

# **Briefing: Health and Care of Older People in England 2017**

February 2017

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# Foreword

Welcome to this year's Health and Care of Older People in England briefing from Age UK.

The report aims to shine a light on how the system of health and care is working for older people in this country at the moment using the best, most authoritative data available, most of it from official sources.

In some places Age UK has carried out additional analysis of this data to come up with new results and conclusions; wherever this is so it is clearly indicated in the text.

Being able to know that we will receive health and care if and when we should need it matters to all of us, at any age, but it is all the more salient as we get older. Many people in their sixties and seventies enjoy good health and do not need any additional support with daily living, but as we move into our ninth decade and beyond this becomes less common and more of us will need help.

By the time we reach our early eighties only one in seven of us will be free of any diagnosed long term health conditions and, once we reach the age of eighty five, eighty per cent of us will be living with at least two. The same pattern can be observed when it comes to care needs: by our late eighties, more than one in three of us have difficulties undertaking five or more tasks of daily living unaided.

When you consider that the numbers of older people aged eighty five and over have increased by a third over the last decade you can see why experts cite a growing older population as one of the most significant factors behind the rising demand for health and care services in this country.

These demographic changes inevitably mean that we need more health and care services than before but the extent to which this is actually happening, with the right kind of health and care services being made available in the right places, is one of the most crucial issues covered by this report.

Looking further ahead, the numbers of older people aged eighty five and beyond are projected to grow exponentially in the next twenty years, doubling by 2036, so an important question that arises is the extent to which we are on the right path towards meeting these increasing needs and demands in future. This vital question for our society and for the generations of older people to come is addressed at the end of this report.

This briefing is based on numerous facts and figures and contains many graphs and charts. But let's never forget that behind them are millions of 'real' older people. That is why, ultimately, we have compiled this report – to aid our understanding of what is working well in terms of health and care and what needs to change to enable all of us to live as well as we possibly can as we age.

## Summary

It would not be possible or appropriate to create a true summary of all the information presented in this report so instead below we have picked out some of the most important facts and figures, expressed as succinctly as possible. They tell a clear story, the implications of which are discussed in the final section of this report. The findings begin with demographics before turning to care services and health services:

### ***The health and care needs of our ageing population***

The numbers of people aged 85+ in England increased by almost a third over the last decade and will more than double over the next two decades (see page 8).

By their late 80s, more than one in three people have difficulties undertaking five or more tasks of daily living unaided and between a quarter and a half of the 85+ age group are frail, which explains why it is people in this oldest cohort who are most likely to need health services and care support (see page 13).

Over the last decade life expectancy gains were mostly concentrated in the years between 2005 and 2011 – and there has been little progress since (see page 9).

Disability free life expectancy at age 65 has been falling from its peak in 2010-12. It increased significantly between 2005-07 and 2009-11, with women gaining an average of 0.5 years of good health and men around 0.3 years. However, since then men have lost 66 per cent of the gains made earlier in the decade and women have lost 60 per cent (see page 10).

There are huge socio-economic differences in disability free life expectancy at age 65 – a fivefold difference between people in the poorest and most affluent areas – e.g. a woman aged 65 has an expected 3.3 years of healthy living in the worst area compared to 16.7 years in the best (see page 11).

### ***The state of social care***

There has now been a £160 million cut in total spending in real terms on older people's social care in the five years to 2015/16 (page 17).

Cash transferred from the NHS to social care has grown from two per cent of the total public spend on older people's social care in 2006/07 to 16 per cent in 2015/16 (page 18).

By 2020/21 public spending on social care would need to increase by a minimum of £1.65 billion, to a total of £9.99 billion, in order to manage the impact of demographic and unit cost pressures alone (page 20).

This year Age UK's analysis shows there are now nearly 1.2 million people (1,183,900) aged 65+ who don't receive the help they need with essential daily living activities. This represents a 17.9 per cent increase on last year and a 48 per cent increase since 2010. Nearly 1 in 8 older people now live with some level of unmet need (page 26).

Age UK estimates that an additional £4.8 billion a year would ensure that every older person who currently has one or more unmet needs has access to social care, rising to £5.75 billion by 2020/21 (page 20).

Age UK analysis suggests that overall local government spending on social care will fall by 8.3 per cent in real terms between 2015/16 and 2019/20 (page 21).

The percentage of our older population receiving social care support fell from 15.3 per cent in 2005/06 to 9.2 per cent in 2013/14 (page 23).

### ***Carers and the care market***

In 2011 there were 8.2 million carers but by 2015 these numbers had risen to over nine million; these carers are helping loved ones who have increasingly complex needs (page 28).

There are now over two million carers aged 65 and over, 417,000 of whom are aged 80 and over (page 29).

Age UK analysis shows over 37 per cent of carers aged 80 and over are providing 20 hours or more of care a week, while 34 per cent are providing 35 hours or more. Yet nearly two thirds of older carers themselves have a health condition or disability, while 72 per cent report feeling pain or discomfort, rising to 76 per cent for those who provide 20 or more hours of care a week (page 29).

Although overall the numbers of carers are rising, there has not been a substantial increase in the proportion of the population providing care. Set alongside rapidly rising levels of unmet need and the impact of changing family structures, greater geographic dispersal and rising State Pension age this suggests that the provision of informal care has not been able to fill the gap left by declining provision of formal care services (page 30).

In 2015/16 48 local authorities reported dealing with at least one home care provider who had ceased trading in their area and 77 local authorities reported dealing with at least one care home which had ceased trading in their area (see page 31).

In 2015/16 the overall staff vacancy rate across the whole of the care sector was 6.8 per cent (up from 4.5 per cent in 2012/13), rising to 11.4 per cent for home care staff. Turnover rates have risen from 22.7 per cent to 27.3 per cent a year over the same three year period (page 31).

96 per cent of older people who fund their own care home placement paid more than local authorities did for the same type of room in the same home. They paid an extra 43 per cent on average overall (page 32).

### ***The state of healthcare***

Between 2005/06 and 2015/16, the annual NHS budget rose from £91 billion to £117.2 billion in real terms but the trend was not a steady increase: the rate of growth remained relatively high between 2005/06 and 2009/10, with funding rising from £91 billion to £108.3 billion at an average of 4.8 per cent a year. However, in 2010/11 funding fell and was slow to recover, rising from £107.5 billion to £113.4 billion in 2014/15 or an average of 1.4 per cent a year (page 33).

NHS funding did increase more substantially last year (2015/16), primarily due to the additional £2 billion pledged in the 2014 Autumn Statement, but this was insufficient to plug the NHS's growing financial deficit (page 33).

Investment was also uneven. Spending on hospital services increased from £43.06 billion in real terms in 2009/10 to £45.78 billion in 2012/13, an increase of 6.3 per cent. But over the same period the primary care GP services budget fell in real terms from £8.45 billion in 2009/10 down to £8.14 billion in 2012/13, while funding for mental health grew by only 2.5 per cent, from £8.88 billion in 2009/10 to £9.1 billion in 2012/13 (pages 33-34).

By the end of 2013/14 the deficit in NHS hospitals was £109 million and this has accelerated rapidly since, reaching £2.5 billion by the end of 2015/16. Despite increases in funding, money coming into hospitals has not been keeping pace with the costs of running services. This is partly explained by gradual reductions in the amounts paid to hospitals for some of the treatments they deliver over recent years, but is also due to hospitals' need to achieve 'safer staffing levels' in the wake of the Mid-Staffordshire Inquiry, with many hospitals seeking to address shortfalls through increased recruitment and costly agency staff (page 35).

To date in 2016/17, NHS Improvement has reported that Hospital Trusts have made £1.2 billion of savings, reducing total year to date expenditure by 2.9 per cent and putting them on course for a £669 million year to date deficit, after taking into account the Sustainability and Transformation Fund. A substantial proportion of these savings has reportedly come from controls on agency staff spending, with providers estimated to reduce agency spend by £900 million this year (page 35).

In 2014, the UK spent the equivalent of 9.12 per cent of GDP on health care, putting it at the lower end of spending with comparable countries and representing a 0.3 per cent drop since 2012. Spending per head of population in the UK was \$3,935 in 2014, compared to \$4,959 in France, \$5,411 in Germany and \$9,522 in Norway. The average spend per head across all OECD countries is \$4,735 (page 36).

The additional £8 billion pledged for the NHS in the last Government Spending Review has been 'front loaded' with almost half coming into the 2016/17 budget. As a result, funding increases in the latter part of the spending review period will be significantly lower, yet predicted levels of unit cost inflation alone are estimated at between 2-3 per cent a year over the period (some experts believe health cost inflation can be as high as six per cent). Nor does this take into account wider pressures on the NHS, including growing demand or the need to invest in long-term transformation (page 37).

There has been relatively little growth in the bulk of the NHS workforce since 2010/11. The overall number of nurses working in adult services has increased, rising 3.5 per cent to 175,820 in 2015/16, but this increase follows the 2013 Mid-Staffordshire Inquiry recommendations on safe staffing levels and is predominantly concentrated in acute hospitals. The numbers of FTE mental health nurses have dropped over this period from 40,275 to 35,998 (10.6 per cent) while the biggest decrease is in community nurses which fell by 13.6 per cent to 33,177 (excluding school nurses).

Doctors have been the fastest growing group amongst health care professional in recent years. However, while the numbers of hospital and community health service doctors increased from 97,130 in 2010 to 104,498 in 2015, the numbers of GPs fell by 3.4 per cent from 35,243 to 34,055 over the same period (page 39).

Demand in general practice has been growing steadily for the past 20 years. Between 1995 and 2008, a longitudinal study concluded that the number of consultations had grown by 38.3 per cent, from 217 million consultations a year to 300 million. For the average GP practice this means the estimated number of consultations rose from 21,100 to 34,200. Updated analysis estimated that consultations would have reached 340 million a year by 2013 (page 40).

Analysis by the Kings Fund found that the number of GP contacts with patients increased by 15.4 per cent between 2010/11 and 2014/15. The proportion of contacts with those aged 85+ increased by 16 per cent over the period, compared to just four per cent amongst those aged 18 to 64 (page 39).

### ***The impact on older people***

The number of older people reporting a good experience of getting a GP appointment is in decline. In 2011/12, 89.5 per cent of people aged 65 and over and 91 per cent of people of those aged 75 and over rated their experience as “very good” or “fairly good” but by 2015/16 this had dropped to 84.1 and 86.3 per cent respectively (page 41).

The numbers of older people attending accident and emergency (A&E) departments have increased significantly in the last five years. In 2009/10 there were 30,831 attendances per 100,000 of the 60+ population, by 2014/15 that had risen to 37,240 – an increase of 20.7 per cent over the period. They were also more likely than younger adults to need further inpatient care - while people aged 65 and over represented 23 per cent of total A&E attendances in 2015, they made up 46 per cent of all admissions from A&E (page 44).

The overall number of hospital inpatient episodes has risen significantly in recent years as well, up by 8.9 per cent from 14.9 million a year in 2010/11 to 16.2 million in 2015/16. Older people account for around 65 per cent of these admissions and generally stay longer in hospital, with people aged 75+ staying an average 9.1 days per admission compared to an average of five for all ages (page 46).

Between 2010/11 and 2014/15 the number of outpatient appointments amongst people aged 60+ increased by a third from 28.1 million a year to 36.1 million. Once again, this increase far exceeds the increase in the overall numbers of people in this age group. Effective use of outpatient services is essential in managing many long-term conditions and for avoiding multiple and repeat visits across different specialties (page 47).

Between August 2010 and July 2016 the number of days delay in being discharged from hospital because of waits for home care had increased by 181.7 per cent, from 12,777 delayed days to 35,994. Waits for residential care placements increased 40 per cent, from 13,459 to 18,973 (page 50).

Since the beginning of 2014/15 the number of days delayed waiting for a care package in your own home has more than doubled. Yet at the same time the total number of people waiting has risen at a much slower rate (28.8 per cent), suggesting waiting times for each individual are getting longer rather than a rapid rise in the number of individuals waiting (page 50).

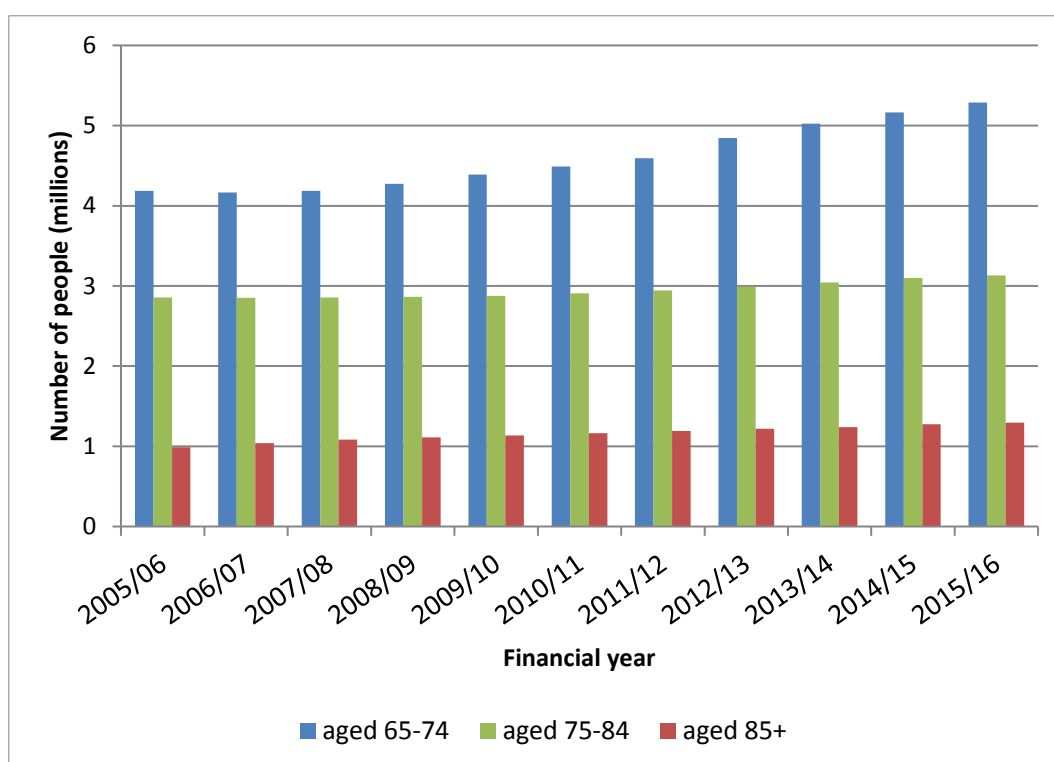
# 1. The health and care needs of our ageing population

It is now well understood that our population is ageing rapidly, and that this is now the single most significant driver for changing health and care needs in our society.

## 1.1 Our growing older population

Between 2005/06 and 2015/16 the total number of people aged 65 or over in England increased by close to 21 per cent, representing nearly 1.7 million extra people. Moreover, the greatest growth in percentage terms has been amongst those aged 85 and over – this age group increased by 31.3 per cent (or more than 300,000 people) over the period.

**Figure 1: Number of people aged 65 and over in England by age group, 2005/06 to 2015/16**

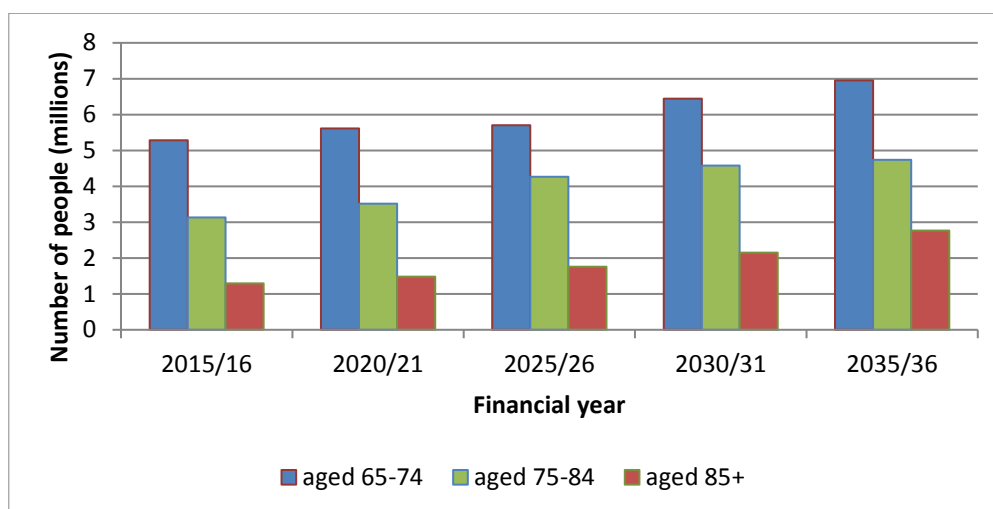


Source: Office for National Statistics (2016<sup>1</sup>)

Looking ahead, population ageing is only set to gather pace. Over the next two decades the total number of people 65 and over is estimated to grow by 48.9 per cent, which amounts to around 4.75 million people. In keeping with current trends, the fastest growing group will be those aged 85 and over with the numbers projected to increase by 113.9 per cent, from nearly 1.3 million people to just under 2.8 million in 2035/36.



**Figure 2: Actual and projected number of people aged 65 and over in England by age group, 2015/16 to 2035/36**

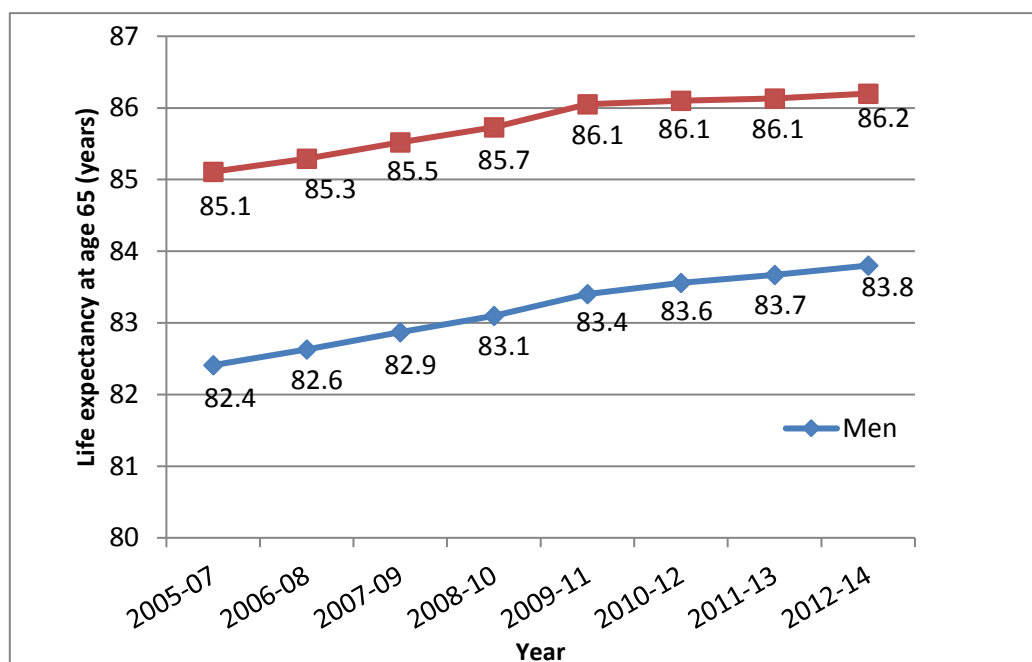


Source: Office for National Statistics (2016<sup>2</sup>, 2016<sup>3</sup>)<sup>a</sup>

## 1.2 Life expectancy and disability-free life expectancy

Over the past decade, overall, we have seen a slow but steady increase in life expectancy. Today, on average, a woman aged 65 in England can expect to live another 21.2 years, while a man can expect another 18.8. However, it is a matter for concern that gains in life expectancy over the last 10 years were concentrated between 2005 and 2010, since then life expectancy has improved little for either sex.

**Figure 3: Average life expectancy at age 65 in England, 2005-07 to 2012-14**



Source: Office for National Statistics (2016<sup>4</sup>)<sup>b</sup>

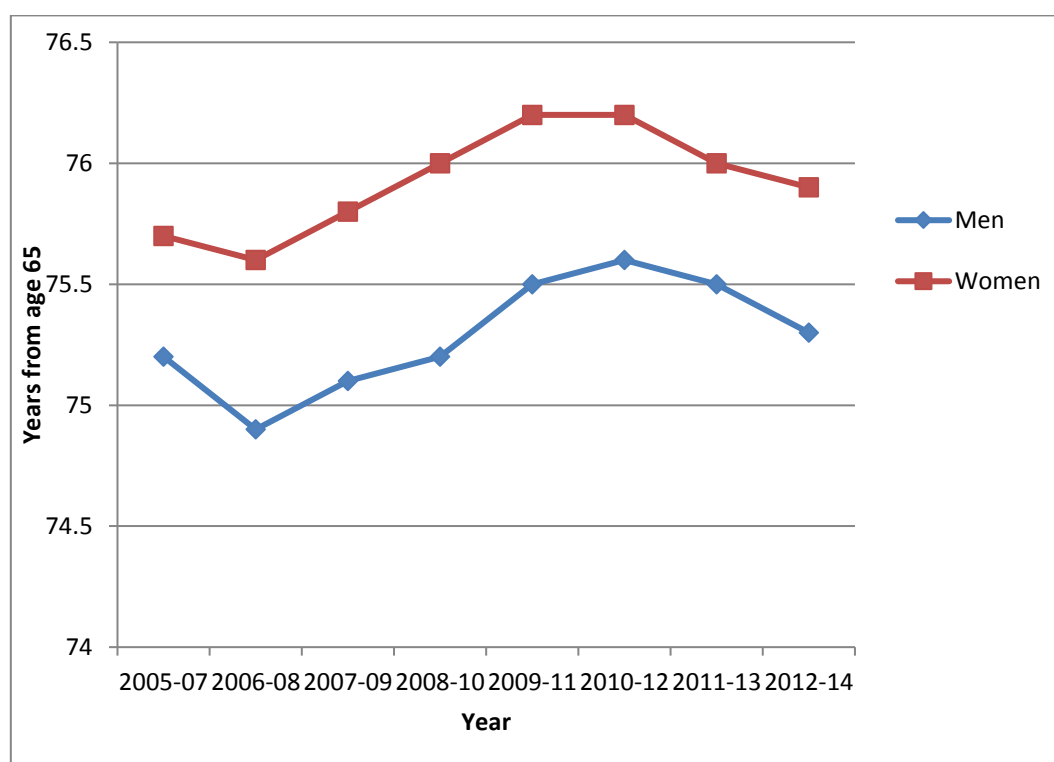
<sup>a</sup> Note: 2015/16 is based on population estimates and 2020/21 to 2035/36 on population projections.

Furthermore, while greater longevity overall is still to be welcomed, unfortunately far too many of those extra years are being spent in poor health. It is of great concern that the most recent data presented here point towards more, not less, ill-health and disability in later life.

Over the last decade disability free life expectancy (DFLE) increased significantly between 2005-07 and 2010-12, and over that time women gained an average of 0.5 years of good health and men around 0.4 years. However, since then DFLE has declined for both sexes. Men have lost a shocking 75 per cent of the gains made in the earlier part of the decade, with women close behind losing 60 per cent. As **figure 4** shows, in 2005-07 a woman could expect to live another 10.7 years free from disability at 65, this peaked in 2010-12 at 11.2 and has now fallen back to just 10.9. Meanwhile men could have expected 10.2 years free from disability in 2005-07, peaking at 10.6 before declining to 10.3.

It has long been the case that increases in life expectancy have outpaced improvements in DFLE, however the gap is now growing faster than before as improvements in life expectancy just about hold their own and past gains in DFLE are eroding. Between 2005-07 and 2012-14 women gained an extra 1.1 years in life expectancy but overall only 0.2 disability-free years. Men gained 1.4 years in life expectancy and ultimately just 0.1 of good health. As a result, more of us are spending more time in later life with multiple long-term conditions, frailty, dementia and social care needs.

