Witness Name: Caroline Abrahams

Statement No.: M7/AGEUK/01

Exhibits:

Dated: 1 May 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF CAROLINE ABRAHAMS, DIRECTOR, AGE UK

I, Caroline Abrahams, will say as follows: -

Brief description of Age UK, including its history, purpose, aims and functions

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. The Age UK network 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.

2. 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.

3. 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, unless explicitly stated otherwise. However, it is important to note that local jurisdictions experienced different challenges and took different approaches in relation to their specific social 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.

4. Age UK has obtained the information and testimony about older people's experiences described in the following statement 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.

5. Age UK uses a range of methods and opportunities to gather and analyse 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 a huge increase in the volume of calls to the advice line – peaking at an 88% increase at the height of concerns.

6. 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 in-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. We also receive a significant number of direct communications from individuals sharing their experiences and concerns.

Overview of the work conducted by Age UK during the relevant period, particularly with regards to matters relating to testing, tracing and isolating

7. During the relevant period our organisations worked closely with public services, professionals and policy makers at both national and local level and held regular discussions about key issues and challenges, including relating to testing, tracing and isolation policy. Throughout the pandemic we extended our usual processes for sharing information and insight, (for example, via standing formal and ad hoc meetings with national bodies, professional networks and policy and insight work) into the real time challenges experienced by older people that emerged through our work and engagement in these networks. We had sustained engagement with national government and officials, including the Department of Health and Social Care, government bodies such as NHS England and the Care Quality Commission, Royal Colleges and other representative or standard setting organisations. We met regularly with the NHS National Clinical Director for Older People and Integrated Person-Centred Care as well as other senior stakeholders.

8. Our national professional and policy leads worked within a range of professional networks and participated in a range of regular meetings and conversations that were 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, other healthcare professionals and care home managers and care workers. We provided many written responses to select committees and other consultation responses, parliamentary briefings and correspondence with ministers. There were both formal and informal opportunities to comment on draft guidance and plans, as well as provide advice on emerging challenges. This included our feedback on testing and associated

communications, access, logistics and prioritisation (particularly on matters related to care homes and home care). Age UK also provided the secretariat for the All-Party Parliamentary Group (APPG) for Ageing and Older People. The APPG works to engage with the political, legislative issues before parliament affecting people in later life. Age UK's External Affairs team worked with the House of Lords COVID-19 Committee to bring together older people from across the UK Cross-nations group on older people led by Age UK External Affairs team.

9. Age UK responded to specific challenges associated with test, trace and isolation policy, with a range of practical and psycho-social support for older people. For example, Age UK provided many briefings helping to make sense of complex guidance and interpret it for the benefit of older people and their informal carers, responding to frequently asked questions and concerns around Covid rules, regulations and policies (e.g. understanding the detail of rules for isolating after a positive Covid-19 test). For older people who needed to isolate, Age UK did work to refer people to priority shopping delivery as well operating a range of shopping and food delivery schemes across the country. Age UK also contacted the financial regulators, the banks and the Post Office to seek solutions to the problems accessing cash facing older people that became apparent. Solutions we advocated for included more offline support for those who needed it, third party access, cash deliveries and special helplines or those who needed additional support. Innovations like carers cards or trusted person cards offered controls to protect against financial abuse. Local Age UK's provided support to older people in the community who were isolating, including delivering food, medications and other essential supplies. We also worked directly with NHS and social care organisations – including providers and commissioners – across England directly and in collaboration with our network of Local Age UK charities.

Extent to which Age UK engaged with the UK Government in respect of Test, Trace and Isolate

10. Age UK was involved in a wide range of national engagement activity as described in the paragraphs above, of which matters related to Test, Trace and Isolate was a part of a broader conversation about different facets of pandemic

policy. Specifically concerning the Test and Trace scheme, Age UK was invited to various consultation events including several discussions chaired by Dido Harding in July 2020, December 2020 and March 2021. At the meeting in December 2020, Age UK raised concerns about the ongoing lack of clarity relating to Test, Trace and Isolation guidance, which was not always published in an accessible format, and often published last minute. We also raised the point that people were receiving mixed messages. For example, we heard reports that messaging on testing in national guidance was not always aligned to information given by Test and Trace call handlers. We flagged significant concerns around digital exclusion leading to unequal access to testing. It was very difficult for people to get a test or access results without access to digital technology, (among those aged 75+ more than two out of five (42%) do not use the internet), leading to many older people not getting tested and people possibly isolating unnecessarily.

Age UK's views on the safety of the UK Government's approach to the Test, Trace and Isolate system for older people

Unsafe discharge of patients into care home facilities

11. The Government's gravest mistake related to testing, perhaps across the entire pandemic, occurred early on when older people's rights were breached through the unsafe discharge of infected Covid-19 patients into care home facilities. Some newly admitted older people were untested, others had tested positive for Covid-19 and were still admitted, and some came into the care home still awaiting test results. This breached the Human Rights Act (Article 2, Right to Life) as many older people died in care homes because of unsafe hospital discharge of Covid-19 patients. Public authorities have a duty of care to protect life and take appropriate steps to safeguard against known risk. This decision to discharge individuals into care settings with uncertain Covid-19 status was a terrible mistake. The policies and guidance at the time (the March Discharge Policy and the April Admissions Guidance) failed to consider the highly relevant consideration of the risk to care home residents or staff from asymptomatic

transmission until mid-April 2020. By then a huge amount of damage had been done.

12. Ruling out Covid-19 was difficult as testing is not 100% accurate, and false negatives were commonly reported in a person's first days of infection. As such, regular testing of care home staff and residents was essential, as was the ability to take necessary precautions to isolate residents with uncertain Covid-19 status until it was safe. Given how unwell most care home residents already were, and the fact residents were in communal living quarters, it was self-evidently important to make sure everything reasonable was done quickly to help care homes keep the virus out and, if and when it got in, fight it effectively so it infected as few older people and staff as possible. However, early decisions taken by Government to restrict testing of care home staff and residents amid growing reports that frailer older people present more 'atypical' symptoms meant that many cases of Covid-19 in care homes went unrecognised in the early stages of the pandemic [REF CA5/01 INQ000176646].

