

The impact of COVID-19 on older people in the United Kingdom

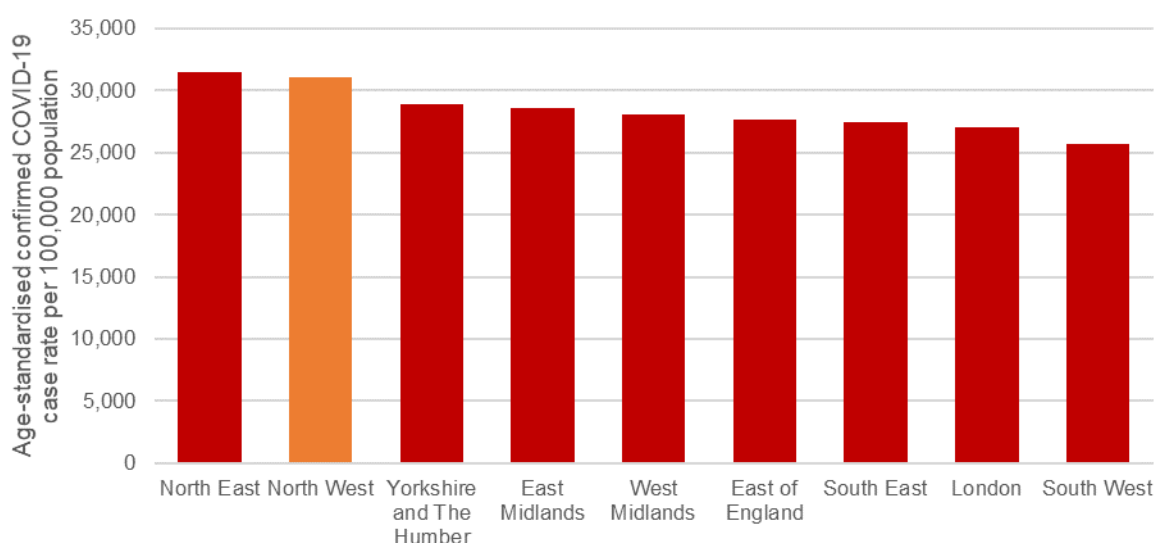
A rapid literature review

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Introduction

The COVID-19 pandemic and the consequent governmental restrictions were a shock to the world. The first COVID case in England was confirmed in late January 2020, and in the North West in early March. To reduce the spread of COVID-19, the government had put the country in full lock down by the end of March 2020, closing down some employment sectors and restricting movements. These measures came and went to different degrees during the pandemic, both at national and regional levels. By early 2022, the North West had seen the second highest rate of COVID-19 cases (Figure 1) and deaths in England (Office for Health Improvement and Disparities, 2022), as well as some of the most severe restrictions.

Figure 1. Cumulative age-standardised confirmed COVID-19 case rate per 100,000 population, in England by region, all ages, March 2020 to March 2022



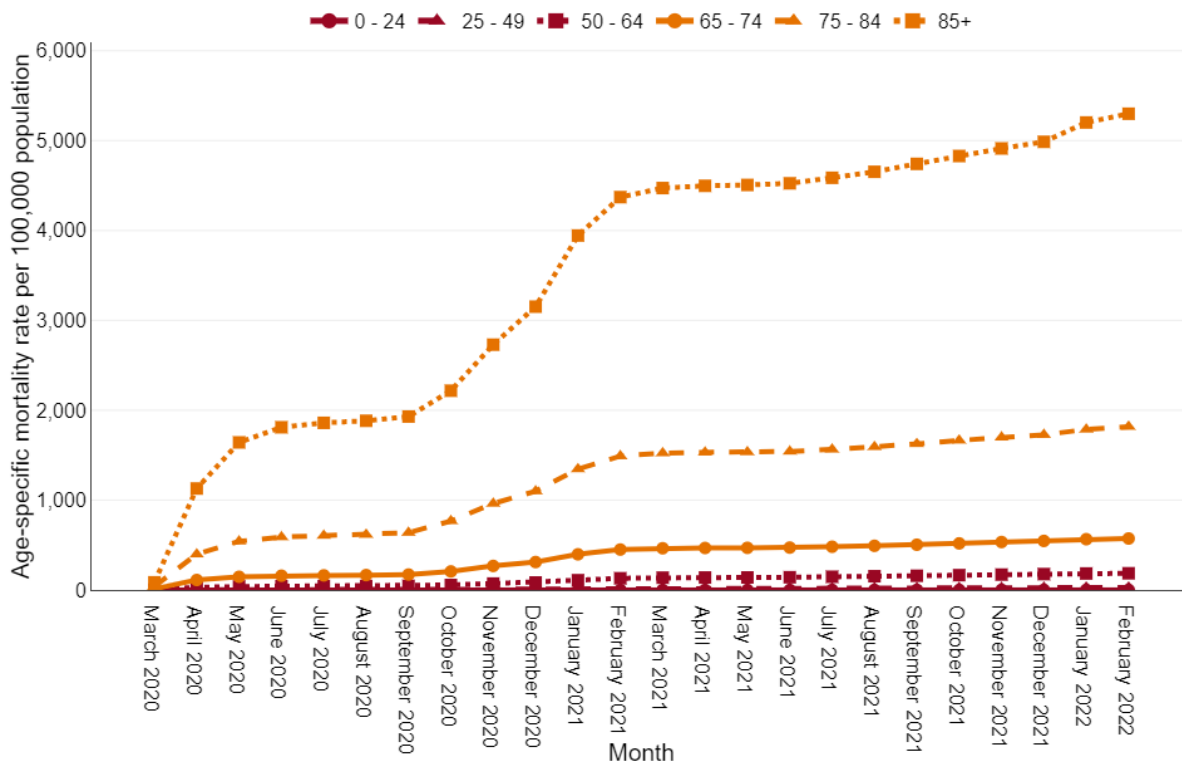
Data source: COVID-19 Health Inequalities Monitoring for England (CHIME) tool

