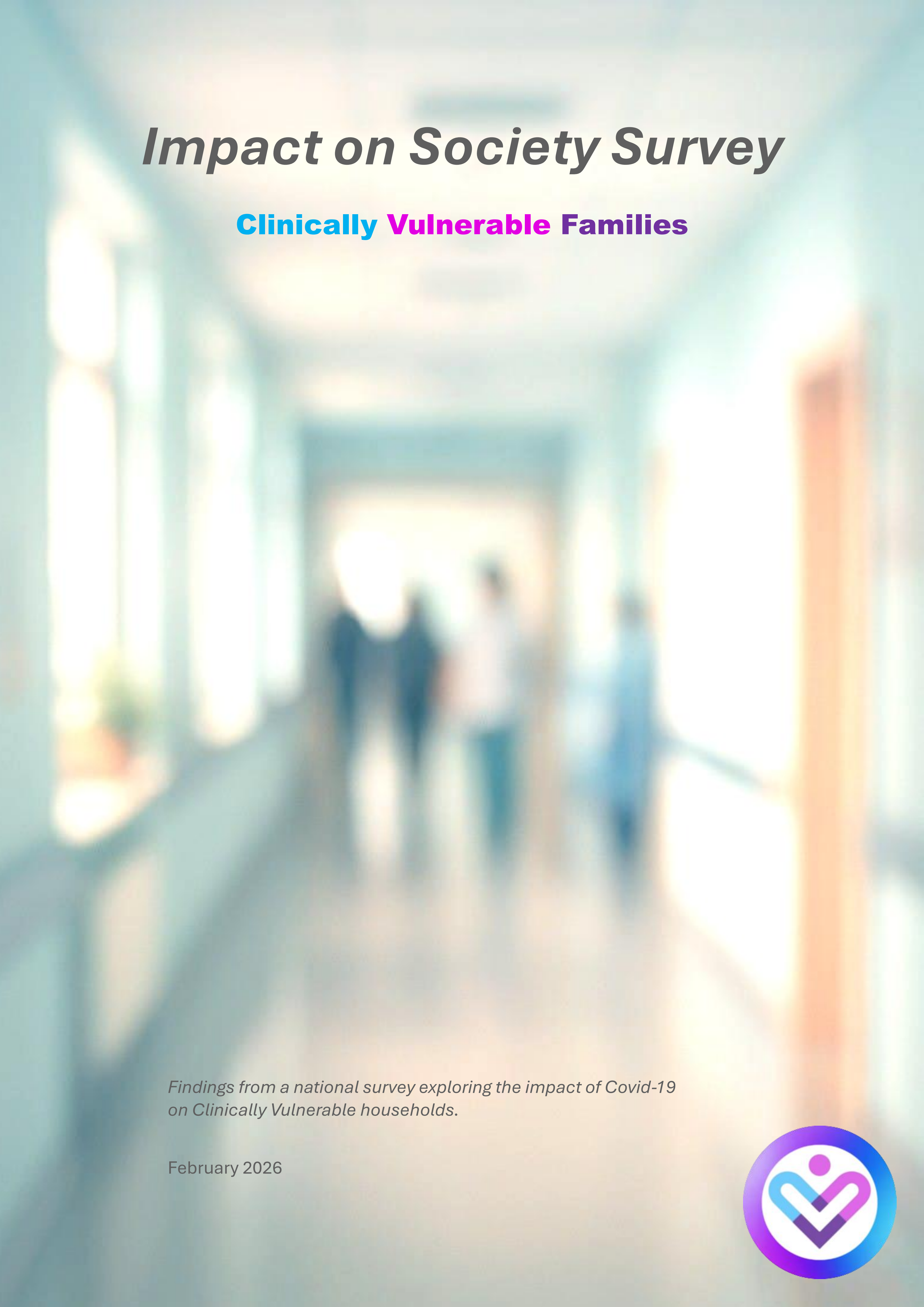

Impact on Society Survey

Clinically Vulnerable Families

Findings from a national survey exploring the impact of Covid-19 on Clinically Vulnerable households.

February 2026

Executive summary

Clinically Vulnerable Families (CVF) is a community organisation in the UK representing people at higher clinical risk from infections and their households. We gather evidence, support peer networks, and advocate for safe access to healthcare, education, work and public life.

CVF's 2025 member survey captured 125 responses from UK households. This included people recognised as 'clinically vulnerable' (CV) due to underlying health risks such as age, and those formerly identified as 'clinically extremely vulnerable' (CEV) people.

The data point to a consistent pattern of exclusion from public life. Deteriorations in mental health, along with barriers to safe healthcare, work, worship and everyday participation, have persisted long after general restrictions ended.

About the survey

Scope

The survey was carried out in May 2025. Questions focused on experiences during the "timeframe" 1 January 2020 - 28 June 2022. **125** CV/CEV UK households were sampled. Mixed-format survey combining structured items and open-text testimony covering mental health, healthcare access, social care, employment/finances, faith and cultural participation.

How to read this report

We present the headline findings exactly as reported in the data; no numbers have been altered or modelled. Qualitative quotes illustrate lived experience.