13. Test, Trace and Isolate infection control measures were particularly challenging to implement in care home settings, a fact that was not anticipated by the Government. Congregate settings are communal by design, to recreate a home living feel, with small clusters of residents living together in single rooms and more communal areas. Consequently, many care home facilities simply did not have the practical capacity to implement isolation measures, for example, to ensure isolation of recipients of care following discharge from hospital and/or with symptoms of Covid-19, and/or a positive Covid-19 test. The Government's understanding of the design and layout of residential care homes was limited, impacting its ability to design implementable isolation measures, which were therefore often not carried out in practice. Unfortunately, even in NHS settings testing was inadequate. In hospital settings we were aware that some older people may inadvertently have been admitted to a general medical ward rather than a Covid-19 cohort ward, placing others at risk of nosocomial infection.

14. The testing system cannot be uncoupled from the availability of Personal Protective Equipment (PPE) as effective testing and PPE were both essential

components in the arsenal of public health infection control measures. Unfortunately, it took significant time for issues relating to lack of testing and PPE to be recognised and worked out. For example, we heard reports of PPE ordered by care providers being requisitioned and diverted to NHS bodies instead of care home and domiciliary care providers. At the same time, private domiciliary care providers, care homes and other private providers were left to fund and source their own PPE. Many struggled to do this, either because they couldn't access supply chains or because the grossly inflated cost of privately sourced PPE prevented them from being able to obtain adequate amounts for their staff. Some reports suggested that the cost of PPE had increased twelve-fold since the start of the pandemic Exhibit CA5/02 [INQ000532614].

15. We know from care home and domiciliary care workers' own testimonies that the lack of access to testing and PPE had been particularly distressing for them. Some have told us how they were asked to reuse or fashion their own masks, and in one example take old bed sheets into their care home to be used as aprons. A domiciliary care worker told us Exhibit CA5/02 [INQ000532614]; "*Do you know we can't even access the tests for COVID? When I first saw it in the news about health and social care workers getting tests, I went to my boss and asked for one, and he said 'no'. So, I went on the CQC website, and if domiciliary carers want a test, you have to apply just like everyone else. Even though we're social care workers.*"

16. The slow and halting progress in organising testing and adequate PPE was a major contributing factor in the tragedy played out in care homes across the country. On 10 April 2020 Age UK issued a statement in which I said*; "In short, it's a mess and one that means care home residents, their families and staff are being badly let down. It would not be an exaggeration to say that some are paying with their lives".* Despite tremendous efforts on the part of those working in the care sector, the tragic result of so many outbreaks of the virus across care homes meant that, as described in a parliamentary briefing from Age UK Exhibit CA5/03 [INQ000101412], between 2 March and 12 June 2020 there were more than 19,000 deaths of care home residents attributable to Covid-19. 45% of deaths involving Covid-19 of people aged 70+ were care home residents. There

were 79% more deaths of care home residents than in the same period in 2019. This impact was not restricted to care homes, and between 2nd March and 12th June 2020 in England and Wales, there were 6,523 deaths of recipients of care in their own homes; this was 3,628 deaths higher than the three-year average, so double the number of deaths that would usually be expected Exhibit CA5/04 [INQ000104086].

Prioritisation of testing to different sectors and in different settings

17. A key safeguarding challenge raised by Age UK and others was the lack of parity in testing and resource allocation for social care, specifically care homes and domiciliary care, raising concerns that the social care sector had been completely left behind. With limited access to testing for these types of care staff – who were considered a priority for testing much later than colleagues in the NHS – care providers were unable to guarantee staff were Covid negative, relying only on visible symptoms as an indicator as requirement for self-isolating Exhibit CA5/02 [INQ000532614]. We were also aware that, by late-May 2020, care homes were being pressured to take people as NHS Trusts had nowhere else to house them, leading to large concentrations of residents with uncertain Covid status. Because there was no way for care homes to decide if they were Covid positive or not, all such residents were forced to isolate for 14 days because of a lack of testing facilities. In practice this meant many unwell, confused older people being transferred from hospital straight into a side room, left alone, and not understanding where they were or why.

18. Another consequence of lack of access to testing in the social care settings was that the number of care workers across residential and domiciliary care having to self-isolate significantly increased, putting additional pressure on a system already struggling to cope with levels of demand. The social care sector needed its staff to be released to carry on working, just like the NHS, if it was to provide support for rapid discharge from hospital. Due to lack of testing facilities, some homes decided to close their doors entirely and encouraged their staff to live in the home alongside residents. Other care providers had to rely heavily on itinerant agency staff to fill gaps and many employed care home staff were also

moving between different group homes. As there was no central register of these staff, there was no visibility of this issue and no way to mitigate these challenges.

19. Overall, the social sector faced insurmountable levels of staff sickness – further depleting a workforce carrying large numbers of preexisting vacancies. The vacancy rate had risen by 2.5 per cent between 2012/13 and 2017/18. It was estimated that 8 per cent of roles in adult social care were vacant, meaning that at any time there were approximately 110,000 vacancies, and this challenge remains. The sector was particularly struggling to recruit registered nurses, with care homes seeing a sharp rise in vacancy rates. Turnover rates increased steadily between 2012/13 and 2017/18 by a total of 7.6 per cent and this churn indicates that employers were struggling to find, recruit and retain staff to the sector. The estimated staff turnover rate of directly employed staff working in the adult social care sector is 30.8 per cent Exhibit CA5/05 [INQ000103564]. Social care was never going to be able to maintain services with safe staffing levels at the height of the pandemic, given that they were already struggling to maintain services and safe staffing levels in the years leading up to it.

