receive.
Q. A related point, which you touch on at paragraph 33 of your report, is what you describe as siloed care delivery. As I understand it, that's the problem that could arise where you've got physical health care being delivered by mental health providers or vice versa. So can that create the problem of someone who's got a preventable physical health condition but they're falling between two stalls?
A. Yes, exactly.
Q. The next way in which you describe stigma is operating

at an individual level, and you've referred to diagnostic overshadowing and self-stigma, and Professor Osborn also referred to those sorts of issues this morning. Can you briefly explain those terms and how it could impact on mortality?
A. So, diagnostic overshadowing references to the situation where somebody with a mental condition presents for a physical problem, but the clinician attributes the symptoms to the mental health condition rather than the actual underlying physical health condition.

So what that then means is that that person is unable to access evidence-based care, good quality care for their physical health need. And there is evidence widely reported in the literature that this can directly lead to poorer health and -- you know, and adverse outcomes for people with severe mental health problems.
Q. And self-stigma?
A. And self-stigma is another process where people internalise beliefs about themselves, which might then impact how far they're able to seek care when they need it or seek out relationships and so on. So, self-stigma is an internalisation of the processes that are otherwise at play.
Q. Finally, you say stigma operates at a research level due to the exclusion of those with severe mental health

conditions from clinical trials. Is there a reason for that?

A. So yes, I mean, when people are -- when clinical trials are operating, there's usually a set of inclusion or exclusion criteria, and very frequently, people with severe mental health conditions will be excluded from those trials. So that then means that research is generated which might not be so applicable to those populations. There's lots of reasons for it. Some of it might be to do with when we're sort of doing drug trials, the industry might want a sort of quicker pathway to regulation and so on.

But what it actually leads to is a sort of scientific neglect for these populations, and we find that when we're trying to develop guidelines, for example, that relate to these groups in terms of clinical management, the evidence for people with severe mental illnesses might be lacking compared to other populations.

Q. Thank you.

Professor, you've also noted at paragraph 34 of your report that people with severe mental illnesses appear to have a greater risk of comorbidities such as cardiovascular disease, but it's right to say there are some important differences about those between ethnic

groups; is that correct?

A. Yes.

Q. And you also refer to the effects of social deprivation, at paragraph 36, which you say is associated with reduced life expectancy, and you say that people with severe mental illnesses are more likely to experience this, for instance, because of high levels of unemployment?

A. Yes.

Q. And lastly, at paragraph 37, you touch on the impact of the medications that are prescribed for the conditions, but it's right to say that whether or not they overall have an adverse or beneficial impact, it's not well understood?

A. No, it is understood. So, many of the medications that are used to help people with severe mental health conditions are associated with some effects, adverse effects around weight gain, a high risk of developing diabetes, and so on. So they can have an impact in terms of physical health but we know from studies that have been done that actually the same medications when people are taking them seem to be associated with improvements in mortality outcomes.

So it's a sort of mixed and slightly complicated association. It might be that the medications are

needed to help people stay well, but they are still associated with physical health problems that also need to be considered and managed.

Q. Thank you.

So Professor, drawing all of that together, you've identified many reasons why people with severe mental illnesses are at risk of early death, but it's your evidence that these are all factors that were essentially pre-existing, and they impacted on the death rates we've heard about prior to the pandemic.

A. Yes.

Q. Thank you, Professor.

I now want to turn to mortality figures post-pandemic and how people with severe mental illness were impacted. At paragraph 40 of your report, you've drawn on your own research, as I understand it, and also on the Clinical Practice Research Datalink. Can you briefly describe what that is, as a resource?

A. So the Clinical Practice Research Database -- Datalink, CPRD, is essentially a dataset of general practice records across -- and it's fairly representative of England -- we use data from CPRD to look at levels of mortality in people with severe mental illnesses following a Covid-19 infection.

Q. And I think you said although that data doesn't cover

Scotland and Wales and different parts of the UK, your view is that if you look at the pre-existing patterns of mortality, there's no reason to believe that this isn't UK-wide even though that resource doesn't cover the whole of the UK?

A. Yes, exactly. And actually in the study that we did do, we were able to look at Northern Ireland and I think it was seven regions across England, and we looked for variation, and we didn't find any evidence of variation. So a higher risk of death following a Covid-19 infection in people with severe mental illnesses, that was the same irrespective of where they resided.

Q. Thank you.

And your conclusion, again from that research, at paragraph 40 is that across the two initial waves of the pandemic, people with schizophrenia and bipolar disorders were more likely to die following a Covid infection than the general population?