**Figure 4: Average disability free life expectancy at age 65 in England, 2005-07 to 2012-14**



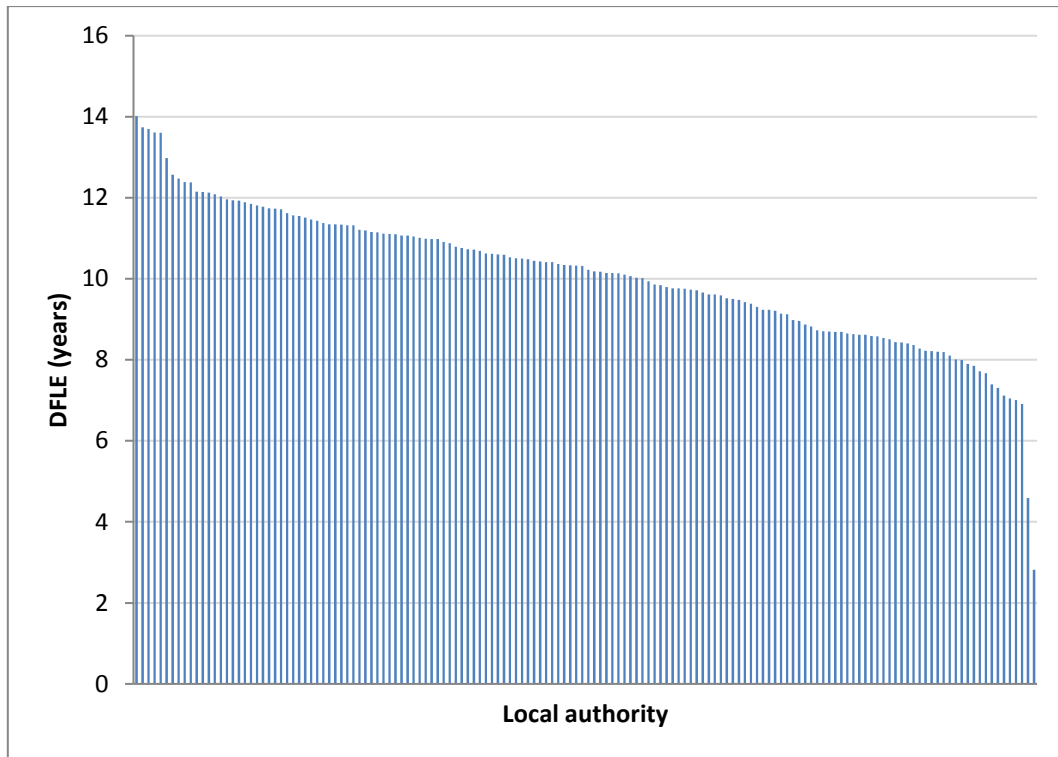
Source: Office for National Statistics (2016<sup>5</sup>, 2012<sup>6</sup>)<sup>c</sup>

<sup>b</sup> Life expectancy at age 65 added to the initial 65 years.

<sup>c</sup> Disability-free life expectancy at age 65 added to the initial 65 years.

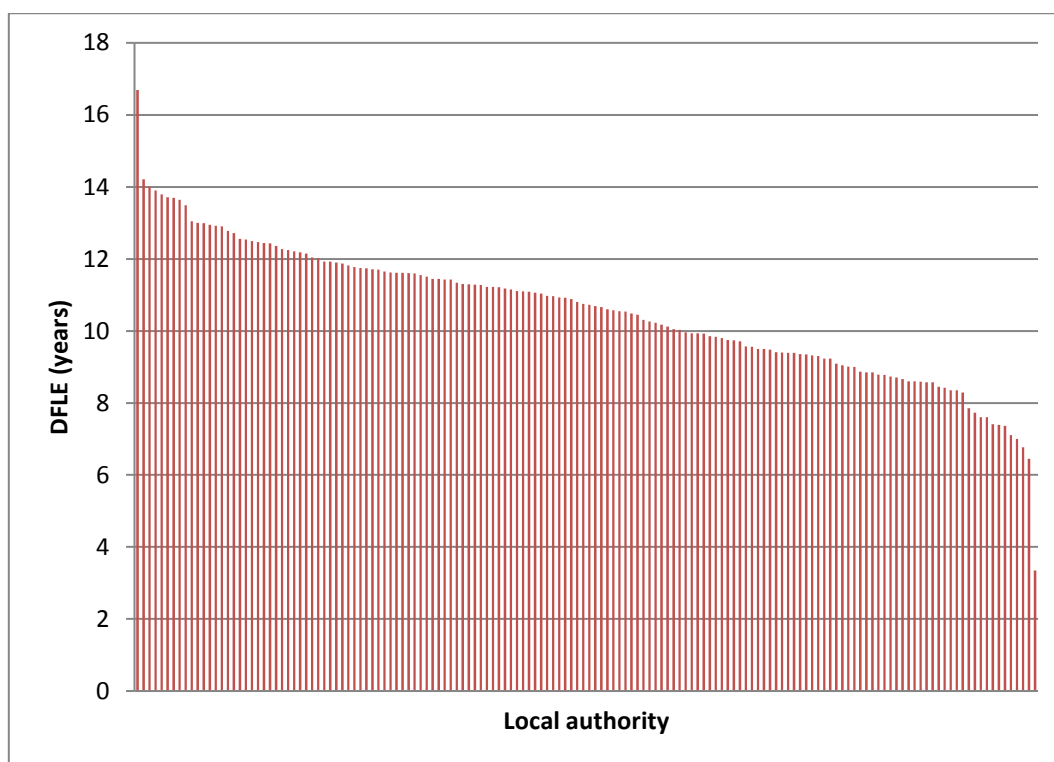
It is also important to note that there is huge inequality within the population. As **figures 5 and 6** illustrate, there is a wide gulf in DFLE at age 65 between local authority areas. In the local authority area with the lowest DFLE, men can only expect 2.8 years in good health at age 65 while women can expect just 3.3. In comparison, in the local authority area with the highest DFLE men can expect 14 years in good health and women 16.7 – for both men and women this represents a staggering near fivefold difference in the prospect of good health after the age of 65.

**Figure 5: Disability-free life expectancy at age 65 by local authorities in England, 2012-14, men**



Source: Office for National Statistics (2016<sup>7</sup>)

**Figure 6: Disability-free life expectancy at age 65 by local authorities in England, 2012-14, women**



Source: Office for National Statistics (2016<sup>8</sup>)

### 1.3 Health and care needs of older people

As we set out in last year's Health and Care of Older People report, the prevalence of nearly all major chronic and long-term conditions increase significantly with age<sup>9</sup>. Yet it is important to recognise that the older population is extremely diverse.

Indeed it would be more accurate to characterise the '65+ generation' as two generations. It is now increasingly common for people in their 60s and even 70s to have living parents or older relatives. There is also huge diversity *within* those generations particularly, as illustrated by **figures 5 and 6**, in the likelihood of living with poor health and disability as we age.

Therefore, while on aggregate a growing older population is driving greater demand for health and care services, it is far too simplistic an equation to say more older people inevitably equals a greater burden of disability and disease. Furthermore it is a calculation that misses both the possibility of improving health in later life and fails to account for the changing nature and complexity of some of our health needs as we age.

The good news is that the onset of age-related conditions and disability can be prevented or delayed. Equally, acquiring a health condition does not necessarily mean high levels of dependency on health and care services. Most people aged 75 and over have one or more health conditions, but almost 50 per cent of them do not consider themselves to be living with a 'life limiting' long-term condition<sup>10</sup>, meaning that even if they have one or more health conditions this is not perceived to have a significant impact on their lives.

However it is always preferable to prevent and mitigate the developments of long term conditions and disabilities and it is of concern that past progress in improving DFLE expectancy has now stalled and appears to be heading in reverse. Without urgent action on preventative measures the numbers of older people living with long-term conditions and disabilities is going to increase significantly over the next 20 years as our older population grows.

It is also important to recognise that much demand for health and care services is driven by the increasing *complexity* of some people's health needs as they acquire multiple long-term conditions and disabilities or become frail.

Frailty is a distinctive health state relating to the ageing process in which multiple body systems gradually lose their in-built reserves, affecting around 10 per cent of people aged 65 and over, rising to between 25 and 50 per cent of those aged 85 and over<sup>11</sup>. Older people living with frailty are at risk of adverse health events, such as a fall or infection, and can experience dramatic changes in their physical and mental wellbeing even after an apparently minor incident.

While having a health condition does not necessarily impact on your life, the more conditions someone has, and the more limitations on their activities of daily living, the more likely they are to need joined up health and social care.

However with early action to reduce the risk of co-morbidities and measures to address frailty, it is possible to improve and sustain people's health. Equally services that provide proactive, holistic support have also been shown to be much more effective in comparison to traditional approaches that operate in separate siloes.

Failing to recognise that fact overlooks important opportunities to improve people's wellbeing and independence and reduce demand on urgent and acute services, by focusing on delivery of much more joined up, holistic health and care services.

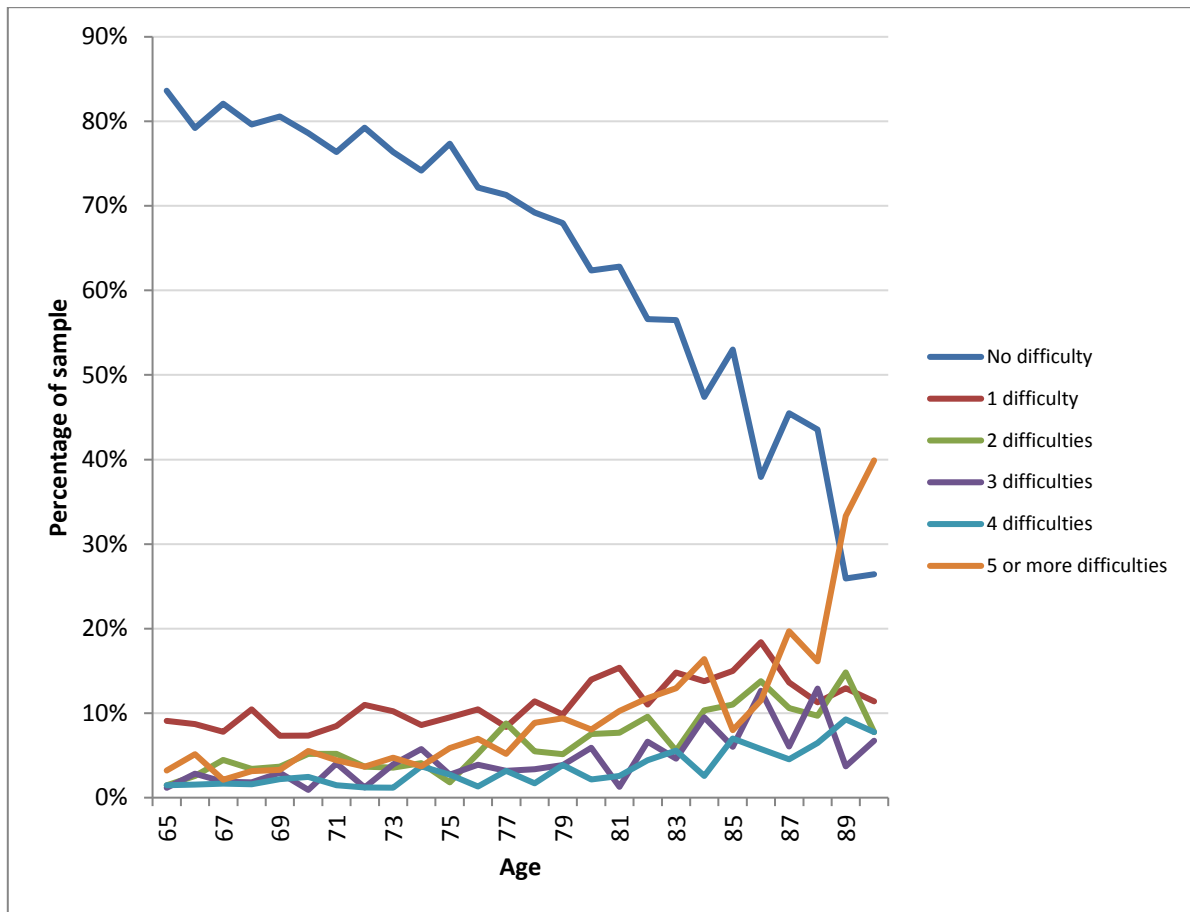
### ***Living with disability, co-morbidities and complex health and care needs***

The proportion of people who have difficulties with activities of daily living<sup>d</sup> increases with age. The percentage of people with at least one difficulty increases from 16.4 per cent at age 65 to around half of those aged 85. By people's late 80s, over one in three people have difficulty undertaking five or more activities of daily living.

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<sup>d</sup> An 'activity of daily living' is defined as a basic task of everyday life. These are split into *instrumental* which are less fundamental such as doing housework, taking medication and preparing meals and *basic* activities of daily living which include more fundamental tasks such as eating, toileting and washing.

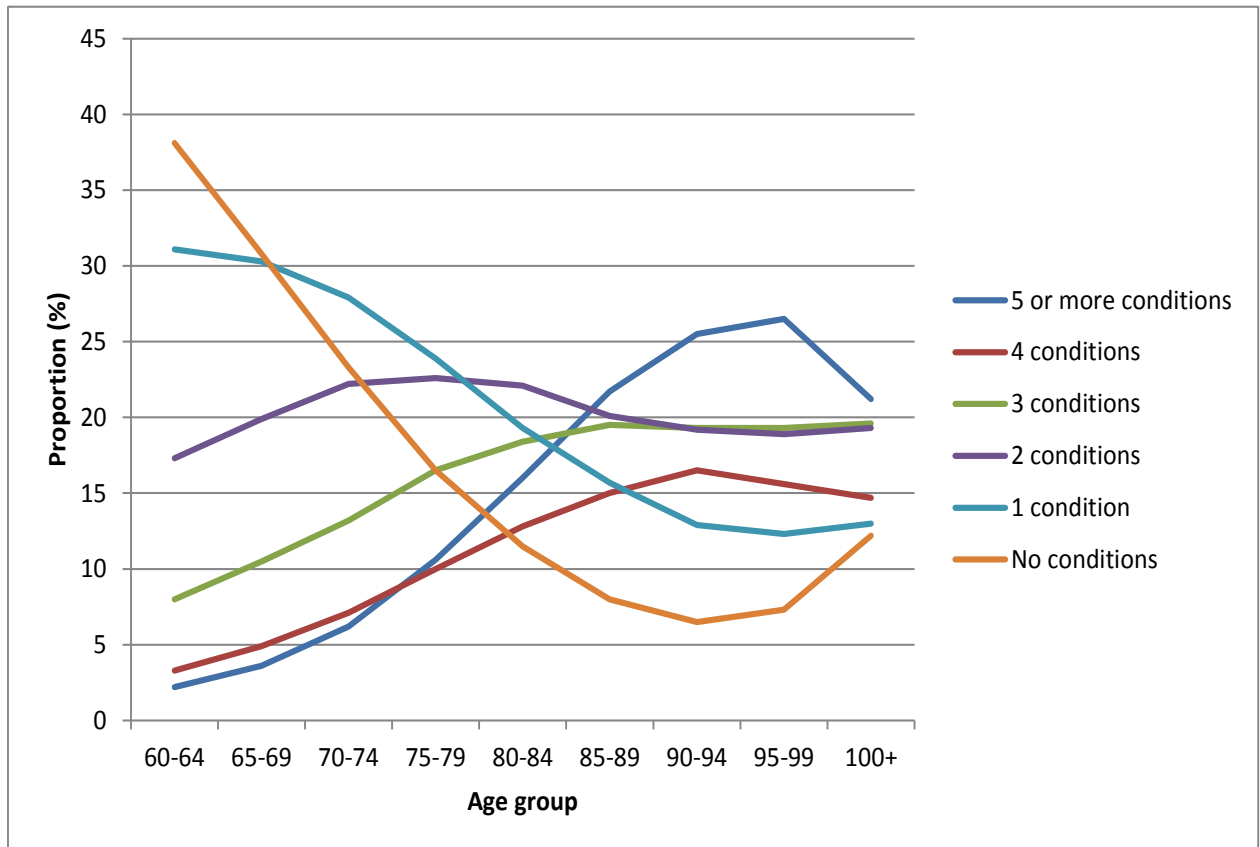
**Figure 7: Number of difficulties with activities of daily living and instrumental activities of daily living by age, England, 2014/15**



Source: English Longitudinal Study of Ageing (2016<sup>12</sup>)

As **figure 8** below shows, while age does not necessarily mean people have long term conditions the likelihood of having one or more long term conditions increases with age. Nearly 40 per cent of people in their early 60s do not have a diagnosed long-term condition. This falls sharply throughout people’s 70s to less than 15 per cent of people in their early 80s and just 6.5 per cent in their early 90s.

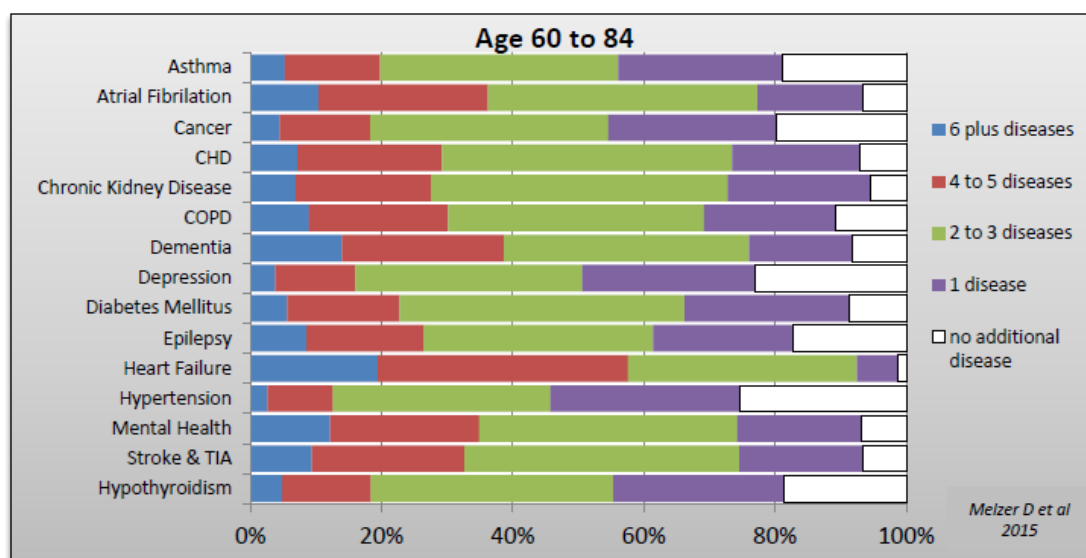
**Figure 8: Number of health conditions by age group in England, 2014**



Source: Age UK and University of Exeter Medical School (2015<sup>13</sup>)

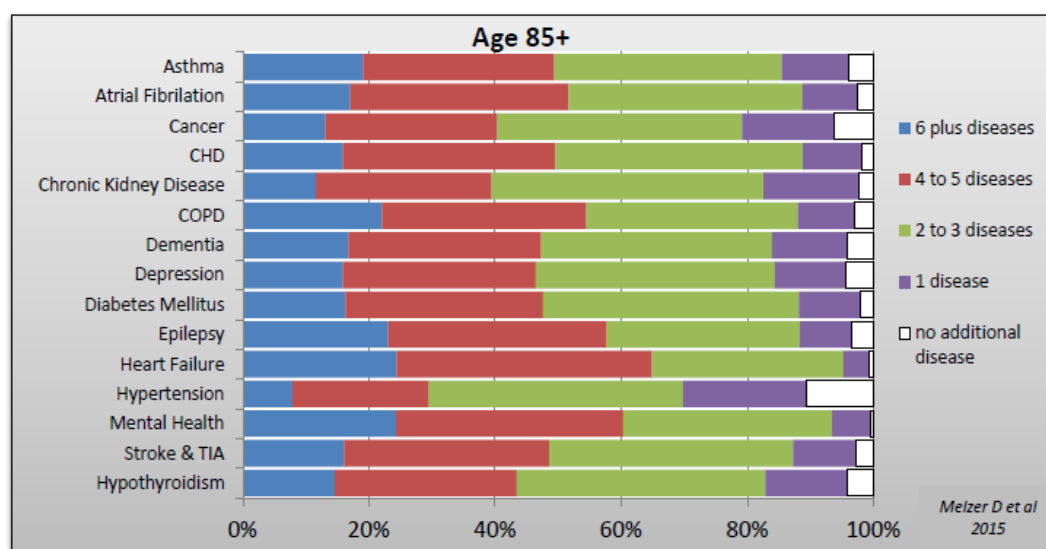
Furthermore, as **figures 9 and 10** below demonstrate, the majority of older individuals with one diagnosed condition live with at least one further condition, and most with two or more. Amongst those 85 and over diagnosed with a condition, more than 80 per cent live with at least two others across most of the condition groups listed, and more than 40 per cent live with 4+.

**Figure 9: Proportion of patients diagnosed with a major disease who also had an additional disease<sup>e</sup>, age 60 to 84, England, 2014**



Source: Age UK and University of Exeter Medical School (2015<sup>14</sup>)

**Figure 10: Proportion of patients diagnosed with a major disease who also had an additional disease, age 85+, England, 2014**



Source: Age UK and University of Exeter Medical School (2015<sup>15</sup>)

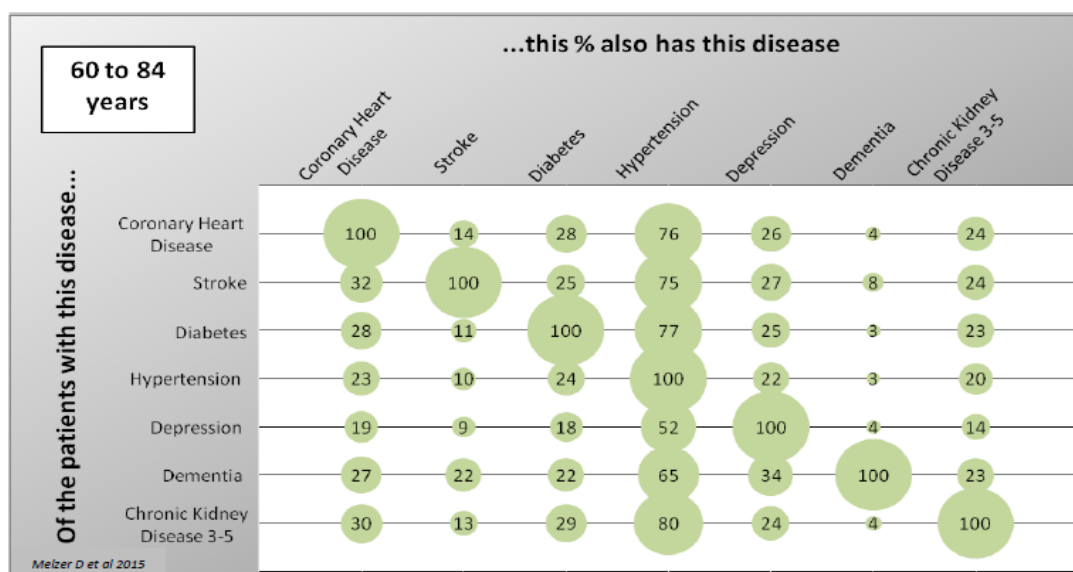
<sup>e</sup> Diseases include coronary heart disease, heart failure, hypertension, stroke, diabetes, asthma, COPD, chronic kidney disease, hypothyroidism, epilepsy, dementia, depression, cancer (in the last 5 years) and severe mental health disorders.



Conditions are also likely to cluster around common risk factors or where one condition is a risk factor for acquiring others. For instance several types of heart disease are risk factors for stroke. Likewise stroke is a risk factor for coronary heart disease, and both share many of the same underlying risk factors such as hypertension<sup>16</sup>. As **figure 12** shows, nearly two in five people aged 85 to 100 years old who had had a stroke also have coronary heart disease and 83 per cent also have hypertension.

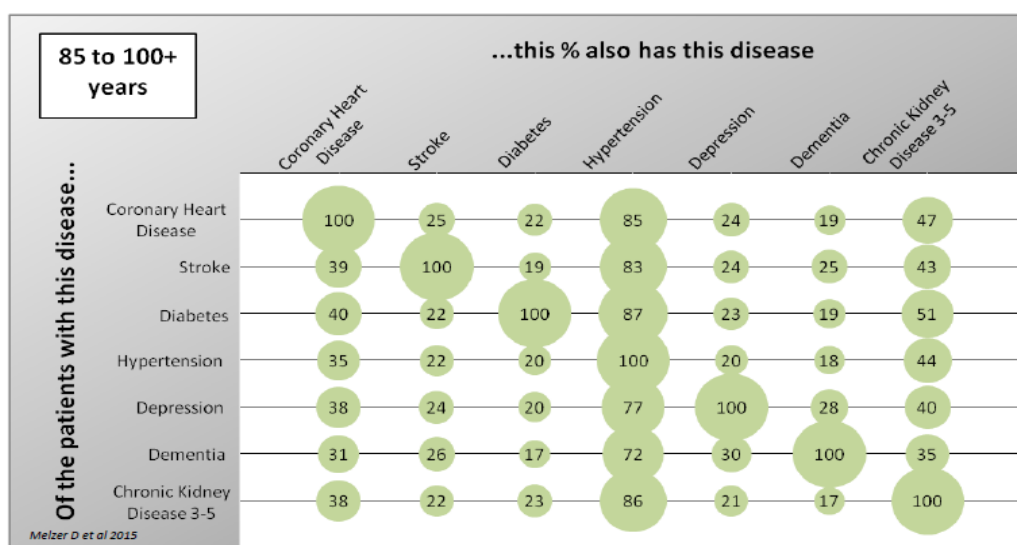
Equally physical ill health can cause tremendous emotional and psychological strain, doubling or tripling the likelihood an individual will suffer from a mental health disorder – particularly anxiety or depression<sup>17</sup>. The figures below show that between around a quarter and a third of people also experience depression alongside another condition.

