M3/AUK/01: Module 3 of the UK Covid-19 Public Inquiry ("the Inquiry")
Response to request for Evidence under Rule 9 of the Inquiry Rules 2006

WITNESS STATEMENT OF CAROLINE ABRAHAMS, CHARITY DIRECTOR, AGE UK

Brief description of Age UK, including its role, aims and functions with respect to the four nations of the United Kingdom

1. 'Age UK' is a national charity that works in England and on matters reserved to the UK government. We are part of a federated network of organisations across the UK working together to support older people in need and help everyone make the most of later life. I have consulted widely across the Age UK network to inform this response. I can confirm this statement is based on what I have been told, and true to the best of my knowledge and understanding.

2. The Age UK network as a whole comprises 130 independently registered charities that operate under a brand agreement which provides a framework for cooperation and collective endeavour. This includes 'Age UK' and 120 local Age UKs working across England and our partners in each of the nations including Age Cymru and 5 local Age Cymru partners, Age NI, Age Scotland and Age Scotland Orkney. In addition Age International works to support older people in more than 40 countries worldwide.

3. Across the UK, the charities reach around one million older people each year, seeking to ensure older people have enough money; are socially connected; receive high quality health and care; are comfortable, safe and secure at home; and feel valued and able to participate in society. Together we: research, advocate and campaign; provide information and advice (online, by phone, face to face and printed materials); deliver public information campaigns, direct services and support; and work to drive improvement and innovation in provision across the private and public sector. Collectively we also provide a wide range of health and social care related services, commissioned by the NHS and Local Authorities.

4. This statement offers the perspectives of 'Age UK' on behalf of the wider group and the overarching themes I draw on here are consistent across the nations. However, it is important to note that local jurisdictions experienced different challenges and took

different approaches in relation to their specific health and care systems. Our partners in each of the nations including Age Cymru, Age NI, Age Scotland and Age International are available to provide any nation-specific or international perspectives as required.

5. Age UK has obtained the information and testimony about older people's experiences described in the paragraphs below via a range of different sources, including older people and their families, community networks, professionals working in key public services and our own frontline workforce and volunteers. Specific examples cited in this work have been selected as typical of the type of stories Age UK has heard and that we hope will help illustrate for the Inquiry the issues described.

6. Age UK uses a range of methods and opportunities to gather and analyse the insight and intelligence from older people, their families and supporters. This includes the Age UK information and advice services – where each year we receive around 15,000 written enquiries and 200,000 calls to the national advice line service alone – and The Silver Line, a free confidential support line for older people, that received 270,000 calls between March 2020 and March 2021. We also receive a significant number of direct communications from individuals sharing their experiences and concerns. Given the unique impact of the pandemic on older people, Age UK also established a major qualitative and quantitative research programme to ensure we fully understood the depth and breadth of experiences, including those of minoritised older people and those experiencing social exclusion. Our work has included several waves of depth research and survey work, qualitative data collection and polling. Taken together, we have collected 100s of 1000s of individual insights and stories from older people and the people close to them.

7. In addition, as a federation we provide a wide range of direct services and support bringing us into contact with large numbers of older people in our communities and their own homes; and our organisations work closely with public services, professionals and policy makers at both national and local level and held regular discussions about key issues and challenges. Throughout the pandemic we enhanced our usual processes for sharing information and insight into the real time challenges experienced by older people that emerged through our work and engagement in these networks. Our national professional and policy leads also work within a range of professional networks, and participated in a range of regular meetings and conversations that established in direct response to the challenges of the pandemic where frontline staff came together to share

experiences and information. These included groups of clinicians, healthcare professions and care home managers and care workers.

8. We preface this witness statement with the understanding that in documenting the systemic challenges and deficits in the care of older people over the relevant period (1 March – 28 June 2020), we are also clear that this was not every older person's experience. We have also heard a huge number of positive stories from older people about excellent healthcare experiences, where health and care professionals across all parts of the system worked hard to care for older people with great compassion and sensitivity, whilst under extreme pressure and at significant personal risk. We also know that many organisations and systems innovated at great speed to keep essential support in place – many of these innovations should be built on and the good practice shared for the future. However there were also many instances where individual care or systemic responses fell short, and where it is essential that lessons are learned.

Older people at risk

9. It is important to state at the outset that Covid-19 and the broader response to the pandemic, including that of the NHS, has had a huge impact on older people's health.

10. Age is the single biggest risk factor for experiencing severe illness and dying from Covid-19. There are more than 10 million people aged 65 and older in England, almost 1 in 5 of the population. The Intensive Care National Audit and Research Centre have studied around 10,000 people critically ill in hospital with coronavirus in the UK. After accounting for people's health, sex, ethnicity and other characteristics they found that, compared to someone aged 60, the risk of dying was about doubled for someone aged 70 and almost quadrupled for someone aged 80. Analysis published by the Office of National Statistics shows that on April, at the height of the first wave, one in eight people over 90 died of Covid-19, compared with less than two in 50,000 aged between 20 and 24 [CA/1 - **INQ000221437**

11. The reasons for this are complex; as we age our immune system function decreases and the likelihood of having a health condition increases. We are at higher risk of living with complex care needs, pre-existing long-term conditions, disability or frailty. An estimated 66% of people aged 70 and over have at least one underlying condition, placing them at increased risk of severe impact from Covid-19.

12. This greater underlying risk of living with complex care needs, pre-existing long-term conditions, disability, or frailty also means the older population are far more reliant on routine health and care services. As a consequence older people were always going to be disproportionately impacted by measures that would impact usual running of health and care services. It is also important to note the wider impact of pandemic on older people's health that, as our evidence has previously documented, led to an increase in or worsening of physical and mental health conditions. So at the same time that older people's access to health and care services was being disrupted or withdrawn, many were also experiencing rapid changes in their health and wellbeing.

13. Furthermore, we are aware that the burden of both infection risk and service disruption fell much more heavily on some groups of older people. Just as there is a social gradient in health across the adult population, there is also a social gradient in healthy ageing. The lower a person's socio-economic advantage, the more likely they are to experience age-related disability and poor health at a younger chronological age, live with poorer health throughout their later life and die sooner than people with greater advantage. For instance, there is a long-established evidence base demonstrating that those living in the most disadvantaged circumstances experience multimorbidity 10 to 15 years earlier that those in the most affluent areas [CA/2 - INQ000217387].

14. As described by national health and care think tank The King's Fund, health inequalities between different groups of people are often analysed across four main categories: socio-economic factors (for example, income level and type of employment); geography (for example, region); specific characteristics (for example, age, ethnicity, sex or sexuality) and socially excluded groups (for example, people who are asylum seekers or experiencing homelessness) [CA/3 - INQ000217398]. As ageing is a universal experience its interaction with other risk factors and characteristics is often overlooked. However, for many older people risks associated with age must be seen in the context of other circumstances and characteristics that accumulate or amplify risk.