A. Yes.

Q. I'm going to obviously deal with that in a bit more detail, but adjusting for other factors, you found a 53% higher risk, and we're talk about any cause --

A. Yes.

Q. -- not just Covid, and that's across the UK? That's your conclusion?

A. It's across England and Northern Ireland, yes.
Q. But you believe it should be --
A. Yes.
Q. -- consistent but across the UK, given --
A. Yes.
Q. -- in effect, the control you've done by looking at different regions, and one in Northern Ireland?
A. Yes.
Q. And at paragraph 43, you also look at this in a different way. You look at data from one UK trust, which you point out is one of Europe's largest, and you compare the deaths in a sample of people with a number of different severe mental health conditions, essentially alongside a control group; is that the way I should understand that?
A. So yes, we looked at deaths during the -- well, prior to the pandemic and then during the pandemic, across nine different diagnostic groups and we compared their experiences to a reference dataset that was collected prior to the pandemic.
Q. And it's right to say, I'll come back to some of the specific conditions, but it's right to say that across the conditions, the severe mental health conditions that you analyse, there was a sharp rise in mortality following the outbreak of the pandemic for all of them;

is that correct?
A. Yes.
Q. And again, we're looking now at all causes of death, not simply Covid-related deaths?
A. So we looked at all-cause mortality and we also looked at Covid-19 deaths.
Q. We'll come back to that, but this is your figure 2. I'm not putting that up on the slide because it's an extremely intricate figure, but it's figure 2 in your report. But thank you very much for describing that.

Would it be fair to say or to summarise that as evidence of the gap widening, the gap you've already described, in terms of mortality for people with severe mental illness, during the pandemic, would you say the gap widened?
A. Yes.
Q. For at least some of these diagnoses?
A. Across the board. It was actually for all diagnoses. Of course there are some issues with precision of estimates, which I can go on to talk about, but ultimately there was a similar pattern across each of the nine conditions that we looked at.
Q. Could you perhaps explain for which diagnoses we can be the most confident about that?
A. So I think the most striking rise in deaths was in

people with intellectual disabilities. That was outside of the scope of the report but it's worth noting that, and these were people who were under the care of secondary mental health services.

We also noted a rise in people with dementia and schizophrenia-spectrum disorders. Also, actually, with affective disorders, substance use disorders, and so on, so actually most of the conditions showed a stark rise following the onset of the pandemic.
Q. Just finally, the point that you've made is illustrated another way at paragraph 43 through figures that show deaths in the second quarter of 2020 during the pandemic were significantly elevated compared to the same point in the previous year in this cohort; is that correct?
A. Yes.
Q. Thank you.
LADY HALLETT: I'm sorry to interrupt. Can I just ask, going back to the point about those that suffered from dementia, as I understand it, although albeit you can get early onset dementia, the vast majority of people with dementia are likely to be over a certain age and they were of course at high risk from the virus anyway because of their age?
A. Yes, that's true. Yes.
LADY HALLETT: Sorry.

MS RAHMAN: Moving on to Covid-specific deaths, that would be your figure 3, which is at paragraph 46 onwards. And we're still, as I understand it, we're looking at 2020 here.

So moving on to excess deaths from Covid itself, the previous figure was all-cause mortality, this hones in on Covid itself, you have said that that also was increased across all the conditions covered, and perhaps coming back to my Lady's point, you highlight that dementia is one of the ones where it was much higher than the general population.

Is that perhaps because of some of the features that my Lady has pointed out, that they'd be at higher risk of the Covid pandemic.
A. **(Witness nodded)**
Q. It's not simply the mental illnesses?
A. I think just to come back to that point, so, yes, there was a higher risk in the dementia group. These figures are also standardised by age, actually, I should say, so that should take into account differences by just being older. And so actually this should tell us what the deaths from Covid-19 were doing in that group, taking into account age and gender.
Q. Thank you. And you've also identified, I think, schizophrenia and eating disorders in particular, at

paragraph 47 of your report, where deaths were much higher than in the general population?
A. Yes.
Q. And are you able to help us with the reasons for that?
A. So I think there's potentially a range of reasons. As I've highlighted throughout the report, many of the factors that were a concern prior to the pandemic continued to be a concern during the pandemic. There were other factors that came into play. So what the figures show is that, going into the pandemic, each of these conditions, people had a higher risk of death. And those deaths from other causes continued to be a concern during the pandemic, but then during the pandemic, there was an added extra risk from contracting Covid-19 and a heightened risk of death as well.
Q. Thank you.
Now, you have mentioned in your evidence before that people with severe mental illnesses are also at increased risk of comorbidities and behaviours affecting mortality. I don't need to take you to it, but at paragraphs 103 and 104 of your report you do confirm that if you look at it from the perspective of those with comorbidities, they were also more likely to die during the pandemic?
A. Yes.