Respondent Profile (Summary)

Most participating households included at least one clinically vulnerable member. Almost half **(46.3%)** reported someone severely immunosuppressed, and around a quarter **(25.4%)** included a person aged 65 or older. Respondents were spread across the UK, the largest proportion from England – South East **(44.6%).** Households were diverse in terms of employment and caring responsibilities, and the majority **(77.9%)** included at least one disabled person.

Terminology

Clinically Vulnerable **-** former **'clinically extremely vulnerable' (CEV)**, and those in priority groups for vaccines as **'clinically vulnerable' (CV)** based on age or underlying health.

1) Mental health and wellbeing

> ***“Five years on my mental health is still in tatters… I had a full suicide plan in place if I caught the virus.”***
> ***Dorota, 53***

Acute harms became chronic for many respondents. Early shielding (formally or informally) brought extreme isolation and anxiety. Subsequent lifting of protections without inclusive safeguards shifted distress toward chronic stress, and in some cases withdrawal.

Depression peaked at 53.6% around “Freedom Day”/ “Living with Covid.” Reported depression moved from ~one-third during the first lockdown to **45.6%** when shielding was paused. Quantitatively, loneliness rose from **38.4%** in the first lockdown to **54.4%** by June 2022 (post “Living with Covid”).

Overall, 95.2% described negative mental or emotional impacts linked to shielding or cautious living. This included stress, depression, anxiety, loneliness, suicidal thoughts, burnout.

Participation in public life remained extremely limited. Only **1.7%** felt able to safely return to public places during the initial reopening. A further **19.0%** returned partially with extra precautions and avoidance of unsafe venues.

Respondents described a persistent background of stress, particularly when leaving the home for essential activities. People in multigenerational or caring households reported the dual burden of protecting others whilst managing their own health.

Common practical changes made during the timeframe included upgrading personal protective equipment to FFP2 or FFP3s. Choosing quieter times for shops and appointments, preferences for outdoor or well-ventilated spaces were also common measures taken.

For many, personal or national protective measures reduced but did not eliminate risks. They therefore did not restore participation to pre-pandemic levels.

Social, Emotional and Practical Impacts

Responses showed that the impacts of the pandemic on clinically vulnerable (CV) and clinically extremely vulnerable (CEV) households were multi-layered, 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

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). Many found it harder to return to their former lives as official protections were lifted.

Infection risk remained a constant concern, particularly in healthcare environments, workplaces, and high-density public spaces without ventilation or masking.

Mental health impacts were profound. Many experienced depression and a sense of hopelessness when mitigations were removed without protections for high-risk individuals.

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

Loneliness was especially acute where the CV/CEV individual lived alone, or where they were the only vulnerable member in the household, creating divisions within families about acceptable risk.

Patterns Over Time

Extreme isolation was cited by respondents In the early shielding period (March–July 2020). They cited anxiety about the unknown risks of Covid-19, and distress at being unable to access routine medical care.

Anxiety remained high despite some easing of restrictions, in mid-2020 and early 2021. This was due to continued vulnerability and concerns about inconsistent public compliance with safety measures. There was a slight decrease in anxiety following vaccinations between November - December 2020 and January - March 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 July - October 2021 ("Freedom Day" / shielding ending) and November 2021 - January 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. This was following the "Living with Covid" policy.

Depression affected one-third of respondents during the first lockdown, rising to **45.6%** when shielding was paused and initiatives such as "Eat Out to Help Out" were introduced. Rates remained relatively stable thereafter, with notable peaks at “Freedom Day” and the “Living with Covid” policy, reaching **53.6%**.

Voices from the Survey

> ***“This [pandemic period] showed me and my family that society views disabled and chronically [ill] lives like mine as disposable.”***
> ***Kath, 31***

> ***“Husband diagnosed with depression and medicated. Oldest child had MH issues / supported by school / Young carers / Barnardo’s. The constant pausing / unpausing and uncertainty of when to shield really affected us all – we felt safer shielding and would rather have just been supported to do this throughout.”***
> ***Heather, 50***

> ***“I was referred to a clinical psychologist... I told the psychologist that the Macmillan counsellor had treated my concerns like a phobia and kept trying to get me to do things I didn’t feel were safe. Like going to a restaurant. ... Her response was ‘You don’t have a phobia. A phobia is an irrational fear and I can see that Covid is a real, legitimate concern.’ I realised I was not mad. I was completely right to feel as concerned as I did, as a vulnerable cancer patient.”***
> ***Jayden, 32***

> ***"I have been immune suppressed for 44 years due to an organ transplant... I have multiple co-morbidities... Yet somehow, I was missed, forgotten & left to fend for myself... When we got an emergency food delivery I cried... because at least I had been remembered."***
> ***Jo, 54***

Ongoing Consequences

By "Freedom Day" (July 2021) and afterwards, as protections were removed and individuals were left to navigate risk alone. many described their mental health impacts shifting towards chronic stress and long-term social withdrawal. Our data suggests serious mental health harms were not just short-term reactions to lockdowns or shielding but are ongoing consequences of prolonged exclusion.

Medical risk remains as high as at the start of the pandemic, for immunosuppressed or immunocompromised respondents, who may not have responded to vaccines. This is compounded by high community prevalence of Covid-19. The continued elevated risk is recognised in current UKHSA/DHSC guidance[1], which advises additional precautions for people whose immune system means they are at higher risk.