**Figure 11: Proportion of people with each major disease who also have another specific diagnosed condition, ages 60-84, England**



Source: Age UK and University of Exeter Medical School (2015<sup>18</sup>)

**Figure 12: Proportion of people with each major disease who also have another specific diagnosed condition, ages 85-100, England**



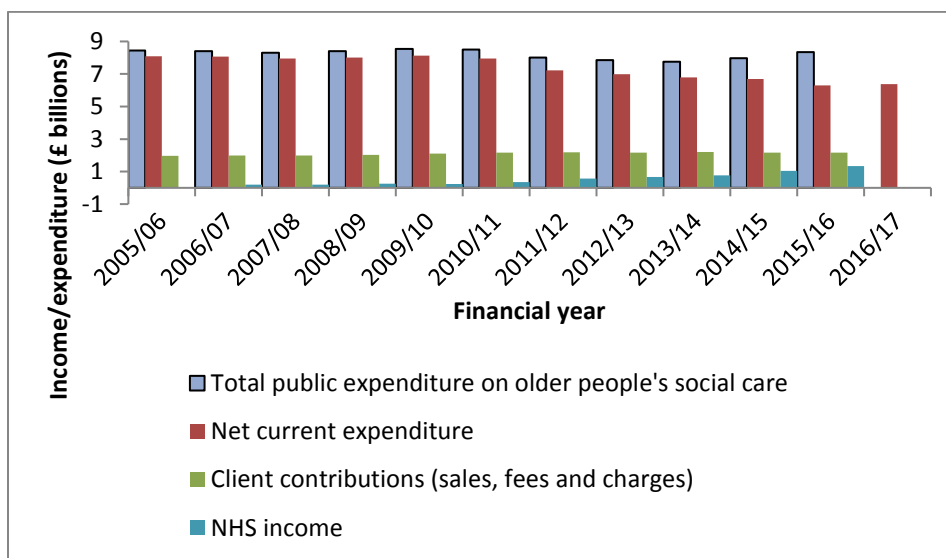
Source: Age UK and University of Exeter Medical School (2015<sup>19</sup>)

## 2. The state of social care

### 2.1 Trends in publicly funded social care services

As **figure 13** sets out, total public spending<sup>f</sup> on older people’s social care, in real terms, fluctuated between £8.3 and just over £8.5 billion between 2005/06 and 2010/11, before falling steeply to £7.75 billion pounds in 2013/14. There was a small increase to £7.97 billion in 2014/15<sup>g,h</sup> before a larger increase in 2015/16 to £8.34 billion. In total, by 2015/16 there had been a £160 million cut in total spending in real terms on older people’s social care since 2010/11. As set out below, this overall trend is largely explained by a sharp decline in spending from local authority funds combined with a growing reliance on NHS cash transfers and other local pooled budget arrangements.

**Figure 13: Expenditure and income relating to older people’s social care, England, 2005/06 to 2016/17 (in 2015/16 prices)**



Source: NHS Digital (2016<sup>20</sup>); Department for Communities and Local Government (2016<sup>21</sup>, 2015<sup>22</sup>) Note: definitions of income and expenditure are in the footnotes<sup>i</sup>

#### Trends in expenditure from local authority funds

<sup>f</sup> All spending figures throughout the report are expressed in 2015/16 prices using the June 2016 GDP deflator (HM Treasury) -

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/533918/GDP\\_Deflators\\_Qtrly\\_National\\_Accounts\\_June\\_2016\\_update.xls](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533918/GDP_Deflators_Qtrly_National_Accounts_June_2016_update.xls). Total public spending is net expenditure plus income from the NHS, joint arrangements and ‘other income’. It does not include client contributions.

<sup>g</sup> Prior to 2014/15 revenue expenditure and financing data, the majority of the budget used to be disaggregated into two components: spend for younger adults (18 to 64) and spend for people aged 65 and over. Since 2014/15 this is no longer the case. For this part of the total public expenditure in 2014/15 and 2015/16 and net current expenditure in 2016/17 we have used the balance of spending between younger adults (18 to 64) and older adults in the NHS Digital Personal Social Services Expenditure and Unit Cost and Department for Communities and Local Government data, to apportion the amounts that are likely to be spent on older people. As a result of this apportioning, figures between 2014/15 and 2016/17 may not add up.

<sup>h</sup> This figure includes spending on self-funders’ social care as it was not possible to separate other important elements such as spending on Direct Payments which is a form of public expenditure of interest in this report [doesn’t apply post SALT].

<sup>i</sup> (1) Net current expenditure is gross total cost minus income. (2) Client contributions include income from charges to self-funders, including client contribution to a Managed Budget and partial or full contribution to residential/nursing/domiciliary care. It does not include top-up payments from a third party. (3) NHS income includes reimbursement from any health body. Expenditure resulting from this reimbursement is included in the net and total public expenditure statistics.

In 2005/06 net current expenditure (i.e. spending from local authority funds) on older people's social care organised by local authorities totalled £8.08 billion. Spending remained relatively constant at around £8 billion a year, reaching £8.12 billion in 2009/10 before entering a period of rapid decline, falling to just £6.31 billion in real terms in 2015/16. The Department of Communities and Local Government's budget projections for 2016/17 anticipate a small increase to £6.37 billion<sup>23</sup>; nonetheless this means total local authority spending on social care for older adults has dropped by £1.57 billion in just six years.

This rapid decline in spending mirrors wider cuts to local authority budgets over the period. The National Audit Office estimated that local authority funding reduced by 25 per cent in real terms between 2010/11 and 2015/16<sup>24</sup>, while the Care Quality Commission have reported that 81 per cent of councils reduced their spending on adult social care over the same period<sup>25</sup>.

### **Trends in income from health**

As **figure 13** above shows, direct cash transfers from the NHS spent on older people's social care organised by local authorities has been rising. In 2006/07, the first year data was collected, the NHS transfer totalled just £204 million, rising to £250 million by 2009/10. However, since 2010/11 the value of the NHS transfer has shot up. In 2010/11 the transfer increased to £350 million, and has since quadrupled to £1.33 billion in 2015/16. As a result, cash transferred from the NHS has grown from two per cent of the total public spend on older people's social care in 2006/07 to 16 per cent in 2015/16. With the NHS now facing serious provider deficits and a substantial gap opening up between income and demand, there must be questions about how long this trend is sustainable.

### **Introduction of the Better Care Fund**

The Better Care Fund (BCF) was originally announced in 2013 as a mechanism to promote *'the transformation of local services to ensure that people receive better and more integrated care and support'* and finally came into effect in 2015/16<sup>26</sup>. The fund is comprised of £3.46 billion from the NHS (ring-fenced from NHS England's overall allocation to Clinical Commissioning Groups) and the re-direction of £354 million from local government funds (including the £220 million Disabled Facilities Grant) to create a total budget of £3.81 billion<sup>27</sup>. Health and Wellbeing Boards set out plans agreed by the local authority and CCG, to spend the fund in accordance with the national policy framework.

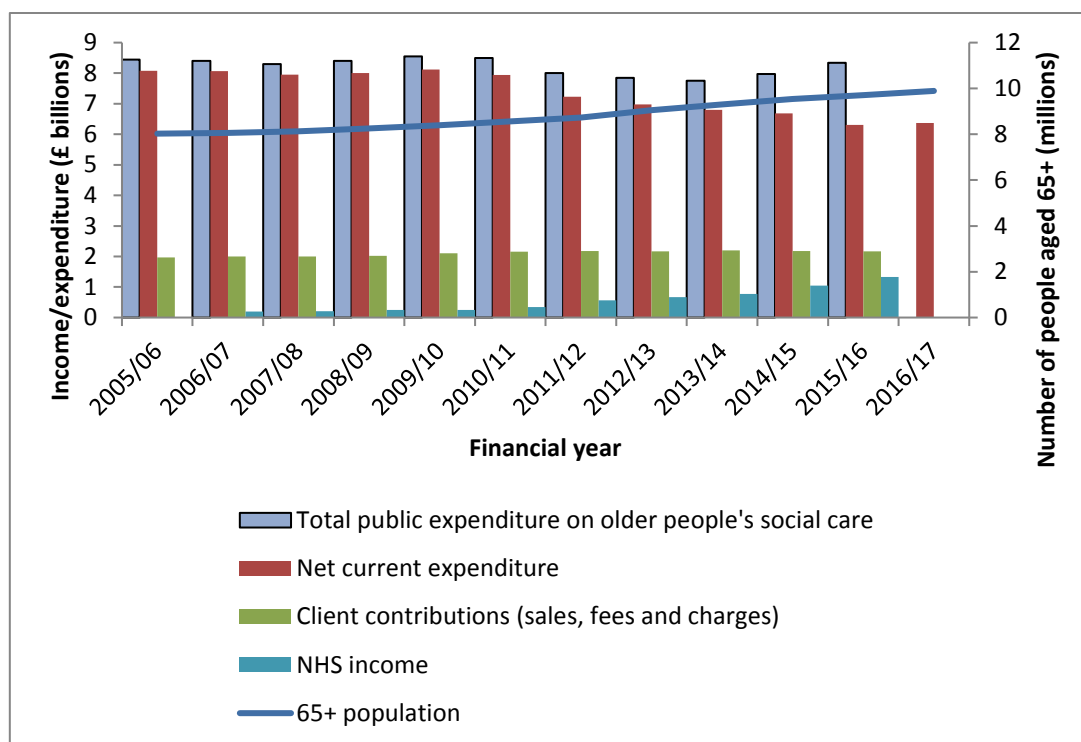
Some localities also agreed to make available additional funds to their BCF allocation. The Department of Health estimated these would add another £1.5 billion to the BCF for 2015/16, bringing the total to £5.3 billion<sup>28</sup> (2015/16 prices). However the final amount appears to be lower, with the Association of Directors of Adult Social Services budget survey showing local authorities only reporting a further £1.24 billion, bringing the final total to £5.05 billion<sup>29</sup>. Despite the policy rhetoric surrounding the Better Care Fund, the Association of Directors of Adult Social Services annual Budget Survey reported that a third of the total BCF fund (£1.67 billion) was spent on protecting adult social care budgets – much of which was spent directly avoiding cuts – rather than invested in new services or transformative efforts<sup>30</sup>.

Furthermore, the 'additional' money includes a number of existing provisions, including the funding for carers' breaks (£130 million), for re-ablement (£300 million)<sup>31</sup> to meet local authorities' statutory duty to provide housing adaptations (Disabled Facilities Grant £220 million) and a further £134 million social care capital fund. The BCF also included new costs associated with implementing the Care Act and growing demographic pressures, with an estimated £1.9 billion allocated to this purpose<sup>32</sup>.

## 2.2 Growing funding pressures on social care

As **figure 14** demonstrates, despite some recent recovery in overall expenditure on older people's social care due to transfers from the NHS, the amount available in 2015/16 was less in real terms than in 2005/06 whilst demand increased with the growth of the older population. While total spending declined from £8.45 billion in real terms in 2005/06 to £8.34 billion in 2015/16, the number of people aged 65 and over increased from 8.03 million to 9.71 million.

**Figure 14: Growth in the 65+ population and expenditure and income on older people's social care, England, 2005/06 to 2016/17 (in 2015/16 prices)**



Source: NHS Digital (2015<sup>33</sup>); Department for Communities and Local Government (2016<sup>34</sup>); Office for National Statistics (2016<sup>35</sup>, 2016<sup>36</sup>)

Rising demand represents only a part of increasing cost pressures on social care. In recent years local authorities have had to contend with a number of additional demands on their budgets, including:

- **Implementation of the Care Act**

Implementation of new provisions set out in the Care Act 2014 requires significant increased expenditure, including: meeting new obligations to provide information and advice to those who pay for their own care; new rights to advocacy support; and enhanced rights to support for unpaid carers. The National Audit Office estimated that it would cost local authorities £2.5 billion to implement the first phase of the Care Act between 2013-14 and 2019-20<sup>37</sup>.

- **Introduction of the National Living Wage**

The new National Living Wage (NLW) came into effect in April 2016 and is having a significant impact on the cost of providing care services. Much of the social care workforce is low paid and will benefit, rightly, from the NLW, set at £7.20 an hour this year and rising to £9 an hour by 2020.

This year alone the Association of Directors of Adult Social Services has estimated that the cost of implementing the NLW will be just over £600 million. Largely as a result, 82 per cent of local authorities have increased fees paid to providers, with 46 per cent increasing fees by more than three per cent<sup>38</sup>. As the NLW increases, so will cost pressures. The Resolution Foundation has estimated the NLW will add £1.4 billion a year in increased wage costs of front-line care workers by 2020<sup>39</sup>.

- **Cost of new requirements for care services**

In addition to the Care Act, local authorities have been required to implement a number of other changes and are facing increased costs as a result.

A series of recent court rulings mean providers, again rightly, will now be required to pay home care staff for travel between appointments<sup>40</sup> and to pay care home staff for sleep-overs<sup>41</sup> both of which will have a significant impact on provider unit costs.

## 2.3 Future funding of older people's social care

### **Social care funding demand – 2016/17 to 2020/21**

The cost of maintaining the current social care system will continue to rise over the course of the decade. As set out in **table 1** below, by 2020/21 public spending for older people's social care would need to increase by a minimum of £1.65 billion to £9.99 billion in order to manage the impact of demographic and unit cost pressure alone. This is a conservative estimate that assumes a constant health profile within the older population, whereas in reality overall demand is likely to outpace general population trends due to the rapidly rising number of the 'oldest old' and flat-lining rates of disability-free life expectancy.

At the same time it is already very clear that the current system is under tremendous financial pressure. We already face huge, and rising, levels of unmet need; growing market instability; and persistent downwards pressure on the quality and adequacy of care provided to older people. Therefore future funding for the system ought to be set at a level which also addresses these trends.

**Table 1** sets out the funding required to ensure that older people who meet the financial eligibility criteria and have one, two or three or more unmet needs receive adequate care. 'Unmet need' is defined for these purposes as having difficulty in carrying out *essential* activities of daily living (ADLs) and being unable to informally obtain the amount of support that they need either formally or informally.

Age UK estimates that an additional £4.8 billion would ensure that all who currently have one or more unmet needs have access to adequate levels of social care, rising to £5.75 billion by 2020/21. It is also important to note, as **table 1** demonstrates, that increasing funding to meet the needs of people who need help with one or more activities of daily living is only marginally more expensive than meeting the needs of people who need help with three or more of these activities – only costing an extra £410 million in 2015/16, rising to £490 million in to 2020/21. Yet supporting people at lower levels of need could have a major impact on

helping people retain their independence and reduce demand for more costly care and healthcare services.

**Table 1: Funding required to maintain the current social care system for older people and to provide an improved system in 2015/16 and in 2020/21 (in 2015/16 prices)**

	Funding to maintain current level of service	Funding for an improved system (1+ unmet care needs)	Funding for an improved system (2+ unmet care needs)	Funding for an improved system (3+ unmet care needs)
<b>2015/16</b>	£8.34 billion	£13.14 billion (+£4.8 billion)	£12.85 billion (+£4.51 billion)	£12.73 billion (+£4.39 billion)
<b>2020/21</b>	£9.99 billion	£15.74 billion (+£5.75 billion)	£15.39 billion (+£5.4 billion)	£15.25 billion (+£5.26 billion)

Source: Age UK analysis (2016<sup>42,43,44</sup>)

### **Future funding projections for older people's social care – 2016/17 to 2019/20**

Unfortunately it is becoming increasingly clear that projected allocations for older people's social care, including the provisions set out in the 2015 Spending Review and Autumn Statement (SR2015), fell far short of what would be required to maintain the wholly inadequate status quo, let alone provide the means to invest in the better and more sustainable system we urgently need.

As we set out below, the SR2015 announced both an increase in funding for the Better Care Fund, with new funds from Government rather than transfers from health and a new adult social care precept, allowing local authorities to raise more money. However these two initiatives would deliver comparatively little for adult social care until towards the end of the SR2015 period, and then at most only an estimated extra £3.19 billion a year in 2019/20 at 2015/16 prices. See **table 2 and 3** below<sup>j</sup>. The amount raised by the precept depends on both local authority decisions, and the size of the local council tax base.

As set out in **table 1** above, Age UK estimates that the demographic pressure of an ageing population will add £1.65 billion to older people's social care costs by 2020/21. Taking into account wider cost pressures and all potential sources of income, a joint statement by the Nuffield Trust, Health Foundation and King's Fund concluded that even taking account of the most optimistic projections of additional funding set out in SR2015 the funding shortfall for all adult social care would grow to around £2.3 billion by 2019/20<sup>45</sup>.

It therefore seems inevitable that local authorities will need to continue to make significant savings. In 2016/17 councils plan to make £941 million worth of savings across adult social care funding. This follows attempted savings of £1.1 billion in 2015/16<sup>46</sup> – nationally local authorities did not quite meet this target and overspent by £168 million as a result, mostly making up the shortfall through reserves<sup>47</sup>. It is hugely concerning that this year local authorities are reporting that the proportion of savings achieved through service reductions will increase from 18 per cent in 2015/16 to 39 per cent<sup>48</sup>.

In December 2015 in its provisional local government finance settlement for England 2017 to 2018, Government announced that councils would be able to increase the rate of have

<sup>j</sup> See Tables 2 and 3

committed to enabling councils to increase the amount raised by the social care precept from two per cent to three per cent in 2017/18 and 2018/19<sup>49</sup> as long as the full amount raised by the precept does not exceed six per cent between 2017/18 and 2019/20. In addition, this means local authorities can raise funds more quickly if they wish. The Government estimates that this could raise up to an additional £208 million in 2017/18.

The Government also announced a 'new adult social care grant' of £240 million for 2016/17. However this is not new money. It is taken from the New Homes Bonus budget which aims to encourage local authorities to create more new homes.

These additions do little towards meeting the £2.3 billion shortfall in 2019/20 anticipated by the Nuffield Trust, the Health Foundation and the Kings Fund mentioned above.

### ***Local authority funding***

Local authority net expenditure (i.e. from local authority funds) on social care was £6.31 billion in 2015/16 and projected to rise slightly to £6.37 for this year (2016/17). As set out above, this represents a £1.57 billion cut in local authority expenditure since 2010/11 when the amount in 2015/16 prices was £7.94 billion. This reflects the wider budget position of local authorities over the same period.

The overall funding picture for local authorities is not set to improve over the remaining SR2015 period either as the central government grant is reduced and, in theory, replaced by locally raised revenue. While in cash terms (2014/15 prices) the Government estimated that local government funding would remain relatively constant over the period – falling to £38.6 billion this year (2016/17) from £40.3 billion in 2015/16 before rising again to £40.5 billion in 2019/20<sup>50</sup> the Government estimated that there would be decrease in real terms of 1.7 per cent per year.

Thus, local authorities will face a real terms cut in their income, with the biggest squeeze coming over the next two years. The Government's analysis states that local government budgets will fall by 8.3 per cent in real terms between 2015/16 and 2019/20<sup>51,52</sup>. It is also unclear how local revenue will adequately fill the gap for many councils given the huge variation in their ability to raise local revenue.

Ultimately it is difficult to see how local authority net expenditure on social care from current sources will increase significantly over this period.

### ***The Better Care Fund***

In addition to planned investment in the Better Care Fund (primarily funded through ring-fenced contributions from the NHS budget) the Government announced in the SR2015 that a further £1.5 billion (2014/15 prices) would be added to the Fund from central resources. As a result the minimum amount now allocated through the BCF from health and central government for all adults' health and social care will rise from £3.81 billion in 2015/16 to £5.33 billion in 2019/20 in real terms. Localities may also continue to add to their BCF allocations via other local arrangements.

However, as **table 2** sets out, this additional investment is heavily 'back loaded' with the full £1.4 billion (2015/16 prices) only becoming available in 2019/20, meaning the extra funding will have no impact in 2016/17 and very little in 2017/18. This is the opposite to additional investment in the NHS over the SR2015 period which is largely 'front-loaded'.

As set out below, the social care precept will not raise significant revenue until towards the end of the CSR period, the social care sector has argued that, as a minimum, the new BCF investment should be brought forward to ease the urgent pressure on care services. The

Local Government Association called for £700 million to be made available immediately in 2016/17<sup>53</sup>. However there was no acknowledgement of this in the Autumn Statement 2016.

**Table 2: Better Care Fund (minimum fund) 2015/16 to 2019/20 (updated to 2015/16 prices)**

£ (billions)	2015/16	2016/17	2017/18	2018/19	2019/20
<b>Planned NHS ring-fenced contribution</b>	£3.46 billion	£3.47 billion	£3.47 billion	£3.46 billion	£3.47 billion
<b>Planned disabled facilities grant</b>	£0.35 billion	£0.39 billion	£0.42 billion	£0.44 billion	£0.47 billion
<b>SR2015 investment in the BCF</b>	£0.00 billion	£0.00 billion	£0.10 billion	£0.78 billion	£1.40 billion
<b>Total (rounded number)</b>	<b>£3.81 billion</b>	<b>£3.86 billion</b>	<b>£3.99 billion</b>	<b>£4.69 billion</b>	<b>£5.33 billion</b>

Source: Department of Health written evidence to the House of Commons Select Committee on Health Inquiry into the Spending Review impact on health and social care<sup>54</sup>

### **The adult social care precept**

The SR2015 also included measures for a new adult social care precept that would enable local authorities to levy an additional two per cent increase in council tax. Local authorities already had powers to raise Council Tax by 1.99 per cent without holding a referendum. Initially, Government anticipated that, if all local authorities took maximum advantage of both these powers in each year for budgets from 2016/17, the precept could raise ‘nearly’ £2 billion a year in 2014/15 prices by 2019/20 for adult social care. Subsequently they revised this estimate to £1.8 billion.<sup>55</sup>

In 2016/17 all but eight local authorities elected to apply the precept, although two did so by less than the full two per cent<sup>56</sup>. As a result, set out in **table 3**, the actual amounts intended to be raised by the precept fell short of Government projections.

The Autumn Statement 2016 made no mention of adult social care, but in December 2016 Government announced additional measures which would allow councils to increase the precept from two to three per cent in 2017/18 and 2018/19 which could add an additional £208 million in 2017/18<sup>57</sup>.

However the amount raised by the precept may not lead to significant overall increases in council budgets, and therefore the money available to spend on all adult social care. Local authorities can increase council tax by 1.99 per cent a year without triggering a referendum, but 40 per cent of councils froze council tax (other than the precept) or raised it to less than the full amount in 2016/17<sup>58</sup>.

Furthermore aggregated figures mask huge geographical variation in the impact of the precept. Overall local authorities reported a small 1.2 per cent cash (as opposed to real) increase in budgets between 2015/16 and 2016/17. However uneven distribution means budgets in 70 local authorities have still fallen despite the levy<sup>59</sup>.