Early in the pandemic, it was identified that the impact of COVID-19 was replicating existing health inequalities and, in some cases, increasing them (Public Health England, 2020). And the largest disparity found was by age, with older people disproportionately affected by COVID-19 because they are at increased risk of infection and of severe outcomes (Public Health England, 2020). As a result, death rates were considerably higher in older people, particularly those aged 75+ (Figure 2).

Some information has been published in the policy arena about the impacts of COVID-19 on older people, but while some are well-researched, others are posited impacts which need to be explored further. Mahmood et al. (2021) identified negative impacts of COVID-19 on deconditioning and falls, and Marmot et al. (2020) found that younger people were nearly twice as likely as older people to report being lonely; this has been a great point of discussion for

many. But most other impacts are anticipated rather than evidenced, and these include an increase in social isolation, a reduction in physical activity, and poorer mental health, physical capacity, and overall health and wellbeing (Public Health England, 2021).

Figure 2. Cumulative age-specific mortality rate per 100,000 population, for deaths involving COVID-19 in North West, by age, March 2020 to February 2022



Data source: COVID-19 Health Inequalities Monitoring for England (CHIME) tool

This rapid literature review therefore aims to bring together evidence from a range of sources to assess both the direct and indirect impacts of COVID-19 and its restrictive measures on older people in the United Kingdom and identify priorities for action as we continue through recovery. This will support the further development of the healthy ageing agenda in the North West and highlight the policy implications for local areas to support healthy ageing.

Methodology

The literature search was **conducted in October/November 2021**. It reviews academic and grey literature from a range of sources. Ebscohost was the primary database used to search for academic literature. Grey literature was identified using the same search terms using NICE Evidence, which has since closed, and a Google search.

Search terms included: ["COVID" OR "Coronavirus"] AND ["Impact" OR "Effect" OR "Consequence"] AND ["Older people" OR "Ageing" OR "Older adults" OR "Elderly" OR "Older people"] AND ["England" OR "Britain" OR "UK" OR "United Kingdom"].

Results for all searches were excluded if they were published before 2020 or not written in English. Following this exclusion, the searches yielded 1,575 results overall. Further exclusions were made, after reviewing the title, abstract, or full text of the remaining results, to identify those most relevant. This identified **82 relevant results**. And for completeness,

we identified an additional 7 reports from the [ELSA project](#), as well as one article identified as relevant in relation to long COVID.

Each article or report was reviewed to identify the impacts of COVID-19 on older people's physical and mental health and wellbeing, as well as on the wider determinants of health, including loneliness and social isolation, employment and deprivation, digital, and health and care usage.

Findings

Social isolation and loneliness

It has been reported that **loneliness among older people did not appear to increase as much as many expected** during COVID-19 (Jones & Jopling, 2021). But loneliness was already very prevalent among older people before the pandemic began, and this was compounded by social distancing (Marmot, et al., 2020).

One study in this review measured the impact on both objective and subjective social isolation, while many studied the impact on feelings of loneliness, and all were found to have increased during the pandemic. However, **subjective social isolation and feelings of loneliness increased more than objective social isolation** (Chatzi & Nazroo, 2021).

