Age UK
Love later life

The State of Health and Care of Older People in England 2023

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FOREWORD

This is the first 'State of the Older Nation' report that Age UK has produced since the **pandemic and as such it's** the first comprehensive analysis of our older population's health and care needs, and how well they are being met, for several years.

We're struck by three key messages:

- **Covid has cast a long shadow over older people's health and social care** – one which continues to this day. Too many people still have poor mental or physical **health which can be attributed to the Covid period. It's not surprising that hospitals** and care services are under pressure because need has unquestionably risen.
- There are particular groups of older people, such as those from some ethnic minorities, or living in deprived communities, whose experience is even worse than the rest of the population.
- The forward trends set out cannot be ignored-it is simply a matter of time before our health and care system buckles under the needs of an increasingly older population.

This report is an all too familiar and depressing read because virtually all the trends are heading in the wrong direction. We are spending a lot of public money on the health and care of older people but the outcomes are disappointing: many lack the social care they need, and/or end up in hospital when this might have been avoided, and then languish there for longer than medically required. This in turn undermines their ability to make a full recovery, as well as making it harder for hospitals to admit new patients. The logjam then backs up so that waits in emergency departments and ambulance response times elongate, with the result that on the worst days the whole system grinds to a disastrous halt.

The 'crisis in the NHS' therefore ultimately reflects our failure to care as effectively as we could and should for our growing older population. Combined with the impact of Covid, **it's a "perfect storm".**

But it d**oesn't have to be like this.**

There is an opportunity now to respond to the evidence presented in this report and change how we are supporting our older population, giving us a much greater chance of success.

There's no escaping the need for us as a country to spend more on the NHS and even more so on social care but, just as importantly, we need to spend it differently. At the heart of this are three areas where change is needed:

- Reverse the decline of primary and community health services and social care so many more older people get more help, earlier, enabling them to stay well for longer at home and reducing their reliance on crisis health care in hospitals.

- Join these community-based services up too so they are genuinely multi-disciplinary, include the voluntary sector, working closely with GPs and their staff. **These services also need to be able to flex to respond to older people's** and their **unpaid carers' wants and needs.**
- **Establish a fundamental principle of 'home first' to our approach to care**. Rather than older people always having to go to hospital it will often make more sense for the hospital to come to them. Hospital at home teams and virtual wards are proliferating as mechanisms for providing clinical oversight and care for older people in their own homes. So too are falls services, community teams whose job it is to help older people after a fall and to prevent their recurrence.

All these approaches and more are already becoming part of the mix in some communities, we simply need many more, everywhere.

Underpinning this should be:

- The people to staff our primary and community health and social care services; as well as paying them fairly for their skills and commitment we also need to increase the overall attractiveness of their roles.
- Support for the health, wellbeing and finances of their unpaid carers. They need more practical support, though a good social care system they could rely on would help the most.
- An infinitely more ambitious cross Government drive to narrow health inequalities between people of all ages, ethnicities and places, to address the social and economic determinants of ill-health.

The huge financial costs to our country and the harm to older people from continuing with our current outmoded way of working are too high.

As the NHS celebrates its 75th Anniversary, the way we treat our older people has to be the most pressing need.

The time for change is now.

Paul Farmer

Caroline Abrahams

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1. THE HEALTH AND CARE NEEDS OF OUR OLDER POPULATION

1.1 England's population is ageing

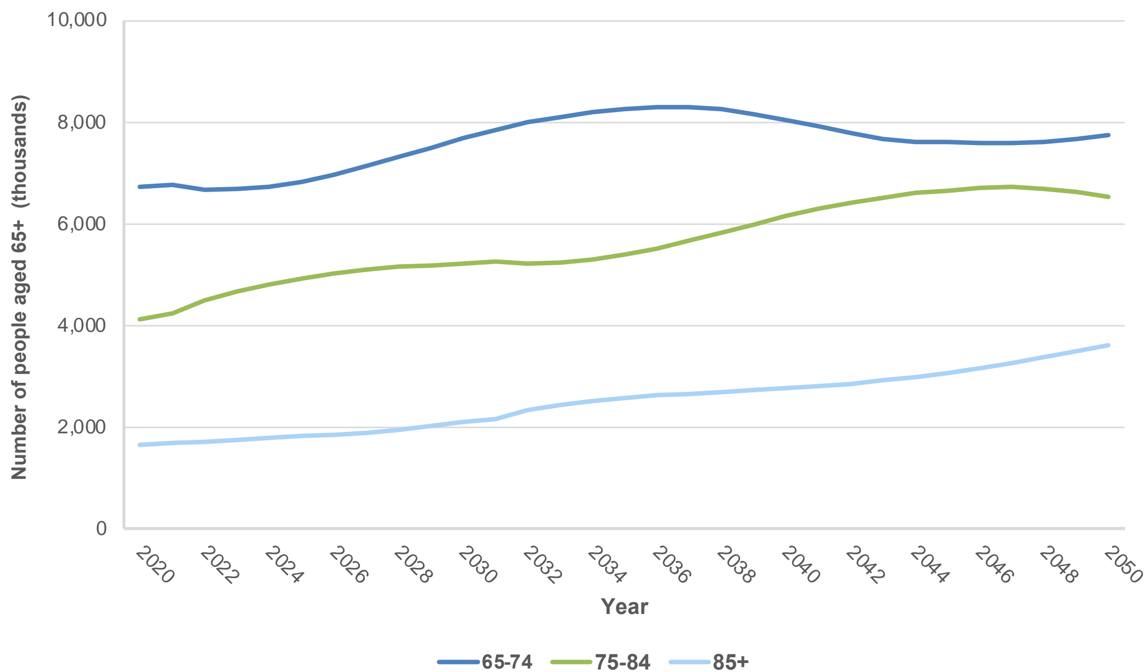
When the NHS was founded and the origins of our adult social care system established more than seven decades ago, one-in-two people died before they reached the age of 65. Now, fewer than one-in-seven people die before the age of 65.[1] With people living longer and having fewer children, the age structure of our population is shifting towards older ages. The number of people aged 65+ relative to the number of people under 65 is increasing.[2] A 65-year-old male can expect to live at least another 18.5 years, while a 65-year-old female can expect to live at least another 21.0.[3] In 2023, there are now 11 million people aged over 65 in England, equivalent to one in five of the total population.[4]

As shown in *Figure 1.1*, the population of people aged 65+ in England is projected to increase by 30.5% between 2023 and 2043 (an increase of 4.0 million people). More immediately, as members of the large cohort of people born after World War II (the 'baby boomer' generation) continue to reach 65 years, the older population is projected to increase by 9.9% in the next five years alone (an increase of 1.3 million people).[5]

The population aged 85+, the age group most likely to need health and care services, is also projected to rise rapidly, increasing by 10.6% by 2028 (an increase of 187,000 people), and by 66.0% between 2023 and 2043 (an increase of 1.2 million people).[6]

[1] ONS (2021). *National life tables: UK*.
[2] ONS (2022). *Overview of the UK population.*
[3] ONS (2021). *National life tables - life expectancy in the UK 2018 to 2020*.
[4] ONS (2022). *National population projections: 2020-based interim*.
[5] ONS (2022). *National population projections: 2020-based interim*.
[6] Numbers do not total due to rounding. ONS (2022). *National population projections: 2020-based interim*.

Figure 1.1 Actual and projected number of people, aged 65+, by age group, 2020-2050, England.



Geographic variation and health inequalities

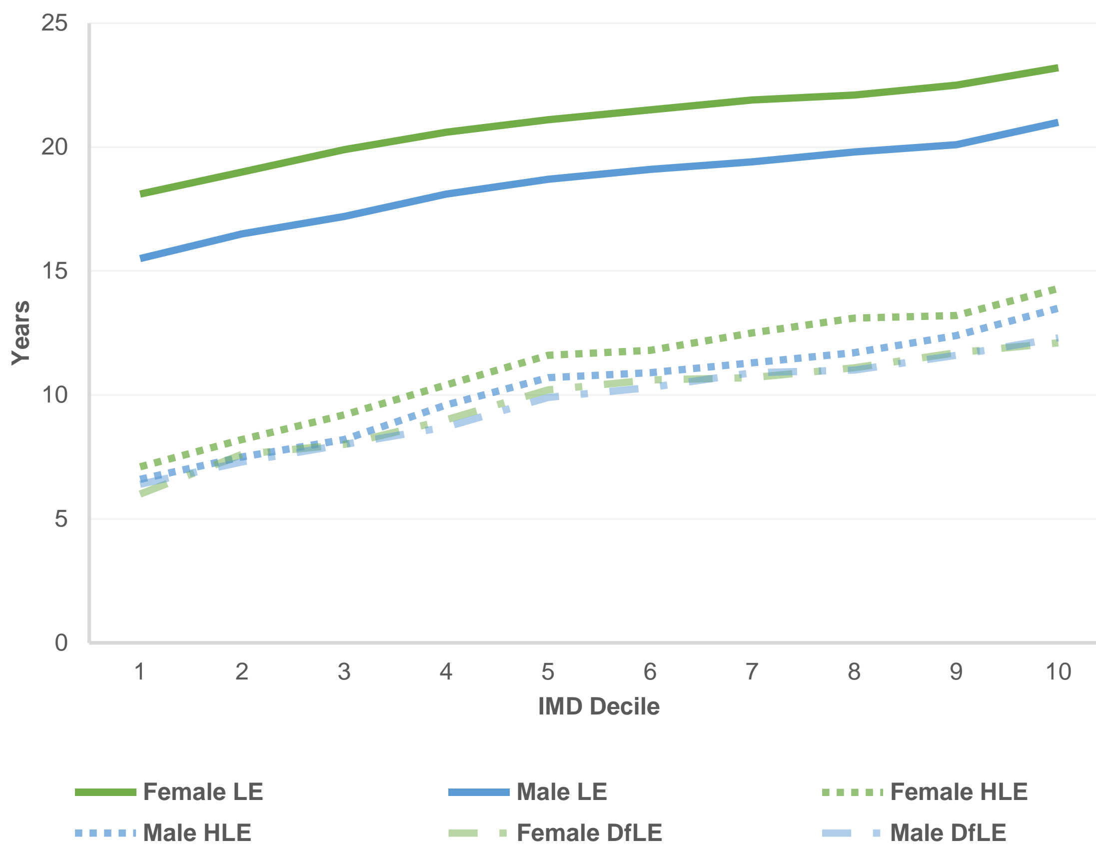
Within England, male life expectancy at birth in 2018-2020 was highest in the South East (80.6 years) and lowest in the North East (77.6 years). This is a sizable regional difference of three years. The pattern for females mirrored that for males, with life expectancy highest in London (84.3 years) and lowest in the North East (81.5) – a difference of 2.8 years.[7]

Life expectancy follows the social gradient – the more deprived the area the shorter the life expectancy – as shown in *Figure 1.2*. This gradient has become steeper in recent years, meaning inequalities in life expectancy have increased.[8]

[7] ONS (2021). Life expectancy for local areas of the UK: between 2001 to 2003 and 2018 to 2020.

[8] Marmot et al (2020). Health equity in England: The Marmot Review 10 years on.

Figure 1.2 Average Life Expectancy (LE), Healthy Life Expectancy (HLE) & Disability-free Life Expectancy (DfLE), at age 65, by deprivation deciles, using the Index of Multiple Deprivation (IMD), 2018-2020, England.



Source: Age UK 2023: Analysis using ONS (2022). *Health state life expectancies by national deprivation deciles, England: 2018-2020.*

In 2018-2020, at age 65 women in the least deprived 10% of areas in England could expect to live 7.9 years longer than women in the 10% most deprived areas, while for men the difference was 9.7 years.[9] Men and women living in the 10% most deprived areas of England saw a significant decrease in life expectancy between 2015-2017 and 2018-2020.[10]

> Understanding the impact and effects of the COVID-19 pandemic
>
> More than 227,000 people in England have died with COVID-19 mentioned as one of the causes on their death certificate since the start of the pandemic [as of July 2023].[11] In the calendar year of 2020, the number of deaths in the UK exceeded the number of live births for the first time since 1976 and only the second time

[9] ONS (2022). Health state life expectancies by national deprivation deciles, England: 2018 to 2020.
[10] ONS (2022). Health state life expectancies by national deprivation deciles, England: 2018 to 2020.
[11] UK Government (2023). Coronavirus (COVID-19) in the UK: Deaths [as at 4 May 2023].

since data has been collected.[12]

While some young and middle-aged adults can develop serious complications or die from COVID-19, the risks rise sharply with age. This is likely because immune systems tend to deteriorate with age and because older people are more likely to have long-term conditions. Nine in ten (91.7%) of the people who have died in hospitals in England and have tested positive for COVID-19 were aged 60+.[13] The proportion of deaths made up of older people has changed over the course of the pandemic, decreasing as vaccination rates – which are highest among the 75+ age group[14] – increased. However, deaths involving COVID-19 continue to be highest for those aged 85+. This has been consistent throughout the coronavirus pandemic.[15]

People with an existing long-term condition or disability were more likely to die. Six out of 10 people who died with COVID-19 between January and November 2020 also had a disability.[16]

During the first wave of the pandemic, 40% of all UK deaths were among care home residents.[17] COVID-19 was found to have had a disproportionate impact on the mortality of care home residents in England compared to older residents of [self-contained] private homes, but only in the first wave. This may be explained by a degree of acquired immunity, improved protective measures or changes in the underlying frailty of the populations.[18]

People from ethnic minority communities were also more likely to die. In the first wave, people from all ethnic minority groups (except for women in the Chinese or "white other" ethnic groups) had higher rates of death involving COVID-19 compared with the white British population.[19] In the second wave, most black and South Asian groups remained at higher risk than white British people.[20] Age remained the biggest risk factor.

Some ethnic groups had more exposure to COVID-19 at work[21], and some of the excess risk can be explained by a higher risk of serious COVID-19 disease linked to

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[12] ONS (2022). *Overview of the UK population: 2020*.

[13] Age UK analysis: *COVID-19 total announced deaths 9 February 2023* [datset, accessed 9th February 2023]

[14] ONS (2023). *Coronavirus (COVID-19) latest insights: Vaccines [as at 3rd February 2023].*

[15] ONS (2023). *Coronavirus latest insights: Deaths* [28-03-2023].

[16] Suleman, M., Sonthalia, S., Webb, C., Tinson, A., Kane, M., Bunbury, S., Finch, D., & Bibby, J. (2021). *Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report.* Health Foundation.

[17] Scobie, S. (2021). *Covid-19 and the deaths of care home residents*. Nuffield Trust

[18] Schultze, A. et al (2022). Mortality among Care Home Residents in England during the first and second waves of the COVID-19 pandemic: an observational study of 4.3 million adults over the age of 65. *The Lancet: Regional Health: Europe*. 14:100295

[19] ONS (2021). *Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021.*

[20] ONS (2021). *Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021.*

[21] ONS (2020). *Why have Black and South Asian people been hardest hit by COVID-19?*

other conditions, such as diabetes and heart disease.[22] However, much of the excess risk has not yet been explained. From January 2022 (when Omicron became the main variant), there was no longer evidence of ethnic minority groups having a significantly higher COVID-19 mortality rate compared with the White British group.[23]

People living in the most deprived local areas were more likely to die. COVID-19 mortality rates in England were more than twice as high for people from the most deprived 10% of local areas compared with people from the least deprived 10%, and almost four times as high for people younger than 65 in those areas.[24]

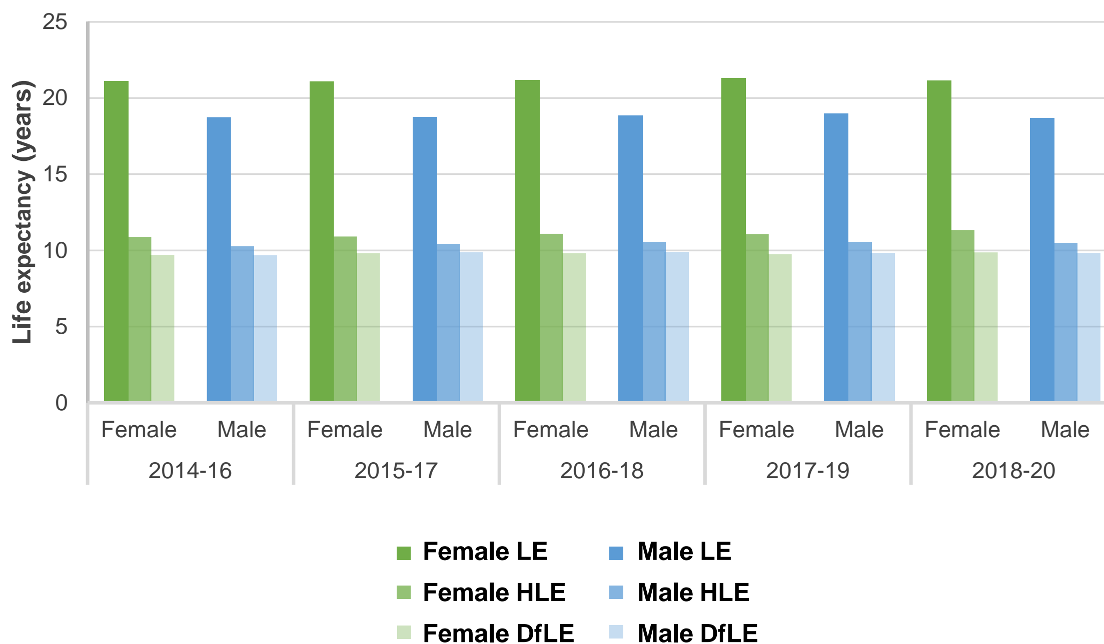
1.2 Life expectancy and healthy life expectancy gains have stalled

England experienced continuous improvement in life expectancy from 1890 to 2010.[25] However, from 2010 this improvement slowed, almost halting for much of the population and even falling for the poorest 10% of women.[26] The scale of the slowdown leaves the UK standing out from other comparable countries.[27]

Life expectancy at birth can be sensitive to changes in infant mortality at the youngest ages[28], but it is important to recognise that improvements in life expectancy at older ages have also slowed in recent years, as shown in *Figure 1.3*. Life expectancy at birth in England in 2018 to 2020 was 79.0 years for men and 82.9 years for women.[29]

[22] UK Research and Innovation (UKRI) (2020). *Why do people from ethnic minorities suffer more from COVID-19?*
[23] ONS (2023). *Updating ethnic and religious contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 23 November 2022.*
[24] Suleman, M., Sonthalia, S., Webb, C., Tinson, A., Kane, M., Bunbury, S., Finch, D., & Bibby, J. (2021). *Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report*. Health Foundation.
[25] ONS (2015). *How has life expectancy changed over time?*
[26] ONS (2022). *Health state life expectancies by national deprivation deciles, England 2018 to 2020*
[27] Health Foundation (2022). *International life expectancy at birth by sex*.
[28] High infant mortality results in lower values of life expectancy at birth than at other ages. In populations with high infant mortality, those surviving the hazards of early childhood have a higher life expectancy than infants and the maximum life expectancy occurs not at birth but at a later age (usually expected to be at age one year). Thus, changes in mortality in the first year of life significantly affect life expectancy at birth. See: Miladinov, G. (2020). Socioeconomic development and life expectancy relationship: evidence from the EU accession candidate countries. *Genus Journal of Population Science* 76:2
[29] ONS (2021). *National life tables - life expectancy in the UK 2018 to 2020*.

Figure 1.3 Average life expectancy (LE), healthy life expectancy (HLE) and Disability-free Life Expectancy (DfLE), among females and males at age 65, 2014-16 to 2018-20, England.



Source: Age UK 2023: Analysis using ONS (2021). *National life tables - life expectancy in the UK 2018 to 2020.*

The average *healthy* life expectancy at birth in England is 63.1 years for men, and 63.9 years for women.[30] Healthy life expectancy at birth is an estimate of the average number of years babies born in a particular year would live in a state of 'good' general health if both mortality levels at each age and the level of good health at each age, remain constant in the future. Healthy life expectancy at birth in the UK showed no significant change during the second half of the last decade.[31]

Disability-free life expectancy shows the average number of years a person would expect to live without a long lasting physical or mental health condition or disability that limits daily activities. Disability-free life expectancy at birth in the UK decreased between 2015-2017 and 2018-2020.[32]

Geographic variation and inequalities

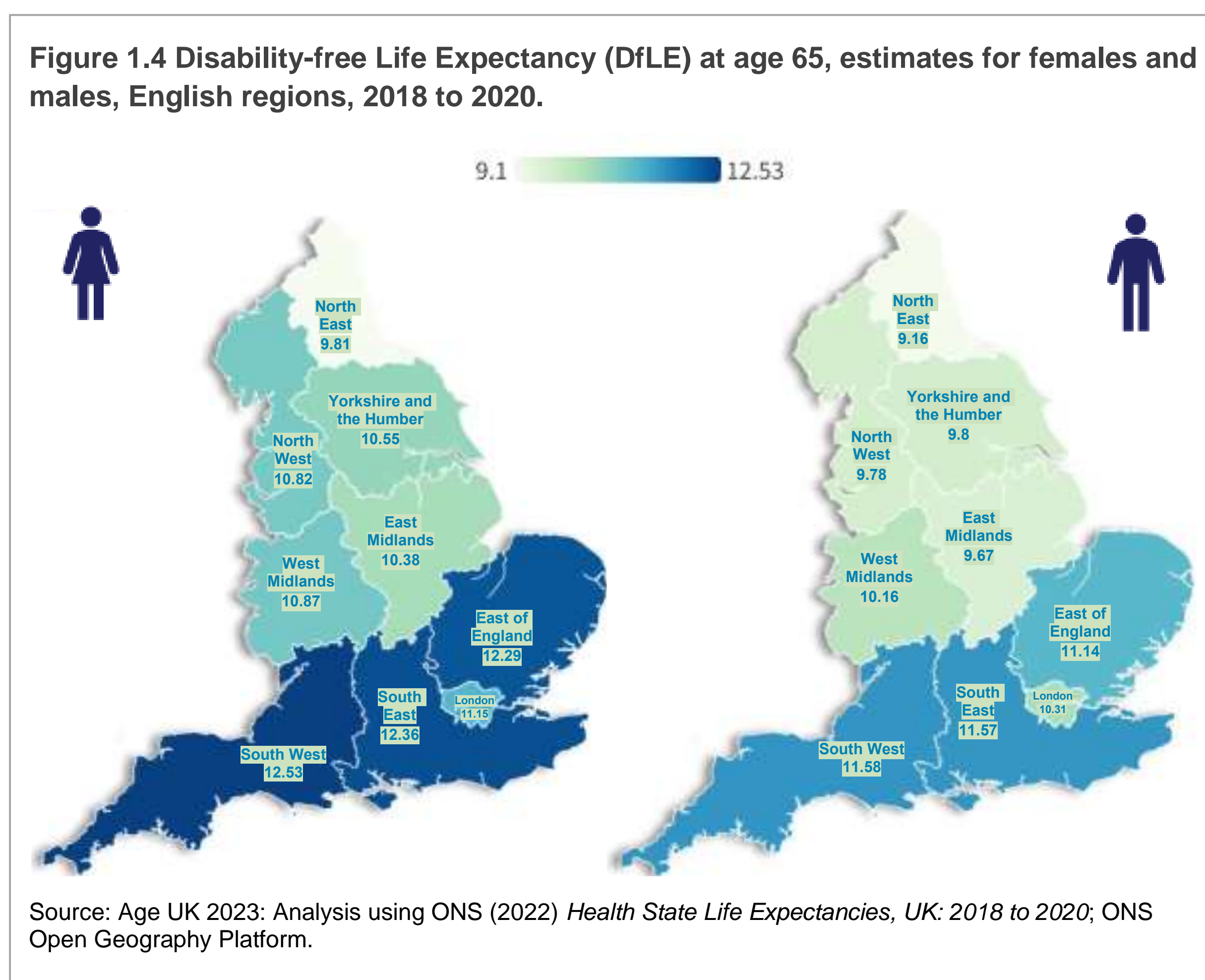
Female healthy life expectancy at birth in the most deprived areas was 19.3 years fewer than in the least deprived areas in 2018 to 2020; for males it was 18.6 years fewer. Male disability-free life expectancy at birth in the most deprived areas was 17.6 years fewer than

[30] ONS (2022). *Health state life expectancies, UK: 2018 to 2020*.
[31] ONS (2022). *Health state life expectancies, UK: 2018 to 2020*.
[32] ONS (2022a). *Health state life expectancies, UK: 2018 to 2020*.

in the least deprived areas in 2018 to 2020; for females it was 16.8 years fewer but there were no significant changes in the inequality since 2015 to 2017.[33]

As well as geographic disparities in life expectancy and healthy life expectancy at birth, there is significant variation in the burden of ill health and disability in later life. This is depicted in *Figure 1.4*, which shows the striking north-south divide. There is of course substantial variation within regions – the north has some very advantaged areas and the south has some very disadvantaged ones – however, the disparity in disability-free life expectancy at age 65 years ranges from 8.11 years in the North East to 11.0 years in the South East for females, and 8.16 years in the North East to 10.82 years in the South East for males.

Figure 1.4 Disability-free Life Expectancy (DfLE) at age 65, estimates for females and males, English regions, 2018 to 2020.



Source: Age UK 2023: Analysis using ONS (2022) *Health State Life Expectancies, UK: 2018 to 2020*; ONS Open Geography Platform.

[33] ONS (2022). *Health state life expectancies by national deprivation deciles, England: 2018 to 2020*.

Understanding the impact and effects of the COVID-19 pandemic

Historically, biological, social and environmental differences have led to different life expectancy outcomes for men and women. Women live longer than men, though as is discussed later in this chapter, those additional years are not in general healthy or disability-free. The gender gap in life expectancy in England narrowed from a high in the 1970s, to 3.7 years in 2019, with mortality falling faster in men than women. However, in 2020 and 2021, the impact of mortality rates from COVID-19 was greater in men than women, which widened the gender gap to 4.0 years.[34]

The COVID-19 pandemic led to a sharp fall in life expectancy in England in 2020, the magnitude of which had not been seen since World War II.[35] Life expectancy in England in 2020[36] fell by 1.2 years for males and by 0.9 years for females – to the level of a decade ago.[37]

Numerous complex and overlapping factors impact healthy life expectancy, including changes in household living standards, poverty rates and demography.[38] Prior to the COVID-19 pandemic, falls in smoking rates had a positive impact, but obesity levels were still rising, and the falling trend in alcohol consumption had evidenced some reversal.[39] While the evidence of the effect of COVID-19 on long-term health is still emerging, changes in lifestyle associated with the pandemic have impacted rates of obesity, physical inactivity and harmful alcohol consumption. We do not yet know how long-term these effects will be.

Obesity rates have increased. In 2021/22, 25.9% of adults aged 18+ in England were estimated to be living with obesity. This was an increase from 25.2% in 2020/21. The prevalence of adults living with obesity varies by age in England, with adults aged 45-74 years having a higher estimated prevalence than the England average.[40]

Activity levels had been rising amongst older people prior to the COVID-19 pandemic. They have broadly been maintained in the 55-64 age group, with the negative impact from the pandemic concentrated around the first national lockdown. However, the improvements among those aged 65+, and particularly the 75+ age group, have been interrupted, with an increase in physical inactivity (undertaking less than 30 minutes of physical activity a week). This may be linked to many older people shielding during the earlier stages of the pandemic and a continued nervousness of mingling indoors or in crowded outdoor spaces. Access to facilities for physical activity was significantly reduced during lockdown periods, with some swimming pools, gyms and other facilities now permanently closed. This older age group may need additional support to recover activity levels, as this is a risk that can further widen inequalities.[41]

Public Health England (PHE) reported how the wider impacts of COVID-19 affected older people (over 65-year-olds), with a focus on deconditioning and falls during the first part of the first lockdown – from March 2020 to May 2020. Deconditioning is the loss of physical, psychological, and functional capacity due to inactivity. It can occur rapidly in older adults, is not straightforward or quick to remedy and, among other health impacts, increases falls risk. Overall, PHE estimated that 110,000 more older people would have at least one fall a year due to reduced strength and balance activity during the pandemic. For each year that these lower levels of strength and balance activity persist, there is projected to be an additional cost to the health and social care system as a result of additional falls of £211 million (incurred over a 2.5-year period).[42]

Research into how the COVID-19 pandemic impacted older people's views and use of alcohol found that members of the UK's 50+ population were most likely to maintain levels of alcohol use from prior to the pandemic. However, when they reported changes in their alcohol use during the pandemic, they were most likely to report having increased their intake. The research also found indications of higher rates of hazardous drinking, where alcohol intake could lead to physical, psychological, or social harm. Increased alcohol use amongst older people was associated with poor mental health during the pandemic, with alcohol reportedly used as a coping mechanism during a stressful time.[43]

1.3 Health and care needs of older people

The prevalence of nearly all long-term conditions increases with age.[44] However, it is important to recognise the diversity within the older population – both within and across age groups. While over the next 20 years a growing older population in England will lead to

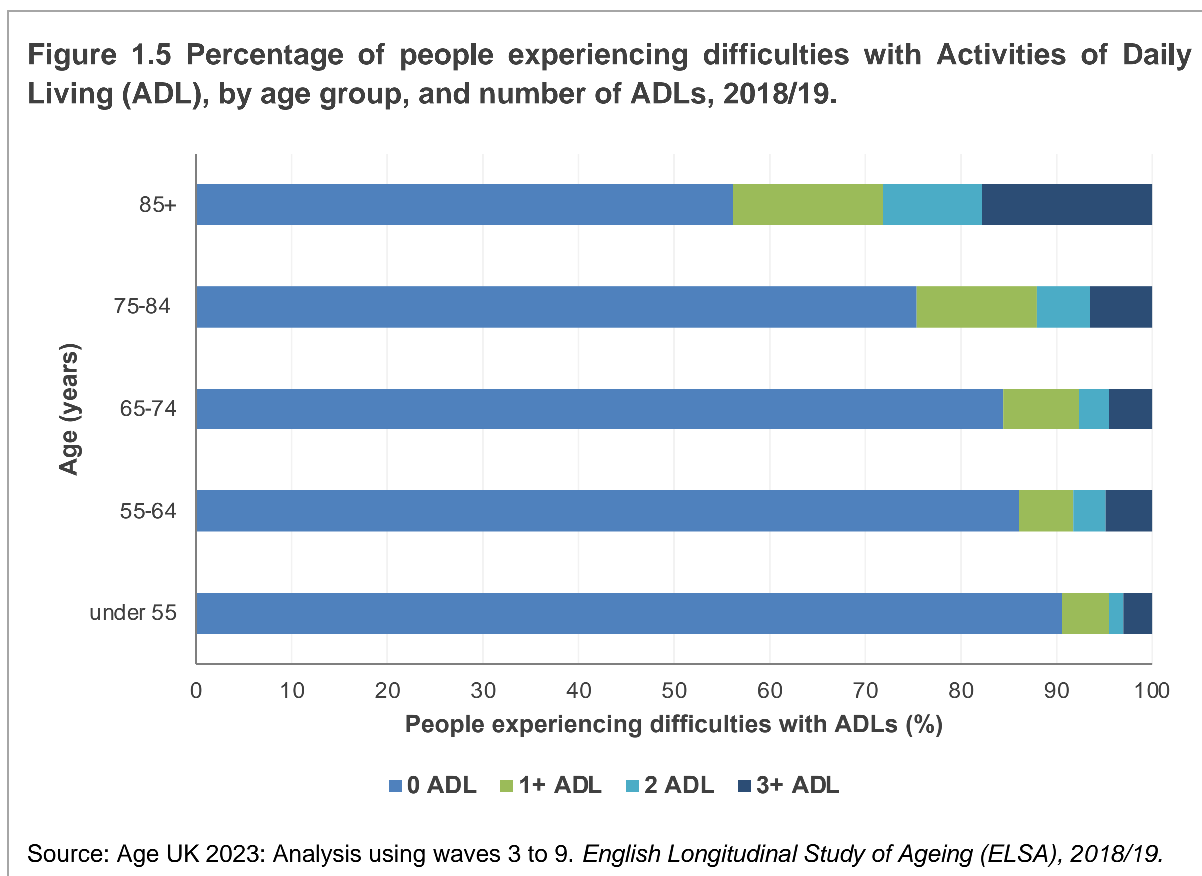
[34] Raleigh, V. (2022). *What is happening to life expectancy in England?* The King's Fund
[35] Raleigh, V. (2022). *What is happening to life expectancy in England?* The King's Fund
[36] Period (single year) and cohort life tables give two different measures of life expectancy. Period life expectancy assumes mortality rates remain constant into the future, while cohort life expectancy uses projected changes in future mortality rates. For example, period life expectancy assumes a 25-year-old today would face the mortality risk of a 40-year-old today when they are 40, when in fact it is more likely this will be lower by the time the 25-year-old reaches the age of 40. (Taken from ONS (2019). *Guide to interpreting past and projected period and cohort life tables*. & Tinson, A. (2022). *Healthy life expectancy target: the scale of the challenge*. Health Foundation).
[37] Analysis of Single-year life tables - England edition: ONS (2021). *Single-year life tables, UK: 1980 to 2020*.
[38] Jagger, C. (2015). *Trends in life expectancy and healthy life expectancy*. Government Office for Science: UK
[39] Tinson, A. (2022). *Healthy life expectancy target: the scale of the challenge*. Health Foundation
[40] OHID (2023). *Obesity Profile: Short statistical commentary, May 2023*.
[41] Sport England (2021). *Active Lives Adult Survey: May 2020/21 Report.*
[42] Public Health England (PHE) (2021). *Wider impacts of COVID-19 on physical activity, deconditioning and falls in older people*.
[43] Bareham, B. et al (2021). *Exploring older people's support needs for making healthier decisions about alcohol during COVID-19*. NIHR Policy and Research Unit Older People and Frailty
[44] DHSC (2012). *Long-term Conditions Compendium of Information: Third edition*

an increasing number of people living with complex health and care needs, there will also be growing numbers of people across all older age groups living without any significant needs for support.