**Table 3: Potential and actual revenue raised through the Adult Social Care precept, 2016/17 to 2019/20 (updated to 2015/16 prices)**

£ (billions)	2016/17	2017/18	2018/19	2019/20
<b>Potential revenue from two per cent ASC precept</b>	£0.39 billion	£0.77 billion	£1.23 billion	£1.67 billion
<b>Potential additional revenue from enhanced precept if levied at three per cent</b>	-	£0.21 billion		-
<b>Actual revenue raised</b>	£0.37 billion	-	-	-

Source: Department of Health written evidence to the House of Commons Select Committee on Health Inquiry into the Spending Review impact on health and social care (potential revenue)<sup>60</sup>, the Provisional local government finance settlement England 2017-2018 (additional revenue)<sup>61,62</sup> and the Association of Directors of Adult Social Services Budget Survey 2016 (actual revenue)<sup>63</sup>

### **Public Health Funding**

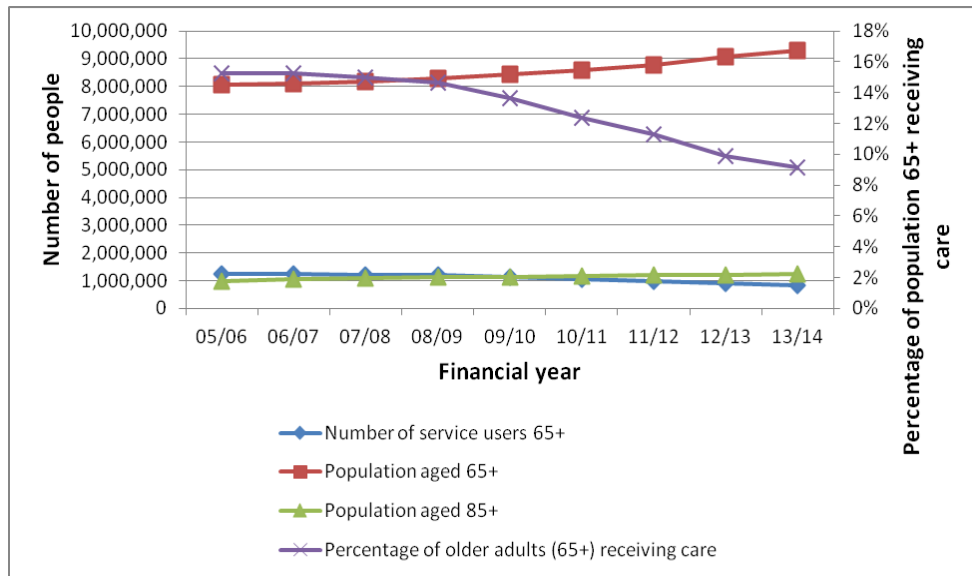
It is also worth noting that Public Health funding has now been delegated to local authorities. However it will see its allocated budget reduced by 3.9 per cent annually from 2016/17, leading to an estimated real terms cut of around £600 million by 2019/20<sup>64</sup> and further impacting on the ability of local authorities to invest in measures aimed at reducing future demand.

## **2.4 The implication of funding cuts for provision of services**

Over recent years Age UK has been tracking the steady declining provision of local authority funded and/or arranged social care support for older people.

In 2005/06 more than 1.2 million older people were receiving social care support from social service departments<sup>65</sup>. By 2013/14 that number had fallen by around 377,000 to just over 850,000<sup>66</sup>. At the same time the numbers of people aged 65 and over rose steadily by 1.9 per cent a year (and the number of people aged 85 and over – those most likely to need care – rose by 3.2 per cent a year). As a result the proportional impact has been greater still, with the percentage of the older population receiving social care support falling from 15.3 per cent in 2005/06 to 9.2 per cent in 2013/14<sup>67,68,69,70</sup>.

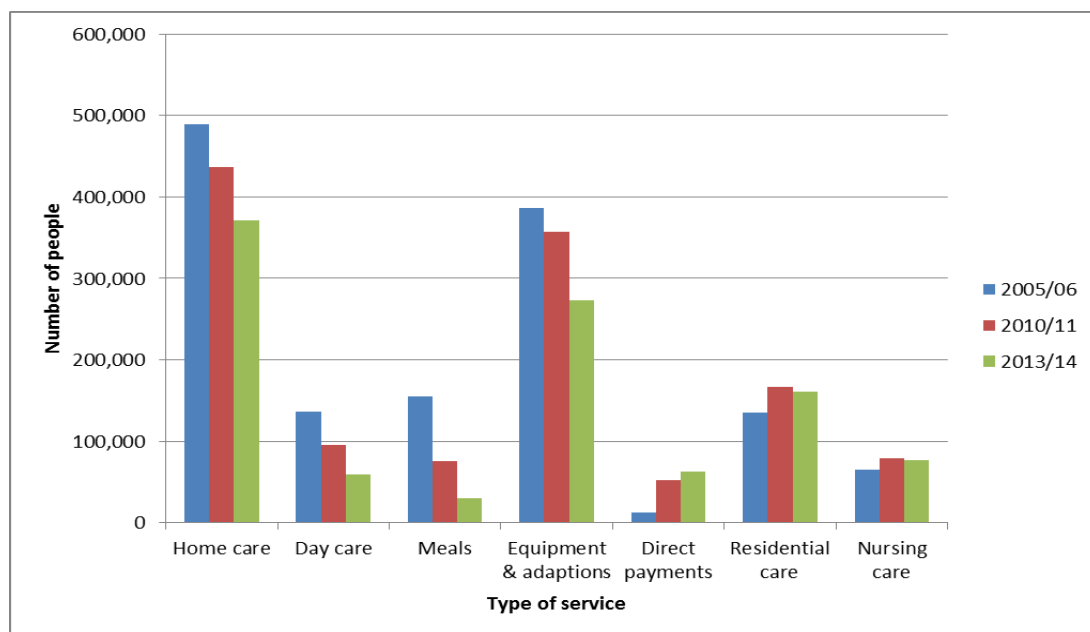
**Figure 15: Number and percentage of people receiving support with social care in England, 2005/06 to 2013/14**



Source: NHS Digital (2014<sup>71</sup>); Office for National Statistics (2014<sup>72</sup>)

Furthermore as **figure 16** shows, home care and community based services, such as meals on wheels and day centres, were hardest hit over the period as local authorities focused limited resources on those with the highest levels of need. Services that have experienced particularly deep cuts are those most associated with prevention, support for independent living and support for informal carers.

**Figure 16: Number of older people supported by social services department by type of social care support, England, 2005/06 to 2013/14**



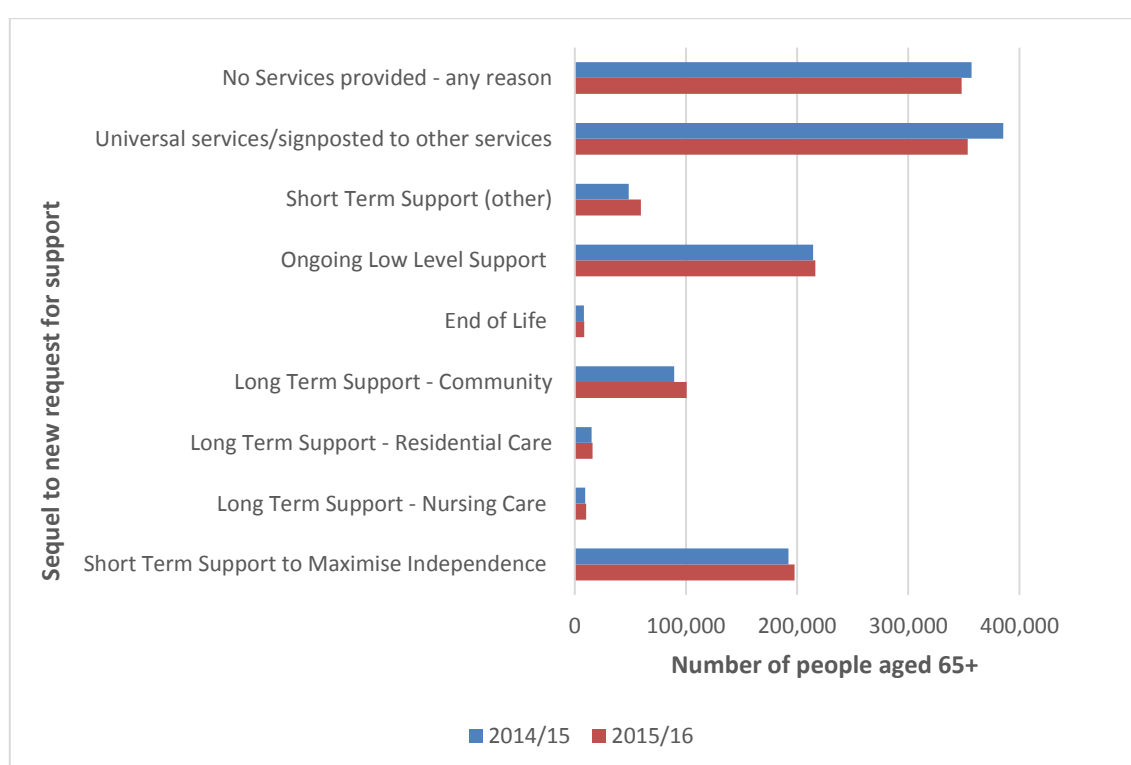
Source: NHS Digital (2014<sup>73</sup>, 2012<sup>74</sup>, 2007<sup>75</sup>)

In 2014/15 the way in which social care activity statistics were collected changed and it is not possible to directly compare the new data with statistics collected between 2005/06 and 2013/14. The aim of the new method was to better capture people provided with short-term support (for example after being discharged from hospital) that may not have been discernible previously.

However the new data gives no reason to suppose that there has been any significant change in long term trends towards fewer people receiving care. As **figure 17** shows, in 2014/15 there were just fewer than 1.32 million new requests for support from people aged 65 and over. Of these, over half (56.2 per cent) were not provided with services or were signposted elsewhere, meaning just 577,110 of those new requests resulted in people receiving some form of short or long-term support following their request. The picture broadly continues in 2015/16 with 1.31 million new requests from older people, leading to 608,825 (or 46.5 per cent) people receiving some form of social care assistance.

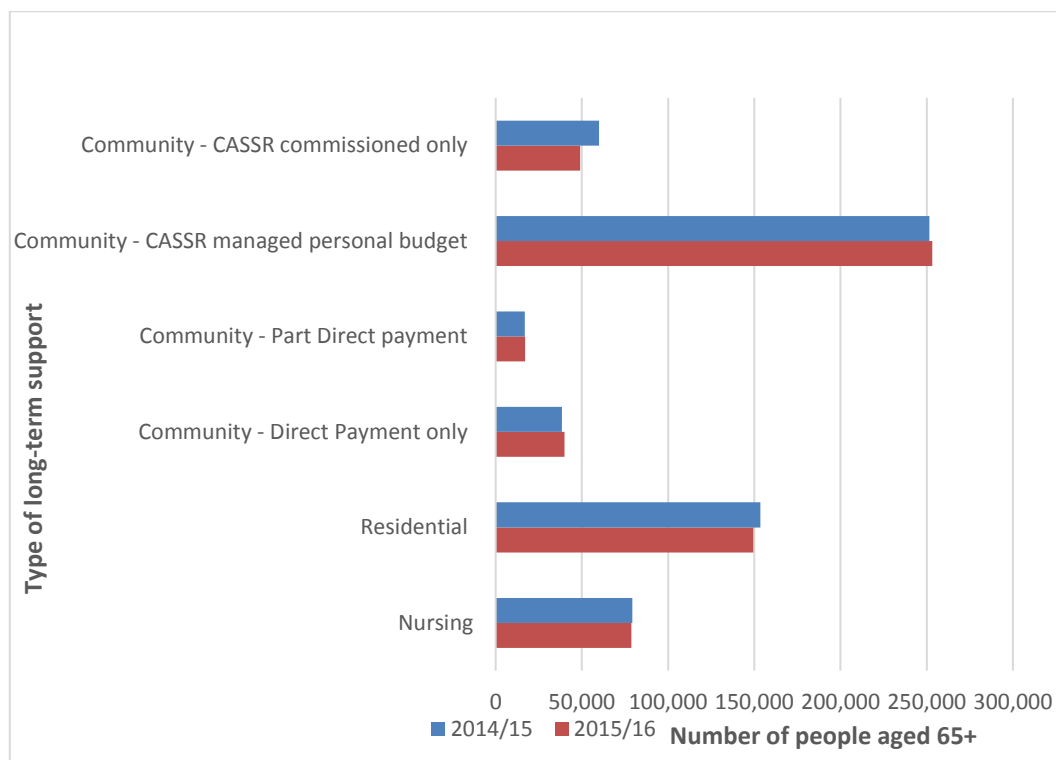
As **figure 18** sets out, the number of older people recorded as receiving long-term support has also remained relatively constant between 2014/15 and 2015/16, falling slightly from 599,680 to 587,460.

**Figure 17: Number of requests for support received from new clients, by the different sequels to that request, people aged 65 and over in England, 2014/15 to 2015/16**



Source: NHS Digital (2016<sup>76</sup>, 2015<sup>77</sup>). Note: Counts are of the number of people aged 65+ during the financial year (April 2014 to March 2015 or April 2015 to March 2016)

**Figure 18: Type of long-term support received, people aged 65 and over in England, 2014/15 to 2015/16**



Source: NHS Digital (2016<sup>78</sup>, 2015<sup>79</sup>). Note: Counts are of the number of people aged 65+ during the financial year (April 2014 to March 2015 or April 2015 to March 2016). CASSR stands for Councils with Adult Social Services Responsibilities.

## 2.5 The impact of social care cuts on older people and their families

The massive reduction in the provision of public funded social care has had a severe impact on older people, their families and carers in recent years.

### ***Rising levels of unmet need***

The need for care is defined by whether or not someone can carry out everyday activities unaided. These are divided into Activities of Daily Living (ADLs) which include tasks that are essential for daily life (such as getting dressed, using the toilet, eating and washing) and Instrumental Activities of Daily Living (IADLs) which include tasks (such as managing medication, paying bills, preparing meals or cleaning) that are vital for someone to be able to manage living independently and with dignity.

Through analysis of data from the English Longitudinal Study of Ageing, it is possible to calculate the number of older people (aged 65+) living in the community who have difficulty undertaking both ADLs and IADLs, and whether their needs are met or not. An 'unmet need' is defined as when an individual reports difficulty with ADLs or IADLs and does not receive support from either formal (paid for) carers or informal family or community networks. This includes older people who receive no support at all or whose support does not meet their needs, such as someone who only receives short periods of help at certain times of day or with some tasks but not others.

In recent years the level of unmet need for care and support within the older population has been rising at an alarming rate. In last year's report Age UK estimated that there were just over one million people aged 65+ who did not receive the help they needed with essential tasks of daily living (ADLs). This figure had grown by 26 per cent since 2010 when the PSSRU estimated there were 800,000 older people with some level of unmet need for social care<sup>80</sup>.

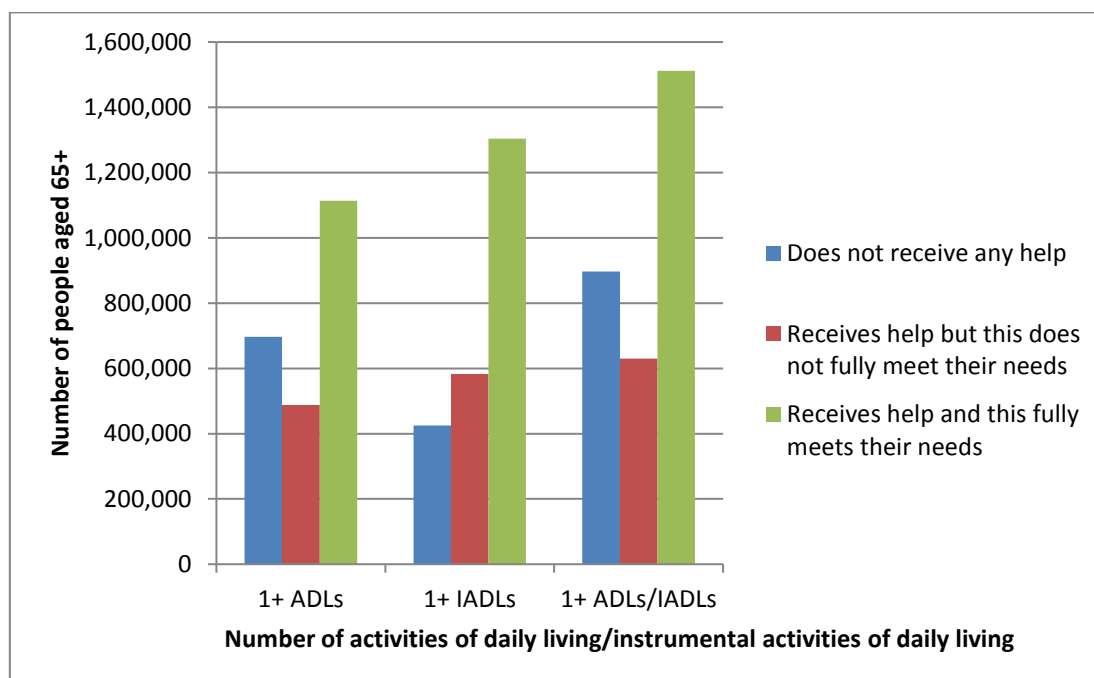
This year Age UK's analysis show there are now nearly 1.2 million people (1,183,900) who don't receive the help they need with essential activities. This represents a 17.9 per cent increase on last year and a 48 per cent increase since 2010. Nearly 1 in 8 older people now live with some level of unmet need with vital everyday tasks.

Furthermore, taking into account instrumental activities (such as shopping and managing medication) as well the figure rises to more than 1.5 million (1,527,300).

As **figure 19** demonstrates, this includes<sup>k</sup>:

- 696,500 people who need help with at least one ADL and receive no help at all;
- 487,400 people living with at least one ADL who do not receive sufficient help to meet their needs;
- 425,500 people who need help with at least one IADL and receive no help at all.
- 583,400 people who need help with at least one IADL and do not receive sufficient help to meet their needs.

**Figure 19: Activities of daily living by whether or not help is received and whether the help meets the need, people aged 65+ in England, 2016**



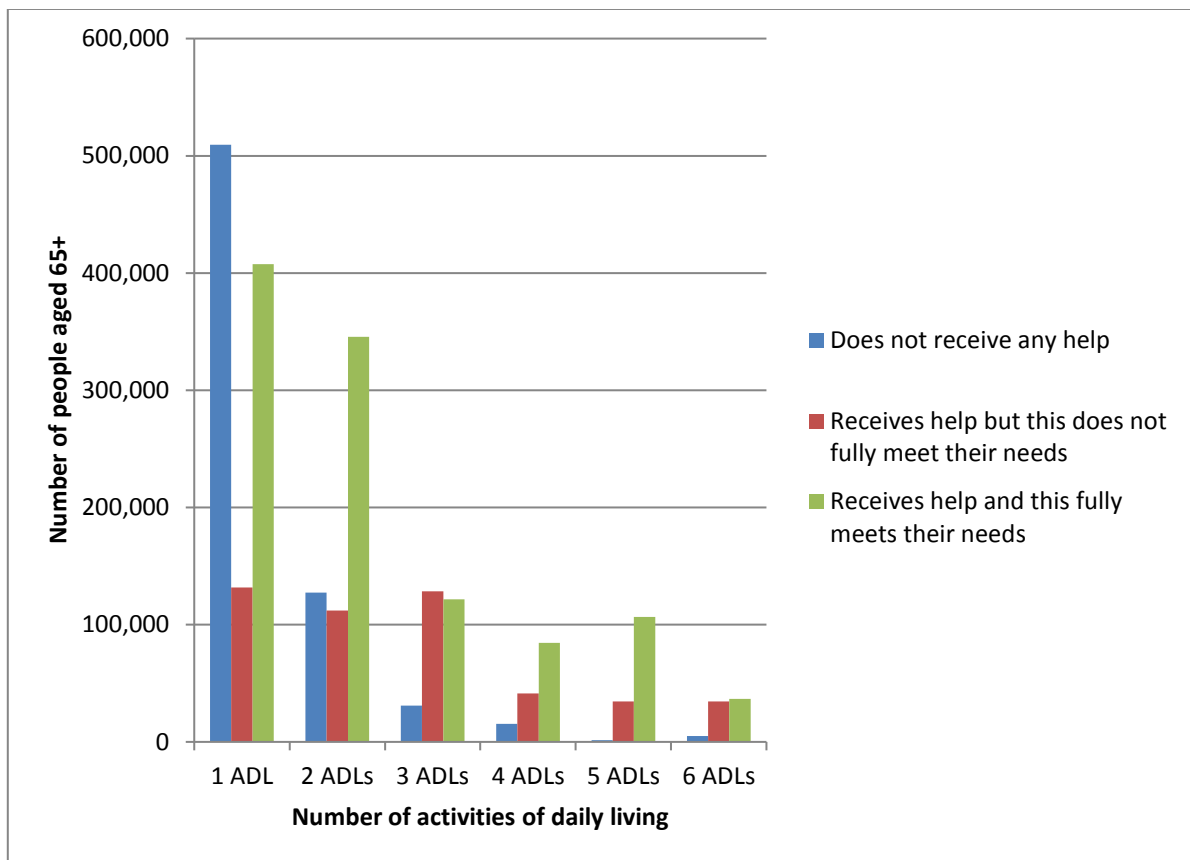
Source: *English Longitudinal Study of Ageing (2016<sup>81</sup>)*

<sup>k</sup> These breakdowns don't add up to the total 1,527,300 as it is possible for one person to have difficulties with both ADLs and IADLs.

The eligibility criteria for care set out in the 2014 Care Act does not draw a precise distinction between ADLs and IADLs, however it is widely agreed that individuals with three or more ADLs, which include tasks essential to everyday life like washing and going to the toilet, would certainly be eligible for support.

It is therefore particularly shocking that there are an estimated 291,400 people aged 65 and over living with three or more ADLs who do not get the help they need; this is nearly half (46.6 per cent) of all those who reported needing help at that level. Worse, we estimate a quarter (52,700) of these individuals receive no help whatsoever.

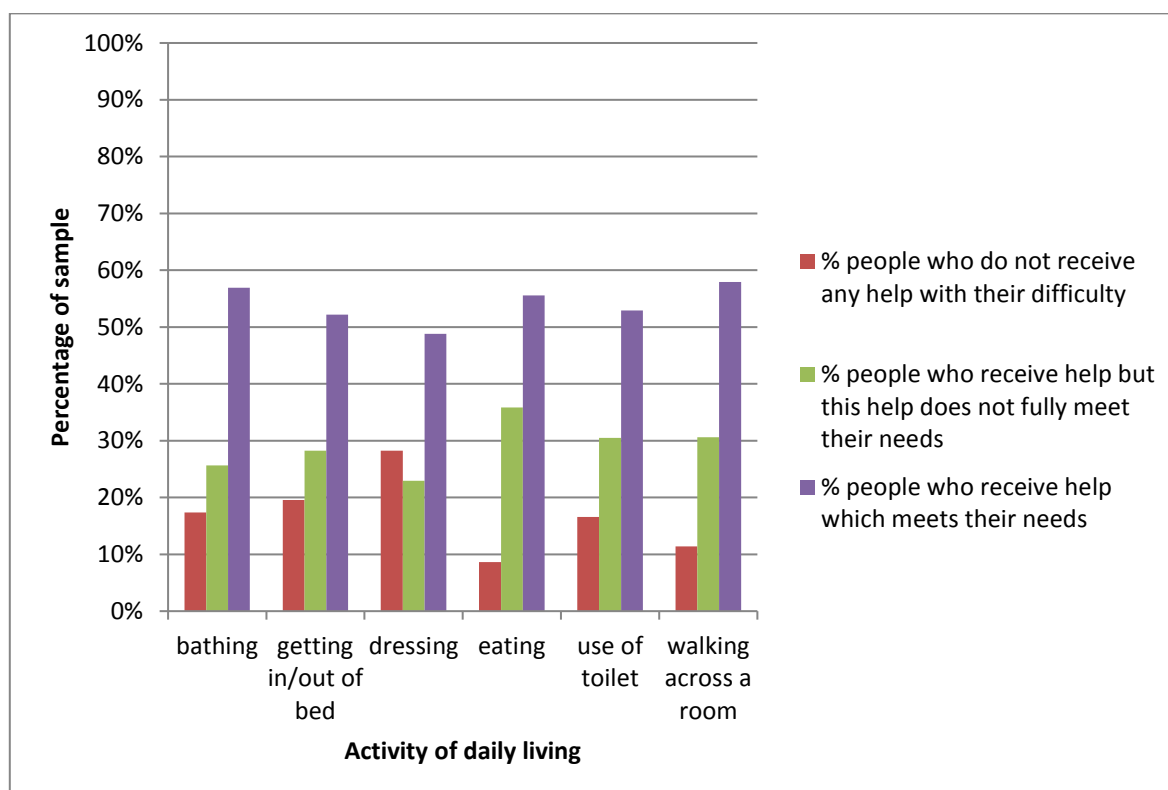
**Figure 20: Number of activities of daily living (ADLs) by whether or not formal/informal help is received or a need is met, people aged 65+ in England, 2015**



Source: English Longitudinal Study of Ageing (2016<sup>82</sup>)

**Figure 21** sets out the percentage of people who report needing help with particular essential everyday tasks. It shows that a little under 1 in 5 people who need help bathing (17.4 per cent), getting out of bed (19.6 per cent) or using the toilet (16.6 per cent) do not receive any support, while only just over half have enough help with these activities to *fully* meet their needs.