While vaccination has reduced risk for most of the population, underlying health conditions continue to heighten the risks faced by Clinically Vulnerable groups. The persistent, unmitigated threat to health has become a source of chronic stress, forcing many to remain isolated long after most of society returned to normal life.

The result is a widening public health equity gap. While most people have resumed normal activities, some Clinically Vulnerable individuals continue to face risks that undermine both physical and mental recovery.

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[1] https://www.gov.uk/government/publications/covid-19-guidance-for-people-whose-immune-system-means-they-are-at-higher-risk/covid-19-guidance-for-people-whose-immune-system-means-they-are-at-higher-risk

2) Access to safe healthcare environments

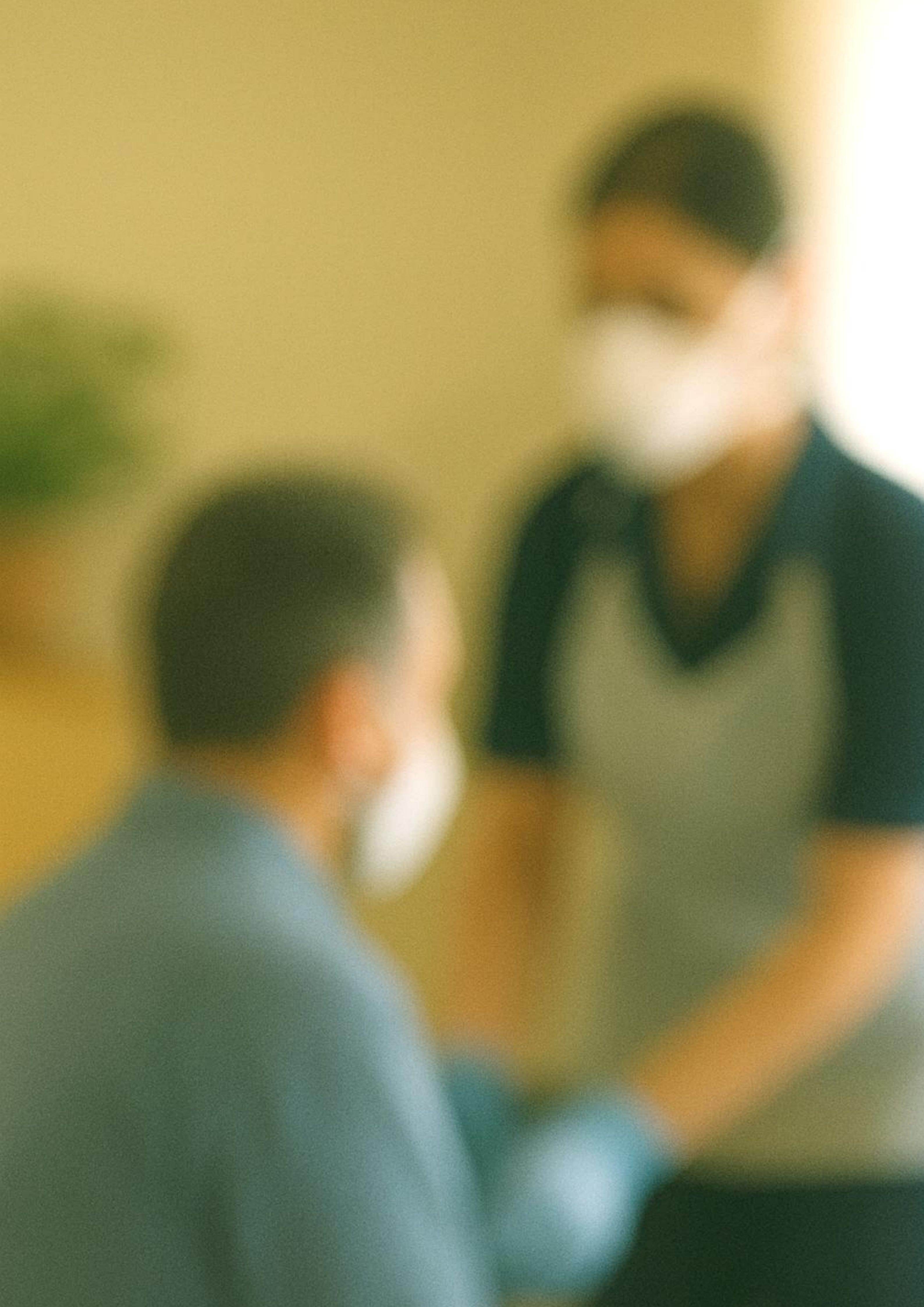
Despite services being "open," many respondents found that they were often functionally inaccessible due to airborne risk. This was particularly true in high-risk clinical settings. From the survey:

> **95.0%** reported that **lack of mask wearing** by staff or patients affected their ability to safely access care.
>
> **91.7%** were also impacted by **poor ventilation or crowded healthcare** settings.
>
> **70.2%** said they experienced a **refusal** to accommodate simple safety requests.
>
> **50.4%** reported being affected by the **withdrawal of remote or online access** options, which had previously enabled safer appointments.

Respondents frequently described choosing between their personal health and safety. The withdrawal of measures such as universal masking and short-term improvements to ventilation in healthcare resulted in cancellations and delays to medical appointments.