While overall a growing older population is driving greater demand for health and care services, it is too simplistic to say that more older people inevitably means a greater burden of disease and disability. It is also a calculation that misses the possibility of improving health in later life, and one that fails to account for the fact that investing in *more appropriate* services and interventions may reduce demand for more expensive forms of care.

As shown in *Figure 1.5*, the proportion of people experiencing difficulties with Activities of Daily Living (ADLs)[45] increases significantly with age. The most recent data suggest that within the 65 to 74 years age group, 15.5% of people experience difficulty with one or more ADL, which rises to 24.6% within the 75 to 84 years age group. By the age of 85+, the percentage of people living with some level of need for care and support rises sharply to 43.9%.

Figure 1.5 Percentage of people experiencing difficulties with Activities of Daily Living (ADL), by age group, and number of ADLs, 2018/19.

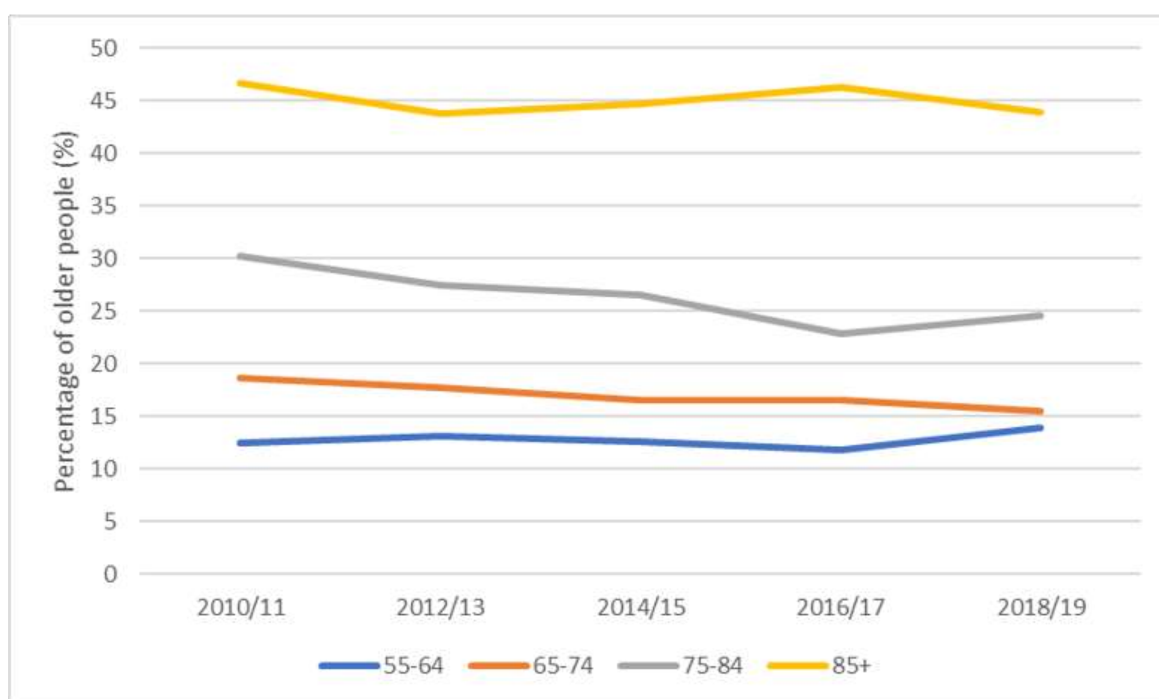


Source: Age UK 2023: Analysis using waves 3 to 9. *English Longitudinal Study of Ageing (ELSA), 2018/19.*

[45] 'Activities of daily living' are routine, everyday tasks related to personal care and mobility about the home. They tend to be tasks we learn as young children, including walking (including getting up and down stairs), eating, toileting, bathing, and dressing.

As shown in *Figure 1.6*, the percentage of people experiencing difficulties with ADLs had shown signs of decreasing over the last decade within the 65 to 74 and 75 to 84 age groups. For the latter group, this pattern reversed in the last available data. The cohort of people aged 55 to 64 years experiencing difficulties with ADLs had also slightly decreased over the last decade, but again, increased slightly in 2018/19. Given the rapid growth in size of these age groups, the population of older people with care needs will nonetheless see a significant increase in absolute numbers. The percentage of people aged 85+ with care needs had decreased between 2006/07 and 2012/13, but has remained relatively static since then. As explored in earlier sections of this report, this 'oldest old' population will see a particularly pronounced increase in absolute numbers in the next couple of decades.

Figure 1.6 Percentage of people experiencing difficulties with Activities of Daily Living (ADLs), by age group, 2010/11 to 2018/19, England.



Source: Age UK 2023: Analysis using waves 3 to 9. *English Longitudinal Study of Ageing (ELSA), 2018/19.*

Understanding the impact and effects of the COVID-19 pandemic

In October 2022, Age UK research[46] found a series of impacts of the COVID-19 pandemic on older people's ability to manage their activities of daily living (ADLs). While we would expect a proportion of older people to say some ADLs were more difficult to manage in any year – pandemic or not – than the year before, the

[46] Age UK (2022). *Age UK polling and insight, undertaken with Kantar – unpublished.* [n=1,632, representative of the UK population].

proportions reporting deterioration were higher than we might expect in a 'normal' non-pandemic year. Almost a third (31%) of older people found it more difficult to get up and down stairs than a year ago, 18% found it more difficult getting into and out of bed, 16% found it more difficult to shower, wash or have a bath, and 24% were finding it more difficult to clean/ tidy their house.

Long-term conditions and multimorbidity

The number of people living with long-term conditions (those that cannot currently be cured but can be managed through medications or therapies[47]) is rising.[48] In England, 40% of adults (aged 16+) report having at least one long term health condition.[49] The most common conditions were: conditions of the musculoskeletal system (13%); mental, behavioural and neurodevelopmental conditions (9%); conditions of the heart and circulatory system (9%); conditions of the respiratory system (8%); and diabetes and other endocrine and metabolic conditions (7%).[49]

Two in five (40%) adults aged 65+ report a limiting longstanding illness, and one in five (20%) has a non-limiting longstanding illness. The proportion of adults aged 65+ with a limiting longstanding illness increases with age, from 31% of those aged 65 to 69, to 57% of those aged 80+. The proportion with a non-limiting longstanding illness did not vary by age.[50]

More than one in four of the adult population in England lives with two or more conditions.[51] The impacts of long-term conditions are common but far reaching. Despite considerable diversity in their disease profile and circumstances, people with multiple conditions frequently share common problems. They may have reduced mobility, chronic pain, shrinking social networks, difficulty participating in work, volunteering or other activities, and lower mental wellbeing.[52] Compared to those with one or no long-term conditions, people with multimorbidity (two or more conditions) have an increased risk of functional decline, poorer quality of life, greater healthcare use and higher mortality.[53]

As *Figure 1.7* shows, long-term conditions are not an inevitability of later life, though the likelihood of having one or more long-term condition does increase with age. While 44.2% of people aged 55 to 64 years have no diagnosed long-term condition, this falls to 26.1%

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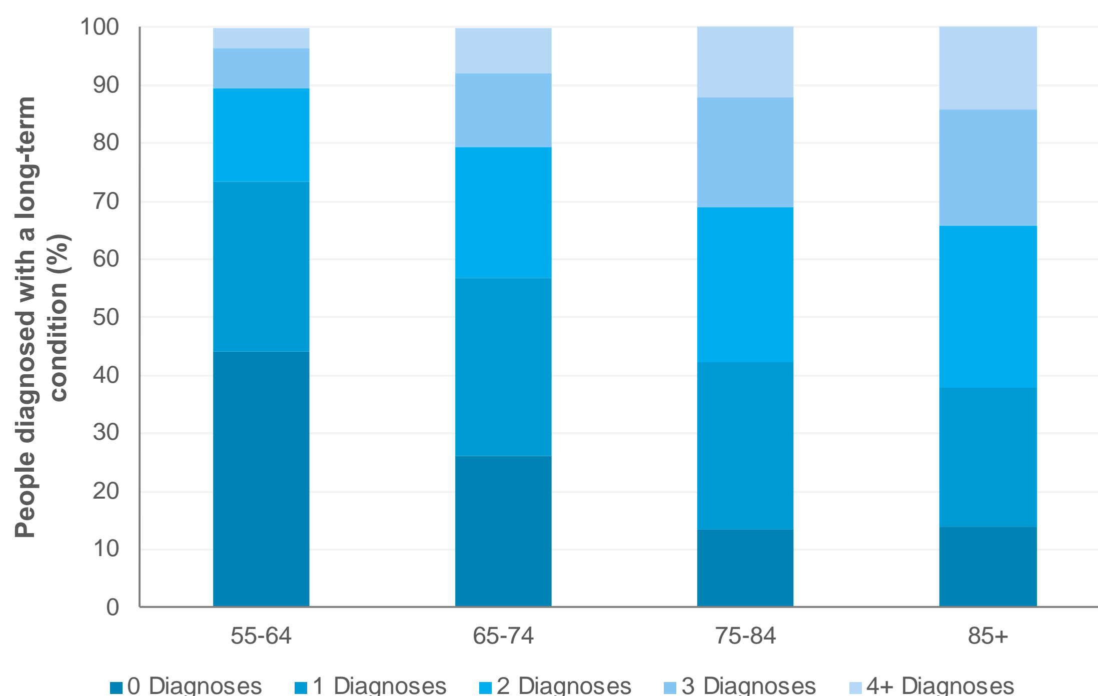
[47] NHS Employers (2020). *Long-term health conditions*.
[48] NIHR (2021). *Multiple long-term conditions (multimorbidity): making sense of the evidence*.
[49] NHS Digital (2023). *Health Survey for England: Adults' health: General health, acute sickness and longstanding conditions*.
[50] NHS Digital (2023). *Health Survey for England: Social Care for Older Adults*.
[51] NIHR (2021). *Multiple long-term conditions (multimorbidity): making sense of the evidence*.
[52] NIHR (2021). *Multiple long-term conditions (multimorbidity): making sense of the evidence*.
[53] Yarnall, A.J., et al (2017). New horizons in multimorbidity in older adults. *Age and Ageing*, 46, 882–888.

of people aged 65 to 74, and to 13.9% of people aged 85+.[54] Multimorbidity is also more common with age.

Figure 1.7 Percentage of people with diagnosed long-term conditions, by age group, 2018/19, England.



Source: Age UK 2023: Analysis using waves 3 to 9. *English Longitudinal Study of Ageing (ELSA), 2018/19.*

Understanding the impact and effects of the COVID-19 pandemic

The same Age UK research cited above (undertaken in October 2022)[55] found almost a third (32%) of older people said their health had gotten worse in the last year, 43% of older people said they had less energy, 27% of older people felt less steady on their feet, and 32% of older people were in more physical pain. Of those who reported their health gotten worse, 28% reported having been diagnosed with a new condition.

Frailty

'Frailty' is a term used frequently, but is often misunderstood. If someone is living with frailty, it does not mean they are incapable of living a full and independent life. When used properly, it describes someone being less able to recover from accidents, physical illness or

[54] All recent studies show that multimorbidity increases with age, but the percentages can range considerably, according to which conditions are counted.
[55] Age UK (2022). *Age UK polling and insight, undertaken with Kantar – unpublished.*

other stressor events.[56] **In practice, being frail means a relatively 'minor' health problem,** such as a urinary tract infection, can have a severe long-**term impact on someone's health** and wellbeing.

Frailty is generally characterised by issues such as unintentional weight loss, reduced muscle strength and fatigue. Frailty is distinct from multimorbidity and someone living with frailty may have no other diagnosed health conditions, but there is an overlap and many people live with both.[57] The National Institute for Health and Care Excellence recommends healthcare professionals consider assessing frailty in adults with multimorbidity.[58]

Falls and fractures are a common and serious health issue faced by older people. Around one in three adults over 65 and half of people over 80 will have at least one fall a year.[59] Falls are the main cause of a person losing their independence and going into long-term care.[60] After a fall, the fear of falling can lead to more inactivity, loss of strength, loss of confidence and a greater risk of further falls.[61]

Older people with frailty are more likely to experience recurrent falls than older people without frailty.[62] Frailty-induced falls are associated with a greater risk of fractures, hospitalisation and a permanent move to a care home. As the severity of frailty increases, the risk of future falls increases. Frailty assessment and diagnosis can be a gateway to support and services, including support to prevent falls.

Mental health

As we get older, changes in our lives, such as retirement, bereavement, or physical illness, can affect our mental health and wellbeing. However, just like other long-term conditions, mental health problems are not an inevitable part of ageing.[63]

Nearly half of adults aged 55 years and over report having experienced depression and/or anxiety at some point in their lives. The most reported triggers for mental health problems are the death of loved ones (36%), financial worries (27%) and their own ill health (24%). One in five (21%) of the people who reported experiencing depression or anxiety said their symptoms had worsened with age.[64]

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[56] NHS England (2022). *Ageing well and supporting people living with frailty*.
[57] Villacampa-Fernandez, P., Navarro-Pardo, E., Tarin, JJ., & Cano, A. (2017). Frailty and multimorbidity: Two related yet different concepts. *Maturitas 95:31-3*5.
[58] National Institute for Health and Care Excellence (NICE) (2016). *Multimorbidity: clinical assessment and management, NICE guideline NG56*.
[59] NHS England (2021). *Falls*.
[60] Age UK (2019). *Falls in later life: a huge concern for older people.*
[61] Age UK (2019). *Falls in later life: a huge concern for older people.*
[62] Cheng, M.H. & Chang, S.F. (2017). Frailty as a risk factor for falls among community-dwelling people: Evidence from a meta-analysis. *Journal of Nursing Scholarship,* 49(5); 529-536
[63] Mental Health Foundation (2022). *What might affect my mental health in later life?*
[64] NHS England (2017). *Half of adults ages 55 and over have experienced common mental health problems, say Age UK*.

One in four older people (25%) report feeling it is more difficult for older people to discuss mental health issues than it is for younger people. The reasons they give for this include society not recognising depression or anxiety as health conditions when they were growing up, and depression and anxiety historically being seen as weaknesses.[65]

Understanding the impact and effects of the COVID-19 pandemic

The Government ended COVID-19 restrictions in England in February 2022. Age UK research published at the same time[66] found many older people to be experiencing anxiety, memory loss, low mood and depression. In some cases, older people reported feeling suicidal or undertaking acts of self-harm.

Common challenges included disturbed sleep patterns and a lack of confidence and motivation to get back to doing normal everyday activities.

The research found that 4.1 million (33%) older people said they felt more anxious, 4.3 million (34%) said they felt less motivated to do the things they enjoy, and 2.9 million (23%) said they are finding it harder to remember things now than they did at the start of the pandemic.

1.4 Other factors affecting health and care needs in later life

There are a range of factors that affect mental and physical health and wellbeing in later life. However, there is emerging evidence that living alone, loneliness, ageing without children and being a carer all have a substantial impact on both health and experience of care. A growing older population, coupled with changing lifestyles, makes these factors likely to become more prevalent.

Living alone

The number of people aged 65+ living alone in 2021 in England and Wales was 3.3 million, a 14.6% increase since 2011. However, this change is smaller than the overall growth in the population for that age group (20.0%), meaning the proportion of the population aged 65+ who are living alone has decreased from 31.5% in 2011 to 30.1% in 2021. The proportion of people aged 75 to 84 years living alone has fallen because of greater numbers of couples and more households containing non-dependent children.[67]

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[65] NHS England (2017). *Half of adults ages 55 and over have experienced common mental health problems, say Age UK*.
[66] Age UK (2022). *New research shows a "hidden" mental health crisis is debilitating older people*.
[67] ONS (2023). *People's living arrangements in England and Wales: Census 2021*.

Ageing without children

The number of people 65+ without adult children is predicted to reach 2 million by 2030. Currently, 10% of people aged 60+ have no children, while 20% of people aged 50+ have no children.[68] The number of women who have not had children has more than doubled in a generation, from 9% of those born in the 1940s to 19% of women born in the 1960s. It is estimated that 25% of women born in the 1970s will not have children. It is estimated that around 23% of men over 45 have not had children or do not have their children in their lives.[69] The number of single and childless older people needing care is projected to increase by 80% by 2032.[70]

As well as people who have not had children either through choice, infertility or circumstance, the organisation Ageing Without Children urges consideration in policy and practice of other groups who are ageing without children. This includes people who have had children, but those children have either died or are unable to offer help or support because they live at a great distance, or have care needs of their own. It also includes people who have had children, but those children are unwilling to offer help and support because they are estranged or have no contact.[71]

Loneliness and isolation

It is possible to feel lonely without being socially isolated, and vice versa[72], however both can have an impact on physical and mental health. Loneliness is associated with an average 26% increased likelihood of mortality in adults, and social isolation with an average 29% increased risk.[73] Loneliness is a recognised underlying factor in driving behaviours that contribute to poor physical health. Longitudinal research has also found higher loneliness to be associated with poorer cognitive function and a worsening in memory and verbal fluency over a decade. However, there is a bidirectional relationship between these factors, as baseline memory and its rate of decline also contribute to an increase in loneliness over time.[74]

One in 12 older people (8.0%) report often feeling lonely.[75] Loneliness has been shown in scientific studies to be associated with a range of poor health outcomes, including high

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[68] Ageing Without Children (2022). *What does 'ageing without children' mean?*

[69] Ageing Without Children (2019). *Statistics: Facts & Figures*.

[70] Ageing Without Children (2022). *What does 'ageing without children' mean?*

[71] Ageing Without Children (2022). *What does 'ageing without children' mean?*

[72] Where social isolation is objectively defined in terms of people's access to interactions and their community, feelings of loneliness occur when people are unable to have the types of interactions they may desire.

[73] Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T. and Stephenson, D., (2015). Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspectives on psychological science* 10(2), pp.227-237

[74] Yin, J. et al (2019). Exploring the bidirectional associations between loneliness and cognitive functioning over 10 years: the English longitudinal study of ageing. *International Journal of Epidemiology*, 48:6, 1937–1948

[75] Age UK analysis of data from wave 12 of Understanding Society, collected 2020-22, scaled up to the UK age 65+ population using ONS mid-year population estimates for 2021.

blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death.[76] Life transitions – and particularly role transition – are known to be disruptive moments that increase the risk of a person becoming or remaining lonely. When existing social connections are challenged or severed – for example through bereavement, the break-up of a relationship, emergence of a serious health issue, or retirement – this can reduce opportunities for 'easy' connection and threaten self-identity.[77]

> Understanding the impact and effects of the COVID-19 pandemic
>
> Relationships and connections became harder to maintain during the pandemic, with 41% of UK adults reporting they felt lonelier than before the first period of lockdown.[78] A qualitative study commissioned by the Department for Culture, Media and Sport found the pandemic to have disrupted people's face-to-face social activities and led to a loss of contact with friends and family. Although social contact had usually been maintained for a while by phone, messaging or video calls, over time participants described the circle of contacts as waning. People who were shielding reported particularly acute feelings of isolation.[79]

Caring responsibilities

We are moving towards a four-generation society. The implications of this are not yet fully understood, but 'sandwich generation carers' are becoming increasingly prevalent.[80] These are people, predominantly women, who provide unpaid care for one or more older person while simultaneously looking after one or more child. In 2019, around 3% of the UK population (more than 1.3 million people) held this twin responsibility.[81] In some families, four generations are involved and the care flows are even more complex, with the two middle generations of parents and grandparents providing care for both children and great grandparents.[82]

Five million people in England and Wales aged five and over reported providing unpaid care according to the Census 2021.[83] However, organisations that support unpaid carers argue

[76] National Institute of Ageing (2019). *Social isolation, loneliness in older people pose health risks*.
[77] Kantar Public (2016). *Trapped in a bubble: An investigation into triggers for loneliness in the UK.* British Red Cross and Co-op www.redcross.org.uk/about-us/what-we-do/action-on-loneliness
[78] APPG on Loneliness (2021). *A connected recovery: Findings of the APPG on Loneliness Inquiry*.
[79] Department for Culture, Media and Sport (DCMS) (2022). *Mental health and loneliness: the relationship across life stages*.
[80] ONS (2019). *More than one in four sandwich carers report symptoms of ill health*.
[81] ONS (2019). *More than one in four sandwich carers report symptoms of ill health*.
[82] Centre for Policy on Ageing (2015). *Older and sandwich generation carers and the impact of caring.*
[83] ONS (2023). *Unpaid care, England and Wales: Census 2021*.

the real figure is likely to be higher.[84] One in five (21%) unpaid carers are aged 55-64 and one in five (20%) of unpaid carers are aged 65+.[85] An estimated 1.5 million people provide 50 or more hours of unpaid care a week.[86]

In 2020, unpaid carers aged 65+ reported being worried about the health implications of caring, with 32% worried about managing the stress and responsibility of being an unpaid carer, and 29% worried about the negative impact of caring on their own physical and mental health.[87] Analysis of GP Patient Survey data by Carers UK found that 60% of unpaid carers report a long-term health condition or disability compared to 50% of non-carers.[88]

Understanding the impact and effects of the COVID-19 pandemic

The demands on unpaid carers have increased, affecting their health. Carers UK report that in February 2022, 81% of unpaid carers responding to their State of Care survey reported they were providing more care than at the start of the pandemic, without access to their usual support. A total of 72% of unpaid carers reported not having had a break from their caring role since the start of the pandemic. This is having a negative impact on **carers' health, with 69% of unpaid carers saying their mental health is worse because of** caring during the pandemic. More than half (54%) of surveyed unpaid carers caring for someone living with dementia reported reaching crisis point in the previous year alone.[89] In mid-2022, almost three-quarters (73%) of Directors of Adult Social Services reported seeing more cases of breakdown of unpaid carer arrangements in their area than in the previous year.[90]

Ethnic minority communities reported providing more hours of unpaid care during the pandemic than white British adults, with 47% of those from African backgrounds reporting providing unpaid care during winter 2020, compared with 32% across the overall adult population. A greater proportion of Bangladeshi (11.9%), Caribbean (12.2%), Indian (10.7%) and Pakistani (10.3%) ethnic groups reported providing more than 20 hours of care a week during this period, compared to white British (9.0%) and Irish groups (7.3%).[91]

One year into the pandemic, Age UK research[92] found that 49% of older carers (around 1.1 million) had less energy than before the pandemic, 35% of older carers (nearly

[84] For example: Carers UK (2023). *Census 2021 data shows increase in substantial unpaid care in England and Wales*, and Carers Trust (2023). *Carers Trust responds to census data showing increase in intensity of care provided by unpaid carers*.
[85] Carers Week (2020). *Carers Week 2020 Research Report*.
[86] ONS (2023). *Unpaid care, England and Wales: Census 2021*.
[87] Carers Week (2020). *Carers Week 2020 Research Report*.
[88] Carers UK (2023). *Key facts and figures about caring* [webpage, accessed 10-05-2023]
[89] Carers UK (2022). *Under pressure: Caring and the cost of living crisis.*
[90] ADASS (2022). *Spring Budget Survey 2022*.
[91] Alarilla, A., Grimm, F. & Stafford, M. (2021). *What happened to unpaid caring during the Covid-19 pandemic?* UK Data Service
[92] Age UK (2021). *Impact of Covid-19 on older people's mental and physical health: one year on*.

800,000) could not walk as far than before the pandemic, and 38% of older carers (nearly 860,000) were in more physical pain than at the start of the pandemic.

Age UK research[93] undertaken later in the pandemic, in October 2022, found 85% of older carers worried about whether they would be able to keep caring or providing support, with 24% of older carers saying they always worried about this.

[93] Age UK (2022). *Age UK polling and insight, undertaken with Kantar – unpublished.*

2. COMMUNITY-BASED TREATMENT, CARE AND SUPPORT

There have been multiple and on-going policy commitments to shift care away from acute hospitals and into community settings in recent decades, with notable examples including the NHS Long Term Plan and its predecessor the NHS Five Year Forward View, along with the Care Act 2014 with its associated Regulations and statutory guidance.

Following the passage of the Health and Care Act (2022), 42 Integrated care systems (ICSs) were established across England on a statutory basis on 1st July 2022. ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. These local partnerships, the strategies they develop and commit to, their decision-making and operations are all intended to focus on shifting treatment, care and support from the acute sector and into people's homes and communities.[94]

2.1 Accessing treatment, care and support

Primary care

Around 90% of patient interaction with the NHS is with primary and community care, including general practice (GP services), dental services, optometry (eye health) services and community pharmacies.[95]

Prior to the COVID-19 pandemic (between 2017/18 to 2019/20), *Figure 2.1* demonstrates a decrease in patient satisfaction with making an appointment with a GP across all older age groups. This increases slightly between 2019/20 to 2020/21, where the percentage of older people reporting a 'Good' (very or fairly good) experience of making a GP appointment increased from 73% in 2020 to 75% in 2021. However, following 2021/22, there is a steep decline in patient satisfaction across all older age groups. The percentage of people aged 65+ reporting a 'Good' (very or fairly good) experience of making a GP appointment decreased in 2022 to 63%, 12% lower compared to the year before.

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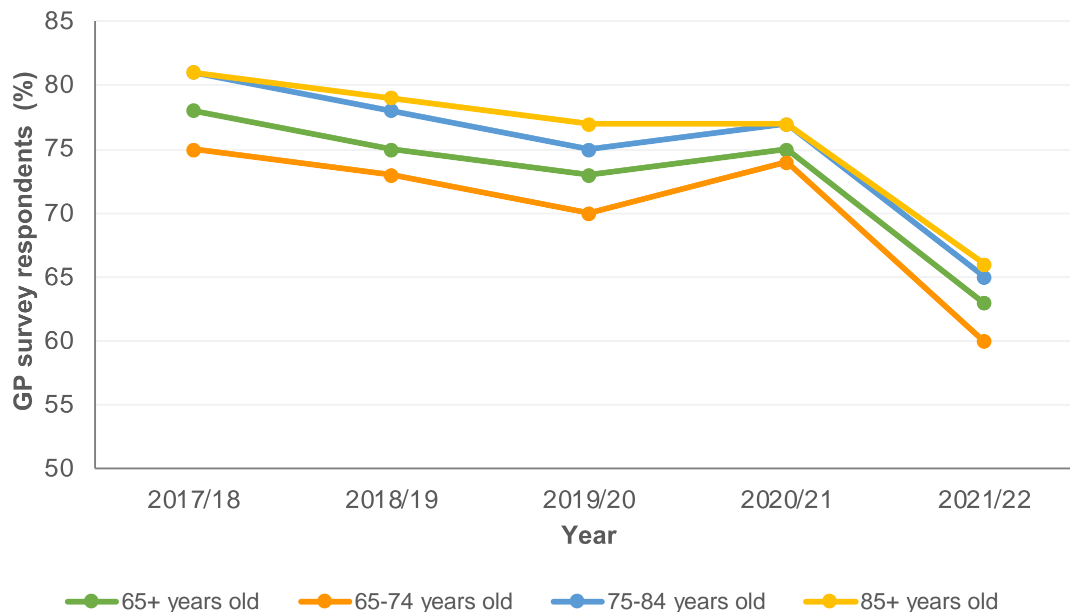
[94] DHSC (2022). *Statutory Guidance: Guidance on the preparation of integrated care strategies*.