20. Lack of access to testing was an issue for family carers and Voluntary, Community and Social Enterprise (VCSE) workers too, both groups being essential for the holistic support of older people (and of other groups). For this reason they should have had parity of access to infection, prevention and control measures but failed to receive it. Age UK called for testing of all carers, social care and VCSE front line workers equitably with the NHS. While the NHS had been prioritised for access to PPE, testing, mental health support, priority access to shops, and pay rises, offers to social care were more limited and generally only arrived very late in the day. The knock-on effects posed a huge challenge for both the social care workforce, and the families and unpaid carers reliant on these services. Many of these people had to look after relatives from afar. Some families reported that they couldn't get into contact with domiciliary and care home providers and simply didn't know if their loved ones were getting the care they needed; *"The people who needed care haven't received all the support they deserve as [the home] has been short staffed"* Exhibit CA5/08 [INQ000509358].

Lack of safeguards to protect the clinically vulnerable from being infected by their carers

21. Much the same challenges in care homes applied in older people's own homes and Age UK raised concerns that the extent of infection and fatality was not being accurately understood within the older population in receipt of domiciliary or home care services. These problems with testing, particularly in the early months of the pandemic, also led to Covid-19 being under-reported on death certificates. It became clear to Age UK that service providers in domiciliary care faced the same on-going challenges accessing testing and PPE for their staff. Some carers may have visited up to 20 different clients a day, including new clients on an ad-hoc or short-term basis. The obvious risk was that a carer who had contracted the virus without knowing it (for example, because they were asymptomatic and unable to get tested) would spread it to a number of older people whose health was already compromised. The itinerant nature of care work was slow to be identified as a key factor in the rapid spread between care homes and people's own homes. We know some older people chose to discontinue social care provision because of valid concerns about contracting the virus from care staff, leaving them struggling to manage essential tasks, including personal care, and support with nutrition and hydration, alone.

Age UK's response to infrastructure of the Test, Trace and Isolate systems and in particular, its impact on the availability and accessibility of the systems for older people

22. As we have described above, the roll-out of regular testing for all care home staff and residents was slow and halting. On 31 July 2020, a letter sent to Directors of Public Health by Prof Jane Cummings, CBE RN Director / Senior Advisor Testing in Adult Social Care, cited difficulties with a specific type of test as well as 'higher than expected demand' and 'some unexpected delays' as reasons why the government's commitment to regular testing across care homes was not being met Exhibit CA5/07 [INQ000051405]. Care homes were prioritised according to local authority areas 'where there was the most need', meaning that some care homes had an even longer wait to access regular testing. In a written consultation

response to the DHSC in November 2020, Age UK highlighted that as late as November 2020 it was *"concerning to hear that providers still report significant delays in turning around test results for staff and the impact this has on their ability to maintain safe staffing levels"* Exhibit CA5/01 [INQ000176646].

23. Age UK intelligence from mid-May 2020 Exhibit CA5/08 [INQ000509358] highlighted that in the period in which care homes required a negative test for admission, testing was difficult if not impossible to book, particularly for those people unable to leave home. Access to testing was not straightforward for many groups of older people, and difficulties in access fell disproportionately on those already more disadvantaged and at risk of exclusion. These included: individuals who were housebound or required significant support to access services; those living in rural areas; people on low incomes or in insecure work; and those with caring responsibilities. Lack of accessible or affordable transport, inflexible employment, lack of practical support (including access to respite care), loss of confidence in travelling or accessing services and lack of mobility have all featured as reasons why people have struggled to reach test sites.

24. Furthermore, we know that some older or disabled people – or their carers – have found it difficult (and in some instances impossible) to administer home testing. Lack of manual dexterity, sight loss, cognitive impairment, are just a few of the challenges people faced in this regard. We received many queries through the Age UK Information and Advice line from older people concerned about the accessibility of the testing programme. Digital exclusion was another significant concern, particularly to book tests in the early days, but with challenges enduring throughout the pandemic. For example, although it later became possible to book a Covid-19 test over the phone, results were still provided by text or email, which acted as a barrier for many older people. It was possible to give someone else's telephone number or email address, but this wasn't an option for some older people, while others did not feel comfortable doing this. We raised these issues with relevant teams on multiple occasions, but did not see convincing evidence that effective action was taken to remedy these challenges meaningfully and consistently. This perhaps reflects the wider point about there being a lack of understanding across government of the significant number of older people who

are not digitally enabled (4.7 million people aged 65 and over don't have the basic skills to use the internet successfully and safely).

25. We were also concerned that detailed information about the testing process was mainly shared online, which meant many older people were unable to get information about current guidance and best practice (ironically, including the main guidance signposting non-digital points of access). This included information about when people needed to be tested by for the test to be effective, and what kind of tests were available to them, depending on how long they had been symptomatic. Such essential information should have been communicated to the public via a range of channels (for example, via printed materials in a range of accessible formats, verbal explanations and demonstrations from trusted professionals in the community) so that everyone was able to understand how the testing process worked and had a range of ways to access this essential information.

Access to testing and support in isolation for highly vulnerable groups of older people

26. Government and many services did not initially understand or take account of the specific challenges of access to testing for socially excluded or marginalised older people, and these people were overlooked in the policies designed with a younger population profile in mind. When we think of older people, we do not tend to consider issues such as homelessness, poverty, substance misuse or severe mental illness, but significant numbers are experiencing these challenges. Older people with low or no income, living in insecure and unsafe housing and highly reliant on local social care services died in the greatest numbers. We have heard extensive testimony from older people experiencing neglect, self-harm, suicidal ideation, malnutrition and substance misuse at home. Further, the withdrawal of free testing in early 2022 made it even more difficult for socio-economically deprived and minority populations (who often have comorbidities) to access testing and stay safe.

