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.

Geographic variation and health inequalities

Within England, male life expectancy at birth in 2018-2020 was highest in the South East

In 2018-2020, at age 65

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

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 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 expectancyQq531.22 35.28 10.2 12.144 reW* nBT/F5 9.96 Tf

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

Public Health England (PHE) reported how the wider impacts of COVID-19 affected

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%.

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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
a particularly pronounced increase in absolute numbers in the next couple of decades.

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).

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 *Age UK polling and insight, undertaken with Kantar – unpublished.* [n=1,632, representative of the UK population].

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-

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 d 337

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

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 mortality in adults, Tf1 0 Tfsss, T

the real figure is likely to be higher.[84]

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 f making a GP appointment increased from 73% in 2020 to 75% in 2021. 9c29(20(to)-3( )-29(75%)-28(in)5( )-29(2021.)3ot5)-4

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.

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 .-66.g28840T9ETQq0.00000cts being made in prev*

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] pattern.[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 [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.

[107] A direct payment means you receive the money to arrange your care, ranethe1 0 0 1 347.83 479.71 Tm0 g0 G[( )] TJETQq0.00000ec

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.

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.

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

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 def64 12 Tf1cr

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.

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 were surveyed were '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

This means people – who

longer capable of delivering care to people in need’.

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

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 g0 0000spive ab0spson

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t[()6( )9becomiortvin necessalrst (a)-2()4( )30(n(2021/22.)] TJETQq0.000008871 0 595.32 841.92 reV

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), 20

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.

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.

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

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]

nF4dlands, up 281%. Thers75W* 4o4 nL3(32-3( )v95.e)( )tt2 84s S.-79((1.91[(t79((0[(t9.37 Tm88.F4dl)-4(a)-2(n)

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

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]

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However, there is a significant and growing gap between the rates paid by local authorities

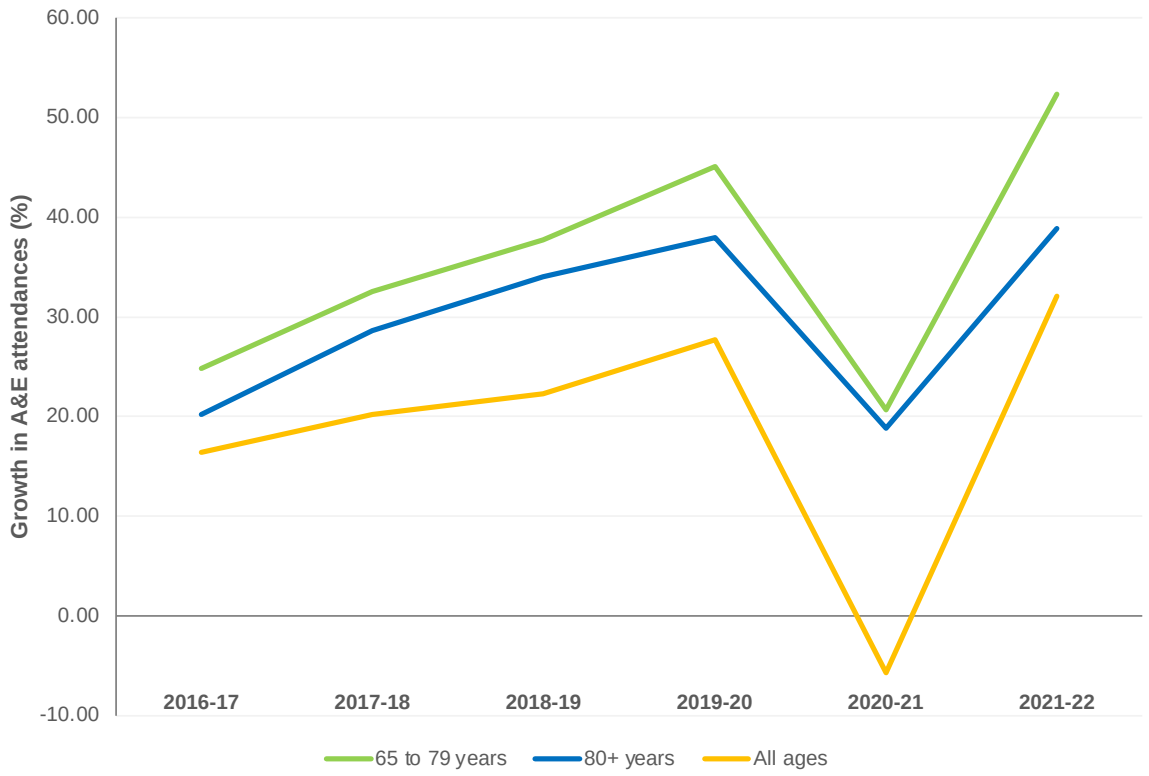
were 24.4 million attendances in A&E in 2021/22, which was close to pre-pandemic levels and represented an increase of 12.1% since 2012/13.[173]

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

Inequalities in A&E attendances per 100,000 population are significant

shows that A&E attendances per 100,000 were 6.1% since 2012/13.

