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The State of Health and Care of Older People in England 2024

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Foreword

There are thousands of individual findings in this report, which might lead you to think that it is impossible to 'see the wood for the trees'. In fact, a coherent story quite clearly emerges, but unfortunately it is not one that on the face of it provides much comfort.

At the highest level, this analysis shows that England's health and care services continue to be under enormous pressure and, despite the best efforts of dedicated staff, unable to meet the needs of all the older people requiring treatment, care and support. The trend towards this was already firmly in place before the pandemic; it was greatly exacerbated during those traumatic two-plus years; there has been a creditable degree of recovery since then in some areas of provision; but in others it has not yet proved possible to arrest the decline in capacity, service availability and performance, with extremely worrying implications for older people and their families and communities. And all this remember, against the context of a rising older population, the growth of which will accelerate still further over the next decade.

The 'canary in the mine' is what is happening to older people in hospitals. However, problems originate in the community. Primary (GP) and community health services, and social care, are either inadequate or are insufficiently joined up and planned in ways that enable older people in declining health to stay well. The statistics in this report show just how many older people are then arriving in hospital in ambulances, sometimes for reasons that could have been prevented; waiting for long periods in A&E; staying in hospital longer than they should, usually for want of enough community-based social care; and then quite often having to return to hospital within a short period of time post-discharge, because it has proved impossible to treat or sustain them appropriately at home or in a care home. The growth in the numbers, and cost, of treating older people in hospital will only accelerate without a fundamental change in how health and care operate.

The public, and in the case of this report the older public, are the principal victims of this disastrous state of affairs. Older people are the biggest users of NHS and social care services and when those services aren't there for them, are sub-optimal in terms of quality or only become available too late, if at all, their chances of sustaining their independence and even their survival are seriously compromised. To put it more starkly, in some cases older people are dying sooner than they should, for want of timely and high-quality diagnoses, treatment, care and support. As ever, some groups of older people are at much greater risk of this than others, especially those with little money, in poorer areas, from minoritised communities, and who live alone or with little or no family support. Tragically, health inequalities are rife within our older population and are growing, as the report shows.

However, older people are not the only victims of our NHS and social care system's struggle to respond to rising demand with resources that are either inadequate or seemingly often in the wrong place. Another group impacted comprises millions of families and unpaid carers, many of them older people themselves. When older people with significant health and care needs are lucky enough to have loving support at home or close by, more and more is being demanded of it, sometimes to an intolerable degree, leading to these informal arrangements breaking down – and sometimes the individuals breaking down too.

Staff in the NHS and social care are also being severely impacted by the pressure of working in services that are sometimes overwhelmed by the numbers of people who badly need their help. This is partly because of understaffing, meaning everyone has to do more; but also because of the emotional distress of knowing they are unable to do as good and complete a job as they want to do or that they find professionally acceptable. The risk is that this becomes a vicious circle, making staff retention harder and harder.

And yet, despite this incredibly challenging situation there is cause for hope, first and foremost because we know what has to happen to change it. There is a strong expert consensus about this, led by Chris Whitty among others, and about the high priority that has to attach to it: shifting the focus of services for older people out of hospital and into the community is arguably the central strategic challenge for health and care over the next decade, because of their sharply growing numbers. The new Labour government has committed to a health mission but it won't deliver it unless and until this happens.

And some of the statistics are chilling. For example, the numbers of district nurses reduced by 17.5% between 2014 and 2023 – a trend in completely the wrong direction, given how important they are in treating older people at home for problems like pressure sores, which can easily develop into serious health issues requiring acute care. The NHS workforce is not growing fast enough in the right places to meet increasing needs and acuity in the community.

Of even greater concern, the numbers of older people in England who are now living with some unmet need for social care have risen significantly in recent years and now stand at two million. In the area of social care it is not clear that the incoming Government really appreciates how urgent the need is to reform and refinance services, dramatically improving their quality and availability. At present, social care is often described as 'a second term priority', largely for reasons of cost, but the problem with this approach is that without a strong and effective social care service, the NHS cannot function effectively. Arguably, the Government's ability to deliver its health mission in this Parliament will ultimately stand or fall on the willingness of Ministers, and the Treasury, to face up to this inconvenient truth.

In the meantime, our older population is frequently in a more precarious position regarding their ability to access the effective health and social care they need, than any of us would like. And it is clear that this is severely undermining the quality, and sometimes the duration, of their lives.

Recommendations

The NHS

- Ensure every Integrated Care System – the body responsible for health and care services in each area – puts in place an Ageing Well Strategy, including how they will invest in public health over the life course and into older age.
- Invest in GP practices, primary care and community services to offer coordinated support for people living with long-term conditions and/or frailty. Investment is needed in the workforce, premises and technology.
- Introduce an ambitious preventative public health strategy which encourages and enables physical activity among older people and those with long-term health conditions, building on Sport England's 'We are Undefeatable' programme.
- Significantly expand the number of 'integrated neighbourhood teams', bringing together health and social care professionals with a range of other support workers to help older people with complex needs to maximise their health and independence.
- Implement a strategy to clear waiting lists, including a return to the 18-week standard and support for people while they are waiting.
- Implement the NHS Workforce Plan, and make sure that all healthcare professionals have the skills they need to support an ageing population.

Social Care

- Stabilise the social care sector and act quickly to consult on putting funding on a sustainable footing.
- Within 18 months, publish a comprehensive plan to reform social care and commit to implementing it during this Parliament.
- Fund an immediate pay rise for care professionals, and within two years publish a comprehensive social care workforce plan, joined up with the NHS Workforce Plan.
- Introduce a right to at least five days of paid Carer's Leave, plus a longer period of unpaid leave.
- Significantly increase access to respite services and practical support for carers that recognises the specific needs of older carers.

1. Health and care needs of the older population

1.1 England's population is ageing

Ageing is neither a linear nor consistent process and one that is only loosely associated with chronological ageing. At the biological level, "ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time".[1] Physiological decline happens across all body systems – commencing from approximately the age of 30 – leading to a gradual decrease in physical and mental capacity, as well as a growing risk of disease.[2] Healthy ageing is defined as "the process of developing and maintaining the functional ability that enables wellbeing in older age".[3]

Trajectories and outcomes of ageing are diverse – there is no typical older person. While some people will maintain their health and independence into their 80s and beyond, others will experience diseases, conditions and disabilities usually associated with later life in their 50s. The World Health Organisation states a large proportion of this diversity, approximately 75%, is the result of the cumulative impact of advantage and disadvantage across people's lives[4] and demographic factors such as sex, ethnicity, levels of childhood nutrition, access to education, financial income, and caring responsibilities all contribute to diverse experiences of ageing.[6]

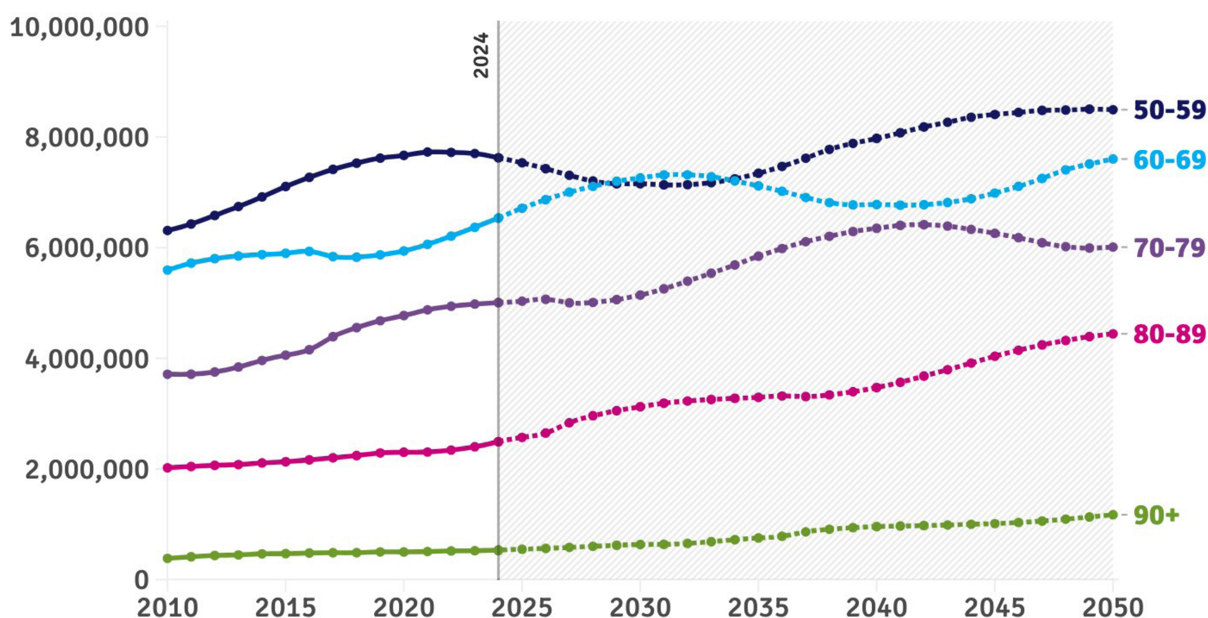
Data pertaining to 'older people' has historically been collected from the age of 65+. Many health- and care-related datasets continue to capture and measure activity and outcomes on this basis. However, we have been struck by how much some members of the 50-64 age group are struggling, and on many different fronts. Over the past three years, Age UK has conducted six waves of research into older people's health and care. We expanded our most recent research to include people aged 50 years and over.

We found some people in their fifties and early sixties have been very severely impacted by the cost-of-living crisis, particularly if they are on low pay or not working because of caring responsibilities, ill health, disability or unemployment, making them reliant on Universal Credit or other working age benefits. In this phase of life, serious health conditions are also likely to emerge, and caring responsibilities develop too. As a result, it is clear to us that less advantaged people in their fifties and early sixties need more policy attention and support than they are currently receiving, to help them make the most of their lives now and to help them to flourish as they age. We have therefore sought to include this age group in our considerations of the state of health and care of older people in England.[7]

The age structure of our population is shifting toward older ages. 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.[8] This was in large part due to the higher risk of infant mortality and communicable diseases, later controlled through advances in immunisation and vaccination. Now, just 1 in 7 males and 1 in 11 females die before they reach 65. In 2024, there are now 22 million people aged over 50 in England, equivalent to two in five of the total population.[9] At age 50, a male can expect to live an average of another 31 years, whilst a female can expect to live an average of 34.2 years.[10]

1. World Health Organisation (2022). Ageing and Health.
2. Preston, J. &Biddell, B. (2021). The physiology of ageing and how these changes affect older people. Medicine. 49(1):1-5.
3. World Health Organisation (2020). Decade of Health Ageing: Baseline Report.
4. World Health Organisation (2022). Ageing and Health.
6. World Health Organisation (2020). Decade of Health Ageing: Baseline Report.
7. For more information and analysis, please see: Boulton, L. (2024). We have to take it one day at a time: Results of Age UK's research into health and care of people aged 50 and over. Age UK.
8. ONS (2024). National life tables: UK.
9. ONS (2024). Principal projection - England population in age groups: 2021-basedd interim edition of this dataset.
10. ONS (2024). National life tables – life expectancy in the UK: 2020 to 2022.

England's older people population is rapidly increasing. As shown in Figure 1.1, the population of people aged 50+ in England is projected to increase by 19.3% between 2024 and 2044 (an increase of 4.3 million people).[11] More immediately, as members of the large cohort of people born after WWII (the 'Baby Boomer' generation born between 1946 and 1964) continue to reach 65 years old, England's older population is projected to increase by 10.6% in the next five years alone (an increase of 1.2 million people).[12] The population aged 85+, the age group most likely to need health and care services, is also projected to rise rapidly, increasing by 13.6% by 2029 (an increase of 202,000 people), and 67.8% between 2024 and 2044 (an increase of 1.0 million people).[13]



Source: Age UK 2024: Analysis using ONS (2024). Principal projection - England population in age groups: 2021-based interim national population projections edition of this dataset, ONS (2023). Population estimates for the UK and constituent countries by sex and age; Historical time series.

1.2 Life expectancy and healthy life expectancy gains have stalled

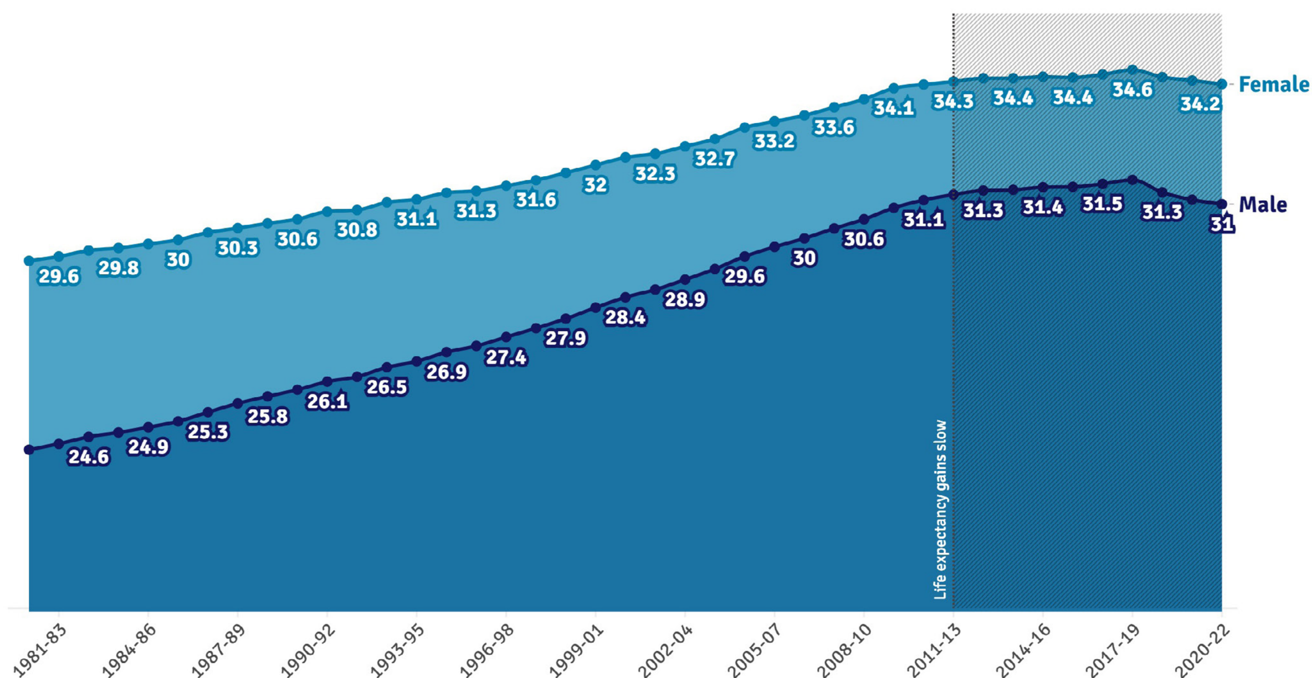
England's improvements in life expectancy have been stalled for more than a decade. England experienced continuous improvement in life expectancy from 1890 to 2010.[14] However, from 2010 this improvement slowed, almost halting for much of the population and even falling for the poorest 10% of women.[15] The scale of the slowdown leaves the UK standing out from other comparable countries.[16]

11. ONS (2024). ONS (2024). Principal projection - England population in age groups: 2021-based interim edition of this dataset.
12. ONS (2024). ONS (2024). Principal projection - England population in age groups: 2021-based interim edition of this dataset.
13. ONS (2024).ONS (2024). Principal projection - England population in age groups: 2021-based interim edition of this dataset.
14. ONS (2015). How has life expectancy changed over time?
15. ONS (2022). Health state life expectancies by different deprivation deciles, England: 2018-2020.
16. The Health Foundation (2022). International life expectancy at birth by sex.

Life expectancy gains at older ages have declined since 2017. Life expectancy at birth is sensitive to changes in infant mortality at the youngest ages[17], so to understand the experiences of older people we must focus on life expectancy at older ages. Improvements here have also slowed in the recent years. Figure 1.2 illustrates the steady increase in life expectancy over the past 40 years, which recently began to decline in 2020-22. At age 50, life expectancy in England in 2014-2016 was 34.4 years for females and 31.4 years for males.[18] In 2020-2022, this had declined to 34.2 years for females and 31 years for males – a fall of 0.2 years for females and 0.4 years for males. Life expectancy aged 65 in England in 2020-2022 was 20.9 years for females and 18.4 years for males[19] – a fall of 0.1 for females and 0.3 for males since 2014-2016.[20]

Fig 1.2 Life expectancy gains at age 50 have slowed over the past decade

Life expectancy at age 50 by sex, 1980 to 2022, England.

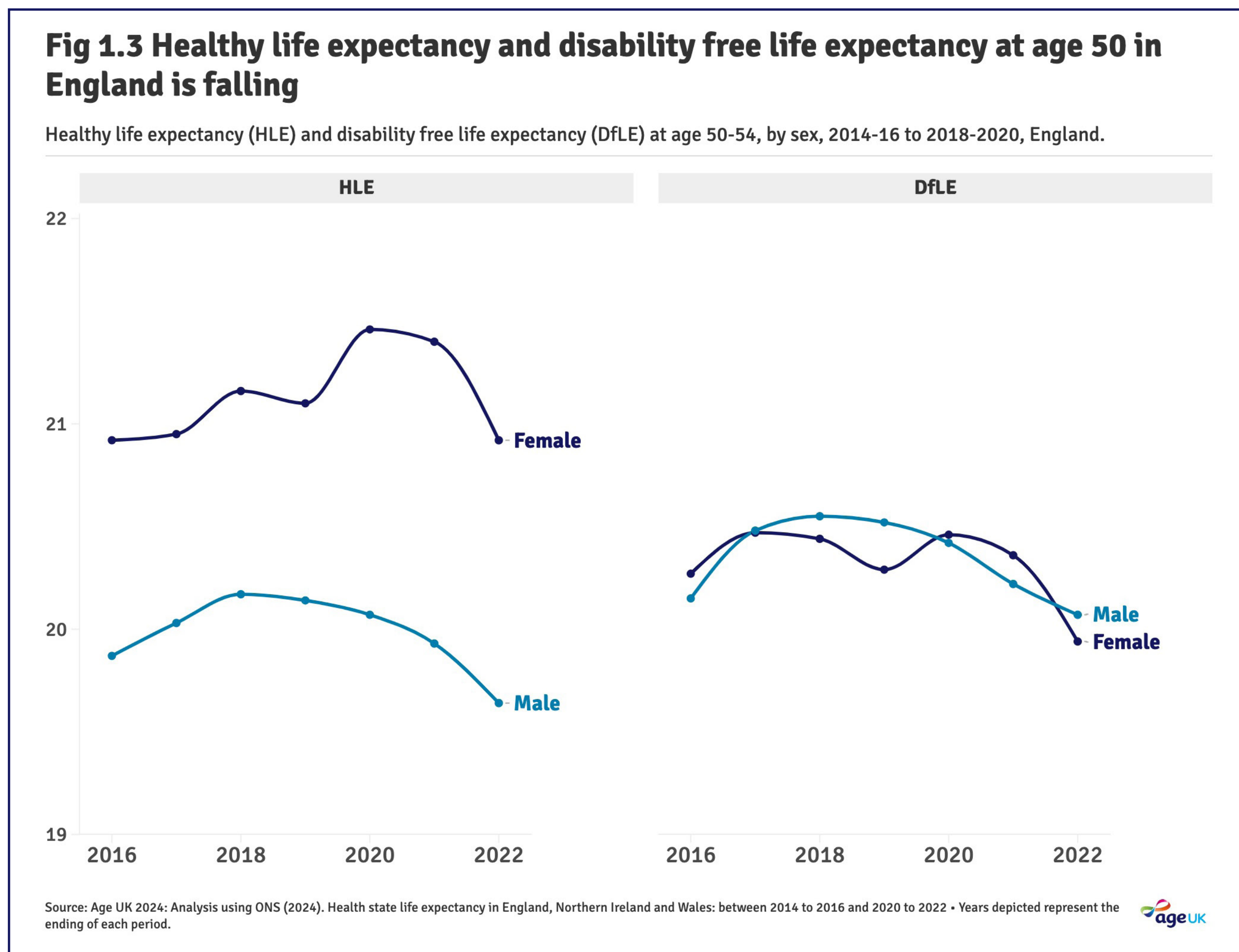


Source: Age UK 2024: Analysis using ONS (2024). National Life Tables – life expectancy in the UK: 1980 to 2022

There is a large gap between life expectancy at birth and healthy life expectancy at birth. 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. While life expectancy at birth in England in 2020-2022 was 82.8 years for females and 78.8 years for males,[21] the average healthy life expectancy at birth in England was 62.7 years for females and 62.4 years for males, indicating a period of 20 years for females and 16 years for males during which the average person can expect to be in poor health.[22]

17. 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.
18. ONS (2024). National life tables: England.
19. ONS (2024). National life tables: England.
20. ONS (2024). National life tables: England.
21. ONS (2024). National life tables – life expectancy in the UK: 2020 to 2022.
22. ONS (2024). Health state life expectancies in England, Northern Ireland and Wales: between 2011 to 2013 and 2020 to 2022.

Healthy life expectancy at birth and at age 50 in England is falling. Figure 1.3 shows healthy life expectancy at birth in England fell by 1.2 years for females and by 0.9 years for males between 2014-2016 and 2020-2022.[23] Over the same period, at age 50, healthy life expectancy remains the same for females at 20.9 years (but fluctuated across the intermediate years) and declined by 0.2 years to 19.9 years for males.[24]



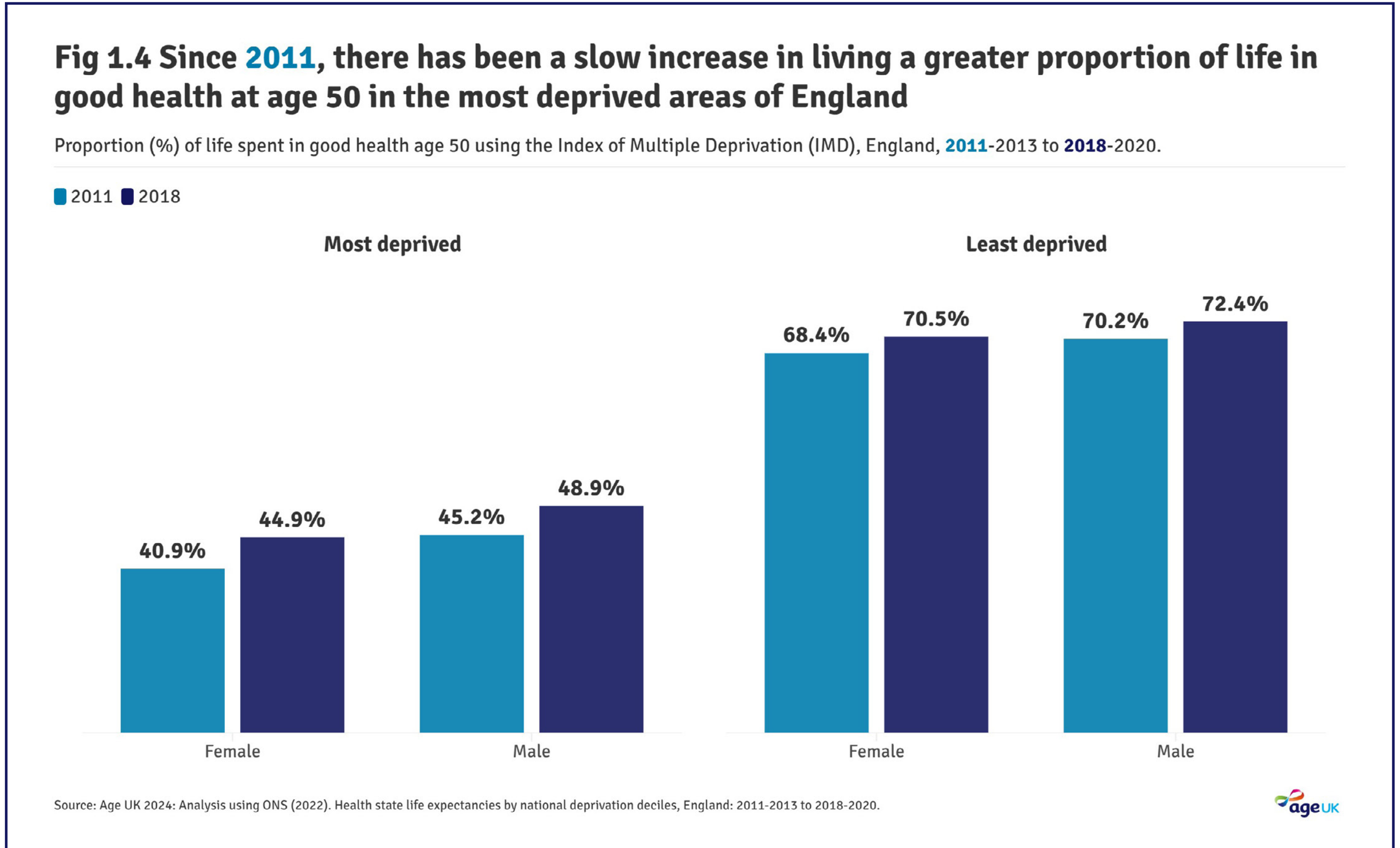
Disability-free life expectancy at age 50 in England has decreased. Disability-free life expectancy shows the average number of years a person would expect to live without a long lasting physical or mental health condition or disability that limits daily activities. In 2020-2022, disability-free life expectancy at age 50 decreased by 0.3 years for females and 0.1 years for males, to 20 years and 16.6 years, respectively, since 2014-2016 (beginning of ONS time series) (Figure 1.3).[25]

The time people spend living with major illness is projected to increase. Modelling by the Health Foundation's REAL Centre and the University of Liverpool[26] projects life expectancy for people living in England to increase further over the next 20 years, but the average age at which people are expected to commence living with major illness is expected to remain constant at 70 years. The modelling puts this at 12.6 years by 2040.

23. ONS (2024). Health state life expectancies in England, Northern Ireland and Wales: between 2011 to 2013 and 2020 to 2022.
24. ONS (2024). Health state life expectancies in England, Northern Ireland and Wales: between 2011 to 2013 and 2020 to 2022.
25. ONS (2022). Health state life expectancies by different deprivation deciles, England: 2018-2020.
26. Watt, T., Raymond, A., Rachet-Jacquet. L., Head. A., Kypridemos. C., Kelly, E. & Charlesworth, A. (2023). Health in 2040: projected patterns of illness in England. The Health Foundation.

1.2.1 Geographic variation and health inequalities

The more deprived an area, the lower the proportion of life spent in good health. Figure 1.4 shows that life expectancy follows the social gradient (people who are less advantaged in terms of socioeconomic position have worse health). Since 2011-2013, the proportion of life spent in good health for older people aged 50 living in the most deprived areas of England has only increased by 4% for females, and by 3.7% for males.



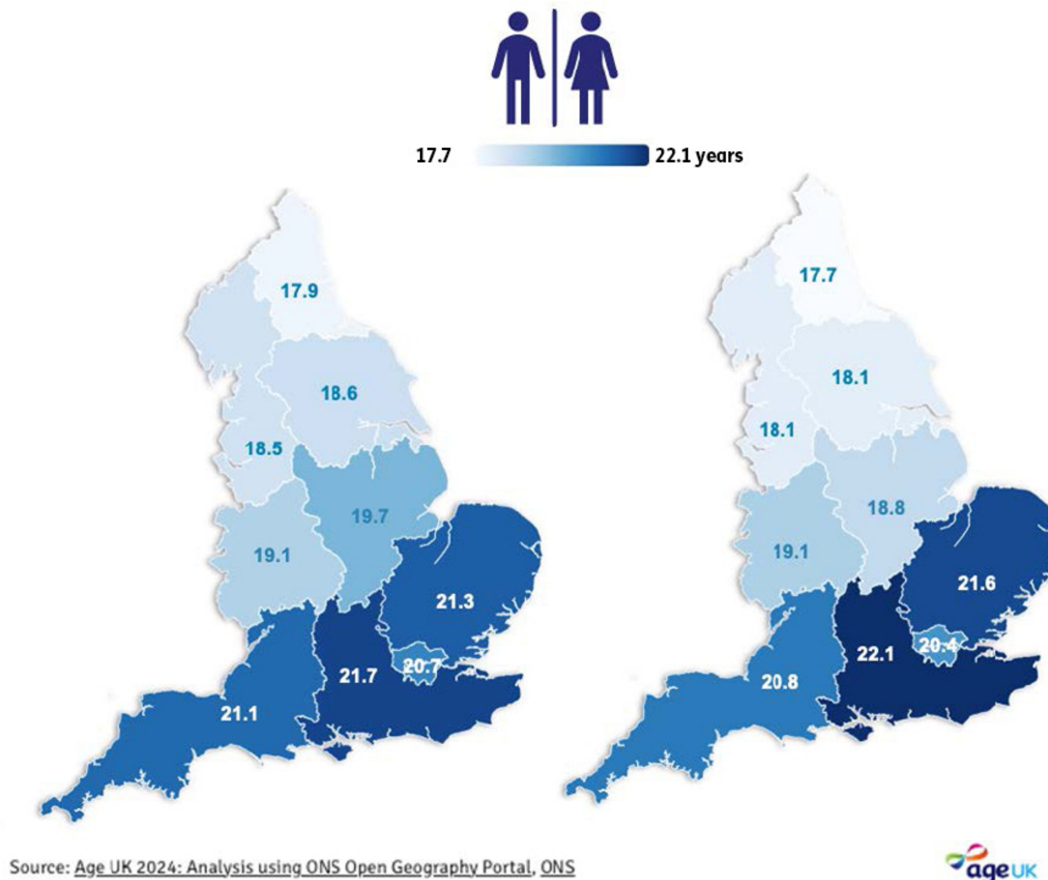
The more deprived an area, the shorter the healthy life expectancy and disability-free life expectancy. Female healthy life expectancy at birth in the 10% most deprived areas was 7.9 years lower than in the least deprived areas in 2018-2020; for males the difference was 9.7 years fewer. Men and women living in the 10% most deprived areas of England saw a significant decrease in life expectancy between 2015-2017 and 2018-2020.[27]

There is a striking north-south divide in the burden of ill health and disability in later life in England. There is of course substantial variation within regions – the north has some very advantaged areas and the south has some very disadvantaged ones. However, if we consider regions as a whole, average female life expectancy is highest in the South West (83.9 years) and lowest in the North East (81.2 years) – a sizeable regional difference of 2.8 years.[28] The pattern for males is similar to that for females, with highest life expectancy at birth in the South East (80.1 years) and lowest in the North East (77.2 years) – a gap of 3.0 years (due to rounding). Disparity in disability-free life expectancy at age 50 years is shown in Figure 1.5. This ranges from 17.7 years to 20.8 years in the North East to South East, respectively for females, and 17.9 years to 21.7 years in the North East to South East for males.[29]

27. ONS (2022). Health state life expectancies by national deprivation deciles, England: 2018-2020.
28. ONS (2024). Life expectancy for local areas in England, Northern Ireland and Wales: between 2001 to 2003 and 2020 to 2022.
29. ONS (2024). Life expectancy for local areas in England, Northern Ireland and Wales: between 2001 to 2003 and 2020 to 2022 [data table 2].

Fig 1.5 There is a North-south divide in the burden of ill health and disability-free life expectancy in later life

Disability-free Life Expectancy (DFLE) at age 50, estimates for females and males, English regions, 2020 to 2022.