Age UK's response to the policies that related to Test, Trace and Isolate;

Lack of understanding of the care sector within government

27. Broadly, and as previously mentioned, Government policies for prioritisation of testing and resource distribution skewed towards NHS facilities, appearing to reflect embedded ageist and ableist attitudes towards older and disabled people. This was coupled with a lack of forethought for safeguarding to enable Test, Trace and Isolate policies to be safely implemented by care home and domiciliary care workers. I have already mentioned that, in designing isolation policy, Government was slow to understand the risks that communal areas might present to older people in care homes, sheltered and extra care housing. Similarly, many older people in these settings are reliant on intimate personal care that precludes meaningful quarantine and isolation policies, and therefore requires meticulous forethought for safeguarding and protecting dignity. For example, because there was no safe space to isolate those in residential care, we know that many older people were left in rooms alone and were not toileted or changed on a regular basis.

28. Social care is on the front line when it comes to keeping older people, younger disabled people, and people with long-term health conditions safe and well, yet this did not seem to be well understood by decision-makers in government, including those responsible for Test, Trace and Isolate policy. Despite the rhetoric, promises of a 'protective ring' around care homes did not materialise in terms of policy or practice in the early stages of the pandemic. From the outset there was an overall failure to prepare the sector to manage the challenges of the pandemic or to safeguard those who relied on its services, or who deliver them too. Age UK suggests a primary reason for this was the lack of representation of older people across national governing structures, which led to the relative invisibility of issues specific to older age groups for decision-makers. There seemed to be a general and pronounced lack of understanding among policymakers in government, including those developing and managing test and trace services, about the social care workforce: who they were, how they lived, and how reliant large numbers were on keeping working to survive financially.

Restrictions on visits to recipients of care by their loved ones

29. Perhaps the most detrimental aspect of the 'isolate' aspect of Test, Trace and Isolate policy for older people related to safe visiting, particularly in care home settings. Following the first wave of the pandemic, care home visiting was repeatedly halted or restricted (many care homes implemented a 'no visitor policy'), in efforts to prevent the virus from spreading, and was then very slow to restart Exhibit CA5/06 [INQ000532615]. These decisions were made with insufficient consideration or understanding of the impact on residents' and families' wider health and wellbeing of keeping them apart, and whilst allowing staff to travel between care homes without any restriction. We are unaware of an equality impact assessment having been undertaken on differential impacts of isolation policy but, had it been, it would have revealed the unequitable impact of this policy on some of the most vulnerable groups of people.

30. It was not until late 2020 that the Prime Minister made the commitment that every care home resident would be able to have two continuous visitors, tested twice weekly, and able to visit someone in person. This commitment wasn't realised until 12 April 2021. We strongly supported the call for the national pilot on visiting which began on 16th November 2020 to be rapidly accelerated into a trailblazer programme, testing the viability of care home residents having a 'designated visitor' who had access to PPE and testing, like staff members. We advised that Government should co-produce with the care sector new guidance on visiting in care homes by early December 2020, giving out a clear message that the default position was that visiting should happen wherever and whenever it could be safely carried out. In fact, many older people living in care homes waited an entire year before they were able to receive visitors.

31. Visiting was extremely slow to resume, and it was suggested that care homes didn't want to have visitors back into facilities in part because this would raise many questions and complaints. People told us that they were deeply concerned about the deterioration of their loved ones and when relatives were able to see their family members in person it was apparent how much they had physically, mentally and emotionally deteriorated. Relatives commonly reported weight loss (a fact less obvious on videocalls), over-medication, ulcers and pressure sores

because of extended periods of isolation. A relative told us; *"[Mum] has lost so much weight which I feel is an effect of no visits. I had a short visit in July and she clung to me and made me promise I would go back soon. I don't know how much longer mum will be with us."* Exhibit CA5/06 [INQ000532615].

32. Care homes themselves reported challenges with confusing guidance and advice on visiting as well as not having received the testing to allow visiting to take place. The contradictions evident in policies that allowed staff to work between multiple homes, but denied visitation rights for residents, revealed that decision makers and those whose advice they were listening to the most, including the public health community, did not know enough about how these settings operated in practice. It also disastrously underestimated the crucial importance to health and wellbeing of contact with loved ones for care home residents, a fact we highlighted multiple times. Interruption to family visits had a particular impact on people living with dementia who did not understand why their relatives were no longer coming to see them. Social care is a holistic service – it is concerned with people's mental and physical health alongside their spiritual and emotional wellbeing – we lose sense of the balance of all these elements at our peril.

Restriction on visits to care homes for residents nearing the end of their life

33. In exceptional circumstances, such as where a care home resident was nearing the end of their life, next of kin were able to visit. However, we know that these concessions were rare. With the pressures facing care homes, family members were not always able to visit or even speak to residents, even when they were at the end of life. This was made worse where family members had little or no access to the internet and could not even connect remotely. 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, meaning thousands of people were left to die without the support of their loved ones. It should also be highlighted that not all older people held or hold the same views about personal safety and risk, and many (particularly those in these circumstances) placed a higher value on seeing their loved ones than isolating from the virus.

34. The public conversation about this was not helped by the term 'visiting', which fails to capture what many relatives and friends often do for people in care homes to supplement the care available from staff. It is not unusual, for example, for the partner of a resident with dementia to spend many hours with them, helping them very slowly to eat and drink sufficiently. A more accurate term would be 'caring' highlighting the general lack of understanding of the contribution of unpaid carers, and the essential support they routinely provide. At times these bans seemed disproportionate to the actual degree of infection risk and did not consider the huge variation across the care sector in terms of size of facility and safeguarding ability. Again, specific challenges were also identified in home care, supported living and extra care housing, all of which received even less governmental attention.