15. It has been widely reported that ethnic minority communities have been among those most at risk of being exposed to and dying from Covid-19. Already overrepresented in the numbers living with long-term, multiple or complex health condition at the outset of the pandemic, older people from ethnic minorities may also be more likely to catch Covid-19 for a range of reasons, including the financial need to work in high-risk frontline roles as described below or likelihood of living in multi-generational housing. In November 2020 Age UK submitted a consultation response to the Commission on Race

and Ethnic Disparities on this topic [CA/4 - INQ000217401]. The response explored the disproportionate impact of Covid-19 on older people from ethnic minority communities – including the fact that, at the time of submission, death rates from Covid-19 were higher amongst all ethnic minority groups (except the Chinese community) and highest amongst black Caribbean men aged 65+ where the death rate was 2.3 times higher than amongst older white men. The submission also highlighted how long-term experiences of discrimination had served to shaped increased underlying risk factors and the challenges associated with the lack of data and research on the experiences of health disparities experienced by older people from ethnic minorities specifically.

16. Some groups of older people have always had worse access or been less likely to be offered appropriate services than other people, and this stark fact was also reflected and amplified during the pandemic, as health and care services were reduced and adapted. Factors that have long disadvantaged some groups in accessing suitable services also overlapped with factors that increased their risk of catching coronavirus.

17. Older people in the least advantaged circumstances faced a higher exposure risk and increased barriers to accessing services because of a combination of factors including, 1) their living and working conditions (for example, increased likelihood of working in low-paid, insecure and frontline work and being under financial pressure to continue working), 2) their housing circumstances (for example, living in multiple occupancy and/or multigenerational housing), 3) higher access barriers to information and advice (for example, many were without access to the internet or for whom English is a second language), and 4) experiences of social isolation, loneliness and exclusion.

18. Added to these risk factors, older carers routinely provide some of the most intensive and personal levels of unpaid care for a loved one, most likely a spouse, and take on the responsibility for accessing day to day provisions of food and other essentials, again raising their risk of exposure to Covid-19. Our evidence is clear that during the pandemic the least advantaged older people have therefore been hit with a “triple whammy” where age, underlying health status and life circumstances further increased the impact of the pandemic on their health.

19. As well as ethnic minorities, inclusion health groups had a very difficult time (for example when many think of older people, they do not typically consider issues such as homelessness, poverty, domestic violence, substance misuse or severe mental illness, but significant numbers are experiencing these challenges), and during the pandemic

many found it much harder to access the support they needed. We have also heard extensive testimony from older people experiencing neglect, self-harm, suicidal ideation, malnutrition and substance misuse at home. Yet many services did not initially understand or take account of the particular challenges of keeping socially vulnerable and marginalised older people safe and well.

20. More generally, strategies for helping socially excluded people did not understand or engage with the intersections with age. For example we know that isolation and loneliness is an issue for older lesbian, gay, bisexual and trans (LGBT+) people and the pandemic has disproportionately increased psychological distress and other vulnerabilities among this group, as evidenced by Opening Doors London's report exploring the experiences and feelings of its members during this turbulent period. ODL provides information and support services specifically for Lesbian, Gay, Bisexual and Trans (LGBT+) people over 50 in the UK [CA/5 - INQ000217402]. Further, some older members of the LGBT+ community reported the onset of the pandemic bringing back memories of the AIDS crisis and associated legacy trauma, impacting the ways they were able to engage with health services as evidenced when the LGBT Foundation published findings from the largest and most substantive research into the impact of the Covid-19 pandemic on LGBT communities in the United Kingdom to date [CA/6 - INQ000217403]. These challenges were compounded by the fact that many face-to-face support services were closed down, leaving people without emotional support. Older lesbian and gay people are also less likely to have children than their heterosexual counterparts, and cannot as readily rely on traditional support systems, placing them at heightened exposure risk during the pandemic.

21. The Age UK report 'Impact of Covid-19 on older people's mental and physical health: one year on' [CA/7 - INQ000176634] shines a clear light on how the pandemic has impacted older people differentially, according to the degree of inequality they are experiencing. As these examples show, some older people had less of a safety net around them to protect against the risks, direct and indirect, posed by both the virus and the impact of the pandemic on usual operation of the NHS.

The NHS response

22. The NHS needed to operate with an understanding of this context and therefore the health and care needs likely to arise in various communities of older people at times of emergency. Unfortunately, as we have set out in previous evidence to this Inquiry, the

Government's overall response to the pandemic was characterised by their failure to anticipate, plan for or respond to the additional risks faced by older people in an emergency, particularly underserved groups and those with the greatest unmet needs. This included a number of instances where decisions regarding policy, information, guidance and resources – or lack thereof – shaped or limited the capacity of the health and care system to respond adequately to older people's needs.

23. There are also examples that I set out in this evidence where, sometimes despite and sometimes in the absence of guidance or instruction, parts of the system failed to give adequate consideration to the needs of older people, or deliver the standards of care they deserved. As a factor this must be seen in the broader context of embedded age discrimination throughout our society, where older people are too often viewed as of less value. Indeed this was a clear theme of much of the discourse throughout the pandemic where cost-benefit of measures and resources aimed at safeguarding the lives of older people was openly queried and discussed.

24. Sadly Age UK is aware that while some aspects of poor or inadequate treatment can be attributed to a lack of understanding or awareness, in other instances the very fact that groups of older people were seen to be highly vulnerable or at risk led their needs being deliberately deprioritised at times by decision makers or individual services or professionals.

Older people's access to primary and community healthcare

The unequal impact of digitization

25. For many older people, the pandemic introduced higher barriers to accessing primary and community health services. For example, the rapid digitization of primary care services at the start of the pandemic meant that many older people found that their GP practice had become inaccessible overnight. Care in the community isn't only about GPs, but many older people rely first and foremost on the services provided out of GP practices, by doctors and practice nurses especially. Difficulties accessing these caused (and continue to cause) huge concern.

26. People struggled to understand how to reach their GP if not in person, not helped by the fact that most signposting information and advice was available online, overlooking the fact that large numbers of older people are not digitally enabled. Many services were

also premised on people having access to a smartphone and internet connection when this is simply not true for a significant number of older people. Whilst internet use amongst older age groups has increased substantially over the past decade, many are still non-users. An Age UK briefing shows that at the start of 2020, nearly half (47%) of people aged 65 & over in Great Britain did not use a smartphone for private use [CA/8 - INQ000217404] and 3.4 million people aged 65+ in the UK were not recent internet users (most of whom had never used the internet). This breaks down as 14% of people aged 65-74 and 46% of those aged 75 who didn't have access to the internet **CA/8** **INQ000217404**. If you couldn't access the information telling you when it was possible to phone up, or indeed find the correct number to call, there was no way for many of those older people who did not have access to the internet or use a smartphone to get in contact with their GP: the doors to the surgery had literally shut.