Specific barriers included crowded waiting rooms with closed windows, inconsistent masking policies between departments, lack of air filtration, and the withdrawal of telephone/video consultations that had previously enabled continuity of care. Some members reported difficulties in arranging safe waiting areas, or staff and other patients not masking (or not masking effectively).

Polls of CVF members in June 2022 and October 2022 found 86.0% and 91.0% respectively delayed or cancelled medical appointments when community Covid - 19 risk was high. These figures help explain the high rates of unmet need described by Clinically Vulnerable people, with **93.4%** of respondents of this survey saying they had struggled to safely access healthcare, including dentistry, or support services during the timeframe.



3) Social care and caring arrangements

> ***“We were mentally and physically exhausted... social work dragged their heels... The needless trauma this caused us was unforgivable.”***
> ***Anne, 57***

Members reported substantial disruption to in-home care, respite, and other social support, often withdrawn abruptly without replacement or clear communication. This resulted in huge pressures on unpaid carers.

Families sometimes suspended care because workers moved between multiple homes without adequate PPE. Later, services lacked capacity to resume, or funding approvals lagged, leaving households unsupported for prolonged periods.

For households needing paid carers or respite before the pandemic, the stop-start nature of provision created long periods without support. Families described agency staff moving between multiple homes without consistent infection-control and reduced availability of Personal Assistants.

People often found they were reliant on others agreeing to take mitigations on their behalf. Several unpaid family member carers reported deteriorating health from sustained overwork, with knock-on effects on employment and family relationships.

Voices from the Survey

> ***“Not having access to carers made my physical health deteriorate which knocked on to mental health. My mother had just died[...] I wasn't able to access advocacy support.”***
> ***Alice, 63***

> ***“No health visitor care. Not even on the telephone. [...] No respite care, no MacMillan care. No help at all was given ever!”***
> **Aria, 30**

> ***“I have a person assistant I pay privately who tests and masks”***
> ***Mary Jane, 49***

4) Work, keyworkers and finances

> *“Reasonable adjustments [were] denied in my workplace, despite having HR and union involvement. [...] This was somewhere I'd worked for 18 years [...] The feeling of grief was overwhelming. [...] The hostility from my workplace was hugely damaging to my mental health. In leaving my job I had to take a £12k per annum pay cut and my career has never recovered.”*
> *Mandy, 41*

Some accounts describe pressure being treated as “difficult” for masking and missed career opportunities for others. A significant number lost their jobs if they refused to accept working environments which they felt were unsafe.

57.6% felt **unsafe going to work.**

57.6% were asked to return in **unsafe conditions.**

54.5% experienced **direct discrimination** linked to CV status.

18.1% reported **indirect discrimination** due to a CV household member.

36.4% were **denied reasonable adjustments.**

30.3% only received a **personal risk assessment.**

59.0% who received adjustments found them **inadequate.**

24.2% took **unpaid leave or resigned** to protect their health**.**

21.2% were **ineligible** for furlough / support**.**

12.1% could not access **sick pay** when needed**.**

Impacts on the broader workforce

33.3% **missed training or development opportunities** compared to non-CV people.

63.6% **felt their jobs were at greater risk -** through pressure to return to unsafe work, furlough decisions, or risk of redundancy.

Finances and benefits

Members highlighted variability between employers. **Good practice examples included**: remote work, redeployment away from high-exposure settings, provision of air filtration.

Poor practice included: unilateral withdrawal of adjustments, pressure to attend crowded meetings, and performance management when staff raised safety concerns.

25.6% of all CV/CEV households reported receiving benefits or financial support. Where a disabled person lived in the household, this rose to **35.2%.**

Financial strain was reported where households reduced hours or left roles to protect health. The exclusion of legacy-benefit recipients from the temporary Universal Credit uplift was raised repeatedly as a fairness concern.

Households described careful budgeting for mitigation (e.g., respirators, purifiers, taxis in place of public transport). This was alongside higher energy costs associated with ventilation in winter.

Voices from the Survey

> ***"I was a keyworker on a zero-hours contract [...] every day at work felt like living with a ticking timebomb. [...] In the end, I made the difficult decision to leave my job a week before the first lockdown [...] Initially I [was] ineligible for furlough, or any other financial support. [...] We have not recovered financially from that time. [...] All of this happened not because I chose to not work, but because there was no safe option available to someone like me."***
> ***Phil, 43***

5) Society, culture and hospitality

> ***"I was unable to attend my daughter's wedding abroad... I felt very lonely... No hugging or physical contact with my close family was difficult... especially when my first grandchild was born."***
> ***Robin, 67***

For many Clinically Vulnerable people, reopening was not experienced as freedom. The removal of protections such as masking, ventilation, occupancy limits made everyday activities more unsafe.

Hospitality, retail, and tourism were repeatedly identified as especially inaccessible, since eating and drinking required unmasking. The government's *"Eat Out to Help Out"* scheme amplified the divide by promoting indoor dining without safeguards at a time when no vaccines or treatments were widely available. This effectively excluded vulnerable households and reinforcing their feelings of abandonment or incentivising risk-taking behaviour.

Venues rarely provided information about ventilation or crowding, leaving people unable to assess risk. Where adjustments were made - such as outdoor seating, occupancy limits, or improved ventilation and air filtration - participation became more possible. Yet these mitigations were inconsistently applied.