**Figure 21: Individual activity of daily living (ADL) by whether or not formal/informal help is received and whether the help meets the need, people aged 65+ in England, 2015**



Source: *English Longitudinal Study of Ageing (2016<sup>83</sup>)*

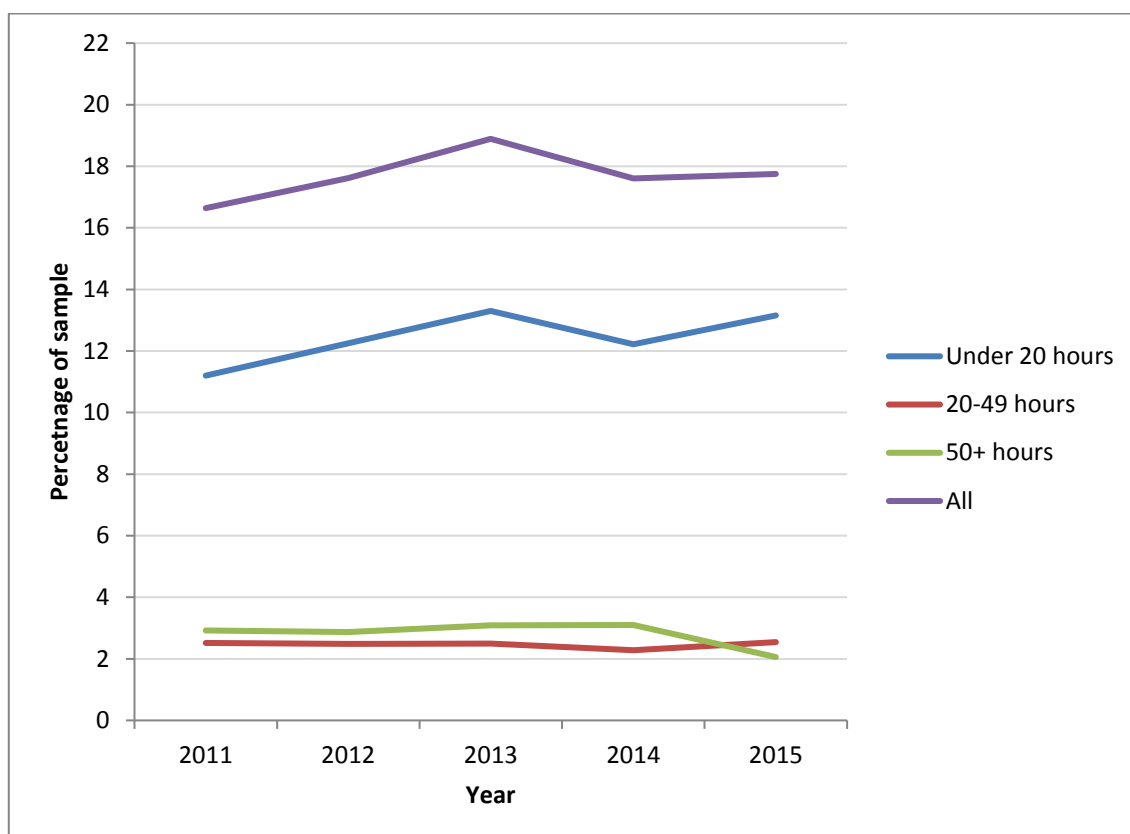
### **Growing pressure on informal care**

Rising levels of need and declining access to local authority care services have also placed increasing pressure on unpaid carers. Indeed there are now serious questions as to whether we are reaching the practical limit of this informal capacity for caring.

The proportion of people who provide unpaid care for family and friends has been slowly tracking upwards in recent years, rising from 16.6 per cent of the population in 2011 to 17.8 per cent in 2015. However, due to overall population growth, the total number of carers is in fact going up much more quickly. In 2011 there were 8.2 million carers,<sup>84,85</sup> while by 2015 these numbers had risen to over nine million<sup>86,87</sup>.

Evidence also suggests that people are caring at greater levels of intensity than in the past with informal carers meeting increasingly complex needs. New analysis by Age UK shows that the average number of ADLs and IADLs of people receiving solely informal support increased over the last 15 years or so, rising from an average of 2.9 in 2002/03 to 3.2 in 2014/15<sup>88</sup>.

**Figure 22: Hours per week spent caring, people of all ages, 2011 to 2015, UK**



Source: Understanding Society (2016<sup>89</sup>)

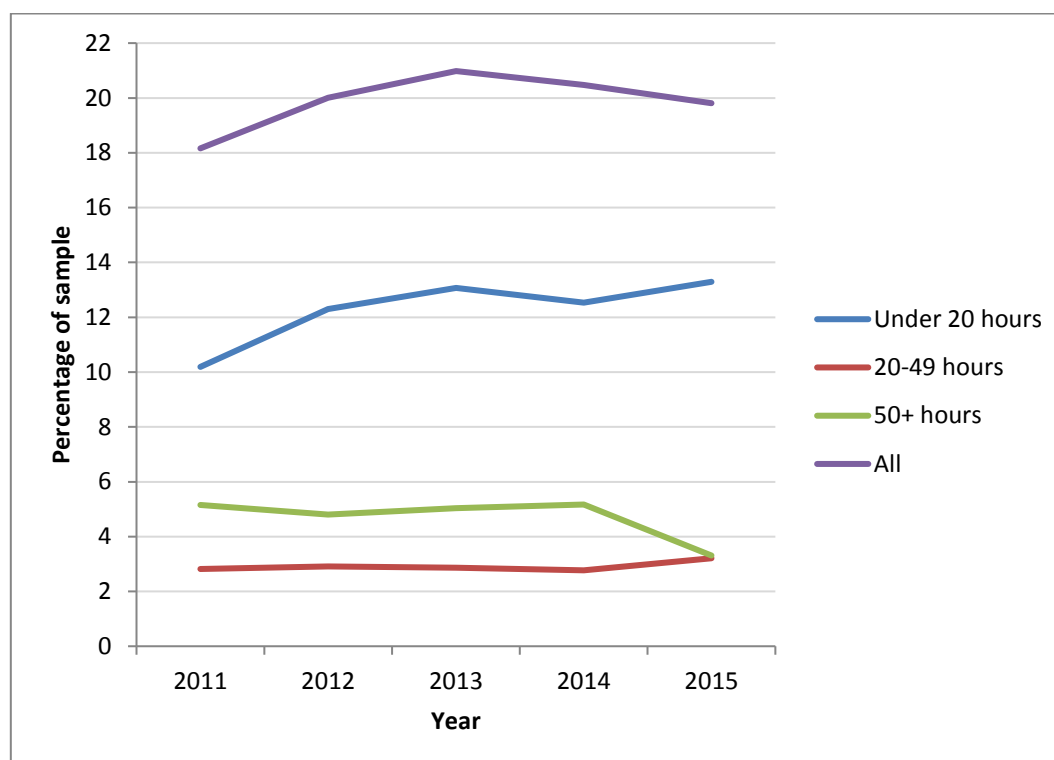
### Older carers

It is also important to recognise that many carers are older people themselves. As **figure 23** demonstrates, with around 1 in 5 people aged 65 and over providing care, older people are slightly more likely to be carers than the population as a whole. There are now over two million carers aged 65+, 417,000 of whom are aged 80 and over.

Older carers are also amongst those most likely to care at high levels of intensity, especially those aged 80 and over caring for a co-resident partner. Indeed, Age UK’s analysis shows over 37 per cent of carers aged 80+ are providing 20 hours or more care a week, while 34 per cent are providing 35 hours or more<sup>90</sup>. Yet nearly two thirds of older carers themselves have a health condition or disability<sup>91</sup>, while 72 per cent of older carers report feeling pain or discomfort, rising to 76 per cent for those who provide 20 or more hours of care a week<sup>92</sup>.



**Figure 23: Hours per week spent caring amongst people aged 65+, 2011 to 2015, UK**



Source: *Understanding Society (2016<sup>93</sup>)*

### **Sustainability of informal care**

The value of the contribution made by informal carers was, according to Carers UK, £132 billion in 2014/15, dwarfing the formal social care system and only just falling short of total expenditure on healthcare<sup>94</sup>. Carers UK have also estimated that, as a result of reduced public funding and growing demand for care, we will need a 40 per cent increase in the number of informal carers over the next 20 years<sup>95</sup>.

The overwhelming scale of the contribution made by family and friends means that even a small shortfall in the proportion of care provided by informal carers would have a large impact on the need for formal care services. However, as **figures 22 and 23** demonstrate, although overall numbers of carers are rising, there has not been a substantial increase in the proportion of the population providing care. New analysis by Age UK has also found that between 2002/3 and 2014/15 the proportion of people needing help with more than one ADL or IADL receiving informal care only rose from 59.6 to 62.1 per cent<sup>96</sup> despite the substantial decrease in local authority provision over that period.

Set alongside rapidly rising levels of unmet need, this strongly suggests that the provision of informal care has not been able to expand significantly to fill the gap left by declining provision of formal care services. Changing family structures, greater geographical dispersal, demands of the workplace (likely to increase with rising State Pension age) and a reliance on older carers, often experiencing poor health themselves, all impact on the capacity of people to care for loved ones. In many cases it is likely to be the sufficiency of care that has suffered as a result – families who are providing support but are simply unable to provide enough to meet all of an individual’s needs.

Taken together, this all points towards families and communities reaching the practical limits of the care they are able to provide in the context of a rapidly ageing population.

## 2.6 Impact of funding cuts on the sustainability of the social care system

Very little of the care funded and/or organised by local authorities is provided directly, the majority is commissioned from the private or third sector. However the care market has become increasingly fragile and dysfunctional as local authorities, often the major purchaser in an area, have driven down the prices they pay to try and manage their own budget reductions. A recent report from the King's Fund and Nuffield Trust has concluded that the market is now in a deeply precarious state, arguing the *'possibility of large-scale provider failures is no longer of question of 'if' but 'when'*<sup>97</sup>.

### **Home care services**

Despite a modest increase in the number of registered locations providing home care services (from 8,168 in March 2015 to 8,458 in March 2016) the picture for local authority funded and/or organised care (accounting for nearly 80 per cent of spending in the market)<sup>98</sup> is nonetheless very unstable.

In 2015/16 48 local authorities reported dealing with at least one home care provider who had ceased trading in their areas, while 59 councils reported at least one provider 'handing back' a contract, meaning they had elected to stop providing services to supported local authority clients<sup>99</sup>. Two of the largest national home care providers have also left the local authority market<sup>100</sup>.

A United Kingdom Home Care Association (UKHCA) survey published in 2016 reported that a further 11 per cent of UK providers thought they were likely to cease trading in the next year and 74 per cent were planning to reduce the amount of local authority funded care they provide - unsurprising given that the same survey found 93 per cent of home care providers said they had faced a real terms reduction in local authority fees in 2015/16, with 20 per cent reporting a cut<sup>101</sup>.

### **Care homes**

The care home sector has not fared any better in recent years. While there has been a nine per cent increase in the number of nursing home beds since 2010, there has been a steady decline in the number of residential home beds over the same period<sup>102</sup>. Moreover there is huge variation across the country, with the reduction in residential beds ranging from 18 per cent in London to two per cent in the East of England. The increase in nursing home beds has been similarly uneven<sup>103</sup>. This represents a significant problem for local authorities and consumers as care markets are hyper-local; it is no use to someone if a suitable, affordable placement is available in Bradford if they live in Bournemouth.

In common with home care services, local authorities are reporting difficulties sourcing care locally with 77 local authorities reported dealing with at least one care home who had ceased trading in their area in 2015/16, and 31 councils reported at least one provider 'handing back' a contract<sup>104</sup>.

### **Social care workforce**

As demand for care services has grown, so has the size of the workforce. There are now around 1.1 million full time equivalent (FTE) roles in the adult social care sector, the vast majority of which are frontline roles directly providing care and support. The overall workforce grew by 18 per cent between 2009 and 2015<sup>105</sup>.

Despite the growing workforce, the care labour market is also showing signs of stress. In 2015/16 the overall vacancy rate in the sector was 6.8 per cent (up from 4.5 per cent in

2012/13) and rising to 11.4 per cent for home care staff<sup>106</sup>. Turnover rates are also high in the sector and have increased, rising from 22.7 to 27.3 per cent a year over the same period. Yet the headline rate also masks greater difficulties in recruitment and retention of key groups of frontline staff, the turnover rate for home care workers and registered nurses was significantly higher than the industry average at 38.1 per cent and 35.9 per cent respectively last year<sup>107</sup>.

### ***Impact on older people and families***

The impact of a distressed market is not just a problem for care providers, but is widely felt by older people and their families as well. It is essential for all care service users – whether they pay for their own care, or receive local authority support or direct payments – that there is a thriving market that supplies a choice of good quality services.

Local authority funded service users are too often experiencing a distressing lack of continuity or poor quality care as carers work under pressure and agencies exit the market or change hands. In other cases older people and families report a real struggle in finding acceptable care at the local authority rate<sup>108,109</sup>. This has a particular impact on people who access (local authority funded) direct payments to organise and purchase their own care.

Furthermore older people and their families entitled to local authority care are frequently being asked to make additional ‘top-up’ payments towards the cost. Laing and Buisson research shows that the extent of these top-ups varies regionally, depending on how wealthy the area is. In North East England, only 18 per cent of residents have to find top ups, but in the South East this rises to 54 per cent. Across the country an estimated 24 per cent (48,000) of care home residents are part funded by top-ups. Laing and Buisson estimate that the size of top-ups varies from about £25 a week to over £100 a week<sup>110</sup>.

People who fund their own care are also increasingly being asked to pay over the odds for services in order to compensate for low local authority payments. Laing and Buisson, in conjunction with Local Government Association members, have carried out research into the extent of these cross subsidies<sup>111</sup>. This research found that 96 per cent of self-funders paid more than local authorities did for the same type of room in the same home. The average level of this premium was 43 per cent.

However it is not just weekly rates where self-funders can find themselves at a disadvantage. A recent report by Age UK found self-funders were also regularly subject to unfair contract conditions in order to help care homes make ends meet, including: long notice periods; upfront ‘administration’ payments; additional demands for payments for services not covered by the contract; and arbitrary rises in fees<sup>112</sup>.

### 3. The state of healthcare

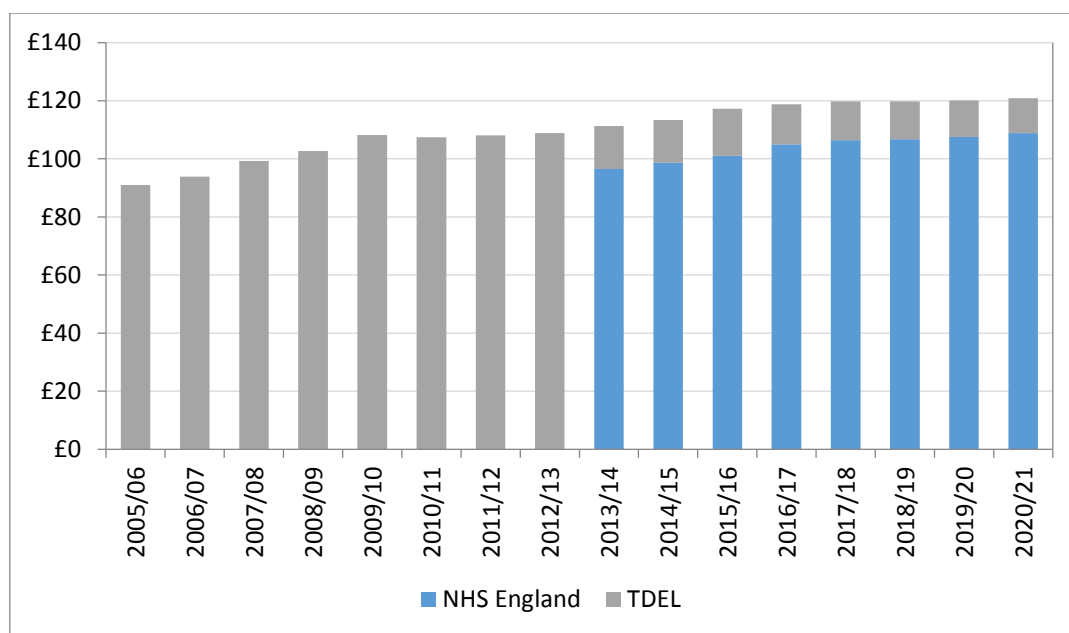
#### 3.1 Trends in public funding of health care services

In terms of headline funding the NHS has fared much better than social care in recent years. Between 2005/06 and 2015/16, the annual budget rose from £91 billion to £117.2 billion in real terms.

The rate of growth remained relatively high between 2005/06 and 2009/10, with funding rising from £91 billion to £108.3 billion at an average of 4.8 per cent increase a year. However, in 2010/11 actually funding fell and was slow to recover, rising from £107.5 billion to £113.4 billion in 2014/15 or an average of 1.4 per cent a year. It is also important to note, as we set out in previous chapters, that this period of funding restraint has coincided with a collapse in social care spending and rapid rise in demand. As a result, despite achieving some funding growth, the NHS has come under unprecedented financial pressure in recent years.

Funding did increase more substantially last year (2015/16), primarily thanks to the additional £2 billion pledged in the 2014 Autumn Statement, however, as we set out below, this has been far from sufficient to plug the growing financial deficit.

**Figure 24: Total department expenditure limit and NHS England expenditure, England, 2005/06 to 2020/21 (2015/16 prices)**



Source: HM Treasury (2016<sup>113</sup>); Department of Health (2016<sup>114</sup>, 2015<sup>115</sup>, 2014<sup>116</sup>), Nuffield Trust, The Health Foundation and The King's Fund (2016<sup>117</sup>)

#### Uneven investment across NHS services

In our 2015 *Health and Care of Older People* report, we set out the sector budget data for hospital services<sup>l</sup>, primary care<sup>m</sup>, community services and mental health care from 2009/10 to 2012/13, the last year of aggregated data from Primary Care Trusts<sup>n</sup>.

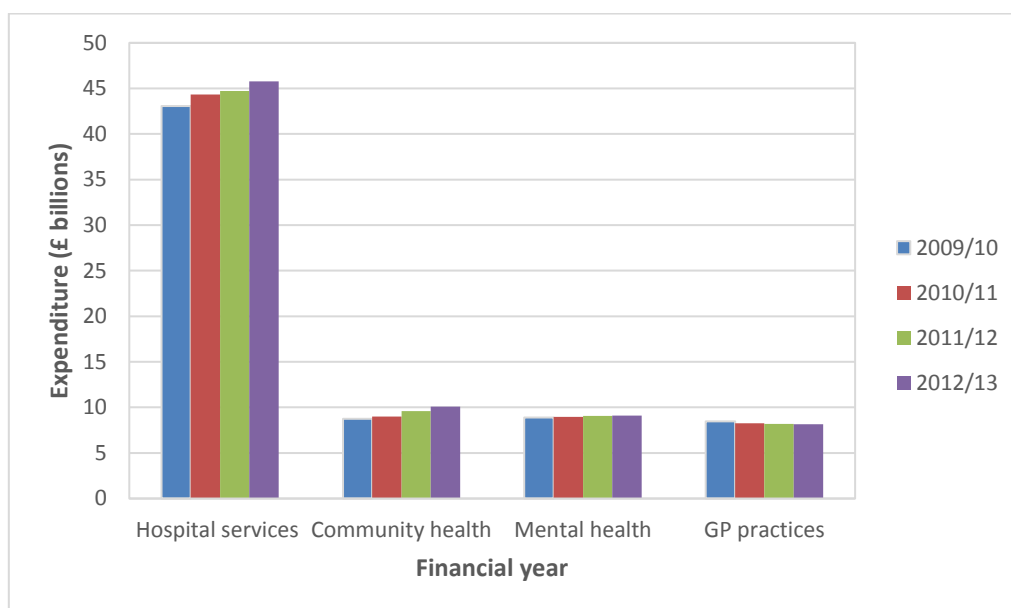
<sup>l</sup> Total spending on general and acute services and accident and emergency services.

<sup>m</sup> Total investment in primary care services net of dispensing and excluding reimbursement of drugs.

As **figure 25** shows, over that period of time investment was not evenly spread across NHS services, with hospital services seeing greater growth in resources and capacity than other services. Indeed spending on hospital services increased from £43.06 billion in real terms in 2009/10 to £45.78 billion in 2012/13, an increase of £2.72 billion or 6.3 per cent.

Yet over the same period the primary care GP services budget fell in real terms by £0.31 billion from £8.45 billion in 2009/10 down to £8.14 billion in 2012/13, while funding for mental health grew by just 2.5 per cent (£0.22 billion), from £8.88 billion in 2009/10 to £9.1 billion in 2012/13.

**Figure 25: Operating expenditure in the NHS by service sector in England, 2009/10 to 2012/13 (2015/16 prices)**



Source: NHS Digital (2014<sup>118</sup>); Department of Health (2013<sup>119</sup>)

While budget data from 2013/14, the first year of Clinical Commissioning Group (CCGs) and NHS England responsibility, is compiled differently it is nonetheless clear that these trends have broadly continued.

As **figure 26** demonstrates the NHS spends the vast majority of its budget on secondary care services. These include NHS Trusts and NHS Foundation Trusts, predominantly made up of acute care hospitals but also including mental health services and other specialist services. In 2013/14 the NHS spent £61.3 billion in real terms on secondary care, rising to £63.15 billion in 2015/16, an increase of £1.84 billion (or 3 per cent).

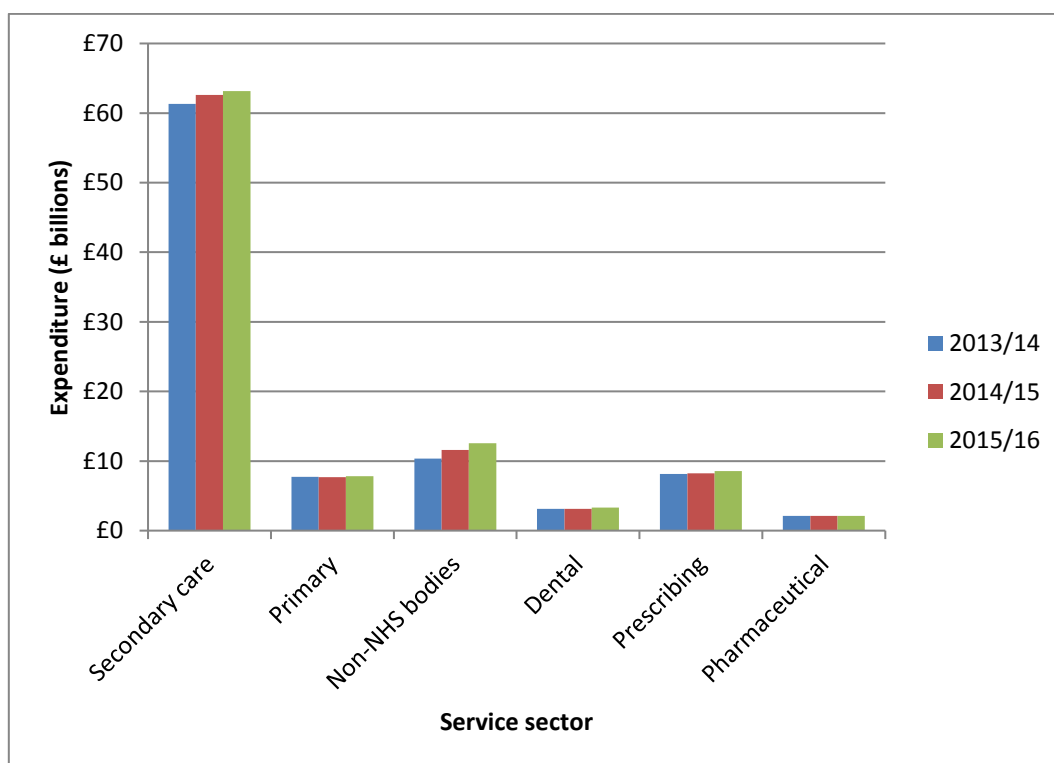
Over the same period spending on primary care (i.e. GP-led services) remained relatively static. In 2013/14 the NHS spent £7.71 billion on primary care, falling to £7.69 billion in 2014/15 before recovering to £7.80 billion in 2015/16 (a 1.1 per cent rise in total).

Furthermore while the biggest growth in funding, from £10.35 billion in 2013/14 to £12.55 billion in 2015/16, came in services commissioned from non-NHS providers (predominantly for community-based services), a significant proportion of this growth is in fact accounted for by transfers for the Better Care Fund activities<sup>120</sup>.

<sup>n</sup> Primary Care Trusts were abolished in April 2013 by the Health and Social Care Act 2012 and their functions transferred to NHS England and Clinical Commissioning Groups.