Q. And finally on this, you told us earlier on that this group is at an increased risk of suicide. Is it right, however, that there isn't any confirmed increase in suicides during the pandemic, as you say at paragraph 104?
A. We couldn't find any evidence to support that, but I think, as I've highlighted in that paragraph, having a severe mental illness like schizophrenia means that people are at increased risk of suicide just from a clinical perspective, so I have no reason to believe that that would have changed during the pandemic, but we couldn't find any data that directly -- (overspeaking) --
Q. You do say that you consider that that group would have been at increased risk, during the pandemic, of suicide? And we will be hearing, my Lady, tomorrow from Mind about some of services they offer to people who were experiencing suicidal ideation.
And again, finally, Professor, is it right to say that the increased deaths are broadly in keeping with the international data on the same groups, as you say at paragraph 48?
A. Yes.
Q. Thank you. We've already -- you've already highlighted that, although it was outside the scope of your report,

it did seem to say earlier on in your report that those with learning disabilities were at very increased risk too?
A. Yes.
Q. Thank you.
Professor, I want to move on to the latter stages of the pandemic, because I think that your studies were focused more at the earlier two waves, essentially.
Now, dealing with vaccination, you've pointed out in your report that this group were prioritised for vaccination, and you've pointed out that, despite that, excess mortality continued to be a concern, and you note studies both in the UK and internationally that suggest that lower vaccine take-up might be a cause of that.
At paragraph 51 of your report you have noted that measures could be taken to improve vaccine uptake in this group.
Could you just summarise your suggestions, please, from paragraph 51.
A. So I think it was a really good thing that Britain prioritised people with severe mental illnesses for vaccination. I think we were one of only a few countries across Europe to do that, and that was really important. But I think what we're starting to note is that despite that, and despite actually then reaching

higher levels of vaccination in these groups, it was not as good as the general population. So, in order to enhance vaccine uptake, and I think more research is needed to try to understand what we can do, but it could be that we can more proactively encourage vaccine uptake, which might be through health services, it might be through incentivising general practice to offer that as part of a health check. It could be through other, sort of, public health measures, such as health education, health promotion, and so on.
So I think lots more can be done, but we did manage to achieve reasonable levels of uptake initially for these groups just down to having prioritised vaccination in the early stages of the pandemic.
Q. Thank you.
Moving on to a subject that you touch on at paragraphs 53-58 of your report, and you considered whether any particular effects on mortality were evident for those with severe mental illness from minority ethnic backgrounds and other protected characteristics. Is it fair to say that essentially there's insufficient data to enable you to reach any firm conclusions here?
A. So I think what I've stated in that bit of the report is that the gap in life expectancy that had been documented in white British people with severe mental illnesses had

been demonstrated to a similar extent in ethnic minority groups prior to the pandemic.

During the pandemic, many of the risks that we've already talked about were experienced to a similar extent amongst each of the ethnic minority groups where studies have been conducted.

So there is a bit of evidence that seems to suggest that higher excess risks from contracting Covid-19 and death was experienced to a similar extent across ethnic minority groups living with severe mental health conditions.

Q. You've said that given pre-existing factors like stigma, these groups may well have faced an element of double jeopardy leading to higher death rates?

A. There has been a suggestion of that, yes.

Q. But you can't really put it any higher than that, given the evidence base?

A. There hasn't been much work done, but of the work that has been done, there's a suggestion that there are similar trends, definitely, at play in ethnic minority groups living with severe mental health conditions.

Q. Thank you, Professor.

Drawing, then, together the evidence in relation to -- on mortality, you've said there's pre-existing reasons for reduced mortality including factors like

stigma in all its forms?

A. Yes.

Q. And it's your evidence that those pre-existing factors are likely to have persisted throughout the pandemic?

A. Yes.

Q. And then there are also more pandemic-specific factors. Just touching on what we heard from Professor Osborn this morning, he explained the impact of availability of PPE and testing and inpatient settings was a factor. And I think you say, and you've highlighted it in your executive summary at paragraph 5, and you deal with it in more detail at paragraphs 99 and 100, you think this issue will have contributed to higher risks of infection and mortality in this group?

A. Yes.

Q. Just dealing with infection control in these settings, we've heard again from Professor Osborn about the challenges, for instance close proximity when caregiving, patients not understanding distancing rules. Are these factors that make it particularly difficult to control infection or made it difficult to do that during the pandemic?

A. Yes, it would have done.

Q. Just in terms of that, and prioritisation of people with mental health illnesses in hospitals, would it be fair

to say that it's not surprising that people with physical conditions like respiratory conditions might be prioritised for PPE, but what you're saying is that there are particular features with those with severe mental illnesses that also needed to be prioritised or at least recognised?

A. Yes, exactly.

Q. Is there -- I think you link this to the idea of parity of esteem, have you got any -- could you expand on why you think that the need for PPE in these settings wasn't fully appreciated in the way you've described?

A. So as I've highlighted in my report, there was a study done looking at inpatient mental health services across London, which seemed to indicate that access to PPE and testing, actually for Covid-19, was quite delayed on those wards. It was a study of older people with severe mental health conditions, and the study essentially found that those delays led to people coming into the wards when they didn't have a Covid-19 infection, contracting the infection, and then being more likely to die. The authors of that study speculate that the levels of deaths as a result of contracting Covid-19 were higher for those who were admitted to those units.