[95] Parkin, E. (2018). *General Practice in England.* House of Commons Library.

Figure 2.1. Percentage of GP Patient Survey respondents reporting a 'Very Good' or 'Fairly Good' experience of making an appointment, by age group, 2017/18 to 2021/22, England.



Source: Age UK 2023: Analysis using NHS England (2022). *Access to GP Services.*

Age UK research undertaken in October 2022 found 45% of older people were concerned about their ability to access their GP.[96]

Understanding the impact and effects of the COVID-19 pandemic

In the annual GP Survey conducted between January and April 2021, 42.3% of people confirmed they had avoided making a GP appointment in the last 12 months. The top two reasons were because people were worried about the burden on the NHS (19.8%), and because people were worried about the risk of catching COVID-19 (17.3%).[97] In 2022, the percentage of people who avoided making a GP appointment because they were worried about being a burden on the NHS remained consistent at 19.7%, while the percentage of people who avoided making an appointment because they were worried about the risk of catching COVID-19 dropped to 12.0%.[98]

A Healthwatch report from March 2021 found that older people were especially worried about "overloading" services and so did not speak to their GP practice unless they felt their health issue was of extreme importance.[99]

[96] Age UK (2022). *Age UK polling and insight, undertaken with Kantar – unpublished.*
[97] Ipsos MORI and NHS (2021). *GP Patient Survey: National Report: 2021 Publication.* [n=850,206]
[98] Ipsos MORI and NHS (2022). *GP Patient Survey: National Report: 2022 Publication*. [n=850,206]
[99] Healthwatch (2021). *GP access during COVID-19: Our review of evidence*. [drawing on over 200,000 experiences]

Health Foundation and Ipsos MORI research undertaken in May 2020 found that 47% of people would feel uncomfortable using their local hospital in the short term if the need arose, and 76% would be concerned about being exposed to COVID-19. However, older people (aged 65+) were more likely than average to say they would feel comfortable (58% compared to 52% overall). Older people were also more likely than the general adult population to access support from a pharmacist, with 21% having sought out this support in the first few months of the pandemic, compared to 14% overall.[100]

Dementia care

The 'Challenge on Dementia 2020' target is for two thirds of the estimated number of people living with dementia in England to receive a formal diagnosis with appropriate post-diagnostic support.[101] The target had been met consistently at the national level from July 2016 until end of March 2020, then dropped below the national ambition in April 2020.[102]

Understanding the impact and effects of the COVID-19 pandemic

The reduction in formal diagnoses of dementia is associated with the impact of memory assessment services being suspended during pandemic lockdown and consequent reduction in GP referrals into those services, in addition to the instruction for older people to shield and stay at home.[103] As of 31st May 2023, 445,216 people over 65 had a recorded diagnosis of dementia in England, 63.1% of the estimated number living with dementia[104]. This remains short of the national target.

Adult social care

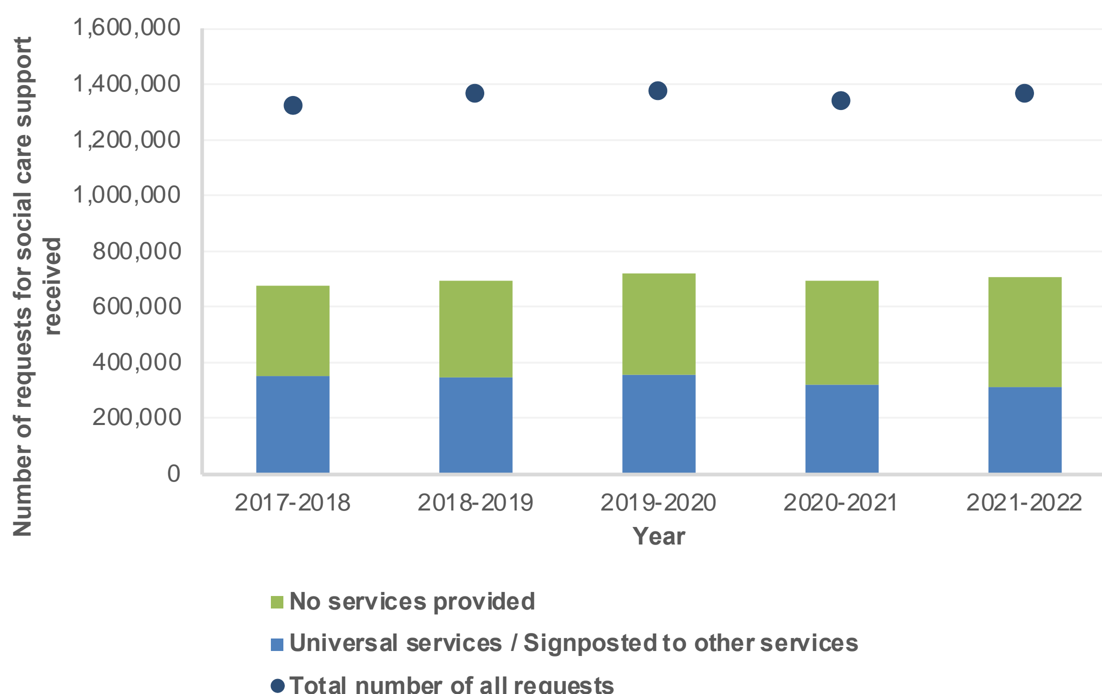
'Social care' means different things to different people, but usually refers to a variety of extra support and professional help to carry out daily tasks and live comfortably. For many older people, 'social care' means personal care, which can include help with washing, dressing, getting out of bed in the morning, help taking medicine, and help with the housework. It can also refer to help with broader activities that are important to a person's wellbeing, such as engaging with activities within their community and maintaining contact with family and friends. Social care also seeks to protect and safeguard people from harm and neglect.

There were 1.37 million new requests for support from older people to English local authorities in 2021/22, accounting for 69.1% of all requests received by Adult Social

[100] Ipsos MORI (2021). *The Health Foundation COVID-19 Survey: A report of findings*. [n=1,983]
[101] Department of Health (2015). *Prime Minister's Challenge on Dementia 2020*.
[102] Health and Social Care Committee (2021). *Supporting people with dementia and their carers*. House of Commons.
[103] Health and Social Care Committee (2022). *Supporting people with dementia and their carers: Government's Response to the Committee's Seventh Report*. House of Commons.
[104] NHS Digital (2023). *Primary Care Dementia Data, May 2023*.

Services Departments.[105] As *Figure 2.2* shows, the total number of requests fell slightly in the COVID-19 pandemic year of 2020/21, then began to increase in 2021/22. The number of new requests for support from older people has remained broadly steady, despite the growing older population.

Figure 2.2. Total number of requests for social care support received from new clients aged 65+ and proportion of requests that resulted in no formal service provision, 2017/18 to 2021/22, England.



Source: Age UK 2023: Analysis using NHS Digital (2022). *Adult Social Care Activity and Finance Report, England, 2021/22.*

Conversely, the Association of Directors of Adult Social Services (ADASS) reports that as of April 2022, most Directors of Adult Social Services observed rises in the numbers of people seeking support in their area: 87% said more people were coming forward for help with mental health issues; 67% reported more approaches because of domestic abuse or safeguarding; and 73% said they were seeing more cases of breakdown of unpaid carer arrangements.[106] These ADASS figures include adults aged 18-64. They are also focused on the number of *people* coming forward, while the data depicted in *Figure 2.2* is focused on the number of *contacts* made with Adult Social Services Departments. Therefore, the different trends may be due to more people contacting Departments but only doing so once, compared with multiple contacts being made in previous years.

[105] NHS Digital (2022). *Adult Social Care Activity and Finance Report, England, 2021/122*.
[106] ADASS (2022). *ADASS Survey: People waiting for assessments, care or reviews.*

ADASS reports that on 31st March 2023, an estimated 434,243 adults were waiting for adult social care assessments, care, Direct Payments[107] or reviews [of existing care packages or Direct Payments].[108] This represents a 47.5% increase since September 2021.[109] More than half (224,978) of this total was people waiting for a care assessment, of whom more than one in three had been waiting for more than six months.[110]

ADASS has previously reported this to have been a consistent increase that has not **reflected the 'normal winter pressures' patterns.**[111] The number of people waiting for an adult social care assessment, for care to begin, for a Direct Payment, or for a review of their care had previously peaked at 542,002 on 30th April 2022.[112]

Almost 7 in 10 Directors reported care providers in their area closing or handing back contracts. Many more said they could not meet all needs for care and support because of **providers' inability to recruit and retain staff.**[113]

Figure 2.3 shows the of new clients aged 65+ who made a request for care that year and received long-term support via nursing, residential or community-based care as the result. The number of new clients receiving long-term support rose by 2% from 130,330 in the pre-pandemic year 2019/20 to 133,170 in 2020/21. However, the number then fell by 4.5% to 127,115 in 2021/22, despite the growing older population and associated projected level of need (as explored in Chapter 1).

The number of new clients aged 65+ provided with short-term support to maximise independence (ST-MAX) over the course of the year had been increasing in the run-up to the COVID-19 pandemic, rising from 204,980 older people in 2017/18 to 211,040 in 2019/20. However, the numbers fell again during the pandemic and have yet to return to pre-pandemic levels.

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[107] A direct payment means you receive the money to arrange your care, rather than having it arranged for you by the local authority. You may have some, or all, of your needs met via a direct payment. More information available from: Age UK (2022). *Factsheet: Personal budgets and direct payments in social care*.

[108] ADASS (2023). *Spring Survey 2023*.

[109] ADASS (2022). *Waiting for Care and Support May 2022*.

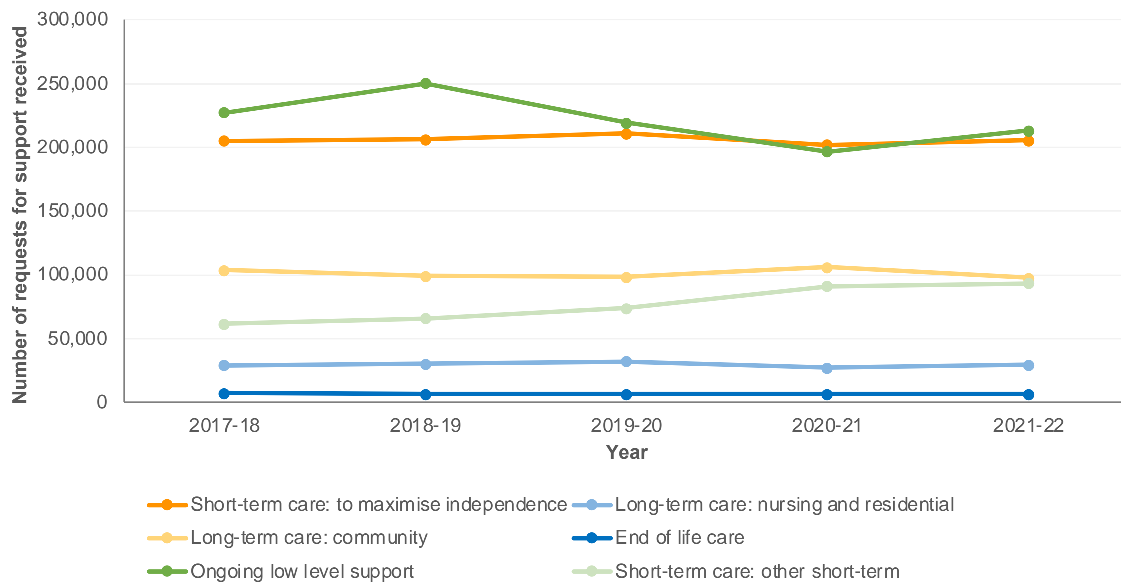
[110] ADASS (2023). *Spring Survey 2023*.

[111] ADASS (2022). *ADASS Survey: People waiting for assessments, care or reviews.*

[112] ADASS (2022). *Autumn Survey Report 2022*.

[113] ADASS (2022). *ADASS Survey: People waiting for assessments, care or reviews.*

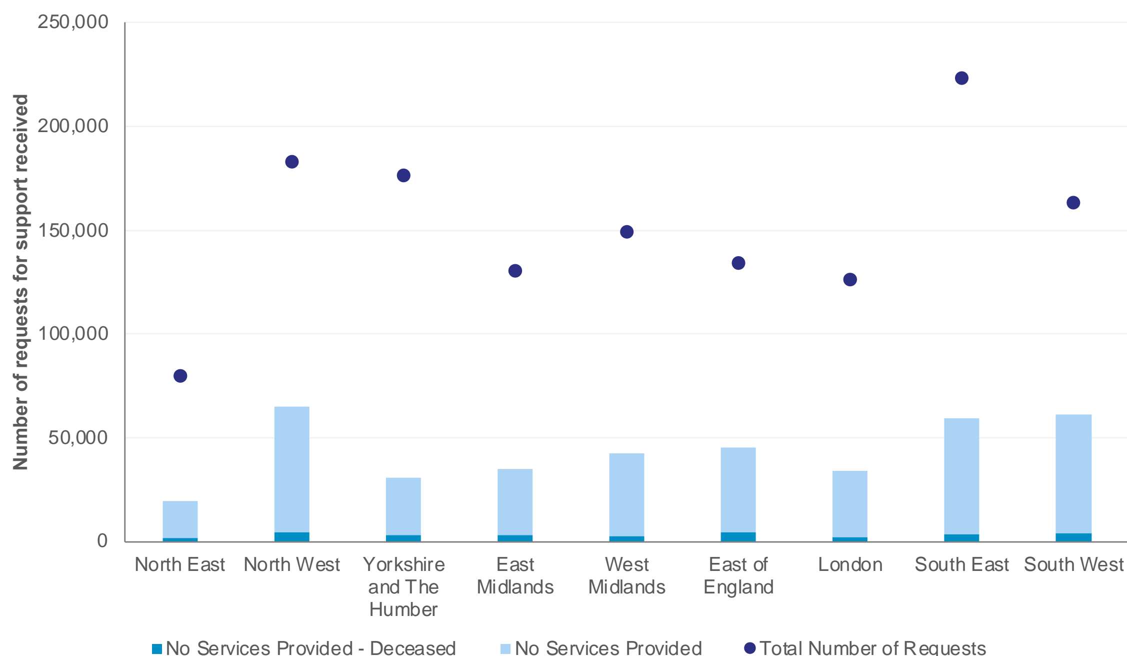
Figure 2.3. Number of requests for support received from new clients aged 65+ that resulted in a formal service, broken down by what happened next, 2017/18 to 2021/22, England.



Source: Age UK 2023: Analysis using NHS Digital (2022). *Adult Social Care Activity and Finance Report, England, 2021/22*.

The distribution of outcomes of request for support varies across regions. As shown in *Figure 2.4*, in Yorkshire and The Humber 17.5% of referrals resulted in no service provided in 2021/22 (either because a decision was made to that effect or because the person to whom the request pertained had died before a decision was made / services were put in place), compared with 37.5% in the South West. The anticipated number of self-funders in an area provides a partial explanation, but is unlikely to be able to account for the full variation.

Figure 2.4. Number of requests for support received from new clients aged 65+ and number that resulted in 'No Services Provided' and 'No Services Provided – Deceased', 2021/22, England regions.

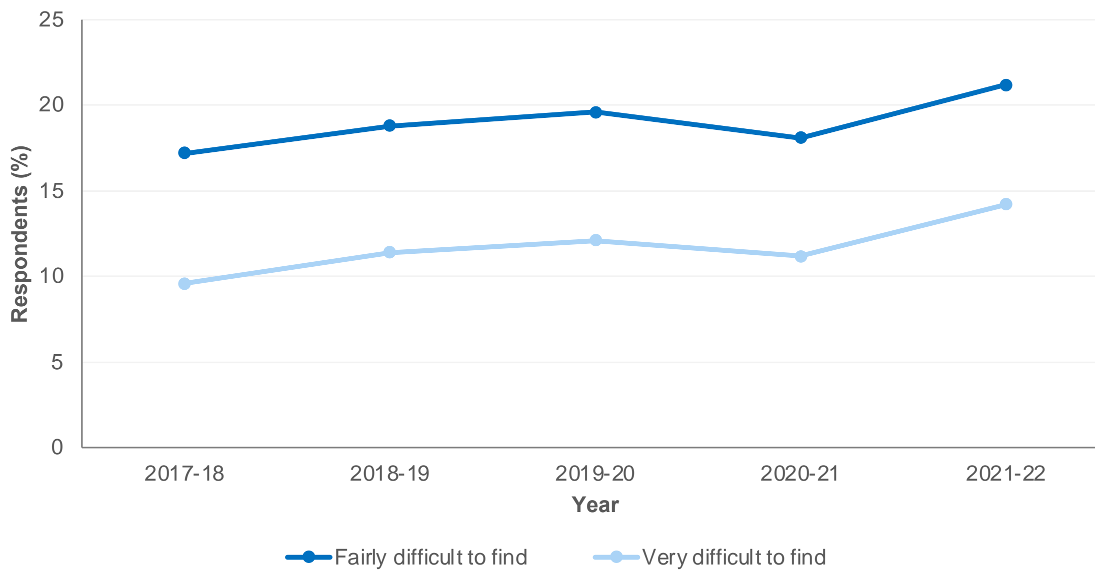


Source: Age UK 2023: Analysis using NHS Digital (2022). *Adult Social Care Activity and Finance Report, England, 2021/122*.

Under the Care Act 2014, local authorities have a duty to provide comprehensive information and advice about care and support services in their local area to help people understand how care and support services work locally, what care and funding options are available, and how they can access care and support services. All information and advice must be provided in formats that help people understand, regardless of their needs. Despite this, as shown in *Figure 2.5*, a steady percentage of people using Adult Social Care services **have reported finding it 'Fairly difficult' or 'Very difficult' to find information and advice** about support, services or benefits. The percentage of people reporting difficulty increased from 29.3% in 2020/21 to 35.4% in 2021/22. Even more concerning is the fact this data pertains to people *already using* Adult Social Care services – no data is available as to the **experience of people who are 'outside of the system'**. This includes people who:

- look for information and advice but choose not to do so through Adult Social Care services;
- are unable to access information through the normal route (for reasons that are not captured by any data); or
- are unaware of the duty of the local authority to provide that support.

Figure 2.5. People using Adult Social Care services who report finding it difficult to find information and advice about support, services or benefits, 2017/18 to 2021/22, England.



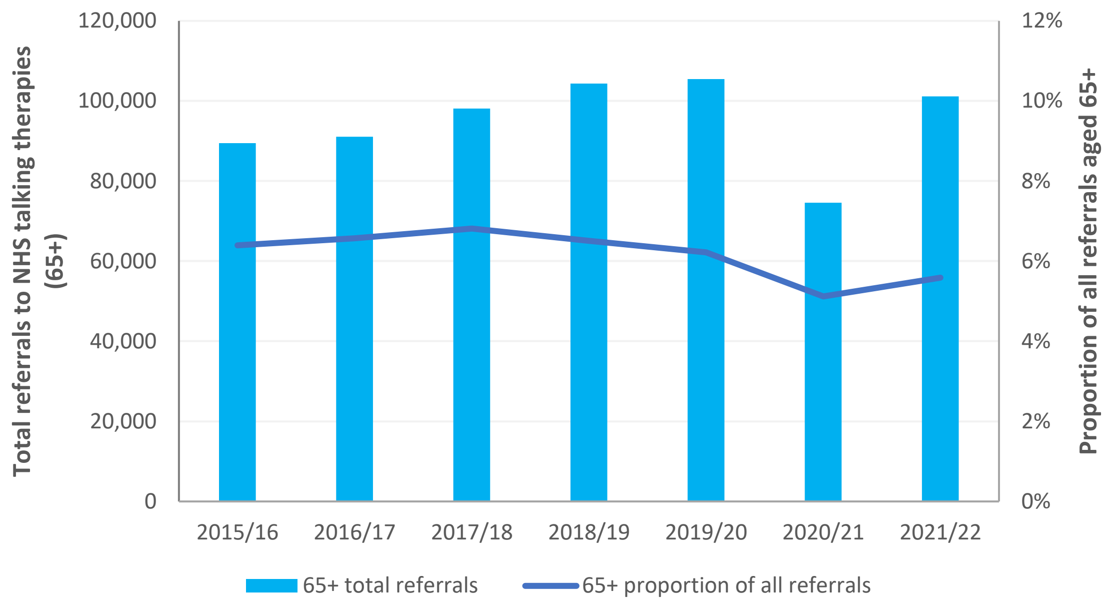
Source: Age UK 2023: Analysis using NHS Digital (2022). *Adult Social Care Activity and Finance Report, England, 2021/22*.

Talking therapies

In 2011, the Department of Health (now Department of Health and Social Care) set an expectation, based on estimated need at the time, that 12% of referrals through the Improving Access to Psychological Therapies (IAPT) programme would be people aged 65 years and over. Twelve years later, as shown in *Figure 2.6*, this is still not close to being reached, with 5.6% of referrals being for people aged 65+ in 2021/22. This percentage was declining before the pandemic. This is despite the percentage of the population of England and Wales aged 65+ having increased from 16.4% in 2011 to 18.6% in 2021.[114]

[114] ONS (2022). Voices of our ageing population: Living longer lives.

Figure 2.6. Referrals to NHS Talking Therapies (also known as Improving Access to Psychological Therapies – IAPT) of people 65+, and as a percentage of all referrals, 2015/16 to 2021/22, England.



Source: Age UK 2023: Analysis using NHS Digital (2022). *Psychological Therapies, Annual report on the use of IAPT services*

Understanding the impact and effects of the COVID-19 pandemic

The proportion of older people accessing Talking Therapies was declining pre-pandemic but declined more steeply during the pandemic and is recovering more slowly than other age groups. Research for the Royal College of Psychiatrists undertaken in August 2022 found 43% of adults with mental illness reported the wait between initial referral and second appointment, – the point when treatment usually starts – had caused their mental health to worsen.[115]

2.2 Receiving treatment, care and support

Adult social care

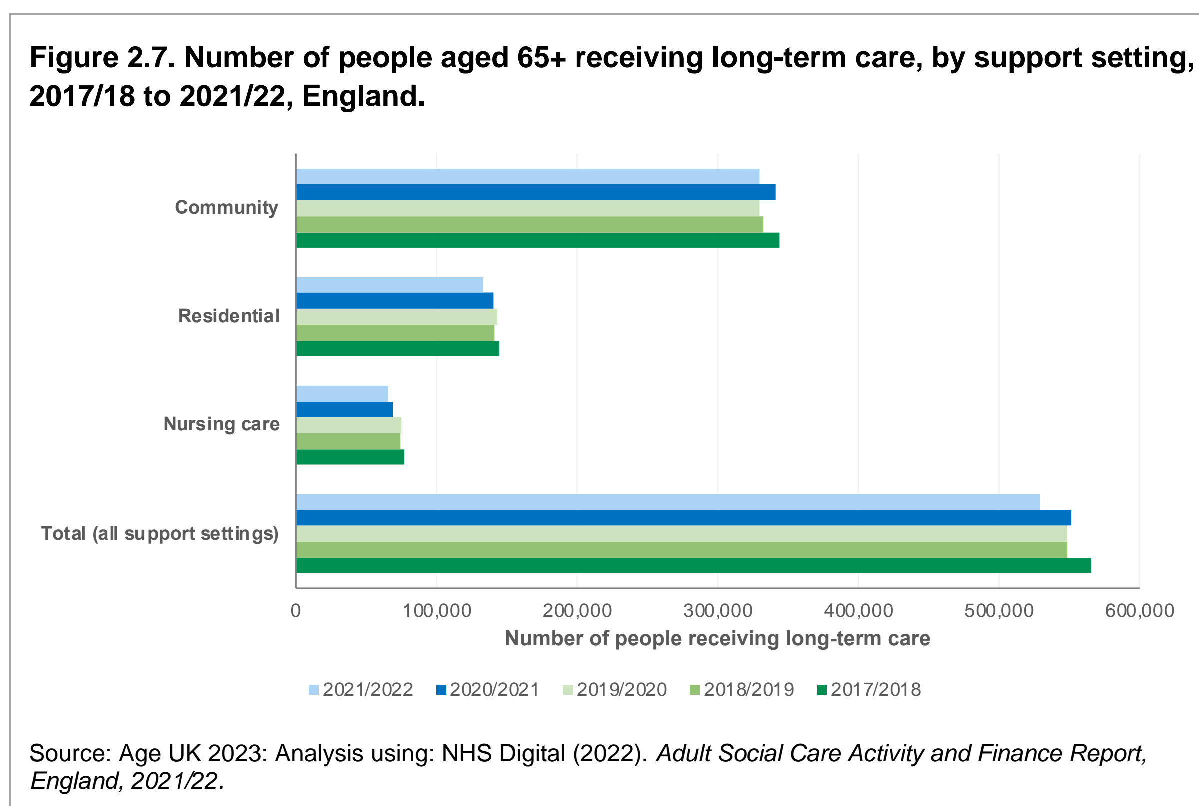
As shown in *Figure 2.7*, the number of older people receiving local authority long-term care over the course of the year fell 6.4% between 2017/18 and 2021/22 – from 565,385 to 529,010 – despite the increasing older population and the rise in need (as described in

[115] Royal College of Psychiatrists (2022). *Hidden waits force more than three quarters of mental health patients to seek help from emergency services*. [n= 535 British adults diagnosed with a mental illness including eating disorders, addiction, bipolar disorder, anxiety and depression]

Chapter 1). As shown in *Figure 2.3*, the number of older people provided with short-term support to maximise independence (ST-MAX) also fell during this period, meaning the reduction in the number of older people receiving long-term care is unlikely to be due to an increase in older people regaining independence and no longer needing long-term support.

The number of older people receiving local authority long-term care over the course of the year increased slightly in 2020/21 as a result of the fact that from 19th March to 31st August 2020 the government, via the NHS, paid for new packages of care and support (or extensions to existing ones) for patients either discharged from hospital or who would otherwise have been admitted to hospital. Data collection does not typically capture people supported by the NHS, but a decision was taken to include activity funded under these COVID-19 hospital discharge arrangements, so long as it met the definition of care provided under the Care Act and was commissioned by the local authority. This may mean that more clients were included in the collection just in this year.[116]

Figure 2.7. Number of people aged 65+ receiving long-term care, by support setting, 2017/18 to 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *Adult Social Care Activity and Finance Report, England, 2021/22.*

Prior to the COVID-19 pandemic, scope for efficiency savings was reducing year-on-year, with evidence that local authorities were having to manage social care funding pressures by other means, including service reductions and smaller care packages, as well as stricter eligibility criteria, and reducing the prices paid to providers.[117] In 2022, just 12% of Directors of Adult Social Services were confident they had the resources to deliver on all of their legal

[116] NHS Digital (2021). *Adult Social Care Activity and Finance Report, England 2020/21*.
[117] Cromarty, H. (2019). *Adult Social Care Funding (England): Briefing Paper Number CBP07903 [hard copy].* House of Commons Library

responsibilities, falling further to just 3% feeling confident about 2023.[118]

As *Table 2.1* shows, prior to the COVID-19 pandemic, an estimated 1.6 million people aged 65 years and over have unmet needs for care and support. The likelihood of having unmet needs increases with age, more than doubling between the age groups 65 to 74 years and 85 years and over.[119]

Table 2.1. Number of people aged 65+ in need of help with 1 or more ADL, by whether or not formal / informal help was received, estimates for 2018/19, England.

	1+ ADL	2+ ADL	3+ ADL
Number of people aged 65+ in need of help…	2,310,000	1,210,000	710,000
…of which received sufficient help	700,000	470,000	300,000
…of which received insufficient help	348,000	276,000	200,000
…of which received no help	1,250,000	450,000	200,000
Number people aged 65+ living with unmet needs, by number of ADLs	**1,600,000**	**730,000**	**400,000**

Source: Age UK 2023: Analysis using waves 3 to 9. *English Longitudinal Study of Ageing (ELSA), 2018/19* & ONS 2022: *Mid-Year Estimates 2021.*

Understanding the impact and effects of the COVID-19 pandemic

When Directors of Adult Social Services were asked (between May and June 2021) what the issue of **biggest concern was about future financial pressures was, they ranked "unit price for care packages to support people with increasing complexity of care needs"** as their top concern, followed by demographic pressures. These areas of concern are consistent with the pre-pandemic answers provided by Directors for the ADASS Budget Survey 2019. COVID-19 related pressures were ranked third in 2021.[120]

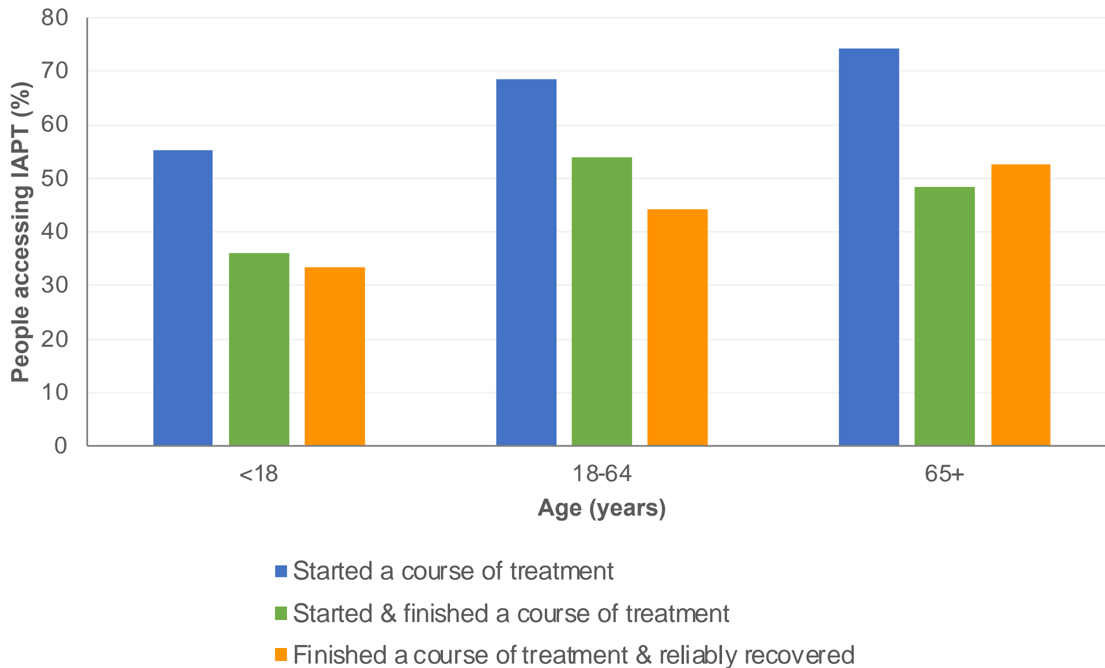
Outcomes from talking therapies

As was shown in *Figure 2.6*, a low number of older people are being referred for NHS Talking Therapies services. However, those who are referred are relatively more successful at finishing a course of treatment and reliably improving than younger adults. This is shown in *Figure 2.9* below, with 53.0% of adults aged 65+ achieving reliable recovery / improvement in 2021/22, compared with 44.0% of adults aged 18 to 64. This ought to

[118] ADASS (2022). Spring Budget Survey 2022.
[119] Age UK (2019). Estimating need in older people: Findings for England.
[120] ADASS (2021). ADASS Spring Survey 2021.

challenge outdated assumptions about how best to treat common mental health conditions in later life.