When measured objectively, social isolation and loneliness increased particularly among older men, those aged 70+ and the more deprived (Chatzi & Nazroo, 2021; Tomaz, et al., 2021). But subjective feelings of social isolation and loneliness were greater (Tomaz, et al., 2021; Zaninotto, et al., 2021), and **loneliness was felt among many older people**, including those who felt lonely before the pandemic began (Brown, et al., 2021; Marmot, et al., 2020; Chatzi & Nazroo, 2021; Mental Health Foundation, 2020). This was reportedly felt more by women, people with multimorbidity and worse health and wellbeing, and the youngest and oldest old (Chatzi & Nazroo, 2021; Okely, et al., 2020; Tomaz, et al., 2021; Zaninotto, et al., 2021).

The **relationship between loneliness and health and wellbeing** appears to be bi-directional (Tomaz, et al., 2021), which is perhaps unsurprising given that people aged 70+ and those assessed as clinically vulnerable to COVID-19 were advised to 'shield' and not leave home during the entirety of the pandemic.

Adherence to social isolation guidance

While older people were mostly compliant with government guidelines, studies have found that many adapted these to their own personal circumstances, based on their level of trust in others and their anxiety about personal risk (Brooke & Clark, 2020; Holton, et al., 2021). Therefore, **not all older people shielded as advised** (Brown, et al., 2021; Steptoe & Steel, 2020), with more and more choosing not to adhere to strict social isolation as the pandemic progressed; Steptoe & Steel (2020) found this proportion to be 55% of older people by June/July 2020.

However, older people from **ethnic minorities** (Age UK, 2021) and those with **multimorbidity were more likely to isolate or stay at home** during the pandemic (Zaninotto, et al., 2020) but, as a result, they experienced markedly higher levels of loneliness, regardless of the size of their household or whether or not they had a partner (Steptoe & Steel, 2020).

Social contact and support

Objective measures of social isolation are primarily linked to the perceived or actual social contact and support that older people had during the pandemic. Social distancing regulations **prevented them from leaving the house** and stopped many older people from volunteering (Chatzi, et al., 2020), even after restrictions were lifted (Jones & Jopling, 2021). But much emphasis has been put on findings that younger people were nearly twice as likely as older people to report being lonely (Marmot, et al., 2020). And some studies have identified potential reasons for this.

Some attribute this to an effective community response in the early stages of the pandemic (Jones & Jopling, 2021). And others mention increasing **contact with neighbours** & people in the community (Tomaz, et al., 2021) and increased volunteering (Chatzi, et al., 2020), which brought mutual support to the volunteer and the beneficiary (Jones & Jopling, 2021).

But one important reason to note for the difference in feelings of loneliness experienced between younger and older people is their respective levels of **resilience**. Jones & Jopling (2021) attribute the lower-than-expected levels of loneliness in this group to life experience in facing difficult times and a more universal lack of social contact pre-pandemic, alongside lower expectations of social contact during the pandemic and a reduced sense of pressure to be socially active for some. This emphasises that, just because older people do not report feeling lonely, it does not mean that they aren't, and they should not be de-prioritised.

The role of digital

Many older people also found **online social contact** to be a lifeline during the pandemic (Brooke & Clark, 2020; Jones & Jopling, 2021) with more than 80% of older people having real time contact by phone or videocall at least weekly with family and friends (Stephoe & Steel, 2020). As a result, several studies found that older people's **use of telephony and computing devices, the internet, and social media increased** during the pandemic (Age UK, 2021; Brooke & Clark, 2020; Fisk, et al., 2020; Jones & Jopling, 2021), and there were reports that levels of social contact and support remained the same or even increased for older people during the pandemic (Docherty, et al., 2021; Okely, et al., 2020; Steptoe & Steel, 2020; Tomaz, et al., 2021). One study also reported greater levels of relationship quality with those in their outer circle (Docherty, et al., 2021).

However, this temporary and remote contact only reduced objective social isolation and **did not stop feelings of loneliness** among older people (Chatzi & Nazroo, 2021), particularly those with small social networks (Tomaz, et al., 2021). It also **increased the digital divide**, as the increased use of digital was mostly seen among existing users (Age UK, 2021; Brooke & Clark, 2020). The pandemic did not prompt many non-users to get online (Age UK, 2021). Barriers to accessing the internet still exist (Age UK, 2021) and some older people, particularly their family members, are concerned about scams and online safety (Jones & Jopling, 2021)

Wider determinants of health

Employment

The UK government's temporary furlough scheme protected many people from being unemployed during the pandemic. But people still lost their jobs. And while young people aged 20-24 were most likely to be working in a 'shutdown sector', older workers aged 50+ were equally as likely to work in these sectors as those aged 25-49. Despite this, **older**

workers were more likely to have been furloughed than those in mid-career, particularly if they were aged 60+ (Centre for Ageing Better, 2020).