35. Age UK and other organisations spent many hours over the course of the pandemic trying repeatedly to persuade officials and their public health advisers to seek a better balance between the risk of infection on the one hand, and the risk of loss of hope among care home residents on the other. We were told the problem with our approach was that there was little or no scientific evidence to support the importance of visiting in care homes, whereas there was a lot of scientific evidence confirming the risk to older people from Covid-19 and its propensity to spread. We understood this view but felt it rather missed the point. As the pandemic continued isolation policy appeared to be, at least in part, a belated over-reaction to the failure to protect older people in care homes during the first wave.

36. Providers interpreted advice that was issued by Government and Local Authority Public Health teams in the context of their own risk analysis and insurance arrangements. In some cases, it didn't matter what the local authority advised was possible, because the homes themselves were not sufficiently staffed, or owners overrode advice (in some cases including that of registered managers), concerned about risks to their staff and residents and whether or not they would be held liable. These decisions on visiting restrictions caused huge tensions between families and care staff. In meetings with officials there were repeated pleas to Government from providers, and others, including Age UK, to stand

behind them to guarantee their insurance positions thereby giving them the scope to take more risks. Test, Trace and Isolate policy did not appear to reckon with these challenges or offer mitigations.

The extent of support available for those that were required to isolate

37. Loneliness related to isolation policy was not only an issue in care homes, with many other older people left struggling in their own homes too. According to research gathered by Age UK before the pandemic, almost 2.6 million people aged 65 and over speak to three or fewer people they know in a typical week. Unfortunately, the restrictions put in place during the pandemic, including isolation policy, have not helped this situation. Loneliness can have a devastating impact on a person's physical and mental wellbeing, making them more vulnerable to an array of health problems, including heart disease, stroke, high blood pressure, dementia and depression. In Age UK's report on tackling loneliness among older people in the COVID winter, a participant *described "Being scared of contact with people and the isolation at same time*" Exhibit CA5/09 [INQ000532617].

38. As well as a lack of emotional support available for those older people required to isolate, there was a lack of practical support too. Early in the pandemic, Age UK raised the alarm that many older people living on their own in the community were running out of food and struggling to replenish their supplies, less because of lack of money and more because they were too frightened to go out, confused by the guidance, or because their usual support networks had collapsed. In May 2020, Age UK and the Malnutrition Task Force (an organisation that aims to combat preventable and avoidable malnutrition and dehydration among older people in the UK) warned that dramatic increases in isolation and loneliness, combined with restricted access to shopping and reduction in essential care and support would leave many older people malnourished or at risk of malnutrition. For example, we heard of people receiving food parcels containing mouldy bread and orange squash in huge cartons, too heavy for frail older people to lift, and that took no account of dietary or cultural requirements. Food supplied was totally unsuitable to eat for most older people who couldn't open packets, get lids off

tins, or carry heavy items into the house (supplies were dropped onto people's doorsteps). There was no understanding that many older people are simply not able to stand and prepare food from scratch (for example, the strength and dexterity to cut and prepare a butternut squash), and even if they could, many would not be able to get the food 'from the plate to mouth' as they required support to feed themselves. Despite these warnings, support for older people isolating in some cases remained seriously substandard.

39. Age UK noted a marked deterioration in the health and wellbeing of older people, with many more 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. Older people experiencing cognitive decline were particularly badly impacted by isolation policy, often confused and scared at being subject to new restrictions on their freedoms – it did not seem that policy took account of their circumstances to ensure restrictions in these cases were necessary and proportionate. A lot of older people living with dementia would have progressed from mild to end stage dementia across the identified time period. There were no memory services available at all and those people had to struggle alone, taking medications prescribed without examination. There was a lack of recognition of these challenges, with many older people struggling greatly even now, and in need of support to find pathways out of the loneliness that isolation policy fostered.

40. Another group who were particularly impacted were unpaid carers. Informal carers, many of whom are women, were often left to carry a greater burden of care, with reduced access to health care professionals and other services or forms of social support. In our meetings with Dido Harding we explained that during the pandemic, calls and referrals for Age UK's telephone friendship service had tripled and were still rising reflecting the impact of the pandemic, and particularly isolation, on people's loneliness and mental health.

41. Isolation policy had a big impact on the care workforce too. The lack of government support available for those that were required to isolate made adherence very challenging for some groups of workers. We heard stories of

infected or symptomatic care workers continuing to report for duty because they couldn't afford to stay off work. Many care workers experienced issues, including those key workers with young children in school. While key workers were enabled to have access to schooling (albeit with lessons delivered online in much the same way as children learning from home), their children would have been required to isolate in much the same way as anyone else if they developed symptoms or were identified as a contact. Government did introduce some measures to try and address these challenges later, through the Infection Control Fund, distributed through Local Authorities in May and July 2020. The fact that this had to be done at all shows how undervalued the sector was, but its effective distribution to the frontline and ultimately into the pockets of care workers would have depended on how effectively the Local Authority distributed it, and how the provider then passed it on.

42. Age UK also received lots of enquiries from older workers in the 'shielded group' who had tested positive for Covid-19 and were worried that their employers may be unwilling or unable to have them back in the workplace, for fear of being unable to keep them safe in line with isolation policy. We argued that Government should have done all it could to support older workers in retaining their employment, for the sake of these older people's finances and wellbeing and in the best interests of our economy too.

Impact of lack of testing on access to essential clinical care

43. On-going challenges sourcing adequate testing risked derailing attempts to control transmission across public services, including hospitals and care settings. This led to knock-on effects for older patients access to both routine and emergency health and care. Older people are the greatest users of elective healthcare and shoulder the burden of pain, loss of function and ill health if waiting lists are not managed well. Unfortunately, we have witnessed ballooning elective waits for routine care. We made these concerns public in various ways including a consultation response on 'Delivering Core NHS and Care services during the Pandemic and Beyond' in May 2020 Exhibit CA5/10 [INQ000508514].