Figure 2.8. Percentage of people accessing Talking Therapies (also known as Improving Access to Psychological Therapies – IAPT) services, by outcome, 2021/22, England.



Source: Age UK 2023: Analysis using NHS Digital (2022). *Psychological Therapies, Annual report on the use of IAPT services*

2.3 Pinch points within community and primary care

Safe working limits for GPs

British Medical Association (BMA) guidance on safe working suggests that up to 25 *routine* doctor-patient contacts a day could be deemed 'safe' working practice, with GPs reaching 'unsafe' practice at 35 or more routine contacts a day. Anything over 15 doctor-patient contacts for *long-term, complex or mental health conditions* could be considered 'unsafe' due to the more demanding nature of the consultations.[121]

There are now 0.44 fully qualified GPs per 1,000 patients in England – down from 0.52 in 2015. For the GPs that remain, this means increasing numbers of patients to take care of.

[121] British Medical Association (BMA) (2018). Workload control in General Practice.

The average number of patients each GP is responsible for has increased by 332 – 17% – since 2015, and now stands at 2,270.[122]

Commonwealth Fund research undertaken just prior to the COVID-19 pandemic found that just **6% of UK GPs reported feeling 'extremely' or 'very satisfied' with** their workload. This was the lowest percentage of the 11 countries surveyed. Furthermore, just 5% of UK GPs **surveyed felt 'extremely' or 'very satisfied' with** the amount of time they can spend with their patients, significantly lower than the satisfaction reported by GPs in the other 10 countries surveyed.[123]

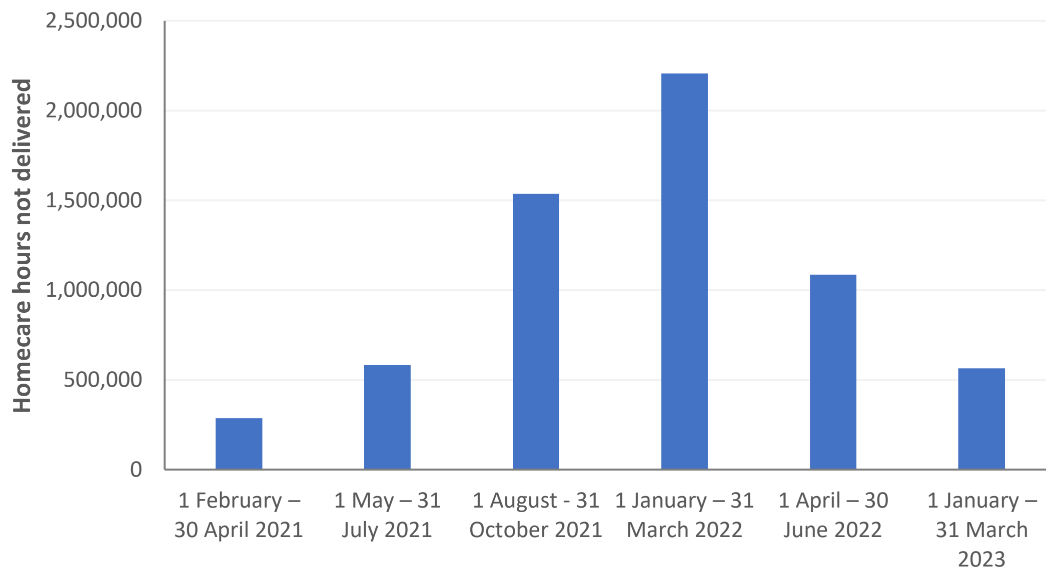
Sustainability of care provision

The public sector provides very little social care directly, with most services being delivered by private and third sector organisations. Local authorities have a duty under the Care Act 2014 to ensure that the market of home and residential care providers is sustainable and offers choice for local authority and privately paying service users alike. However, local authorities – often the major purchaser in an area – have sought to manage their own budget reductions by driving down the prices they pay for services. At the same time the costs for those same providers have increased, particularly over the last year with inflationary pressures. As a result, the care market has become increasingly precarious and dysfunctional in many parts of the country.

Austerity, since 2010/11, halted strong pre-recession growth in the number of homecare contact hours paid for by local authorities. As a result, the home care market was significantly exposed to challenges in public funding, and overall, the total amount of home care delivered fell by 3 million hours between 2015 and 2018.[124] As funding has recovered in real terms, that trend has since reversed with ADASS reporting the number of hours of homecare delivered to have increased by 35.3% (40,288,271 hours to 54,544,949 hours) from January-March 2022 to the same period in 2023 alone[125]. However, as shown in *Figure 2.10* below, local authorities continue to struggle with staff capacity with 564,584 hours of home care *not* delivered due to staff capacity. This is below the peak of 2,206,187 hours in 2022 but still almost double the amount in an equivalent period in 2021 (286,148 hours). Nor, despite increasing provision, is it necessarily sufficient to meet the needs of older and disabled people, with access to appropriate care remaining a key concern for many service users and carers.

[122] BMA analysis of NHS Digital General Practice Workforce Statistics – November 2022, available from: BMA (2022). *Pressures in general practice data analysis*.
[123] Health Foundation (2020). *Feeling the strain: What The Commonwealth Fund's 2019 international survey of general practitioners means for the UK*
[124] (£) Laing, W. (2019). *Homecare and Supported Living: UK Market Report, Second Edition.*
[125] ADASS (2023). *ADASS Spring Survey 2023.*

Figure 2.9. Number of homecare hours not delivered due to staffing capacity (directly, arranged by and/or funded by Adult Social Services Departments), 2021 to 2022, England.



Source: Age UK 2023: Analysis using ADASS (2023). ADASS *Spring Survey 2023*.

This means people – who have been assessed as eligible for state-funded care and support and therefore have high levels of need – are not getting the essential care and support they need, leading to an increase in unmet need and under-met need. ADASS reports this will **"restrict their ability to live full lives, and…for some, foreshorten life".**[126] ADASS also reports that complexity has increased with the average number of hours per person per week increasing by 30 minutes between 2021/22 and 2022/23. [127]

The Homecare Association has outlined some of the key reasons providers are struggling to meet demand for care. In a survey of homecare providers, 91% reported they had not been able to recruit enough care workers, 69% had cited existing care workers leaving and 59% believed fees were too low. [128]

The care home market was similarly challenged prior to the COVID-19 pandemic, with numbers of care home beds in some local authorities having fallen substantially over a five year period (to July 2019), including Tower Hamlets by 30%, Southwark by 27% and Waltham Forest by 26%.[129] A 2019 report by Incisive Health, commissioned by Age UK, **concluded 'the current model has broken down in some areas of the country and is no**

[126] ADASS (2022). *Autumn Survey Report 2022*.
[127] ADASS (2023). *ADASS Spring Survey 2023*.
[128] Homecare Association (2023), *Care Provision and Workforce Survey 2023*.
[129] Care Quality Commission (CQC) (2019). *The state of health care and adult social care in England 2018/19*.

longer capable of delivering care to people in need'. [130] The report researchers identified **that 'care deserts' were emerging in parts of the country as a result, where ade**quate social care provision was no longer reliably available to older people regardless of how their services are funded.

In 2019, 79% of Directors of Adult Social Services reported concern about their ability to meet the statutory duty to ensure market sustainability within existing budgets.[131] This picture has not particularly improved, with 82% reporting concern for financial year 2023/24[132] and 76% ahead of financial year 2024/25 in the latest Spring Survey.[133] A total of 66% of Directors also reported that providers in their areas had closed, ceased trading, or handed back local authority contracts.[134] ADASS reports this to be a significantly worse picture than both during the height of the pandemic and prior to the pandemic. Directors are also concerned about the quality and choice of in their local care market. 65% reported that quality and choice had reduced compared to the pre-pandemic period. [135]

Older people and families are increasingly making up the shortfall in public funding. Amounts raised through client contributions have increased in recent years, while the number of older people receiving long-term services has declined. People paying privately for services are also significantly cross-subsidising the system. In the September 2021 announcement of social care funding reforms in England, the Government acknowledged the existence of endemic cross-**subsidisation, pledging: "The overall system will be made** fairer, to ensure those who fund their own care do not pay more than state-funded ind**ividuals for the equivalent standard of care".**[136] In November 2022, the Government announced these reforms would be paused until at least October 2025.[137]

Navigating adult social care

As shown in Section 2.1 above, more than half of requests for social care support result in either no services being received, or the older person being signposted to universal services or elsewhere. Section 2.2 shows the number of people aged 65+ receiving long-term care has reduced by 6.4% - or 36,000 – from 2017/18 to 2021/22, despite the number of people aged 65+ with unmet needs having increased during the same period.

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[130] Incisive Health (2019). *Care deserts: the impact of a dysfunctional market in adult social care provision*.
[131] ADASS (2019). *ADASS Budget Survey 2019.*
[132] ADASS (2022). *ADASS Spring Survey 2022*.
[133] ADASS (2023). ADASS Spring Survey 2023.
[134] ADASS (2023). *ADASS Spring Survey 2023.*
[135] ADASS (2022). *ADASS Spring Survey 2022*.
[136] Prime Minister's Office, 10 Downing Street (2021). *Record £36 billion investment to reform NHS and social care [press release].*
[137] Foster, D. (2022). *Proposed adult social care charging reforms (including cap on care costs*). House of Commons Library

Research[138] by the National Institute for Health and Social Care Research (NIHR) found people in England who pay for their own social care receive little assistance in making choices about their care, even though arranging care requires a range of skills that they may not have. While some people have friends or family that can help or make recommendations, not everyone is able to rely on this. The research found people need skills in searching for information, deciding on the level of care they need, weighing up alternatives, managing a budget and dealing with employment or care home contracts. The researchers concluded that getting it wrong can be expensive and could mean that needs are not met.

Detrimental waiting times

As outlined earlier, ADASS research found 434,243 people were waiting for an adult social care assessment, for care to begin, for a Direct Payment, or for a review of their care as at 31st March 2023.[139] Six in 10 councils (61%) have reported having to prioritise assessments and only being able to respond to people where abuse or neglect is highlighted; for hospital discharge; or after a temporary period of residential care to support recovery and reablement.[140] Between November 2021 and March 2023, the number of people who have waited over 6 months for an assessment of any kind almost doubled (up 99%).[141]

There are even wider issues with waiting for support. Most older people wish to stay in their home for as long as possible.[142] Behind this sits an attachment to the home, an entity that keeps older people busy and active, shields privacy and freedom, and boosts sense of identity and self-esteem.[143] Home adaptations – changes made to the fabric and fixtures of a home to make it safer and easier to get around and to use for everyday tasks – have an important role to play in ensuring the homes of older people can accommodate changing needs and are comfortable, healthy and safe.[144]

Local authorities administer funding for adaptations, which generally fall into two categories. 'Minor' adaptations are those with a value of less than £1,000, and include grab rails, lever taps in kitchens and bathrooms, small ramps, and raising or lowering plug sockets, light switches, and key holes. 'Major' adaptations are those with a value of £1,000 or more, and include level access showers, walk-in baths, and installing ceiling track hoists, stair lifts and 'through the floor' lifts.

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138 NIHR (2021). *People who fund their own social care receive little help to navigate the system*.
139 ADASS (2023). *ADASS Spring Survey 2023*.
140 ADASS (2022). *Waiting for Care and Support: May 2022*.
141 ADASS (2023). *ADASS Spring Survey 2023*.
142 Communities & Local Government Committee (CLGC) (2018). *Housing for older people: Second Report of Session 2017-19*. House of Commons.
143 Zhou, W., Oyegoke, A.S. & Sun, M. (2019). Causes of Delays during Housing Adaptation for Healthy Aging in the UK. *International Journal of Environmental Research and Public Health 16(2): 192.*
144 Communities & Local Government Committee (CLGC) (2018). *Housing for older people: Second Report of Session 2017-19*. House of Commons.

NHS Digital's biennial survey of adult carers of adults found there has been a decrease in the number of cared-for people accessing equipment and minor adaptations (such as grab rails) in their home. There has also been a year-on-year decrease since 2012/13 in the number of cared-for people accessing lifeline alarms.[145]

Disabled Facilities Grants (DFGs) are capital grants that are available to people of all ages and in all housing tenures to contribute to the cost of major adaptations. They can provide funding for a wide range of assistive technologies to support people in and around their homes as part of adaptations, such as lifts, stairlifts, wash and dry toilets, grab rails, and level access showers.[146]

The Housing Grants, Construction and Regeneration Act 1996 mandates that adaptations are approved and completed within a maximum of 18 months in England once a council has received a completed application form (6 months to decide the application and 12 months to complete the works).[147] However, this statutory time limit does not include the time it takes to be assessed as eligible to apply or any of the steps taken before the application goes in.

Research by the Bureau of Investigative Journalism found that in some areas of England, people are left waiting for up to 12 months for an initial DFG assessment, often waiting for input by an occupational therapist (OT) or similar person. In one council, the wait was more than 18 months. An application cannot be made without this assessment. The research also found that in some areas people are waiting two to three years for the home adaptation to be completed once approved.[148] This means some older and disabled people are confined to the downstairs part of their homes only, unable to independently get upstairs, go into their back garden, or go to the toilet in private.

In England, the maximum amount councils can give each DFG applicant is £30,000[149] – a cap that has not been raised since 2008. The Bureau of Investigative Journalism found nearly 80% of local authorities in England and Wales are using discretionary powers to top up funding, but the extra money a person can get varies wildly by council – some offer another £30,000 but Manchester can offer up to £70,000 – and in some areas, the top-up is a grant, but in many it is a loan.[150]

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[145] NHS Digital (2022). *Personal Social Services Survey of Adult Carers in England, 2021/22*.

[146] DLUHC & DHSC (2022). *Disabled Facilities Grant (DFG) delivery: Guidance for local authorities in England*

[147] Housing Grants, Construction and Regeneration Act 1996: c. 34 and c. 37.

[148] Gayle, V., Hamada, R. & Boutaud, C. (2022). *Disabled people trapped waiting years for vital home adaptations*. Bureau of Investigative Journalism

[149] DLUHC & DHSC (2022). *Disabled Facilities Grant (DFG) delivery: Guidance for local authorities in England*

[150] Gayle, V., Hamada, R. & Boutaud, C. (2022). *Disabled people trapped waiting years for vital home adaptations*. Bureau of Investigative Journalism

3. IMPACT ON OLDER PEOPLE, ON THEIR FAMILIES AND ON ACUTE CARE

3.1 High levels of unmet need

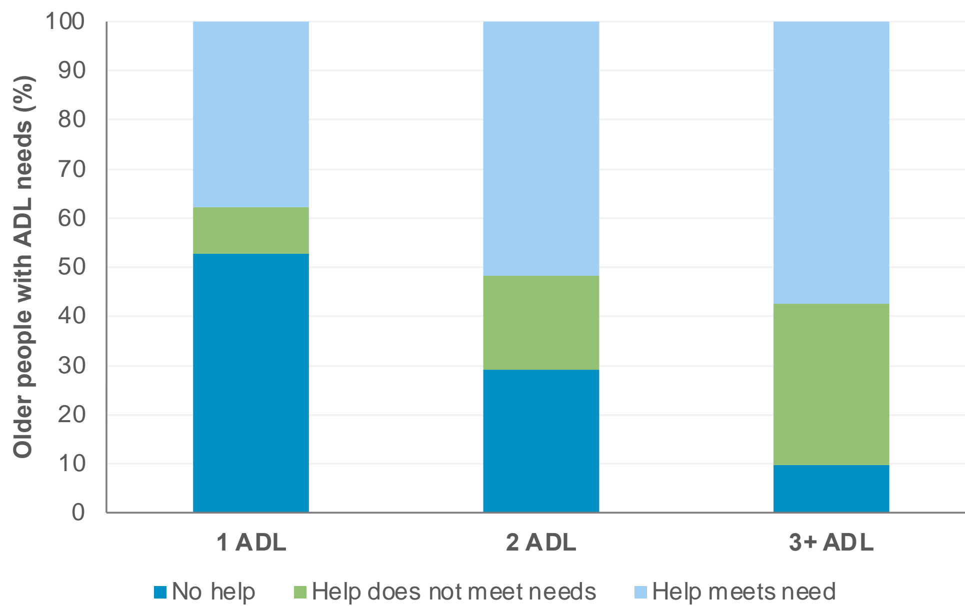
The huge reduction in the provision of publicly funded social care has had a severe impact on older people, their families and carers in recent years. A concerning proportion, 17%, of Directors of Adult Social Services report that reducing the number of people in receipt of care was important or very important for them to achieve necessary savings in 2022/23, up from 8% in 2021/22.[151] If local authorities successfully develop preventative approaches that increase independence and reduce need for care, then this is a positive ambition. However, if local authorities gate-keep resources in a way that leaves people in need without appropriate care and support, then it both breaches the law and risks costlier interventions becoming necessary further down the line.

As shown in *Table 2.1*, an estimated 1.6 million people aged 65+ have unmet needs for care and support, including hundreds of thousands of people who are unable to complete three or more ADLs and receive no help or help that does not meet their needs.

Figure 3.1 sets out the percentage of older people who report needing help with specific essential everyday tasks, which further illuminates the levels of unmet need. It shows that an alarming percentage of people are either not receiving any help with basic tasks like getting in and out of bed, using the toilet and eating, or they are receiving help that does not meet their needs.

[151] ADASS (2022). *ADASS Spring Survey 2022*.

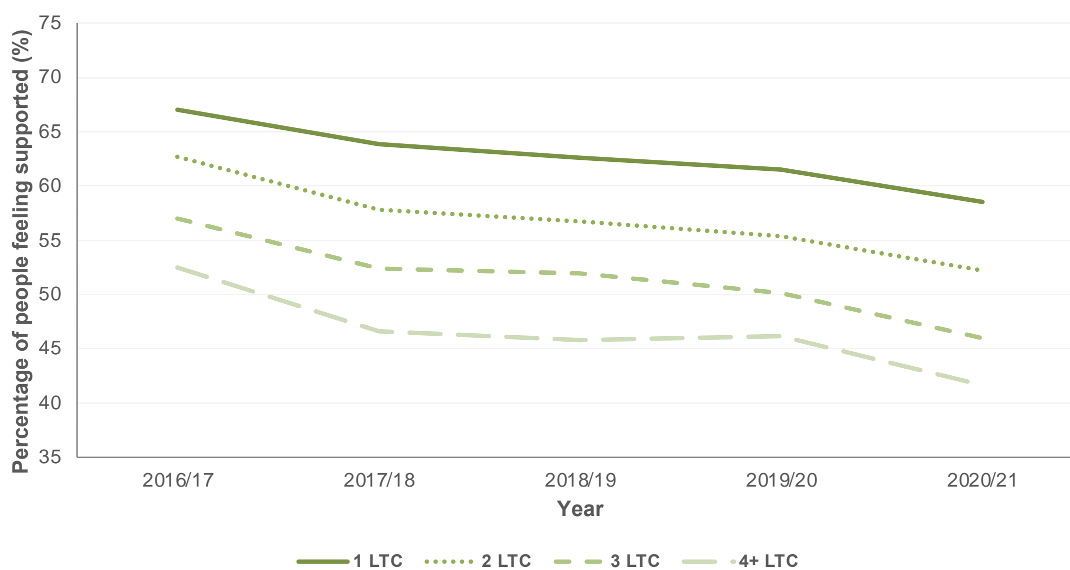
Figure 3.1. Percentage of people aged 65+ with various ADL needs, broken down by whether or not they receive help, 2018/19, England



Source: Age UK 2023: Analysis using waves 3 to 9, English Longitudinal Study of Ageing (ELSA), 2002-2019

The more long-term conditions you have, the less likely you are to feel supported to manage them. *Figure 3.2* shows that in 2020/21, 58.5% of people with one long-term condition feel supported to manage their condition, while only 41.6% of people with four or more long-term conditions feel supported to manage them.

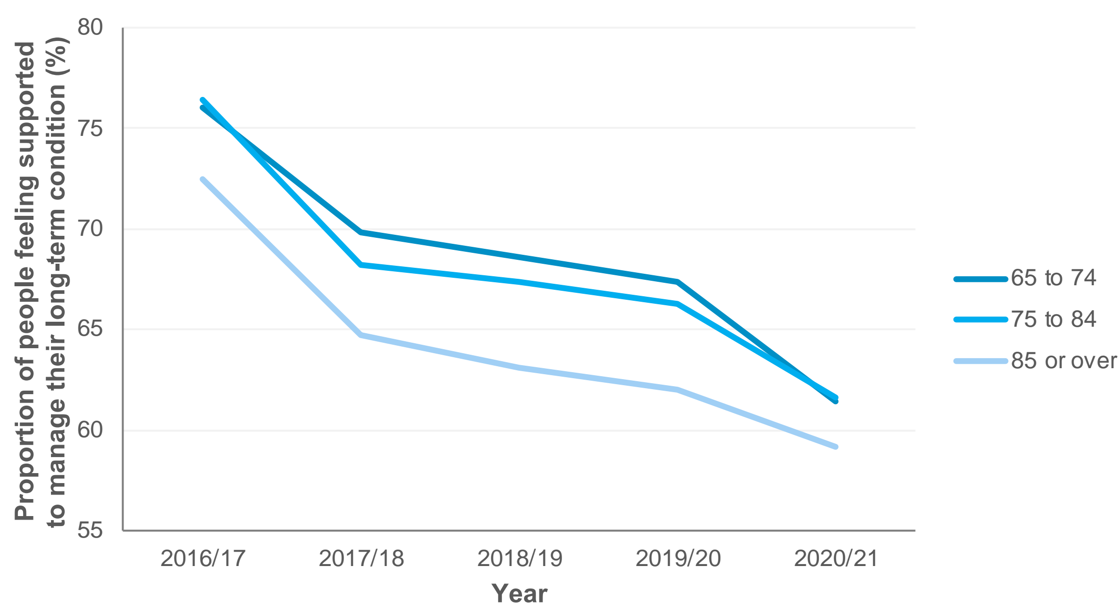
Figure 3.2. Percentage of people feeling supported to manage their long-term condition (LTC), by number of LTCs, 2016/17 to 2020/21, England.



Source: Age UK 2023: Analysis using NHS England (2022). *GP Patient Survey 2022*.

Prior to the pandemic, people aged 85+ were feeling the least supported to manage their long-term condition/s. However, as *Figure 3.3* shows, the proportions of older people aged 65-74 years and 75-84 years who feel unsupported have dropped to similar levels. The proportion of people that feel supported has decreased by 14.6% over the last five years in the 65-74 years age group, and by 14.8% in the 75-84 years group. The proportion of people aged 85+ that feel supported has also decreased by 4 percentage points over the last five years.

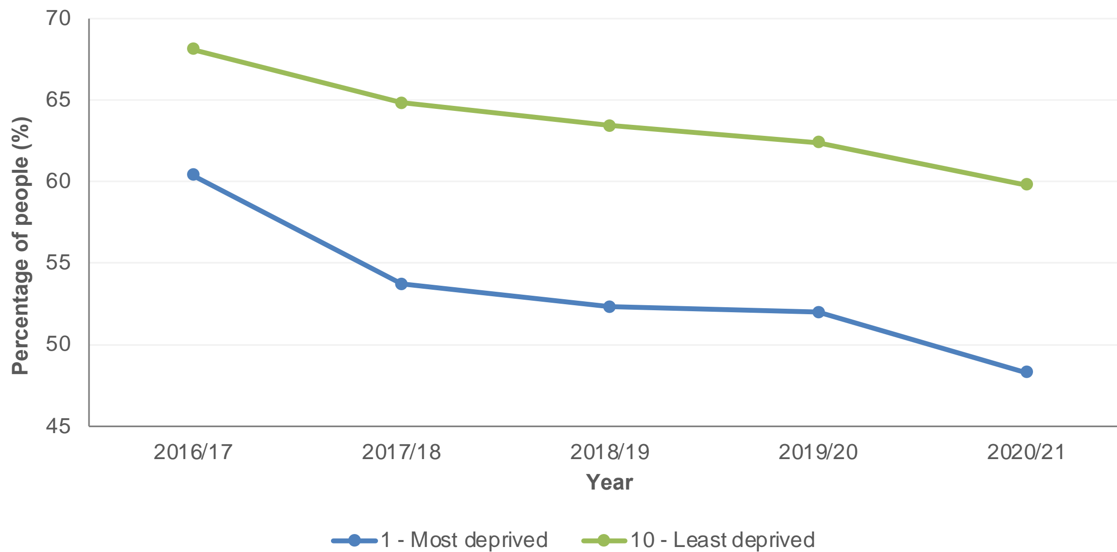
Figure 3.3. Percentage of people that felt they had enough support to manage their long-term condition/s, by age, 2016/17 to 2020/21, England.



Source: Age UK 2023 analysis of NHS Outcomes Framework: Proportion of people feeling supported to manage their long-term condition (2022). *GP Patient Survey 2022*.

People in the most deprived areas feel less supported to manage their long-term conditions than those in the least deprived areas. As *Figure 3.4* shows, 59.8% of people felt supported to manage their long-term condition/s in the least deprived areas in 2022, while 48.3% felt supported in the most deprived areas – a difference of 11.5 percentage points between the two groups. The proportion of people feeling supported to manage their long-term conditions has fallen amongst those in both the most deprived and the least deprived areas since 2014/15.

Figure 3.4. Percentage of people that felt they had enough support to manage their long-term condition/s, by deprivation, 2016/17 to 2020/21, England.



Source: Age UK 2023: Analysis using NHS England (2022). *GP Patient Survey.*

Private expenditure on healthcare

Another key trend to note is rising private expenditure on healthcare. There was a peak of 71,000 self-funded treatments (paid in-full by individuals rather than through insurance) in the UK in the period April to June 2021, a 42% rise on the same period in 2019 (pre-pandemic). This had reduced to 66,000 self-funded treatments in the period July to September 2022, but this still represents a 32% increase on the same period in 2019.[152]

The largest increase in self-funded procedures between July to September 2019 and July to September 2022 was hip replacements in the East Midlands, up 281%. There were also increases of over 200% in self-pay procedures for knee replacement surgery in Yorkshire and The Humber (278%), and knee replacement (258%) and hip replacement (244%) in the North West.[153]

The number of people taking out private health insurance has also increased, with Bupa, Aviva and Vitality, three of the largest insurers in the UK, collectively added 480,000 new customers in 2022.[154] Growth in this sector is happening in parallel with increasing NHS waiting times (as explored below). Taken together, these trends may suggest patients increasingly feel they have no option but to pay to receive timely treatment for essential care.

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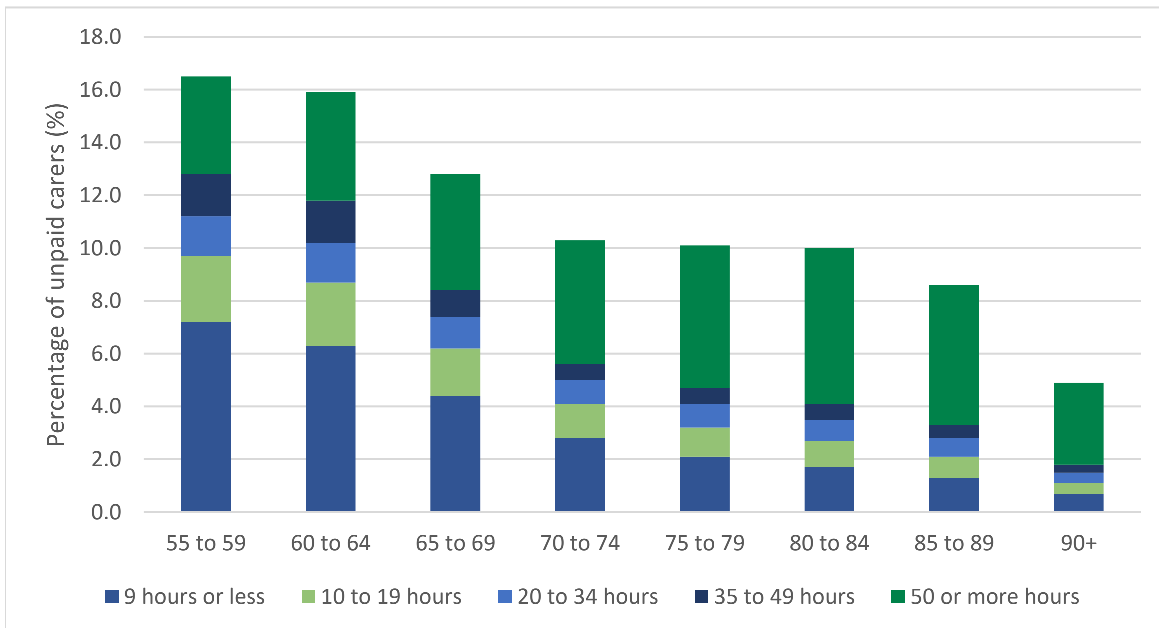
[152] (£) Gargan, I. (2023). Self-pay stalls but private patient demand remains high. *Healthcare Markets* 27(3):7, LaingBuisson
[153] (£) Rupalia-Seyani, P. (2023). The big picture. *Healthcare Markets* 27(3):18-25, LaingBuisson
[154] Lovett, S. (2023). Nearly half-a-million take out private health insurance in 2022 as NHS crisis deepens. The Telegraph

3.2 Growing pressures on unpaid carers

The combination of a growing and ageing population, increasingly complex needs and reducing access to care services also places significant pressure on unpaid carers. Unlike healthcare, most social care is provided informally by unpaid partners, family and friends, who provide personal care and practical help and coordinate formal services. The value of informal care in England was estimated to be nearly £100 billion per year in 2018.[155] Unpaid carers in England and Wales contribute £445 million to the economy every day – £162 billion per year.[156]

One in five (21%) of unpaid carers are aged 55-64 and one in five (20%) of carers are aged 65 and over.[157] As *Figure 3.5* shows below, older people are more likely to provide intensive levels of care. As noted in Chapter 1, research undertaken in 2020 found that unpaid carers aged 65 and over were worried about the health implications of caring, with 32% worried about managing the stress and responsibility of being an unpaid carer, and 29% worried about the negative impact of caring on their own physical and mental health.[158]

Figure 3.5. Percentage of people who are carers and the number of hours of care they provide per week, by age group, 2021, England.