It is clear secondary care continues to dominate healthcare spending and investment, despite repeated efforts to shift more care into the community and to make better use of primary care. It is true that the most expensive care will always be delivered in hospital, however a King's Fund analysis showed spending on GP services, as a percentage of total NHS funding, declined from just over 8.3 per cent in 2010/11 to 7.9 per cent in 2014/15, its lowest in 10 years<sup>121</sup>. The General Practice Five Year Forward View has set out an ambitious plan to stabilise and transform primary care<sup>122</sup>, but the NHS has a steep climb to reverse historic trends and provide adequate levels of investment across GP services.

**Figure 26: Expenditure by service sector in England, 2013/14 to 2015/16 (2015/16 prices)**



Source: NHS England (2015<sup>123</sup>, 2016<sup>124</sup>)

### **Rapidly growing deficits**

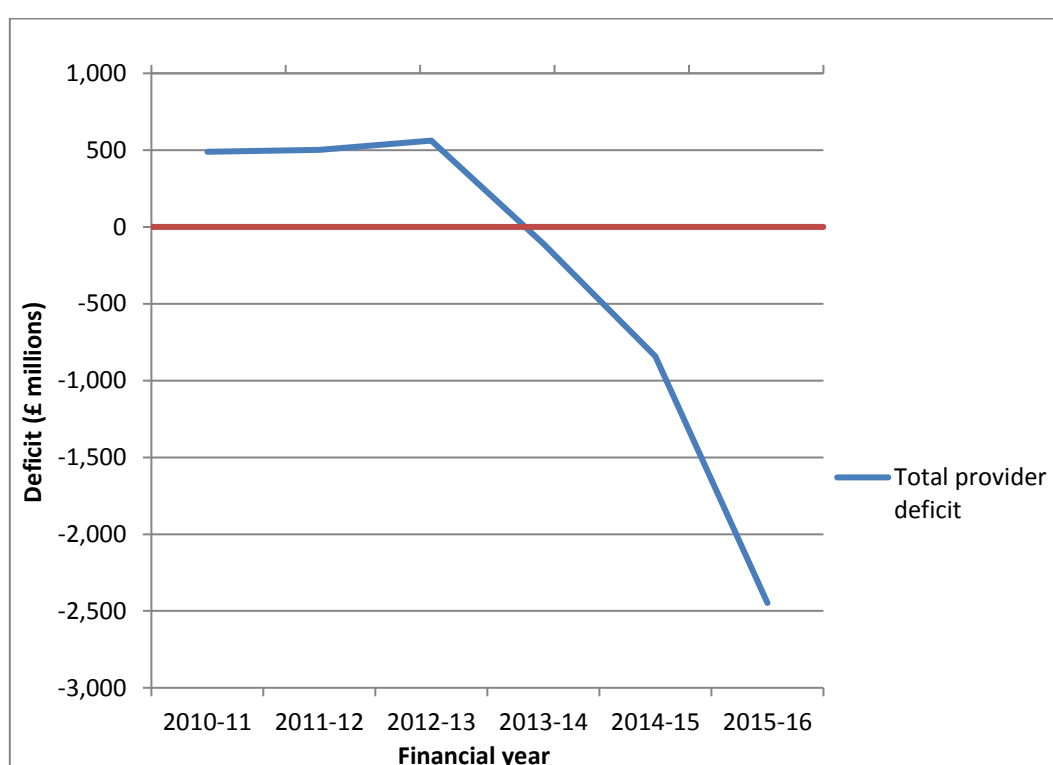
Overall spending on health has increased in nearly all years since 2005/06 and as recently as 2012/13 the NHS service provider sector, including NHS Trusts and NHS Foundation Trusts, had an overall surplus of £562 million (2015/16 prices)<sup>125</sup>. However, since then the financial position of NHS hospitals has deteriorated sharply.

By the end of the 2013/14 financial year the sector was £109 million in deficit and this deficit has accelerated rapidly since, reaching £2.5 billion by the end of 2015/16<sup>126</sup>. In summary, despite increases in funding, money coming into hospitals has not been keeping pace with the costs of running services. This is partly explained by gradual reductions in the amount paid to hospitals for some of the treatments they deliver over recent years. 'Tariffs' are the prices set nationally for many procedures performed by hospitals<sup>127</sup> and they have been reduced by around 1.6 per cent a year since 2010/11<sup>128</sup> as part of national efficiency drives. However, achieving 'safer staffing levels', in the wake of the Mid-Staffordshire Inquiry, has also had an impact with many hospitals seeking to address shortfalls through increased recruitment and agency staff<sup>129</sup>.

In the face of these funding pressures hospitals are pursuing steep savings targets for 2016/17, with cost improvement programmes (CIPs) of around 4.2 per cent of turnover<sup>130</sup> and restrictions on recruitment<sup>131</sup>. To date in 2016/17 NHS Improvement has reported that Trusts have made £1.2 billion of savings, reducing total year to date expenditure by 2.9 per cent and putting them on course for a £669 million year-to-date deficit. A substantial proportion of these savings has reportedly come from controls on agency staff spending, with providers estimated to reduce agency spend by £900 million this year<sup>132</sup>.

Since older people make up 65 per cent of people admitted to hospital<sup>133</sup>, these challenging circumstances will have a disproportionate impact on people in later life. While ending reliance on agency staff is to be welcomed in many respects, it raises concerns that providers are operating under-staffed rather than replacing more expensive agency workers with permanent roles.

**Figure 27: NHS provider net deficit in England, 2010/11 to 2015/16 (2015/16 prices)**



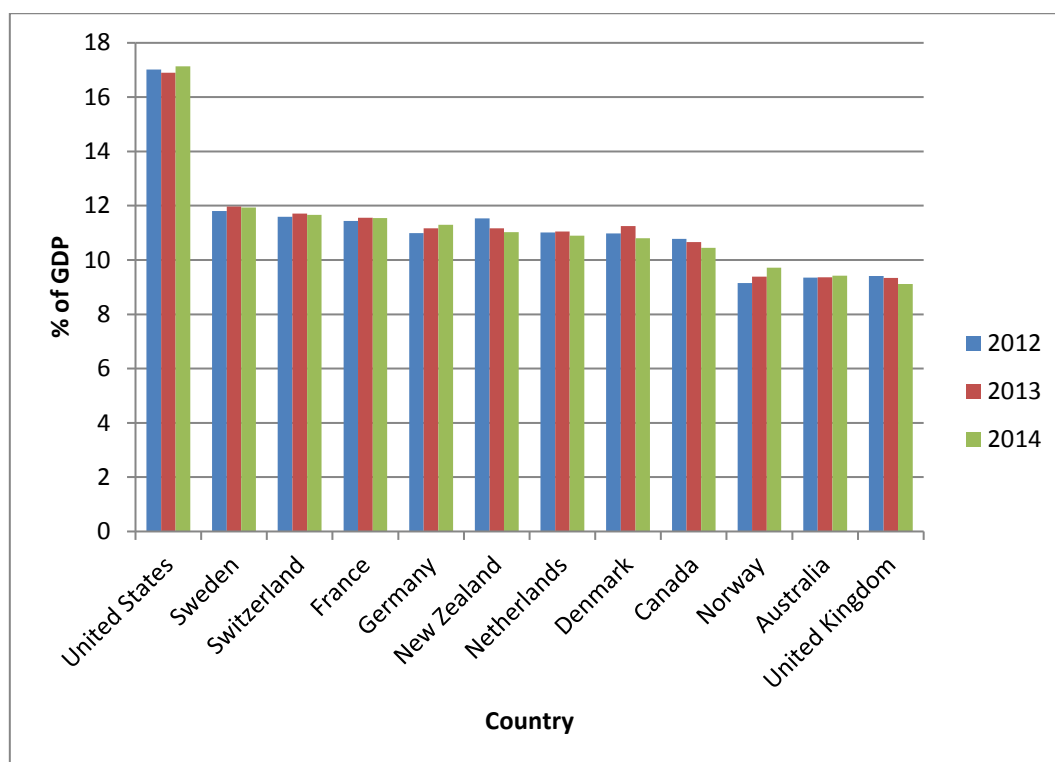
Source: Department of Health (2016<sup>134</sup>)

### **International comparisons**

In 2014, the UK spent the equivalent of 9.12 per cent of GDP on health care, putting it at the lower end of spending with comparable countries<sup>135</sup> and representing a 0.3 per cent drop since 2012. Spending per head of population in the UK was \$3,935 in 2014, compared to \$4,959 in France, \$5,411 in Germany and \$9,522 in Norway<sup>136</sup>. The average spend per head across all OECD countries is \$4,735.

There are some differences in the proportion of total spending coming from public money (with the rest predominantly made up by private healthcare). In France 78.2 per cent and in Germany 77 per cent of spending is publicly funded, compared to 83.1 per cent in the UK<sup>137</sup>. However, the proportion of publicly funded care is higher in both Sweden and Norway, at 84 and 85.5 per cent respectively.

**Figure 28: International comparisons of health expenditure as a percentage of total GDP, 2012 to 2014**



Source: The World Bank (2016<sup>138</sup>)

### 3.2 Future funding 2016/17 to 2020/21

In 2014 the NHS Five Year Forward View estimated the gap between NHS funding and demand would grow to around £30 billion a year by 2020/21<sup>139</sup>. In response in the 2015 Comprehensive Spending Review (CSR) the former Chancellor committed to increase NHS England’s budget by £8 billion in real terms between 2016/17 and 2020/21<sup>140</sup> – this was in addition to £2 billion already allocated to the NHS for 2015/16 through the 2014 Autumn Statement. Even accepting these headline figures, the additional funding agreed nonetheless leaves the NHS with a highly challenging £20-22 billion gap to close through improvements in productivity and efficiency over the period. Furthermore that efficiency challenge will have to be achieved in the context of dramatic reductions in non-NHS provision, particularly social care.

As set out in **figure 24**, the additional £8 billion pledged in the CSR has been ‘front loaded’ with almost half of the additional £8 billion (£3.8 billion or an overall 3.7 per cent funding increase) coming into the 2016/17 budget. As a result funding increases in the latter part of the spending review period will be significantly lower. The rate of growth will drop to 1.3 per cent in 2017/18, 0.3 per cent in 2018/19 and 0.7 per cent in 2019/20 before recovering to 1.3 per cent in 2020/21<sup>141</sup>. Yet predicted levels of unit cost inflation alone are estimated at between 2-3 per cent a year over the period<sup>142</sup> (though experts believe health cost inflation can be as high as six per cent<sup>143</sup>), plus this does not take into account wider pressures on the NHS, including growing demand or the need to invest in long-term transformation.



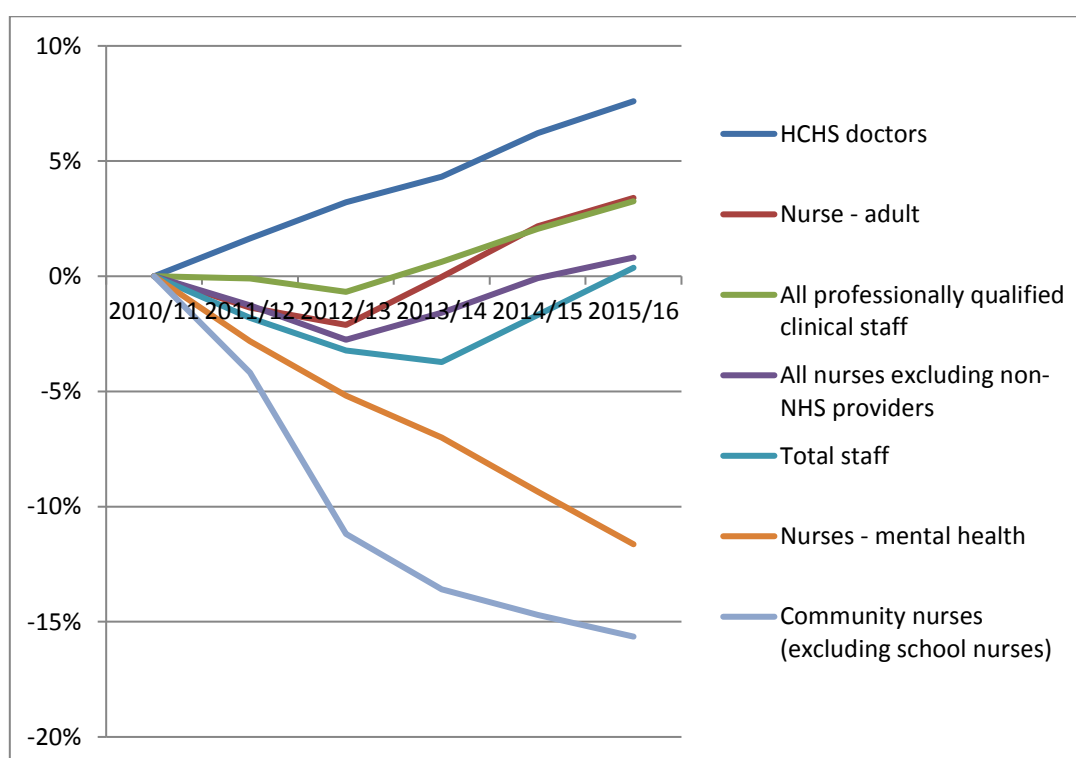
In addition the CSR did not protect or increase the full Department of Health operating budget, only funding for 'frontline' NHS services. Funding for arms-length bodies necessary for running and regulating the NHS (including funding for agencies such as the Care Quality Commission, responsible for ensuring the safety and quality of NHS services, and Health Education England, which oversees the delivery of a comprehensive and appropriately qualified medical workforce) is set to fall from £16.2 billion in 2015/16 to £12 billion by 2020/21<sup>144</sup>. There was also a £200 million reduction in funding to local authorities to deliver public health programmes in 2015/16 with total reductions of £600 million (9.7 per cent) over the spending review period<sup>145</sup>.

As a result the total health budget will grow by little over £2 billion between 2016/17 and 2020/21 and additional savings, over those efficiencies already planned, are likely to be necessary. In addition to further savings in NHS frontline spending, other areas of cost control will likely have long term consequences for the sustainability of the NHS, particularly any moves to reduce training and investment in NHS infrastructure.

### 3.3 Healthcare workforce

There has been relatively little growth in the bulk of the NHS workforce since 2010/11. The total full time equivalent (FTE) staff working in the NHS, excluding primary care and those working for non-NHS providers, in 2010/11 was 1,011,146<sup>146</sup>, dropping to 974,669 in 2013/14 before recovering to 1,014,808 in 2015/16, a growth of 0.4 per cent for the period.

**Figure 29: Percentage growth in FTE workforce since 2010/11 in England, 2010/11 to 2015/16**



Source: NHS Digital (2016<sup>147</sup>)

#### Nursing

As **figure 29** sets out, the overall number of nurses working in adult services has increased, rising 3.5 per cent to 175,820 in 2015/16 and contributing to a 3.3 per cent overall increase in professionally qualified staff. However, the rise in nursing numbers must be seen in the

context of the 2013 Mid-Staffordshire Inquiry recommendations on safe staffing levels, which has seen nursing staff increases predominantly concentrated in acute hospitals. The number of FTE mental health nurses has dropped over this period from 40,275 to 35,998 (10.6 per cent) while the biggest decrease is in community nurse numbers which fell by 13.6 per cent to 33,177 (excluding school nurses).

Declining numbers of community nurses, including district nurses and community matrons, is a particular cause for concern as it affects key services relied on by many older people. Unfortunately it is not possible to gain an accurate picture of the number of nurses working in the community as services provided by non-NHS (i.e. private or voluntary sector) providers are not required to submit workforce information. However although spending on non-NHS providers has increased in recent years, wider evidence suggests that community nursing numbers are indeed under significant pressure.

The Transforming Community Services programme which took effect in April 2011 saw a significant number of nurses transferred to roles in non-NHS providers; however the decline in community nurses pre-dates the programme. Since then there is little indication these trends have reversed.

A King's College London survey of community nursing staff in 2013 found nurses contending with both higher workloads and staff shortages; 83 per cent of respondents agreed there were not 'enough staff to get the work done' and a further 66 per cent reported that 'care is often compromised due to low staffing levels'<sup>148</sup>. These findings are echoed by a 2014 King's Fund report into community services which found a pattern of staff shortages, difficulties in recruitment and caseloads that had become larger and more complex<sup>149</sup>.

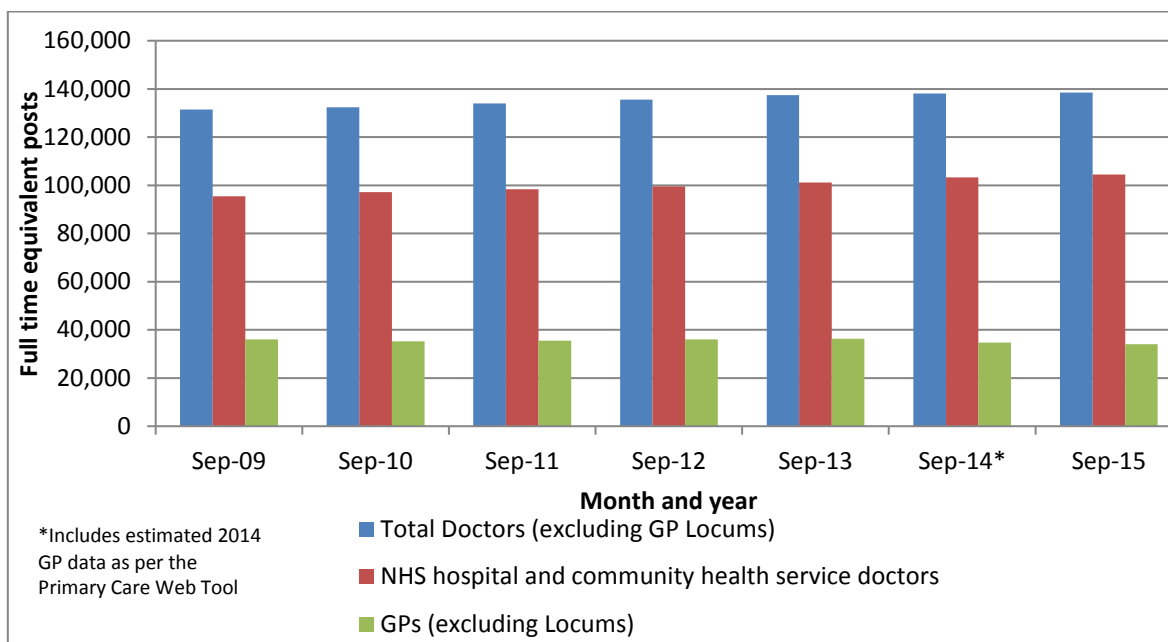
## Doctors

Doctors have been the fastest growing group amongst health care professionals in recent years. **Figure 30** sets out the total number of FTE doctors across hospital, community and primary care services in September of each year. In total their numbers have risen consistently from 132,373 in September 2010 to 138,553 in September 2015, an increase of 4.6 per cent.

However the impact has again been uneven across services. While the numbers of hospital and community health service doctors increased from 97,130 in 2010 to 104,498 in 2015, the numbers of GPs in fact fell by 3.4 per cent from 35,243 to 34,055 over the same period.

This reduction in GP numbers has occurred despite a longstanding Department of Health policy to increase GP training numbers in England to 3,250 a year by 2015. However GP training numbers fell far short of the target, achieving just 2,700 a year between 2010/11 and 2013/14. This cumulative recruitment shortfall has been compounded by rising numbers of GPs leaving the workforce, including GPs approaching retirement<sup>150</sup>. In June 2015 the Secretary of State for Health pledged to increase the GP workforce by 5,000 by 2020<sup>151</sup> to address the shortfall, an ambition reiterated in NHS England's 2016 General Practice Forward View<sup>152</sup>. However in the current context, achieving this pledge is likely to remain extremely challenging.

**Figure 30: Number of doctors by type in England, September 2009 to September 2015**

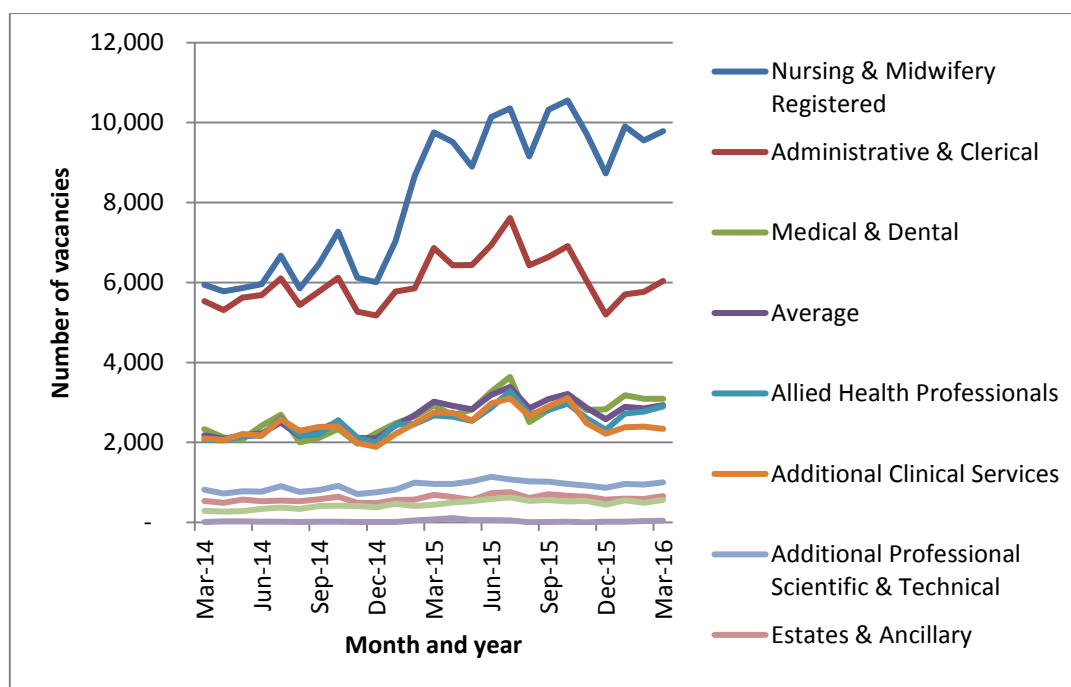


Source: NHS Digital (2016<sup>153</sup>)

### Vacancies

There has also been an overall increase in the number of staff vacancies for NHS jobs. The data collected is currently experimental and should not be used as a definitive picture of the number of unfilled jobs in the NHS. However it provides a useful insight into which job roles are in higher demand and potentially proving harder to fill.

**Figure 31: Number of advertised full-time equivalents published per month in England, March 2014 to March 2016**



Source: NHS Digital (2016<sup>154</sup>)

### 3.4 Trends in primary care and community care

Unfortunately statistics on activity in primary and community care services are not collected nationally, and this lack of data is itself a huge cause for concern. It is clear that demand on primary and community care has been increasing through a combination of: rising numbers of people living with long-term health conditions; growing numbers of frailer older people with complex needs; and the impact of long stated policy ambitions to shift services from acute to primary and community settings. Yet the system fundamentally lacks the data to assess the degree to which primary and community care services are able to cope – and what evidence there is appears to suggest that these services are under severe strain.

#### ***Rising demand in primary care***

Demand in general practice has been growing steadily for the past 20 years.

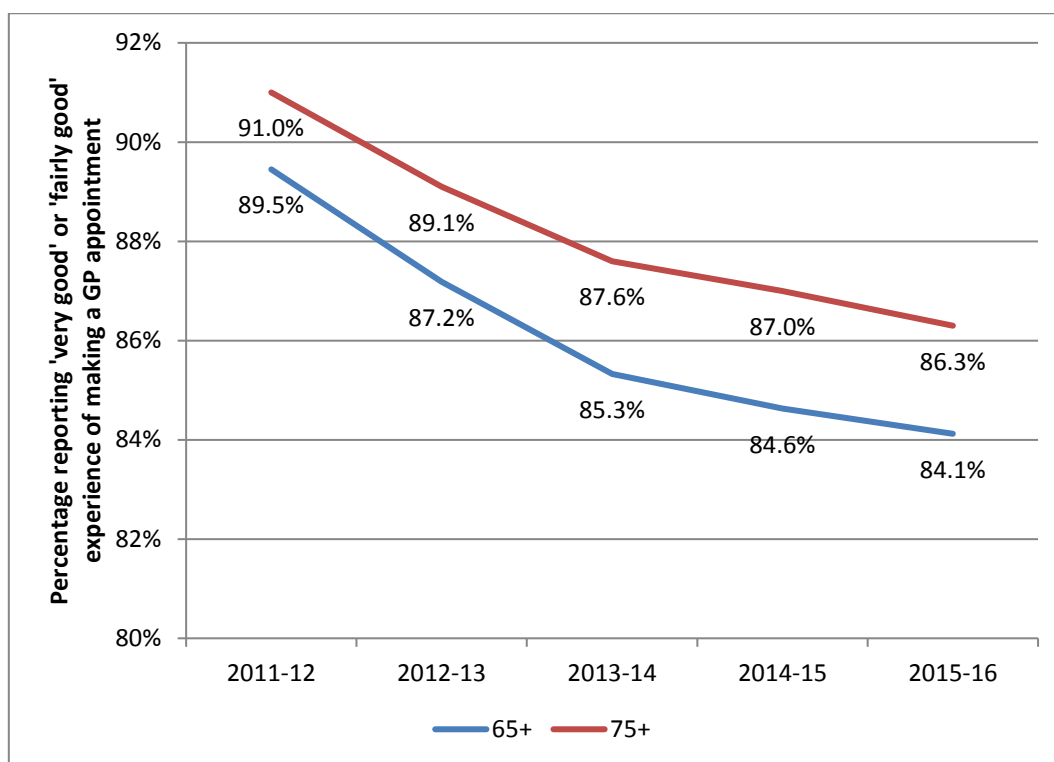
Between 1995 and 2008 a longitudinal study concluded that the number of consultations had grown by 38.3 per cent, from 217 million consultations a year to 300 million. For the average GP practice this means the estimated number of consultations rose from 21,100 to 34,200<sup>155</sup>. Updated analysis by NHS England estimated that consultations would have reached 340 million a year by 2013<sup>156</sup>.