As a result, the Centre for Ageing Better (2020) found that **one in four older workers were furloughed** during the first lockdown, and the Office for Budget Responsibility (OBR) estimated that **15% of these would become unemployed**. Before the pandemic hit, an estimated 10-20% of older workers were in insecure work (Pit, et al., 2021), and 2% had lost their job by May 2020. A further 25% felt it likely they would lose their job as a result of COVID-19 (Pit, et al., 2021).

This is of particular concern when evidence shows that older workers are far less likely to return to work after a redundancy. And, while some older people enjoyed furlough, some were **concerned about the future**, and many hoped to avoid redundancies. 68% of older people not in work said they did 'not feel confident that they will be employed in the future', including 20% of those who were furloughed (Pit, et al., 2021). The **most damaging impacts** from the loss of employment hit older workers and Pakistani and Bagladeshi groups (Marmot, et al., 2020).

Of the older people who continued working during the pandemic, nearly a quarter reported **worsening health**, including mental health, impacted by COVID-19 (Pit, et al., 2021). But again, **older key workers showed more resilience** than their younger counterparts, with 16% of people aged 65+ feeling it likely they would burnout in winter 2020/21 compared to 63% of those aged 18-24 (Jooshandeh, 2020).

Informal carers

There is mounting evidence that unpaid caring should be considered a social determinant of health, as often carers experience poor physical and mental health (Public Health England, 2021). During the pandemic, many older carers reduced or stopped caring completely, which may have been beneficial for them. But **nearly a quarter of older carers increased their levels of caring**, and **more than one in ten older people became new carers** for someone outside of their household.

Women were more likely to stop caring than men (Chatzi, et al., 2020), which likely highlights pre-pandemic caring responsibilities outside of their own household. But **those aged 80+ were less likely to stop, reduce or increase levels of care** (Chatzi, et al., 2020), reflecting existing caring responsibilities of partners within their household.

Increases in caring reflect the lack of services available during lockdown, and this was **mostly experienced by those aged 50-59** (Chatzi, et al., 2020) who are likely to have been caring for their elderly parents, whether furloughed or employed (Centre for Ageing Better, 2020). This is likely to have compounded older workers' worsening health during the pandemic. Variations in social support service usage for people with dementia also impacted on the mental wellbeing of older people and unpaid carers (Giebel, et al., 2021).

Finances

Many older people, particularly those who do not rely on work-based income, have **avoided the worst financial consequences** of the pandemic, and for the majority of older people, finances were either unaffected or improved (Crawford, 2021; Osterrieder, et al., 2021; Smith & Taylor, 2021). But still, 20% of older people found themselves in a worse overall financial situation after the pandemic began (Crawford & Karjalainen, 2020; Osterrieder, et al., 2021).

And **those who continued to work during COVID-19 were more likely to report a loss of income**, causing them more worry (Crawford, 2021; Osterrieder, et al., 2021). Older people with multimorbidity were also particularly worried about finances, obtaining food and other essentials (Zaninotto, et al., 2020).

Financially, **those with an already lower net financial wealth and those from minority ethnic groups were hit the hardest** (Crawford & Karjalainen, 2020; Marmot, et al., 2020). And some older people had to reduce their spending or their savings to get by during the pandemic, while others drew on savings, borrowed money, or sought help and support to cover losses in income. **Some older people even faced multiple financial struggles** and took advantage of many different types of non-work based financial support, causing high levels of mental distress (Smith & Taylor, 2021).

Fluctuations in the stock markets also hit those with wealth held in risky assets and Defined Contribution pensions (Crawford & Karjalainen, 2020), and one study found that, as a result of the pandemic, **retirement income would be lower** for a third of all older people, rising to 45% of those in paid work (Crawford, 2021).

The negative financial impact of the pandemic on older people does appear to have improved as the pandemic progressed, but **some older workers now plan to retire later with a lower retirement income**, demonstrating the long-lasting effects of the pandemic (Crawford, 2021).

Mental health and wellbeing

Mental health and wellbeing were **most prevalently reported** in the literature identified for this review. And the findings can be divided into mental health, wellbeing and coping strategies during the pandemic.