Many expressed frustration that online or hybrid access to cultural events, which had been valuable, was quickly withdrawn once protective measures were lifted. The sudden loss of hybrid access was experienced as another layer of exclusion, removing opportunities for connection that had briefly opened up.

1.7% felt able to safely return to public places during periods of reopening due to mitigations they took. A further 19.0% only partially returned to public spaces, taking extra precautions and avoiding places they deemed unsafe. For many families, what was celebrated publicly as a *"return to normal"* marked a new phase of exclusion.

Voices from the Survey

> ***"We stopped many of the social events we had done… I've only seen my US family once since 2020."***
> ***Rachel, 43***

> ***"Living in such isolation would be considered as a cruel and unusual punishment… we feel completely abandoned by the state."***
> ***Gayle, 60***

6) Faith, worship and rites of passage

> ***"We felt like our faith-based values - caring for the vulnerable - were completely abandoned. It hurt more coming from people we trusted."***
> ***Leah.***

Among respondents who had engaged in religious life, participation was widely affected. **54.6%** said significantly affected, **35.9%** somewhat, and **9.3%** said they were unaffected.

Early online services helped, but later withdrawal of mitigations and online access left many feeling abandoned or excluded from communities and key rituals. Hybrid and outdoor services early in the pandemic were widely valued.

Later, the removal of live streaming and mitigations created difficult choices around funerals, weddings and communal worship. Several respondents described tensions within congregations about masking and ventilation that affected their sense of belonging.

Clear expectations set by faith leaders, together with practical precautions, made a noticeable difference to inclusion. Steps sometimes taken included opening windows and doors, services without singing, providing a masked area, or remote options.

Voices from the Survey

> ***"I hadn't realised until it stopped how much my weekly services meant to me in terms of my mental health. The community and social aspect of going to church is very important to me and when this stopped it was very hard. Unfortunately, two significant events happened during the timeframe that greatly challenged my Christian faith and without the weekly face-to-face support, I felt very isolated. All this has made me turn my back on organised religion and I am no longer a practicing Christian."***
> ***Morgan, 43.***

Voices from the Survey

“We were regular attendees at our village church and our children loved messy church. I felt our church were unsupportive and unchristian! We no longer attend church and I no longer feel part of that community.”
Taylor, 45.

"We used to attend in person every week, but when we returned to some face-to-face worship, we attended once a month, and it remains more or less that. Online attendance is brilliant to have, but not quite the same as attending in person.”
Katty, 38.

"In my culture funerals and wakes are big… I was excluded from being able to safely say goodbye in the way that I wanted."
CVF member (Cypriot/Irish)

7) Housing and living situations

> ***"[We] had to resort to shielding the most vulnerable in a tent out of the house – not ideal for someone who has a serious respiratory condition which is affected by cold, damp, etc."***
> ***Rowena, 45.***

Many respondents explained that housing made shielding impractical. This was especially true in overcrowded homes, some with shared bathrooms/kitchens, or limited ventilation and private outdoor space.

Those living alone or in rural areas described deep isolation when mitigations elsewhere were withdrawn.

Families were asked to follow guidance that assumed access to spare rooms, separate bathrooms, and controllable airflow. Some did not have these options. Respondents described **higher heating costs** when ventilating in cold weather, and a **lack of practical support** (e.g., rehousing, temporary accommodation, or help with adaptations) to make shielding feasible.

Of the respondents who told us their housing was not completely suitable for shielding:

53.1% experienced **overcrowding** (unable to isolate).

59.4% had **shared facilities** (kitchen or bathrooms).

21.8% cited issues with **poor ventilation**.

18.8% were **unable to access outdoor space** (garden or balcony).

9.4% experienced **housing insecurity** or eviction threats.

One family reported **using a tent in the garden** to isolate.

Voices from the Survey

> ***"We had 4 adults and a young baby in a small 3-bed house. 2 adults were keyworkers and 2 adults were CV. We had to use a mattress on the floor when my daughter was instructed to isolate so she be in a room away from the rest of the household, but we still had to share bathroom facilities with her."***
> ***Martha, 60.***

Voices from the Survey

> ***“My daughter did not have her own bedroom, we had no communal space… We needed home adaptations — this has only just been completed 5 years later.”***
> ***Emily, 45.***

> ***“Ideally the shielded partners of keyworkers should’ve been offered temporary accommodation.”***
> ***Louise, 46.***


Living
with
COVID
Guidance
for shielded
patients

8) “Following the guidance”

> *“Public messaging was disastrous. At first it encourages empathy but that quickly changed, with ’Eat Out to Help Out’ and ‘Freedom Day’, to encouraging the public to ignore Covid and to resent vulnerable people who became unpleasant reminders and a burden.”*
> *Samir, 45*

Shielding was one of the very first pieces of formal guidance at the start of the pandemic. People were asked to rapidly make major changes to their daily lives in order to stay safe. For many, the feasibility of following this advice depended on their housing.