27. For those who did have the ability to access online GP services, many struggled to navigate the online booking system and triage processes (e.g., requests made for photos when many didn't own or didn't know how to use a digital camera). Telephone appointments were also a challenge to book, as increased demand meant many people were unable to get through. Many older people live with additional needs, (e.g., hearing impairment or cognitive dysfunction), making effective communication by telephone appointment or video consultation challenging. Particularly disadvantaged by the digital mode shift were underserved groups of older people, including people living with disabilities, people living with cognitive impairment and those for whom English is not their first language.

28. Without adequate translation resources, many older people who did not use English as a first language were reliant on family or friends to translate on their behalf. Problems with this approach ranged from mistranslation, to patients being unwilling to disclose important but sensitive health information in the presence of a family member. For example, one man told us about his struggles to access care for his 80-year-old Somalian mother after her mental health seriously declined leaving her agitated. He was expected to translate personal questions about his mother's mental health during a telephone consultation, something he said he 'could not face', leaving her without access to care.

29. There was also an increase in expectation for patients to do basic checks such as blood pressure and pulse readings in virtual appointments, along with other checks for specific conditions (e.g. lung capacity). Many older people felt uncertain about the accuracy of

their self-testing. Even amongst those who don't have accessibility challenges, and who are digitally enabled, many people are simply not comfortable with remote support when it comes to their health, uncomfortable sharing personal information digitally, or feel it fails to deliver the same benefits. In another case, the family of an 85-year-old man with a serious knee injury told us he had tried calling his GP but was directed to the online system. While his family were able to organise an appointment, the subsequent physio sessions were also conducted over the phone with family trying to act as an intermediary. The family reported this left their father feeling 'completely isolated' from professionals who were meant to be helping.

Suspension of routine care for older people with long-term health conditions

30. There was also widespread suspension or diversion of routine medical care that many people, and particularly older people, need to sustain their health and wellbeing. Numbers of outpatient visits, GP appointments and medication reviews were all lower than would usually have been the case to manage multiple or complex conditions. Many health and care services stopped altogether, particularly those that operated face-to-face. In some instances, community health staff stopped visiting and important services were withdrawn or greatly reduced. Services highlighted as particularly difficult to access included blood tests, rehabilitation and physiotherapy, speech and language therapy, mental health services, drug and alcohol services, rheumatology and orthopaedics.

31. Alongside this, appointments and many planned procedures were cancelled or postponed far into the future. Waiting lists for treatment rose rapidly and, for many older people, that meant living with symptoms including chronic pain that are impossible to ignore and had a devastating impact on their quality of life, psychological wellbeing, ability to move, work or keep active. For example, our research showed how increased pain impacted on some older people's appetite and diet. As part of that study, we heard from friends and family of older people who were concerned that their loved ones had stopped eating or drinking and were losing weight [CA/10- INQ000176650]. The same survey results showed that 43% of people with a long-term health condition are unable to walk as far as before, compared to 13% of people without a long-term health condition. These problems were exacerbated by difficulties in communicating with specialist teams and feeling that there was no one to turn to for support. One respondent explained; "*Although I have a husband and family I am so alone. I sit and cry for no reason. My mood is so low as I feel so isolated. I am now taking pills for pain & low mood.*"

32. As previously stated, older people are much more likely to rely on access to both routine and urgent health services, as well as formally or informally provided care and support to prevent physical deconditioning and loss of cognition, both major risks to the older population. Once an older person has lost muscle mass, cardiovascular fitness or strength and balance, it is very difficult to recover. Unfortunately, as a consequence of these service interruptions, a significant number of older people have seen a decline in their health and wellbeing alongside a rise in anxiety and depression, muscle deconditioning, malnutrition, memory loss and increased frailty. This had the negative impact of lowering general resilience so that older people were left in worse shape to recover from Covid-19 or other adverse health events. At population level, the task of managing overall demand on the health and care system was made more difficult.

33. Lagging rates of referrals, and lower volumes of diagnostic and screening tests and medication reviews increased the risk of patients presenting later with more advanced illness and may explain some of the picture as it relates to excess and avoidable deaths. A patient cited in Age UK's recent 'Fixing the Foundations' report [CA/11-INQ000217378] comes to mind. Marie started to experience severe back pain at the beginning of the pandemic. She tried to access support from her regular GP who she felt knew her family well but struggled to navigate the new triage system. She eventually saw a doctor who examined her in her garden and diagnosed a chest infection, but the pain intensified and an ambulance was called. In hospital an X-ray showed her spine was fractured in four places. There was no in-person follow up once she returned home. She explained: *"The doctor phoned me up once a month to check me because of this morphine. I didn't see anybody. So, got through best way I could*." [CA/11 - INQ000217378]. This is just one of many such experiences older people have shared with us.

Impact on older people's mental health

34. Alongside physical healthcare, the risk to older people's mental health was not sufficiently recognised. Prior to the pandemic, Age UK'S 2018 research report "All the Lonely People: Loneliness in later life" demonstrates that one in four older people were already living with a mental health condition, while 1.4 million were chronically lonely [CA/12 - INQ000217380]. Covid-19 and the health and care system's response to the pandemic has exacerbated this situation. Many older people have seen their mental health plummet. We heard from older people who had lost pleasure in their lives and were experiencing low mood, anxiety and depression. Rates of depression among over

70s have doubled since the start of the pandemic, and in Age UK polling 36% of older people told us they had lost motivation to do the things which they used to enjoy. Sadly, a minority of older people also told us that they were unable to cope with the situation and were considering suicide, and we saw an increase in behaviours symptomatic of self-harm, eating disorders and self-neglect (which often manifest differently compared to commonly understood symptoms which are more typical of younger age groups).

35. The Office for National Statistics' own analysis shows that severe anxiety was found to be twice as common among those who had been shielding than those who had not [CA/13- INQ000217381], with older people telling us that continuous messages of increased vulnerability meant they were living in constant fear of contracting Covid-19. Unfortunately, the studies that Government have relied on to understand the impact of pandemic on the mental health of the population have significant design flaws with regards to older people, who were either under-represented or excluded. This has led to their needs being overlooked and has fuelled a myth that older people have been less seriously affected than other age groups, which is untrue.

36. Other patients managing long-term conditions had no access to specialist support and no idea when it could be reinstated, although a few were redirected to other clinics. Poor communication included an inability to reach existing consultants, being handed across to new healthcare professionals with no knowledge of past history and minimal information supplied about cancelled / moved appointments. All of this had an impact on older people's mental health. We have had consistent reports of older people not washing, taking care of their appearance, eating, taking medication or managing health conditions, going outside, or cleaning their house. For many of these older people their families and loved ones felt this was completely out of character.

37. Age UK has previously documented examples of older people having less access to (or been less likely to be offered) services than others, and this too was reflected and heightened during the pandemic. For example, NHS Talking Therapies (previously IAPT) has never achieved its access objectives for older people, and sadly the evidence is that access declined significantly during the pandemic, and has not recovered.