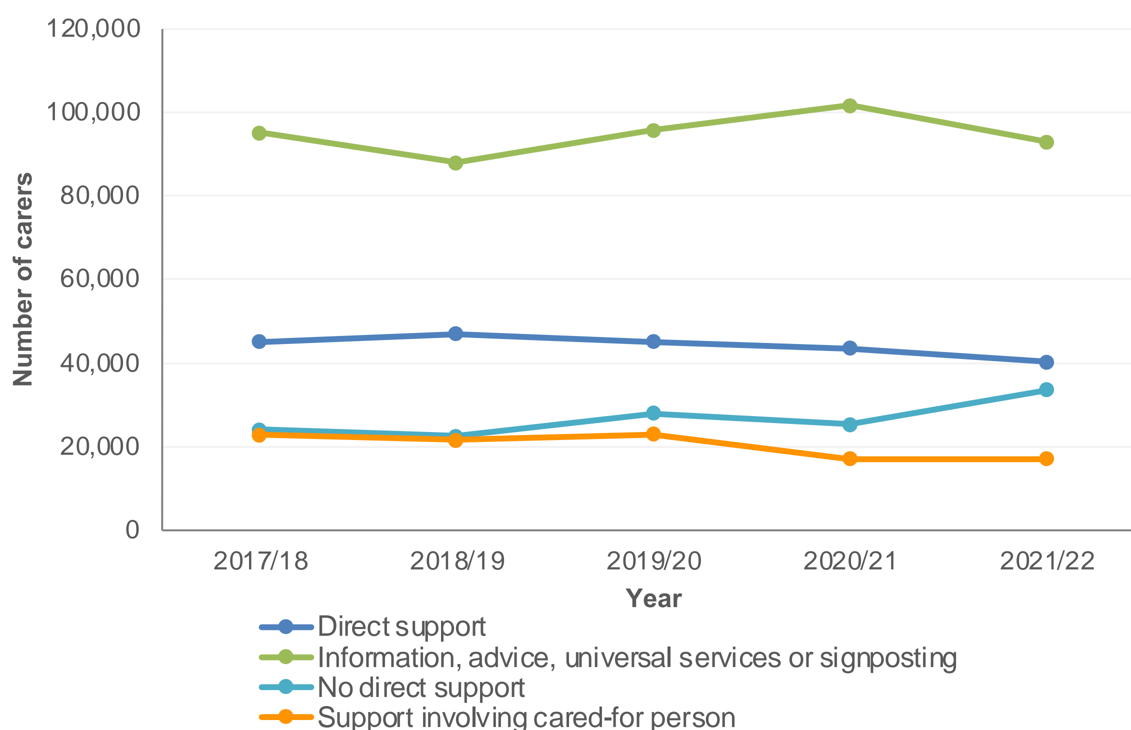


Source: Age UK analysis 2023: ONS (2023). Unpaid care by age, sex and deprivation, England, Census 2021

[155] National Audit Office (NAO) (2018). Adult social care at a glance.
[156] Petrillo, M. & Bennett, M. (2023). *Valuing Carers 2021*. Centre for Care with Carers UK.
[157] Carers Week (2020). *Carers Week 2020 Research Report*.
[158] Carers Week (2020). *Carers Week 2020 Research Report*.

Figure 3.6 provides a clear indication that access to some of the key support services that carers rely on has been reducing, despite the demands placed on carers by the pandemic. Since 2017/18, the number of carers provided with respite for the cared-for person has dropped by 25.0%, while access to direct support for the carer has fallen by 10.5%. This is despite the demands on unpaid carers having increased, affecting their health. As noted in Chapter 1, Carers UK report that in February 2022, 81% of unpaid carers responding to their State of Care survey reported they were providing more care than at the start of the pandemic. The research findings echo the reported activity of local authorities, with a total of 72% of unpaid carers reporting not having had a break from their caring role since the start of the pandemic, which was associated with a negative impact on carers' health. More than two-thirds (69%) of unpaid carers said their mental health is worse because of caring during the pandemic.[159] As also reported in Chapter 1, in mid-2022 73% of Directors of Adult Social Services reported seeing more cases of breakdown of unpaid carer arrangements in their area.[160]

Figure 3.6. Types of support provided or arranged by local authorities for carers of adults, 2017/18 to 2021/22, England.



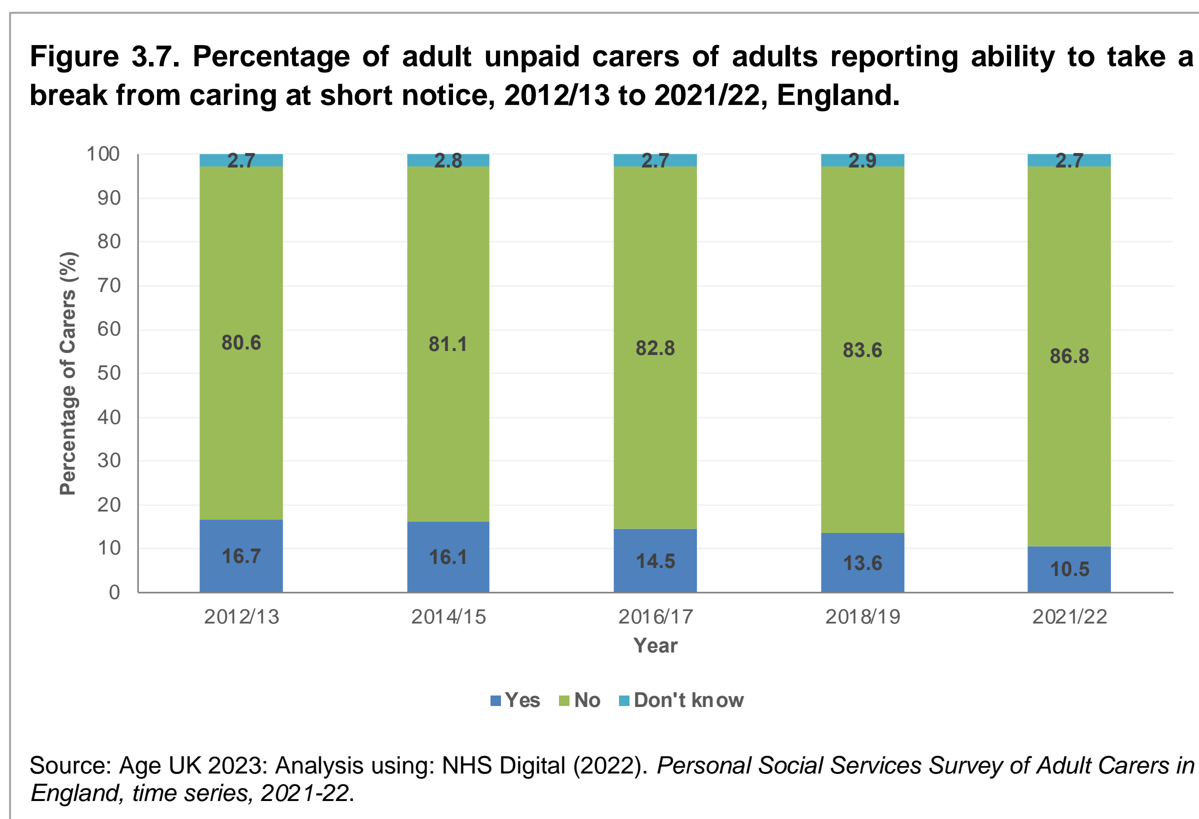
Source: Age UK 2023: Analysis using: NHS Digital (2022). *Adult Social Care Activity and Finance Report, England, 2021/22.*

[159] Carers UK (2022). *Under pressure: Caring and the cost of living crisis.*
[160] ADASS (2022). *Spring Budget Survey 2022*.

Prior to the COVID-19 pandemic, the 2018/19 biennial national survey of carers of adults (administrated by local authorities) found 60.6% of unpaid carers reported caring to cause feelings of stress, up from 58.7% in 2016/17. In 2021/22[161], this had increased to 63.6%. The proportion of unpaid carers reporting disturbed sleep increased from 64.0% in 2016/17 to 66.0% in 2018/19 and then to 67.1% in 2021/22. The proportion reporting feeling depressed increased from 43.4% in 2016/17 to 45.1% in 2018/19 and then to 48.3% in 2021/22. The percentage of carers with a mental health problem or illness has increased from 8.1% in 2016/17 to 10.9% in 2018/19 and to 13.2% in 2021/22.[162] More than one in five unpaid carers (22.3%) reported caring made an existing condition worse.[163]

As *Figure 3.7* shows below, only 10.5% of carers report being able to take a break from caring at short notice or in an emergency in 2021/22. This is down from an already low 13.6% in 2018/19. Even when breaks from caring are long in the planning, only 13.3% of carers report being able to take a break for more than 24 hours in 2021/22. As shown in *Figure 3.8*, this is down from 19.6% in 2018/19 and 22.3% in 2014/15.

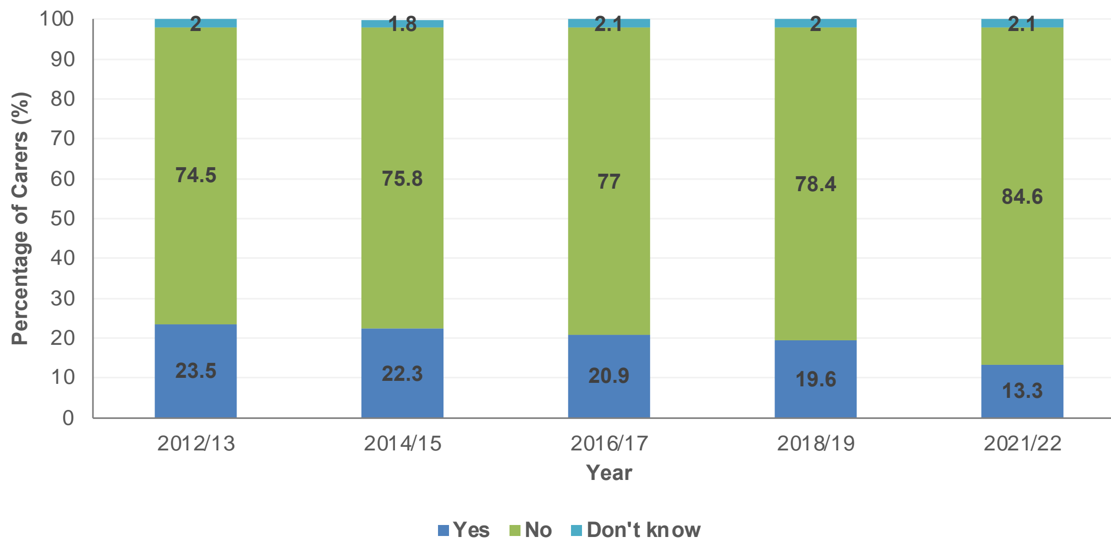
Figure 3.7. Percentage of adult unpaid carers of adults reporting ability to take a break from caring at short notice, 2012/13 to 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *Personal Social Services Survey of Adult Carers in England, time series, 2021-22*.

[161] Due to the additional pressures that the COVID-19 pandemic brought on services, NHS Digital decided to postpone 2020/21 collection by one year. The survey remains biennial, with the next collection due 2023/24.
[162] NHS Digital (2022). *Personal Social Services Survey of Adult Carers in England, 2021-22*.
[163] NHS Digital (2022). *Personal Social Services Survey of Adult Carers in England, 2021-22*.

Figure 3.8. Percentage of adult carers of adults reporting ability to take a break from caring for more than 24 hours, 2012/13 to 2021/22, England.

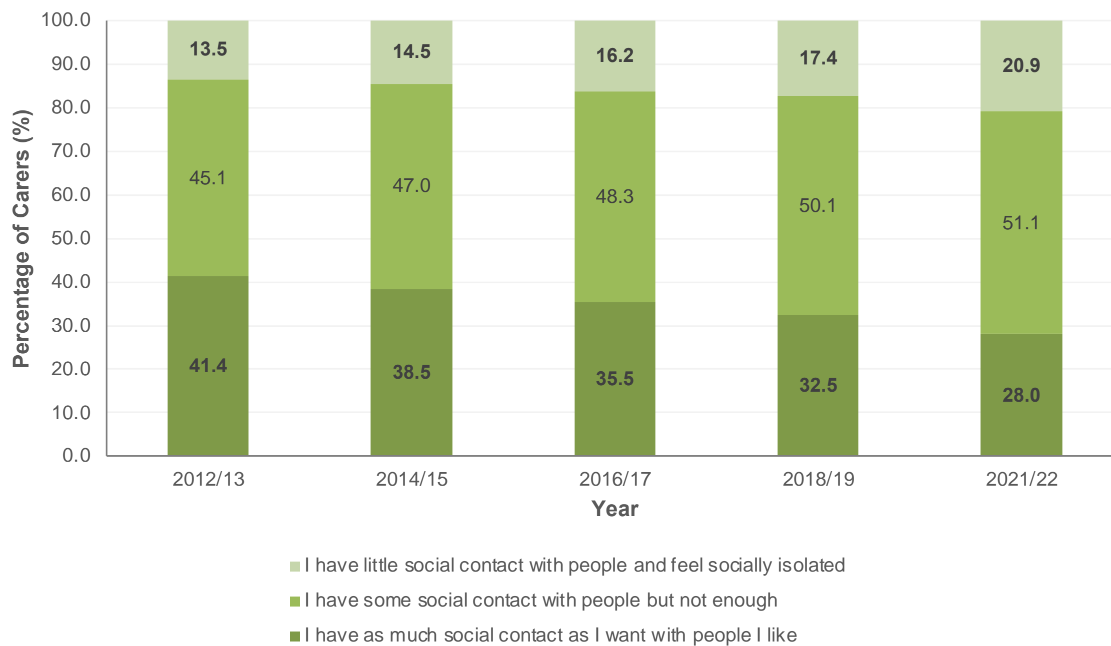


Source: Age UK 2023: Analysis using: NHS Digital (2022). *Personal Social Services Survey of Adult Carers in England, time series, 2021-22*.

As shown in *Figure 3.9* there has been a steady decline in the proportion of carers who have felt they have as much social contact as they want with people they like. This decreased as the pandemic impacted, from 32.5% in 2018/19 to 28.0% in 2021/22. The proportion of carers that felt they have little social contact and feel socially isolated increased from 17.4% in 2018/19 to 20.9% in 2021/22.[164]

[164] NHS Digital (2022). Personal Social Services Survey of Adult Carers in England, 2021-22.

Figure 3.9. Percentage of adult carers of adults reporting on the social contact, 2012/13 to 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *Personal Social Services Survey of Adult Carers in England, time series, 2021-22*.

The proportion of carers that feel they have encouragement and support has also fallen year on year; most recently from 34.6% in 2018/19 to 31.5% in 2021/22. The proportion of carers that feel they have no encouragement or support increased from 20.7% in 2018/19 to 22.8% in 2021/22.[165]

Third-party top-up fees and charges

A third-party top-up fee is the difference between the rate a local authority is willing to pay a care home and the chosen care home's fee. In theory these should only apply when someone has chosen a more expensive care home after they have been offered suitable options within the local authority rates. This could be because a person would prefer to live in a care home that costs more than the local authority is prepared to pay for genuine extras (such as a large room, a better view, or a private balcony). Or it could be because they were previously self-funding their care home fees and want to stay in the same home now that they are eligible for local authority funding. There is no legal requirement for anybody to agree to pay a third-party top-up fee and the decision to meet this cost must be entirely voluntary. An estimated 11% of care home residents pay top-up fees or have them paid on their behalf.[166]

[165] NHS Digital (2022). Personal Social Services Survey of Adult Carers in England, 2021-22.
[166] (£) Laing, W. (2022). *Care Homes for Older People: UK Market Report- Thirty-Second Edition.*

However, there is a significant and growing gap between the rates paid by local authorities and those paid by self-funders. There is also evidence of third-party top-ups being used inappropriately where older people and their families are entering into arrangements without understanding their rights and/ or being pressured into paying a top up when they are eligible for publicly funded care. In recent years the Ombudsman has found continuing errors relating to top-up fees, with people and their families being incorrectly charged for care. This includes being given limited or poor information about top-up fees, leading them to enter into agreements they do not understand, or being led to believe the fees to be mandatory.[167] Local authorities can also be unwilling to fund placements in more expensive homes when self-funders reach the floor of their assets, meaning that families are faced with the prospect of finding a top-up (which may be unaffordable) or moving their relative at an incredibly vulnerable time in their life.

Just prior to the instigation of the first COVID-19 pandemic period of lockdown in England, the Ombudsman issued a warning to local authorities that leaving top-up fees to **negotiations between homes and residents or their families "can potentially leave people vulnerable to the risk of fee increases", adding the Care Act statutory guidance is "quite** clear that leaving the administration of top-**up fees to care homes was wrong".**[168]

3.3 Stretched acute services

Accident & Emergency (A&E) attendance

Accident and Emergency (A&E) attendances offer another insight into the effectiveness of primary and community care. Access has been found to be predictive of A&E attendance insofar as studies have found there are 18 fewer A&E attendances per 100 population for each kilometre closer a person lived to a GP practice.[169] Immediately prior to the COVID-19 pandemic there were 25 million attendances at A&E.[170] The average growth per year over the period 2010/11 to 2019/20 was 2%, compared with the England population average growth of 1% per year over a similar period.[171]

Attendances reduced dramatically during the COVID-19 pandemic national lockdowns, resulting in 17.4 million attendances in 2020/21 (a reduction of 30.3%).[172] However, there

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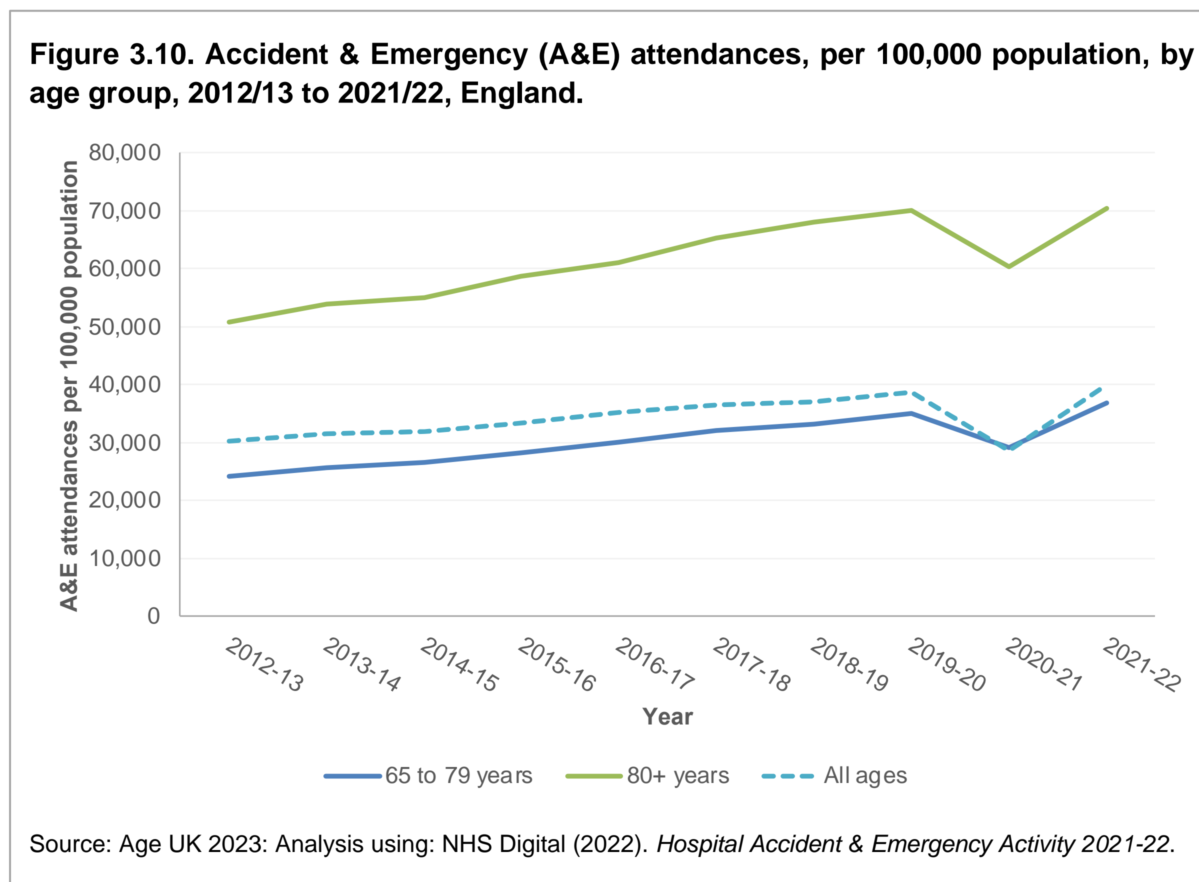
[167] Local Government & Social Care Ombudsman (LGSCO) (2019). *Annual Review of Adult Social Care Complaints 2018/19*.
[168] Local Government & Social Care Ombudsman (LGSCO) (2022). *Annual Review of Adult Social Care Complaints 2021/22.*
[169] Giebel, C., McIntyre, J.C., Daras, K. et al (2019). What are the social predictors of accident and emergency attendance in disadvantaged neighbourhoods? Results from a cross-sectional household health survey in the north west of England. *BMJ Open* 9(e022820).
[170] NHS Digital (2020). *Hospital Accident & Emergency Activity 2019-20*.
[171] NHS Digital (2020). *Hospital Accident & Emergency Activity 2019-20*.
[172] NHS Digital (2021). *Hospital Accident & Emergency Activity 2020-21.*

were 24.4 million attendances in A&E in 2021/22, which was close to pre-pandemic levels and represented an increase of 12.1% since 2012/13.[173]

Figure 3.10 shows that A&E attendances per 100,000 population are significantly greater for people aged 80+ compared to the general population.

Figure 3.10. Accident & Emergency (A&E) attendances, per 100,000 population, by age group, 2012/13 to 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.

Inequalities persist within A&E attendance. There were around twice as many attendances to A&E departments in England for the 10% cent of the population living in the most deprived areas (3 million), compared with the least deprived 10% (1.5 million).[174] Not being in employment and living in poor quality housing are among socioeconomic factors found to increase the likelihood of attending an A&E service.[175]

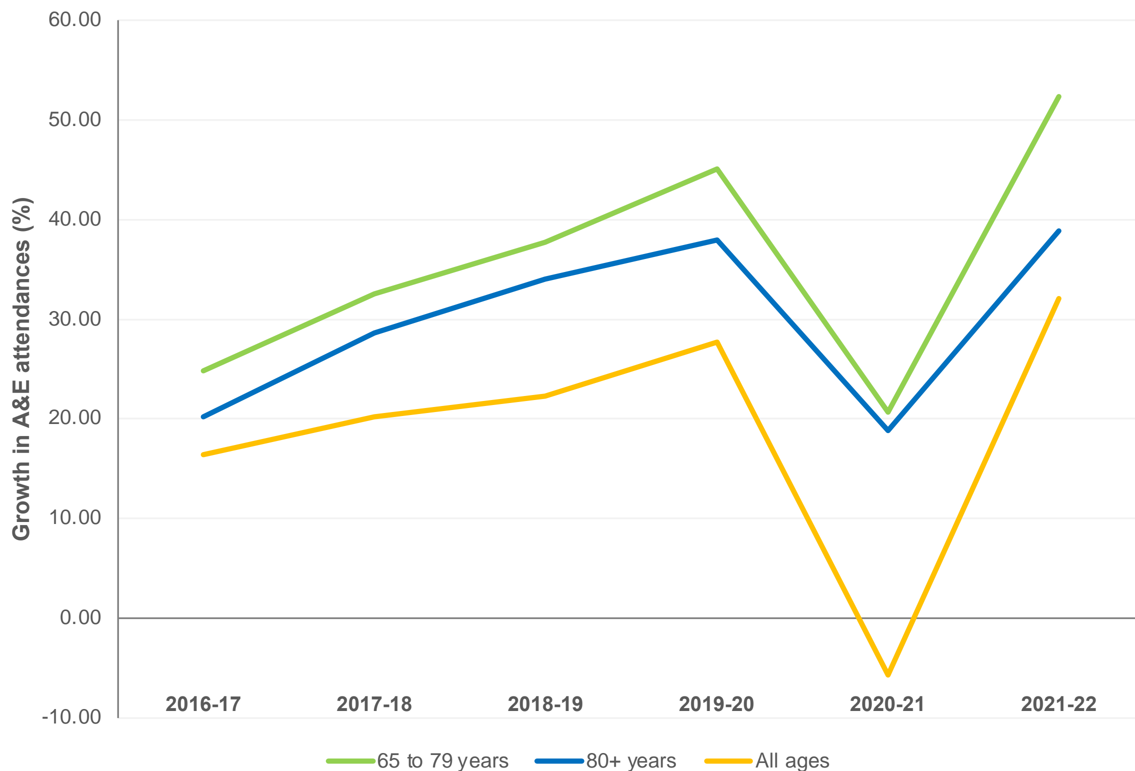
Figure 3.11 shows that A&E attendances are increasing faster among people aged 65 to 79 and 80+ than the rest of the population.

[173] NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.

[174] NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.

[175] Giebel, C., McIntyre, J.C., Daras, K. et al (2019). What are the social predictors of accident and emergency attendance in disadvantaged neighbourhoods? Results from a cross-sectional household health survey in the north west of England. *BMJ Open* 9(e022820).

Figure 3.11. Percentage growth in Accident & Emergency (A&E) attendances, since 2016/17 across subsequent years to 2021/22, by age group, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.

A&E performance remains significantly below the NHS Constitution standard of 95% of people being seen within four hours. People waiting over four hours became more common between 2015 and 2020.[176] When A&E attendances fell during the first national lockdown, four-hour wait performance improved, with 86.8% of patient attendances spending 4 hours or less in A&E. However, since then performance has declined to its worst level on record. For 2021/22, only 76.7% of patient attendances spent four hours or less in A&E.[177] The Royal College of Emergency Medicine said in their 2023 analysis that the average wait for someone over 80 was 16 hours, up from an already high 9 hours a year before. [178]

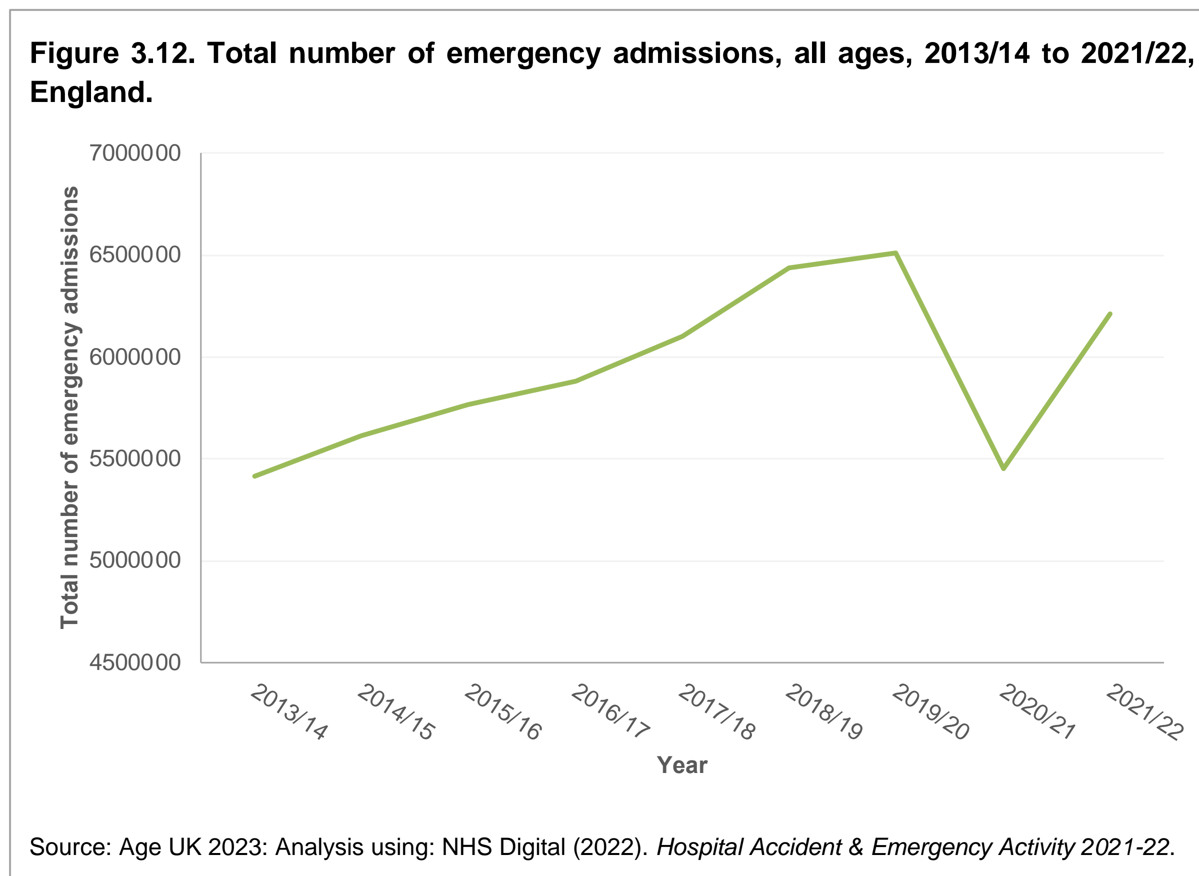
Emergency admissions and readmissions

Figure 3.12 shows that the number of emergency admissions to hospital sharply increased in 2021/22 but has yet to return to pre-pandemic levels. Prior to the pandemic, the number of emergency admissions had increased year-on-year since 2014/15. This increase has been particularly driven by older people, with attendances amongst those aged 85 and over

[176] Baker, C. (2022). *NHS key statistics: England, November 2022*. House of Commons Library
[177] NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.
[178] The Guardian (31 January 2023), *Elderly people waited nearly twice as long in A&E in England as in 2021*

rising quickly. Falls were the largest cause of emergency admissions for people aged 65 and over.[179]

Figure 3.12. Total number of emergency admissions, all ages, 2013/14 to 2021/22, England.