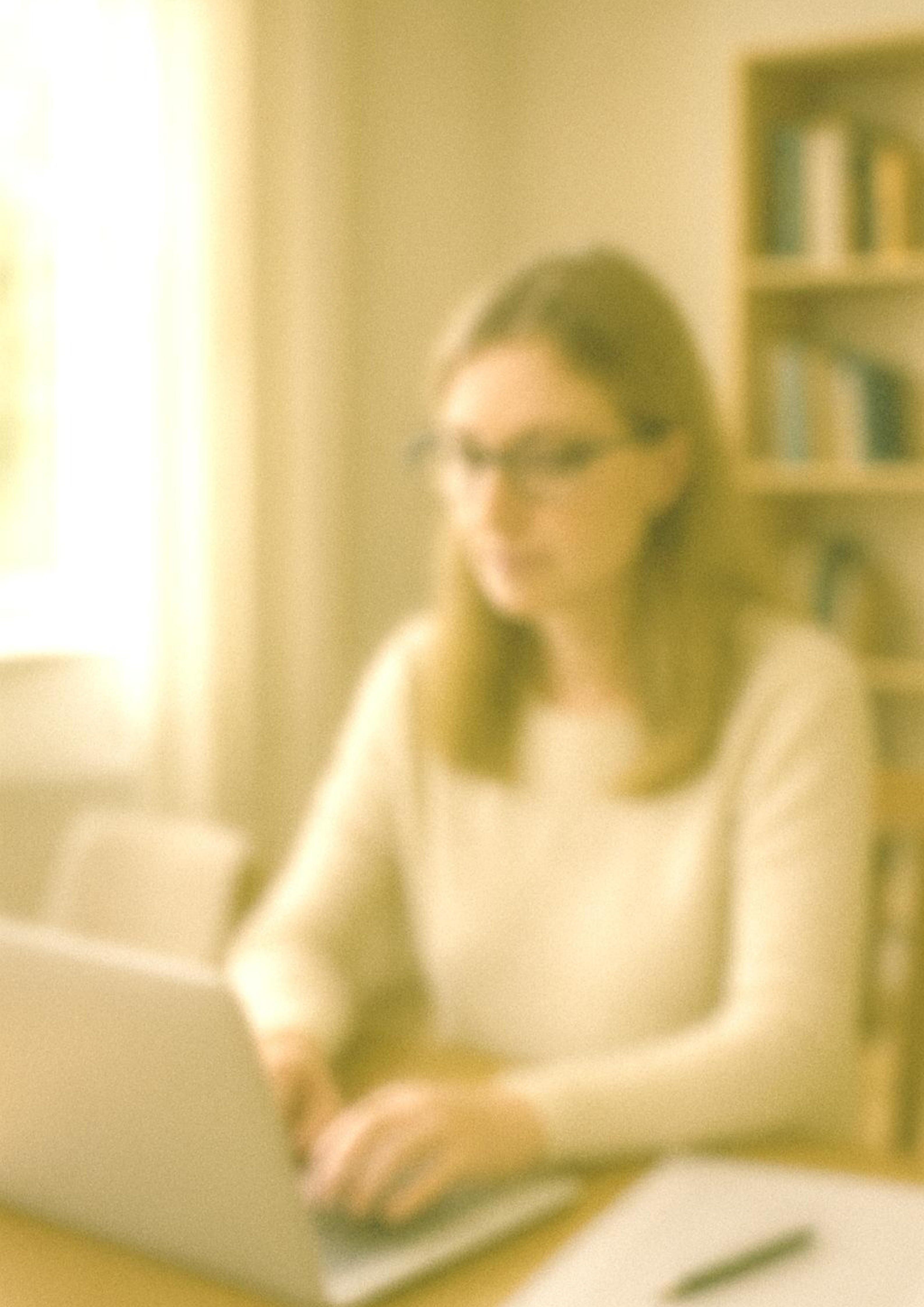
More than 1 in 4 of respondents said their home was not fully suitable for shielding, with around 1 in 10 saying it was entirely unsuitable.

This shows emergency protective isolation measures were impossible for many.

Members consistently reported confusing, delayed, or non-existent guidance tailored to CV needs - especially during transitions: end of shielding, “Freedom Day,” “Living with Covid”.

Communication gaps pushed households to self-advocate and rely on peer networks (e.g. CVF) for practical risk management, heightening stress and social conflict. CVF members frequently faced confusion around shielding letters, changing eligibility, and where to find local guidance on infection rates, vaccines or antivirals meant many had to rely on these networks.

Guidance which should have provided protections, failed the Clinically Vulnerable. The phrase “following the guidance” was often used by authorities to dismiss the concerns of Clinically Vulnerable people about missing safety measures - particularly in healthcare, schools, and workplaces.



9) What helped (as reported by respondents)

Voices from the survey

> ***"Being allowed to work from home did help but once Freedom Day hit so was the expectation I would be office based."***
> ***Michelle, 59***

Responses highlighted several key supports that made life safer or more manageable during the pandemic. These positive adaptations often reduced risks and enabled access to essentials, health, and social connection. Main themes that emerged included:

Priority access to essentials: Many participants benefited from supermarket delivery slots enabling priority food or prescription deliveries.

> ***"Priority delivery of groceries by Waitrose was good."***
> ***Richard, 42***

> ***"Food delivery was vital."***
> ***Helen, 62***

Vaccination and healthcare access: Priority vaccinations and remote healthcare appointments (e.g. telephone consultations) were described as protective and reassuring.