Impact on older people living with dementia

38. Another group of older people profoundly impacted by the changes to healthcare services and systems were those living with dementia as evidenced in a survey

conducted by Age UK on the topic of the impact of Covid-19 on older people's mental and physical health. Carers, families, and friends of people living with dementia have told us that they have seen rapid deterioration in their loved one's cognitive function, which has affected memory, sleep, mood, and behaviour [CA/10 - INQ000176650]. In hospital settings, dementia patients were often alone with no visitors and no understanding of where there were, or where their family were. Service disruption has also led to delays in dementia diagnosis, with unmanaged cognitive decline having an enormous psychological impact on both the person with dementia as well as their family and carers.

Older people and access to medications in the community

39. For some older people, pharmacies have played a more prominent, and positive, role in their healthcare during the pandemic. Many patients and members of the public utilised the electronic prescription service for the first time during the lockdown. Some patients also report having repeat prescriptions arranged due to mobility decreasing or shielding. However, for many older people barriers to access increased.

40. Navigating the daily realities of NPI (including lockdowns and sustained periods of social distancing) was often much harder for older people living with mobility challenges, frailty and disability. Tasks that were inconvenient for the general population (for example, supermarket shopping according to one-way systems, mask-wearing, waiting in long queues) were totally impossible for some older people to manage, particularly if they experienced additional physical or cognitive challenges, such as sensory impairment, physical disability, incontinence or dementia. As a result, and when combined with the fact that many older people had been advised to stay largely or exclusively indoors, access to essential goods and services quickly emerged as one of the most pressing issues for older people in March 2020. This included access to pharmacy and medications with access to prescriptions and over the counter items becoming more difficult for some older people. Digital and physical barriers to access, supply issues, and delays with getting scripts renewed were all cited as common concerns.

41. Risks around medicines management also increased during this time. For instance, the Department of Health and Social Care's own analysis shows that the more health conditions someone has, the more medications they are likely to take. However, taking multiple medications – known as polypharmacy – increases the risk of a range of problems including adverse side effects, drug interactions and mismanagement. This occurs more frequently as we age with a third of all people over 80 on eight medicines or

more [CA/14 - INQ000217383]. Many older people had to forgo medicines reviews. Alongside this, mental health medications were a particular concern, with a notable rise in prescribing for antidepressants, antipsychotics, hypnotics and sedatives, and corresponding concerns that GPs were overprescribing because it was the only therapeutic intervention available to them at the time.

42. The DHSC National Overprescribing Review published its report in September 2021 outlining the extent of the problem, suggesting that at least 10% of prescribed items need not have been issued [CA/14 - INQ000217383]. Prescriptions for people over 60 represent the majority of all prescribed items. The report further included warnings about remote practices brought in during the pandemic and subsequently embedded, saying that these will need to be monitored into the future to ensure they are safe and effective.

43. Across all groups there is a recognition that Covid-19 has exacerbated already existing problems with the length of NHS waiting lists for elective care. Our research with Thinks Insight (previously Britain Thinks) [CA/16 - INQ000217385] showed that people felt that they had to be very proactive, and even pushy, to get the care they needed. This was highlighted as a significant concern, particularly among those who care for elderly parents with health needs, as many felt that some older people would be less able to navigate the system, follow up on referrals and advocate strongly for the care that they needed. Again, health and care systems did not seem to account for older people when undertaking impact assessments about the most equitable way to manage constraints on services and reductions in planned care.

The impact of limited social care services on healthcare systems

44. We recognise that the Module 3 guidance states that a later module will examine the impact on care service recipients and the care sector. However, it is right to acknowledge social care services in this witness statement, as to a great extent caring for the health of many older people makes health and social care services indivisible in practice. At some point in their lives, most often towards the end, many older people can come to rely on hands-on care to meet their daily needs. This includes activities that are an essential part of managing health conditions such as taking medication, maintaining mobility and skin health, managing incontinence, and maintaining adequate nutrition and hydration. More typically, it falls to informal carers, including spouses and partners, to help, but some will receive support from care workers. Therefore, it must be understood that healthcare systems are complex and adaptive structures and include healthcare interactions outside

of the hospital or GP setting. The availability and quality of residential care home and home-based or domiciliary care, has a direct impact on the NHS, with interdependencies in operation across every aspect of the system. Therefore, in the case of older people as well as other vulnerable groups, social care is a critical component of healthcare provision without which many older people are simply unable to manage their health and independence.

45. As early as 10 March 2020, I publicly warned that *"the Government has to step up to advise on how the sector can plan a more coordinated and resilient response. The absence of this type of strategic planning is bound to fuel suspicions that social care is being treated as less of a priority than is necessary and appropriate"* [CA/17-INQ000108529]. The unsafe discharge of older people into care homes without testing for Covid-19 was perhaps the plainest example of failure to imagine and deliver effective care for the health of older people beyond the hospital corridor. In future, discharge to vulnerable settings should only happen where measures are in place to ensure the safety of the patient leaving hospital and the safety of people at the discharge address. The pandemic has had a significant impact on social care, but the challenges stretch back years. As detailed below, this had a profound impact on the healthcare systems' ability to deliver care outside of the hospital setting.

Healthcare services for older people living in care homes

Lack of essential clinical care

46. We were aware of places where there were no visits to care homes being made by the GP or any other clinically qualified person. This was very difficult in care homes where there were nursing staff, but even more problematic in residential care where there were no qualified nurses and NHS community teams were relied upon to provide all clinical care. In some cases, residential care home staff were left to perform clinical tasks and provide clinical care that they weren't trained or skilled to undertake, including with respect to strokes, fractures, falls, cuts and wounds. Age UK heard of residential care homes who were not able to administer controlled drugs because there were no suitable registered staff and it took time for these rules to change. The consequence of this was that many older people were left without access to adequate clinical care and in great pain and discomfort.

Impact on palliative care

47. We also heard reports that older people in care homes were left to die of Covid-19 and other illnesses without sufficient clinical support or sometimes access to palliative care teams or palliative care medicines. Age UK heard reports of care staff being told that their job was to provide end of life care for residents who were sadly dying from the virus, without enough back up support from GP and community based palliative care services, and without the possibility of these older people being admitted to hospital. Such prescribing and treatment expectations were beyond residential care staff training and experience. Residential care services were not able to give anticipatory medicines (as these are controlled drugs) and in some places supplies of end-of-life medication ran out. Age UK worked with others across the care sector to raise these concerns and drive changes in policy to allow better access to palliative care medicines; however we know change came too late for many older people. These are serious breaches of accepted practice.