44. Lack of access to testing also played into the very serious challenges we raised around non-conveyance practices of older people to hospital. We 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. Age UK was involved in protracted arguments about these practices with responsible organisations (DHSC, NHSE). At worst this meant a lack of access to urgent services in hospitals for older people with significant needs living in the community or in care homes, simply on the basis of their age or where they lived.

45. Some care home residents were denied admission to hospital 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-19 and would not be considered for further care. The clinician described intervening personally on behalf of a resident he in fact judged to have a case of treatable pneumonia. Lack of access to testing had clear and direct impacts. Such interventions were few and far between as most GPs had stopped in-person visits to care homes altogether.

The use of apps and technology for Test, Trace and Isolate

46. Digital exclusion is linked to age, as well as disability and socioeconomic factors and quickly emerged as a major barrier to older people accessing support and services during the pandemic. As already mentioned, access to the Test and Trace scheme leant heavily on use of the NHS app and roll-out of the scheme was digitally focused, excluding many older people. An implicit assumption was made that everyone had access to a smart phone, email address and internet access (for example, to receive alerts about contact tracing), but this was by no means the case for every older person. The NHS app was not accessible to older people without a smart phone and, as previously mentioned, most of the national guidance and communications were digital.

47. Many older people may have had access to the internet but lacked the skills or confidence to engage in a broad range of digital services. Others lacked the funds for or access to digital technology at home and may have been relying on places such as public libraries. As a result, many older people were unprepared and unable to manage the Test and Trace NHS app, book tests or receive results online. While we welcomed any new technology that helped tackle the virus, our chief concern was that no-one should be disadvantaged or locked out of services simply because they didn't have a smartphone or weren't on the internet. As it was, older people who were offline during the pandemic were significantly disadvantaged, and often very disconnected Exhibit CA5/10 [INQ000532618].

Fraudsters targeting older people under the guise of Test and Trace

48. Criminals were quick to step into the information vacuum created in part by this digital divide, placing many older people at risk of fraud. As the Test and Trace system was rolled out across the country, contact tracers were getting in touch with those who had had recent close contact with people with a positive Covid-19 test. Fraudsters attempted to take advantage of this process by posing as contact tracers and gathering personal information by deception. For example, Age UK Somerset reported in October 2021, *"We've been getting reports of people receiving "track and trace NHS" phone calls, saying "we need to send you a kit. It's £50. Can you give me card details?"* Similarly, Age UK Bromley & Greenwich were informed by the Metropolitan Police Cyber Crime unit that there had been a 400% increase in Coronavirus and Covid-19 related scams in March 2020 with victim losses at nearly £1 million.

49. It is very easy for fraudsters to clone and spoof numbers like the one used by the Test and Trace service and more could have been done to anticipate and mitigate this risk. For example, the NHS and government websites could have added advice to contact relevant government agencies such as Action Fraud if suspicions were raised about the person calling. The Government, NHS and Public Health England (PHE) needed to reassure the public across a range of channels that tracers would never ask for bank details, payment, pins and passwords over the phone. Concerns over the virus were worrying enough, and

scams can have a catastrophic and life-changing impact on older people, not just financially but to their health, wellbeing and confidence. As it was, the Government response to fraud protection for older people was largely ineffective.

The enforcement strategies that were adopted in relation to Test, Trace and Isolate

50. There was a significant degree of fear of breaking the rules amongst the older population. A consequence of this fear of law breaking was that many older people and their carers over-interpreted guidance and took a highly cautious approach. Some older people and families cancelled their existing care packages to protect themselves or their loved ones from infection. Others worried about breaking the law and non-resident family and friends stepped back from providing essential support, unclear about what was allowed (for example confusion as to whether older people were permitted to have cleaners enter their homes). The lack of clear guidance on this subject overlooked the extent to which many older people rely on cleaners to complete essential tasks they cannot manage themselves (changing bed linen, cleaning the bathroom, doing laundry, running errands) and to provide low-level care that many older people rely on to stay well. Consequently, many older people with care needs did not receive the support they required. Others who developed new care needs during the pandemic, struggled to access any support at all. These types of social support may be 'less formalised', but the pandemic has taught us that they should not be regarded as 'less important'. We feel more could have been done to anticipate and communicate with older people about these types of challenges.

51. The importance of 'lower level' social support for older people with care and support needs was further highlighted by the adverse impact of shutting down universal services. The confusion and lack of clarity over Test, Trace and Isolate rules and enforcement strategies, coupled with lack of consistent access to testing, caused many services and forms of support to close or withdraw over this period, including day centres, support groups and other home visitors. The impact of this was sometimes equal to or greater than the lack of access to healthcare. For older people with care and support needs, closures of clubs,

classes, facilities, churches, leisure centres (many of which either haven't reopened or have reopened in ways inaccessible to those communities) have had a massive impact on health and wellbeing.

The variation of the Test, Trace and Isolate rules across the United Kingdom

Perspectives of Age Northern Ireland

52. Colleagues at Age Northern Ireland describe broadly similar challenges to those already outlined. Like Age UK, in the first months of the pandemic, the focus was on protecting hospital capacity and urgent discharge of people from hospital who were medically fit took place from March 2020. Similarly, in Northern Ireland most social care is delivered by the independent sector, with providers raising concerns about access to PPE supplies around March 2020. Guidance was not clear about whether PPE was a requirement, for example for domiciliary care workers. This changed, so that by mid-April 2020 the independent sector was receiving PPE through local Health and Social Care Trusts. It took some time to put in place systems and processes to understand and support care home providers, residents and care workers.