1.3 Health and care needs of older people

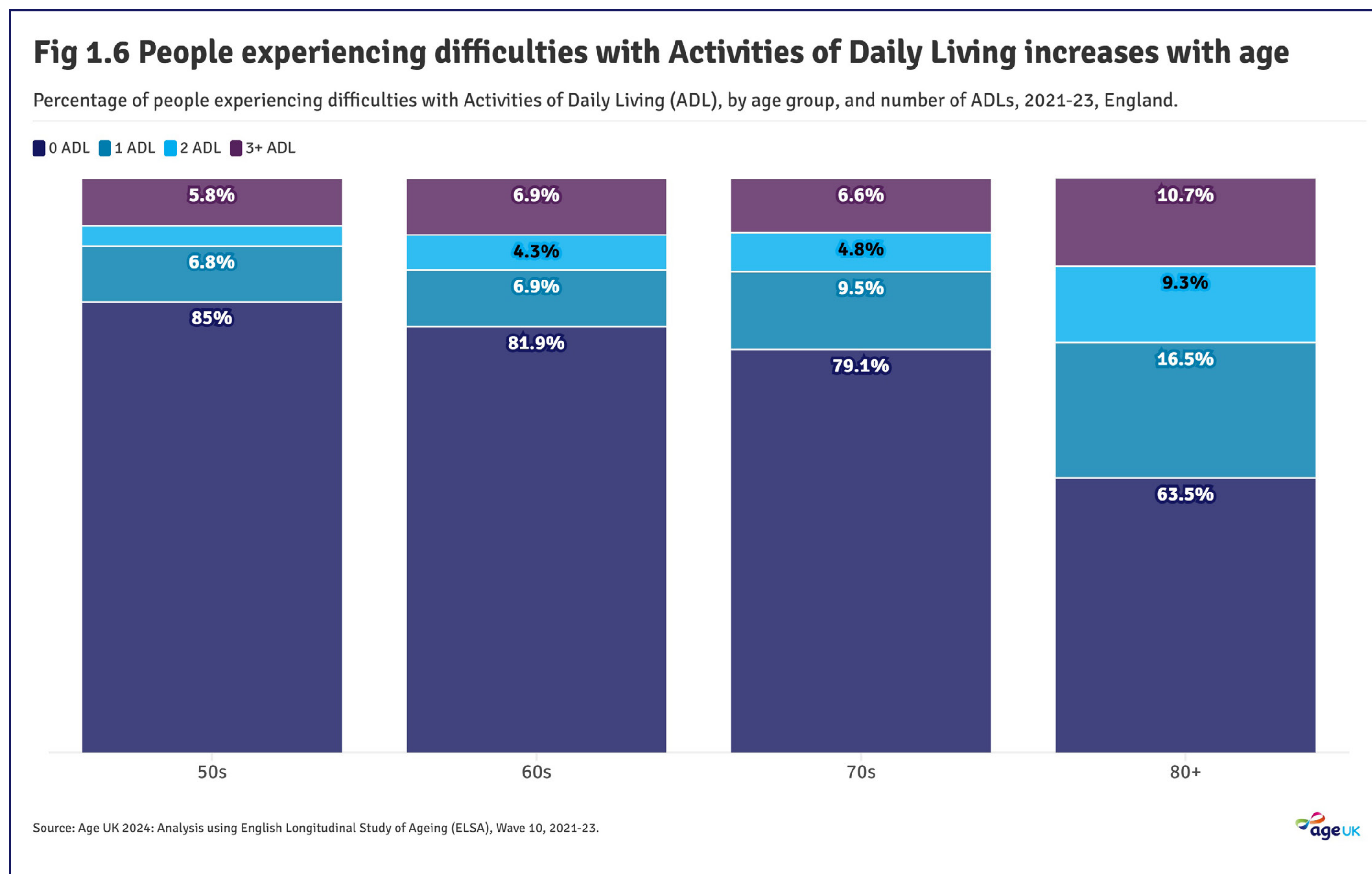
It is important to recognise the diversity of the older population – both within and across age groups. The prevalence of nearly all long-term conditions increases with age,[30] but while a growing older population in England will likely lead to an increasing number of people living with complex health and care needs, there will also likely be growing numbers of people across all older age groups living without any significant needs for support.

The divergence between ageing with and without health and social care needs can be seen at age 50. Compared to people aged over 60, recent Age UK polling data has shown that in the past 12 months, older people aged 50-59 are more likely to: find it the most difficult to look after themselves and process new information, have a significantly greater amount of anxiety, and provide a greater amount of care or support to someone they live with or someone in another household.[31] For older people living in poverty, those aged 50-59 are twice as likely to report very bad health, compared to those aged 65+.[32]

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

30. DHSC (2012). Long-term Conditions Compendium of Information: Third edition.
31. Age UK (2024). We have to take it one day at a time.
32. The Health Foundation (2024). Relationship between poverty, age and health.

The proportion of people experiencing difficulties with Activities of Daily Living (ADLs)[33] increases with age. As shown in Figure 1.6, the most recent data suggest that within the 60s age group, 18.1% of people experience difficulty with at least one ADL, which rises to 20.9% within the 70s age group. By the age of 80+, the percentage of people living with some level of need for care and support rises sharply to 36.5%.



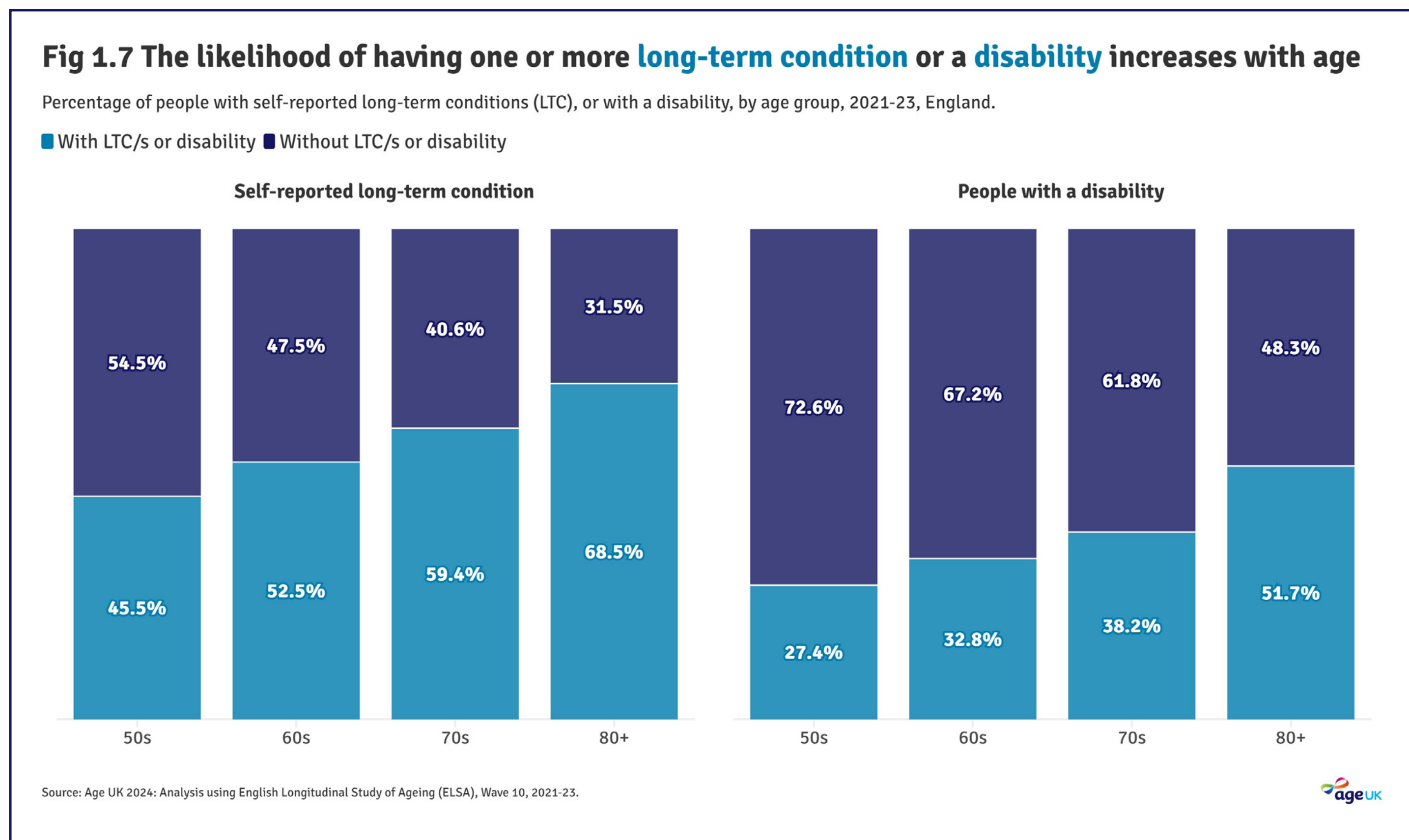
1.3.1 Long-term conditions and multimorbidity

The number of people living with long-term conditions (those that cannot currently be cured but can be managed through medications or therapies[34]) is rising.[35] In England, 40% of adults (aged 16+) report having at least one long-term health condition.[36] 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%).[37]

The number of people living with major illness is projected to increase. Modelling by the Health Foundation's REAL Centre and the University of Liverpool[38] projects the number of people living with major illness will increase by 37% by 2040. This is nine times the rate at which the working age population (people aged 20 to 69) is expected to grow (4%). The analysis lays out the potential scale and impact of the growth in the number of people living with major illness as the population ages. The analysis assigned scores to 20 conditions based on how likely the illness is to affect people's use of primary care and emergency health services and likelihood of death. The modelling predicts an increase in the prevalence of 19 out of these 20 diseases [the exception being coronary heart disease, where significant preventative investment has been made], including increases of more than 30% in the number of people living with conditions such as cancer, diabetes and kidney disease.

33. '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.
34. NHS Employers (2020). Long-term health conditions.
35. NIHR (2021). Multiple long-term conditions (multimorbidity): making sense of the evidence.
36. NHS Digital (2023). Health Survey for England: Adults' health: General health, acute sickness and longstanding conditions.
37. NHS Digital (2023). Health Survey for England: Adults' health: General health, acute sickness and longstanding conditions.
38. Watt, T., Raymond, A., Rachet-Jacquet. L., Head. A., Kypridemos. C., Kelly, E. & Charlesworth, A. (2023). Health in 2040: projected patterns of illness in England. The Health Foundation.

Long-term conditions are not an inevitability of later life, but the likelihood of having one or more long-term condition does increase with age. Figure 1.7 shows that while 54.5% of people in their 50s have no diagnosed long-term condition, this falls to 47.5% of people in their 60s to 40.6% of people in their 70s, and to 31.5% of people aged 80+. The number of people with a disability is also shown to be more common with age, where 27.4% of people in their 50's are likely to have a disability. This almost doubles to 51.7% for people 80+.



More than one in four of the adult population in England lives with two or more conditions.[39] The impacts of managing multiple 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.[40] People with multimorbidity (two or more conditions) have an increased risk of functional decline, poorer quality of life, greater healthcare use and higher mortality than people with one or no long-term conditions.[41]

The complexity of illness is projected to increase, particularly impacting older age groups. The modelling by the Health Foundation's REAL Centre and the University of Liverpool[42] also indicates high numbers of people will be living with multiple long-term conditions that are predominantly managed in primary care. For example, in 2019 people aged 85+ had an average of 5.2 diagnosed conditions. By 2040, the modelling projects people aged 85+ will have an average of 5.7 conditions, increasing the complexity of managing their health needs.

39. NIHR (2021). Multiple long-term conditions (multimorbidity): making sense of the evidence.
40. NIHR (2021). Multiple long-term conditions (multimorbidity): making sense of the evidence.
41. Yarnall, A.J., et al (2017). New horizons in multimorbidity in older adults. Age and Ageing, 46, 882–888.
42. Watt, T., Raymond, A., Rachet-Jacquet. L., Head. A., Kypridemos. C., Kelly, E. & Charlesworth, A. (2023). Health in 2040: projected patterns of illness in England. The Health Foundation.

1.3.2 Frailty

Frailty is a term often used but often misunderstood. If someone is living with frailty, then 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 other stressor events.[43] 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 distinct from multimorbidity and someone living with frailty may have no other diagnosed health conditions. However, there is an overlap, and many people live with both.[44] Frailty is generally characterised by issues such as unintentional weight loss, reduced muscle strength and fatigue. The National Institute for Health and Care Excellence recommends healthcare professionals consider assessing frailty in adults with multimorbidity.[45]

Falls and fractures are a common and serious health issue faced by older people. Around one in three people aged 65+ and half of people aged 80+ will have at least one fall a year.[46] Falls are the main cause of a person losing their independence and going into long-term care.[47] 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.[48]

Older people with frailty are more likely to experience recurrent falls than older people without frailty.[49] 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.[50] Frailty assessment and diagnosis can be a gateway to support and services, including support to prevent falls.

1.3.3 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.[51] Age UK research[52] (undertaken prior to the COVID-19 pandemic) found nearly half of adults aged 55+ reported having experienced depression and/or anxiety at some point in their lives. The research found the most commonly reported triggers for mental health problems to be the death of loved ones (36%), financial worries (27%) and a person's own ill health (24%). One in five (21%) of the people who reported experiencing depression or anxiety said their symptoms had worsened with age.

Some groups of older people have a higher risk of mental health difficulties than others. A literature review undertaken by the Centre for Mental Health in England[53] identified evidence that some groups of people in later life have a higher risk of mental health difficulties than others. These include: older people in residential and nursing facilities; older people living with long-term physical conditions and disabilities; older people living with dementia and neurodegenerative diseases; older people living in poverty; older carers; and older people from minoritised communities and immigrants.

43. NHS England (2022). Ageing well and supporting people living with frailty.
44. Villacampa-Fernandez, P., Navarro-Pardo, E., Tarin, JJ., & Cano, A. (2017). Frailty and multimorbidity: Two related yet different concepts. Maturitas 95:31-35.
45. National Institute for Health and Care Excellence (NICE) (2016). Multimorbidity: clinical assessment and management, NICE guideline NG56.
46. NHS England (2021). Falls.
47. Age UK (2019). Falls in later life: a huge concern for older people.
48. Age UK (2019). Falls in later life: a huge concern for older people.
49. 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.
50. 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.
51. Mental Health Foundation (2022). What might affect my mental health in later life?
52. NHS England (2017). Half of adults ages 55 and over have experienced common mental health problems, say Age UK.
53. Centre for Mental Health (2024). Mental health in later life: Understanding needs, policies and services in England.

The COVID-19 pandemic (and responses to it) adversely impacted the mental wellbeing of many older people. Age UK research published in February 2022[54] 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. Common challenges included disturbed sleep patterns and a lack of confidence and motivation to get back to doing normal everyday activities.

One in four older people (25%) report it feels more difficult for older people to discuss mental health issues than it is for younger people.[55] 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.[56]

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, mean these factors are likely to become more prevalent.

1.4.1 Living alone

There were 3.3 million people aged 65+ living alone in England and Wales in 2021.[57] The number of people aged 65+ living alone in England and Wales increased 14.6% between 2011 and 2021. 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+ living alone has decreased from 31.5% in 2011 to 30.1% in 2021.[58]

Older people living alone have more long-term conditions. Health Foundation analysis[59] of the patient records of 1,447 older people registered at a large general practice in south east London found nearly half (49.8%) of people aged 65 or older living alone had three or more long-term conditions, compared to 42.2% of older people living with others. The research also found that more than 1 in 4 older people living alone had a mental health condition, compared to 1 in 5 people living with others.

1.4.2 Ageing without children

The number of people aged 65+ without adult children is predicted to reach 2 million by 2030.[60] Currently, 10% of people aged 60+ have no children, while 20% of people aged 50+ have no children.[61] 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.[62] It is estimated that around 23% of men over 45 have not had children or do not have their children in their lives. The number of single and childless older people needing care is projected to increase by 80% by 2032.[63]

54. Age UK (2022). New research shows a “hidden” mental health crisis is debilitating older people.
55. NHS England (2017). Half of adults ages 55 and over have experienced common mental health problems, say Age UK.
56. NHS England (2017). Half of adults ages 55 and over have experienced common mental health problems, say Age UK.
57. ONS (2023). People’s living arrangements in England and Wales: Census 2021.
58. ONS (2023). People’s living arrangements in England and Wales: Census 2021.
59. Dreyer, K., Steventon, A., Fisher, R. & Deeny, S.R. (2018). The association between living alone and health care utilisation in older adults: a retrospective cohort study of electronic health records from a London general practice. BMC Geriatrics, 18:269.
60. Ageing Without Children (2022). What does ‘ageing without children’ mean?
61. Ageing Without Children (2022). What does ‘ageing without children’ mean?
62. Ageing Well Without Children (2019). Statistics: Facts & Figures.
63. Ageing Well Without Children (2022). What does ‘ageing without children’ mean?

Adult children are more likely to be unpaid carers compared with the rest of the population.[64] The share of adult children providing unpaid care in 2021 was 28.8% in England.[65] As well as people who have not had children either through choice, infertility or circumstance, the organisation Ageing Well 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.[66]

1.4.3 Loneliness and isolation

It is possible to feel lonely without being socially isolated, and vice versa[67]**, 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.[68] Loneliness is a recognised underlying factor in driving behaviours that contribute to poor physical health. Longitudinal research has also found higher levels of 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.[69]

One in 12 older people (8.0%) report often feeling lonely.[70] Loneliness has been shown in scientific studies to be associated with a range of poor health outcomes, including high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death.[71] 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.[72]

1.4.4 Caring responsibilities

We are moving towards a four-generation society[73] **and 'sandwich generation carers' are becoming increasingly common.**[74] 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 a twin responsibility.[75] 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.[76]

64. ONS (2023). More adults living with their parents.
65. ONS (2023). More adults living with their parents.
66. Ageing Without Children (2022). What does 'ageing without children' mean?
67. 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.
68. 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.
69. Yin, J. et al (2019). Exploring the bidirectional associations between loneliness and cognitive functioning over 10 years: the English longitudinal study of ageing. National Journal of Epidemiology, 48:6, 1937–1948.
70. 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.
71. National Institute of Ageing (2019). Social isolation, loneliness in older people pose health risks.
72. Kantar Public (2016). Trapped in a bubble: An investigation into triggers for loneliness in the UK. British Red Cross and Co-op.
73. See, for example: UK Commission for Employment and Skills (2014). Four-generation workplaces on the rise as report reveals the future of work.
74. ONS (2019). More than one in four sandwich carers report symptoms of ill health.
75. ONS (2019). More than one in four sandwich carers report symptoms of ill health.

More than 1 in 10 of the older population in England and Wales is an unpaid carer.[77] Five million people in England and Wales aged five and over reported providing unpaid care according to the Census 2021.[78] However, organisations that support unpaid carers argue the real figure is likely to be higher.[79] There were almost 1.2 million unpaid carers aged 65+ in England and Wales.[80] An estimated 1.5 million people provide 50 or more hours of unpaid care a week.[81]

Caring has a significant impact on carers' physical and mental health. Carers UK's annual State of Caring research found 82% of carers felt the impact of caring on their physical and mental health would be a challenge over the coming year – an increase from 77% in 2022.[82] Over three quarters (79%) of carers said they feel stressed or anxious, 49% feel depressed, and 50% feel lonely. More than half (54%) of carers said their physical health had suffered, and 22% said caring had caused them injuries.[83] Research by Age UK found 70% of older carers feel under strain, and 62% have lost sleep due to worry.[84]

Large numbers of older carers are putting off their own health treatment because of their caring role. Carers report it being difficult to manage the logistics and emotional labour of their own health treatment, with 44% of carers reporting they had put off health treatment because of their caring role.[85] People caring for over 50 hours a week were even more likely to put off health treatment (51%).[86] Almost half of the older carers in England and Wales are providing more than 50 hours of unpaid care a week.[87] Research by Age UK found 55% of older carers live with a long-term illness or disability themselves.[88]

77. ONS (2023). Profile of the older population living in England and Wales in 2021 and changes since 2011.
78. ONS (2023). Unpaid care, England and Wales: Census 2021.
79. See, for example: 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.
80. ONS (2023). Profile of the older population living in England and Wales in 2021 and changes since 2011.
81. ONS (2023). Unpaid care, England and Wales: Census 2021.
82. Carers UK (2023). State of Caring 2023.
83. Carers UK (2023). State of Caring 2023.
84. Age UK (2023). 1.5 million older unpaid carers (aged 65+) admit to feeling under strain.
85. Carers UK (2023). State of Caring 2023.
86. Carers UK (2023). State of Caring 2023.
87. ONS (2023). Profile of the older population living in England and Wales in 2021 and changes since 2011.
88. Age UK (2023). 1.5 million older unpaid carers (aged 65+) admit to feeling under strain.

2. Community-based treatment, care and support

There have been repeated policy commitments in recent decades to shift care away from acute hospitals and into community settings. Notable examples including the NHS Long Term Plan (2019) and its predecessor the NHS Five Year Forward View (2014), along with the Care Act 2014 and 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 1 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 within their area footprints. Part of the rationale of these local partnerships is to facilitate a shift in treatment, care and support away from the acute sector and into people's homes and communities.

2.1 Accessing treatment, care and support

2.1.1 Primary care

The largest volume of NHS activity is in primary care – people receiving services from their local GP practice (with a GP or another member of the practice staff, such as a nurse or physiotherapist). In 2023/24, there were an estimated 360.5 million appointments in general practice.[89] In recent years there has been an increase in the proportion of GP appointments conducted by telephone. However, in 2023/24 two-thirds (66.5%) of appointments were conducted face-to-face.[90]

The increase in full-time equivalent GPs is not keeping pace with the increase in demand for appointments. During the early stages of the COVID-19 pandemic, primary care appointments fell, but activity rose above pre-pandemic levels in April 2021 and has remained consistently higher since.[91] The number of total appointments in general practice, excluding COVID-19 vaccination appointments, increased by 4.9% – from 336.7 million in 2022/23[92] to 353.4 million in 2023/24.[93] Meanwhile, the number of full-time equivalent (FTE) GPs (including trainees) increased by just 2.5% between March 2023 and March 2024 – from 36,428[94] to 37,325.[95]

Older people's satisfaction with making a GP appointment has plummeted since the pandemic. There has been a steep decline in older people's satisfaction with making a GP appointment since the COVID-19 pandemic. The percentage of people aged 65+ reporting a 'Good' experience of making a GP appointment decreased from 75% in 2021 to 63% in 2022. It fell a further percentage point in 2023 and now stands at 62%.[96] See Section 2.3.1 for further analysis.

Older people are the most frequent attenders of dental services. The Office for Health Improvement & Disparities (OHID) undertook an adult oral health survey in 2021 that focused on patterns of behaviour before the COVID-19 pandemic (in order to avoid being skewed by the impacts of the pandemic and responses to it, such as periods of lockdown).[97] People aged 65+ were most likely to report they attend the dentist at least every six months (58% of those aged 65 to 74, 62% of those aged 75+). The proportion of adults who said they did not attend the dentist more frequently because they had no need to go or there was nothing wrong with their teeth decreased with age, from 71% among the youngest adults (aged 16 to 24) to 34% among those aged 65 to 74.

89. Age UK analysis of: NHS Digital (2024). Appointments in General Practice, March 2024. NHS Digital final estimate - calculated using known appointments and scaling up to factor in registered patients not included in the collection.
90. Age UK analysis of: NHS Digital (2024). Appointments in General Practice, March 2024. NHS Digital final estimate - calculated using known appointments and scaling up to factor in registered patients not included in the collection.
91. Baker, C. (2024). NHS Key Statistics: England. House of Commons Library.
92. Age UK analysis of: NHS Digital (2023). Appointments in General Practice, March 2023. NHS Digital final estimate - calculated using known appointments and scaling up to factor in registered patients not included in the collection.
93. Age UK analysis of: NHS Digital (2024). Appointments in General Practice, March 2024. NHS Digital final estimate - calculated using known appointments and scaling up to factor in registered patients not included in the collection.
94. NHS Digital (2023). General Practice Workforce, 31 March 2023.
95. NHS Digital (2024). General Practice Workforce, 31 March 2024.
96. GP Patient Survey (2023). 2023 Results [online tool]. Survey sent out in January and results published in July.
97. OHID (2024). Adult oral health survey 2021.

Many people are unable to access NHS dental treatment. In January to March 2023, 2.6 million adults were asked about their views on NHS dentistry as part of the GP Patient Survey.[98] Participants were asked if they had tried to obtain an appointment with an NHS dentist and, if so, whether they had been successful. More than half (53%) of respondents tried to get an NHS appointment in the last two years. Of these, 75% had been successful, meaning one in four had been unable to access treatment. Among those who were not successful, the most common reason was 'No, the dentist was not taking new NHS patients' (40% of unsuccessful respondents), the second was 'No, no appointments were available' (39%), with the remaining 21% unsuccessful for another reason.

Only 3% of dentists believe current plans to recover and reform NHS dentistry will lead to their practice seeing more NHS patients.[99] In February 2024, the Government published their plan to "recover and reform" NHS dentistry.[100] This included a commitment to "significantly expand access so that everyone who needs to see a dentist will be able to". The lynchpin of delivery was introducing mobile dental vans "to take dentists and surgeries to isolated under-served communities". However, in April 2024, NHS England launched a pre-procurement exercise "to understand the range of services available to achieve this and to realise the ambitions of the Dental Recovery Plan" that noted "the limited availability of vans and workforce to deliver mobile dental services".[101] Just 3% of dentists polled by the British Dental Association believe the plan will result in their practice seeing more NHS patients, with 43% reporting it will do the opposite, and lead to their practice seeing fewer NHS patients.[102]

2.1.2 Adult social care

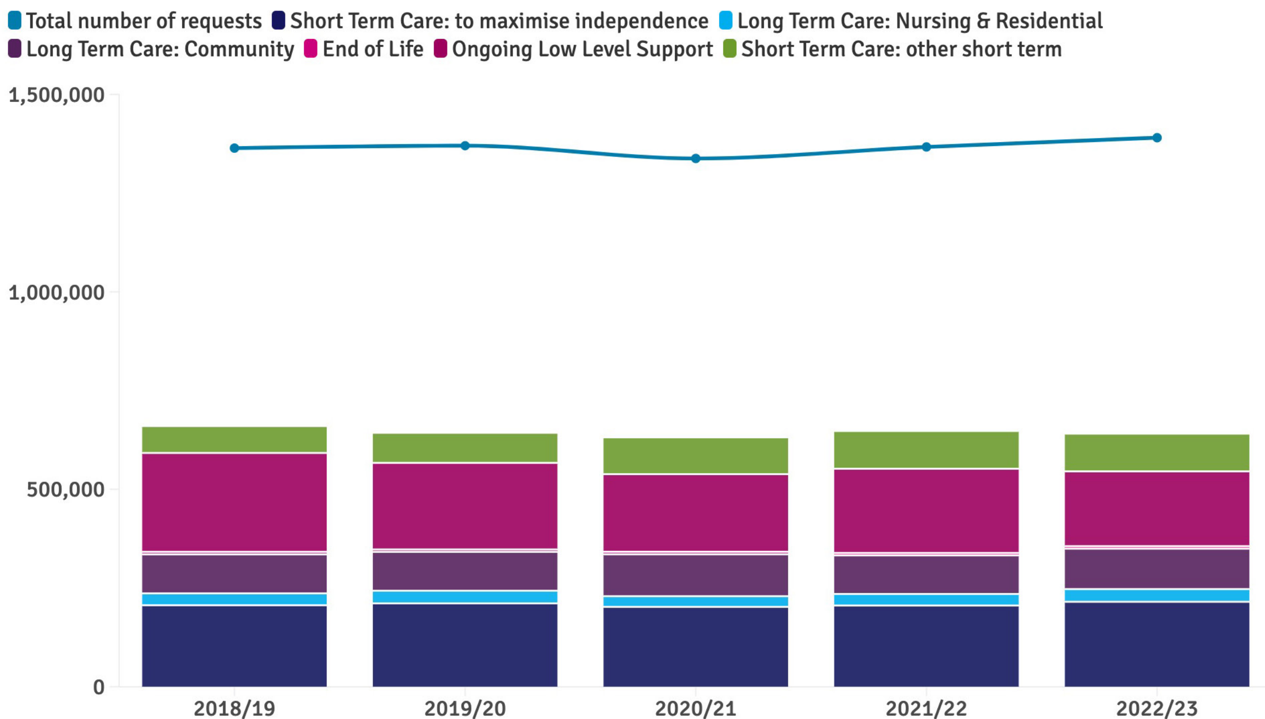
There were 1.39 million new requests for support from older people to English local authorities in 2022/23, accounting for 69.5% of all requests received by Adult Social Services Departments.[103] Adult social care means different things to different people, but usually refers to a variety of extra support and professional help to carry out essential 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 housework. It can also refer to broader activities that are essential 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.

The number of new requests for support from older people has remained broadly steady, despite the increasing older population. As shown in Figure 2.1, the total number of requests fell slightly in the COVID-19 pandemic year of 2020/21, then began to increase in 2021/22. Recorded requests for support have remained broadly flat while both the size of the older population and the number of older people living with some level of unmet or under-met need are increasing, which suggests people may be experiencing greater barriers in coming forward for help.

98. NHS England (2023). Summary of the Dental Results from the GP Patient Survey – January to March 2023.
99. Dentistry (2024). Only 1% of dentists trust the recovery plan, poll finds.
100. DHSC (2024). Faster, simpler and fairer: Our plan to recover and reform NHS dentistry.
101. NHS England (2024). NHS Mobile and Alternative Dental Services – early engagement.
102. Dentistry (2024). Only 1% of dentists trust the recovery plan, poll finds.
103. NHS Digital (2023). Adult Social Care Activity and Finance Report, England, 2022/23.

Fig 2.1 New requests for support from older people aged 65+ for long-term support for Adult Social Care is not keeping up with the growth and projected level of need

Total number of requests for social care support received from new clients aged 65+ and proportion of requests that resulted in formal service provision, 2018/19 to 2022/23, England.



Age UK 2024: Analysis using NHS Digital (2023). Adult Social Care Activity and Finance Report, England, 2022/23.

Hundreds of thousands of adults are waiting for councils to action their care. ADASS reports that in August 2023 [104] an estimated 470,576 adults were waiting for an adult social care assessment, delivery of care, implementation of a Direct Payment [105], or a review of an existing care package or Direct Payment.[106] This represents an 8.4% increase since March 2023 [107], and a 59.9% increase since September 2021 [108] [ADASS surveys are undertaken in ad hoc months]. More than half (249,589) of this total was people waiting for a care assessment, of whom more than one in three had been waiting for six months or more.[109]

104. ADASS (2023). Adult Social Care Budgets & Waiting Times: Autumn Survey Report 2023.
105. 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 (2023). Factsheet: Personal budgets and direct payments in social care.
106. ADASS (2023). Adult Social Care Budgets & Waiting Times: Autumn Survey Report 2023.
107. ADASS (2023). Spring Survey 2023.
108. ADASS (2022). Waiting for Care and Support, May 2022.
109. ADASS (2023). Adult Social Care Budgets & Waiting Times: Autumn Survey Report 2023.

Councils report having to prioritise some assessments over others. Six in 10 councils (61%) reported having to prioritise their assessment capacity 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.[110]

This means thousands of older people are waiting without care and support. ADASS notes that some will be relying on family carers, while others "will not be living a decent life and are likely to be deteriorating", and a proportion will need admission to hospital or will see their health and wellbeing significantly deteriorate.[111]

"Unpaid carers are being left to pick up the pieces of shortages in health and social care support to the detriment of their own health and wellbeing".[112] ADASS reports that 91% of Directors agree or strongly agree that unpaid carers had come forward with increased levels of need in 2022/23, and 73% of Directors observed an increase in cases of breakdown of unpaid carer arrangements.[113] Where Directors reported an increase in carer breakdown, carer burnout was the number one contributing reason.[114]

The number of new clients aged 65+ receiving long-term support increased in 2022/23 but does not appear to be keeping up with growth in the older population and associated projected level of need. Figure 2.2 shows the number of new clients receiving long-term support rose by 2.0% from 130,330 in the pre-pandemic year 2019/20 to 133,170 in 2020/21, but then fell by 4.5% to 127,115 in 2021/22. The number increased by 5.9% to 134,560 in 2022/23. However, this only represents a 3.2% increase between 2019/20 and 2022/23, despite the 5.4% growth (over half a million) in those aged 65+, and a 12.6% increase in those aged 75.

The distribution of outcomes of request for support varies across regions. As shown in Figure 2.2, in Yorkshire and The Humber 16.9% of referrals resulted in no service provided in 2022/23 (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 33.6% in the North West. The anticipated number of self-funders in an area may provide a partial explanation but it is unlikely to account for the full variation.

Figure 2.2 also shows the variation in regional trends over the last five years. Yorkshire and Humber has experienced a substantial decrease in the number of referrals since 2018/19, while the North East, West Midlands and South East have seen increases. Referral numbers in areas including London and the North East have remained steady. Figure 2.2 also demonstrates the varying impacts of the COVID-19 pandemic, with some areas seeing a spike in referrals in 2020/21, while others saw referrals fall.

110. ADASS (2022). Waiting for Care and Support, May 2022.
111. ADASS (2022). Waiting for Care and Support, May 2022.
112. ADASS (2023). Spring Survey 2023.
113. ADASS (2023). Spring Survey 2023.
114. ADASS (2023). Spring Survey 2023.

Fig 2.2 For older people aged 65+, requests for support from local authorities have highly variable outcomes across regions in England

Number of new requests for support received from people aged 65+ and number that resulted in no provision of formal services, by region, 2018/19 to 2022/23, England.