Mental health

Anxiety and depression reportedly increased among older people during the pandemic (Docherty, et al., 2021; Steptoe & Steel, 2020; Zaninotto, et al., 2021), and the Centre for Ageing Better (2021) found that more than one in three older people aged 50-70 saw their mental health deteriorate. This reflects both the **exacerbated symptoms** experienced by older people with an existing mental health condition during the pandemic and the **new feelings** of anxiety, low mood and depression experienced by many older people for the first time (Age UK, 2021).

However, these studies used self-reported measures and, when assessing this objectively, Richardson et al. (2021) only found strong evidence for increased depression in males, despite self-reported depression being similar between the sexes (Richardson, et al., 2021). Furthermore, Brown et al. (2021) found that **fewer than one in ten older people actually met the criteria indicative of depression or anxiety**. As with loneliness, this highlights the difference between subjective & objective measures of depression and the caution with which one should interpret any findings.

But self-reported measures still help give us an understanding of mental wellbeing, and the rise in anxiety and depression was found to be steeper for those with multimorbidity and the clinically vulnerable, with severe symptoms being twice as common among those shielding (Steptoe & Steel, 2020; Zaninotto, et al., 2021). However, the **largest and most worrying increases in mental distress were seen among those in the weakest financial position**

before the pandemic began, despite this group having the highest level of pre-existing mental distress (Smith & Taylor, 2021). This will have widened existing inequalities.

Some studies identified **factors that are likely to have contributed to poorer mental health** during the pandemic. These included separation from family, friends and social support (Hassan, et al., 2021; Mental Health Foundation, 2020), home conditions (Centre for Ageing Better, 2020), and the pandemic itself, reducing many older people's confidence in doing everyday activities outside of the house (Age UK, 2021).

But despite all this, older people, including those who are LGBT+, were less likely to report stress or anxiety than younger people, demonstrating, yet again, **greater resilience than their younger counterparts** (Marmot, et al., 2020; Mental Health Foundation, 2020).

Wellbeing

As well as impacting mental health, **many older people experienced poorer wellbeing**, feelings of hopelessness, and mood disturbance during lockdown (Docherty, et al., 2021), and those who were shielding experienced impaired life satisfaction, happiness, sense of purpose, sleep & general quality of life (Steptoe & Steel, 2020). This low mood and poor mental health **led some older people to self-neglect** (Age UK, 2021), putting some at increased risk of malnutrition during lockdown (Baic, 2021).

But those experiencing the **worst impacts** on wellbeing were reportedly women, those sleeping poorly and doing less physical activity, the more deprived, those finding it difficult to get by financially, and those with lower perceived social support (Centre for Ageing Better, 2021; Tomaz, et al., 2021).

Some older people, however, were more concerned about others worse off than themselves (Brooke & Clark, 2020), and **helping others was positively associated with wellbeing** in this group (Bell, et al., 2021). More positive changes in mental health difficulties and psychological wellbeing were associated with higher levels of intellect, emotional stability, and extraversion, while negative changes were more likely for those with more symptoms of anxiety or those who live alone (Okely, et al., 2020).

After lockdown, the pandemic continued to be a source of great anxiety for some older people (Age UK, 2021), and **wellbeing, depression and total mood disturbance continued** to be negatively affected (Docherty, et al., 2021). However, feelings of hopelessness decreased (Docherty, et al., 2021).

Coping strategies

Osterrieder et al. (2021) found that **older people in the UK were just as likely as younger people to cope with not going out** for 29 days or longer, except for essential needs or work. And only a few older people reported not coping well in June 2020, compared to a much larger proportion of younger people (Mental Health Foundation, 2020). This is because, while older people experienced disruptions and identified a number of challenges and concerns about lockdown, **they adapted**. Adaptions took the form of connecting with family and friends online and arranging deliveries of essential goods, either from business or by family members (Holton, et al., 2021).

Over half of older people also identified **positive aspects of lockdown and factors that were important in getting them through**. These related to community, both on and offline, and living a 'simpler', 'slower' and 'easier' life while still keeping themselves busy, both physically

and mentally (Brooke & Clark, 2020; Brown, et al., 2021). These people also recognised the importance of being able to leave the house and having access to a garden and outside space. Tomaz et al. (2021) confirmed this, finding that living in a remote area was linked with better wellbeing during the pandemic.

Physical health and wellbeing

Three studies included in this review found that **many older participants had good health** during the pandemic, or saw improvements in physical health, mobility, self-care and the ability to perform usual activities (Brown, et al., 2021; Docherty, et al., 2021; Tomaz, et al., 2021). However, older people were particularly susceptible to the more severe effects of COVID-19 infection, and there is strong evidence that **the risk of long-COVID increases with age**, with most experiencing persistent tiredness and some also experiencing persistent respiratory and related symptoms (Whitaker, et al., 2021).