And I suppose the main kind of -- one of the bigger elements to sort of pick up, which is -- which I'd

raised earlier is around parity of esteem. So the authors suggest that because mental health services were given a lower parity of esteem compared with general medical services at this time of intense national pressure, it had an impact which then led to these adverse effects in older people admitted to mental health units.

Q. So that's one study. Is it the Livingston study at paragraph 99 of your report?

A. Yes.

Q. And it is one study looking at a particular cohort of older adults?

A. Yes.

Q. But it is across five trusts --

A. Yes, in London, yeah.

Q. -- where that was found. And so they are suggesting that that can be fitted into the idea of lack of parity of esteem --

A. Yes.

Q. -- and understanding of risks to this particular cohort?

A. Yes.

Q. Thank you.

You've also considered other pandemic factors, we've discussed them: lower vaccine uptake **--**

A. **(Witness nodded)**.

Q. -- despite prioritisation of the group. And a final question on this section, which you may or may not be able to answer, to what extent do you consider the primary drivers of excess mortality within these groups to be pandemic-specific and to what extent rooted in pre-existing structural inequalities that you've set out?

A. So I think it's a bit of both. I think that the pre-existing risk factors continued during the pandemic but I also think that during the pandemic other pressures such as reduced access to services, some of the stresses of -- that we all experienced during the pandemic, some of the issues around PPE and so on, had an impact too, in terms of mortality during the pandemic. And of course, there's that study that you'd already raised: well, we know that when people with severe mental illnesses are infected with Covid-19, certainly in the early stages of the pandemic, prior to vaccination rollout, they had a higher risk of death.

So I think it's a bit of both, pandemic-related factors and pre-existing risks which continued.

Q. Thank you very much, Professor.

I'm now going to move to the second part of your report, that's section 5 from paragraph 99. And this is about the changes and symptoms experienced by people

with these illnesses and you say at the outset that many of these studies are very limited in terms of their quality and generalisability so it's fair to say that your findings here do have significant caveats; is that correct?

A. Yes.

Q. So I will take you to what I understand to be the main points you have reached.

Again, we've heard from Professor Osborn and from yourself that there is a reduction in people presenting or seeking care for severe mental illnesses, and he's described that as a treatment gap because just because they didn't present, doesn't mean that they still didn't have the symptoms's?

A. **(Witness nodded)**

Q. And he's also described people delaying seeking help and then presenting in a worse condition.

It seems to me that you agree with that analysis, essentially at paragraph 62 of your report.

A. Yes, I do.

Q. Moving on to the issue of online care, similarly to Professor Osborn, you seem to say that it was welcomed by some, but some people found that it adversely impacted on their symptoms; is that correct?

A. Yes.

Q. And I think you also highlight those with severe mental conditions from minority ethnic groups?

A. Yes.

Q. And you talk about lack of, or poor internet connection, insufficient computer equipment and skills, and loss of clinical face-to-face contact? Those are the sorts of issues that they experienced?

A. Yes.

Q. Now, I'm going to, given what you've said about really the lack of evidence, taken specific diagnoses in fairly short order. There are two or three where you've made quite a lot of detailed findings, and the first is people with schizophrenia, delusional disorders and severe depressive and bipolar disorders, and this is from paragraph 63 onwards, section 4.1.

Again, what you're saying is that there is a lack of data and, it seems, inconsistent findings on the impact on symptoms. Is it fair to say some studies didn't report deterioration and some did?

A. Yes.

Q. And I'd just like to ask you about one study, then, that you've mentioned at paragraph 68 of your report. And you've said that it didn't cover those from the UK. It's an international study. But it says people with some of these conditions were more likely to report

greater self-isolation, distress, anxiety, depression and Covid-19-related stress. And it highlighted social isolation, and loneliness during lockdowns, and disruption to healthcare were cited in those studies as causes for deterioration?

A. Yes.

Q. So I'd just like to put on screen a couple of the accounts that are part of our Every Story Matters report on mental health and wellbeing, which are of course from the UK. The first is someone from England who describes that they had a schizoaffective disorder and that the lockdowns hit them hard, and describes specifically the limit to phone contact for a two-year period, and they believe this had a devastating impact on mental wellness, and felt abandoned.

Then, on the next page, we've got somebody from Wales, who says:

"As somebody who lives with bipolar disorder, I am used to regular face to face sessions with a psychiatrist. This stopped and was replaced with six monthly calls for five minutes. I have not had a medication review or face to face meeting since the end of 2019 and have suffered with a major depressive episode in that time, and no help was made available."