More recently the King's Fund, in their 2016 report *Understanding pressures in general practice*<sup>157</sup>, analysed activity in primary care. Their analysis again found that the number of contacts with patients had increased by 15.4 per cent between 2010/11 and 2014/15. While an increase in the number of people registered with practices was found to account for a proportion of this growth, with practice lists increasing by an average of 10 per cent over the period, the remainder of increased activity is due to a rise in the number of consultations per patient per year, from an average of 4.29 in 2010/11 to 4.91 2014/15. This trend is particularly marked amongst the 'oldest old'. The proportion of total contacts taken up by those aged 85 and over increased by 16 per cent over the period, compared to just four per cent amongst those aged 18 to 64.

However as we set out above, rising levels of activity in primary care have not been matched by any significant growth capacity, and this now appears to be having a significant impact on access to services.

The annual GP Experience Survey has recorded a decline in the number of older people reporting a good experience of getting a GP appointment. In 2011/12, 89.5 per cent of people aged 65+ and 91 per cent of people of those aged 75+ rated their experience as "very good" or "fairly good". By 2015/16 this had dropped to 84.1 and 86.3 per cent respectively.

**Figure 32: Percentage of patients who report a 'very good' or 'fairly good' experience of making a GP appointment, age groups 65+ and 75+, England**



Source: NHS England (2016<sup>158</sup>)

### **Rising rates of ambulatory care sensitive conditions**

Ambulatory care sensitive conditions (ACSCs) are conditions for which effective treatment and management by primary care and community-based services should limit the need for hospital treatment. Common ACSCs in later life include urinary tract infections (UTIs), pneumonia and chronic obstructive pulmonary disease (COPD).

Unfortunately hospital admission rates amongst older people for many ACSCs have risen rapidly over the last 10 years, suggesting that primary and community care services are increasingly struggling to manage demand and/or provide the care people require to stay well at home. In particular it raises questions about whether these services are equipped with the time and resources they need to manage increasingly complex patients, or if their efforts to do so are being undermined by a lack of access to wider services including social care.

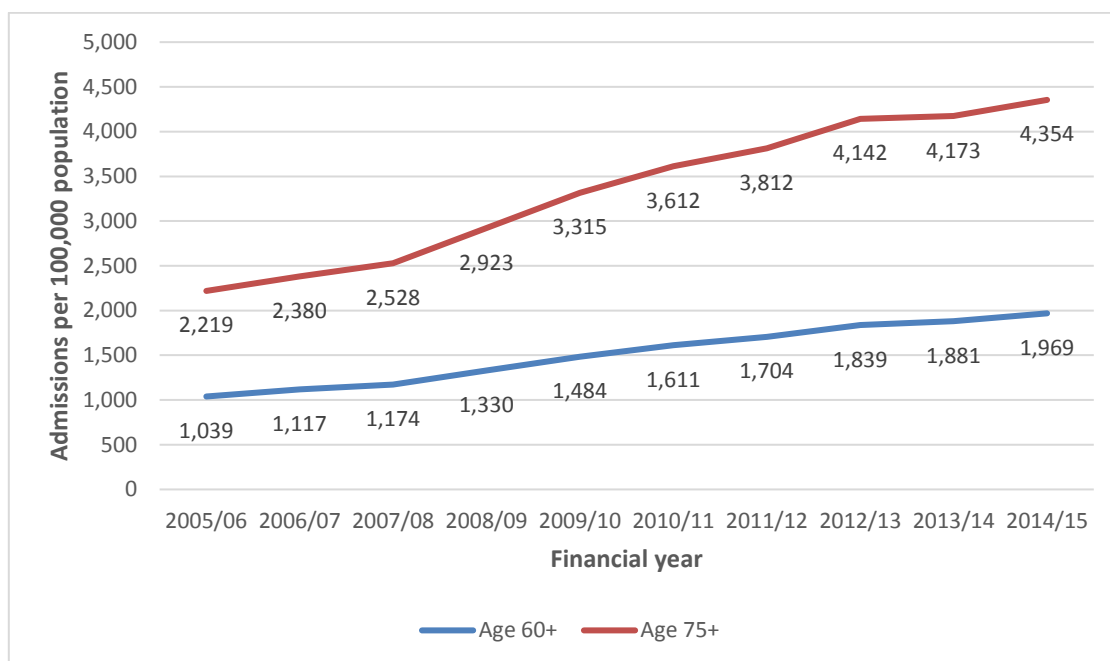
### **UTIs**

UTIs are very common in older people, with older women being particularly at risk. They can be caused by dehydration; difficulty in maintaining personal hygiene (or receiving poor personal care in relation to hygiene); or catheterisation, both in hospital and in the community. They can cause fever, delirium and in more serious cases, sepsis (infection in the blood) and account for 17.2 per cent of all healthcare associated infections (HCAs). Access to good quality community nursing and social care support can often be key in preventing or quickly diagnosing and treating UTIs.

As **figure 33** shows, between 2005/06 and 2014/15, the number of admissions for UTIs went up from 2,219 per 100,000 people aged 75 and over to 4,354, an increase of 96.2 per cent.

These figures may also reveal shortfalls in the management of older people on admission, where a 'dipstick' test and cursory assessment may lead to UTIs being misdiagnosed, over-treated or cause other conditions to be overlooked<sup>159,160</sup>. This rapid increase therefore also speaks to wider problems about inadequacy of assessment when older people come in and illnesses that are preventable both before and during admission.

**Figure 33: Admission rate for urinary tract infections per 100,000 people aged 60+ and 75+ in England, 2005/06 to 2014/15**



Source: NHS Digital (2016<sup>161</sup>) and Office for National Statistics (2016<sup>162</sup>)

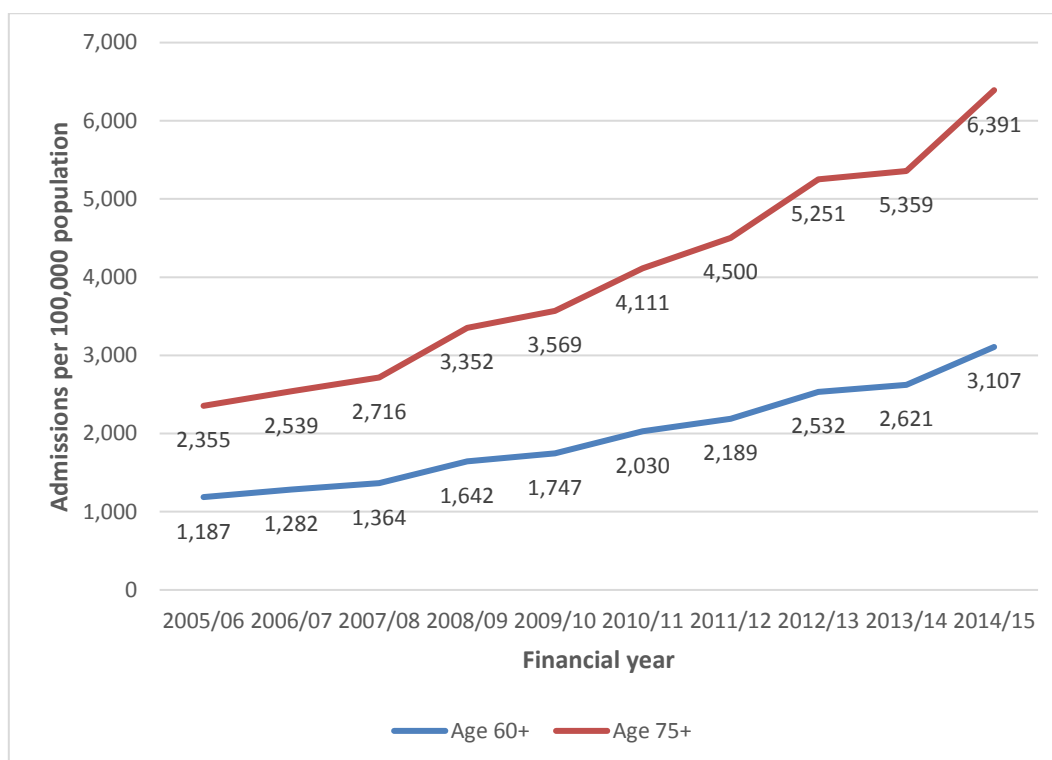
### **Pneumonia**

Pneumonia is the most common healthcare associated infection<sup>163</sup> and age is a specific risk-factor for both suffering from an episode of community-acquired pneumonia (CAP) and having complications as a result. Living with multiple long-term conditions, something more likely to affect older people, increases the risk of CAP<sup>164</sup> and people aged 85-89 years have seven times more episodes of CAP than people aged 65-69 years<sup>165</sup>. More than half of all pneumonia-related deaths occur in people over the age of 84<sup>166</sup>.

Again there has been substantial growth in the number of admissions to hospital for pneumonia, increasing from 2,355 admissions per 100,000 people aged 75 and over in 2005/06 to 6,391 in 2014/15, a rise of 171.4 per cent. The rate of admissions grew by 19.3 per cent in one year alone between 2013/14 and 2014/15.

Common to other ACSCs, these increases could be attributed to poorer access to alternative community-based services<sup>167</sup>. A study published in 2016 examining the reasons behind growing admissions concluded that an ageing population alone was not a factor<sup>168</sup>. Instead it pointed to the fact that some low-severity cases are now presenting to hospital when they would previously have been managed in primary care<sup>169</sup> and the pressure on hospitals to discharge people more quickly following an admission<sup>170</sup>; again suggesting that struggling primary and community care services are at least part of the problem.

**Figure 34: Admission rate for pneumonia per 100,000 people aged 60+ and 75+ in England, 2005/06 to 2014/15**



Source: NHS Digital (2016<sup>171</sup>) and Office for National Statistics (2016<sup>172</sup>)

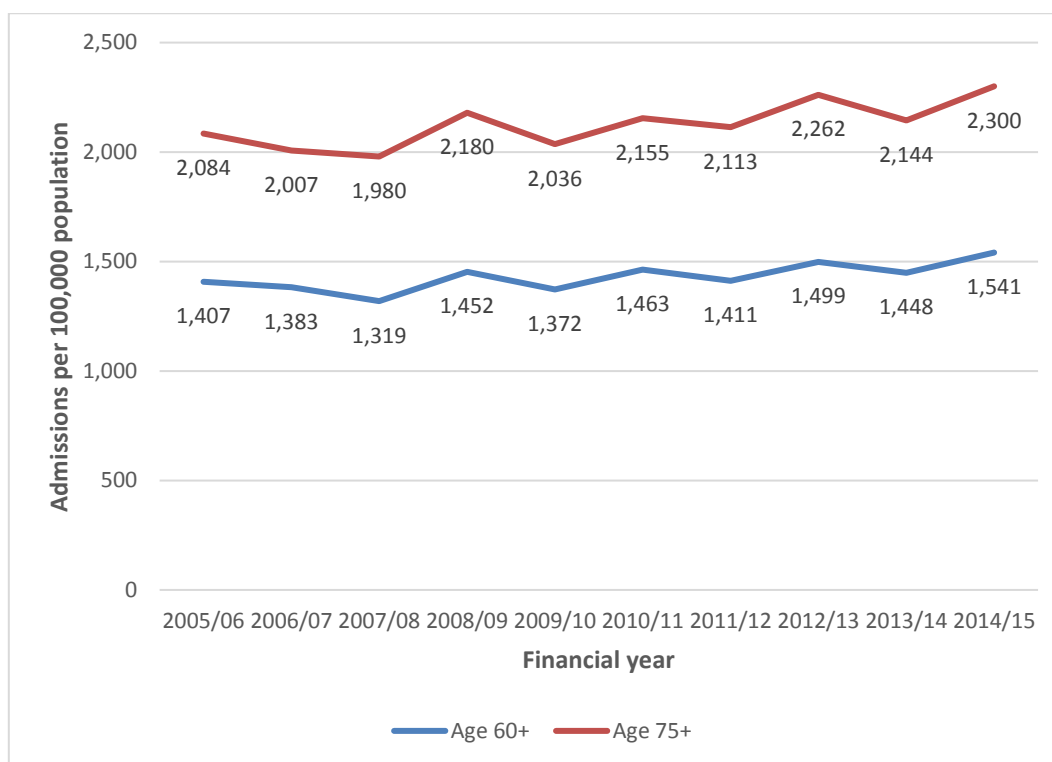
## **COPD**

Chronic obstructive pulmonary disease (COPD) is a long-term condition that causes breathlessness, severe coughing, and limits a person's ability to be physically active. The risk of COPD increases as we age, with older men at greater risk compared to women<sup>173</sup>. Overall prevalence is estimated at 8.9 per cent for all people aged 75+<sup>174</sup>.

COPD is also the long-term ACSC causing the highest rate of unplanned admissions to hospital for people aged 75+. COPD admissions for those aged 75+ have been slowly tracking upwards for many years, increasing by 10.4 per cent from 2,084 in 2005/06 to 2,300 per 100,000 in 2014/15. This compares to a small drop in COPD admissions for all ages<sup>175</sup>.

Living with multiple long-term conditions, which is increasingly the norm amongst older people, can exacerbate COPD and complicate treatment, particularly where other conditions are not addressed at the same time<sup>176</sup>. National Institute for Health and Care Excellence (NICE) guidance on older people recommends treatment in hospital for people with severe co-morbidities<sup>177</sup>, which may help to explain why overall rates of admissions have increased over the past 10 years. However, these factors also suggest that a combination of poor COPD management alongside poor management of comorbidity in older populations is impacting on preventable hospital use.

**Figure 35: Admission rate for chronic obstructive pulmonary disease per 100,000 people aged 60+ and 75+ in England, 2005/06 to 2014/15**



Source: NHS Digital (2016<sup>178</sup>) and Office for National Statistics (2016<sup>179</sup>)

### 3.5 Trends in secondary care

Despite attempts to reduce demand for acute sector activity, including shifting services and care into community settings, hospital activity for older people has been increasing across the board in recent years, both for routine and elective services as well as urgent and emergency care.

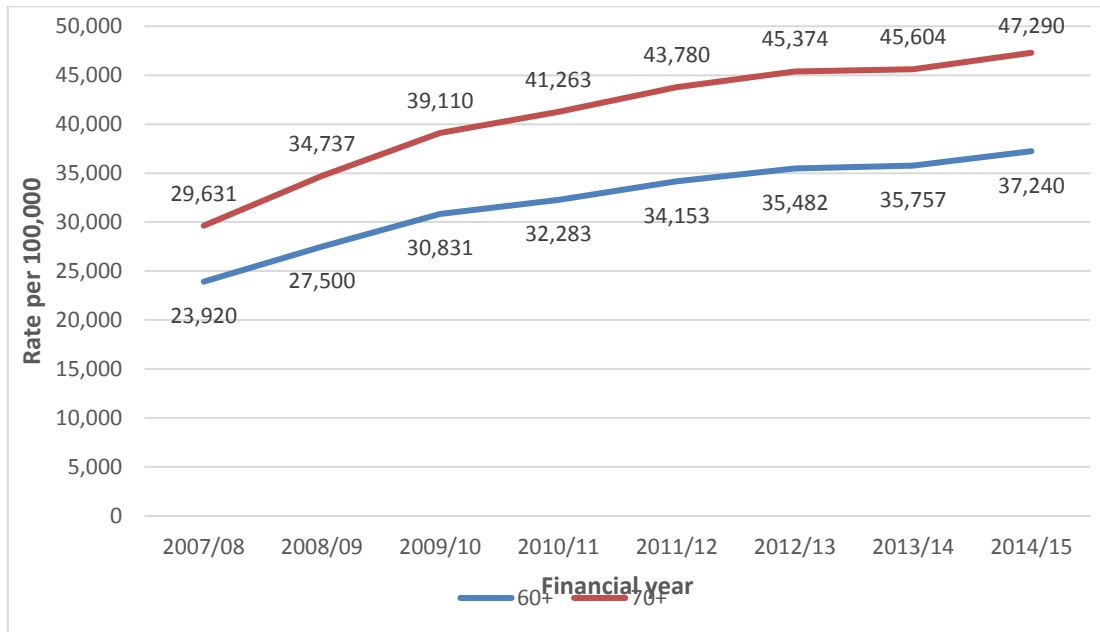
#### Rising demand for urgent and emergency care

The numbers of older people attending accident and emergency (A&E) departments have increased significantly in the last five years alone. In 2009/10 there were 30,831 attendances per 100,000 of the 60+ population, by 2014/15 that had risen to 37,240 – an increase of 20.7 per cent over the period. Meanwhile attendances amongst people aged 70+ increased from 39,110 to 47,920 per 100,000 (a 22.5 per cent increase).

Although the overall majority of A&E attendances are amongst those under the age of 65, older people are more likely to attend and often present with more complex needs that take time to manage appropriately. Indeed, the 2015 NHS Benchmarking report calculated that while people aged 65+ represented 23 per cent of total A&E attendances in 2015, they made up 46 per cent of all admissions from A&E<sup>180</sup>, meaning older attendees were substantially more likely to need further inpatient care than younger adults. On both counts, it is clear that rapid increases in A&E attendance amongst older people are a significant contributing factor to growing pressure on A&E departments.



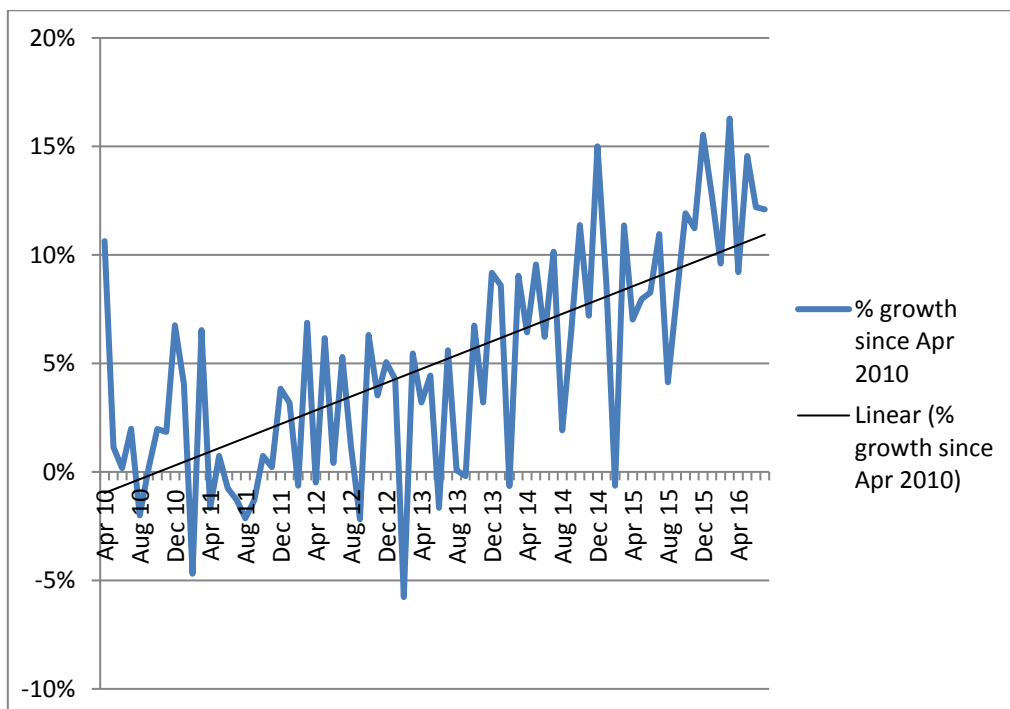
**Figure 33: Accident and emergency attendances per 100,000 of people aged 60+ and 70+ in England, 2007/08 – 2014/15**



Source: NHS Digital (2016<sup>181</sup>) and Office for National Statistics (2016<sup>182</sup>)

More broadly emergency admissions are increasing as a whole, including admissions from other services or initiated by a GP. In April 2010 there were 434,087 emergency admissions amongst people of all ages. By April 2016 this had increased by 9.2 per cent to 474,060. While data is not available by age, it is likely that emergency admissions amongst older people specifically are rising rapidly, mirroring the trends observed around A&E attendance.

**Figure 34: Percentage growth in emergency admissions as compared to April 2010 (all ages)**



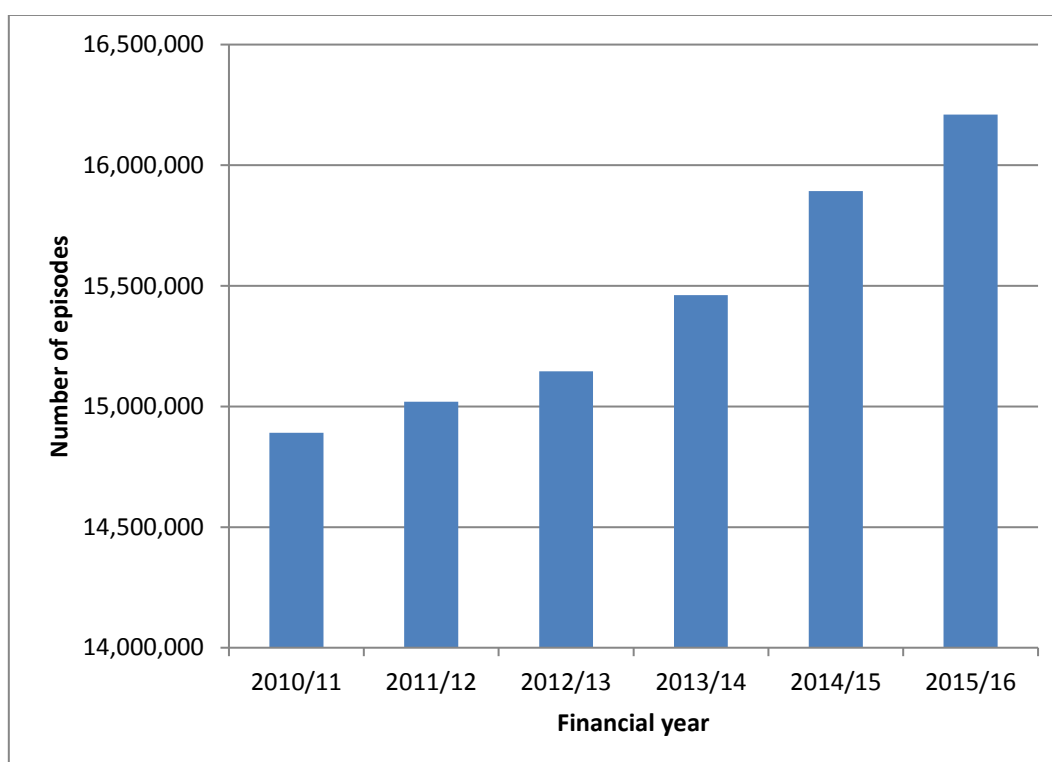
Source: NHS Digital (2016<sup>183</sup>)

### ***Increasing levels of inpatient activity***

The overall number of hospital inpatient episodes has risen significantly in recent years as well, increasing by 8.9 per cent from 14.9 million a year in 2010/11 to 16.2 million in 2015/16. Older people account for around 65 per cent of these admissions<sup>184</sup>.

Finished admission episodes relate to a single continuous stay in hospital rather than a single patient or course of treatment. As a result growing numbers of admissions may point to more people being admitted multiple times in a year rather than just an overall increase in the number of people needing inpatient care. Rising levels of urgent and emergency care set alongside rapidly increasing admissions for ACSCs do indeed suggest that indeed some people are becoming reliant on repeat inpatient care.