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

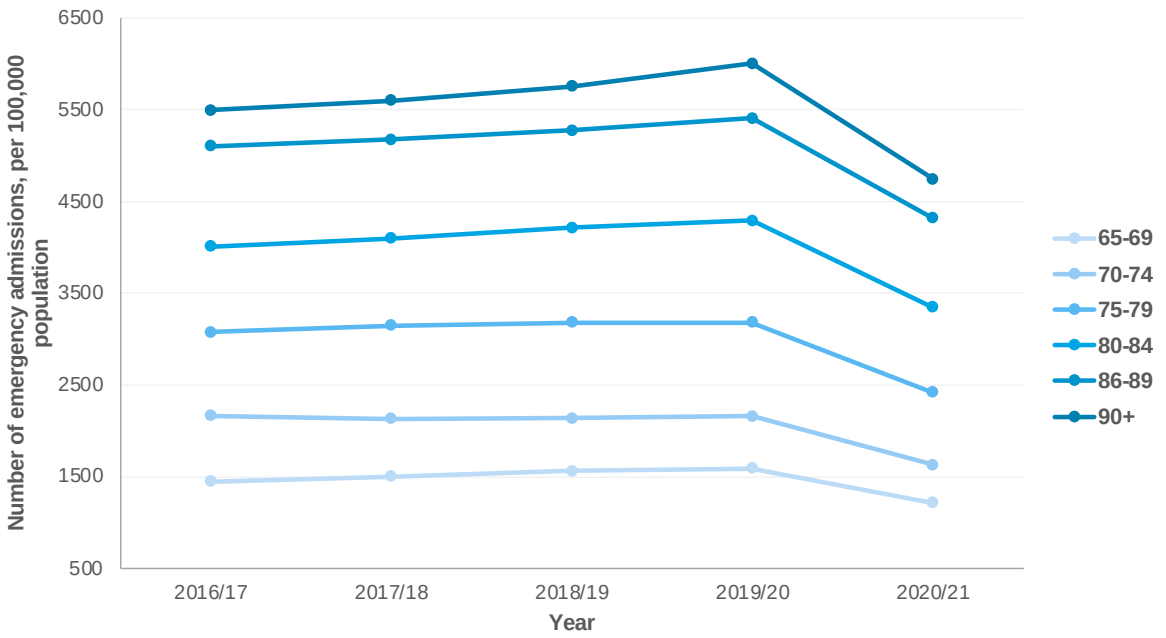
[176] Baker, C. (2022). *NHS key statistics: England, November 2022*. House of Commons Library
[177] NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22*.
[178] The Guardian (31 January 2023), *Elderly people waited nearly twice as long in A&E in England as in 2021*

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

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,

Some emergency admissions are clinically appropriate and unavoidable, but others could be avoided by providing alternative forms of urgent care, or appropriate care and support0rrs

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]

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 pande

[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*.

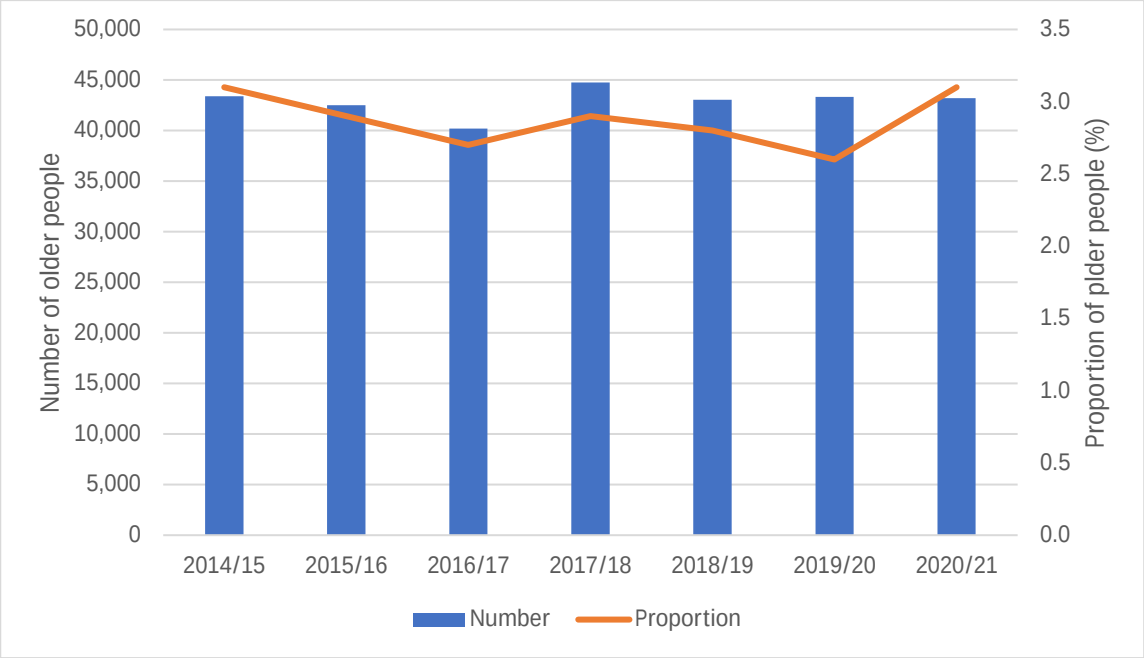
aged 75+ are much more likely to need an outpatient appointment than people aged 65 to 74.