And despite the findings above, Age UK (2021) estimated that **millions of older people saw a decline in their physical health and function** during the pandemic, and the Centre for Ageing Better (2021) put it at 1 in 5 older people aged 50-70. For some, **catching COVID-19 made their health worse** and, for a minority, deterioration of health & wellbeing was severe enough to affect their independence (Age UK, 2021).

Research also found **evidence of accelerated cognitive decline**, leaving some older people forgetful & confused (Age UK, 2021; Docherty, et al., 2021). This supports findings that a decrease in wellbeing and social support during the pandemic was correlated with an increase in memory problems (Okely, et al., 2020). But **this may have been temporary**, as Docherty et al. (2021) found that confusion and memory were no longer impacted after lockdown ended.

The pandemic also led to an **increase in older people in the community who were at risk of malnutrition**. Most vulnerable to this were older people recovering at home from mild-to-moderate COVID-19, those discharged from hospital after severe COVID-19 infection, and those with extended periods of social isolation as a result of social distancing (Baic, 2021). This supports findings that loneliness is associated with poorer wellbeing and self-rated health (Tomaz, et al., 2021).

Those whose health was **most affected** during the pandemic were older people with pre-existing health or care needs, older carers and those on low incomes (Age UK, 2021; Centre for Ageing Better, 2021).

Health behaviours

Two studies in this review found older people who increased their physical activity during lockdown (Brown, et al., 2021; Docherty, et al., 2021), and one found that older people maintained their pre-lockdown physical activity levels (Richardson, et al., 2021). However, many of these people had access to a private outdoor space, which is not necessarily representative of all older people. And Brown et al. (2021) found that **many more older people were less active than before the pandemic**, which is consistent with findings from a number of other studies (Centre for Ageing Better, 2021; Mahmood, et al., 2021; Okely, et al., 2020; Rowlands, et al., 2021).

Age UK (2021) also found that one in four older people are unable to walk as far as before the pandemic and one in 3 had less energy, and Mahmood et al. (2021) found a considerable **reduction in older people's strength and balance activity**, with the greatest change in 70-

74. This is likely linked to increased sedentary and screen time (Richardson, et al., 2021; Tomaz, et al., 2021), which seemed to relate to worse wellbeing (Tomaz, et al., 2021), and is a big risk factor for increased falls.

The largest rise in inactivity was experienced by those aged 65-84 (Centre for Ageing Better, 2021), and **inequalities in physical activity in older people persisted** during the pandemic (Mahmood, et al., 2021), with older women and those who are heavier, inactive and/or from minority ethnic groups most at risk of lower physical activity (Rowlands, et al., 2021).

Few studies were found that investigated the impact of the pandemic on other health behaviours, but the Centre for Ageing Better (2021) found that one in thirty older people aged 50 and 60 **drank and smoked more during lockdown**. A few studies also found that the pandemic had an adverse effect on the quality of older people's sleep (Okely, et al., 2020; Steptoe & Steel, 2020; Tomaz, et al., 2021; Zaninotto, et al., 2020). And Zaninotto et al. (2020 and 2021) found that older people with multimorbidity were more likely to report detrimental changes in health-related behaviours, including less physical activity, watching more TV, sitting more, sleeping poorly, and eating less than usual.

Recognising that the impacts of the pandemic are not universal across all older people, Okely et al. (2020) identified that more **positive changes** in physical activity and sleep quality were associated with greater intellect, emotional stability, extraversion, and higher cognitive ability. **Negative changes** were more likely for those with a history of CVD, more symptoms of anxiety, or those who live alone.

Health and care services

Access to services

During the pandemic, access to prescription medication continued largely unaffected for older people (Propper, et al., 2020). However, their **ability to access GP, dentist and other health and care services during this time tended to be limited**, especially for those with the worst health, who were more than twice as likely not to see or talk to a GP when they sought one (Propper, et al., 2020; Zaninotto, et al., 2020; Zaninotto, et al., 2021).

In 2020, Zaninotto et al. found that one in five older people with multimorbidity did not have access to the health and care support they needed, but by 2021, more than one in two were unable to access a GP or a dentist. Brown et al. (2021) found that the majority of older people were able to access the health, social/council, pharmacy or voluntary services they needed during lockdown, but this sample was not representative of the whole population.

Continuity of care

Propper et al. (2020) found that **older people were more likely to experience a disruption to their hospital care** than others. Many experienced a delay to their medical or dental appointment (Centre for Ageing Better, 2021), and between one in six and one in eight had a hospital operation or treatment cancelled (Propper, et al., 2020; Zaninotto, et al., 2021). More deprived older people, and those with multimorbidity and worse self-reported health, were most likely to experience disruption to both health and care services (Propper, et al., 2020; Zaninotto, et al., 2021).