Professor, do these sorts of issues reported to us

chime with the sorts of issues that the international studies capture?
A. Yes, this absolutely resonates, and I think later on I go on to talk about some of the qualitative studies which have been done in this area, and they -- both of these quotes align with what those qualitative studies also report.
Q. The study that you describe suggests a number of strategies that might be used to mitigate this sort of impact, including frequent phone calls, home visits, or even exemptions to restrictions based on certain diagnoses. What's your view on that?
A. I think it's a balance of -- and I understand it was a very difficult time in terms of needing to control the spread of the virus, but I think what a lot of the evidence seems to indicate is that people were really severely impacted in terms of their mental health, through some of the measures that were taken.
You raised the issue of, you know, difficulties in accessing digital online consults. We know from some of the evidence which we've reviewed that community centres, for example, helped people with severe mental health conditions to get online to, you know, have their clinical assessments, and so in some situations it may have been preferable to have supported that maybe

earlier on in the pandemic.
But I suppose it's that balance against needing to protect the population from the spread of the virus against the needs that people with severe mental health conditions may have had at that time.
Q. Thank you very much.
Can I turn now to eating disorders and this is from paragraph 69 onwards in your report, section 4.2.
You've said, in summary, that several systematic reviews suggest symptoms did get worse, but you have quite significant reservations about the quality of that evidence; is that correct?
A. Yes.
Q. And why is that?
A. I think, for the reasons that we've -- that we've already discussed, many of the studies didn't necessarily have data on people's mental health conditions prior to the pandemic, the longitudinal studies may have suffered with lost follow-up, the way that the diagnosis was also made is a concern.
However, of the studies that I have included in that section, I think it's broadly consistent with what we know, which is that there does seem to have been a decline for people with eating disorders in terms of some of their -- in terms of their condition, and

I think that's also consistent with what potentially Professor Osborn reported in terms of service use for people with eating disorders, in the session this morning.
Q. Yes, and in terms of the sorts of impact that we're talking about in terms of eating disorders, if I can just run through that list, it's at paragraph 70 of your report. What you're talking about is changes in routines, such as physical activity, which could lead to an overfocus on exercise. Is that one of the problems?
A. That was one of the issues raised in one of the studies, yeah.
Q. And loss of control?
A. **(Witness nodded)**
Q. Changes of relationship with food. So for this particular group that could mean difficulties getting hold of what might be classed as safe foods?
A. **(No audible answer)**
Q. Distress from the media, including messaging about avoiding weight gain during the pandemic; was that something that you saw in these studies?
A. Yeah.
Q. And finally, reduced social support and disruption to healthcare provision which we've touched on.
A. Yes.

Q. Now, that was one of the issues that has also come up again in Every Story Matters. This issue of support. Is there a particular factor for people with eating disorders, which is around monitoring their own weight, which the pandemic and the restrictions had an effect upon?
A. Well, again, it came out in one of the studies that we reduced and I think that's highlighted in paragraph 71. So people with eating disorders were reported in this study as having to monitor their own weight in order to inform remote clinical management. So I suppose that in itself can be distressing but it also means that people might have been able to hide the fluctuations in their weight in a way that had they been able to see the clinicians face-to-face might not have been the case.
Q. Again, if I could get up on the screen something from the report, Every Story Matters, it's INQ000659895 at page 41.
What is said there by a contributor from Scotland is that they found it easy to hide their eating disorder, their family was shocked when they saw them for the first time due to the loss of weight, and not being able to have them checking up on them was really the big issue there.
And then below that, there's something about

struggling with mental health since the age of 11, from another contributor. And again, a description of the eating disorder worsening and going unnoticed because everybody was so stressed and busy, and there's a description of daily fights at dinner, depression worsening because of a lack of social connection, not seeing of friends and family, and this person has said that they began to self-harm multiple times a day.

Again, do these accounts chime with what you saw in the research, despite its limitations about how eating disorders were impacted by the pandemic?

A. Yes.

Q. Thank you.

I want to turn now to obsessive compulsive disorder. Again, you highlight very limited research in the UK, but is it right, Professor, that outside the UK, studies suggest certain features would likely have impacted on symptomatology, such as over-exposure to news, leading to fears of contamination, and compulsive behaviour around cleaning and hand washing.

A. Yes.

Q. Thank you. I don't have any more points. I think that's the only point you make about that.

Turning then to paragraph 78 of your report, people with neurodevelopmental disorders. Most of that

evidence is out of scope, as you point out, as it's focused on children and their caregivers, but you do point out that there's one study that suggests increased depressive and anxiety symptoms in adults with autism. And, as I understand it, the distress is particularly due to disruption in normal routines, such as shopping, and lack of clarity around lockdown. Is that something that would cause particular distress potentially?

A. Yes, as reported in this study.

Q. Though, conversely, the lack of stimuli and social overload and increased sense of solidarity were reported by some as positives, I understand?

A. Yes.

Q. Professor, finally, you've touched in your report on some other conditions like panic disorders, post-traumatic stress, and personality disorders, but it's right to say that there's too little evidence on that to base any firm conclusions?

A. Yes.

Q. I want to move on now to some observations you've made at paragraph 83, 88 and 91 about evidence of disproportionate impact, in terms of deterioration of symptoms, on people from minority ethnic groups.

You refer at paragraph 88 to the Hildersley paper, and I think you had some involvement in that paper; is

that correct?