48. It was not until later in 2020 that visiting guidance in care homes and hospitals was adapted to ensure in-person visits for people at the end of life, leaving thousands of people dying without the support of their loved ones. People have suffered as a result of not being able to say goodbye to their loved ones, or attend their funeral accompanied by friends and family. As a consequence, many older people, their families and loved ones, have experienced complex traumatic bereavement (even in cases where deaths were anticipated) as a result of not being with them in the last months of their lives, or due to the manner in which they died. What amounted to an effective ban on the usual rituals around dying and bereavement has left an unprecedented legacy of grief, trauma and loss for many older people.

Healthcare services for older people living at home (domiciliary care and assisted living)

49. Alongside concerns about the availability of clinical care in residential and care home settings were concerns about care in the community and for those living in their own homes. Since the start of the Covid-19 pandemic, a third more people have died at home in England, raising significant questions about whether people were able to access the care they needed at home and the quality of that care [CA18 - INQ000217388]. With palliative care challenges similar to those described in care home settings above, these older people were not afforded the dignified, comfortable, pain-free death that they should have been. And again, because of shielding restrictions, many people died

without the company of their loved ones. The combined impact of disruption to end-of-life care services and more people dying at home has raised significant questions about the level of service provision and the quality of end-of-life care since the start of the pandemic. How well the healthcare system is able to provide high quality, compassionate care for the dying, alongside their loved ones and carers, is a true test of whether the core values of that healthcare system are operative in practice. Very sadly, healthcare systems failed that test many times over the course of the pandemic across all settings.

Lack of essential Personal Protective Equipment

50. A generalised lack of preparedness was evident across healthcare system supply chains. For example, it did not seem that effective mechanisms were in place for ensuring there were adequate essential food, medical and other supplies, with widespread shortages of Personal Protective Equipment being a clear example of this issue. Hands on personal care unavoidably exposes vulnerable older people to the risk of infection. The consequence of this lack of PPE was to put many older people's lives at risk, along with those frontline workers across health, social care and voluntary sector services who were caring for them. These challenges extended to, and were often even worse in care settings, with reports of care workers across residential homes and domiciliary care having to source their own PPE supplies - generally at vastly inflated prices.

Lack of care staff

51. There was a similar lack of business continuity planning across both health and social care, as Government plans did not seem to anticipate the impact of Covid-19 staff sickness on essential non-Covid related core health services, social care or the provision of other forms of support, including through the voluntary sector. There was a failure to consider how these services would be delivered with significant numbers of healthcare personnel being unavailable for work. Alongside health and care workers, there were other groups of people who were providing support to older people and those living with health conditions or disabilities, and we need to recognise the impact on them as well. For example, many people working in the voluntary, community and social enterprise sector, including local Age UKs, provide a lot of frontline and health-related support services and are relied upon by huge numbers of older people to stay well. These services were greatly impacted by many of the same challenges as those that hit statutory services, such as access to PPE, managing the staffing gaps and the risk of

infection. For some Age UK services this lack of PPE impacted formal, CQC registered, care services, as well as our wider health-related support services, which had even less access to protection.

Impact on access to urgent and emergency care

52. We have also heard extensively from older people both in care homes and community settings who were either unable or unwilling to access urgent or emergency care for acute health conditions when they needed it. In some cases, this was because they were discouraged or prevented from accessing services, amounting to direct discrimination against older persons. Age UK was particularly concerned by non-conveyance practices. At worst these meant a lack of access to urgent services in hospital for people with significant needs living in the community or in care homes, simply on the basis of their age or where they lived. In some places these policies or informal practices amounted to effective bans on older people being admitted to hospital, whether they had Covid-19 or not. Some care home residents were denied admission for any reason (including fractures, strokes and injuries) as a result. In one example, we were told by a senior clinician overseeing a community hub through the pandemic that any older resident with respiratory symptoms was assumed to have contracted covid and would not be considered for further care. He described intervening personally on behalf of a resident he in fact judged to have a case of treatable pneumonia.

53. We are also aware of cases where older people and their families were directly discouraged from accessing healthcare services by clinicians or healthcare providers, or simply told that in the event of a health event they would not be given access to services. In one such example, we heard from a woman caring for her husband with COPD, cognitive impairment and epilepsy who told us she had been contacted 'out of the blue' by his GP in late March 2020 and told 'bluntly' that if he became ill he wouldn't be taken into hospital or receive any treatment. She was told that a DNACPR notice had been placed on his file. As you would expect, she described this experience as having 'frightened and upset her a great deal' and felt it left her not knowing what to do if her husband experienced breathing difficulties.

Impact on access to intensive and critical care in hospitals

54. In hospital settings, the Department of Health and Social Care came perilously close to adopting an effective national blanket policy on admissions to critical and intensive care

units which would have denied access to intensive and critical care to the older population at large, on the basis of their age. In March 2020 the Department's Moral and Ethical Advisory Group was tasked with drawing up national guidance to support decision making for access to critical and intensive care. The proposed criteria they were developing, and the iterations that we saw, gave huge weighting to a person's chronological age [CA/19 **INQ000117795** [CA/20 - **INQ000188825** [CA/20a - INQ000283943].

55. Throughout this time, we were aware that parts of the country were close to breaching bed capacity in the acute sector, with clinicians preparing to make deeply difficult decisions about resource allocation. It is our understanding based on many conversations and feedback that whilst the guidance and resource allocation tool associated with it were not formally endorsed or published by the Department, this and similar tools were used in some acute settings.

56. Age UK made clear to the Group our outrage about age ever being used as a proxy for health status and prospects of survival. We were fully aware of the evidence that the risk of severe infection and fatality rises with age, but we contended that in a system with significant pre-existing evidence of age discrimination there were huge and unacceptable risks that it would be misused to deny acute care to older people, whether this was warranted or not. We set out four major concerns.

57. First that the data and evidence were still emerging. We were concerned that the interactions between pre-existing health conditions, frailty and age were not yet fully understood in the context of Covid-19. Experiences of biological ageing are hugely diverse and only have a loose association with chronological ageing. The physical condition of any one individual at a particular age will be informed by a range of factors and will be largely shaped by their environment and circumstances across the life course – this is the foundation of health inequalities and disparities in healthy life expectancy and life expectancy. Therefore chronological age alone is typically a poor proxy for health status. While we fully appreciated that the pandemic scenario meant decisions may need to be made with imperfect or limited access to evidence, recommending an effective 'blanket' policy establishing ceilings of care on the basis of age could amount to a serious breach of older people's human rights, and was not a step to be taken lightly or without compelling evidence and in careful consultation with impacted stakeholders.

58. Second, the policy also implicitly relied on correct assessment of an individual's frailty status and identification of relevant health conditions. In reality accurate information about a person's health prior to an acute episode of ill health is often unavailable to clinicians. Frailty scores and assessments are not yet routinely undertaken or recorded for example, and a third of dementia cases are estimated to be undiagnosed. As a consequence, clinical decisions can end up being informed by a combination of assumptions based on a person's chronological age, factors such as use of mobility or sensory aids and their presenting condition. Yet a time of acute illness is, of course, not a good reflection of someone's usual physical and cognitive function and other health conditions, such as dementia, may be assumed.