53. Test, Trace, Protect was managed by the Public Health Agency (PHA) in Northern Ireland. Following a pilot in April in 2020, PHA were involved in tracing all positive cases from 18 May. PHA provided advice to care homes around Covid-19 possible outbreaks, and testing was extended to all care home residents and staff in August 2020. Additional funding was provided to care homes by DoH for extra cleaning and extra staff. PHA also provided information and guidance on its website for the public, professionals, health care workers and care workers.

54. Colleagues in Northern Ireland report a more positive picture of nutrition support for older people who were in isolation. Food parcels were distributed from 6 April 2020 by local councils, working with DoH/GPs to identify people at risk and with local community groups and, in some cases, with age sector groups. This process was led by the Department for Communities and seemed to work well. Unlike Age UK, Age NI did not hear reports of food that was unfit for human

consumption. Some older people did advise that they did not need a weekly parcel, and some indicated that the food packed was not what they would usually eat (for example, a number of older people referred to the amount of pasta they received and would have preferred some fresh vegetables/fruit) but the overall response was to welcome this support.

Perspectives of Age Scotland

55. Colleagues in Age Scotland faced similar challenges to those already identified in this response. Specific to what worked well in Scotland, Age Scotland colleagues described that simple communication from the Scottish Government and First Minister about their "Test and Protect" programme was "good and effective". The rationale for it and how people could interact with it was frequently mentioned at First Minister daily news briefings and printed information materials to all households happened in good time. The door drop materials were simple, clearly written but comprehensive, answering the key questions people had. It was "endorsed" by the First Minister, who had high levels of trust from the public at that time, and so it was felt to be a good way to deliver the message. However, those who needed information in other languages or formats were directed to a website or QR code which created a significant barrier for older people who were digitally disconnected. Other challenges around digital inclusion included those without smart phones being unable to "check in" to public and hospitality settings when visiting them. From Summer 2020 onwards, in major settlements (towns and cities) there was good availability for members of the public to pick up of lateral flow tests. However, over-reliance on digital routes for requesting tests and uploading results excluded those not digitally enabled. Another major challenge was that care homes and social care services were not given parity of access to rapid tests and availability was far more restrictive than in comparison to NHS.

Perspectives of Age Cymru

56. Colleagues in Age Cymru faced similar challenges to those already identified in this response.

Public communications and guidance that was delivered in relation to Test, Trace and Isolate

57. It did not seem that the Government tested its own communications function with older audiences. They often reacted negatively to fear-based Test, Trace and Isolate messaging, adversely impacting their mental wellbeing by increasing their anxiety. Being labelled 'vulnerable' was difficult for some older people – who found the label stigmatising and increased their fear and fostered a sense of being a burden on society. In public messaging, older people were treated as a homogenous group, regardless of health status, and messages were generally paternalistic. As previously mentioned, the lack of clarity on rules led to many older people over-interpreting the obligation to isolate e.g. extending the period of self-isolation and becoming increasingly socially isolated. Age UK expended considerable energy clarifying rules and guidance, explaining and communicating the evidence, providing reassurance and supporting older people to make safe decisions. We would clarify questions with NHSE and NHS Test and Trace service if we couldn't find the answer ourselves from the guidance, but as often the challenge was translating the guidance into a more readily understood form of words for older audiences. We also found that, in practice, interpretation of the guidance was inconsistent locally (for example, different care home settings had different resources to support with test and trace, which impacted implementation).

58. Older people we spoke to were often acutely aware that they were at great risk of becoming seriously ill or even dying if they contracted Covid-19. This led to some being too worried to go out at all. Our sense too was that quite a lot of older people had stopped trying to follow the changing Government advice and were making their own, usually very cautious decisions, themselves. There was evidence that people were staying away from older family and friends through concern about passing on the virus. We were hearing this most often about older people living in care homes, but there were also instances of appalling loneliness described to us concerning older people living in their own homes.

59. These risks associated with Test, Trace and Isolate policy on older people's mental health were not sufficiently recognised. Prior to the pandemic, one in four older people were already living with a mental health condition, while 1.4 million were chronically lonely. Covid-19 and the governmental response to the pandemic has exacerbated this situation. Severe anxiety was found to be twice as common among those who had been shielding than those who had not, 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 relied on to understand the impact of pandemic on the mental health of the population had significant design flaws with regard to older people, who were either under-represented or excluded. This led to their needs being overlooked and fuelled a myth that older people have been less seriously affected than other age groups, which is untrue.

Failure to engage local VCSE networks to help with distribution and administration of testing

60. As already described, the rules relating to Test and Trace protocols were often fiendishly complex, open to interpretation, and frequently, only available to access online. We knew, as an organisation, that we had to respond quickly to understand the new information and what it meant for older people, many of whom would not be able to access information via digital channels. Age UK has produced public-facing guidance to support older people at risk in emergencies across a range of topics. Perhaps the most relevant expertise Age UK held related to the challenge of getting older people vaccinated. Age UK was already running an extensive winter campaign including flu vaccination uptake in the older population, underpinned by a programme of insight, research and toolkits. Yet despite Age UK's specific and unique organisational knowledge, and strong track record of delivery, it was not systematically engaged to support the Test, Trace and Isolate communications efforts.

61. We would also like to highlight communications challenges around 'step down' policies related to Test, Trace and Isolate policy. For example, the older people we support reported high levels of anxiety and fear at the prospect of ending free

testing, particularly those who were themselves, or who lived with, someone who was clinically vulnerable. People had a lot of fear and lack of confidence about leaving home but this was not properly considered in official communications around changes in rules and regulations. In our conversations with policymakers, we re emphasised that messaging around 'getting back to normal' would not work for some of the people that we support (for example, people with long-term health conditions and disabilities), who needed much more targeted support to deescalate the fear and anxiety associated with social interactions.