**Figure 36: Total finished admission episodes in England, 2010/11 to 2015/16 (all ages)**



Source: NHS Digital (2016<sup>185</sup>)

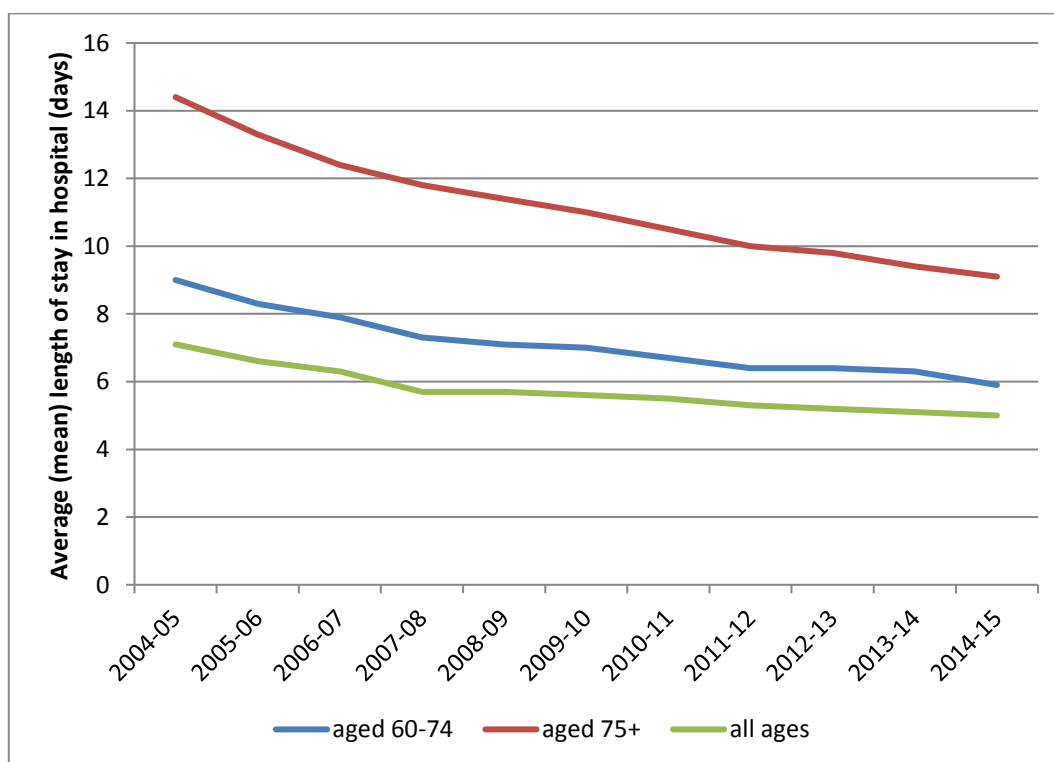
### ***Patchy progress on length of stay***

The length of time someone stays in hospital has consistently fallen over the last ten years, as shown in **figure 36**. This has been driven by a number of factors including better availability of procedures that can happen in a single day<sup>186</sup>; an acknowledgement that people may be more at risk of de-conditioning during long stays; and wider efforts to reduce the number of beds in the hospital sector, contributing to the UK having amongst the fewest hospital beds per 1,000 people in OECD countries<sup>187</sup>.

This fall applies across age groups, but older people generally stay longer in hospital, with people aged 75 and over staying an average 9.1 days per admission in 2014/15 compared to an average of five for all ages<sup>188</sup>. This largely reflects the fact that older individuals are likely to have more complex cases and require greater support to ensure a safe and effective discharge.

Yet we also know that care can be disjointed, and rather than addressing a person's needs in a single package of care, older people can find they are moved multiple times within the hospital with no single team taking overall responsibility<sup>189</sup>. Older people are also at higher risk of hospital acquired infections, a fall in hospital<sup>190</sup> and of losing functional capacity, which can in turn extend their length of stay. These figures also hide a small, but increasingly significant, proportion of people that stay for more extended periods. NHS Benchmarking have established that five per cent of people in hospital stay for 21 days or longer, accounting for 41 per cent of all bed days<sup>191</sup>. As will be covered later, this is in the context of increasing growth in delayed transfers of care out of hospital into the community, which further stretch the capacity of the hospital sector.

**Figure 36: Average length of hospital stay amongst people aged 60+ in England, 2004/05 to 2014/15**



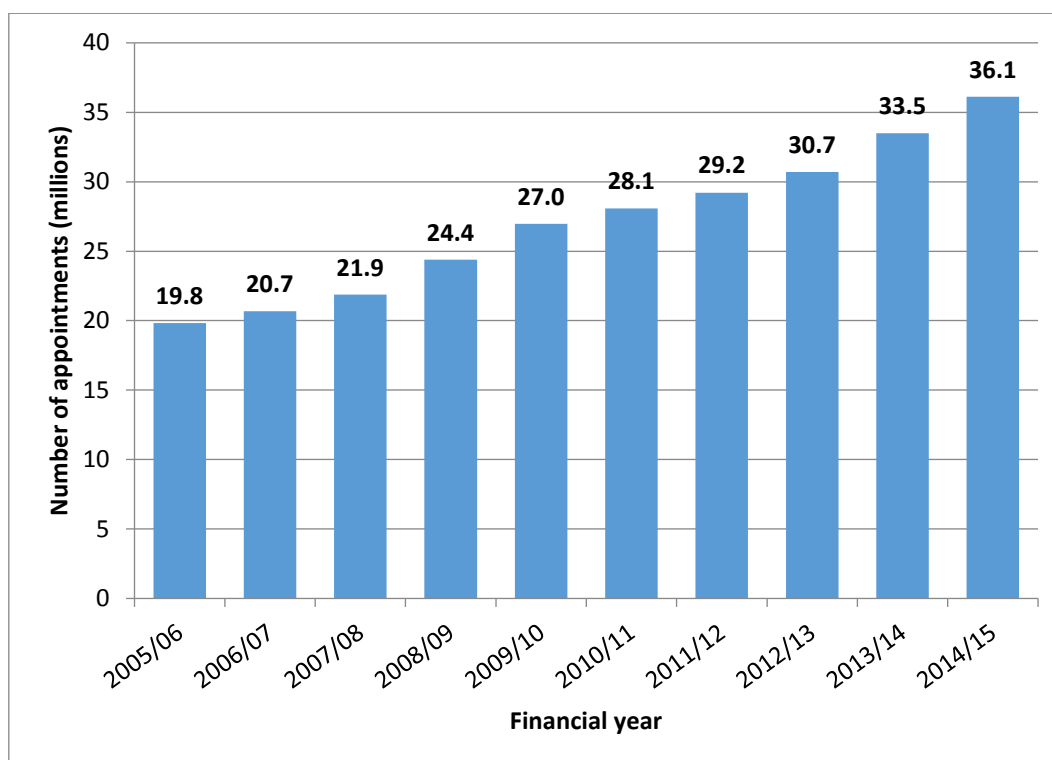
Source: NHS Digital (2016<sup>192</sup>)

### **Increasing levels of outpatient activity**

Alongside increasing inpatient activity, since 2010/11 there has been significant growth in outpatient appointments including, for example, diagnostic appointments, check-ups for pre-existing conditions, or minor procedures.

Between 2010/11 and 2014/15 the number of outpatient appointments amongst people aged 60+ increased by 28.5% from 28.1 million a year to 36.1 million. Once again this increase far exceeds the increase in the overall numbers of people in this age group. Effective use of outpatient services is essential in managing many long-term conditions and for reducing longer-term needs. However, poorly coordinated services can also lead to multiple and repeat visits across different specialties.

**Figure 35: Outpatient appointments amongst people aged 60+ in England, 2005/06 – 2014/15<sup>193</sup>**



Source: NHS Digital (2016<sup>194</sup>)

### 3.6 Pinch points in the system

There is growing evidence that current deficits in the provision of health and social care services are causing ‘pinch points’ within the NHS.

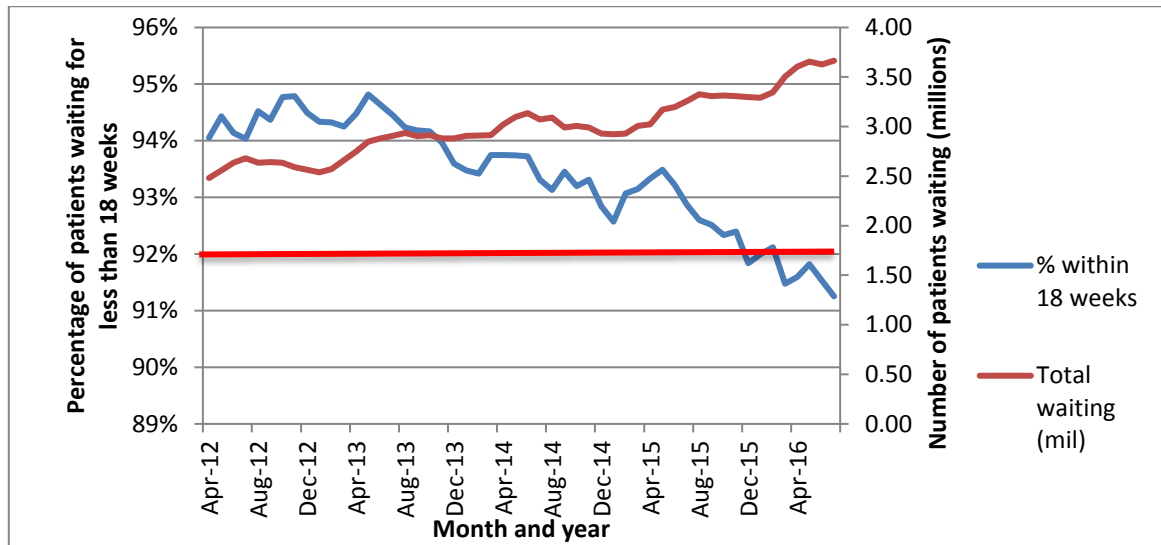
With the NHS, and hospitals in particular, under an obligation to meet need when it arrives at their door, it is the case that activity levels will keep rising in line with demand, which helps to explain huge deficits in the provider sector. Yet it is also clear that rising demand and constrained resources are having a detrimental impact on quality and access as the NHS grapples with challenge of providing appropriate care in the right place for more patients, particularly a rapidly rising number living with multiple conditions and complex needs.

#### Increasing waiting times

Since 2008 the NHS has been required to treat people following referral within 18 weeks, with providers required to ensure a minimum of 92 per cent of patient start their treatment within this timeframe<sup>195</sup>. However these standards have been slipping. As **figure 36** sets out below, in 2012 the percentage of people who began treatment within 18 weeks was over 94 per cent, peaking at nearly 95 per cent. Since early 2013 these numbers have been in decline hitting a low of 91.3 per cent in July 2016, with the 92 per cent standard last being met in February 2016.

Furthermore there has been a substantial increase in the number of people on waiting lists, reaching 3.66 million in July 2016<sup>196</sup>. This represents an increase of 33.1 per cent since April 2013. If you also count the last available figures from the ten NHS Trusts that did not submit data in the latest round then the figure is just short of four million people waiting<sup>197</sup>, the highest numbers since before the 18 week target was introduced.

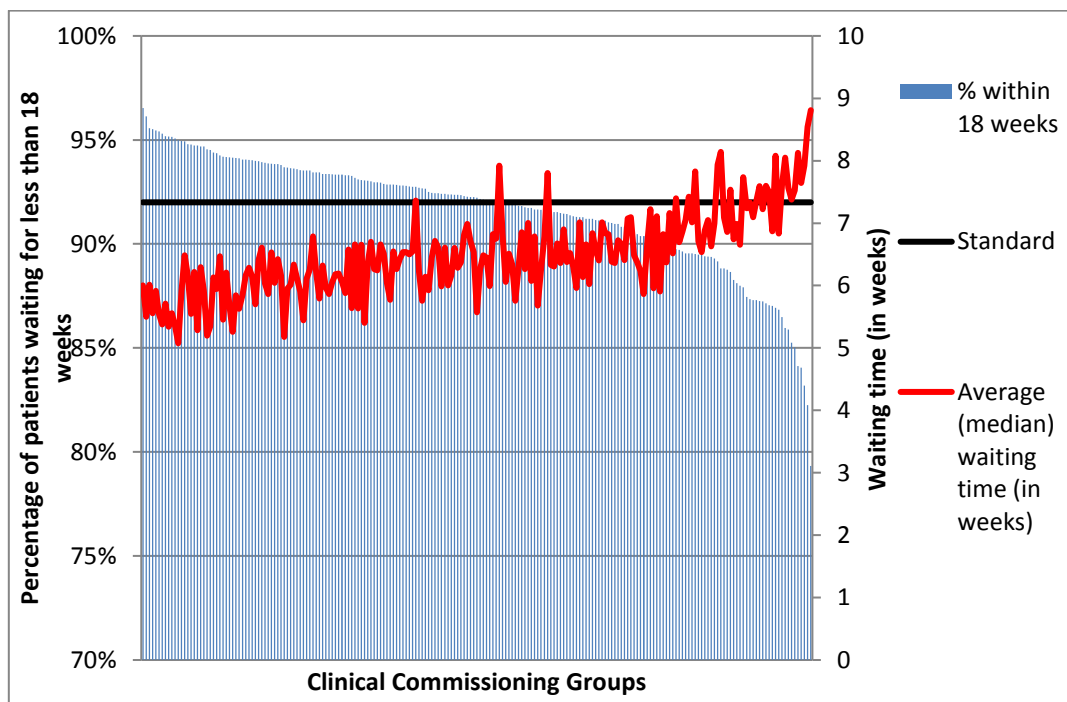
**Figure 36: Percentage and total number of patients waiting 18 weeks from treatment to referral in England, April 2012 to July 2016**



Source: NHS England (2016<sup>198</sup>)

There is also huge variability in how long people are waiting for treatment depending on where they live. As **figure 37** shows, in the best performing CCG area 96.5 per cent of people are waiting less than 18 weeks to begin treatment, while in the worst performing area this drops to just 79.3 per cent. In terms of the average waiting times, people in the worst performing areas are waiting on average 3.7 weeks longer for treatment compared to the best performing (8.8 weeks against 5.1 weeks). This also means that 45.5 per cent of clinical commissioning groups are not meeting the 92 per cent standard set by NHS England.

**Figure 37: Percentage of people waiting less than 18 weeks to begin treatment and average waiting time by clinical commissioning group (July 2016)**



Source: NHS England (2016<sup>199</sup>)

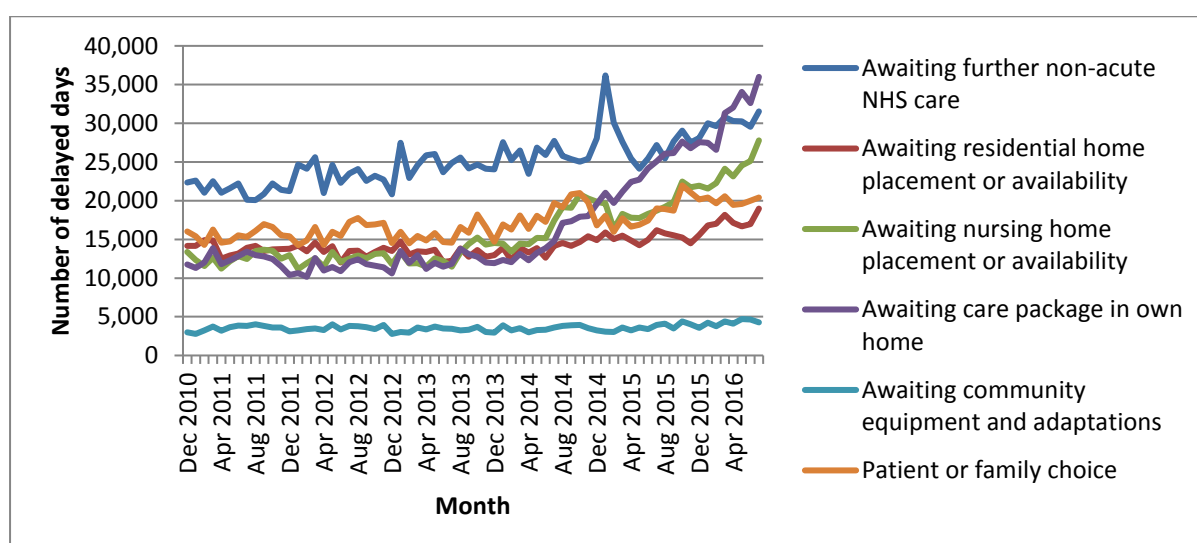
## Rising levels of delayed discharge

Many people accessing hospital services are experiencing significant delays in being discharged home or into the care of another NHS service, such as a rehabilitation unit. Historically, waiting for further non-acute NHS care, for example community or mental health services, was the leading cause of such delays. However while days lost to delays for non-acute NHS care have continued to track upwards, delays attributed to waiting for a home care package have now rocketed from fifth to first place, overtaking NHS care as the leading cause of delays in March 2016. Between August 2010 and July 2016 the number of delayed days attributable to packages of home care had increased by 181.7 per cent from 12,777 to 35,994 delayed days. Over the same period waits for nursing home placement or availability have also seen a similarly disproportionate rise of 103.8 per cent (from 13,632 days in August 2010 to 27,786 in July 2016), while waits for residential care placements have increased 40 per cent from 13,459 to 18,973.

Overall, the number of days lost to delayed transfers of care have been rising over the past six years, increasing from 109,918 in August 2010 to 184,188 in July 2016 (or by a total of 67.6 per cent). However a large part of this growth has occurred since 2014/15. For example since the beginning of 2014/15 the number of days delayed waiting for a care package in your own home has more than doubled. Yet at the same time the total number of people waiting has risen at a much slower rate (28.8 per cent) suggesting waiting times for each individual are getting longer rather than a rapid rise in the number of individuals waiting.

Longer stays in hospital can increase the risk of adverse events such as falls, healthcare acquired infections (such as pneumonia and urinary tract infections) and reduced mobility through loss of muscle mass. Therefore, delayed discharges mean that older people are not only at further risk of adverse events but they also are likely to go home in worse health than they otherwise could have been. For the system as a whole, this further highlights the pressure of poor availability of social care services in people's homes and the significant pressure this creates on hospitals at a time they are least able to afford it. The National Audit Office (NAO) examined this issue in 2016, concluding that 2.7 million hospital bed days are needed by older people that no longer have acute needs at an estimated cost of £820 million<sup>200</sup>.

**Figure 38: Number of monthly delayed days by reason amongst people of all ages, England, August 2010 – July 2016**



Source: NHS England (2016<sup>201</sup>)

## 4. Fit for the future?

This report makes two things uncomfortably clear: that we aren't remotely where we need to be yet in creating the right health and care system for our growing older population, and sadly that many of today's older people are suffering as a result.

Most starkly, 1.2 million older people with a social care need in England don't receive the help they need and their numbers are rising every day, as the State funded system retreats. The tell-tale signs that we're seriously off the pace in terms of adjusting our health and care system to meet the needs of an ageing population are there. They include the growing numbers of care providers shutting up shop; the struggle to get people to work in the care sector and retain them - with similar issues in parts of the NHS too; and problems right across the NHS in being able to respond to the demands being placed on it.

The pressures on hospitals at the moment, especially in A & E, are dominating the news headlines but really they are simply the most visible manifestation of a whole system that is struggling to cope, many of whose most fundamental problems lie in the unglamorous, day to day work to sustain older people's health and wellbeing at home, all of which is struggling and elements of which are in marked decline, most notably State funded social care.

This is increasingly well understood by NHS leaders and it is why they say that social care must receive more funding: they can see how serious the consequences of underfunding social care are for our health provision. For if a lack of social care clogs up the throughput of patients in hospitals, because older people cannot be safely discharged, then everyone who needs a bed is adversely affected.

The Government's overall policy intention is, in Age UK's view, the right one: to join up services across health and care and bring them closer to older people, in order to help them to retain their independence for as long as possible, with trips to hospital reserved for the occasions when their medical conditions demand it. However, the problem at present is that we are an awfully long way from realising this vision, we fear in large part because there is not enough funding to achieve it.

The NHS and councils are working hard to produce and implement a Sustainability and Transformation Plan (STP) in each of forty four areas across England, designed to help their local health and care system evolve to meet changing needs. But unfortunately, against the context of growing funding pressures in the NHS, much of the debate about these STPs has, understandably, so far often been negative. This is because there of a suspicion that these plans are more about taking money out, typically through reducing spend in hospitals, than about morphing services 'for the right reasons' – e.g. to align with changing demography.

Somehow, we have to wrest back the debate about the STPs to a more positive place, because they are the best hope we currently have of getting our health and care system into a position in which it is better equipped to meet the needs of a growing older population. It would be hugely helpful if the Government injected more resources into the STP process, specifically to smooth the transition from where local health and care systems are now to where they decide they need to get to.

We need to recognise that however tough things are now, they threaten to get a lot worse: the numbers of over-85s in our society, the most frequent users of our health and care services, are set to rise rapidly over the next two decades. This means we have to move fast in driving the necessary changes in health and care because otherwise we will fall so far behind we will be unable to catch up.

In Age UK's view there is simply no avoiding the fact that a growing ageing population brings a requirement for more investment in health and care services, just as when the numbers of births go up it means more primary school places will be required four or five years down the track. However, governments have been reluctant to accept this and commit the necessary resources to drive and support reform, and their failure to do so over many years goes a long way to explaining why we find ourselves in such a difficult position today.

When you track the trends in funding over recent years it becomes clear that NHS spending has fluctuated; sometimes plateauing or even declining in real terms when it should have been steadily rising in response to an increasing cost base and growing demand. The upshot is that we now spend less per head on health services here than the OECD average, and we also have fewer hospital beds per head.

Social care, always the NHS's poor relation, has struggled financially for even longer and really what we see now is the result of policymakers tragically underestimating its strategic significance and consistently underfunding it. The previous Government and, so far, this one, have responded to the growing problems in social care by propping it up just enough to stave off complete collapse, with sizeable cash transfers from the NHS and by allowing councils to raise a local Council Tax precept. In addition, some Ministers have been suggesting that 'families must do more'.

However, this report suggests that all three responses are living on borrowed time: the NHS is itself under such financial stress that it is hard to see how it can keep 'bailing out' social care; the Council Tax precept is unlikely to raise as much money as hoped and the areas with the greatest social care needs tend to have lower tax bases. In addition, new analysis carried out for this report suggests that we may be close to hitting the buffers when it comes to the numbers of informal carers who are able and willing to look after loved ones, for although the numbers of carers are continuing to increase numerically, they are not doing so as fast as the population of older people is growing overall. Further considerations are that many carers are themselves older and so there are limits to what we should ask them to take on and that they can physically do; and, of course, an increasing number of older people do not have any families living nearby or, sometimes, at all.

Another approach which is being suggested by some as a potential solution is for the voluntary sector to step in to alleviate the pressures on the NHS and social care. Voluntary organisations already make a difference to many older people with health and care needs, and many policymakers think that we could, with the right support, do more. For example, some organisations, including Age UK, have developed innovative, evidence based services, 'wrapped around' the needs of older people - exactly the kinds of services we need to ramp up, according to experts.

However, even on the most optimistic analysis there aren't enough voluntary sector services like these to make 'the difference' that our older population of approaching twelve million requires, within an acceptable timescale. In fact, at the moment, low level, voluntary sector support services are tending to wither away, because the council funding which once sustained them has fallen catastrophically and there is no obvious substitute funding stream. So the reality is that the voluntary sector can help but, for reasons of pace and scale, the primary role in tackling the problems facing health and care today must lie with the State and thus with Government.



If you believe, as Age UK does, that the current situation cannot be allowed to go on then you may conclude, like us, that the need for a proper discussion about how we fund the sustainable, joined up health and care services our growing older population needs cannot be put off any longer. So it is good news that the Government has recently established a review of social care and integration, led by a new team of civil servants working out of the Cabinet Office.

It is important that this review is wide as well as deep, and is allowed to go to where the evidence takes it, even if this means it runs up against some 'sacred cows' – such as the possibility of raising taxes on income or wealth. The review must also be realistic about just how much or little money different older people actually have, and what their outgoings are – for despite suggestions in some quarters that the older population has, effectively, 'never had it so good', there are huge differences in income and wealth among the nearly twelve million older people in this country, with the great majority not especially comfortably off at all.

There will be no easy solutions to the crisis in social care but the huge public interest in the kind of country we want to live in, after the EU referendum, means that in some ways now is actually a very good time to debate how we best care for our growing older population, and how we pay for it. For surely, this goes to the heart of our identity as a nation and who we want to be. This is why at Age UK we think it is crucial that the review has a public-facing element so that everyone, including older people themselves and their families, and health and care professionals at the sharp end, can have their say.

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