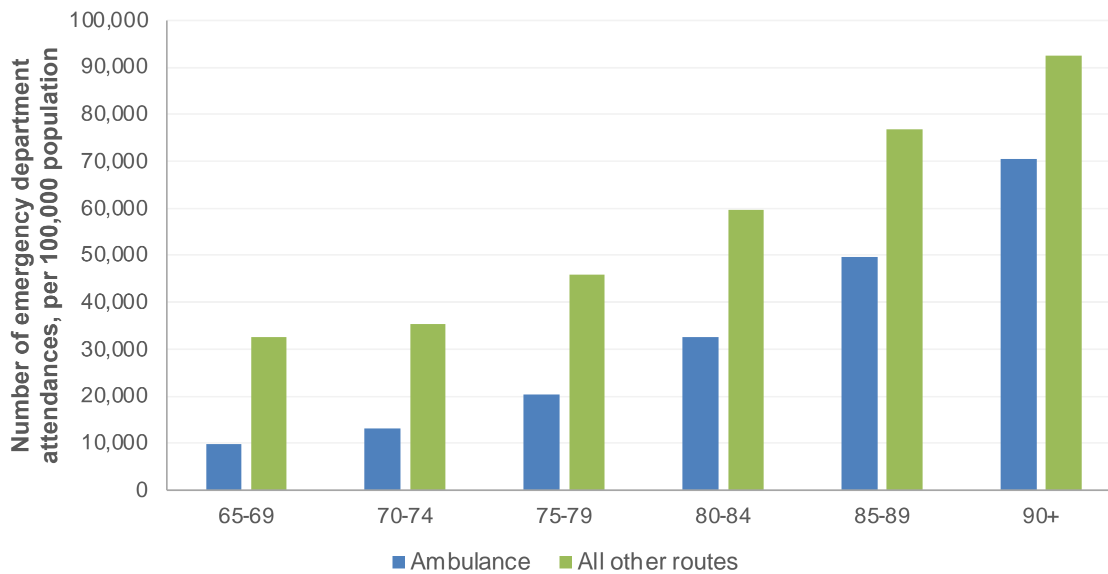


Source: Age UK 2023: Analysis using: NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.

Overall, people over 65 represent 21.2% of total A&E attendances. [180] However, this age group makes up 48.8% of attendances that arrive by ambulance[181], indicating a higher level of complexity and acuity. Of people that arrive by ambulance, 41.3% are admitted to the hospital[182], indicating that older people are coming in with more urgent needs and are much more likely to require an inpatient stay. As *Figure 3.13* shows, the oldest old are even more prone to arriving by ambulance.

[179] NHS Digital (2019). *Hospital Accident & Emergency Activity 2018-19*.
[180] NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.
[181] NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.
[182] NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.

Figure 3.13. Emergency Department attendances, arrival by ambulance & all other routes, per 100,000 population, by age group, 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.

Some emergency admissions are clinically appropriate and unavoidable, but others could be avoided by providing alternative forms of urgent care, or appropriate care and support earlier to prevent a person becoming unwell enough to require an emergency admission. This is explored below.

Emergency *readmissions* – where patients are readmitted to hospital in an emergency within 30 days of discharge – may result from potentially avoidable adverse events, though others may be due to unrelated or unforeseen causes of admission. In 2021/22, there were 263,245 emergency readmissions of people over 75 within 30 days of discharge. This translates into 1 in 6 (18%) emergency admissions in over 75s occurring within 30 days of last being discharged from hospital[183].

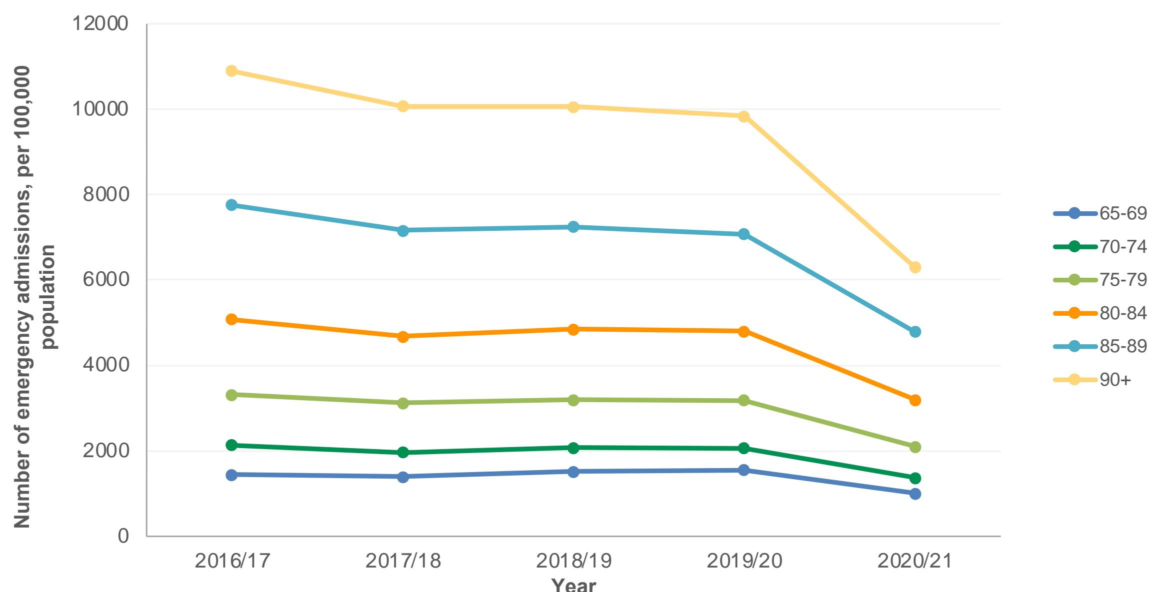
Ambulatory care

Figure 3.14 shows the number of emergency admissions for acute conditions that should not usually require hospital admission, per 100,000 population. These ambulatory care sensitive conditions (ACSC) include vaccine-preventable diseases, ear / nose / throat infections, angina, and other conditions that could potentially have been avoided if the patient had been better supported in primary and community care. The leading causes of these admissions are kidney / urinary tract infections (UTIs), pneumonia and cellulitis (a deep skin tissue infection that can be caused by pressure sores). The rate of emergency

[183] NHS Digital (2022). Compendium - Emergency readmissions to hospital within 30 days of discharge.

admissions for ACSC increases with age.[184] Admissions had showed little change in the years leading up to the pandemic and dropped off significantly as admissions were impacted by the pandemic.

Figure 3.14. Emergency admissions for acute conditions that should not usually require hospital admission, per 100,000 population, by age group, 2016/17 to 2021/22, England.

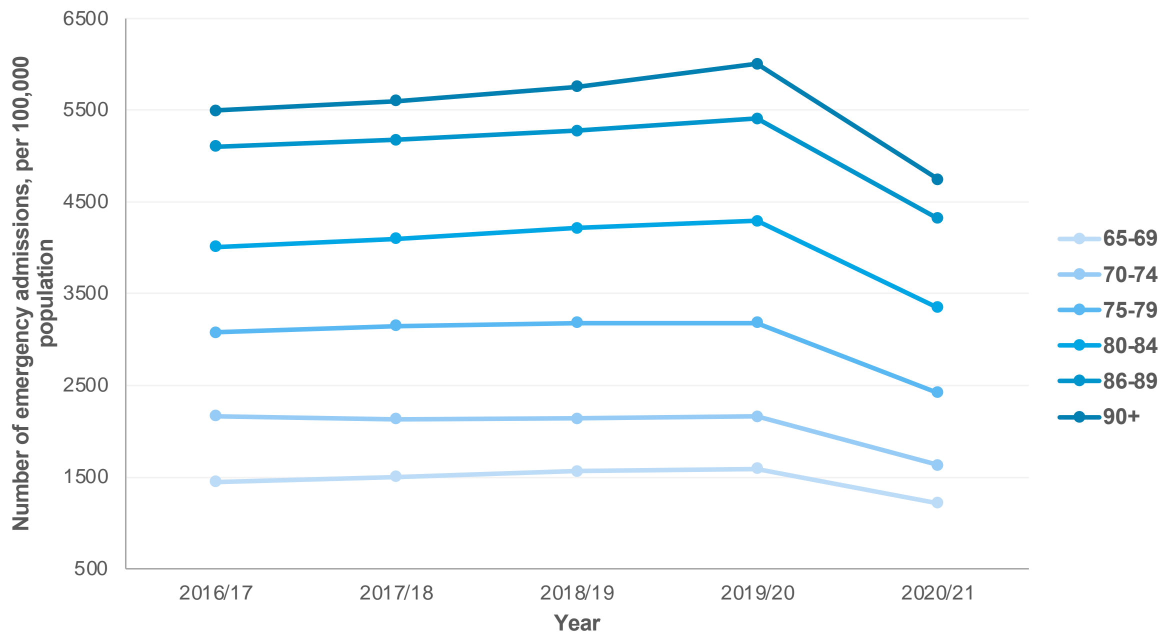


Source: Age UK 2023: Analysis using: NHS Digital 2022: Emergency admissions for acute conditions that should not usually require hospital admission

Figure 3.15 shows the number of emergency admissions for specific long-term conditions that should not normally require hospitalisation, per 100,000 population. These conditions include diabetes, epilepsy and hypertension (high blood pressure). Where a person has been admitted for one of these conditions, it may indicate that their condition has not been optimally managed in the community. Emergency admissions rates for specific long-term conditions that should not normally require hospitalisation increase with age and are particularly increasing across the oldest-old age groups. The rate dropped significantly during 2020/21 due to pandemic-related policies. More recent data is not yet available, but all signs indicate pressures are significant.

[184] NHS Digital (2022). *Emergency admissions for acute conditions that should not usually require hospital admission*.

Figure 3.15. Emergency admissions for specific long-term conditions that should not usually require hospital admission, per 100,000 population, by age group, 2016/17 to 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital 2022: Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Discharge and length of stay

A delayed transfer of care occurs when a patient is ready for discharge from acute or non-acute care and is still occupying a bed. Immediately prior to the pandemic, the problem of delays appeared to be returning, with 148,000 delayed days across England in December 2019, which is 15% higher than the same month a year earlier. The combined figures for the last quarter of 2019 were the highest in two years.[185] These data ceased to be collected during the COVID-19 pandemic and will not be resumed, with February 2020 the last published data.[186]

Since 2016, NHS Trusts in England have been encouraged to operate a 'Discharge to Assess' model, which means that: "Where people who are clinically optimised and do not require an acute hospital bed but may still require care services, are provided with short-term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken **in the most appropriate setting and at the right time for the person."**[187] In March 2020, during the early stages of the COVID-19 **pandemic, HM Government announced "a**

[185] NHS England (2020). *Delayed Transfers of Care Data 2019-20*.
[186] NHS England (2022). *Delayed Transfers of Care*.
[187] NHS England (2016). *Quick guide: Discharge to Assess*.

discharge to assess model will be introduced across England" on the basis that: "Discharge requires teamwork across many people and organisations and the funding and eligibility blockages that currently exist cannot remain in place during the COVID-19 emergency period".[188]

The government guidance applicable at the time (withdrawn 25th August 2020) directed rapid discharge of everyone clinically ready. It required transfer off wards within one hour of a discharge decision to a designated discharge area, and then discharge from hospital as soon as possible, normally within two hours.[189] While these time-based directives have been withdrawn, the discharge to assess model remains the norm across NHS Trusts in England and has been formalised into legislation.[190]

The new model of hospital discharge includes a focus on whether patients meet the 'criteria to reside'. Every person on every general ward should be reviewed on a twice daily ward round and assessed against a short set of questions.[191] Since December 2021 NHS England has published data on patients in England remaining in hospital when they no longer meet the criteria to reside. In December 2022, an average of 13,440 patients a day remained in hospital despite no longer meeting the criteria to reside. This was 30% more than the daily average for December 2021.[192] When collected as delayed transfers of care, the same period in 2018-19 averaged approximately 4,500 beds[193].

One effect of this is that far more people are staying longer in hospital. *Figure 3.16* shows the average number of long stay occupied beds (7 days or more) over each winter since 2020/21. In the case of those in hospital for more than two weeks, this has gone up by 52% in that period.

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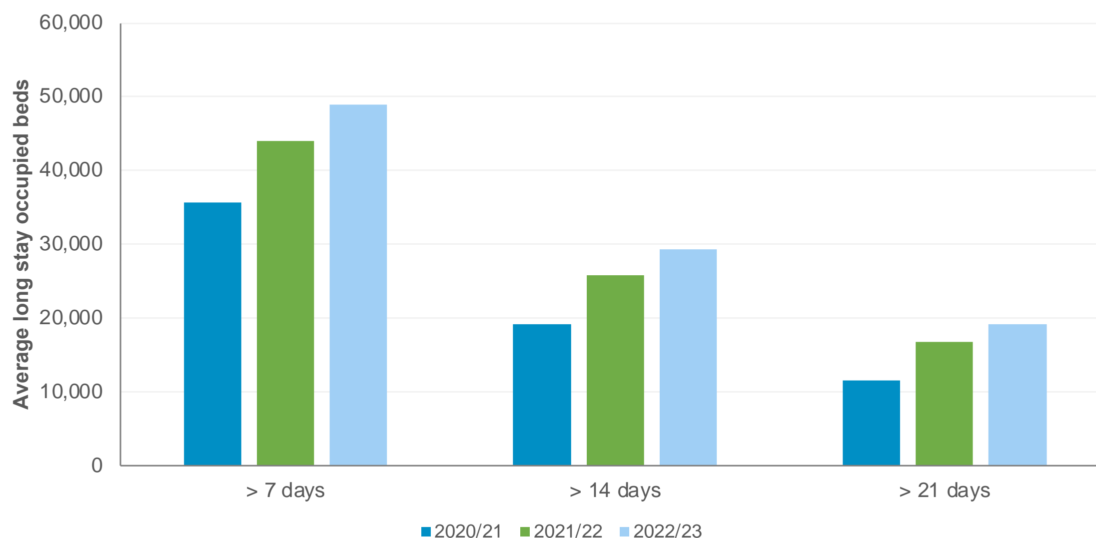
[188] HM Government (2020). *COVID-19 Hospital Discharge Service Requirements*.
[189] HM Government (2020). *COVID-19 Hospital Discharge Service Requirements*.
[190] Section 91 of the Health and Care Act 2022
[191] For example, whether they require intravenous fluids, are in the last hours of life, or are within 24 hours of an invasive procedure. See: Annex D – Criteria to Reside in: DHSC(2022). *Hospital Discharge and Community Support Guidance*.
[192] NHS England (2022). *Discharge delays (acute)*.
[193] NHS England (2020). *Delayed Transfers of Care Data 2019-20*.

Figure 3.16. Average number of long stay occupied beds by year, all ages (each period 30 Nov to 2 April inclusive), 2020/21 to 2022/23, England.



Source: Age UK 2023: Analysis using: NHS England 2020-2023: Urgent and Emergency Care Daily Situation Reports, 2020-21, 2021-22, 2022-23

These data are not disaggregated by age, but the National Audit Office has previously estimated that 85% of people delayed in hospital are over 65.[194] The published data does not include reasons for delays in discharging people from hospital when they no longer meet the criteria to reside, but the Government's own analysis states that on average 24% of patients are awaiting homecare, 16% are awaiting residential or nursing home placements, and 24% are waiting to begin intermediate care.[195]

Waiting times for treatment

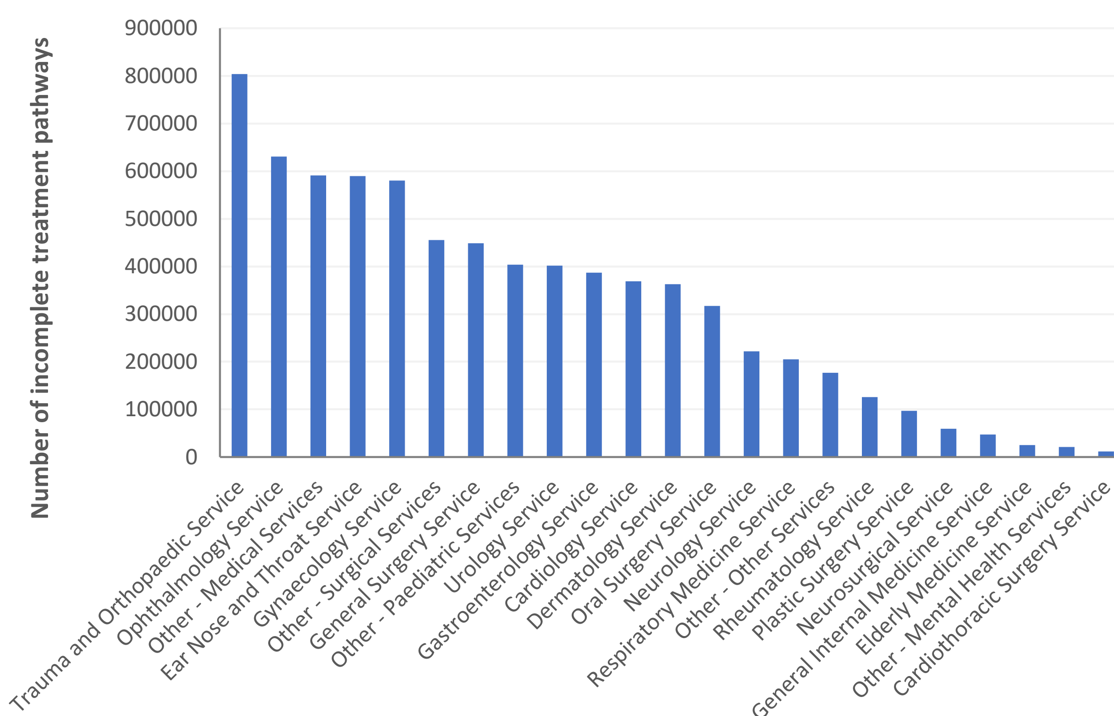
The NHS constitution states that patients referred by their GP for non-urgent consultant-led treatment should start that treatment within 18 weeks. The waiting time target is that 92% of those on the waiting list at any given time should have been waiting for less than **18 weeks. There is also a ‘zero tolerance’ policy on patients waiting longer than 52 weeks.** Prior to the pandemic, the target for 92% of patients to have been waiting for less than 18 weeks had not been met since March 2016. At the end of February 2020, 83.2% of patients waiting to start treatment were waiting up to 18 weeks, and there were 4.4 million patients on the waiting list to start treatment.[196]

In March 2020, during the early stages of the COVID-19 pandemic, all non-urgent elective

[194] NAO (2016). *Discharging older patients from hospital*
[195] DHSC & NHS England (2023). *Delivery plan for recovering urgent and emergency care services*.
[196] NHS Digital (2020). *Statistical press notice: NHS referral to treatment waiting times data, February 2020*.

operations were postponed to free up inpatient and critical care capacity.[197] National guidance[198] was published in July 2020, outlining targets to return to near-normal levels of activity, but a further wave of COVID-19 cases led to another pause in activity. NHS England published new targets to reduce waits for elective treatment in February 2022. The ambition is to eliminate waits of over 78 weeks by April 2023 and 52 weeks by March 2025.[199] *Figure 3.17* shows that the treatment function with the largest waiting list is Trauma and Orthopaedics, which will include many older people waiting for joint replacement surgery.

Figure 3.17. Total incomplete treatment pathways by treatment function March 2023, England.



Source: Age UK 2023: Analysis using: NHS England 2023: Consultant-led Referral to Treatment Waiting Times Data 2022-23, March

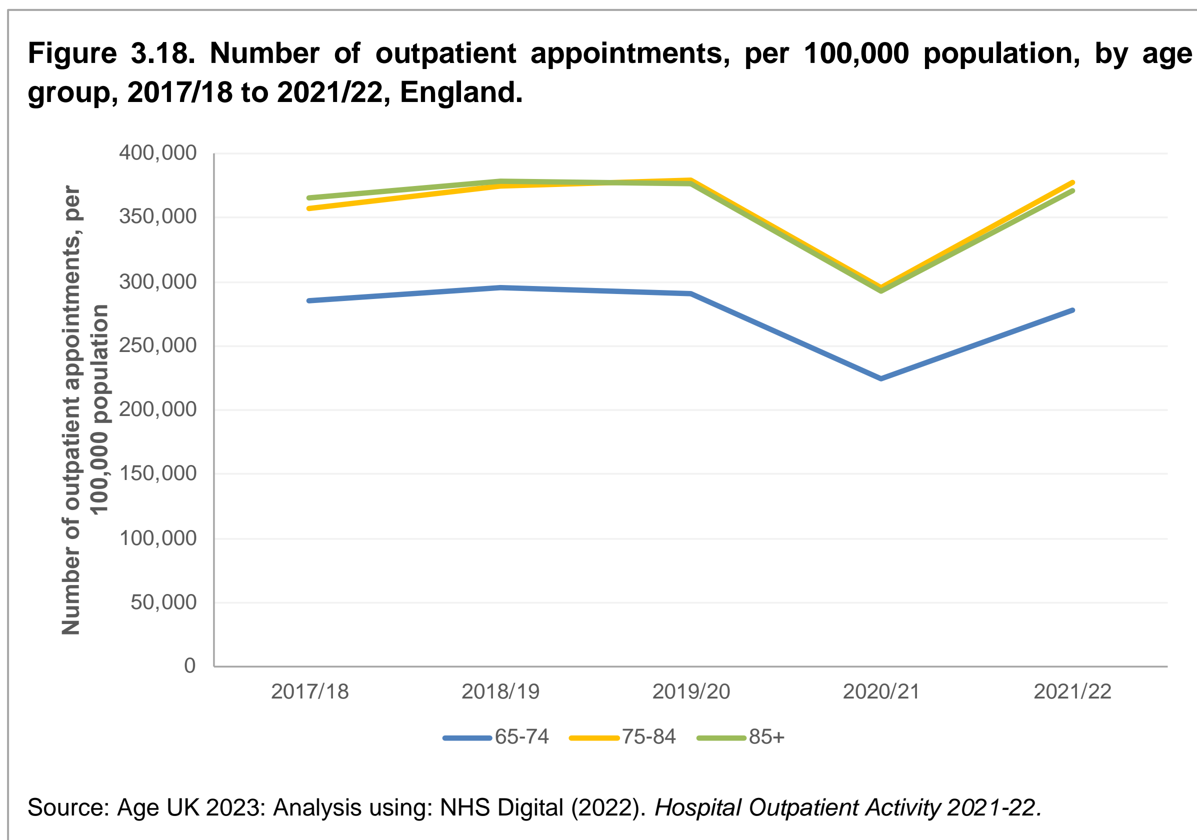
Outpatient activity

In 2021/22, there were 122.3 million outpatient appointments. This is an increase of 20.0% from 2020/21, but a 2.1% decrease from the level of outpatient appointments before the COVID-19 pandemic (there were 124.9 million in 2019/20).[200] *Figure 3.18* shows that people

[197] NHS England (2020). *Letter to NHS leaders: Next steps on NHS response to COVID-19*.
[198] NHS England (2020). *Letter to NHS leaders: Third phase of NHS response to COVID-19*.
[199] NHS England (2022). *2022/23 priorities and operational planning guidance*.
[200] NHS Digital (2022). *Hospital Outpatient Activity 2021-22*.

aged 75+ are much more likely to need an outpatient appointment than people aged 65 to 74.

Figure 3.18. Number of outpatient appointments, per 100,000 population, by age group, 2017/18 to 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *Hospital Outpatient Activity 2021-22*.

Reducing bed numbers and bed capacity

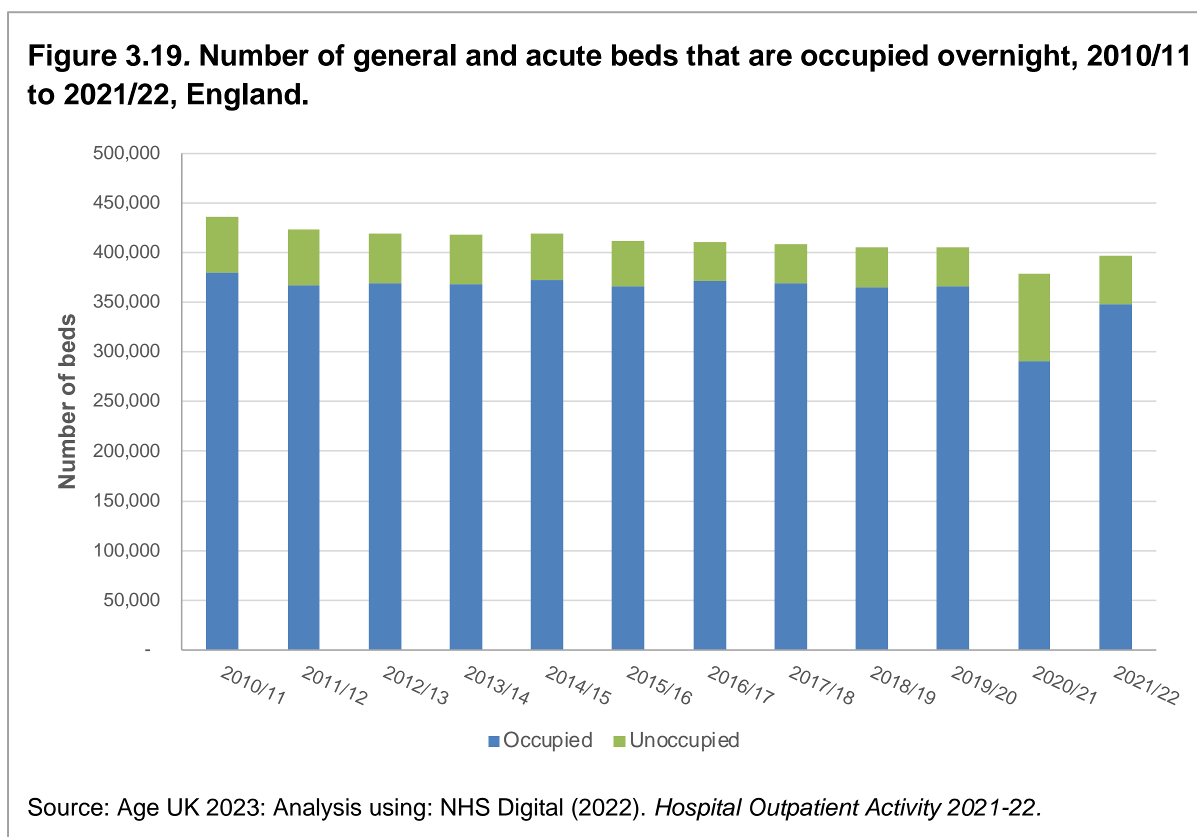
The NHS has been reducing the number of beds for decades: over the three decades prior to the COVID-19 pandemic, the total number had been reduced by more than half, from around 299,000 in 1987/88 to 141,000 in 2019/20.[201] Several changes in the way that healthcare is provided had made this possible, notably improvements in treatment and surgery that had led to a rise in day-only appointments, shorter recovery times and hospital stays, as well as the gradual shift from long-term care in institutional settings to care in the community.[202] However, even prior to the pandemic, demographic changes and increasing demand for secondary care suggested demand for beds was likely to increase over time. In 2019/20, overnight general and acute bed occupancy averaged 90.2%, and regularly exceeded 95% in winter,[203] well above the level many consider safe. The National Audit Office has suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises, and increased numbers of

[201] Ewbank, L., Thompson, J., McKenna, H. et al (2022). *NHS Hospital bed numbers: past, present and future*. King's Fund
[202] Ewbank, L., Thompson, J., McKenna, H. et al (2020). *NHS Hospital bed numbers: past, present and future*. King's Fund
[203] NHS Digital (2021). *Bed Availability and Occupancy Data – Overnight: 2020-21 time series*.

healthcare-acquired infections.[204]

Figure 3.19 shows the COVID-19 pandemic had a significant impact on the way hospitals manage and deliver services, which impacted on the availability and use of hospital beds. It is not yet clear when and at what level hospital beds will stabilise after the pandemic. There are still large numbers of NHS hospital beds occupied by people who are either in hospital because of COVID-19 or are in hospital and happen to have COVID-19. This means there are actually fewer beds available than there were pre-pandemic.[205]

Figure 3.19. Number of general and acute beds that are occupied overnight, 2010/11 to 2021/22, England.



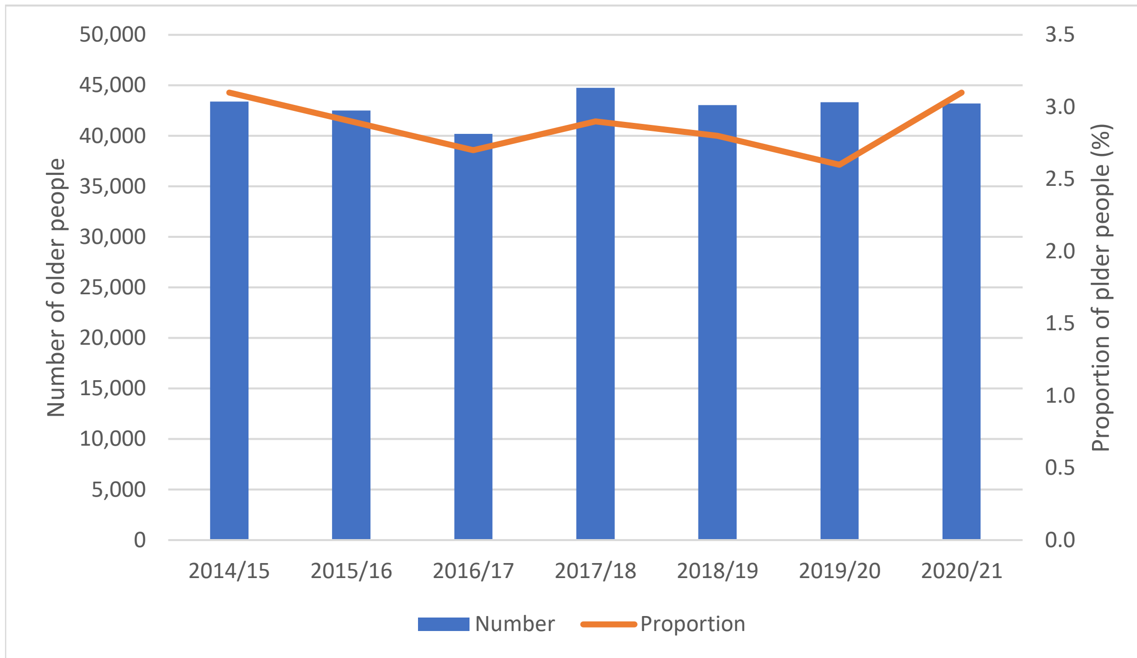
Source: Age UK 2023: Analysis using: NHS Digital (2022). *Hospital Outpatient Activity 2021-22*.