Reducing bed numbers and bed capacity

The NHS has ged tien

healthcare-

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.*

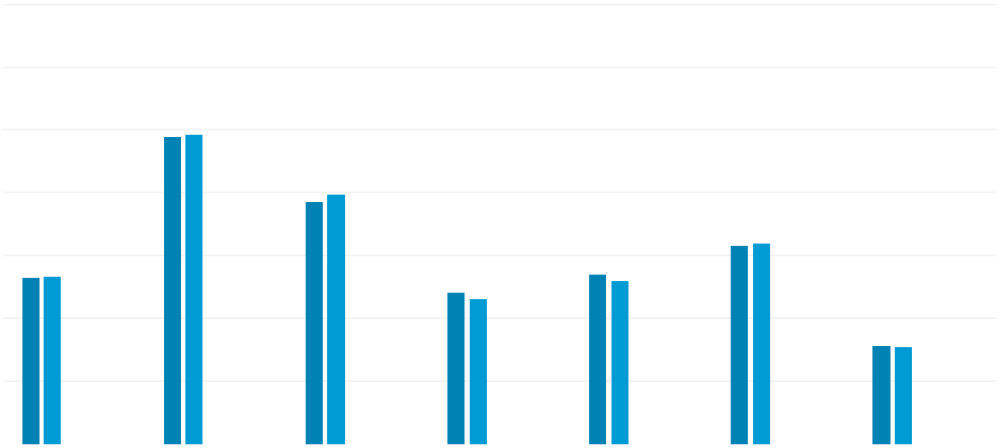
4.1 Workforce size and structure

The very large majority of NHS staff – 1.2 million – work in 'Hospital and Community Health Services' as direct employees of NHS trusts 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 fulyr, TJE36.86

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]

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]

As *Figure 4.4* shows, domiciliary (home) care services have had the highest vacancy rates

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

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

[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 (o8245(0)-3(2)9(2)-3().)] TJETQq0.000008871 0 595.32 841.92 reW*nBT/F13 9 Tf1 0 0 1 193.24 97.704 Tm

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

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.

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).

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

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*.

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

that the Social Care Precept would raise from a 1% limit in 2022/23 to 2% in 2023/24.[277]

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

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 – before the impacts of the COVID-19 pandemic were still emerging –

The Ageing Well programme, outline in the NHS Long Term Plan, included a commitment [illegible] 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

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2. COMMUNITY-BASED TREATMENT, CARE AND SUPPORT

Figure 2.[( )] TJETQq0.000008871 0 595.32 841.92 reW* nI...4ests th* n109.39 f76(.[( )] TJETnBT/F4 11.3389TnE

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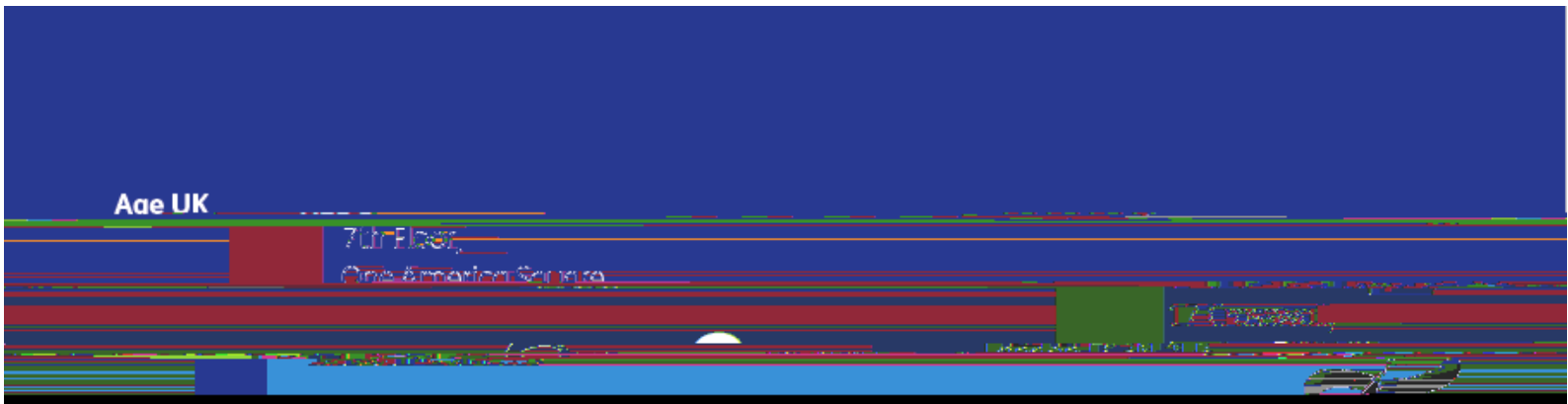
3. THE HEALTH AND CARE NEEDS OF OUR OLDER POPULATION

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


Age UK