Cancer care makes up some of this disruption, despite 'Cancer Hubs' with telephone consultations being set up; non-essential surgical cancer procedures were deferred, radiotherapy schedules were adapted, and most clinical cancer trials were interrupted. NICE

also had to issue specific recommendations to shorten or postpone systemic cancer treatments to reduce toxicity (Desideri, et al., 2020).

Because of the increased pressure on the health and care system during the pandemic, GPs said that **monitoring chronic conditions was seen as less of a priority** (Alboksmaty, et al., 2021). However, some of these primary care teams were proactive in addressing this gap and developed their own approaches to continue chronic disease self-monitoring. They prioritised some patient groups who needed more attention, such as those living alone, those who needed regular monitoring for their medications, elderly in care homes, patients with chronic medical conditions, patients with dementia, and the shielded groups.

However, GPs also reported some **delays in coordination of services** with other teams, such as referrals to secondary and tertiary care (Alboksmaty, et al., 2021). And **social support usage for dementia decreased significantly** during the pandemic (Giebel, et al., 2021). Being unable to access these services contributed to worse quality of life and anxiety in older people and those affected by dementia, with higher variations in service usage associated with increased anxiety and lower mental wellbeing in older people, people with dementia, and unpaid carers.

Use of services

In the early stages of the pandemic, **older patients' care-seeking behaviour changed radically**, with patients more willing to practice self-management for minor conditions (Alboksmaty, et al., 2021; Propper, et al., 2020). However, this was not driven by an increased sense of empowerment and activation, but rather by patients' increased fear of contracting COVID-19 (Alboksmaty, et al., 2021). As a result, between 14% and 25% of older people requiring GP care, and between a third and three quarters requiring community care, did not contact these services (Propper, et al., 2020; Alboksmaty, et al., 2021). This realised GP concerns that stay-at-home messages might be interpreted as meaning avoiding medical attention (Alboksmaty, et al., 2021).

Coupled with the lack of face-to-face consultations during the pandemic, this raised **concerns among GPs** about potential risks of misdiagnosis, delayed care, missing early signs of disease deterioration, and the inability to monitor and update medications for patients with complex conditions (Alboksmaty, et al., 2021). Some of this turned out to be a reality, as **dementia diagnosis rates dropped** during the pandemic to below half the pre-pandemic rate (Zaninotto, et al., 2021). However, **diagnosis rates for arthritis, chronic lung disease, diabetes and hypertension all increased** in older people during the pandemic, and the reasons for this are unclear (Zaninotto, et al., 2021).

Use of digital

Thanks to social distancing measures, **the pandemic dramatically increased the use of tele- and video-consultations** in the UK and brought very rapid changes in the delivery of GP and outpatient services (Fisk, et al., 2020). Appointments for remote consultations became more available and easier to book, and **patients seem to have accepted this** as the norm (Alboksmaty, et al., 2021).

These consultations meant that patients in rural areas could be accessed more easily (Canady, 2021). But GPs were **concerned about the accessibility of remote consultations**, especially among elderly patients, as there are challenges of conducting effective consultations remotely (Alboksmaty, et al., 2021; Canady, 2021). One is a question

of access and technological know-how, while another is a question of effective and quality care, particularly for complex elderly patients (Alboksmaty, et al., 2021).

Telehealth did not have a place in the UK government's plans before the COVID-19 pandemic hit, and the use of telecare services will have come as a shock to many service users, resulting in the potential for some users to feel that it provides a relatively poor offering (Fisk, et al., 2020). In addition, **42% of older people aged 75+ do not use the internet** (Age UK, 2021), and some health professionals were concerned about their older patients' ability to access and engage in remote consultations (Alboksmaty, et al., 2021; Canady, 2021).

The reach of these new telehealth initiatives to older people in the UK during the pandemic is uncertain (Fisk, et al., 2020). But we do know that **digital offerings have excluded some people and widened the digital divide**, as those who are older or from ethnic minority backgrounds were less likely to take up a virtual group weight management programme hosted during the pandemic (Abbott, et al., 2021).

The most frequent reason for declining this was **lack of internet access and/or lack of digital skills**, but some just wanted to take part in face-to-face sessions. In cases such as this, group activities were often replaced with one-to-one telephone support, which had a **profound impact on the services offered to those who were lonely and isolated** (Jones & Jopling, 2021).