Total number of all requests | No services provided | No services provided - deceased | Universal Services/Signposted to other services

North East | North West | Yorkshire and the Humber

East Midlands | West Midlands | East of England

London | South East | South West

Number of requests: 0, 50,000, 100,000, 150,000, 200,000, 250,000

2018/19 2019/20 2020/21 2021/22 2022/23

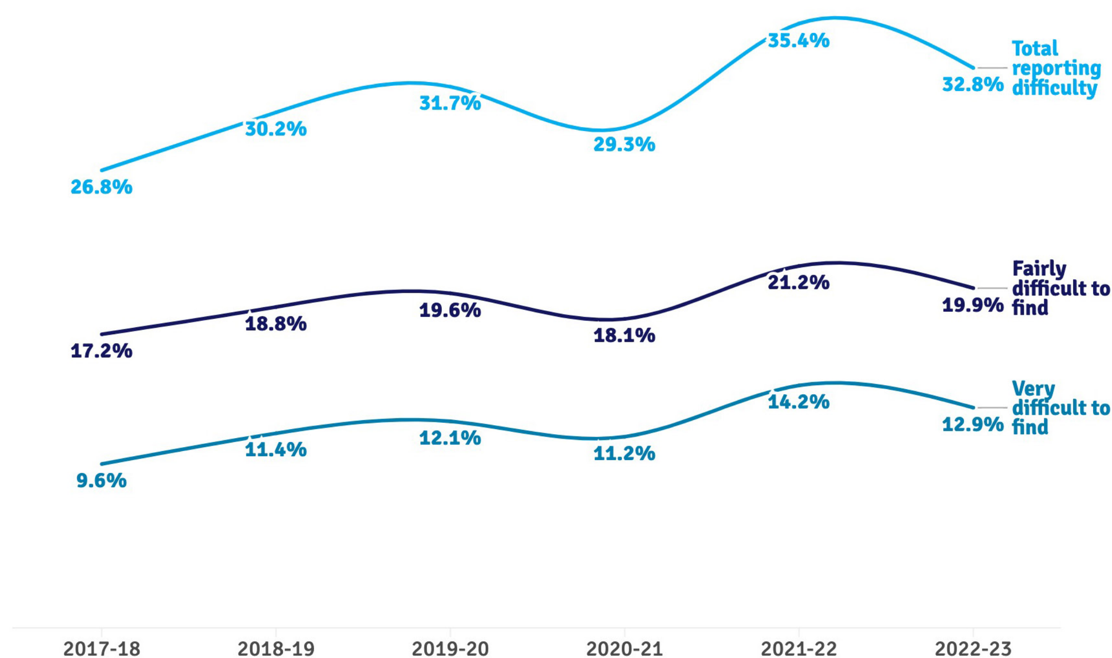
Age UK 2024: Analysis using NHS Digital (2023). Adult Social Care Activity and Finance Report, England, 2022/23.

Almost one third of people already using Adult Social Care services who seek information and advice about support, services and benefits report finding it difficult to do so – no data is available as to the experiences of people 'outside the system'. Under the Care Act 2014, local authorities have a duty to provide comprehensive information and advice about care and support services in their 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 2.3, 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. This picture has slightly improved, with 32.8% of people reporting difficulty in 2022/23, but this still means almost one third of people seeking information and advice about support, services and benefits report finding it difficult to do so. As noted above, this data pertains to people already using Adult Social Care services.

Fig 2.3 One third of people already using Adult Social Care services find it difficult to seek information and advice about support, services and benefits

People using Adult Social Care services who report finding it difficult to find information and advice about support, services or benefits, 2017/18 to 2022/23, England.



Source: Age UK 2024: Analysis using NHS Digital (2023). Personal Social Services Adult Social Care Survey, England, 2022/23

2.1.3 Home adaptations

Most older people wish to stay in their home for as long as possible[115] – home adaptations can enable this to happen. This is usually because of 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.[116] 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.[117] 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, stairlifts and ‘through the floor’ lifts.

115. Communities & Local Government Committee (CLGC) (2018). Housing for older people: Second Report of Session 2017-19. House of Commons.
116. 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.
117. Communities & Local Government Committee (CLGC) (2018). Housing for older people: Second Report of Session 2017-19. House of Commons.

Unpaid carers report decreased access to home adaptations for those they care for. The annual Survey of Adult Carers in England found there has been a year-on-year decrease since 2012/13 in the number of carers reporting access to equipment and adaptations for the person they support.[118]

Disabled Facilities Grants are capital grants 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. 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).[119] However, this statutory time limit does not include the time it takes to be assessed as eligible or any of the steps taken before the application goes in.

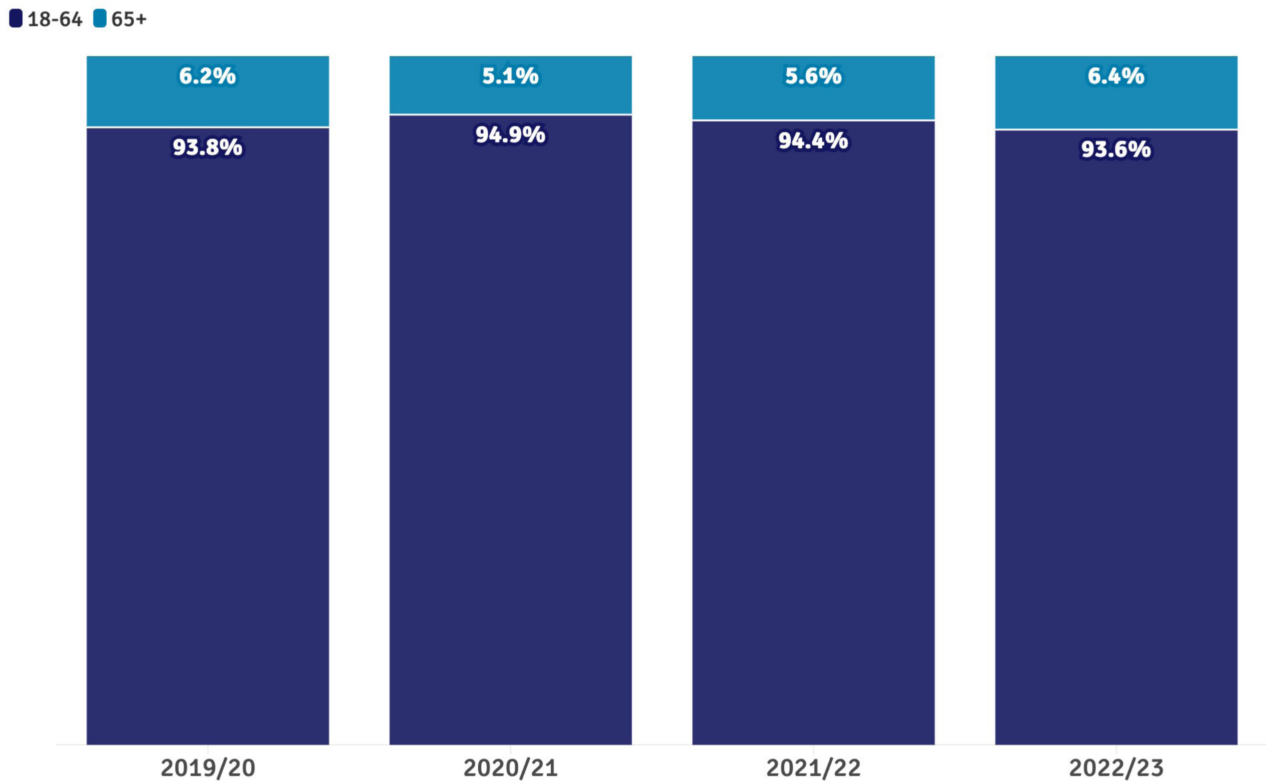
Waiting times for Disabled Facilities Grants exceed the mandated legal maximum waiting times in at least some areas. Research by the Bureau of Investigative Journalism[120] found that in some areas of England, people are left waiting for up to 12 months for an initial DFG assessment, often waiting for input by an occupational therapist 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. 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. While waiting time data is not available for all local authorities for 2022/2023, local Age UK branches report there to have been further delays due to a backlog of cases post-pandemic, with little sign of improvement.[121]

The amount of Disabled Facilities Grant available and the conditions attached to it vary across councils. In England, the maximum amount councils can give each DFG applicant is £30,000[122] – a cap that has not been raised since 2008. The 2022 Bureau of Investigative Journalism[123] 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 councils offer another £30,000, while Manchester can offer up to another £70,000. The postcode lottery is further exacerbated by the top-up being a grant in some areas and a loan in others.

2.1.4 Mental health

The percentage of referrals to NHS Talking Therapies for older people is still far short of the national expectation. In 2011, the Department of Health and Social Care said, based on estimated need at the time, that 12% of referrals through the Improving Access to Psychological Therapies (now known as NHS Talking Therapies) programme would be people aged 65+. Thirteen years later, as shown in Figure 2.4, this is still not close to being reached, with 6.4% of referrals being for people aged 65+ in 2022/23. This percentage was declining before, and dropped further during, the pandemic. For comparison, the proportion of the population of England and Wales aged 65+ increased from 16.4% in 2011 to 18.6% in 2021.[124]

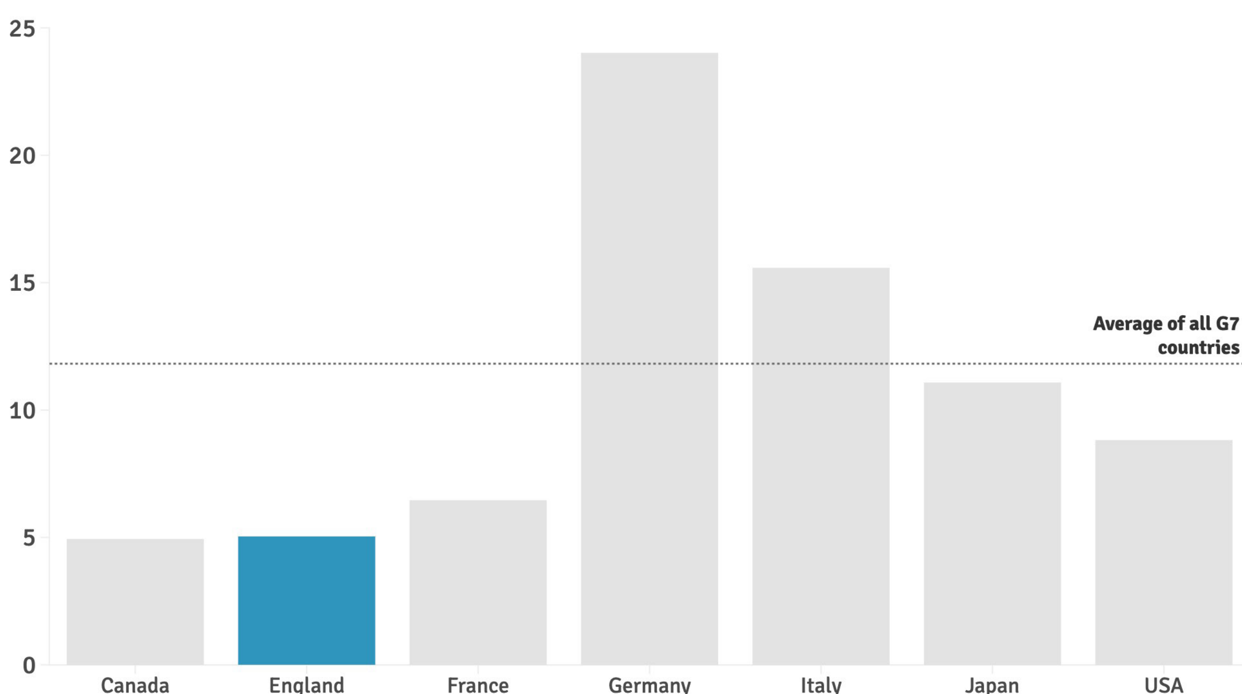
118. NHS Digital (2022). Personal Social Services Survey of Adult Carers in England, 2021/22.
119. Housing Grants, Construction and Regeneration Act 1996: c. 34 and c. 37.
120. Gayle, V., Hamada, R. & Boutaud, C. (2022). Disabled people trapped waiting years for vital home adaptations. Bureau of Investigative Journalism.
121. Age UK (2024). A Step Change: Improving delivery of the Disabled Facilities Grant.
122. DLUHC & DHSC (2022). Disabled Facilities Grant (DFG) delivery: Guidance for local authorities in England.
123. Gayle, V., Hamada, R. & Boutaud, C. (2022). Disabled people trapped waiting years for vital home adaptations. Bureau of Investigative Journalism.
124. ONS (2023). Profile of the older population living in England and Wales in 2021 and changes since 2011.



The 'Challenge on Dementia 2020' target, consistently met prior to the COVID-19 pandemic, has not been met since. The 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.[125] It 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[126] as the COVID-19 pandemic and the response to it began to impact health services – particularly the closure of memory assessment services.[127] As at 31 January 2024, 64.5% of people aged 65+ who are estimated to have dementia had a recorded diagnosis.[128] This remains short of the national target but is an improvement on 31 January 2023 when the rate was 62.0%.[129]

125. Department of Health (2015). Prime Minister's Challenge on Dementia 2020.
126. Health and Social Care Committee (2021). Supporting people with dementia and their carers. House of Commons.
127. 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.
128. NHS Digital (2024). Primary Care Dementia Data, February 2024.
129. NHS Digital (2023). Primary Care Dementia Data, February 2023.

A lack of NHS diagnostic capacity means people may not be able to access dementia treatments in time for them to be effective. Two new drugs – lecanemab and donanemab – are currently being assessed and may be licensed in 2024 for future use by the NHS in England.[130] To be eligible for either of these, a person needs to be in the early stages of dementia and have had scans to confirm high levels of amyloid in their brain. Analysis undertaken by experts from organisations including Alzheimer's Research UK, Alzheimer's Disease International and the Alzheimer's Society, has flagged concerns about the NHS's readiness to respond to new dementia drugs. Concerns include whether there are sufficient PET and MRI scanners to ensure timely and equitable access for people across the country, as well workforce capacity issues – As shown in Figure 2.5, England has the second-lowest number of specialists needed to diagnose the dementia, such as neurologists, old age psychiatrists and geriatricians among the G7 countries.[131]



2.2 Receiving treatment, care and support

2.2.1 Adult social care

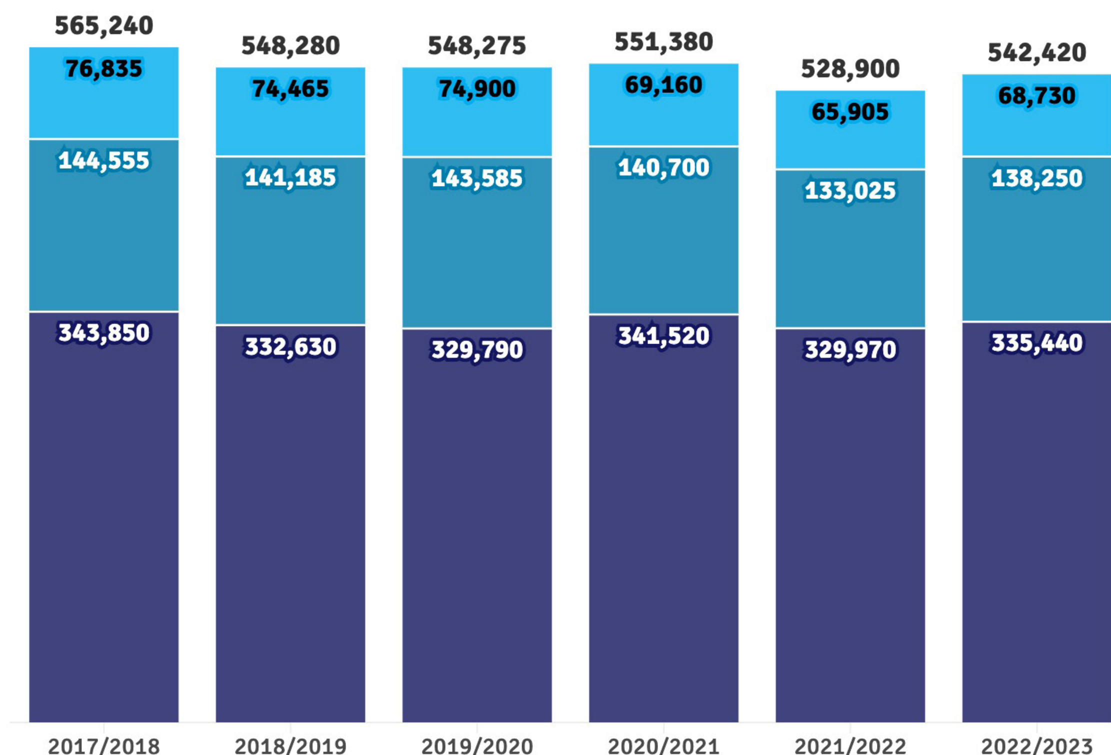
Fewer older people are receiving local authority long-term care than before the pandemic, despite the increasing older population and rise in need. As shown in Figure 2.6, the number of older people receiving local authority long-term care over the course of the year fell 1.1% between 2019/20 and 2022/23 – from 548,450 to 542,545 – despite the increasing older population and the rise in need (as described in Chapter 1).

130. Garratt, K., Rough, E. & Wilson, S. (2024). General debate: New dementia treatments – research briefing. House of Commons Library.
131. Mattke, S., Shi, Z., Hanson, M. et al. (2024). Estimated Investment Need to Increase England's Capacity to Diagnose Eligibility for an Alzheimer's Treatment to G7 Average Capacity Levels. The Journal of Prevention of Alzheimer's Disease.

Fig 2.6 Fewer older people aged 65+ are receiving local authority long-term care

Number of people aged 65+ in receipt of long-term care provided or arranged by their local authority, by support setting, 2017/18 to 2022/23, England.

Community Residential Nursing care



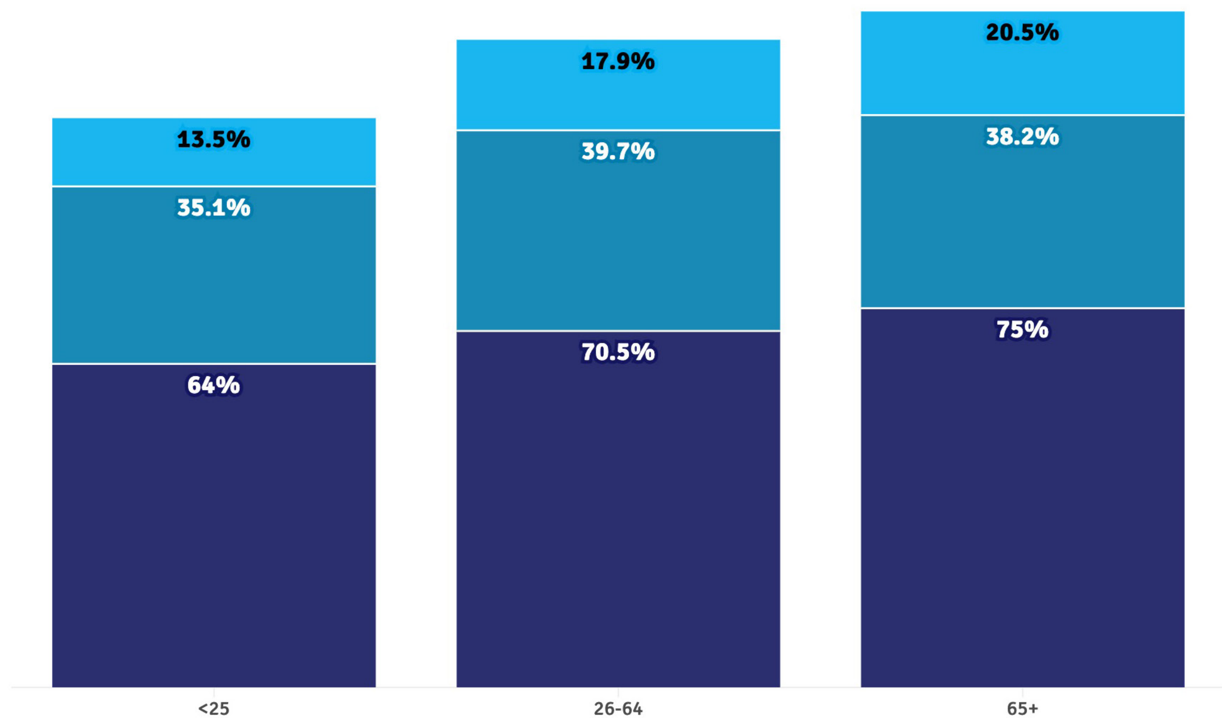
Source: Age UK 2024: Analysis using NHS Digital (2023). Adult Social Care Activity and Finance Report, England, 2022/23 • Prison CASSR has been excluded - stacked totals represent cumulative total of 'Community', 'Residential', and 'Nursing Care'.

Directors of Adult Social Services are "increasingly pessimistic about their ability to meet their legal duties within their budgets".[132] 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 putting downwards pressure on the prices paid to providers.[133] In 2021/22, just 12% of Directors of Adult Social Services were confident they had the resources to deliver on all of their legal responsibilities, falling further to just 3% feeling confident in 2022/23.[134] The latest ADASS report for 2023/24 makes clear that Directors are "increasingly pessimistic about their ability to meet their legal duties within their budgets".[135]

132. ADASS (2023). Spring Survey 2023.
133. Cromarty, H. (2019). Adult Social Care Funding (England): Briefing Paper Number CBP07903 [hard copy]. House of Commons Library.
134. ADASS (2022). Spring Budget Survey 2022.
135. ADASS (2023). Spring Survey 2023.

2.2.2 Mental health

Despite low numbers of referrals for older people, they are more likely to achieve reliable recovery / improvement than younger adults. As shown in Figure 2.4, few 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 showing reliable improvement. This is shown in Figure 2.7, with 20.5% of adults aged 65+ achieving reliable recovery/improvement in 2022/23, compared with 17.9%% of adults aged 25-64. This ought to challenge outdated assumptions about how best to treat common mental health conditions in later life.



2.3 Experiences of treatment, care and support

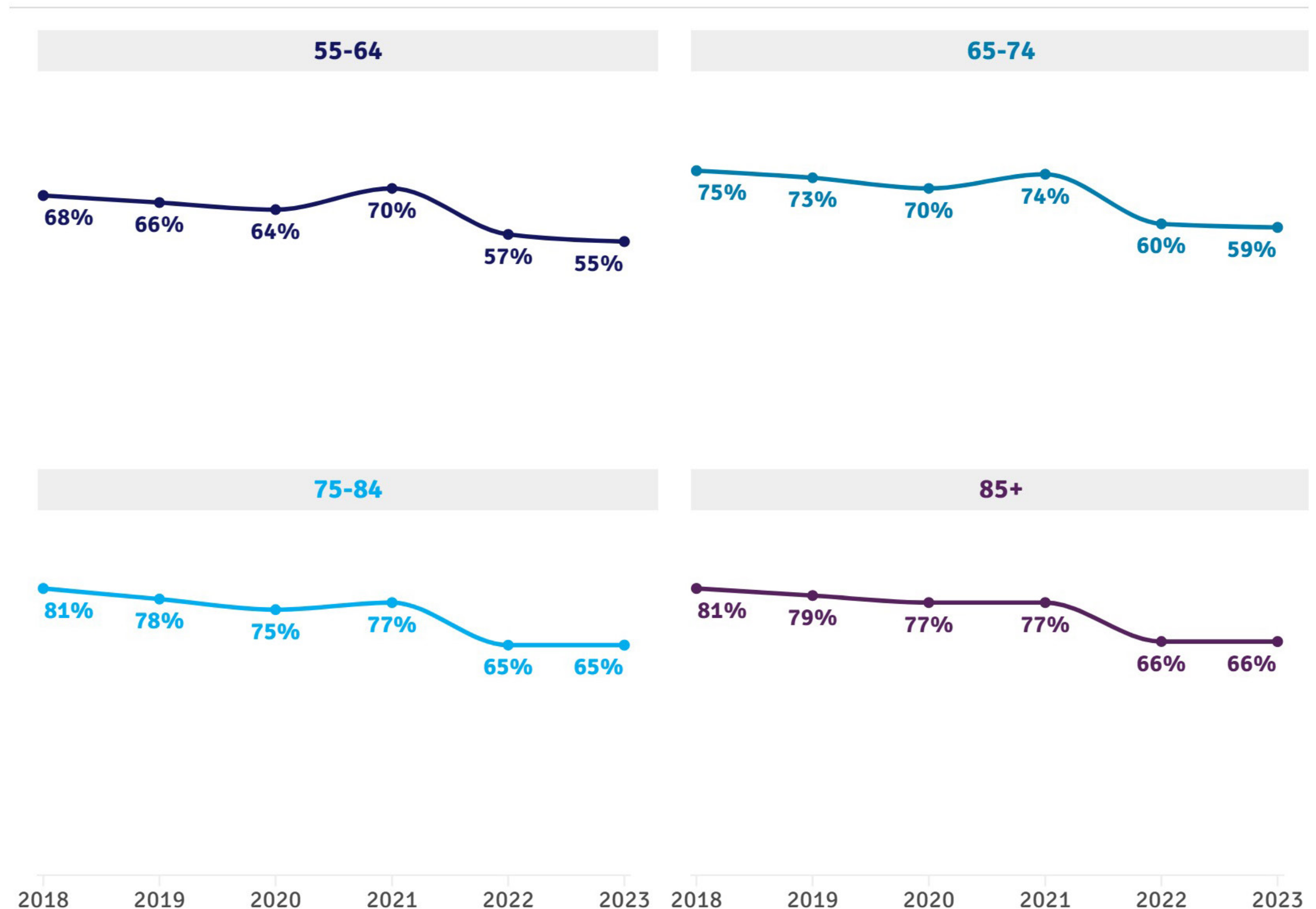
2.3.1 Primary care

Older people's satisfaction with making a GP appointment has plummeted since the COVID-19 pandemic. The GP Patient Survey runs every year, with data collected January to March. Figure 2.8 demonstrates that prior to the pandemic (from 2018 to 2020) there had been a year-on-year decrease in older people's satisfaction with making an appointment with a GP. This increased slightly in 2021, with 75% of people aged 65+ reporting a 'Good' experience, but there has since been a steep decline in older people's satisfaction. The percentage of people aged 65+ reporting a 'Good' experience of making a GP appointment decreased 12 percentage points to 63% in 2022 and fell a further percentage point in 2023 – now standing at 62%.[136]

136. GP Patient Survey (2023). 2023 Results [online tool]. Survey sent out in January and results published in July.

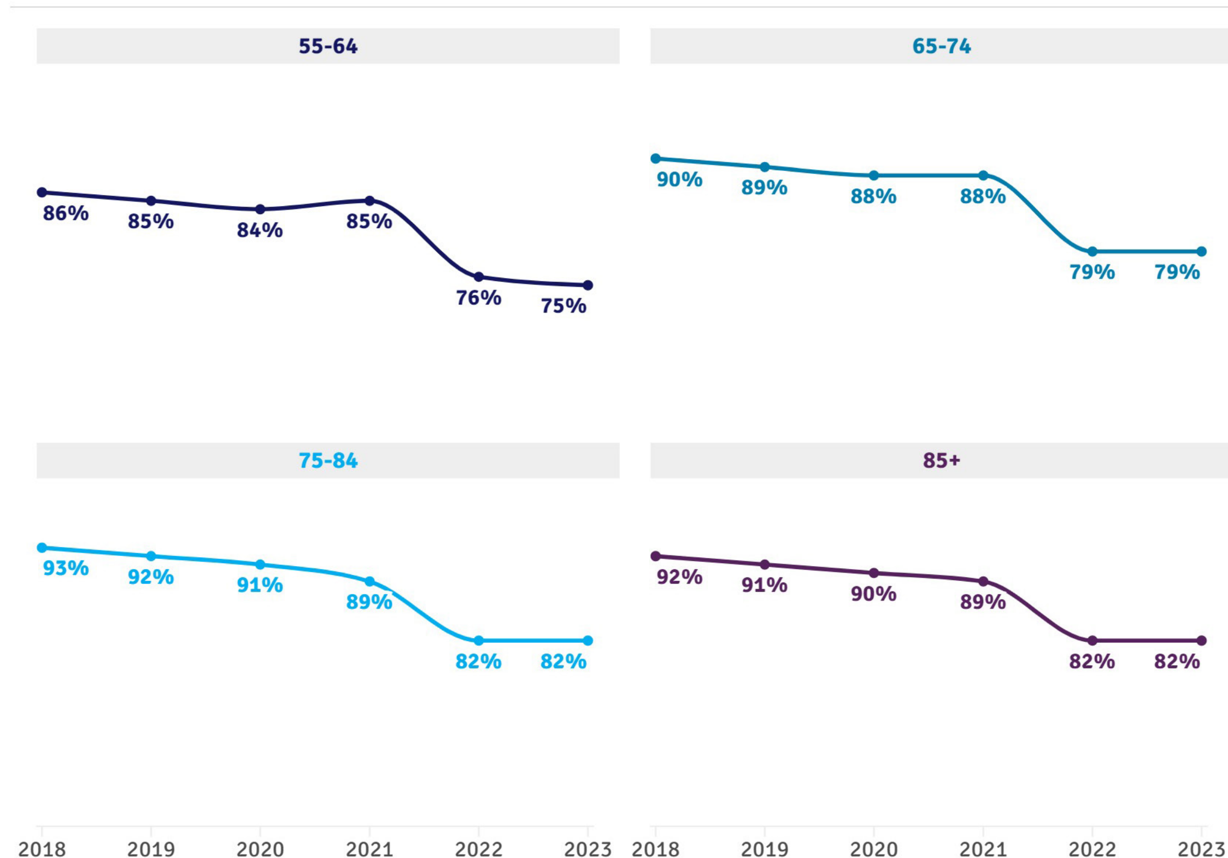
Fig 2.8 Satisfaction levels of older people making a GP appointment is lower than during the pandemic

Percentage of GP Patient Survey respondents aged 55-64 to 85+ reporting a 'Very Good' or 'Fairly Good' experience of making an appointment.



Age UK 2024: Analysis using NHS (2023). GP Patient Survey.

Older people's general satisfaction with their GP practice has also fallen since the pandemic. As shown in Figure 2.9, satisfaction was slowly decreasing prior to the COVID-19 pandemic, with the percentage of older people reporting a 'Good' experience of their GP practice falling by 1% year-on-year from 2018 to 2021. Satisfaction then plummeted by 8% in 2022 and showed no sign of recovery in 2023.



2.3.2 Adult social care

Public satisfaction with social care is at an all-time low. The British Social Attitudes survey, carried out by the National Centre for Social Care Research (NatCen) in September and October 2023, and published by the Nuffield Trust and The King's Fund, shows public satisfaction with social care services has dropped to just 13% – the lowest level ever recorded. More than half (56%) of people reporting dissatisfaction with social care said they did so because people were not getting the social care they need, while 49% said there was not enough support for unpaid carers.[137]

People who have had recent contact with social care services are more dissatisfied than people who have not. Almost two-thirds (64%) of respondents to the British Attitudes Survey who had used or had contact with social care services (for either themselves or someone else) in the past 12 months reported being dissatisfied, compared with 49% of people who had not used or had contact with social care services.[138]

Older people are more dissatisfied with social care services than people aged 18-64. Respondents to the British Attitudes Survey aged 65+ more dissatisfied (63%) than respondents aged 18–64 (55%).[139]

137. Nuffield Trust (2024). British Social Attitudes Survey: Public satisfaction with social care hits new low.
138. Nuffield Trust (2024). British Social Attitudes Survey: Public satisfaction with social care hits new low.
139. Nuffield Trust (2024). British Social Attitudes Survey: Public satisfaction with social care hits new low.

2.4 Pinch points within community-based treatment, care and support

2.4.1. Capacity in primary care

Capacity in primary care is not keeping pace with growing need. As noted in Section 2.1.1, the gradual increase in FTE GPs is not keeping pace with the increase in demand for appointments. Section 2.3.1 depicts the significant fall in older people's satisfaction with making GP appointments and with their GP practice as a whole.

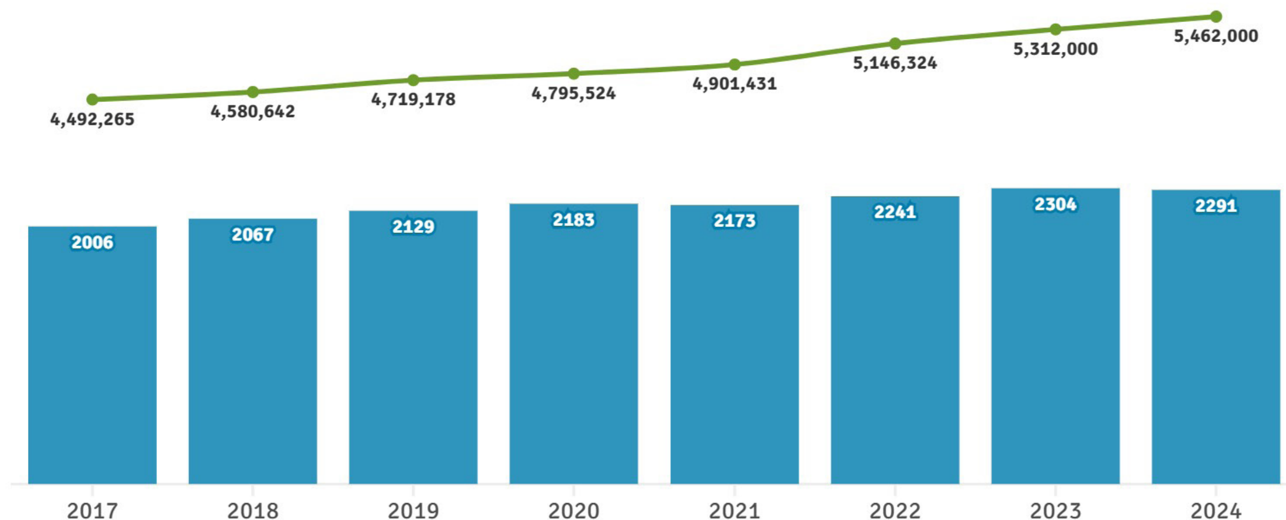
GPs are operating beyond 'safe' working practice. British Medical Association (BMA) guidance on safe working suggests that up to 25 routine doctor-patient contacts a day could be deemed 'safe' working practice, with GPs reaching 'unsafe' practice at 35 or more routine contacts a day. Anything over 15 doctor-patient contacts for long-term, complex or mental health conditions could be considered 'unsafe' due to the more demanding nature of the consultations.[140] Surveys undertaken by Pulse (a magazine and news website aimed at people working in general practice) in both 2022 [141] and 2023 [142] found GPs see an average of 37 patients within a full-time day.