> ***"Priority access to vaccines"***
> ***Yvette, 41***

> ***"Telephone health appointments, many of our unnecessary in person appointments take place via telephone or video call"***
> ***Elizabeth, 47***

Home working and adjustments: The ability to work from home was one of the most frequently mentioned supports, allowing people to remain employed while reducing exposure.

> ***"Being allowed to work from home was a huge positive for me, working kept me sane and in touch with people and I could do it safely. Priority access to vaccines was a huge relief"***
> ***Jacinta, 56***

Community and school support: A smaller but important number cited school support and community networks as helpful.

> ***"Support from children's primary school was really positive."***
> ***Mattie, 45***

However, a number of respondents stressed that support diminished after restrictions eased, or that they did not feel adequately supported at all, reporting *"Nothing positive to say".*

10) Analysis

The 2025 CVF *Impact on Society* survey demonstrates that the risks and exclusions experienced by Clinically Vulnerable (CV) and Clinically Extremely Vulnerable (CEV) households have not ended with the formal close of the pandemic. Instead, what began as acute disruption in 2020 has for many respondents evolved into chronic disadvantage.

This has been compounded by the withdrawal of mitigations and safeguards that once enabled some level of participation in society. This is particularly problematic for those who are not protected, or only partially protected, by vaccines - including people who are immunosuppressed or immunocompromised

From emergency to inequality

Early formal shielding was widely experienced as traumatic, but it did at least formally acknowledge the additional risks faced by CEV people. Respondents described a shift over time: as restrictions lifted for the general population, their own risks remained and often had not changed, but recognition of those risks declined.

What was initially framed as everyone's responsibility to protect the vulnerable had, by mid-2021, been shifted onto individuals as a personal burden. This was particularly problematic given the widespread failure to provide risk assessments or to implement what should have been considered to be 'reasonable adjustments' for high-risk populations in workplaces and public spaces.

The quantitative data reflect this shift. Loneliness rose from **38.4%** at the start of shielding to **54.4%** by mid-2022**,** while depression (which sometimes included suicidal ideation) peaked around *"Freedom Day"* and the *"Living with Covid"* policy. This suggests that the removal of protections - rather than the virus itself, which remained a constant presence, but had different peaks - was the driver of worsening mental health outcomes.

The survey paints a picture of structural neglect: people were not only afraid of infection, but of being abandoned to manage their own risk without institutional support.

Healthcare

An important distinction emerges between whether services were *open* and whether they were *accessible*. While the NHS was always *open* some services including routine care and planned surgery were halted. However, even when services became available, **93.4%** of respondents said they struggled to safely access healthcare.

Mask withdrawal, poor ventilation, and crowded waiting rooms created environments functionally inaccessible to those at higher risk. In effect, healthcare due to its exceptionally high risk profile was not always accessible to the most vulnerable patients.

The result was avoidance of care, based on the balance of risks. CVF's June 2022 member polls showed that in **86.0%** had or would cancel or delay appointments during high transmission periods, and by October 2022 the number had risen to **91.0%.**

The public health concern extended beyond the CV community. Delayed diagnosis and treatment translated into higher downstream demand, and more severe outcomes, on already stretched systems. A key lesson is that: availability does not guarantee accessibility - safety is essential for inclusion.

Employment and economic security

Workplace experiences revealed a similar pattern of insufficient protection for high-risk workers. Only **30.3%** reported being given a risk assessment, and even where adjustments were made, **59.0%** found them inadequate. This indicates that many employers treated the requests for safety from Clinically Vulnerable people as optional or unreasonable.

The economic consequences were profound.1 in 4 households relied on benefits, whilst facing the additional costs of mitigations (masks, air filters, or taxis to avoid public transport). Some respondents left jobs or took pay cuts, resulting in long-term income harms. Health inequality translated directly into financial inequality. Where government protections such as furlough or Universal Credit uplifts excluded certain groups (e.g. legacy benefit claimants), these inequities were further entrenched.

Social and cultural participation

Society's return to "normality" was, for many respondents, a driver of further exclusion. The withdrawal of hybrid or online access to cultural, religious, and social life was described as devastating. What had briefly opened up inclusive participation was abruptly closed again. This created a tension between technological adaptations which existed and worked well, with subsequent government policies and choices made by institutions to remove them.

The result was that what was branded as "*reopening*", for some, instead felt like a reclosing. Only **1.7%** of respondents reported being able to safely return to public spaces with the wider population. National recovery was, for a significant group, experienced as deepening marginalisation.

What helped?

Priority deliveries, remote consultations, home-working, and community support schemes were repeatedly cited as positive. These interventions show that inclusion is possible when risks are acknowledged and mitigations embedded. However, the withdrawal of many of these supports after 2021 show how easily gains can be lost.

Policy inconsistencies and consequences

Perhaps the most striking inconsistency lies in vaccine provision. Respondents face the removal of Covid-19 vaccine eligibility in autumn 2025, despite ongoing recognition that the same groups remain eligible for annual flu vaccines because of similar risks. This divergence undermines trust in public health policy and reinforces the perception that CV lives are undervalued.

The consequences of this decision are not only medical but psychosocial. Respondents expressed heightened anxiety, a sense of abandonment, and fear of preventable hospitalisation or death. The comparison to flu vaccines highlights that policy is a choice - risks are recognised and mitigated for flu, but not for Covid.