59. Third we were concerned about the capacity and capability of the health service to implement a policy fairly and consistently, even one based on the best available evidence. The impact of ageist assumptions and poor understanding of older people's – and indeed disabled people's – health resulting in their being denied access to treatments and care from which they could benefit was well documented pre-pandemic. The evidence we saw during the pandemic, set out elsewhere in this statement, made clear that this continued to be the case with regard to both access to treatment for Covid-19 and other health problems that emerged over this period, with countless examples of people being left without access to adequate care. Given historic attitudes and challenges it seemed inevitable that, so far as older people were concerned, age would become the solo default determining criteria. We felt the risk of this was particularly high at a time when clinicians were under tremendous pressure and often being drafted to work in areas of healthcare outside of their usual experience or speciality, and doing so without access to adequate support from experienced clinicians in care of older patients.

60. Last we were acutely aware of the panic such an approach would instil in older people and their families, were its existence to become publicly known. Despite the intention to develop an internal tool to guide clinical decision-making, it was inevitable in our view that it would receive widespread media attention and become the subject of public debate. Older people were already acutely aware of open discourse surrounding the 'value' of their lives throughout this period of time, which was already serving to undermine their trust in vital institutions of Government and the NHS.

61. In May 2020 Age UK submitted a response to the Joint Committee on Human Rights COVID-19: human rights implications for older people setting out apparent failures to

meet the government's public sector equality duty under the Equality Act and Breaches under the European Convention on Human Rights [CA/21 - INQ000217389].

Imposition of Do Not Attempt Cardiopulmonary Resuscitation notices

62. There was other evidence of 'blanket' policies being applied to older people (orders imposed without considering a person's individual circumstances or wishes, meaning that those 65+ would likely have been denied access to care). Unfortunately, in some cases individuals told us they felt under pressure to agree to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notices and/or to decline the option of being admitted to hospital in an emergency. Age alone should never justify the application of a DNACPR or be used as a proxy for health status. In some cases, relatives were sent letters to sign on a relative's behalf, with no assessment of an individual's capacity to make their own decisions. We also heard accounts of people receiving phone calls in their own homes from unknown callers to persuade them to compete DNACPR instructions and care home managers under pressure to sign wholesale DNACPR instructions on behalf of all residents within a home.

63. Following pressure from Age UK and others Government and NHS England took steps to make clear that such approaches are unacceptable. However, Age UK is aware that even when these policies were supposedly withdrawn, there was evidence that such practices continued. A series of joint statements was issued from Age UK between March and November 2020 on emerging and concerning issues related to the pandemic. These statements related to the rights of older people in the UK to treatment during this pandemic (March, 2020), older people being pressurised into signing do not attempt CPR forms (April, 2020) and protecting older people's rights in the next phase of the pandemic (November, 2020) [CA/22 - INQ000217390].

Impact on older frontline workers in the health and care system

64. Age UK observed an assumption that older people didn't go out to work – when in fact there were around 1.3 million people aged over 65 in the labour market heading into the pandemic. With regards to healthcare services specifically, large number of older people were working in public administration, hospital cleaning services and frontline delivery roles. Similarly, those returning to health & care work (including retirees) at the height of the pandemic skewed towards the older end of the workforce and it is not clear whether these risk factors (age in combination with other protected characteristics) were taken

into consideration in terms of decisions for deployment and the necessary processes to protect vulnerable older staff at greater risk of infection.

Communications failures and older people's avoidance of healthcare services

65. Older people also reported delaying or avoiding seeking healthcare treatment for fear of overburdening the NHS and/or vulnerability to contracting Covid-19 if taken into hospital. The consequence of this was that many older people were wary and gave up and completely disengaged from services, left to manage without access to repeat prescriptions or routine support services designed to manage their conditions. This fear of becoming a burden was one reason why the central drive to direct more people towards 111 services to relieve pressure on emergency 999 services didn't work well in practice. Alongside reports that staff were not sufficiently trained, there was a lack of understanding about how this message would be received by older audiences, many of whom felt that if they couldn't go to their GP, they shouldn't go anywhere. Fearful of infection or of breaking the law, many older people put their health and welfare at risk by foregoing help and support they urgently needed.

66. As well as fewer patients being treated, 2020 saw six million fewer people referred into consultant-led elective care than in 2019. As above, we know some people delayed seeking emergency medical attention due to Covid-19, including 30% of those who had a stroke during the pandemic [CA/23 - INQ000217391]. In England and Wales, the number of stroke admissions fell by around 13% in April 2020, with fewer people experiencing milder stroke presenting at hospital. Stroke deaths in private homes were 52% higher than usual during the Covid-19 surge. Missed diagnosis or delayed treatment mean that not only are there more people living with ill health for longer, their conditions and symptoms are likely to be more severe when they do obtain treatment and risk poor long-term outcomes. These 'missing patients' remain the biggest unknown in planning to address the backlog of unmet need created by the pandemic [CA/24 - INQ000217392].

67. Communications failures had a direct impact on older people's ability to access healthcare services safely and effectively. In the event of a massive emergency the idea that you will need to communicate with those at highest risk of impact, and those with specialist knowledge of those audiences, should clearly be a priority. Despite this, government agencies pursued very ad hoc engagement with Age UK. Organisations like ours have significant communications expertise for older audiences and Age UK supported NHS England extensively in some of their communications, when our advice

was sought. Other branches of Government either did not seek or were resistant to taking on board our expertise. We had done a lot of work pre-pandemic on vaccination uptake amongst older people and could have shared the learning and insight prior to the onset of the pandemic, or during the early months of vaccination development.

68. Shielding was another area where our advice was frequently rejected. Throughout 2020 and 2021 we engaged extensively with the Department of Health and Social Care regarding shielding. The Department held regular shielding meetings with organisations supporting people at high risk from Covid-19, these discussions covered both policy, practical implementation and communications. Age UK also engaged in a range of conversations and written exchanges where views and advice were provided to officials.

69. At the outset of the pandemic Age UK understood the need to provide rapid advice to those living with health conditions and disabilities (including physical frailty). We undertook a huge amount of work to communicate the risks and guidance to those older people and their families and carers. This was in addition to the fact that all older people were considered to be 'clinically vulnerable' if not 'extremely clinically vulnerable'. We received a large volume of questions and requests for help from those people impacted. These ranged from a need for more detailed information and guidance in how to apply the advice to their specific circumstances – for example from those who relied on formal and informal forms of care and support – to those who were in urgent need of practical help and were finding themselves unable to access support (e.g. access to food and medication).