Growth in the number of full-time equivalent GPs is not keeping pace with population growth of older people aged 65+. The number of people each FTE GP is responsible for has significantly increased. The number of FTE GPs (including trainees) increased by 3.1% across the decade from 30 September 2013 to 30 September 2023 – from 36,294 [143] to 37,419.[144] Yet, as set out in Chapter 1, the population increased by 6.0% between 2013 and 2022, with a 14.5% increase for over 65s, and a 20.6% increase for over 70s. As shown in Figure 2.10, the average number of patients each FTE GP is responsible for now stands at 2,291, per 100,000 patients.[145] This is an average increase of 285 patients per GP, or 14.2%, since June 2017 [146], demonstrating the increasing workload in general practice.

140. BMA (2018). Workload Control in General Practice: Ensuring Patient Safety Through Demand Management.
141. Merrifield, N. (2022). GPs working average 11-hour day, major survey reveals. Pulse.
142. Parr, E. (2023). 40% of GP practices set limit on number of patients seen per day. Pulse.
143. Health & Social Care Information Centre (2014). General and Personal Medical Services: England 2003-13.
144. NHS Digital (2023). General Practice Workforce, 30 September 2023.
145. BMA analysis of NHS Digital (2024). General Practice Workforce Statistics – February 2024, available from: BMA (2024). Pressures in general practice data analysis [accessed 11.04.2024].
146. BMA analysis of NHS Digital (2024). General Practice Workforce Statistics – February 2024, available from: BMA (2024). Pressures in general practice data analysis [accessed 11.04.2024].

Fig 2.10 Growth in the number of GPs is not keeping pace with population growth of older people aged 75+

Number of full-time equivalent GPs per 100,000 population, June 2017 to June 2024, England, against population estimates and projections of over 75's, mid 2017 to mid 2024.



Source: Age UK analysis using: NHS Digital (2024). General Practice Workforce Statistics, June 2024 - Fully qualified GPs, ONS (2024). Principal projection - England population in age groups: 2021-based interim national population projections edition of this dataset, ONS (2023). Population estimates for the UK and constituent countries by sex and age; Historical time series. • Numbers of GP represents June of each year.

The majority of primary care physicians have experienced increased workloads and emotional distress since the start of the COVID-19 pandemic. Commonwealth Fund research undertaken across 10 high-income countries including the UK in 2022, found that 91% of UK primary care physicians reported their workload to have increased since the COVID-19 pandemic began. A majority of the UK's primary care physicians also reported experiencing emotional distress since the start of the pandemic – 67% of physicians aged under 55 (second highest behind New Zealand at 74%), and 54% of physicians aged 55+ (the highest of all 10 countries).[147]

2.4.2 Sustainability of social 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 people drawing on local authority and privately funded services 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.

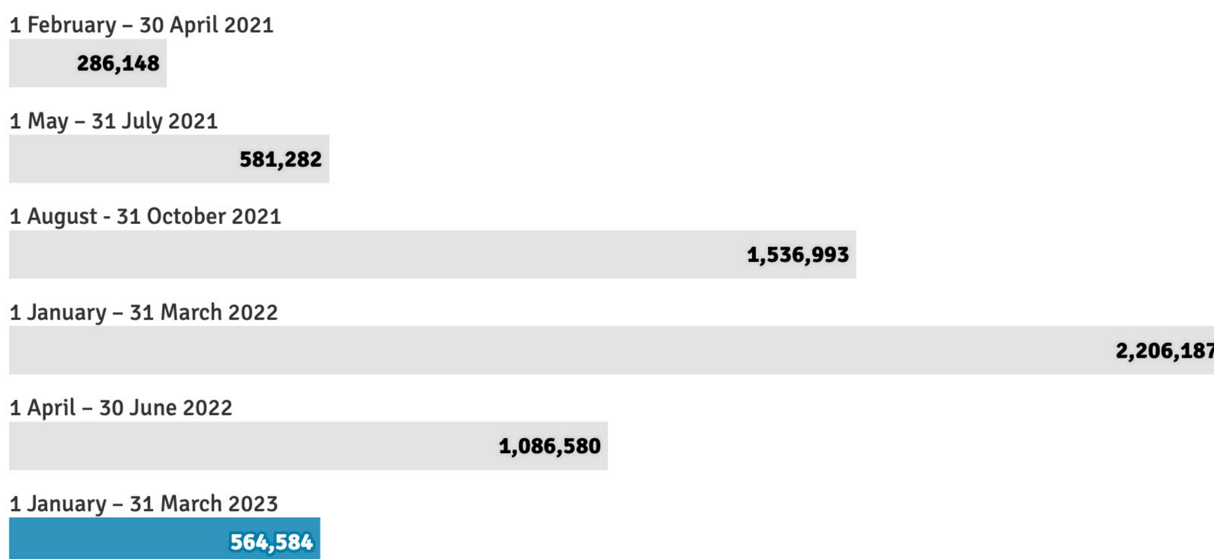
147. The Commonwealth Fund (2022). Stressed Out and Burned Out: The Global Primary Care Crisis.

Two-thirds (66%) of Directors of Adult Social Services reported residential and homecare providers in their area had closed or handed back contracts in 2022/23.[148] This is significantly higher than during the pre-pandemic period of October 2019 to March 2020, when 43% of Directors reported providers in their area to have closed or handed back contracts.[149] ADASS cites rising overheads such as rents, food and electricity to be of particular concern for residential providers, with workforce challenges a continuing challenge for all providers. ADASS notes the prevalence of provider closure and contract hand-backs to "demonstrate the fragility of a care system which is threatened by market forces" and recognises "these changes can have a significant impact on people's lives" including increased mortality.[150]

Thousands of hours of homecare are not being delivered because of staff capacity issues. The home care market has been significantly exposed to challenges in public funding, particularly since 2010/11 austerity halted strong pre-recession growth in the number of homecare contact hours paid for by local authorities. Overall, the total amount of home care delivered fell by 3 million hours between 2015 and 2018.[151] 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 January-March 2023.[152] However, as shown in Figure 2.11, local authorities continue to struggle, with 564,584 hours (48%) of home care not delivered due to staff capacity. This is below the peak of 2,206,187 hours (50.7%) in 2022 but is nonetheless almost double the amount in an equivalent period in 2021 (286,148 hours).

Fig 2.11 Local authorities continue to struggle with 564,584 hours of homecare not delivered due to staffing capacity

Number of homecare hours not delivered by local authorities due to staffing capacity (directly, arranged by and/or funded by Adult Social Services Departments), 2021 to 2023, England



Source: Age UK 2024: Analysis using ADASS (2023). ADASS Spring Survey 2023.

148. ADASS (2023). Spring Survey 2023.
149. ADASS (2021). Written evidence submitted by the Association of Directors of Adult Social Services to the Public Accounts Committee Inquiry into Adult Social Care Markets.
150. ADASS (2023). Spring Survey 2023.
151. (£) Laing, W. (2019). Homecare and Supported Living: UK Market Report, Second Edition.
152. ADASS (2023). Spring Survey 2023.

This means people are not getting essential care and support, leading to an increase in unmet need and under-met need. These are all people who have been assessed as eligible for state-funded care and support. ADASS reports this will “restrict their ability to live full lives, and… for some, foreshorten life”.[153] 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.[154] And the challenges are not unique to local authority arranged and/or funded care. The Care Quality Commission reports homecare providers in their Market Oversight scheme have been limited in the number of homecare hours they can deliver because of workforce challenges, with hours down nearly 15% in the last 2 years.[155]

Where homecare is being delivered, it may be delayed, limited, or not as specified. A 2023 Care Quality Commission (CQC) survey of adult social care providers found that less urgent visits are not being prioritised.[156] This includes, for example: calls that should have two care workers being delivered by only one person, with too little time allocated to each visit; overloaded rotas; overlapping call times; and not allowing for travel time between clients. Respondents echo ADASS’s findings, reporting packages of homecare being cut, delayed or not delivered at all, with the CQC noting that less time spent with people “reduces the amount of care they are receiving, which can lead to a deterioration in their quality of life”.[157]

Community based care has not expanded to keep up with demand. As shown in Figure 2.12, although the number of registered care home services increased by 37% between 2018 and 2023, the direct care workforce in the sector only increased by 6.7%, from 450,000 in 2017/18 to 480,000 in 2022/23.

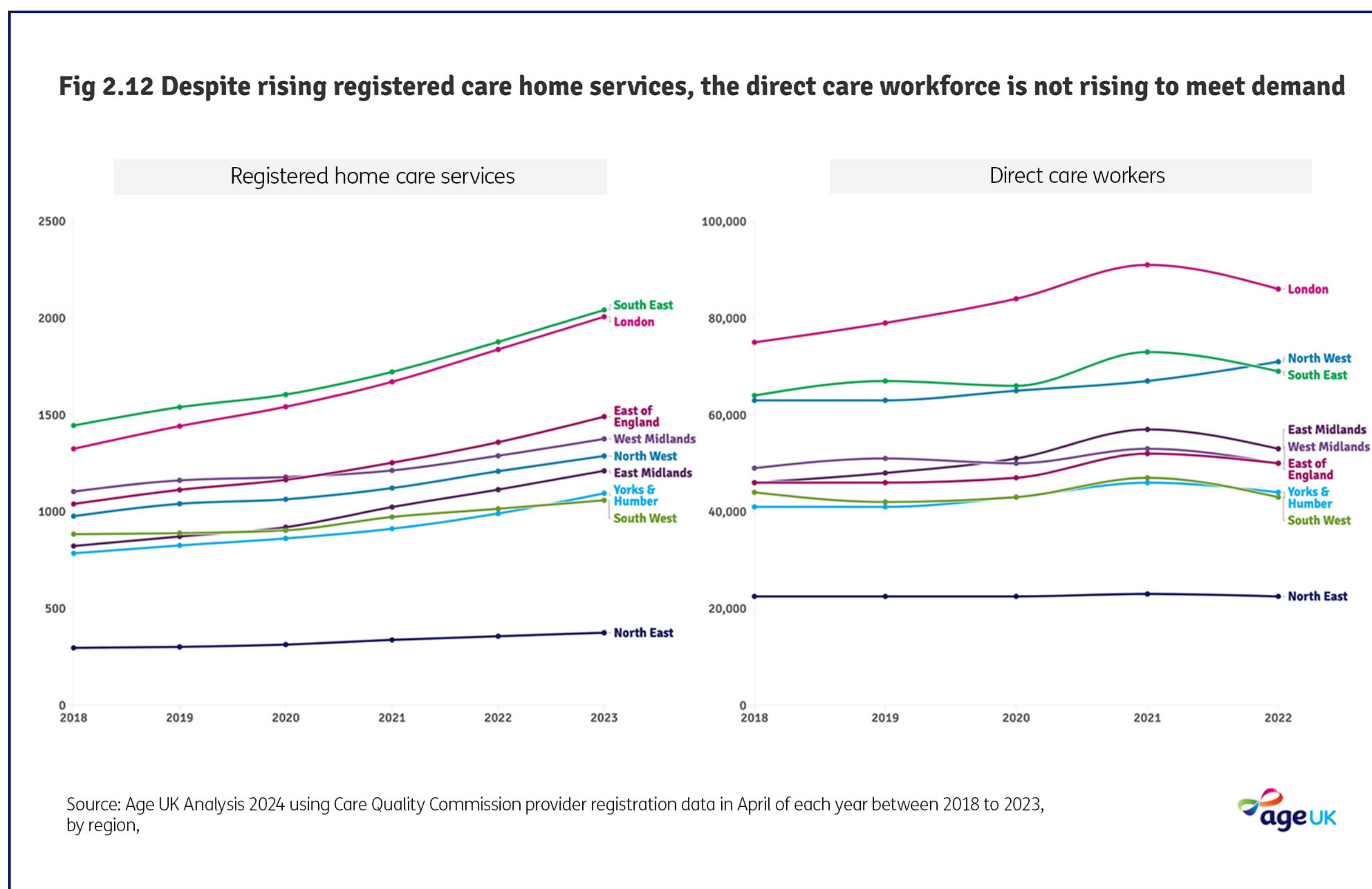


Fig 2.12 Despite rising registered care home services, the direct care workforce is not rising to meet demand

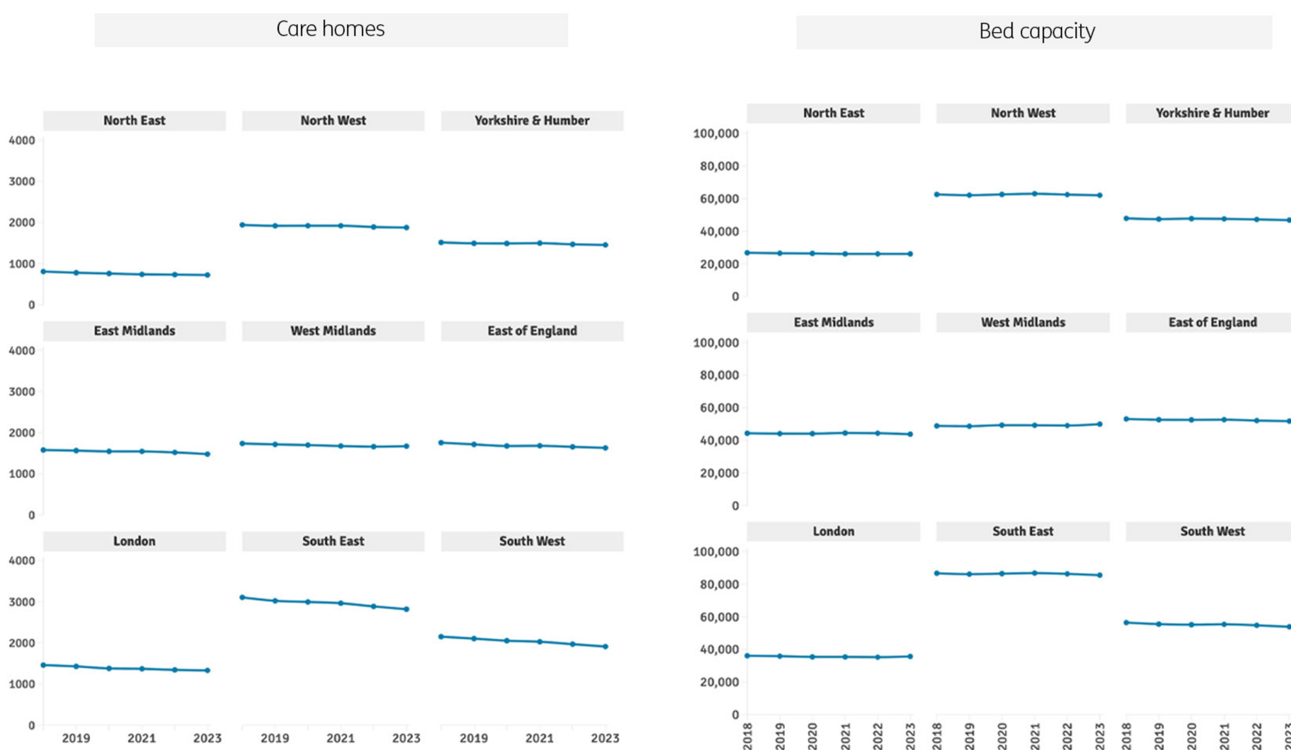
Source: Age UK Analysis 2024 using Care Quality Commission provider registration data in April of each year between 2018 to 2023, by region,

153. ADASS (2022). Autumn Survey Report 2022.
154. ADASS (2023). Spring Survey 2023.
155. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.
156. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.
157. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.

Care home profitability remains at historically low levels according to data from the Care Quality Commission's Market Oversight scheme.[158] Like the homecare market, the care home market was challenged prior to the COVID-19 pandemic. As shown in Figure 2.13, the number of care homes has declined across England by 7.1% in registered locations since 2018.[159] Over the last 6 years, total bed capacity as fallen by 1.4% across England, which ranges from an increase of 2.2% in the West Midlands, to decrease of 4.6% in the South West.[160]

The CQC reports that while much of the pressure has been a result of staff costs, between October 2022 and March 2023, they saw the impact on profitability because of increases in non-staff costs, including gas and electricity price rises, as well as inflation in food and other costs.[161]

Fig 2.13 Social care service providers are struggling to remain viable, as bed capacity and the number of care homes across England are declining



Source: Age UK Analysis 2024 using Care Quality Commission provider registration data in April of each year between 2018 to 2023, by region, England , Skills for Care (2024). Adult Social Care Workforce Data.

Older people and families are increasingly making up these shortfalls 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 individuals for the equivalent standard of care".[162] In November 2022, the then Government paused these reforms for a further three years.[163] In July 2024, the newly elected Government decided not to proceed with them full stop.

158. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.
159. Age UK Analysis 2024 using: Care Quality Commission provider registration data in April of each year between 2018 to 2023, by region, England.
160. Age UK Analysis 2024 using: Care Quality Commission provider registration data in April of each year between 2018 to 2023, by region, England.
161. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.
162. Prime Minister's Office, 10 Downing Street (2021). Record £36 billion investment to reform NHS and social care [press release].
163. Foster, D. (2022). Proposed adult social care charging reforms (including cap on care costs). House of Commons Library.

2.4.3 Navigating social care

Many adults are confused about who is responsible for providing them with social care, where to go if they need help, and the process for accessing support. Healthwatch research undertaken in 2022 found people who try to access support are largely unaware that local authorities are responsible for adult social care. They are more likely to speak to their GP or another NHS worker (42%) than their local authority (15%).[164] Healthwatch also found people to be confused about the purpose of adult social care assessments, with only 40% of respondents aware that the assessment determines eligibility for state-funded/arrange care and support.[165] These findings echo research by the Health Foundation undertaken in 2023 which found 31% of people neither agree nor disagree and 25% say they do not know whether social care services in their area are good. Asked whether local NHS services were good, 26% neither agree nor disagree and 2% don't know – highlighting the relative lack of public awareness of social care compared to the health service.[166]

People from lower-income households are less likely to know where to go if they need help, or what the process is for accessing support. Healthwatch's research found a correlation between household income and awareness of social care provision and process, with those from more well-off households more likely to know their local authority is responsible for social care. Men from lower-income households were more likely to be confused about the process of accessing care and support than any other.[167]

Navigating social care requires a range of skills that people may not have. Research by the National Institute for Health and Social Care Research (NIHR) undertaken in 2021 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.[168] While some people have friends or family that 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.

2.4.4 Medicine shortages

"[T]he past two years have seen constantly elevated medicines shortages, in a new normal of frequent disruption to crucial products, which if anything worsened in 2023".[169] In November 2023, the British Generic Manufacturers Association (BGMA) reported a record number of products to be facing supply issues, citing treatment areas with issues including diabetes, lung conditions, osteoporosis, heart disease, and depression.[170] By January 2024, BGMA analysis indicated a 100% increase in shortages compared with January 2022.[171]

The majority of prescription items are dispensed to people aged 60+. Of the more than 1.2 billion prescription items dispensed in the community in 2023/24, , 61.2% were dispensed to people aged 60+.[172] This percentage has increased – as would be expected with a growing older population – rising from 59.6% when first reported in 2014/15.[173] This will mean that older people are more exposed to the risks of medicines shortage compared to other age groups. Healthwatch reported in April 2024 that 'three in ten (30%) of those over 65 said they had a problem getting medicine in the last year because of shortages, compared to 15% of people aged 18-to-24'.[174]

164. Healthwatch (2022). Getting social care right starts with good information and advice. Polling undertaken by YouGov on a representative sample of 1,800 adults living in England.
165. Healthwatch (2022). Getting social care right starts with good information and advice. Polling undertaken by YouGov on a representative sample of 1,800 adults living in England.
166. Allen, L, Briggs, A., Burale, H. et al (2023). Public perceptions of health and social care: what are the priorities ahead of a general election? Health Foundation.
167. Healthwatch (2022). Getting social care right starts with good information and advice. Polling undertaken by YouGov on a representative sample of 1,800 adults living in England.
168. NIHR (2021). People who fund their own social care receive little help to navigate the system.
169. Dayan, M,, Hervey, T., McCarey, M., Fahy, N., Flear, M., Greer, S.L. & Jarman, H (2024). The future for health after Brexit. Nuffield Trust.
170. BGMA (2023). Spiralling VPAS rebate starts to bite as record number of medicines face supply issues.
171. Duddy, C. (2024). Medicines shortages. House of Commons Library.
172. NHS Business Services Authority (2024). Prescription Cost Analysis – England 2023/24.
173. NHS Business Services Authority (2024). Prescription Cost Analysis – England 2023/24.
174. Healthwatch (2024). Pharmacy: what people want.

Pharmacists report people being at risk of immediate harm and even death due to shortages. In 2023, 92% of respondents to a survey of people working in pharmacies undertaken by Community Pharmacy England reported daily supply issues[175], and 87% said their patients' health was being put a risk due to medicine supply issues.[176] In 2024, Community Pharmacy England reported 91% of pharmacy owners said they had seen a "significant increase" in the problem since last year.[177]

Health charities report drastic deterioration in some people's health and wellbeing due to shortages. For example, Parkinson's UK warned people had been left with "devastating effects" after being switched to a generic version of Sinemet (carbidopa/levodopa) due to shortages, citing one patient, who had lived well with Parkinson's for 17 years but who developed slow speech, and was left in pain and with an uncontrolled tremor after his medication was switched.[178] Epilepsy Action reported in February 2024 that their helpline had seen five times as many enquiries on medication stock than in the previous year, with some people reporting the stress had triggered more seizures.[179]

2.4.5 A paucity of data but a concern for older people: Continence Care

Urinary and faecal incontinence are not inevitable consequences of ageing but are closely associated with age. There is no centrally collected official data on the number of people with continence care needs.[180] However, NHS England's guidance on continence care cites research that estimates 14 million people (adults and children) in the UK to have some degree of urinary incontinence, 6.5 million adults to have some form of bowel problem, and over 500,000 adults to have faecal incontinence.[181] Urinary incontinence increases with age and is common in people aged 80+.[182] Severe urinary incontinence in women aged 70-80 is about double that of men.[183] Faecal incontinence is also closely associated with age.[184]

The National Audit of Continence Care found the quality of continence care to be worse among people aged 65+ than in other age groups.[185] The National Audit also found many services were not providing care in line with NICE guidance.[186] NHS England has since published its Excellence in Continence Care guidance, however the Government has made no assessment of its implementation and does not intend to do so.[187] Effective community-based continence services can restore dignity to people and improve quality of life.[188] They can also save valuable NHS resources.[189] Research undertaken by the University of West England found the quality of continence care to be a predisposing factor to nursing and residential home placement.[190]

In older people, incontinence and associated bladder and bowel disorders may be associated with skin breakdown, falls, urine infection and catheter associated urinary tract infection which in turn often causes confusion.[191] Confusion can result in falls, head injury or femur fractures requiring an acute hospital admission. NHS England reports incontinence or dependence on a urinary catheter to significantly increase the level of dependency in frail older people, which may delay discharge from hospital or initiate a move into a residential or nursing care setting.[192]

175. Community Pharmacy England (2023). Our response to BGMA report on medicines supply issues.
176. Community Pharmacy England (2024). NHS medicines shortages putting lives at risk.
177. Campbell, D. (2024). Medicine shortages in England 'beyond critical', pharmacists warn. The Guardian.
178. Robinson, J. (2023). 'Devastating effects' caused by switching between branded and generic Parkinson's disease medication. The Pharmaceutical Journal.
179. Epilepsy Action (2024). Epilepsy medicine shortages continue.
180. Lewis, A. & Powell, T. (2023). Research briefing: Bladder and bowel continence care. House of Commons Library.
181. NHS England (2018). Excellence in Continence Care: Practical guidance for commissioners, and leaders in health and social care.
182. NHS (2024). Urinary incontinence: Causes.
183. Nitti, V.W. (2001). The Prevalence of Urinary Incontinence. Reviews in Urology. 3(1): S2–S6.
184. NHS England (2018). Excellence in Continence Care: Practical guidance for commissioners, and leaders in health and social care.
185. Royal College of Physicians (2012). National Audit of Continence Care (NACC).
186. Royal College of Physicians (2012). National Audit of Continence Care (NACC).
187. Markham, N. (2023). UK Parliament: Written question, HL 610, tabled 27 November 2023, answered 11 December 2023. London: House of Lords
188. APPG for Continence (2013). Continence Care Services: England 2013 Survey Report.
189. APPG for Continence (2013). Continence Care Services: England 2013 Survey Report.
190. Percival, J., Abbott, K., Allain, T., et al (2021). 'We tend to get pad happy': a qualitative study of health practitioners' perspectives on the quality of continence care for older people in hospital. BMJ Open Quality 10:e001380.
191. NHS England (2018). Excellence in Continence Care: Practical guidance for commissioners, and leaders in health and social care.
192. NHS England (2018). Excellence in Continence Care: Practical guidance for commissioners, and leaders in health and social care.

3. Impact on older people, their families and 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. Directors of Adult Social Services report they plan to deliver £806 million in savings in 2023/24, equating to about 4% of net adult social care budgets.[193] 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. The Local Government Information Unit's annual finance survey found 16.2% of councils intend to cut adult social care services in 2024/25.[194]

Half of councils in England could effectively declare bankruptcy in the next five years, further impacting older people, their families, and carers. Half of councils (51%) have warned they are likely to issue a section 114 notice in the next five years, and 14 local authorities (9%) said they are likely to issue such a notice within the next financial year.[195] Section 114 notices are issued by a council's chief finance officer if they consider in-year expenditure is likely to exceed available resources, or if there is no prospect of setting a balanced budget for the year ahead. The Local Government Information Unit warns there is "a huge shift away from section 114 notices as exceptions… towards section 114 notices as a normal occurrence".[196]

Some older people funding their own care are also going without the care they need. The Care Quality Commission recently concluded that some self-funders are going without some of the care they need because of the cost-of-living crisis, increased provider fees and, in some instances, lack of capacity in the market to provide the full services required.[197]

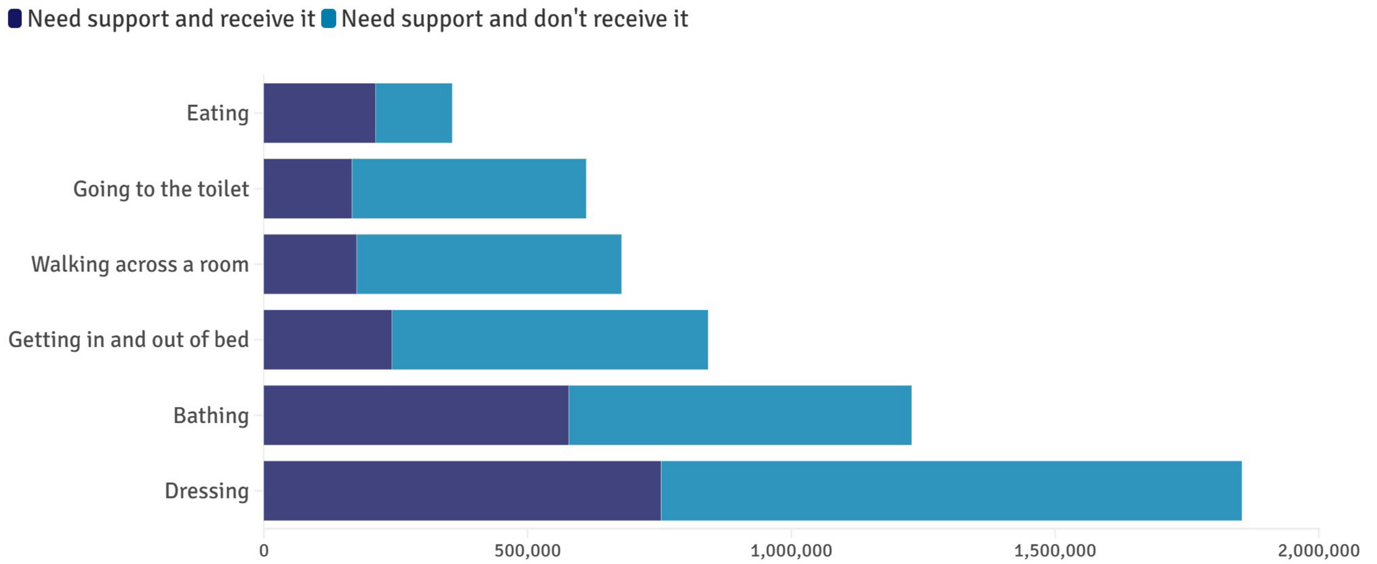
An estimated 2 million people aged 65+ have unmet needs for care and support.[198] This includes hundreds of thousands of people who are unable to complete three or more ADLs and receive no help or help that does not meet their needs.

One in five older people report needing help with specific essential everyday tasks – further revealing the levels of unmet need. Figure 3.1 shows that a large proportion 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.

193. ADASS (2023). Spring Survey 2023.
194. Stride, G. & Woods, M. (2024). The State of Local Government Finance in England 2024. Local Government Information Unit (LGIU).
195. Stride, G. & Woods, M. (2024). The State of Local Government Finance in England 2024. Local Government Information Unit (LGIU).
196. Stride, G. & Woods, M. (2024). The State of Local Government Finance in England 2024. Local Government Information Unit (LGIU).
197. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.
198. Age UK 2024: Analysis using English Longitudinal Study of Ageing (ELSA). Wave 10. 2021-23.

Fig 3.1 A large proportion of people aged 65+ report needing help with essential everyday tasks but do not receive it – further revealing the levels of unmet need

Number of people aged 65+ who need support with various ADL needs, broken down by whether or not they receive help, 2022/23, England.

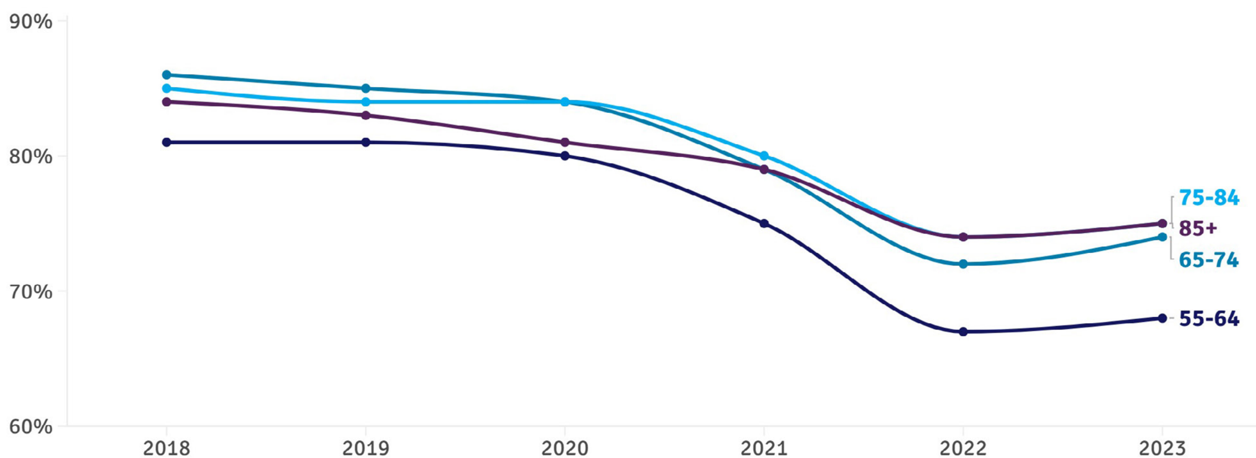


Source: Age UK 2024: Analysis using English Longitudinal Study of Ageing (ELSA), Wave 10, 2021-23, ONS (2024): Estimates of the population for the UK, England.

The proportion of older people feeling supported to manage their long-term condition/s has significantly fallen over the last five years. Prior to the pandemic, people aged 85+ were feeling the least supported to manage their long-term condition/s. However, as Figure 3.2 shows, the proportion of older people aged 65+ who feel supported has dropped to similar levels: for the 55 to 64 group, this has dropped by 13%, by 12% for 65 to 74, 10% for 75-84 and by 9% for 85+, since 2018.