A. Yes, that's the paper from my group.

Q. Thank you.

So this was a large population-level study, and but it was right -- it's right to say it was focused on secondary mental health service users in one geographical area; is that correct?

A. Yes.

Q. And it found that while overall admissions to mental health units dropped, a larger proportion of admissions were compulsory, so detentions essentially?

A. Yes.

Q. We've already heard this morning from Professor Osborn about what a compulsory or involuntary admission is, and essentially he's confirmed it means people being detained, justified because they require treatment under legislative powers. So not on a voluntary basis. Do you agree broadly with that description?

A. Yes.

Q. And he's also described how some people were presenting later essentially in crisis. Does that accord with your understanding of this increase during the pandemic?

A. Yes.

Q. And this particular study, Professor Osborn referred to another one, but you referred to black Caribbean service

users being 1.54 times more likely to be compulsorily admitted in that study during the first lockdown; is that correct?

A. Yes, first and second lockdown in 2020.

Q. And the second lockdown it was elevated for both black Caribbean and black African groups; is that right?

A. Yes.

Q. And, again, it's right to say that both black Caribbean and black African groups were already known to be more likely to be compulsorily detained; is that correct?

A. Yes.

Q. But you've suggested that these findings may suggest that the pandemic has magnified pre-existing inequalities; is that correct?

A. Yes.

Q. Now, Professor, we've heard a lot of evidence on this theme, but what do you mean by it when you say it magnified pre-existing inequalities?

A. So what I mean is that, as you've highlighted, we knew about these inequalities prior to the pandemic, there'd been a Modernising the Mental Health Act review in 2018 that picked up exactly these issues, and what I mean by "magnified" is that these issues continued to be a concern during the pandemic but got worse for some of those groups that had been highlighted prior to the

pandemic, due to a range of factors.

So, in effect, amplified -- Or, you know, the same problems continued with the addition of inequalities being exacerbated through the pandemic.

Q. In terms of learning, Professor, one of the issues you're highlighting is a rise in crisis-driven detentions. Are there any practical safeguards or interventions that could be considered to prevent this in a future pandemic or civil emergency?

A. So there are moves at the moment, really arising from the Modernising Mental Health Act review, to improve services in terms of access to care. So there's a Patient Care and Race Equality Framework which is currently being rolled out across England and so I think some of those sorts of interventions to try and make mental health care more accessible for minoritised groups may start to shift the dial a bit.

Q. Thank you, Professor.

Now, you mentioned earlier on that you've considered some qualitative studies, that's involving more in-depth individual accounts, and you talk about those at paragraph 93 onwards. And they did specifically consider the experiences of those with severe mental illnesses from minority ethnic groups -- and other minority groups; is that correct?

A. Yes.

Q. And you say that they are more in-depth but is it fair to say that there are more limits in terms of generalisability?

A. Yes.

Q. However, you have noted here, and again later in your report, at 110, that when you look at those accounts, many of those interviewed did complain of stigma and discrimination in the way they were treated; is that correct?

A. Yes.

Q. That's something you've highlighted about their experiences in your executive summary as well, as a significant finding?

A. Yes.

Q. Despite the fact it's a qualitative source.

A. Yeah.

Q. Overall, though, as against that, again from your executive summary, you say that there is a dearth of data relating to the impacts of -- in people with serious -- severe mental illness and other protected characteristics, and you say that is a major concern to you. Can you expand on why?

A. Because -- so it's a major concern because we may assume that things might be worse if we were able to collect

that data but we're unable to make any assessment because we don't have the information to allow us to understand what is happening for people from racially minoritised backgrounds or who have other protected characteristics living with severe mental health problems.

Q. And is it right to say, I think you might say this somewhere in your report, those missing from the data, they were possibly the people in the worst situations --

A. Quite -- (overspeaking) --

Q. -- and we can't learn without knowing what happened?

A. Yes.

Q. One group you do mention in the report is might groups, refugees and asylum seekers.

A. **(Witness nodded)**.

Q. Are you aware of any data recording the impact of the pandemic on the mental health of such groups who also have severe mental illnesses?

A. I didn't come across any studies that had looked specifically at people with severe mental illnesses.

Q. So, Professor, in conclusion to your report at paragraph 110, you say that the pandemic exposed and exacerbated pre-existing inequalities but it's fair to say when it comes to the impact on ethnic and other minorities, that conclusion has been based on quite

limited data?

A. Yes.

Q. However, is it also right to say that that in itself is part of what you've already described to us as part of stigma at research level?

A. Yes.

Q. Thank you.

Leading on to that and some other points about it, you say that concerns about data collection had been longstanding. Can you give us an idea, from your recollection, how longstanding? When were these concerns first raised, to your recollection?