70. Unfortunately, particularly with regard to communications, our advice was largely rejected. This included both suggestions for adding and clarifying information based on the feedback we received, and – given the profound impact of shielding on emotional, psychological and physical wellbeing – how language and communications could be better managed to build trust and confidence amongst these individuals as the pandemic progressed. In doing so we sought to explain the extent to which 'shielders' felt 'abandoned' by Government policy and communications and the impact that this was having on their attitudes and behaviours. One such example includes detailed advice given to officials regarding the new guidance for clinically extremely vulnerable individuals published in October 2020. Age UK's Head of Health Influencing provided verbal feedback in a meeting on 8th October 2020 with representatives of the Department's shielding policy and external affairs teams, followed up by detailed written comments annotated on the draft document on 9th October 2020 [CA/24a --

INQ000283944], [CA/24b - INQ000283945]. It is my understanding that while the validity of our advice was recognised and valued by staff in those conversations it was rejected by more senior officials.

Long-term effects of the Covid-19 pandemic on the ways in which older people receive healthcare and future patterns of need

Increase in unmet need

71. We have mentioned the issue of frailty, a biopsychosocial phenomenon that at its root impacts resilience and the ability to bounce back from physical and psychological shocks. It is predominantly experienced by older people. The impact of both existing and prospective frailty in the community was not considered in any meaningful sense, nor the expert advice of geriatricians sought at the early stages of the pandemic. Many older people are finding they are unable to return to previous levels of fitness and resilience, especially people living with frailty. As research published by the Richmond Group of Charities (of which Age UK is a member) has shown, there has also been a marked general deterioration amongst older people with care needs as well as declines in the health of informal carers, with many more people reporting a range of challenges including physical and mental deconditioning, accumulation of chronic illness, loss of cognitive function, decreased confidence and reduction in their overall quality of life and wellbeing [CA/23 - INQ000217391].

72. The psychological impact of so much stress, uncertainty and isolation is also leading to increased loneliness and worsening health behaviours. Age UK tracked the impact on older people's health and wellbeing over the course of the pandemic, our research has found nearly 1 in 3 older people reported loss of mobility during this period, 1 in 4 report that they now live in more pain and 1 in 5 have experienced symptoms of cognitive decline [CA/7- INQ000176634]. Unfortunately, as it is borne out by our on-going research, many older people will not fully recover or regain lost function.

73. This increase in unmet need is of course placing a greater demand on frontline health and care services, where long-running challenges and resource pressures have been building for over a decade. Added to this are the high numbers of older people who are now coming forward for care that they avoided in the early stages of the pandemic. This is reflected in the crisis in access to primary and community care services, and the record rise in waiting times for elective treatments. In January 2023, there were over 7.2

million people waiting for treatment, the highest number since records began [CA/25-INQ000217395]. Each and every day we hear from people who cannot access the right diagnosis, treatment and support and are suffering avoidable harm or severely impaired quality of life as a result.

74. While we must tackle the backlog of elective care that has built up over this period, it would be a mistake to think that addressing waiting lists is our only challenge. We must also recognise the extent to which the acute phase of the pandemic and subsequent cost of living crisis has substantially changed the trajectory of the nation's health for the worse. Increased demand will not dissipate in the foreseeable future and services will need to develop their capacity in response. To address the issue of resilience (both for the individual and the system) a more comprehensive offer in the community is urgently needed, both from GPs and community services, that can anticipate care needs and build a package of support around people to reduce the risk of deterioration.

Workforce

75. It must also be acknowledged that workforce issues were the single biggest challenge in health and social care, even before the Covid-19 pandemic, with a staff survey from the British Medical Association showing burnout levels already on the rise [CA/26-INQ000217396]. The people who work across health and care are its greatest asset and are key to delivering high-quality care, yet workforce recruitment, retention and wellbeing issues have been exacerbated by the pandemic with even higher rates of ill-health, anxiety, post-traumatic stress disorder and depression now reported amongst staff, as evidenced in the NHS Staff Survey [CA/27- INQ000217397].This impact was evident early on, when half of 1,000 health care workers surveyed across the UK by IPPR/YouGov [CA/28- INQ000217399] in April 2020 reported that their mental health had deteriorated since the start of the Covid-19 pandemic.

76. The workforce crisis cannot fail to have an impact on the quality and quantity of care older people receive. Day in, day out, the staff working in health and care services make a huge difference to people's lives. Since the start of the pandemic, they have been under incredible strain to keep services going. A legacy commitment must be to prioritise the health and wellbeing of carers, both paid and unpaid, across the health and social care workforce.

Lack of accurate data across key services

77. This crisis has also highlighted the relative invisibility of older people in health datasets and analysis. Age UK has long argued that improvements must be made to data collection and analytical methods in order to fully understand diverse experiences across the older population, particularly those of minoritised groups. Too often data on older people is presented in the category 'over 65/65+' with no further breakdowns beyond that age cut-off. The UK and devolved governments were aware of such data deficiencies before the pandemic. Data disaggregated by age, but also sex and other relevant social characteristics, are essential to effective and equitable public policy making that is inclusive of older people.

Characterisation of Covid and Long Covid

78. For diagnosis and treatment of both Covid and Long-Covid, Age UK remains concerned that symptom presentation in older people can be different and that this has been poorly understood and articulated. Differential presentation of Covid-19 symptoms, including probable delirium, were recognised by geriatricians, care professionals and others working with older people a long time before the possibility was more broadly considered in guidance. We know lots of conditions present differently in people living with frailty, and so researchers and clinical leaders should have been looking to establish a pattern of differential presentation from the outset, as awareness of atypical presentations is critical to facilitate early identification, particularly given the fact that Covid-19 impacts older people more severely than other groups.

79. There may also be under-recognition and under or delayed-diagnosis of Long-Covid in older people whose symptoms including problems with balance and mobility, and chronic fatigue, may be written off as 'age-related'. We are also particularly worried that cognitive loss related to Covid-19 is being misdiagnosed or overlooked. Further, we are increasingly concerned by emerging evidence of prolonged risk of cardiovascular outcomes following infection, even when the original infection was mild. We believe that Long-Covid needs further research and that there should be greater recognition that the risks in older people may differ to those in younger age groups. We are also concerned that older people are experiencing differential access to Long-Covid support services, including unacceptable variation by geography.

Addressing pre-existing health and social care systems challenges

80. Many challenges were entrenched long before the onset of Covid-19– though exacerbated and accelerated by the added pressures. The pandemic therefore exposed existing frailties within systems and infrastructure that were not able to cope with the added pressure. The NHS is much leaner and 'runs hot' compared to many of its European neighbours, with little slack in the system to respond in times of crisis. To address current health threats, and to prepare for future crises, longer-term contributory factors must be reckoned with: the implementation of the recently published workforce strategy, investment in fit-for-purpose premises and systems, and measures to resolve the on-going crisis in social care is well made and must be urgently addressed.

