"There are currently no expectations of additional controls specifically for these groups. But make sure your existing controls (social distancing, good hygiene and cleaning, ventilation, supervision etc) are applied strictly." [LW10/013 – INQ000652697]

17. For CEV workers, HSE suggested slightly stronger measures in guidance such as enabling home working or adjusting duties, but without reference to enforceable rights under the Equality Act. Measures were framed as what is "reasonably practicable" [LW10/013 – INQ000652697], stopping well short of offering "reasonable adjustments" under the Equality Act. This stands in stark contrast to how groups with recognised protected characteristics were treated under the same guidance. For instance, employers were required to carry out specific individual risk assessments for pregnant workers, and where safety could not be ensured, were obligated to suspend the worker on paid leave. The guidance, [LW10/013 – INQ000652697] explicitly acknowledged the risks to pregnant workers and set out legal mechanisms to protect them - a level of protection not offered to other Clinically Vulnerable people, despite their similarly high health risks. Similar enforceable rights were not available to CV or CEV workers and CVF feels that this highlights a key structural failing. As a consequence, Clinically Vulnerable people were often left without suitable protection, and found themselves dependent on employer discretion.

18. Our lived experience is that Clinically Vulnerable people were left in something of a legal vacuum. Highly at risk, but without formal protection or even the right to refuse unsafe work. Unlike disabled people, CV and CEV workers could not rely on the Equality Act to request adjustments or protection based on their Clinically Vulnerable status and found they frequently had no route for legal recourse if denied safety measures.

PART B – Impact on Mental Health and Wellbeing

19. See Annex A for two separate case studies that share the experience of living in a CEV household and the experience of a CEV person.

20. The pandemic created sustained psychological pressures for Clinically Vulnerable people that went beyond the immediate threat of infection. Extended shielding (formal or informal), repeated disruption to healthcare access, and prolonged

exclusion from everyday activities meant that risk management became a constant feature of daily life. Many experienced the erosion of protective measures as a signal that their safety was no longer a public priority, amplifying feelings of isolation and abandonment. Their challenges were often compounded by pre-existing health conditions which created new barriers to social connections, and disrupted access to sources of emotional support.

21. An important factor in this has been the way ongoing medical risks have been deprioritised or ignored in public policy and service planning. For Clinically Vulnerable people, the knowledge that exposure to airborne infections may cause severe illness or death is not hypothetical. The removal of mitigations in healthcare and public spaces has forced many to choose between protecting their physical health and participating in essential activities, including medical appointments, and attending education or workplaces. The persistent threat to physical safety has, in turn, been a significant driver of legitimate anxiety, social withdrawal, and loss of trust in systems.

22. CVF gathered insight from its members, through our recent 'Impact on Society' survey [LW10/014 - **INQ000657072**]. The survey ran in the summer of 2025 and received 125 responses from people in Clinically Vulnerable households across the UK, capturing experiences over multiple stages of the pandemic. It combined structured questions on specific impacts (e.g. healthcare access, mental health, community participation) with open-text accounts that provided rich qualitative detail. The responses illustrate both the scale and persistence of the mental health toll, showing how it evolved through different phases of the crisis.

Survey Findings

23. 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. Key themes emerging from the data included:

    i. Social isolation was reported as a major factor for most respondents, associated with shielding, ongoing risk from airborne infections, and the

withdrawal of mitigations (e.g. masking in public and healthcare settings) leaving many finding it harder to return to their former lives.

ii. 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.

iii. Many experienced depression and a sense of hopelessness when mitigations were lifted without protections for high-risk individuals.

iv. 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.

v. Reports of loneliness were particularly acute in households not only where the CV/CEV individual lived alone, but also where they were the only vulnerable member, creating divisions within families about acceptable risk and behaviours.

Patterns over time

24. In the early shielding period (March–July 2020), respondents to CVF's survey, cited extreme isolation, anxiety about the unknown risks of Covid-19, and distress over being unable to access routine medical care. The results of the survey also showed that, in mid-2020 and early 2021, anxiety remained high despite some easing of restrictions, due to continued vulnerability and concerns about inconsistent public compliance with safety measures. There was a slight decrease in anxiety following vaccinations between Nov - Dec 2020 and Jan - Mar 2021 (first vaccinations for CEV individuals), where the proportion reporting high anxiety decreased from 86.4% to 82.4% (-4%). A further decrease was observed between Jul - Oct 2021 ("Freedom Day" / shielding ending) and Nov 2021 - Jan 2022 (rise of Omicron / booster period), from 92.0% to 86.4% (-5.6%). Loneliness rose from 38.4% during the first lockdown to 54.4% by June 2022, following the introduction of the "Living with Covid" policy [LW10/014 - **INQ000657072**].

feature of safe care. With appropriate controls, it is possible to reduce transmission of multiple airborne infections (e.g. Covid-19, influenza, RSV, measles), whilst supporting safe access for all patients and ensuring equitable access for Clinically Vulnerable people, thereby improving our resilience against future surges of all airborne infections.

118. Nothing really changed when shielding was paused; the unaddressed risks around healthcare settings remained and consequently our community felt exposed to high-risks with limited options available to them or the protections in place to mitigate their vulnerabilities. For them, Covid-19 still represented a significant and serious threat to their lives or the health of their families and wider communities.

Accessing social care services and support during the pandemic

119. Many respondents to CVF's survey described substantial disruption in accessing social care services, often during critical periods when such support was most urgently needed. Across the UK, CVF members reported that services such as in-home care, personal assistance, respite, and other social support were significantly reduced or withdrawn altogether, frequently without replacement or meaningful communication.

120. Frequently, these changes had profound consequences on their mental health, physical wellbeing, and capacity to remain safe while shielding or self-isolating.

Withdrawal or suspension of home support services

121. Several respondents reported that home care support was paused or unavailable, even for those with severe disabilities or high dependency.

Quote 23 – Alex, 45 (England)

"All support for my relative with severe mental illness disappeared overnight. And support had been very limited to start with. I was left with 24/7 unpaid caring responsibilities on top of my job on top of my own health conditions. It was unmanageable and unbearable and has had a long term impact on my health."