62. There was a lack of recognition of the scale and scope of Age UK's offer and reach to both older people and systems leaders as a trusted source of information. Failure to engage organisations like Age UK to communicate messages in an accessible way to older audiences led to lack of trust and confidence in government messaging. The subsequently low rates of vaccine uptake amongst some groups of older people demonstrate one particularly negative impact of this communications failure. It did not seem that the Government Test, Trace and Isolate scheme worked consistently or effectively with Age UK, to harness our long-established and successful approach to methods of engagement with older people.

What Age UK considers could have been done differently in relation to Test, Trace and Isolate

63. Delivering any kind of national response to an emergency like a pandemic was always going to be a challenging prospect. Some of the challenges that played out with regards to Test, Trace and Isolate policy were unavoidable due to the high levels of uncertainty and complexity of the challenges. Even so, we believe there are places where Test, Trace and Isolate scheme fell significantly short in ways that were preventable, and lessons should be learned for future emergencies. We contend that the Government should have been alert to the fact that certain groups of people, including older and disabled people, were going to be especially vulnerable in a pandemic and require priority access to testing and associated infection control measures.

Recommendations

64. **Address ageism, representation and expertise in government structures.** It is the view of Age UK that if more people with a deeper understanding of the care sector and the needs of older people had been advising government, there would have been greater recognition of the challenges that the sector – predictably – faced with regard to Test, Trace and Isolate policy and the need to plan mitigation strategies accordingly. A general lack of knowledge and understanding about ageing and the lives of older people led to the operational blind spots in Test and Trace policy described in this statement. We must ensure that the needs and rights of older people are properly represented in government structures so that at times of crisis, when policymakers are unable or unwilling to look beyond government for advice, there are informed voices within government who understand the needs of older people.

65. Currently, there's no individual or Government strategy to look at these types of issues in the round. For as long as this is the case, the big issues for older people risk being overlooked by decision-makers. Government should undertake a review of the membership and role of the Moral and Ethical Advisory Committee and create a Commissioner for Older People in England to contribute to a network of such Commissioners across the UK, alongside a Minister for Older People in Westminster. Older people in Northern Ireland and Wales already have an Older People's Commissioner working to protect their rights, listen to diverse older voices and make sure no one is left behind. Age Scotland recommend that a Commissioner for Older People in Scotland needs to be established (for the same reasons outlined for England). The Scottish Government should have an older people's minister with responsibility across government and the portfolio discussed at Cabinet. There was a minister for older people during the relevant period, but it felt restricted to the equalities portfolio area and was downgraded in Spring 2023 to fall within the remit of Minister for Equalities, Migration and Refugees when Humza Yousaf MSP became First Minister of Scotland.

66. **Work more closely with the voluntary and community sector,** including in scenario planning for future pandemics and also in the development and roll out

of targeted public communications. Policy implementation models of the scale and complexity of Test, Trace and Isolate must place focus on and support the multi-disciplinary team and cross-sector relationships that are necessary to deliver schemes of this type. Age UK has expertise in communication to older people, as do many other health and care charities vis a vis their beneficiaries, and has invested a considerable amount of time and effort to understand how best to communicate with them. Support from voluntary and community sector organisations should be engaged before crises hit. This is especially important as local authority budgets continue to fall, limiting what they can do directly.

67. **It is essential that those who cannot or do not want to use the internet are not excluded or disadvantaged as a result.** Analysis from Age UK shows that the pandemic has not in fact produced a sea-change in older people's use of digital technology, with nearly two million over-75s in England still digitally excluded in the post Covid-19 world. Much more investment in digital skills training and IT hardware is needed to support older people who are digitally excluded to get online safely and improve their skills. At the same time, alternative routes like phonelines need to remain open and properly staffed, so that people can talk to a human being if they want to.

68. **Establish a new and higher standard of social care**. This means long-term investment in comprehensive social care reform, a comprehensive community offer for older people and mandatory strategies for ageing well. The Government must rebuild the care system with properly funded and thoroughgoing reform, and care work must become an attractive and properly paid career, its terms and conditions on a par with the same jobs carried out in the NHS. For example, long-term investment in social care would enable targeted capital investment into built environments to aid infection control, so every home has a space they can use to keep people safely connected, even during a pandemic.

69. **Implement a rights-based framework for older people to ensure** rights and dignity are at the core of adult social care reform. If older people's human rights had been more expansive, better defined and properly communicated and understood, we believe that outcomes might have been different. Ethics advice

should be incorporated into operational decision-making frameworks that are widely used and understood inside and outside of times of crisis. Redress mechanisms should also be put in place for those receiving social care, including for people who pay and arrange their own care (who cannot currently make a claim under the Human Rights Act). The UK Government should champion the development of a UN Human Rights Convention for Older Persons to reflect a shared ethical consensus and benefit older people everywhere, including here.

70. **Begin the practical steps necessary to ensure that a future Test and Trace process can identify those most vulnerable**. A positive first step would be a review of guidance in respect of the Civil Contingencies Act (CCA) and Local Resilience Forums (LRFs). The CCA needs strengthening to ensure that it doesn't fail to give regard specifically to the rights of older people, such as by making explicit references to upholding human rights. Further, membership of LRFs should be revised to better reflect a wider range of partnership working and to ensure that the voices of partners with relevant expertise are heard at a local planning stage. Currently there is no comprehensive register of the vulnerable settings where people are likely to be drawing on support, above and beyond those already known to a Local Authority.

71. Vulnerable people may be known to voluntary and community services, energy suppliers, GP services, faith leaders and others. While we hope that greater integration between NHS and local authority services will eventually help bridge the divide, there is currently no failsafe mechanism to join the dots between services to ensure that people are not falling through the gaps. As a first step however, and as a minimum requirement, we recommend that a register of all vulnerable settings should be maintained at LRF and place level for use in an emergency. This would greatly aid future test and trace efforts.

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.

PD

Signed: _____

Dated: _____1 May 2025