81. In 2018 Age UK published a report called The Failing Safety Net [CA/29 - INQ000217400]. The 'failing safety net' of the title referred to a series of missed opportunities whereby NHS and social care services were not there to catch someone when they needed it. The outcome was usually an admission to hospital, the final resort for many people who had simply deteriorated too far or who were put at frequent risk of a crisis. The pandemic may have created some new challenges but the nature of what older people describe was often there all along: that is, a health and care system that is clunky and under-resourced, especially but not exclusively within its social care and community health service components. Care that can support and sustain older people to stay well at home can be the foundation of an effective and sustainable health and care system. At the moment, these foundations are often broken or simply not there at all.

82. Older people were always going to be at the eye of this type of storm, a fact that the UK Government should have accounted for in planning, preparedness and resilience decisions for healthcare systems. Age UK hopes this statement will aid the Inquiry to understand the impact these leadership failures across the healthcare system have had on the lives of many older people and their loved ones, and learn the necessary lessons, so that the nightmare scenarios we have seen play out for older people through the Covid-19 pandemic are never repeated.

Lessons learned in relation to the way the healthcare system operates in the event of a future pandemic

Drawing on our experiences throughout the pandemic, Age UK has set out a number of recommendations for healthcare systems below and have previous made separate representations highlighting lessons learned for Government and national bodies [CA/30 -

INQ000104086]. These recommendations should be viewed in the context of national policy and decision-making that shaped the response of the health and care system.

1. **Implementation of a rights-based framework and measures to root out and challenge age discrimination across the health and care system:** The pandemic has highlighted and exacerbated pre-existing discrimination towards older people. Ageist assumptions embedded deep into policy, delivery and decision-making should be tackled within society and across health and care services. Government should establish a clear rights-based framework for older people for public bodies and across public sector delivery to ensure that difficult health-care decisions affecting older people are guided by a commitment to dignity and the right to health. The NHS should take steps to identify and tackle age discrimination in delivery and professional practice. As a first step, it must be address how older people's rights will be safeguarded in the event of an emergency when resources are under significant additional pressure and make clear that blanket policies or decision-making is unacceptable.

2. **Recognition of the importance of maintaining routine services**: Effective continued operation of day-to-day health and care services are imperative for people to manage pre-existing health conditions and access essential services and support vital to their welfare. The need for resilience in the event of a major incident must be an active consideration in decisions about funding, policy and operational management of the NHS and broader health system at all times. As the pandemic has demonstrated, while the NHS is capable of rising to the challenge in a crisis, the fact it operates as such a lean service in normal times means there is very limited scope to manage a sustained period of disruption without significant consequences for 'business as usual'. Operational capacity to manage additional demands – be they seasonal or extraordinary – must be seen as part and parcel of an efficient service, not a sign of waste.

3. **Prioritisation of primary care preparedness:** Primary care needs to develop its capacity and capability to respond should a similar crisis occur in the future. GP services need to be prepared to manage any necessary shifts to models of care, including digital transformation, guided by principles of inclusion and equality, with the crucial importance of good communications to all audiences, including older people, recognised as central, right from the start. This will also support the aim to keep people safe at home and enable timely discharge avoiding the risk of hospital-

acquired Covid infection (exemplifying the generalised risk of hospital admission for older people). Proactive approaches to admissions avoidance and greater efforts to support faster discharge and active recovery, should be invested in on a longer-term basis.

4. **Proactive support for vulnerable groups:** Despite best planning and efforts it is always likely to be the case that an emergency scenario such as a pandemic will lead to changes or disruption in the usual running of the health system and services may be accessed or delivered. Therefore in addition to measures that build underlying operational capacity and resilience, including by ensuring systems and services are as accessible as possible, it is important that health and care systems consider how they will meet the needs of those who are at greatest risk during an emergency. Measures should consider how services will be delivered to those at significant risk of infection, who are digitally or socially excluded, who have complex needs likely to deteriorate without careful management and those who come to the end of their life during that period. Maintaining services for care home residents and those receiving care at home should be a key consideration.

5. **Recognise the interdependency of the health and care system:** In practice the health and care system is indivisible for many older and disabled people with care workers in practice taking on responsibility for tasks essential to managing and maintaining health. In previous evidence to this Inquiry we have set out the lack of recognition and support for the care system at critical points over the course of the pandemic and the impact this has had on the health and wellbeing of older people and carers. In future the principle of considering health and care services as a whole should be embedded into policy and decision-making.

6. **Drive forward a recovery strategy for older people:** Millions of older people are now living in a poorer state of mental and physical health than would otherwise be the case. Ageing should be better considered in all decision making, guidance and policy development, and we recommend system leaders maintain an up to date understanding of those populations and invest in specialist expertise and advice. This includes proactive research to optimise prevention, treatment and rehabilitation strategies, alongside social strategies to help people to cope with a legacy of social isolation, increased frailty, traumatic bereavement and mental ill-health.

7. **Prioritise health equality in older populations and tackle disparities in outcomes:** The differential impacts of the pandemic on the health of older people,

particularly those from ethnic minority backgrounds, carers, those living with chronic health conditions such as dementia, those living with disability and those living in the most deprived and marginalised communities, reveals stark inequalities in our health system that must be urgently addressed. Every effort must be made to reduce these unjust and avoidable differences in access, experience and outcomes for older people as a whole, and to reduce disparities amongst those older people at greater risk of disadvantage and discrimination in particular. An important first step will be to address data deficiencies and promote the collection, further disaggregation and broad dissemination of data by a comprehensive breakdown of characteristics including age, sex, sexuality, ethnicity, disability and income.

8. **Embed partnership working with VCSE and care sector:** In rebuilding from the pandemic there is an opportunity to be much more strategic in connecting national and local voluntary sector offers in partnership with health and care teams across the UK. Where it worked well, the voluntary sector's support was invaluable. However, more could have been done, and we should seize the opportunity to move from pockets of excellence towards meaningful VCSE partnerships becoming fully embedded throughout the health and care system. This should include involving older people, carers and relevant VCSE partners in emergency scenario planning.

9. **Address long-term contributory factors**: Last but certainly not least, Government must account for the need to protect the underlying resilience of the older population, and the health and care services and support on which many of them rely.
A coordinated and costed long-term workforce plan for both health and social care must be a priority. As important and urgent is creating a culture where health and care staff are well led and supported, highly valued and able to thrive. In order to put healthcare on a sustainable footing, the very real underlying and interconnected challenges outlined in this witness statement– workforce, social care, health disparities – must be tackled. The social determinants of health matter. If older people are living in poverty, in cold and damp homes, without access to good nutrition or social connection, their health is at undue risk. As well as being morally wrong, this places additional stress on the health and care system as need and cost escalate.

Witness Name: Caroline Abrahams
Statement No.:
Exhibits:

Dated: 12/10/2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF CAROLINE ABRAHAMS, CHARITY DIRECTOR, AGE UK

I, Caroline Abrahams, will say as follows: -

Please see enclosed response

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Personal Data

Signed: _____

Dated: _____12 October 2023_____