Wider implications

The findings suggest that the pandemic created a two-tier society. For the majority, life has returned to the old normal, and difficult memories of the pandemic have faded. Yet for Clinically Vulnerable households, the absence of safeguards has increased exposure risks. By overlooking unequal health risks, important questions arise about equity, and rights.

The abrupt withdrawal of mitigations and support systems, along with the data required to monitor risks from variants has resulted in persistent barriers for those facing the greatest risks. While vaccines and treatments now protect many, access can be difficult and eligibility is limited, leaving gaps in protection. Until airborne risks are reduced - in healthcare, workplaces, public spaces - Clinically Vulnerable people will continue to live with the challenges that come with disproportionate risk to Covid.

Future airborne epidemics and pandemics are likely, so a resilient approach must not rely on individuals negotiating for protection. Safe participation needs to be the default. Clean indoor air and masking in health and care settings should be treated like hand hygiene is - standard practice, year-round. Hybrid access should be available as a reasonable adjustment.

Employers should expect to provide risk-based adjustments for Clinically Vulnerable people. Social care must adapt to accommodate safety needs so families are not simply left to cope alone when pressure rises. Government communication should be practical, timely and consistent across the UK nations.

Implications for policy and practice:

1. Clean indoor air and mask wearing must be standard across health and care settings as routine safety infrastructure, not temporary emergency additions during periods of increased pressure on systems.

2. Allow hybrid access (remote options, flexible work) as a part of standard inclusion practice.

3. Ensure risk assessments and reasonable adjustments for Clinically Vulnerable staff are meaningful, reviewed, and enforceable.

4. Support household-level mitigations (for example, guidance for filtration and ventilation, and public information on the use of FFP2/3 masks to protect individuals).

5. Commission mental health support for Clinically Vulnerable people and families.

Long-term harms and the future

Looking ahead to autumn 2025, many of those who were previously advised to shield as CEV, or who are CV due to underlying health conditions or age-related risks, will also no longer be offered NHS vaccines.

The consequences of this decision are likely to be significant. It will remove the only remaining layer of protection for millions of people in groups who remain at high risk of severe illness, hospitalisation, or death from Covid.

This stands in sharp contrast to decisions made in other countries, and the annual 'flu vaccination programme. This continues to be offered to many of the same groups (and even extends to certain household contacts) on the basis of comparable risks.

This inconsistency leaves millions of Clinically Vulnerable people facing preventable risk. This will no doubt further undermine their trust and confidence in public systems that appear to have prioritised cost-cutting and moving on over meaningful protection for those most at risk.

Appendix A:

Respondent and Household Characteristics

A total of 125 people took part in the survey, with 95% responding to the optional demographic questions.

Household composition

54.5% included a clinically vulnerable (CV) person

46.3% included a severely immunosuppressed (SI) person (eligible for antivirals)

36.4% included a CEV shielded person (not eligible for antivirals)

25.4% included someone aged 65+ (16.9% aged 65–74; 9.3% aged 75+)

29.8% included at least one healthy (non-CV/CEV/SI) person

Geography

Respondents lived across the UK: England – South East (44.6%), Midlands (17.4%), North West (10.7%), South West (7.4%), Scotland (9.1%), Wales (3.3%), Northern Ireland (4.1%), and North East (4.1%).

Gender and identity

95.8% of households included at least one female

79.7% included a male

3.4% included a non-binary person

22.2% of households included at least one person identifying as LGBTQ+

Ethnicity

The majority (97.5%) identified as White: English/Welsh/Scottish/Northern Irish/British. Small numbers identified as White: Irish (2.5%), other White (4.1%), Asian (1.6%), Black (1.6%), Mixed (1.6%), or other minority identities (<1% each).

Disability

77.9% of households included at least one person recognised as living with a disability.

Employment and household situation

In full-time employment: 60.3%

In part-time employment: 37.2%

Receiving benefits or financial support: 26.4%

Retired: 26.4%

Carer for someone else: 23.1%

Children in full-time education: 28.1%

Unemployed: 10.7%

Student: 11.6%

Living in social housing: 3.3%

Smaller numbers reported insecure or disrupted work (e.g. ill health, furlough, or loss of employment).

Method and limitations

This is a self-selecting CVF member survey capturing experiences across the UK; results describe the responding community and illuminate patterns in lived experience. Where relevant, we report historical CVF poll figures for context (clearly labelled in the source material). All figures above are reproduced from the CVF survey and quoted without alteration.

Design and sampling: This was a voluntary survey of adults in CVF's UK community. Respondents who identified as living in CV households during the Inquiry timeframe. The instrument combined fixed-choice items with open-text prompts.

Interpretation: Findings describe the experiences of respondents and should not be read as a population estimate. Nevertheless, the consistency of patterns across themes provides credible insight into barriers and enablers for CV households.

Limitations: Online distribution may under-represent people without internet access. Recall bias is possible for events earlier in the timeframe. The survey was completed by adults; households may include children whose perspectives are represented indirectly.

Ethics and privacy: Responses were anonymised; quoted material uses pseudonyms and minimal context to protect identity. Verification to confirm genuine contributors was undertaken without retaining identifiers.