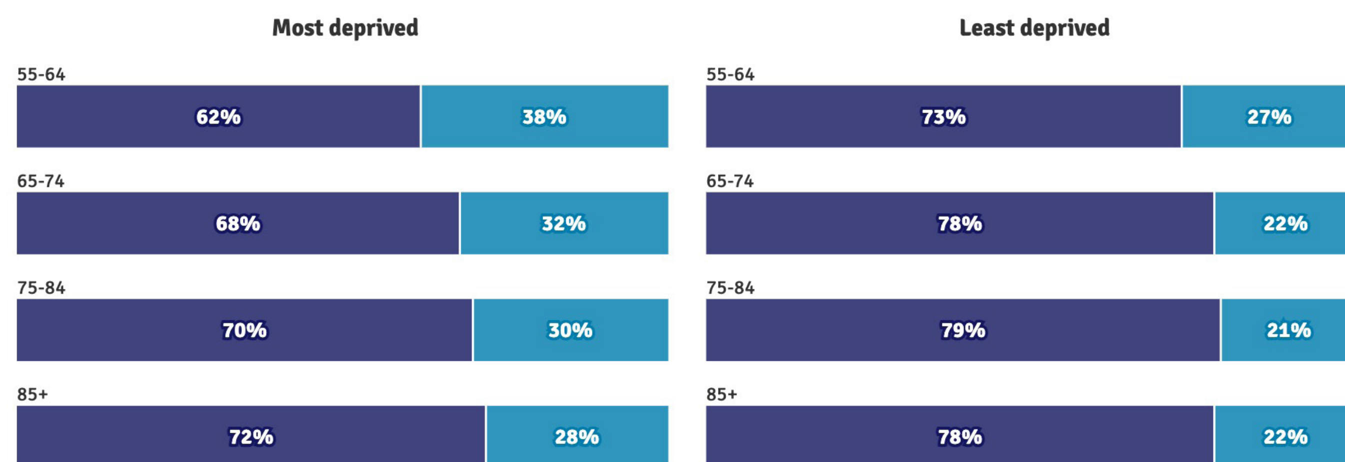
Fig 3.2 Older people feeling supported by local services or organisations to manage their long-term condition/s has fallen

Percentage of older people who felt they had enough support from local services or organisations to manage their long-term condition/s, by age, 2018 to 2023



Source: Age UK 2024: Analysis using NHS (2023). GP Patient Survey.

People living in the most deprived areas of England feel less supported to manage their long-term conditions than people living in the least deprived areas. Around three-quarters (74%) of people aged 65+ living in the most deprived areas of England feel they have had enough support from their local services or organisations to manage their long-term condition/s.[199] As shown in Figure 3.3, this falls to 68% of people aged 65-74 living in the most deprived areas, which contrasts with 78% of people living in the least deprived areas.[200]



3.1.1 Private expenditure on healthcare

Use of private healthcare is increasing. Research undertaken for Engage Britain in July 2022 found 10% of respondents to a nationally representative survey (n=2075) reported using private healthcare in the previous 12 months.[201] The number of people paying to see a private GP also appears to be rising, with one provider of private general practice reporting a 41% like-for-like increase in the number of GP appointments it provided in the first six months of 2023 compared with the first six months of 2022.[202] Take up of health insurance also appears to be increasing, with one of the UK's largest healthcare insurers reporting a 22.2% increase in the number of people covered by its private medical insurance between 2020 and 2022.[203]

199. GP Patient Survey (2023). 2023 Results [online tool]. Survey sent out in January and results published in July.
200. GP Patient Survey (2023). 2023 Results [online tool]. Survey sent out in January and results published in July.
201. Engage Britain (2022). Millions turning to private healthcare forced into financial worry.
202. Spire Healthcare (2023). Spire Healthcare results for the six months ended 30 June 2023.
203. (£) Neville, S., Alabi, L.O. & Cocco, F. (2023). Britons turn to private healthcare as NHS crisis worsens. Financial Times.

People use private healthcare for a full range of healthcare needs; however, consultations and diagnostic treatments appear to be most popular. A nationally representative survey (n=2003) for the Independent Healthcare Providers Network, found 44.3% of people who had used private healthcare had done so to have a consultation with a doctor, while 31.7% had had a consultation with another healthcare professional, and 29.9% had had a diagnostic treatment (such as a scan).[204] Further research by the Patients Association found people place such importance on diagnostics that 60% would consider paying for the tests they need if they faced a long wait on the NHS.[205] Minor operations (where the person returns home the same day) were also popular, with 27.6% of people who had used private healthcare reporting they had accessed these services, but major operations (requiring at least one overnight stay) and ongoing treatment for serious problems (such as cancer) were less popular, at 18.5% and 4.4% respectively.[206] These trends perhaps reflect more people being able to afford self-paying for lower cost clinic, rather than higher cost hospital activity. LaingBuisson reports self-funder activity volumes appeared to have plateaued in the hospital sector in 2022/23 – at around 71,000 reported activities per quarter across 2022/23, up from a steady 50,000 activities per quarter reported in 2019. However, they suspect there to be considerable unreported activity in the clinic sector, "where it is estimated that almost half of revenues are generated from self-funders".[207]

Increases in private expenditure on healthcare are driven by procedures usually undertaken by older people. According to the Private Healthcare Information Network, cataract procedures continued to be the top procedure by volume in the period July-to-September-2023.[208] Developing cataracts is a common experience of ageing. Most people start to develop cataracts after the age of 65, though some people in their forties and fifties can also develop cataracts.[209] The biggest increases by volume for the most common procedures between the periods July to September 2022 and July to September 2023 was upper gastrointestinal endoscopies, which increased by 6%, followed by primary hip replacement at 4%.[210] In the NHS, the large majority of people in receipt of hip replacement procedures are aged 50+ (93.9% in 2021/22).[211]

Increasing use of private healthcare risks widening inequalities. Research undertaken by Healthwatch, based on the experiences of 65,000 people, found 40% of employed people who described their financial status as 'very comfortable' reported having access to free or discounted private GP appointments through their place of work, compared to 10% of employed people who described themselves as 'just getting by' and 'really struggling'.[212] The same trends were found in relation to access to private physiotherapy and mental healthcare. Healthwatch also concluded that people in better jobs / financial positions were much more likely to access health-related workplace benefits.[213] The employment rate for people aged 65+ was 11.4% in the period January to March 2024, meaning the large majority of older people will not have access to work-based benefit like private healthcare.[214] The research undertaken for Engage Britain cited above, found that of the 10% of respondents reporting they had used private healthcare in the previous 12 months, almost half (46%) said they had had to cut back on spending, use savings, or go into debt to do so.[215]

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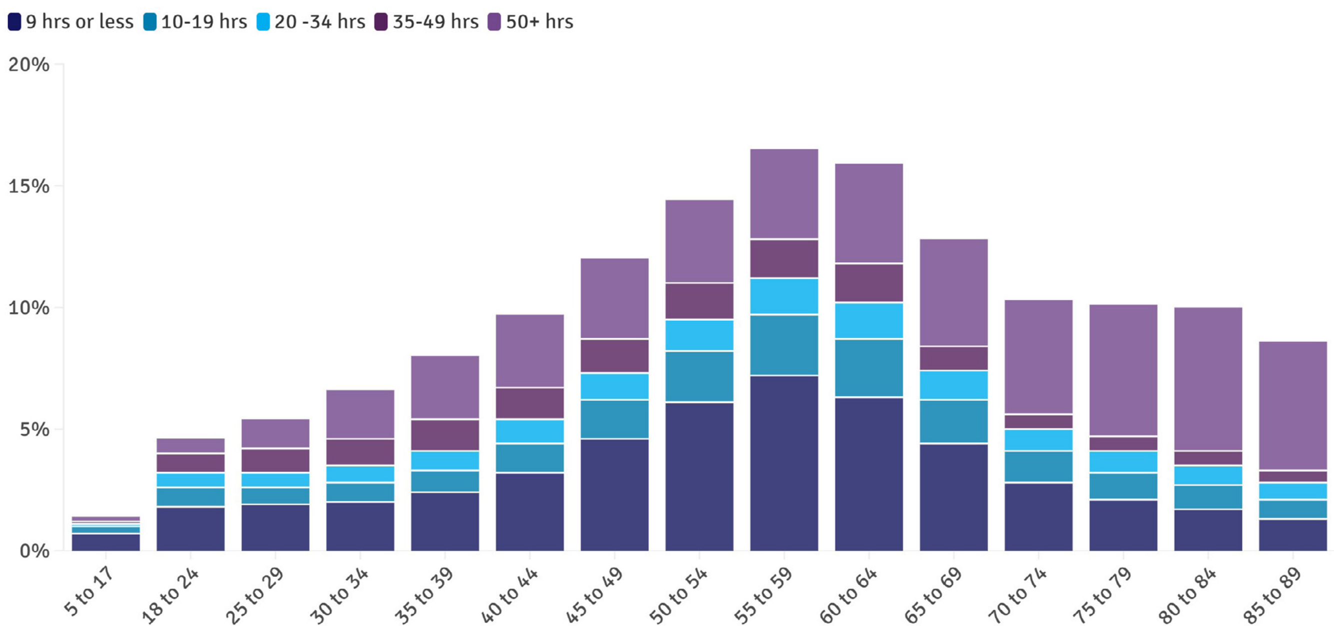
204. Independent Healthcare Providers Network (2023). Going Private 2023.
205. Patients Association (2024). Patients place huge importance on diagnostic services but face barriers to access – new report.
206. Independent Healthcare Providers Network (2023). Going Private 2023.
207. (£) Laing, W. & Read, T. (2023). LaingBuisson research shows strong bounce back for private healthcare. Healthcare Markets 27(9):6. LaingBuisson.
208. (£) Wells, R. (2024). 2023 set to be a record year for private admissions despite softening self-pay. Healthcare Markets 28(3):6. LaingBuisson.
209. RNIB (2024). Cataracts.
210. (£) Wells, R. (2024). 2023 set to be a record year for private admissions despite softening self-pay. Healthcare Markets 28(3):6. LaingBuisson.
211. NHS Digital (2023). Finalised Patient Reported Outcome Measures (PROMs) in England for Hip and Knee Replacement Procedures (April 2021 to March 2022).
212. Healthwatch (2023). The public's perspective: The state of health and social care.
213. Healthwatch (2023). The public's perspective: The state of health and social care.
214. ONS (2024). Employment rate 65+ People: %.
215. Engage Britain (2022). Millions turning to private healthcare forced into financial worry.

3.2 Growing pressures on unpaid carers

"Unpaid carers are being left to pick up the pieces of shortages in health and social care support to the detriment of their own health and wellbeing".[216] 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. As noted in Chapter 2, ADASS reports that 91% of Directors strongly agree or agree that unpaid carers had come forward with increased levels of need in 2022/23, and 73% of Directors observed an increase in cases of breakdown of unpaid carer arrangements.[217] Where Directors reported an increase in carer breakdown, carer burnout was the number one contributing reason.[218]

Unpaid carers make a significant economic contribution. The value of informal care in England was estimated to be nearly £162 billion per year in 2021 – 29% more in real terms than 2011.[219] This means unpaid carers in England and Wales are making a significant economic contribution by saving the public pursue £445 million every day.[220]

The majority of unpaid carers are older, and older carers are more likely to provide intensive levels of care than younger carers. At the time of the 2021 Census, 60% of unpaid carers were aged 50+[221] with the highest percentage of unpaid carers in people aged 55 to 59.[222] As Figure 3.4 shows below, older people are more likely to provide intensive levels of care of more than 50 hours per week. Women are more likely to provide unpaid care than men in every age group up to 75 to 79; however, from the age of 80+, men are more likely to provide unpaid care.[223] As noted in Chapter 1, caring has a significant impact on carers' physical and mental health.



216. ADASS (2023). Spring Survey 2023.
217. ADASS (2023). Spring Survey 2023.
218. ADASS (2023). Spring Survey 2023.
219. Petrillo, M. & Bennett, M.R. (2023) Valuing Carers 2021: England and Wales. Carers UK.
220. Petrillo, M. & Bennett, M.R. (2023) Valuing Carers 2021: England and Wales. Carers UK.
221. Peytrignet, S., Grimm, F. & Tallack, C. (2023). Understanding unpaid carers and their access to support. The Health Foundation.
222. Carers UK (2023). State of Caring 2023: Carers' employment rights today, tomorrow and in the future.
223. ONS (2023). Unpaid care by age, sex and deprivation, England and Wales: Census 2021.

Many carers – especially those providing intensive levels of care – report needing some or more breaks from caring. Carers UK's annual survey of carers found that 47% of carers said they needed some or more breaks or time off from caring.[224] People who were caring for over 50 hours a week were more likely to say they needed a break from caring (54%) than people caring for less than 50 hours a week (35%).[225]

Despite this there is less provision of key support services for carers. Figure 3.5 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 2019/20, the number of carers provided with respite or support for the cared-for person has dropped by 16.9%, while access to direct support for the carer has fallen by 11.5%. This is despite the demands on unpaid carers having increased, affecting their health – as outlined in Chapter 1.

Fig 3.5 Despite high demand since the pandemic, access to key support services that carers rely on has been reducing

Types of support provided or arranged by local authorities for carers of adults, 2017/18 to 2022/23, England.

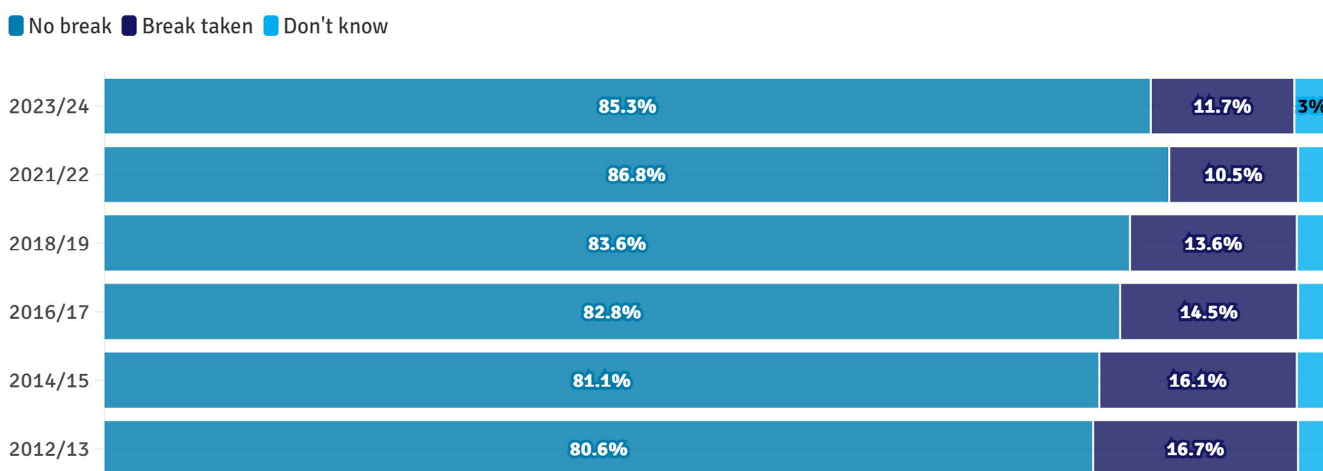
Source: Source: Age UK 2024: Analysis using: NHS Digital (2023). Adult Social Care Activity and Finance Report, England, 2022/23

224. Carers UK (2023). State of Caring 2023: The impact of caring on health.
225. Carers UK (2023). State of Caring 2023: The impact of caring on health.

Only 1 in 10 carers (10.5%) report being able to take a break from caring at short notice or in an emergency. Many carers reported the support that would enable them to take a break was unavailable or unsuitable, with 27% of carers relying on family and friends to provide replacement care and enable them to take a break, and just 10% receiving replacement care from a health or social care service.[226] As Figure 3.6 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.[227] 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. This is down from 22.3% in 2014/15[228] (when the Care Act 2014 placed new duties on councils in England in relation to unpaid carers and broadened carers' statutory entitlements to assessment, care, and support).

Fig 3.6 Almost 9 out of 10 carers cannot take a break from caring at short notice or in an emergency

Percentage of adult unpaid carers of adults reporting ability to take a break from caring at short notice, 2012/13 to 2023/24, England.



Source: Age UK 2024: Analysis using NHS Digital (2024). Personal Social Services Survey of Adult Carers in England, time series, 2023/24.

Carers are increasingly struggling with their physical and mental health. Prior to the COVID-19 pandemic, the 2018/19[229] national survey of carers of adults (administrated by local authorities) found 60.6% of unpaid carers reported caring to cause feelings of stress. In 2021/22[230], this had increased to 63.6% and to 63.9% in 2023/24[231]. Just 46.7% of carers feel they can look after themselves in 2023/24, down from 49.2% in 2021/22 and substantially down from 51.9% in 2018/19[232]. The percentage of carers with a mental health problem or illness has increased from 10.9% in 2018/19 to 13.2% in 2021/22 and 13.4% in 2023/24[233]. More than one in five unpaid carers (22.4%) reported in 2023/24 that caring made an existing condition worse.[234] Carers UK's annual 'State of Caring' survey suggests these trends are set to continue: 82% of carers reported the impact of caring on their physical and mental health would be a challenge in 2024, up from 77% the previous year.[235]

226. Carers UK (2023). State of Caring 2023: The impact of caring on health.
227. NHS Digital (2022). Personal Social Services Survey of Adult Carers in England, 2021/22.
228. NHS Digital (2015). Personal Social Services Survey of Adult Carers in England, 2014/15.
229. NHS Digital (2019). Personal Social Services Survey of Adult Carers in England, 2018/19.
230. NHS Digital (2022). Personal Social Services Survey of Adult Carers in England, 2021/22.
231. NHS Digital (2024). Personal Social Services Survey of Adult Carers in England, 2023/24.
232. NHS Digital (2024). Personal Social Services Survey of Adult Carers in England, 2023/24.
233. NHS Digital (2024). Personal Social Services Survey of Adult Carers in England, 2023/24.
234. NHS Digital (2024). Personal Social Services Survey of Adult Carers in England, 2023/24.
235. Carers UK (2023). State of Caring 2023: The impact of caring on health.

3.2.1 Third party top-up fees and charges

An estimated 11% of care home residents pay top-up fees or have them paid on their behalf.[236] 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.

In recent years the Ombudsman has found continuing errors relating to top-up fees, with people and their families being incorrectly charged for care. 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. 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. Recent findings by the Ombudsman include people 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.[237] 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.

The Ombudsman has reiterated to local authorities that the Care Act statutory guidance is "quite clear that leaving the administration of top-up fees to care homes was wrong".[238] Just prior to 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".[239]

3.3 Stretched acute services

3.3.1 Accident & emergency attendance

Accident and Emergency (A&E) attendances offer another insight into the effectiveness of primary and community care. Access to primary care has been found to be predictive of A&E attendance. One study found there are 18 fewer A&E attendances per 100 population for each kilometre closer a person lived to a GP practice.[240]

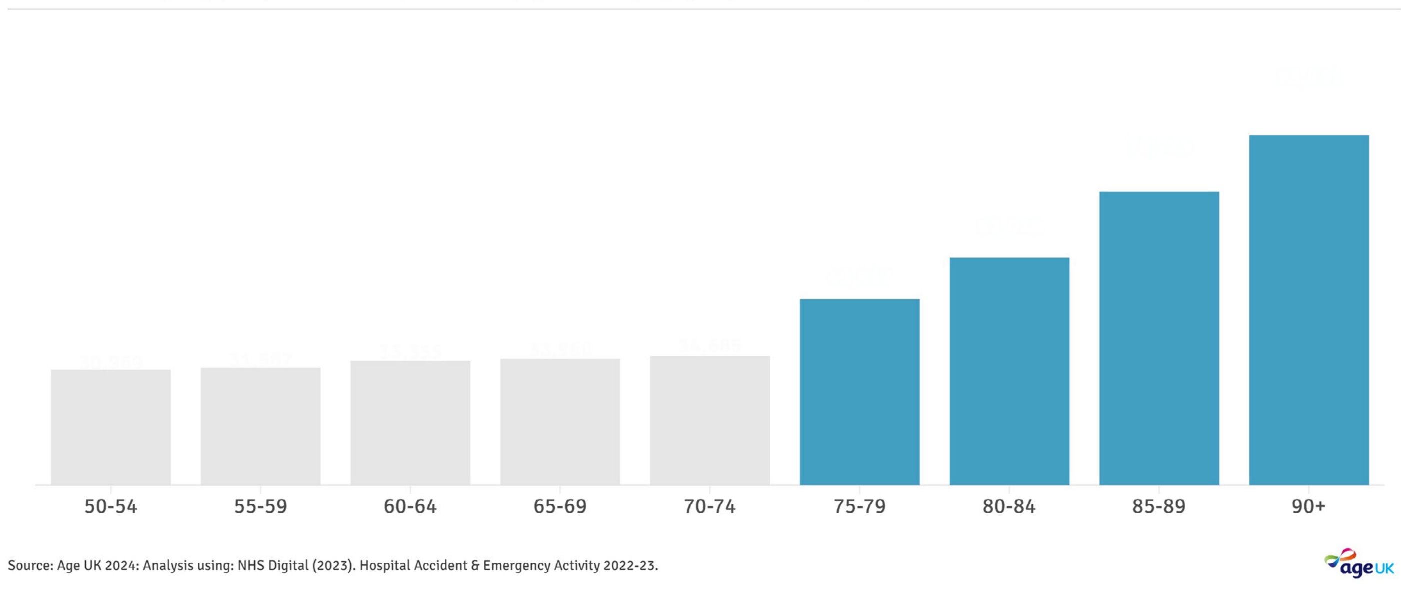
A&E attendances have returned to pre-pandemic levels. Immediately prior to the COVID-19 pandemic there were 25 million attendances at A&E.[241] Attendances reduced dramatically during the COVID-19 pandemic national lockdowns, resulting in 17.4 million attendances in 2020/21. However, there were 24.4 million attendances in A&E in 2021/22[242] and 25.3 million in 2022/23 – a slight increase on pre-pandemic levels.[243] Analysis of provisional data indicates 24.2 million attendance in A&E in 2023/24.[244]

236. (£) Laing, W. (2022). Care Homes for Older People: UK Market Report – Thirty-Second Edition.
237. See, for example: Local Government & Social Care Ombudsman (LGSCO) (2019). Annual Review of Adult Social Care Complaints 2018/19 and LGSCO (2020). Annual Review of Adult Social Care Complaints 2019/20.
238. LGSCO (2020). Ombudsman reminds councils about care home top-up fees.
239. LGSCO (2020). Ombudsman reminds councils about care home top-up fees.
240. 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 2019;9:e022820.
241. NHS Digital (2020). Hospital Accident & Emergency Activity 2019/20.
242. NHS Digital (2022). Hospital Accident & Emergency Activity 2021/22.
243. NHS Digital (2023). Hospital Accident & Emergency Activity 2022/23.
244. Age UK analysis: NHS England (2024). A&E Attendances & Emergency Admissions 2023/24.

The likelihood of attending A&E rises significantly with age. As shown in Figure 3.7 there are 49,917 attendances for every 100,000 people aged 75-79, rising through the age bands to 93,931 attendances per 100,000 amongst those aged over 90.

Fig 3.7 Your risk of needing to attend A&E may increase at 75+ years

Accident & Emergency (A&E) attendances, per 100,000 population, by age group, 2022/23, England.



People living in more deprived areas are more likely to attend A&E than people living in less deprived areas. ONS analysis of 2021/22 A&E attendances found the odds of attending A&E were 1.7 times greater for people living in the most deprived 10% of areas than for people living in the least deprived 10% of areas. The odds of A&E attendance increased with the level of deprivation.[245] Not being in employment and living in poor quality housing are among the socioeconomic factors found to increase the likelihood of attending an A&E service.[246]

A&E performance remains below even amended NHS standards. There are a number of government pledges on NHS waiting times, including a maximum 4-hour wait in A&E from arrival to admission, transfer or discharge.[247] The operational standard in place since 2010 is that not more than 5% of people attending A&E should be waiting more than four hours to be admitted, transferred or discharged. Performance against the four-hour target was in decline pre-pandemic, with 31.4% of people waiting more than four hours in December 2019, compared with 7.1% in December 2013. Performance improved at the height of the pandemic – associated with significantly fewer attendances at A&E – but reached a crisis point in December 2022 when 50.4% of people attending Type 1 A&E (i.e. the most urgent and serious patients) waited for more than four hours. The overall figure across all urgent care services was 70.7% 2022/23.[248] An intermediary threshold target was introduced, with the new aim of 76% of people to be waiting a maximum of four hours by March 2024,[249] eventually falling short at 74.4%.[250]

245. ONS (2023). Inequalities in Accident and Emergency department attendance, England: March 2021 to March 2022.
246. 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 2019:9(e022820).
247. DHSC (2023). Handbook to the NHS Constitution for England.
248. NHS Digital (2023). Hospital Accident & Emergency Activity 2022/23.
249. NHS England (2023). Delivery plan for recovering urgent and emergency care services – January 2023.
250. NHS Digital (2024). A&E Attendance and Emergency Admissions: March 2024 Statistical Commentary.

There has been a huge increase in the number of older people experiencing a 'trolley wait' of 12 hours or more. A 'trolley-wait' is the time between a decision being taken to admit someone who has attended A&E to a ward and the person actually being admitted to the ward. This used to be a relatively rare occurrence. Ten years ago, 1,239 attendances a year experienced a wait longer than 12 hours (2014/15).[251] In 2023/24, this number reached 439,411, a 355-fold increase.[252] Two in three of those who waited 12 hours or more were older people.[253] Older people also experienced longer waits overall, with an average wait of 7 hours in 2023 compared to 6 hours for all patients.[254] Analysis by the Royal College of Emergency Medicine found that there were almost 300 excess deaths a week in A&E associated with long delays.[255]

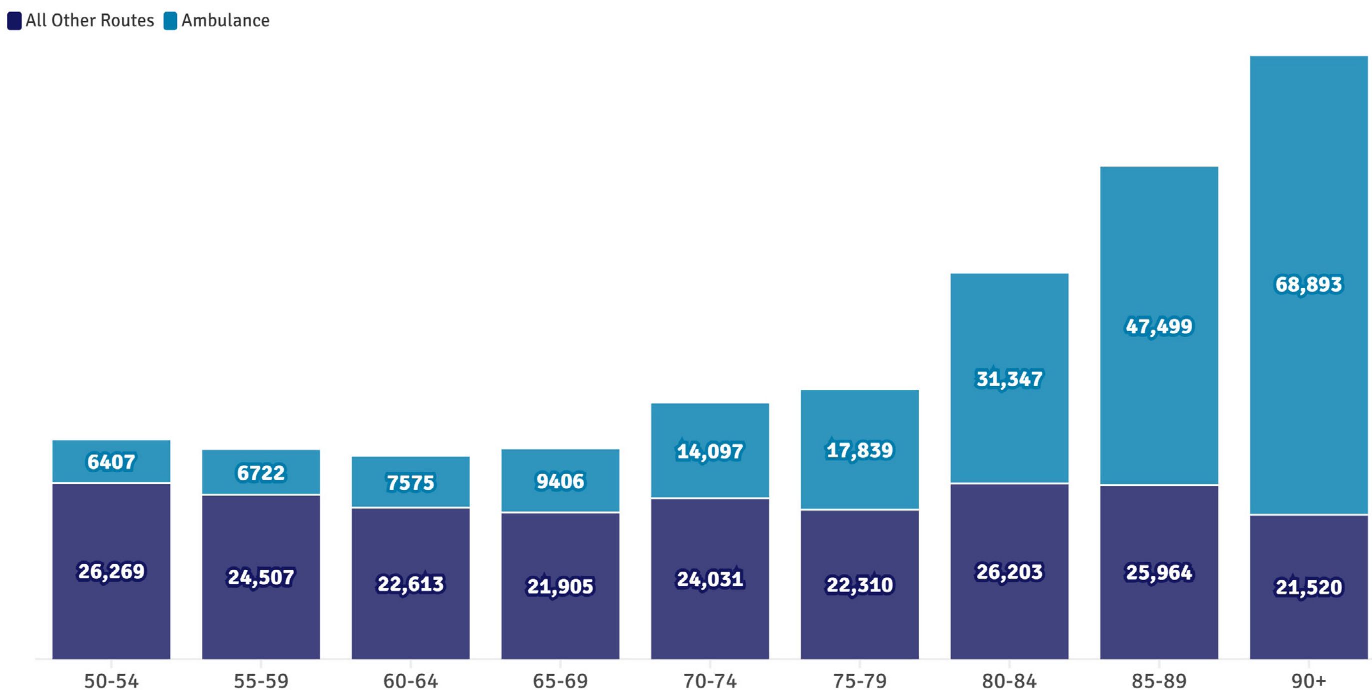
The proportion of 'low acuity' patients attending A&E seems to be far lower than expected. Low acuity cases are those that could often be seen by alternative services to A&E, such as Minor Injury Units and Urgent Treatment Centres. An NHS England trial of new acuity measures at 17 A&E sites found the proportion of patients with low acuity was just 4%.[256] The trial had been undertaken with an expectation of finding between 20-40% of patients with low acuity.

3.3.2 Emergency admissions and readmissions

Emergency admissions are continuing to increase. There were 6.1 million emergency admissions in 2022/23 and 6.5 million in 2023/24[257] – an increase of 6.6%.[258] The number of emergency admissions to hospital sharply increased to 6.2 million in 2021/22[259] from 5.4 million in 2020/21.[260] 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+ rising quickly. Falls were the largest cause of emergency admissions for people aged 65+.[261]

Overall, people aged 50+ represent over one-third (36.5%) of total A&E attendances.[262] However, this age group makes up 65% of attendances that arrive by ambulance,[263] indicating a higher level of complexity and acuity. Figure 3.8 shows older age groups are more likely to arrive by ambulance, with a sharp rise from 17,839 people per 100,000 in the 75-79 group, to 68,893 per 100,000 in the 90+ group. 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.

251. NHS Digital (2015), A&E Attendances and Emergency Admissions 2014-15.
252. NHS Digital (2024), A&E Attendances and Emergency Admissions 2023-24.
253. (£) Donnelly, L. (2024). Elderly patients waiting for seven hours on A&E trolleys. The Telegraph.
254. (£) Donnelly, L. (2024). Elderly patients waiting for seven hours on A&E trolleys. The Telegraph.
255. Royal College of Emergency Medicine (2024). Almost 300 deaths a week associated with long A&E waits despite UEC Recovery Plan.
256. (£) Discombe, M. (2024). A&Es not being overwhelmed by 'low acuity' patients, NHSE Review reveals. Health Services Journal.
257. NHS Digital (2023). Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - 2022/23.
258. NHS Digital (2024). Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency date - 2023/24.
259. NHS Digital (2022). Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - 2021/22.
260. NHS Digital (2021). Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency date - 2020/21.
261. NHS Digital (2023). Hospital Accident & Emergency Activity 2022/23.
262. NHS Digital (2023). Hospital Accident & Emergency Activity 2022/23.
263. NHS Digital (2023). Hospital Accident & Emergency Activity 2022/23.



Emergency readmission rates are higher for adults aged 75+ than younger age groups.[264] An emergency readmission occurs when someone is readmitted to hospital as an emergency within 30 days of their most recent discharge. Emergency readmissions may result from avoidable adverse events, though others may be due to unrelated or unforeseen causes of admission. In 2014/15 17.3% of people aged 75+ had an emergency readmission within 30 days of discharge. This gradually increased year-on-year, plateauing at 18.6% in 2018/19 and 2019/20. The readmission rate for people aged 75+ soared in the first full year of the COVID-19 pandemic to 19.6% but reduced to 17.9% in 2021/22 and further to 17.2% in 2022/23.[265] However, this still translates to 1 in 6 of emergency admissions in people aged 75+ occurring within 30 days of last being discharged from hospital.[266]

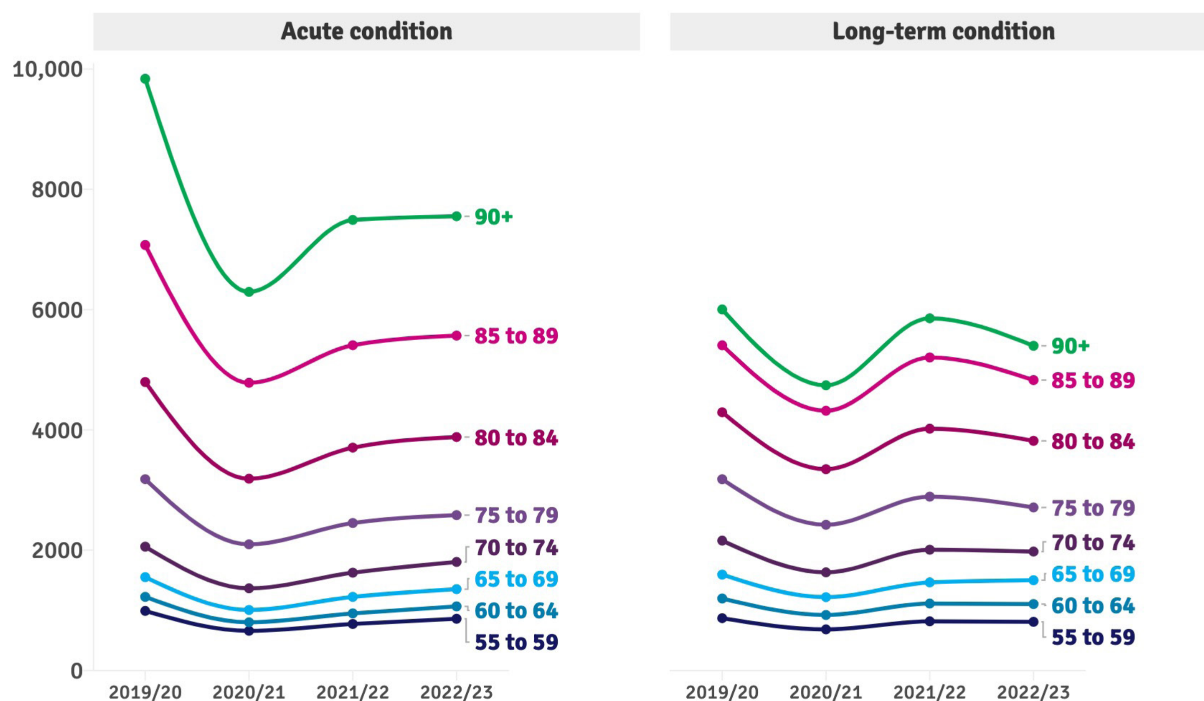
3.3.3 Unplanned hospitalisation

The rate of emergency admissions for acute conditions that should not usually require hospital admission increases with age.[267] Figure 3.9 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). Admissions had shown little change in the years leading up to the pandemic, then dropped off significantly as admissions were impacted by the pandemic. The rate of admissions began to rise again into 2021/22, with less pronounced increases in 2022/23.