A. So there's been fairly longstanding concerns around the quality of data for ethnicity and other protected characteristics, even prior to the pandemic. So as an example, the last nationally representative survey of mental health in ethnic minority groups was done a few decades ago. So these are longstanding issues. There's been concerns around the quality of data collected for ethnicity and, again, other protected characteristics, and health records, as well. There have been moves to try and improve things and I think since the pandemic, some of those measures are better collected but there has been, across the field, concerns that we don't really collect the information to be able to understand

how mental health and other associations might play out for some of these groups.

Q. Are there any specific reasons why this hasn't been collected over this long period of time?

A. So, for health records, those are records that are collected routinely in the process of delivering care, so they need concerted effort to ensure that data relating to ethnicity and other protected characteristics are indeed captured. So that requires potentially additional funding, it involves working with the people that are delivering care to collect that sort of data, and so, to a certain extent, although there have been moves to try to improve things, it might be that more needs to be done in order to support people to collect that data on, you know, people in contact with care.

In terms of the national surveys, there had been moves to boost one of the more recent mental health surveys by ethnicity, but there were some challenges with recruiting people to those studies, and in the end it was decided that it would not be feasible to continue to collect that data on ethnic minority people and their mental health.

Q. Thank you very much.

Professor, at section 5 of your report, you draw

together factors that impacted on outcomes, both in terms of mortality rates and symptoms. So, both parts of your report. I just want to pick up on a few points, and I'm not going to focus on once we've discussed before, or that Professor Osborn has already dealt with.

At paragraph 106 of your report, you touch on pre-existing factors. We've heard a lot about these in various ways:

"... financial insecurity, unemployment, alcohol and substance misuse and intimate partner violence were known to increase in frequency during the pandemic and [you say that] may have played a role in exacerbating mental disorders for some groups ..."

I just want to ask you about one of those and one of the comments you make in terms of intimate partner violence. You may or may not know that the definition under the Domestic Abuse Act 2021 encompasses, physical, sexual, psychological, economic and controlling behaviours. Does your comment about that extend to all of those different sorts of behaviours?

A. I wasn't aware of that definition, so I'm not sure, to be honest.

Q. That's fine.

A. The sentence relates to a study that I've referenced there by Chandan and colleagues in the British Journal

of Psychiatry, which essentially found an association between people experiencing intimate partner violence and then their subsequent risk of developing mental health conditions.

Q. Thank you. And at paragraph 107 of your report you've highlighted the importance of social support from community organisations such as mental health charities, places of worship, or support networks. As a general point, would you agree that factors such as social isolation, loss of routine and disrupted support impacted specifically on the people with severe mental illnesses?

A. Yes.

Q. And you've also said that people with these illnesses who had access to networks were protected to some degree from a deterioration in mental health, that's also drawn from your research?

A. Yes.

Q. You've touched on one issue in your report at paragraph 82, I don't need you to go back to it, but it's on the experience of those living with mental -- within mental health residential settings and, on the same thing -- on the same theme, the impact of a lack of access to the usual networks and routines. Are you aware of anything that would explain to us the impact

from visiting restrictions on the mental health of psychiatric inpatients?

A. I didn't come across any studies which specifically explored that from the perspective of service users. There was one study that we identified which looked at challenges that mental health service providers identified during the early phases of the pandemic, and that was raised as a concern.

Q. Thank you.

Professor, leading to the end of my questions, summarising your overall conclusion in lessons learned, which is from paragraphs 113 onwards in your report, in section 6, essentially you're saying that the pandemic has deepened mental health challenges in this group, and that's beyond mortality?

A. Yes.

Q. And you've set out a number of lessons learned at the end of your report, which could inform future pandemic responses?

A. Yeah.

Q. I won't go through all of them but is it correct to say that some of them are to the effect that the pandemic has reinforced the need to tackle pre-existing inequalities such as in relation to reduced life expectancy?

A. Yes.
Q. Are you essentially saying that without taking on board these lessons now, you can't be confident that issues such as excess mortality would not be replicated in the event of another pandemic or civil emergency?
A. Yes.
Q. We've already established that one of your main concerns is lack of data, meaning some impacts are not fully understood. In terms of Covid-specific lessons, we've also discussed the importance of prioritisation for vaccination and improving vaccine take-up, that's one of the big lessons I think from your report?
A. Yes.
Q. You also highlight the importance of access to PPE, testing, and training for those working with people with severe mental illnesses; is that right?
A. Yes.
Q. And that's given the particular challenges of infection control that we've discussed?
A. Yes.
Q. Thank you, Professor.

In relation to non-pharmaceutical interventions like lockdown, you, like Professor Osborn, have noted the issue of delayed presentation and you suggest that community organisations can play an important role in

mitigating the effects of social isolation and digital exclusion. That seemed to be another of your main lessons learned.
A. Yes.
Q. And finally, you suggest that experts on mental health and neurodevelopmental conditions, including people with lived experience, could help with designing interventions, guidelines, and public messaging?
A. Yes.
Q. Is there anything else specific to the pandemic that you would like to highlight as a lesson learned?
A. No, I think that's covered all of it.
MS RAHMAN: Professor, those are all my questions but there may be some more for you.
LADY HALLETT: Thank you, Ms Rahman.