Reablement and rehabilitation

The NHS Five Year Forward View (published 2014) noted that older people may be able to avoid unwanted permanent admissions to care homes with the aid of reablement/rehabilitation, and the Care Act 2014 focused on prevention, including these services. As shown in *Figure 3.20*, despite the intentions of these policies and of the Better Care Fund, the proportion of older people receiving reablement/rehabilitation after discharge from hospital fell from 3.1% in 2014/15 to just 2.6% in 2019/20, before slightly increasing in 2020/21.

[204] National Institute for Health and Social Care Excellence (NICE) (2018). *NICE guideline 94: Bed occupancy*.
[205] BBC Radio 4 (2023). *More or Less: Ambulance response times, teacher pay and Irish pubs [First broadcast 22 January 2023]*.

Figure 3.20. Number and percentage of people aged 65+ discharged from hospitals to their own home (including a residential or nursing care home or extra care housing) for rehabilitation, 2017/18 to 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *Adult Social Care Activity and Finance Report, England, 2021/22*.

4. HEALTH AND SOCIAL CARE WORKFORCE

The NHS is the country's largest employer.[206] There are an estimated 1.3 million full-time equivalent staff working in the NHS.[207] An estimated 1.2 million full-time equivalent staff work in the adult social care sector in England.[208] However, the adult social care headcount is larger than that of the NHS – 1.5 million[209] compared with 1.4 million.[210] Together the health and care workforce makes up around 1 in 10 of the total workforce in England.[211] A further 40,000 people work in core public health roles.[212]

The Health and Social Care Committee's recent inquiry into workforce recruitment, retention and training issues concluded that the NHS and social care sector "are facing the greatest workforce crisis in their history".[213] The Care Quality Commission (CQC) recently noted that "persistent understaffing across health and social care poses a serious risk to the safety and wellbeing of people who use services".[214]

As shown in *Figure 4.1*, while most professions have seen increases in full-time equivalent staffing, their numbers are not keeping pace with the growing and ageing population. This is despite a longstanding policy objective of shifting NHS care away from hospitals and closer to people's homes. Growth in staff numbers are still heavily tilted toward acute care with around 16% more adult nurses between 2016/17 and 2021/22 compared with only 7% more community nurses. GPs growth is even slower at 6% compared with almost 30% more doctors across other specialties. District nursing numbers have been consistently gone down during that period.

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[206] Rolewicz, L., Palmer, B. & Lobont, C. (2022). *The NHS workforce in numbers*. Nuffield Trust

[207] NHS Digital (2023). *NHS Workforce Statistics – February 2023*.

[208] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*

[209] Foster, D. (2022). *Adult social care workforce in England*. House of Commons Library

[210] NHS Digital (2023). *NHS Workforce Statistics – February 2023*.

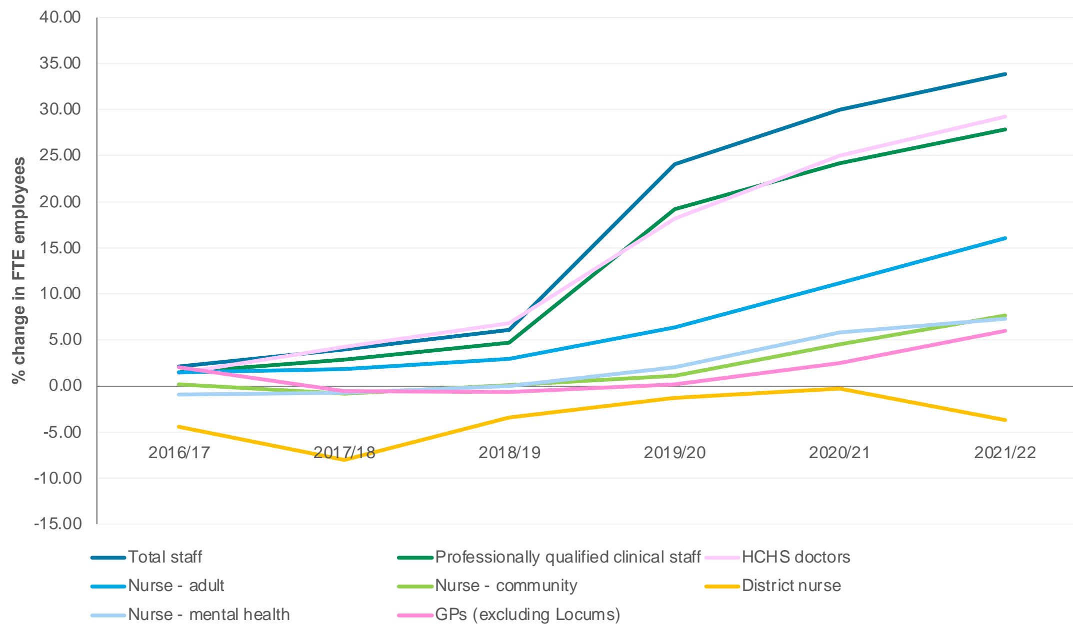
[211] King's Fund (2018). *The health care workforce in England: Make or break?*

[212] NHS (2022). *The core public health workforce*.

[213] Health and Social Care Committee (2022). *Workforce: recruitment, training and retention in health and social care*. House of Commons

[214] CQC (2022). *The state of health care and adult social care in England, 2021/22*.

Figure 4.1. Percentage change in full-time equivalent health workforce, 2016/17 to 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *NHS Vacancy Statistics*.

District nurses play an essential role in not only acute, complex and end-of-life care, but also in preventative care that supports older people to maintain independence and manage long-term conditions. If there are insufficient numbers of district and community nurses, then hospitals may not only need to delay discharging patients but will also see increases **in admissions and readmissions. This has been described as a "vicious cycle" in terms of** recruitment and retention, with understaffing increasing the pressure on the district nursing workforce, which in turn causes more nurses to leave and thus increases the demand-capacity gap.[215]

The Health and Social Care Select Committee undertook an inquiry into the health and social care workforce in 2022. The Committee concluded: **"The persistent understaffing of** the NHS now poses a serious risk to staff and patient safety both for routine and emergency **care".**[216]

[215] Maybin, J., Charles, A. & Honeyman, M. (2016). *Understanding quality in district nursing services*. King's Fund / King's Fund (2022). *NHS workforce: our position*.
[216] Health and Social Care Committee (2022). *Workforce: recruitment, training and retention in health and social care*. House of Commons

4.1 Workforce size and structure

The very large majority of NHS staff – 1.2 million – **work in 'Hospital and Community Health Services' as direct employees of NHS tru**sts providing ambulance, mental health and community, and hospital services. This includes the approximately 21,000 staff that work as local planners and commissioners of health services (previously as part of Clinical Commissioning Groups and now Integrated Care Boards). In addition, around 150,000 full-time equivalents work in primary care (including general practice, community pharmacies and dentistry).[217]

More than half (52.5%) of the Hospital and Community Health Services full-time equivalent workforce is made up of professionally qualified clinical staff. This group includes all hospital and community services doctors, qualified nurses and health visitors, midwives, qualified scientific, therapeutic and technical staff and qualified ambulance staff.[218]

The average age of staff in the NHS tends to be towards the mid-40s.[219] The NHS workforce comprises 77% female and 23% male workers.[220]

The adult social care workforce comprises care workers, social workers, occupational therapists, support and outreach workers, personal assistants, registered nurses and registered managers. Around a quarter of the workforce (24%) were on zero-hours contracts in 2021/22, compared to 3% of the wider population.[221] Analysis of 2020/21 data found 55% of home care workers to be on zero-hours contracts.[222]

The average age of an adult social care worker was 45 years in 2021/22, with over a quarter of workers (430,000 filled posts) aged 55 years and over. The adult social care workforce comprises 82% female and 18% male workers.[223]

4.2 The future workforce gap

While financial problems can be solved by increasing funding, it is far more difficult to solve workforce challenges. The Health Foundation estimates the NHS will need over 4,000 more doctors and almost 19,000 more nurses just to tackle the existing Covid-19 backlog (i.e., to

[217] Rolewicz, L., Palmer, B. & Lobont, C. (2022). *The NHS workforce in numbers*. Nuffield Trust
[218] NHS Digital (2022). *NHS Workforce Statistics – August 2022. [Hospital and community services combined with primary care].*
[219] Jabbal, J. (2022). *Young people are the future: How can recruiters encourage more of them to join the NHS workforce?* The King's Fund.
[220] NB. This data was due to be updated in 2021 but has been delayed by the Covid-19 pandemic. NHS Employers (2019). *Gender in the NHS.*
[221] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*
[222] Foster, D. (2022). *Adult social care workforce in England*. House of Commons Library
[223] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*

get back to the 18 weeks standard for waiting times across the NHS).[224] Separately, the Health Foundation projects an overall workforce supply-demand gap of around 179,000 full-time equivalents across NHS Hospital and Community Health Services and general practice in England by 2024/25.[225]

Skills for Care estimates the need for an extra 480,000 people working in social care by 2035 to keep pace with demand. In addition, the adult social care workforce may lose a further 430,000 workers in the next 10 years if those aged 55 and over decide to retire.[226]

Understanding the impact and effects of the COVID-19 pandemic

The Office for Students sets intake targets for education providers to control the number of people studying medicine per year (there is no cap on nursing students). In England, medicine school places are usually capped at 7,500, although the cap was lifted in 2020[227] and 2021[228] due to the impact of the covid pandemic. The cap was re-introduced in 2022.[229] The Health and Social Care Committee has recommended the cap be increased to 14,500 medical school places a year, and to achieve this the Government must consider increasing medical schools, clinical placements and speciality training positions, as well as their geographical spread.[230]

4.3 Recruitment and retention

Full-time equivalent staff vacancies in NHS trusts in England stood at 133,446 in the quarter to September 2022. This is the highest number of vacancies in the five years the relevant data has been collected (since the April to June quarter of 2017).[231]

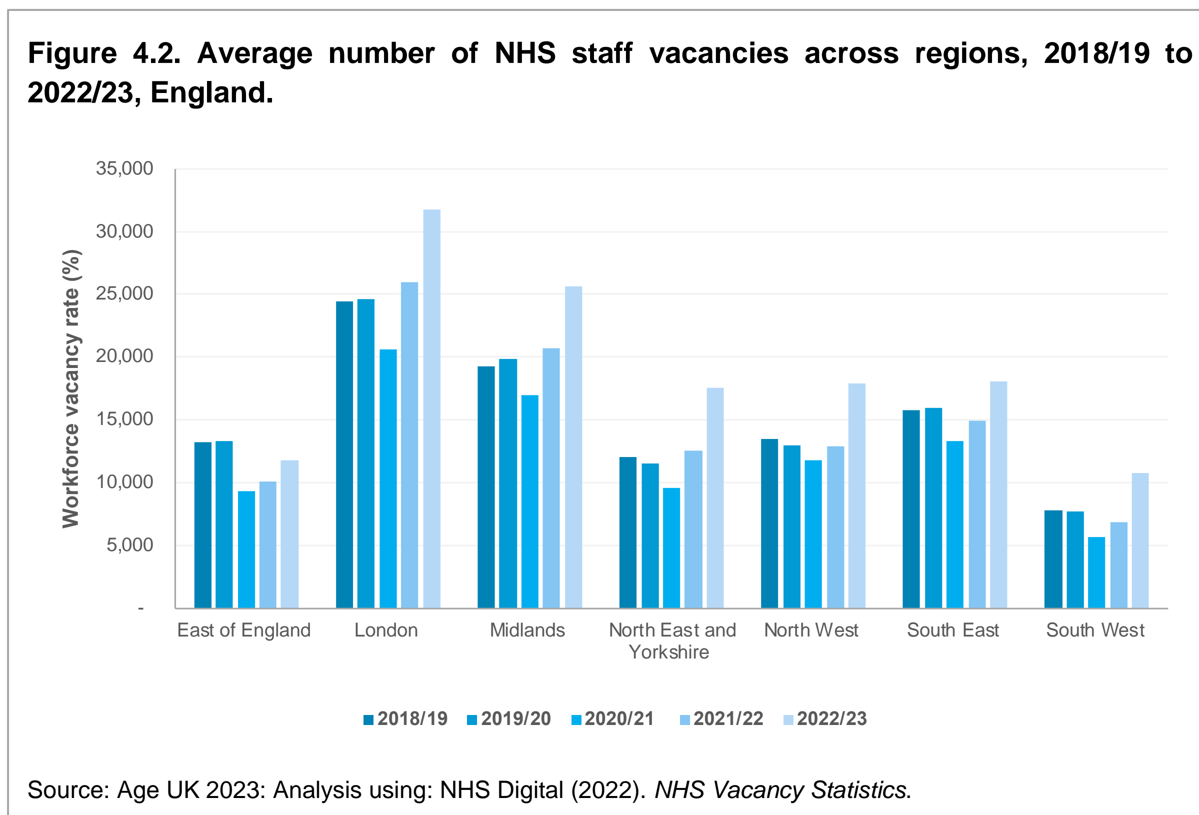
The vacancy rate in the quarter to September 2022 stood at 9.7%, which is the same as in the previous quarter and is also a five-year high.[214]

In the quarter to September 2022, there was a vacancy rate of 11.9% within the NHS Registered Nursing staff group (47,496 vacancies), which was an increase from the same period the previous year when the vacancy rate was 10.5% (39,931 vacancies).[215]

[224] Health Foundation (2022). *Government must be realistic about the time and resources needed to clear the NHS backlog.*
[225] Shembavnekar, N. et al (2022). *NHS Workforce Projections 2022*. REAL Centre at the Health Foundation.
[226] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*
[227] Department for Education (2020). *Action agreed to support students in to preferred universities*.
[228] Department for Education (2021). *Extra places on dentistry and medical courses for 2021*.
[229] BBC News (2022). *Government defends medical student cap number*.
[230] Health and Social Care Committee (2022). *Workforce: Recruitment, retention and training in health and social care: Third Report of Session 2022-23*. House of Commons
[231] NHS Digital (2022). *NHS Vacancy Statistics England, April 2015 – September 2022 (experimental statistics)*.

However, as set out in *Figure 4.2*, NHS workforce shortages are distributed unevenly across the country, with total vacancies highest in London and the Midlands.

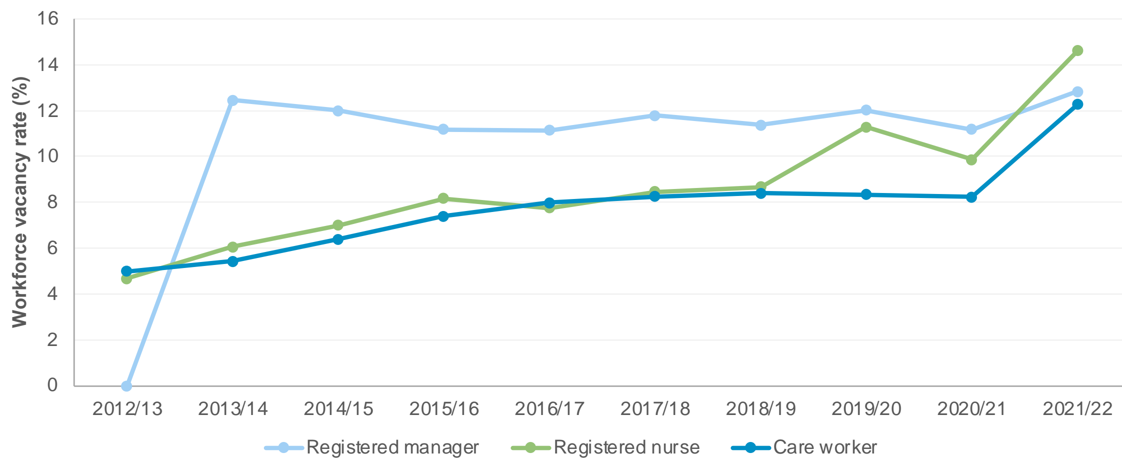
Figure 4.2. Average number of NHS staff vacancies across regions, 2018/19 to 2022/23, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *NHS Vacancy Statistics*.

As *Figure 4.3* demonstrates, the social care sector is also struggling to fill vacancies. The vacancy rates for registered managers, registered nurses and care workers are all the highest they have been since this data started being collected in 2012/13. The CQC reports many registered nurses working in social care have moved to jobs with better pay and conditions in the NHS, and some care homes have had to stop providing nursing care because of this.[216]

Figure 4.3. Workforce vacancy rate for key adult social care roles, 2012/13 to 2021/22, England.

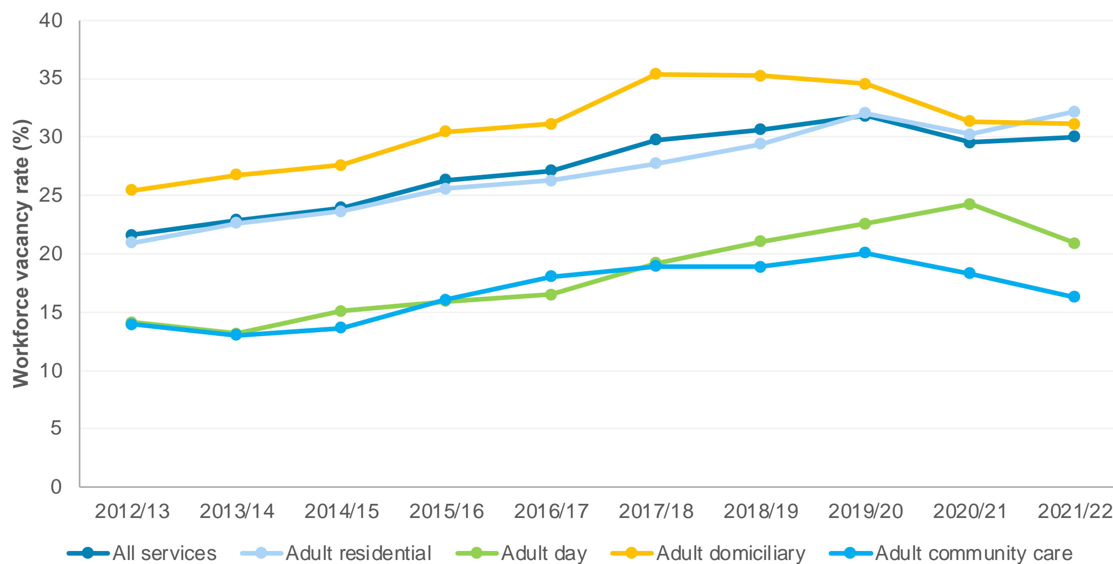


Source: Age UK 2023: Analysis using: Skills for Care (2022). The state of the adult social care sector and workforce in England – 2022.

As *Figure 4.4* shows, domiciliary (home) care services have had the highest vacancy rates for the last decade, only overtaken by residential care services in 2021/22. This may in part be explained by the huge reduction in registered nursing posts in social care, which reduced by 10,000 between 2015/16 and 2021/22.[232]

[232] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*

Figure 4.4. Workforce vacancy rates for adult social care by service type, 2012/13 to 2021/22, England.



Source: Age UK 2023: Analysis using: Skills for Care (2022). The state of the adult social care sector and workforce in England – 2022.

The number of vacant adult social care sector posts increased by 52.0% in the last year – from 110,000 in 2020/21 to 165,000 in 2021/22. The vacancy rate now stands at a record 10.7%. While demand for adult social care is growing (as evidenced in previous chapters), the number of people in the workforce has shrunk by 50,000 since 2019/20.[233]

Recruitment challenges include pay, with 4 out of 5 jobs in the economy paying more than jobs in social care.[234] Care worker pay is among the lowest in the economy in general[235], **and social care providers are consistently 'outbid' by the retail and hospitality sectors.**[236] A lack of parity of pay with the NHS is also a challenge[237], with average social care worker pay being £1 per hour less than that received by NHS healthcare assistants who are new to their roles.[238] **Pay also impacts retention, with on average, care workers with five years' (or more)** experience in the sector receiving just 7p per hour more than a care worker with less than one year experience.[239]

[233] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*
[234] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*
[235] Foster, D. (2022). *Adult social care workforce in England*. House of Commons Library
[236] Health and Social Care Committee (2022). *Workforce: recruitment, training and retention in health and social care*. House of Commons
[237] Health and Social Care Committee (2022). *Workforce: recruitment, training and retention in health and social care*. House of Commons
[238] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*
[239] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*

Adult social care turnover rates remain high at 29%, meaning 400,000 people left their jobs last year. Around 63% of leavers remain within the sector,[240] but this represents significant costs to employers, with the recruitment of one replacement care worker estimated to cost up to £3,600.[241] Turnover rates are even higher for the youngest staff at 52.6% and for registered nurses at 44%.[242]

Adult social care turnover rates consistently increased between 2012/13 and 2019/20, by a total of 10.2 percentage points. The rate decreased by 1.8 percentage points in 2020/21, with the change in direction associated with fewer jobs available in the wider economy and some employees feeling the duty to stay with their employers and help the people they care for through the COVID-19 pandemic. The rate began to increase again in 2021/22 (by 0.5 percentage points) with the wider economy opening back up and more opportunities becoming available in other sectors.

In December 2021, the Care Quality Commission (CQC) introduced an adult social care workforce survey, which explores with care homes and homecare providers the impact of workforce challenges and staffing shortages on the services they deliver to people. The

[240] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*
[241] Foster, D. (2022). *Adult social care workforce in England*. House of Commons Library
[242] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*

survey found that among staff wanting to leave the sector, pay and conditions, staff burnout and increased cost of petrol/diesel were all issues driving their decisions.[243]

Understanding the impact and effects of the COVID-19 pandemic

In May 2021, witnesses told the Health and Social Care Committee inquiry into workforce burnout of their worry about the "exhaustion of large groups of staff" and about staff who were going above and beyond in the face of their own trauma, with an "unimaginable" impact on those who had to return to busy hospital wards after supporting people through the death of their loved ones over the phone. In social care, colleagues faced "heartbreak" at the excess deaths of those for whom they were caring, coupled with a sense of feeling "abandoned" as the focus early in the pandemic had been on the NHS. Workforce burnout was described by many as the highest in the history of the NHS and care systems and as such, it is an extraordinarily dangerous risk to the future functioning of both services.[244]

In its October 2021 report on the state of health and social care in England, the Care Quality Commission said the negative impact on health and care staff of working under the sustained pressure of the pandemic – including anxiety, stress, and burnout – "cannot be underestimated".[245]

As well as impacting recruitment and retention, there is an association between burnout and patient safety. A meta-analysis of 21 studies concluded burnout to be linked to a decline in patient safety and outcomes, and an increase in patient dissatisfaction and complaints.[246]

4.4 Nationality trends

As of June 2022, 83.5% of NHS staff in England are British, 8.9% are non-EU nationals and 5.3% are EU nationals (for 2.3% of staff nationality is unknown). In total, 214 different nationalities were represented among NHS staff in June 2022. Indian, Filipino and Nigerian are the most-commonly reported nationalities after British.[247]

International staff have always and will always be an important part of the health and social care workforce. However, the Health and Social Care Committee's recent inquiry into workforce recruitment, retention and training issues concluded the level of international

[243] CQC (2022). *The state of health care and adult social care in England, 2021/22*.
[244] Health and Social Care Committee (2021). *Workforce burnout and resilience in the NHS and social care*. House of Commons
[245] CQC (2021). *The state of health care and adult social care in England 2020/21*.
[246] de Lima Garcia, C. et al (2019). Influence of Burnout on Patient Safety: Systematic Review and Meta-Analysis. *Medicina* 55(9), p.553.
[247] Baker, C. (2022). *NHS staff from overseas: statistics*. House of Commons Library

recruitment in which NHS England is engaging "is unsustainable",[248] particularly given the global shortfall of healthcare workers, which the World Health Organisation predicts will reach 10 million by 2030.[249] This has also been acknowledged by NHS England, explaining **the NHS "is exposed to high marginal labour costs and** risks the sustainability of services in **the longer term given the growing global demand for skilled healthcare staff".** [250]

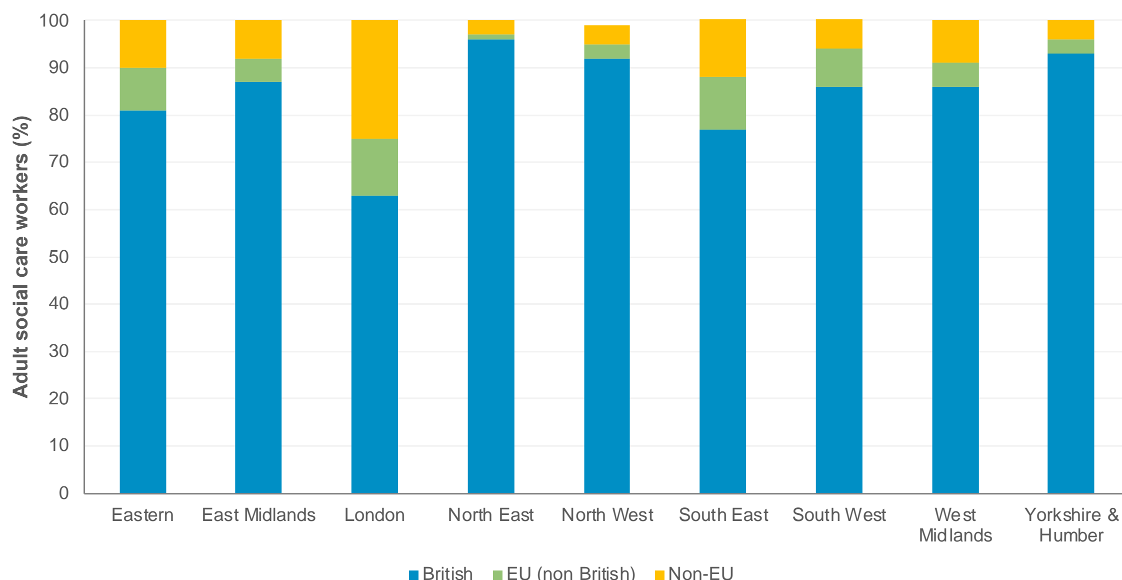
In 2021/22, 47% of new GP trainees in England were international medical graduates.[251] Graduate doctors who qualified in non-UK medical schools are more likely to leave within six years of joining than graduate doctors who qualified in UK medical schools. Only 66% of international medical graduates who first took up a licence to practise in 2015 were still licensed in 2021, compared to 89% of UK graduates.[252] However, in 2022, the General Medical Council issued 6,950 certificates of the type typically requested by doctors looking to work abroad. This is up from 5,576 in 2021.[253]

Skills for Care estimates 82% of filled posts in the adult social care workforce were held by workers with a British nationality in 2021/22. An estimated 10% of posts were held by workers with a non-EU nationality (excluding British) and 7% by workers with an EU nationality.[254]

As *Figure 4.5* shows, reliance on an international workforce varies across regions, with 63% of the adult social care workforce identifying as British in London, compared to 96% in the North East.

[248] Health and Social Care Committee (2022). *Workforce: recruitment, training and retention in health and social care*. House of Commons
[249] World Health Organisation (2022). *Health workforce.*
[250] NHS England (2023). *NHS Long Term Workforce Plan*.
[251] Royal College of General Practitioners (RCGP) (2022). *Text of letter sent to the Home Secretary*.
[252] General Medical Council (2022). *The state of medical education and practice in the UK: The workforce report 2022*.
[253](£) de Quetteville, Harry (2023). *The Australian brain drain bleeding the NHS dry*. The Telegraph
[254] Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*

Figure 4.5. Nationality of the adult social care workforce, by region, 2022/23, England.



Source: Age UK 2023: Analysis using: Skills for Care (2022). The state of the adult social care sector and workforce in England – 2022.