264. Age UK analysis: NHS Digital (2023). Emergency readmission to hospital within 30 days of discharge – compendium readmissions dataset.
265. Age UK analysis: NHS Digital (2023). Emergency readmission to hospital within 30 days of discharge – compendium readmissions dataset.
266. NHS Digital (2023). Emergency readmission to hospital within 30 days of discharge – compendium readmissions dataset.
267. NHS Digital (2023). Emergency admissions for acute conditions that should not usually require hospital admission.

Fig 3.9 The rate of emergency admissions for acute and long-term conditions that should not usually require hospital admission increases with age

Emergency admissions for specific acute and long-term conditions that should not usually require hospital admission, per 100,000 population, by age, 2019/20 to 2022/23, England.



Source: Age UK 2024: Analysis using NHS Digital (2023). Emergency admissions for acute conditions that should not usually require hospital admission.

Emergency admissions rates for specific long-term conditions that should not normally require hospitalisation increase with age. They are particularly increasing across the oldest-old age groups. Figure 3.9 also 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. The rate dropped significantly during 2020/21 due to pandemic-related policies but rose again in 2021/22. The rate of admissions saw some reductions in the older age groups in 2022/23.

3.3.4 Hospital discharge and length of stay

The problem of delayed transfers of care appeared to be returning to the levels seen before the COVID-19 pandemic. A delayed transfer of care occurs when a person is ready for discharge from acute or non-acute care and is still occupying a bed. There were 148,000 delayed days across England in December 2019, which is 15% higher than the same month a year earlier.[268] The combined figures for the last quarter of 2019 were the highest in two years.[269] These data ceased to be collected during the COVID-19 pandemic, with February 2020 the last published data.[270]

268. NHS England (2020). Delayed Transfers of Care Data 2019-20.
269. NHS England (2020). Delayed Transfers of Care Data 2019-20.
270. NHS England (2022). (Discontinued) Delayed Transfers of Care.

A 'Discharge to Assess' model was introduced across England in the early stages of the COVID-19 pandemic and is now the norm across NHS Trusts. 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 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 at the right time for the person".[271] In March 2020, the Government announced a Discharge to Assess model would 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".[272] The Discharge to Assess model has been formalised into legislation.[273]

Discharge delays increased significantly during the pandemic and have remained high.[274] The new model of hospital discharge includes a focus on whether a person meets 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.[275] 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 people a day remained in hospital despite no longer meeting the criteria to reside.[276] This was 46.9% more than the daily average of 9,150 for December 2021.[277]

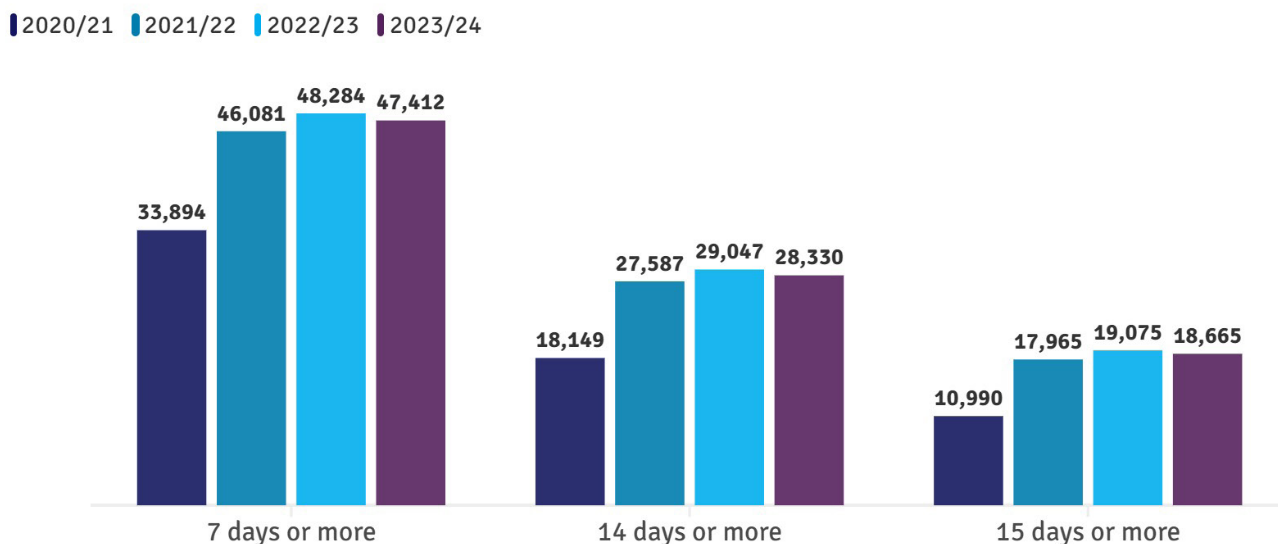
Discharge delays have started to fall, but a large number of people remain in hospital despite being clinically ready to leave. In December 2023, an average of 12,610 people a day remained in hospital despite no longer meeting the criteria to reside, which was a reduction of 6.2% on December 2022 but still much higher than in December 2021.[278] The equivalent number in the last December collection for Delayed Transfers of Care (2019) was 4,777.[279]

This is contributing to people experiencing long stays longer in hospital, with the majority of them likely to be older people. Figure 3.10 shows the average number of long stay occupied beds (a patient who occupies a bed for at least 7 days or more) over each winter since 2020/21, demonstrating significant increases between 2020/21 and 2021/22, and small decreases between 2022/23 and 2023/24. These data are not disaggregated by age, but the National Audit Office has previously estimated that 85% of people delayed in hospital are aged 65+ [280] and the actual proportion today likely to be even higher.

271. NHS England (2016). Quick guide: Discharge to Assess.
272. HM Government (2020). COVID-19 Hospital Discharge Service Requirements.
273. Section 91 of the Health and Care Act 2022.
274. DHSC & NHS England (2023). Delivery plan for recovering urgent and emergency care services.
275. 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 (2024). Hospital Discharge and Community Support Guidance.
276. NHS England (2022). Discharge delays (Acute) – December 2022.
277. Foster, D. (2023). Delayed hospital discharges and adult social care. House of Commons Library.
278. Age UK analysis of: NHS England (2024). Discharge delays (Acute) – December 2023.
279. NHS England (2020). (Discontinued) Delayed Transfers of Care 2019/20.
280. National Audit Office (2016). Discharging older people from hospital.

3.10 People continue to have long stays in hospital with the majority being older people

Average number of long-stay patients that occupied beds for 7 days or more, 14 days or more, or 21 days or more, all ages, 2020/21 to 2023/24, England.



Source: Age UK 2024: Analysis using NHS England 2020-2024: Urgent and Emergency Care Daily Situation Reports, 2020-21 to 2023-24. • Each period is 30th November to 31st March inclusive.

Most delays are caused by waits for adult social care. The Government's own analysis found that on average 24% of people are awaiting homecare, 16% are awaiting residential or nursing home placements, and 24% are waiting to begin intermediate care.[281]

3.3.5 Waiting times for treatment

Prior to the COVID-19 pandemic, the target for 92% of people to have been waiting for less than 18 weeks for non-urgent consultant-led treatment had not been met since March 2016. There is also a 'zero tolerance' policy on people waiting longer than 52 weeks. At the end of February 2020, 83.2% of people waiting to start treatment were waiting up to 18 weeks, and there were 4.4 million patients on the waiting list to start treatment.[282]

Waits grew longer during the pandemic and new targets were set. In March 2020, during the early stages of the COVID-19 pandemic, all non-urgent elective operations were postponed to free up inpatient and critical care capacity.[283] National guidance was published in July 2020, outlining targets to return to near-normal levels of activity,[284] 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, with the ambition to have eliminated waits of over 78 weeks by April 2023 and 52 weeks by March 2025.[285] In January 2023, further guidance was issued with the midpoint ambition to have eliminated waits of over 65 weeks by March 2024.[286]

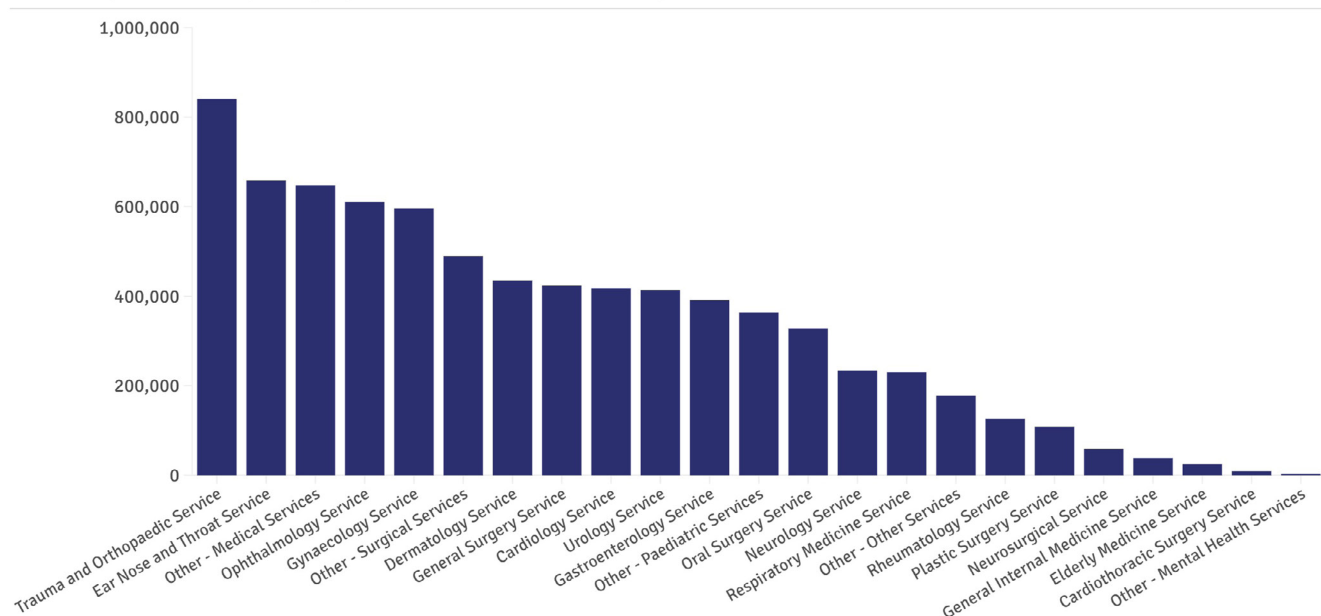
281. DHSC & NHS England (2023). Delivery plan for recovering urgent and emergency care services.
282. NHS Digital (2020). Statistical press notice: NHS referral to treatment waiting times data, February 2020.
283. NHS England (2020). Letter to NHS leaders: Next steps on NHS response to COVID-19.
284. NHS England (2020. Letter to NHS leaders: Third phase of NHS response to COVID-19.
285. NHS England (2022). 2022/23 priorities and operational planning guidance.
286. NHS England (2023). 2023/24 priorities and operational planning guidance.

In June 2024, the waiting list was 7.62 million, with 41% of people waiting longer than 18 weeks.[287] Some people are on multiple referral-to-treatment pathways, and the number of unique people waiting is estimated to be around 6.3 million. In 58.9% of cases the patient had been waiting up to 18 weeks, thus not meeting the 92% standard. In 302,693 cases, the patient was waiting more than 52 weeks.[288] The target to eliminate waits of over 65 weeks by March 2024 had not been met, with 58,024 cases of people waiting 65 weeks or more, an increase of 10,000 on just three months earlier.[289]

The treatment function with the largest waiting list is Trauma and Orthopaedics, which will include many older people waiting for joint replacement surgery. As shown in Figure 3.11, more than 840,000 people are waiting for Trauma and Orthopaedics as of June 2024 – an increase from 766,000[290] and 830,000[291] respectively in June 2022 and 2023.

Fig 3.11 The treatment function with the largest waiting list is Trauma and Orthopaedics, which will include many older people waiting for joint replacement surgery

Total incomplete treatment pathways by treatment function, June 2024, England.



Source: Age UK 2024: Analysis using NHS England 2024: Consultant-led Referral to Treatment Waiting Times Data 2023-24, June.

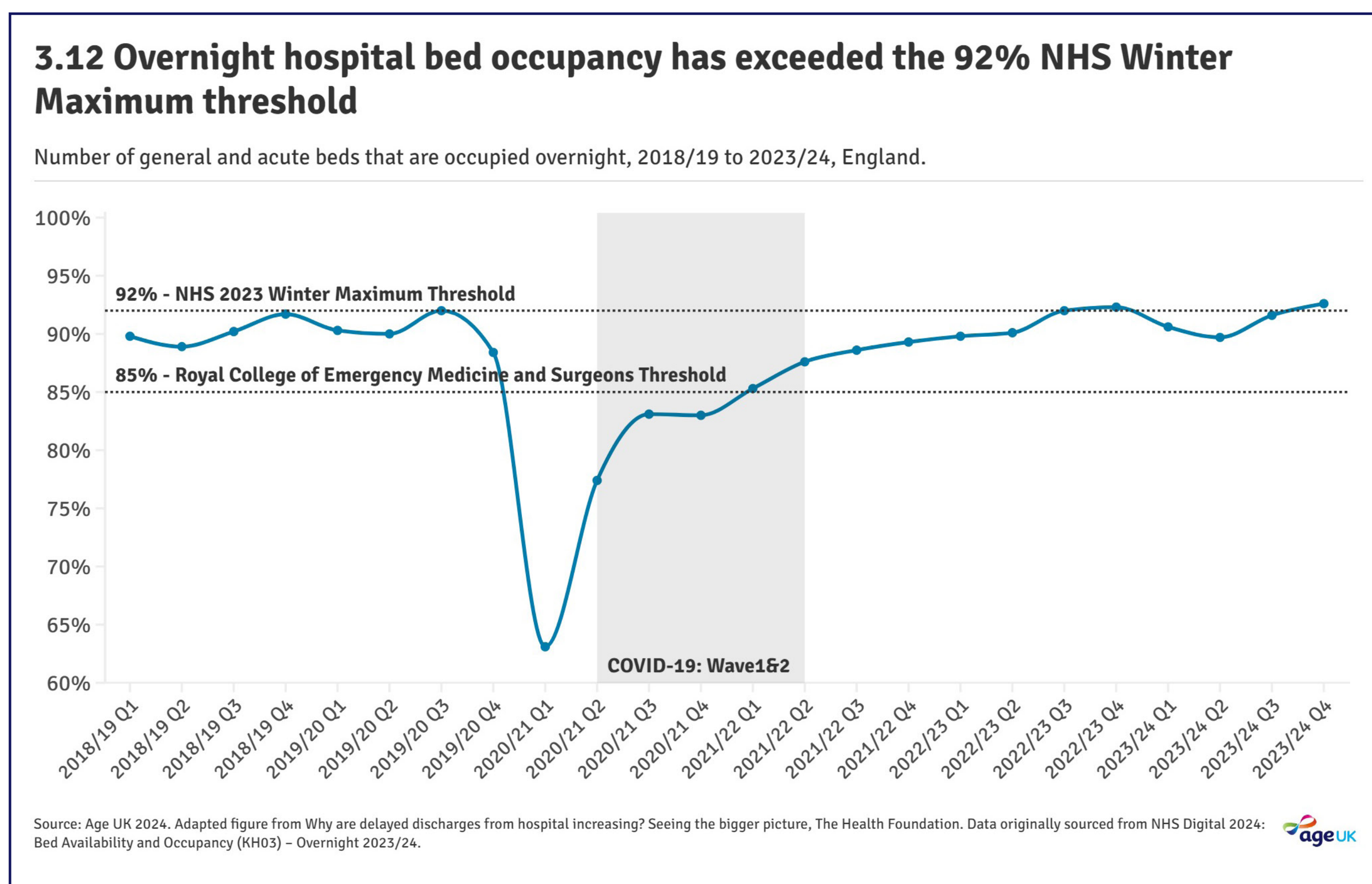
3.3.6 Reducing bed numbers and bed capacity

Bed capacity in England is now at significantly lower levels than in other developed countries.[292] 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.[293] 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.[294] However, even prior to the pandemic, demographic changes and increasing demand for secondary care suggested demand for beds was likely to increase over time.

287. NHS England (2024). Statistical Press Notice: NHS referral to treatment (RTT) waiting times data – June 2024.
288. NHS England (2024). Statistical Press Notice: NHS referral to treatment (RTT) waiting times data – June 2024.
289. NHS England (2024). Statistical Press Notice: NHS referral to treatment (RTT) waiting times data – June 2024.
290. NHS England (2022). Statistical Press Notice: NHS referral to treatment (RTT) waiting times data – June 2022.
291. NHS England (2023). Statistical Press Notice: NHS referral to treatment (RTT) waiting times data – June 2023.
292. Freedman, S. & Wolf, R. (2023). The NHS productivity puzzle. Institute for Government & Public First.
293. Ewbank, L., Thompson, J., McKenna, H. et al (2021). NHS Hospital bed numbers: past, present, future. King's Fund.
294. Ewbank, L., Thompson, J., McKenna, H. et al (2021). NHS Hospital bed numbers: past, present, future. King's Fund.

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 healthcare-acquired infections.[295] In 2019/20, overnight general and acute bed occupancy averaged 90.2%, and regularly exceeded 95.0% in winter [296] – well above the level many consider safe. The 2020/21 NHS national planning guidance stated bed occupancy should be reduced to a maximum of 92% "through acute bed expansions, increasing community care, investment in primary care and improvements in length of stay and admission avoidance".[297]

Bed occupancy exceeded 85% throughout 2022/23 and 2023/24. Figure 3.12 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. The bed occupancy rate in Q4 2023/24 for overnight general and acute beds was 92.6% - higher than both National Audit Office and NHS recommendations.



3.12 Overnight hospital bed occupancy has exceeded the 92% NHS Winter Maximum threshold

Number of general and acute beds that are occupied overnight, 2018/19 to 2023/24, England.

Source: Age UK 2024. Adapted figure from Why are delayed discharges from hospital increasing? Seeing the bigger picture, The Health Foundation. Data originally sourced from NHS Digital 2024: Bed Availability and Occupancy (KH03) – Overnight 2023/24.

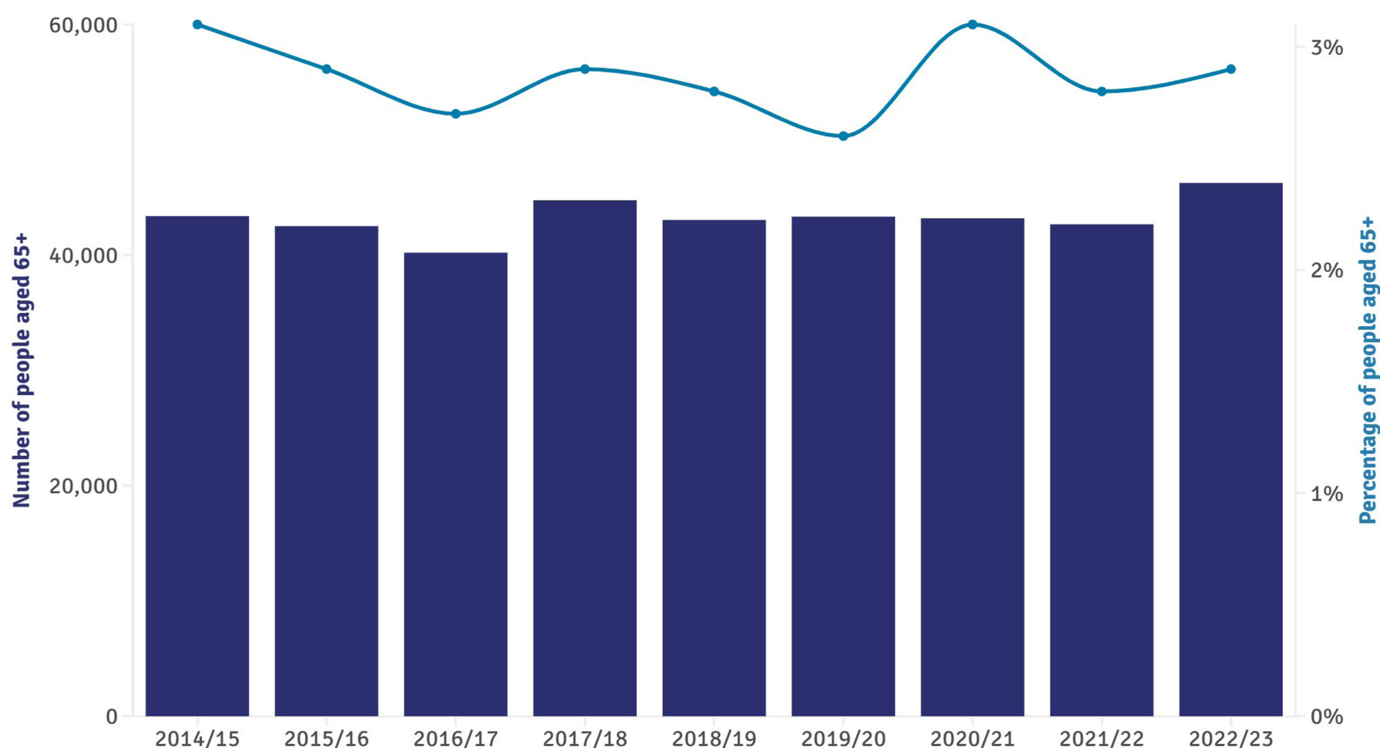
3.3.7 Reablement and rehabilitation

The proportion of older people receiving reablement/rehabilitation after discharge from hospital is lower than in 2014/15 when policies were put in place to promote its benefits. 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, while the Care Act 2014 strengthened the social care focus on prevention, including through these services. As shown in Figure 3.13, despite the intentions of these policies, the percentage of older people receiving reablement/rehabilitation after discharge from hospital has not grown at all and in fact slightly fallen from 3.1% in 2014/15 to 2.9% in 2022/23.

295. National Institute for Health and Social Care Excellence (NICE) (2018). NICE guideline 94: Bed occupancy.
296. NHS Digital (2021). Bed Availability and Occupancy Data – Overnight: 2020-21 time series.
297. NHS England and NHS Improvement (2020). NHS Operational Planning and Contracting Guidance 2020/21.

Fig 3.13 Percentage of people aged 65+ receiving reablement/rehabilitation after discharge from hospital has dropped since 2014 when policies were made to promote its benefits

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, 2014/15 to 2022/23, England.



Source: Age UK 2024: Analysis using NHS Digital (2023). Adult Social Care Activity and Finance Report, England, 2022/23.

The majority of occupational therapists say they feel unable to provide the necessary level of support to meet rehabilitation needs in their area. A March 2022 survey of members by the Royal College of Occupational Therapists (RCOT) found 83% of respondents reported an increase in demand for occupational therapy rehabilitation over the previous six months, and 70% said they felt unable to provide the necessary level of support to meet rehabilitation needs in their area.[298] The RCOT's Workforce Survey Report 2023 in indicates these pressures are increasing, with 86% of respondents now reporting an increase in demand for occupational therapy rehabilitation, and 79% saying they feel the complexity of people's needs had increased due to delayed intervention, resulting in an increased need for occupational therapy input.[299]

Tens of thousands of older people could benefit from greater capacity in home-based reablement and rehabilitation services. Analysis undertaken by the County Councils Network (in the autumn of 2023 that looked to the winter of 2023) concluded 40,000 older people could have a more independent long-term outcome as a result of receiving effective home-based reablement.[300] They also estimate the effectiveness of reablement services could be improved for the 200,000 people already benefiting from them – ultimately saving local government £440m, with these outcomes primarily a result of increasing therapy input into the services.[301]

298. RCOT (2022). Rehabilitation workforce survey.
299. RCOT (2022). Workforce survey report 2023.
300. County Councils Network (2023). Finding a way home: How health and social care can optimise hospital flow and discharge this winter to improve outcomes and performance.
301. County Councils Network (2023). Finding a way home: How health and social care can optimise hospital flow and discharge this winter to improve outcomes and performance.

4. Health and care workforce and infrastructure

The recruitment, training and retention of the workforce is a key challenge for health and care in England.[302] In 2022, the Health and Social Care Select Committee undertook an inquiry into the issues and concluded: "The persistent understaffing of the NHS now poses a serious risk to staff and patient safety both for routine and emergency care".[303] In terms of social care, the Committee concluded: "continuity of care… can only be addressed by improving retention in the sector… A long-term sustainable strategy is needed with the prospect of pay progression, professional development, and career pathways".[304]

NHS England published the NHS Long Term Workforce Plan in June 2023. Commissioned by the Government to respond to health-related workforce challenges, the plan recognises: "The lack of a sufficient workforce, in number and mix of skills, is already impacting patient experience, service capacity and productivity, and constrains our ability to transform the way we look after our patients. A growing shortfall would mean growing challenges and lost opportunities".[305] The plan sets out actions to address projected staffing shortfalls. These include increasing education and training, improving NHS culture and leadership with more support for career progression, and expanding use of some technologies and innovation, including associate roles. Actions in the plan are backed by £2.4 billion in Government funding up to 2028/29.[306]

Various policies have been announced to address adult social care workforce challenges. Some of these are identified in the previous UK Government's white paper, People at the Heart of Care,[307] but "there is no plan to publish a further workforce strategy for adult social care".[308] Initiatives include the development of a care workforce pathway and associated training, as well as a digital skills passport "to address issues of portability of staff training and development by providing a permanent and verifiable record of skills, behaviours, and achievements that would be accessible to employees and could be shared with new or potential employers".[309] DHSC published the first phase of the care workforce pathway in January 2024, outlining the knowledge, skills, values, and behaviours needed to work in adult social care, as well as learning and development options.[310] However the new UK Government announced in July 2024 that it would not be taking forward previously announced plans to fund up to 37,000 care staff through the new level 2 care certificate at a cost of £53.9 million, through the Adult Social Care Training and development fund, and there remains some uncertainty at this time as to the Government's future plans for upskilling the care workforce.[311]

The workforce is one of many interlinked elements of infrastructure that are essential to the delivery of health and care. NHS and social care infrastructure includes land and buildings (such as hospitals, community facilities, care homes, GP surgeries and pharmacies), equipment (such as ambulances, MRI scanners, aids and adaptations and community transport vehicles), plant and machinery and technology (such as computer systems, software and databases), and research and development facilities and resources. Social care also includes e-Marketplaces for people who are funding their own care or are receiving direct payments to be able to search for, consider and buy care and support services online), and research and development facilities and resources.

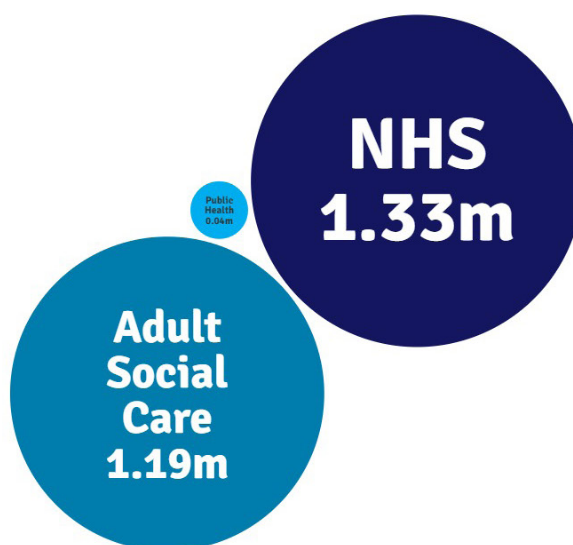
302. Health and Social Care Committee (2022). Workforce: recruitment, training and retention in health and social care. House of Commons.
303. Health and Social Care Committee (2022). Workforce: recruitment, training and retention in health and social care. House of Commons.
304. Health and Social Care Committee (2022). Workforce: recruitment, training and retention in health and social care. House of Commons.
305. NHS England (2023). NHS Long Term Workforce Plan.
306. NHS England (2023). NHS Long Term Workforce Plan.
307. DHSC (2021). People at the Heart of Care – White Paper.
308. Markham, N. (2023). UK Parliament: Written question, HL 8443, tabled 13 June 2023, answered 10 July 2023. London: House of Lords.
309. DHSC (2022). Adult Social Care Digital Skills Passport – Conducting a Discovery.
310. DHSC (2024). Care workforce pathway for adult social care: Overview.
311. DHSC (2024). Government sets out plans to develop the domestic care workforce.

4.1 Workforce size and structure

The combined health and care workforce is estimated to make up around 1 in 10 of the total workforce in England.[312] As depicted in Figure 4.1, there are an estimated 1.33 million full-time equivalent staff working in the NHS[313] and a further 1.19 million full-time equivalent staff are estimated to work in England's adult social care sector.[314] However, the adult social care headcount is slightly larger than that of the NHS, with 1.52 million staff[315] compared with 1.49 million.[316] A further 40,000 people work in core public health roles.[317]

Fig 4.1 The combined health and care workforce is estimated to make up around 1 in 10 of the total workforce in England

Full-time equivalent (FTE) workforce for Health, Adult Social Care, and Public Health, 2023/24, England



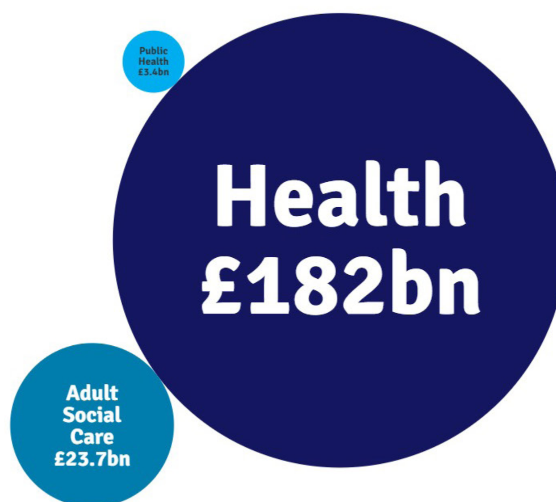
Source: NHS Digital (2024). NHS Workforce Statistics - November 2023; Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023; NHS (2024). The core public health workforce.

The NHS is the country's largest employer,[318] **but the adult social care workforce is employed across multiple sectors and thousands of organisations.**[319] The majority of people in the social care workforce (84%) are employed in the independent (private and voluntary) sector, with 7% in local authorities, and 8% working for people in receipt of direct payments.[320] A further 109,000 people work in adult social care posts filled in the NHS.[321] Figure 4.2 illustrates the relative public spend, across health, adult social care and public health.

312. The Kings Fund (2018). The healthcare workforce in England: Make or break?
313. NHS Digital (2024). NHS Workforce Statistics - November 2023.
314. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
315. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
316. NHS Digital (2024). NHS Workforce Statistics - November 2023.
317. NHS (2024). The core public health workforce.
318. Nuffield Trust (2024). The NHS workforce in numbers. [regularly updated; accessed 20-02-2024].
319. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
320. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
321. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.

Fig 4.2 Spending allocated to the NHS is nearly 8 times greater than that spent on social care

Public spending on Health, Adult Social Care, and Public Health, 2022/23, England



Source: Rocks, S. & Boccarini, G. (2023). Health care funding: Three key questions about funding in England. Health Foundation; NHS England (2023). Adult Social Care Activity and Finance Report, England, 2022/23; DHSC (2022). Local authority circular: Public health ring-fenced grant 2022 to 2023.