Ms Weereratne. Over that way.

Questions from MS WEERERATNE KC

MS WEERERATNE: Good afternoon, Professor, I ask questions on behalf of the Migrants' Rights Consortium.

One of our key concerns is the lack of understanding of and planning for migrant groups excluded from essential services.
A. **(The witness nodded)**
Q. Now, you've already been asked, quite helpfully, some questions around data collection specifically in

relation to migrant groups and you've already said that there hasn't been any, as far as you're concerned or you're aware of.

Your report, you've just been taken to part 6, which is about lessons learned, and one of the points at paragraph 119, you refer to the need for improve data collection for vulnerable groups, including those with protected characteristics.

The bit I wanted to ask you about now is towards the end of paragraph 119 where you talk about innovative data collection strategies. Do you recall that?
A. Yes.
Q. And really, the simple question, firstly, is: to what extent those innovative strategies which you say are now being implemented are being implemented with regard to migrant groups including refugees and asylum seekers?
A. So there have been developments since the pandemic in terms of large-scale linked data which brings together electronic health records with other types of administrative data. In terms of migration, that would require bringing together datasets like Census 2021 which does ask a question about country of birth and years residing in the UK, linked to health records, for example.

I'm aware that that linkage has been done. It's not

yet readily available outside of the ONS. So those datasets are being curated, they're being developed. Whether or not they could be used in a future pandemic would need to be seen because they're sort of static data linkages. So they wouldn't necessarily tell us about a future event, but nonetheless bring in data on migration status and have the ability to inform future research using those sorts of data sources.
Q. So if I'm right, what I understand you've just said is that those data linkages are important to understand the situation as it is now, let's say, and that would inform any future pandemic, should there be one?
A. Yes, it could be used, yeah.
Q. Right. And just finally, then, just to wrap that up, I've understood you to be saying that it's a major concern of yours that there should be improved data collection in this group of those with severe mental illness in particular, but it must include all vulnerable and marginalised groups, including the migrant groups that I've identified, in order to better understand and hopefully to rectify health inequalities now and for future pandemics; is that correct?
A. Yes.
MS WEERERATNE: Thank you very much.
LADY HALLETT: Thank you very much.

Ms Davies, who is that way.

Questions from MS DAVIES KC

MS DAVIES: Professor Das-Munshi, can you hear and see me all right?

A. Yes.

Q. My name is Liz Davies and I ask questions on behalf of the Domestic Abuse Group, which is a group of three organisations in the violence against women and girls sector.

You were asked by Ms Rahman a few minutes ago about paragraph 106 of your report. You don't necessarily need to look at it, but you record that intimate partner violence was known to increase in frequency during the pandemic, and that may have played a role in exacerbating mental disorders for some groups. You put that in with a number of other factors but that's one of the factors.

It's right and fairly obvious, isn't it, that being subject to domestic violence can impact a person's mental health such that severe and enduring mental illness can develop?

A. Yes.

Q. Yes. And, therefore, one could say that the rise in domestic abuse that happened during the pandemic may be one of the contributing factors to the increased severe

and enduring mental illnesses during the pandemic, or is that too simplistic?

A. That might be a little bit too -- so I think trauma, including intimate partner violence, has been associated with an increased risk of developing some mental health conditions, but I think as a single factor on its own leading to a rise in mental health problems is perhaps a little bit too simplistic, and there are probably other contributors that have contributed to a rise, if indeed there has been a rise since the pandemic.

Q. Can I just ask you about a number of factors that might contribute to a decrease in mental health for somebody who is a victim-survivor of domestic abuse in the context of the pandemic? One might be difficulties in securing support during lockdown; that might contribute to an increase in mental ill health?

A. Yes.

Q. Yes, another one might be a difficulty in finding safe places to stay in lockdown as compared to pre-pandemic, non-pandemic times; again, that might be a contributing factor?

A. Yes.

Q. And another might be where the pandemic produced new patterns of abuse, and specifically abuse around coercive control. For example, we have evidence that

perpetrators of domestic abuse were limiting victims' access to technology, exploiting the fear of the virus, and even deliberately infecting their victims at times. Any of those would potentially be a contributing factor to an increase in severe and enduring mental illness?

A. These can all potentially contribute to a decline in somebody's mental health.

MS DAVIES: Thank you very much. I'm grateful.

I'm grateful my Lady.

LADY HALLETT: Thank you, Ms Davies.

That completes the questions we have for you, Professor. Thank you very much indeed for your help. You haven't got too far to go, have you?

THE WITNESS: No.

LADY HALLETT: I thought we'd acquired you from somewhere relatively local. So thank you very much for your written report, obviously, and for coming along today to help us. Very grateful.

THE WITNESS: Thank you.

LADY HALLETT: And I shall return at 10.00 tomorrow.

(4.19 pm)

(The hearing adjourned until 10.00 am the following day)

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