The **resilience and resourcefulness of patients and carers** were therefore very important in supporting older people to engage with technology, emphasising the value of family, social care, and community (Alboksmaty, et al., 2021). And facilitating contact with family and friends using video calls for patients were among the innovations and resources found helpful in mental health services (Canady, 2021).

Discussion

Summary of findings

Many older people have shown resilience in the face of the pandemic, which may have made it seem as though they have been less impacted by it than younger people. But some have still experienced damaging effects of both COVID-19 infection and social distancing measures. And those who are, lonely, struggling financially, less healthy and from an ethnic minority background experienced the worst and widest-ranging effects of the pandemic, but it is unclear how long-lasting these impacts may continue to be.

Those who were shielding or from ethnic minority groups were more removed from society than their peers of people from younger age groups. This exacerbated pre-existing loneliness and caused confusion and memory loss. And though the effect on confusion and memory loss was temporary, it highlights just one of the detrimental yet modifiable impacts of social isolation and loneliness in older age, which can be felt regardless of the size of their household and whether or not they have a partner.

Contact with family, friends and neighbours, whether on or offline helped many older people to cope with social isolation, and many existing internet users have increased their usage. But online contact was no substitute for in-person contact, and many older people are still non-users with no interest in getting online. This has important implications for how we move through this new digital age that the pandemic has catalysed, particularly in relation to health and care.

Retirees were largely unaffected financially by the pandemic. But some older people have lost jobs, income, and savings, and many of those affected believe that their retirement plans need to change. It is unclear whether these effects are lasting, but previous evidence suggests that older people are much less likely to re-enter the job market after being made redundant. Some older workers also increased the level of unpaid care they were providing during the pandemic, and little is known about whether this has continued and how they are able to balance these extra responsibilities, particularly with the increase in working from home. More research is needed to understand these longer-term effects.

But, while many older people have shown resilience, the fears, isolation and financial worries caused by the pandemic and its restriction measures have caused mental distress and poor wellbeing for some, leading some older people to self-neglect. And some older people expressed fear of returning to normal, even after restrictions were lifted, particularly for those most at risk of severe infection, including those with multimorbidity and those from an ethnic minority background.

However, this review has also identified factors that have protected older people against the worst impacts of the pandemic, and these should be built upon to help improve healthy ageing for all. These are linked to some of the five ways to wellbeing, including connecting with others, being physically active, and helping others.

The impacts of COVID-19 on some older people's physical and mental health have clearly been detrimental, and they have been more likely to have had treatments and operations delayed or cancelled. Some are still awaiting treatment, and some are continuing to suffer from long-COVID.

Older people's physical inactivity also increased, putting them at increased risk of falls, and few have sought healthcare when needed, either for fear of catching COVID-19 or the inability to access remote consultations. As a result, dementia diagnoses have dropped but, for reasons that are unclear, diagnoses of other long-term conditions have increased.

Strengths

This literature review uses a range of evidence from a range of databases, taken from both academic and grey literature. Most of the findings were based on large, representative sample sizes, some using existing longitudinal cohorts and very strong and respected data sources.

Together, the studies also represented a range of research methods, providing both quantitative and qualitative data, as well as insights from healthcare professionals and academics. The use of grey literature also helps to limit any potential publication bias, and provides insights not found in academic literature.

Limitations

However, there were some quality issues with some of the studies. There are often no quality controls on grey literature and, due to the nature of the pandemic, some studies used online methods to recruit and engage with participants. Some also had very small sample sizes for the methodologies used, meaning that some findings were not representative of all older people, particularly ethnic minority groups, those who are not online and those who are less educated.

The definition of older people also varied from study to study, sometimes making it difficult to triangulate findings and figures; some were specific to people aged 50 to 70, while others for people aged 65+. And no evidence was identified that explored the intersectionality and cumulative effects of being an older person alongside other vulnerability factors, including ethnic minority background, LGBT+, and disabled groups.

Implications

Implications for decision-makers include:

- Being aware of the use of objective and subjective measures when assessing loneliness, anxiety and depression, understanding that each has their merits but very different inferences.
- Helping people to get online will require support from family and friends, but alternatives to digital should be provided, so that services do not exacerbate loneliness for those who are not and will not be internet users
- Recognising & capitalising on the protective factors identified during lockdowns to support healthy ageing, including helping older people realise the five ways to wellbeing can help older people to be healthier with high levels of wellbeing

Further research is required into:

- The longer-term impacts of COVID-19 on employment, unpaid caring, and retirement plans and income
- Older people's health and wellbeing concerns given the persistence of COVID-19 in everyday life, particularly those who are most vulnerable, including those with multimorbidity and those from ethnic minority backgrounds

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