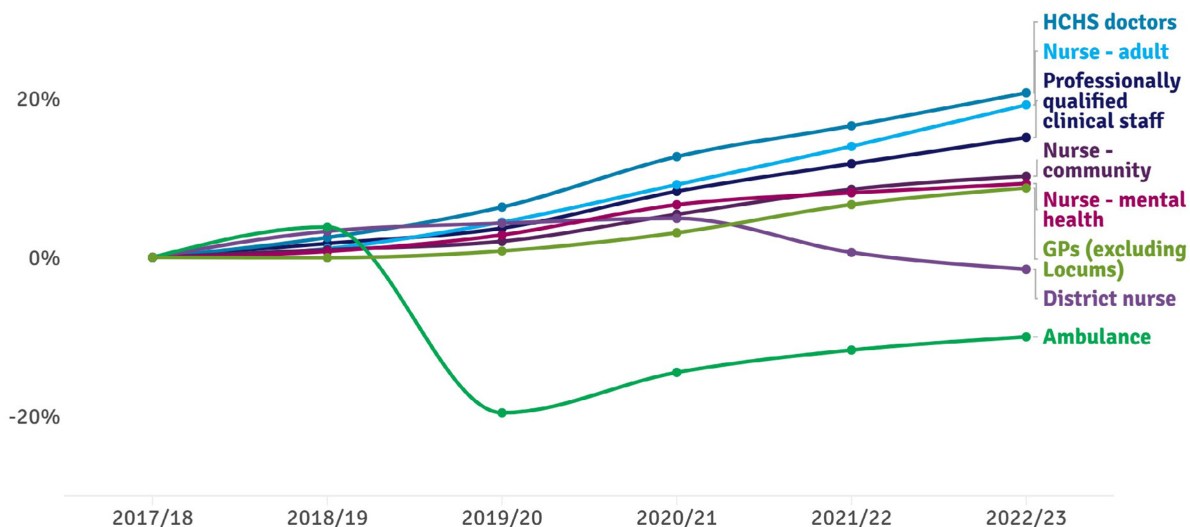
The NHS workforce is growing, but this is not always translating into either significantly greater productivity or improved services [322] – partly demonstrated by current NHS waiting lists (see Section 3.3.5). The Institute for Fiscal Studies reported in November 2023 that productivity growth in the NHS was significantly below the growth in headcount.[323] The Health Foundation, commenting in a Financial Times article, points out that the largest category of new staff since 2018 has been junior doctors, saying 'so you have a mix of staff that now is more skewed towards junior members of staff, who can therefore do less'.[324] There has also been little growth in core infrastructure and estates that could be more effective in driving improvements.

At the same time, despite a longstanding policy objective of shifting NHS care away from hospitals and closer to people's homes, growth in staff numbers is heavily tilted toward acute care, as shown in Figure 4.3, growth in community and primary care staffing is relatively slow, and district nursing numbers have plummeted.

322. Mallorie, S. (2024). NHS workforce in a nutshell. The King's Fund.
323. Institute for Fiscal Studies (2023). Is there really an NHS productivity crisis?
324. Financial Times (30 May 2023). NHS productivity lags as recruitment fails to keep pace with demand.

Fig 4.3 Growth in the community NHS workforce has either been slow or declining

Percentage change in full-time equivalent health workforce since 2017/18 to 2022/23, England



Source: Age UK analysis: NHS Digital (2023). NHS Workforce Statistics - November 2023.

Most NHS staff directly provide hospital, mental health, community, or ambulance services, or support the staff who do so. This accounts for 1.11 million of the 1.33 million full-time equivalent workforce.[325] The remaining 217,000 full-time equivalent workforce provide NHS infrastructure support, including central functions, property and estates, and senior management.[326] More than half (52.8%) of full-time equivalent staff are professionally qualified clinical staff. This includes doctors, nurses, midwives, health visitors, qualified scientific, therapeutic and technical staff, and qualified ambulance staff.[327]

The NHS workforce is the most diverse it has ever been, but there is more work to do. The average age of staff in the NHS tends to be towards the mid-40s.[328] The NHS workforce is disproportionately female (76.7%),[329] but women represent only 37% of very senior managers.[330] Almost one-quarter (24.2%) of NHS staff report being of Asian, Black or another minority ethnicity,[331] compared with 19.3% of the working age[332] population of England and Wales.[333] However, ethnic minority staff make up 15% of people in managerial level positions, and 11.3% of senior managerial level positions.[334] Latest figures show 4.2% of NHS staff have declared a disability on their NHS Electronic Staff Record. However, 23.2% of staff who responded to the relevant question in the 2021 NHS Staff Survey indicated they have a disability,[335] which is more reflective of the 24% of people who self-reported they have a disability through the UK's Family Resources Survey.[336] The NHS Equality, Diversity and Inclusion Improvement Plan recognises and sets out actions to address "the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce".[337]

325. Age UK analysis of NHS Digital (2024). NHS Workforce Statistics - November 2023.
326. NHS Digital (2024). NHS Workforce Statistics - November 2023.
327. NHS Digital (2024). NHS Workforce Statistics - November 2023.
328. Jabbal, J. (2022). Young people are the future: How can recruiters encourage more of them to join the NHS workforce? The King's Fund.
329. NHS England (2021). NHS celebrates vital role hundreds of thousands of women have played in the pandemic.
330. NHS England (2023). NHS equality, diversity and inclusion improvement plan.
331. NHS England (2023). NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts.
332. 'Working-age population' is defined by the Office for National Statistics as everyone aged 16 to 64.
333. ONS (2023). Working age population. HM Government.
334. NHS England (2023). NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts.
335. NHS England (2023). Workforce Disability Equality Standard 2022 data analysis report for NHS trusts.
336. DWP (2023). Family Resources Survey: financial year 2021 to 2022.
337. NHS England (2023). NHS equality, diversity and inclusion improvement plan.

The full-time equivalent adult social care workforce has slightly increased. It increased from 1.17m in 2021/22 [338] to 1.19m in 2022/23.[339] This is an increase of 1.7%. The adult social care workforce comprises care workers, social workers, occupational therapists, support and outreach workers, personal assistants, registered nurses, and registered managers. As noted above, the adult social care workforce is employed across independent and local authority organisations, as well as people in receipt of direct payments. There are an estimated 18,000 adult social care organisations in England, providing care across 39,000 locations.[340]

A disproportionately large proportion of the adult social care workforce is on zero-hours contracts. Over a fifth of the adult social care workforce (22%) were on zero-hours contracts in 2022/23, including 32% of care workers.[341] This compares to 3.5% of the wider economically active population.[342] Domiciliary care services had the highest proportion of workers employed on zero-hours contracts (42%), especially among care workers (50%).[343]

The adult social care workforce is skewed towards an older and female profile. In 2022/23 the adult social care workforce comprised 81% female workers.[344] The mean age of all care workers is 43 years, with 29% aged 55+, compared to 21% of workers in the economically active population.[345] From a workforce planning point of view, workers aged 55 and over may retire within the next ten years. Almost one-quarter (23%) of the adult social care workforce report being of Asian, Black or another minority ethnicity,[346] compared with 19.3% of the working age [347] population of England and Wales.[348]

The largest proportion (48%) of the Public Health Specialist workforce is based in local authorities. This is followed by 19% at the UK Health Security Agency, 17% in the NHS, 14% in Higher Education Institutes, and 4% at the Office for Health Improvement and Disparities.[349] Females make up most of the Public Health Specialist workforce in all but the Higher Education Institutes sector.[350] In all five of the sectors, the majority of the workforce has stated their ethnicity as White.[351]

4.2 The future workforce gap

Without "concerted and immediate action", the NHS will face a workforce gap of more than 260,000–360,000 staff by 2036/37.[352] This figure comes from modelling of NHS workforce demand over a 15-year period, undertaken by NHS England to inform the NHS Long Term Workforce Plan. The plan projects an increase to the permanent NHS headcount workforce to between 2.2 and 2.3 million staff in 2036/37, assuming the plan's actions are fully implemented.[353] Alongside an expansion of medical associate professional roles (including physician associates and anaesthesia associates), this comprises an additional 60,000 to 74,000 doctors, 170,000 to 190,000 nurses, 71,000 to 76,000 allied health professionals, and 210,000 to 240,000 support workers.[354] The Institute for Fiscal Studies estimates that by 2036/37, one in eleven (9%) of all workers in England will work for the NHS, compared with one in seventeen (6%) in 2021/22.[355]

338. Skills for Care (2022). The state of the adult care sector and workforce in England – 2022.
339. Skills for Care (2023). The state of the adult social care sector and workforce in England - 2023.
340. Skills for Care (2023). The state of the adult social care sector and workforce in England - 2023.
341. Skills for Care (2023). The state of the adult social care sector and workforce in England - 2023.
342. ONS (2024). EMP17: People in employment on zero hours contracts.
343. Skills for Care (2023). The state of the adult social care sector and workforce in England - 2023.
344. Skills for Care (2023). The state of the adult social care sector and workforce in England - 2023.
345. Skills for Care (2023). The state of the adult social care sector and workforce in England - 2023.
346. Skills for Care (2023). The state of the adult social care sector and workforce in England - 2023.
347. 'Working-age population' is defined by the Office for National Statistics as everyone aged 16 to 64.
348. ONS (2023). Working age population. HM Government.
349. The fifth census of Public Health Specialists in England took place in October 2022. It incorporates Public Health Specialists and Directors of Public Health, i.e. all staff on the specialist registers regardless of their job title). Findings are reported in: Edbrooke-Hyson, V. (2023). A Capacity Review - Public Health Specialists in 2022. Health Education England.
350. Edbrooke-Hyson, V. (2023). A Capacity Review - Public Health Specialists in 2022. Health Education England.
351. Edbrooke-Hyson, V. (2023). A Capacity Review - Public Health Specialists in 2022. Health Education England.
352. NHS England (2023). NHS Long Term Workforce Plan.
353. NHS England (2023). NHS Long Term Workforce Plan.
354. NHS Digital (2024). NHS Workforce Statistics - November 2023.
355. Warner, M. & Zaranko, B. (2023). Implications of the NHS Workforce Plan. Institute for Fiscal Studies (IFS).

Expanding training places does not necessarily result in people enrolling on training, completing training, or going on to practise their profession. For example, the NHS Long Term Workforce Plan commits to growing training places for district nurses by 41% to 2028/29.[356] However, research undertaken by the Queen's Nursing Institute has found a significant gap between the commissioned number of places to undertake the District Nurse Specialist Practitioner Qualification, and the number of students enrolled each year, with a 9% reduction seen from 2021/22 to 2022/23.[357] They report efforts to shift care closer to people's homes are being hampered by insufficient numbers of district nurses.[358]

An influx of newly qualified staff may reduce safety in the short-term. A University of York study of team composition and productivity undertaken across an NHS Trust's three hospitals (52 wards) found the probability of a patient death is lower for teams with a greater number of qualified and senior nursing staff. There was a lower probability of a patient death in teams where nurses have more experience in the Trust, and a lower probability of death for patients treated by staff who regularly work together and on the ward in question. The results also showed higher mortality rates when there is an unexpected absence of a senior nurse who leads the team.[359]

An influx of newly qualified staff may reduce productivity in the short-term. Analysis by the Nuffield Trust suggests a combination of a higher proportion of staff being new to their career, new to the NHS and new to their role provides important context in ongoing attempts to understand the NHS's productivity problem.[360] This coheres with research undertaken by the Institute for Government which found the balance of the doctor and nurse workforce looks to have shifted towards less experienced practitioners.[361] They found the NHS has lost many experienced staff who are being replaced by junior staff. They found the number of new staff affects patient flow through hospitals because many new staff don't have the experience to make the kinds of decisions – like if further tests are needed before discharge – which can see patients discharged quicker. Moreover, the time taken to train junior staff drains the capacity of the more experienced staff who remain in post.[362]

The NHS Long Term Workforce Plan does not consider the implications for the NHS pay bill of recruiting large numbers of new staff. The UK Government has allocated £2.4 billion of additional funding for the training of new staff. However, the NHS Long Term Workforce Plan does not consider what the Institute for Fiscal Studies (IFS) identifies as the "much larger"[363] medium-term implications of a large increase in staff wage and overhead costs. The IFS also anticipates that a rapid increase to the workforce will "likely require NHS wages to become more generous in real terms and – potentially – match or even exceed growth in wages in the rest of the economy".[364]

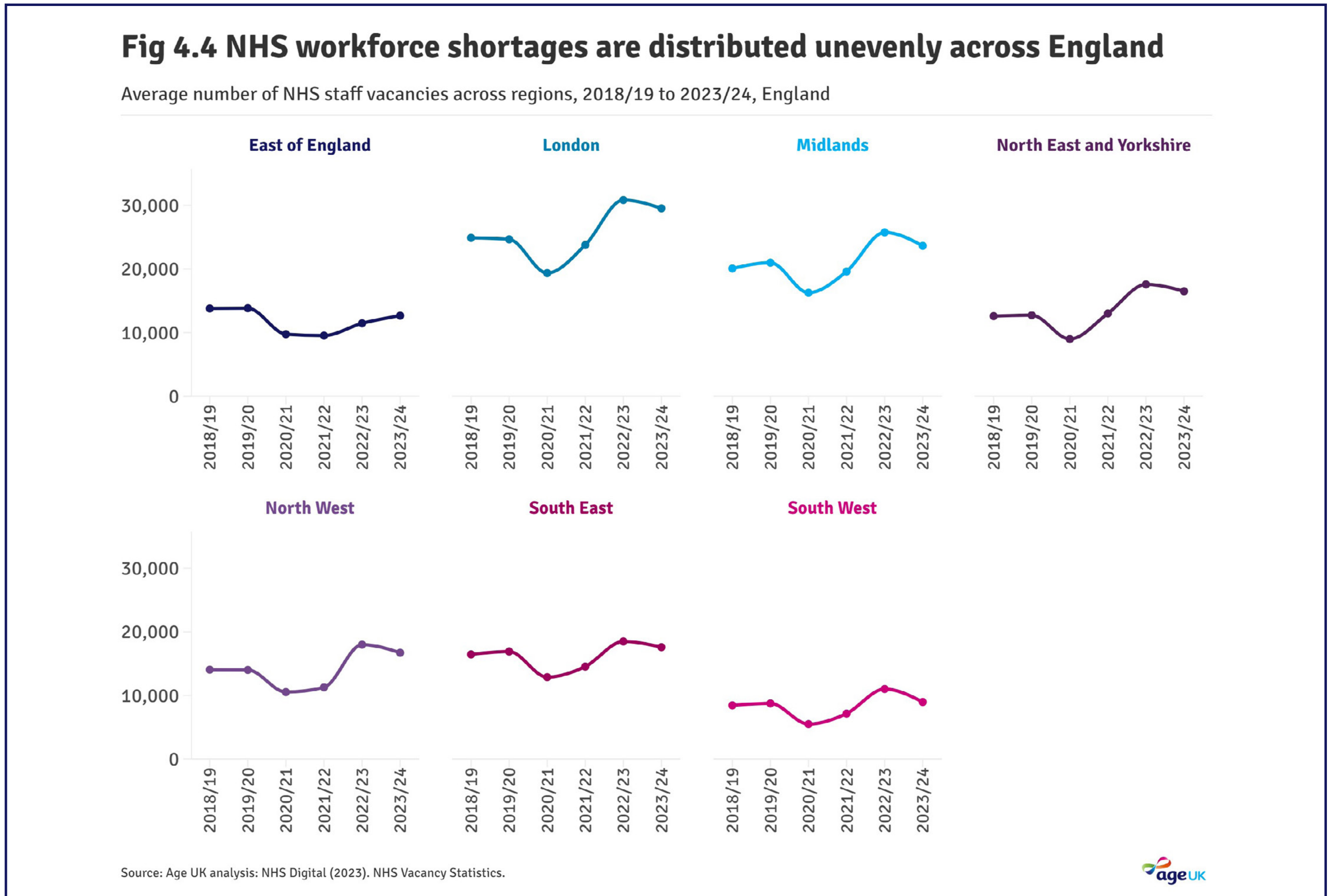
The adult social care workforce needs an extra 440,000 people by 2035 to keep pace with demand. This is a 'base case' projection by Skills for Care, based on the projected number of older people who will be aged 65+ in 2035.[365] In addition, the adult social care workforce may lose a further 440,000 workers in the next 10 years if those aged 55+ decide to retire.[366]

356. NHS England (2023). NHS Long Term Workforce Plan.
357. Queen's Nursing Institute (QNI) (2023). QNI study shows falling numbers gaining District Nurse Specialist Practitioner Qualifications.
358. Queen's Nursing Institute (QNI) (2023). QNI study shows falling numbers gaining District Nurse Specialist Practitioner Qualifications.
359. Kelly, E., Propper, C. & Zaranko, B. (2022). Team composition and productivity: evidence from nursing teams in the English National Health Service. Health, Econometrics and Data Group, University of York.
360. Rolewicz L (2024). The changing experience levels of NHS staff. Chart of the week, Nuffield Trust.
361. Freedman, S. & Wolf, R. (2023). The NHS productivity puzzle. Institute for Government & Public First.
362. Freedman, S. & Wolf, R. (2023). The NHS productivity puzzle. Institute for Government & Public First.
363. Warner, M. & Zaranko, B. (2023). Implications of the NHS Workforce Plan. Institute for Fiscal Studies (IFS).
364. Warner, M. & Zaranko, B. (2023). Implications of the NHS Workforce Plan. Institute for Fiscal Studies (IFS).
365. Skills for Care (2023). The state of the adult social care sector and workforce in England - 2023.
366. Skills for Care (2023). The state of the adult social care sector and workforce in England - 2023.

4.3 Recruitment and retention

There are more, but still not enough, people working in the NHS. The vacancy rate for FTE staff in English NHS trusts reduced from 9.0% in the quarter to 31st December 2022 to 7.6% in in the quarter to 31st December 2023, but 110,781 FTE posts remained unfilled.[367] Of these vacant posts, 34,709 were FTE registered nurse vacancies (8.4% vacancy rate). This is a decrease on the same period the previous year when there were 43,251 FTE registered nurse vacancies (10.7% vacancy rate).[368] Around 8,758 vacancies were FTE registered doctor vacancies (5.7% vacancy rate). This is a small increase on the number of FTE registered doctor vacancies in the same period the previous year (8,709) but represents a small decrease to the vacancy rate (5.9%).[369]

NHS workforce shortages are unevenly distributed across the country. As set out in Figure 4.4, total vacancies are highest in London, the Midlands, and the South East. Most areas saw a small reduction in vacancies over the last year, though the East of England saw a continued trend of increasing vacancies since the COVID-19 pandemic.



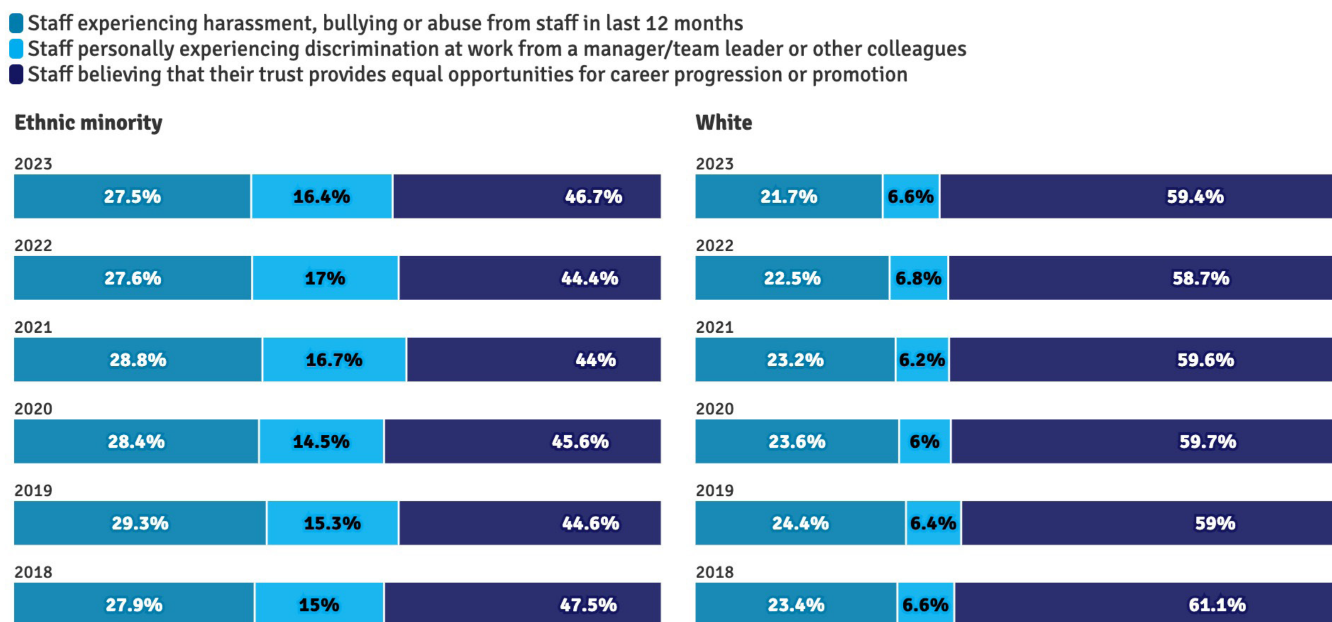
While NHS workforce wellbeing has slightly improved over the last few years, burnout, exhaustion, and work-related stress remain very high. The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. In 2023, 34.2% of staff reported they find their work emotionally exhausting, 30.4% that they feel burnt out because of their work, and 27.7% that they feel exhausted at the thought of another day/shift at work. All these measures have shown small improvements over the last few years. However, 41.7% of staff reported they had felt unwell as a result of work-related stress in the last 12 months, and while this is an improvement on 2020, 2021 and 2022, it remains higher than prior to the COVID-19 pandemic in 2019 (40.5%).[370]

367. NHS England (2024). NHS Vacancy Statistics England, April 2015 to December 2023, experimental statistics.
368. NHS England (2024). NHS Vacancy Statistics England, April 2015 to December 2023, experimental statistics.
369. NHS England (2024). NHS Vacancy Statistics England, April 2015 to December 2023, experimental statistics.
370. NHS Survey Coordination Centre (2024). NHS Staff Survey National Results.

Reduced discretionary efforts from staff may have contributed to hospitals being a tenth less productive than they were before the pandemic. Analysis undertaken by NHS England concluded "adjusted productivity [taking into account a range of factors, including the increasing frailty and acuity of patients admitted to hospital as emergency patients] would be around 11% lower than before the pandemic or 8% if we adjusted for the impact of industrial action". While NHS England conclude there are some contributing factors, such as constraints on social care capacity that part explain this, they note: "This still leaves a gap which we cannot yet explain from national data. In particular, we cannot yet estimate the impact of reduced staff discretionary effort as we have come through the pandemic and industrial action".[371]

While the proportion of doctors leaving has returned to pre-pandemic levels, the number of doctors leaving has increased in the last year.[372] Research undertaken for the General Medical Council identified different groups of migrating doctors based on common characteristics, contexts and factors influencing their migration decisions. These were: burnt-out GPs; international mid-career doctors who felt they'd exhausted all possible career opportunities; international mid-career doctors who recounted negative experiences at work in relation to their identity as a foreign national; mostly UK-trained doctors in their mid to late career who were frustrated with the UK health system; explorers (predominantly younger early-career doctors and older later-career doctors); doctors who had experience of and regularly chose to work in new countries; and salary seekers, who were typically men in their mid-40s.[373]

Figure 4.5 illustrates further reasons that may influence retention of ethnic minority NHS staff; compared to their White counterparts, ethnic minority NHS staff are more likely to experience harassment and bullying from staff, personal discrimination from colleagues at work and believe they are less likely to receive an equal opportunity for progression or promotion.[374]

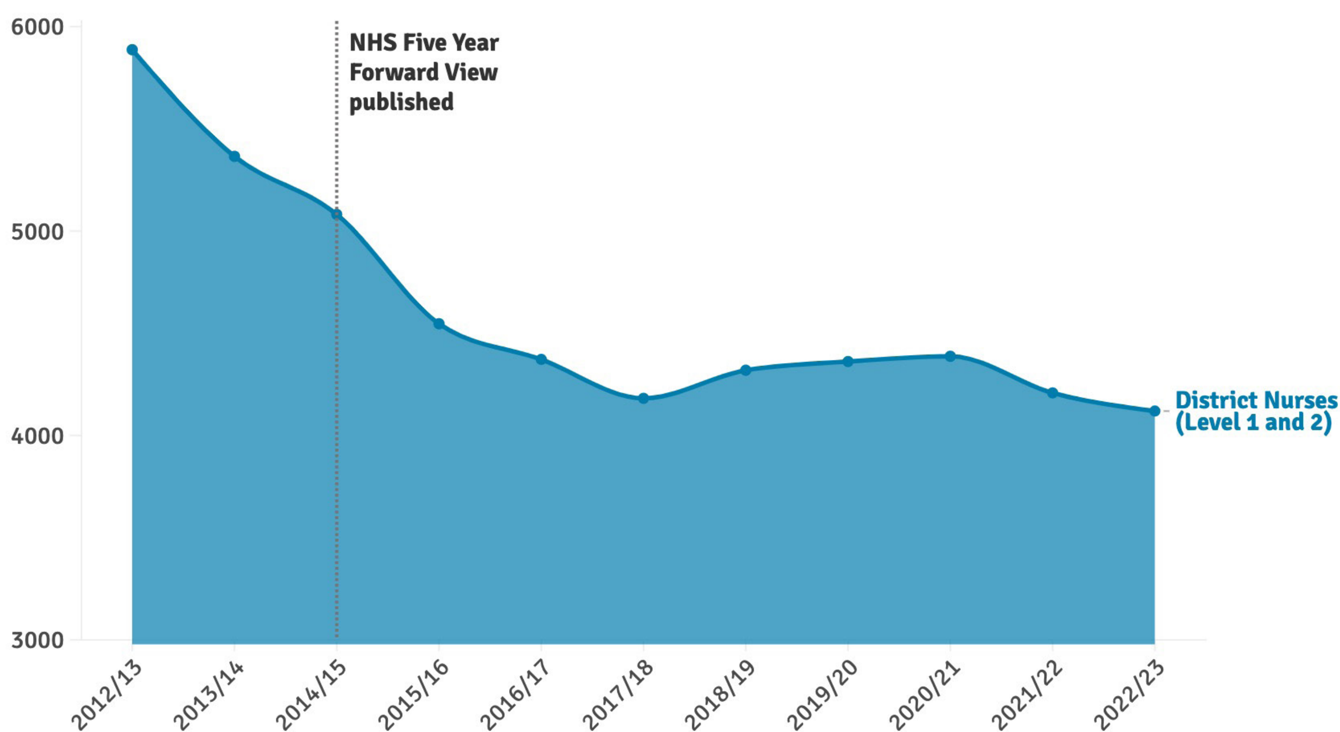


371. Kelly, J. (2024). NHS Productivity [NHS England Board paper – meeting of 16 May 2024]. NHS England.
372. General Medical Council (2023). The state of medical practice and education in the UK.
373. Powell, J. et al (2023). Understanding doctors' decisions to migrate from the UK. Shift Insight.
374. Age UK Analysis 2024 using: NHS Workforce Race Equality Standard 2023. WRES Indicator 6-8.

The number of NHS district nurses has reduced by 17.5% since the NHS Five Year Forward View was published with a commitment to "shift care closer to home"[375] – as shown in Figure 4.6, the number of district nurses has reduced from 5,165 in October 2014 when the NHS Five Year Forward View was launched[376] to 4,262 in October 2023.[377] District nurses manage teams of community nurses and support workers, as well as visit house-bound patients to provide treatment, care and advice, including wound management, catheter and continence care, and medication support. A study by the Queen's Nursing Institute into recruitment and retention issues within district nursing identified an ageing workforce heading for retirement, unmanageable caseloads, working large amounts of unpaid overtime, and having insufficient time to devote proper care to patients as significant challenges for the profession.[378] The broader picture of nursing is less bleak, with the number of permanently registered nurses in England having increased by 8.3% between March 2020 (563,757) and March 2023 (610,359).[379]

Fig 4.6 The number of NHS district nurses has reduced by 17.5% since the NHS Five Year Forward View was published with a commitment to "shift care closer to home"

Number of full-time equivalent NHS district nurses, 2012/13 to 2022/23, England.



Source: Age UK analysis: NHS Digital (2023). NHS Workforce Statistics - November 2023.

375. Hunt, J. [Secretary of State for Health]. HC Debate – Five Year Forward View (23 October 2014). Volume 589. Column 1044.
376. 4,643 first level and 527 second level. NHS Digital (2024). NHS Workforce Statistics - November 2023 [Staff Group, Care Setting and Level data set].
377. 3,932 first level and 330 second level. NHS Digital (2024). NHS Digital (2024). NHS Workforce Statistics - November 2023 [Staff Group, Care Setting and Level data set].
378. Queen's Nursing Institute (2019). District Nursing Today: The View of District Nurse Team Leaders in the UK.
379. Nursing and Midwifery Council (2023). The NMC Register - England: 1 April 2022 – 31 March 2023.

The NHS depends on temporary staffing to fill vacancies, despite recognising a heavy reliance on temporary staff to be associated with a higher risk of patients dying.[380] Temporary staffing includes both internal 'banks' of staff and external agency workers. Since 2015, there have been caps on the hourly rates paid for all agency staff in the English NHS that are designed to ensure agency pay is in line with equivalent, directly employed NHS staff. Agency spending in England reduced by a third in just two years to £2.9bn in 2017/18 and then remained relatively flat going into the COVID-19 pandemic.[381] However, the price caps include 'break glass' provisions that allow trusts to override them "in exceptional circumstances and where there are risks to patient safety and clinical quality".[382] Spending on agency staff increased by 23% (from £2.4bn to £3.0bn) between 2018/19 and 2021/22.[383] Spending on internal bank staff increased even more dramatically during the same period, rising by 51% – from £3.5bn to £5.2bn.[384] This puts the total spend on temporary staffing at £8.2bn in 2021/22. LaingBuisson reports the total spend on temporary staffing to be higher still for 2022/23, at £10.4bn (an increase of 26.8%).[385]

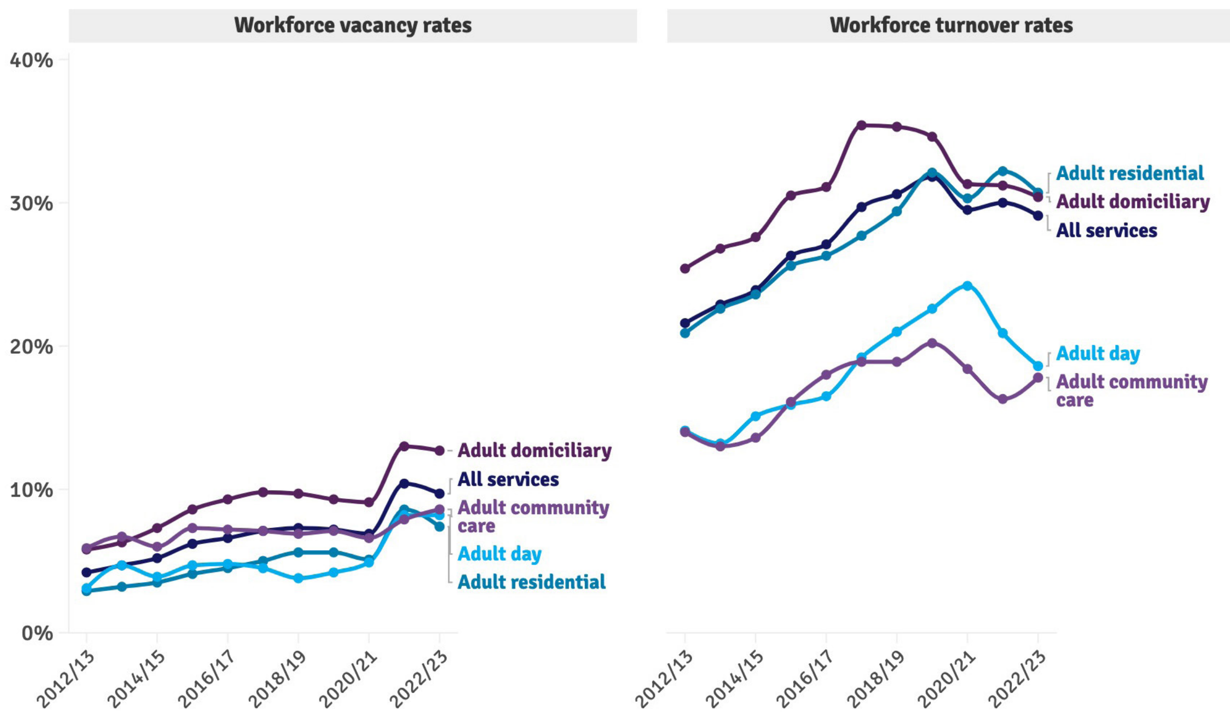
There are concerns about safe staffing levels. "Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed [by health and care providers] in order to meet the requirements".[386] There is no set formula for calculating safe staffing levels or ratios, but the British Medical Association has warned that both patient and staff safety are at severe risk because of current levels.[387] The Royal College of Nursing has warned that staffing levels are poor in many places and on most shifts, with patient care being compromised as a result of unsustainable pressures.[388] England has a low number of both doctors per person and nurses per person compared to its peer countries.[389]

There are not enough people working in adult social care. As Figure 4.7 demonstrates, the social care sector is also struggling to fill vacancies. While the vacancy rate reduced from 10.6% in 2021/22 to 9.9% in 2023/24, there were still an average of 152,000 vacant posts a day.[390] The decade-long trend is for the adult social care vacancy rate to be significantly higher than that of the wider economy.[391] The fall in the vacancy rate, from the historic high in 2021/22, was driven by a sharp increase in the number of overseas staff recruited to work in adult social care.[392] The 2021/22 historic high was, at least in part, due to the impacts of the COVID-19 pandemic alongside the end of EU freedom of movement under the post-Brexit immigration system which initially restricted international recruitment into social care.[393]

380. Aiken, L. H., Shang, J., Xue, Y., & Sloane, D. M. (2013). Hospital use of agency-employed supplemental nurses and patient mortality and failure to rescue. Health Services Research, 48(3), 931–948. – Cited in the NHS Long Term Workforce Plan, paragraph 1.8.
381. O'Dowd, A. (2024). NHS temporary staffing bill "skyrockets" to £10.4bn. BMJ 384:q140.
382. Monitor (2015). Price caps for agency staff: impact assessment.
383. NHS England (2023). NHS Long Term Workforce Plan.
384. NHS England (2023). NHS Long Term Workforce Plan.
385. O'Dowd, A. (2024). NHS temporary staffing bill "skyrockets" to £10.4bn. BMJ 384:q140.
386. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
387. BMA (2021). Medical staffing in England: A defining moment for doctors and patients.
388. Royal College of Nursing (2022). Nursing Under Unsustainable Pressure: Staffing for Safe and Effective Care.
389. Anandaciva, S. (2023). How does the NHS compare to the health systems of other countries? The King's Fund.
390. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
391. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
392. King's Fund (2024). Social care 360: workforce and carers.
393. Allen, L. & Shembaynekar, N. (2023). Social care workforce crisis: How did we get here and where do we go next? The Health Foundation.