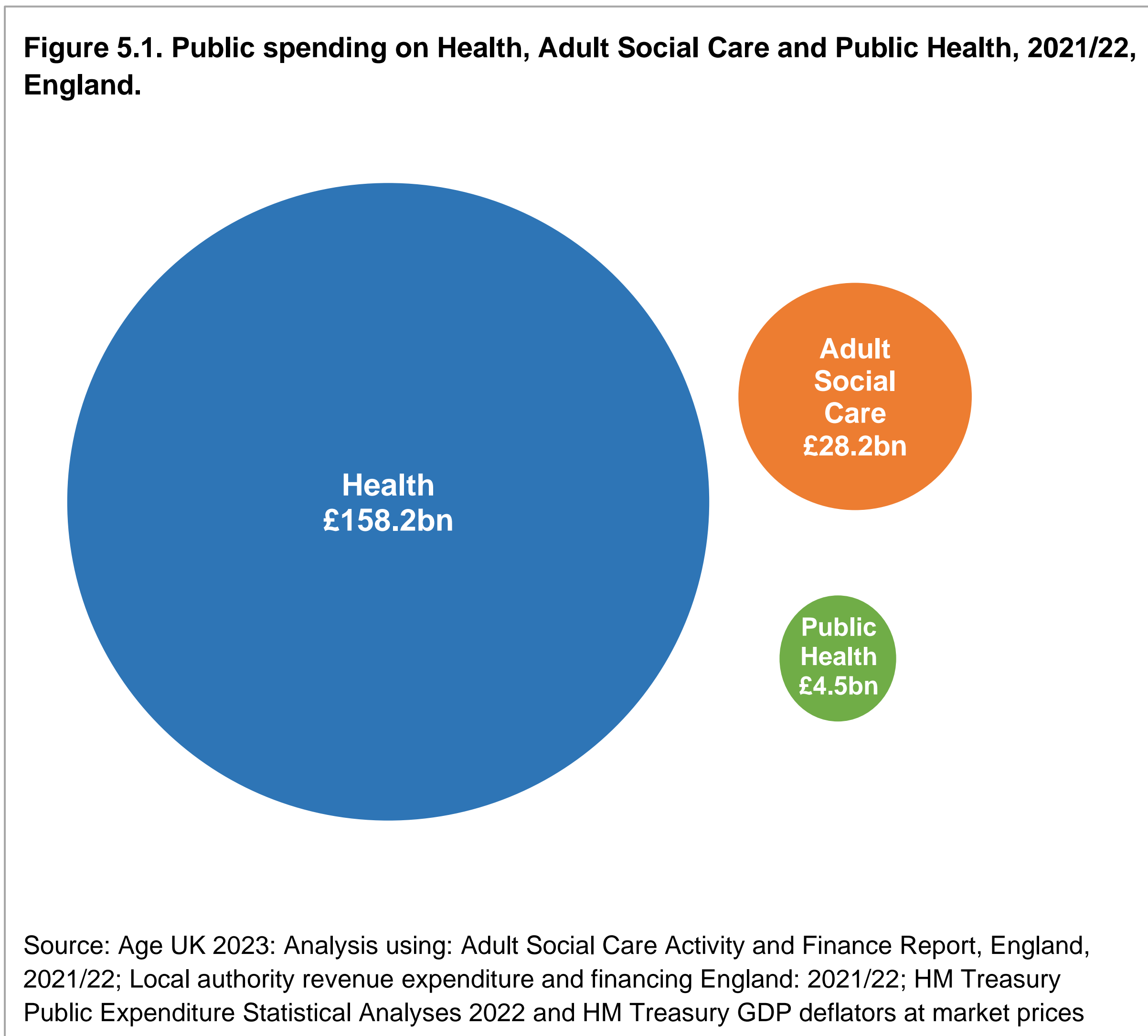
Freedom of movement (which enabled European Union citizens to work in any UK job) ended on 31 December 2020 and a new points-based immigration system was introduced. Historically there has been little direct recruitment of international workers into social care and most who started to work in social care were already in the UK.[255] However, following a recommendation from the Migration Advisory Committee in December 2021, the Government made care workers eligible for the Health and Care Worker visa and added the occupation to the Shortage Occupation List. The change came into effect on 15 February 2022 for an initial period of one year. To qualify for the Health and Care Worker visa, care workers must earn at least £20,960 a year or £10.75 an hour.[256] Early evidence from care providers suggested that around 47% of filled care worker posts in adult social care are paid above this amount.[257] The Government has indicated an intention to keep care workers on the Shortage Occupation List for at least another year, by making £15 million available to local authorities in 2023/24 to help support international recruitment within the adult social care sector.[258]

[255] Foster, D. (2022). *Adult social care workforce in England*. House of Commons Library
[256] UK Visas and Immigration (2023). *Skilled Worker visa: shortage occupations.*
[257] Skills for Care analysis of social care providers completing ASC-WDS in 2022/23. Skills for Care (2022). *The state of the adult social care sector and workforce in England – 2022.*
[258] DHSC (2023). *International recruitment fund for the adult social care sector: guidance for local authorities*.

5. HEALTH AND SOCIAL CARE FUNDING

Public spending on local authority provided and/or arranged care in England is significantly smaller than spending on health in England. In 2021/22, the ratio was about one to six.

Figure 5.1. Public spending on Health, Adult Social Care and Public Health, 2021/22, England.



Source: Age UK 2023: Analysis using: Adult Social Care Activity and Finance Report, England, 2021/22; Local authority revenue expenditure and financing England: 2021/22; HM Treasury Public Expenditure Statistical Analyses 2022 and HM Treasury GDP deflators at market prices

5.1 NHS funding

The Government's 2023/24 mandate to NHS England was published in June 2023 and set out a total revenue resource limit of £168.4bn and a total capital resource limit of £444m for 2023/24.[259]

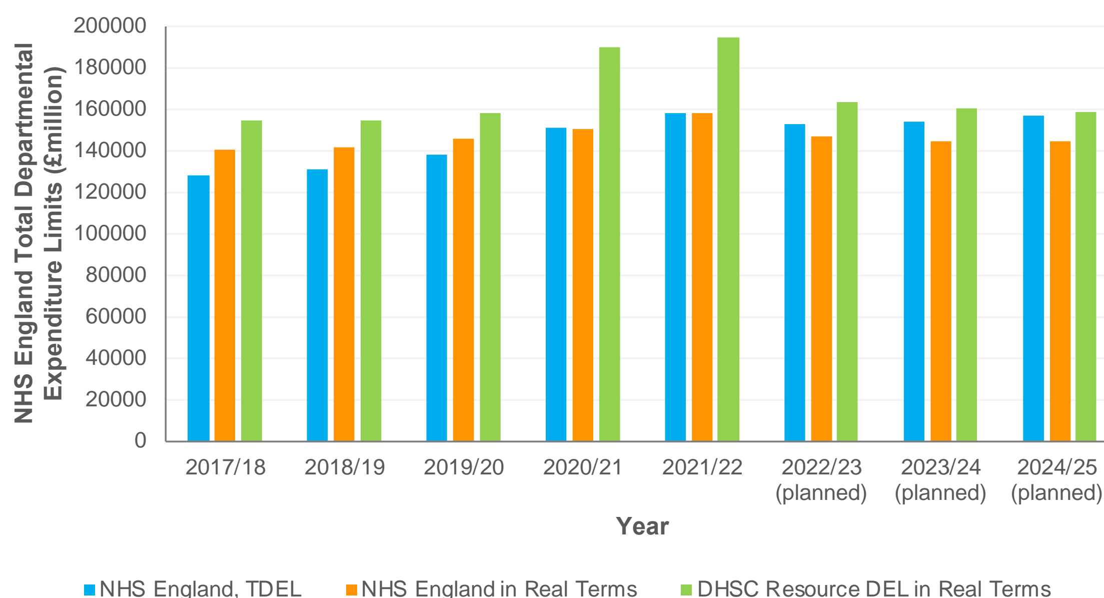
The largest five-year moving average in real terms spending growth (8.7%) occurred over the period 1999/2000 to 2003/04. The lowest five-year moving average of 1.1% was observed in 1982/83 to 1985/6 and in 2010/11 to 2014/15.[260] Annual average real growth

[259] DHSC (2022). *2022/23 Variation to the Financial Directions to NHS England*.
[260] Harker, R. (2020). *NHS Funding and Expenditure*. House of Commons Library.

rate in UK public spending on healthcare was 1.6% from 2014/15 to 2018/19.[261]

However, as has been explored in previous chapters, demographic changes mean the NHS serves more people and a greater number of people with more complex needs.

Figure 5.2. NHS England Total Departmental Expenditure Limits (TDEL), 2022/23 prices, 2014/15 to 2024/25, England.



Source: Age UK 2023: Analysis using: HM Treasury (2022). Source: Age UK 2023 analysis of HM Treasury (2022). Public Expenditure: Statistical Analyses 2022 and HM Treasury GDP deflators at market prices (31st March 2023).

Immediately prior to the COVID-19 pandemic, in January 2020, the Government committed to increase investment in the NHS in the years to 2024 under the *NHS Funding Act 2020*[262]. The Government stated this would result in a £33.9 billion increase in cash terms by 2023/24, with total NHS England spending rising to £148.5 billion in 2024 (which represented a £20.5 billion increase in real terms).[263] The legislation placed a legal duty on both the Secretary of State for Health and Social Care and the Treasury to uphold minimum levels of cash NHS revenue funding, with the additional funding spent as seen fit by NHS England, who had set out intentions in the NHS Long Term Plan. The funding settlement only applied to the NHS England revenue budget and did not cover other areas of the Department of Health and Social Care's spending such as capital investment, education and training, regulation, the local authority public health grant, and social care.

[261] Gershlick, B., Kraindler, J., Idriss, O. & Charlesworth, A. (2019). *Health and social care funding: Priorities for the new government*. Health Foundation.
[262] NHS Funding Act 2020
[263] Loft, P., Powell, T., Brien, P. & Harker, R. (2020). *NHS Funding Bill (2019-20).* House of Commons Library

Understanding the impact and effects of the COVID-19 pandemic

The COVID-19 pandemic resulted in significant increases to the health budget. In the 2022 Spring Statement, the Government noted £121.2m in 2020/21 and £81.0m in 2021/22 as ringfenced COVID-19 funding.[264]

5.2 Public health funding

Public health and preventative services can prevent and delay onset of chronic illness, disability and dependency, as well as reduce their impact. Services can directly help reduce the demand for, and therefore public expenditure on, health and social care for older people, both by decreasing future need for care and by supporting those already in receipt of care to stay well for longer.

In 2021/22 local authorities spent a total of £4.2 billion (£4.47 billion in 2022/23 prices).[265] However, as in previous years, this exceeded their central grant allocation of £3.3 billion[266] as local authorities have topped up expenditure, particular in response to the pandemic.

Prior to the COVID-19 pandemic, English councils spent over £3.2bn on public health in 2019/20. This is a decrease of £50m from 2018/19 and a decrease of £252m from 2016/17.[267] Analysis undertaken by the Health Foundation found that, on a real terms (accounting for inflation) per person basis, the public health grant has reduced by over 26% between 2015/16 and 2023/24. While additional funding for drug and alcohol treatment has been allocated to local authorities, this is time-limited and taking account of this additional spend still leaves broader public health funding 21% lower on a real terms per person basis since 2015/16.[268]

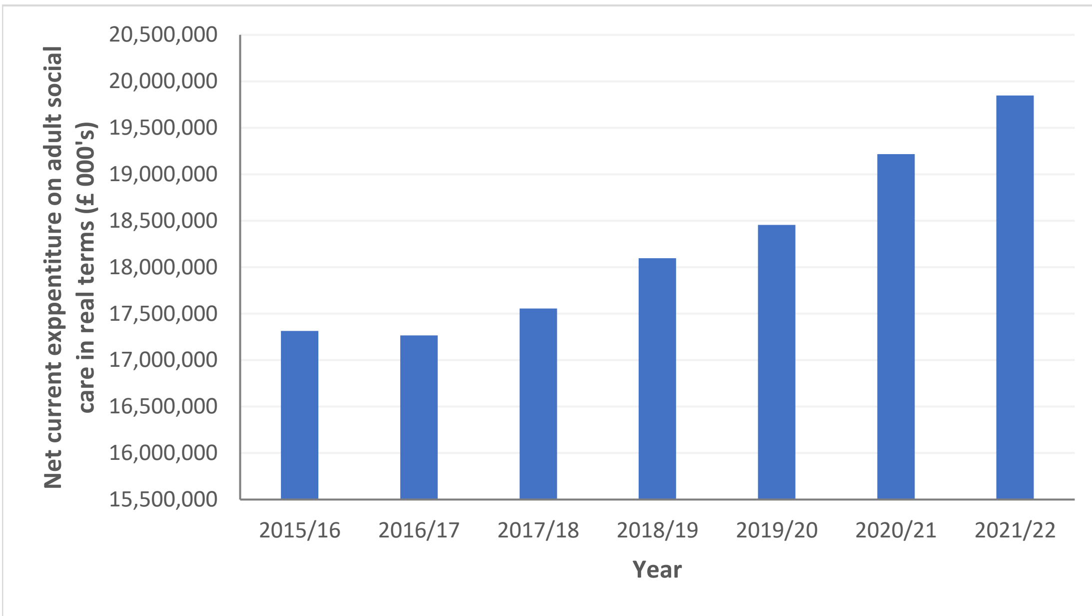
5.3 Adult social care funding

There is no national government budget for adult social care in England. Local authorities primarily fund the care they provide and arrange through three types of income: 1) local authority funds including council tax (and the social care precept), government grants and business rates, 2) means-tested client contributions, and 3) transfers from the NHS and other joint funding arrangements.

[264] HM Treasury (2022). *Spring Statement 2022*.
[265] DHLUC (2023). *Local Authority Revenue Expenditure and Finance England: 2021 to 2022 final outturn*
[266] DHSC (2021). *Public health ring-fenced grant 2021 to 2022*
[267] Local Government Association (LGA) (2022). *Explaining variation in spending – public health*.
[268] Health Foundation (2023). *Public health grant*

In 2021/22 total current expenditure on adult social care in England (which accounts for spending by local authorities from their own funds) was £19.0 billion (£19.8 billion in 2022/23 prices).[269]

Figure 5.3. Net current expenditure on adult social care in real terms, 2022/23 prices, 2014/15 to 2021/22, England

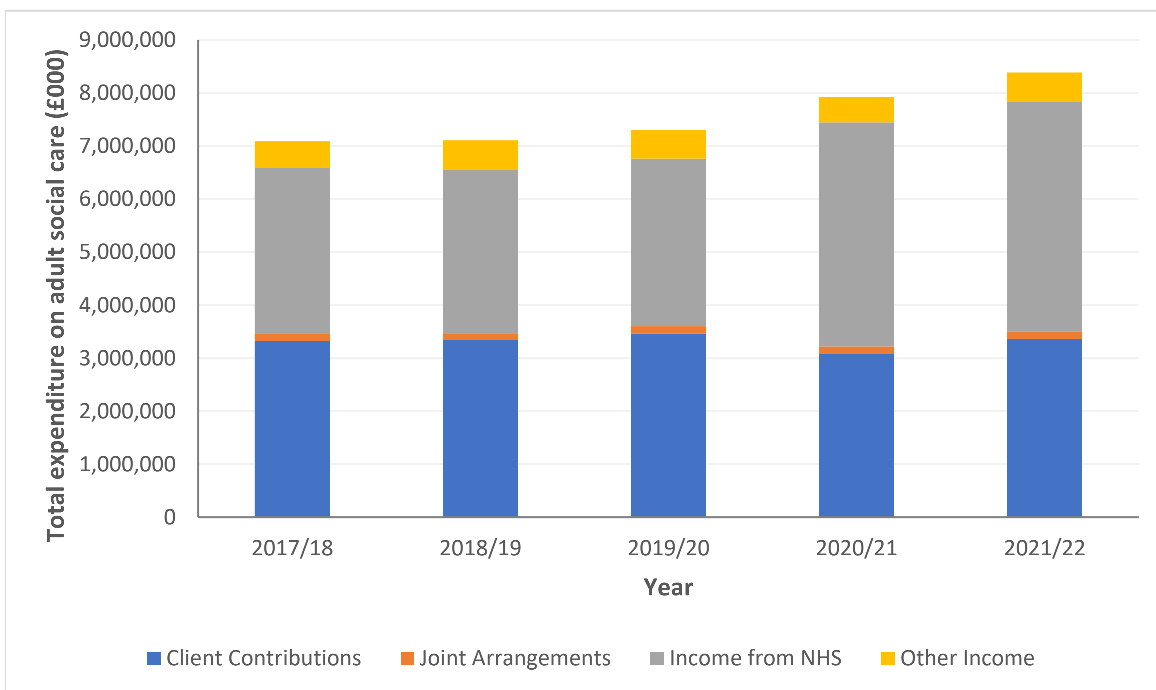


Source: Age UK analysis 2023, using: NHS Digital: Personal Social Services: Expenditure and Unit Costs, 2014/15 to 2015/16 & NHS Digital: Adult Social Care Activity and Finance Report, 2016/17 to 2021/22: England, and HM Treasury GDP deflators at market prices (31st March 2023).

Expenditure from local authority core budget has been increasing steadily from its low point in 2014/15, broadly returning to levels last seen in 2010/11. However, as *Figure 5.4* demonstrates, there has also been substantial increase in funding through the other revenue streams: notably income from the NHS and other sources.

[269] DLUHC (2022). *Local authority revenue expenditure and financing England: 2021 to 2022 final outturn*.

Figure 5.4. Total expenditure on Adult Social Care by source of income in real terms, 2022/23 prices, 2017/18 to 2021/22, England.



Source: Age UK analysis 2023 of Adult Social Care Activity and Finance Report, England, 2021/22 and HM Treasury GDP deflators at market prices (31st March 2023).

Income from means-tested client contributions has also increased and now stands at £3.3 billion, an increase of £32 million in real terms since 2017/18. [270] In contrast, as explored in Chapter 2, the number of people aged 65+ receiving local authority long-term care has decreased by 36,375 just since 2017/18. This inverse relationship between the total number of people receiving care and the total amount of client contributions is concerning. It suggests local authorities are increasing their charges for adult social care to mitigate reductions in government funding – and that older people using services are bearing an increasing financial burden.

Spending on adult social care has increased in real terms in recent years, as set out in *Figure 5.3 and 5.4* – although it should be noted that additional funds made available specifically to support the sector through the pandemic account for a proportion of funding increases in 2020 and 2021. However, as set out in Section 2.1, this has not translated into greater service provision. This is a consequence of higher costs for care driven by inflation and pressure to increase wages. 93% of Directors of Adult Social Care cite overheads (such as food costs, rent and other expenses) as a key driver in higher unit costs for residential and nursing care. In homecare, recruitment and retention of the workforce was cited by 87% of Directors responding.[271]

[270] NHS Digital (2022), *Adult Social Care Activity and Finance Report, England, 2021-22*.
[271] ADASS (2023). *ADASS Spring Survey 2023*.

Care funding 2023/24 and 2024/25

In the 2022 Autumn Statement, the Government announced £2.8 billion would be made available for adult social care in England in 2023/24, rising to £4.7 billion in 2024/25.[272] The additional funding falls into three funding streams, including:

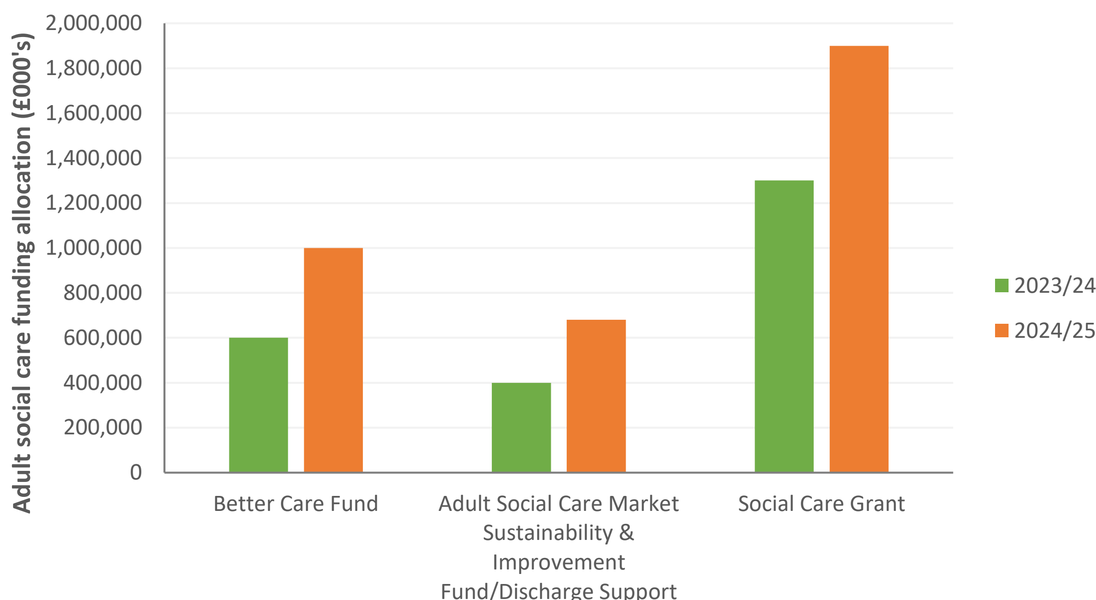
- £1.3 billion in 2023/24 rising to £1.9 billion in 2024/25 in additional local authority **grant funding for both adult and children's social care** (which in 2023/24 is estimated to be split 59% / 41% in favour of adult social care)[273]

- £600 million allocated to the Better Care Fund – the existing stream designed to support health and social care integration, i.e., split with the NHS – to finance services to support hospital discharge – rising to £1 billion in 2024/25

- And £400 million in 2023/24 and £680 million in 2024/25 distributed through a grant ringfenced for adult social care (The Adult Social Care Market Sustainability and Improvement Fund).[274]

[272] HM Treasury (2022). *Autumn Statement 2022*.
[273] ADASS (2022). *Spring Budget Survey 2022*.
[274] DLUHC (2022). *Adult Social Care Market Sustainability and Improvement Funding allocations 2023/24*.

Figure 5.5. Adult social care funding allocation (£000), 2023/24 and 2024/25, England



Source: Age UK analysis 2023 of Adult Social Care Market Sustainability and Improvement Funding allocations 2023 to 2024. Department for Levelling Up, Housing and Communities (2022).

Source: Age UK analysis 2023, using: _, and HM Treasury GDP deflators at market prices (31st March 2023).

ADASS argues that, given much of the funding is split with the NHS and with children's services, "the continued assertion by senior government Ministers that adult social care will have access to a 'historic £7.5bn funding settlement'[275] over the next two years does not represent reality and unhelpfully raises expectations about what can be achieved amongst people who access care and support and care providers".[276]

Council tax and the adult social care precept

In addition to this, local authorities have been able to increase council tax levels (over and above any increase up to the referendum threshold) for each year since 2016/17 to raise extra funds through a 'Social Care Precept'. The Government announced in November 2022 that the Social Care Precept would raise from a 1% limit in 2022/23 to 2% in 2023/24.[277] This is in addition to local authorities' ability to raise core council tax by 3% without a referendum from April 2023, up from 1.99% in 2022/23.[278]

[275] For example in tweets by Minister for Care, Helen Whately (2022): https://twitter.com/Helen_Whately/status/1601307787002511360
[276] ADASS (2023). *Spring Budget 2023: Representation by the Association of Directors of Adult Social Services (ADASS)*.
[277] HM Treasury (2022). *Autumn Statement 2022*.
[278] HM Treasury (2022). *Autumn Statement 2022*.

The Government's 2022 Autumn Statement announcement extended these revenue raising powers again for local authorities which, if exercised in full, could raise up to £550 million in 2023/24[279] and £1.2 billion in 2024/25. The full headline amount of an additional £7.5 billion for social care over these two years will only be realised if local authorities do so.

Adult social care funding gap

As the population grows and ages, rising demand for treatment, care and support, plus increasingly complex needs, are putting further pressure on the health and social care systems.

Estimates of the size of the adult social care 'funding gap' vary. In October 2020 – while the impacts of the COVID-19 pandemic were still emerging – the Health and Social Care Committee estimated an additional £7 billion per year was required by 2023/24, which it described as a "starting point…to cover demographic changes, uplift staff pay in line with the National Minimum Wage and to protect people who face catastrophic social care costs".[280]

The Committee pointed out that this "will not provide any improvement in access to care, which is urgently needed… The full cost of adequately funding social care is therefore likely to be substantially higher than £7 billion, potentially running to tens of billions of pounds".[281] The Health Foundation has suggested that an additional £14.4 billion a year will be required by 2030/31 to meet future demand, improve access to care, and pay more for care.[282] In August 2022, the Levelling Up, Housing and Communities Committee endorsed these estimates as "credible" and recommended the Government "urgently needs to allocate more funding to adult social care in the order of several billions each year, at least £7 billion".[283]

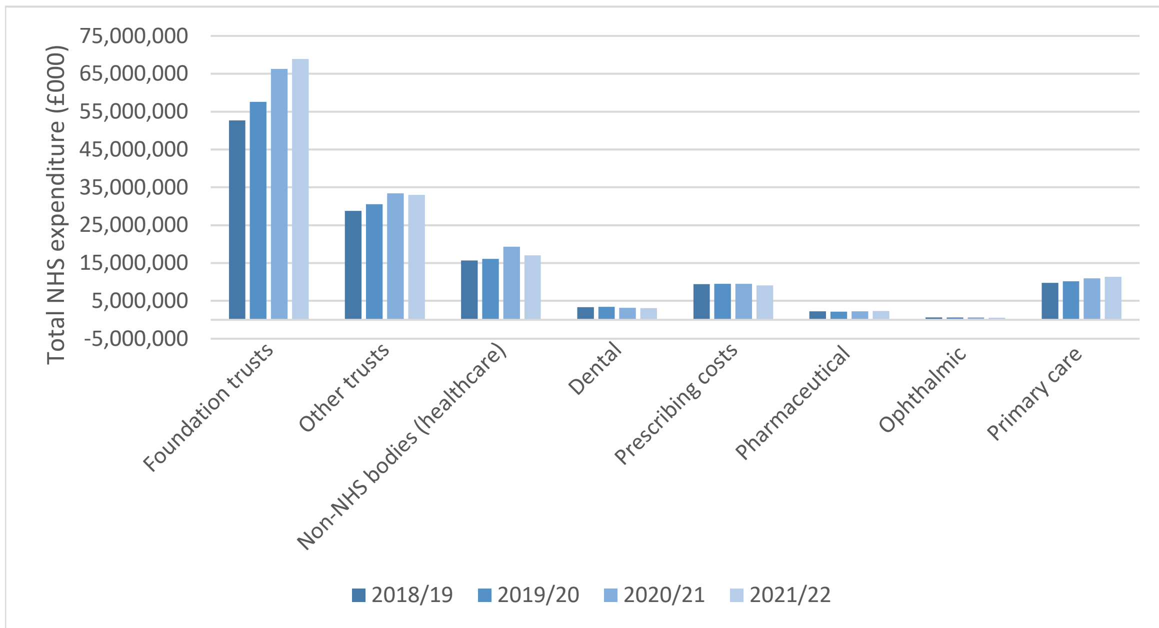
5.4 Uneven and short-term investment

As *Figure 5.6* and *Figure 5.7* show, the NHS spends the vast majority of its budget on secondary care – mostly hospital – services. The 2014 NHS Five Year Forward View set out a vision of shifting care away from hospitals and closer to people's homes, which was reinforced in the 2019 Long-Term Plan. Yet despite this, spending on hospitals has increased, while spending on primary care has only risen relatively modestly, particularly

[279] Kenyon, M. (2022). *Council tax rise makes up £550m of the extra £2.8bn social care funding*.
[280] Health and Social Care Committee (2020). *Social care: funding and workforce, Third Report of Session 2019-21*. House of Commons
[281] Health and Social Care Committee (2020). *Social care: funding and workforce, Third Report of Session 2019-21*. House of Commons
[282] Idriss, O., Tallack, C., Shembavnekar, N. & Carter, M. (2021). *Social care funding gap*. The Health Foundation
[283] Levelling Up, Housing and Communities Committee (2022). *Long-term funding of adult social care, Second Report of Session 2022-23*. House of Commons

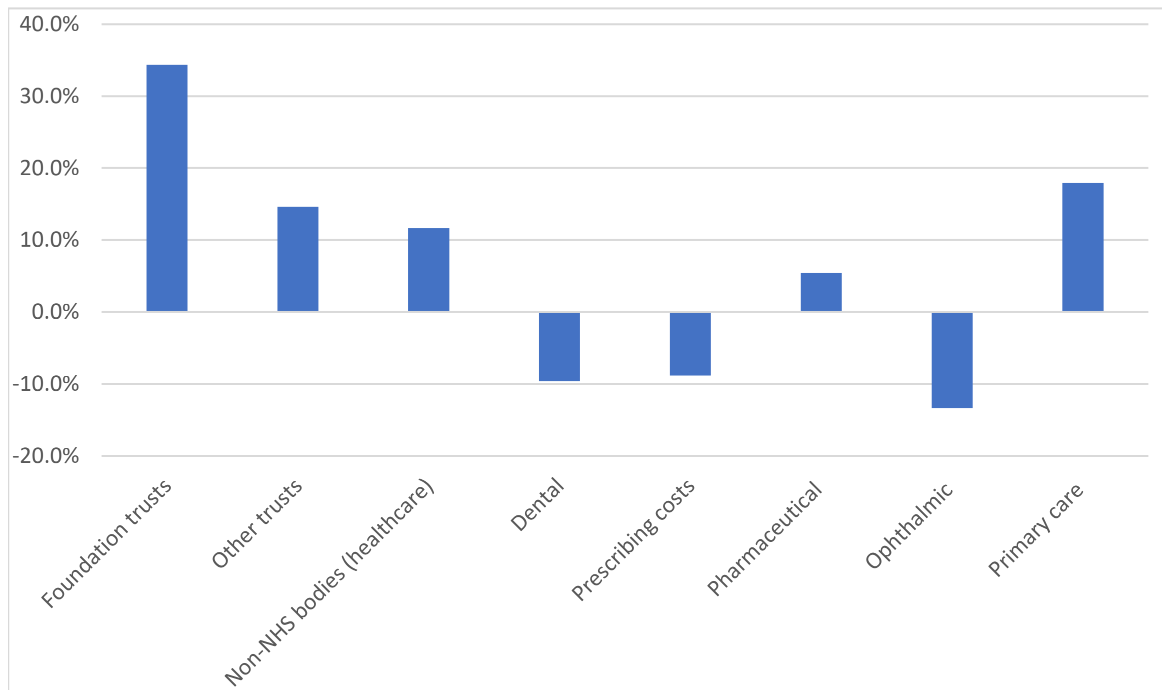
with regards to pharmaceutical services, and ophthalmic and dental services spending has plummeted.

Figure 5.6. NHS expenditure by sector, 2022/23 prices, 2018/19 to 2021/22, England



Source: Age UK analysis: NHS England (2023), Annual Reports 2018/19-2021/22, and HM Treasury GDP deflators at market prices (31st March 2023).

Figure 5.7. Change in NHS expenditure by sector, 2022/23 prices, 2017/18 to 2021/22, England



Source: Age UK analysis: NHS England (2023), Annual Reports 2018/19-2021/22, and HM Treasury GDP deflators at market prices (31st March 2023).

The Ageing Well programme, outline in the NHS Long Term Plan, included a commitment to rolling out "anticipatory care", later renamed "proactive care". This strand of the programme was intended to identify people living with complex needs, mostly older people with frailty, and intervene early to prevent later crises or deterioration. The limited funding for proactive care was later rolled into the baseline budgets of Integrated Care Systems with no national commitment for it be implemented. As of July 2023, it is still not officially launched as an intervention.

This speaks to the wider challenge of failing to provide care and support, across health and social care, that can help older people to stay well for longer. It points to the necessity to grow funding in secondary care to meet those crises when they occur rather than prevent them. And even then, the care older people receive in those moments is sub-optimal, often contributing to even further decline. This is not a sustainable model for either the future of older people's wellbeing or the future of the NHS.

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GLOSSARY

A&E	Accident and Emergency
ADASS	Association of Directors of Adult Social Services
ADL	Activities of Daily Living
APPG	All Party Parliamentary Group
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DfLE	Disability-free Life Expectancy
DHSC	Department of Health and Social Care
ELSA	English Longitudinal Study of Ageing
FTE	Full-time Equivalent
GDP	Gross Domestic Product
HLE	Healthy Life Expectancy
LE	Life Expectancy
OBR	Office for Budget Responsibility
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PHE	Public Health England (now OHID and UKSHA)
UKSHA	UK Health Security Agency

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