Fig 4.7 The social care sector is struggling to fill vacancies in almost every key adult social care role

Workforce vacancy and turnover rates for key adult social care roles, 2012/13 to 2022/23, England.



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

More than half (54%) of adult social care providers report difficulties recruiting new staff.[394] Retaining staff is also a challenge, with almost one-third (31%) of adult social care providers reporting difficulties.[395] Providers cite low pay, high pressure, and staff burnout as key causes of many care workers leaving the sector for better paid jobs in less pressurised environments.[396] Research commissioned by Skills for Care found 30% of care workers who were still working in the sector reported leaving their previous job because of poor workplace culture or communication.[397]

Care worker pay is amongst the lowest in the economy.[398] In 2022/23, direct care workers were paid a mean hourly rate of £10.43 in the independent sector and a mean hourly rate of £12.16 in the local authority sector. Senior care workers were paid a mean hourly rate of £11.09 in the independent sector and £14.23 in the local authority sector. Personal assistants were paid a mean of £10.92 an hour.[399] Skills for Care reported some employers to be offering bonuses, golden hellos, and incentive payments to increase recruitment and retention in 2021/22, but their research indicates these have not continued into 2022/23.[400] Through their adult social care provider information return, the Care Quality Commission identified the cost-of-living crisis to have "pushed some care staff into vulnerable financial positions... providers describe that some care staff are struggling to afford basics".[401]

394. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.
395. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.
396. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.
397. Silversides, K. & Astakhov, M. (2023). Understanding the reasons care workers move on and their future intentions. QaResearch for Skills for Care.
398. Foster, D. (2024). Adult social care workforce in England. House of Commons Library.
399. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
400. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
401. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.

Experienced social care staff earn almost the same as new starters. Care workers with five or more years' experience are, on average, earning around just 6p more per hour than care workers with less than one year of experience. Pay progression has worsened over time, with care workers in the same position an additional 33p per hour in 2016.[402] In 2022, the Migration Advisory Committee reported care workers who have been working with the same employer for between five and 10 years could expect to earn 3% more than those who had been with the same employer for less than a year. This is set against a differential of 7% in competing occupations.[403] Organisations including ADASS have warned for some years that investment into NHS pay progression has not been paralleled in adult social care, exacerbating recruitment and retention challenges.[404] In 2022 and 2023, average care worker pay was £1 per hour less than healthcare assistants (HCAs) in the NHS that are new to their roles, and HCAs in the NHS with two or more years' experience are paid 53p more than HCAs who are new in post.[405]

In adult social care, the number of days lost to staff sickness is reducing but is still higher than before the COVID-19 pandemic. The number of days lost to sickness has steadily reduced from 8 days per person in April 2022 to 6.4 days in July 2023. However, in 2019/20 the average number of days lost to sickness per person was 4.6.[406] More than 1.6 million days (1,653,117 FTE days) of sickness absence were taken by local authority-based [adults and children's] social care staff in 2022-2023 in total. A study undertaken by the British Psychological Society and British Association of Social Workers found that mental health, stress, and work-related stress was behind nearly one-third (30%) of social care staff sickness absence in councils in England in 2022/23. This equates to 500,021 FTE days.[407]

Too many people are leaving their adult social care roles, with a third leaving social care completely. The adult social care turnover rate decreased from 28.9% in 2021/22 to 28.3% in 2022/23.[408] However, 390,000 people left their roles in 2022/23, with a third of them leaving social care completely.[409] A high turnover, even when people continue working in the sector, disrupts continuity of care and uses precious resources. The turnover rate for care workers was 35.6% in 2022/23, which is much higher than that of senior care workers at 15.3%.[410] Senior care worker roles often have higher pay, guaranteed hours, and more training and qualification opportunities than care workers roles. Registered nurses working in adult social care also have a high turnover rate (32.6% in March 2023) compared with registered nurses and health visitors working in the NHS (10.9% in March 2023).[411]

It is costly to replace adult social care staff. In 2017, Skills for Care estimated costs of £3,642 to replace a member of staff.[412] Adjusted for inflation, this figure is now likely to be closer to £4,660.[413] This includes buying in agency cover until the vacancy is filled, advertising the post, interviews, checks, induction and a probation period with additional supervision.[414] These recruitment costs represent a large proportion of the average annual wage of a care worker – 21.9% of the average independent sector care worker's FTE salary (£21,300[415]) in 2022/23.

402. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
403. Migration Advisory Committee (2022). Adult Social Care and Immigration: A Report from the Migration Advisory Committee.
404. ADASS (2018). Autumn Budget 2018 – Representation by the Association of Directors of Adult Social Services.
405. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
406. Care Quality Commission (2023). The state of health care and adult social care in England 2022/23.
407. British Psychological Society (2023). One third of social care workforce sickness absence due to mental health and stress, troubling new figures reveal.
408. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
409. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
410. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
411. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
412. Skills for Care (2020). The state of the adult social care sector and workforce in England – 2020.
413. Calculated using the Bank of England's Inflation Calculator [20.03.2024].
414. Skills for Care (2019). The state of the adult social care sector and workforce in England – 2019.
415. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023 [data pack].

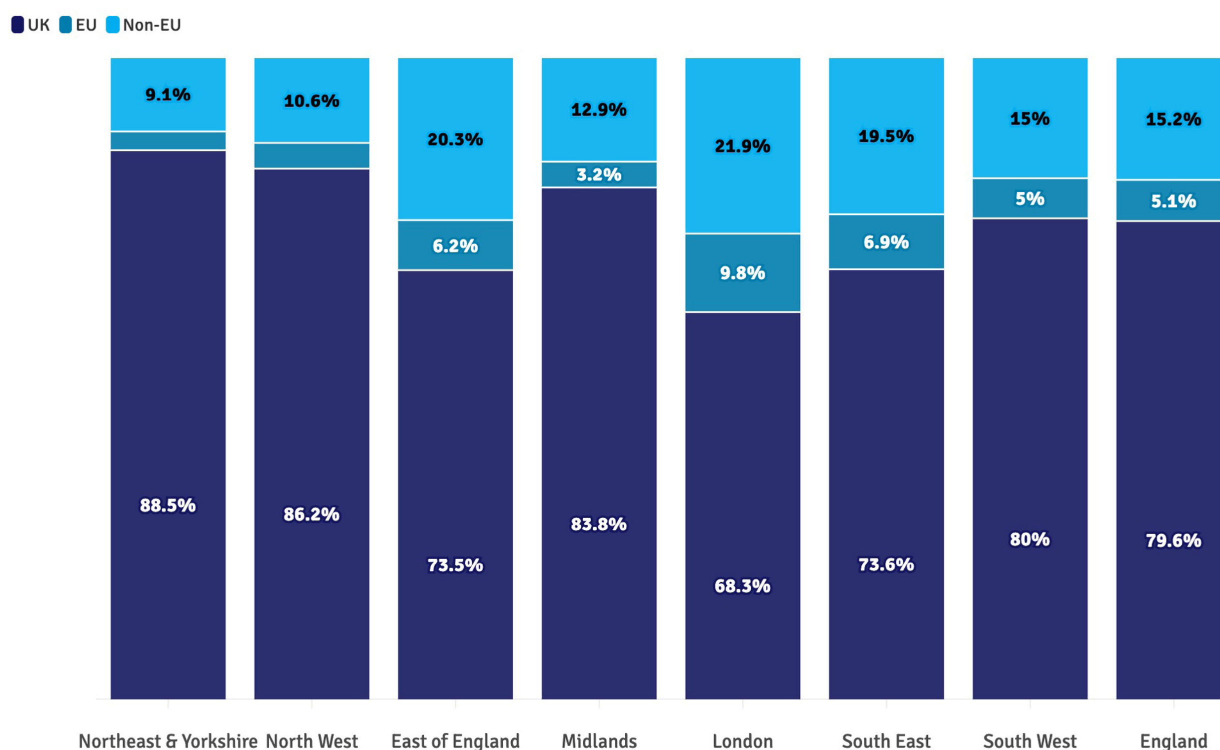
4.4 International recruitment

International staff account for nearly 1 in every 5 people who work in the NHS. International staff have always and will always be an important part of the health workforce. As of June 2023, 81.3% of NHS staff in England for whom a nationality is known are British, 8.6% report an Asian nationality, 5.2% are EU nationals, and 3.8% report an African nationality. Indian, Filipino, Nigerian, Irish and Polish are the most-commonly reported nationalities after British.[416] In recent years there has been a sharp increase in the proportion of NHS staff reporting an Asian or African nationality.[417] The increase in the proportion of staff reporting EU nationality that was seen in the early 2010s stopped after the EU referendum and the proportion has since fallen slightly.[418]

Some regions are more dependent on international staff in the NHS workforce than others. As shown in Figure 4.8, in the North East and Yorkshire, 88.5% of staff with a known nationality are British, while in London 68.3% are British.[419]

Fig 4.8 Some regions, such as the East of England and London, are more dependent on international staff in the NHS workforce than others

Nationality of the NHS workforce, by region, 2022/23, England.



Source: Age UK analysis: NHS Digital (2023). Supplementary information on NHS Staff by nationality and region - June 2023.

International recruitment into the NHS workforce is growing. The proportion of people joining the NHS with UK nationality is falling. In 2022/23, 68.7% of joiners had UK nationality, down from a range of 80-85% in the pre-pandemic years. For nurses it fell to 55.3%, down from a range of 75-85%. The data shows that the proportion of all joiners reporting an EU/EEA nationality has also fallen since 2015/16, from 10.9% to 6% in 2022/23. Meanwhile the percentage of joiners with a non-EU/EEA nationality rose sharply between 2017/18 and 2022/23, from 9.9% to 25.3%.[420]

416. Baker, C. (2023). NHS staff from overseas: statistics. House of Commons Library.
417. Baker, C. (2023). NHS staff from overseas: statistics. House of Commons Library.
418. Baker, C. (2023). NHS staff from overseas: statistics. House of Commons Library.
419. Baker, C. (2023). NHS staff from overseas: statistics. House of Commons Library.
420. Baker, C. (2023). NHS staff from overseas: statistics. House of Commons Library.

The number of international medical graduates (IMGs) joining the GP Register almost tripled from 2018/19 to 2022/23, but IMGs are more likely to leave than UK graduates. The number of international medical graduates increased by 192% from 2018/19 to 2022/23, while the number of UK graduates joining the GP Register fell by 4% across the same period.[421] GMC analysis has shown UK graduates are more likely to revalidate their license to practice than doctors who received their Primary Medical Qualification from outside the UK and international medical graduates.[422]

Thousands of nurses, including many who were internationally recruited, are leaving the UK to work elsewhere. Recent analysis by the Health Foundation found the number of UK-registered nurses moving to other countries doubled in just one year between 2021/22 and 2022/23, to a record 12,400. Of these, almost 9,000 were overseas-trained nurses who first trained outside the UK and the EU. This is four times the number of nurses looking to leave than in 2018/19. Most of the nurses leaving the UK have moved to the US, New Zealand or Australia, where nurses are paid substantially more than in the UK.[423]

There is a global shortfall of health workers. The World Health Organisation (WHO) projects this to reach 10 million by 2030, predominantly in low- and middle-income countries.[424] The WHO warns that if health worker migration is not adequately managed, then "international mobility and migration of health workers from countries facing heath worker shortages can weaken their health systems and widen inequities".[425] Heath and social care organisations in England must not actively recruit from those countries the WHO recognises as having the most pressing health and care workforce-related challenges. These are known as 'red-list' countries. However, concerns have been raised about a rise in recruitment from red-list countries, including Nigeria, Ghana and Pakistan.[426]

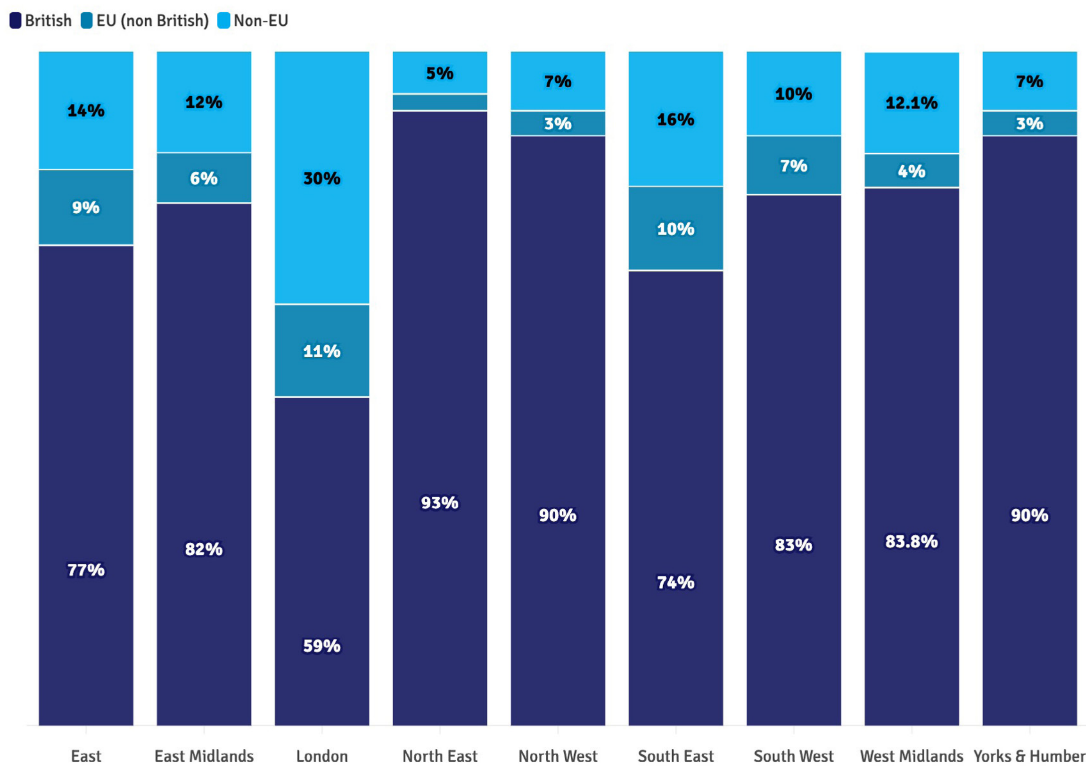
International staff account for nearly 1 in every 5 people who work in adult social care. In 2022/23 around 81% of the adult social care workforce had a British nationality,[427] compared with 84% in 2021/22.[428] The proportion of the workforce identifying as an EU nationality fell slightly, from 7% in 2021/22[429] to 6% in 2022/23.[430] The proportion of the workforce identifying as non-EU nationality increased from 9% in 2021/22[431] to 13% in 2022/23.[432]

Some regions are more dependent on international staff in the adult social care workforce than others. As shown in Figure 4.9, international staff make up 41% of the adult social care workforce in London, compared to just 7% in the North East of England.

421. General Medical Council (2023). The state of medical practice and education in the UK.
422. General Medical Council (2022). The state of medical education and practice in the UK.
423. Bazeer, N., Kelly, E. & Buchan, J. (2024). Nursing locally, thinking globally: UK-registered nurses and their intentions to leave. Health Foundation.
424. World Health Organisation (WHO) (2024). Bilateral agreements on health worker migration and mobility: Maximising health system benefits and safeguarding health workforce rights and welfare through fair and ethical international recruitment.
425. WHO (2024). Health Workforce Migration.
426. Nuffield Trust (2022). The costs of Brexit make severe challenges even harder for the NHS and social care.
427. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
428. Skills for Care (2022). The state of the adult social care sector and workforce in England – 2022.
429. Skills for Care (2022). The state of the adult social care sector and workforce in England – 2022.
430. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
431. Skills for Care (2022). The state of the adult social care sector and workforce in England – 2022.
432. Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.

Fig 4.9 International staff make up 41% of the adult social care workforce in London, compared to just 7% in the North East of England

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



Source: Age UK analysis: Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023. • This is local authority and independent sector data only – data about personal assistants funded through direct payments is not available.

International recruitment into adult social care has grown following UK Government policy efforts. In 2022, the Migration Advisory Committee noted that historically there had been “very little direct recruitment of migrant workers into social care” and “most workers starting a job in social care were already in the UK”.[433] The UK Government states it is “committed to helping providers make more effective use of international recruitment to help grow the adult social care workforce”.[434] Senior care workers were added to the Shortage Occupation List and made eligible for the Health and Care Worker visa route in April 2021, with care workers following in February 2022. This means workers who have a licenced sponsor and meet the salary threshold can come to the UK to take up these roles. According to Home Office data, the number of visas issued to social care workers, excluding dependants, reached a record 106,000 in 2023.[435] Skills for Care reports international recruitment increased more than fivefold for direct care providing roles in the independent sector between 2021/22 and 2023/24.[436]

In December 2023, the UK Government announced a package of restrictions on visas for care workers and senior care workers.[437] Applications for care workers and senior care workers received after 11 March 2024 will no longer be able to bring dependants to the UK as part of their visa (those already in this visa route will be able to remain).[438] Restrictions have resulted in a sharp fall in visa applications from nurses and care workers. Health and Care main applicants are down 81% or 46,800 in the four months to July 2024, compared with the same period last year.[439]

433. Migration Advisory Committee (2022). Adult Social Care and Immigration: A Report from the Migration Advisory Committee.
434. DHSC (2023). International recruitment fund for the adult social care sector: Guidance for local authorities.
435. The Migration Observatory (2024). Social care sector continues to drive demand for overseas workers as new data shows public sector roles dominate work visas. University of Oxford.
436. Skills for Care (2024). The size and structure of the adult social care sector and workforce in England.
437. Home Office (2023). Net migration measures – further detail.
438. NHS Employers (2024). Skilled worker: Health and Care Visa.
439. Cecil, N. (2024). Visa crackdown leads to big fall in foreign health and care workers and students coming to the UK. The Standard.

Modern slavery is "a trend and a feature"[440] of adult social care. The national Modern Slavery Helpline reports a 1,100% increase in recording of potential victims of modern slavery in the adult social care sector pre- and post- care workers being added to the Shortage Occupation List – from 63 in 2021 to at least 800 in 2023.[441] James Bullion, Chief Inspector of Adult Social Care and Integrated Care noted in evidence to the Health and Social Care Committee: "A few years ago we would have had a market based on more free movement from Europe. Where you have got a situation where you are dependent on a visa and you are then dependent on an employer the possibility for exploitation then increases significantly".[442] Migration Observatory warned care workers "will become more isolated if they come to the UK alone, and so may become more vulnerable to exploitation".[443] In December 2023, the UK Government confirmed: "No assessment has been made of the potential impact of the changes to visas... on the mental health and general well-being of workers in health and care roles".[444]

4.5 Wider infrastructure

Capital spend on NHS infrastructure is "essential to the long-term sustainability of the NHS's ability to meet healthcare need". Published in 2019, the UK Government's five-year Health Infrastructure Plan also notes capital spend to be essential to unlocking efficiencies and helping manage demand. Furthermore, it recognises capital spend to be "fundamental to high-quality patient care, from well-designed facilities that promote quicker recovery, to staff being better able to care for patients using the equipment and technology that they need".[445]

4.5.1 Estates

The NHS backlog of building maintenance will cost billions to resolve. The total capital assets employed across the health system in England have a value of over £50 billion,[446] but many assets do not meet the demands of a modern health service. For example, 14% of the NHS estate predates the formation of the NHS in 1948 and includes numerous Victorian-era buildings.[447] A review of NHS capital expenditure published by the National Audit Office just prior to the COVID-19 pandemic, found an estimated total backlog maintenance[448] of £6.5bn, with £1.1bn of the backlog being high-risk, "putting patients at risk of harm".[449] In late 2023, the total cost of eradicating the NHS backlog maintenance in England had risen to £11.6bn, with the high-risk backlog standing at £2.4bn.[450] These figures do not include planned maintenance – they only account for work that should have already taken place.

There has been a "lack of progress" in terms of improving hospitals and building new ones. The UK Government launched the New Hospital Programme in October 2020, outlining eight hospital building projects that were already under construction or pending final approval, with the pledge for 40 more to be completed by 2030. There has been significant debate about what constitutes both a "hospital" and a "new hospital".[451]

440. James Bullion, Chief `Inspector of Adult Social Care and Integrated Care at the Care Quality Commission, in oral evidence given to the Health and Social Care Committee. Health and Social Care Committee (2023). Oral evidence: Social care: changes to legal migration measures, HC 411. London: House of Commons.
441. Booth, R. (2024). Modern slavery in social care surging since visa rules eased. The Guardian.
442. Health and Social Care Committee (2023). Oral evidence: Social care: changes to legal migration measures, HC 411. London: House of Commons.
443. The Migration Observatory (2024). Social care sector continues to drive demand for overseas workers as new data shows public sector roles dominate work visas. University of Oxford.
444. Stephenson, A. (2023). UK Parliament: Written question, HC 5734, tabled 7 December 2023, answered 12 December 2023. London: House of Commons.
445. DHSC (2019). Health infrastructure plan: A new, strategic approach to improving our hospitals and health infrastructure.
446. DHSC (2019). Health infrastructure plan: A new, strategic approach to improving our hospitals and health infrastructure.
447. NAO (2020). Review of capital expenditure in the NHS.
448. Backlog maintenance' is a measure of how much would need to be invested to restore a building to a reasonable working condition.
449. NAO (2020). Review of capital expenditure in the NHS.
450. NHS England (2023). Estates Returns Information Collection, Summary page and dataset for ERIC 2022/23.
451. Full Fact (2022). Is the Government going to build 48 new hospitals by 2030?

The Public Accounts Committee held an inquiry into the programme and concluded in November 2023 that it was "extremely concerned by the lack of progress the New Hospital Programme has made in the three years since its creation", that there "appears to be insufficient funding for DHSC to build all the hospitals it plans, and to an adequate size, by 2030", and that it has "no confidence that even [a] reduced target of 32 new hospitals is achievable by 2030".[452] In late July 2024, the recently elected Government announced they would "reset" the programme and set out a new costed timetable for delivery.[453]

Upgrades to infrastructure need to be made in an environmentally sustainable and responsible way. Hospitals in England are already subject to the impacts of heatwaves and increased flooding. An overheating incident is logged when an occupied ward or clinical area's daily maximum temperature exceeds 26°C, the temperature at which some people become unable to cool themselves effectively.[454] In 2022/23, the number of incidents of overheating in English NHS Trusts reached a record 6,822, up 23% on the previous year.[455] The number of serious flooding incidents, where water caused disruption such as by breaching a building or flooding a road, rose from 176 to 279 between 2021/22 and 2022/23.[456]

Rectification of reinforced autoclave aerated concrete (RAAC) issues has added billions to capital costs. During the Public Accounts Committee's inquiry into the New Hospital Programme, seven hospitals were added to the programme because they need rebuilding due to issues with reinforced autoclave aerated concrete (RAAC).[457] Five are entirely made of RAAC and the National Audit Office reports an average estimated cost of £1bn each to rebuild them.[458]

Reinforced autoclave aerated concrete (RAAC) is also an issue within adult social care. DHSC reports it "does not hold sufficient proxy data covering the wide range of organisations and settings involved in service delivery to make meaningful estimates of RAAC prevalence".[459] However, safety concerns about the use of RAAC have affected social care facilities including day centres and care homes. In September 2023, Westside Community Centre in Basingstoke closed because RAAC panels were used in its construction,[460] affecting older people's activities including seated Pilates, short mat bowls, and senior art classes. Efforts are underway to move activities to temporary sites including shop units.[461] In January 2024 it was announced that Mount St Mary's in Leeds, home to 60 older people, will be demolished because of RAAC crumbling across the roof, with all residents having to move to alternative accommodation.[462]

Dozens of council-owned or operated care homes in England are empty or have been repurposed because they are not fit for purpose. Freedom of Information requests submitted by the Liberal Democrats asked English councils to detail council-owned or operated care home buildings that are not currently being used to provide care services. Forty-six of 152 councils with adult social services responsibility replied to the Freedom of Information request. They reported 94 care homes that are not being used for their original purpose, of which 37 are not fit for purpose, 15 are empty, 19 are being refurbished, and 15 are being used for other purposes such as office accommodation. With only 46 of 152 councils with adult social services responsibility responding to the Freedom of Information request, it is likely there are dozens more council-owned or operated care homes in a similar situation.[463]

452. Public Accounts Committee (2023). The New Hospital Programme: First Report of Session 2023/24.
453. 29 July 2024, Oral statement to Parliament: Chancellor statement on public spending inheritance.
454. Department of Health (2015). Health Technical Memoorandum 07-02 – making energy work in healthcare, Section 1.4.16.
455. Bawden, A. (2023). Overheating and flooding at hospitals in England 'pose threat to patient safety'. The Guardian.
456. Bawden, A. (2023). Overheating and flooding at hospitals in England 'pose threat to patient safety'. The Guardian.
457. DHSC (2023). New Hospital Programme – media fact sheet.
458. NAO (2023). Progress with the New Hospital Programme.
459. Dunn, S. (Second Permanent Secretary) (2024). Reinforced Autoclave Aerated Concrete – letter to the Chair of the Public Accounts Committee. DHSC.
460. Cullum, J. (2023). Westside Community Centre closes after dangerous concrete found. Basingstoke Gazette.
461. Crossman, L. (2024). Westside Community Centre: Services to continue running. Basingstoke Gazette.
462. Oscroft, K. (2024). Mount St Mary's care home in Leeds to be demolished after RAAC concrete found. ITV News.
463. £) Hazell, W. (2023). Many care homes lying empty despite 37,000 people on waiting list, investigation reveal. The Telegraph.

A new national health security campus is at least 15 years behind schedule and £2.5bn over budget. The UK Government planned, through the UK Health Security Agency (UKSHA), to enhance and replace public health infrastructure with a focus on high-containment laboratories that are essential for protecting the nation against potentially highly infectious diseases. A plan to open a new health security campus in Harlow, Essex by 2021 was projected to cost £530m (in 2015 prices).[464] Costs now stand at more than £3.2 billion (2023 prices), despite changes to scope and timetable, with the facility estimated to open in 2036 at the earliest.[465] The National Audit Office reported in February 2024 that "as things stand, the UK's future resilience to dangerous diseases and value for taxpayers' money are both being undermined by failures in decision-making for a key part of the national infrastructure".[466]

4.5.2 Equipment

The UK has fewer CT and MRI scanners than any of the comparator countries.[467/468] This is despite a commitment in 2019's NHS Long Term Plan for capital investment to be made into new equipment, including CT and MRI scanners.[469] Analysis undertaken by experts from organisations including Alzheimer's Research UK, Alzheimer's Disease International and the Alzheimer's Society [noted in Section 2.1.4], has flagged concerns about whether there are sufficient PET and MRI scanners to ensure timely and equitable access to new dementia treatments for people across the country.[470] Their analysis concluded England has the lowest per capita number of PET scanners of any G7 country (1.20 per 1 million people) and the lowest number of MRI scanners (6.31 per 1 million people).[471] Coroners have issued numerous prevention of future death reports and responses that conclude shortages of imaging equipment and associated workforce likely contributed to a patient's death, and warn the NHS that a lack of imaging capacity could lead to more deaths.[472]

4.5.3 Sustainability of the third sector

The financial stability of third sector organisations has significantly fallen. The latest Third Sector Trends in England and Wales study found that 26.1% of third sector organisations reported their financial stability had fallen significantly in 2022, compared to 13.6% in 2019.[473]

Third sector infrastructure support has reduced over the last decade. Local infrastructure organisations bring community organisations together, build capacity, foster partnerships, and provide leadership.[474] Research from 360 Giving closures, but the effect is that infrastructure support is now more stretched and less available than a decade ago.[475]

464. NAO (2024). Investigation into the UK Health Security Agency's health security campus programme.
465. NAO (2024). Investigation into the UK Health Security Agency's health security campus programme.
466. NAO (2024). Investigation into the UK Health Security Agency's health security campus programme.
467. Comparator countries identified by The King's Fund are: Japan; United States; Australia; Greece; Germany; Italy; Austria; Finland; Sweden; Denmark; Spain; Ireland; Belgium; France; New Zealand; Netherlands; Portugal; and Canada.
468. Mallorie, S. (2023). Comparing the NHS to the health care systems of other countries: five charts. The King's Fund.
469. NHS England (2019). The NHS Long Term Plan.
470. Mattke, S., Shi, Z., Hanson, M. et al. (2024). Estimated Investment Need to Increase England's Capacity to Diagnose Eligibility for an Alzheimer's Treatment to G7 Average Capacity Levels. The Journal of Prevention of Alzheimer's Disease.
471. Mattke, S., Shi, Z., Hanson, M. et al. (2024). Estimated Investment Need to Increase England's Capacity to Diagnose Eligibility for an Alzheimer's Treatment to G7 Average Capacity Levels. The Journal of Prevention of Alzheimer's Disease.
472. (£) Hignett, K. (2021). NHS warned multiple times that imaging shortages may kill. Health Services Journal.
473. Chapman, T. (2023). Third Sector Trends in England and Wales 2022: Finances, assets and organisational wellbeing. Community Foundation.
474. Desforges, M. (2024). Why local VCS infrastructure organisations are crucial to public sector reform, and how we can work with local government to accelerate them. NAVCA.
475. Kane, D. & Cohen, T. (2023). Sector Infrastructure Funding and Analysis. 360 Giving.

Third sector engagement with public service contracts is reducing. The latest Third Sector Trends in England and Wales study[476] found that micro (income <£10,000) and small (income £10,001 to £49,999) organisations have remained disinterested in public-service delivery contracts since 2013. Medium-sized (income £50,000 to £249,999) and larger (income £250,000 to £999,999) organisations have become progressively less likely to engage in bidding for or delivering contracts. Only the largest third sector organisations (with income above £1million) have sustained involvement in such work – although more than a third of the largest organisations do not, and engagement has plateaued. This is not a surprise – local Age UK organisations report being asked to maintain activity without contract uplifts, despite significant inflationary cost pressures.

More people are contacting Adult Social Services Departments for help because of a lack of other services in the community. In their Spring Survey 2022, ADASS found 51% of Directors of Adult Social Services reported more referrals and requests for support because of the lack of other services in the community.[477] Concurrently, almost 350,000 people are being signposted by Adult Social Services Departments to other services in the community each year, while a rapidly increasing number of people contacting Departments for help are provided with no services at all. As shown in Figure 2.1, 377,580 people were provided with no services in 2022/23, up 13.6% on the pre-pandemic year of 2019/20 (332,165 people).

476. Chapman, T. (2023). Third Sector Trends in England and Wales 2022: Finances, assets and organisational wellbeing. Community Foundation.
477. ADASS (2022). Spring Budget Survey 2022.

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